Annual Director of Public Health Report 2021/22

People, Partnerships, Place

Seizing new opportunities to improve health

Barking & Dagenham

Foreword

Welcome to my public health report for 2022, in what continues to be unique times, as we go on to manage and recover from the pandemic. COVID-19 has shone a light on inequalities within our communities and has deeply changed our lives. This, combined with the cost of living crisis and the extraordinary demands on our health and care services, will have a major long-term impact on Council services, residents, and local businesses.

Over the years my Annual Reports have argued for the development of integrated care approaches focused on population health need. Many of our older residents are living longer with multiple, complex, long-term conditions and increasingly need long term support from many different services and professionals. Also, the focus can't just be about older adults, prevention and delivering early intervention services for parents, children and families is as important in breaking the generational cycle of health inequalities to support children and young people to enjoy good health across their life course.

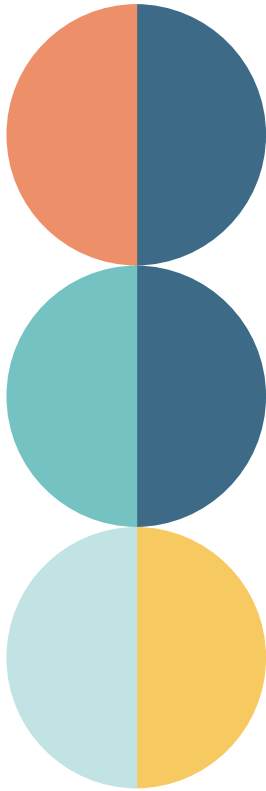
Consequently, residents young and old too often receive disjointed care from services that are not effectively co-ordinated around their needs. This can negatively impact their experiences, lead to poorer outcomes, create duplication and inefficiency. To deliver support that better meets needs of the population, different parts of the NHS, voluntary sector, schools, social care and wider Council services need to work in a much more joined-up way.

This is a fundamental principle of Integrated Care Systems (ICSs), which, following the passage of the 2022 Health and Care Act have been formalised as legal entities with statutory powers and responsibilities. However, it is important to recognise its limitations. It is not possible to legislate for collaboration and co-ordination of local services; this requires changes to behaviours, attitudes and relationships among staff and leaders right across the system. However, stronger local decision making is central to completely changing the relationship between our residents, the NHS and the Council, in deciding the delivery approaches we take to achieve the best outcomes, at the right cost.

We are therefore refreshing our Joint Local Health & Wellbeing Strategy for the period 2023 -2028 to give a vision and clarity to outcomes the ICS needs to improve. But, as most issues impacting on people's health are outside of the health service, the heart of this will be tackling health inequalities supported by the value of relationships and connecting with residents in designing or delivering changes in services, to meet the individual needs and characteristics of our communities.

My report gives a professional perspective that informs this approach based on sound epidemiological evidence and analysis taken primarily from our Joint Strategic Needs Assessment 2022. I hope my observations in the following chapters act as a starting point for identifying 'where to look' before 'what to change' and finally how to change, with the introduction providing a context setting as we recover from the pandemic and manage the impact of the cost of living crisis.

Chapter 1 continues my theme over the years of using the opportunities provided by population health management to advance the design and delivery changes by learning from residents, the frontline and building a roadmap to 'spread, scale, and sustain'. I make the case for using the delegated NHS responsibilities for Barking & Dagenham to speed up integrated care delivery at locality level by using population



health management to drive real change. To achieve this, we need to be outcome and quality driven and place-based focused, with multidisciplinary teams working together in localities to maintain unified care, which meet needs to effectively manage demand. This should be supported by data transparency and sharing to ensure streamlined care.

Chapter 2 follows on to explore the opportunities to improve outcomes for children and families through the lens of the 0-19 Healthy Child programme and national initiatives such as Start for Life and Family Hubs. I consider 'what good looks like' and how this can be developed to benefit residents through the new arrangements for the ICS and locality working.

Chapter 3 shares the steps we have taken to address health inequalities through population level interventions using borough assets to promote healthy lives and highlights areas where we need to do more. Effective place-based action requires action based on civic, service and community interventions, along with system leadership and planning, indicating more can be done system wide through our new partnership arrangements.

In the final chapter I discuss the scale of health protection work to protect residents from the impacts of COVID-19. The UK COVID-19 Inquiry has been set up to examine the UKs response, impact experienced and to learn lessons for the future. The Inquiry's work is guided by its Terms of Reference and in response to the Inquiry, I reflect on how we successfully managed through the first three waves of the pandemic, learn to adapt our ways of working, live with restrictions, and prepare for its ongoing management.

As we approach the challenge of winter, we know that vaccine hesitancy remains a significant issue. For flu, the personal risk perception is likely to have reduced following limited case numbers in recent seasons. For COVID-19, learning to live with the 'new normal' may also lead to lower interest. Together with the UK Health Security Agency we will be putting significant efforts into promoting the importance of vaccination, mainly amongst groups with the lowest uptake, greatest vulnerability, and lowest vaccine confidence. National and local advertising campaigns will begin shortly, and there will be regular briefings available on the epidemiology of both viruses and vaccine uptake data.

I hope you find the 2021/22 Report of the Director of Public Health for Barking and Dagenham of interest and value. Comments and feedback are welcome and should be emailed to **matthew.cole@lbbd.gov.uk**.

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

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Introduction

Last year's Report was written in the middle of the pandemic and its clear the indirect impacts of COVID-19 will have a greater and lasting impact on health and wellbeing across our communities, and our own commitment of *"one borough; on community; no-one left behind"*.

I highlighted how our residents were more impacted and at greater risks of COVID-19 infection due to the poor health many of our residents' face, the same is true of the current threats to our health and wellbeing. In this report I look at what those threats are, what we are doing and how by working on evidence-based, collaborative action we can reduce the risks and improve the health of our residents.

Getting Back to Business

This annual report signals a start of a new period when we get 'back to business' with addressing inequalities and putting equity at the heart of all we do.

The Health Foundation and Institute of Health Equity published Building Back Fairer as an evidence-based approach to putting health equity at the centre of post-pandemic recovery. It suggested that long standing issues of poor health and widening health inequalities were a basic reason for the UK doing worse than other countries during COVID-19, in respect to infections, deaths and economic damage. We need to place the following 'Marmot Principles' (see figure 1) and associated indicators at the heart of what we do, including our new Joint Health and Wellbeing Strategy in 2023.

1. Increase and make equitable funding for social determinants of health and prevention.
2. Strengthen partnerships for health equity.
3. Create stronger leadership and workforce for health equity.
4. Co-create interventions and actions with communities.
5. Strengthen the role of business and the economic sector in reducing health inequalities.
6. Extend social value and anchor organisations across the NHS, public services and local authorities.
7. Develop social determinants of health in all policies and implement Marmot Beacon indicators.

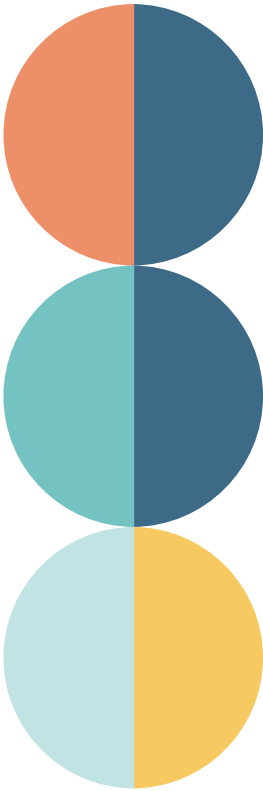
Figure 1: 'Marmot Principles' for a fairer, healthy society

Common Language and Focus

Over the last year major work has been undertaken to develop the emerging Integrated Care Systems and the elements that sit within the borough (e.g. the Place Based Partnership). A key learning from the process has been- even with the same aim there is a lack of common language, focus or approach across the health sector.

Key terms that are used regularly are used to mean different things. So, it is important we are clear on key concepts that provide the basis of our work (figure 2 describes some of these pictorially):

- **Deprivation** – Lack of the usual resources often considered necessary for life (e.g. unemployment, poor housing, social isolation, etc.)
- **Poverty** – Lack of the usual financial resources often considered necessary for life
- **Health inequalities** - Avoidable and unfair differences in the health and wellbeing of groups and individuals which are avoidable and can be reduced



- **Health equity** – Everyone has a fair opportunity to be as healthy as possible
- **Proportionate universalism** – Using resources to benefit everyone (universal) and giving them relative to need (i.e. those with the greatest need get the most access)
- **Social justice** – Removal of the barriers that create inequalities ('liberation')

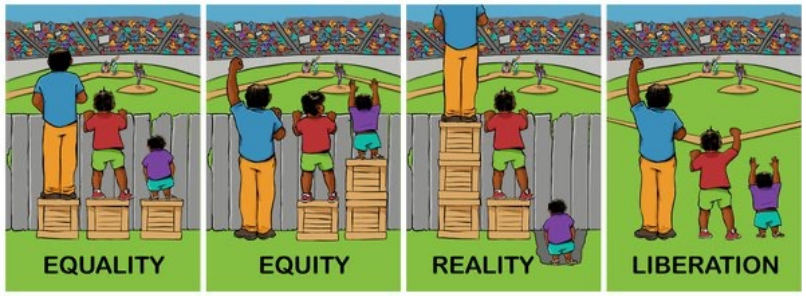


Figure 2: Equality, Equity, Reality and Liberation

Current Context: COVID Recovery and the Cost of Living Crisis

COVID-19 Legacy on Health and Service Demand

The 'direct' impacts of COVID-19 on health and health services have reduced, but not disappeared and indirect impacts have worsened. The Health Foundation's 'year on' study shows that death for COVID and 'long COVID' ill health continues, with deaths 3 to 4 times higher in the most deprived areas. Indirect impacts include mental health and well-being, which is well below pre-COVID levels and includes lower levels of resilience. The report also suggests three wider key risks to health and wellbeing and health inequalities: lost learning and educational attainment; economic inactivity; and family finances and income.

Services have also seen extraordinary (and unmanageable) increases in demand. Waiting lists for NHS services have reached previously unseen levels, but these increases are much higher in deprived areas (55% compared to 36%) due to greater demand and unequitable offer of services. Local authority delivered social care services also face unrealistic demand. It is estimated that an almost 300,000 waiting list for an assessment of care needs would hit 400,000 by November 2022 - double the 2021 total. Action is required across the systems to manage this increasing need.

However, as we work on recovery from the consequences of the COVID pandemic we also now face a cost of living crisis which could have equally devastating consequences on the health of our community. Because of the rise in cost of living, nationally over half (55%) of people feel their health has been negatively impacted. People are unable to make healthy choices and even before the pandemic the poorest fifth of UK households would need to spend 40% of their disposable income to meet healthy eating guidelines.

This current crisis adds to the recognised scale and challenge of long-standing economic deprivation, identified in a bold and necessary ambition following the independent Growth Commission of *"one borough; one community; no-one left behind"*. However, the commission also recognised the opportunity that record population growth offered.

Impacts of the Cost of Living Crisis

Even before the crisis, after adjusting for inflation, average weekly pay in London was 5.9% below 2010 levels in 2019, with lower paid sectors seeing a greater gap (e.g. hospitality, retail and construction). Average rents are rising faster in London than other regions, with new tenancies 15.7% more expensive in May 2022 than May 2021. The National Institute for Economic and Social Research (2022) estimated 1 in 200 (6.5%) of London households could face food and energy bills greater than their disposable income in 2022-23.

These numbers would be much greater across our community where poverty and deprivation are high. Barking and Dagenham (B&D) was the fifth most deprived area in England in 2019, up from the 20th in 2004 and community concerns raised include:

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

Looking at data can be misleading as it appears we have similar or even less of a challenge than other boroughs (e.g., new tenancy rental cost increases was the second lowest in London at 3.3% versus the 15.7% average). But that is not the case, data provided by the Councils Insight Hub indicates that our residents have fewer financial resources to provide resilience and are more vulnerable to these changes. Figure 3 shows a greater exposure amongst our residents to risk factors that make them more vulnerable to the crisis.

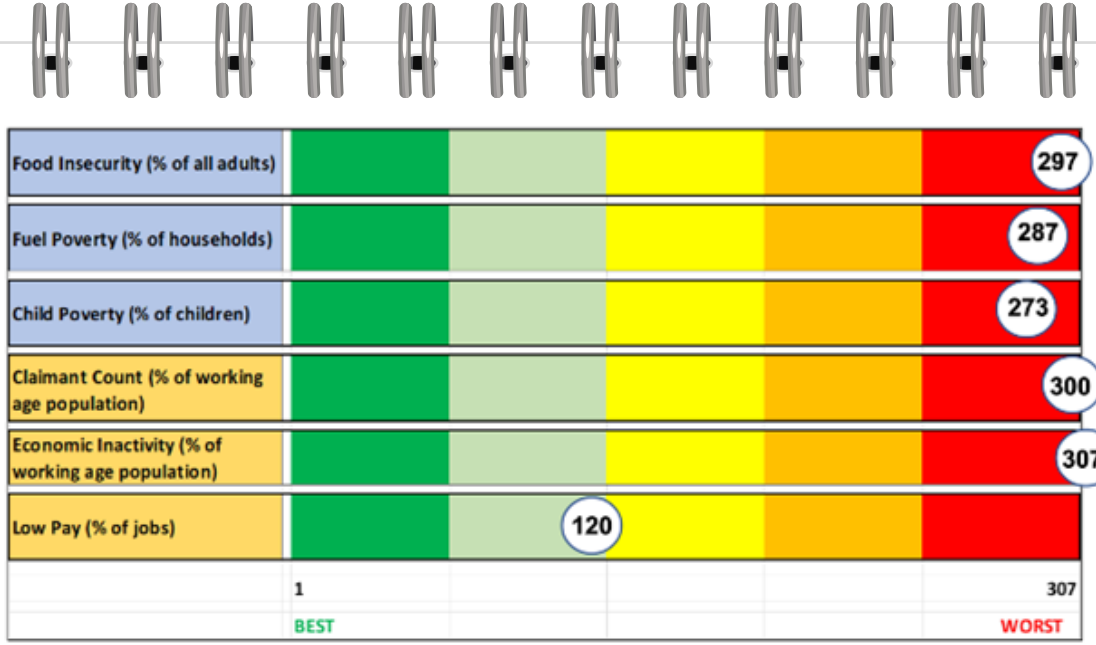


Figure 3: Vulnerability of B&D residents to cost of living crisis compared to 307 other English local authorities

Further data from our Insight Hub also highlighted areas of particular concern, such as:

Food insecurity

Over half of our residents (53.7%) live in the 20% most deprived areas in the country and a healthy diet is likely to become unaffordable. An unhealthy diet is one of the leading causes of disease in England, including an unhealthy weight, heart disease and some cancers.

Fuel poverty

Pre-crisis almost 1 in 4 (22.5%) of our households lived in fuel poverty compared to 13.5% nationally and 15.2% across London. Cold homes are associated with increased respiratory and cardiovascular disease, minor ailments such as flu and poor mental health.

Debt

Higher levels of existing debt and lower levels of economic assets means our residents are at greater risk of debt and associated poor health (e.g. poor mental wellbeing, poor social wellbeing, developing unhealthy behaviours and health-harming changes in the wider factors e.g. housing).

Lessening the Health Impacts

Although as much as possible should be done to reduce the impacts of current living costs, negative impacts on health are unavoidable. So, it is important that we lessen those impacts.

Prof' Sir Michael Marmot's Institute of Health Equity undertook an evidence review of The impact of the economic downturn and policy changes on health inequalities in London before the previous recession in 2008. Its recommendations included action to assess and respond to an area's need by:

- Ensure sufficient and affordable housing, including reducing fuel poverty
- Ensure an adequate supply of good jobs, including stimulating employment and encouraging 'good' work
- Local measurement, monitoring and cross-sector working
- Ensure sufficient incomes, including financial incentives to work and good quality, affordable childcare
- Sufficient provision of services to cope with likely issues, including advice and information services; mental health services; schools places; GP services, inter-borough safeguarding and coordinated provision of services for rough sleepers and the homeless

Chapter 1: ‘Population Health’ and the Population’s Health

My Annual Report 2015/16 focussed on the needs of the whole population (population health) and integrated care that predicts and addresses preventable needs (population health management). With the Integrated Care System (ICS) now in place, it is timely to review how this approach works locally.

Taking a population health approach means moving from a focus on illness to one that promotes wellbeing, prevention of ill-health and reduction of health inequalities across a whole population (rather than just focusing on individuals). The King’s Fund identifies four pillars of population health, (see figure 4) which need to be considered when developing any programme to improve health and reduce health inequalities at locality level and wider.

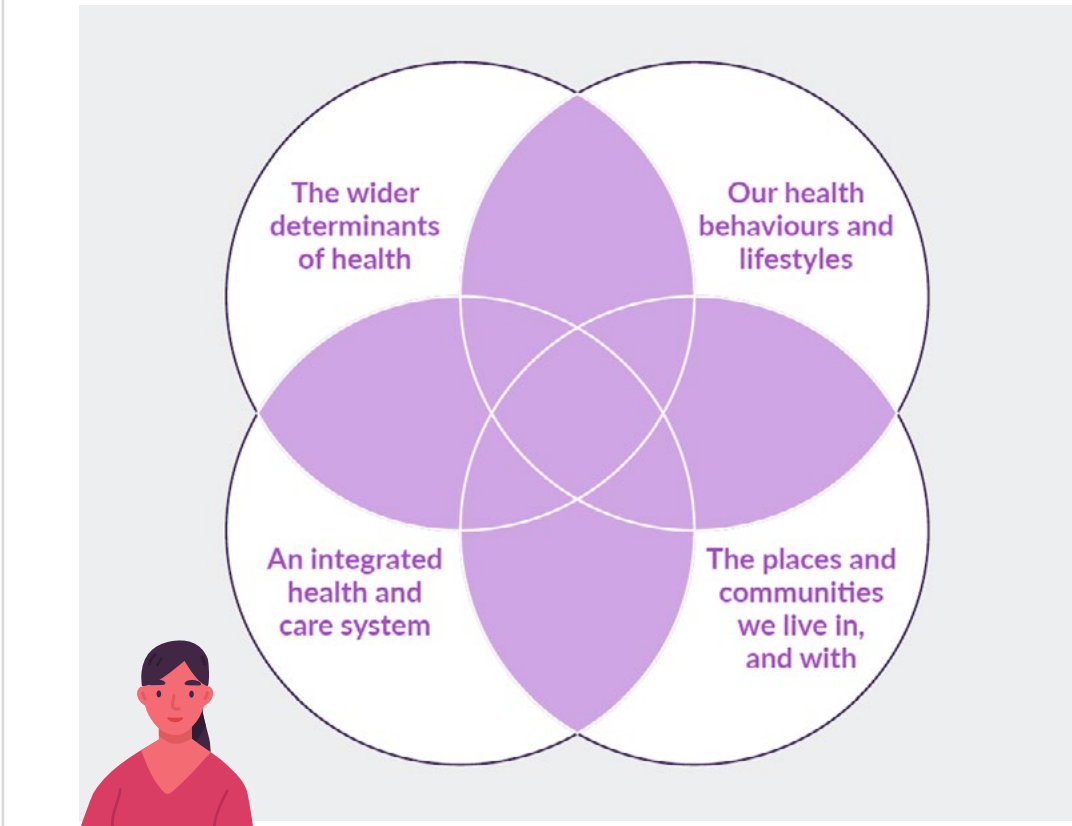


Figure 4: Pillars of Population Health

Predicting and Addressing Preventable Needs

The lived reality for residents is that at each stage of life they experience inequalities in health and wellbeing compared to people living in other parts of London and England. These disadvantages add up across a lifetime leading to early avoidable ill health that impacts our life opportunities and overall outcomes such as healthy life expectancy.

Therefore, to address these inequalities and with a population growing as quickly as that of ours, predicting and addressing preventable needs is critical. For health and wellbeing, it is possible to find trends in the causes of/risks to ill health, which can predict and allow you to prevent later impacts. It is important to consider not just levels of disease, but how health (good and bad) impacts wellbeing and how we live our lives.

Nationally, health and wellbeing has been on the decline and health inequalities on the increase for over a decade. Healthy life expectancy describes the number of years a baby born can expect to live in self-assessed good health. In B&D healthy life expectancy is just 58.1 and 60.1 years of age for males and females. These are the lowest and third lowest respectively in London, and below England averages. Across the borough 49,357 years are 'lost' annually through ill health, disability, or early death (termed Disability Adjusted Life Years).

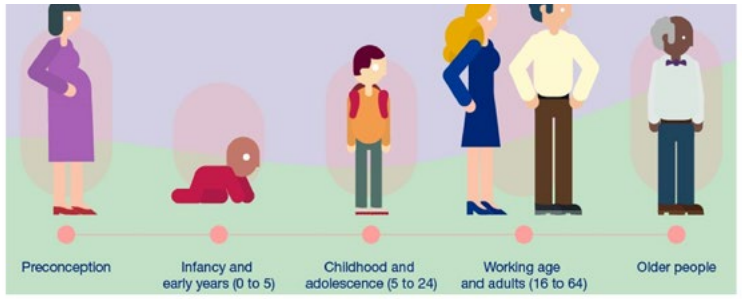
Analysing what causes this low healthy life expectancy highlights how we have the highest rates of some cardiovascular disease (CVD) (heart disease and stroke); respiratory conditions (chronic obstructive pulmonary disease (COPD)) and cancer (lung) in London (see table 1).

Table 1: Ranking of 'top 10' health conditions in Barking and Dagenham in London and England (2019)

Cause	Rate *(per 100,000)*	*London rank (out of 32)*	*England. Rank (out of 150)*
Ischemic heart disease	1,343	*1*	*34*
Low back pain	1,093	*5*	*124*
Chronic obstructive pulmonary disease	902	*1*	*15*
Lung cancer	878	1	18
Depressive disorders	725	13	18
Headache disorders	705	13	17
Diabetes mellitus	676	18	65
Stroke	543	1	80
Falls	519	7	67
Neonatal disorders	507	13	58

Many of these diseases are preventable. An 'unmet needs' analysis has been started to estimate the number of undiagnosed people with these common conditions (CVD; COPD; diabetes and dementia) that could be receiving treatment, before the condition develops into more serious disease. This can be used to help focus work to find cases and provide support to manage conditions.

Figure 5 below, provides further data on key facts which impact on health and result in health inequalities.



	Obesity in pregnancy	Low birth weight at term	Good development at 2-2.5yr	Child poverty	Unhealthy weight at 10/11 years	Economic inactivity 16-64yr	Domestic abuse per 1,000	Healthy Life expectancy M/F	Life expectancy M/F
B&D	27.4%	4.2%	38.8%	48%	44.7%	30%	16.0	58.1/60.1yrs	77/81.7yrs
London	17.8%	3.3%	79.6%	36%	38.2%	20.5%	10.5	63.8/65 yrs	80.3/84.3yrs
England	22.1%	2.9%	82.9%	27%	35.2%	20.9%	14.2	63.1/63.9yrs	79.4/83.1yrs

Figure 5: Health inequalities for our residents across the life course

Delivering with Communities and Maximising Community Assets

As part of the North East London (NEL) ICS, a Place-based Partnership (PbP) has been set up which will allow a place-based approach to delivering services and programmes which puts people and communities in the centre of decision making rather than services being 'done to' people, which supports the locality service model already in development in the borough. However, this approach requires a change in culture as well as practice, with collaboration between people; communities; services and commissioners at its heart.

Considering the 'needs' of individuals and communities helps inform how we shape support, services and investment. But whilst considering health care needs, it is important to recognise that, the majority of health – around 80% - is defined by wider issues (e.g. socioeconomics, environment and health behaviours). A Population Health Management approach can help us achieve this.

Our residents and communities are an 'asset' and putting trust and control in the hands of communities is critical for improving and sustaining good health, wellbeing and reducing inequalities. A 'glass half full' underpinned the response to COVID-19 and is being built on by developing changes such as community locality leads and neighbourhood networks. Figure 6 uses the image of a glass to show how the borough is full of assets as well as challenges / needs (i.e. half full and half empty) and we have put in place interventions using these assets to address the needs.

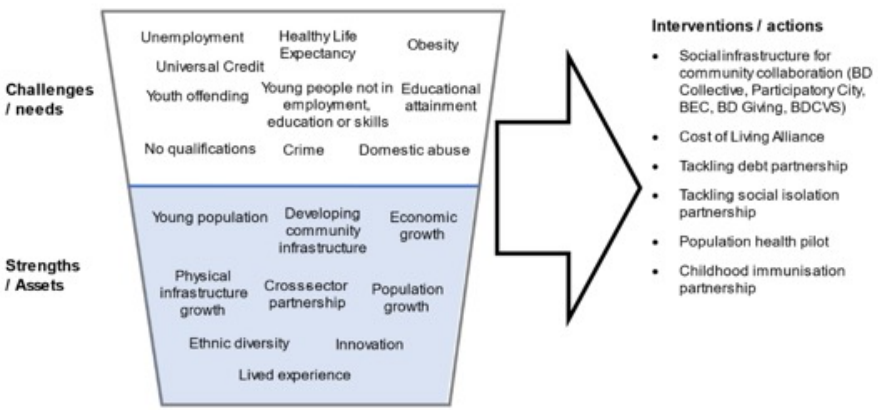


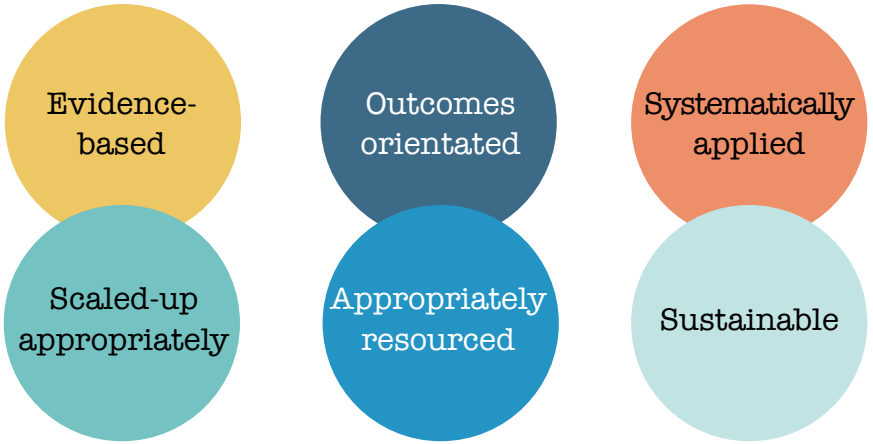
Figure 6: Using community assets to develop solutions to B&D challenges ('glass half full')

Delivering health improvement through place based/locality working

A place-based approach delivered through locality working can achieve population-scale change if the following three types of interventions (i.e. the Population Intervention Triangle) are considered:

- Civic-level interventions
  (e.g. licensing, economic development)
- Community-based interventions
  (e.g. using and building assets within communities)
- Services-based interventions
  (e.g. quality and scale, reducing variation)

The Population Outcomes through Services (POTS) Framework (see figure 7) is an evidence-based model through which the new PbP/ locality leadership can make a real difference to address health inequalities. Interventions delivered within this model, to be effective should consider the following six principles:



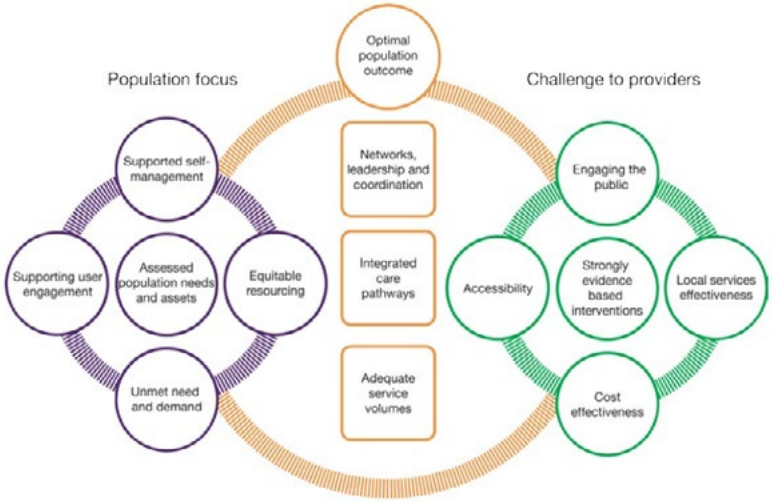


Figure7: The Population Outcomes Through Services (POTS) framework

Thsee two case studies are already some examples of taking a place- based approach.

Case Study: Targeted Debt Support and Prevention for Vulnerable Residents Pilot

A review of our Support and Collections services showed the Council was too quick to begin legal proceedings when residents fell in to rent arrears. Therefore, a preventative approach was tried to support people in debt. The aim was to encourage people (who could) to set up a payment plan, support residents that couldn't pay, avoid costly recovery processes, and improve engagement with residents. A group of residents with multiple debts, and more than one vulnerability were identified and sent them personalised texts offering support. The Homes and Money Hub then called and worked with them.

By measuring outcomes of this group against a control (5 interventions as business as usual) we achieved:

- 26% engagement
- Delivered 127 support interventions e.g., setting up payment plans, awarding Discretionary housing payment and other benefits support
- Improved collections status
- Lower rates of legal and bailiff action
- Improved recording of wider issues e.g., mental health and domestic violence (11% improvement vs control)

This pilot approach showed better outcomes for residents as well as improving revenue for the Council and is now being built into business as usual.

Case Study: Frailty Transformation Board

Compared to pre-pandemic times, referrals into falls treatment teams in the over 65 years of age, have seen a percentage increase of 80%. For this reason, 2021/22 the Frailty Transformation Board invested £1.2M, in the delivery of the fall's strategy across the next two years so residents could access evidenced based falls prevention education, strength and balance activities related with preventing musculoskeletal conditions, improving bone health and overall psychological wellbeing.

The Barking, Havering and Redbridge falls prevention working group reported successful delivery against the falls recovery action plan and services managed to *'turn around'* the referral to treatment time that was nearly 18 weeks in December 2021. Now, the average wait to be seen by the Falls Community Team, is between 0-4 weeks, alongside reductions in A&E attendances and admissions. Also, 95% of residents attending strength and balance exercise, reported an improvement in their balance and self-confidence with 15% reporting a recurrent fall.

In August 2022, residents fed back their views and experiences and highlighted:

- The most important aspects of care (1) maintaining independence (2) feeling respected (3) advice and guidance whilst waiting for a referral
- Communal strength and balance exercise were a necessity, as it combined physical activity with a shared experience
- A need for improved access to medication reviews, a contributing factor for falls
- Consent for GPs to share care records, encouraging pro-active prevention (case finding) and reducing the need to repeat stories

This feedback will form part of the continuous improvement cycle of the falls pathway under the prevention strategy.

Considerations for the Future

How can the ICS and specifically the PbP, through the localities, support coordination and collaboration for all four pillars of population health and lead the coordination of the Population Outcomes through Services (POTS) Framework for the area?

How can we take a systematic approach to early identification and treatment for health conditions causing the greatest problem to individuals, communities and the care system?

How can we create shared understanding based on data and evidence of need to develop community, civic and services-based interventions?

Conclusions

Table 2 describes the differences between a traditional approach and a place based approach which help us to understand the principles we need to build into this way of working. Development of the PbP as part of the NEL ICS will accelerate the place-based approach introduced through the locality model way of working, to improve the population's health and deliver a population health management programme i.e., to deliver primary and secondary preventative approaches (preventing the development of ill health and early identification and treatment of a condition to prevent or delay its progression).

Table 2: Moving From Traditional To Place-based Health

Current system	Place-based health
Closed	Open
Separate service silos	Whole system approach
Vertical top down model	Horizontal model across places
Institution led	Person centred
Largely reactive	Largely preventative
Focussed on treating ill health	Focussed on promoting wellbeing
Health in a clinical setting	Wider determinants of health in communities
Services 'done to' citizens	Balance of rights and responsibilities

Chapter 2:
A New Approach for Improving The Health and Wellbeing of Children and Young People

As described in our JSNA, we have a rapidly growing, young and diverse population as well as having the highest birth rate and rates of child poverty in London. The 2010 Marmot Review explained how social determinants of health play a huge role in a child's overall health and wellbeing and can influence health outcomes and inequalities experienced.

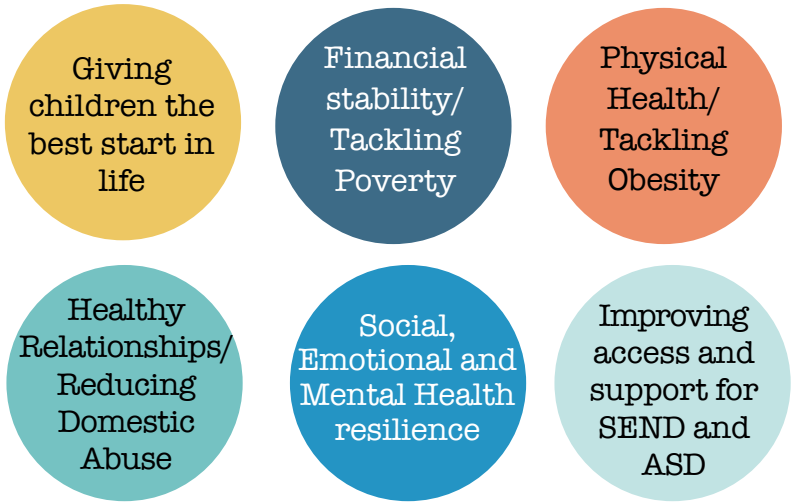
This provides an opportunity to 'get it right' from the earliest time in a child's life, making sure that they are school ready; supported to achieve; find fairly paid, good quality employment and have better financial stability in their adulthood. Developing healthy foundations also reduces the risk of long-term health conditions (like diabetes and heart disease), mental ill health and poor physical health leading to early frailty – all of which can impact their ability to work and remain financially resilient.

Babies, Children and Young People's Plan

A borough Babies, Children and Young People's (BCYP) strategic plan is due to be published in Autumn 2022. This plan will use a multi-agency collaborative partnership approach to address the issues and concerns currently faced by our BCYP.

The plan's vision is ***"Working together to give the best chance in life to babies, children, young people and their families..."***, achieved by focusing on 5 key ambitions:

Within this, 6 priority areas for action have been identified, which are:



The action plan will take these ambitions and priority areas, define clear and measurable outcomes and, as a system, develop and commit to clear actions which are underpinned by the latest data, evidence and best practice and will be delivered within the context of the new Place-based Partnership (PbP) governance structure.

Delivering the BCYP Plan – the Role of the Start for Life programme, Family Hubs and Family Hub Networks

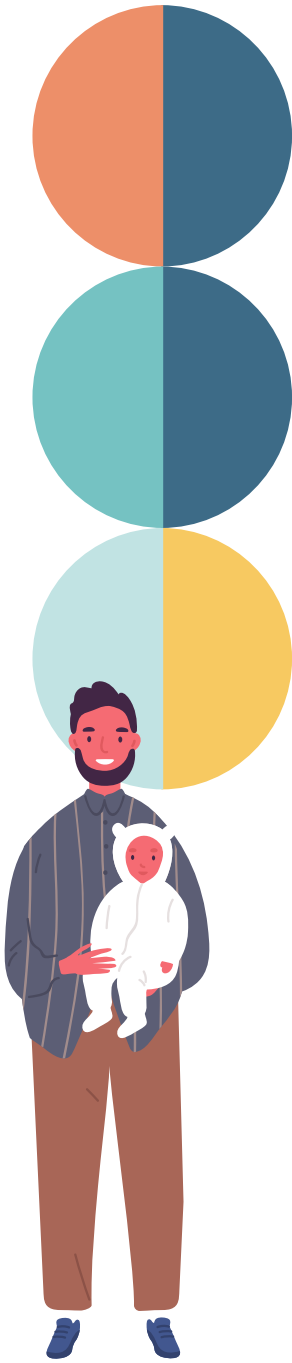
To achieve the 'Best Start for Life' Marmot objectives and deliver the outcomes in the BCYP Plan, the Council and partners will be implementing the national 'Start for Life' programme, building on delivery of the Healthy Child Programme and setting up three locality-based Family Hubs as the focus for integrated working across the system and Family Hub networks in the borough.

SEND: Special educational needs and disabilities **ASD:** Autism spectrum disorder

There is a strong evidence base for Family Hubs presented by the Family Hubs Network and the National Centre for Family Hubs and the Start for Life funding has specified that the offer must include support for parenting, parent- infant relationships, perinatal mental health, infant / breast feeding, and home learning environment. This will be a new way of working for our local BCYP services, so it is important the new model is developed in line with evidence base, best practice, and local need.

For midwifery, health visiting and school nursing, best practice includes a focus on the high impact areas for different life stages – maternity, early years and school-aged years. These include breast feeding; mental health; healthy weight; parenting support; child development; emotional resilience and reducing inequalities. These areas line up with the aspirations and outcomes in the BCYP plan, so the system should ensure that delivery aims to follow best practice set out in the high impact area guidance.

Family Hubs aim to be more accessible, better connected and relationship centred. They will be a central access point to services and support within a locality, connected to all other delivery sites in the area. Therefore to ensure that services match the needs of families who need them most, and are accessible for them, a needs assessment is needed to ensure they offer the right services and are situated in areas of greatest need within a locality (for example high birth rates and under 5s populations), a needs assessment would help to determine where hubs would be best situated and whether there are additional needs in certain areas which need provision for.



Opportunities and Ways of Working

The new Start for Life offer, and Family Hubs model gives an opportunity for innovation, a chance to change the way we work and who we work with, to meet the needs of families. The Family

Hubs model gives more opportunity to work with the community and voluntary sector to outreach into communities and engage families who are not currently being reached.

Therefore, it is essential to use all opportunities to engage with families and connect them with support, using a 'one front door' and 'making every contact count' model. Therefore, services don't all have to be delivered in the Family Hubs, significant outreach from hubs to engage families will also be important. This should include spokes in other areas within the locality (such as community hubs, GP surgeries and Voluntary and Community sector premises) to connect with families in places they access and feel comfortable in. Working with the community, faith and voluntary sector to shape pathways and develop services using a co-production approach is essential to reach communities, allow for local innovation, and for sustainability. For example, linking with the Council's Community Hubs programme.

Family Hubs are an opportunity for NHS, local authority and community and voluntary organisations to work together in an integrated and collaborative way and wrap around families to ensure that important opportunities- such as vaccinations, are not missed and to reduce disconnect between services and make strong links between maternity; primary care; 0-19; Early Help; community and voluntary; homes; money advice and any other services used. It is also an opportunity to shift from a crisis intervention system into one of early intervention, to prevent the escalation of need into costly statutory services.

Ensuring Success

To successfully implement Start for Life and the Family Hubs model, strong strategic leadership at both an organisational and 'place' level is vital to allow a new integrated model to be developed and delivered to make a sustainable change to the way we provide services and improve outcomes. This level of transformation also requires robust governance arrangements to support a whole system change and monitor progress against the outcomes in the BCYP plan and the 6 action areas highlighted in the Vision for the 1001 Critical days report (including an empowered workforce, continual improvement, and leadership for change).

Clear strategic vision and system wide strategic collaboration will secure join-up with other large programmes, such as Community Hubs, to prevent duplication, maximise our limited resources, and ensure that families are clear on what is being offered.

To help this joined-up working, there is a need for better data sharing across the system – both in terms of sharing information on individuals, and sharing large scale data for service planning, evaluation and quality improvement. This will improve spotting of risks/ vulnerabilities; ensure all agencies have necessary information to support families; allow for better planning and targeting of services; facilitate stronger collaboration and allow the tracking of progress towards shared outcomes.

Links to Universal Services, including the 0-19 Healthy Child Programme

Maternity services have a unique connection with parents, so it is essential they give out the right information, assess risk, and work with other services to meet family needs. Perinatal mental health and infant feeding are key focus areas of Family Hubs, and these are both areas where maternity services can have huge impact on outcomes if the right immediate support and referral pathways are in place. We have 2 main maternity sites and providers – Queen's Hospital (BHRUT) and Barking Birthing Centre (Barts) which presents an additional challenge with joining up with other services. Family Hubs may be able to help with this challenge and strengthen join-up between maternity services and other partners such as primary care, the voluntary sector and health visiting.

A 6-8 week check for all babies and mothers in the borough performed by GPs in primary care. This includes checks for both mother and baby around feeding, mental health, healing and general health and discussion on future vaccinations. There is huge opportunity here to identify issues, provide correct advice, reassurance and/or connection to appropriate services – so it is important that the workforce is given appropriate information and training to allow them to keep up to date with guidance, useful information and services available. Having primary care linked into Family Hubs allows for them to work in an integrated way with other universal and targeted services to ensure families can access help when they need it.

SPOTLIGHT ON CHILDHOOD VACCINATIONS:

Nationally, there has been a steady decline in childhood immunisation rates over the last decade, and now there is significant risk to children from vaccine-preventable diseases such as polio, measles and meningitis. B&D shares this downward trend, currently having over 20% of 2 year olds with no MMR vaccination, but has a strong desire to reverse it. Planning is underway for primary care outreach to improve uptake of childhood immunisations and address the inequalities that this may bring for unvaccinated children.

Intended outcome:
Increased childhood vaccination coverage

The 0-19 Healthy Child Programme, funded by the public health grant and delivered by NELFT, will form a core part of the Family Hubs and Family Hub Networks offer. This includes the health visiting and school nursing services, and the National Child Measurement Programme (NCMP). Included in this provision are antenatal contacts; new birth visits; 6-week, 1 year and 2.5 year checks; infant feeding advice and support; public health support for schools and safeguarding activities. This provision is universal (for all families) with extra targeted and specialist support for those families with additional needs. Changing this service to meet the needs of our children and families by delivering the Family Hubs model, the Start for Life agenda, and the requirements of the Healthy Child Programme is a priority for the coming year.

How will we know if Family Hubs have been successful?

The following measures would be a good way of measuring the impact of Start for Life and Family Hubs on the outcomes for local families:

1. Increased rates of breastfeeding (initiation and continuation)
2. Families being more aware of how to access medical care – evidenced by a reduction in children's A&E attendance rates
3. Improved rates of childhood immunisations
4. Improved uptake of the 1 year and 2-2.5 year checks – especially in groups which do not currently attend them (and groups with worse school readiness)
5. All children achieving developmental milestones (Physical, emotional and social) and a Good Level of Development at the 2-year check
6. Families with children with SEND happy that special educational needs are being met, and school/ early years settings are providing adequate support
7. A reduction in exposure to Adverse Childhood Experiences (particularly domestic abuse, parental conflict, and parental mental health conditions)
8. Reduced rates of childhood overweight and obesity, and increased rates of physical activity
9. Early identification of risk and issues, with more families receiving 'Early Help' rather than social care interventions
10. A reduction in inequalities within all the above outcomes (by improving outcomes of those who are below average)
11. Improved mental health in children and young people (measured by WEMWBS[1] score)
12. Reduced incidents of school exclusions and serious youth violence

1. Warwick-Edinburgh Mental Wellbeing Scales (measuring mental wellbeing in the general population)

Conclusions

The CYPs population has increased, but investment and capacity has largely remained the same. Further increases in need will continue, so we have an opportunity to carry out the JSNAs recommendation of 'reviewing universal service capacity to ensure that it is suitable to the pace and scale of change in the CYP population in recent years'. This would allow a better understanding of the current and predicted need; the best model to meet this, give improvements in outcomes and understand the costs. It is possible more funds will be needed for any future model, so in the spirit of a levelling up agenda, it is important to look at ICS funding to ensure our borough receives a share appropriate to the need and challenges faced.

We know that we have a high need population, but we don't have an in-depth understanding of how this need affects service priorities or restrictions. There is a need for an in-depth review of our 0-5 (health visiting) and 5-19 (school nursing) services, working with commissioners, providers, local organisations, schools, and families to determine what is being done well; where there are gaps, shortfalls and pressures; what can be done to improve outcomes; how the service can adapt to provide this and what additional investment or input might be needed.

Current 0-19 services are not providing the level of improvement in outcomes which our babies, children and young people need. Informally, reasons that the service is stretched include funding challenges, national staff shortages, an increasing population including more families with high and complex needs (including higher than average needs for additional support and high safeguarding caseloads), and a shortage in specialist school nursing provision for pupils with SEND meaning that mainstream public health school nurses are having to cover this workload. It is likely that both additional investment, service change and innovation is needed to adjust the outcomes that we are getting from our 0-19 services.

In the short term, there is also a need for the system to invest in additional specialist school nursing provision for the additionally resourced provision to allow the public health school nurses in the 0-19 programme to fulfil their role as public health leaders within the mainstream schools system. They need to have dedicated public health school nursing capacity to help them to understand their data; determine what might work for them; plan and implement health and wellbeing policies and activities and facilitate partnerships with the wider support offer, especially provision from the community, faith and voluntary sector (e.g. SW!TCH Futures Advocate Mentor programme). This will provide the support outline in the Healthy Child Programme to assist our schools to help keep their pupils safe, resilient, healthy, and provide additional support where necessary.

Considerations for the Future

To give the best start in life, the following key areas should be focused upon in the implementation of Start for Life and Family Hubs:

Strong Strategic Leadership and Governance –both at organisational and place to join up agendas, models, programmes and services.

Joined-up and Outcomes-Based Commissioning and Provision – the need for shared outcomes (provided by the BCYP plan), system commitment to delivery and continuous monitoring of progress against outcomes with commissioners working together.

A Stronger Focus on Inequalities of Provision and Outcomes – we need to improve and close the gaps between outcomes. We need to better understand our population's needs, how they utilise services and what outcomes they get.

Better Joining Between Organisations, Programmes and a Whole Family Approach to Delivery – all organisations involved in delivery need to be engaged, working collaboratively and supported to flex their services to meet need. The family should be at the heart with focus on supporting the whole family to maximise health and wellbeing.

Improved Data Sharing – The system and all stakeholders need to facilitate this to plan, evaluate and quality improve services.

Key Questions:

How can we achieve the aspirations in the BCYP plan? What do we need to do to get there? And how can we work together as a system to do this?

Based upon the data for outcomes in our population, which additional areas should our Family Hubs focus on?

What can the Council and system do to help CYP recover from the impacts of COVID-19? (e.g. poor mental wellbeing; time away from schools; increased obesity and lack of access to services for 2 years).

How will our key BCYP and families' services (including the 0-19 Healthy Child Programme) change their arrangements to deliver the BCYP plan ambitions through a joined up Start for Life offer and Family Hubs model?

Chapter 3:

‘Equity’ in services that improve health – providing healthy lifestyle services to those who need them most

Introduction

‘Health inequalities’ are avoidable differences in the health and wellbeing of groups and individuals caused by opportunities (or lack of) to lead a healthy life and were a focus of last years report. One of the key questions was *‘How can we ensure that our resources, time, people and assets are targeted and balanced to the needs of our community’*. In the last year we have explored this question across key Council health improvement services that address key causes of health inequalities:

- **Weight Management Services –** Children living in low-income areas are more than twice as likely to live with obesity than those living in the highest income areas, and 80% of children with obesity in childhood will live with it in adulthood, without help. Weight management services help individuals and families understand and change behaviours that cause unhealthy weight.
- **Stop Smoking Services** – People in routine/manual jobs are 2.5 times more likely to smoke than those in managerial jobs and those with a lower income are 20% less likely to plan to quit. Using a stop smoking service makes it three times more likely a quit will be successful.
- **The NHS Health Check** – People living in low income areas of England are almost four times more likely to die from CVD than those in high income areas. Everyone aged between 40 and 75 years of age is invited every five years to an ‘NHS Health Check’ to spot early signs of stroke, kidney disease, heart disease, type 2 diabetes and dementia and provide support to lower risks.

These services are particularly important for both reducing health inequalities and improving health across the population as we are more impacted from the issues they address.

- **Unhealthy weight** – In 2019/20, 26.5% reception aged children, 46.3% of year 6 aged children and 44.7% of children aged 10-11 were above a healthy weight.
- In 2020/21, it was estimated that 64.5% of adult residents (aged 18+) live with overweight or obesity, which is the 3rd highest percentage when compared to all London boroughs.
- **Smoking** – Almost 1 in 5 (18.1%) of our adults smoke, contributing to our higher levels of diseases such as COPD; cancers; earlier death and the worst outcomes in hospital admissions linked to smoking compared to other London boroughs.
- Most people start smoking and become addicted to nicotine when they are still young. Children whose parents or siblings smoke are around four times more likely to smoke than those in non-smoking households.
- The smoking status at time of delivery provides information on the number of women smoking at time of delivery (childbirth). In 2020/21, 7.6% of our pregnant women were smoking at this time - the highest in London but lower than the England average of 9.6%.
- Smoking has a huge economic impact in addition to the impact on smokers' health. An analysis of the impact of smoking on productivity estimates that smoking costs £77.84m a year, as seen in table 3.

Table 3: Estimated annual costs of smoking to B&D

Area		Cost
1. Smoking related loss of productivity		£65.27m
2. Healthcare costs due to smoking related illnesses	Hospital admissions	£2.76m
	Primary care	£3.69m
3. Social care costs due to smoking related illnesses	Residential care	£2.23m
	Domiciliary care	£2.47m
4. Cost of smoking related fires		£1.42m
Total		£77.84m

- **Cardiovascular Disease (CVD)** – We have the highest levels of early death from CVD and CVD deaths considered preventable in London.

We looked at who uses these services to understand if they met the needs of our community and those who would benefit from them most. In other words, were they 'equitable' by giving those who need the most support an equal chance of a healthy life. We did this for the three characteristics where inequalities are most seen: age, gender and ethnicity.

Within the smoking service, we found very low numbers of under 18s accessing support; a higher number of male smokers (22.8%) compared to females (10.1%), but more females accessed the service and successfully quit (63% in 20/21) and an over representation in White British service users (65%) compared to the groups estimated smoking numbers (23%). This group also overrepresented in outcomes, as 77% of users successfully quitting (20/21) were White British.

For weight management services, we found low numbers of referrals for children aged 12 and under; high numbers of referrals (69%) to weight management programmes for females (mostly aged 35-54) compared to males and higher percentage of White ethnicities (male and female) being referred onto programmes, even though higher numbers of Black males and females are above a healthy weight by comparison.

Equity at Scale in Services

Without a proactive focus on targeting greatest need, inequality - or inequity in services is unavoidable, this can be seen in funding, demand, and level of need. Nationally GP Practices in deprived areas see 10% more patients (as people in poor areas develop poor health earlier, with an 18 year gap in disability-free life expectancy), but receive around 7% less funding per need-adjusted patient than those in the most affluent areas.

However, providing services alone is not enough to reduce barriers for those in greatest need. Services need to consider and address barriers to access and should be informed by the target population. This is best done through community-centred approaches involving communities at all stages from identifying needs through to implementation and evaluation. The Population Outcomes Through Services (POTS) framework (Figure 7, page 13) illustrates this well. Three key factors: access, experience and outcomes (identified by NHS England's National Healthcare Inequalities Improvement Programme) also looks to ensure health equity in delivering services.

In understanding unhealthy behaviours and linked inequalities, it also is important to consider that we do not have equal risk of unhealthy behaviours. A Kings Fund analysis of four key unhealthy behaviours – smoking, excessive alcohol consumption, poor diet and low levels of physical activity – found 'clustering' of these behaviours. Those in deprivation are more likely to undertake unhealthy behaviours (often multiple) and have multiple needs.

And when supporting change to reduce risk, behaviour change science tells us that behaviour (and success of change) is determined by three things: capability; motivation and opportunity (see figure 8). Therefore, services should take a person focused perspective to identify which behaviour the individual is more open to change and provide the appropriate support.

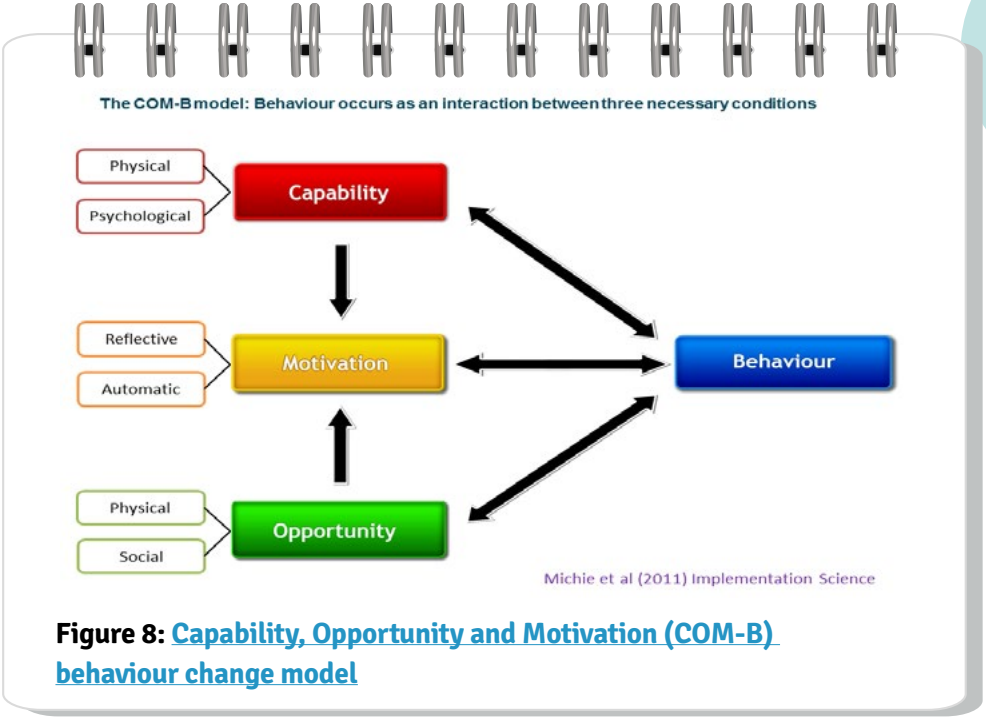


Figure 8: Capability, Opportunity and Motivation (COM-B) behaviour change model

Considerations for the Future

How do we ensure a person-centred approach that identifies the right time and service to support an individual to make a positive change to behaviour, working across services and community?

How can we 'hardwire' equity in access, experience and outcomes into delivery and monitoring to ensure services are working and resources are being used well?

A Look at Weight Management Services, Stop Smoking Services and Health Checks

Delivering Weight Management Services

Overweight and obesity does not affect all groups equally and can lead to physical and mental health issues across the life course into old age (see figures 9 and 10). Addressing this issue is complex and no single solution alone can support people to reach or maintain a healthy weight at population or individual level because of the multi-factorial causes and contributors.

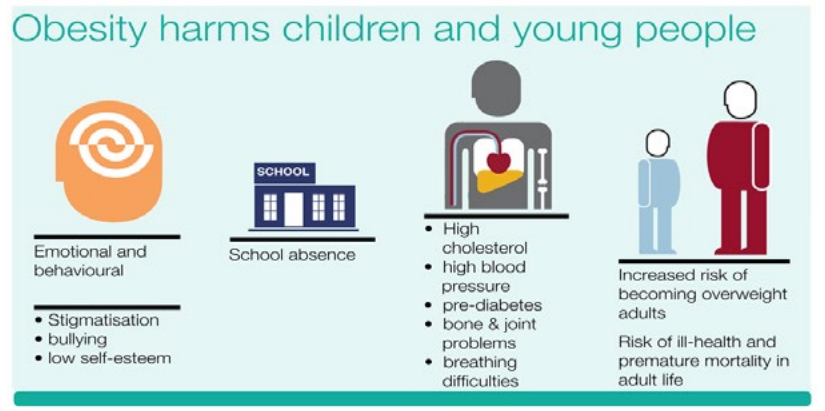


Figure 9: The ways in which obesity can harm children and young people

Figure 10: The ways in which obesity can harm adults

What are We Doing?

Below outlines our current children, young peoples and adult weight management offer. This is delivered by multiple partners and is funded by the Office for Health Improvement and Disparities (OHID).

Children Weight Management	
Service	**Delivery**
HENRY	HENRY training and support; HENRY programme to the family
Community Solution	Extended Brief Intervention (EBI)
Al Madina Redeemed Christian Church of God Creative Wellness Wonder	HENRY Healthy Families: Growing up Programme
Harmony House	HENRY Healthy Families: Right from the Start programme
Thames View Community Project	Delivery of 6 activities (Boxfit, football, tennis, gardening, cooking, walking) targeting both physical health and nutrition to approximately 200 children aged 5-12 years

Adult Weight Management	
Service	**Delivery**
Momenta	Culturally appropriate cardiovascular disease (CVD) prevention project to two PCNs (North and New West) Training community voluntary services to deliver culturally appropriate CVD prevention project in the community
Harmony House Al Madina	Culturally appropriate CVD prevention project in the community
MoreLife	Pre-pregnancy/post-natal support-exploring the approach
Community Solutions	Exercise on referral, Weight Management service

Role of Social Prescribing in Weight Management

Social prescribing is when health professionals (often in primary care) refer people to a range of local non-clinical interventions or services (for social, emotional, physical or practical needs), typically provided by voluntary and community sector organisations.

The NHS Five Year Forward View, the General Practice Forward View and the NHS Long Term Plan all highlight the value of social prescribing and for building effective networks with partners. This work is being led by the primary care networks (PCNs) and Community Solutions, with the current GP framework contract providing funding for one social prescribing link worker per PCN.

Evidence suggests social prescribing can deliver meaningful benefits to wellbeing, health and reductions in use of health services. There is no current evidence of direct benefits around weight loss, but social prescribing can form a key part of a personalised, preventive support offer to people with long-term conditions. This could include increased levels of physical activity; greater engagement with health advice and increased self-esteem and confidence which will support efforts to make lasting health behaviour changes.

Conclusions

Obesity is one of the key health priorities which requires urgent attention.

Weight management services need to be provided in a way which are accessible and appropriate to the populations who need them most. The use of health technologies could be useful to explore as set out in recent NICE guidance as part of a suite of service offers.

Weight management services, whether online or face to face should highlight a complete approach to health and well-being instead of only losing weight. Programmes should focus on social relations; daily activities; habit change and positive success as part of a daily balanced life and ensure they are:

- Evidence based and fulfil guidance (e.g. NICE)
- Delivered in an equitable way (access, experience, outcomes)
- Part of an integrated approach (e.g. Across health behaviours, across services, etc.)
- Coproduced with and meet the needs of our population
- Appropriately monitored and adopt a quality improvement approach, where possible

However, weight management services are only part of the system wide approach needed to address obesity. Leadership of this approach to achieve agreed outcomes, needs to surround a culture where staff understand the importance of talking to people about their weight and ensure consistent up to date knowledge of the local weight management offer and opportunities/services to help get people active, alongside addressing related environmental and social issues. Increasing access to safe open spaces for walking and cycling, allowing opportunities for physical activity and promote wellbeing are important contributions to a thorough obesity strategy.

Examples of related outcomes:

- **Proportion of the population meeting recommended '5-a-day' on a 'usual day'**
- **Percentage of adults (aged 18 and over) classified as overweight or obese**
- **Percentage of physically active adults**
- **Percentage of physically inactive adults**

Public Health Outcomes Framework

Delivering Stop Smoking Services

Stopping smoking at any time has significant health benefits, even for people with a pre-existing smoking-related disease. Providing a combination of behaviour change and pharmacotherapy increases a smoker's likelihood of quitting three-fold, compared to no support (see figure 11).

The most effective way to quit smoking is the use of stop smoking aids with expert behavioural support from local stop smoking services. These include prescription medication, nicotine replacement therapies and e-cigarettes. This package of support is 3 times as successful compared to quitting unaided or with over-the-counter nicotine replacement therapy.

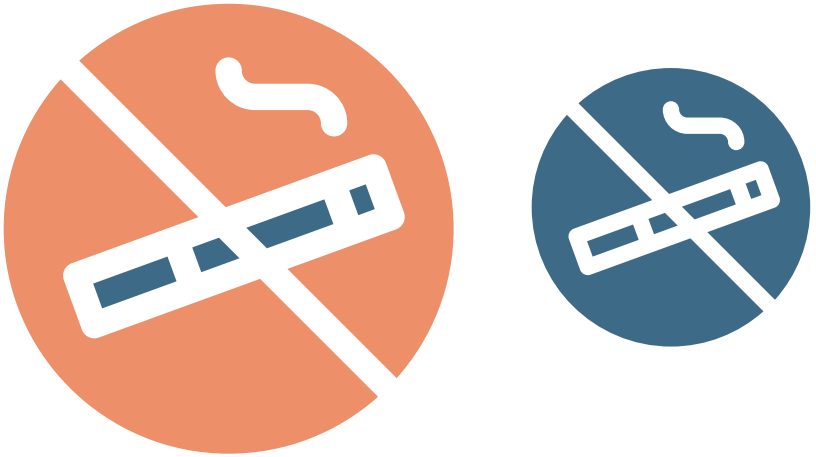


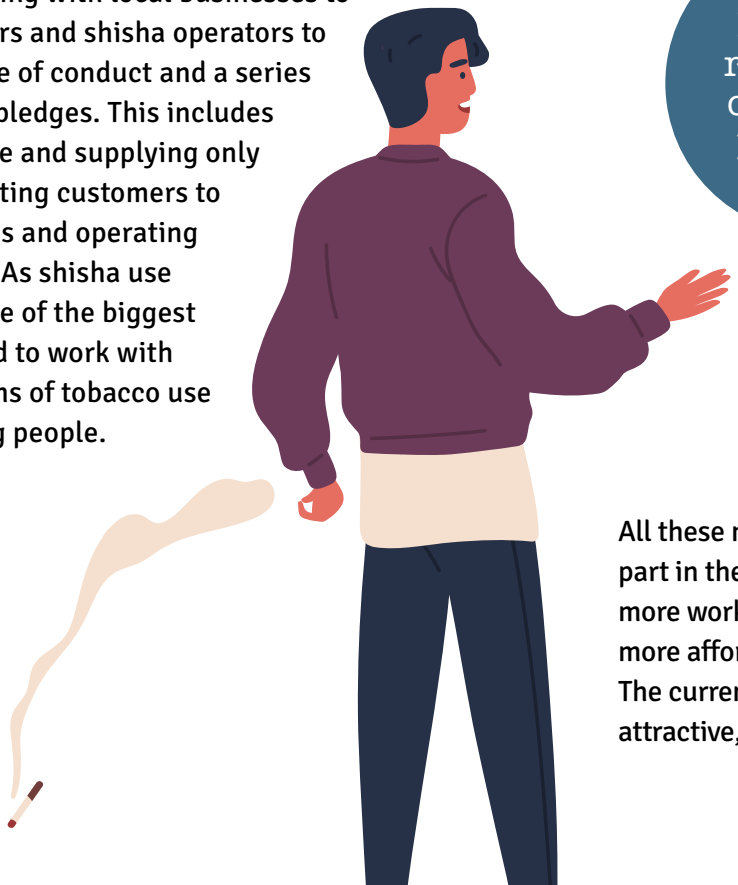
Figure 11: Stop smoking – what works?

What are We Doing?

Our specialist stop smoking service is provided by Community Solutions, the Council's integrated 'front door' to support. Unlike other stop smoking services, this is not a stand-alone service. As added value, it is completely integrated into Community Solutions, and service users are offered a wide range of support in addition to healthy lifestyle advice. Service users are connected with other Community Solutions and wider Council/voluntary sector services that may meet their needs such as housing advice, support with money and debt issues, access to a community food club and support with social isolation and loneliness using a Make Every Contact Count ("MECC") approach, reflecting the often complex needs of people who wish to quit. The service utilises existing and emerging Community and Family Hubs, with all staff trained to use carbon monoxide monitors and refer into the specialist service.

The stop smoking service is training many frontline staff within the Council and partner agencies, including the Trading Standards team, so they can offer Very Brief Advice and embed smoking cessation within their work. Trading Standards continue to carry out test purchases to identify and tackle under-age and illicit tobacco sales. In addition, all planning applications for shisha premises will be considered by Trading Standards and Environmental Health before approval and representations are submitted where structures or placement is considered undesirable.

Vaping and shisha use among young people are the biggest challenges currently. Our stop smoking service is working with partners across NEL to develop a shisha campaign particularly targeting young people. Additionally, the Trading Standards teams are working with local businesses to encourage tobacco retailers and shisha operators to sign up to a voluntary code of conduct and a series of regulatory compliance pledges. This includes safeguarding young people and supplying only electronic shisha, signposting customers to smoking cessation services and operating transparently and legally. As shisha use among young people is one of the biggest challenges, there is a need to work with schools to address all forms of tobacco use among children and young people.



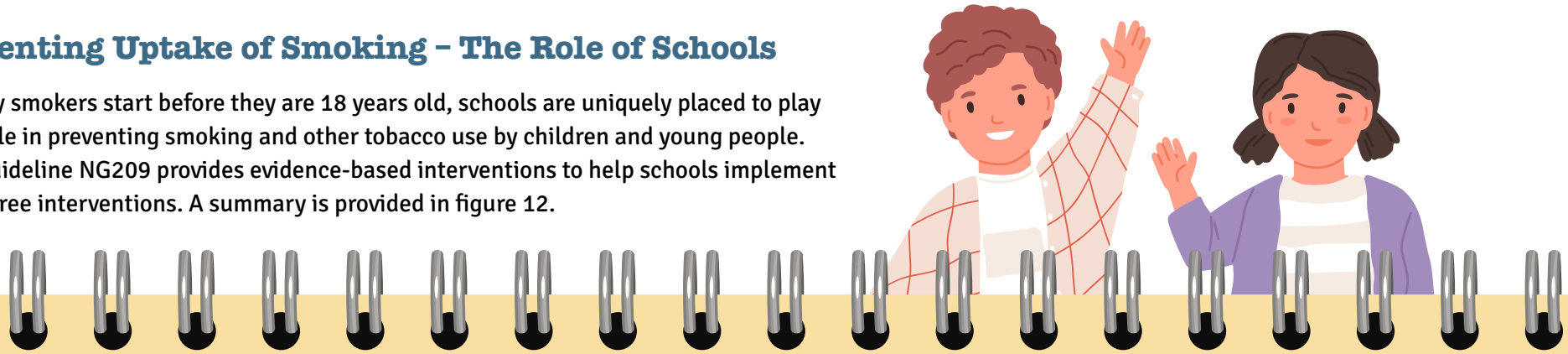
Tackling the Social, Structural and Policy Context in Relation to Smoking Cessation

Targeted individual intervention will have greater impact if it is done within a context of wider social and structural changes including:

All these measures have been applied in this country and played some part in the overall reduction of smoking prevalence, however, there is more work to do. For example, illicit tobacco is cheaper, which makes it more affordable especially for young people and in areas of deprivation. The current cost of living crisis may make illicit tobacco even more attractive, therefore enforcement agencies must be watchful.

Preventing Uptake of Smoking – The Role of Schools

As many smokers start before they are 18 years old, schools are uniquely placed to play a key role in preventing smoking and other tobacco use by children and young people. NICE guideline NG209 provides evidence-based interventions to help schools implement smoke free interventions. A summary is provided in figure 12.



1. **Ensure smoking prevention interventions in schools are:**
   - Part of a local tobacco control strategy
   - Consistent with regional and national tobacco control strategies
   - Integrated into the curriculum
2. **Develop a whole-school smokefree policy with young people and staff:**
   - Include smoking prevention activities (led by adults or young people)
   - Include staff training and development
   - Take account of cultural, special educational or physical needs
3. **Ensure the policy forms part of the wider strategy on wellbeing, relationships education, relationships and sex education (RSE), health education, drug education and behaviour.**
4. **Apply the policy to everyone using the premises (grounds and buildings), always. Do not allow any areas in the grounds to be designated for smoking (apart from caretakers' homes, as specified by law).**
5. **Combine information about the health effects of tobacco use and the legal, economic, and social aspects of smoking, into the curriculum. E.g., create relevance when teaching subjects such as biology; chemistry; citizenship; geography; mathematics and media studies.**
6. **Tobacco use should be discussed and challenged, aim to develop decision-making skills through active learning techniques. Include strategies for enhancing self-esteem and resisting the pressure to smoke from the media, family members, peers and the tobacco industry.**
7. **As part of the curriculum discourage children, young people and young adults who do not smoke from experimenting with or regularly using e-cigarettes.**
8. **Make it clear why those who do not smoke should avoid e-cigarettes to avoid accidentally making them desirable.**
9. **Encourage parents and carers to become involved. E.g., let them know about classwork or ask them to help with homework assignments.**

Figure 12: School-based interventions for preventing smoking and other tobacco use.

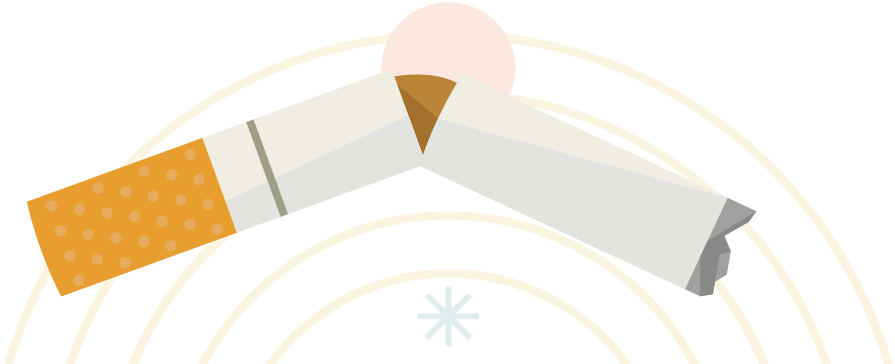
Conclusions

Smoking is the leading preventable cause of illness, early death and health inequalities. Schools have a vital role to play in preventing children and young people from smoking. The roll out of the NHS tobacco dependency service will help address some of the barriers to accessing stop smoking services when in hospital, as all inpatient smokers will be assessed and offered support to quit smoking. Therefore, NHS services need to work with local stop smoking services to complement each other and avoid duplication.

Given the ethnic composition of the borough, it is essential that the stop smoking service increases access to smokers from all communities including Black, Asian and Eastern European to help address existing inequalities that have been worsened by the COVID-19 pandemic.

Smoking at time of delivery is reducing. However, more needs to be done, as we continue to have the highest proportion of women smoking at time of delivery in London. This is particularly important, as smoking during pregnancy puts the unborn child at a disadvantage even before they are born. It increases the risk of still births, threatens the child's best start to life and contributes to health inequalities. The NHS tobacco dependency service will be addressing this as it continues to be rolled out across NHS Trusts.

Our goal should be to work towards the Government's ambition for England to be smokefree by 2030 - when smoking is no longer normalised in society. This has been defined as when smoking rates are 5% or less.



Considerations for the Future

- As we move forward, we need to think about the improvements we'd like to see locally, below highlights some key outcomes to work towards:

Short term	Medium term	Long term
Improve recording of ethnicity data to ensure more accurate data on smokers Increase number of smoking quitters year on year, in particular men, black and Asian minority groups and eastern Europeans Reduce rates of smoking in: • pregnant women • routine and manual workers • people with severe mental illness Reduce vaping and shisha use in young people Continue low uptake of smoking in children and young people Minimise the proliferation of Shisha outlets and illegal tobacco sales	Reduce smoking attributable hospital admissions and mortality	Smoke free society by 2030 (5% or less people smoking)

- What more needs to be done working with communities, to make local smoking cessation services more accessible to males and the borough's diverse ethnic groups?
- How will smoking cessation services respond to the emerging NEL ICS and tobacco dependency treatment being rolled out in NHS Trusts as part of the NHS Long Term Plan?
- What role can the new Place-based Partnership play in delivering a system side approach to preventing uptake and helping people to stop smoking?

Delivering the NHS Health Check Programme

Cardiovascular disease (CVD) is the leading cause of death globally and causes 38% of all non-communicable premature deaths. World Health Organization states 75% of all CVD deaths take place in low- and middle-income countries and communities, which is supported by research emphasising the strong correlation between levels of deprivation and CVD mortality.

The high CVD death rate is evidenced by our under 75 mortality rate from all cardiovascular diseases being the highest in the country, matched by the latest deprivation scores showing us as the third most deprived borough in London.

Figure 13: The NHS Health Check

Wider Costs

CVD and its related diseases place great strain on the NHS and accounts for nearly £9 billion a year in healthcare costs across the UK. Between 2015 and 2018, by improving treatment and preventative action for atrial fibrillation and hypertension, the NHS was able to prevent 9,710 heart attacks and 14,500 strokes, saving £72.5 million and £201.7 million, respectively. Treating high risk atrial fibrillation patients prevented 14,200 strokes within the three years accounting for a total of £241.6 million saved.

NHS Health Check has provided a form of early diagnosis and intervention for those at risk and has saved over £3 million in costs that would have been spent on CVD related admissions within the borough (see figure 13).

What are We Doing?

The NHS Health Check service is available at GP surgeries across the borough and before the pandemic some community pharmacies were also delivering this. Though, the pharmacy offer was suspended during the pandemic and is currently in the process of being re-established.

In quarter 4 of 2021/22s financial year, a total of 1,321 health checks were offered locally making up 2.5% of the eligible population, similar to London (2.5%) and England (2%). Out of the 1,321 residents offered an NHS Health Check in that quarter, 972 (73.6% of invites) took up the offer which was higher than the London average of 48.2% England average of 40.7%.

Once a resident has had their Health Check, there are several supportive health and lifestyle services that residents can use/ join if required, such as:

NewMe healthy lifestyle services

Free local support with stopping smoking, healthy eating and exercising

Exercise on referral

A 12-week programme to increase physical activity and make lifestyle choices aimed at reducing CVD risk

Eat Healthier

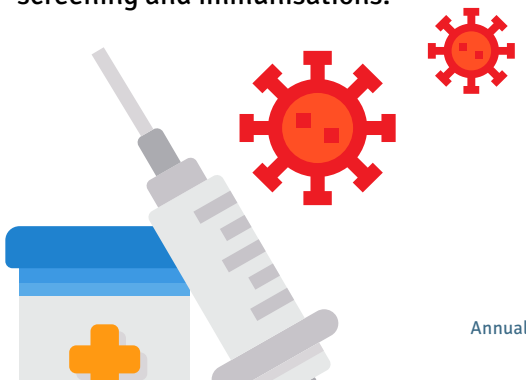
A 12-week programme to improve awareness of food and drink (including alcohol) consumption

The B&D Black, Asian and Minority Ethnic Inequalities Profile, as demonstrated in the most recent JSNA highlights that these communities are being diagnosed with long term conditions before the age of 40 and with a lower age of multimorbidity (the presence of two or more chronic conditions in a person at the same time) in the black community compared to white populations, which means they are missing vital preventative interventions, as the NHS Health Checks targets people from age 40.

To address this, an inequalities pilot project has been set up to deliver Health Checks to individuals within the Black, Asian and Minority Ethnic communities aged between 30 and 39. This £80,000 pilot is being delivered by Together First CIC, the GP Federation, who will use their existing relationships with GP practices and patients to invite those eligible to attend a Health Check. The pilot aims to understand:

- **Effectiveness of a targeted programme in populations with earlier development of CVD risk factors**
- **'What works' to encourage people from key minority ethnic populations to undertake a Health Check**

The pilot will explore delivery of Health Checks, alongside other interventions such as vaccination in community locations to improve access amongst the underserved. Learning from this pilot will help address inequalities in uptake of other services such as cancer screening and immunisations.



How Can We Improve Uptake?

On a national level, higher uptake has been found among older people, individuals in deprived areas and people with a family history of CVD; as well as higher uptake amongst Bangladeshi, Caribbean and Indian ethnic groups compared to their white and Chinese counterparts, when checks are delivered in familiar settings such as places of worship or local community hubs.

However, a survey conducted to understand what local models are used to deliver the NHS Health Check in 2019/20 across local authorities found that 93% of local authorities commission General Practices (GPs) to deliver some of the health checks compared to community outreach providers (27%) and pharmacists (19%). This is because GP clinical patient records are the main method to check for eligibility whereas community outreach and pharmacists are more likely to take an opportunistic identification approach. This can be seen in Kent County Council, where it was found that sending text message reminders to patients and IT prompts to clinical staff are effective ways of increasing uptake.

Financial incentives have also been found to be a motivation for GP practices to target priority groups for the NHS Health Check. In Wigan, equality monitoring showed that the working age population were less likely to attend, due to GP working hours being a barrier. A new contract included weighted payments for patients based on age (younger patients attracted higher payments), alongside a requirement for 20% of appointments to be offered outside of 9-5 working hours for ease of access.

Conclusions

Models introduced elsewhere such as home blood pressure monitoring and digital NHS Health Check assessments may help to provide more accessible service. Although, the Health Check services needs to be better focused to tackle health inequalities experienced by the underserved groups such as the homeless and individuals not registered with GPs. The programme should also be provided in a wider context of CVD prevention addressing smoking, weight management and the wider determinants of health.

Considerations for the Future

- There is a need for the Place-based Partnership to prioritise improvements in early detection, management and prevention of CVD and its linked illnesses. Utilising recent analysis identifying the level of undiagnosed disease, interventions need to focus on bridging this gap and ensure those from underserved groups can access the Health Check service.
- Based on guidance, evidence and existing good practice, the following outcomes should be considered by the Partnership:
    - Increased number of health checks offered to the black and minority ethnic groups and reduce the gap between the white British and minority ethnic groups for those offered and receiving health checks
    - Greater Health Check accessibility for underserved groups
    - B&D to rank below the national and regional averages for under 75-year-old mortality rate from all cardiovascular diseases
    - Residents equipped with knowledge to better manage their health
    - Increase in the number of residents using health and wellness initiatives
    - Reduce the health inequalities experienced by residents
- How can we strengthen the referral pathways to services especially amongst underserved groups?
- What more can be done to improve accessibility to service amongst the Black, Asian and Minority Ethnic and other underserved groups?
- How can we involve community leaders to ensure the importance of the NHS Health Check is understood? (i.e., amongst black and Asian groups)
- Is there an opportunity to create more tailored lifestyle services to the most at-risk groups?
- How do we adopt the most effective methods of inviting residents for a health check?

Chapter 4:
COVID-19

COVID-19 had a shocking impact and affected some communities more than others. At the beginning of June 2022 nearly 70,000 residents had tested positive for Coronavirus and up to 8,000 of those could have developed into Long COVID. The pandemic has had other indirect impacts such as delayed appointments because of reduced access to healthcare, potentially contributing to avoidable deaths.

Figure 14 sets out the COVID-19 case rates from the beginning of the pandemic, with peaks showing the different waves. Case rates at the beginning were underestimated, as testing was extremely limited during that period and testing levels, along with case rates across London have fallen following the Omicron wave. The closure of local testing sites and the end of free universal testing on 1 April 2022 contributed to the fall.

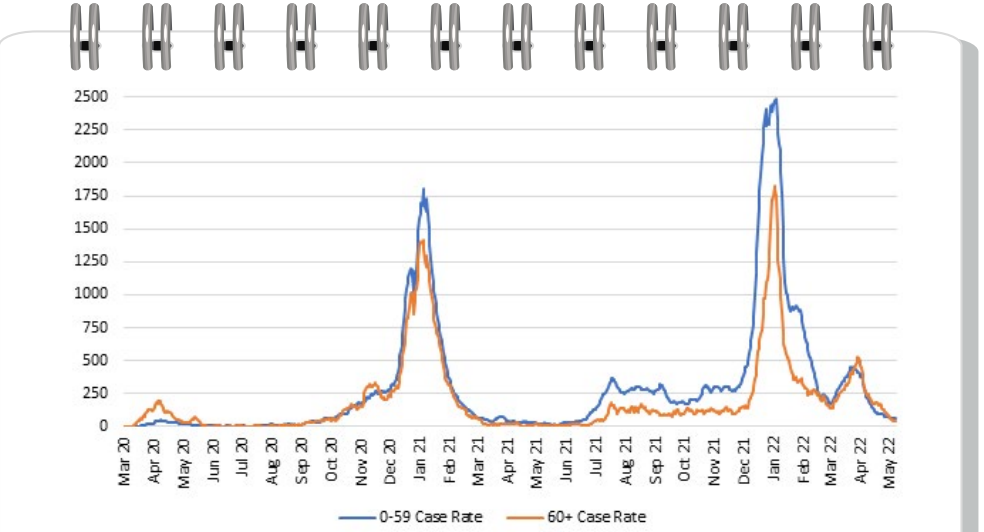


Figure 14: B&D COVID-19 case rates per 100,000 residents

Source: [Cases in B&D | Coronavirus in the UK (data.gov.uk)]

Impacts of COVID-19

At the height of the pandemic, many health services were suspended. In addition, fear of catching COVID-19 led to people not accessing health services that were available. As a result, the pandemic has and will continue to have an impact on health and livelihoods, worsening existing inequalities. Some of these are summarised here:

- **Missed opportunities for early detection of cancers, cardiovascular disease risks and dental health problems due to interruption of services**
- **A rise in vaccine preventable illnesses due to missed childhood immunisations**
- **Development or worsening of existing mental health issues, smoking and drug and alcohol issues**
- **Increase in obesity due to continued inactive lifestyles**
- **Increased workload for health services due to a backlog, following reduced access**
- **Workplace and business closures, leading to redundancies**
- **School closures affecting children's education and in some cases wellbeing**
- **Non-contact of support services, 'hidden harms' e.g., domestic abuse, children's safeguarding issues**

2. https://coronavirus.data.gov.uk/details/cases?areaType=ltla&areaName=Barking%20and%20Dagenham

What are We Doing?

Initially, testing and isolation were the main ways of managing COVID-19, along with other infection prevention and control measures (hands-face-space-fresh air). The introduction of vaccination in December 2020 saw the development of local initiatives to vaccinate all eligible groups. This included dedicated teams visiting care homes and housebound residents, setting up community-based vaccination centres and several hyper local pop-up clinics to increase access to under-served communities. Other new initiatives were also developed in the borough to support residents.

Testing

- testing played a key role in our efforts to contain and lessen the impact of the pandemic by identifying infected individuals, to help prevent further person-to-person spread. With support from Department of Health and Social Care (DHSC) and UK Health Security Agency (UKHSA), we set up PCR and LFT test sites across the borough, targeting areas of highest need and where variants of concern were initially identified. Learnings from this will enable us to set up further test sites quickly when needed.

Contact Tracing

– our local service complemented the national service. This enabled us to follow up people by telephone or home visit, offering advice and support to those required to isolate due to testing positive or being identified as close contacts. This service ended when the requirement to self-isolate ended. With the experience that we gained; we can reinstate a local contact tracing service rapidly if needed.

BD-CAN Plus

– our community and social sector mobilised to work with the Council to help our vulnerable residents. The Council was able to rapidly organise a network of support; linking together council services, voluntary sector and residents to form the BD CAN Plus network. This network coordinated and delivered a range of support on jobs, homelessness, debt advice and other practical support including delivery of food and medicines to shielding and other vulnerable residents. The network of volunteers also played a crucial role in the running of the COVID-19 vaccination site.

Infection Prevention and Control (IPC) Support

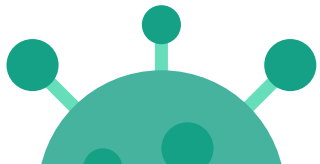
– the pandemic highlighted the critical role of specialist IPC support to social care. UKHSA and North East London Foundation Trust (NELFT) IPC team supported adult social care, but NELFTs capacity was stretched and they could only support care homes. The role of social care within the healthcare system is important and its most important the future of IPC support to settings across NEL is reviewed. It is essential any future service should have both a proactive and reactive role with enough capacity to manage the demand of high-risk areas such as care settings including other settings outside care homes.

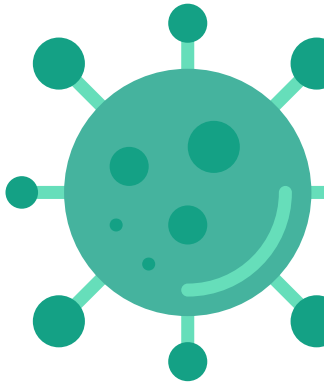
Vaccination

- vaccination has been shown to reduce the transmission of COVID-19 and contribute to reducing severe illness and deaths. We developed good partnerships with the NHS, schools, community and faith groups to help improve access to vaccinations, but we still have a challenge- with one of the lowest COVID-19 vaccination rates among children and young people in London. We continue to share intelligence on areas of low uptake with relevant community groups to help with more targeted interventions involving community champions.

Long COVID Service

- while many of those who have COVID-19 fully recover, many people also suffer long-term effects, including fatigue, breathing difficulties, depression and difficulty concentrating. Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT), in collaboration with NELFT set up and continue to provide a Long COVID clinic to support those who may be struggling with long-term effects.





What Actions are Most Effective?

Non-pharmaceutical interventions (NPIs) are the most effective public health interventions against COVID-19 after vaccination. They can be applied to different degrees and combinations, however, NPIs restrict people's lives and may have a negative impact on the economy and peoples wellbeing. Evidence based NPIs for managing COVID-19 include:

- Promoting and facilitating social distancing in all settings
- Using well-fitting masks appropriately, in public
- Avoiding crowded places, especially indoors
- Testing
- Isolation
- Regular cleaning of frequently touched surfaces
- Appropriate ventilation of indoor spaces
- Limiting the size of gatherings

These interventions have now stopped since being enforced at scale and it would be challenging to continue local operation for some, without national authority.

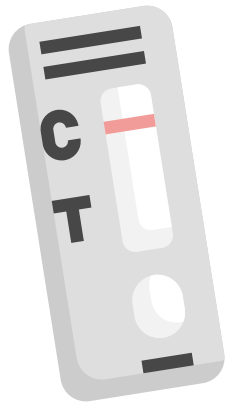
Conclusions

The worst of the pandemic has passed for now, but it is not over. As social contact returns there is likely to be a reappearance in influenza activity in winter 2022/23 to levels like or higher than before the pandemic. More recently the rise of Monkeypox has led the World Health Organisation to declare it a public health emergency of international concern. In some cases, it has also created a larger pool of susceptible children to common childhood infections, leading to outbreaks such as norovirus, chickenpox, and scarlet fever. There is also potential for co-circulation of respiratory viruses and for circulation to be longer than usual.

The pandemic highlighted gaps in IPC within social care, schools, workplaces, and other settings. We worked to support settings and embed enhanced IPC measures, but it is important to continue support, as good IPC helps prevent all infections.

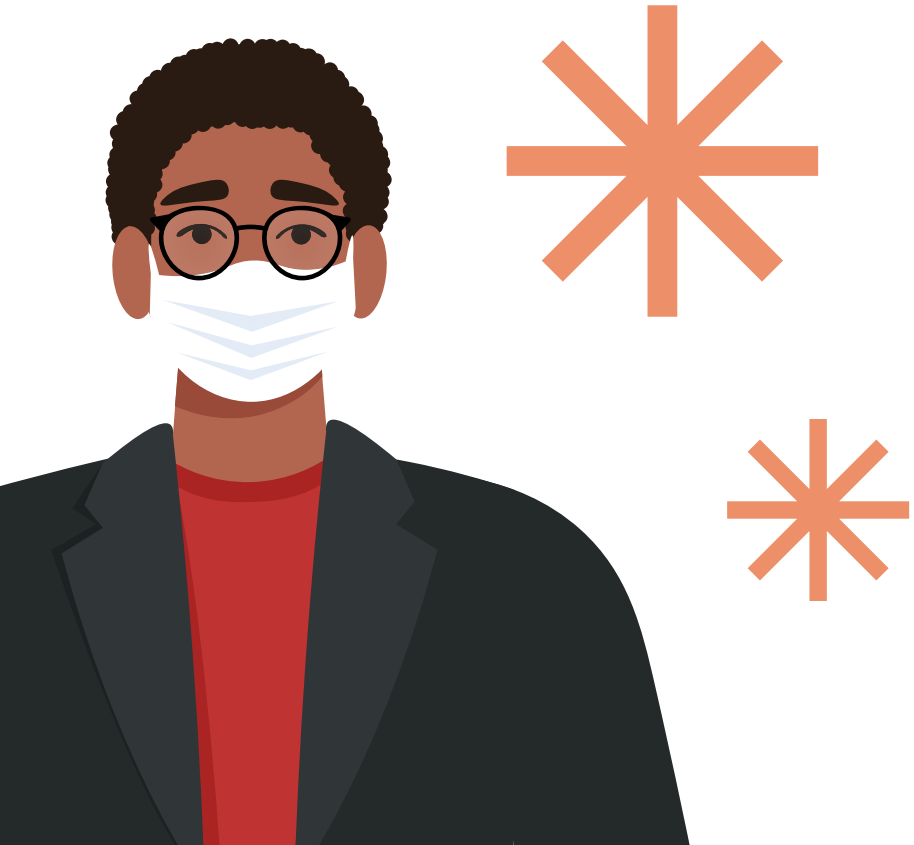
Schools were severely affected by the pandemic and worked hard to manage outbreaks and implement control measures. However, more can be done. Ventilation is important because of how the virus spreads, therefore schools need to review ventilation systems to ensure rooms have adequate ventilation to lower the risk of COVID transmission and other infections. Continuing to support the mental health and wellbeing of children is also an important role within a school setting.

Schools play a central role in ensuring good uptake of childhood immunisations and a multi-agency approach is needed to restore confidence and increase uptake of the COVID-19 vaccine and other immunisations. This is more urgent, following the detection of vaccine derived polio virus in sewage and reported cases of other vaccine preventable illnesses like measles in London.



High risk settings such as care homes were overly affected during the pandemic and many care homes closed to visitors, damaging residents' wellbeing and caused delays in the COVID-19 vaccine roll out. With support, care homes enhanced their IPC practices. An important enabler was the DHSCs Adult Social Care Infection Control Fund, which helped care homes to implement enhanced IPC measures and support backfilling staff absences due to self-isolation. As this funding has stopped, care homes need to find ways of maintaining adequate IPC as needed.

Current and future Long COVID cases will potentially require care from health and/or social care services. Occupations of those reporting such symptoms are overrepresented in health care, social care and teaching or education, meaning on top of direct impacts, Long COVID may also disrupt delivery of key services.



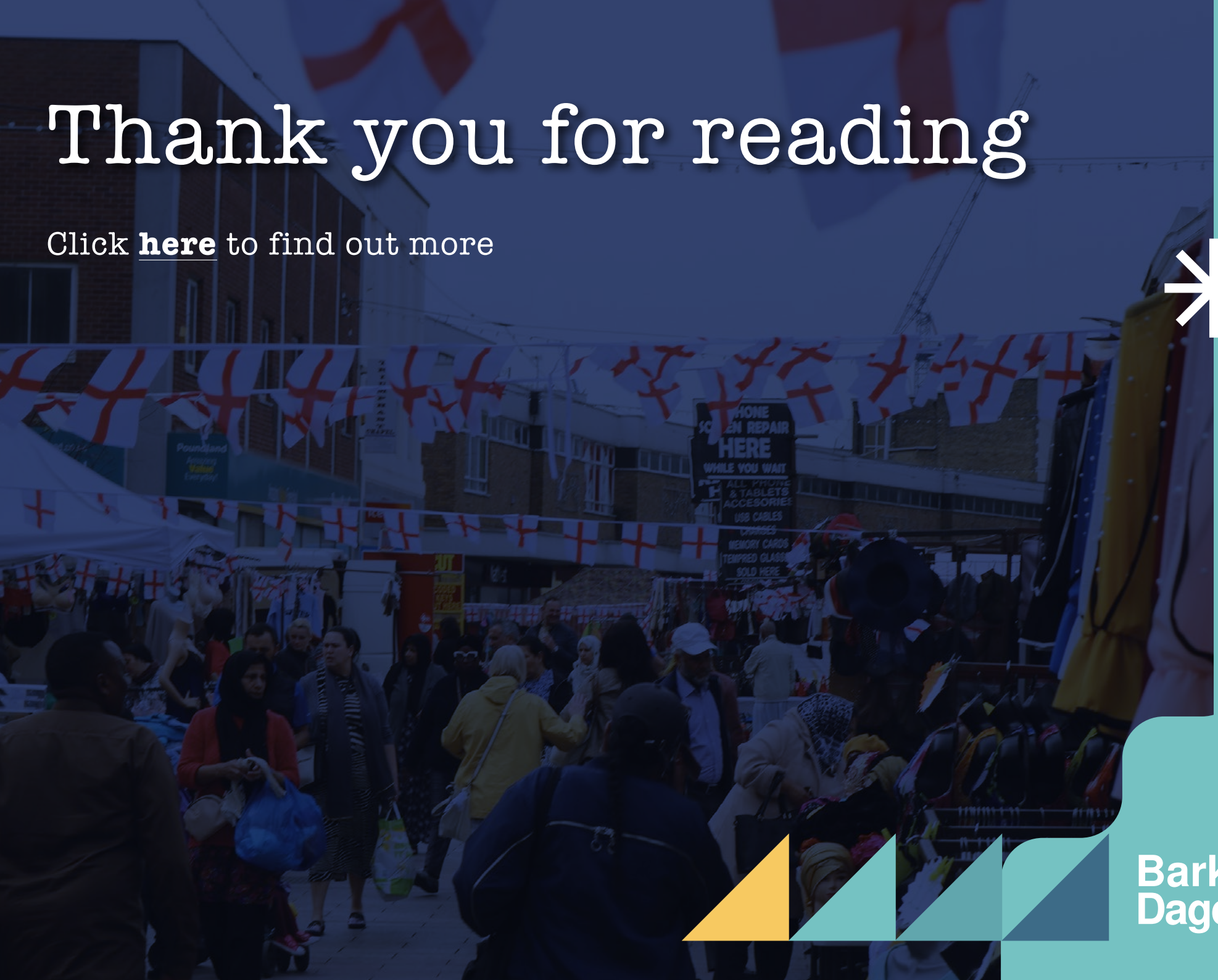
Considerations for the Future

- Inadequate IPC support to high-risk settings is under consideration across NEL and needs to be resolved as a matter of urgency.
- There is a need for the Council and partners to maintain the ability to rapidly re-establish control measures (e.g. testing, contact tracing, enhanced cleaning and supporting the vulnerable to self-isolate) in response to increasing cases, outbreaks, or variants of concern.
- Local intelligence (e.g. case rates in small areas) helps identify community outbreaks quickly and is important in a targeted and effective response. In the absence of universal testing, we need to work with UKHSA to identify outbreaks early.
- We need to build on and replicate excellent partnership working (to uptake of immunisations; cancer screening; tackling inequalities and in the distribution of cases and vaccination uptake). Data sharing arrangements must be implemented across different providers and the emerging Integrated Care Boards and Place-based Partnerships could facilitate this.
- We need to continue to increase the COVID-19 vaccination, working with communities where uptake is lowest, alongside other 'competing' immunisation programmes. This should include new approaches to addressing low uptake in some age, ethnic groups and localities.
- To recognise and address the health inequalities exacerbated by the pandemic, through all Place-based Partnership programmes.

Acknowledgments

I'd like to thank many colleagues who have provided input, information, advice and guidance:

Andrew Stock; Benhildah Dube; Carys Rees; Craig Nikolic; Dr Jackie Chin; Ellen Bloomer; Elspeth Paisley; Erik Stein; Fiona Noah; Jacquie Hutchinson; Jane Hargreaves; Jane Leaman; Jenny Houlihan; Jess Waithe; Julia Cory; Julia Kanji; Julia Pearson; Justine Henderson; Mike Brannan; Nathan Singleton; Pauline Starkey; Paul Starkey; Rebecca Nunn; Richard Johnston; Sandeep Sharma; Sarah Addiman; Sophie Keenleyside; Yaccub Enum; Zoinul Abidin.



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