Getting Serious about Prevention Together

DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT 2024-25

Barking & Dagenham

Contents

Foreword

Welcome to the Director of Public Health's Annual Report for 2024/25.

"The winds of change are yet again sweeping through the NHS, the Council, BD Collective and local communities, driven in part by an exciting public health agenda.

Although change and challenge are a fact, some things remain constant. The need to prioritise improvement in the health and wellbeing of residents, to reduce health inequalities, to ensure equity in resource distribution, and to work in partnership with our partners, continues.

Our Health and Wellbeing Board and Integrated Care Board Sub-Committee (Committees in Common) remains the forum for debate and challenge between partners, ensuring agreement and shared commitment to achieve change and improvement."

On 3rd July 2025, the Government released the '10 Year Health Plan for England: Fit for the future' [1] A long-term strategy to reform the NHS and public health services in response to the Covid-19 pandemic and the need to transform the healthcare system. This plan is a roadmap to create a new health model, fit for the future, and is centred around three key shifts: from a service treating sickness to one focused on preventing illness occurring in the first place; from delivering care in hospitals to delivering care closer to home, and digital transformation of service delivery. A welcome feature of the plan is the introduction of a national peer review system for public health teams. This initiative is intended to promote transparency, accountability, and continuous improvement across local authorities.

In London, the 30-odd boroughs act as "places" within five integrated care boards with the ambition to move away from acute hospital treatment to local, neighbourhood health care using digital advances to make living healthier more accessible and efficient is a bold and welcome shift in national policy. However, an obvious concern voiced by the Kings Fund is social care. Because of years without reform, many are unable to access the care, they need having a huge impact on the NHS as well. Although the Casey Commission is the vehicle for social care reform, reporting back in 2028.

Health care cannot be fixed without also fixing social care so it must be hoped that thinking about how the two can best work together happens sooner than 2028 [2]

From a Public Health perspective, the Government has taken a significant step forward in changing how the nation thinks about health by recognising it is not just about treatment when something is wrong. Instead, we need to prevent illness and disease by improving the quality of the myriad of factors that determine how healthy we are – our houses, our education, our jobs, our diet, our community, our access to open spaces, our freedom to live in a smoke free environment – and much much more.

As well as the increasingly understood social determinants of our health, the Government has also recognised the danger of industry influence on our health. The commitment to deliver the Tobacco and Vapes Bill and stop the advertising and sponsorship of vapes and other nicotine products is very welcome, as is the renewed promise to restrict junk food advertising and ban the sale of high-caffeine energy drinks to children.

These basic building blocks of health, alongside protection from the things that we know harm health, must be improved for residents if we are to realise the Government's ambition of preventing illness and disease so that there are fewer people unable to work due to ill health, and less pressure on our health and social care services.

In respect of the health and social care system we have the highest projected population growth in north east London and currently lack the essential infrastructure for health and care. There is insufficient primary care capacity for existing growth in Barking and Dagenham and no acute provision whatsoever within the borough. The most immediate opportunity the 10 Year Plan presents to residents is the new 'Neighbourhood Health Service' that could improve access to and quality of integrated care.

An opportunity to grasp as neighbourhoods are a fundamental building block within our system and are the core way that many of our out of hospital services will function in the future.

In February 2024 the Local Government Association conducted a Public Health peer challenge in Barking and Dagenham. The findings validate our current arrangements and give direction to the next steps to ensure the collective efforts of all our partners are focused on delivering the shared outcomes in our Joint Local Health and Wellbeing Strategy 2023-28 and closing the gap for those with the poorest outcomes.

A key message to act on is that services on their own will not improve our agreed public health outcomes or manage demand for NHS and care services without a radical upgrade in prevention that addresses the wider social determinants of health. Central to realising the opportunities is the need to change the co-production relationship between our residents and our health and care commissioners to determine the way we provide services where the best outcomes can be delivered at the right cost.

To do this we need to maintain a laser-like focus to improving population health through our emerging neighbourhood plan, be clear where our inequalities in outcomes within and between communities are.

There is much still to do, but the guiding principles should be for tangible actions underpinned by tools such as Population Health Management that inspire residents in terms of what we can achieve and to gather enough meaningful actions so we can see that the sum of these actions leads to real change. Without this we risk not being able to exploit the opportunities presented by the 10 Year Plan as well as taking the next step to make a real difference.

My report gives a professional perspective that informs this approach based on sound evidence and objective explanation, taken mostly from our 2024-27 Joint Strategic Needs Assessment. 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.'

In Chapter 1, I outline how we have used the Marmot approach, stemming from the Marmot Review in 2010, which is a framework for addressing health inequalities by tackling the social determinants of health. Without a clear focus on the important things that matter, improvement efforts fail to marshal enough time, energy and resources behind the actions that matter. Using the framework, we identified and agreed two Place outcomes which align with reducing the gap in both female and male healthy life expectancy:

- Preventing and managing long term conditions.
- Improving the number of children achieving a good level of development by age five.

Followed up in **Chapter 2** I set out how we can deliver these two outcomes through our emerging Integrated Neighbourhood Teams.

Chapter 3 examines where we can build on and strengthen our prevention and management of long-term conditions through the importance of prioritising prevention and early detection of conditions strongly linked to health inequalities. I examine how we can enhance our approach through Integrated Neighbourhood Teams using active case finding and targeting the right clinical and non-clinical support, in the right places, at the right time to improve residents buy in to our disease management and prevention programmes.

Chapter 4 takes forward our approach to innovation to improve long term condition outcomes and the care experience for residents. The emerging neighbourhood plan and the establishment of the proposed neighbourhood health provider offers further opportunities for this. I examine in partnership with UCLPartners and Macmillan how we can improve the cancer journey for residents through this approach.

Chapter 5 identifies how we can build on our current work to deliver the recently published Department for Education 'Giving Every Child the Best Start in Life'.[3] This publication sets out the vision for achieving this and the first steps to deliver the Government's Plan for Change commitment for a record 75% of children to be school ready by 2028. The priority is targeting the right support, in the right places, at the right time, for the right children.

Chapter 6 examines the work being undertaken on Health and Housing and where we can mitigate the health impacts of Emergency Temporary Accommodation on Children, Young People and Families.

Finally, in **Chapter 7** I put forward how we can unlock the potential of the Public Health Grant through an enhanced value for money approach. We are moving to a stronger focus on Public Health outcomes grounded in the lived experience of our residents.

I hope you find the 2024/25 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.

1 Agreeing place based outcomes

“This chapter gives a context for the advice within the rest of the report as it provides an understanding of the evidence of what works to address health inequalities and sets out the two outcomes that have been agreed as areas of focus over the 10 years across the Barking and Dagenham partnership.

Each subsequent chapter provides detail of the Barking and Dagenham focused actions which need to happen to achieve these outcomes.”

In November 2008, Professor Sir Michael Marmot was asked by the then Secretary of State for Health to chair an independent review to propose the most effective evidence-based strategies for reducing health inequalities in England from 2010.

The final report, Fair Society, Healthy Lives, [4] was published in February 2010, and concluded that reducing health inequalities would require action on six policy objectives:

1. Give every child the best start in life.
2. Enable all children, young people, and adults to maximise their capabilities and have control over their lives.
3. Create fair employment and good work for all
4. Ensure healthy standard of living for all.
5. Create and develop healthy and sustainable places and communities.
6. Strengthen the role and impact of ill-health prevention.

The detailed report contains many important findings, some of which are summarised below, which remain truly relevant to the health needs and inequalities experienced by people living in Barking and Dagenham today.

- People living in the poorest neighbourhoods in England will on average die seven years earlier than people living in the richest neighbourhoods.
- People living in poorer areas not only die sooner but spend more of their lives with disability.
- The lower one's social and economic status, the poorer one's health is likely to be i.e. the social gradient of health inequalities.
- Health inequalities arise from a complex interaction of many factors - housing, income, education, social isolation, disability - all of which are strongly affected by economic and social status.
- Not only is there a strong social justice case for addressing health inequalities, but there is also a strong economic case. The annual cost of health inequalities relates to lost taxes, welfare payments and costs to the NHS.
- Health inequalities are largely preventable, and action requires action across all the social determinants of health, including education, occupation, income, home, and community.

Key to Marmot's approach to addressing health inequalities is to create the conditions for people to take control of their own lives. This requires action across the social determinants of health and beyond the reach of the NHS. This places emphasis on the role of local government who along with national government departments, the voluntary and private sector have a key role to play.

Central to the Review is the recognition that disadvantage starts before birth and accumulates throughout life.

A review of Marmot Report in Feb 2020 [5] - 10 years on, commissioned by the Health Foundation added two more policy areas and identified that health inequalities appeared to be widening and life expectancy stalling. (see Figure 1)

Figure 1 – Living Longer in Good Health

The Review reinforced the importance of social determinants of health and highlighted the impact of public spending cuts. It also covered key indicators and actions associated with the objectives identified in the original review, which helps map current action and gaps in delivery, alongside the creation of a performance management dashboard.

The evidence presented in the review remains relevant today demonstrated by a growing movement of "Marmot Places" over the last few years, such as Coventry, Manchester, Gwent, Luton, Lancashire and Cumbria have partnered with Marmot's team to adopt these principles or methodology to their work on inequality. East London NHS Foundation Trust (ELFT) is a Marmot Trust [6]

However, many of these issues are complex and require long term focus to achieve population level outcomes, alongside shorter-term actions. This is demonstrated by an independent evaluation of the work in Coventry (the first Marmot City established 10 years ago) demonstrated positive impact after 6 years and showed:

- A 20% reduction in the number of neighborhood areas listed as the most deprived, according to the Office for National Statistics Index of Multiple Deprivation.
- Stabilising of different in life expectancy between women in the most and least deprived areas, despite a national increase in this gap.
- A 6-month reduction in the gap in male life expectancy, again against a national increase.

System partners in Barking and Dagenham are already active in running a range of projects and programmes that seek to address inequalities; for example, those funded through the Health Inequalities Fund. Some of these programmes address a particular building block of health (such as housing or employment) or particular health behaviour (such as physical inactivity or tobacco use) whilst others are broader, taking an asset-based community development approach (including the Community locality leads).

The aim of adopting the Marmot Place approach is not to duplicate any of these existing programmes or create a new strategy but to provide an overall strategic and evidence-based framework that brings these different strands of work together, to address agreed partnership outcomes within a common performance dashboard, which holds individual organisations to account.

Principles of the approach

- It will create a framework which incorporates priorities and outcomes of relevant existing strategies.
- It will become Business as Usual for all stakeholders through underpinning existing work such as the NHS outcomes-based commissioning pilot, single outcomes framework and the neighbourhood team working.
- It will identify evidence-based actions focused on delivery of short, medium and long term outcomes, within a performance framework holding partners to account for delivery.
- Requires commitment for delivery across the partnership and from its leadership, recognising health as an asset and poor health as contributing to a wide range of factors underpinning the deprivation in the borough.

Lessons from Coventry

- Enhance partnership working.
- Importance of political leadership and shared accountability.
- Require robust public engagement.
- Focusing on equity and qualitative measurements alongside quantitative data to improve services, especially in deprived areas.

Utilising the Marmot Framework in Barking and Dagenham

The Marmot framework provides an evidence base to inform local areas to consider what they could be doing to address health inequalities, emphasising that most is driven by wider determinates of health rather than health service provision.

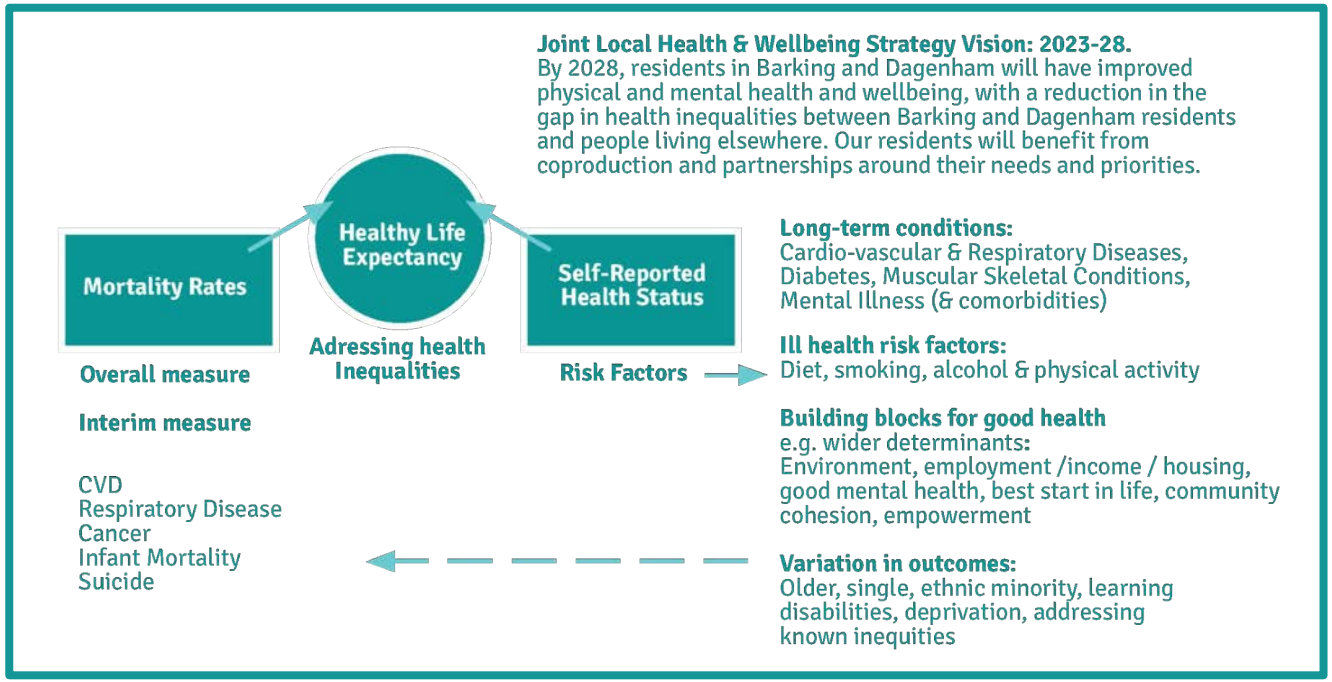
Therefore, the evidence within the Marmot Framework supports the identification of actions to deliver Barking and Dagenham's overall aim is to address the gap in Healthy life Expectancy and the specific outcomes that have been agreed.

In Barking and Dagenham Healthy Life Expectancy has been seen to the biggest health inequality for residents which is also driving high health and social costs and impacted on the wider determinants of health that is recognised in the Marmot framework.

Healthy life expectancy, the number of years someone is expected to live in good health, is significantly influenced by both individual behaviours and broader societal factors.

In my last annual report (2022/23) I set out the key factors which impact on Healthy Life Expectancy [7] which are illustrated again within the diagram below:

Figure 2
Diagram summarising the relationship of self-reported health status, mortality rates and healthy life expectancy



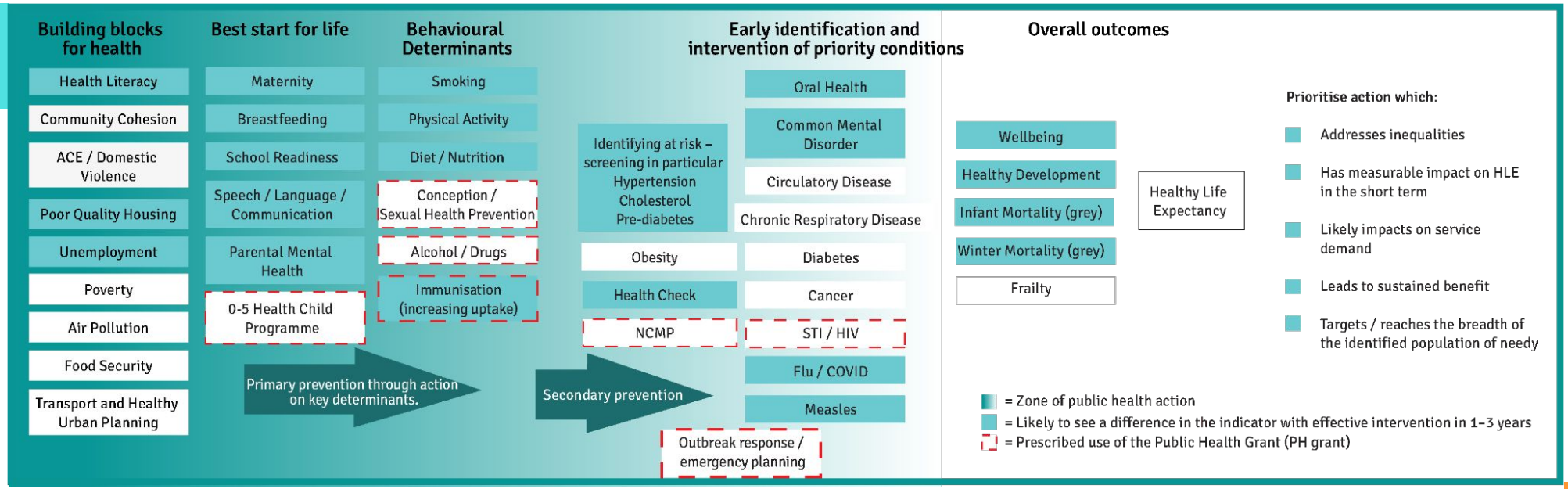
Place based outcome framework

The development of a place based single place-based outcomes framework provides a fantastic opportunity to improve efficiency, synergies, and impact of partnership activities. It will also provide more clarity on what we are measuring, why and what is /is not impacting outcomes. Taking forward learning from 'Marmot areas' a focus on two outcomes have been agreed; although more work is required to understand the specifics of these outcomes – the population of need and specific actions required.

The broad areas to be addressed to reach our overall aim to improve the gap in Healthy Life Expectancy are illustrated in the logic model (See Figure 3). The next step is to develop individual logic models relevant to the agree outcomes to identify what short medium- and long-term actions are needed to increase Healthy Life Expectancy.

This needs to happen within the context of emerging Neighbourhood Plan that works with a wide range of existing and developing plans e.g. Adults and Communities Strategy, Best Chance for Babies Children and Young People Strategy, Joint local Health and Wellbeing Strategy, the Corporate Plan, Borough Manifesto, to ensure all have relevance to an agree outcomes framework.

Figure 3
Logic model: Action to improve/reduce inequality in Healthy Life Expectancy in Barking and Dagenham over next 5 years based on key local needs



Delivering Measurable action

The Health and Wellbeing Board and Integrated Care Board subcommittee (Committees in Common (CiC)) has given it is commitment to developing a performance framework to help us to see our direction of travel towards addressing health inequalities.

As part of this commitment four potential place-based health outcomes have been discussed across the partnership and with the Leader and Deputy leader of the Council. This work is aligned with embedding the Marmot Framework at place as it will utilise the Marmot evidence base to determine action and indicators; which particularly focus on the social determinants of health; much of which are within the responsibilities of the Council.

Proposed Outcomes

- Improving the number of children achieving a good level of development by five.
- Creating fair employment and good work for all
- Reducing obesity and smoking.
- Preventing and managing long term conditions.

All actions would target the community groups with the greatest needs.

The CiC held a development workshop in February 2025 to consider the four outcomes and undertook a Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis to support prioritisation. The workshop concluded that while the proposed outcomes were

supported, no single outcome emerged as a clear priority, indicating a need for decision-making by the CiC; it was noted that some actions overlap significantly, and logic modelling will aid in understanding deliverables, with governance through existing delivery groups and alignment to relevant strategies, followed by an update at June 2025 Committees in Common meeting.

To support prioritisation an options appraisal following the CiC development workshop using the following criteria to help the next step of prioritisation:

- Clear evidence base for impact in the short term.
- Significant problem in Barking and Dagenham and will help to address health inequalities.
- Builds on current strategic intention of partner organisations.

The following are the findings

Improving the number of children achieving a good level of development by five

- **Clear evidence base for impact in the short term:** Short term action would focus on pre- and post-natal care, stages of early development and provision of community programmes to empower parents to take an active role in their children's development.
- **Significant problem in Barking and Dagenham and will help to address health inequalities:** The area has a high young population, and addressing early childhood development can significantly impact health inequalities and impact on the whole family and community. 6 out of 10 children aged 5 achieve a good level of development (lower than London and England rates).
- **Builds on current strategic intention of partner organisations:** This aligns with the development of programmes supported via family hubs; Start for Life; Early help; review of maternity services; new 0-19 service and the wider child poverty agenda. This would include improving access to benefits; housing improvements; improving air quality; increasing access to healthcare and offering educational support to children and parents.
- **Inhibitors:** Difficult to access children in greatest need and often children unknown to services as they have moved in from another borough.

Creating fair employment and good work for all

- **Clear evidence base for impact in the short term:** This outcome impacts good health, addresses poverty, and improves social outcomes but difficult to measure impact in short term. Access to apprenticeships and reduction in numbers of young people not in education and employment (NEATs), increase in access to local employment opportunities through anchor institutes are indicators.
- **Significant problem in Barking and Dagenham and will help to address health inequalities:** Indicators show that Barking and Dagenham residents experience slightly lower levels of employment and significantly higher rates of economic inactivity than London and England averages for those of working age (16–64-year-olds), they claim out of work benefit at a significant higher rate that the England average.
- **Builds on current strategic intention of partner organisations:** This aligns with local procurement to encourage good work. As well as tackling childhood poverty and an NHS agenda to support people with long term conditions back into work.
- **Inhibitors:** Size/scale of issue, systemic financial challenge, and engagement with businesses.

Reducing obesity and smoking

- **Clear evidence base for impact in the short term:** short term indicators such as reduction in smoking, increase in physical activity and access to green open space could be demonstrated.
- **Significant problem in Barking and Dagenham and will help to address health inequalities:** Obesity and smoking are significant health issues - Adult smoking prevalence in the borough is however higher than both the national and regional averages; over 7 in 10 (70.5%) adults are overweight; and the percentage of adults defined as physically active in Barking and Dagenham was 51.9% in 2021/22, which is significantly lower than the London and England averages.
- **Builds on current strategic intention of partner organisations:** This aligns with social prescribing and national funding to promote physical activity. Has a close alignment with the preventing and managing long term conditions agenda.
- **Inhibitors:** Helping people to address unhealthy behaviours is a complex and a long-term agenda. There is for example a need to address lack of motivation and unhealthy environments and requires working at national, regional, and local levels.

Preventing and managing long term conditions (LTCs)

- **Clear evidence base for impact in the short term:** This outcome leverages universal services – through systematic support. It is relatively easy to identify people with LTCs and measure support and short-term impact.
- **Significant problem in Barking and Dagenham and will help to address health inequalities:** For every 1,000 residents aged 65+ registered with a GP, approximately 328 have at least 1 long term condition, the lowest of all peer boroughs. Barking and Dagenham has the second highest rate of long-term conditions when compared to its peer boroughs, in those aged 20 – 64.
- **Builds on current strategic intention of partner organisations:** Engages every partner, for example through health checks and social prescribing. It supports the social care prevention agenda; tackling poor health literacy and aligns to the reduction of poverty agenda. Aligns with reducing smoking and obesity and access to employment.
- **Inhibitors:** In depth community-based work needed to understand and engage with underserved populations.

Following this options appraisal the Committees in Common agreed to focus on two outcomes which align with reducing the gap in both female and male healthy life expectancy:

1. **Preventing and managing long term conditions,** ensuring early diagnosis and pathways are clear to support early intervention and align with reducing obesity and smoking through targeting services to those whose need is greatest and increasing access to good employment.

2. **Improving the number of children achieving a satisfactory level of development by age five,** which provides a strong building block for the future of Barking and Dagenham.

What does Marmot say works to address these outcomes?

Give every child the best start in life

Inequalities in the early years have lifelong impacts:

interventions to disrupt inequalities are most effective and have been shown to be cost-effective with significant returns on investment.

The Marmot review highlights how childhood experiences are important in shaping lifelong outcomes. It emphasises the need for effective interventions during this period to disrupt inequalities and improve health and social outcomes.

- **Lifelong impacts of early inequalities:** Inequalities experienced in early childhood can have lasting effects, making early intervention crucial for disrupting these disparities.
- **Positive early experiences correlate with success:** Positive experiences in early life are linked to better educational performance, social development, and overall health outcomes in adulthood.
- **Consequences of adverse experiences:** Adverse childhood experiences (ACEs) are associated with negative outcomes, including poverty and poor health, highlighting the need to address these issues early on.
- **Strategies for reducing child poverty:** The document outlines strategies to reduce child poverty, which is a significant factor in the prevalence of ACEs, particularly among children from workless families.

The 2010 Marmot Review sets out the following objectives for the early years:

- Reduce inequalities in the early development of physical and emotional health, and cognitive, linguistic, and social skills.
- Ensure high quality maternity services, parenting programmes, childcare, and early years education to meet needs across the social gradient.
- Build the resilience and wellbeing of young children across the social gradient.

Marmot Review also makes the importance of Addressing Child Poverty as a contributor to this aim. The review highlights that:

- Reducing child poverty is an essential health and equity strategy, as well as important for influencing other outcomes throughout life.
- Child poverty is highest for children living in workless families - in excess of 70 percent of children in these families are in poverty.
- Impact of poverty is an increase in the likelihood of experiencing adverse childhood experiences (ACEs).
- ACEs elevate the risk that children and young people will experience damage to health, or to other social outcomes, across the life course.
- Common types of ACEs are abuse and neglect; living in a household where there is domestic violence, drug or alcohol misuse, mental ill health, criminality, or separation; and living in care.

Preventing and Managing Long Term Conditions

The Marmot Review emphasises the importance of prioritising prevention and early detection of conditions strongly linked to health inequalities.
Key actions include:

- **Investment in Prevention:** Increase long-term and sustainable funding for ill-health prevention across the social gradient.
- **Evidence-Based Interventions:** Implement programs targeting the social gradient, such as:
  - Improving the scale and quality of health care interventions.
  - Targeted health behaviour interventions for specific populations to address behaviour change for example smoking cessation and alcohol reduction.
  - Addressing Obesity: Improve access to healthier food choices, reduce obesogenic environments, and implement population-wide obesity interventions.
- **Early Years Investment:** Prevent ill health by investing in early childhood development, healthy schools, and employment.
- **Environmental Improvements:** Address air pollution, improve housing conditions, and provide access to green spaces to mitigate health risks.
- **Workplace Health:** Encourage good work practices, reduce workplace stress, and improve safety standards.
- **Community Engagement:** Strengthen social capital and resilience through community development and volunteering initiatives.
- **Monitoring and Evaluation:** Use data-driven approaches to track health inequalities and assess intervention effectiveness.

Public Health Advice

- ☑ All partners at place need to sign up to delivering the agreed two outcomes and be held accountable to delivery by the Committees in Common through a performance framework.
- ☑ The performance framework needs indicators which demonstrate delivery of evidence-based actions (utilising the Marmot Framework) over the short medium and long term.
- ☑ Strategic commissioning needs to consider the delivery plan associated with the agreed outcomes.
- ☑ The Public Health Grant and Health Inequalities Fund will only fund actions within the agreed delivery plans.
- ☑ Local communities and VCFSE organisations must be recognised/postioned as equal partners in designing and delivering prevention initiatives

2 Delivering outcomes through Integrated Neighbourhood Teams

“On 3rd July 2025, the Government released the ‘10 Year Health Plan for England: fit for the future - GOV.UK. [8]

*The Plan commits the Government to three shifts – **hospital to community, analogue to digital and sickness to prevention** – that will be core to the new health model.”*

The Plan outlines a long-term strategy to reform the NHS and public health services in response to the COVID-19 pandemic and the need to transform the healthcare system. A cornerstone of the Plan is "place" and "neighbourhood" working. The new operating model to streamline how local government and the NHS work together, making Integrated Care Board's (ICBs) coterminous with strategic authorities by 2035 where possible. The aim is that:

- A neighbourhood health plan will be drawn up by local government, the NHS, and its partners at single or upper tier authority level under the leadership of the Health and Wellbeing Board, incorporating public health, social care, and a reformed Better Care Fund.
- ICBs will bring together local neighbourhood health plans into a population health improvement plan to inform commissioning decisions.

In London, the 30-odd boroughs act as "places" within five integrated care boards. For each place, an "integrator" organisation is to be selected. The borough-level integrators could be NHS Trusts, local authorities, primary care providers, or even a partnership of several. They will host the functions needed to bring separate neighbourhood services and providers together, under the London Neighbourhood Health vision [9] . In time managed by a single community health provider. Neighbourhoods are a fundamental building block within our system and through Place are the core way that many of our out of hospital services will function in the future. The model is explicitly about community development and

capacity; using the neighbourhood footprint to address health inequalities; networks of practitioners working together through local relationships and awareness of community; integrated teams operating in an integrated service model (or team of teams) as well as about services working together at a neighbourhood level with a direct interface with acute and other services.

One of the major themes in health care policy over the last 15 years has been the development of integrated care and a more place-based approach to how services are organised. Two years ago, the Fuller Stocktake [10] proposed the development of Integrated Neighbourhood Teams, and the 10 Year Health Plan for England: fit for the future - GOV.UK [11] reinforces this desire to bring services closer to home through a shift of care from hospital to community. The implementation is these teams are now underway across the country.

These Integrated Neighbourhood Teams are multi-disciplinary teams that work together within a specific geographic area to deliver coordinated health and social care services – aiming to improve the overall health and wellbeing of the local population by providing joined-up, preventative care, and addressing health inequalities.

They will focus on improving access to services, reducing health inequalities, and fostering collaboration among different organisations, while also employing a public health approach to health issues through personalised care plans and data-driven interventions.

However, the government's 10 year Health Plan focuses more on reforming the NHS and public health services, so if we are serious about addressing health inequalities, we need to take this opportunity to develop a wider local response – responding to the desire within the Plan to shift the NHS from sickness to prevention. I believe our Health and Wellbeing Board and Integrated Care Board Sub-Committee will drive decisions to establish our future Neighbourhood Plan and provide us with an opportunity to take a wider perspective on health and wellbeing – taking on board the evidence base within the Marmot Framework which, as I described earlier will require work to tackle the social determinants of health.

A "Neighbourhood Health Certificate" is proposed in the NHS Plan, which is not a formal, standalone document or process in the UK health system but is a concept which relates to the broader NHS strategy of shifting care into communities and integrating services at a local level. This involves initiatives like the Neighbourhood Health Implementation Programme (NHIP) and NHS Neighbourhood Teams, which aim to improve health outcomes by delivering more care closer to people's homes.

This Place based Public Health approach was first mentioned in my reports in 2016/17 and 2018/19 which described an evolving locality model in Barking and Dagenham, which enables a place-based response to improve the health and wellbeing of our residents and reduce service demands. I further described in my People, Partnerships and Place 2021/22 report on the development of the Place-based Partnership and the actions needed to address inequalities using the Marmot principles within the population intervention triangle should remain the model of place-based working. And the 2023 report which described how placed based working can contribute to improving healthy life expectancy working through:

- creating a shared understanding of health outcomes based on data and evidence of need to develop community civic and services-based interventions (the population intervention triangle (see Figure 5).
- Coordination of more accessible and engaged services using the POTS framework (See Figure 7).

The principles remain the same now within Integrated Neighbourhood Teams, where there is an immediate opportunity to invest non-recurrent Public Health Grant reserve along with other Council investment into a two-year transformation plan to establish a neighbourhood plan using a Public Health approach, and work together to address the two agreed outcomes. This follows a recommendation of a recent review [12] led by the Nuffield trust that Integrated Neighbourhood Teams should try to set objectives in broader terms about population health, inequalities, and crucially patient and staff experience.

The following diagram (see Figure 4), produced within the healthcare public health framework for Wales [13] provides a useful overview of how a public health approach can be adopted within a Neighbourhood Health Service.

Figure 4

A Healthcare public health approach as an umbrella encompassing established and evolving work

Prevention Based Health & Care

- A vehicle to drive policy into practice and achieve a tangible shift towards prevention across the health and care system.
- The PBHC Framework aims to enable prevention to be embedded by those involved in strategic and operational planning: designing and implementing service pathways; improving the quality and delivery of frontline care;' and leading service transformation and delivery.
- It Highlights the need to address workforce capability (C), opportunities (O) and motivation (M) in leading/delivering preventative action.

Reducing Inequalities through Primary and Community Care

- Partnerships engagement and influence to enhance understanding of health inequalities, through provision of data, evidence and signpost to training.
- System working to develop a culture of curiosity about where and why health inequalities exist and champion proportionate actions.
- Supporting identification of through collaboration with people with lived experience and those on the front line and in communities.
- Co-production of solutions with people with lived experience.

Value in Health

- A philosophy, a policy and a tangible action plan being delivered by Health Boards across Wales, based on Prudent healthcare principles.
- Cost – Quality – Outcome
- Focuses on development of outcomes' measurement (PROMs/PREMs).
- Using data to support the improvement of healthcare services and value for patients; costing measurement and analysis; unwarranted variation; programme budgeting & marginal analysis.
- Supporting leads to be stewards of resource by influencing high value care for the populations they care for.

Environmentally sustainable health and care e.g. Greener Primary Care

- Globally, the healthcare sector is responsible for approximately 4–5% greenhouse gas emissions.
- Greener Primary Care supports the four independent primary care contractor services in Wales to improve the environmental sustainability of their day-to-day practice.
- Actions are required by a variety of people making small changes.
- Digital tools and technologies will be used to reduce carbon impact. And to reach the Welsh Government decarbonisation targets.
- Advocates for the large number of people making small changes, as this will have a bigger impact overall than a small number of people making big changes.
- This work is equally applicable for the wider healthcare and integrated health care system.

Population Health Management

- Data-informed planning and delivery of proactive are to achieve maximum impact for the health and wellbeing of the population
- Highlights a short to long term approach for the developing population health management in Wales
- Advocates for collective action – health and care share a cohesive population health approach; strong emphasis on linked, person-level datasets for the whole population to enable segmentation, risk stratification
- Focus on prevention and community well-being.

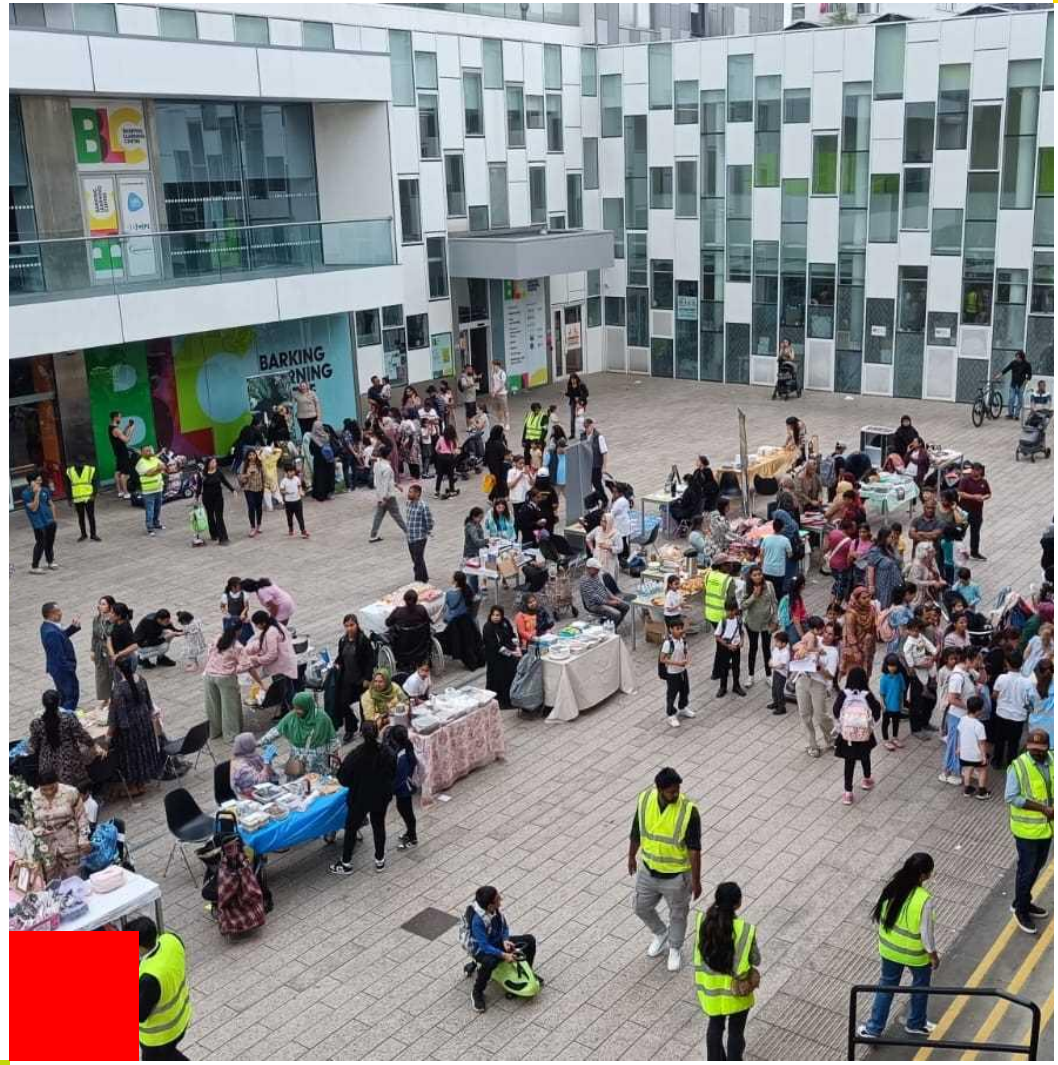
However, community empowerment needs to be at the centre of efforts to reduce health inequalities and creating conditions for individuals to take control of their own lives, which was one of the key features of the Marmot Review. For some communities this will mean removing structural barriers to participation, for others facilitating and developing capacity and capability through personal and community development. [14] [15]

By taking this Public Health approach will enable a focus on the agreed outcomes (as previously described):

1. **Preventing and managing long term conditions,** ensuring early diagnosis and pathways are clear to support early intervention and align with reducing obesity and smoking through targeting services to those whose need is greatest and increasing access to good employment.

2. **Improving the number of children achieving a good level of development by age five,** which provides a strong building block for the future of Barking and Dagenham.

We propose using a proportion of the Public Health Grant reserve to embed the 'marmot' approach as part of the transformation plan. This is positive as Public Health programmes should be adaptive to the pace of change and innovative in approach. Our co-production work has shown that there are areas where we could make changes to improve outcomes for residents by ensuring that



the Grant is used to deliver real outcomes and provide a stronger focus on preventative interventions and a more effective reach into neighbourhoods.

The Health and Wellbeing Board and Integrated Care Board Sub-Committee recommendation to establish a task and finish group to establish this may be now more effectively subsumed into the Neighbourhood Plan transformation group.

The Public Health Teams generally, and particularly Directors of Public Health, are going to be an important part of the operating model and are in an ideal position to support this transformation – leading the analytical, community development, commissioning support, population management and evidence-based reviews and programme management support needed within Integrated Neighbourhood Teams; as well as leadership 'at place' to deliver effective place-based action, framed within a long-term, place-based approach involving civic, community, and services-based interventions, as illustrated by the Population Intervention Triangle to the right.

But as the smallest Public Health team in north east London and indeed one the smallest in the capital to deliver against a context of a borough with one the highest health needs in England, there is a case for investment in the team.

Details of key health inequalities and current activities associated with these outcomes to support plans can be found in chapters 1,3 and 5.

Figure 5

Population Intervention Triangle

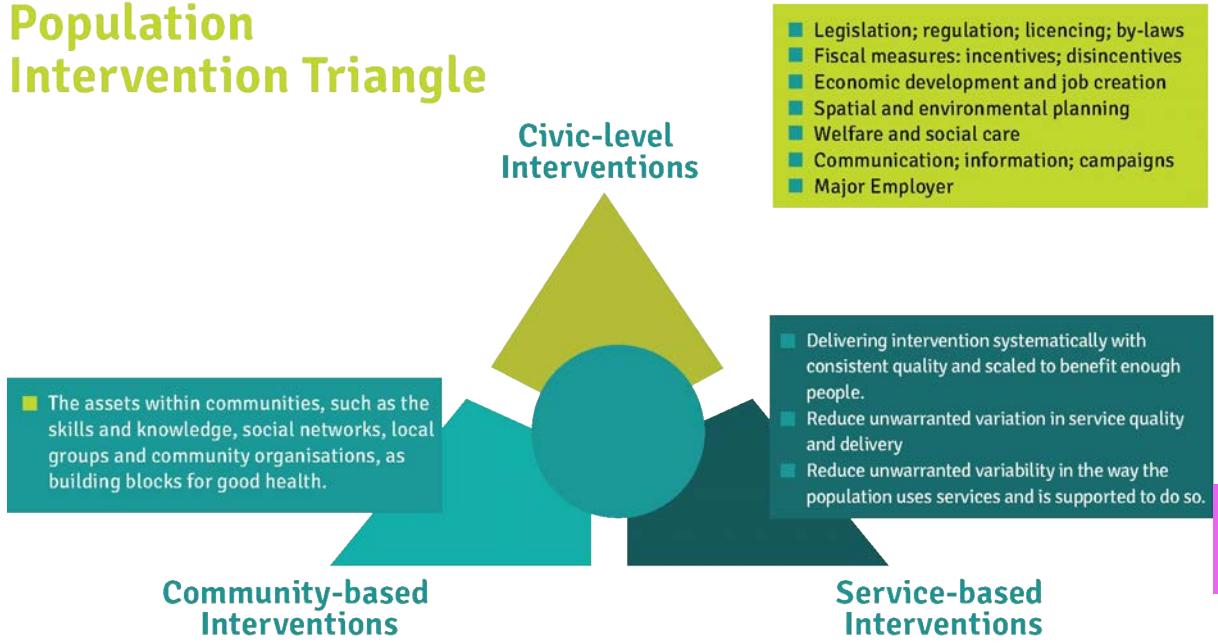


Figure 6

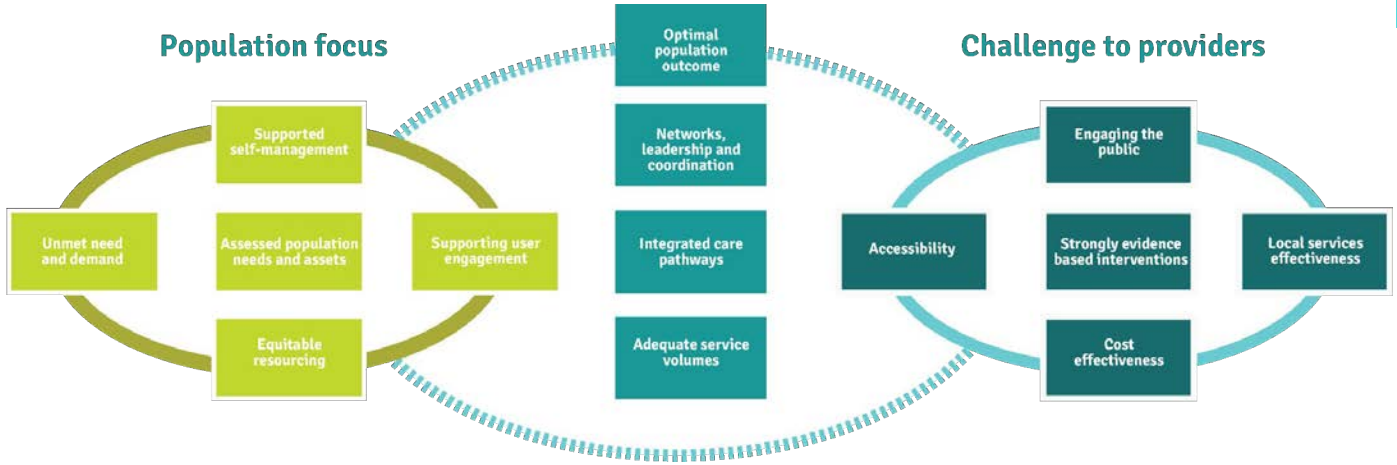
Governance framework

Robust governance is also needed which supports the delivery of the agreed outcomes through integrating service planning with clear leadership, evidence -based delivery plans setting out responsibilities across all partner organisations, co produced with residents would be required.

Service- based Interventions

To deliver accessible services to address inequalities in outcomes, the Neighbourhood Plan is advised to utilise the Population Outcomes through Services (POTS) framework (see figure 7). Utilising this framework will support the development of effective interventions that are evidence-based, outcome-oriented, sustainable, and appropriately resourced. Further description of the elements within the model can be found: [16]

Figure 7



Using a Logic Framework to define actions to deliver an agreed outcome

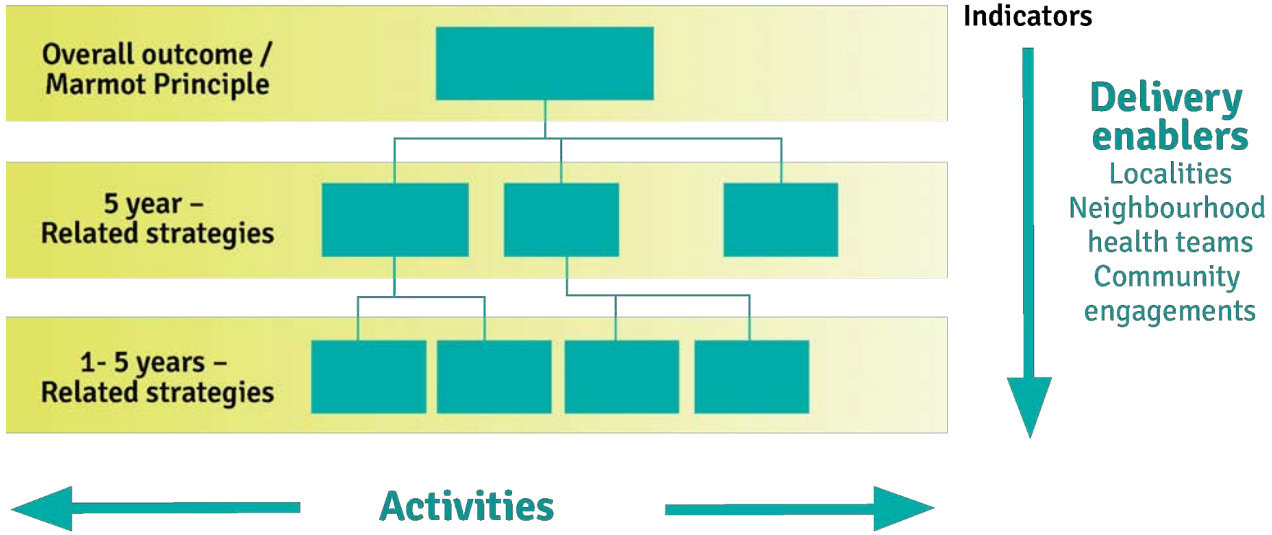
Well-designed logic frameworks can enable (see Figure 8):

- A common understanding among the different project partners of what the project entails with agreed and focused objectives;
- a thorough exploration of the key assumptions and the cause and effect links between the various objective levels to reduce the risk of project failure;
- planned activities and outputs that are collectively necessary and sufficient to achieve the high order objectives; and
- a systematic framework for monitoring and evaluation.

Figure 8

Example logic model template

Aim: to address the gap in years residents spend in good health (Health Life Expectancy)



Public Health Advice

- ☑ To ensure that decisions across place and neighbourhood teams are routinely informed by evidence that is tailored to the local context, including a detailed understanding of health inequalities … [and ensure] population-based approach to care planning and delivery.
- ☑ Each Integrated Neighbourhood Team need to take a Public Health approach to address health and health inequalities through the development of a plan to deliver the agreed outcomes.
- ☑ Developing the Integrated Neighbourhood Team plan would include the need to understand the specific populations which experience the most inequalities relating to the outcome and relation to long term conditions - the specific condition or multiple long term conditions of focus; utilising the intervention triangle and the Population Outcomes Through Services models (described previously).
- ☑ Each neighbourhood should develop a logic model describing actions and performance indicators over a short, medium, and long-term period for the place based agreed outcomes
- ☑ A case of investment is supported for expansion of the Public Health team to support NHS Strategic Commissioning and in establishing a strong neighbourhood health service at place to enable and support the delivery of neighbourhood working and related place priorities.
- ☑ Neighbourhood approach depends on grass roots partnership - residents, small VCFSE groups and faith networks are vital to understanding barriers and motivating participation.

3
Getting serious about prevention (no really!)

*“Moving from a focus on “**sickness to prevention**” is one of the Government’s three big shifts and a foundation of the 10 Year Health Plan for England [17].*

As far back as 400 BC the Greek philosopher Hippocrates (the father of Western medicine) declared “Walking is man’s best medicine” and encouraged a preventative approach to health.

So, what can or should be different this time? ”

Getting 'fully engaged' on prevention

The Government's Health Mission and Health Plan is not the first time the impacts and costs of ill health have been considered, including a focus on the NHS. Around the year 2000 the esteemed banker Derek Wanless was asked by the Treasury to independently lead a commission on future demands of ill health on the NHS (and wider society). The First Review [18] called for a significant increase in NHS funding (leading to a 50% increase). A second report [19] in 2004 highlighted the limitations of the NHS and the need to shift the focus from just caring for the sick to promoting good health through a *"fully engaged scenario"* using all parts of society, including the public.

Previous policies have repeated key themes, including the NHS Five Year Forward View [20] declaring *"Getting serious with Prevention."* However, whilst progress has been made (e.g. on smoking), rhetoric has never led to a shift in action (or funding) at scale. So why now?

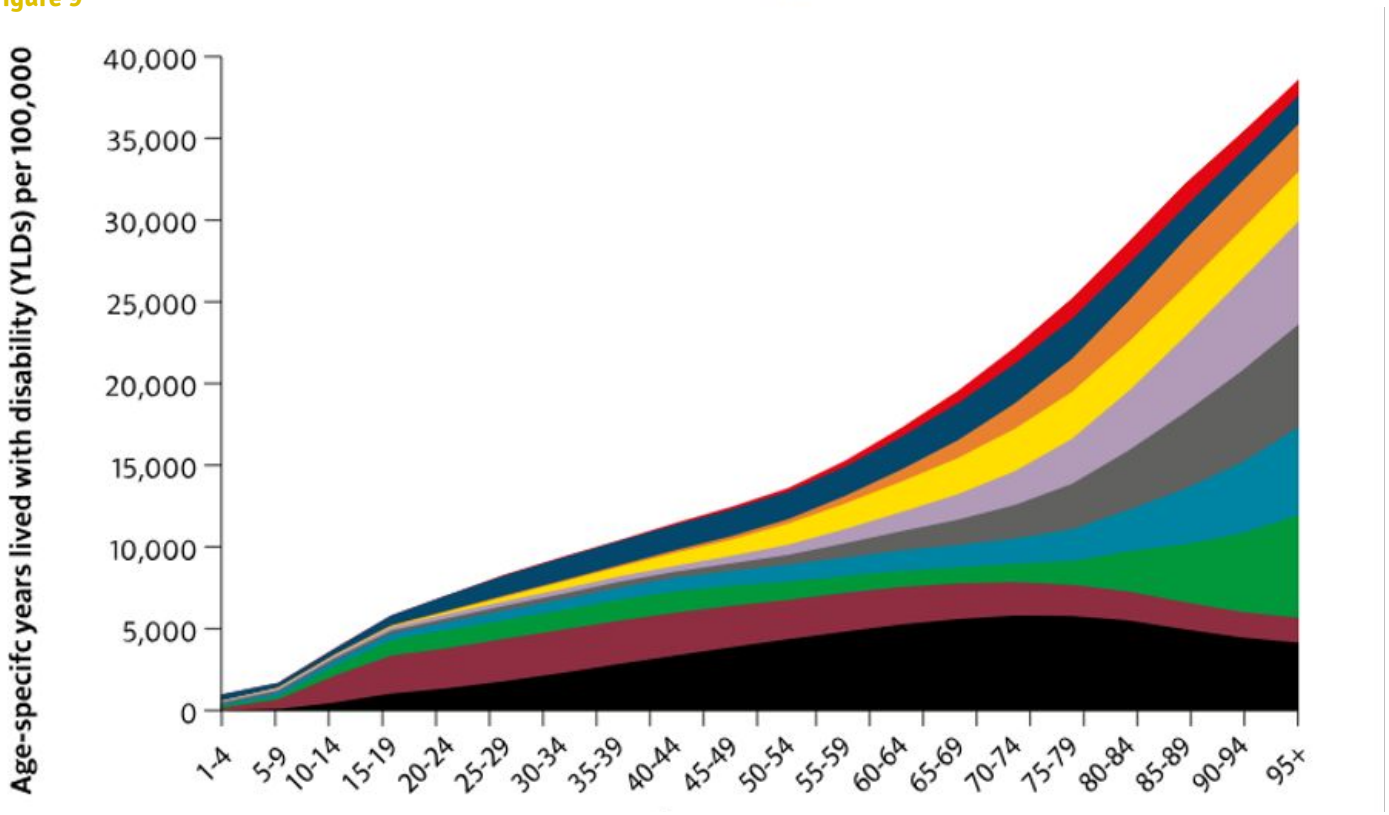
Ill health and long-term conditions a 'wicked issue'

The UK is increasingly the 'sick man' of high-income countries, with ill health a 'wicked issue' (i.e. developed over time with no single solution). Data show the UK has had the second highest disease burden in the "Group of 7"

major industrial countries (behind only the USA) since 1990. It is not just a 'health issue,' with the UK the only Group of 7 country with an employment rate lower than before the COVID-19 pandemic. [21]

Incidence of disease is also starting at a much younger age (see Figure 9). Data show growth across all the major disease factors amongst the 16 to 64 years who are economically inactive because of long-term sickness, with associated major increases in health-related welfare claims for the young and middle-aged.

Figure 9



Multiple health conditions is a particular issue, with someone dropping out of work due to ill health will have an average of four diagnosed health conditions. A considerable proportion of this burden falls on already stretched social care services through increasing numbers, complexity, level, and length of support needs; two-thirds of adult social care budgets now dedicated to working age and lifelong disabled adults and predicted to increase by 50% by 2030. [22]

Inequalities and disproportionate impact

This new 'pandemic' of preventable ill health has seen stalling or possibly worsening in life expectancy and healthy life expectancy, unprecedented in recent history and across high income countries. [23] However the burden of this ill health is not equal across society, with significant and widening "health inequalities" (i.e. avoidable and unfair differences in health).

The Health Foundation predicts that by 2040 people in the 10% most deprived areas can be expected to be diagnosed with a major condition 10 years earlier than those in the least deprived areas (see Figure 10). It estimated that 80% of the increase in working age ill health will happen in the 50% most deprived areas, with particular increases in inequalities for chronic pain, anxiety and depression, and type 2 diabetes. [24]

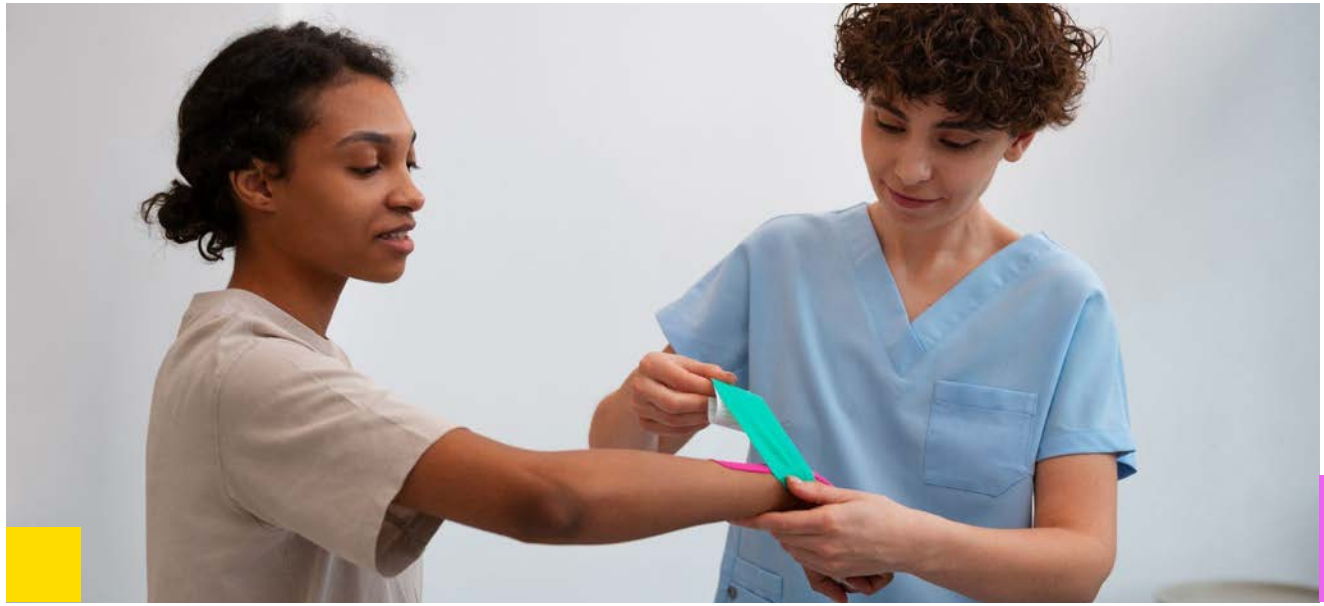
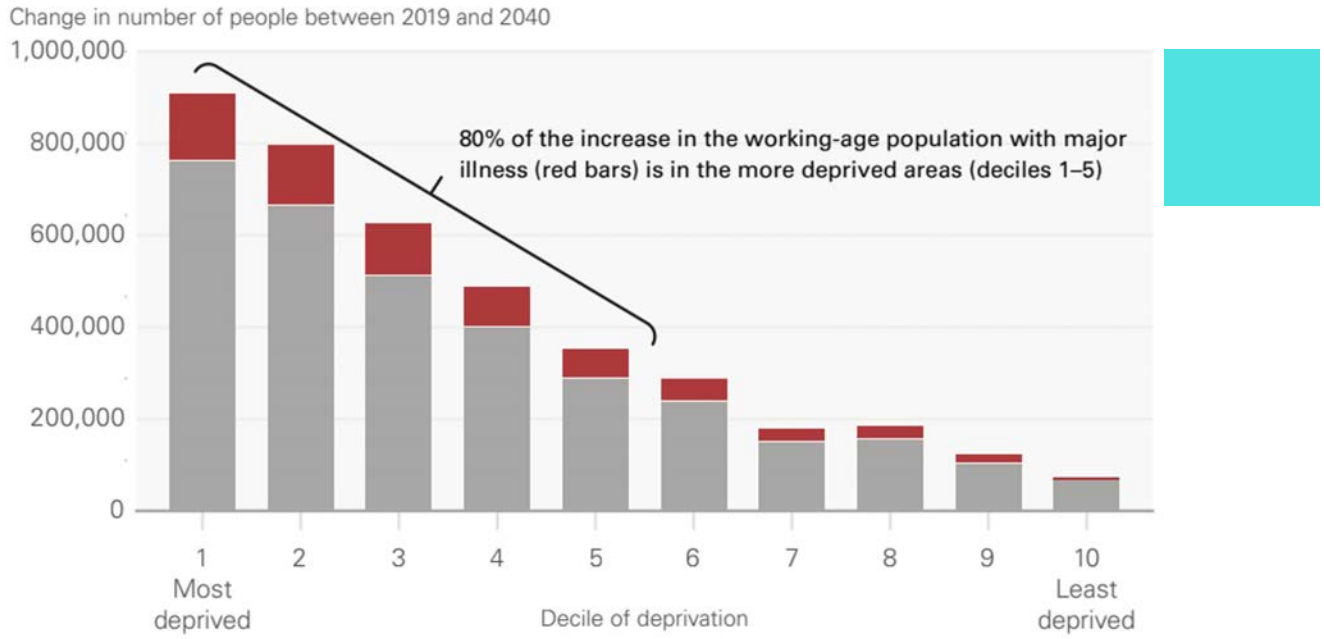
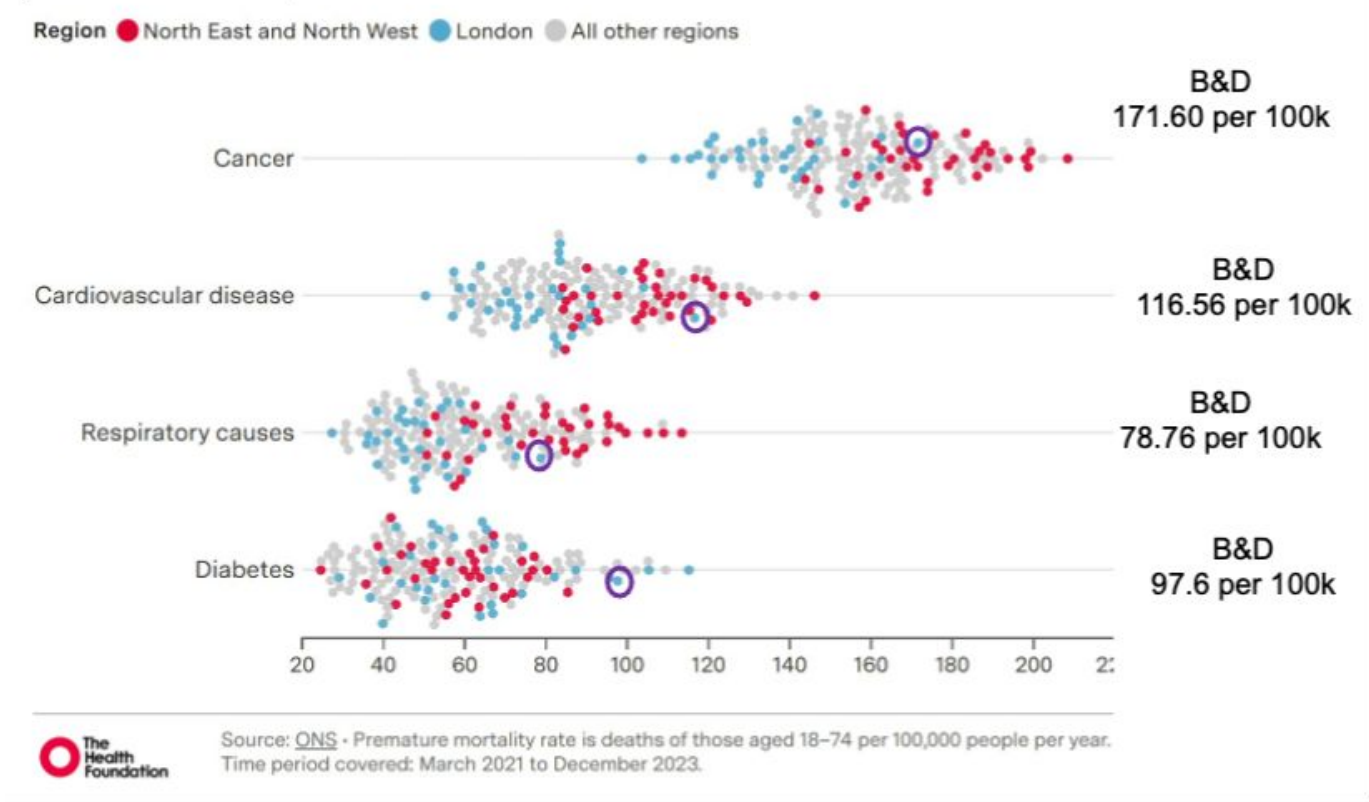


Figure 10
Projected change in number of people aged 20-69 years with major illness between 2019 and 2040



A recent Health Foundation analysis of geographic inequalities in premature mortality [25] demonstrated that Barking and Dagenham is the only London borough to have a premature mortality rate higher than England and Wales average (503.67 deaths per 100,000 versus average of 435 per 100,000). It also illustrated how Barking and Dagenham is an outlier compared to London counterparts for poor outcomes across the key causes of death and inequalities in premature mortality, i.e. cancer, cardiovascular disease, respiratory causes, and diabetes (Figure 11)

Figure 11
Premature mortality rate (accounting for age and sex) for selected causes, in England and unitary authorities in Wales, 2021–23



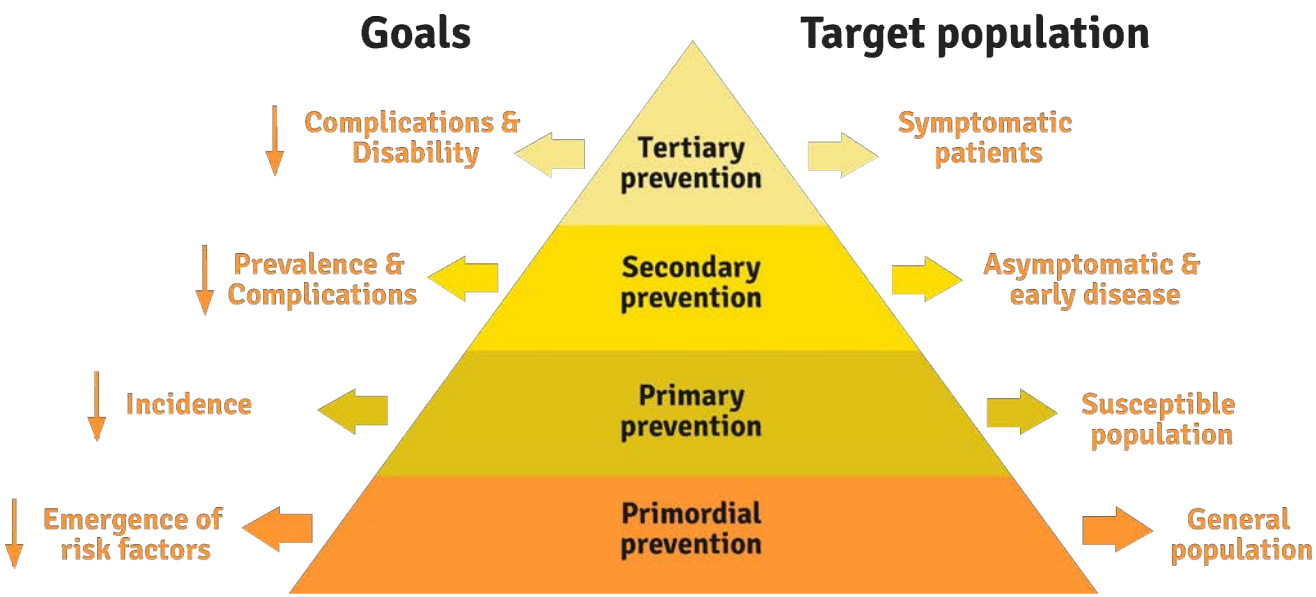
The art of prevention – Separated by a common language

To say there is no action on prevention would be false and diminish significant work and achievements. However, it is difficult to understand what is, is not and should be happening as there are different types of prevention, each with different goal, target populations and interventions. Figure 12 explains the 'prevention' pyramid.

It is important to recognise that types and interventions for prevention vary significantly by:

- **Cost –** e.g. low costs of smoke-free and other policy interventions.
- **Cost effectiveness –** e.g. three to four times lower costs of public health versus NHS interventions.
- **Timescale of effect –** e.g. social determinants of health interventions (e.g. housing, employment) compared to clinical interventions (e.g. prescribing statins).
- **Consent –** e.g. restrictions on advertising high fat sugar and salt product requires political support but limited not consent of individuals.
- **Acceptability –** e.g. opposition to immunisation compared to screening.

Figure 12
Types of preventative intervention ('prevention pyramid')



Developing a prevention programme requires selecting a mix of interventions which vary across these characteristics (e.g. costs, timescale of effect, etc.).

Developing our preventative approach

The Health and Wellbeing Board and Integrated Care Board Sub Committee (Committees in Common (CiC)) has made *"Preventing and managing long-term conditions"* one of two Place health outcomes. This will support work already under way to increase a focus in Prevention across Barking and Dagenham, primarily in respect to scale, focus and effectiveness. This is also being embraced and embedded in emerging neighbourhood plan and working approaches (e.g. neighbourhood networks, community health and wellbeing pop-ups).

Examples of these developing approaches include:

- **Primordial prevention –** Working to develop healthy physical activity and food environments through our Physical Inactivity Place Partnership and Good Food Plan.
- **Primary prevention –** Coproduction of vaccination approach to target communities with low uptake.
- **Secondary prevention –** Targeted earlier NHS Health Check at people aged 30-39 years of 'high-risk' individuals to address poorer outcomes between our ethnic groups and communities.

- *Tertiary promotion* – Roll out of the Macmillan Cancer Support-funded Improving Cancer Journeys Learning Programme. [26] (see Chapter 4).

Prevention is everyone's business

"...is everyone's business" is a common post-script for most complex 'wicked' issues, but is genuinely essential for prevention of long-term conditions as we cannot 'treat our way' out of the current situation. The need for a 'fully engaged scenario' was referred to back in 2002 in a national review and work has been undertaken on understanding the unique contributions of different sectors (e.g. Figure 13 summarises a model developed by Tower Hamlets Public Health Team on the roles of social care and health care sectors to Long Term Conditions prevention).

It has long been known that healthcare has an important, but limited contribution to population health outcomes. Therefore, it is critical that action on the social determinants of health is aligned to support health improvement and the reduction of health inequalities. To support this, it is helpful to understand the inter-relationship between long term conditions and wider outcomes. For example, an Office of National Statistics analysis [27] looked at the contribution of six common conditions on people's earnings, their ability to work, and the social security benefits they receive for five years after a first hospital diagnosis. The highest total loss of earnings for over the five years were for stroke (£18,785), chronic kidney disease (£14,721), and heart failure (£10,446). Probability of employment reduced most in the fourth year for those diagnosed with stroke (12.1%), chronic kidney disease (9.4%) and heart failure (7.7%). The greatest increase in probability of benefit receipt in the fourth year were for chronic kidney disease (16.3%), stroke (14.0%), and heart failure (12.2%)

Figure 13
Primary, secondary, and tertiary prevention model for social and health care need (developed by Tower Hamlets Public Health Team)

Prioritisation

With almost 1 in 3 (30.9%) of Barking and Dagenham patients having a long-term condition (including 1 in 6 (16.1%) before the age of 40) [28] and multiple conditions prevalent across the population, it is easy to consider the prevention challenge too big to tackle. However, modelling [29] suggests small change would make a significant difference, i.e. 20% reduction in six major disease categories—cancer, cardiovascular disease, chronic respiratory illness, diabetes, and mental health and musculoskeletal disorders—could raise national Gross Domestic Product by almost 1% in 10 years.

While prevention needs to be embedded across care, there is also value in focussing where the biggest opportunity for impact can be made, to maximise outcomes for limited resources. This could be based on i) the number of people who could benefit; ii) the opportunity to deliver and effectiveness of interventions; and iii) overlap in prevalence and impact of interventions with other conditions.

In Barking and Dagenham, the most prevalent long-term condition based on recorded prevalence within General Practice registers is hypertension, with over 1 in 10 patients diagnosed with the condition (11.89% or 29,180 patients); modelling suggests a further 11,265 residents have undiagnosed hypertension. The second most prevalent condition is diabetes mellitus with around 1 in 14 patients diagnosed, (7.04% or 17,283 patients); with 2,964 residents likely to have undiagnosed diabetes.

Looking at causes of inequalities in life expectancy

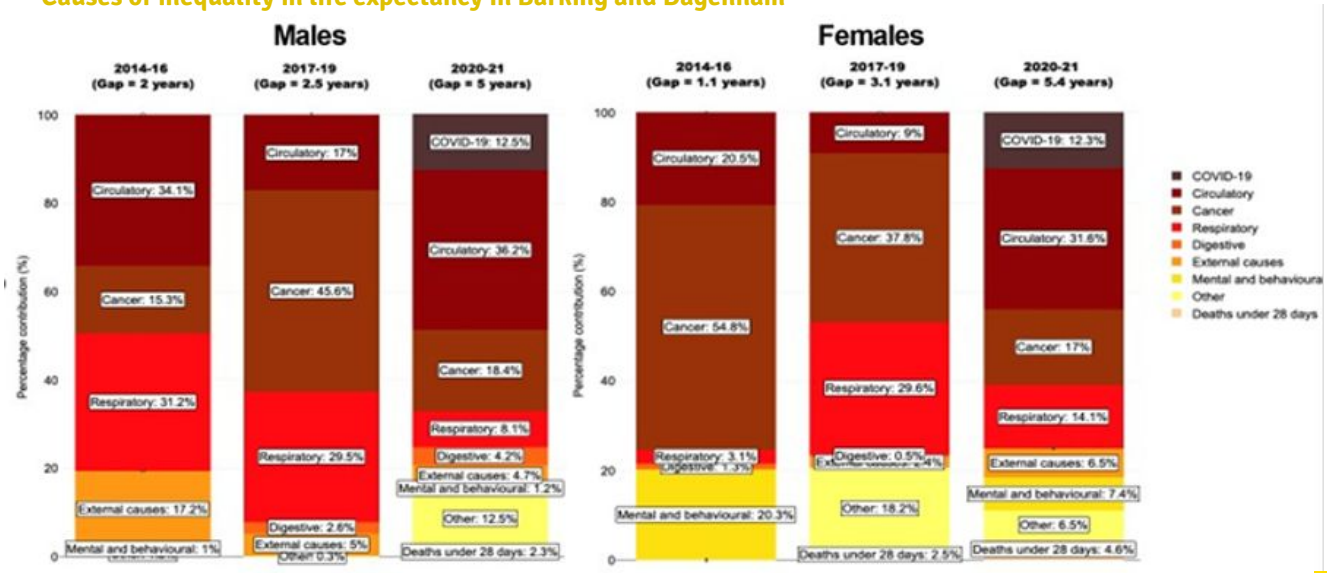
within Barking and Dagenham (i.e. gap between the least and most deprived quartiles) the largest contributor is circulatory diseases, for both males and females (see Figure 14).

Data on the number of people who could benefit suggests a focus on hypertension, which also has the benefits of strong links to a range of circulatory diseases (including heart diseases), as well as many other conditions, including diabetes mellitus, obesity, and chronic kidney disease.

Furthermore, a focus on cardiovascular diseases would and be able to benefit from national and regional investments, e.g. the pan-London *"A Million Hearts and Minds"* preventative programme that aims to support an ambition for London to become the healthiest global city.

Figure 14

Causes of inequality in life expectancy in Barking and Dagenham



Source: OHID (2022). Segment tool. Available at: https://analytics.phe.gov.uk/apps/segmenttool/

Case study

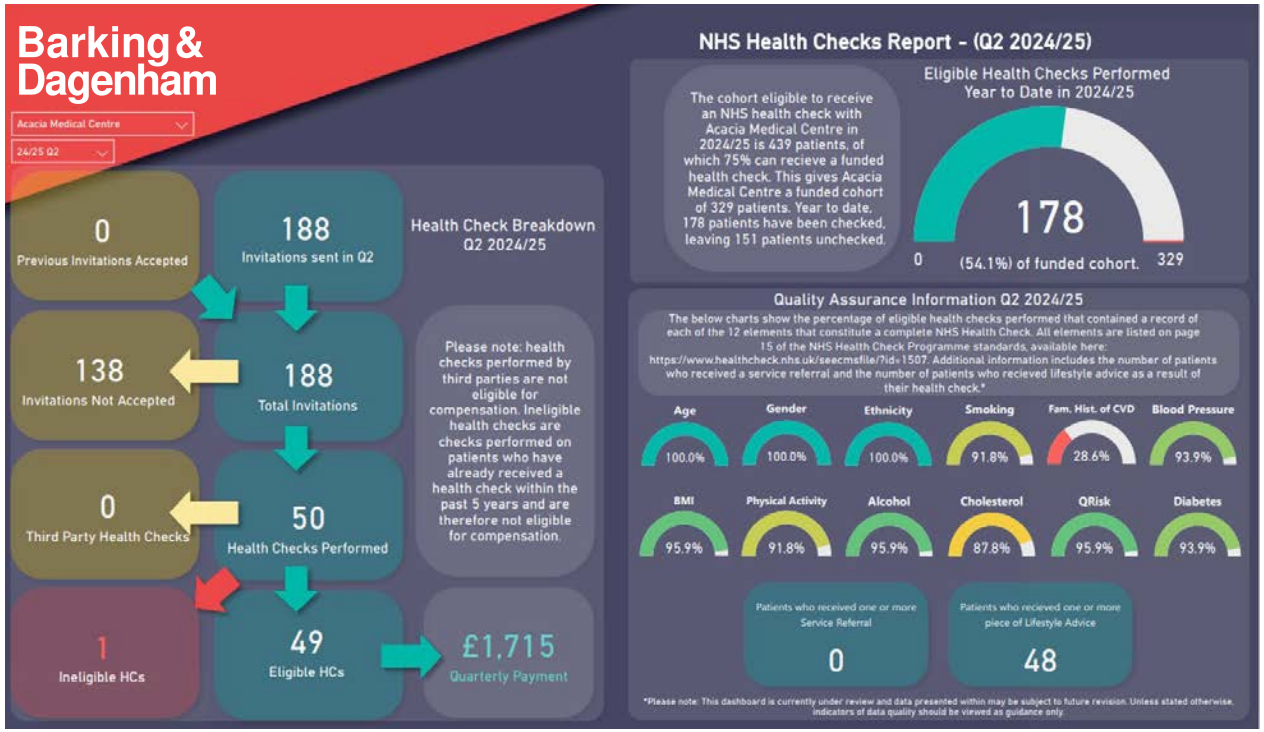
Quality improvement in NHS Health Check

NHS Health Check in general practice is a success story for Barking and Dagenham. The percentage of NHS Health Check received by the total eligible population in 2023/24 was 25% higher than 22/23 and 100% higher than 21/22, and the highest in London in Q4.

Modelling suggested high numbers of undiagnosed and unmanaged associated health conditions, therefore the expected lower than expected outcomes. Consequently, the Public Health Team and the Clinical Lead worked together to develop a programme to maximise outcomes through a collaborative programme of support and quality improvement.

An enhanced programme started in 2024/25, including:

- Transparent financial allocations to ensure all practice are resourced to achieve the national 75% target.
- Practice and Primary Care Network-specific quarterly analysis of NHS Health Check data.
- Piloting NHS Health Check outreach events by the GP Federation, Together First.
- Phase 3 pilot of earlier targeted NHS Health Check in residents aged 30-39.
- Quality and impact audit pilot to develop a consistent, systematic approach to monitor quality and impact by Together First.
- Tailored support from the training partner (Smart Health Solutions) to support capacity development across general practices.
- NHS Health Check in community pharmacies with the Local Pharmaceutical Committee.



Although this programme is still rolling out, data demonstrates that practices are continuing to deliver NHS Health Check to a higher proportion of eligible residents than most other areas.

Public Health Advice

- [x] Ensure decisions across the system, place and neighbourhood teams are informed by evidence tailored to the local conte… (including health inequalities) and take a population-based approach to care delivery and planning.
- [x] Develop consensus across Place regarding the scale, trends, and wider implications of long term conditions (e.g. on support needs from NHS, social care, and community support).
- [x] Utilise quality improvement to understand the performance of existing interventions and maximise outcomes.
- [x] Develop insight/understanding of our complex population to understand needs and 'what works.'
- [x] Consider including prevention across all elements of health and social care, with a specific, focus on the interventions and levels of potential with the greatest impact and implement consistently at scale.
- [x] Deliver a cross-partner delivery plan for the long-term conditions, considering prioritising cardiovascular diseases or hypertension and developing a prevention programme that includes a mix of interventions that vary by cost, timescale, and delivery partner.
- [x] Utilise Population Health Management for targeted prevention.
- [x] Prevention can only succeed if it is socially owned rooted in community action, peer support and community identity.

4 Improving Cancer Journeys in Barking and Dagenham

“The NHS 10 year plan includes a significant focus on neighbourhood health services, aiming to shift care from hospitals to communities and integrate services within local areas. Thus, providing ***an opportunity to strengthen our existing neighbourhood based proactive care model.”***

Based on integration and coordination within local communities the Plan aims to enhance our current model by bringing together various services like general practice, community health, mental health, acute care, social care, and voluntary organizations to provide proactive and personalised care for individuals, especially those with complex needs.

Our approach has always been to use innovation to improve outcomes and the care experience for residents. **The London Case for Change**" and the "**London Target Operating Model and Next Steps for Implementation**" for a neighbourhood health service in London provides further opportunities for this [30]

Key is how quickly our current providers (Together First, Primary Care Networks, BD Collective, the Council, North East London NHS Foundation Trust, Barking Havering and Redbridge University Hospitals NHS Trust etc.) can collaborate and configure themselves to run their neighbourhood provision with a focus on delivering improved outcomes.

In partnership with UCLPartners and Macmillan we explore through this approach how we can improve the cancer journey for residents.

MACMILLAN CANCER SUPPORT

UCLPartners Health Innovation

Introduction

A cancer diagnosis can be overwhelming: bringing emotional distress, physical effects such as pain, fatigue, or nausea, and practical challenges like managing work, finances, and daily responsibilities. These concerns often impact both the individual and their loved ones.

In Barking and Dagenham, we are committed to improving the experience and outcomes for residents affected by cancer. The Improving Cancer Journeys (ICJ) programme, developed in partnership with UCLPartners and Macmillan, offers personalised support and practical help to people navigating a diagnosis — not just with treatment, but with the wider impacts on housing, finances, mental health, and everyday life.

Understanding the impact

Cancer affects every part of a person's life – and too often, support systems do not reflect that reality. People are left to manage alone, not knowing where to turn for help.

- 1,200 residents in Barking and Dagenham are diagnosed with cancer each year
- Many face challenges beyond treatment, financial stress, emotional health, isolation, and navigating complex services

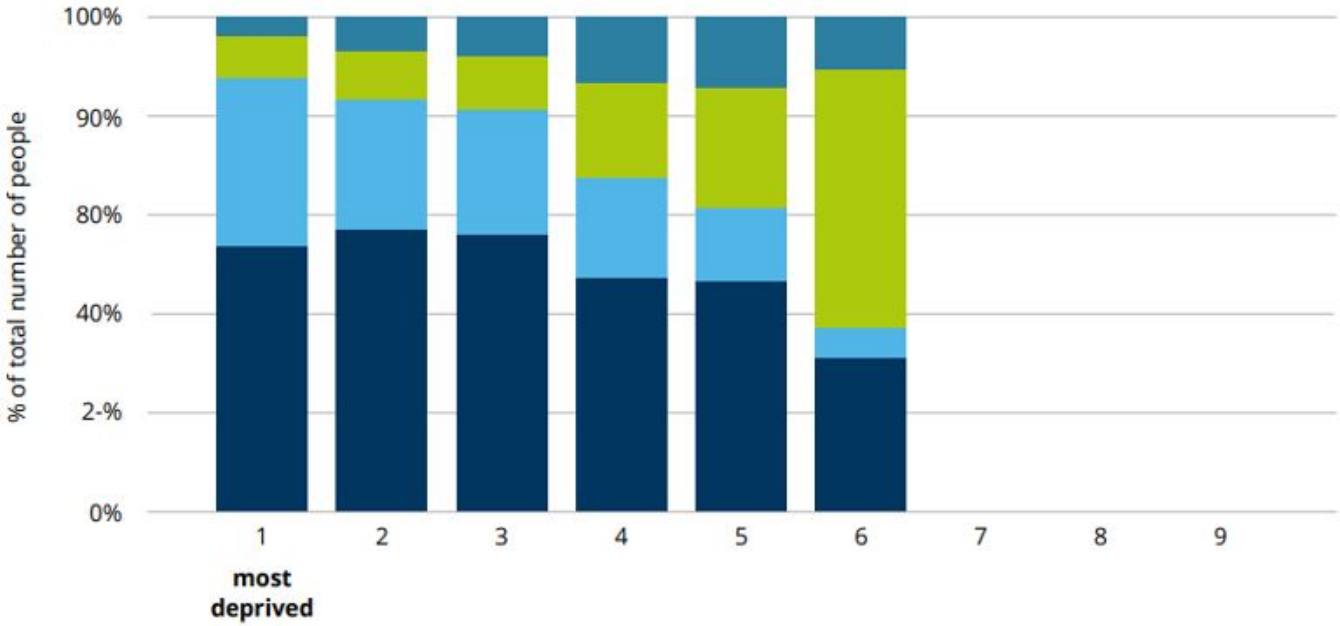
Barking and Dagenham, is one of the most deprived boroughs in London and England [31] has been selected for this programme due to the specific challenges faced by its residents. Deprivation contributes to approximately **19,000 additional cancer related deaths** annually in England. [32]

Research shows that people in deprived areas:

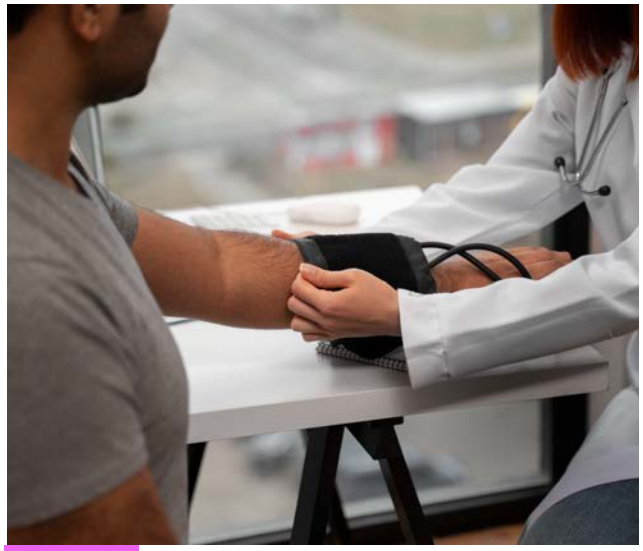
- Experience greater **barriers to seeking help** [33]
- Are more likely to have **multiple long-term health conditions** [34]
- Have **less continuity** of care [35]
- Are more often **diagnosed** with cancer through **emergency care** [36]
- Are **less likely to receive treatment**, such as chemotherapy for Stage 4 cancer compared to those living in more affluent areas [37]

Graph 2

Proportion of people living in the most deprived to least deprived areas of Barking and Dagenham by ethnicity (White, Black, Bangladeshi and Pakistani) compared to the total population



This graph illustrates that the population of Barking and Dagenham are living in the most deprived areas of the country, with no areas in IMD 7 or above. The Black and White population of Barking and Dagenham are more likely to be living in the most deprived areas, whereas the Bangladeshi and Pakistani groups are more likely to live in lesser deprived areas.



We also have a **young population** with the average age of 33 [38] and many residents who face significant health challenges which will affect how cancer impacts their lives. As most of the population is of working age, the burden of cancer could be particularly disruptive, not only to individuals but also to families, the people they care for and the local economy. [39]

In addition, Barking and Dagenham is home to a vibrant and increasingly diverse community, with a growing number of residents born outside the UK. [40] This diversity underpins the borough's evolving identity, but it also highlights deeply rooted health inequalities.

There is a well-established link between ethnicity, deprivation, and cancer outcomes. [41] Communities from Bangladeshi, Pakistani, and Black backgrounds are more likely to live in deprived areas [42] where structural barriers can lead to delayed cancer diagnosis, reduced access to preventative services like screening, and limited availability of timely, high-quality treatment. [43] These factors are often compounded by challenges such as language barriers, lower levels of health literacy, and mistrust of healthcare systems – all of which can contribute to poorer cancer outcomes. [44] As Barking and Dagenham's population continues to evolve, it is vital that services are culturally responsive and equity-driven, ensuring that no one is left behind in the fight against cancer.

Support for people affected by cancer in Barking and Dagenham

In 2024, the **most commonly diagnosed cancers** in Barking and Dagenham were:

1. Prostate
2. Breast
3. Bowel
4. Gynaecology
5. Skin

People's concerns usually fall into these categories:

- **Practical:** Issues such as work, finance, transport, and caregiving
- **Emotional:** Feelings of anxiety or worries about the future
- **Physical:** Symptoms of cancer, treatment side effects, and overall well being.

The **top concerns reported by cancer patients** to their clinical team at Barking Havering and Redbridge University Hospitals NHS Trust were:

1. Tiredness, exhaustion, and fatigue
2. Worry, fear or anxiety
3. Money or finance
4. Thinking about the future
5. Uncertainty

To address these concerns, patients and their families need information and referrals to support services tailored to their needs.

People living with or affected by cancer in Barking and Dagenham can access a range of support – from emotional wellbeing services to practical advice and post-treatment guidance. These services are provided by the NHS, GPs, community groups and charities, all working to ensure residents receive the care they need.

> *"I couldn't even walk properly some days – it was like my body just wouldn't work."*
>
> - *Cancer patient in Barking and Dagenham*

> *"I asked the doctor, Will I get to see her grow up? and they could not give me an answer"*
>
> - *Cancer patient in Barking and Dagenham*

However, access to this support can be uneven across the borough. A person's background, cultural norms, how well they understand the system, or whether they are connected to the right networks can all affect what help they receive – and when. Efforts are ongoing to improve consistency, raise awareness, and ensure that no one faces cancer alone, regardless of background or postcode.

Listening, learning, and improving

We know that not everyone with a cancer diagnosis – or those close to them – is getting the support they need. Over the past year, we have worked with **UCLPartners** to understand what is getting in the way, and where we can do better. We have looked at how people currently access help, what is missing, and what could make a real difference.

We also spoke directly to patients about their experiences.

> *"I didn't even know it was an option until years after treatment"*
>
> - *Cancer patient in Barking and Dagenham*

Not everyone is being reached – and that matters

Following discussions with health and care staff and community representatives, we identified key challenges:

- Low awareness of the support offer among both professionals and people affected by cancer.
- Integration of existing services with GPs, Council and community organisations remains inconsistent so staff are not aware of what is available for their patients.
- Need to diversify engagement to reach older people, those with learning disabilities and ethnic minority groups.
- Data sharing across systems is complex, and patients must tell their story multiple times.

We also found that some people are saying no to a conversation about their cancer journey – not because they do not want to help, but because they are not sure what is being offered or how it could support them. Sometimes the information is not clear, or it is not in a format that works for them.

We recognise that some patients may face additional challenges in accessing care. For example, those **diagnosed in Emergency Departments or while on a hospital ward** may not be picked up by the system. These groups are more likely to come **from deprived backgrounds or be from Black or Asian communities –** groups that already face poorer outcomes. If we do not act, this could widen existing health inequalities.

There are other barriers too, **Stigma around cancer** in some cultures can stop people from seeking support. And for some, past experiences have led to **mistrust** in the health system.

We must do better at making sure everyone has the chance to access support in ways that feel relevant, respectful, and clear.

> *"I felt dismissed by the consultant and GP when raising concerns about pain"*
>
> *"When they discussed my concerns, it made me feel powerless. Like my voice did not matter"*
>
> - *Cancer patient in Barking and Dagenham*

Working together to make change happen

Over the next three years, London Borough of Barking and Dagenham is working in partnership with **Macmillan, UCLPartners,** and a wide range of local organisations – including **GPs, hospital teams, voluntary groups, and community services.**

Together, we are building a better way to support people living with cancer – making sure they get the emotional, physical, and practical help they need, when and where they need it.

Our Vision

Personalised cancer care should be just as valued as clinical care.

We are building on the success of Improving Cancer Journeys programme in Scotland, where a more community-based model led to greater uptake in the most deprived areas – reaching people who often miss out on traditional services.

Why we are doing things differently

We know that services already exist to support people with cancer – but **they do not always reach everyone** who needs them. The current model is mostly hospital-based and medically focused. It can feel distant, institutional, and not always right for people's wider needs. We want to change that and address wider healthcare inequalities.

Our approach supports national health priorities by moving care closer to home, using community settings and digital tools where appropriate. This is about making cancer care more personalised, accessible, and sustainable – not duplicating what is already out there but improving how and where people get support. We will be testing innovative approaches to identify what works.

"My vision is that we impact patients in the best possible way, in a way they need. I see this as an opportunity to learn and transfer knowledge to other boroughs that have similar significant challenges. My vision is that patients and their families have timely access to adequate health and wellbeing support as well as clinical"

- Lead Cancer Nurse at Barking Havering and Redbridge University Hospitals NHS Trust

What is the Improving Cancer Journeys Learning Programme?

Improving Cancer Journeys is a person-centred approach to cancer care. Our aim is to identify and address non-clinical needs – from emotional support to housing and employment – through timely coordinated support.

Our guiding principles

These are the principles shaping our approach:

- **Support happens in the community** – not in hospitals.
- Conversations take place in safe, accessible spaces where people live.
- **Co-designed with the community** – not done to them.
- People affected by cancer are at the heart of shaping what the service looks like.

It is a whole-system effort

- Hospitals, GPs, the Council, local charities, and community organisations all work together.
- **We build on what is already strong.**
- We do not reinvent the wheel – we connect, support, and grow what already exists in our neighbourhoods.

Partners include

Barking & Dagenham

PCN Central Barking & Dagenham
Your Health, Our Priority

NHS
Barking, Havering and Redbridge University Hospitals
NHS Trust

NHS
North East London
NHS Foundation Trust

NHS
North East London
Cancer Alliance

NHS
North East London

MACMILLAN CANCER SUPPORT

UCLPartners
Health Innovation

Health Innovation Network
Local change, national impact

Local Voluntary, Community, and Social Enterprise organisations, including

BD COLLECTIVE

Faith Action

Conclusion

The improving Cancer Journeys Learning Programme will be more than a service – it is a shift in how we support people living with and beyond cancer. By working together across sectors, listening to what matters, and responding to real-life needs, we are creating a model of care that is compassionate, responsive, and person centred.

We are proud of what we have started and committed to going further.

Have you or someone you love been affected by cancer?

We are looking for people with lived experience to help shape a better future for others. Your voice can make a real difference. Get involved and be part of improving cancer care and support.

Want to learn more?
Visit: Improving Cancer Journeys Learning Programme - UCLPartners [45]

5 Ready for school ready for life

“In my last report I focused on actions which relate to adults and actions that can affect short term change, acknowledging that action across the life course is important as today’s children will be tomorrow’s adults.”

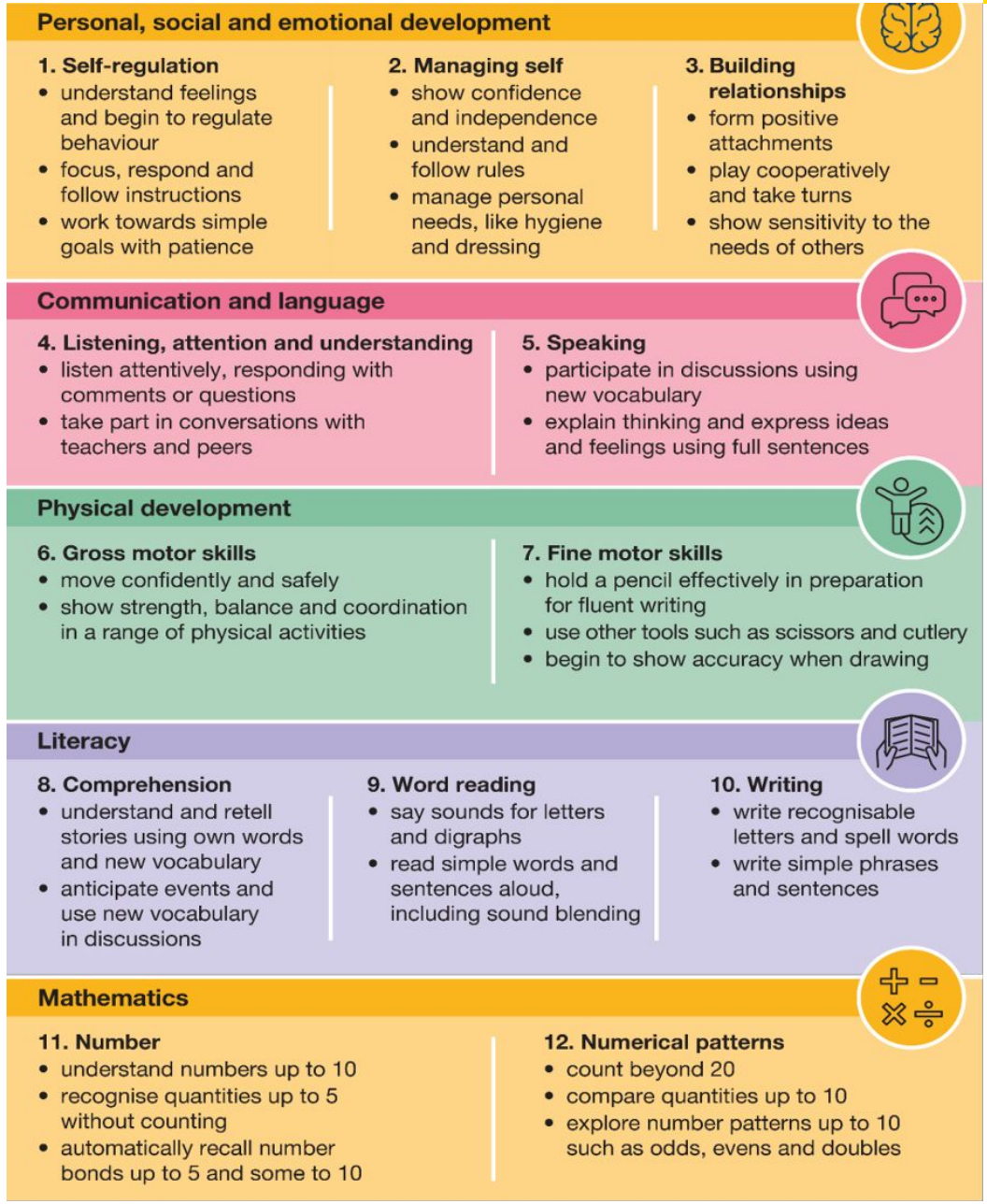
To become well adjusted, thriving adults it is right to assume that children and young people may require help along their life journey. Locally there are several universal and targeted services that can provide various levels of support to children and young people at set and flexible times dependant on need.

Effective local public health approaches deliver evidence-based action in each of the following life stages, broadly described as Best Start encompassing preconceptions up until age 5 and school age. Importantly, our actions focus on parents and caregivers as well as children and young people, taking a whole family approach and building on national reforms identified in the recently published Department for Education 'Giving Every Child the Best Start in Life'. This publication sets out steps to deliver the government's Plan for Change commitment for a record 75% of children to be school ready by 2028.

Children are born ready and eager to learn.

However, for each child to reach their full potential, they need opportunities to interact in positive relationships and to be in environments that enable and support their development. Starting with the first 1001 days being ready for school signals strong social skills, such as being able to cope emotionally with being separated from parents, being relatively independent in their own personal care and having a curiosity about the world and a desire to learn. A child's readiness for school can be attributed to the sum of many parts, a ready family, a ready community, and ready services, underpinned by a healthy deference to the importance of the first 1001 days.

Figure 17
Development Goals for Children



Defining school readiness

Readiness for school' or 'school readiness' has several definitions, but broadly refers to children being socially, emotionally, and physically ready for entry to school at age 5. The school readiness measure includes assessment of 12 early learning goals, using the EYFS statutory framework for group and school-based providers. Readiness is assessed at the end of reception year by school teachers and is currently not mandatory.

Within the current context the 2 and 2.5 year mandated review conducted by Health Visitors as part of the Health Child Programme is of particular importance because evidence supports being ready to learn at 2 years, can lead to being ready for school by 5 years meaning that by school entry, the child will have reached a level of holistic development which enables them to be ready to learn. Invariably setting them on course for achieving future development milestones.

Readiness for school is important because it predicts future academic attainment and life outcomes. The 1,001 days from pregnancy to the age of two set the foundations for an individual's cognitive, emotional, and physical development. Therefore, early identification of need (health, education, and social) gives a child a greater chance to succeed.

There are several factors that can have an impact on child development. The following tables summarise these areas.

Figure 18
What are the characteristics of a school ready child?

Table 1: The Child

		Barking and Dagenham	England
Low birthweight	Babies born with low birthweight are at a higher risk for delays in language acquisition, problem-solving skills, and overall cognitive abilities, which can make early learning more challenging.	3.8% Public Health Outcomes Framework (PHOF, 2023).	2.8% (PHOF, 2023)
Active Play	Supports coordination and social skills. Physical activity also improves child attention span, which is fundamental to learning, helping children develop problem-solving.		
Connections & Social Interactions:	Healthy relationships with family, friends, and caregivers improve emotional regulation, communication skills, and collaboration—essential qualities for classroom dynamics.		
Oral Health & Nutrition	Breastmilk supports the development of a strong immune system, helps reduce illness-related absences in early years, lowers the risk of developmental delays, and fosters emotional security. A balanced diet supports brain development, concentration, energy levels, and overall health. Early years dental health sets the foundation for lifelong oral hygiene, impacting a child's overall health, well-being, and ability to thrive.	83.4% of newborns received breast milk as their first feed. 29.4% of 5-year-olds have experience of dental decay. 14.8% of children in obese.	71.7% (PHOF, 2023) 23.4% (PHOF, 2023) 10.1% (PHOF, 2023)
Immunisations	Vaccination coverage is the best indicator of the level of protection a population will have against vaccine preventable communicable diseases. Coverage is closely correlated with levels of disease	By age 2, 75.5% of children have had one dose. (23/24, PHOF)	88.9% (23/24 PHOF)

Table 2: The family's impact on school readiness

A good home & home environment	A stable, nurturing home environment fosters emotional security, resilience, and cognitive growth. Supportive relationships, routines, and a safe space for learning create a foundation for academic success.	
Parental Income	Higher income often provides access to greater educational resources, healthcare, nutritious food, and extracurricular activities, all of which contribute to cognitive and social development. In the Barking and Dagenham residents 2023-24 Cost of Living survey, results show that there is an ongoing high level of anxiety around the cost-of-living. The most common answer given when asked how worried residents are is still 5 – "my living costs have increased, and I am not able to cope". 18% of children in Barking and Dagenham under 16 live in absolute low income families. 23% of children in Barking and Dagenham under 16 live in relative low-income families.	Eng 15.6%; Lon 12.3% Eng 19.8%; Lon 15.8%
Parental Education & Skills	Educated and skilled parents are more likely to engage in stimulating conversations, read with their children, and encourage curiosity, all of which boost language development and problem-solving skills.	
Parental well being & parenting	Parenting is influenced, although not determined, by parents' own childhoods and their current lives, including their own mental wellbeing, their social and material circumstances, and their networks of support.	

Inequities in Child Health

Early investment in the support and services that families need is recognised by the government as vital due to its protective impact upon child physical and cognitive development, social development, readiness for school and later educational outcomes. Public health policy in the UK is clear as to the importance of **early investment** to preventing smaller challenges developing into more serious issues.

This supports not only the health and wellbeing of children and families but our society and economy in the future (Darling et al, 2020). These sentiments are echoed in the recently published Giving Every Child the Best Start in Life [46] strategy. This landmark reform brings together early years, and family services and puts children's first year at the heart of work to improve life chances and is backed by nearly £1.5 billion over the next three years to raise quality, close gaps and break down the barriers to opportunity for every child.

Being ready for school signals being ready for life. Therefore, every child and young person irrespective of the circumstances they are born into should have an opportunity to maximise their life prospects, however, not every child or family have the support they need for their child to be physically healthy, emotionally secure, and ready to learn.

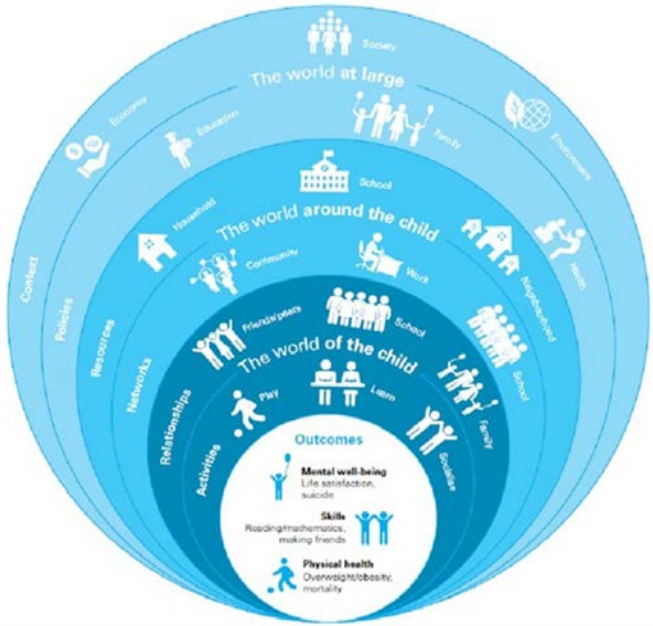
There is a clear **social gradient** in children's health seen clearly through the impact of family circumstances on child mortality and morbidity. The most deprived 10 percent of children are nearly twice as likely to die as the most advantaged 10 percent of children, and children in more deprived areas are more likely to face a serious illness during childhood and to have a long-term disability [47]

Inequities in child health and development start early; they exist at pregnancy, birth and during the early years. Several factors contribute to this relating to the family (e.g., family income), the child's health status, and services (access to services). Risk factors for good child development can often accumulate over the life course, having long-term consequences on health and social outcomes such as educational attainment and employment.

School readiness is a building block of health because it facilitates the development of cognitive, emotional, and social skills that support lifelong well-being. Early experiences shape healthy habits, resilience, and the ability to face challenges.

The social determinants of health or social circumstances of health are a wide range of complex and interconnected factors that influence health. These social circumstances play a significant role in achieving wellbeing during early childhood, influenced and driven by the socioeconomic circumstances of the family. These circumstances are out of the child's control (Figure 19) but directly impact their access to health-promoting activities and environments.

Figure 19
Unicef's multilevel framework of Child Wellbeing



Our Children Our Place

Barking and Dagenham has the highest proportion of children in England and Wales: over a quarter of residents (26%) are under 16. Additionally, we have the highest proportion of under 5s in England and Wales: 7.9%. Barking and Dagenham has the second highest birth rate in England and Wales, with 66.7 live births per 1,000 women aged 15-44 in 2023. The Covid pandemic has had profound impacts on all children, with the disruption to schools, prolonged social isolation, health anxiety, and economic instability all contributing to poor mental health and impacting on development for younger children. Post Covid we are seeing higher demand for children's mental health services, and an increase in the number of children who are obese and a decrease in children having vaccinations. We are the most deprived borough in London, with nearly half of our children and young people living in poverty after housing costs. This sits against a backdrop of lack of parity of investment, widening inequalities post Covid, and an unprecedented cost of living crisis.

It is interesting to note that in 2023/24, approximately 7 in every 10 Barking and Dagenham's children achieved a Good Level of Development (GLD) by the end of Reception year, for those children on free school meals, it was 6 in 10.

What is interesting about these figures is that they are similar and better respectively than the England average. Nationally children living in more deprived areas have lower rates of achieving school readiness than higher income areas and children eligible for free school meals are also less likely than their peers to meet expected levels of development. This position is testament to local early years services and our communities, particularly as many of our 2.5year olds are starting from a less advantageous position, i.e. In the same year 75% of 2.5-year-olds achieved a good level of development compared to 80% for England. [48] Our children are likely to face multiple future disadvantages which will mean they risk falling behind those starting from a lower base who are not from a deprived background. [49]

In 2023/4, 76.7% of children achieved the expected level of communication in language skills at the end of the reception year, a performance worse than the national average. It is noted that differences in child language capabilities are recognisable in the second year of life and have an impact on school readiness. There is a pronounced social gradient in early language development, with more young children from disadvantaged backgrounds having poor language skills. The strong association between deprivation and language delay is due to differences in the 'communication environment,' including the number of words children hear and breadth of parental vocabulary (Public Health England, 2020). Nationally, children from the poorest homes are a year behind in their language and literacy skills by the age of 5. [50]

Figure 20

Percentage of children achieving a good level of development at the end of reception 2021 -2024

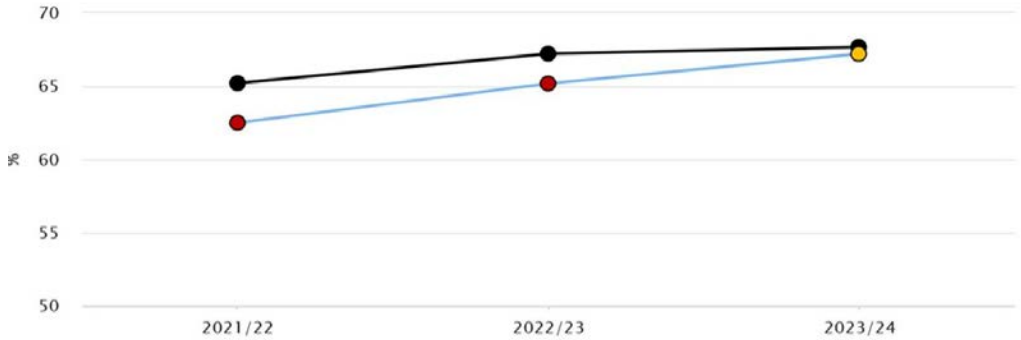
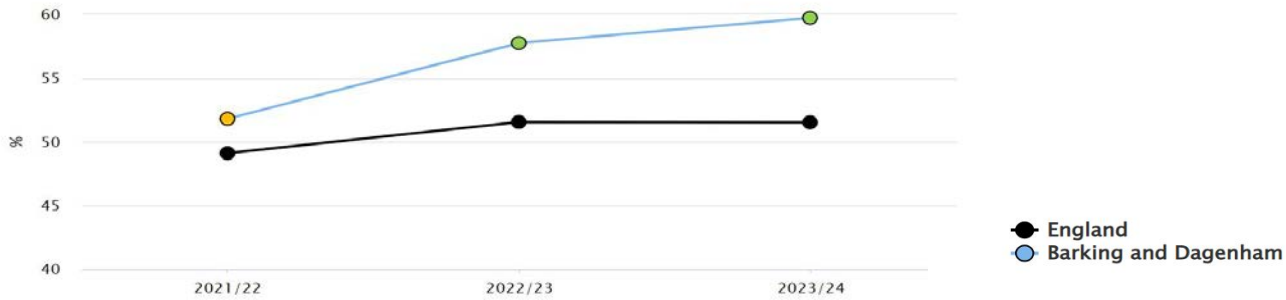


Figure 21

Percentage of children achieving a good level of development at the end of reception receiving free School Meals 2021 -2024



A disadvantaged childhood

Disadvantage can be summarised as encompassing not only i**ncome** and **poverty** but also a lack of social and cultural capital and control over the decisions that affect life outcomes. Child poverty in Barking and Dagenham is amongst the highest in London boroughs with just under half of its children living in households on the poverty line (after housing costs).

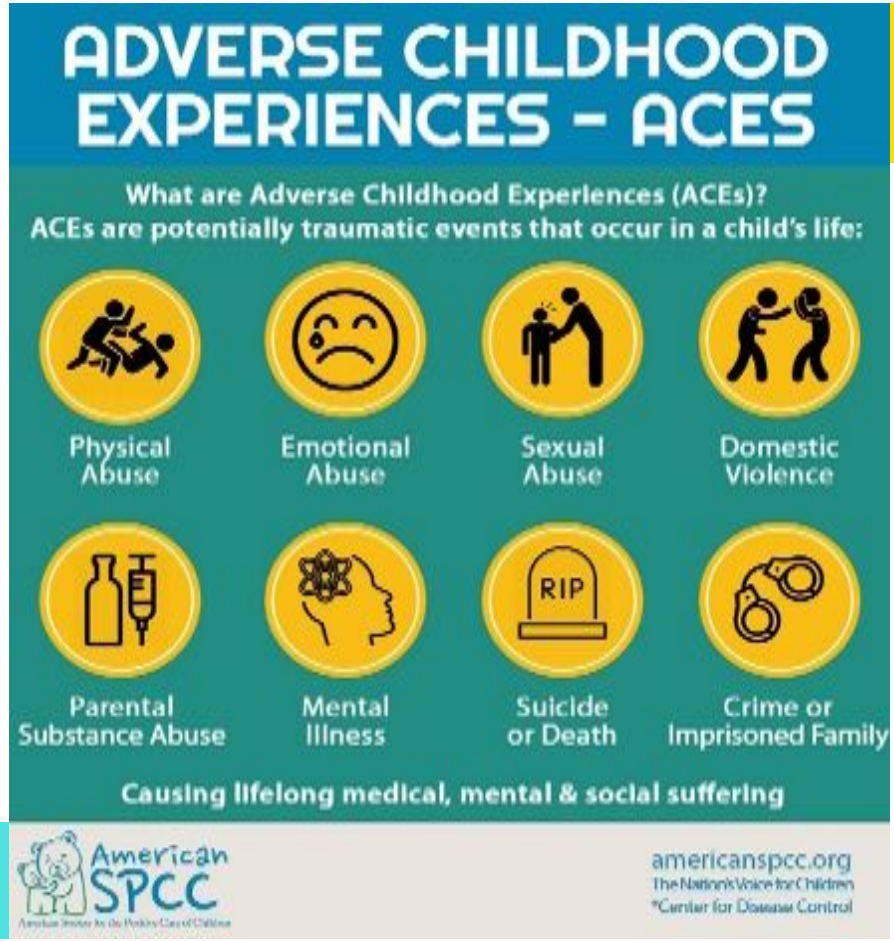
There is considerable housing need within the borough. Housing is often of poor quality and overcrowded and waiting lists for housing are some of the largest in the country. The rate of households with children that are homeless or at risk of homelessness is worse than the England average.

Disadvantaged children are disproportionately more likely to lack the necessary foundations for a good level of health and well-being, a nutritious diet, and a supportive and stimulating home environment to learn and perform in school. Across nearly every health outcome, disadvantaged children are worse off. The relationship between disadvantage and educational attainment is complex and it is noted that disadvantaged children are not a homogenous group, their outcomes and experiences of education vary by many factors including gender, ethnicity, first language, special educational needs, disability, family history of disadvantage, geography and the performance measure used. Children in Barking and Dagenham experiencing poverty, poor housing and mental health challenges are at risk of **inequality in health, wealth, and educational attainmen**t.

Adverse childhood experiences (ACEs) are situations which lead to an elevated risk of children and young people experiencing damaging impacts on health, or other social outcomes, across the life course. ACEs are present across society, inequalities in wealth, **disadvantage,** and the existence of poverty impact on the chances of experiencing ACE. Children growing up in disadvantaged areas, in poverty, and those of a lower socioeconomic status are more likely to be exposed to ACEs compared to their more advantaged peers – and more likely to experience 'clustering' (co-occurring) of ACEs. Research has shown that exposure to distinct types of adversity is strongly associated with harmful effects on health that last into adulthood [51]

There are several child groups at risk of experiencing ACEs in Barking and Dagenham given the high levels of disadvantage e.g.- high rates of child poverty, high levels of domestic abuse, high demand for social care, and high rates of homelessness amongst families with children.

Figure 22
Adverse Childhood Experiences (ACEs)



Children at risk of experiencing disadvantage

Households are considered to be below the UK poverty line if their income is below 60% of the median household income after housing costs for that year. This definition however lends no meaning to the experience or deeper meaning of poverty. The Welsh Child Poverty Strategy [52] provides some aid in this area by defining poverty as 'A long term state of not having sufficient resources to afford food reasonable living conditions or amenities or to participate in activities such as access to attractive neighbourhoods and open spaces which are taken for granted by others in society '

In Barking and Dagenham 42% of children and young people are considered to live in poverty after housing costs. Experiencing poverty increases the likelihood of developing poor mental and physical health, with this risk continuing into adulthood. One of the **strongest** predictors of wellbeing in early years is the mental health and wellbeing of the mother or caregiver. [53] Children of mothers with mental ill health are more likely to have mental health challenges and perform poorly at school.

Children who experience poverty also:

- Have a higher risk of premature death.
- Are more likely to experience poor educational outcomes.
- Have higher rates of stress and are more likely to develop mental illness.

Implications for school readiness

- The gap in attainment between children growing up in poverty and their peers starts early and lasts through school.
- School readiness and academic attainment are intricately linked, as a child's preparedness for school can significantly impact their ability to succeed academically.
- The disadvantage gap among pupils aged five in Barking was 3.1 months in 2023. Nationally it was 4.6 months, an increase of 0.4 months since 2019. [54]
- Disadvantaged children start school behind their more advantaged peers with the gap in performance widening as they progress through the education system.

Figure 23
Determinants of the Disadvantage Gap

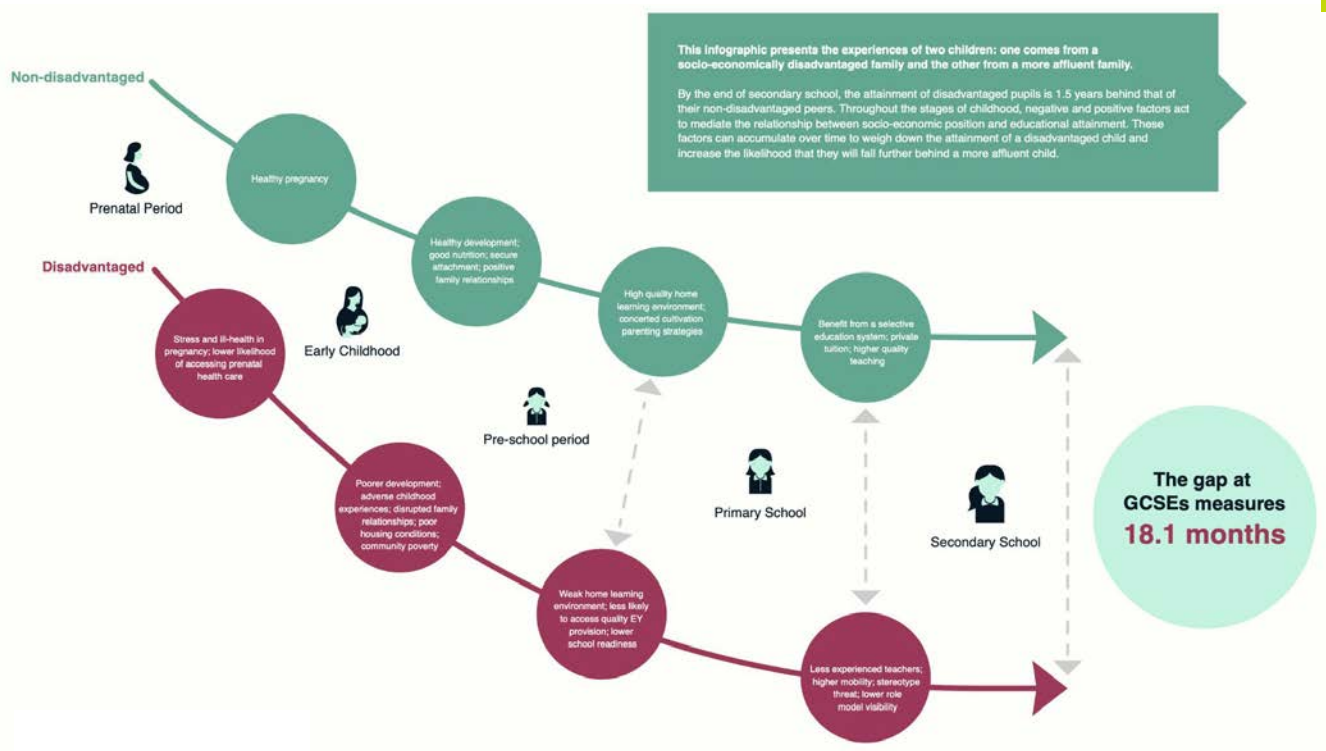
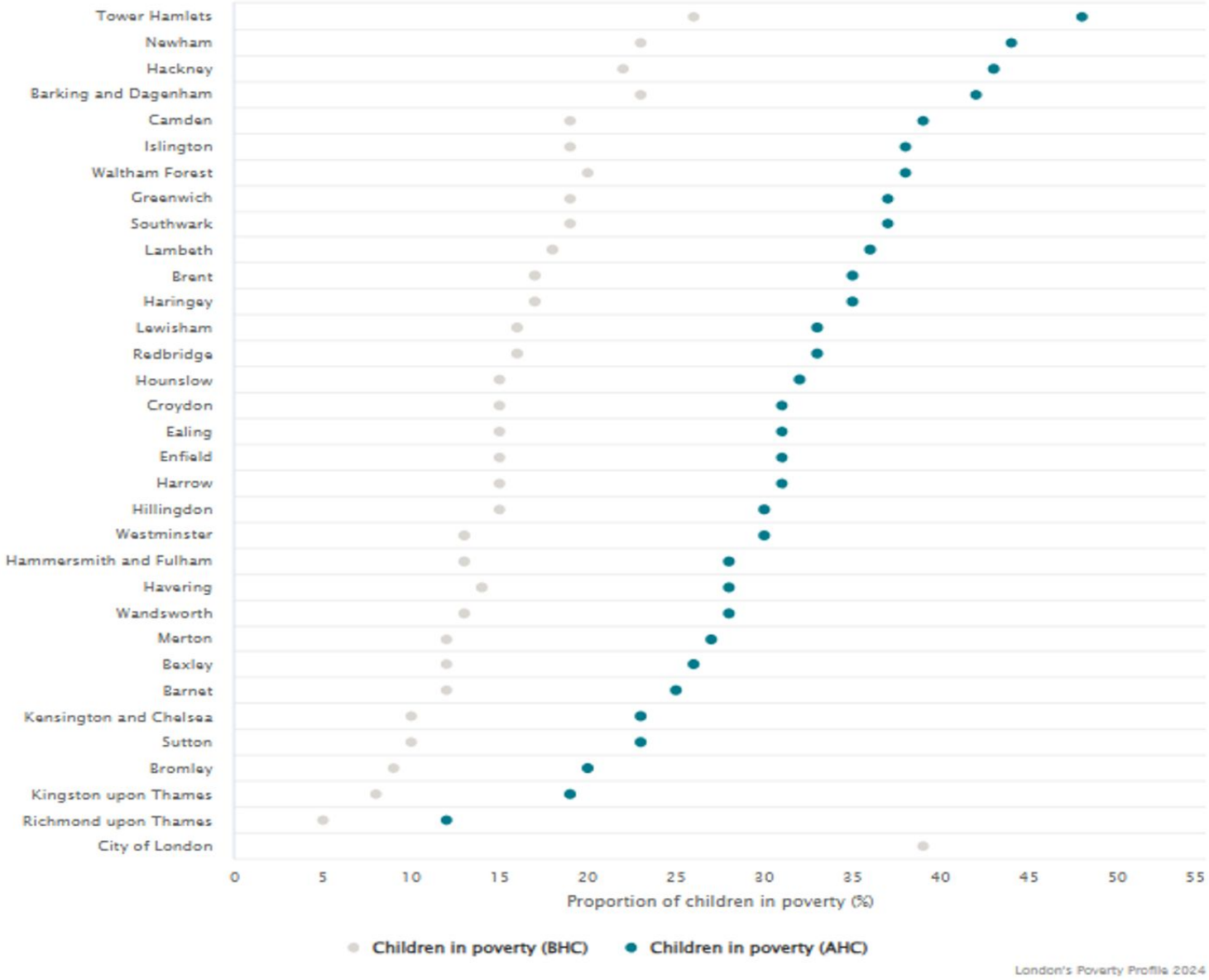


Figure 24

The proportion of children in poverty before and after housing costs by London borough (2022/23)



Data source: Local indicators of child poverty, Centre for Research in Social Policy, Loughborough University for End Child Poverty; Children in low-income families: local area statistics, DWP

The National Strategic Landscape

It is a national and local priority to ensure that every child has the best start in life. Building on the commitments made in the Plan for Change and laying down the foundations for further reform the Department of Education has pledged to spend 1.5 billion over the next three years on improving Family Services and the early years education as detailed within Giving Every Child the Best Start in Life [53] strategy. The forms within this document go hand in hand with the move to a neighbourhood health service as set out in the government's 10 year plan [55] and the three radical shifts hospital to community analogue to digital and sickness to prevention

Reforms build on historical policies such as Public Health England's **Best start for life which sought** to ensure parents had the support they needed during pregnancy, the postnatal period, and the early years of their child's life.

The Marmot Review 10 years on noted that "since 2010, progress has been made in early years development, as measured by children's readiness for school. Clear socioeconomic inequalities persist, with a graded relationship between these measures and level of deprivation. For low-income children, levels of good development are higher in more deprived areas than in less deprived areas." This, and other publications also set out the evidence that a good level of development in the early years is related to longer term positive outcomes such as better education attainment, higher income, and better health.

A new **Families First Early Help** policy, also known as the Families First Partnership (FFP) programme, is being rolled out in Barking and Dagenham over the current fiscal year (25/26). This government initiative aims to transform children's social care by providing earlier and more integrated support to families. It is anticipated that this will support child development by fostering stronger family relationships, promoting early intervention, and ensuring a more cohesive and coordinated approach to support services.

From 2026 a Free **School Meals (FSM) policy** will be rolled out across England. Any school child whose parents receive Universal Credit will be eligible for FSM. Currently, their household must earn less than £7,400 a year to qualify. This is a welcome addition to current child poverty policy and has promising outcomes. A report from the Institute for Social and Economic Research suggests access to free school meals reduces childhood obesity and increases reading progress. specifically, the study found that UFSM reduced obesity prevalence in Reception children by 7-11% and resulted in two weeks' additional progress in reading by Year 6 (Holford & Rabe,2024).

The Local Government Outcomes Framework [56] **(LGOF) is** a new initiative launched by central Government in July 2025 to reshape how councils are held accountable and supported in delivering services to their communities. The level of development at the end of reception, and the proportion of children achieving a good level of development at the 2 – 2.5-year review, have been identified as outcome measures to be included in this new outcomes framework. The Ministry for Housing Communities & Local Government will lead a process of agreeing targets with local authorities using the powers set out in Part 1 of the Childcare Act 2006, which also places duties on other partners to work together with the local authority. Targets will be in place by December 2025. In addition to the two outcome measures above, the LGOF is also seeking feedback on an outcome measure for Best Start Family Hubs and their services.

The Local Strategic Position

The strategic vision for Babies Children and Young People (BCYP) in Barking and Dagenham is articulated through the Best Chance Strategy 2023-2025 and overseen by the Best Chance strategic partnership. The strategy is currently being refreshed and will be underpinned by an action plan and data dashboard which will align with a central BCYP system outcome*. This outcome measure has been agreed by system partners and will feature in the Borough Manifesto; it is also one of the two Marmot indicators agreed by the Committees in Common.

**By the end of Reception Year there will be an improvement in the percentage of children achieving a good level of development compared to the previous year'*

'Local Target: By 2028 76% of Children in LBBD will achieve a Good Level of Development by the end of reception year.

What works to improve school readiness?

National best practice suggests the following improve school readiness

- Good maternal mental health (actions include development of a shared vision and plan, effective screening and referral to services, family strengthening and support, and increased public awareness). Learning activities, including parents speaking to their baby and reading with their child (actions include research to identify current practices and potential cultural barriers, developing a strategic plan, dissemination of information to reach the community, and evaluation).
- Enhancing physical activity (actions include developing initiatives which target adults working with children, providing information to parents and carers, and integrating physical activity into activities in early years settings).
- Parenting support programmes (actions include understanding parent's needs, intervening early, increasing the accessibility of programmes, increasing integration and coordination of programmes, and improving the quality and evidence base for parenting. A 2018 EIF report [57] updated the evidence base for the Healthy Child Programme 0-5. The full report sets out which activities have good evidence of improving child and parent outcomes, which have weak evidence, and which have been found to have no effect on support services.
- High-quality early education (actions include investment, integrated services, workforce training, parental engagement, staff to child ratios, focus on cognitive and non-cognitive aspects of learning, adoption of more responsive and nurturing staff / child relationships, and a more equal balance of child and adult initiated activity).

Innovating to improve readiness: Creative Health

There is no single definition of creative health but there is a consensus that it refers to the use of creative, artistic, cultural or heritage assets to positively improve the health and wellbeing of individuals and communities (Salami-Oru & Devitt, 2023).[58] Embedding arts, creativity, culture, heritage and the natural environment alongside other community and non-clinical approaches to health and social care (such as social prescribing) can help to improve health across the life course, including a good level of development by age five.

An inquiry by the UK All Party Parliamentary Group Arts Health & Wellbeing (APPGAHW) found that, arts engagement can mitigate impact of the social determinants by influencing **perinatal mental health** and child cognitive development; shaping education and employment opportunities, compensating for work related stress; building individual resilience and enhancing communities additionally:

- **Social and Emotional Development** Creative activities such as group singing dance and pretend play promote social bonding empathy and emotional expression. Fancourt & Finn (2019) report for the World Health Organisation highlights evidence that creative play improves emotional regulation and reduces anxiety and behavioural problems in children.
- **Language & Communication** Storytelling music and arts -based activity support language acquisition and verbal skills exposure to music and rhythm has been linked with better phonological awareness which underpins early reading skills.
- **Cognitive Development** Creative play fosters executive function such as memory attention and problem solving engaging in drawing, singing and movement activity supports brain plasticity and cognitive flexibility. There is a growing evidence base which supports early creative interaction supporting secure attachments and better developmental outcomes. [59]

Case study

Multi-agency school readiness - A pilot

Year on year, an increasing number of children in the borough enter school nursery with high and complex needs. Some are already known to professionals and are on a diagnostic pathway, but more children are being admitted with additional needs that have not yet been identified, assessed, or recognised and/or accepted by parents/carers.
In addition to this, more neurotypical children arrive at nursery with attainment levels that are significantly below those that are typical for children of the same age, including:

- Personal development – self-care, particularly toileting.
- Personal development – self-help and independence.
- Social development – interacting with other children and adults, early play skills.
- Communication and language – spoken language.
- Physical development – gross motor skills, but particularly fine motor skills.

These are some of the early signs of neglect that Barking and Dagenham Safeguarding Children

Partnership (BDSCP) wanted to tackle more effectively and ensure that children had the best start at school. A multi-agency school readiness pilot was designed. Key partners included Targeted Early Help, the Early Help Consortium (a voluntary sector partnership), the 0-19 Universal Children's Service, the Speech, Language and Communication for Life Team, and teachers and specialists from two primary schools.
A cohort of 20 children were identified, and parents/carers were invited to take part. 3 were already known to SEND services, and 2 identified for further assessment. 18 were not toilet trained. A programme of activities was designed to support these families in advance of school attendance. This included home visits, delivering six Get Set for Nursery sessions across various themes, and individual targeted family support where needs were identified.

Outcomes of the pilot included:

- 9 children toilet trained by the end of the 6 sessions. More children were toilet trained over the summer period before they started school.
- 19 out of 20 children had their two-year development check.
- Schools reported that the 20 children settled in quickly to the school environment and did not experience any long-term anxiety. Most children have been observed playing alongside others well and engaging with one another in role play and construction areas.
- Better links between health visitors and schools. 19 children have now had their two-year check completed.
- Positive relationships developed and trust built between families, school, and other professionals. Parents/carers have been happier to leave their children more quickly too.

In 2025/26 plans are in place for this programme to be repeated in eight schools.

Start for Life and Family Hubs

Barking and Dagenham was one of the 75 local authorities across the country to receive funding from the Department for Education for a Start for Life and Family Hub programme in 2022. Since this time, the programme has developed at pace supporting parents and carers to care for and interact with their children from conception to age 2, bringing about system transformation to fundamentally redesign, improve and join up how local health and children's services are delivered for babies, children, and their families. The programme is committed to supporting local children to 'grow play learn and thrive' as outlined in the new strategy Giving Child the Best Start in Life. [60]

Our Family Hubs provide integrated support to children and families across the Borough; based in the North, East and West of the Borough and coterminous with three of our Neighbourhood Health Hubs. Partnership working through co delivery and co-location with voluntary and community services is also delivered in these locations.

The Start for Life programme in Barking and Dagenham delivers services grouped around the following key areas:

1. Infant feeding
2. Parenting Support
3. Perinatal Mental health and Parent-Infant relationships
4. Home Learning Environment and Early Language

Building on national guidance the service aspires to co create a strengthened service with local families, focusing on creating partnerships, integrated working, developing a digital offer linked with the 'My Children' in the NHS App and connecting more families to local hubs and services, particularly those at greater risk of experiencing inequalities.

The Healthy Child Programme

In Barking and Dagenham, the Healthy Child programme is delivered through an Integrated 0 to 19 Contract between North East London NHS Foundation Trust (NELFT) and Barnardos. The foundations for achieving a good level of development are laid throughout the first years of life. Supporting every child to achieve the best start is a central part of the health visitor's role, working in partnership with parents to promote child development and to assess needs and identify problems or issues at the earliest opportunity, including signposting to specialist support if needed.

Building on national guidance the service aspires to co The Healthy Child Programme delivers the following health and development mandatory checks to all children:

1. New Birth Visits
2. 6-8 week check
3. 1 year check
4. 2-2.5 check - includes the Ages and Stages questionnaire (ASQ)

The 0-19 service was recommissioned in January 2025 'Ready to learn at 2, ready for school by 5' is a priority area and includes the following:

- Additional universal assessment at 1 year review for early identification of developmental concerns.
- Additional targeted assessment at 2-2.5 years review – to include Speech, Language and Communication Needs screening and ASQ-SE2 for social and emotional development.
- School readiness developmental pathway for children identified below threshold at 2-2.5-year review – with additional support and follow up assessment between 3 and 4 years.

Key Performance Indicators linked to these focus areas are in place reported through quarterly contract monitoring for the service. This provides a clear view of service improvement where we can review changes alongside any impact on GLD. A further focus in the new contract is on Integrated and referral pathways. This is a Year 1 quality improvement area of work to improve understanding and use of existing pathways across the workforce. Specific areas are:

1. data sharing
2. integrated approaches
3. Working at the earliest stage of identification of developmental concerns.

Increased partnership and systems integration is a founding principle for the Healthy Child Programme. In our area we are focussed on the use of data and insights to inform continuous improvement. To deliver better outcomes we are forming strategic partnerships, appointing to shared operational roles, and building shared language across early identification.

Public Health Advice

In conclusion, giving every child the best start in life is important because

- ☑ Inequalities in the early years have lifelong impacts.
- ☑ It is the period of life when interventions to disrupt inequalities are most effective.
- ☑ Interventions in the early years have been shown to be cost-effective (Marmot, 2022).

Consideration should therefore be given to the following:

- ☑ Consensus should be gained regarding a definition of 'disadvantage' and concerted action by partners to mitigate the inequities experienced by specific disadvantaged child groups led by the Best Chance Partnership.
- ☑ Marmot principles should be embedded into place with 'a good level of development by age 5' prioritised as an area for action underpinned by a three-year transformation plan.
- ☑ Development of knowledge and understanding into what works in improving school readiness in disadvantaged child groups.
- ☑ Strengthen Start for Life system transformation through service governance, co-creation with families, redesigning and improving the current offer, joining up the offer with health and social care. For example, co-location of Health Visitors and Family First Workers at Hub sites, identifying a fourth Start for Life Hub site to fully align with the Neighbourhood Health Locality offer.
- ☑ Build on existing governance by creating a Start for Life 1001 Day's Board to oversee the Start for Life transformation programme.
- ☑ Quality improve the existing good level of development pathway at 2.5 years and maximise child outcomes through a root and branch review and close working with the Department of Health and Social Care to develop an improvement plan.
- ☑ Consider commissioning an academic study to explore and understand the relationship between local GLD scores at age 5, NEET percentages, academic attainment, and limited social mobility.
- ☑ The forthcoming Neighbourhood Plan should include Best Start Delivery priorities to ensure early years needs are captured. This process should be supported by the pausing of the Best Chance Delivery Strategy refresh until the next financial year. This step would also support the Best Chance Delivery Plan development process considering the large number of unfolding reform actions occurring locally and in the wider system.
- ☑ Creative Health initiatives are innovative options that can be used to support local child health and wellbeing.

6

Health & Housing - Mitigating the impacts of emergency temporary accommodation on children, young people, and families

“It was identified that families in temporary accommodation (TA) were at a particularly considerable risk of negative health and wellbeing impacts due to their housing situation.

This chapter takes a more detailed look at this risk and proposes local actions to mitigate the risks for children, young people, and their families.”

The recent Barking and Dagenham Homelessness Health Needs Assessment [61] (HHNA, 2024) undertaken by the Public Health Team identified that various groups of people were experiencing homelessness of various kinds in Barking and Dagenham. It was identified that families in temporary accommodation (TA) were at a particularly considerable risk of negative health and wellbeing impacts due to their housing situation.

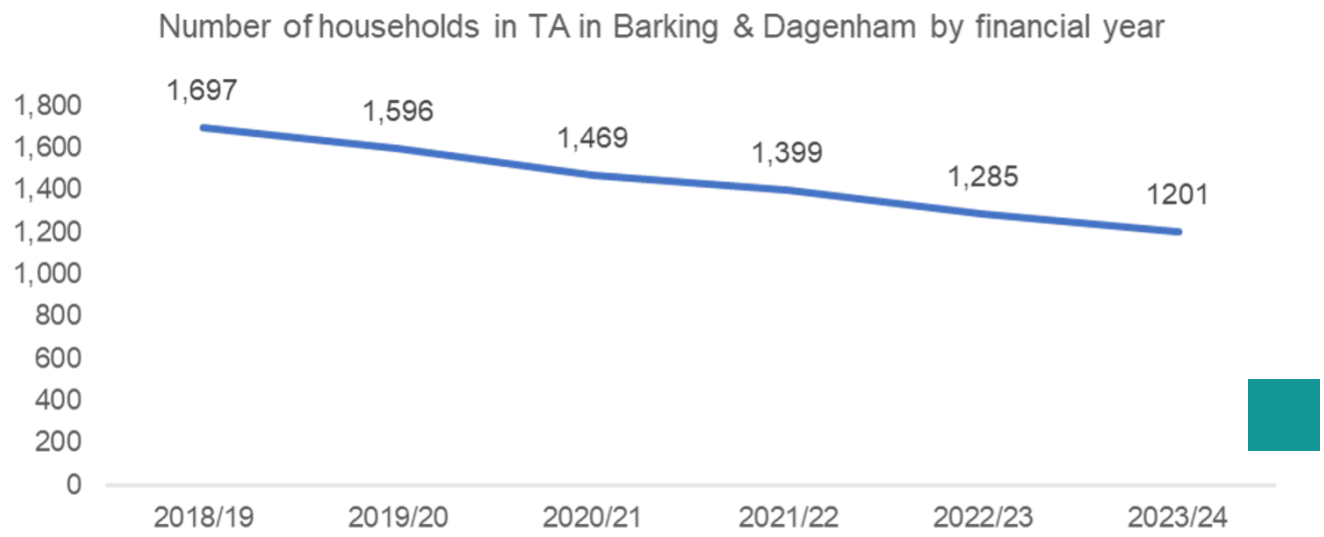
This chapter takes a more detailed look at this risk and proposes local actions to mitigate the risks for children, young people, and their families. This is especially relevant in the context of both the refresh of the council's Housing Strategy and the council's focus on improving school readiness through improving the proportion of children reaching a Good Level of Development at Age 5. As noted in Chapter 4, children living in TA in Barking and Dagenham are a key group at risk of experiencing inequality in health, wealth, and educational attainment.

The evidence base on the impact of housing instability on children's physical, cognitive and emotional development, and on childhood mental health needs expansion, but suggests complex, interrelated associations. [62] There is evidence that frequent moves in early childhood can affect cognition and attention, although the family and economic circumstances in which the moves take place has the greatest influence (Shared Health Foundation, 2020).[63] The Children's Commissioner (2025) [64] has shown a clear link between insecure housing and young people's later educational attainment however: pupils whose home postcode never changed between Reception and Year 11 were most likely to get five GCSEs passes, Year 11 were most likely to get five GCSEs passes, including English and maths (65%) whilst just half (50%) of those with three home moves over their school career achieved this; and just over one-in-ten (11%) of those with ten moves.

Temporary Accommodation in Barking and Dagenham

Barking and Dagenham provides TA to prevent or relieve homelessness and fulfil its statutory duties to residents and non-residents. Households may be placed in TA for the short term before being placed in more permanent housing. Examples of TA include council-owned and private rented self-contained units, hostels, and bed and breakfast hotels. North East London NHS Foundation Trust's (NELFT) Specialist Health Visiting Service report that at least 13 hotels and hostels in Barking and Dagenham were accommodating families in 2024.

Figure 24 – Households placed in TA by the Council 2018/19-2023/24



As reported by the GLA (2024), more than half of all TA placements nationally are made by London boroughs. At the end of March 2024, there were 65,280 homeless households (approximately 170,000 people) in temporary accommodation arranged by London boroughs; 44,070 (67.5%) of these households included children, with a total of 86,810 children between them. As shown in the HHNA, only 1,201 (1.8%) of these households were placed in TA by the Council, and the total number of households placed in TA in Barking and Dagenham has steadily decreased since 2018/19 (see Figure 1) which goes against the London trend.

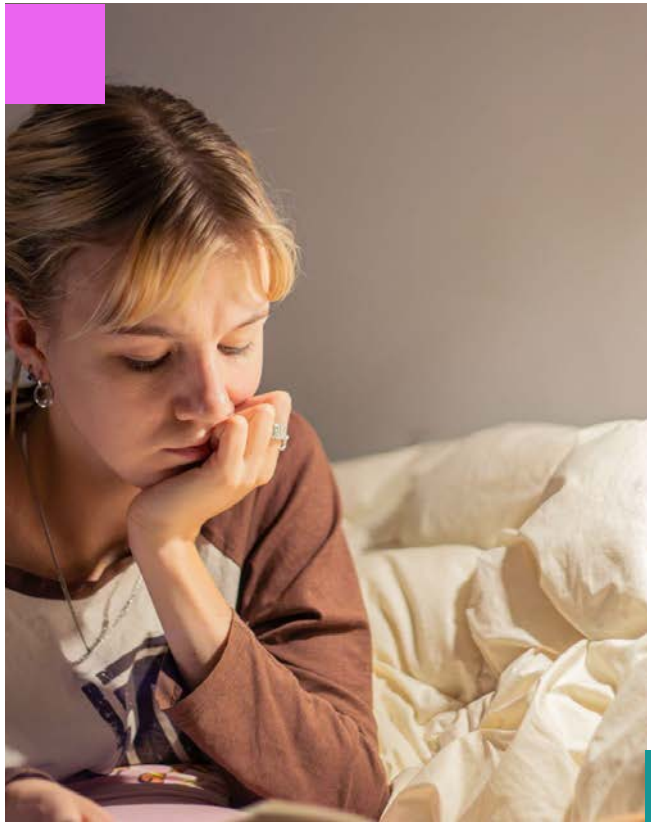
In addition to falling use of TA, the Council has also successfully reduced the average duration of all placements in TA in the borough, with the average duration of placements involving children falling from 672 days (22 months) in 2018/19 to 186 days (6 months) in 2022/23.

Despite the positive trends in use of TA by the Council, Barking and Dagenham is still affected by the increase in the use of TA across London. A currently unknown number of families have been placed in the borough by other local authorities. Data held by the council shows that from 2020-23, London boroughs made at least 1,410 placements into the borough, compared to just 45 placements that the Council made in other London boroughs.

The Children's Commissioner (2025) [65] noted that "While the Homelessness Code of Guidance outlines that local authorities should be notifying the receiving local authority when placing households in another local area, this guidance is not always followed, and the placing local authority only has to notify the host local authority when the placement is complete. In addition, there is currently no requirement for the local authority to notify other agencies (including a child's school and GP) when a child becomes homeless."

The HHNA found this to be the case for many families being placed in Barking and Dagenham by other authorities. NELFT Health Visiting Service report that they are frequently not made aware of families with under 5s moving into TA in Barking and Dagenham, despite this being a universal service for all families with under 5s in the borough.

A snapshot between October and December 2023, found that 980 households with children were in TA in the borough, including placements made by other boroughs. This is 14% higher than if would be expected if these families had all been placed by the Council. The Council is also aware that some of these externally placed families have been living in TA in the borough for up to 6 years, making mitigation of the impact of TA by Barking and Dagenham health services even more crucial.



Case study

S208 London Borough of Barking and Dagenham Proposals

Notify2, a web-based system developed in 2000 to facilitate Section 208 (s208) notifications for out-of-borough homelessness placements within London, has seen a significant decline in usage. As of 2025, only six of the 33 London local authorities actively use the platform, with most boroughs opting for email-based notifications instead. Following consultations with borough stakeholders, the Leaders' Committee (March 2025) approved the recommendation to close Notify2 by 31 May 2025.

A series of 4 workshops organised by London Councils took place during May and June 2025 to oversee the transition, improve data reporting, and enhance inter-borough coordination on out-of-area placements.

The workshops agreed a new template for use as part of the s208 process that will capture wider information about the family to improve connections and referrals into health, education, and social care. All notifications across London are now sent to standardised email addresses.

As of June 2025, Barking and Dagenham receives c. 90 s208 notifications a month indicating that placements into borough are high. However, there is no standard notification when/if the family moves on. S2028 are received within 14 days of a family being placed in area but this is only part of the picture when families spend far longer in our borough.

To improve health outcomes for children and families, initial conversations between 0-19 commissioning and housing have looked at how s208 notifications can be automatically sent to health colleagues to ensure they are aware of the arrival. Even when families attend services in their original boroughs as soon as they are resident in the borough, they now join the 0-19 Health Child Programme overall caseload.

Health Impacts of Prolonged Residence in Temporary Accommodation

The HHNA identified that children, young people, and parents in TA were at a considerable risk of negative health and wellbeing impacts including:

- Higher rates of clinically diagnosed mental health issues such as depression, personality disorder, anxiety, and psychosis.
- Higher smoking rates and lower consumption of fruit and vegetables.
- Social isolation, children being exposed to intimidating behaviours by other adults and receiving less support from their parents.
- Delayed development due to confinement in small, overcrowded, poorly heated and noisy living spaces, being unable to play, or do school homework.
- NELFT's 0-19 Healthy Child Programme Specialist Health Visiting Service undertook a snapshot of need in August 2024. This found a high level of need for children and young people in TA in Barking and Dagenham, with 71% meeting health thresholds for vulnerability under the national Healthy Child Programme.
- Below is a summary of published and local evidence of the impact of TA on physical, mental, and emotional, and social and developmental health and wellbeing of babies, children, young people, and parents. Additionally, there is evidence that, nationally, housing deprivation most severely affects single mothers, disabled children, and Black Minority Ethnic (BME) families i.e. housing disadvantage is heightened in groups of people who already experience inequality.

Physical wellbeing and safety

Trust for London (2023)[66] reported that a significant proportion of people in TA also have physical health problems. Public Health England (PHE, 2020) [67] identified poor housing conditions and (a related) lack of access to green space as two indicators that contributed to vulnerability in childhood.

There is convincing evidence for associations between negative housing environments such as damp and overcrowding and: childhood injury; damp and asthma morbidity (including more frequent attendance at A and E); infectious disease; sleep problems; and familial chronic stress. [68] [69]

An increase in Sudden Unexplained Death of an Infant (SUDI) rates in north east London is thought to be potentially linked to increased levels of co-sleeping due to homelessness, financial hardship, and overcrowding. Local insight has identified a number of mothers-to-be in Barking and Dagenham presenting to various services across health and council services with no resources or support, and at risk of homelessness.

Case study

Safe Sleep Project

The Public Health Team and the Neglect Improvement Programme identified a key safety concern related to pregnant women and significant poverty e.g. caused by homelessness, financial hardship, No Recourse to Public Funds, recent arrival, or a combination of these factors.
This led to the "Safe Sleep" project, targeting those most vulnerable who meet agreed criteria through our key services.

This project aims to reduce SUDI, and improve the baby's health, wellbeing, and development – giving them the best start to life.

Families in TA with newborn babies who meet the eligibility criteria will be a key cohort to benefit. will Women with a newborn baby will be given resources to support mother and baby at 3 stages in the first year of the baby's life:

Stage 1

As soon as the baby is born (Moses basket, stand, baby clothes & accessories)

Stage 2

At 3-6 months old (swap moses basket for a travel cot, mattress, sheets, baby sleeping bag)

Stage 3

At 12 months old (Access to cot via hardship fund, more baby accessories + toys to aid development)

Case study

Ripple School Family Drop In

NELFT's 0 to 19 Healthy Child Programme Specialist Health Visiting Service identified a high level of vulnerability among families in TA in Barking and Dagenham. They identified that children's physical, social and emotional development was being impacted by extended periods in hotels and hostels, and the lack of play space.

The Public Health and Localities teams identified some funding for a pilot to address the lack of play space for these children. The Council and Ripple School are initiating a 6-month pilot project to provide a safe easily accessible family drop-in at weekends, near to hotels and emergency accommodation in Barking. The drop in will start in August 2025 and provide the following:

1. safe play space inside and outside
2. basic food preparation facilities, including hobs for hot food
3. laundry facility and personal hygiene supplies
4. signposting to other services

The drop-in sessions will be supported by the school site staff and by Barking Churches Unite. An evaluation will be undertaken with families using the facilities.

Mental health and emotional wellbeing

Evidence shows a general link between living in TA and poor mental health – 4 distinct recent studies in UK all found reported prevalence of poor mental health in TA to be between 66 and 78%. [70] Studies reported participants having minimal choice and control and feeling "continually displaced." This lack of agency led to a significant impact on people's ability to maintain their mental health and wellbeing, often leading to increased stress and anxiety. PHE (2020) [71] highlighted that promoting resilience and learning to deal with adversity reduces future risk from Adverse Childhood Experiences (ACEs), including housing insecurity.

Substantial impacts on parental mental health were found among families in TA, impacting on parenting authority, material resources, parenting environments and access to social support. This resulted from negative self-concept in the parental role, challenges to autonomy and self-efficacy, daily hassles, physical environment and service context, stigma, child characteristics and lack of support (Bradley et al., 2018). [72]

Universal approaches targeted for young people in TA were found to be effective e.g. cognitive behavioural therapy (CBT) led to improvements in depression and substance use, and family-based therapies also reported decreases in substance use (Wang et al., 2019).

Social development and educational attainment

A study in Newham (Citizens UK, 2024) [73] into how inadequate housing affects early child development / educational experience of children and young people from 0-18 found that it has a detrimental impact on many aspects of children and young people's lives including their ability to play, learn, study, socialise with friends and more generally thrive in their home. In mitigation, they found that schools, voluntary and statutory organisations all play key roles in supporting children and families, with school-based social workers / support workers playing a particularly vital role.

Shelter (2023) [74] explored the lived experience of families in TA. They found that it entrenches poverty and can have a devastating children's lives. They found that almost half (47%) of children have had to move schools and more than half (52%) of parents report their children have missed days of school; of these, more than one in three (37%) have missed more than one month. One in four (26%) parents say their children are unable to keep up in school or have performed poorly as a result of living in temporary accommodation. Shelter and YouGov (2020) [75] also found that children living in bad housing were more likely to be excluded from school and had a higher rate of absenteeism than children who were adequately housed.

What does this mean for supporting children and families in Barking and Dagenham?

The recently published national strategy 'Giving Every Child the Best Start in Life' [76] (Department for Education, 2025) sets a target for a record proportion of children to be school-ready by 2028. This will be delivered through the Barking and Dagenham Best Chance Partnership. The Partnership has agreed several pledges which embody our partnership values, the way we want to and need to work to achieve the challenging ambitions that we have set, and what children, young people, parents, and carers have told us matters most. These values form a golden thread running through our approach to working with children, young people, parents, and carers, enabling provision of care and support in a way that reduces inequality and equity in improved outcomes.

An evidence review was undertaken to identify how these pledges should be applied to support families in insecure housing:

Table 3: Best Chance in Life Pledge	What does the Evidence say about Families in Insecure Housing?	Summary of Evidence-Based Actions to Support Families in TA
Baby, child, young person, and family centred, and going the extra mile	Person-centred multi-agency wrap-around provision is recommended for households in TA especially for children. Barriers to achieving this person-centred provision included ethnicity, immigration status, and fear at the individual and family level; policies and absence of care plans at system level; and transportation limitations and poor housing conditions at the community level. The impact of housing insecurity was lessened for children by friendship and support, staying at the same school, having hope for the future, and parenting practices. However, being housed out of borough creates significant barriers to accessing health and education services and maintaining this important continuity. Adaptive parenting behaviours can help mitigate the impacts on families. Services could support these behaviours through fostering positive self-concept in the parental role, parental mental health, material resources, autonomy, and self-efficacy, and reducing stigma.	■ Person-centred, wrap-around support. ■ Facilitating maintenance of friendships and staying at the same school. ■ Keeping families in their home borough wherever possible. ■ Support for parenting behaviours and parental mental health. ■ Promotion of autonomy in decision-making.
Committing to early intervention and prevention	There is some evidence that the following initiatives have been successful in local areas to mitigate the adverse impacts of housing deprivation: ■ Local Safeguarding Partnerships should include Housing. ■ Multi-agency home safety training courses for front line staff to reduce accidents. ■ A single point of access for referrals for information, advice, and guidance (IAG) on housing, social care, health, and voluntary services. Other proposals include screening vulnerable families, including those in insecure accommodation, for social determinants of health needs and/or comprehensive health assessment for preventative care e.g. oral health. There is support for whole family support practitioners in school to work with young people and their families to support their educational experience and achievement and identify and unpick underlying causes of persistent absence. There is also evidence that intervention for parents in housing insecurity can be improved via psychosocial pathways such as improved maternal self-efficacy and social support.	■ Local Safeguarding Partnerships should include Housing. ■ Multi-agency home safety training courses for front line staff to reduce accidents. ■ A single point of access for referrals for finance and safety IAG. ■ Screening for social determinants of health and health needs. ■ School-based whole family support practitioners. ■ Maternal / parental psychosocial support pathways.

Compassion, respect, transparency, and openness	Prioritising giving children, young people and families choice and control over situations that affect them helps mitigate the negative impacts of insecure housing. There is some evidence that lack of agency in housing processes negatively affects mental health, for instance. Positive outcomes for Young Adults can be supported by understanding the complexity of their lives and creating contextual circumstances that encourage engagement. This includes: ■ Prior service planning (including resourcing, training staff, and incorporating safety measures). ■ Creating positive experiences, flexibility, patient-centeredness, & being informative and reassuring. ■ Creating an enabling environment (including effective communication, building rapport, and avoiding negative judgements). ■ Having realistic expectations and designing approaches that empower.	■ Maximising family agency and control over decisions that affect them. ■ Considering contextual circumstances for specific groups of individuals, such as Young Adults, in service design, creating an enabling environment and in engagement.
Collaborating and joining up, organised around communities	Many sources highlighted that schools, voluntary and statutory organisations play a vital role in supporting children and families living in inadequate housing. School-based social workers/support workers in particular play a vital role in support. There is evidence that community engagement is an effective intervention in supporting the mental well-being of parents and children living under housing insecurity. For example, community-based participatory strategies are effective in engaging vulnerable families to develop interventions for oral health improvement. TA Action Groups (TAAGs), in which residents have an active and inclusive role, can also reduce isolation, support expression of views and provide a means for meaningful engagement.	■ Engage all of schools, voluntary and statutory organisations in wrap-around support, including school based social workers/support workers. ■ Participatory engagement is an effective approach to mental health promotion and reduction of social isolation e.g: o Community-based participatory engagement in developing sustainable interventions. o Temporary Accommodation Action Groups (TAAGs).

Tackling inequality of outcomes and experiences	There is evidence that, nationally, housing deprivation most severely affects single mothers, disabled children and BME families i.e. housing disadvantage is heightened in groups of people who already experience inequality. There is strong evidence for associations between negative housing environments such as damp, overcrowding and infection and: childhood injury; damp and asthma morbidity; and familial chronic stress. Several references stressed the importance of understanding levels of health literacy, cultural health beliefs and language barriers. One investigation of cultural sensitivity reported the importance of home visiting in breaking down language, cultural and health literacy barriers for families with children under 5.	■ Taking a comprehensive and holistic approach to wrap-around support, since housing deprivation most severely affects those already experiencing inequality. ■ Home visiting can help break down language, cultural and health literacy barriers for families.

Public Health Advice

- [x] The Council should continue to work with authorities across London to ensure the host authority is notified before an out-of-area placement is made. The council should also put in place processes to notifying relevant agencies, including schools and NHS services, when a child is placed in TA in Barking and Dagenham by any agency.
- [x] The forthcoming Neighbourhood Plan must work with our housing and homelessness, anti poverty strategies to tackle the root causes of the housing crisis.
- [x] Consider how to deliver comprehensive and holistic wrap-around support to all families in TA in Barking and Dagenham. This should include:
  - The feasibility of a whole family support practitioner for every school to work with young people and their families to identify vulnerabilities and address persistent absence, as per the model in Newham.
  - Promotion of autonomy and self-efficacy in decision-making.
  - Parental psychosocial support pathways and support for parenting behaviours.
- [x] Embed a participatory engagement approach to working with families in TA, empowering families, and individual young people to be central to developing solutions.
- [x] Embed an understanding of health literacy, cultural health beliefs, language barriers and home safety training across all front-line service provision.
- [x] Home visiting is key in breaking down language, cultural and health literacy barriers for families with young children.

7 Unlocking the potential of the Public Health Grant

“We are at a time of unprecedented demand for care, driven by ill health and inequity in the distribution of health within and across the English regions. With individuals in more deprived areas such as Barking and Dagenham experiencing poorer health outcomes, including higher rates of illness, shorter life expectancy, and a greater burden of chronic diseases.”

It points to a need for greater emphasis on preventive care, competency in overall higher value commissioned services and an integrated approach to population health. The range and cost of new and existing health care and care interventions is growing. This means that skills in determining priorities, in knowing what to commission and what not to commission and understanding how to maximise value are vital. [77]

Whilst councils and their partners in north east London (NEL) are having to manage this growing demand within the reality of services unable to meet this demand head on. This is creating major concerns about the capacity of the system to cope, with almost daily news reports of services creaking and straining under the pressure. It is agreed that maintaining the status quo is not sustainable and councils and NHS organisations in NEL are facing hard choices and being forced to make difficult decisions about how they can best allocate their limited resources.

Barking and Dagenham is no different in having to face and deal with this unprecedented position, but it also has its own individual social and economic challenges to meet in doing so without increasing district general hospital provision or significant investment in community-based health and social care services. Therefore, we cannot just treat/care our way out of it, investment in prevention is the only real solution and in health care shortening the period of illness.

The independent Darzi investigation, [78] which revealed that spend on acute care has risen from 47% in 2002 to 58% in 2022, while primary care has fallen 27% to 18%. Combined with the CF and NHS Confederation analysis, this highlights the stark need for health service and local authority leaders to invest more in prevention, and to focus on the highest-impact interventions [79]

Prevention programmes play a key role in providing part of the solution to these challenges. 'Prevention is better than cure' is an old saying and it would be equally true, if less catchy, to say that 'prevention is more cost effective than cure.'

Population level approaches are estimated to cost on average five times less than individual interventions and evidence shows that 'a wide range of preventive approaches are cost effective, including interventions that address the environmental and social determinants of health, build resilience and promote healthy behaviours, as well as vaccination and screening'. [80]

Therefore, investing in evidence based, well targeted preventative interventions around children and young people and long-term conditions can significantly reduce the financial impact on health and social care providers, wider society, and individuals themselves. [81]

What does good Public Health spending look like?

The Public Health Grant (PHG) is central government funding provided by the Department of Health and Social Care to Local Authorities in England. In 2025/26 our PHG ring fenced allocation is £20,285,782. [82] The purpose of the Grant is to provide local authorities with the resources required to discharge their public health functions and to reduce health inequalities between the people in its area. Public Health being in local government in England has the benefit of enabling leadership and decision making appropriate to population needs within the context of having the right building blocks in place, such as good-quality jobs and homes, access to education, transport and healthy food, and adequate income and resources.

Therefore, establishing Value for Money for PHG expenditure must be caged in terms of the effective addressing of need through targeting services to those who would benefit most (proportionate universalism). Addressing areas of greatest need also inherently addresses inequalities and improves overall population health through reducing inequality gaps and raising the average. Albeit it should be emphasised that services alone could never address the increasing health burden in Barking and Dagenham which requires government led action in addressing the wider determinants of health.

According to the Local Government Act 1999, 'A best value authority must make arrangements to secure continuous improvement in the way in which its functions are exercised, having regard to a combination of economy, efficiency, and effectiveness'. [83]

- **Economy:** The strategic allocation of the PHG and other grant funds to eligible service provision to support delivery of key outcomes, in line with population need, commissioning framework and national guidance.

- **Efficiency:** Service models and commissioned services are reviewed to ensure that the council uses its resources well and productively, minimises waste and duplication and seeks to continuously develop to deliver improved outcomes. This includes maximising investment in the specialist and wider public health workforce to ensure delivery of statutory duties, including public health expertise.

- **Effectiveness:** Ensuring investment of PHG delivers improvements in key public health outcomes, supported, and informed by evidence and quantitative and qualitative intelligence.

Over the last two years the Office for Health Improvement and Disparities has increased their focus on assuring local authority Public Health spend is compliant with best practice. This has led to a cultural shift in service delivery, with an increasing focus on outcomes and impact. In line with public-sector funding in general and future financial uncertainty has meant commissioners now need to see real, demonstrable results from the services they fund.

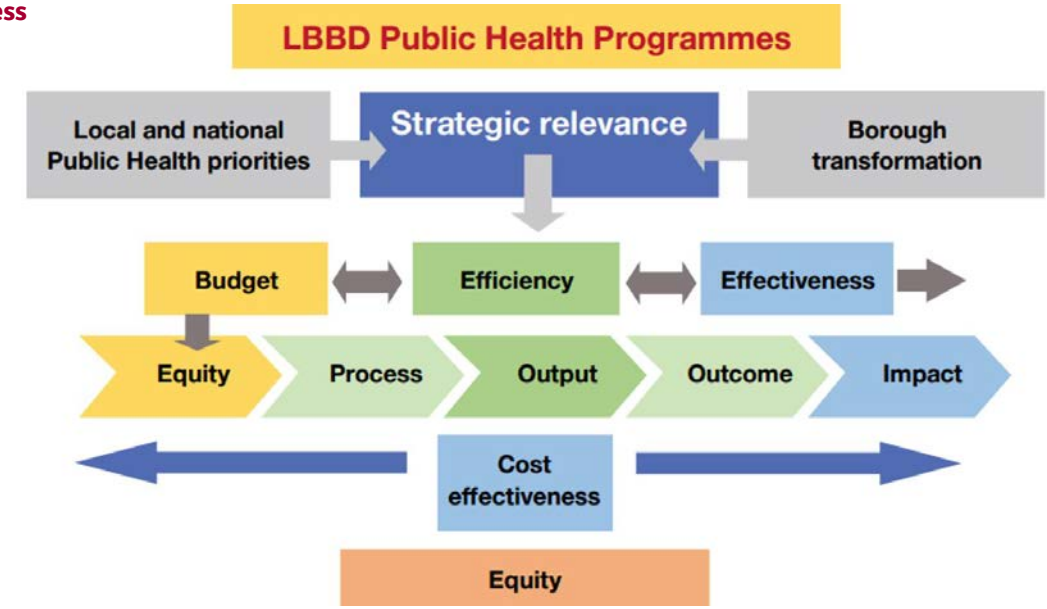
In the past, commissioning generally focused on outputs. This gives no indication of how effective an intervention has been and does not provide evidence of the longer-term financial benefits for the public purse.

The Council and our partners have an agreed approach to delivering priorities. We are clear in our aim of wanting to make the best use of all the resources available to support residents to take responsibility for themselves, their homes, and their community, by ensuring programmes promote greater self-reliance and focus on the root causes of demand not servicing the symptoms.

The first step is to look closely at 'why we provide programmes, who we provide them for and how we can manage demand to ensure that we deliver statutory and other services for residents, with capacity for the future.' Undertaking a regular and systematic programme of service evaluations is therefore essential in determining the effectiveness of specific interventions and, in turn, in deciding how to allocate resources to projects and programmes so that they have the greatest positive impact in achieving the outcomes of our Joint Local Health and Wellbeing Strategy 2023-2028 .[84]

This includes evaluating the full range of PHG funded programmes being delivered by the Council and our partners. The process for doing this is outlined in Figure 26. For example, the PHG is being used to drive thinking as well as change where we have been modelling to demonstrate the limitations of weight management services and evidence the need that we were well beyond the tipping point for services addressing the societal issue of unhealthy weight.

Figure 26
Evaluation process



In 2024, the Council commissioned a comprehensive Independent Public Health Spending review following a Local Government Association Public Health Peer Review. Both reports referenced the need to assure that public health funding is prioritised towards preventative services and functions as a strategic response to the ongoing financial constraints, thereby optimising long-term health outcomes for residents.

A key message from both reports was using the PHG to mitigate current demand pressures within health and care services should be discouraged. Preventative services should be given precedence over reactive interventions due to their proven cost-effectiveness, ability to reduce demand on critical services over the medium-long term, and their alignment with national health and care priorities.

We have taken steps this year in response to the authors recommendations to strengthen our annual Public Health budget setting process, informed by clear financial and Public Health planning parameters (such as inflationary pressures, including any related to pay awards, service utilisation trends and demand pressures, service or programme impact and value for money considerations).

The authors of both reports challenged us to use historic and forecast spend, demand, utilisation and performance of services/projects and upcoming procurements to ensure that commissioned services remain relevant and that the priorities are aligned with the wider Council vision outlined in our Borough Manifesto [82] whilst focussing on the greatest health inequalities and the most urgent needs in the borough.

So, what does this mean?

We need to assure that delivery of services is relevant and targeting need by looking at the productivity of these programmes. Productivity can mean different things to different people but is often viewed with a degree of cynicism as being synonymous with 'cutting services to cut costs.

Thinking about productivity is fragmented and confused. Improving productivity is often seen as an issue of reducing the cost not improving the outcome. In most public sector organisations cost reduction is devolved to each function or team with little understanding of the effect on the whole system. If getting much higher productivity in our 0-19 Healthy Child Programme could be achieved by having more coordinators, nurses, and support staff, this would be seen as a problem because of the impact on the workforce budget.

Whilst it is true that being more productive can sometimes involve cutting both costs and services this is not an automatic result, and decisions need to take the long view into account when assessing the benefits of a given intervention. Whilst they should be based on delivering the outcomes residents want in the best way and at lower cost this sometimes means that a greater investment is needed in certain neighbourhoods to prevent more debilitating and costlier conditions developing that impact on both NHS and social care demand.

Assessing productivity is also about making sure that prevention services are keeping pace with change and innovation and have the right tools and support to do the job required of them. However, clearly measuring the effectiveness of programmes is key to their success and services need to be able to demonstrate that they are making a positive difference to the health and wellbeing of residents and the neighbourhoods in which they live.

Measuring effectiveness is not just about producing rows of numbers and percentages, whilst important these are only one form of indicator of how well things are going but have often been used as the sole measure. Showing that services are making a real difference and assessing effectiveness is a more qualitative and, in truth, more difficult exercise. This is particularly the case in the field of public health where the benefits of specific interventions may not be realised for many years.

We are collaborating with our partners to move away from this approach to one more focused on outcomes grounded in the lived experience of our residents. Ensuring that services can assess and report outcomes in a meaningful way will enable us to shape services and use our resources most effectively. Services also need to be available to everyone that would benefit from them. Whilst public health programmes are evidence-based resident's experiences of life are vastly different across our communities which means that the way services are delivered across our neighbourhoods needs to reflect this.

What works in one neighbourhood or with one group may not be the best fit in another. Barking and Dagenham is a truly diverse borough with many social and economic factors leading to inequalities in wellbeing. Services need to be relevant and fit in with the way people live their lives, they also need to provide an attractive offer to differing groups and individuals and be accessible to all.

Recent insight and co-production work with residents has shown that this is not always the case and that whilst we are reaching many residents there is more, we can do to co-produce interventions with all groups and all communities. In general, the evaluations completed to date do show that the services provided through use of the Grant are valuable and do provide many residents with the impetus and tools to make significant life changes. However, we live in a dynamic and continually evolving borough and reviewing services to ensure we are getting best value will often result in challenges to the way we do things.

This is healthy as programmes should be adaptive to the pace of change and innovative in approach. Our co-production work has shown that there are areas where we could make changes to improve outcomes for residents by ensuring that the Grant is used to deliver real outcomes and provide a stronger focus on preventative interventions and a more effective reach into neighbourhoods.

Criteria for use of the Public Health Grant

It is important to note that the Grant will not/cannot pay for everything and in some cases (especially the social determinants of health) it could add value to the existing legal responsibilities of the council e.g. improving housing quality (damp mould etc).

Our Place based outcomes are now agreed:

- Improving the number of children achieving a good level of development by five.
- Preventing and managing long term conditions.

Local authorities have a legal duty to improve the health of the population and may do this across the full range of services that they provide. However, just because an activity contributes to improving the health of the population does not make it automatically eligible for funding through the PHG. The criteria for the use of the PHG is distinct and you should be able to demonstrate that the primary purpose of investment will improve key public health outcomes. [85]

We will be using the following best practice informed criteria in allocating the Grant to support the realisation of these outcomes and our other priorities:

- Adherence to statutory requirements to ensure eligible use: public health spending should correspond to the PHG spending conditions and statutory duties of Upper Tier Local Authorities and Directors of Public Health as outlined in legislation.
- Is public health the primary purpose of the activity being funded (based on CIPFA Service Reporting Code of Practice for Local Authorities 2024/25).
- Investments are proportional to the public health outcomes: when the PHG is invested in services that confer some public health benefit (but it is not the main and primary purpose) the level of investment should be proportionate to the impact on outcomes.
- Improves health outcomes and addresses health inequalities as defined in our Joint Local Health and Wellbeing Strategy 2023-28 and the Joint Strategic Needs Assessment 2024-2027 (through targeted approaches and evidence-based practice).
- Helps to manage short- and long-term demand on health and council services.
- Measurable short-term (1-3 years) and medium (5 years) impacts.
- Requires system wide action through the Place based Partnership.
- Engages local communities.
- Contributes to a balanced set of public health actions (Health in All Policies)
- Is supportive or aligned to wider accountability, performance, and improvement mechanisms aligned / complementary to broader Place priorities and workstreams

Opportunities presented by the development of a new 10-year Health Plan for England.

From a Public Health perspective, the Government has taken a significant step forward in changing how the nation thinks about health by recognising it is not just about treatment when something is wrong. Instead, we need to prevent illness and disease by improving the quality of the myriad of factors that determine how healthy we are – our houses, our education, our jobs, our diet, our community, our access to open spaces, our freedom to live in a smoke free environment – and much more.

The challenge now is to ensure these developments are universal and to procure best value from the services within the NHS itself as well as Public Health and social care at a time when we know resource pressures are intense. The Health and Wellbeing Board and ICB Sub-Committee (Committees in Common) need to drive decisions on the most effective and efficient use of resources taking account of the need and addressing health inequalities (Unlocking Prevention - Integrated Care Systems). [86]

Neighbourhoods are a fundamental building block within our system and the model is explicitly about community development and capacity; using the neighbourhood footprint to address health inequalities; networks of practitioners working together through local relationships and awareness of community; integrated teams operating in an integrated service model (or team of teams) as well as about services working together at a neighbourhood level with a direct interface with acute and other services.

Investment in prevention represents excellent value for money compared with health care spend. It is clear that opportunities to prevent the early deterioration of health are being missed, while the need for such interventions is increasing. Therefore, how we use the PHG to improve Public Health outcomes going forward will need to be aligned to Integrated Neighbourhood Teams in our four neighbourhoods. Thus, providing an opportunity for us to think differently in how we address deep-seated equity and access issues.

The way forward

Our Joint Local Health & Strategy 2023-2028 recognises the need for a combination of population and targeted individual preventive approaches, but it should be noted that, on average, individual-level approaches were found to cost five times more than interventions at the population level [87] In general, evidence also shows that investing in upstream population-based prevention is more effective at reducing health inequalities than more downstream prevention.

The National Institute for Health and Care Excellence found that many public health interventions were a lot more cost effective than clinical interventions (using cost per Quality Adjusted Life Year (QALY)), and many were even cost-saving. Investment in prevention reduces health costs and lowers welfare benefits. Therefore, there may be an opportunity that outcomes can be further improved by clustering a variety of cost-effective approaches in the design and delivery of programmes in the emerging Neighbourhood Plan to enhance the effectiveness and productivity of overall services.

Unlocking the potential of the Public Health Grant to improve residents' health is a priority. Building on our current Grant investments that have been driving cultural and structural changes across Place should be maintained, e.g. leading co-production of Health Inequalities Programme across place to drive change as well as use address evidence-based needs), funding BD Collective's neighbourhood networks (which evolved from Community Locality Leads pilot), new ways of working such as needs-driven, community-led Community Chest, service transformation such as earlier targeted NHS Health Check, etc.

However, the potential will not be fully realised without a call to action around using a population health approach across all Place funding, not just PHG if we are going to deliver on the Government's promise to halve the gap in healthy life expectancy between the richest and poorest regions. The prerequisite being for intervening early in infancy, childhood, and young adulthood at critical stages in the development of habits that will affect resident's health in later years.

Whilst our work should, and will, continue to challenge health inequalities in the adult population through the provision of high quality, well targeted interventions.

However, the longer-term health of the borough lies with ensuring that children and young people, growing up today, do not acquire harmful lifestyle habits and that we do not continue to store up problems for the future.

Best Practice Principles

- ☑ Adherence to statutory requirements to ensure eligible use: public health spending should correspond to the PHG spending conditions and statutory duties of Upper Tier Local Authorities and Directors of Public Health as outlined in legislation.
- ☑ Investments are proportional to the public health outcomes: when the Public Health Grant is invested in services that confer some public health benefit (but it is not the main and primary purpose) the level of investment should be proportionate to the impact on outcomes.
- ☑ Monitor, evaluate and review the use of the grant: investments should have the outcome measures described and these should be regularly reviewed.
- ☑ Data and evidence should be used to evaluate effectiveness and to understand whether public health spending is delivering improvements in key public health outcomes. It is especially important to evaluate service access and understand whether the service can reach vulnerable and targeted populations and reduce health inequalities.
- ☑ Support the delivery of the best value: eligible use of the Grant which supports the concepts of economy, efficiency, and effectiveness.
- ☑ Ensure proper governance of the Grant.

Acknowledgements

I would like to thank the following members of my team, UCLPartners, Macmillan and North East London NHS Foundation Trust Library for their contributions to this report:

- Mike Brannan
- Julia Bleet
- Joanne Broadbent
- Sue Ford
- Shelly Khan
- Richard Johnston
- Jane Leaman
- Carol Matenga
- Ellen McIntosh UCLPartners
- Rebecca Nunn
- Rachel Penniston UCLPartners
- Penny Pyke
- Teresa Salami-Oru
- Neha Shah
- Pauline Starkey
- Adebimpe Winjobi
- Ashley Yonga UCLPartners
- Faye Laker
- TWIN-Associates Design

References

1. https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future?utm_medium=email&utm_campaign=govuk-notifications-topic&utm_source=75c7d921-2fe4-43f7-b41c-dd51fcafbd1a&utm_content=immediately
2. https://www.kingsfund.org.uk/insight-and-analysis/long-reads/ten-year-health-plan-explained?dm_i=1XLP,8Z6W0,D1OOPL,11H19N,1
3. https://www.gov.uk/government/publications/giving-every-child-the-best-start-in-life
4. https://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review
5. https://www.instituteofhealthequity.org/resources-reports/marmot-review-10-years-on
6. https://www.elft.nhs.uk/information-about-elft/our-strategy-vision-and-values/population-health/being-marmot-trust
7. https://www.lbbd.gov.uk/sites/default/files/2024-02/LBBD%20ADPHR%202023.pdf
8. https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future?utm_medium=email&utm_campaign=govuk-notifications-topic&utm_source=75c7d921-2fe4-43f7-b41c-dd51fcafbd1a&utm_content=immediately
9. https://www.england.nhs.uk/london/our-work/a-neighbourhood-health-service-for-london/a-neighbourhood-health-service-for-london/
10. https://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/
11. https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future?utm_medium=email&utm_campaign=govuk-notifications-topic&utm_source=75c7d921-2fe4-43f7-b41c-dd51fcafbd1a&utm_content=immediately
12. https://www.nuffieldtrust.org.uk/news-item/integrated-neighbourhood-teams-lessons-from-a-decade-of-integration
13. https://phw.nhs.wales/publications/
14. Buck D, Wenzel L. Communities and health. The Kings Fund London: 2018. Available at: https://www.kingsfund.org.uk/publications/communities-and-health.
15. Marmot M, Allen J, Goldblatt P, Boyce T, McNeish D, Grady M, Fair Society, Healthy Lives: The Marmot Review. London; 2010.
16. https://assets.publishing.service.gov.uk/media/5b642ab240f0b635792683cc/Reducing_health_inequalities_system_scale_and_sustainability.pdf
17. https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future/fit-for-the-future-10-year-health-plan-for-england-executive-summary
18. https://webarchive.nationalarchives.gov.uk/ukgwa/+/http:/www.hm-treasury.gov.uk/consultations_and_legislation/wanless/consult_wanless_final.cfm
19. https://webarchive.nationalarchives.gov.uk/ukgwa/+/http:/www.hm-treasury.gov.uk/consultations_and_legislation/wanless/consult_wanless04_final.cfm
20. https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
21. https://obr.uk/box/how-do-pre-pandemic-health-trends-in-the-uk-compare-internationally/#:~:text=It%20shows%20that%20the%20UK,immediately%20prior%20to%20the%20pandemic
22. https://www.countycouncilsnetwork.org.uk/wp-content/uploads/The-Forgotten-Story-of-Social-Care.pdf
23. https://www.health.org.uk/evidence-hub/health-inequalities/trends-in-life-expectancy-and-healthy-life-expectancy#:~:text=Between%202011%E2%80%9313%20and%202017,reduction%20of%200.4%20in%20England
24. https://www.health.org.uk/reports-and-analysis/analysis/geographic-inequalities-in-premature-mortality
25. https://www.health.org.uk/reports-and-analysis/analysis/geographic-inequalities-in-premature-mortality

26. https://uclpartners.com/project/improving-cancer-journeys-learning-programme/
27. https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandwellbeing/articles/impactofhealthconditionsrequiringhospitalisationonearningsemploymentandbenefitsreceiptenglandapril2014todecember2022/april2014todecember2022
28. https://app.powerbi.com/view?r=eyJrIjoiZmIzYjY1NzUtM2ZhMy00NmNmLTk0ZTctMDllNzAyYjRkNWZhIiwidCI6IjM3YzM1NGIyLTg1YjAtNDdmNS1iMjIyLTA3YjQ4ZDc3NGVlMyJ9&pageName=ReportSection
29. https://urldefense.com/v3/__https:/institute.global/insights/economic-prosperity/the-macroeconomic-case-for-investing-in-preventative-health-care-UK__;!!CVb4j_0G!TKad56gRQ6icAhlB--VDQa-K4xO9KEaE7_WQfrQSFOnf5QnlJeZ5ITTg6zE1rY9sHTN1NyZSVMEQcqMD6YUPbApPcbcb7CtC8HRX2To$
30. https://www.england.nhs.uk/london/our-work/a-neighbourhood-health-service-for-london/
31. https://www.lbbd.gov.uk/sites/default/files/2024-02/LBBD%20ADPHR%202023.pdf
32. https://www.cancerresearchuk.org/health-professional/cancer-statistics/mortality/deprivation-gradient#heading-Three
33. https://pmc.ncbi.nlm.nih.gov/articles/PMC5157686/
34. (Multiple conditions and health inequalities: addressing the challenge with research) https://evidence.nihr.ac.uk/collection/multiple-long-term-conditions-multimorbidity-and-inequality-addressing-the-challenge-insights-from-research/
35. (Health inequalities: Improving early cancer diagnosis for everyone - Cancer Research UK - Cancer News https://evidence.nihr.ac.uk/collection/multiple-long-term-conditions-multimorbidity-and-inequality-addressing-the-challenge-insights-from-research/
36. (Health inequalities: Improving early cancer diagnosis for everyone - Cancer Research UK - Cancer News https://news.cancerresearchuk.org/2023/11/23/health-inequalities-early-cancer-diagnosis/#:~:text=And%20people%20with%20cancer%20in,in%20the%20least%20deprived%20areas.
37.
38. (Sociodemographic variation in the use of chemotherapy and radiotherapy in patients with stage IV lung, oesophageal, stomach and pancreatic cancer: evidence from population-based data in England during 2013–2014 | British Journal of Cancer) https://www.lbbd.gov.uk/sites/default/files/2023-06/LBBD%20JHWS%202023-28.pdf
39. https://www.lbbd.gov.uk/sites/default/files/2024-02/LBBD%20ADPHR%202023.pdf
40. https://www.lbbd.gov.uk/sites/default/files/2024-02/LBBD%20ADPHR%202023.pdf
41. https://pmc.ncbi.nlm.nih.gov/articles/PMC9264889/
42. https://www.instituteofhealthequity.org/resources-reports/a-snapshot-of-health-inequalities-in-london/full-report.pdf
43. https://www.nature.com/articles/s41416-018-0028-7
44. https://www.instituteofhealthequity.org/resources-reports/a-snapshot-of-health-inequalities-in-london/full-report.pdf
45. https://uclpartners.com/project/improving-cancer-journeys-learning-programme/
46. https://www.gov.uk/government/publications/giving-every-child-the-best-start-in-life
47. https://www.health.org.uk/sites/default/files/upload/publications/2020/Health%20Equity%20in%20England_The%20Marmot%20Review%2010%20Years%20On_full%20report.pdf
48. https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/
49. https://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report-pdf.pdf
50. https://www.savethechildren.org.uk/blogs/2018/mind-the-gap-getting-our-children-ready-for-school
51. https://www.thelancet.com/pdfs/journals/lanpub/PIIS2468-2667(17)30118-4.pdf
52. https://www.gov.wales/child-poverty-strategy-wales-2024-html

53. https://epi.org.uk/publications-and-research/maternal-mental-health/
54 https://epi.org.uk/annual-report-2024-local-authority-gaps-2/
55. https://www.gov.uk/government/publications/giving-every-child-the-best-start-in-life
56. https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future
57. https://assets.publishing.service.gov.uk/media/686baaa82cfe301b5fb677d1/Local_Government_Outcomes_Framework_priority_outcomes_and_draft_metrics_1.pdf
58. https://www.eif.org.uk/files/pdf/eif-annual-report-2018-19.pdf
59. https://www.eastsussexjsna.org.uk/media/nsaicfgy/the-east-sussex-creative-health-position-paper-september-2023_.pdf
60. https://www.researchgate.net/publication/342485057_Fancourt_D_and_Finn_S_2019_What_is_the_evidence_on_the_role_of_the_arts_in_improving_health_and_well-being_A_scoping_review
61. https://www.gov.uk/government/publications/giving-every-child-the-best-start-in-life
62. https://www.lbbd.gov.uk/sites/default/files/2025-06/BD_Homelessness%20Health%20Needs%20Assessment%202024-25%20-%20FINAL.pdf
63. https://discovery.ucl.ac.uk/id/eprint/10134291/
64. https://sharedhealthfoundation.org.uk/wp-content/uploads/2021/09/Housing-and-Childrens-Health-and-Social-Care-Publication.pdf
65. https://www.childrenscommissioner.gov.uk/blog/no-child-should-be-homeless-how-housing-instability-affects-a-childs-gcse-grades/
66. https://www.childrenscommissioner.gov.uk/blog/no-child-should-be-homeless-how-housing-instability-affects-a-childs-gcse-grades/
67. https://trustforlondon.org.uk/research/groundswell-temporary-accommodation-research/
68. https://assets.publishing.service.gov.uk/media/5f4e8896d3bf7f0a2d41c511/Public_health_approach_to_vulnerability_in_childhood.pdf
69. https://sharedhealthfoundation.org.uk/wp-content/uploads/2021/09/Housing-and-Childrens-Health-and-Social-Care-Publication.pdf
70. https://england.shelter.org.uk/professional_resources/policy_and_research/policy_library/briefing_the_impact_of_homelessness_and_bad_housing_on_childrens_education
71. https://trustforlondon.org.uk/research/groundswell-temporary-accommodation-research/
72. https://assets.publishing.service.gov.uk/media/5f4e8896d3bf7f0a2d41c511/Public_health_approach_to_vulnerability_in_childhood.pdf
73. https://web.p.ebscohost.com/ehost/detail/detail?vid=0&sid=126983f0-a3d9-4528-8e6c-b714f5fb37f5%40redis&bdata=JkF1dGhUeXBlPXNzbw%3d%3d#AN=127795108&db=pbh
74. https://citizensuk.contentfiles.net/media/documents/CITIZENS_-_The_Impact_of_inadequate_housing_on_educational_experience_v4.pdf
75. https://england.shelter.org.uk/professional_resources/policy_and_research/policy_library/still_living_in_limbo
76. https://england.shelter.org.uk/professional_resources/policy_and_research/policy_library/briefing_the_impact_of_homelessness_and_bad_housing_on_childrens_education
77. https://www.gov.uk/government/publications/giving-every-child-the-best-start-in-life
78. https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Femail.nhsconfed.org%2Fc%2FAQiRgxMQiOtvGNjCi6QBIO6chxnU93lU8CUEKnDEJSigvkLo0FTlEdSSRhcTKNCIr2GyLQ&data=05%7C02%7Cjoseph.gammie%40nhsconfed.org%7Cef80acdfd28149834d8708dce4933533%7Cb85e4127ddf345f9bf62f1ea78c25bf7%7C0%7C0%7C638636568113337206%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C0%7C%7C%7C&sdata=ZyK8eu8xLDOrzP8oQPVEel6xH02%2FsW3oRYrg8xf4pUg%3D&reserved=0
79. https://www.nhsconfed.org/news/investing-more-prevention-could-deliver-ps11-billion-return-investment
80. https://iris.who.int/bitstream/handle/10665/170471/Case-Investing-Public-Health.pdf
81. https://www.health.org.uk/reports-and-analysis/analysis/investing-in-the-public-health-grant
82. https://www.gov.uk/government/publications/public-health-grants-to-local-authorities-2025-to-2026/public-health-ring-fenced-grant-financial-year-2025-to-2026-local-authority-circular

83 https://www.lbbd.gov.uk/sites/default/files/2023-06/LBBD%20JHWS%202023-28.pdf
84. https://www.lbbd.gov.uk/sites/default/files/2023-06/LBBD%20JHWS%202023-28.pdf
85. https://www.gov.uk/government/publications/public-health-grants-to-local-authorities-2025-to-2026/public-health-ring-fenced-grant-financial-year-2025-to-2026-local-authority-circular#annex-a-grant-determination-ring-fenced
86. https://www.nhsconfed.org/publications/report-unlocking-prevention-integrated-care-systems
87. https://iris.who.int/bitstream/handle/10665/170471/Case-Investing-Public-Health.pdf)

Barking & Dagenham