Director of Public Health Annual Report 2012
A Changing World
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Although change and challenge is a fact of life, some things remain constant. The need to prioritise improvement in the health and wellbeing of the population, to work to reduce inequalities, to ensure equity in resource distribution, and to work in partnership with relevant organisations continues. The Health and Wellbeing Board is the forum for debate and challenge between partners, ensuring agreement and shared commitment to achieve change and improvement.

My Annual Report this year takes the theme of change as its focus, as we face the significant challenge of improving resident’s health and wellbeing at a time of significant demographic change and financial constraint. This is a watershed moment where our focus must be on transformation, with our Health and Wellbeing Board leading the way beyond the practical steps of transition to developing a local vision for improving the health and wellbeing of our residents, supported by new models for implementation and delivery.

The transfer of public health functions to the local authority offers a new opportunity to address many of the wider social determinants of ill-health that continue to entrench health inequalities across generations. It supports us to move away from a medical model that emphasises interventions that are done to people towards developing the communities within which people can take more control of their own health and wellbeing.

It is vital that the current process of transition sets the best foundations on which to build the delivery of population health improvement, including using the evidence gained from investment by both the Council and NHS Barking and Dagenham to facilitate industrial scale change to reduce mortality (death) and morbidity (illness). Industrial scale change is about doing things that we know can have an impact on the health, wellbeing and future life chances across the whole life course on a scale that gives all residents the opportunity to benefit. Prioritising the use of the Public Health Grant to fund a smaller number of large scale programmes needed to achieve change in the health of our residents must be a key area of focus for the Health and Wellbeing Board.

A cornerstone of our new system will be the need to share information within a sound governance framework. Appropriate sharing of information within and between our partner organisations is central to improving the health of the population, safeguarding the vulnerable and ensuring joined-up care. The NHS number should act as a unique identifier that all organisations in health, social care and education can use to make sure that the best interests of individual patients and users are understood and protected. At organisational level, the system changes are bringing challenges to the availability of the information required to understand needs and to plan services, and it is essential that as partners we agree how we can work together within a legal and governance framework that benefits our communities.

As Director of Public Health, my role is now set out in law. Local authorities are required to appoint a Director of Public Health, acting jointly with the Secretary of State for Health. More detail is given in my report about the exercise of the Council’s public health functions, but the spirit of the role remains unchanged: to advocate for the health of the population and its improvement and protection.
The Annual Report has been an important statement about the health of the population ever since the early days of the Medical Officer of Health. The report is the Director of Public Health’s professional perspective about the health and health needs of local communities, based on sound epidemiological evidence and objective interpretation. The report is available to the public as well as to decision makers. The Health and Social Care Act 2012 includes a duty on the Director of Public Health to write a report, and a duty on the Council to publish it, enshrining in law a long standing practice. The report remains an important vehicle for informing local people about the health of their community, as well as providing information for partners and a basis for making decisions about how best to address priorities and gaps. The requirement for the report to be annual also allows progress to be recorded and evaluated.

We face the significant challenge of improving resident’s health and wellbeing at a time of significant demographic change and financial constraint.
This report has been written to draw attention to some of the opportunities for change and improvement and to underline the extent to which the population and the structures are changing.

Although in the past the report of the Director of Public Health took a more comprehensive approach to assessing the health status and health needs of the local population, this function is now undertaken through the statutory Joint Strategic Needs Assessment. This gives the Director of Public Health the opportunity to highlight issues and priorities, and this report has been written to draw attention to some of the opportunities for change and improvement and to underline the extent to which the population and the structures are changing, while setting this within the broader context of changing society.

Taking the themes overall, key strategic messages emerge:

### Supporting people to stay healthy

- There is a shared need to shift focus and resources to prevention and early intervention. This applies across the life course.
- The greatest health gain for the population is not in the improvement of acute care, necessary though that is, but in optimising the health of people with long term conditions through self-management and effective primary and community care. Consistent quality standards are fundamental to ensuring that the impact of illness is minimised.

### Integration of care

- The financial and demographic challenges facing health and social care make integrated care an urgent necessity, as well as being in the best interests of patients. At the heart of an integrated model of out-of-hospital care must be the aim to improve reablement and recovery outcomes for all, whilst recognising the conflict between people’s rights under the NHS Constitution to a universal service, and the eligibility criteria that are a consequence of the pressure on social care.
- Steps should be taken to continually improve patient’s experience of integrated care, while also empowering communities to test new approaches. Good models of integrated care can and will look different in different areas.
- Patients and service users need to see that agencies are working together for their benefit; this is demonstrated through culture and behaviour as well as everyday practice.

### Care and support of children

- Be clear who is responsible for safeguarding vulnerable children: Previous failings in safeguarding show the dangers of a disconnected system and unclear procedures. With the reorganisation of the NHS there is an imperative to ensure all organisations and their staff understand both the individual and the system responsibility for safeguarding.
- Enhance the involvement of children and young people in their services: We need to do more to ensure young people are consulted on how their healthcare is provided, and that they have access to information on health, illness and services.
- Continue to improve primary care for children and young people: We need to support plans for extra training for GPs about child health and ensure inclusion of key elements of the Healthy Child Programme, improving awareness in primary care about public and population health.
- Continue our focus on improving arrangements for transition between services: Transition between children and adult services involves a risk that patients fall between the gaps and fail to receive the care they need. We need to consider how transition pathways for young people can be improved.
- Maintain children’s mental health as a priority: During the year we will be assessing the progress made on this important priority.
Enable schools to improve child health and wellbeing: Local schools have an important role to play in improving child health and wellbeing. For the commissioning of high quality, integrated services, we will need to work with schools in a coordinated effort. I believe that understanding the role of school nurses and investment in their work should be prioritised in a similar way to the work of the national health visiting programme. Without such a focus on school nurses, we will not join up the different parts of the workforce for school-age children, and ensure safe transition of young people to adult life and adult services.

Protecting people's health
The new public health responsibilities of the Council include the requirement to protect people’s health, which covers planning for and responding to emergencies, and ensuring protection from communicable and non-communicable diseases including through immunisation and screening programmes. Meeting these responsibilities will need effective working between the Council and the new health system organisations, including Barking and Dagenham Clinical Commissioning Group, Public Health England and the NHS Commissioning Board. Details about how these functions and relationships will work in practice are still emerging. It is essential that scrutiny and challenge ensures that programme delivery meets the needs of local people.

High quality care
The majority of acute hospital services for the residents of Barking and Dagenham are commissioned from Barking, Havering and Redbridge University Hospitals NHS Trust by Barking and Dagenham Clinical Commissioning Group. The Trust faces difficult challenges in meeting service and financial pressures and delivering care to consistently high standards, as evidenced by recent Care Quality Commission investigations and reports. The Council’s responsibility to protect the health of the population extends to healthcare acquired infections and serious incidents, and the Health and Wellbeing Board is an important forum for agreeing actions.

I hope you find the 2012 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

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Around one in three people living in Barking and Dagenham were born outside the UK.

Nearly three out of every four of those residents born outside the UK have been resident in the UK for five or more years.

One in ten households have no-one in the household for whom English is the main language.

The population size of Barking and Dagenham increased by 13% between the 2001 and 2011 censuses.

Barking and Dagenham has the highest proportion of children aged 0 to 4 and 0 to 14 in England.

One in four of the population is under the age of 15, and one in ten under the age of five years.

The number of children under the age of 5 increased by almost 50% between 2001 and 2011.
The number of births each year increased by 52% between 2002 and 2011.

Seven wards have had increases in the number of children under five of more than 60% between 2001 and 2011 and four wards have seen births increase by more than 30%.

62% of school pupils are from ethnic minority communities. Nearly half of primary pupils and one-third of secondary pupils speak English as a second language. Over 100 different languages are spoken in our schools.

Only about half of babies are fully or partially breastfed by six to eight weeks of age.

Barking and Dagenham has the third highest rate of child obesity in England at Year 6 and the second highest at reception age.

Smoking is the biggest single cause of preventable mortality. About 100 residents each year die from smoking related diseases including lung cancer, chronic obstructive pulmonary disease, heart disease and stroke.

Barking and Dagenham has the second highest estimated smoking prevalence in London at 23% overall and 29% in routine and manual workers.

Barking and Dagenham is estimated to have the highest percentage of obese adults in London, more than one in four adults is obese.

An estimated one in five of the adult population drink alcohol at hazardous levels. The number of alcohol related hospital admissions increased by nearly one-third between 2007-08 and 2010-11.

Abortion rates are the second highest in the UK. In 2011, 1,532 pregnancies were terminated under the Abortion Act.

Around 600 people in Barking and Dagenham are receiving HIV related care, 60% of these are women. Two-thirds of people with HIV are diagnosed at a late stage, when treatment is more difficult and expensive.

Barking and Dagenham has the highest emergency hospital admission rate in London. Admissions for conditions that should normally be managed in the community are high and put pressure on hospital services. There are considerable differences in admission rates between general practices.

Diagnosis rates and effective treatment of common conditions such as asthma, heart disease and diabetes varies considerably between general practices, resulting in hospital admissions that could be avoided and poor health that could be improved.
Barking and Dagenham
A changing population

A diverse population

People living in Barking and Dagenham originate from many different countries, speak many languages and practice many different religions.

Figures from the 2011 census show that nearly one in three people (31%) living in Barking and Dagenham were born outside the UK, increased from one in ten people at the time of the 2001 census. Even so, Barking and Dagenham still has one of the highest proportions in London of people born in England, ranked 9th of the 33 boroughs, and nearly three-quarters of those born outside the UK have been resident in the UK for five or more years. Nevertheless, over 30,000 people living in Barking and Dagenham arrived in the UK since the 2001 census. Most people move to the UK at a young age, either as school children (31% of those born outside the UK arrived when they were below the age of 18) or young working age (45% arrived aged 18 to 30).

Of those born outside the UK, 24% were born in EU countries, forming 8% of the total population. The population of Europeans born outside the UK are mainly from the new European countries of Lithuania, Poland and Romania. People from these three countries comprise 4% of the total population of Barking and Dagenham. Those born in Africa form 11% of the total population, of whom 40% are from Nigeria, and those born in the Middle East and Asia form 9% of the total population, three-quarters of whom were born in India, Pakistan and Bangladesh, and almost equally divided between those three countries.

Children born to mothers born outside the UK contribute significantly to the African and Asian communities; in 2011 60% of births were to mothers born outside the UK, of which nearly half were to mothers born in Africa and one-quarter to mothers born in the Middle East and Asia.

The 2011 census data shows that 65% of residents hold a UK passport, 8% hold passports for other EU countries, 6% for African countries and 4.6% for Middle East and Asian countries. The 16% of residents who do not hold a passport are most likely to be British, as those born in other countries would need a passport to enter the UK. The data on passports held fits with that on national identity, with 79% of residents acknowledging a UK identity.

All people in four out of every five households in Barking and Dagenham have English as the main language, although one in ten households has no one in the household for whom English is the main language. For the remainder, at least one person in the household speaks English as their main language, although in about one in 30 households this person is a child under the age of 16.

Christianity is the most common religion in Barking and Dagenham. In the census, one quarter of people said they had no religion or did not state a religion. Of those that stated their religion, 75% are Christian, 18% Muslim, 3% Hindu and 2% Sikh.
An increasing population

The number of people living in the borough is increasing rapidly and will continue to do so. The population increased by 13% (22,000) between the 2001 and 2011 censuses to 185,900. By the time of the next census in 2021 it is predicted that the population will have increased by a further 16%.

Barking and Dagenham is situated at the heart of the Thames Gateway, which is a major development area for London and the South East. There are three key regeneration areas within Barking and Dagenham; Barking Town Centre, Barking Riverside and South Dagenham, and the potential for up to 25,000 additional homes (as described in the Local Development Framework Core Strategy).

Population growth varies between wards; since the 2001 census four wards have seen a population increase of over 20% (Abbey, Gascoigne, Longbridge and Thames). The big growth in the number of young children is more widely distributed, with seven wards seeing increases in the number of children under the age of five of more than 60%. Changes of this magnitude have a major impact on the need for schools, healthcare and community facilities.

All people in four out of every five households in Barking and Dagenham have English as the main language, although one in ten households has no one in the household for whom English is the main language.
A young population

The 2011 census shows how different the age structure of the population of Barking and Dagenham is from the London and England population. The local population age structure is heavily weighted towards the young and very young – Barking and Dagenham has the highest proportion of children aged 0 to 4 years and 0 to 14 years in England. One in four of the population is under the age of 15, and one in ten is under the age of five.

The number of young and very young children has increased rapidly, putting pressure on our schools and children’s services. The number of children under the age of five increased by almost 50% between the 2001 and 2011 censuses (18,676 in 2011 compared with 12,542 in 2001), and the number of children under the age of 15 increased by one quarter (45,764 in 2011 compared with 36,112 in 2001).

The high proportion of children is balanced by a smaller proportion of the working age population than that in London and a smaller proportion of older people than in England as a whole. The proportion of the population aged 40 and over is very similar in Barking and Dagenham to that in London (37.5% in Barking and Dagenham, 39.7% in London), but dramatically different to the population of England as a whole (49% aged 40 and over). For people aged 20 to 39, Barking and Dagenham also has a smaller proportion than London (31% compared with 36% for London) but a higher proportion than England (27%).

Between 2001 and 2011, in spite of the overall population increase of 13% (from 163,944 to 185,911) the number of people aged 65 and over has reduced by 20% (from 24,116 to 19,321). This reduction is in the 65 to 84 age range, while the population aged 85 and over has increased by 7% (from 2,856 to 3,063). The proportion of the population aged 65 and over in Barking and Dagenham is 10%, similar to the proportion in London (11%) but a much smaller proportion than England as a whole at 16%.
One in four of the population is under the age of 15, and one in ten is under the age of five.

Fig 2: Population pyramid comparing 2011 Census population structure for Barking and Dagenham with the structure for England

Source: Office for National Statistics, Census 2011
A rising number of births

The number of people living in Barking and Dagenham is increasing, and in contrast to many places this population increase is primarily related to the number of births and the increasing number of young children living in the borough. Total births have increased by 52% between 2002 and 2011, from 2,419 to 3,688 births per year. This increase is also reflected in the number of children aged 0 to 4 years, which increased by almost 50% between the 2001 and the 2011 censuses. This is the highest growth for this age group of any local authority in England and Wales.

This increase in the number of births is partly related to an increase in the number of women in the child-bearing age range (15% increase in women aged 15 to 44 from 38,000 to 43,000) but more importantly related to a 33% increase in the general fertility rate (live births per 1,000 women) over the last ten years. The total fertility rate (basically the average number of live children women have) was 2.45 in 2011, which is the highest in England.

The increase in the number of births is not evenly distributed across the borough, although 11 out of the 17 wards have seen a growth of more than 20% since 2004. The wards with the biggest increase in the number of births are Longbridge (48% increase), Alibon (36%), Goresbrook (34%) and Abbey (33%). The impact has been felt at both the NHS Trusts which are the main providers of maternity care to local residents – Barking, Havering and Redbridge University Hospitals NHS Trust and Newham University Hospital, now part of Barts Health NHS Trust. At both these hospitals the number of births has increased by about 25% since 2004. The increase in the number of births to local residents is predicted to continue, with an additional 500 births (14%) by 2016.

Mothers giving birth have increasingly diverse places of birth themselves, with fewer mothers born in the UK, reducing from a peak of 1,670 in 2006 to 1,470 in 2011. In 2010, 58% of live births were born to non UK born mothers, mainly to mothers born in Africa (27%), Europe (17%) and Southern Asia (13%).

These changes in mother’s birthplace have an impact on the need for culturally sensitive care, and the overall increase in the number of babies born increases the actual numbers (although the proportion is not changing) needing intervention during labour and the numbers of babies who need additional care because their weight is low at birth. For example, although the proportion of babies born with low birthweight is stable at about 8%, the actual number has increased by about 20% to around 300 each year.

A rising number of children

The child population in Barking and Dagenham is one of the fastest growing in the country, putting pressure on early education, school places and other services for children. The resident population of around 57,000 children and young people aged 0 to 19 represents 30% of the total population. The increase in the number of children under five years is particularly marked, increasing by about 50% in the last ten years, and predicted to increase by a further 10% in the next ten years.

This increase in the number of young children has a rapid impact on the need for primary school places. Between 2007 and 2012 the primary school population has increased from 18,760 to 22,809. Based on 30 pupils per class, this represents a need for 135 more primary school classes. As the children grow older this increase will become manifest in secondary schools as well, and although the increase in secondary school pupils since 2007 has only been 6%, these numbers will also grow rapidly. Of course it is not only school places that are needed for these children, but support from health visitors and school nurses as well as access to health services.

The increasing population diversity also impacts on schools. In 2012, 62% of school pupils are from ethnic minority communities and nearly half of primary school pupils and one-third of secondary school pupils speak English as a second language. Over 100 different languages are now spoken by children in local schools.
Barking and Dagenham has the ninth highest level of child poverty in England and more than one-third of children are living in households with incomes significantly below average. At the time of the 2012 school census, 29% of pupils were eligible for free school meals, compared to the national average of 17%.

The number of children who are looked after or on child protection plans is also rising, with a rate of increase faster than that seen nationally. Between 2006-07 and 2010-11 the number of referrals made to children’s social care rose by 88%. A subsequent reduction in 2011-12 may reflect the beneficial effect of structural changes with six multi-agency locality teams and the implementation of a triage team.

The number of children subject to child protection plans increased by 66% between 2008-09 and 2010-11, and, after a reduction in 2011-12, the number has risen again to around 250, a rate of 46 per 10,000 children. The number of Looked after Children has also increased considerably. At the end of 2011-12 there were 427 Looked after Children, a rate of 86 per 10,000 children aged 0 to 17 years, and this number is continuing to increase, compared to a decrease across London and even other East London boroughs.

These figures starkly demonstrate the speed of the increase in the young population in Barking and Dagenham, and give some insight into the scale of service development that is needed to address the inevitable needs. It is not only the numbers that are increasing, but the disadvantage of living in poverty and dependency on low wages and welfare benefits which affect the health and wellbeing of children and families. This impact is likely to increase in 2013 as the welfare benefit changes introduced in April make already difficult lives even more challenging.
Ensuring healthy babies

Booking for care in early pregnancy

Women are encouraged to be seen and assessed by a healthcare professional, usually a midwife, before they are 13 weeks pregnant. This early assessment helps to identify any special health needs planning of their care and includes advice on living a healthy lifestyle during pregnancy.

Maternity services should aim to see at least 90% of women before they are 13 weeks pregnant, which was only achieved for mothers registered at six GP practices in 2010-11. For pregnant mothers in Barking and Dagenham, on average about 75% are seen at this critical early time. More detailed local analysis indicates that teenage mothers are less likely to be seen in early pregnancy than mothers aged 20 or older. We need to ensure that our services see more women in early pregnancy, as well as ensuring that local mothers understand the importance of early care.

Smoking at the time of delivery

 Quitting smoking during pregnancy is probably the most important thing a mother can do to safeguard the health of their developing child. Smoking during pregnancy may restrict the oxygen supply to the baby, and increase the risk of miscarriage, stillbirth, premature birth and low birthweight.

Around one in eight local mothers are smokers at the time of delivery. This is less than the local smoking prevalence of 23% and suggests that many mothers do give up smoking, at least during their pregnancy.

Smoking is also harmful to babies and small children, and this harm persists even when relatives and friends smoke in a different room to the child. Supporting parents to quit smoking must be a key priority for smoking cessation services.

Breastfeeding

Breastfeeding is beneficial to both babies and mothers, and it is recommended that babies are exclusively breast fed for the first six months. Breastfeeding protects babies from infections and diseases, including diarrhoea and vomiting and infections that may result in hospital admission. It also protects babies from obesity and associated Type 2 Diabetes later in life.

In Barking and Dagenham, around three in four mothers start breastfeeding immediately after the birth of their baby, but by six to eight weeks after delivery only just over one-in-five babies are totally breastfed, while about half of babies are fully or partly breastfed. In contrast, in Redbridge about one in three babies are totally breastfed at six to eight weeks.

Successful breastfeeding is more likely with effective support and advice before birth, in the immediate hours after delivery and during the first few weeks after birth. Midwives, health visitors and specialist voluntary sector organisations all have an important role.
Health needs of children – child obesity

Barking and Dagenham has almost the highest rate of child obesity in England. Obesity rates measured in the National Child Measurement Programme (NCMP) for 2011-12 show that, at the age of 10 to 11 years (Year 6), 26.9% of children are obese, with only City and Hackney at 27.1% and Southwark at 28.3% having higher rates. Even at the age of four to five years (School Reception) obesity rates are already high at 13.7%, with only Newcastle upon Tyne having a higher rate at 14.5%.

The results of the NCMP for 2011-12 are of great concern, as although rates have been high since measurements started in 2007-08, they have been relatively stable. While it is too soon to know whether the increase in 2011-12 for children aged 10 to 11 will be sustained, it is certainly a call to action.

At the national level, child obesity prevalence in Year 6 increases with increasing deprivation, from 13.7% in the least deprived areas to 24.3% in the most deprived. Obesity prevalence in these children also varies by ethnic origin, with Black and Black British and Asian and Asian British having the highest prevalence.

There is a clear and continuing case for investment in programmes that support children to achieve and maintain a healthy weight. These include actions to increase the level of safe opportunities for play and physical activity, and weight management programmes to support and advise those children who are already overweight and obese. Our strategy to tackle child obesity needs to be strengthened across the whole system to address this worrying local position.

Barking and Dagenham does lots of great things that improve the life chances and the health and wellbeing of children and young people in the borough. However, many of these things are done on a small scale, working well for pockets of the population, rather than at an industrial scale to address the industrial scale challenges. Two examples of where we have experience at programmes that benefit the health, wellbeing and future life chances of young people across the borough are swimming and healthy eating programmes.

There is an opportunity to consider the re-introduction of the subsidised swimming programme. Swimming is an important form of physical activity but more than that it is a life skill that can save lives and is an activity that can be carried on into adulthood without teams or group association. Swimming has been shown to improve mental wellbeing as well as having a positive impact on educational and personal development for children and young people.

We need to focus on increasing the number of children and young people enjoying swimming from toddlers to adulthood. There are three aspects to this:

- Increasing the number of children (under 4 years) and responsible adults swimming through facilitated structured adult and toddler classes.
- Increasing the number of children and young people (aged 5 to 18) accessing swimming through schools, during curriculum and extended school hours.
- Increasing access for children and young people to swim outside school hours through structured programmes and subsidised entry to swimming facilities in the borough.

Healthy eating is also key to building a healthy future for children and young people and there is already pilot work in the borough increasing the uptake of free school meals amongst those that are entitled to them. We are also doing good work to increase awareness and understanding of healthy eating.
amongst children and young people, while recognising that we could do more, bringing together the lessons learnt from the five-a-day fruit schemes in schools and from breakfast clubs to develop an industrial scale intervention to ensure every child in the borough has a healthy, nutritious start in life.

Inevitably there are some significant barriers to developing and implementing best practice into industrial scale programmes, but if we really are to make a difference for our young people we need to make brave decisions and implement evidence based programmes on a scale large enough to make a meaningful difference.

Health needs of adults

NHS Health Check

The NHS Health Check Programme started across England in 2009. It aims to identify and help prevent heart disease, stroke, diabetes and kidney disease. Everyone between the ages of 40 and 74, who has not already been diagnosed with one of these conditions, is invited once every five years to have a check to assess their risk of heart disease, stroke, kidney disease and diabetes. Those people who are identified as being at particular risk or with early signs of disease are offered lifestyle advice or referred to their GP as appropriate.

Barking and Dagenham was one of the first areas to introduce the programme, and at the end of 2011-12 nearly 20,000 people out of an eligible total of 41,300 (population aged 40 to 74 years without chronic conditions) had accepted a health check. After three full years of operation we are on target to achieve the 30,000 checks that are planned, based on 75% of the eligible population having checks over a five year period.

Evidence from the health checks undertaken so far demonstrates the need for lifestyle advice and interventions amongst the population. The prevalence of smoking was higher than the population overall, and around one in five people having a health check were obese (Body Mass Index of 30 or over). In terms of conditions needing intervention, around one in five were prescribed statins, one in ten were diagnosed with high blood pressure and three in every hundred were diagnosed with diabetes1. While this level of diagnosis may not be maintained throughout the programme, there are clearly a substantial number of people in the community unaware of conditions for which they need treatment.

The original health check includes questions about health and family history, and measurement of height, weight, blood pressure and blood cholesterol. From April 2013, questions about alcohol consumption will be introduced to the check, and people aged 65 to 74 will be given information to raise their awareness about dementia and the availability of memory services.

NHS Health Check is one of the few public health services that will be mandatory for local authorities to commission from the Public Health Grant. In Barking and Dagenham, the high levels of illness and early death from conditions such as cardiovascular disease and diabetes and the evidence from the early part of the programme about the level of undiagnosed illness demonstrates the value of the programme, and the importance of maintaining an effective programme supported by the essential follow-on lifestyle advice programmes, including the Healthy Adults Programme and smoking cessation services.

The impact of smoking

About 100 Barking and Dagenham residents every year die from diseases associated with smoking. The number of deaths from lung cancer and chronic obstructive pulmonary disease is significantly above the national average, and deaths from heart disease and stroke are also high. Smoking is the biggest single cause of preventable mortality and ill health, and around 5.5% of the NHS budget is spent on smoking related healthcare.

Modelled estimates of smoking prevalence from the Household Survey calculate that 23% of all adults over the age of 18 years, resident in Barking and Dagenham, are smokers. Only Hackney, amongst London boroughs, has a higher prevalence at 25%. Levels in routine and manual workers are estimated to be higher at 29%. Although prevalence remains high, current estimates show a substantial reduction from the 32% level which was estimated ten years ago.

NHS Stop Smoking Services are well established, and over the last ten years the number of people using them has increased four times to over 800,000 people. About half of those people who attend the service and set a quit date have successfully quit four weeks after the date they set, although no data is collected on their long-term success at stopping smoking. In 2011-12, 2,625 people set a quit date with NHS Stop Smoking Services, and 1,505 had successfully quit at four weeks, a success rate of 57%. Of those setting a quit date, 45% were men, and their success rate was 59%. For women the success rate was 56%.

Stop Smoking Services are used by people of all ages, but the proportion of those who set a quit date who are successful quitters increases with age, from 50% in those under 35 years to 69% in those aged 60 and over.

Stop Smoking Services are only one aspect of the comprehensive local tobacco strategy which covers 2010 to 2014 and addresses issues such as counterfeit and illegal tobacco as well as working in partnership with schools and youth services to try to reduce the number of young people that take up smoking.

Smoking remains a significant cause of illness and early death, and although there have been many developments in recent years with the introduction of smoke free public buildings and the increasing recognition of the harm that smoking in the home does to children, the need continues to discourage people from taking up the habit and to support them quitting. There is still a way to go to reduce local smoking prevalence even to the average for England, currently estimated to be 20%.

Obesity in adults

The prevalence of obesity in adults and children is a major challenge and Barking and Dagenham is estimated to have the highest percentage of obese adults in London. This means that more than one in four adults has a BMI (Body Mass Index) of more than 30. Figures from 2011-12 indicate that there were 1,200 obesity related hospital admissions by local residents, costing around £3.4 million. Obesity rates vary according to socioeconomic status, with low income and deprivation having a greater impact on female obesity levels than male. In addition, there is a higher prevalence of obesity among some ethnic groups, in particular among Black Caribbean and Pakistani women.
The high costs of obesity result from the increased risk of many chronic conditions, including diabetes, high blood pressure, heart disease and strokes, and certain cancers. Child obesity is a particular concern, increasing the risk of premature death and chronic diseases in later life. As many as 8% of deaths in the UK are thought to be attributable to obesity, and being obese at the age of 40 is thought to reduce lifespan by seven years. This compares with about 18% of deaths being due to smoking, and a 13 year reduction in lifespan.

In England, adult obesity levels are estimated to be 26%. Local levels have been modelled at relatively small area level (Middle Level Super Output Area (MSOA), of which there are 22 in Barking and Dagenham) using data from general practice and from the Health Survey for England. Of the 22 MSOAs, nine are among the 10% of MSOAs with the highest obesity levels in England. General practice data is thought to significantly underestimate obesity prevalence, demonstrated by the threefold variation in obesity rates, from 8% to 25%. Locally, 13 practices report obesity prevalence rates of less than half the England level of 26%. Obesity related hospital admission rates per 1,000 registered obese patients vary fivefold between general practices, from 27 per 1,000 to 138 per 1,000, but this variation is likely to be partly due to the low registration of obese patients in some practices.

Acting to reduce the level of adult obesity is critical to improving health and reducing early death. Urgent actions include:

- Increase case finding in general practice to identify those patients who need support to reduce their weight.
- Ensure that those people who attend for the NHS Health Check and are found to be obese are referred to weight management and physical activity programmes.
- Assessing care and support needs for all obese people and commissioning appropriate services and support.

Fig: 5 Adult obesity prevalence in Barking and Dagenham (MSOA level)

<table>
<thead>
<tr>
<th>Prevalence % (Adults)</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>24.5 – 27.6</td>
<td>27.6 – 29.1</td>
</tr>
<tr>
<td>29.2 – 30.3</td>
<td>30.4 – 30.9</td>
</tr>
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</table>

Source: National Obesity Observatory
Addressing adult obesity

There is evidence that even a modest weight loss of 5 to 10% in obese people can bring health benefits. A Healthy Adults Programme is in place to help people with weight management and to support people to increase the amount of physical activity that they do.

Weightwatchers® programme

Many studies have shown that providing effective support and advice on how to eat healthily and how to lose weight is a challenge. Commercial weight loss programmes are an economic way of providing sustained support and have some evidence for their effectiveness. In Barking and Dagenham, referral to an NHS funded Weightwatchers® programme has been available since December 2009, and was established in response to clinicians who wanted a local service for their patients that would provide support in a non-clinical environment.

The service works on the basis of referral by the patient’s GP or another clinician such as a pharmacist or community nurse. Users register by phone and receive vouchers for a twelve week programme. Users are not asked to contribute financially to the programme, as it is thought that this might deter those most in need. The cost to the NHS is £55 for each twelve week programme.

In the two years between January 2010 and December 2011, evaluation of the WeightWatchers® service demonstrated that 51% of users completing a 12 week programme lost at least 5% of their body weight. Nearly 1,000 patients were referred each year, of whom one-third completed the full programme. Most commonly, users were white women in their 40s, although the age range for those completing the programme was from 17 to 84 years. Only about 10% of those completing the programme were men, and about 85% describe their ethnic origin as white. While referrals have been made from all GP practices, 11 practices referred 3 or fewer patients. Assessing value for money, on the basis that successful completion of a twelve week course with a weight loss of at least 5% of body weight is the objective of the programme, the cost is about £330 per user achieving this objective.

The level of obesity in Barking and Dagenham demonstrates a clear need for weight loss and weight management support, to which this service is making a cost effective contribution. However, we need to understand better how to make the service more attractive to men and to those from minority ethnic groups, as well as promoting the service to all GP practices and health care workers to ensure that access is more equitably distributed across the borough.
Exercise on referral

Active for Life is an exercise on referral programme that has been commissioned from the London Borough of Barking and Dagenham. The programme is delivered by trained professionals who provide a structured programme of physical activity and promote the importance of taking a balanced approach to healthy eating. The objectives of the programme are to provide motivation and support to bring about positive behavioural change, promote long-term lifestyle changes through addressing eating and activity behaviours, create opportunities for being more active and offer practical safe advice and resources that will play a key role in helping the person to sustain their weight loss and continue an active lifestyle.

The Exercise Referral Offer includes a 12 week prescribed exercise programme, plus free gym membership for up to nine months at one of the Council’s leisure centres for those completing the 12 week programme. It is available to those who are recommended by their doctor or another health professional as someone who could improve their health by increasing their activity levels.

Since the programme became fully established in April 2012, an average of just over 100 new attendees have started this programme every month, with a total membership after six months of almost 500 people, of whom nearly half have completed the programme and gone on to take up the nine months free gym membership.

Preliminary data suggests that this programme is attracting a similar group of people to the Weightwatchers© programme, that is more women than men (about half as many men as women are participating in the exercise programme) with an average age in their mid 40s. Evaluation is needed to determine the impact and cost effectiveness of the programme, and we plan to publish this in 2013.

Healthcare needs for people with alcohol problems

Drinking excessive quantities of alcohol has an impact on individuals, their families and on wider society. As well as the direct physical and psychological effects on the drinker, it affects the health and wellbeing of their families and friends, and can harm themselves and others through the risk of violent behaviour and traffic accidents. Alcohol is a key driver for crime and disorder in the borough and the borough is rated 316 out of 326 local authorities for alcohol related recorded crimes.

We estimate that about one in five (20% equating to 26,646 people) of the adult population of Barking and Dagenham are hazardous alcohol drinkers, with nearly 6,000 of them drinking sufficient amounts to be harmful to health. Around 20% of adults are binge drinkers and six wards have been identified as binge drinking hotspot areas. Barking and Dagenham is ranked the 12th worst borough in London for binge drinking.

Across England, alcohol related hospital admissions doubled in the ten years between 1997 and 2007, and continue to rise with more than one million admissions per year in England. In Barking and Dagenham the number of alcohol related hospital admissions increased by 31% between 2007-08 and 2010-11 to 3,701 admissions, and the rate per 100,000 population is 9th highest of the London boroughs.
Almost two-thirds of alcohol related admissions are men, and while the highest rates are at older ages reflecting the greater effect on health with increasing age, around one-quarter of admissions are people under the age of 45 years. On average, about 80% of admissions are as an emergency, but this varies with age and for patients under 30, around 90% are emergencies. The most common diagnoses are for the acute effects of alcohol and for symptoms associated with withdrawal, with alcoholic cirrhosis of the liver being the third most common diagnosis.

Alcohol related admissions are strongly correlated with deprivation, and there is a twofold variation between the ten GP practices with the highest rate of admissions compared to the ten with the lowest rate. At ward level, variation is similar, with Mayesbrook, the ward with the highest rate at 2,743 per 100,000 population, having a rate almost twice that of the ward with the lowest rate, Longbridge (1,471 per 100,000 population). Other wards with high rates are Village (2,680), Gascoigne (2,606) and Alibon (2,576).

Treatment for people with alcohol problems

The National Treatment Agency for Substance Misuse publishes data about the number of local people estimated to have alcohol problems and receiving help through structured programmes. They estimate that there are over 2,000 dependent drinkers in Barking and Dagenham and about 500 people receiving treatment. The number of people accessing treatment for alcohol dependency has more than doubled over the last three years. The average age of people in treatment is 40 years, and two-thirds of them were unemployed at the time of starting treatment. One-quarter were living with children. The average length of treatment is three to four months, although 20% were in treatment for more than a year.

Community alcohol services provide specialist alcohol misuse services for problem drinkers, their families and for professionals working with them. Services include advice, information, assessment, counselling, community and inpatient detoxification, outreach and day care programmes.

The borough aims to become a place where residents and visitors choose to drink alcohol in a safe and responsible manner and where harm from its effects is responded to quickly. We are developing a comprehensive alcohol strategy which will focus on:

- Reduction in alcohol related harm.
- Improved health outcomes for people misusing alcohol.
- A safer community with a reduction in victims of alcohol related harm.
- Preventing young people from drinking alcohol.
- Strong and resilient families that are able to meet their individual needs.

Fundamental to achieving improvement is an effective treatment and care pathway which addresses both clinical and public health concerns, linking community, primary care and specialist interventions. Work is underway to develop and implement this pathway.
but may be discharged without such an assessment. Suicide is more common by men than women, with a ratio of about three to one. Suicide rates had been falling across England, but locally the rates in recent years have increased.

Self-harm hospital admission rates for Barking and Dagenham residents are 7% above the national average for men and women combined. The level for women is particularly high at 23% above the national level, whereas for men it is 10% below. The area covered by the wards of Eastbury, Mayesbrook, Thames, Abbey and Gascoigne have the highest rates locally. The highest levels of self-harm by women are by those under the age of 30, with around 75 admissions per year of women aged 15 to 24 years. For men the pattern across all age groups up to 60 years is more evenly distributed, so for middle aged people there is an excess risk for men compared with women.

Admission for self-harm is more likely with methods that involve self-poisoning, but the level of admissions may be related to service delivery and availability of psycho-social support; this needs further investigation.

Although numbers of suicides are small, the rate for male suicide by Barking and Dagenham residents increased from 8.4 per 100,000 males in 2005 to 2007 to 13.8 in 2008 to 2010. This represents around 10 men each year, and Barking and Dagenham’s male suicide rate exceeds the London average by around 28%. Because numbers are small and will fluctuate it is difficult to draw any conclusions, but in the period 2007 to 2011 the highest rates were in Valence, Becontree and Longbridge.

Suicide and self-harm is a small but important indicator of mental health needs and the resilience, stability and support that people experience. Necessary action includes identification and support of high risk groups, together with effective care pathways for those who self-harm. In addition, we need to ensure that our mental health services are accessible and effective and meet the needs of local people.
Women’s health – abortion statistics in Barking and Dagenham

Abortion rates in Barking and Dagenham are the second highest in the UK, with only Brent in North West London having a higher rate in 2011. Abortion rates are higher in major cities, but even so the rates in cities such as Manchester and Birmingham are about a third lower than the rate locally.

Data on all abortions carried out under the terms of the 1967 Abortion Act are reported to the Chief Medical Officer and published annually. In 2011, there were 1,532 pregnancies terminated by Barking and Dagenham residents, of which 94% were funded by the NHS and carried out by the independent sector and 3% were carried out in NHS hospitals. The cost of the procedure varies according to the time in pregnancy when it is carried out and the contract price agreed, but the annual cost will be at least £600,000.

While it is simplistic to state that improving availability of contraception, and particularly long acting contraceptive methods, reduces the demand for abortions, there is obviously some relationship between the support and advice given to women who get good advice about the risks of pregnancy and the effectiveness of different methods of contraception and those who do not. This is particularly true when a woman has already had one abortion – in women aged under 25 years, 37% are repeat abortions.

Barking and Dagenham has the 5th highest rate of abortions in women under the age of 18 years in the UK, at 26 per 1,000. This is unsurprising given the pregnancy rate in under 18s, which although decreasing from the 2002 peak, remains well above the rate for London and England.

There were 48 abortions carried out for teenagers under the age of 16 in the three years 2009 to 2011, and 226 for teenagers aged 16 and 17. There is a continuing need to look at how well our services are meeting the needs of young people for sexual health advice and protection.

Although the number of abortions carried out for young women under the age of 18 is of concern, the highest abortion rate per 1,000 women is actually amongst women aged 20 to 24 years. The rate has varied year on year, but there has been no sustained reduction and the rate has remained between 64 and 75 since 2003.
The changes in commissioning being introduced as a consequence of the Health and Social Care Act 2012 split the commissioning of sexual health services between three commissioners – the Council, Barking and Dagenham Clinical Commissioning Group, and the NHS Commissioning Board. Community clinics providing advice and contraceptive services will be commissioned by the Council, abortion services will be commissioned by the clinical commissioning group, and the NHS Commissioning Board will commission primary care to deliver contraceptive services in general practice. Coordinated, and where appropriate integrated, commissioning is critically important to ensure that advice and a full range of contraceptive methods are available to all those who need them, and that abortion services can be accessed safely and without delay.

There were 1,532 pregnancies terminated by Barking and Dagenham residents, of which 94% were funded by the NHS and carried out by the independent sector and 3% were carried out in NHS hospitals.

**Fig 8: Abortions by age (number), Barking and Dagenham, 2011**

![Bar chart showing abortions by age](chart1)

Source: Department of Health

**Fig 9: Abortions by age (rate per 1000 women), Barking and Dagenham, 2011**

![Bar chart showing abortions by age](chart2)

Source: Department of Health
Changing patterns of disease – HIV

HIV (human immunodeficiency virus) is a virus most commonly caught by having unprotected sex or by sharing infected needles and other injecting equipment to inject drugs. It attacks the immune system, making it more difficult for the body to fight infections and disease. The final stage of HIV infection is AIDS, when the body can no longer fight life-threatening infections. There is no cure for HIV, but there are treatments to enable most people with the virus to live a long and healthy life.

HIV continues to be one of the most important communicable diseases in the UK. It is an infection associated with serious morbidity, high costs of treatment and care, significant mortality and a high number of potential years of life lost. Each year, many thousands of individuals are diagnosed with HIV for the first time. The infection is still frequently regarded as stigmatising and has a prolonged ‘silent’ period during which it often remains undiagnosed. Highly active antiretroviral therapies have resulted in substantial reductions in AIDS incidence and deaths in the UK.

Across the UK, about 6,000 new cases of HIV are diagnosed each year, of which about half result from sex between men and half from heterosexual sex. About 95% of cases are related to sex. Nationally, around three times as many men as women are diagnosed with HIV infection.

In Barking and Dagenham, around 50 new cases of HIV are diagnosed each year, and around 600 people are receiving HIV-related care. Locally, the pattern of diagnosed disease is very different to that of the UK as a whole, with only 10% resulting from men having sex with men, and over half the cases being diagnosed in heterosexual women. Of those people receiving treatment, 60% are women and the median age of those receiving treatment is 40 years. The majority of patients accessing care are Black-African (74%).

Early diagnosis of HIV infection is critically important both to reduce the effect of the infection on the individual and to reduce the risk of transmission. In Barking and Dagenham, two-thirds of those people diagnosed were diagnosed late (defined as a CD4 cell count less than 350). This compares with 49% in London overall. HIV testing needs to be widely offered in order to reduce the stigma of testing and to increase the level of early diagnosis. This only happens currently for women booking for antenatal care, where the prevalence is 50% higher than across London as a whole (0.6% compared with 0.4%). All new patients registering in primary care and all acute hospital admissions should be tested for HIV. This is particularly important in the south of the borough where HIV prevalence is higher, especially in Abbey, Gascoigne, Eastbury, River and Village wards.
Emergency admissions for ambulatory care sensitive conditions

Many common chronic illnesses are amenable to active management in primary and community settings, which reduces the risk of acute exacerbations and emergency hospital admissions. Around 40% of hospital admissions are unplanned and a significant proportion of these are related to conditions such as congestive heart failure, diabetes, asthma, angina, epilepsy and high blood pressure, which generally should be managed without emergency admission. The NHS has defined a list of conditions that are defined as ambulatory care sensitive conditions (ACSC) and optimising patient care will reduce the number of these admissions.

Barking and Dagenham has the highest emergency admission rate in London. In 2011-12 there were 100 admissions per 1,000 population in Barking and Dagenham, which was an increase of 11.4% from the level in 2010-11. The emergency admissions rate for ACSCs was 16.5 per 1,000 population. The cost of these admissions in Barking and Dagenham is around £5.5 million a year, and the impact in terms of pressure on accident and emergency services and use of hospital beds is substantial, adding to the challenges that Barking, Havering and Redbridge University Hospitals NHS Trust face in meeting the demands of the local population.

The NHS has defined a list of conditions that are defined as ambulatory care sensitive conditions (ACSC) and optimising patient care will reduce the number of these admissions. The percentage of all emergencies that are for ACSCs varies by age group. For children under the age of 10, nearly one-quarter are for these conditions, which include admissions for dehydration and gastroenteritis, asthma and ear, nose and throat infections. The percentage is lower amongst older children and adults, then increases again for older adults aged 70 and over to nearly one-in-five of the emergency admissions.

The most common condition overall for these admissions is influenza and pneumonia, which affects all ages but is more common in older people. Over half the admissions result from this, together with dehydration and gastroenteritis, convulsions and epilepsy, asthma and cellulitis.

Amongst general practices, total emergency admission rates vary more than two fold, with costs per head ranging from £71 to £304. There is even greater variability for ACSCs (although the numbers are smaller), with admission rates varying from 6 per 1,000 practice population to 23 per 1,000, which equates to a cost variation ranging from £9 to £53 per head, and the percentage of emergencies that are ACSCs varying from 11% to 21%. These figures are based on 2,792 admissions for ACSCs out of a total of 17,371 emergency admissions.

**Fig 10: Cost per head, Ambulatory Care Sensitive Emergency Admissions, by practice, Barking and Dagenham**

Source: NHS Secondary Uses Service data, analysis by Peter Congdon

Note: Column on extreme right is PCT average, all other columns are individual practices.
These differences can also be seen at ward level. Total emergency admissions rates are highest in Heath and Valence wards, where the rates are around 40% higher than the wards with the lowest admission rates (Gascoigne, Thames and Abbey). For children under the age of 10, Chadwell Heath has the highest emergency admission rate, with Abbey, Gascoigne and River the lowest. For ACSCs the situation is similar, with high rates for all ages in Heath and Valence, and for children under 10 the highest rates are in Chadwell Heath and in Heath ward.

There is an association between total emergency admission rates and ACSC emergency admission rates and deprivation. In Barking and Dagenham, the rate of total emergency admissions in 2011-12 for people in the most deprived quintile was 109 admissions per 1,000 population, 27% higher than the rate for people from the least deprived quintile (86 admissions per 1,000 population). For ACSCs the rate is 13 per 1,000 in least deprived quintile, but there is less variation for the more deprived quintiles, with a rate between 16.1 and 17.2 per 1,000. Further work is needed to identify the factors that are related to these differences, which are likely to be a combination of higher levels of illness, poorer access to primary care and preventative interventions and more health and lifestyle behaviours that affect people’s risk of illness.

Asthma and the variation in hospital admissions across Barking and Dagenham

Asthma is a long-term lung disease that generally starts in childhood, causing wheezing, chest tightness, shortness of breath and coughing. It can affect as many as one in four children, but less than 5% suffer persistent or repeated attacks. In adults prevalence is difficult to measure as other causes of chest disease such as chronic obstructive pulmonary disease become more common with age.

Good primary care will help to keep patients with asthma out of hospital. Treatment focuses on controlling inflammation and relieving symptoms when they occur. Proactive care and regular reviews can significantly reduce the need for hospital admission, and a good understanding of the condition and the confidence and support to self-manage makes an important contribution to maintaining good health.

There is wide variation in the quality of care and the rate of hospital admissions for asthma. In Barking and Dagenham there are around 100 admissions per year. Evidence suggests that around 70% of admissions may be preventable with appropriate early interventions.
As well as maintaining an asthma register, QOF also includes reporting on recorded smoking status amongst young people aged 14 to 19 with asthma and the percentage of patients who have been reviewed in the previous 15 months. Recorded smoking status is above 83% at every general practice, and 14 practices report 100% of patients in this age group have smoking status recorded. Unfortunately no information is required on the percentage of young people with asthma that are smokers. Asthma patients who have been reviewed in the previous 15 months vary from 58% to 100%, but 13 practices have review levels below 80% and there is clearly an opportunity to improve the standard of primary care for people with asthma.

There are wide variations in emergency admission levels for asthma. In 2011-12 there were around 300 admissions of Barking and Dagenham residents, about half of which were children under the age of 15. The average rate per 1,000 patients for admissions with a main diagnosis of asthma is 15 per 1,000 patients, but in the practices with the highest rate it is double that level. Variation is also clear at ward level, with Chadwell Heath, Abbey, Heath and Longbridge having the highest rate of emergency admission per 100,000 residents where asthma is the main diagnosis.

Asthma represents a considerable disease burden and is one of the most common chronic conditions. There are an estimated 13,500 asthma related GP consultations every year in Barking and Dagenham. In addition, asthma emergency admissions are much more likely among children and admission can frequently be prevented with effective care. By reducing the variation in asthma diagnosis in primary care and ensuring high standards of treatment and support, there is significant potential to improve the lives of local people who are affected by what can be a very distressing condition.

Fig 11: Emergency Asthma Admissions per 1,000 Expected Asthma Patients, 2011-12, Barking and Dagenham Practices

Source: NHS Secondary Uses Service data, analysis by Peter Congdon
Note: Column on extreme right is PCT average, all other columns are individual practices.
In 2010-11 there were 1,206 hospital admissions for CHD, of which 697 were emergency admissions.

Coronary Heart Disease admissions, deaths and variation

Coronary Heart Disease (CHD) is a major cause of morbidity and mortality, and is the cause of around half the deaths from cardio-vascular disease. It is also a leading reason for admission to hospital, particularly unplanned admissions. The impact of CHD can be alleviated by identifying cases in primary care and providing appropriate advice and care.

CHD is associated with smoking, high blood pressure and diabetes, as well as lack of regular exercise and being overweight. Barking and Dagenham has a recorded prevalence in the general practice Quality and Outcomes Framework (QOF) below the national average, which suggests there is a substantial level of under-reporting. Modelled prevalence estimates suggest that Barking and Dagenham is actually likely to have the highest CHD prevalence among London boroughs, at 6.5% of adults aged over 16, and compared with 5.8% for England as a whole. Comparing prevalence recorded on QOF with modelled prevalence suggests that only three out of every five people with CHD have actually been recorded on the QOF register, which represents a substantial number of people who may not be getting the care they need.

At practice level, the percentage of cases on the QOF register compared with the modelled prevalence varies from 36% to 81%. There are also nine indicators recorded in QOF which indicate the appropriateness of care, including blood pressure monitoring and treatment; these also show considerable variation between practices.

The effectiveness of preventative and primary care management impacts on the need for hospital admission, especially unplanned emergency admissions. In 2010-11 there were 1,206 hospital admissions for CHD, of which 697 were emergency admissions. The emergency admission rate in Barking and Dagenham was 22% above the England wide average level. The difference at ward level is marked, with Abbey and Mayesbrook having three times the admission rate per 1,000 population compared with Village and Eastbury. At practice level there is also substantial variation in admission levels, but the relationship between case finding (high levels of QOF prevalence compared with modelled prevalence) and admission levels is not clear cut, and it is not as simple as the more cases diagnosed and treated, the fewer the admissions.
Turning to deaths, Barking and Dagenham has a high number of deaths, both under the age of 75 and at all ages. Deaths under the age of 75 are 35% above the average level for England as a whole, and at all ages mortality in Heath, Parsloe and Valance wards are more than 50% above the national average.

CHD is a major cause of illness and early death in Barking and Dagenham. Emergency admissions are high and contribute to those admissions considered avoidable as well as having considerable cost implications. There is considerable variation between practices in cases diagnosed, hospital admissions and death rates. Better case registration in general practice, and applying accepted and relatively straightforward, standards of care, could impact considerably on the lives of local people and the pressures on the local health system.
Preventing illness and early death – Diabetes

Diabetes is a condition that is increasing rapidly, with an estimated doubling of cases in the UK since 1996 from 1.4 million to 2.9 million people (Diabetes UK). It is one of the biggest health challenges facing the UK, associated with the ageing population and the rapid rise in overweight and obese people. The National Diabetes Audit estimated that there are about 24,000 excess deaths each year due to diabetes, and delays in diagnosis mean that many people present when they already have complications such as advanced retinopathy, neuropathy or arterial disease.

The National Diabetes Audit also found a strong link between deprivation and increased rates of early death from diabetes. Death rates among people under 65 from the most deprived backgrounds were double that of the least deprived. People from Asian and Black ethnic groups are more likely to have diabetes and to develop the condition at younger ages. In Barking and Dagenham, the rate for years of life lost under the age of 75 years is particularly high for men.

In Barking and Dagenham around 9,000 people have diabetes, as recorded on diabetes registers in primary care. It is estimated that around 700 adults also have diabetes and are not yet diagnosed. Early diagnosis and effective management will not only improve the health of those with diabetes, but can contribute considerably to reducing the costs of complications and hospital admissions.

People with diabetes are mainly cared for in primary care, and a number of measures in the Quality and Outcomes Framework are available to assess the quality of care received. Key aspects of clinical management are assessed both for measurement and management, which means that we can see both whether the appropriate checks have been undertaken and how well critical parameters are controlled. The majority of practices in Barking and Dagenham perform well on most measures, although only about half of people diagnosed with diabetes have an HbA1c measurement below the recommended level and nearly 20% of people have a blood pressure outside the recommended limits even though it has been checked.

4: HbA1c occurs when haemoglobin joins with glucose in the blood. The more glucose in the blood the more HbA1c is present, and measuring the level gives a more accurate estimate of the amount of glucose in the blood than measuring the blood glucose at a point in time.
Complications from diabetes may result in emergency admissions and interventions. In Barking and Dagenham the rate of emergency admissions is above the national levels (emergency admissions per 100,000 population estimated as 120 for 2011-12 compared with 107 for England). Figures from 2009-10 show that Barking and Dagenham experienced high rates of admission for diabetic ketoacidosis and coma (43 per 100,000 compared with 27 per 100,000 for England) but lower rates for lower limb amputations (9 per 100,000 compared with 11 per 100,000 for England).

At ward level, estimated prevalence of diabetes varies from 5.7% in Eastbrook to 7.3% in Chadwell Heath. Wards with the highest annual hospital admission episodes per 1,000 patients are Valence and Alibon. Hospital admission episodes have also been compared to prevalence at general practice level, and show that 12 practices in Barking and Dagenham have episode to patient rates over twice the average for outer north east London. These practices tend to be those serving relatively deprived wards, but the opportunity still exists for improving standards of care.

Diabetic retinopathy is a condition caused when diabetes affects the small blood vessels in the retina, the part of the eye that acts rather like a film in a camera. Diabetic retinopathy progresses with time but may not cause symptoms until it is quite advanced and close to affecting a person’s sight. Screening for diabetic retinopathy is offered annually to all diabetics aged 12 and over, with nearly 2 million people a year being screened in England. It is estimated that in England, every year 4,200 people are at risk of blindness caused by diabetic retinopathy and there are 1,280 new cases of blindness caused by diabetic retinopathy and about 400 people per year can be saved from sight loss. In Barking and Dagenham the number of people with diabetes who have retinopathy diagnosed by screening is above the national average, but only around 80% of people with diabetes accept the offer of screening. Encouraging more people to take up the offer of screening and reduce their risk of eye disease progressing is another important opportunity to improve their health.
Deaths in Barking and Dagenham – what are the leading causes?

Knowing what are the most common causes of death helps us to know what the important diseases and conditions are for which we must plan care. For those deaths that are termed premature (taken as deaths before the age of 75), there are implications for our prevention programmes and for improving standards of care for those with long-term conditions.

Although the leading causes of death vary between men and women, the most common cause – ischaemic heart disease, is the same for both sexes. Ischaemic heart disease accounts for 18% of deaths in men and 13% of deaths in women. Cancer of the lung and trachea is the second most common cause of death in men and the 4th most common cause in women, causing almost one in 10 deaths in men and almost one in 15 deaths in women. As the majority of cases of lung cancer result from smoking, which is a very significant contributor to ischaemic heart disease as well, it follows that smoking is a big killer of local residents.

Other common causes of death are cerebrovascular disease and chronic lower respiratory diseases, which also are related to smoking.

Premature mortality is an important marker of inequalities and is related to deprivation. For women, lung cancer is the leading cause of premature mortality, and lung and breast cancer together account for almost one in five premature deaths. For men the leading causes of premature death are similar to the causes at all ages, with death by suicide, accidents and chronic liver disease also featuring.

At ward level, all age mortality is highest in River, Valence and Heath wards, whereas premature mortality peaks in Gascoigne ward as well as Valence and River wards. Analysis at neighbourhood level (Lower Super Output Area or LSOA) enables comparisons to be done between the most deprived and the least deprived neighbourhoods. The greatest inequality is for ischaemic heart disease. Gascoigne ward has a higher level of mortality for ischaemic heart disease, while Valence and Village have the highest premature lung cancer mortality.

Causes of death have implications for prevention, primary care, and for community care provision, as well as for palliative care. In Barking and Dagenham, 65% of deaths occur in hospital and 19% at home\(^5\), and there is evidence that people living in deprived areas are more likely to die in hospital and less likely to die at home or in a hospice than those living in more affluent areas. We need to continue to improve health and social care at the end of life for those that need it. In particular we need to:

- Improve access, quality and consistency of out of hospital palliative care and good access to hospice palliative end-of-life care.
- Provide more support for carers.
- Encourage people to discuss and plan for the end of their life.

Access to high quality palliative care outside the hospital and to hospice care will only improve in our health and social care system when it becomes a priority for local people.

Welfare Reform will affect the lives of many people in Barking and Dagenham. Around 25,000 residents receive housing and council tax benefit and may receive less benefit from April 2013.

Barking and Dagenham has the highest percentage in London of households in fuel poverty, affecting around 9,000 households.

Barking and Dagenham is ranked 22nd of 326 local authorities in the 2010 Index of Multiple Deprivation and seventh amongst London boroughs. The entire borough lies within the most deprived 50% of Lower Super Output Areas in England.

The waiting list for housing is around 14,500. Barking and Dagenham is estimated to have the highest rate of evictions in England.

More than one in four people earn less than the London Living Wage. The proportion of people that are unemployed is one-third higher than for London as a whole.

Around 24,000 residents claim benefits such as Job Seekers Allowance and incapacity and carer’s benefits, and will be affected by the introduction of Universal Credit.

More than one in every three children live in poverty.

12 out of 18 key indicators for children’s health show that the health of children in Barking and Dagenham is significantly worse than the London average.

Realising the legacy of the Olympic and Paralympic Games remains an important approach to improving the health and wellbeing of the people of Barking and Dagenham.

Increase in the number of lone parent households with dependent children.
Social inequalities

Social inequality exists when there is unequal distribution of wealth and therefore disparity in people’s access to the same housing, health and care as those with greater wealth. In the UK, the NHS is expected to provide equal access to care regardless of income, but access to decent housing is dependent on income (either through employment or benefits) and access to care may be means tested. Councils can mitigate the greatest social inequalities through their policies, but the continuing reductions in local authority funding at a time of increasing population need inevitably affects local people.

Welfare Reform

The Coalition Government is partway through a major programme of reform of welfare benefits that will affect the lives of many people in Barking and Dagenham. These changes include the introduction of Universal Credit and Personal Independence Payment, changes to Employment Support Allowance, provision for a Benefit Cap and the localisation of Council Tax Benefit. Changes to Housing Benefit have also been introduced and will be extended in 2013 to affect people living in homes bigger than necessary for their family size. The Department of Work and Pensions states that the reform of the benefit system is aimed at making it fairer, more affordable and better able to tackle poverty, worklessness and welfare dependency.

Although some changes were introduced in 2011 and 2012, including to Housing Benefit with the maximum number of bedrooms reduced to four and capping of the maximum payments per week, the most significant changes will be introduced in 2013 with the introduction of the new Universal Credit. These reforms will see a range of working-age benefits and entitlements, such as Jobseeker’s Allowance, Income Support and Housing Benefit, paid as a single Universal Credit to simplify the welfare system. While this is intended to reduce the complexity of claiming support and to ensure that people who work are better off than people on benefits, controversy continues and while the Department for Work and Pensions alleges that more than 3 million people will be better off under the new system, they also acknowledge that around 2 million people would be better off refusing the offer of extra work under the Universal Credit scheme.

In Barking and Dagenham, around 25,000 residents are receiving Housing and Council Tax Benefit, of whom one-third are aged 60 or older and nearly half are working-age people currently on Job Seekers Allowance. Many of these people will both receive less in benefit and have to make increased payments as a result of the Welfare Reform changes. These people are amongst the most deprived and vulnerable of our residents and their health and wellbeing will inevitably be affected.

Even without further changes to the welfare system the impact of changes introduced so far will be cumulative as covering the costs of daily life becomes increasingly difficult. The additional changes in April 2013 are expected to bring significant additional impact, and these, together with the pressures on council budgets and how those affect local residents, will be monitored for their impact on the health of local people.

Fuel poverty

A household is considered to be in fuel poverty if more than 10% of its income is spent on home heating. Energy prices have risen steeply in the last couple of years, and families on low incomes can be hit particularly hard by a combination of inefficient heaters and poorly insulated homes. They are also likely to be reliant on meters if they do not have the credit ratings that are necessary to take advantage of the discounts that come with the direct debit system.

The most recent data on fuel poverty is for 2010, and shows that the percentage of households in the borough that are in fuel poverty, at 13.5%, is the highest in London. Of the 66,530 households in Barking and Dagenham, 8,985 are estimated to be fuel poor. At neighbourhood level, the percentage varies from 7% to 17% of households; that is nearly one in every five homes in the most deprived parts of the borough.

Being able to afford to heat your home, at least to a level that is healthy, even if less than ideal, is essential, particularly for families with children and those people with chronic illnesses. This is another aspect of health and wellbeing that the welfare reform programme and the consequent reduction in benefits is likely to affect.
Deprivation

Barking and Dagenham is ranked 22nd of 326 local authorities in the 2010 Index of Multiple Deprivation, and 7th amongst London boroughs. The index compares indicators covering income, employment, health deprivation and disability, education, skills and training, barriers to housing and services, crime and the living environment.

Detailed analysis of deprivation is available at Lower Super Output Area (LSOA), of which there are 109 in Barking and Dagenham. Eleven LSOAs are in the most deprived 10% in England and the entire borough lies within the most deprived 50% of LSOAs in England.

Fig 16: Indices of Deprivation 2010

Source: Office for National Statistics, analysis by London Borough of Barking and Dagenham
Housing

Twenty years ago the Council had about 40,000 homes and a waiting list of approximately 3,000. Now the number of homes has halved to 19,500 and the waiting list is around 14,500. Housing provision is changing with many high-rise blocks being demolished and replaced with modern low rise homes.

Data published by Shelter in December 2012 showed that Barking and Dagenham has the highest rate of evictions in England, at one in every 37 homes. In 2011-12 there were 1,970 possession claims issued by mortgage lenders and landlords. The majority of these will progress to repossession and eviction with families losing their homes.

Barking and Dagenham has the cheapest rent levels in London, and the changes to Housing Benefit make the borough attractive to people who need to find cheaper private rented property. For the Council, the changes to the rental market have made it very difficult for them to find accommodation for homeless households resulting in a massive increase in the use of Bed and Breakfast accommodation. Two years ago there were only seven single people in Bed and Breakfast, but in 2012 the number of households rose to around 200, including families with children.

It has been necessary to accommodate some of these people out of the borough and also for them to stay in this accommodation for longer than six weeks. While the Council is committed to doing everything it can reduce Bed and Breakfast numbers, and had reduced the numbers by about one-third by the end of 2012, such living is clearly harmful to health, particularly the health of children.

Full implementation of the Government’s housing reform programme is expected to add to the number of people who become homeless and those needing temporary accommodation, as the private rental housing sector becomes too expensive for people who rely on benefits to help with their housing costs. While the Council is making some increase to the supply of council housing it is likely that more accommodation will need to be sourced outside the borough, as part of its temporary accommodation strategy.

In 2011-12 there were 1,970 possession claims issued by mortgage lenders and landlords.
Income and employment

Barking and Dagenham has high levels of poverty which impacts on the health of local residents. More than one in four people earn less than the London Living Wage of £8.55 per hour, a level calculated by the Greater London Authority (GLA), as that needed to achieve an adequate standard of living (based on the 60% of median income + 15% margin).

About half the population is defined as economically active, equating to 74% of the population aged 16 to 64, and a similar proportion to London (75%). At 12.2%, the proportion of people unemployed is one-third higher than for London as a whole, and although the level has been relatively stable since 2010, it is much higher than the lowest point in recent years which was in 2007. In addition, the kind of jobs that people who live in Barking and Dagenham have are very different to people in London as a whole, with far fewer people working in managerial and professional occupations (30% Barking and Dagenham, 55% London) and more people working in administrative and secretarial jobs (15% Barking and Dagenham, 11% London), skilled trades (14% Barking and Dagenham, 7% London) and elementary occupations (16% Barking and Dagenham, 9% London). The majority of jobs are in the services industry, although the proportion of jobs in manufacturing is high (16%) compared with London as a whole (4%).

The focus of employment in less well paid jobs is reflected in pay, with mean pay levels around 30% below the London level, and median pay around 15% lower than the London level.

Around 24,000 people are claiming benefits, including job seekers allowance and various incapacity and carers’ benefits. At 21% of the population aged 16 to 64, this proportion is much higher than the London level of 15%, and the proportion has increased by 15% in the last 10 years.

Low wages and living in poverty particularly affects children. More than one in four children in Barking and Dagenham live in poverty (living in families where their income is less than 60% of median income, even with benefits). They are more likely to suffer chronic ill health, live in homes that are not kept warm, and do less well at school. As adults, as well as suffering ill health, they are more likely to be unemployed or homeless, to be offenders, to abuse drugs and alcohol and to be in abusive relationships.

It is a high priority for the Council to raise household incomes by investing in infrastructure and encouraging investment in new business industry. While the Council has been successful in increasing the opportunities for skills training, narrowing the socio-economic gap between Barking and Dagenham and other parts of London is proving more resistant in the current economic climate and a continuing focus is needed if people’s employment opportunities, and income levels and consequently their health and wellbeing are to improve.

The impact of health inequalities on children

The London Health Observatory, in their work to support understanding about the health of children in the Olympic Boroughs, identified 18 indicators from a list of 146 indicators that are currently available. The 18 indicators represent a cross section from before birth up to the age of 18 years that are robust predictors of growth, development and life expectancy, and the data included was that available up to June 2012.
## Figure 17: Baseline picture of child health

<table>
<thead>
<tr>
<th>Indicator Name</th>
<th>Stage</th>
<th>Barking and Dagenham</th>
<th>London</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy at birth (girls)</td>
<td>Demography/outcomes</td>
<td>81.1</td>
<td>83.3</td>
</tr>
<tr>
<td>Life expectancy at birth (boys)</td>
<td>Demography/outcomes</td>
<td>77.0</td>
<td>79.0</td>
</tr>
<tr>
<td>Children living in poverty</td>
<td>Demography/outcomes</td>
<td>37.0</td>
<td>29.7</td>
</tr>
<tr>
<td>Antenatal assessment by 12 weeks</td>
<td>Antenatal (pregnancy to birth)</td>
<td>58.3</td>
<td>56.8</td>
</tr>
<tr>
<td>Low birth weight (&lt;2500g)</td>
<td>Antenatal (pregnancy to birth)</td>
<td>7.0</td>
<td>7.8</td>
</tr>
<tr>
<td>Smoking in pregnancy</td>
<td>Antenatal (pregnancy to birth)</td>
<td>13.6</td>
<td>6.5</td>
</tr>
<tr>
<td>Breast feeding initiation</td>
<td>Infancy (0-1)</td>
<td>72.5</td>
<td>87.5</td>
</tr>
<tr>
<td>Infant mortality</td>
<td>Infancy (0-1)</td>
<td>5.0</td>
<td>4.5</td>
</tr>
<tr>
<td>MMR immunisation by age 2</td>
<td>Early years (2-5)</td>
<td>81.4</td>
<td>83.8</td>
</tr>
<tr>
<td>Obese children (age 4-5 years)</td>
<td>Early years (2-5)</td>
<td>13.9</td>
<td>11.1</td>
</tr>
<tr>
<td>Children achieving a good level of development age 5</td>
<td>Early years (2-5)</td>
<td>55.0</td>
<td>60.0</td>
</tr>
<tr>
<td>Children who have someone to talk to</td>
<td>Child (6-12)</td>
<td>63.0</td>
<td>62.0</td>
</tr>
<tr>
<td>Physically active children</td>
<td>Child (6-12)</td>
<td>54.3</td>
<td>55.2</td>
</tr>
<tr>
<td>First time entrants to Youth Justice System</td>
<td>Adolescence (13-18)</td>
<td>1210</td>
<td>1270</td>
</tr>
<tr>
<td>GCSE achieved 5A*-C including English and Maths</td>
<td>Adolescence (13-18)</td>
<td>56.6</td>
<td>61.0</td>
</tr>
<tr>
<td>Not in education, employment or training</td>
<td>Adolescence (13-18)</td>
<td>6.9</td>
<td>6.2</td>
</tr>
<tr>
<td>Children and young people smoking</td>
<td>Adolescence (13-18)</td>
<td>3.0</td>
<td>2.9</td>
</tr>
<tr>
<td>Teenage conception rate</td>
<td>Adolescence (13-18)</td>
<td>56.0</td>
<td>43.7</td>
</tr>
</tbody>
</table>

Source: Childs Play? The antenatal to adolescent health legacy in the Olympic boroughs. London Health Observatory 2012 http://www.lho.org.uk/Download/Public/17039/1/Childs%20Play%20Appendix%201%20FINAL.pdf

**How to interpret this table:**

**Red:** Borough is doing significantly worse than the average for London.

**Amber:** Borough is doing statistically similar to the average for London.

This demonstration that in 12 of these key indicators, Barking and Dagenham is doing significantly worse than the average for London, is a major concern, especially as for many indicators Londoners fare worse than those living in other parts of England. The good news is that, where trend data is available, many of the indicators are showing improvement.

Amongst those indicators where particular improvements are continuing are immunisation (latest uptake for Measles, Mumps and Rubella immunisation at age two was 87.8% compared with 81.4% in 2010-11 shown in the table above) and antenatal assessment by a midwife or maternity healthcare professional by the end of the 12th week of pregnancy (improved from 58.3% in 2009-10 to 85.2% for those women delivering between April and June 2012). Some indicators are showing encouraging signs of improvement but it is too early to know whether that will be maintained. Examples are teenage conceptions (most recent quarterly averages are around 48 per 1,000 girls aged 15 to 17 years compared with 56 per 1,000 which was the 2007 to 2009 average) and smoking at the time of delivery (July to September 2012 was 12.1% compared with 13.6% in 2010-11).
Realising the legacy of the Olympic and Paralympic Games

As one of the Olympic and Paralympic Games Host boroughs, Barking and Dagenham agreed with other host boroughs to aim for better outcomes for their population in terms of:

- Delivering high quality regeneration.
- Education attainment and skills.
- Reducing worklessness, benefit dependency and child poverty.
- High quality homes.
- Increasing health and wellbeing.
- Reducing crime and anti-social behaviour.
- Maximising the sporting legacy and increasing sports participation.

The Olympic and Paralympic Games were a global and local success and demonstrated how local communities can benefit from the investment and energy created. The challenge now is to maintain the momentum and ensure that the commitment to a long term legacy focusing on economic growth and the principle of convergence will realise the intent to bring the life chances of our residents into line with those enjoyed by other Londoners.

Delivering the Olympic legacy is crucial to the health and wellbeing of local people. The convergence goals focus on three themes – creating wealth and reducing policy, supporting healthier lifestyles and developing successful neighbourhoods.

The Olympic legacy promise includes:

- Transport links and other infrastructure developments to encourage new businesses and enable access to markets.
- Long-term housing plans to tackle overcrowding and provide an appropriate mix of public, affordable and market housing that supports the growing population.
- Skills development so that local residents have the skills employers need and job development with the promotion of new creative, high tech, IT and green industry bases.

The Convergence Supporting Healthier Lifestyles Programme is at a critical point, with a risk that the convergence priorities are not embedded in health and wellbeing strategies, and that programme funding will not be identified to continue to drive this collective approach to improving health and reducing inequalities. The Programme’s objectives, including giving children the best start in life, reducing premature mortality from preventable causes, and increasing participation in sport and physical activity are at the core of the challenges that Barking and Dagenham are working to address.

At particular risk, as the memory of the Games fades, is the objective of using the momentum of the Games to motivate, raise aspirations and promote cultural activity.

Working together, originally as Host Boroughs and now as Growth Boroughs, with a coherent regeneration strategy, will support our collective work to improve the health and wellbeing of our communities and it is essential that we work to maximise the potential of this partnership. Achieving the priorities agreed by the Host Boroughs remains critical to improving health and wellbeing in Barking and Dagenham.
Changes in Structure
The Health and Social Care Act 2012 has resulted in significant changes to the way that public health and health services are commissioned. Public health becomes the responsibility of local authorities.

The Health and Wellbeing Board becomes statutory on 1 April 2013. It must publish a Joint Health and Wellbeing Strategy and lead partnership working to make progress on the priorities identified in the strategy.

A Public Health Grant is being provided to local authorities to enable them to deliver their public health responsibilities.

For Barking and Dagenham the grant for 2013-14 is £12,921 million. This is 18.8% below the target allocation which takes account of the public health needs of the population.

The Director of Public Health is accountable for the delivery of the Council’s public health duties and responsibilities.

Progress in public health will be measured by the Public Health Outcomes Framework. There are indicators in all four domains where improvement is needed.

Local health services will be commissioned by Barking and Dagenham Clinical Commissioning Group and by the NHS Commissioning Board. The NHS Outcomes Framework sets out where improvement in effectiveness, experience and quality should be achieved.

Priorities for health and wellbeing have been agreed in the Joint Health and Wellbeing Strategy.
The Health and Social Care Act 2012

The Health and Social Care Act 2012 has resulted in significant changes to the way that public health and health services are commissioned. A new national body, Public Health England, will provide the focus for improvements in the public’s health, and the responsibility to address the local population health improvement passes to local councils. Commissioning of health care services becomes the responsibility of the new clinical commissioning groups, which are led by local clinicians who will directly commission services for their populations.

For patients and the public, access to NHS services continues to be based on need and not ability to pay. Patients will have access to a wider range of services from the charity or independent sector as well as NHS providers. It is also intended that they will have a stronger voice and influence through the new Healthwatch organisations.

The Act includes a number of other structural changes that affect the management of the NHS. The NHS Commissioning Board authorises and monitors the performance of clinical commissioning groups, allocates resources and commissions both complex specialised services and primary care. The NHS Trust Development Authority will work with those NHS Trusts that do not have foundation status to achieve it. Health Education England will provide oversight and leadership for professional education and training.

Of critical importance to the effective shaping of local services for health and wellbeing are the new health and wellbeing boards, which bring together local commissioners of health and social care, elected Councillors and representatives of Healthwatch to agree integrated approaches to improving health and wellbeing.

The Barking and Dagenham Partnership has had a Shadow Health and Wellbeing Board since 2009. With the implementation of the Health and Social Care Act, the Board will become statutory in April 2013. There is a statutory duty on Barking and Dagenham Clinical Commissioning Group to work in partnership with the Council and they must involve the Health and Wellbeing Board in the preparation of their commissioning plan, which itself must take account of the Joint Health and Wellbeing Strategy published by the Board.

Public Health Grants to Local Authorities

The Department of Health published the ring fenced grants for local authorities to spend on public health services for their local populations in 2013-14 and 2014-15 on 10 January 2013. As well as the allocations, details about the allocations formula, grant conditions and reporting arrangements were also published. Local authorities will, from April 2013, have a duty to take appropriate steps to improve the health of their population, and lead on reducing health inequalities.

The public health grant for Barking and Dagenham for 2012-13 is £12,921 million and for 2014-15 is £14,213 million.

The public health grant for Barking and Dagenham for 2012-13 is £12,921 million and for 2014-15 is £14,213 million.
The public health grant is being provided to give local authorities the funding they need to discharge their public health responsibilities. They should be used to:

- Improve significantly the health and wellbeing of the local population.
- Carry out health protection functions delegated from the Secretary of State.
- Reduce health inequalities across the life course.
- Ensure the provision of population healthcare advice.

The grant is being made under Section 31 of the Local Government Act 2003 and there are conditions attached to its use, covering purpose and reporting. It is ring fenced for the purposes defined and the Chief Executive will have to confirm that the grant has been used for the required purpose. It may be used for both capital and revenue. It is expected that funds will be utilised in year but there is provision for any underspend to be carried forward as part of a public health reserve.

The grant is calculated from a starting position of historical NHS Primary Care Trust spend on defined public health services, uplifted for each of the two years by a percentage that takes account of distance from a target spend per head. A target grant for each local authority is derived from a formula which has been recommended by the Advisory Committee on Resource Allocation (ACRA), based on detailed analysis of those factors which impact on a population’s health needs and need for public health services.
The public health grant will be used for the services and expertise that are necessary to meet the Council’s Public Health responsibilities.

The target spend per head of population is based on weighted population size which is the resident population adjusted for:

- Relative need – areas with higher need have higher shares, all else being equal.
- Unavoidable geographical variation in the costs of providing services (the Market Forces Factor MFF) – higher cost areas have higher shares, all else being equal.
- Age and gender – some public health functions are clearly directed at certain age and gender groups.
- For drug services previously funded through the Pooled Treatment Budget, resident populations for 2013-14 are retrospectively adjusted for outcomes.

The weighted populations are converted into a target proportion of the total national budget available and converted into monetary allocations.

ACRA’s recommendations include a number of factors which generally favour those populations in poor health and with the greatest need. It follows, therefore, that they have a positive impact on the application of the formula in Barking and Dagenham.

- Standardised Mortality Ratio (SMR) for those aged under 75 years, applied at local level to take account of inequality within local authorities as well as between local authorities. Those parts of the borough with the highest levels of deprivation are effectively translated into a higher population size to reflect the additional needs of people living in those circumstances. This weighting increases the 2013 population estimate of 196,094 to a weighted population of 258,697.

- Market Forces Factor (MFF): The MFF Index accounts for variations in unavoidable geographic costs of providing public healthcare services between local authorities. It is applied to the weighted population so that local authorities in higher cost areas receive additional funding to ensure that they can afford the same level of services relative to need as those in other areas.

- Mandatory and non-mandatory age-gender adjustments: Age-gender adjustments have been applied to recognise the cost of those services with the highest proportion of public health spend which are also directed at specific age-gender groups to weight for relative needs between different age-gender groups.

There are six public health services for which age-gender adjustments are calculated:

- Nutrition, obesity and physical activity.
- Alcohol misuse.
- Tobacco misuse.
- Sexual health.
- Children’s services age 5 to 19.
- Drug misuse.

Weighting is calculated for each of these areas separately and then applied to the relevant weighted population.

The MFF for Barking and Dagenham is 1.10. Effectively this means that 10% is added to the SMR<75 weighted population to give a weighted population size of 283,965.
Pace of change: The final allocation is determined by Pace of Change policy, which sets the differential growth in allocations which local authorities receive. The starting position is taken from 2010-11 baseline spending estimates as published in February 2012, adjusted for Prunart Care Trust updates and uplifted to 2012-13 values.

For Barking and Dagenham, the target allocation is set at £14,463m which is £74 per head. The actual allocation of £12,921 million is 18.8% below target. The 2013-14 increase is 10.0%, the maximum increase that is given under the Pace of Change policy, reflecting the opening baseline allocation being below target.

The public health grant will be used for the services and expertise that are necessary to meet the Council’s Public Health responsibilities. Certain services will be mandatory for the Council to commission or provide, including access to sexual health advice and supplies, NHS Health Check assessments, the National Child Measurement Programme, support to NHS commissioners, and aspects of health protection and emergency preparedness.

In 2013-14, the programme areas and the proportion of the grant which will be needed for them are shown in Figure 18.

**Fig 18: Public Health Grant % distribution by programme, (provisional) Barking and Dagenham**

- Promoting health (including drugs and alcohol services) 26%
- Sexual health 20%
- Healthy children 18%
- Healthy adults 10%
- Health intelligence 2%
- Public Health healthcare 1%
- Health protection 1%
- Staffing and corporate 8%
- Other and uncommitted 14%

Source: London Borough of Barking and Dagenham
Changes in structure – the role of the Director of Public Health

Every local authority must employ a specialist Director of Public Health (DPH), appointed jointly with the Secretary of State for Health. The DPH is accountable for the delivery of the Council’s public health duties and responsibilities. It is an important and senior post; the DPH is a statutory chief officer and the principal adviser on all health matters to elected members and officers, with a leadership spanning all three domains of public health: health improvement, health protection and healthcare public health.

Many of the responsibilities of the DPH arise directly from Acts of Parliament, and match the corporate public health duties of the Council. The DPH is responsible for:

- All of the Council’s duties to take steps to improve health.
- Any of the Secretary of State’s public health protection or health improvement functions that s/he delegates to local authorities.
- Exercising the Council’s functions in planning for, and responding to, emergencies that present a risk to health.
- The Council’s role in co-operating with the police, the probation service and the prison service to assess the risks posed by violent or sexual offenders.
- Such other public health functions as the Secretary of State specifies in regulations.

In addition to these corporate responsibilities, the DPH has a personal duty to write an annual report on the health of the local population, which the Council has a duty to publish. This is an important opportunity for the DPH to draw attention to aspects of people’s health, care and wellbeing where improvement is needed and to highlight local priorities and actions that they consider need more focus if people’s health is to improve.

In order to discharge their responsibilities and deliver real improvements in local health, the DPH needs both an overview of the totality of the Council’s business and the opportunity to influence decision making. They must also have day-to-day responsibility for the Council’s public health budget, although the Chief Executive has the formal accountability to the Secretary of State for Health for spending the budget appropriately.

The DPH is the person to whom elected members and senior officers look to for leadership, expertise and advice on the whole range of public health issues, from outbreaks of disease and emergency preparedness through to improving local people’s health and concerns around access to health services. The DPH is an active member of the Health and Wellbeing Board, leading the development of the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy. The DPH has the professional and technical expertise to know how to improve people’s health, understanding what determines good and poor health, how to change behaviour and how to promote health and wellbeing in ways that reduce inequalities in health. The role necessitates acting across the life course and across the system, encompassing work with the directors of children’s and of adult’s services including supporting actions that meet the needs of vulnerable children and adults, and with NHS commissioners to ensure a whole system approach where commissioning of healthcare meets identified priorities and needs.

The implementation of the new role of the DPH as set out in the Health and Social Care Act 2012 creates exciting opportunities to support, influence and challenge local decision making to ensure that improving the health and wellbeing of local people and reducing health inequalities within and between communities is central to the decisions made by the Council and the clinical commissioning group. It is over 150 years since the appointment of the first Medical Officer of Health in Liverpool in 1847, but the fundamentals of the role remain unchanged – to be an independent voice advocating for local people, basing arguments on research and sound analysis of the evidence, being resourceful and pragmatic, and ultimately working tirelessly to make a difference for local people.

The Public Health Outcomes Framework highlights key areas of local health and wellbeing needs and directs us to the priorities that we need to address.

Changes in structure – introducing the Public Health Outcomes Framework

The Public Health Outcomes Framework is intended to support the whole system to demonstrate that outcomes are being improved. The framework focuses on two high level outcomes:

- Increased healthy life expectancy – taking account of quality as well as length of life.
- Reduced differences in life expectancy and healthy life expectancy between communities.

These outcomes apply across the life course, and will be delivered across a broad range of public health indicators grouped into four domains:

### Figure 19: Public Health Outcomes Framework 2013

<table>
<thead>
<tr>
<th>DOMAIN 1</th>
<th>DOMAIN 2</th>
<th>DOMAIN 3</th>
<th>DOMAIN 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving the wider determinants of health</td>
<td>Health improvement</td>
<td>Health protection</td>
<td>Healthcare public health and preventing premature mortality</td>
</tr>
<tr>
<td>Objective:</td>
<td>Objective:</td>
<td>Objective:</td>
<td>Objective:</td>
</tr>
<tr>
<td>Improvements against wider factors that affect health and wellbeing, and health inequalities</td>
<td>People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities</td>
<td>The population’s health is protected from major incidents and other threats, while reducing health inequalities</td>
<td>Reduced numbers of people with preventable ill health and of people dying prematurely, while reducing the gap between communities</td>
</tr>
</tbody>
</table>

Source: Department of Health
Data for the first set of indicators has been published by the Public Health Observatories in England at www.phoutcomes.info/documents/PHOF_00AB.pdf

These show the need to address a wide range of issues across the whole spectrum of public health, with the main indicators where Barking and Dagenham is in a significantly poor position listed in figure 20.
### Figure 20: Indicators in the Public Health Outcomes Framework for which Barking and Dagenham is significantly lower than England average

<table>
<thead>
<tr>
<th>Improving the wider determinants of health</th>
<th>1.01 Children in poverty</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1.12 Violent crime</td>
</tr>
<tr>
<td></td>
<td>1.14 Complaints about noise</td>
</tr>
<tr>
<td></td>
<td>1.15 Statutory homelessness</td>
</tr>
<tr>
<td></td>
<td>1.16 Less use of outdoor space for exercise and health reasons</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health improvement</th>
<th>2.02 Breastfeeding</th>
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<td>2.04 Under 18 conceptions</td>
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<td>2.06 Children overweight and obese</td>
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<td>2.14 Smoking prevalence</td>
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<td>2.17 Number of people with diabetes</td>
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<td>2.20 Cancer screening coverage</td>
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<td>2.22 Take-up of NHS Health Check Programme</td>
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<td>2.23 People with a low score for self-reported wellbeing</td>
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<td>2.24 Injuries due to falls in people aged 65 and over</td>
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<tr>
<th>Health protection</th>
<th>3.02 Chlamydia diagnoses</th>
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<td>3.03 Low levels of immunisation</td>
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<th>Healthcare public health and preventing premature mortality</th>
<th>4.03 Mortality from causes considered preventable</th>
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<td>4.04 Under 75 mortality rate from cardiovascular disease</td>
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<td>4.05 Under 75 mortality rate from cancer</td>
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<td>4.06 Under 75 mortality rate from liver disease</td>
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<td>4.07 Under 75 mortality rate from respiratory disease</td>
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<td></td>
<td>4.11 Emergency readmissions within 30 days of discharge from hospital</td>
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</tbody>
</table>

Source: Public Health Observatories in England

Careful interpretation of data such as that published in the Public Health Outcomes Framework is necessary. For example, for some indicators being below the England average is better – as it is for road casualties and deaths, for some it is worse – such as mortality rates from preventable causes. In addition, there is some time delay in the publication of the data at national level used for comparisons, and sometimes improvement achieved locally is not yet reflected in the national comparisons – this is the case for childhood immunisation.

Also, other aspects of health and wellbeing may be of concern but not included in the national framework, and it is important to include these in the Joint Health and Wellbeing Strategy. Nevertheless, taken as a whole, the Public Health Outcomes Framework highlights key areas of local health and wellbeing needs and directs us to the priorities that we need to address.
Changes in structure – Barking and Dagenham Clinical Commissioning Group

The changes to the health system as a result of the Health and Social Care Act 2012 mean that NHS Barking and Dagenham will close on 31 March 2013 and that commissioning of most clinical services will be done by the local clinical commissioning group, with the NHS Commissioning Board commissioning primary care and specialised services.

Clinical commissioners are required to work with the Health and Wellbeing Board and to take account of the priorities set out in the Joint Strategic Needs Assessment. They should focus on improving the quality of care that patients receive and the outcomes for patients with all mental and physical conditions that are amenable to treatment.

There are five domains to the NHS Outcomes Framework and within each of these domains, tackling health inequalities is included, so that those most in need achieve the most gain from the interventions commissioned.
There are five domains to the NHS Outcomes Framework and within each of these domains tackling health inequalities is included, so that those most in need achieve the most gain from the interventions commissioned. The domains address effectiveness, experience and quality and taken together have the potential to address many of the concerns about health and health services for local people.

Clinical Commissioning Groups (CCG) are member associations that commission services from their member practices as well as from NHS and independent providers. Care needs to be delivered in the right place, with the right quality, at the right time. Care that does not need to be delivered in hospitals should be delivered by community and primary care services, but CCGs need to ensure that quality and governance frameworks protect patients from the potential conflicts of interest that arise when member practices benefit from the increase in income associated with transfer of care. The Director of Public Health, as an advocate for the health of the local population, will maintain a focus on patient outcomes and bring to the attention of the CCG any concerns about quality and effectiveness of patient care.
Priorities for health and wellbeing – The Joint Health and Wellbeing Strategy 2012 to 2015

The Joint Health and Wellbeing Strategy was developed by the Barking and Dagenham Partnership, and represents agreement between the Council and other statutory sector organisations with the voluntary sector and the public on the challenges to health and wellbeing and how to address them.

The important challenges are detailed in the Joint Strategic Needs Assessment, and are summarised as:

• Population growth and changes in our local population.
• Income poverty resulting in reduced wellbeing through the impact of factors such as poor mental health, fuel poverty, and limited access to services.
• High levels of lifestyle risk including smoking, obesity and low levels of physical activity.
• Continued high death rates from diseases including heart disease, cancer and chronic lung disease.
• Some specific conditions that remain a challenge, such as dementia.

The outcomes that we want to achieve through our Joint Health and Wellbeing Strategy are:

• To increase the life expectancy of people living in Barking and Dagenham.
• To close the gap between the life expectancy in Barking and Dagenham with the London average.
• To improve health and social care outcomes through integrated services.

The Strategy sets out four priority themes:

• Care and Support – Ensuring that patients, service users and carers have control and choice over the shape of the care and support that they receive in all care settings.
• Protection and Safeguarding – Protecting local people from the threats to their health and wellbeing including infectious disease and deaths relating to extreme weather. Enablers to protect health such as the built environment and housing stock, and safeguarding of individuals of all ages and identities from abuse, crime and ill-treatment.
• Improvement and integration of services – Improving treatment and care by benchmarking against best practice and where we identify that care has failed. Exploring new and different ways of providing health and social care that is more accessible and person centred with particular emphasis on improving this for older people and disabled children.
• Prevention – Supporting local people to make lifestyle choices at an individual level which will positively improve the quality and length of their life and overall increase the health of the population.

Actions, outcomes and outcome measures are then mapped across the life-course against these priority themes.

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