Director of Public Health
Annual Report 2013

Making the healthier choices
the easier choice for all
My report has been informed by and supports the achievement of the Council's and wider communities' vision “Encourage growth and unlock the potential of Barking and Dagenham and its residents”.

The five priorities for achieving this vision are:

1. Ensure every child is valued so that they can succeed
2. Reduce crime and the fear of crime
3. Improve health and wellbeing through all stages of life
4. Creating thriving communities by maintaining and investing in high quality homes
5. Maximise growth opportunities and increase the income of borough residents
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Foreword

Matthew Cole
Director of Public Health
Financial constraints affect both individuals and public services, and we need collectively to recognise that our life choices and our choices about the facilities and services we use impact on our ability to live healthy lives and meet the needs of local people. The recommendations in my report last year were warmly welcomed and remain the cornerstone of my approach – supporting people to stay healthy, integrated and high quality care, protecting people’s health and the care and support of children. This rightly acknowledges that health is a prerequisite in our vision to encourage growth and unlock the potential of Barking and Dagenham.

In a year which has seen the partners ‘storming and norming’ as they adopt their new responsibilities, there is no doubting the collective passion to act in the interests of all residents, especially those most vulnerable: children, women, older people, the less well off, and those living with long term conditions and disability at any stage of life.

The focal point of this renewed passion has been the Health and Wellbeing Board which has led the way in signalling the changes required in the way the Council and NHS Barking and Dagenham Clinical Commissioning Group work with our partners and residents. Key has been a renewed focus on engagement in the strategic challenge of focusing commissioning decisions on the right areas to deliver sustained improvement in population health outcomes.

**So what are the big public health issues at the heart of this challenge?**
Three continue to dominate our thinking:

I. The first is the burden of ill health demonstrated by the significant numbers of our population in poor health and the high mortality rates, especially from coronary heart disease, stroke, cancers and respiratory disease.

II. The second is to continue the essential development and investment in primary care and social care provision to deliver the ‘better care outside the hospital’ agenda, without which our hospital services are unsustainable.

III. The third is to take account of our rapidly changing population in our commissioning strategies and delivery plans, so that services keep pace with changing needs and numbers.
Addressing these three is critical to delivering enhanced life expectancy from birth for our residents. Currently more than half (56.7%) of all deaths under 75 in Barking and Dagenham were from conditions considered amenable to healthcare. Nearly 2,200 potential years of life per 100,000 registered patients are being lost through such causes. We will only achieve reduction to the national averages through a large scale sustained and consistent approach – from birth onwards – to health promotion, primary prevention, early diagnosis and effective treatment in order to impact on the mortality rates seen in Barking and Dagenham.  

Traditionally, we have viewed obesity from medical and nutritional perspectives. Obesity is, however, fundamentally a behavioural problem. To combat obesity, residents need to change their eating habits and their levels of physical activity. Healthy habits need to be established in childhood, when the right eating and activity patterns will bring lifelong benefit.

In December 2013 we held an Obesity Summit which brought together a range of findings from experimental psychology and behavioural change programmes showing how health behaviour can be influenced by the environmental context. While the evidence for this influence is undeniable, there remains the question of whether the ‘nudge’ approach is sufficient to deal with the complex and deep-rooted health and social issues that concern us here in Barking and Dagenham. Solving these issues requires more than mere nudges. If we are to achieve really sustainable behaviour change, we need to develop integrated programmes that draw on the latest behavioural change research and motivate residents to live a more healthy and sustainable lifestyle in today’s environment. Both personal incentives and large scale actions have a role to play, with public and private sector partners working together for the benefit of the community.

Such behaviour change approaches apply more widely than to the traditional lifestyle and health promotion services. A challenge for our commissioners and service providers is to stimulate behaviour change through service design and delivery in care and illness services as well as health and wellbeing services, recognising that, for example, stopping smoking, healthy eating and appropriate exercise may be as important to recovery as diligent adherence to taking recommended medicines.

My report this year focuses on four areas of opportunity where the contributions that all partners can make will deliver both the wider public health agenda and appropriate access to and uptake of high quality health and social care services. The report gives a professional perspective based on sound epidemiological evidence and objective interpretation taken from our Joint Strategic Needs Assessment and other published data.
I hope my observations in the following chapters act as a starting point for sharing local experience and helping ourselves, our partners and our residents, to reflect on the need to commission services that are flexible, reflect need and are delivered closer to people’s homes.

In Chapter 1, I explore the opportunity presented by Transforming Primary Care in London: General Practice – A Call to Action. Since around two thirds of our emergency hospital admissions involve residents with long term conditions, keeping this group as healthy as possible and helping them cope with any exacerbation of their illness is key to reducing pressure on Barking, Havering and Redbridge University Hospitals NHS Trust emergency departments and beds.

In meeting the challenge my GP colleagues will need to embrace new models of care that are an essential part of the longer term solution. We need to look beyond illness to the wider social and public health context to be more proactive in reaching out to high risk groups and working together with the Council to tackle the wider determinants of ill-health. This is essential if the future impact of increasing numbers of people experiencing multi-morbidity and dementia is to be reduced, against a backdrop of tighter financial controls and cuts that pose risks to the quality of care.

However, change and improvement in clinical services is difficult and the effort and resources required to extend and sustain this should not be underestimated. Solutions will need to balance the evidence and clinical expertise with the views and needs of local people and frontline clinicians.
I continue this theme in Chapter 2 where there is one statistic that stands out to me more than any other. Following my involvement in the Health and Adult Services Select Committee Scrutiny Review on mental health and the impact of the Government’s welfare reforms I have been struck by the fact that mental illness will affect one in four of us at some point in our lives.

Support for our mental health and services for when we are mentally ill are not just about health services but about every aspect of our daily lives. Over half of those with mental ill health say that stigma is a barrier to employment. Locally a great deal of action is already taking place, but greater efforts to integrate our collective working across organisational boundaries is needed in order to achieve sustained mental health improvement.

Chapter 3 examines the context for health improvement and how the Council can use its broad range of responsibilities to create opportunities to improve public health through creating a healthier environment. We have a great opportunity as one of London’s leading growth boroughs, but the challenge is to create sustainable, healthy communities, where people feel safe in their homes and are able to access high quality, affordable housing with excellent transport links to recreational and economic opportunities. With the ever increasing pressures on Council spending, this gives a compelling case to construct and engage in meaningful partnerships that put health improvement at the centre of local policy making.

A lot of good work is already happening and the Health and Wellbeing Board needs to ensure this is brought together across the Council and with our partners to ensure a clear strategic focus. We need to move away from traditional medical models and targets that some have argued detracted from local priorities. A shift in resources is needed to enable residents to make the healthier choice the easier choice. This will involve increased focus on planning controls around sales of health damaging products, building on experience of others such as voluntary agreements on “super-strength” alcohol. There is also a strong argument to realign our smoking cessation resource to a more balanced approach that discourages residents taking up the smoking habit in the first place.

Mental illness will affect one in four of us at some point in our lives

Support for our mental health and services for when we are mentally ill are not just about health services but about every aspect of our daily lives. Over half of those with mental ill health say that stigma is a barrier to employment. Locally a great deal of action is already taking place, but greater efforts to integrate our collective working across organisational boundaries is needed in order to achieve sustained mental health improvement.
In Chapter 4, I focus on the evidence and analysis on how we can enhance our interventions to improve early years outcomes in the crucial first five years of life, and identify what matters most in preventing poor children becoming poor adults. With the Council taking over the commissioning responsibilities for the Healthy Child Programme (0-5 years) in 2015 it affords the opportunity to rethink the role of the health visitor, together with other key early years programmes such as Family Nurse Partnership as well as our Troubled Families programme. An effective and well delivered integrated early years programme leading through to adolescence is fundamental to making the next generation a healthier one.

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

Matthew Cole
Director of Public Health

Background Papers

- Barking and Dagenham’s Community Strategy 2013-2016
- Longer Lives
- ‘Transforming Primary Care in London: General Practice – A Call to Action’
- NHS England – Better Care Fund Planning
- ‘Fair Society Healthy Lives’ (The Marmot Review)
- Independent Review on Poverty and Life Chances

Notes

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References: All references are given as weblinks, enabling the reader to source the original documents and data sources. Traditional formal references have not been used.
Transforming care

Barking and Dagenham is growing and becoming more diverse
At this time there is the necessity, the motivation and momentum to transform the entire organisation and delivery of health and care services to the extent that has not existed throughout the existence of the NHS. This need encompasses primary, community, hospital and social care services and is driven by the need to ensure that meeting the needs of the population goes hand in hand with services that are of high quality, sustainable and affordable. The NHS in particular is still modelled in many ways on the possibilities and expectations of the 1940’s, with predominantly five day working and hospital focused care that is at odds with the demands and possibilities of modern life and modern technology.

Barking and Dagenham is growing and becoming more diverse. My Annual Report last year described the changes highlighted by the 2011 Census: the 13% increase in population size between the 2001 and 2011 censuses, the almost 50% increase in the number of children under the age of 5 between 2001 and 2011, and that around one in three people living in Barking and Dagenham were born outside the UK. The high proportion of the population that are children and the increasing population diversity brings many challenges, and deprivation and health inequalities impact on the prevalence of long term conditions, the low life expectancy and the high level of premature mortality compared with other places in England. Barking and Dagenham ranks 133rd worst out of 150 local authorities for premature mortality overall, and for cancer and lung disease we rank 142nd worst. These conditions place a significant burden on our health and care services, and as well as working with people to prevent these illnesses we need to work with our primary, community and hospital services to ensure that they give the best possible care as efficiently and economically as possible.

Around one in three of the population have a long term condition, increasing to around half of people aged over 60 years. People with long term conditions are the most frequent users of healthcare services, accounting for 50% of GP appointments, 70% of inpatient bed days and 70% of the primary and acute care budget. More systematic and pro-active management of people with long term conditions underpins the highest priorities for commissioners aiming to transform the health and care system.

People with long term conditions are the most frequent users of healthcare services

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Transforming our health care system

Ten priorities for commissioners

1. Active support for self-management
2. Primary prevention
3. Secondary prevention
4. Managing ambulatory care sensitive conditions
5. Improving the management of patients with both mental and physical health needs
6. Care co-ordination through integrated health and social care teams
7. Improving primary care management of end-of-life care
8. Medicines management
9. Managing elective activity – referral quality
10. Managing urgent and emergency activity

Care for people with long term conditions

Optimum case finding and care for people with long term conditions is one of the biggest opportunities to reduce the need for emergency care, hospital admission and even primary and community support. People whose conditions have been diagnosed, who understand their condition, the treatment and the lifestyle which will enable them to be as healthy as possible, and who feel supported and able to access care and advice easily when needed are most likely to cope at home and remain relatively well. The variation in care for long term conditions across Barking and Dagenham is well illustrated by the published data for the care of people with diabetes, and builds on the data presented by the Council’s Health and Adult Services Scrutiny Review on Type 2 Diabetes Services published in 2013.

Care for people with diabetes

Diabetes care has been studied by the National Diabetes Audit for the last nine years. The Audit reports on four key questions about care drawn from the National Service Framework – Is everyone with diabetes diagnosed and recorded on a practice diabetes register?; What percentage of people with diabetes receive the NICE recommended care processes and achieve the NICE defined treatment targets? and What are the disease outcomes in terms of acute and long term complications?
The most recently published report for NHS Barking and Dagenham Clinical Commissioning Group (published 30 October 2013) covers the care given in 2011/12. The participation rate by practices locally was very high, with 39 of the 40 practices participating, and the percentage of the population of all ages diagnosed with diabetes was similar to the level for England and Wales (4.69% or 9,293 people in Barking and Dagenham compared with 4.73%). Data is not provided on the variation between practices but the General Practice profiles report QOF data (Quality and Outcomes Framework – part of the general practice payment arrangements) shows that for people aged 17 and over the average prevalence in 2012/13 was 6.8% and the practice variation was between 3.27 and 11.0%.

Figure 1.1
NHS Barking and Dagenham CCG: Diabetes QOF Prevalence (17+) 2012/13

Source: National General Practice Profiles
http://fingertips.phe.org.uk/profile/general-practice/data#mod,5,pyr,2013,pat,19,par,07L,are,-,sid1,2000002,ind1,-,sid2,-,ind2,-
On care processes, the National Diabetes Audit reports that the eight care processes expected in line with NICE Guidance were only completed by 45.9% of practices, well below the 60.5% reported for England and Wales as a whole, and in the bottom 25% of all clinical commissioning groups for the eight processes combined. Again there is substantial variation, from over 80% of patients receiving all eight processes to less than 5%. Diabetic eye screening is excluded from this analysis for technical reasons, but separate figures from the Diabetes Eye Screening Programme show that at Quarter 4, 2012/13, 79% of people eligible for screening for diabetic retinopathy had received it.

On treatment targets, NHS Barking and Dagenham CCG is again in the bottom 25% of CCGs, with only 19% of patients achieving all three of the measured treatment targets, although this is not far below the very poor position for England and Wales of 20.8%. Again there is variation between practices as shown in the two figures opposite.

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### Figure 1.2

**Percentage of patients achieving HbA1c <58mmol/l, cholesterol <5mmol/L and their relevant blood pressure (BP) target for all GP practices within NHS Barking and Dagenham CCG 2011/12**

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### Figure 1.3

**Percentage of all patients in NHS Barking and Dagenham CCG achieving treatment targets by treatment target and audit year**

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8 Diabetes admission rates for Redbridge CCG average 0.9 per 1000, below the national average, and therefore not an outlier on this measure.

Inevitably the outcome of these shortcomings in care include more hospital admissions and premature mortality. People with diabetes are 38% more likely than those without diabetes to die early and account for more than a quarter of all admissions for heart failure. Diabetes admissions rates in Barking and Dagenham (2.1 per 1000) are well above the England average (1.1 per 1000), and the variation between practices is substantial. In addition, the average admission rate per 1000 for NHS Havering CCG practices is even higher than in Barking and Dagenham at 2.9 per 1000, resulting in substantial pressure on inpatient beds.

Figure 1.4
Diabetes Admissions per 1,000, NHS Barking and Dagenham CCG, 2010/11

The National Diabetes Inpatient Audit provides information on hospital in patients with diabetes. The most recent audit covers a 5 day period in September 2012, and includes inpatients at both Queens and King George Hospitals in Barking, Havering and Redbridge University Hospitals NHS Trust. At the time of the audit there were 36 inpatients at Queens (5.5% of the beds audited) and 42 inpatients at King George (13.3% of the beds audited). At Queens, 97.1% of the patients had been admitted as an emergency and 89.7% of the patients at King George had been admitted as an emergency, compared with 83.6% in England as a whole. At Queens, 26.5% were admitted specifically for management of their diabetes and 64.7% for other medical reasons. This figure is very different to the equivalent figures for King George (7.1% and 71.4%) and to those for England (7.6% and 67.2%) and is indicative of the breakdown of diabetes management in individual patients that results in pressure on the emergency facilities at Queens Hospital. Length of stay data is not available at hospital level but at national level patients with diabetes admitted to hospital as an emergency have a longer median length of stay than patients admitted electively (8 days compared with 5 days). A wealth of other data from the audit enables comparison to be made about various aspects of care compared with other hospitals in England.
NHS England has recently published Action for Diabetes, a response to National Audit Office and Public Accounts Committee reports\(^{10}\). This action plan acknowledges the low rates of delivery of basic care processes and low rates of attainment of treatment goals and describes the steps that they will lead to drive more prevention of Type 2 diabetes and earlier diagnosis of all diabetes, as well as supporting better management of diabetes in primary care and providing tools and resources to support commissioners in driving quality improvement in secondary care.

### Transforming Primary Care – General Practice

General practice is the cornerstone of the NHS, where 90% of patient contact takes place. GPs coordinate care and help patients navigate the system, as well as prevent, diagnose, treat and manage illness. General practice is part of the spectrum of health services outside hospitals, which also include dental, ophthalmic and community pharmacy services, primary care based urgent services and community services including community mental health services. While undertaking 90% of NHS activity general practice consumes only 7.5% of the cost. It is a system recognised around the world for the economy of its gate-keeping to the more expensive hospital based services.

Barking and Dagenham is now relatively well provided for in terms of the number of GPs in the borough. In 2012 the NHS Workforce Census recorded 132 GPs, equivalent to 99 full time equivalents (FTE) and an average practice size of 5096 (1,544 patients per GP, 70.6 GPs per 100,000 population), compared with an average practice size for London of 6113 (1,651 patients per GP, 66.4 GPs per 100,000 population). Almost half of general practices in Barking and Dagenham have 4 or more GPs (19 out of 40 practices), and only 3 practices remain that are single handed. However GPs in Barking and Dagenham are more likely to be aged 60 or over (36.6% in Barking and Dagenham compared with 17.9% in London)\(^{11}\).

Between the 2011 and 2012 censuses of the GP workforce there has been a significant shift to larger practice size and a large increase in the number of GPs. The number of single handed practices reduced from 13 to 3, and the number of GPs increased from 102 (85 FTE) to 132 (99 FTE). Consequently average list size increased from 4808 to 5096, but the number of patients per GP decreased from 1932 to 1544\(^{12}\). These improvements mean that Barking and Dagenham GPs are in a good position to give leadership to the necessary transformation of primary care. The increase in the number of doctors was not matched by any meaningful increase in general practice staff (285 FTE in 2011, 275 FTE in 2012 of whom 41 FTE were practice nurses) and this needs to be addressed to ensure comprehensive and accessible services can be provided at each practice premise.

General practice has essential strengths; it is the source of medical generalist expertise, treating the whole person regardless of age, gender or the nature of disease, dealing with a range of problems, uncertainties and risk, taking into account the social and emotional context\(^{13}\). General practice provides coordination and continuity of care, and there is evidence that a good relationship with their GP is associated with positive outcomes for patients – better, more appropriate care, better health outcomes, lower healthcare costs.

Nevertheless, the strain that health and care services are under, with unmanageable pressures on emergency departments and hospital beds, cannot be addressed simply by restructuring delivery of care within hospitals, and there is widespread recognition that primary care services have a major contribution to make to the pressures facing the NHS. The ‘Call to Action’ made by NHS England describes the pressures on both primary and secondary care that have led to the need for a new model of primary care to meet current and future needs. The eight strands of the case for change are all highly relevant in Barking and Dagenham.

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13. [http://www.lmc.org.uk/visageimages/Policy/EPI%20Final.pdf?dm_t=0,0,0,0,0](http://www.lmc.org.uk/visageimages/Policy/EPI%20Final.pdf?dm_t=0,0,0,0,0)
### Transforming Primary Care in London – Case for Change

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<th>What’s happening in Barking and Dagenham</th>
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<td>Population</td>
<td>London’s population growth and complexity are placing unprecedented levels of demand on general practice and the current service is struggling to respond effectively to rising health needs</td>
<td>13% increase in population size between 2001 and 2011 census and continuing to grow, such that 1-2 new GPs are needed every year simply to keep up with the increase in population size</td>
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<td>Economic</td>
<td>London faces a significant financial challenge. Practice finances are declining in real terms, exacerbating their inability to invest in service improvements. Delivering smaller pump-priming investment in primary care has the potential to release greater cost efficiencies over time</td>
<td>General practices have invested to improve services, but average income is declining and new investment is needed to deliver major change</td>
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<td>Service changes</td>
<td>London CCGs are leading ambitious proposals to reconfigure local services to improve care that hinges heavily upon the ability to increase the capacity and capability of primary care services</td>
<td>Service reconfiguration at Barking, Havering and Redbridge University Hospitals NHS Trust is essential to meet quality standards and effective management of demand, putting pressure on primary care</td>
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<td>Service improvement</td>
<td>Across the country, there are significant unexplained variations between practices for key aspects of diagnosis and treatment. Reducing variation has the potential to save lives and enable people to live longer</td>
<td>Examples of variations between practices are frequent in local practices, and Barking and Dagenham practices are outliers on a number of measures of referral rates and hospital admissions</td>
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<td>Coordinated care</td>
<td>Patients with long term conditions account for more than 50% of GP appointments and consume more than 75% of the total health and social care spend. Improved care coordination delivers better health outcomes, more satisfied patients and at lower cost</td>
<td>Barking and Dagenham has high rates of premature mortality for conditions such as heart and lung diseases, and high levels of emergency admissions for a range of long term conditions. Working together across the health system will enable GPs to be more flexible and spend more time with those patients who need this</td>
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<td>Accessible care</td>
<td>Access impacts on patient experience and the quality of care they receive and also matters to practices whose workloads can become unmanageable if access is not well managed. If patients find it hard to access general practice their diagnosis and treatment may be delayed or they may choose to go to A&amp;E because it is open and available</td>
<td>High rates of emergency admissions for local patients may be due to difficulties accessing the GP. The most recent patient survey reported that 19% of patients who were not able to get an appointment at a convenient time went to A&amp;E or a Walk in Centre, compared with 12% for London as a whole</td>
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<td>Proactive care</td>
<td>Stark health inequalities exist across London. Health promotion and primary prevention by general practice working in partnership with others will be key to reducing morbidity, premature mortality, health inequalities and the future burden of disease</td>
<td>Barking and Dagenham is the 22nd most deprived local authority in England and is 133rd worst out of 150 local authorities for premature mortality. Health promotion and prevention in primary care is critical to achieving improvements in people’s health</td>
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<td>Infrastructure</td>
<td>Most practices in London remain relatively small and could benefit from shared economies of scale. London has a high number of single-handers and GPs nearing retirement as well as a significant practice nurse shortage and patchy use of other primary care roles. Existing digital opportunities are not being well utilised. London has a higher than average proportion of smaller general practice premises.</td>
<td>Although the number of single handed practices is now low in Barking and Dagenham there is a high proportion of GPs aged 60 or over and practice staff increases are not keeping pace with the increase in the number of GPs. By 2015 practices will be contractually required to provide online facilities to book appointments and order prescriptions.</td>
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Addressing consistency in the quality of clinical care in general practice

The Kings Fund, in their report on the challenges faced by general practice in London and the improvements needed to address them, looked at eight areas of clinical care where improvement should be focused\(^\text{16}\). These are:

- Health promotion and ill-health prevention
- Diagnosis
- Referrals
- Prescribing
- Acute, emergency and urgent care
- Managing long-term conditions
- Mental health and dementia
- End-of-life care.

They are all highly relevant to our position in Barking and Dagenham and provide a practical and clinically meaningful approach to the outcomes we need to be realised from service improvement. In health promotion and ill-health prevention for example, effort is obviously needed to reduce the number of people who smoke, are obese, and drink excessive alcohol. Immunisation levels are improving and are now above the London average but still below England levels. Both breast and cervical screening coverage also, while similar to the average level for London, are below the level for England as a whole and should be improved, particularly screening for breast cancer, which is still a relatively common disease.

Hospital care shows high levels of use and significant variation between practices. There is a twofold variation in the average number of GP referrals to outpatients and the local average of 258 per 1,000 practice population is well above the England average of 192. Emergency admissions for chronic conditions also show considerable variation between practices although the average is similar to that for England as a whole.

### Figure 1.5

**GP referrals to outpatients – 1st attendance (per 1,000)**

**NHS Barking and Dagenham CCG 2010/11**

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<td>Gables Surgery</td>
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<tr>
<td>Porters Avenue Health Centre</td>
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<td>Dr Moghal’s Practice</td>
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<td>Dr Ahmad’s Practice</td>
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<td>Broad Street Medical Practice</td>
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<td>Dr Shah’s Practice</td>
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<td>Dr Haider’s Practice</td>
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<td>Dr Jaisalw’s Practice</td>
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<td>Dr Fateh’s Practice</td>
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<td>Highgrove Surgery</td>
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<td>Heathway Medical Centre</td>
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<td>Dr Moghal &amp; Associates</td>
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<td>The White House Surgery</td>
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<td>Dr Goriparthi’s Practice</td>
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<td>Dr Haq’s Practice</td>
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<td>Lawn’s Medical Care</td>
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<td>Dr Mittal’s Practice</td>
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<td>Dr Chibber’s Practice</td>
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<td>Dr Niranjan’s Practice</td>
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<td>Dr Quansah’s Practice</td>
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<td>Dr Goyal’s Practice</td>
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<td>Dr Eshan</td>
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<td>Dr Kashyap’s Practice</td>
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<td>Dr Teotia’s Practice</td>
<td>193</td>
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<tr>
<td>Dr Afer’s Practice</td>
<td>189</td>
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<tr>
<td>Shifa Medical Practice</td>
<td>153</td>
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</tbody>
</table>

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- England (average) 192 per 1,000
- NHS Barking and Dagenham CCG (average) 258 per 1,000
- NHS Barking and Dagenham CCG (individual practices)

**Source:** [http://fingertips.phe.org.uk/profile/general-practice/data#mod,5,pyr,2013,pat,19,pac,07,Larea,-sid1,2000012,ind1,623-4,sid2,-,ind2,-](http://fingertips.phe.org.uk/profile/general-practice/data#mod,5,pyr,2013,pat,19,pac,07,Larea,-sid1,2000012,ind1,623-4,sid2,-,ind2,-)

Figure 1.6

Emergency admissions for ambulatory care sensitive conditions (chronic conditions) per 1,000 practice population
NHS Barking and Dagenham CCG, 2010/11

While there may have been some improvement in the position since 2010/11, the period of this most recently published data, it is unlikely that the variation has been eliminated. Publication of data from the CCG Outcomes Indicator Set as well as the Public Health and Adult Social Care Outcomes Frameworks will enable further work to be undertaken on improvement opportunities in primary care and across the health and care system, highlighting where action is most needed.

21st Century Primary Care?

The NHS England Report Transforming Primary Care in London sets out criteria for the transformed primary care services. The underlying principles encompass:

**Coordinated care** – effective care management led by primary care and focusing particularly on those with long term conditions, the frail elderly, those with dementia and those at the end of their lives, assessing risk, planning care and integrated case management provided by multi-disciplinary integrated care teams delivering personalised care plans

**Accessible care** – providing frequent continuous support for those who need it and convenient, responsive, timely care for those who seek it

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Source: [http://fingertips.phe.org.uk/profile/general-practice/data#mod,5,pyr,2013,pat,19,par,07L,are,-,sid1,2000007,ind1,374-4,sid2,-,ind2,-](http://fingertips.phe.org.uk/profile/general-practice/data#mod,5,pyr,2013,pat,19,par,07L,are,-,sid1,2000007,ind1,374-4,sid2,-)
Proactive care – increasing the focus on health and wellbeing and working actively to keep people healthy through health promotion and ill health prevention support.

To deliver these principles new models of primary care are proposed that bring practices together and achieve economies of scale and expertise. Federations, networks and bigger partnerships are seen as necessary to extend the services available and to encompass a wider range of specialist knowledge to support generalist care. In addition, workforce development with more emphasis on multi-disciplinary working and investment in technology are considered to be critical.

Transforming primary care is not an isolated activity, and not restricted to general practice. Community pharmacy is a front line service and also subject to NHS England’s Call to Action. Pharmacists are the third largest health profession after doctors and nurses and train for five years to develop their knowledge and skills. The aims for community pharmacy are to: develop the role of the pharmacy team to provide personalised care, be a full partner in more integrated out-of-hospital services, provide a greater role in healthy living advice, improving health and reducing health inequalities, and to deliver excellent patient experience which helps people to get the most from their medicines.

Fully implementing these aims in Barking and Dagenham will make an important contribution to transforming services.

Integrated care

Integrated care means bringing together the providers of the range of care services that are needed by a population or an individual so that the services are coordinated and bring maximum benefit to the recipient. Integration may be through merger of services or through providers working together in networks and alliances.

Integration between health and care services is being driven by the Better Care Fund (formerly the Integration Transformation Fund), a mandated pooled fund which is to be deployed locally on health and social care services working together to improve outcomes for the public, provide better value for money, and be more sustainable. The Better Care Fund will be introduced in 2015/16 and CCGs are required to plan in 2014/15 the actions they will take to create the funding that they will have to contribute.

In Barking and Dagenham an integrated care strategy has been developed which seeks to transform the relationship between local people and the organisations which are responsible for their care. Improvements in people’s experience of care fundamentally means care and support in their own home, or as close to home as possible, and minimising the time they spend in hospital. In turn this reduces the pressure on A&E services and hospital beds and enables our local hospitals reconfiguration plans to go ahead and be successful.
While details of the planned changes are still being developed, the opportunities for improvement in people’s health and experience of health and care services are clear and I am confident that the proposed changes will be beneficial for health and wellbeing outcomes.

Transforming secondary care

Hospital services are also the subject of national review and proposals for more consistently high service quality with better outcomes and more efficient working. Two major reviews have been published by NHS England, the Urgent and Emergency Care Review\(^\text{19}\) and the initial findings of the NHS Services, Seven Days A Week Forum\(^\text{20}\).

Barking, Havering and Redbridge University Hospitals NHS Trust has already implemented 7 day working in some medical specialities. The additional senior cover and increased availability of support services at the weekend is intended to improve patient flows and drive down the length of hospital stay. Early results have been mixed and it is recognised that clinical leadership and widespread engagement is critical to success. It is only to be expected that the introduction of new ways of working, which affect community and social care services as well as the hospital, will take some time to become effective, but pressure must continue to achieve improvements that are essential for local people.

The Seven Days a Week Forum has developed a set of clinical standards describing the standard of urgent and emergency care that all patients should receive seven days a week. Action Plans to deliver these standards are expected to be set out in local contracts for 2014/15. They set very precise requirements about the maximum time intervals within which consultant assessment, multi-disciplinary team assessment and integrated management plans should be undertaken, and the requirement for access seven days a week to diagnostics, interventions and psychiatric assessments and the availability of community, primary and social care services, both to support discharge and perhaps more importantly to mitigate the risk of admission.

The role of the Council in transforming care

Health care services for the residents of Barking and Dagenham are largely provided across a larger geography that also covers the London boroughs of Havering and of Redbridge. Our local hospital, Barking, Havering and Redbridge University Hospitals NHS Trust, as well as our community and mental health service, North East London NHS Foundation Trust, provide care across all three boroughs and beyond. NHS Barking and Dagenham Clinical Commissioning Group works closely with Havering and Redbridge CCGs and some of the senior managers work across all three CCGs.

Addressing the health needs and ensuring the availability of health services for the people of Barking and Dagenham does not therefore happen in isolation, but in partnership, particularly across the three boroughs, and also beyond. With the implementation of the Health and Social Care Act 2012 and the Council’s health leadership role through the Health and Wellbeing Board, the Council has a role and responsibility to local people that means working in partnership across the three councils. This partnership is developing at officer level, but leadership from councillors themselves will add to the value and effectiveness of partnership working. It should also be recognised that commissioning of health and social care services is heading towards integration, and however future arrangements are politically organised, the Council will wish to have a strong influence on how the needs of local people are met.

\(^{19}\) http://www.nhs.uk/NHSEngland/keogh-review/Documents/UECR.Ph1Report.FV.pdf
Mental Illness & Mental Wellbeing
Mental health, mental wellbeing and mental illness are terms that are often used interchangeably and may mean different things to different people. In this Chapter I use mental illness as the collective term for clinically diagnosed conditions such as depression and anxiety and mental wellbeing as a positive concept which is about a person being happy, flourishing and getting the most out of life. Given that people with a diagnosed mental illness can also experience mental wellbeing, for example when they are engaged in positive activities, mental health is frequently actually referring to ‘mental illness’, and ‘public mental health’ generally refers to population wellbeing I have tried to maintain clarity by subsequently using only the terms ‘mental illness’ and ‘mental wellbeing’ wherever possible.

Mental illness

Mental illness is common and debilitating. Amongst people under 65 nearly half of all ill health is mental illness, and the effect on people’s lives is generally more disabling than physical illness. On average a person with depression is more disabled than someone with angina, arthritis, asthma or diabetes. The risk of mental illness increases with age – 25% of older people have depressive symptoms that require intervention, and 40% of people over the age of 85 are affected. Dementia affects 5% of people over the age of 65 and 20% of those aged over 80. Major depression is found in 20-25% of people with dementia. In care homes, 40% of people have depression and 30% have anxiety.

It has been estimated that one in four adults will experience at least one diagnosable mental health problem in any one year. Mixed anxiety and depression is the most common mental disorder, which is amongst the ‘neurotic’ forms of mental disorder. These can be described as extreme forms of normal emotional experiences such as depression, anxiety or panic. Less common mental disorders have ‘psychotic’ symptoms, which interfere with a person’s perceptions of reality and include hallucinations, delusions and paranoia. Mental illness also includes dementias, drug and addiction associated problems and personality disorders. In this report I am focusing on the impact of the neurotic disorders and the importance of effective management to maximise the potential for recovery.

The burden of mental illness resulting from the neurotic forms of disorder is substantial.

2 https://www.rcpsych.ac.uk/pdf/Position%20Statement%204%20website.pdf
4 http://www.ncbi.nlm.nih.gov/pubmed/19648541
Mental health problems have an important economic cost that extends well beyond the cost of health and social care. People who are mentally ill are less likely to be in employment and those who are in work are more likely to take days off. It has been estimated that, among people in work, mental illness accounts for 40% of absenteeism from work. For people out of work, mental illness became the most common reason for claiming Incapacity Benefit (now replaced by Employment Support Allowance) and mental health charities have expressed concern about the arrangements for work capability assessments.

The relationship between unemployment and health has been recognised since the depression of the 1930’s, with research demonstrating that unemployment increases rates of depression, particularly amongst those who have never worked, who are primarily young people. Population mental health in men got worse within two years of the 2008 recession and this was not just associated with unemployment but appears also to relate to job insecurity amongst those men who are employed. The same effect was not shown in women in that study, but future studies may identify similar effects.

Mental illness in Barking and Dagenham

Applying estimates of the prevalence of mental illness to the population of Barking and Dagenham, and taking into account the various risk factors such as poverty, unemployment and long term illness which all increase the prevalence of the neurotic disorders, over 20,000 local people will be suffering from the various anxiety and depression disorders. About half of these will have mixed anxiety and depression, just over one-quarter will have generalised anxiety disorder and one-fifth will have depression.

Figure 2.1
Risk of mental illness with varying levels of household income, England 2008/09

For each income quintile, proportion of people aged 16 to retirement who are assessed as being at a high risk of mental illness

<table>
<thead>
<tr>
<th>Household income quintiles</th>
<th>Poorest fifth</th>
<th>2nd</th>
<th>3rd</th>
<th>4th</th>
<th>Richest fifth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>25%</td>
<td>20%</td>
<td>15%</td>
<td>10%</td>
<td>5%</td>
</tr>
<tr>
<td>Women</td>
<td>25%</td>
<td>20%</td>
<td>15%</td>
<td>10%</td>
<td>5%</td>
</tr>
</tbody>
</table>


6 http://www.bmj.com/content/338/bmj.b629
7 http://bmjopen.bmj.com/content/2/5/e001790.abstract?sid=081c0b6d-85f8-4614-b712-a6e655a9d4c
9 http://apprcpsych.org/content/10/3/216.full.pdf+html?sid=6eaal06d9-146d-481c-8d4-13ed29f0a4b
10 Estimate based on Psychiatric Morbidity Survey, used for population with depression and/or anxiety disorders as defined for IAPT programme http://www.hscic.gov.uk/catalogue/PUB11365
Management of mental illness in primary and community care

Before the 1950’s little could be done for the anxiety and depressive disorders, but treatment has been revolutionised first by anti-depressant drugs and since the 1970’s by psychological therapies. About half of all patients with anxiety conditions will recover after an average of 10 sessions of Cognitive Behaviour Therapy (CBT), in most cases without recurrence. About half of patients with depression will also recover with CBT, although about half of those who recover will have one or more further episodes\(^\text{11}\). It has been estimated that only around one-quarter of people with mental illness receive treatment. This may be due to a number of factors, including lack of recognition that the individual with anxiety or depression actually is suffering from a diagnosable condition that can be treated, as well as reluctance to access treatment and lack of availability of treatments. NICE Guidance provides the treatment model which should now be the norm. Stepped models are applied for both anxiety and depression.

**Figure 2.2**

**The NICE stepped-care model for Generalized Anxiety Disorder (GAD), NICE 2011**

- Follow the stepped-care model shown below, offering the least intrusive, most cost effective intervention first.

<table>
<thead>
<tr>
<th><strong>Focus of the intervention</strong></th>
<th><strong>Nature of the intervention</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>STEP 4:</strong> Complex treatment-refractory GAD and very marked functional impairment, such as self-neglect or a high risk of self-harm</td>
<td>Highly specialist treatment, such as complex drug and/or psychological treatment regimens, input from multi-agency teams, crisis services, day hospitals or inpatient care</td>
</tr>
<tr>
<td><strong>STEP 3:</strong> GAD with an inadequate response to step 2 interventions or marked functional impairment</td>
<td>Choice of a high-intensity psychological intervention (CBT/applied relaxation) or a drug treatment</td>
</tr>
<tr>
<td><strong>STEP 2:</strong> Diagnosed GAD that has not improved after education and active monitoring in primary care</td>
<td>Low-intensity psychological interventions; individual non-facilitated self-help, individual guided self-help and psychoeducational groups</td>
</tr>
<tr>
<td><strong>STEP 1:</strong> All known and suspected presentations of GAD</td>
<td>Identification and assessment; education about GAD and treatment options; active monitoring</td>
</tr>
</tbody>
</table>

**The NICE stepped-care model for Depression, NICE 2009**

- This model provides a framework for organising the provision of services, and helps patients, carers and practitioners to identify and access the most effective interventions. The least intrusive, most effective intervention is provided first. If a person does not benefit from that intervention, or declines an intervention, they should be offered an appropriate intervention from the next step.

### Focus of the intervention

**STEP 4:** Severe and complex depression, risk to life; severe self-neglect

**STEP 3:** Persistent subthreshold depressive symptoms or mild to moderate depression with inadequate response to initial interventions; moderate and severe depression

**STEP 2:** Persistent subthreshold depressive symptoms; mild to moderate depression

**STEP 1:** All known and suspected presentations depression

### Nature of the intervention

- **STEP 4:** Medication, high-intensity psychological interventions, electroconvulsive therapy, crisis service, combined treatments, multiprofessional and inpatient care

- **STEP 3:** Medication, high-intensity psychological interventions, combined treatments, collaborative care and referral for further assessment and interventions

- **STEP 2:** Low-intensity psychological and psychosocial interventions; medication and referral for further assessment and interventions

- **STEP 1:** Assessment, support, psychoeducation, active monitoring and referral for further assessment and interventions

**Source:** [http://www.nice.org.uk/nicemedia/live/12329/45890/45890.pdf](http://www.nice.org.uk/nicemedia/live/12329/45890/45890.pdf)

Effective management therefore depends on case findings and provision of drugs and psychological therapies as appropriate. Local data on the prevalence of depression from the General Practice Quality and Outcomes Framework (see figure 2.4) for 2012/13 suggests a high level of under diagnosis and wide variation between practices.

The average prevalence in Barking and Dagenham practices was 3.3% (4951 people age 18 and over) against an England average of 5.8%. Given the economic profile of the local population it is unlikely that the prevalence of depression is below the national average.
Figure 2.4
Depression prevalence in NHS Barking and Dagenham CCG, General Practice Quality and Outcomes Framework, 2012/13

Source: http://fingertips.phe.org.uk/profile/general-practice/data#mod,5,pyr,2013,pat,19,par,07L,are,-,sid1,2000003,ind1,848-4,sid2,-,ind2,-

Once identified, NICE good practice requires assessment of severity at the time of diagnosis and again at 2-12 weeks after diagnosis. Data from the 2012/13 QOF shows that most practices in NHS Barking and Dagenham CCG are above the England average for this indicator, although 7 practices are below the England average (England average 75.4%, NHS Barking and Dagenham CCG average 82.2%)12.

Improving Access to Psychological Therapies

The benefits of talking therapies were recognised by the establishment of the Improving Access to Psychological Therapies (IAPT) programme in 2007. Talking Therapies: A four-year plan of action13 set the expectation that by the end of 2014/15 a minimum of 15% per annum of those in need will be able to access psychological therapies, with the expectation that at least 50% of those completing treatment will recover. Over a million people in England have accessed therapy through this programme14, which is intended to pay for itself by reducing the healthcare usage by those who recover, with an average benefit of 3 fewer GP visits and 1.5 fewer hospital bed days per recovered patient. In London an estimated one million people suffer from depression and/or anxiety every year and therefore around 150,000 people should be able to access evidence-based psychological therapies each year.

12 http://fingertips.phe.org.uk/profile/general-practice/data#mod,5,pyr,2013,pat,19,par,07L,are,-,sid1,2000003,ind1,848-4,sid2,-,ind2,-
14 http://www.iapt.nhs.uk/site/files/iapt-3-year-report.pdf
In Barking and Dagenham the estimated population in need is 20,417 (adults age 18 and over) and therefore the target for access to psychological therapies is 3062 each year. Data is collected quarterly and an estimate for access for the most recent four quarters shows that only just over half of the estimated population in need are accessing therapy (Cumulative population access for 2012/13 1569 patients, 7.7% of total estimated population in need, 51% of 15% target population for IAPT access\(^\text{15}\)). The rate of recovery for local people however is good, with 52.3% ‘moving to recovery’ in quarter 4 2012/13 and 43 people moving off sick pay or benefits. Employment advice is a core part of psychological therapy services, because people who are out of work are more likely to experience depression and anxiety disorders, and being in work is advantageous to mental wellbeing.

The IAPT service is still developing, with an expansion of capacity for adults still needed and services for children and young people in development. This is an important service for local people and, with access levels for adults only half of the target level, and probable under-diagnosis of depression, action is needed by GP in both their providing and commissioning roles to ensure that local people can receive the services that will help to address their mental health needs.

Recent research suggests that the introduction of IAPT services does not reduce the prescribing of antidepressant medication\(^\text{16}\). The reasons for this are not clear, but may be related to waiting times for IAPT and the need for immediate action. Referral data to IAPT indicates that only about two-thirds of those referred enter treatment, and it is possible therefore that some of those referred decide that medication is working for them. Prescribing practice should be in line with NICE quality standards\(^\text{17}\), but it should be noted that medication plays a more significant role in depression than it does in anxiety disorders. Although antidepressant prescribing in Barking and Dagenham is increasing, it is difficult to draw any conclusions without analysis of prescribing practice against NICE quality standards.

\(^{15}\) http://www.hscic.gov.uk/catalogue/PUB11365
\(^{16}\) http://www.ingentaconnect.com/content/rcgp/bjgp/2013/00000063/00000014/art00038
\(^{17}\) http://www.nice.org.uk/media/01D/03/DepressionQSCostAssessment.pdf
\(^{19}\) http://cep.lse.ac.uk/events/lectures/layard/RL030303.pdf
\(^{20}\) http://cep.lse.ac.uk/events/lectures/layard/RL040303.pdf
\(^{21}\) http://cep.lse.ac.uk/events/lectures/layard/RL050303.pdf
People who have a good sense of wellbeing have lower rates of illness, recover more quickly, and generally have better physical and mental health than those who do not.

Since 2011, the Office for National Statistics has undertaken an experimental annual population survey to estimate subjective wellbeing. A sample of adults aged 16 and over were asked ‘Overall, how satisfied are you with your life nowadays?’, ‘Overall, to what extent do you feel the things you do in your life are worthwhile?’, ‘Overall, how happy did you feel yesterday?’ and ‘Overall, how anxious did you feel yesterday?’ and asked to score on a scale of 0 to 10 where 0 is ‘not at all’ and 10 is ‘completely’. Responses to these questions are included as indicators in the Public Health Outcomes Framework, with Barking and Dagenham residents scoring slightly above the score for England; however it is questionable how valid the responses to these questions are and whether any meaningful change in response levels will occur.

In 2003, Professor Lord Richard Layard explored the concept of happiness as a sense of feeling good and enjoying life, and the correlation with better immune system responses and lower levels of stress causing cortisol. He postulates that humans want to be happy and that we act to promote our happiness, but cautions that our wants, which have a major effect on our happiness, are derived from society and we want things and experiences because other people have them. Research on happiness and life satisfaction (the European equivalent approach) shows that the level of happiness has remained remarkably constant over the last fifty years, while the prevalence of clinical depression has increased. In general, rich people are happier than poor people, and as average incomes improve for both rich and poor, this does not change. This relates both to getting used to what we have (habituation) and comparing what we have with what others have (rivalry).

Knowledge about what others have has risen exponentially in recent years with access to the internet and particularly with social media – within seconds of a celebrity acquiring something that most people could barely imagine owning this information is widely shared.

What makes people happy is typically income, work, private life, community, health, freedom and a philosophy of life. The greatest reduction in happiness results from issues which impact on the sense of being needed – both loss of employment and job insecurity and loss of family relationships particularly separation and divorce. Loss of health also has a significant impact on happiness. Security of families and communities is influenced by national and local policy if geographical mobility is increased. If one accepts that happiness, satisfaction and wellbeing are essentially the same, or at least correlated, it makes sense to address mental wellbeing through the key influencers of family and community security (including crime reduction and environmental enhancement), employment and income security (including benefits for those for whom they are relevant) and health (both improving mental and physical health and optimising the mental and physical wellbeing of those with illnesses and long term conditions).

Interventions to improve population mental wellbeing should include both universal approaches and actions targeted at groups at higher risk including children in care and those subject to bullying and abuse, unemployed and homeless people, people from ethnic minorities and those suffering from addictions. Poor mental wellbeing with low self-esteem commonly underlies risk taking behaviours including smoking, alcohol and drug misuse, higher risk sexual behaviour, unhealthy eating and lack of exercise.

Improving mental wellbeing early in life through interventions in childhood will protect health and wellbeing and promote the resilience to handle future adversity. This will include strategies to promote the wellbeing of the child’s parents and family and the effective treatment of parental mental illness.
Closing the gap: Priorities for essential change in mental health

In January 2014 the Department of Health published a document to support the Mental Health Strategy No Health Without Mental Health setting out 25 aspects of mental health care and support where tangible changes will be expected within the next couple of years. All of these changes are important, and some of them specifically relate to aspects explored in this report. These include continuing priority for access to psychological therapies, including for children and young people, recognising that half of those with lifetime mental health problems first experience symptoms by the age of 14, and 75% do so by their mid-twenties. Also highlighted are improved recognition of mental health problems, including postnatal depression and recognition of mental health problems in children, and people with mental health problems living longer and healthier lives, both through better integration of physical health needs with mental health care and through more support for lifestyle challenges such as smoking and alcohol misuse.

Focusing on improving mental wellbeing and addressing mental illness

Building the resilience of people and communities to cope with life’s challenges and maintain their wellbeing in the face of adversity is critical to supporting people with all forms of mental illness. The report Building Resilient Communities explores the role of councils and their partners in the upstream interventions that can help people achieve wellbeing, based on the Five Ways to Wellbeing evidence that identified actions to promote personal wellbeing published in 2008.

5 Ways to Wellbeing

Connect...
With the people around you. With family, friends, colleagues and neighbours. At home, work, school or in your local community. Think of these as the cornerstones of your life and invest time in developing them. Building these connections will support and enrich your every day.

Be active...
Go for a walk or run. Step outside. Cycle. Play a game. Gardening. Dance. Exercising makes you feel good. Most importantly, discover a physical activity you enjoy and that suits your level of mobility and fitness.

Take notice...
Be curious. Catch sight of the beautiful. Remark on the unusual. Notice the changing seasons. Savour the moment, whether you are walking to work, eating lunch or talking to friends. Be aware of the world around you and what you are feeling. Reflecting on your experiences will help you appreciate what matters to you.

Keep learning...
Try something new. Rediscover an old interest. Sign up for that course. Take on a different responsibility at work. Fix a bike. Learn to play an instrument or how to cook your favourite food. Set a challenge you will enjoy achieving. Learning new things will make you more confident as well as being fun.

Give...
Do something nice for a friend, or a stranger. Thank someone. Smile. Volunteer your time. Join a community group. Look out, as well as in. Seeing yourself, and your happiness, linked to the wider community can be incredibly rewarding and creates connections with the people around you.

Source: New Economics Foundation Five Ways to Wellbeing, 2008
http://www.neweconomics.org/publications/entry/five-ways-to-well-being-the-evidence
For individuals, understanding what impacts on mental wellbeing, how to develop resilience and what positive steps to take will bring benefit. The MIND booklet on how to improve and maintain your mental wellbeing is another resource recommended to individuals and professionals as a straightforward approach to improving wellbeing25.

The recommendations in the recent Mental Health Scrutiny Review undertaken by the Council’s Health and Adult Services Select Committee, although focusing on the impact of austerity and welfare reform on local people, fits well with approaches to community action to promote wellbeing. In addition, many of the programmes funded through the Public Health Grant contribute to mental wellbeing through providing opportunities for people to connect and to access facilities such as leisure services. Promotion of mental wellbeing and prevention of mental illness is integral to all policies implemented by the Council and our partners. Impact assessment on mental wellbeing should be explicitly addressed when developing and implementing policy and actions. In particular, antenatal, early years and education professionals have a critical role to promote mental wellbeing and identify signs of mental illness in families and children.

For those with mental illness, awareness training for both staff and the public can help individuals, their friends and family, and the professionals with whom they interact, to recognise when professional help is needed. The Mental Health First Aid Programme, funded through the Public Health Grant, is an example of such a programme. Mental health care services, for both the common and the less common mental disorders need to be accessible and of high quality. The priorities detailed in the Closing the Gap publication are a good starting point for assessing the critical aspects that mental health care services commissioned for local people should achieve.

25 http://www.mind.org.uk/information-support/tips-for-everyday-living/wellbeing/#.UozMJ_kjQc
Healthier

Barking and Dagenham

Establishing Barking and Dagenham as a place where healthy lifestyles are easy to adopt
The Health Impact Pyramid

The transfer of responsibility for public health from the former Barking and Dagenham Primary Care Trust to the London Borough of Barking and Dagenham provided an opportunity to reconsider the conceptual framework within which the Council and its partners work together to protect and improve the health of local people.

Frieden’s Health Impact Pyramid\(^1\) provides a model which usefully integrates the contributions that all partners can make with recognition of the interface between population and individual action. The pyramid describes five levels where action can be taken, which cross the spectrum from the effect on the individual to that on the population and from action by the individual to action by Government.

Socioeconomic factors include those actions that address the familiar social determinants of health – defined by the World Health Organisation as the conditions in which people are born, grow, live, work and age. Both council services and council influence are critical to ensuring that residents benefit from a good education, homes that are free of health and safety hazards and an environment that is both safe and promotes healthy living.

Addressing socioeconomic factors is well recognised particularly since the publication of Sir Michael Marmot’s review into health inequalities in England, Fair Society Healthy Lives\(^2\), in 2010. Less well developed is our thinking about what we can do to change the environmental context to make healthy choices the default choices. These choices should not depend on income or education but be open to everyone, easy to choose (or be subject to penalties if ignored) and hard not to benefit from. Restricting smoking and alcohol consumption in public places are examples of changing the environmental context, as are building designs.

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1. [http://www.idph.state.ia.us/adper/common/pdf/healthy_iowans/health_pyramid.pdf](http://www.idph.state.ia.us/adper/common/pdf/healthy_iowans/health_pyramid.pdf)
that make stairs easier to use than lifts, and restricting sales of high sugar or high alcohol drinks. This approach adds to that explored by Thaler and Sunstein in their book Nudge: Improving decisions about health, wealth and happiness, first published in America in 2008. Their concept of nudge focuses on non-forced compliance without forbidding any options. Thus they use the example of putting fruit at eye level in a school cafeteria where it is easy to reach, as opposed to banning junk food. Of course supermarkets have used this concept for many years by putting sweets by the cash tills, an example of encouraging unhealthy eating by making unhealthy choices the easy choices.

Long lasting protective interventions include screening and immunisation. The approach to these is based on specific populations, for example children from birth to five years old, but the intervention is delivered to each individual. As the individuals who receive these interventions are normally healthy, or perceive themselves to be healthy, at the time of participation in the programme there needs to be a clear demonstration to the individual that the effort required to participate is justified and participation should be made as easy as possible.

Clinical interventions obviously cover the care needed by those with disabilities and diseases where intervention should be focused on reducing disability and prolonging life. The greatest potential population health impact is prevention and management of cardiovascular disease. The actual impact depends both on access to effective care and to diligent uptake of the recommended interventions, such as stopping smoking and drugs to reduce high blood pressure.

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Information and psychological based interventions such as education and counselling may be seen as the cornerstone of health improvement but are of limited impact unless applied consistently and repeatedly, and supported by actions at other levels of the pyramid. The public health approach needs to bring together the epidemiological evidence that quantifies the level of morbidity and premature mortality in the community (as set out in the Joint Strategic Needs Assessment) with strategies that support and reinforce healthy behaviours and lifestyles and interventions at community and individual level and effective delivery of programmes of care that build consistently through each level of the pyramid for maximum impact.

4 I’ll have what she’s having, Alex Bentley, Mark Earls and Michael J. O’Brien, Massachusetts Institute of Technology, 2011 http://www.amazon.co.uk/Ill-Have-What-Shes-Having/dp/026201615X
No matter what population level interventions we put in place, each individual has to actually change their behaviour if their health and wellbeing is limited by aspects of their lifestyle. The fundamentals of how we live our lives - what we eat and drink, how much we exercise, and how we connect with each other and wider society form the basic building blocks of our health and happiness. The approach to behavioural change explored in I’ll have what she’s having is based on improving our understanding about why people behave as they do and how to use that knowledge to increase the chances of the behaviour changes we want to see. The title is taken from the phrase used in the 1989 film When Harry met Sally, and highlights how social learning – copying from people around us – shapes human behaviour. In recognising that our decisions are generally not rational or necessarily in our best interests the authors describe how the availability of knowledge about how others behave through social connectedness influences ideas, behaviours and social practices at a scale never previously possible.

Starting from the position that man is a social animal, making decisions which draw on the customs and rules of the people with whom we regularly interact, the authors demonstrate the extent to which humans copy others, whether that be the majority, friends and family, or those people who are admired. Copying can be random, and is certainly not directed at copying those strategies which might be deemed to be best for us, for example those that improve our health and wellbeing. But if we work on the basis that copying or imitating is key to spread or adoption of new behaviours, we need also to stimulate the right kind of individual learning that initiates the change that others copy and that we wish populations to adopt. Whether the thing is better is less important than who else is doing it, and the copying behaviour maybe subconscious. Copying something that is popular and successful reduces the risk of standing out from the crowd, and stimulating copying is the basis for some approaches to attempts to influence health behaviours, for example encouraging participation in sports alongside the 2012 Olympic Games.

In applying this approach to our public health programmes that aim to encourage healthy choices, we can learn from examples of marketing successes outside the world of health improvement and how ideas spread and evolve amongst people. Rational choice is more likely when there are few similar options and few people making the choice. As the number of similar options increases the choice becomes more of a random guess – given a choice of ten products at a similar price and with similar benefits there is little to direct the choice other than guess work.

But working at population level, the interaction between individuals making the choice becomes more important, and copying the choice which appears to be the most successful is more likely. In this circumstance, the influence of prestigious individuals can be important, and suggests that giving high profile to the preferred choice, for example through local leaders, can help adoption of the preferred choice. However when there is no distinction between the choices and little discernable advantage in any specific choice, popularity may only be sustained by things such as brand loyalty.

One of the challenges for public health programmes is to demonstrate the distinctive benefits of adopting a healthy lifestyle, which needs to be immediate as well as long term. Historically public health has tended to be seen as achieving benefits in the long term, and this applies both to policies and targets as well as to the effect on individuals. A lifestyle change promoted as an approach to increasing life expectancy is unlikely to grip the imagination of either councillors who will need to approve the investment or individuals who will need to adopt the lifestyle change.
For most people, the benefits need to outweigh the costs and effort in the short term if they are to be attracted to making the change. In addition the change needs to be attractive and well promoted and people need to see that the behaviour or change is becoming increasingly normal – that is that it is being copied by large numbers of people.

Behavioural science is a developing field which helps us to understand how people make decisions and how relationships and networks interact in a social system. The vast expansion of networking possibilities in recent years with the development of social media has added impetus to our natural curiosity to better understand the human brain, how decisions are made and how our decisions impact on others. As we continue our search to encourage people to make the healthier choices out of the many choices available to them we need to ensure that new knowledge influences the design and implementation of our programmes and investments that support people’s lifestyle choices.

Electronic or ‘E’ cigarettes are fast becoming a major public health controversy. The arguments rage on a number of fronts - Are e-cigarettes good because they are less damaging to health than conventional cigarettes or are they bad because they risk renormalising and glamorising smoking? Are they a long term alternative to conventional cigarettes or are they a form of nicotine replacement therapy to aid quitting smoking? Do they encourage people, especially young people, to become nicotine addicted who would not have started conventional cigarette smoking? Are they a consumer product or a drug? Are we trying to limit and control people’s right to choose a safer way of taking nicotine, and why is nicotine so controversial when alcohol and caffeine are freely available?

Smoking is the largest preventable cause of avoidable mortality in the UK. In Barking and Dagenham it is estimated that 23% of people smoke and around 100 residents die every year from diseases associated with smoking, with 5% of the NHS budget spent on smoking related healthcare. If the aim of public health policy is to reduce harm from smoking, e-cigarettes could make a significant contribution. Although like every other aspect of the e-cigarette debate there is great controversy over the health related impact, with little evidence at this stage of the safety or risks from this method of nicotine delivery, it is clear that the major impact from conventional cigarette smoking on health is from the tars and other chemicals in the smoke, rather than in the nicotine itself. E-cigarettes
appear to be comparable in safety to other nicotine replacement products. Arguably, the discomfort with e-cigarettes is based on them being designed to look and feel like cigarettes. They include a cartridge that holds a liquid, usually containing nicotine, which is vaporised when the user sucks on the device.

The e-cigarette debate goes right to the heart of the conflicting purpose and intention behind legislation and other actions to reduce tobacco smoking. Smokefree legislation, introduced to protect the public from the proven harm resulting from inhalation of second hand smoke, is widely seen as a contributor to reducing the social acceptability of smoking and the number of people who smoke. For many, this latter effect has become the prime purpose. Opposition to e-cigarettes focuses on the re-introduction of ‘smoking’ – technically ‘vaping’ as users of e-cigarettes inhale a vapour, as a lifestyle, that the marketing of e-cigarettes undermines tobacco control policies, and that the increasing involvement of the tobacco industry with the resources to submit products for licensing is likely to change the current position on what licensed products are available.

E-cigarettes are a highly topical and fast moving aspect of public health, and are likely to be the source of many arguments. Discussion continues on the European position with restriction of the concentration of nicotine now being debated. A recent debate (17 December 2013) in the House of Lords outlined many of the current concerns and the Government’s position in the developing field. Product licensing, advertising and sales to children were amongst the issues covered in the debate. While controls are undoubtedly necessary, there is no doubt that e-cigarettes are less harmful than smoking tobacco, and that restricting availability and over-regulation will discourage or forbid smokers from moving to safer forms of nicotine delivery and avoid the potential for reductions in illness and early death that a safer form of nicotine delivery can offer.

The Children and Families Bill is currently being amended to include a ban on children under 18 purchasing e-cigarettes, as well as making it illegal for adults to buy traditional cigarettes for anyone under 18. We can expect sales, licensing and advertising all to be addressed over the coming months.

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5 http://www.bmj.com/content/348/bmj.f7686.pdf\#full-text
6 http://www.palgrave-journals.com/jphp/journal/v32/n1/full/jphp201041a.html
7 http://www.bmj.com/highwire/filestream/678668/field_highwire_article_pdf/0/bmj.f7473.full.pdf
9 http://www.mhra.gov.uk/NewsCentre/PressReleases/CON286855
10 http://www.publications.parliament.uk/pa/id201314/dhansrd/text/131217-10001.htm
Obesity is a major public health challenge and one which is a high priority for us in Barking and Dagenham, as agreed by the Health and Wellbeing Board. More local people are overweight and obese than the average level for England, and people eat less healthily and are less physically active than average in England. These high levels of obesity start in childhood; data from the National Child Measurement Programme shows that only 57.9% of local children in Year 6 (age 10-11) are of healthy weigh and one out of every four children of this age is obese. In adults the estimated prevalence of obesity is 28.7%.

Only 15% of residents take part in the recommended 5 sessions of physical activity lasting 30 minutes every week, and 40% do not do even one single 30 minute activity a week. Evidence is increasing about the harm resulting from the amount of sugar that we eat. The World Health Organisation is reported to be considering halving the recommended maximum amount of sugar in our diet, from 10% to 5% of daily calories. Any official encouragement to reduce sugar in our diets is likely to be strongly resisted by the food industry, with sugar being widely present in processed foods under more than 50 different names. Even at the currently recommended maximum intake of 10% of daily calories the amount of sugar in a can of regular Coke (35 grams or 9 teaspoons) is half of the recommended maximum for men and more than half for women. Guidelines published by the American Heart Association advise that added sugars should be limited to 9 teaspoons a day for men and 6 for women. Sugar improves mood by stimulating the release of the hormone Serotonin, but this is followed by a sugar ‘crash’ which results in craving more sugar. Too much sugar in the bloodstream results in production of insulin to help store the excess sugar (glucose) as fat. With continuing high sugar intake the cells in the body become less responsive to insulin and higher levels need to be produced. Eventually Type 2 diabetes develops when the ability of the cells to respond to insulin has virtually stopped.

Sugar intake is another example of a high profile and fast moving debate. January is a time for post-Christmas diets and New Year resolutions, and in January 2014 the media devoted a considerable number of column inches to discussing how much sugar we eat. The Prime Minister responded in Parliament to a question about the Action on Sugar campaign to reduce the sugar content of food and drinks and commented on the importance of addressing obesity and Type 2 diabetes. Valence Primary School in Dagenham hit the headlines with its decision to only allow water to be drunk in school, and not fruit juices or squash, as part of its Healthy Schools application and to re-enforce the benefits of eating and drinking healthily. In addition, NICE have published new recommended thresholds for BMI (body mass index) for adults from black, Asian and other ethnic groups that are lower than those for white European adults (increased risk of chronic conditions at BMI of 23 kg/m² or more and high risk of chronic conditions at BMI of 27.5 kg/m² or more, compared with 25 and 30 for white European adults). Obesity and sugar intake is surely going to continue to be in the headlines, and the Council and our partners need to continue to address obesity as one of our highest priorities to improve local people’s health.
Barking and Dagenham
as a place where healthy lifestyles are easy to adopt

While e-cigarettes and dietary sugar illustrate current controversies in public health the principles of healthy living are well established, as is the value of creating the context for healthy living through an integrated approach built on a consistent set of values that re-enforce those principles.

Strong and visible actions should make it obvious to residents that Barking and Dagenham is:

A place that supports and promotes active lives providing opportunities for increased walking, cycling, active play and active leisure and reduced sedentary behaviour.

A place that makes the healthier eating and drinking choice the easier choice where breastfeeding and healthy weaning are supported, fruit, vegetables and foods and drinks high in fibre and low in fat, sugar and salt are easily available, where appropriate portion sizes are understood and available and where less healthy foods and drinks are less commonly chosen.

A place for healthy organisations to support active lives, healthier food choices and physical and mental wellbeing with nurseries, children’s centres, schools, colleges, leisure centres, workplaces educating and promoting healthy living.

Local leadership can play a key role in changing the cultures and normal behaviours in an area. The out-going Mayor of New York City, Michael Bloomberg, has taken political leadership to a new level with the breadth of the Take Care New York policy, which is credited with increasing life expectancy, reducing infant mortality and lifestyle improvements such as reducing the number of adults who are not physically active and reducing those consuming one or more sugar-sweetened drinks per day. Although local legislation to cap the size container that sweetened drinks could be sold in was declared illegal on appeal, the sugar content of these drinks and the level of obesity in the city was well publicised by the legal process. Successful actions in New York include the extension of the Smoke Free Air Act to include smoking in parks, beaches and pedestrian plazas, mobile Green Carts to increase the availability of fresh produce and leading the National Salt Reduction Initiative.

Closer to home, colleagues in Ipswich have reported success with their Reducing the Strength initiative, whereby a voluntary agreement with retailers not to sell alcoholic drinks with a strength of more than 6.5% alcohol by volume has resulted in a reduction by half in alcohol related street incidents

While these examples of high profile leadership by councils and their partners catch the headlines,

20 http://www.ipswichstar.co.uk/news/ipswich_trailblazing_bid_to_banish_super_strength_alcohol_lauded_as_success_1_2809210
21 http://www.bbc.co.uk/news/uk-england-suffolk-24274991
the everyday actions of council departments significantly impact on people’s health and opportunities need to be taken to enhance the health improvement aspect of all the Council’s work. ‘The Health of the People is the Highest Law’ is the English translation of the phrase first stated by Cicero in the first century BC and put by Southwark Council above the entrance to the new Walworth Clinic in 1937. The trail blazing opportunities taken by ambitious councils in the early 20th century to improve the health of their residents may not take quite the same form today but meaningful opportunities both for Council action and Council leadership remain.

Amongst the opportunities that the Council have to contribute to people’s health, actions relating to housing, transport and green spaces are important. In November 2013 the Greater London Authority (GLA) published a series of borough specific guides highlighting how positive changes to the environment support better health. The seven environmental factors that are considered are: green spaces, active travel and transport, surface water flood risk, air quality, healthy food, fuel poverty and overheating. The guides include local data from the Public Health Outcomes Framework and connect the environmental factors to the Outcomes Indicators which will be directly affected by improvement or worsening of the indicator.

The guide for Barking and Dagenham highlights that, although the borough has some excellent district parks, a substantial proportion of the population of the borough live further away than the recommended distance (400 metres) from a local, small or pocket park (see figure). Both access and use are important, and we know that only 45% of local people participate in physical activity for 30 minutes once a week, and only 15% for the recommended 5 times a week.

Figure 3.2
Pocket Park Areas of Deficiency
London Borough of Barking and Dagenham

Public Open Space
Other Open Space
Areas of deficiency in access to Local, Small and Pocket Parks

Public Open Spaces are categorised according to a site hierarchy documented in The London Plan. This draft dataset of designations was sourced from published borough documents, and by liaising with some borough officers. It is a dynamic dataset and will be updated on an ongoing basis. The London Plan sets out a maximum desirable distance which London residents should travel in order to access public open spaces. For Local, Small and Pocket Parks this is 400m or less. Areas of deficiency are mapped based on actual walking distances along roads and paths from modelled open space access points.


Produced by Greenspace Information for Greater London
www.gigl.org.uk
On active travel and transport, the guide reminds us that low numbers of residents participate in active travel, with the percentage of people cycling to work below the London average and the percentage of motor vehicle use 7% above the London average. Motor vehicle use also impacts on air quality, with particular problems along the A13. The Council has acknowledged that the air quality in many parts of the borough falls below the standards set by Government, and has declared the whole borough an Air Quality Management area for nitrogen dioxide and particulates. Air pollution can be a factor in deaths from which Barking and Dagenham have some of the highest rates in London, including ischaemic heart disease, cancer of the lung, and chronic lower respiratory disease. The London Travel Demand Survey shows that on journeys taken by the average Londoner just 12.6 minutes per day is spent walking and the average trip length is just 400 metres. Apart from road safety, condition of the pavements is a primary concern for pedestrians.

Healthy food is certainly a challenge for local people. Affordable food of the right nutritional value needs to be readily available, while unhealthy food tends to be cheap and easy to buy. In Barking and Dagenham it is estimated that only 25% of adults eat healthily, defined as people eating five or more portions of fruit and vegetables a day. Modelled data shows that the variation of the borough, with parts of Heath, Albion, Parsloes and Mayesbrook having particularly low consumption.

A community food provision project is currently taking place in Barking and Dagenham. This involves fruit and vegetable produce being sold from a mobile food store. The price of this produce is approximately 60% cheaper than local supermarkets. The initiative was originally taking place on one site in the borough and has now been extended to two other sites. The three sites are: outside Leys Children’s Centre, on the Scrattons Farm Estate and outside George Carey Church of England School on Barking Riverside. These three sites were identified as being areas where there is poor access to fresh fruit and vegetable produce.

The Public Health Grant has provided us with the opportunity to invest or to continue investment in some programmes which actively address health and wellbeing needs and increase the opportunities that people have. The Health and Wellbeing Board have agreed commissioning priorities that address people’s needs throughout their lives.
## Public Health Commissioning Priorities
and examples of programmes funded

<table>
<thead>
<tr>
<th>Commissioning Priority</th>
<th>Examples of programmes funded</th>
</tr>
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| 1. Transformation of health and social care | Leisure offer for people over the age of 65  
Active age centres  
Tenancy support |
| 2. Improving premature mortality, including smoking cessation and cancer screening | Smoking prevention and cessation support services  
Pulmonary Rehabilitation Services |
| 3. Tackling obesity and increasing physical activity | From Seed to Plate – schools based programme  
Weight Management services for children 0-19 and adults  
Young people’s activity programmes  
Youth Access Card  
Cycle Clubs  
Exercise on Referral |
| 4. Improving sexual and reproductive health | Sexual health services including contraception and sexually transmitted diseases  
Chlamydia Screening  
HIV prevention  
Teenage pregnancy and youth services |
| 5. Improving child health and early years | Family Nurse Partnership and Baby Family Intervention project  
Breast feeding and early years nutrition  
School years prevention  
Healthy Child Programme age 5-19 |
| 6. Improving community safety | Youth offending boot camp  
Children’s Domestic Violence service  
Community Safety Partnership |
| 7. Alcohol and substance misuse | Drug and Alcohol Services  
Alcohol and Drug Prevention |
| 8. Improving mental health across the life course | Mental wellbeing for children and adults  
Mental Health First Aid |
| 9. Reducing injuries and accidents | Accident Prevention |
| 10. Mandated services | NHS Health Check programme  
Emergency Planning  
National Child Measurement Programme  
Public health support to NHS Barking and Dagenham Clinical Commissioning Group |
If we are to support our residents so that healthier choices are the easier choices we need to shift our thinking and resources to back them.

We need to work with local businesses on approaches that recognise their commercial pressures but curb the encouragement of things like super sizing and high sugar and high alcohol products. We need to ensure our local environment and buildings encourage everyday activities like walking as well as sports and leisure. As professionals, we need to walk the talk. We need also to challenge our commissioners and service providers to stimulate behaviour change through service design and delivery in care and ill-health services as well as health and wellbeing services, recognising that, for example, stopping smoking, healthy eating and appropriate exercise may be as important to recovery as diligent adherence to taking recommended medicines. Most importantly we need to work together as a partnership on simple messages that demonstrate our collective commitment to improving the health and wellbeing of local people.
Giving every child the best start in life is crucial for securing health and reducing health inequalities across the life course. The foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid in early childhood. What happens during these early years, starting in the womb, has lifelong effects on many aspects of health and wellbeing – from obesity, heart disease and mental health, to educational achievement and economic status.

Health for all children
the Healthy Child Programme

At the time of the 2011 Census, Barking and Dagenham had the highest proportion of children aged 0–4 of any local authority in England. The number of births each year is increasing (in 2012 there were 3,957 births compared with 3,688 in 2011) and the estimated population of under 5’s in 2014 (based on 2012 projections) will be over 20,000, with a further 11% increase by 2019. The health of our children is fundamental to meeting our responsibilities to improve the health of our population.

Active engagement with NHS England to ensure that the local programme meets the needs of Barking and Dagenham residents is essential to ensure that the programme is effective in improving the health of our children, reducing inequalities and improving life chances, and ensuring the right resources are transferred to maintain continuity and affordability.

The HCP offers every family a programme of screening tests, immunisations, developmental reviews and information and guidance that promotes future health and wellbeing. In so doing, it identifies and refers those families who need more intensive interventions and support to reduce inequalities in their children’s health, wellbeing and achievement.

Poverty is one of the biggest risk factors for children’s development, with children from poorer families less likely to be breastfed, more likely to be exposed to tobacco smoke and more likely to be injured at home and on the roads. The path to poor health and social outcomes starts before birth, with children in families with multiple risk factors such as debt, substance misuse, poor housing and domestic violence being more likely to experience development and behaviour problems, mental illness, substance misuse, teenage pregnancy, low educational attainment and offending behaviour.

1 http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review
Healthy Child Programme reviews:
- Review of child health and development
- Early identification of family strengths and any risks
- Parenting support
- Health promotion

Antenatal Care

- Antenatal Review
- New Baby
- 6 week check for mother
- 1 year Review
- 2 - 2½ year Review

Postnatal Care

- Antenatal Education / preparation for parenthood
- 4/5 years Primary School Entry
- 11/12 years School Transition Review
- 16 - 19 years Immunisation Status Review

- Formal health programme including dental health, keeping safe, nutrition, speech, language and communication, play
- National Child Measurement Programme - Measure height and weight at 4/5 and 11/12

HCP from Pregnancy to 5 years

- 0 - 12 weeks
- Birth
- 6 weeks
- 1 year
- 2½

HCP 5 - 19 years

- 4/5 years
- 11/12 years
- 16 - 19 years

- Immediate physical external examination after birth
- 72 hour Newborn Exam
- 5 - 8 day Bloodspot Screening
- 8 week immunisation
- 3, 4, 12 month immunisation
- 13 month immunisation
- Preschool Booster at 3yrs and 4mths

Detailed research has been undertaken to identify the factors that affect child outcomes. As an example, figure 4.2 shows the maternal factors that have been shown to be particularly influential when the child is 3 years old. Important factors influencing child outcomes include living in poverty and having parents who disagree about the upbringing of the child, as well as more obvious factors such as the child having a life-limiting illness and poor general health of the mother.

Figure 4.2

**Strength associations between maternal factors influencing at age 3 and outcomes for child development at age 5**

PREview strength of associations:
Maternal factors, age 3 years, and child outcomes, age 5 years.
PREview Planning Resources www.chimat.org.uk/preview

Source: http://www.chimat.org.uk/preview/midwives

PREview Planning Resources www.chimat.org.uk/preview/evidence
Delivering the Healthy Child Programme – the role of Health Visiting

Health visitors are the key professionals who lead delivery of the HCP. They are nurses or midwives with specialist training in family and community health and are therefore public health nurses who work at community, family and individual level.

Health visitors are envisaged as the leaders of child health locally

In 2011, the Government implemented a programme to expand and revitalise health visiting services to deliver the universal HCP and to lead health improvement through children’s centres, including healthy eating, accident prevention and emotional wellbeing. Health visitors are envisaged as the leaders of child health locally, fostering partnerships between GPs, midwives and children’s centres.

A recently published literature review shows the positive impact and value that health visitors can have, including helping mothers to feel more confident and to interact with their child in ways that help the child’s learning, development and behaviour. This research helps to identify how the organisation of health visiting services, as well as the individual skills, attributes and approach of the health visitor, affect child outcomes. Relationship formation, home visiting and a continuing process of needs assessment are collectively important to effective health visiting, impacting on aspects of child health such as breast feeding rates and uptake of immunisations. Health visitors understanding of family members and the family situation in the context of the universal service is used to identify when specific support is needed such as with postnatal depression, nutrition and obesity prevention and parenting support (Universal Plus services), as well as the health visiting contribution to vulnerable families and those with complex needs (Universal Partnership Plus services). The evidence suggests that health visiting services should be planned and organised as a single, holistic form of provision, centred around the universal service, and with the opportunity to form relationships, undertake home visits and work flexibly to meet parents perceived needs.

Figure 4.3
The Health Visiting Service and what it means for families

Your community has a range of services including some Sure Start services and the services families and communities provide for themselves. Health visitors work to develop these and make sure you know about them.

Universal services from your health visitor and team provide the Healthy Child Programme to ensure a healthy start for your children and family (for example immunisations, health and development checks), support for parents and access to a range of community services/resources.

Universal plus gives you a rapid response from your HV team when you need specific expert help, for example with postnatal depression, a sleepless baby, weaning or answering any concerns about parenting.

Universal partnership plus provides ongoing support from your HV team plus a range of local services working together and with you, to deal with more complex issues over a period of time. These include services from Sure Start Children’s Centres, other community services including charities and, where appropriate, the Family Nurse Partnership.


Health visitor numbers have been in decline nationally and the health visitor Implementation Plan is designed to increase the numbers of health visitors by around 50% by 2015. When implemented, the ratio of Health Visitors to children aged 0-4 years will be around 1:300, with higher ratios in areas of greater need, such as Barking and Dagenham. NHS England estimate that the numbers of health visitors needed locally is nearly double the number of posts in July 2011 (46.2 whole time equivalents in July 2011), aiming for 87.7 whole time equivalent health visitors in post by 2015, giving a ratio of 1:240 per children under the age of 5.

The opportunity to realise the potential benefits of an effective health visiting service which helps to deliver the child outcomes to which we aspire is dependent on three critical factors:

- Organisation and delivery of a service that is in line with the evidence for effectiveness, including home visits, relationship building and staff with the skills and attributes to support the families with whom they work.
- Sufficient numbers of trained health visitors to enable each to have a manageable caseload and a realistic chance of knowing each child and their family sufficiently well to provide necessary support.
- Sufficient resources invested by NHS England up to March 2015, and transferred to the Council from April 2015, to maintain service levels at the staff numbers that NHS England themselves have recommended as necessary to meet local need.

Without the health visitor workforce that is needed to implement in full the Health Visitor Implementation Plan, current resources are focused on new birth visits and complex issues such as safeguarding that fit into Universal Partnership Plus services. This means that the HCP is not currently implemented in full, and that only around 60-70% of 1 and 2 year old children are receiving the reviews that are important to identifying opportunities to promote and improve health and wellbeing. Ensuring a smooth transition of the commissioning of the health visiting service from NHS England to the Council when services for children aged 0-5 years are transferred in October 2015, supported by sufficient resources to fund the recommended number of posts, is a high priority for 2013/14.
Delivering the Healthy Child Programme – School Nursing

While the plan to expand and refocus health visiting services to support the Healthy Child Programme for children aged 0-5 years has had considerable publicity, far less attention has been paid to a similarly important need to ensure that the school nursing service is competent and sufficient to meet the needs of children aged 5-19.

The 5-19 Healthy Child Programme focuses on early intervention and prevention through a progressive universal model, which supports all children while identifying and meeting the needs of those most at risk, including safeguarding responsibilities and addressing health inequalities. It includes improving emotional health and wellbeing, promoting healthy weight (including delivery of the National Child Measurement Programme), advice and support for sexual health and drugs, alcohol and tobacco misuse, supporting children with longstanding illness and disability, immunisation programmes and signposting services.

The programme includes a detailed schedule of the universal and progressive care that should be provided to children.

In 2012 the Government published Getting it right for children, young people and families, which set out the vision to maximise the contribution of school nurses. The service model aligns to that developed for health visiting, with community, universal, universal plus and universal partnership plus services and safeguarding as a strong thread throughout. The school nurse is pivotal to the delivery of the Healthy Child Programme, their role includes health promotion, advice, signposting to other services, active treatment and procedures, education, support, protection, safeguarding and service coordination.

School nurses work in partnership with other agencies and as part of a wider multi-disciplinary team to support the health and wellbeing of school-aged children. They are expected to:

- lead, deliver and evaluate preventative services and universal public health programmes
- deliver evidence based approaches and cost effective programmes or interventions that contribute to children and young people’s health and wellbeing (reduction in childhood obesity, reduction in under 18 conception rates, reduction in prevalence of chlamydia and management of mental health disorders) coordinating services and referring to other agencies and expertise as needed
- support a seamless transition into school, from primary to secondary school and transition into adulthood
- manage the interaction between health and education so that the child or young person enjoys good health and wellbeing (including emotional health and wellbeing) therefore achieving optimal education
- lead the support for children and young people who have complex or additional needs including providing or coordinating support, education and training for families, carers and school staff
• identify children and young people in need of early help and where appropriate providing support to improve their life chances and prevent abuse and neglect (including working with children and young people at risk of becoming involved in gangs or youth violence)
• contribute as part of a multi-agency team, to the response for children, young people and families who have multiple problems.

The population of children and young people aged 5-19 years is predicted to increase by almost 20% between 2014 and 2021 (from an estimated 43,137 in 2014 to 51,610 in 2021), and therefore simply keeping pace with the population increase is unlikely to be achievable through efficiency approaches. An increase in investment is under discussion, recognising both the high level of need in our population as well as the increase in numbers of children.

School nurses carry out a critical public health role with school aged children. They are highly valued by children, education staff and parents and make a significant contribution to the lives and wellbeing of children and young people, supporting them to address health issues as well as providing universal services such as health reviews and immunisations.

The school nursing service will continue to have a key role in ensuring the health of our children and young people and contributing to our ambition that every child is valued, supported and challenged so that they develop the ambition, skills and resilience to succeed.
In addition to health visiting as a universal service with a focus on prevention and early intervention, more intensive support is needed for those families which are at high risk of poor outcomes or which are extremely costly to the public purse because of the high level of interventions needed. Two examples of local programmes are described below.

Family Nurse Partnership (FNP)\(^1\)\(^1\)

FNP is a programme for first time parents aged 19 and under, which starts early in pregnancy and continues until the child is 2 years old. It is a licensed programme developed in America and based on research that demonstrates the benefits to vulnerable young mothers and their children of a structured programme of home visits focusing on support and personal development with the aim of achieving positive outcomes including improved health and health behaviours in pregnancy, reduced child abuse and neglect, improved school readiness for the child and improved economic prospects for the mothers.

FNP is delivered in over 90 areas in England. In Summer 2013 the local programme involved 53 clients. Staff recruited to the programme undergo intensive training in the various programme elements, and the slow build up, both in staff recruitment and capability, as well as the progressive nature of enrolment to the programme and programme delivery, means that it is too early to see whether local outcomes can match those demonstrated by research. Currently the focus is on measures of enrolment and continuation in the programme, and on delivery of the prescribed content both in terms of numbers of home visits and the content of the developmental work undertaken during those visits. Responsibility for commissioning the programme will transfer from NHS England to the Council in April 2015.

The FNP is dependent on receiving referrals from midwives within a prescribed timescale. The recent difficulties and re-configuration of maternity services locally has meant that insufficient referrals are being made to the programme. Effort is now being made to increase awareness of the programme and improve referral rates.

FNP is a licensed programme and there are tensions between the need of the FNP to adhere to its strict fidelity goals whilst working in a holistic way with the family as a whole. To ensure that families which need support but do not meet the referral criteria for FNP we are introducing a complementary local programme, the Baby Family Intervention Project, and will watch closely the outcomes of both these programmes.

Troubled Families Programme\(^1\)\(^2\)

This programme was launched by the Government in 2011 and is an attempt to provide intensive support that enables troubled families to turn their lives around. For the purposes of the programme, the Government defines troubled families as households which:

- are involved with crime and anti-social behaviour
- have children not in school
- have an adult on out of work benefits
- are of high cost to the public purse.

Councils are encouraged to work with families in ways that evidence shows to be more effective, such as:

- joining up local services
- dealing with each family’s problems as a whole rather than responding to each problem, or person, separately
- appointing a single key worker to get to grips with the family’s problems and work intensively with them to change their lives for the better for the long term
- using a mix of methods that support families and challenge poor behaviour.
Locally, 538 families have been identified that meet the criteria for inclusion in the programme and the Council is working with 412 of those (at September 2013). Payment is made to the Council by the Government on the basis of results achieved, partly as an ‘attachment fee’ for starting to work with the family and partly for outcomes achieved, such as fewer school exclusions, reduced antisocial behaviour or take-up of continuous employment. Although the programme currently tends to engage with children of school age, the hope is that more families with younger children will be included in the future, thus maximising the cost benefits and harm reduction from early intervention.

There is an expectation that local authorities put in whole system reforms both to streamline and join up local services in order to provide better outcomes for families and reduce costs. This provides an opportunity to promote the more effective integration of services locally with a focus on early intervention which will secure better returns on investment.

In particular there is a need for all departments and agencies to work in a holistic way with families. A whole family approach is needed using an assessment of the needs of the family as a whole and a family action plan which is agreed by all agencies. In essence we need one family, one assessment, one action plan and one named worker for the family. In Barking and Dagenham it has been agreed that the family Common Assessment Framework (CAF) will be the tool used for assessing the needs of the family. However not all agencies have signed up to using this and there is a reluctance by partner agencies to take on the lead professional role.

Changing the culture of an organisation or adapting the way a service has previously been delivered is always challenging. This is particularly so in the present climate of austerity where services have genuine concerns about capacity. However integrated working results in better outcomes for children and families and is a more supportive way of working for professionals if they can free themselves from a silo mentality.

In addition, it is difficult to understand how the needs of children or young people can best be met without considering the needs of the family which invariably contain poverty, domestic violence, poor mental and physical health, smoking, drug and alcohol misuse.

The Troubled Families Programme must be seen as a borough wide virtual team with dedicated troubled family workers being just one resource to be deployed in securing outcomes and with all Council departments and partners actively contributing to the programme.

Assessing the needs of a family as a whole requires a cultural shift for services and agencies which are used to focusing on the needs of single individuals within a family with whom they are working. Developing a whole family approach will need to be developed through professional training and the commissioning of future services which makes the expectation explicit. Job descriptions and contracts will need to reflect this cultural shift.

http://fnp.nhs.uk/
https://www.gov.uk/government/policies/helping-troubled-families-turn-their-lives-around
Measuring progress

All commissioned programmes have key performance and outcome indicators which are monitored throughout the commissioning cycle. In addition, the Public Health Outcomes Framework\(^\text{13}\) and the NHS Outcomes Framework\(^\text{14}\) include a number of indicators relating to children, and a child health profile is published annually for the borough by the Child and Maternal Health Intelligence Network\(^\text{15}\). Together these amount to a large number of indicators and we have been exploring whether we can identify a simple list of ten of these indicators which will give us a good picture of the health and wellbeing of local children and the actions taken by the Council and our partners to improve this. These measures should be ones that are readily measurable and have a chance to move in the right direction if effective interventions are in place. Inevitably, homing in a shortlist means that some important indicators will become part of a larger, second line set, but a shortlist of ten makes it easier to have a clear grasp of the challenges we face and the improvements we are achieving. I have also focused on indicators that are more likely to be included in the future Health Premium indicator set. The list below is for discussion and debate, which in itself will focus attention on the issues and ensure that our commitment to improving the outcomes for children and young people is realised.

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13 http://www.phoutcomes.info/
Proposed ten high level indicator set:

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Barking and Dagenham data</th>
<th>Rationale</th>
<th>Definition</th>
<th>Date and source of data</th>
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<tbody>
<tr>
<td>Children in Poverty</td>
<td>33.9% of children under the age of 16</td>
<td>Childhood poverty leads to premature mortality and poor health outcomes for adults, as well as impacting on children’s aspirations and attainment.</td>
<td>Proportion of children living in families in receipt of out of work benefits or in receipt of tax credits where their reported income is less than 60 per cent median income.</td>
<td>2011 <a href="http://www.hmrc.gov.uk/statistics/child-poverty-stats.htm">http://www.hmrc.gov.uk/statistics/child-poverty-stats.htm</a></td>
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<tr>
<td>Under 18 Conception Rate</td>
<td>46.3 per 1000 females aged 15-17</td>
<td>Most teenage pregnancies are unplanned and around half end in abortion. Teenage pregnancies are associated with worse outcomes for young parents and their children.</td>
<td>Conceptions in women aged under 18 per 1000 females aged 15-17.</td>
<td>2011 <a href="http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-294336">http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-294336</a></td>
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<tr>
<td>Breast feeding prevalence at 6-8 weeks</td>
<td>54.8% of babies totally or partially breast fed</td>
<td>There is evidence that breastfed babies experience lower levels of infection and of obesity.</td>
<td>Percentage of infants that are totally or partially breastfed at age 6-8 weeks, of the total number due a 6-8 week check.</td>
<td>Quarter 3 2012/13 <a href="http://webarchive.nationalarchives.gov.uk/20130402145952/http://transparency.dh.gov.uk/2012/11/29/breastfeeding-data-download/">http://webarchive.nationalarchives.gov.uk/20130402145952/http://transparency.dh.gov.uk/2012/11/29/breastfeeding-data-download/</a></td>
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<td>Immunisation MMR second dose</td>
<td>89%</td>
<td>The combined DTaP/IPV/Hib is the first in a course of vaccines offered to babies to protect them against diphtheria, pertussis (whooping cough), tetanus, haemophilus influenzae type and polio.</td>
<td>Children who received 3 doses of DTaP/IPV/Hib vaccine at any time by their first birthday as a percentage of all children whose first birthday falls within the time period.</td>
<td>Quarter 2 2013/14 <a href="http://www.hpa.org.uk/webw/HPAweb&amp;HPAwebStandard/HPAweb_C/1211441442288">http://www.hpa.org.uk/webw/HPAweb&amp;HPAwebStandard/HPAweb_C/1211441442288</a></td>
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<tr>
<td>Immunisation DTaP/IPV/Hib at 12 months</td>
<td>85.4%</td>
<td>MMR is the combined vaccine that protects against measles, mumps and rubella. The first MMR vaccine is usually given within a month of their first birthday. A booster dose is given before starting school.</td>
<td>All children who received two doses of MMR on or after their first birthday and at any time up to their fifth birthday as a percentage of all children whose fifth birthday falls within the time period.</td>
<td>Quarter 2 2013/14 <a href="http://www.hpa.org.uk/webw/HPAweb&amp;HPAwebStandard/HPAweb_C/1211441442288">http://www.hpa.org.uk/webw/HPAweb&amp;HPAwebStandard/HPAweb_C/1211441442288</a></td>
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<td>Child obesity Age 4-5 years</td>
<td>25.9%</td>
<td>Overweight and obesity levels are high locally, with Barking and Dagenham having the fifth highest obesity rate in England. There is a risk of obesity persisting in adulthood and of future obesity related ill health.</td>
<td>Proportion of children aged 4-5 classified as overweight or obese. Children are classified as overweight (including obese) if their BMI is on or above the 85th centile of the British 1990 growth reference (UK90) according to age and sex.</td>
<td>2012/13 <a href="http://www.hscic.gov.uk/catalogue/PUB13115">http://www.hscic.gov.uk/catalogue/PUB13115</a></td>
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<td>Child obesity Age 10-11 years</td>
<td>40.2%</td>
<td>Studies tracking child obesity into adulthood have found that the probability of overweight and obese children becoming overweight or obese adults increases with age. At age 10-11 years Barking and Dagenham has the fifth highest obesity rate in England.</td>
<td>Proportion of children aged 10-11 classified as overweight or obese.</td>
<td>2012/13 <a href="http://www.hscic.gov.uk/catalogue/PUB13115">http://www.hscic.gov.uk/catalogue/PUB13115</a></td>
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<td>Children achieving a good level of development at age 5</td>
<td>46%</td>
<td>The development of children’s cognitive, behavioural, physical and emotional capabilities, ensures that children can take full advantage of the learning opportunities available to them in school. Although not included currently in the Public Health Outcomes Framework it brings together the contribution of partners and is the most feasible measurement of early years development.</td>
<td>Percentage of pupils achieving at least the expected level in the Early Learning Goal within the three prime areas of learning and within literacy and numeracy are classed as having “a good level of development”. In 2013 52% of pupils in England achieved a Good Level of Development.</td>
<td>2013 Early Years Foundation Stage Profile <a href="https://www.gov.uk/government/publications/early-years-foundation-stage-profile-results-2012-to-2013">https://www.gov.uk/government/publications/early-years-foundation-stage-profile-results-2012-to-2013</a></td>
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<td>1st time entrants to youth justice system</td>
<td>472</td>
<td>Mapping relevant risk factors associated with youth crime can help inform commissioning of evidence based early intervention, therefore maximising the life chances of vulnerable children and improving outcomes for them.</td>
<td>Rate of 10-17 year olds receiving their first reprimand, warning or conviction per 100,000 10-17 year old population.</td>
<td>2012/13 <a href="https://www.gov.uk/government/publications/criminal-justice-statistics-quarterly-march-2013">https://www.gov.uk/government/publications/criminal-justice-statistics-quarterly-march-2013</a></td>
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<tr>
<td>16-18 year olds not in Education, Employment or Training (NEETs)</td>
<td>5.4%</td>
<td>Young people who are not in education, employment or training are at greater risk of a range of negative outcomes, including poor health, depression or early parenthood.</td>
<td>The estimated number of 16-18 year olds not in education, employment or training divided by the total number of 16-18 year olds known to the local authority whose activity is either not in education, employment or training (NEET), or in education, employment or training (EET).</td>
<td>2012 <a href="http://www.education.gov.uk/childrenandyoungpeople/youngpeople/participation/neet/a0064101/16--to-18-year-olds-not-in-education,-employment-or-training">http://www.education.gov.uk/childrenandyoungpeople/youngpeople/participation/neet/a0064101/16--to-18-year-olds-not-in-education,-employment-or-training</a></td>
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