

50 Steps to a Healthier Newham

2025/26 Annual Report



Foreword

This second annual report of 50 Steps to a Healthier Newham 2024-2027 gives real cause for optimism. It shows what can be achieved when communities, services and partners work together with a shared commitment to making Newham a healthier and fairer place for everyone.

Over the past year, we have seen encouraging improvements across many key areas of health and wellbeing previously resistant to change. Nearly half of the public health outcomes we track have improved since 2019. People are living longer, premature deaths among men are falling, more babies are being breastfed and more children and young people are physically active. We have also seen improvements in smoking, loneliness, healthy weight and suicide, while inequalities in life expectancy have narrowed. These are important signs that, despite the pressures our residents face, Newham is moving in the right direction.

This progress reflects the strength of partnership working across the council, the NHS, our voluntary, community, faith and social enterprise organisations, schools and local communities. It also reflects our determination to put equity at the heart of what we do. Over the past year, more of our 50 Steps have turned what we know about health inequalities into practical action, focussing support on the communities that face the biggest barriers to good health.

We know, however, that the job is far from finished. Too many residents continue to experience poorer health because of circumstances beyond their control. Challenges including insecure housing, financial pressures and food insecurity remain, while there is more to do to improve areas such as children's oral health, cancer screening and immunisations. Our task is not only to improve health overall, but to make sure that progress is experienced consistently across Newham.

I want to thank everyone who has contributed to 50 Steps this year: our residents, community organisations, partners and dedicated frontline staff. The progress in this report gives us confidence that change is possible. As we enter the final year of this strategy, and start thinking about the strategy that will carry us into the future, we will build on that momentum, listen to our communities and continue working together towards a healthier, fairer Newham for everyone.

Councillor Susan Masters

Chair of the Newham Health and Wellbeing Board
Cabinet Lead for Health, Adult Social Care and
Environment, London Borough of Newham



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Introduction

This report provides an overview of progress in delivering 50 Steps to a Healthier Newham 2024-2027 during its second year, 2025/26. 50 Steps is the Newham Health and Wellbeing Board's collective plan to improve health and reduce health inequalities across the borough. It brings together Newham Council, the NHS, voluntary, community and faith sector organisations, schools, employers, and many other partners in a shared commitment to create a healthier, fairer Newham for everyone.

The report updates partners and stakeholders on a selection of indicators reflecting the breadth of 50 Steps:

- Public health outcomes in Newham and how these have changed over time;
- Key performance indicators for each of the 50 Steps;
- Progress towards the equity objective for each step.

The indicators represent a small proportion of the work that took place delivering the strategy in 2025/26. The report does not attempt to comprehensively describe this wealth of activity, which is led and reviewed in detail within our partnership forums and working groups that sit underneath the strategy.

We have much to be proud of. For example, breastfeeding has increased (56% of babies are now breastfed six to eight weeks after birth, compared to 39% two years ago) and smoking prevalence has continued to fall. The suicide rate in Newham has fallen in the last two years, and is below that in London and England. We have continued to grow the number of Healthy School Streets in the borough; we have increased the number of new or improved sports, leisure and play facilities; and we have worked to support residents around air quality, with the number of people using our online air quality resource having increased. With 717 organisations and community members now involved in the social movement programme, our engagement and partnership with local communities continues to grow.

At the same time, there is still more to do. Newham still lags behind London and England in some key public health indicators, such as eating '5-a-day', children's oral health and cancer screening. We will continue tailoring our approach to such issues, working with residents and partners to ensure services are high quality and work for local people. We also need sustained efforts to improve equity in services and provision for the most vulnerable groups. We can achieve this through building on what residents tell us and our learning from recent years, using the Newham Health Equity Programme tools and resources to guide continual improvement. On top of this, persistent challenges such as food insecurity, fuel poverty and homelessness continue to impact residents' health and disproportionately affect Newham. We will continue using our local levers to address these wider determinants of health as well as influencing and advocating at regional and national levels.

Together, we are committed to building on the foundations laid so far, working in partnership to deliver lasting improvements in health and wellbeing for all who live and work in Newham.

Public health outcomes

To understand how public health outcomes have changed in the borough since the 50 Steps work began in 2019, we have looked at the longer-term trend in key indicators. This helps us to review progress, understand where we are improving and target further action where it is needed.

The signs of progress are very positive; the 2025/26 update shows a marked improvement across many areas of health.

Compared to 2019, we have seen an improvement in nearly a half of our indicators (20 out of 46 show an improving trend) with 13 remaining unchanged and 13 having deteriorated. This indicates a substantial improvement in the overall direction of travel for the 50 Steps outcomes that we measure.

This year we have seen further reductions in the number of people smoking, more children and young people being physically active, an increase in the proportion of adults with a healthy weight and more babies being breastfed. There has also been a reduction in the suicide rate and the proportion of residents who often feel lonely.

These improvements will continue to have a strong positive benefit to health long term and remain a good sign of progress.

Key overall measures of health for males (life expectancy and premature mortality) have both improved, largely driven by improvements in cardiovascular mortality. Inequalities in these measures have fallen for both males and females which is a good sign of improvements in equity generally.

We have also continued to see improvements in good levels of development for children starting school, the uptake of bowel cancer screening, and emergency admissions for falls have improved further.

As per last year, a number of areas need particular focus, including oral health in children, uptake of breast and cervical cancer screening and immunisation, and prevention of infectious diseases, such as sexually transmitted infections, HIV and TB. Successful drug treatment, healthy weight and healthy eating also remain significant areas of priority.

We continue to work with communities to understand barriers to accessing and benefitting from services, as well as focussing on wider determinants of health that impact many health outcomes, such as employment and income, the food environment, housing and active travel.

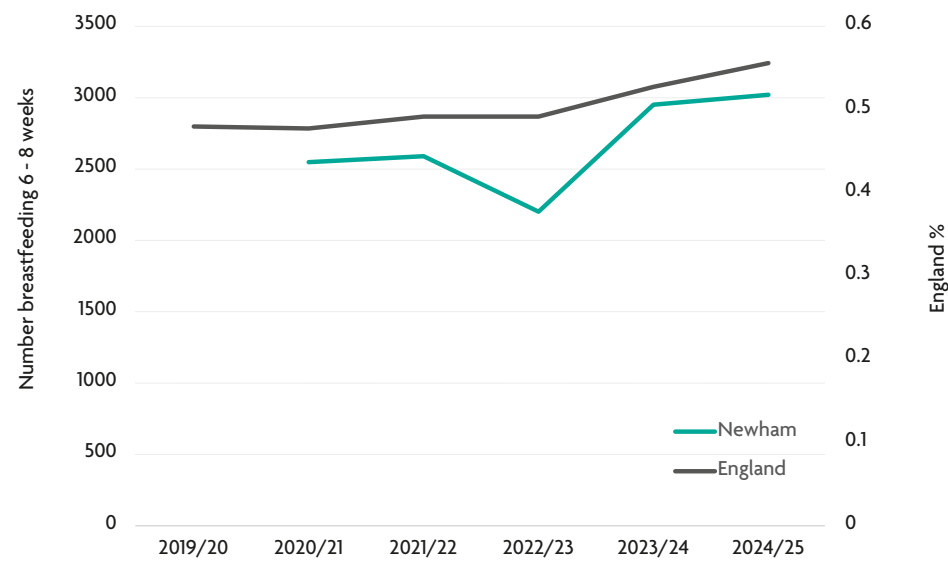
The appendix details the key public health outcomes monitored through the 50 Steps, including how we compare to London and change over time.

Trends

Infant feeding

Breastfeeding at 6-8 weeks in Newham has increased since 2022/23, in line with England. As of 2024/25 there are now over 3,000 infants breastfeeding at this milestone.

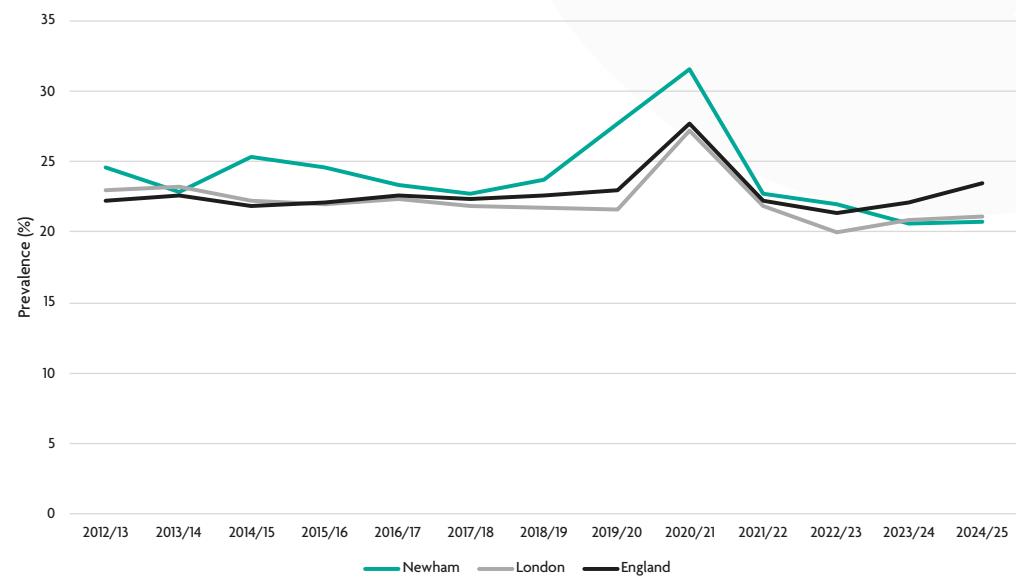
Figure 1: Number of breastfeeding 6-8 weeks



Child healthy weight (Reception age)

The proportion of four- to five-year-olds in Newham with overweight (including obesity) has fallen substantially since the 2020/21 pandemic peak and is now similar to the England average.

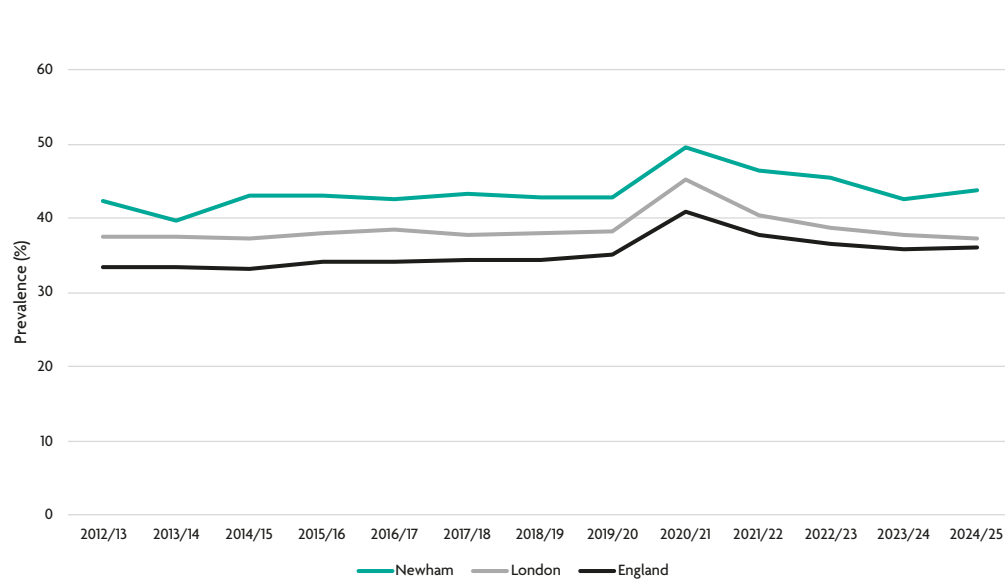
Figure 2: Prevalence of overweight among Reception age (4-5 years) children in Newham, London and England (2012-2025)



Child healthy weight (Year 6)

The proportion of Year 6 children in Newham with overweight (including obesity) has fallen slightly since the 2020/21 pandemic peak but is still higher than London and England.

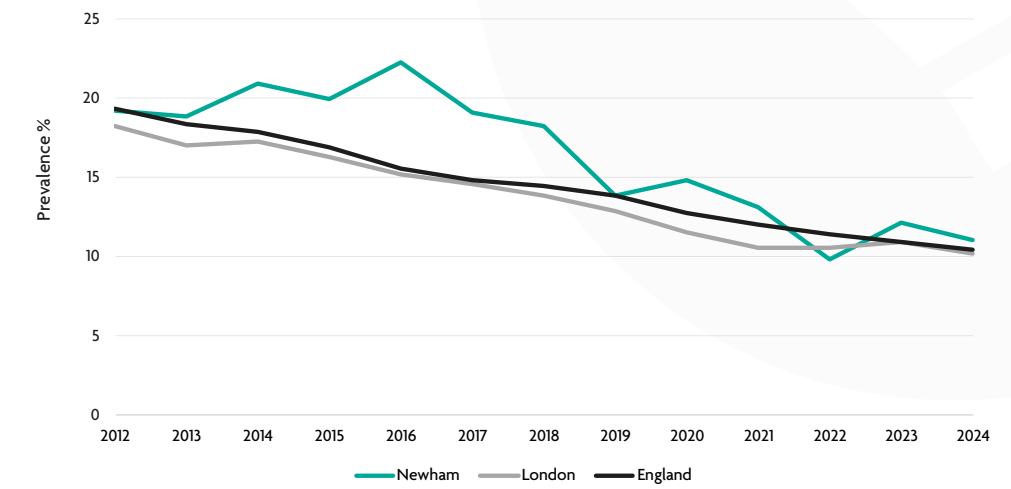
Figure 3: Prevalence of overweight among Year 6 age (10-11 years) children in Newham, London and England (2012-2025)



Smoking prevalence

Smoking prevalence in Newham has continued to fall in line with England and London. Since 2019, smoking prevalence has fallen from 14% to 11%.

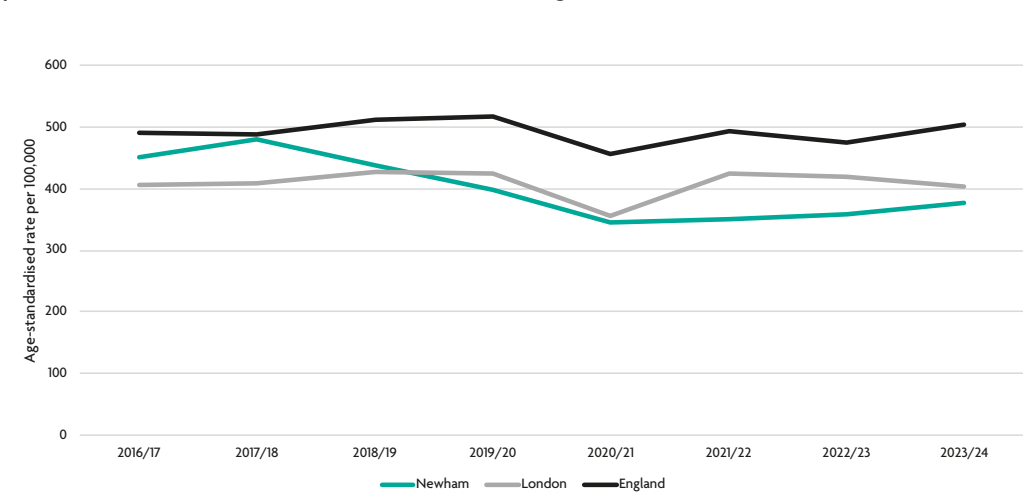
Figure 4: Smoking prevalence (among 18+) in Newham, London, England (2012-2014)



Alcohol-related hospital admissions

Hospital admissions from alcohol-related conditions fell during the pandemic. Unlike London and England, however, the admissions rate didn't recover to pre-pandemic levels and is now below the London and England average.

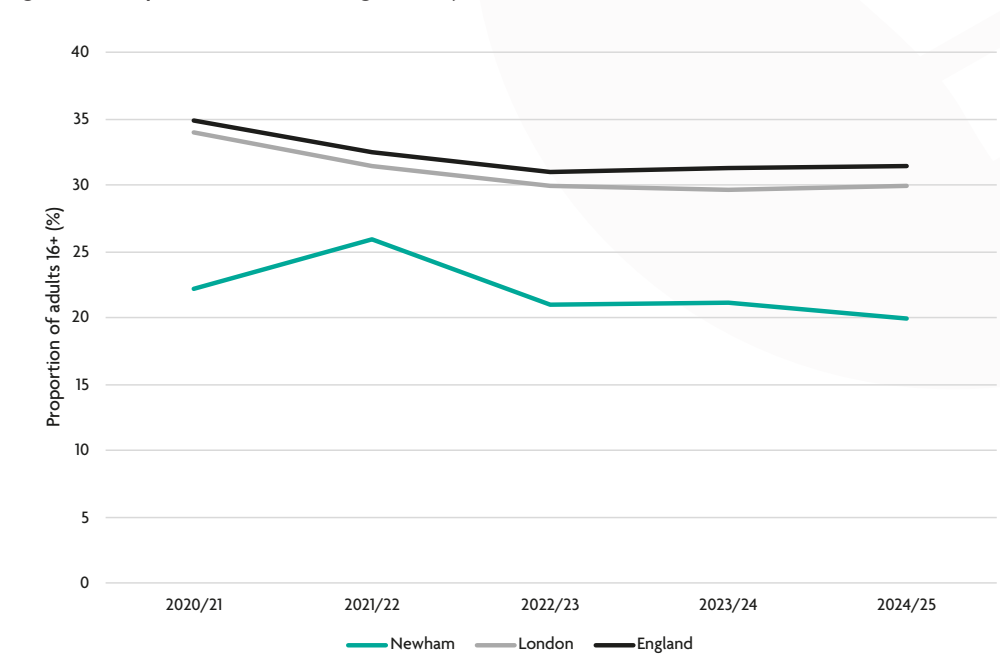
Figure 5: Rate of admission episodes for alcohol-related conditions (narrow)—all persons, 2016-2024 in Newham, London and England



Healthy eating

Newham lags behind both London and England in the share of adults eating five fruit or vegetables a day. It has seen a decline since 2021/22, from 1 in 4 to now only 1 in 5 meeting this target.

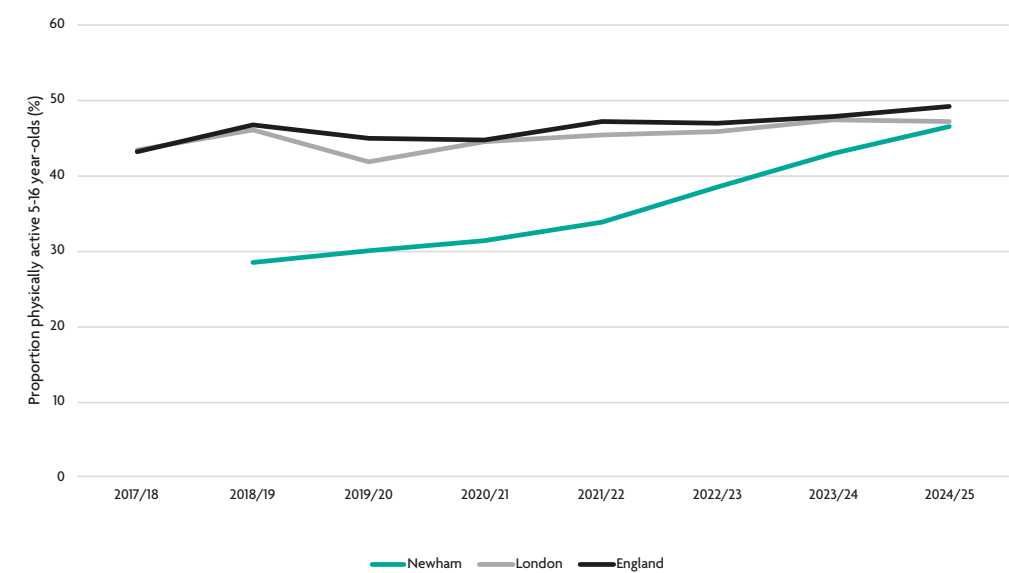
Figure 6: Proportion of meeting 5-a-day



Physical activity (5-16 year olds)

Physical activity among 5-16 year olds has increased significantly in Newham and is now similar to the London and England average.

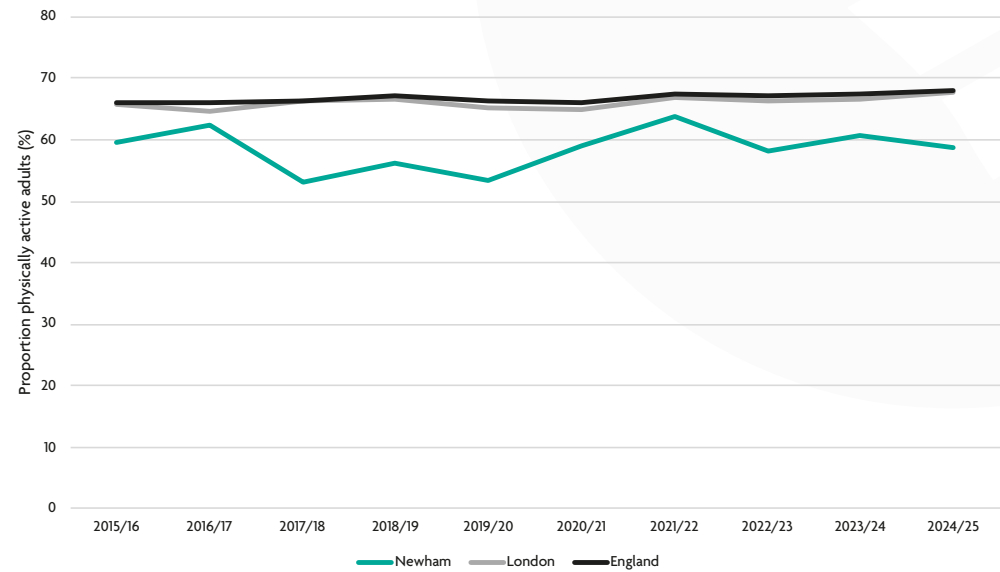
Figure 7: Proportion of physically active (at least 60 minutes per day) 5-16 year olds



Physical activity (adults)

Physical activity in adults has remained consistent around 60% and is slightly lower than both London and England.

Figure 8: Proportion of physically active adults



50 Steps equity objectives: 2025/26 update

Equity is a golden thread that runs through the 50 Steps strategy. Each step includes an equity objective, and in some cases, an indicator selected to address a known inequality or support fair access and outcomes across Newham's diverse communities.

Progress against the equity objectives is measured using the 'Four steps to improving equity' framework, developed by the Newham Health Equity Programme. The framework draws on established approaches including public health problem-solving, appreciative inquiry and quality improvement. It supports users to focus on a key area, understand the inequalities and develop, test and evaluate evidence-informed solutions.

Four steps to improving equity

 Understanding the picture as is	 Digging deeper into the root causes	 Considering the change idea	 Implement and evaluate
• Do service users reflect the local demographics/target population? • Are ONS20 ethnicity groups used for data collection? • Is there any variation in people's experience of the service? • Is there any variation in people's outcomes? Newham Equity Toolkit—use DILLN to benchmark service user data against Newham's population. Promote conversation and reflection within your team about what equity means, why it matters and your own positionality.	• What might be the causes of variation? • What more information might you need to make sense of the situation? • Is there a difference in your service and similar services locally/regionally? Newham Equity Toolkit—use the ART framework to review how accessible, relevant and trusted the service is by users. Conduct a literature review to understand any patterns/similarities/ good practice.	• What does 'good' look like, and how might you get there? • What else is happening in the system that may affect the outcome of your work? • How might you prioritise/decide what to do? Newham Equity Toolkit—review case studies and best practice. Co-produce change with residents and VCFS groups that represent the service users you want to reach, as identified by DILLN.	• Plan: measuring success • Do • Study/review • Act/modify The four stage are a cycle, when will you review this again? Newham Equity Toolkit—use the ART framework and DILLN to evaluate the changes you have made in your next service review.

Year	 Understanding the picture as is	 Digging deeper into the root causes	 Considering the change idea	 Implement and evaluate
Number of steps in each position, end of 2024/25	18	2	10	20
Number of steps in each position, end of 2025/26	5	6	7	32

2025/26 Progress at a glance

**41**
steps showed positive progress

**22**
steps moved to a later stage

**19**
steps progressed within the same stage

**64%**
are now at Implement & evaluate (32 out of 50 steps)

Most equity objectives have moved beyond identifying inequalities and are now delivering and testing solutions.

Key learnings

Learning so far shows that equity work is most effective when it is prioritised, supported with the right tools and expertise, and informed by good data.

1. Equity objectives create focus and momentum

Having a clear equity objective for each step has helped partners identify where inequalities exist and focus attention on what needs to change. Progress has been strongest where responsibility is clearly owned by individual steps or shared across partners. However, continued support is needed to keep equity prioritised alongside other delivery pressures.

The Newham Health Equity Team has played an important role in demystifying the work, developing tools and approaches, and helping partners move through the Four Steps framework. This shows the value of specialist support, while also highlighting that equity work needs sustained capacity, confidence-building and follow-through to become embedded as business as usual.

2. Targeted support helps partners move from intention to action

Case study: [Step 7](#)

Step 7 identified that Black boys were under-represented in mental health support services and over-represented in safeguarding and acute care pathways. In response, a targeted pilot was commissioned with two Black-led VCFSE organisations, AKNH Place and REIN, to support young people aged 13-18 at risk of poor mental health. Building on an earlier Health Inequalities-funded project, the service was co-designed with young Black men, mentors, psychologists and support workers. It combined preventative wellbeing activities with social and clinical support, while explicitly recognising and responding to the harms of racism. Participants reported improved wellbeing, greater trust and more positive experiences of accessing healthcare.

3. Good equity data enables targeted delivery – but gaps in data can block progress

Where good demographic and geographical data is available, partners have been able to identify gaps and adapt delivery. Where data is missing or inaccessible, progress has been slower because partners cannot confidently identify who is being missed or design targeted interventions.

Case study: [Step 44](#)

Step 44 used demographic and geographical data from PLINTH to assess representation in the social movement programme. The analysis identified a gap in participation from organisations in the southwest of the borough, prompting the recruitment of four additional organisations from that area.

Case study: [Step 20](#)

Step 20 has struggled to progress because reliable data on children who are not registered with a GP is not available, making it difficult to design targeted interventions.

This work will continue in 2026/27, with the Newham Health Equity Programme team continuing to support and encourage partners to make progress across all steps – moving from understanding inequalities to delivering and evaluating change.

Giving children and young people the best start in life



Step 1: Give babies and children under five the best start in life

KPI	Baseline value (date)	2024/2025 value (date)	2025/2026 value (date)
Proportion of mothers exclusively breastfeeding at 10-14 days	44% (2023/24)	42.24% (2024/25)	42% (2025/26)

Note:

This data is not directly comparable to the breastfeeding at 6-8 weeks indicator presented above because this indicator shows exclusive breastfeeding whilst breastfeeding at 6-8 weeks is defined as exclusive or partial breastfeeding.

Equity objective:

Improve equity in uptake of children's vitamins, looking specifically at minoritised ethnic groups.

2025/26 goal:

Take actions to address under-representation, including improving data collection and targeting engagement to communities with lower uptake.

2025/26 update:

In 2025/26, the transformation of the Healthy Start vitamins programme was completed. We implemented a simple, data-led model, increasing the number of distribution sites to more than 40 community sites, bringing Healthy Start vitamins, Vitamin D provision and Healthy Start Card promotion closer to residents. This reduced access barriers, minimised travel requirements and improved opportunities to reach underserved communities.

We completed a Healthy Start needs assessment, which identified several barriers to equitable access, including low awareness of the scheme, language barriers, digital exclusion, complex eligibility requirements and additional challenges faced by some families with no recourse to public funds. Analysis also identified variation in uptake between wards, where some areas, including Green Street East and Canning Town South, had lower uptake than expected, suggesting potential unmet need within these communities.

Targeted, data-led outreach demonstrated that these barriers can be addressed. In 2025, a Policy in Practice campaign contacted 1,263 Newham residents identified as likely to be eligible for Healthy Start, resulting in an additional 107 residents successfully claiming the benefit, a 4.5% increase in borough-wide uptake and generating more than £11,450 of additional financial support for families within the first year alone.

In 2026/27:

During Year 3, the focus will be on embedding a sustainable, high-quality distribution model that improves access and uptake among minoritised ethnic groups. The new programme model and IT system will enable targeted engagement, communications and distribution initiatives based on identified needs and population data. We will continue to work with partners to increase Healthy Start Card uptake, implement recommendations from the needs assessment, and use regular monitoring to evaluate impact, improve equity of access, and reduce inequalities in vitamin uptake by April 2027.

Case study

Well Newham Vitamins

Vitamin D is essential for healthy bones, teeth and muscles, yet deficiency is common among higher-risk groups, including older adults and families facing financial barriers. Providing free vitamins supports prevention and reduces inequalities. Promoting the Healthy Start card also enables low-income families to access healthy food and vitamins.

The Well Newham Vitamins programme provides a coordinated, borough-wide offer improving access to essential nutrition across the life course. This includes free vitamin D supplements for residents aged 60+, Healthy Start vitamins for pregnant women and children under five, and support to access and use the Healthy Start card. Vitamins are distributed through community locations such as libraries, pharmacies and places of worship, alongside information to promote healthy behaviours and maximise uptake.

“

Collecting Healthy Start vitamins every two months has been very easy, particularly as I do not have access to public funds. It has helped me feel more confident about my children's nutrition.”

Resident attending Newham Nurturing sessions

“

The Healthy Start vitamins have made a real difference. They are easy to access, and the staff at the children's centres are always friendly and supportive. The service also provides a valuable opportunity to stay informed about what's happening locally, especially when I'm not digitally connected.”

Resident attending children's centre

Step 2: Provide an efficient and effective Early Help offer, to give information, advice and support to families

KPI	Baseline value (date)	2024/2025 value (date)	2025/2026 value (date)
Proportion of infants who receive a face-to-face new birth visit by a health visitor within 14 days	93% (April 24)	95% (April 25)	97.5% (April 26)

Equity objective:

Increase uptake of Early Help services for families with additional needs.

2025/26 goal:

Complete Equity Data Analysis to understand the communities that are accessing Family Hubs and prevention services to inform future planning and budgetary decisions. Ensure services are accessible to marginalised groups and address any access barriers to support. Implement targeted inclusion initiatives to improve access.

2025/26 update:

Data analysis was undertaken using the DILLN (Does it Look Like Newham) tool to understand uptake across each Family Hub strand in comparison with Newham's population profile. Following this analysis, six listening sessions were conducted with 72 residents from communities with lower attendance rates, including Black African, Black Caribbean and Mixed Heritage, and White British families, fathers and male carers, maternity service users and families with No Recourse to Public Funds (NRPF). The sessions provided an opportunity for open discussion on the barriers to, and enablers of, accessing Best Start Family Hubs and prevention services. Although overall uptake of Best Start Family Hub services increased compared to 2024/25, patterns of low attendance from these groups persisted.

Insights from the listening sessions, alongside the DILLN analysis, were used by service leads to develop change ideas to improve the accessibility, relevance and trust of services. Several changes were implemented in response to feedback, including a dedicated 'Fun for Fathers and Male Carers' session at Shipman Best Start Family Hub.

In 2026/27:

The focus for Year 3 is to move from intervention design to implementation and evaluation. Family Hubs will implement interventions during autumn/winter 2026 and undertake evaluation activities to assess impact, identify learning and increase uptake of services for families with additional needs by 2027.

Step 3: Enhance the role played by schools, Youth Zones and other settings for children and young people in enabling good health and wellbeing

KPI	Baseline value (date)	2024/2025 value (date)	2025/2026 value (date)
Number of schools achieving Bronze, Silver and Gold Healthy Schools status	Bronze: 48 Silver: 11 Gold: 2 (April 24)	Bronze: 54 Silver: 21 Gold: 5 (April 25)	Bronze: 65 Silver: 26 Gold: 12 (April 26)

Equity objective:

Target our Healthy Schools programme to support schools in Newham’s more deprived areas so that they progress their achievements at least as quickly as schools in other areas of Newham.

2025/26 goal:

Equity mapping will inform targeted Healthy Schools work to schools with a higher proportion of children aged 0–15 living in income-deprived families, using the IDACI deciles.

2025/26 update:

Progress was made towards improving health equity within the Healthy Schools Programme through the development of a more data-driven approach to understanding school engagement and progression across Newham. A borough-wide mapping exercise of Newham schools was completed, analysing Healthy Schools accreditation status, programme engagement levels, IMD deprivation data and participation in health-related initiatives.

The analysis found no statistically significant relationship between Healthy Schools accreditation status and factors such as Free School Meal eligibility or average pupil IMD. This suggests that deprivation alone does not explain variations in accreditation across the borough and that other factors may be influencing engagement with the programme.

To better understand these factors, we reviewed the 39 schools that are not yet accredited in Newham through the Healthy Schools programme. We identified which of these fell within IMD quintiles 1 and 2 and defined them as priority schools.

In 2026/27:

Healthy Schools will target support towards the 22 priority schools in IMD quintiles 1 and 2 that are not currently accredited through the Healthy Schools London programme. We will work directly with these schools to understand and address barriers to participation, providing tailored advice, practical support and regular follow-up to help them progress towards accreditation.

By April 2027, we aim for at least six of these schools (25%) to achieve Healthy Schools London accreditation. This will increase participation among schools serving some of Newham’s most disadvantaged communities and help reduce inequalities in programme engagement and outcomes across the borough.

Step 4: Support children and young people to maintain good oral health

KPI	Baseline value (date)	2024/2025 value (date)	2025/2026 value (date)
Number of children who have engaged in supervised tooth brushing sessions	1,317 (2023)	432 (2024)	311 (2025)

Note:

The numbers fell in after 2024 as Dental Wellness Trust (a non-commissioned service) stepped back, which reduced provision. Although the funded Supervised Tooth Brushing programme launched in 2025, numbers of children engaged were lower than expected due to funding delays which impacted implementation. For 2026/27, the funding challenges have been resolved and we are increasing staffing capacity, which should increase the programme’s reach.

Equity objective:

Increase the geographical spread of where supervised tooth brushing sessions are run in the borough.

2025/26 goal:

Launch the national supervised tooth brushing programme, targeted to the most deprived parts of the borough.

2025/26 update:

Phase 1 of the Supervised Toothbrushing Programme was launched. Public Health coordinated the distribution of toothbrushing kits, provider-led training was completed for participating settings, and communications materials were developed to support engagement and encourage parental consent.

We began targeted work with parents and carers to raise awareness of the programme and increase uptake among families in communities experiencing the highest levels of oral health need.

In 2026/27:

Delivery will be targeted to approximately 100 schools, early years settings and childminders identified through the updated IMD 1 and 2 mapping, ensuring resources are focussed on children living in areas of greatest deprivation and highest oral health need. This targeted approach will support the programme’s core objective of reducing oral health inequalities through proportionate investment in communities at greatest risk of poor oral health outcomes.

A targeted communications campaign will be launched in autumn 2026, including parental engagement activities and support for early years settings and childminders. In addition, the introduction of easier consent processes will help reduce administrative barriers, improve parental consent rates and support more equitable participation across priority communities. Together, these measures are expected to increase programme uptake, strengthen sustainability and maximise the programme’s contribution to reducing oral health inequalities across the borough.

Case study

Supervised Tooth Brushing

Tooth decay is the most common oral health issue in young children and is largely preventable, yet disproportionately affects deprived communities. It can impact children's health, wellbeing and learning. Supervised tooth brushing supports early habit formation and reduces inequalities by embedding consistent oral health behaviours.

Newham launched the Supervised Tooth Brushing Programme following national funding, targeting children aged three to five in early years settings and primary schools. The programme delivers daily supervised tooth brushing (10–15 minutes) led by trained staff, supported by the Oral Health Promotion team. Settings receive training, equipment and resources, alongside take-home packs for families. The programme is funded nationally for three years to support long-term delivery.

As an example, MN had been struggling to brush his teeth at home. He would either eat the toothpaste or play with the toothbrush instead of brushing properly. After consistently taking part in the toothbrushing programme, he is now able to brush his teeth successfully and has stopped eating the toothpaste, as reported by his mother.



Child, AR, enjoying learning how to brush his teeth

Step 5: Support children and young people to achieve and maintain a healthy weight

KPI	Baseline value (date)	2024/2025 value (date)	2025/2026 value (date)
Percentage of children accessing the tier 2 weight management service who complete it	70% (2023/24)	93% (2024/25)	88% (2025/26)

Equity objective:

Ensure that children and young people accessing healthy weight services are representative of Newham's population.

2025/26 goal:

Efforts will focus on expanding outreach to schools in areas with predominantly White populations, such as West Silvertown and Beckton (White Other groups), as these groups are under-represented in the service. From September 2025, a targeted partnership with Newham's leisure provider, GLL, will be launched, involving collaboration with Healthy Schools across the borough to enhance engagement and impact.

2025/26 update:

Nutrition Kitchen is Newham's main healthy weight service for children and young people. Overall, there were slight improvements in representation in 2025/26 compared to 2024/25.

Children from Black African groups were equitably represented, whereas in 2024/25 they were under-represented: 13% of referred children were from Black African groups in 2025/26, up from 7% in 2024/25. Children from Bangladeshi groups continued to be equitably represented: they made up the largest proportion (26%) of Nutrition Kitchen services users but also formed a very similar proportion of overweight and obese children in Year 6.

Children from Pakistani groups continued to be over-represented, but this improved slightly compared to last year: they formed 11% of overweight and obese children but made up 13% of referred children in 2025/26 (down from 16% in 2024/25). Likewise, children from Indian groups continued to be the most over-represented, but this also slightly improved when compared to the year before: they formed 9% of overweight and obese children but made up 18% of referred children in 2025/26 (down from 22% in 2024/25).

Children from Other White groups remained the most under-represented in the service, accounting for 12% of overweight and obese children but only 6% in 2025/26. This was up from 5% in 2024/25, showing a slight improvement in representation.

In 2026/27:

Working with School Health Services, over the next year we will aim to increase referrals for children from under-represented groups, for example those from Other White groups.

Case study

Obesity and diet-related illness are high in Newham, especially in deprived communities, with rising food costs making things worse. Nutrition Kitchen tackles this head-on by giving residents practical skills to cook healthy, affordable food. By delivering practical, affordable cooking sessions in trusted, local community settings, it not only builds food skills but also creates welcoming spaces where residents connect with others, build confidence and feel part of their community.

Participation is high, with Nutrition Kitchen exceeding completion targets in consecutive years. In 2025/26, 315 adults completed the programme, with 52% achieving at least 3% weight loss. For children and young people, 92% of 367 completers maintained or reduced Body Mass Index (BMI) in 2025/26. Every participant increased fruit and vegetable intake. Nutrition Kitchen also trains more than 50 Healthy Cooking Champions each year and reaching 1,600+ residents annually and over 3,800 in the past three years in places like homelessness accommodations, care homes, learning disabilities, mental health and other community hubs.

“

I learnt how to make different food choices to make my meals more healthy, like using less salt, using less oil and how to use the same ingredients to get different types of meals... I got to meet other mothers and gained a community. I also lost weight on the course, I enjoyed the cooking.”

Resident



Step 6: Make Newham a safer place for children and young people

KPI	Baseline value (date)	2024/2025 value (date)	2025/2026 value (date)
Number of hours young people are engaging in influencing activities	1,625 (2023/24)	2,177 (2024/25)	3,691 (2025/26)

Equity objective:

Reduce disproportionality amongst Black young boys and men in the youth justice cohort.

2025/26 update:

Newham Youth Justice Service had a high proportion of children from Black groups: 36% were from Black groups, compared to the London average of 35%. Children from Black groups were over-represented compared to the Newham population, where 24% of 10-18-year-olds are from Black ethnic groups.

Newham Youth Justice Service addressed this disproportionality, racism and inequality through a coordinated programme of anti-racist practice, targeted interventions, robust governance and data-led scrutiny.

Targeted support was provided to Black and minoritised children through initiatives such as Lift As We Climb mentoring, culturally responsive interventions, adultification awareness training and aspiration-raising programmes. Disproportionality data was routinely scrutinised by the Youth Justice Management Board, with particular focus on ethnicity, stop and search, arrests, remands, custody outcomes and reoffending.

The service also worked to ensure children and families had equitable access to services through co-production, restorative approaches, workforce development, and tailored support for groups experiencing disadvantage, with the overall aim of reducing over-representation, improving equity and delivering fairer outcomes for all children.

As part of the Turnaround Project (Early Intervention and Prevention), the Youth Justice Service commissioned the SMILE-ing boys: this eight-week programme is designed to support boys from Black ethnic groups to challenge perceptions and stereotypes, and empower children through a series of photography, poetry and discussion-based art workshops. The programme was completed by 27 boys over three cohorts, with each cohort completing eight sessions.

In 2026/27:

Year 3 will focus on moving from identifying disproportionality to achieving measurable reductions in racial inequality and improving outcomes for Black and Global Majority children.

We will implement the Diversity, Disproportionality and Achieving Equity Action Plan, embedding anti-racist and culturally responsive practice across all services, strengthening scrutiny of remand, custody and sentencing decisions, and using robust data to monitor and address unequal outcomes.

The service will work with partners to tackle the underlying causes of inequality, including school exclusions, exploitation and social disadvantage, while ensuring that the voices of children, families and communities shape service development.

Promoting good mental health

Step 7: Join up the mental health support for children and young people and their carers

KPI	Baseline value (date)	2024/2025 value (date)	2025/2026 value (date)
Number of individuals accessing the Children and Young People Mental Health Integrated Front Door	No data	297 (2024/25)	437 (2025/26)

Equity objective:

Ensure the children and young people accessing the mental health Integrated Front Door are representative of Newham’s population.

2025/26 goal:

We will deepen our understanding of the children that don’t reach the Integrated Front Door (IFD) and why this might be to help further improve equity. We will also increase awareness of the IFD in colleges to improve access for older age groups.

2025/26 update:

Newham’s Children and Young People’s Mental Health Integrated Front Door (IFD) is a multi-agency service for children and young people with emerging emotional wellbeing and mental health needs, aiming to improve timeliness and quality of support, moving away from individual service silos towards more creative, integrated community-based approaches. Children who reach the IFD are offered help before difficulties escalate; children who do not are more likely to come to the attention of services later when things are more serious, and through a safeguarding route rather than a supportive one.

In 2025/26, we progressed our understanding of the needs of young Black boys, who are under-represented at the IFD while being over-represented in safeguarding (MASH) referrals. To address this under-representation, we developed the young Black boys pilot with community partners (see below).

We also increased schools’ awareness of the IFD, with colleges identified as the next priority for outreach given lower access rates for older age groups.

In addition, our New-MAC partnership with Queen Mary University London’s Youth Resilience Unit, which supports this equity work, was formally launched at an event at the Houses of Parliament in May 2025, hosted by Sir Stephen Timms.

In 2026/27:

We will be moving into the implementation stage of the young Black boys pilot in September 2026, working with REIN and ANKH Place. We will undertake targeted interventions focussing on young people aged 13-18, including those who may not currently be engaged with services but who are identified as at risk in relation to their social and emotional mental health and wellbeing and wider associated factors. This aims to directly address the equity gap between IFD access and MASH referral for children from Black African/Black groups that was identified in Year 2.

Step 8: Promote mental wellbeing and prevent the impacts of poor mental health

KPI	Baseline value (date)	2024/2025 value (date)	2025/2026 value (date)
Number of residents participating in Newham Recovery College	283 (2023/24)	978 (2024/25)	1,138 (2025/26)

Equity objective:

Ensure people accessing mental health support through Newham’s Directory of Service are representative of Newham’s population.

2025/26 goal:

We will complete mapping and analysis work to identify who is using services and where gaps exist, and develop practical recommendations for interventions to improve equity.

2025/26 update:

In Year 2, we completed an audit to identify the types of mental wellbeing services available on Newham’s Directory of Service, who they are targeted at, where they are located, and where gaps exist.

We found that there is a broad mix of provision, with social connection and physical activity the most common categories of mental wellbeing service. Geographically, activities are concentrated in the northwest of the borough, while the northeast has the fewest listings, raising equity of access questions. However, this may reflect reduced visibility rather than true gaps. Provision for children and young people is strong (35% of listings target children and young people), as is provision for families (targeted by 23% of listings). Few offers were explicitly aimed at residents from South Asian groups (3%), Black/African/Caribbean groups (2%), Eastern European groups (2%) and refugee/migrant communities, although many services are universal. Fewer than one per cent explicitly mention severe mental illness, suggesting a gap in clearly signposted community support for people with severe mental illness. Only 16% mention evening or weekend availability, which may constrain access for working carers and parents.

In 2026/27:

In 2026/27, we will review the demographics of residents using the services to assess over- and under-representation compared to need. We will carry out outreach in areas of low listings, such as the northeast, to understand provision and potential gaps.

Step 9: Make treatment and support services for people with mental illness more accessible

KPI	Baseline value (date)	2024/2025 value (date)	2025/2026 value (date)
Number of residents accessing adult Community Integrated Mental Health Teams (CIMHS)	6,886 (2023/24)	7,108 (2024/25)	6,412 (2025/26)

Equity objective:

Ensure residents accessing Newham Talking Therapies are representative of the target population.

2025/26 goal:

We will interrogate the Newham Talking Therapies data to assess whether there is unwarranted variation in relation to need.

2025/26 update:

Access to Talking Therapies roughly aligns with Newham's 16+ population but there is some over- and under-representation. People from White British (+3.8%), Black Caribbean (+3.3%) and Bangladeshi (+1.7%) groups are the most over-represented. This means these groups make up a higher percentage of Talking Therapies access than their share of the 16+ population. People from Indian (-6.4%), Other White (-3.7%) and Other Asian (-3.0%) groups are the most under-represented. This means these groups make up a lower percentage of Talking Therapies access than their share of the 16+ population.

There is a large difference between women and men accessing Talking Therapies, with access disproportionately female. Although Newham is majority (53%) male, women make up two-thirds (67%) of those who access Talking Therapies.

Although Talking Therapies does seem to roughly align with Newham's age profile, it does skew slightly younger compared to the general 16+ population. Those aged 25-34 (+6.5%) and 20-24 (+5.3%) are over-represented in accessing Talking Therapies compared to their population. Those aged 50-64 (-3.7%) and 65-74 (-3.7%) are under-represented in accessing Talking Therapies compared to their population.

In 2026/27:

In 2026/27 we plan to strengthen our data collection and sharing agreement with NHS colleagues for Newham Talking Therapies data. Working with our Public Health Intelligence colleagues, we will establish a Talking Therapies dashboard and use it to interrogate access and outcomes, assessing whether there is unwarranted variation relative to need.

Step 10: Make Newham a place where everyone can feel connected

KPI	Baseline value (date)	2024/2025 value (date)	2025/2026 value (date)
Number of people participating in cultural events and activities	59,032 (2023/24)	67,234 (2024/25)	60,972 (2025/26)

Equity objective:

Reduce reported loneliness among groups with evidence-based risk factors for loneliness.

2025/26 goal:

We will focus on reducing loneliness for older people (50+) and those who have physical disabilities.

2025/26 update:

In 2025/26, the Be Connected team and the Community Pathways team were established. The Be Connected team offers support for residents experiencing chronic loneliness. Key target groups include the LGBT+ community (especially older residents and those from ethnic groups where it is more of a stigma) and residents with learning and/or physical disabilities who are less able to access social, cultural and nightlife experiences. The team started taking referrals and building relationships with local community groups, charities and businesses, while promoting the service to increase awareness and identify opportunities to reduce loneliness and social isolation.

The Community Pathways team collaborates with a wide range of organisations and partners to support Care Act eligible residents in staying active and connected. Through timely, high-quality six-week interventions, the team works with residents to identify their strengths, achieve personal goals and reduce reliance on commissioned care where appropriate. Both teams collect protected characteristics data, which will enable us to assess under- and over-representation once the services are established.

In 2026/27:

Both the Be Connected team and the Community Pathways team will use demographic data to assess under- and over-representation in the services, which will enable action to increase equity of access and outcomes.

The Be Connected team will establish a borough-wide loneliness network, bringing together voluntary, community and faith sector groups that support isolated residents to share good practice and identify and address gaps. We will also develop inclusive nightlife and social opportunities for people with physical and learning disabilities, continue one-to-one support to improve residents' quality of life and expand initiatives such as Men in Sheds to help people progress into longer-term social connection and community participation.

The Community Pathways team will continue to strengthen partnerships with voluntary, community, faith and statutory sector organisations to improve access to information, support and local opportunities.

By targeting groups who are at greater risk of loneliness, including older adults, people living with dementia, unpaid carers and those experiencing social isolation, we aim to support more residents to feel connected, confident and able to participate in the activities and relationships that matter most to them.

Preventing illness and providing high quality health and care services

Step 11: Support adults and older people to achieve and maintain a healthy weight

KPI	Baseline value (date)	2024/2025 value (date)	2025/2026 value (date)
Number of people completing Live Well Newham weight and movement service and achieving 3% or greater reduction in body weight	266 (27% of completers) (2023/24)	268 (31% of completers) (2024/25)	103 (34% of completers) (2025/26) Data is not fully complete for the year yet

Note:

The data covers the cohorts who started in June 2025 to those who started in June 2026. Data is not fully complete for 2025/26 because Live Well courses are 12 weeks, so some participants have not yet completed the course, and weight loss can be measured at completion only.

In addition, the number of residents accessing the service is expected to be lower than in previous years due to the introduction of a new provider and revised service specifications, outcomes and targets. As 2025/26 is the first year of the new contract, lower uptake was anticipated during the mobilisation period, with activity expected to increase as the service matures.

Equity objective:

Increase access to weight interventions for people with learning disabilities and mental health issues.

2025/26 goal:

We will recommission the Live Well Newham healthy weight services and expect to see improvements in completion rates and weight loss outcomes for adults, children and young people. We will focus on learning disabilities and piloting dedicated healthy eating support for people with a learning disability and their carers, co-designed with residents and families. The target is for at least 20 residents with a learning disability, plus their carers, to start in the first year of the pilot service, and at least 12 to complete it. The aim is to grow numbers over time based on success of the pilot and availability of funding in subsequent years.

2025/26 update:

In 2025/26, we piloted a dedicated healthy eating support for people with a learning disability and their carers, co-designed with residents and families. The service exceeded targets with 29 starters (target: 20) and 28 completers (target: 12), with 50% of service users achieving 3% weight loss, far exceeding expectations.

The service focussed on promoting independence and confidence, and improving wellbeing, peer support and a good quality of life. Insight and feedback has told us that there are not many activities for this group despite their needs.

In 2026/27:

The aim for 2026/27 is to open a new physical healthy eating and cooking hub for residents with learning disabilities in another area of high need in the borough and have comparable uptake and completion rates.

Step 12: Reduce the prevalence and impact of long-term conditions on residents' lives

KPI	Baseline value (date)	2024/2025 value (date)	2025/2026 value (date)
Percentage of people with elevated risk of cardiovascular disease who are receiving cholesterol-lowering treatment	No data	60%	61%

Note:

The KPI was amended from the original strategy because the data was no longer available.

Equity objective:

Ensure that people completing the type 2 diabetes remission programme are representative of Newham's at-risk population.

2025/26 goal:

Improve recording of ethnicity to enable us to analyse representation and work towards a target of no GP practices with zero referrals to the remission programme.

2025/26 update:

Variation in referral, uptake, attrition and outcomes has been seen for the type 2 diabetes remission programme, an evidence-based intensive diet, coaching, mindfulness and meal replacement programme. National and local evaluations indicate the programme can be effective in all ethnicities, and can help participants achieve weight loss of 7-15%, with a NEL average of 9kg. However, ethnicity data recording remains poor: only 19% have complete information from primary care.

In 2025/26, we carried out a targeted deep dive in both primary care and provider data to understand the patterns and risk factors. Low-referring practices were identified and follow-up qualitative interviews carried out with the leads from those practices.

In addition, surveys of GPs and GP trainees were completed to understand barriers to and confidence around referring and giving diet advice. We found that confidence in initiating the programme could be improved and social determinants are poorly understood. This points to an opportunity for training solutions, which could improve confidence and referral patterns.

In 2026/27:

We will explore options for revising the local delivery of the programme, including follow-up work in primary care linked to Neighbourhood Health delivery to improve referral practice and good-quality, actionable health promotion conversations.

Step 13: Improve prevention and early diagnosis of cancers and cardiovascular diseases

KPI	Baseline value (date)	2024/2025 value (date)	2025/2026 value (date)
Proportion of eligible population taking up NHS Health Checks	87% (2023/24)	61% (2024/25)	67% (2025/26)

Note:

National target is 66%, which we have exceeded.

Equity objective

Reduce the number of avoidably late cancer diagnoses in line with the Core20PLUS5 strategy.

2025/26 goal:

We will work towards a goal of 70% of cancer diagnoses detected at early stages.

2025/26 update:

In 2025/26, we carried out a detailed evaluation of community equity work, focussing on increasing cervical cancer screening uptake in two underserved communities in Newham: Romanian and Bangladeshi/Bengali communities. This work was delivered through a partnership between Public Health, VCFSE organisations, and primary care.

We found that translation of screening information into multiple local dialects and use of bilingual health advocates significantly increased engagement at community events. Likewise, in-person community sessions led by trusted local organisations created safe spaces for dialogue, particularly addressing cultural stigma and fear around cancer. Phone outreach delivered in residents' native languages also helped increase screening uptake, but uptake remained variable, especially among those with lower health literacy or persistent screening hesitancy.

In 2026/27:

We will complete the evidence base on who is still missing from screening, why, and what methods are most effective in reaching them. This includes mapping non-uptake by IMD quintile, ethnicity and language need. We will deliver a series of hyper-local community information events (one per neighbourhood by Q3 2026/27) with interpreters and local champions to build trust and address misconceptions around screening. A feedback mechanism will be built into each event to understand residual concerns, improve future sessions and close the loop with attendees.

A report summarising the outcomes of the outreach and screening uptake data will be shared directly with GP practices via neighbourhood leads. Practices with persistently low uptake will be offered targeted support, including bilingual materials, training for frontline staff and QI facilitation if needed.

We will commission local VCFSE partners to co-deliver screening awareness and navigation support, with a focus on high-need groups. Delivery partners will produce monthly insight reports on barriers, enablers and recommendations for system-level improvement.

Step 14: Support residents to enjoy safe relationships and maximise their sexual and reproductive health

KPI	Baseline value (date)	2024/2025 value (date)	2025/2026 value (date)
STI testing rate	8,824 per 100,000 (2023)	8,750 per 100,000 (2024)	8,535 per 100,000 (2025)

Note:

STI testing rates decreased in both London and Newham between 2024 and 2025, falling by 3.3% and 2.5% respectively, with the decline in Newham being less pronounced than across London as a whole.

Equity objective

Improve PrEP (pre-exposure prophylaxis) uptake and HIV screening among Black African residents.

2025/26 goal:

Improve HIV prevention and early diagnosis by increasing the number of Black African residents receiving HIV screening by 500 in 2025/26 compared with 2024/25 and achieving a 20% increase in PrEP uptake among Black African residents in 2025/26 compared with 2024/25.

2025/26 update:

HIV screening: 2,219 Black African and Caribbean residents were screened for HIV in 2025/26. This represented a 59% increase compared with 2024/25.

PrEP uptake: 81 Black African and Caribbean residents initiated PrEP in 2025/26. This represented an 80% increase compared with 2024/25.

In 2026/27:

We will aim to reduce the number and proportion of HIV cases diagnosed at a late stage. We aim for a 20% increase in the number of Black African residents accessing PrEP in 2026/27 compared to 2025/26, with a minimum number of 97. To do this, we will engage with Black African residents to understand barriers to HIV screening and PrEP, and we will aim to commission a co-developed intervention based on resident engagement.

We aim to increase screening of Black African residents in 2026/27 via the GP opt-out screening programme by 20%. We will do this through GP data targeting (practices with the highest percentage of Black African residents), targeted training for selected practices and promotional materials to targeted practices.

Step 15: Promote health and independence through adult social care

KPI	Baseline value (date)	2024/2025 value (date)	2025/2026 value (date)
Proportion of people who are extremely satisfied or very satisfied with the care and support they receive	61% (2023/24)	60% (2024/25)	61% (2025/26)

Equity objective:

Ensure that people accessing preventative interventions are representative of the target population.

2025/26 goal:

The pilot to reduce deconditioning among hospital inpatients will launch, and equity data will be reported.

2025/26 update:

In early 2026, the Preventing Hospital Acquired Deconditioning (HAD) pilot was launched in Newham Hospital, with the aim of helping people stay active during recovery at hospital. Newham Hospital employed dedicated therapists to assess patients and encourage them to stay active. Staff were trained to spot and support patients who might be at risk of HAD: in April 2026, 21 training sessions were run, with a total of 157 staff attending.

The programme saw benefits in terms of increased activity levels amongst patients. Within a week of the first cohort of patients starting Fit2Sit – an initiative whereby patients are encouraged to be out of their beds, ready for self-care and breakfast as well as therapy activities – the number sitting out of bed rose from three to 13 out of the 17 who were suitable.

Patients were given resources and activities to help them stay active. As an example of the impact of the programme, one patient who used these resources went on to complete the exercises every day: within four days, the patient went from mostly staying in bed to walking independently across the ward.

In 2026/27:

In 2026/27, the Preventing Hospital Acquired Deconditioning (HAD) pilot will expand, starting Fit2Sit on another ward and launching group therapy activities to support patients to stay active. Patients at high risk of HAD will also be supported with nutrition interventions (high protein snack and meals). We will evaluate the first 12 months to assess outcomes and equity.

Addressing smoking and substance misuse



Step 16: Make Newham smokefree by 2030

KPI	Baseline value (date)	2024/2025 value (date)	2025/2026 value (date)
Proportion of service users with a quit at four weeks	60% (2023/24)	63% (2024/25)	52% (2025/26)

Equity objective:

Reduce smoking prevalence among people treated for substance misuse.

2025/26 goal:

We are aiming to achieve 51 four-week quits in this cohort and maintain the quit rate at 60%.

2025/26 update:

There was a 38% quit rate at four weeks achieved for people receiving treatment for substance misuse, with only eight people quitting. This was lower than target, which in part was linked to operational challenges with service delivery. These challenges have since been resolved and we expect outcomes to improve as a result.

In 2026/27:

We will engage with residents who experience substance misuse, and with our substance misuse service provider, to better understand how these groups can be better supported and tailor stop-smoking service provision to improve uptake and outcomes.

Step 17: Support residents to recover from the impacts that alcohol and drug misuse have on their life, their family and the wider community

KPI	Baseline value (date)	2024/2025 value (date)	2025/2026 value (date)
Number and annual percentage change in residents receiving treatment and support from the substance misuse service	1,631 (2020/21)	1,568 (2021/22) -3.9% from baseline	1,575 (2022/23) +0.4% from 2021/22

Note:

This is the most up-to-date data we are able to publish due to restrictions from the Office for National Statistics. However, the trend shows an increase in numbers receiving treatment, demonstrating the impact of the increased funding for substance misuse services from the Office for Health Improvement and Disparities (OHID) since 2021/22.

Equity objective

Increase uptake of substance misuse prevention and treatment services by residents from Black and Asian groups and women.

2025/26 goal:

Dig deeper into the data to understand why women and people from Black and Asian groups are under-represented and look to develop new services / programmes to address inequities.

2025/26 update:

In 2025/26, 22% of people in treatment were female compared to 23% last year. This is lower than the national proportion (30% female), suggesting there is under-representation. In 2025/26, 55% of those presenting to treatment services were from a global majority background (compared to around 60% of Newham's adult population).

Commissioners are establishing a PowerBI dashboard which will support better understanding of how those with protected characteristics are referred to the substance misuse service and what outcomes they experience as a result of receiving treatment.

In 2025/26, Newham Rise carried out work to better understand the needs of women in treatment, with the aim of opening women-only spaces. We also developed a satellite (co-location) arrangement within Family Hubs, and established links with the Midwifery Link role, to improve access and increase engagement with treatment services among women who may otherwise face barriers to support.

We continued working to widen reach into local communities, with a particular focus on outreach in community centres and faith venues. We are opening new locations where residents with lived experience say they are needed.

In 2026/27:

In Year 3 we will focus on improving access to treatment and recovery support for women leaving prison, with a focus on ensuring that the services are accessible, relevant and trusted.

We will work with HMP Bronzefield to explore current challenges and barriers that affect transfer to community treatment, and seek reciprocal arrangements with other CGL drug and alcohol services operating within the prison, to improve service presence and referral pathways.

In partnership with Hestia and Advance (women's service), we will continue to identify and address additional support needs for women prior to release.

We will continue our outreach work in community centres and faith venues where residents with lived experience say they are needed.

Case study

Driving down smoking where harm is greatest

Smoking remains a leading cause of preventable death and drives major health inequalities in Newham. While adult smoking prevalence fell from 15% in 2020 to 11% in 2024, rates remain much higher among certain priority groups. Tackling these gaps is central to Newham's ambition to become Smokefree by 2030.

Newham's specialist Stop Smoking service, delivered by Queen Mary University of London (QMUL) and VCFSE partners provides targeted, community-based support to help residents quit smoking. The model combines clinical expertise with neighbourhood outreach to reach people least likely to access support.

Since January 2021, the service has supported over 2,500 residents to quit smoking. In 2024/25 alone, more than 900 people achieved a four-week quit, with quit rates consistently around 60%, and in the first three quarters of 2025/26, the service achieved over 500 quits. Community-led VCFSE delivery has strengthened reach into high-prevalence neighbourhoods and priority groups, improving access and equity. Service user satisfaction has strengthened year-on-year, with 95% of residents rating the service 'Excellent' in 2025/26.

“

I got to a point where I said enough is enough, I need to quit smoking. But I knew I couldn't do it alone. I heard about the service through an advert; I got in touch and booked an appointment and managed to give up.”

Quit Well Newham Service User



Creating an inclusive borough



Step 18: Create an age-friendly Newham

KPI	Baseline value (date)	2024/2025 value (date)	2025/2026 value (date)
Number of residents aged 50+ accessing Well Newham services	12,146 (2023/24)	5,116 (2024/25)	4,129 (2025/26)

Note:

In 24/25 there was a major revamp of the Well Newham IT platform and subsequent retraining of frontline staff. In addition, the Well Newham model changed to increase its long-term sustainability. These factors are likely to explain the drop in referrals among people aged 50+ between 2023/24 and 2024/25. Since then, we have been engaging with key stakeholders such as social prescribers and GP practice managers to encourage them to focus on 50+ population referrals by building their capacity through practice meetings. This has resulted in increased referrals for 50+ population across the borough as reported by the social prescribers. However, the dip from the last year is attributable to the change in the backend system of the Joy platform, in which Joy removed the demographic details fields from the referral forms across NEL. This issue and changes to the case management system prompted social prescribers to make referrals through different routes, rather than through Joy, making the data dynamic and incomparable across years. The Well Newham team is working with the Joy technical team to resolve these problems.

Equity objective

Ensure that people accessing frailty services are representative of Newham’s frail population.

2025/26 goal:

Frailty services will be reviewed across North East London to identify areas for improvement. Through this we will work to further improve equity of access to services in Newham.

2025/26 update:

Work continued to set up the new community Comprehensive Geriatric Assessment (CGA) service. This will be a multidisciplinary service that identifies a person’s medical, social and functional needs and develops an integrated and coordinated care plan to address these needs.

In 2025/26, a diverse mix of residents accessed frailty-related outpatient services, broadly reflecting Newham’s frail population. The following groups were slightly under-represented: Other Asian (5% of service-users compared to 8.2% of the frail population); Bangladeshi (7.5% of service-users compared to 10% of the frail population); Pakistani (6% of service-users compared to 9.9% of the frail population). The White British group was over-represented (37.5% of service users compared to 25.2% of the frail population), and Caribbean groups were slightly over-represented (9.4% of service-users compared to 9% of the frail population). This is broadly similar to 2024/25 in terms of representation.

In 2026/27:

We will move to a single point of access frailty service longer term. In 2026/27, the Comprehensive Geriatric Assessment (CGA) service will begin taking referrals. The aim is for the CGA to ensure that it is reaching a diverse range of residents by collecting demographic information on patients and using the ART framework to make sure it is accessible, relevant and trusted so residents of all backgrounds have equal opportunity to benefit from the service.

Step 19: Make Newham a neurodiversity- and disability-friendly borough

KPI	Baseline value (date)	2024/2025 value (date)	2025/2026 value (date)
Proportion of people with a learning disability completing their annual health check	18+: 86% 14-17: 84% (2023/24)	18+: 86% 14-17: 84% (2024/25)	18+: 87.2% 14-17: 79.8% (2025/26)

Equity objective:

Increase access to healthcare services for people with a learning disability and autistic people.

2025/26 goal:

Increase uptake of bowel and breast screening for residents with a learning disability by a minimum of 5%.

2025/26 update:

Breast and bowel cancer screening levels for people with a learning disability in Newham are now significantly above the local average and national benchmarks. The goal to increase uptake by 5% has been met.

In 2025/26, 67 people (64%) with a learning disability who were eligible for screening were supported to complete the bowel cancer screen. This was better than the national average of 47%, and local uptake in the previous year of 42%.

Forty-one people needed intensive support and repeated follow-up. Three people were subsequently referred to a colorectal specialist due to blood in their faeces.

In 2025/26, 71 women (55%) with a learning disability who were eligible for screening were supported to complete the breast cancer screens. This compares with 41% in April 2024 (and 21% in 2023). All these individuals needed intensive support, and a few women needed repeated follow-up with specialists when suspicious lumps or masses were found.

In 2026/27:

We are focussing on increasing uptake of bowel and breast screening for residents with learning disabilities by a minimum of 5%.

This will include addressing issues identified by the service:

- Fear of completing the test and of having cancer
- Finding completing bowel screening intrusive and embarrassing
- Limited understanding of what bowel screening is due to health literacy and a language barrier
- Difficulty with obtaining a sample / carer support not available to obtain a sample and send off completed test kit
- Misplacing the test kit and forgetting to complete the test
- Residents or carers finding it difficult to request a test kit
- Low individual risk perception or limited consideration of future consequences of bowel cancer
- Having a number of other health conditions so unable to focus on bowel screening

Step 20: Improve access to healthcare for inclusion health groups

KPI	Baseline value (date)	2024/2025 value (date)	2025/2026 value (date)
Number of practices who have signed up to Doctors of the World safe surgeries and engaged with the safe surgeries network	4 (Apr 24)	10 (Apr 25)	2 (Apr 26)

Note:

There were a number of challenges – including a shortage of staff, and changes in partner organisations – in 2025/26 that impacted regular engagement and monitoring of Safe Surgeries. We plan to meet regularly with the new Safe Surgeries lead at Doctors of the World to discuss strategies and actions to increase engagement with Safe Surgeries.

Equity objective

Increase GP registration for babies and children from inclusion health groups.

2025/26 goal:

Work with FutureNHS to improve the availability and quality of data, which we will then review regularly. This will form the basis for tailored interventions to increase GP registration.

2025/26 update:

The last data update on unregistered children was in January 2025. In 2025, we worked with Federated Data Platform (NHS) and Newham Health Collaborative colleagues to try and get regular, accurate data, but the data on unregistered children is not routinely recorded, which limited our ability to deliver targeted interventions.

In 2026/27:

In partnership with organisations who work directly with inclusion health groups and collect data on outcomes, we will amend the equity objective to focus on other ways to increase access for inclusion health groups with more measurable and tangible outcomes.

Step 21: Help people seeking sanctuary to settle and lead independent, healthy and happy lives

KPI	Baseline value (date)	2024/2025 value (date)	2025/2026 value (date)
Proportion of people seeking asylum placed in a contingency hotel who are registered with a GP	No data	99%	97%

Note:

There has been an increase in the number of people seeking asylum being dispersed from Newham faster which may be why there has been a slight decrease in the percentage registered with a GP.

Equity objective:

Increase ESOL (English for speakers of other languages) uptake among people seeking sanctuary.

2025/26 goal:

Create a single point of contact ESOL programme to further increase uptake, a model that works well in other places. Agree a standard level with Newham ESOL providers to ensure there is consistency across the borough.

2025/26 update:

As of April 2026, of those refugees and people seeking asylum who were known to the council, 89% were either enrolled (including those awaiting enrolment following their initial assessment) or did not need ESOL or were not eligible (as they been in the UK under six months).

In 2026/27:

From April 2026 we will start a pilot for conversational ESOL classes specifically for those who are not yet eligible for funded ESOL classes (those who have been in the UK under six months). These classes will be near two of the largest asylum hotels. They will run twice a week and make English provision more accessible to people seeking sanctuary, by allowing those who have been in the country less than six months to start learning English and begin their journey to independent settlement.

We will evaluate this pilot, looking at how effective it has been in providing students the foundation to move into funded ESOL at six months+. We will examine equity measures, such as the countries where attendees are from, to ensure that people taking up the offer are representative of the target population. Assuming continuation of grant funding, we will look to continue the classes if our evaluation finds positive uptake and outcomes.

Step 22: Ensure that services that meet the needs of the most vulnerable groups are effective and of high quality

KPI	Baseline value (date)	2024/2025 value (date)	2025/2026 value (date)
Number of residents using Domestic Abuse services	880 (2023/24)	1,027 (2024/25)	1,378 (2025/26)

Equity objective:

Increase the uptake of domestic abuse services by male and LGBTQ+ survivors groups.

2025/26 goal:

To increase reach, we will implement a new contract model with dedicated support for these groups alongside stronger equity monitoring and outcomes reporting.

2025/26 update:

We implemented the new contract model with dedicated support for male and LGBTQ+ survivors groups, and commissioned a full SafeLives review to look at the experience of those with lived experience and the barriers to support across the system.

The number of male survivors accessing support increased by 52% over the last year, partly because we set up three new co-location services within adult social care, East London Foundation Trust and Change Grow Live. We also increased our outreach services across Newham, offering both domestic abuse training and awareness sessions to local community groups. Our commissioned domestic abuse service provider offered sessions in multiple languages.

We broadly maintained the level of LGBTQ+ survivors, but we are seeing a gradual increase.

We have an independent domestic violence advisor who works solely with marginalised survivors experiencing harmful practices, FGM, domestic servitude and honour-based abuse. This role also provides specialist support to survivors with no recourse to public funds.

In 2026/27:

We are aiming to promote domestic abuse services and increase referrals for men, trans and non-binary survivors. We will develop a domestic abuse equalities and inclusion working group, with the aim of identifying operational barriers and delivering the relevant recommendations from the SafeLives review.

Case study

Improving the food offer to children placed in Catered Asylum Accommodation

Over 500 residents live in catered hotels at any one time, whilst they await a decision about their asylum claim. These residents have little control over what they eat.

Reviewing menus revealed that children's meals contained lots of ultra processed food, were high in fat and salt, and were unsuitable for weaning children. A partnership involving Public Health, VCFSE sector organisations, Infant Feeding teams, Health Visiting and children's centres was set up with the aim of making the food healthier and more appropriate for weaning children, to meet UNICEF Baby Friendly Initiative standards.

The partnership resulted in Newham being the first place in the country to improve the quality of food for children seeking asylum living in Home Office hotels. As a result of several years of advocating for higher quality food to the hotel providers and pushing against resistance, children's menus are now healthier, more nutritious and better for weaning children, with fresh blended vegetables, more healthy protein, lentils and pulses. This will benefit every family in the local hotels, and will influence food provision in hotels across the country.

Protecting residents from threats to their health

Step 23: Prevent and control health threats

KPI	Baseline value (date)	2024/2025 value (date)	2025/2026 value (date)	2026 value (date)
Proportion of people with TB in Newham who complete treatment within 12 months	81% (2022)	85% (2023)	82.8% (2024)	84.2% (2025)

Equity objective:

Improve completion of treatment among people with tuberculosis (TB) and social risk factors.

2025/26 goal:

We will look to address delays between symptom onset and diagnosis as a key priority for improving patient outcomes and equity.

2025/26 update:

According to provisional UKHSA data, of all TB cases notified from January 2024 to December 2024, 64% of people with social risk factors completed treatment compared to 80% of those without.

Our TB Rapid Review identified developing pathways to services as a key priority for the Newham TB Partnership. The pathways will support patients with TB around the social determinants of their health and wellbeing – such as housing, migration and adult social care – with the aim of improving the patient journey and supporting treatment completion. A draft rough sleeper pathway was co-developed with the housing team, and it will be stress tested with the TB team locally.

In 2026/27:

We will develop and deliver a borough-wide social mobilisation campaign, including community-based case finding, to build relationships and improve understanding of TB. This will increase relevance and partner buy-in, supporting the development of pathways that improve the patient journey and promote treatment completion.

Step 24: Increase immunisation uptake and reduce inequity in coverage

KPI	Baseline value (date)	2024/2025 value (date)	2025/2026 value (date)
Number and percentage uptake of seasonal flu vaccinations given to priority groups	64,746 (39%) (Sep 23 – Mar 24)	59,531 (36%) (Oct 24 – Mar 25)	60,625 (36.3%) (Sep 25 – Mar 26)

Equity objective:

Reduce variation in vaccination uptake across primary care networks.

2025/26 goal:

We will work to reduce the gap in MMR uptake between Newham primary care networks and improve data reporting to help target efforts.

2025/26 update:

We initiated an equity data review with one GP practice using the equity toolkit to identify underserved communities and tailor interventions according to need. We progressed a borough-wide immunisation data platform with NEL ICB to address key data gaps identified during the 2025 measles outbreak. We were selected as one of six trailblazer London boroughs to increase uptake of MMR1 vaccines among 1–11-year-olds and reduce the number of 0-dose children. Being data driven, we will deliver hyper-local, innovative vaccine interventions to improve uptake.

In 2026/27:

We will use improved immunisation data to target under-immunised communities and deliver hyper-local interventions in trailblazer and pilot sites (with Vaccination UK, school nursing and health visiting), improving MMR1 and MMR2 uptake. We will analyse and interpret the data from the equity data reviews across four GP practices, and use this to inform our work.

This will be underpinned by the whole-system MMR Action Plan that is in development, to build capacity and support a scalable approach to reducing variation across the borough.

Case study

Trust, access and rapid protection in a school outbreak

In March 2025, following confirmation of a travel-associated hepatitis A case in a Newham primary school, extensive mixing during the infectious period meant post-exposure vaccination was offered on site to the whole school community. The aim was to prevent further transmission while ensuring equitable access.

The school population was predominantly Muslim and the incident occurred during Ramadan, requiring sensitive, faith-aware communication to support informed consent. Early engagement with the school community identified faith-specific concerns about vaccination during Ramadan that needed to be addressed to avoid children missing out on vaccination. A partnership approach was essential to deliver rapid protection at scale while addressing access, trust and shared system responsibilities.

A short video recorded by a local imam, co-developed with Public Health and the school, reassured families that vaccination does not invalidate the fast. Vaccine delivery teams reflecting the local community enabled trusted, supportive conversations with parents and carers. 167 children (around 80% of those eligible) were vaccinated on site, with additional vaccines via primary care, far exceeding our expectations of uptake. No further cases of hepatitis A occurred, demonstrating the success of the response.

For the wider system, this established a repeatable model combining early local insight, trusted community voices and clear system roles to support rapid, equitable outbreak response.

Creating a healthier food environment



Step 25: Create a healthier food environment

KPI	Baseline value (date)	2024/2025 value (date)	2025/2026 value (date)
Value of advertising estate in Newham where the Nutrient Profile Modelling based Newham Healthier Advertising Policy is controlling content and actively promoting healthier food	£40,000 (2023/24)	£40,000 (2024/25)	£163,000 (2025/26)

Equity objective:

Increase the number of sites advertising healthy food in Newham’s most deprived areas.

2025/26 goal:

The Newham Healthier Advertising Policy and the procurement for advertising estate across the borough will go live.

2025/26 update:

Over the last year, we dramatically increased compliance with the Healthier Advertising Policy alongside expansion in the council’s estate. We worked closely with advertising partners, training and supporting them to ensure that the tools are in place to guarantee compliance.

The policy now covers council estate, including 636 lamppost sites, six roundabout and verge sites and all new digital assets.

Eight locations were selected for new freestanding digital advertising units. Five units are now installed and will display images and content promoting healthy food, alongside other health policy compliant advertising. All five of these sites are located in areas ranked within IMD quintiles 1-2, with 80% within IMD quintile 1.

In 2026/27:

We will continue expanding the reach and impact of the Healthier Advertising Policy by ensuring all new council-controlled advertising sites are compliant. We will monitor implementation and continue evaluating the policy’s contribution to creating healthier, more equitable neighbourhoods.

Step 26: Nurture a local food culture of eating well, sustainably, for a just transition to a green economy

KPI	Baseline value (date)	2024/2025 value (date)	2025/2026 value (date)
Number of partners engaged by Sustainable Food Newham	10 (Apr 24)	15 (Apr 25)	32 (May 2026)

Equity objective:

Prioritise areas with least access to green spaces for new growing spaces.

2025/26 goal:

We will work towards opening a second horticulture enterprise and three school orchards in other areas of low green space.

2025/26 update:

We planted three school orchards in areas of low green space: Plashet School, School 21 and Royal Docks Academy.

We secured an agreement with Chef Angela Hartnett to fund a food-growing enterprise based at Winsor Primary School, which includes engagement activities with the pupils.

In 2026/27:

We will secure an agreement to open another community food-growing enterprise in the Royal Docks.

Step 27: Continue to grow whole school approaches to food

KPI	Baseline value (date)	2024/2025 value (date)	2025/2026 value (date)
Application by schools of the Eat for Free grant principles (% of total principles accumulated across schools)	New data	74%	76%

Equity objective:

Provide support to the high number of students who fall between the national free school meals threshold and the Child Poverty Action Group (CPAG) line on poverty.

2025/26 update:

Newham Council, as part of the School Food Review, campaigned for national rollout of universal free school meals to include everyone in a household receiving universal credit. Since the announcement of ‘Expanded Free School Meals’, which extends access to free school meals to all children living in households on universal credit, we continued working to ensure that the implementation is a success. This included support to the Education team on the re-registration process of all students.

In 2026/27:

We will continue to maximise free school meals registration and uptake, working to capture all newly eligible pupils in the ‘Expanded Free School Meals’ cohort. We will focus on the opportunity to implement universal secondary school meals through direct engagement with caterers, headteachers and pupils, ensuring that – as we do in primary with Eat For Free – we work to achieve whole-school approaches to food alongside high-quality meals.

Step 28: Continue to improve food security for all residents

KPI	Baseline value (date)	2024/2025 value (date)	2025/2026 value (date)
Number of Newham Food Alliance partner attendances at Social Welfare Alliance training	554 (Apr 24)	621 (Apr 25)	727 (Apr 26)

Equity objective:

Increase the use of the food clubs by those most affected by the benefit cap and those who have no recourse to public funds.

2025/26 goal:

Grow the number of food clubs, given that several Newham Food Alliance organisations are interested in adding a food club to their offer, continuing to move beyond food banks. We also expect the number of families with no recourse to public funds reached by food clubs to continue to grow.

2025/26 update:

In 2025/26, Newham’s food clubs supported on average 447 individuals with no recourse to public funds each week, up from an average of 413 individuals a week in 2024/25.

The number of individual food clubs increased from 15 to 16. In addition, one Newham Food Alliance partner added another weekly food club session.

In 2026/27:

In 2026/27 we are seeking to grow this number, with several Newham Food Alliance organisations interested in adding a food club to their offer, continuing to move beyond food banks. We also expect the number of families with no recourse to public funds reached by food clubs to continue to grow.

Making Newham a place for people and planet



Step 29: Deliver a just transition in addressing climate change

KPI	Baseline value (date)	2024/2025 value (date)	2025/2026 value (date)
Carbon saved by reducing the number of high carbon inhalers prescribed in Newham	6,563,744 kg of CO2 equivalent per 1,000 patients (2023)	6,249,291 kg of CO2 equivalent per 1,000 patients (2024)	5,978,602 kg of CO2 equivalent per 1,000 patients (2025)

Equity objective:

Use climate-health risk as a key criterion in prioritising key neighbourhood retrofit projects.

2025/26 goal:

Survey 120 homes, with interventions taking place on site.

2025/26 update:

The Warm Homes programme is part of a national government-funded scheme to improve the energy efficiency of our social housing. We are upgrading 359 council homes across our borough, focussing on properties that are most affected by damp and mould, and have low energy performance ratings – both of which are linked to a range of adverse health outcomes. Improving the energy performance of these properties will therefore deliver environmental and health benefits in properties with high need.

So far we have surveyed 93 homes within the Warm Homes programme, plus a further 11 that were surveyed but found not to meet the grant conditions and therefore removed from the programme.

In 2026/27:

All 359 homes in the Warm Homes programme will have been surveyed. We aim for 20% of the 359 homes to have had the retrofitting work completed by the end of the financial year.

Step 30: Improve air quality and protect residents from exposure

KPI	Baseline value (date)	2024/2025 value (date)	2025/2026 value (date)
Number of people using Air Aware, Newham's online air quality resource	2,500 (Apr 24)	3,400 (Apr 25)	5,600 (Mar 26)

Equity objective

Strengthen the role of health services and professionals in air quality action to protect vulnerable patient groups. [Equity objective was amended from the original strategy to reflect the broader contribution that NHS services are making to improving air quality and protecting patients.]

2025/26 goal:

Host a joint Clean Air Day event between Newham Council and NHS providers to increase knowledge and awareness of air pollution and ways to protect patients and staff. Launch Newham's refreshed Air Quality Action Plan with specific healthcare-focussed commitments.

2025/26 update:

Clean Air Day 2025 successfully took place on 19 June 2025 at Star Lane GP Practice. The event brought together healthcare professionals, environmental specialists and local stakeholders to strengthen collaboration on air quality initiatives.

Newham Council continued to strengthen its partnership with Tollgate Medical Centre, which maintained a patient gardening group over the past year, resulting in improvements to the site's green space: this provided a valuable venue for community engagement activities.

The draft Air Quality Action Plan (AQAP) 2025–2030 was developed with NHS partners and commits to reducing exposure to air pollution outside hospitals and health centres.

Newham Hospital undertook a number of initiatives to improve air quality, including planting a pocket forest on the hospital estate. This was funded by the council, and the 1,760 trees were planted by staff and volunteers. The trees will play an essential role in improving air quality and promoting a healthier space for everyone who visits. The hospital is also developing a landscape strategy and implementation plan for its nearly 11-hectare estate, transforming fragmented and underutilised green spaces into a connected landscape that supports health and wellbeing for staff, patients and local people.

In 2026/27:

We will strengthen collaboration with healthcare partners and reduce exposure to air pollution in healthcare settings. We will do this by encouraging healthcare providers to install air quality monitoring sensors around the perimeter of hospitals and health centres. This will help gather real-time pollution data, identify peak exposure periods, and support patients, staff and visitors in making informed decisions about travel routes to and from healthcare facilities.

We will deliver a community awareness campaign to raise awareness of local sources of air pollution near healthcare facilities, promote behavioural change and encourage residents to take action to reduce their contribution to emissions.

We will progress plans for a research bid to assess air quality around health centres and co-design approaches to reduce people's exposure to pollution.

Step 31: Increase active and sustainable travel through schools, employers and faith organisations

KPI	Baseline value (date)	2024/2025 value (date)	2025/2026 value (date)
Number of Healthy School Streets sites	19 (Apr 24)	50 (Apr 25)	64 (Apr 26)

Equity objective:

Increase the proportion of children travelling actively to and from school.

2025/26 goal:

Continue to encourage and support education settings to engage with Transport for London's 'Travel for Life' scheme and take meaningful steps to increase active travel.

2025/26 update:

Transport for London's 'Travel for Life' scheme awards points to schools, nurseries and colleges for activities they have undertaken to enable active travel, such as cycle lessons or walking buses, and outcomes in active travel. In 2025/26, a record 40 schools were supported to achieve gold accreditation in the TfL Travel for Life programme (in addition to eight 'engaged', three bronze and two silver), representing the most meaningful actions and results on enabling sustainable travel to school. This contributed to an increase in the Healthy Streets Scorecard score, from 34% to 40% (out of a maximum possible score).

In 2026/27:

We will work to maintain the levels of gold accreditation in the TfL Travel for Life programme and increase engagement.

Step 32: Create a healthy urban environment

KPI	Baseline value (date)	2024/2025 value (date)	2025/2026 value (date)
Proportion of the borough as low-traffic neighbourhood	44% (2023/24)	45% (2024/25)	45% (2025/26)

Equity objective:

Prioritise areas with the lowest car ownership, which are typically more deprived and most impacted by car use, for the implementation of low-traffic schemes.

2025/26 goal:

Collect baseline data on traffic and air quality in the prioritised areas, to inform future schemes.

2025/26 update:

In 2025/26, data analysis was conducted using demographic and deprivation data to rank potential areas to prioritise for low-traffic neighbourhoods, based on deprivation and low car ownership. This will inform decisions about future low-traffic neighbourhoods to ensure areas of greatest need are prioritised.

In addition, West Ham Park low-traffic neighbourhood was converted to permanency.

In 2026/27:

We aim to have progressed feasibility surveys for a low-traffic neighbourhood in a high-priority area of low car ownership.

Step 33: Involve residents in every new low-traffic scheme, encouraging them to travel actively and use their local spaces

KPI	Baseline value (date)	2024/2025 value (date)	2025/2026 value (date)
Number and percentage of residents taking part in initiatives in the new low-traffic area	New data	342; 4% of LTN area residents (2024/25)	1,024 took part in initiatives in the West Ham Park scheme; 10% of residents of LTN area (November 2024 to November 2025)

Equity objective:

Ensure that residents involved in community-led street design are representative of Newham’s population.

2025/26 goal:

Continue to use the DILLN (Does it Look Like Newham) tool to assess representation and design engagement activities to reach under-represented groups.

2025/26 update:

In 2025/26, we implemented a large range of engagement activities in support of the West Ham Park People Friendly Streets project. For example, we carried out an online survey and map-based tool, intercept surveys, written correspondence, bike events, update workshops, door knocking, leaflets, on-street signage, ‘Hello Lamp Post’ QR code digital engagement and councillor briefings, generating over 1,000 survey responses and hundreds of additional comments and conversations. Several activities were specifically targeted at under-represented groups, most notably four dedicated Blue Badge holder workshops (online and in person) designed to understand the experiences of disabled residents and the operation of the exemption scheme. We also sought to improve accessibility through Easy Read, audio and BSL versions of materials, translation services, hard-copy communications, targeted door knocking in low-engagement areas and both online and face-to-face opportunities to participate.

In 2026/27:

Any feasibility assessment or engagement to assess participation will use the DILLN (Does it Look Like Newham) tool to assess whether the participants are representative of Newham’s population as a mandatory part of the process, and we will take steps to maximise representation.

Step 34: Use libraries and community spaces to improve residents’ health and wellbeing

KPI	Baseline value (date)	2024/2025 value (date)	2025/2026 value (date)
Number of visits to Newham libraries	1,302,944 (2023/24)	1,328,407 (2024/25)	1,320,613 (2025/26)

Equity objective:

Deliver targeted Bookstart interventions to under-5s and their families who live in the most deprived areas of the borough.

2025/26 goal:

Strengthen our ‘one-council’ approach between libraries and Newham’s Family Hubs, where every family receiving support through a Hub will automatically be enrolled with their local library. This initiative is designed to strengthen community connections and promote early literacy for families with the greatest needs.

2025/26 update:

Bookstart packs were delivered to everyone who was eligible, with the majority delivered through Children’s Centres, private, voluntary and independent providers, and family support partners including Newham Nurture, The Magpie Project and Happy Baby Community. 4,620 baby packs were delivered, 1,960 toddler packs (with 320 extra packs awarded this year due to our effective partnership working with The Magpie Project, Newham Nurture and Happy Baby Community) and 3,822 pre-schooler packs.

We worked with Family Hubs and the Health Visiting team to achieve library enrolment as part of their engagement with families, with the goal of increasing our early engagement with families through our Library Service to help promote literacy and a lifelong love of reading, language development, improve early years outcomes and access to information and support from birth.

In 2026/27:

We will achieve 100% distribution of Bookstart packs within the programme cycle. This means delivering the packs to all eligible babies and children: 5,760 baby packs, 1,638 toddler packs and 3,822 pre-schooler packs.

We will deepen engagement in the most deprived areas through targeted outreach sessions, including library-led visits and pop-ups in Family Hubs and community venues. We will embed automatic enrolment for library membership from birth through partnership with the Health Visiting team and Family Hubs as part of the Best Start in Life programme. As part of the next phase of the programme, we will set targets for the number of families to be automatically enrolled.

Promoting health through housing

Step 35: Design healthy homes

KPI	Baseline value (date)	2024/2025 value (date)	2025/2026 value (date)
Number of properties inspected per year	10,470 (2023/24)	11,065 (2024/25)	10,636 (2025/26)

Equity objective:

Use Social Value Health Impact Assessments to promote health equity through major housing developments and other relevant developments.

2025/26 goal:

The social value and health impact assessment (SV-HIA) policy will be implemented once the Local Plan is adopted.

2025/26 update:

Policy BFN3 in the draft Local Plan commits to requiring developments in Newham to undertake social value and health impact assessments, delivering social value, health and wellbeing: all developments in Newham should maximise social value and to make a positive contribution to the health and wellbeing of our communities. This policy already holds significant weight and is being used in pre-application discussions.

In 2026/27:

Policy BFN3 is expected be adopted by the end of 2026, when the council adopts the Local Plan at Full Council. Once adopted, the policy is supported by a suite of practical implementation tools, including a Guidance Note for applicants, a Screening Tool integrated into the validation process, and a social value and health impact assessment (SV-HIA) checklist providing a structured assessment framework. The SV-HIA assessment framework will ensure that planning decisions contribute directly to improving health equity in the borough.

Step 36: Prevent homelessness and promote the health of people living in insecure or low-quality accommodation

KPI	Baseline value (date)	2024/2025 value (date)	2025/2026 value (date)
Number of people sleeping rough on a single night	23 (Apr 24)	17 (Mar 25)	14 (Mar 26)

Equity objective:

Reduce the disproportionate impact of homelessness on health through strong multi-agency partnership working.

2025/26 goal:

Begin implementing the North East London Homeless Health Strategy in Newham, connected to delivery of 50 Steps and Newham’s Homelessness Response Programme.

2025/26 update:

We worked in partnership with stakeholders, residents and Housing colleagues to develop a comprehensive Homelessness and Rough Sleeping Needs Assessment. This looked at the scale, drivers and impact of homelessness in Newham, using the data, evidence and national policies to make recommendations for ways to reduce the scale and impact of homelessness. It looked in particular at the inequities in homelessness – whether certain groups were disproportionately more likely to become homeless or experience greater harms when homeless and whether certain groups were disproportionately more likely to remain homeless for longer.

In 2026/27:

We will complete the Homelessness and Rough Sleeping Needs Assessment, co-developing the recommendations with stakeholders across the homelessness system. These recommendations will feed into the new Homelessness and Rough Sleeping Strategy, ensuring that the new strategy addresses the inequities in homelessness.

Step 37: Reduce the number of cold homes by tackling fuel poverty and making homes more energy efficient

KPI	Baseline value (date)	2024/2025 value (date)	2025/2026 value (date)
Number of residents supported by the Stay Warm in Newham Project and the Community Charged Energy Support Programme	Stay Warm in Newham Project: 141 residents Community Charged Energy Support Programme: 187 Households (2023/24)	Stay Warm in Newham Project: 201 residents Community Charged Energy Support Programme: 459 Households (2024/25)	No data (project funding ended)

Equity objective:

Prioritise fuel-poor households for financial support.

2025/26 goal:

Develop innovative approaches to target financial support to those with the greatest needs, such as those experiencing fuel poverty and groups most vulnerable to cold homes, such as young children and older people.

2025/26 update:

We used insights from data to proactively identify and engage older residents who may be entitled to Pension Credit and other financial support, helping 242 residents claim Pension Credit worth £1.1 million. We delivered advice and support through co-located services in Family Hubs and NHS clinical settings, enabling earlier intervention and improved access for vulnerable households who may not otherwise seek support. Through the Household Support Fund, we provided targeted financial support to more than 30,000 households with children, helping families manage the impact of rising living cost. We generated £4.4 million in additional income for residents, helping households manage rising living costs and reducing the risk of financial hardship. All these groups who are in need of financial support are also likely to be at risk of fuel poverty.

In 2026/27:

Continue to target financial support to those with the greatest needs, such as those experiencing fuel poverty and groups most vulnerable to cold homes, such as young children and older people.

Increasing participation in leisure and sport

Step 38: : Increase access to leisure and sport through community-based programmes

KPI	Baseline value (date)	2024/2025 value (date)	2025/2026 value (date)
Number of attendances at community leisure programmes	30,535 (Apr 23 – Jan 24)	14,702 (2024/25)	17,518 (2025/26)

Note:

Greenwich Leisure Ltd (GLL) took over operation of the community leisure programme in April 2024. Attendances were lower in 2024/25 while GLL mobilised the new community programme. Data from 2025/26 show attendances at leisure programmes are increasing, and the Step 39 KPI shows that attendances at leisure centres have also been going up.

Equity objective

Ensure that people accessing BetterPoints are representative of the Newham population.

2025/26 goal:

Target specific demographic groups that are under-represented in BetterPoints. For example, introduce a Travel for Worship programme to engage more residents from under-represented ethnic groups.

2025/26 update:

We used the DILLN (Does it Look Like Newham) tool to better understand the demographics of current users of BetterPoints, to understand where a targeted approach was required. The insight showed that there was an over-representation of residents from White British (7%), Indian (4%) and Pakistani (4%) groups and under-representation of residents from Other White (5%), Black African (4%) and Bangladeshi (4%) groups using the app compared to the age 15+ population. In addition, most users of the app were female.

We implemented the 'Travel for Worship' campaign to gain a more detailed understanding of different ethnic groups' engagement levels and how we can extend the programme's reach into more diverse communities. We started producing monthly case studies to engage residents from culturally diverse backgrounds and males.

In Year 2 there was a total of 3,097 registered users using the Better Points app, compared to 2,125 in Year 1.

In 2026/27:

We will adapt comms messaging to link better with cultural dates (e.g. Ramadan), and continue to promote travel to worship to engage more residents from under-represented ethnic groups.

We will review the way schools participate in the Primary School Challenge to make sure the approach is fair for schools of different sizes (at present, smaller schools have an advantage, meaning they are more likely to win prizes in the Challenge). For example, in 2026/27 we will be offering an additional prize to the school with the most participants taking part, which will benefit larger schools.

Step 39: Deliver a high-quality and accessible sport and physical activity offer in Newham

KPI	Baseline value (date)	2024/2025 value (date)	2025/2026 value (date)
Number of participants and attendances at leisure centres, including inactive populations	1,021,065 (Apr 23 – Jan 24)	1,147,299 (2024/25)	1,246,257 (2025/26)

Equity objective:

Ensure that people using Newham’s leisure centres are representative of Newham’s population.

2025/26 goal:

Analyse demographic representation using the Newham Health Equity Toolkit DILLN (Does It Look Like Newham) tool and use the findings to introduce targeted campaigns.

2025/26 update:

Work was undertaken with Greenwich Leisure Limited (GLL) to establish better data accuracy, allowing the full dataset to be analysed using the DILLN tool in 2026/27.

A Physical Activity Needs Assessment was undertaken in 2025/26, showing that Newham has lower physical activity rates for both adults and children and young people compared to London and England averages. In 2024/25, an estimated 31% of adults were inactive, compared with 25% across London and nationally, and an estimated 33% of children and young people were less active (less than 30 minutes of activity per day) compared to 30% in London and 28% in England. The needs assessment also highlighted that inactivity is more likely among women and girls, older people (55-74), people from low-income households, people with a disability and residents from Asian groups (particularly women). We predict that the forthcoming DILLN review will also highlight some of these inequalities in use of leisure centre facilities.

In 2026/27:

We will undertake the DILLN review to understand whether people using Newham’s leisure centres are representative of Newham’s population. This will include reviewing usage by protected characteristics and wider inclusion factors such as age, gender, ethnicity, disability and deprivation. We will then undertake targeted communications and develop targeted initiatives and programming of the current offer to address equity gaps.

Step 40: Deliver high-quality leisure facilities and infrastructure

KPI	Baseline value (date)	2024/2025 value (date)	2025/2026 value (date)
Number of new or improved sports, leisure and play facilities	5 (2023/24)	8 (2024/25)	13 (2025/26)

Equity objective:

Prioritise areas most in need for new or improved leisure, sport and play facilities.

2025/26 goal:

Use intelligence on needs and gaps in the borough, including from National Governing Bodies, local data and resident feedback to inform future facilities and upgrades.

2025/26 update:

Work is under way to finalise the fit out of the new Manor Park gym, with plans to open in 2027. This will provide a new, state-of-the-art gym in a neighbourhood that is currently underserved.

The capital investment programme was successfully completed at Newham Leisure Centre, including the development of new soft play provision and party room, a refreshed gym and studio space with new equipment, creation of a women's-only gym and spin room. There were approximately 30,000 visits to soft play since September 2025 and there was a steady increase in health and fitness memberships.

A one-year extension was agreed for the equipment lockers for 10 lockers and planning applications were submitted for both Beckton District Park South and Plaistow Park PlayZones. The capital investment programme was successfully completed at East Ham Leisure Centre, including refurbishment to the gym, free weights area, studio and women's-only gym, new equipment and flooring in the studio space. There was a steady increase in health and fitness memberships.

The wheeled sports offer was completed at King George V, with plans to launch and activate in summer 2026.

In 2026/27:

The next phase of work includes (not exhaustive list):

- Swing Fitness boxes
- Star Park Basketball Court improvements
- New Beckton Park Community Sports Facility (UEL/Football Foundation/Essex FA)
- Tennis/padel improvements
- Identify further priority sites as identified through the emerging leisure strategy
- Play improvements (sites TBC)

Case study

BetterPoints Newham Challenge

The BetterPoints Newham Challenge launched in March 2024 as a three-year behaviour change programme designed to incentivise active travel and increase physical activity among inactive residents and staff. Using the BetterPoints app, users have their activity automatically recorded and are rewarded with BetterPoints, a digital currency that can be exchanged for shopping vouchers or donated to charity. To support users in meeting national physical activity guidelines, participants earn one point per minute of activity, up to 150 minutes per week, and are entered into daily and weekly prize draws, helping to build motivation, sustain engagement and encourage long-term active lifestyles.

Once users have completed 100 activities, they are invited to tell us their story of how they have become more active since using the app. We are using their stories to help inspire others in the borough to move more and earn rewards.

“

I walk to many places instead of using public transport, and I recently invested in a bicycle, which I use in the evenings to cycle around parks and even for grocery shopping. I've lost more than 7kg since using the app. My energy levels have gone up, my stamina has improved significantly and so has my metabolism. I feel much lighter and happier. The challenges on the app keep me going, and they make staying active fun and rewarding.”

Sharmin, Newham resident and one of the Move More Motivators



Building an inclusive economy



Step 41: Support residents to achieve financial security

KPI	Baseline value (date)	2024/2025 value (date)	2025/2026 value (date)
Number and proportion of residents who are not claiming benefits that they are entitled to	New data	24,649 (estimated) (Apr 25)	25,892 (estimated) (Apr 25)

Note:

This data is based on initial information from the Low Income Family Tracker (LIFT) platform. It is an estimate and may be subject to change.

Equity objective

Focus support for those who are most in need by reducing disproportionality in uptake of benefits among those who are entitled to receive benefits.

2025/26 goal:

Implement interventions to improve targeting of, and access to, financial support by boosting capacity in the voluntary, community and faith sector and targeting the council’s Our Newham Money service to groups most at risk of crisis.

2025/26 update:

We provided targeted interventions to help residents claim the benefits to which they are entitled. These interventions were targeted towards residents with underclaimed benefits, often at the point of crisis, and achieved in excess of £4.4 million in income maximisation.

In 2026/27:

To deliver the Crisis and Resilience Fund, we will commission the VCFSE to offer community debt and benefit advice, based on the identified need and key cohorts, with a particular focus on supporting people from low-income backgrounds. We will work in partnership with the commissioned provider to ensure clear referral routes.

Step 42: Improve the contribution of work to people’s health and wellbeing

KPI	Baseline value (date)	2024/2025 value (date)	2025/2026 value (date)
Number of Newham employers signed up to London Living Wage	87 (Apr 24)	91 (Apr 25)	96 (Apr 26)

Equity objective:

Provide support for people from communities where work is least health promoting.

2025/26 goal:

We are aiming to have a joined-up system where there is no wrong front door.

2025/26 update:

Outreach and referral pathways across employment, health and community services continued to be strengthened, developing a ‘No Wrong Front Door’ approach to ensure that residents can access appropriate support regardless of their point of entry into services. We successfully implemented Connect to Work, which supports people with health conditions, and Individual Placement Support Drugs & Alcohol (IPSDA), which supports people with a history of drug and alcohol use to get into employment and training. Our summer jobs programme supported 13 young people aged 16-24 who face health-related issues.

In 2026/27:

We will strengthen our joined-up employment and health support system, ensuring there is no wrong front door for residents. Through improved referral pathways, targeted outreach, and partnership working across Connect to Work, IPSDA, health services, community organisations and Disability Confident employers, we will increase access to coordinated support and help more residents with long-term health conditions to move into sustainable, health-promoting employment.

We will use resident feedback and lived experience insights to continuously adapt and improve services, ensuring support remains accessible, responsive and tailored to residents’ needs.

We will also be launching the Newham Youth Hub, a collaboration between Newham, DWP and West Ham Foundation. This will be based at West Ham Facility in Beckton and will be providing dedicated support to young people aged 16-24.

Partnerships rooted in the community

Step 43: Deliver and embed the Well Newham programme

KPI	Baseline value (date)	2024/2025 value (date)	2025/2026 value (date)
Number of residents engaging with the Well Newham Directory of Service	20,612	13,875	17,687 (2025/26)

Note:

The figures for the previous years (baseline and 2024/25) have been corrected in this report after we found an error in previous reporting. All three years shown are now comparable, showing that referrals via the Well Newham Directory of Service (Joy) went up between 2024/25 and 2025/26.

Equity objective

Ensure residents engaging with Well Newham are representative of Newham’s population.

2025/26 goal:

We have a target to increase ethnicity data capture by 10% to support continual improvement in equity. In addition, accessibility considerations will continue to be a focus in 2025/26 to improve access for all.

2025/26 update:

There was a 38% increase in the ethnicity recording on Joy compared to Year 1. Out of the total referrals, 29% had their ethnicity data recorded.

Out of those whose ethnicity is reported, there was an over-representation of White British, Bangladeshi and Black African population groups and Indian, Other White and Pakistani population groups were under-represented (as compared to Newham population estimates).

In 2026/27:

We aim to improve recording of ethnicity data on Joy, with a target of ethnicity being recorded for at least 50% of all referrals. To achieve this, we will initiate regular community practice calls with social prescribers and engage with GP practice managers to reinforce the importance of collecting and recording ethnicity data, improving both awareness and data quality.

Step 44: Build a social movement for health

KPI	Baseline value (date)	2024/2025 value (date)	2025/2026 value (date)
Number of organisations and community members involved in the social movement programme	297 (Apr 24)	664 (Apr 25)	717 (2025/26)

Equity objective:

Increase the number of organisations involved in social movement activities that are led by people from Newham communities.

2025/26 goal:

Collect and interpret data on the diversity of VCFSE organisations involved in our ‘social movement for health’ to understand representation and identify gaps.

2025/26 update:

The community basic health checks and training programme grew to 21 participating organisations. The organisations represented a broad range of community interests and support services, including food banks, faith-based organisations, men’s mental health initiatives, deaf community integration and support services, homelessness support and a range of other community-based initiatives. A geographical gap was identified in the southwest of the borough so four new organisations were recruited within this area.

In 2026/27:

We will identify any gaps in community representation in the basic health checks and training programme, with an initial focus on North Woolwich, which has a lack of health prevention-related services.

To address identified gaps, we will use PLINTH – the council’s customer relationship management platform – to connect and engage with organisations led by local people.

We will review the reach of organisations that are already in the programme and recruit new organisations to fill any gaps in provision for identified cohorts, using the DILLN (Does it Look Like Newham) tool and CVD risk and prevalence data to establish priority cohorts.

We will continue to work with NHS partners to support VCFSE organisations with training on health priorities, including cholesterol, diabetes, nutrition, and weight management.

Step 45: Make health promotion and communications more inclusive so all residents can get the information they need

KPI	Baseline value (date)	2024/2025 value (date)	2025/2026 value (date)
Visits to website pages that relate to key health promotion campaigns	2652 (Stop smoking (1362); Stoptober (384); Kickstart (595); Diabetes (195); Winter wellness (116) New: Total page views: 25,110	2,222 (Stop smoking (1380); Stoptober (169); Kickstart (23); Diabetes (436); Winter wellness (214) New: Total page views: 27,529	Top Pages: 2,563 (Helping everyone in newham to live well), 1,805 (What's on near me?), 1,471 (Events for frontline workers, volunteers and champions), 1,058 (Stop Smoking) New: Total page views: 39,353

Equity objective:

Increase access for Deaf residents for health promotion activity.

2025/26 goal:

Increase Well Newham activities targeted or tailored to Deaf residents. Create a Deaf-specific Well Newham webpage and set a target of at least 100 page views.

2025/26 update:

A Deaf-specific Well Newham webpage was created and had 830+ views, far exceeding our target of 100 views. We also delivered up to 12 engagement sessions with residents through our Community Champions programme, with British Sign Language (BSL) interpreters in attendance to ensure accessibility. In addition, we increased the promotion of services available through Joy over the past year, helping to improve awareness and access to support for Deaf residents.

In 2026/27:

We will aim for a further increase in uptake of Well Newham events for Deaf residents. We aim to double the number of views of the Deaf-specific Well Newham webpage and hold Well Newham events with Deaf residents. This will be done by further strengthening our partnership with Healthwatch and Deafroots, such as through our summer and winter events, co-production activities and neighbourhood engagement events.

Step 46: Improve health literacy and cultural competence across Newham

KPI	Baseline value (date)	2024/2025 value (date)	2025/2026 value (date)
Number of live health literacy improvement initiatives across system partnership	New data	3 (2024/25)	3 previous projects completed, 3 new projects live and 2 projects in academic partnerships ongoing, 1 being planned

Equity objective:

Prioritise groups with the lowest health literacy in interventions to improve health literacy.

2025/26 goal:

Complete the evaluation of the health literacy pilots to identify key learnings and inform future activities.

2025/26 update:

Three health literacy pilot projects, targeted to those with the lowest levels of health literacy, took place in 2025/26. The aim was to understand what works to improve health literacy in Newham.

The language review of Newham Hospital letters successfully identified issues with outpatient appointment letters and led to improved contact information, a new SOP and a governance process for reviewing content.

Fake Health News sessions helped young people build confidence and skills to identify and question health misinformation online. Following positive feedback, the session was co-produced with Young Health Changemakers and will be adapted for delivery in schools.

The school project helped identify opportunities to integrate health access and rights content into the PSHE/RSHE curriculum, informed by engagement with school health and wellbeing leads. It shaped the development of Newham-specific resources to help young people understand their health rights, available services and how to access support.

In 2026/27:

We will establish and implement a set of health literacy standards for all Public Health campaigns and communications. These standards will include designing content for the average reading age of Newham residents, using plain language, prioritising visual over text-heavy communications, presenting clear and actionable messages and applying accessible design principles. We will complement this with targeted training for healthcare and behaviour change professionals to help them identify and address health literacy barriers within their populations. As part of this work, we will deliver three to five campaigns using these standards and develop a training package to build capability across the system.

Case study

Newham Community Health Champions

The Newham Community Health Champions programme was established in May 2020 as the first in the country in response to COVID-19. The crisis highlighted the need to reach residents through trusted community voices. Using accessible tools such as WhatsApp, simple infographics and Zoom sessions, residents were supported to share accurate health information within their own networks and feed community concerns back to Public Health. Champion insight directly influenced Newham's local COVID-19 response. The model became nationally recognised, with Newham leading the pan-London Champions Coordinators Network until 2025.

COVID-19 exposed long-standing health inequalities linked to access, trust and awareness. When the emergency phase ended, these challenges remained. The programme was relaunched in July 2024 to protect this legacy and shift from crisis response to long-term prevention and health equity, ensuring ongoing two-way dialogue between communities and Public Health.

Over 530 Community Health Champions are now connected, sharing health information, training opportunities and community insight. Champion feedback continues to inform work on priorities including mental health, diabetes and screening uptake. The approach is now also used across the council to support themed Champion networks, such as Autism, Ramadan, Cost of Living and Screening Champions.

The network will continue to grow, with targeted Champion programmes, training and peer support to address priority health inequalities.



Driving quality across our health and care partnership

Step 47: Improve equity in health and care by embedding a culture of curiosity and improvement in the Newham Health Equity Programme

KPI	Baseline value (date)	2024/2025 value (date)	2025/2026 value (date)
Number of anchor organisation services and teams participating in Health Equity Programme improvement activity	2 (Apr 24)	187 (Apr 25)	LBN Senior Leadership Forum (100) Adult Social Care Commissioning (30) FH teams (5) Benefits (3) Placemaking (1) Public Health (7) East London Foundation Trust Neighbourhoods (40) Libraries (2) Total: 188

Equity objective:

Increase the number of services that better serve the population profile of Newham.

2025/26 goal:

Aim to increase the number of services using the DILLN (Does it Look Like Newham) tool.

2025/26 update:

In 2025/26 over 30 projects used the DILLN (Does it Look Like Newham) tool.

Uptake was achieved on an organisational wide level, including use in Adult Social Care, Children's Social Care, Public Health, ELFT and Newham Health Collaborative's Roving Team for Primary Care, as well as interest and uptake from non-health related teams, such as Council/Tax benefits, Placemaking & Complaints teams.

We collaborated with the council strategy team and head of equity, diversity and inclusion (EDI) to introduce equity as a key creator of benefit across the council senior leadership teams. We continued to work with the strategy team to embed the toolkit into core processes e.g. equality impact assessments.

In 2026/27:

We will continue to support teams to progress through the 'Four Stages to Improving Equity' framework. We will continue to jointly develop, implement and measure the impact of change ideas in Children's Social Care and Adult Social Care equity improvement deep dives. We will create a programme evaluation framework and strengthen the system enablers to support this work. Finally, we will work with NHS colleagues implementing Neighbourhood Health to ensure this approach to equity can be embedded as a core principle and practice.

Step 48: Reduce variation across health and care in Newham

KPI	Baseline value (date)	2024/2025 value (date)	2025/2026 value (date)
Proportion of patients aged under 80 with high blood pressure who are effectively treated (to target)	New data	65%	67%

Equity objective:

Reduce primary care variation in effective blood pressure management.

2025/26 goal:

Develop an improvement action plan, considering how to enable and support all practices to achieve good standards of care and reduce unwarranted variation.

2025/26 update:

In 2025/26 we analysed blood pressure management at Primary Care Network (PCN) and GP practice levels, looking at the proportion of patients under 80 years old with hypertension whose last blood pressure reading was to the appropriate treatment threshold (termed ‘treatment to target’).

The PCNs in north Newham and northeast Newham were achieving the highest levels of treatment to target, all above 70%. The lowest-scoring PCN was achieving treatment to target in 57% of cases. There was substantial variation among individual GP practices, ranging from 49% to 94%.

In 2025/26, the local Neighbourhood Health priorities were developed. The South-West locality prioritised preventing uncontrolled hypertension and reducing the health burden of cardiovascular disease to improve outcomes and address inequities, including the gap between practices.

In 2026/27:

The South-West locality will design and pilot ways to improve treatment of high blood pressure to improve outcomes and reduce inequities, including variation between practices in the locality. This will be in partnership with Public Health, the Newham Health Equity Programme and the pan-London Million Hearts and Minds Campaign, and will embed equity from the start, focussing on Black African, Black Caribbean and socioeconomically deprived groups and addressing variation between practices. As part of Newham’s Neighbourhood Health programme, it will also create learning which can be scaled across the borough.

Partnering in research, data and intelligence

Step 49: Develop the Newham Centre for Health and Care Equity

KPI	Baseline value (date)	2024/2025 value (date)	2025/2026 value (date)
Number of Centre for Health and Care Equity outputs	10 (2023/24)	5 (2024/25)	5 masters dissertation collaborations 100+ students from UEL and QMUL undergraduate student placements from across disciplines—marketing, business and medicine

Equity objective:

Focus the Centre's research and learning on clearly defined equity issues in Newham.

2025/26 goal:

Strengthen the three-way collaborative working between communities, universities and the council and improve how local research is used to inform policy and practice.

2025/26 update:

There were five masters dissertation collaborations and 100+ students from the University of East London (UEL) and Queen Mary University London (QMUL) undergraduate student placements from multiple disciplines – marketing, business and medicine (building on 2024/25 which saw five masters dissertation collaborations and no student placements).

Dissertation topics focussed on discrete, defined inequalities issues relating to the 50 Steps strategy, such as food security, breastfeeding support, health literacy and more. In addition, student placements gave local students the opportunity to contribute to the body of research on health inequalities in Newham.

We initiated a review of the Centre in partnership with university and VCFSE partners to understand progress and impact so far and inform the next phase of activities.

In 2026/27:

We will co-produce a theory of change for the Centre with input from all key stakeholders (university, council, VCFSE). From there we will build a learning and evaluation framework.

A theory of change will allow the Centre to refine its priorities on specific equity issues and areas which will allow us to focus our efforts to allocate time and resource more effectively to address health equity.

Step 50: Make the best use of intelligence and insight to drive decision-making

KPI	Baseline value (date)	2024/2025 value (date)	2025/2026 value (date)
Delivery of key outputs including 50 Steps refresh, JSNA and place based intelligence		Key public health intelligence outputs in 2024/25: • Newham Joint Strategic Needs Assessment (JSNA) 2025 • Newham Children's JSNA 2025 • 2025 Neighbourhood Profiles • DILLN (Does it look like Newham) tool • Long-term condition dashboard • Depression Equity Dashboard • Schools Equity Dashboard • Avoidable Hospital Admissions Dashboard • Suicide Dashboard • Adult Social Care JSNA & needs assessment • Adult Safeguarding equity analysis • Children's Services equity analysis All outputs include equity analysis.	Health needs population surveillance including measures of equity Equity analysis of reablement, hospital re-admissions and avoidable admissions Development of new system to monitor uptake of Healthy Start Vitamins and Vitamin D programme including equity analysis

Equity objective:

Continue analysing equity in all public health analysis and increase the range of datasets that are suitable for equity analysis. We will update on this objective through narrative description about the datasets and analysis available.

2025/26 update:

All analyses continued to include consideration of equity issues and analysis of variation by ethnicity where data allows. Recent work highlighted inappropriate ethnicity coding used across the council in line with national guidance and discussions were begun to try and adopt accurate practice locally.

Examples of equity work based on ethnicity included:

- Analysis of Early Help data, showing that children of Black African ethnic groups tend to be more represented in targeted or specialised services and less represented in universal services. This allowed Children's Services to consider how to better reach resident groups in universal services more effectively rather than allowing Black African families to rely on more acute services where need is more advanced.
- Analysis of adult social services use by ethnicity, which found that typically communities of Asian ethnic groups often had lower use of services and in particular were less likely to take up Direct Payments. Equity was one of two areas of Adult Social Care practice rated 'good' by CQC in the 2025 inspection.

In 2026/27:

Work in 2026/27 will continue to include consideration of equity issues which is standard practice in intelligence analysis. Equity analysis of use of adult social services by ethnicity will be repeated to determine whether any changes in use of service by ethnicity have happened.

An Adult Social Care Tackling Racism, Inequality and Disproportionality programme will be set up with directorate-level steering groups.

Appendix: outcome indicators

Overarching outcomes

Outcome	Baseline		Year 1 (2024/25)		Year 2 (2025/26)		Comparison to London average	Comparison to 2019
	Data year	Value	Data year	Value	Data year	Value		
Life expectancy at birth, males	2022	78.9	2023	Males = 79.0	2025	Males = 80.1		↗
Life expectancy at birth, females	2022	83.0	2023	83.5	2025	84.1		→
Healthy life expectancy, males	2020-22	62.7	2021-23	61.8,	2022-24	62.8		→
Healthy life expectancy, females	2020-22	63.3	2021-23	62.2	2022-24	63.1		→
Premature mortality rate, males	2022	461.0 / 100,000	2023	446.1 / 100,000	2025	428.3 / 100,000		↘
Premature mortality rate, females	2022	272.6 / 100,000	2023	254.6 / 100,000	2025	260.2 / 100,000		→
Inequality in life expectancy, males	2017-19	7.2 years	2018-20	8.1 years	2022-24	5.7 years		↘
Inequality in life expectancy for males, females	2017-19	5.7 years	2018-20	6.6 years	2022-24	0.3 years		↘
Percentage of residents with high or very high life satisfaction	2022	65%	2023	56%	2025	86% (Note: new methodology)	Cannot be calculated	New methodology

50 Steps theme: people

Outcome	Baseline		Year 1 (2024/25)		Year 2 (2025/26)		Comparison to London average	Comparison to 2019
	Data year	Value	Data year	Value	Data year	Value		
Prevalence of breastfeeding 6-8 weeks after birth	2022/23	39%	2023/24	52%	2024/25	56%	Cannot be calculated	↗
Proportion of children ready for school	2022/23	71%	2023/24	71%	2024/25	72%		↗
Prevalence of children's healthy weight, reception	2022/23	76%	2023/24	77%	2024/25	77%		↗
Prevalence of children's healthy weight, Year 6	2022/23	52%	2023/24	55%	2024/25	54%		→
Percentage of 5-year-olds with dental decay	2021/22	34%	2022/23	40%	2023/24	40%		↗
Number of young people who report feeling safe in their local area (daytime), age 16-24	2022	59%	2023	51%	2025	92% (Note: new methodology)	Cannot be calculated	New methodology
Depression prevalence (18+)	2022/23	6.7%	2023/24	7.0%	2024/25	8.1%		↗
Proportion of residents who always or often feel lonely	2020-22	9%	2021-23	9%	2022-24	8.5%		↘
Suicide rate	2020-22	5.9 / 100,000	2021-23	4.7 / 100,000	2022-24	4.6 / 100,000		↘
Diabetes prevalence	2022/23	9%	2023/24	9%	2024/25	9%		↗
Coronary heart disease prevalence	2022/23	1.6%	2023/24	1.7%	2024/25	1.7%		→
Cardiovascular disease mortality, males	2022	321 / 100,000	2023	310 / 100,000	2025	296 / 100,000		↘
Cardiovascular disease mortality, females	2022	209 / 100,000	2023	201 / 100,000	2025	197 / 100,000		↘
Cancer mortality, males	2022	263 / 100,000	2023	311 / 100,000	2025	250 / 100,000		→

Outcome	Baseline		Year 1 (2024/25)		Year 2 (2025/26)		Comparison to London average	Comparison to 2019
	Data year	Value	Data year	Value	Data year	Value		
Cancer mortality, females	2022	183 / 100,000	2023	202 / 100,000	2025	204 / 100,000		→
Cervical screening coverage, age 25-49	2023	57%	2024	56%	Data not available	Data not available		↘
Cervical screening coverage, age 50-64	2023	72%	2024	72%	2025	72%		↘
Colorectal screening coverage	2023	57%	2024	57%	2024	57%		↗
Breast screening coverage, age 53-70	2023	48%	2024	52%	2025	56%		→
Emergency admissions due to falls, age 65+	2022/23	1,421 / 100,000	2023/24	1,739 / 100,000	2024/25	1,758 / 100,000		↘
Prevalence of adults overweight/obese	2021/22	47%	2022/23	63%	2024/25	62%		↘
Smoking prevalence	2022	11%	2023	13%	2024	11%		↘
Smoking prevalence in routine and manual occupations	2022	10%	2023	9%	N/A	Data unavailable: there has been no update since 2023		↘
MMR vaccination coverage (2 doses at 5 years old)	2022/23	68%	2023/24	68%	2024/25	67%		↘
Flu vaccination coverage, age 65+	2022/23	63%	2023/24	60%	2024/25	55%		↘
Incidence of TB	2019-21	42 / 100,000	2020-2022	41 / 100,000	2022-2024	41 / 100,000		→
Late HIV diagnoses	2020-22	38%	2021-2023	46%	2022-24	45%		↗
New STI diagnosis rate	2022	1,160 / 100,000	2023	1,263 / 100,000	2024	1,311 / 100,000		↗
Successful completion of drug treatment, opiate	2022/23	2.6%	2023/24	4.6%	2024/25	4.4%		→
Successful completion of drug treatment, non-opiate	2022/23	22%	2023/24	18%	2024/25	23%		→

50 Steps theme: place

Outcome	Baseline		Year 1 (2024/25)		Year 2 (2025/26)		Comparison to 2019	Comparison to 2019
	Data year	Value	Data year	Value	Data year	Value		
Proportion eating '5 a day'	2021-22	26%	2022/23	21%	2024/25	20%		↘
Proportion of physically active adults	2022/23	58%	2023/24	61%	2024/25	59%		↗
Proportion of residents with high or marginal food security	2021	51%	2022	41%	Data not available	Data unavailable: there has been no update since 2022	Cannot be calculated	No long-term trend data
Number of households in temporary accommodation	2021/22	5579 households	2023/24	6154 households	2024/25	6777 households		↗
Proportion of deaths attributable to particulate air pollution	2022	7.5%	2023	6.6%	2024	7.2%	Cannot be calculated	↘
Proportion of trips made by walking, cycling or public transport	2021	76%	2024	70%	Data not available	Data not available		→
Proportion of households in homes in fuel poverty	2021	18%	2022	15%	2023	13%	Cannot be calculated	↘
Winter mortality index	Aug 2020 - July 2021	104.80%	Aug 2021 - July 2022	10.20%	Data not available	Data not available		→
Proportion of people in employment, age 16-64	2022/23	75%	2023/24	71%	2024/25	66%		↘
Proportion of people in employment, age 50-64	2022/23	55%	2023/24	69%	2024/25	67%		→

To find out more:
newham.gov.uk/50Steps

