Barking & Dagenham

Notice of Meeting

HEALTH & WELLBEING BOARD

Tuesday, 8 November 2022 - 6:00 pm
Council Chamber, Town Hall, Barking

Date of publication: 31 October 2022

Fiona Taylor
Acting Chief Executive

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Membership

Cllr Maureen Worby (Chair)	LBBD (Cabinet Member for Adult Social Care and Health Integration)
Dr Ramneek Hara	NHS North East London Integrated Care Board
Elaine Allegretti	LBBD (Strategic Director, Children and Adults)
Matthew Cole	LBBD (Director of Public Health)
Louise Jackson	Metropolitan Police
Cllr Syed Ghani	LBBD (Cabinet Member for Enforcement and Community Safety)
Kathryn Halford	Barking Havering & Redbridge University NHS Hospitals Trust
Cllr Jane Jones	LBBD (Cabinet Member for Children's Social Care and Disabilities)
Cllr Elizabeth Kangethe	LBBD (Cabinet Member for Educational Attainment and School Improvement)
Sharon Morrow	NHS North East London Integrated Care Board
Elspeth Paisley	BD Collective (Lifeline Community Resources)
Nathan Singleton	Healthwatch - Lifeline Projects Ltd.
Melody Williams	North East London NHS Foundation Trust

Standing Invited Guests

Cllr Paul Robinson	LBBD (Chair, Health Scrutiny Committee)
Narinder Dail	London Fire Brigade
Anju Ahluwalia	Independent Chair of the B&D Local Safeguarding Adults Board
Vacant	London Ambulance Service
Vacant	NHS England London Region

AGENDA

1. **Apologies for Absence**

2. **Declaration of Members' Interests**

   In accordance with the Council's Constitution, Members of the Board are asked to declare any interest they may have in any matter which is to be considered at this meeting.

3. **Minutes - To confirm as correct the minutes of the meeting on 13 September 2022 (Pages 3 - 8)**

4. **Covid-19 Update in the Borough (Pages 9 - 18)**

5. **Annual Report of the Director of Public Health (Pages 19 - 63)**

6. **NEL Integrated Care Strategy Update (Pages 65 - 74)**

7. **Barking and Dagenham Place-based Partnership Winter Summit (Pages 75 - 86)**

8. **Healthwatch programme of work - 22/23 Progress Report (Pages 87 - 151)**

9. **Forward Plan (Pages 153 - 159)**

10. **Any other public items which the Chair decides are urgent**

11. **Any other confidential or exempt items which the Chair decides are urgent**

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Barking & Dagenham

Our Vision for Barking and Dagenham

ONE BOROUGH; ONE COMMUNITY; NO-ONE LEFT BEHIND

Our Priorities

Participation and Engagement

- To collaboratively build the foundations, platforms and networks that enable greater participation by:
  - Building capacity in and with the social sector to improve cross-sector collaboration
  - Developing opportunities to meaningfully participate across the Borough to improve individual agency and social networks
  - Facilitating democratic participation to create a more engaged, trusted and responsive democracy
- To design relational practices into the Council's activity and to focus that activity on the root causes of poverty and deprivation by:
  - Embedding our participatory principles across the Council's activity
  - Focusing our participatory activity on some of the root causes of poverty

Prevention, Independence and Resilience

- Working together with partners to deliver improved outcomes for children, families and adults
- Providing safe, innovative, strength-based and sustainable practice in all preventative and statutory services
- Every child gets the best start in life
- All children can attend and achieve in inclusive, good quality local schools
- More young people are supported to achieve success in adulthood through higher, further education and access to employment
- More children and young people in care find permanent, safe and stable homes
- All care leavers can access a good, enhanced local offer that meets their health, education, housing and employment needs
- Young people and vulnerable adults are safeguarded in the context of their families, peers, schools and communities

- Our children, young people, and their communities' benefit from a whole systems approach to tackling the impact of knife crime
- Zero tolerance to domestic abuse drives local action that tackles underlying causes, challenges perpetrators and empowers survivors
- All residents with a disability can access from birth, transition to, and in adulthood support that is seamless, personalised and enables them to thrive and contribute to their communities. Families with children who have Special Educational Needs or Disabilities (SEND) can access a good local offer in their communities that enables them independence and to live their lives to the full
- Children, young people and adults can better access social, emotional and mental wellbeing support - including loneliness reduction - in their communities
- All vulnerable adults are supported to access good quality, sustainable care that enables safety, independence, choice and control
- All vulnerable older people can access timely, purposeful integrated care in their communities that helps keep them safe and independent for longer, and in their own homes
- Effective use of public health interventions to reduce health inequalities

Inclusive Growth

- Homes: For local people and other working Londoners
- Jobs: A thriving and inclusive local economy
- Places: Aspirational and resilient places
- Environment: Becoming the green capital of the capital

Well Run Organisation

- Delivers value for money for the taxpayer
- Employs capable and values-driven staff, demonstrating excellent people management
- Enables democratic participation, works relationally and is transparent
- Puts the customer at the heart of what it does
- Is equipped and has the capability to deliver its vision

MINUTES OF
HEALTH AND WELLBEING BOARD

Tuesday, 13 September 2022
(6:00 - 8:00 pm)

Present: Cllr Maureen Worby (Chair), Elaine Allegretti, Matthew Cole, Cllr Syed Ghani, Cllr Jane Jones, Sharon Morrow, Elspeth Paisley, Melody Williams and Kathryn Halford

Apologies: Dr Jagan John, Cllr Elizabeth Kangethe, Fiona Taylor, Sue Lees and Anju Ahluwalia

12. Declaration of Members' Interests

The Integrated Care Director (ICD) at the North East London Foundation Trust (NELFT) declared an interest in relation to Item 23 on the basis that NELFT are currently in the process of an asset transfer of the site and building to Barking, Havering and Redbridge NHS Trust (BHRUT).

The Chair ruled that this was not a disqualifying interest.

13. Minutes - To confirm as correct the minutes of the meeting on 14 June 2022

The minutes of the meeting held on 14 June 2022 were confirmed as correct.

14. Covid-19 Update in the Borough

The Director of Public Health (DPH) updated the Committee.

Cases numbers were low however the DPH cautioned that widespread testing was not being undertaken. The latest vaccination programme was being rolled out. The first phase involved vaccinating care home residents and the next phase would involve vaccinating over 50s.

It was intended that the Covid-19 and flu vaccine would be given at the same time, however this had still not been clarified. A new Covid-19 vaccine would be deployed which was designed to provide protection against the omicron variant as well as the original.

The start of the new school term and the Queen’s funeral will have an impact on cases and the DPH warned that the Winter period would be challenging. The DPH confirmed that, in Barking and Dagenham, it would be delivered via GPs.

The Board noted the update.

15. Monkey Pox Update

The DPH disclosed that London was the epicentre of the outbreak accounting for 69% of UK cases. 2,304 cases in London were confirmed. The number of cases had declined from 30-40 cases in June and July to five cases per day in August. Most cases had occurred among men who have sex with men. The DPH stressed

that the risk from monkeypox to the general population was small and that the situation continued to be monitored.

The Board noted the update.

16. Childhood Immunisations Report

The Public Health Principal (PHP) updated the board. Childhood immunisation rates in London were below World Health Organization targets and was lower in deprived communities. The PHP highlighted MMR, HPV and Flu vaccinations as a particular area of concern.

The PHP then outlined the plan of action to address the relatively low vaccination rates;

- A national MMR communications campaign;
- A Polio booster for children in London aged 1-9;
- Immunisation Co-Ordinators who are supported by practices;
- Communications with parents and guardians via schools;
- Vaccination ‘catch up’ clinics in community locations;

A campaign to promote childhood immunisations will be undertaken via

- Residents’’ newsletter;
- Council website and social media;
- Libraries and children centres;
- Family/Community hubs;
- Community and faith groups;
- Community events/festivals;

In response to questioning, the ICD explained that NELFT was providing child immunisation information, sending communications to families and contacting parents to ascertain why they were not vaccinating their children and challenging false perceptions relating to vaccines.

The Board noted the update.

17. Integrated Care System Place Arrangements

The DPH informed the Board that all key milestones had been delivered in terms of getting shadow arrangements for place-based partnership and the ICB Subcommittee. The inaugural meeting was due to take place on 29 September.

The DPH the explained how the governance structure would work. Place based governance would consist of the Partnership Board and the Integrated Care Board. The Health and Wellbeing Board would meet in common with the Partnership Board and Integrated Care Board.

As the first meeting in common it was planned to present the terms of reference for the Executive Committee, the Adult Delivery Group and Children Delivery Group for approval.

The DPH also announced that Dr Rami Hara would be joining the Health and Wellbeing Board as a representative of the Integrated Care Board whilst Sharon Morrow, previously the representative of the Clinical Commissioning Group, would continue as a representative of the Integrated Care Board on an interim basis.

The Integrated Care Partnership and the Health and Wellbeing Board will be required to work collaboratively on drawing up an Integrated Care Strategy. Plans produced by NHS North East London ICB will be subject to the approval of the Health and Wellbeing Board.

The Board noted that it has taken a considerable amount of time to establish the structure and that the governance requirements was greater, and some questions remained. The Board also noted the challenge for NHS NEL ICB as it covered seven boroughs which were considerable in their demographic differences. Additionally, the appointment of a new Secretary of State for Health and Social Care may result in further changes.

The Board noted the update.

18. Pharmaceutical Needs Assessment

A Representative from Healthy Dialogues (RHD), who assisted in carrying out the Pharmaceutical Needs Assessment (PNA).

RHD explained that the purpose of the PNA was to inform plans on the commissioning of specific and specialised pharmaceutical services and to support the decision making process for applications for new pharmacies undertaken by NHS England. The PNA will apply from 1 October 2022 to 30 September 2025.

The RHD said that the assessment concluded that Barking and Dagenham's pharmacy provision was satisfactory with 39 dispensing pharmacies within the borough as well as provision in neighbouring boroughs are within a mile of the borough borders. The RHD said that they could not foresee any gaps in provision and no areas were identified as in need of additional provision during the lifetime of the PNA.

The Local Pharmaceutical Committee (LPC) sits on the partnership board and have indicated that they favour developing joint services. Pharmacies have agreements with NHS England which include minimum opening hours. Commissioning would transfer to the ICB from April 2023.

The Board agreed to ratify the Pharmaceutical Needs Assessment.

19. Joint Strategic Needs Assessment

A summary of the Joint Strategic Needs Assessment (JSNA) was presented to the Board. The JSNA was jointly produced joints across Barking and Dagenham, Havering and Redbridge. The JSNA was grouped into four pillars.

The JSNA showed the following in relation to Pillar 1- wider determinants of health-

- Life expectancy in the borough was lower than for London and England;

- 19% of residents are income deprived compared to 11% in Havering and 12% in Redbridge;
- The unemployment rate in Barking and Dagenham was 9.1% compared to the London average of 6.5% and the England average of 5.1%.
- The proportion of working age people in employment was 62.6% compared to the rate in London of 73.8% and the rate in England of 74.7%.

In relation to Pillar 2-Health behaviours and lifestyle, the JSNA showed-

- 18.1% of adults in the borough smoked which was the highest rate in London;
- 66% of adults were overweight or obese which was the second highest rate in London;
- 10% of children were overweight or obese by the age of five which was the second highest figure in London;
- 50% of children were overweight or obese by the age of 11 which was the highest figure in London

In addition to this, the CPH added that 37.1% of alcohol dependent adults completed a course of treatment as did 5.7% of opiate users.

The Consultant in Public Health (CPH) disclosed that the priority actions would be social prescribing and to factor health into all policies undertaken by the Council and partner organisations.

In relation to Pillar 3-places and communities, the JSNA showed-

- 19.8% of adults walked as a form of travel, which was below the London average which was 22.1% and the England average which was 15.1%.
- Abbey and Gascoigne wards are at particular risk from climate change
- Air pollution was attributed to 6.8% of deaths which was higher that the figure for London which 6.4% and the England average which was 5.1%.

The priority action was address travel infrastructure and a partnership response to address climate change and air pollution.

In relation to Pillar 4-places and communities, the JSNA showed-

- 10.3% of Children and Young People had mental health issues which was higher than the England average of 9.2%;
- 49% of residents with a long term condition felt that they received the assistance that they needed;
- Upon attaining the age of 65, makes could expect to live for another 8.4 years and females for another 8.5 years. This was below the average for London and England.

The priority actions would be to strengthen children's adolescent services and to support older residents at risk of falls, social isolation, and preventable illness.

The DPH cautioned that progress on addressing the issues highlighted by JSNA had been disrupted by Covid-19 and that the legacy of the pandemic would negatively impact heart disease, diabetes and deaths at home.

The Chair, whilst acknowledging that there had been improvements over the last thirty years, concluded that the rate of improvement was not satisfactory noting that the issues identified in previous JSNAs had not been fully addressed. The ICD at NELFT acknowledged this noting that preventative action is challenging since it requires building up engagement with communities, especially deprived areas and motivating them to change. The ICD highlighted the issue of child obesity noting that many residents would be surprised at data showing 50% of children are overweight by the age of 11 as society has lost sight of what an ideal weight is and that addressing this would be a challenge.

The Board agreed to approve the Joint Strategic Needs Assessment.

20. Barking and Dagenham Place Partnership bid to NEL Integrated Care System for health inequalities funding in FY22/23

The CPH announced that the Council had succeeded in its bid for £1.1 million and work was underway on the work streams with BD Collective and Community Park. A clinical director had been appointed and it was intended that the partnership agreements would be concluded by the end of the September 2022.

The Board congratulated the public health team and their partners for their success and noted the report.

21. Barking and Dagenham Better Care Fund Plan

BCF provides funding support to councils and NHS organisations to jointly plan and deliver services. The fund consists of £30 million to improve social care outcomes such as community services, integrated discharge hub and initiatives such ‘home first’ and ‘discharge to assess.’ Among other areas, the BCF also pays for social workers, care packages as well as providing support for carers.

Since the inception of the BCF, the council has worked with Havering and Redbridge when it comes to submitting the bid to NHS England. The Director of Commissioning-Adults (DCH) explained that, every year, NHS England ask councils and NHS organisations to submit an application outlining the planning and finance for proposed services. The DCH added that NHS England gave applicants six weeks to submit their applications. The deadline was 26 September.

NHS England asked applicants to structure their submissions around two key objectives-

Enable people to stay well, safe and independent at home for longer;
And
Provide care in the right place at the right time

In addition to the objectives, the submission also contained provision for carers that Barking and Dagenham have considerable experience owing to the carers charter. The submission also contained a demand and capacity plan as requested by NHS England.

The DCH also disclosed that, going forward, there would be a review of joint provision with Havering and Redbridge and that this could lead to disaggregation

in some services.

The Board approved the submission to the Better Care Fund.

22. Proposed Community Diagnostic Centre at Barking Community Hospital

BHRUT Programme Director for Diagnostics and CDCs updated the Board.

The CDCs are the result of an independent review and are designed to increase capacity, place diagnostics in a community setting and to quicken access by enabling direct access via a GP referral rather than through a consultant. The Government has provided funding and BHRUT intends to invest £14.9 million in Barking Community Hospital to boost diagnostic capacity and a CT scanner had already been installed. Funding would also be provided to use existing diagnostic resources for longer periods enabling those who cannot attend during working hours to attend.

In response to questioning, the direct access provision would, at first, relate to simpler treatments. In addition it was planned to construct a network of direct access centres across North East London and patients would be able to use the site closest to their home or work. The PDD said that this process would take five years.

The Board noted the update.

23. Forward Plan

The Chair reminded Board members and partner organisations that items for future consideration should be emailed to the Governance Officer as soon as possible especially if the item was a key decision.

The Board noted the Forward Plan

24. Any other public items which the Chair decides are urgent

The Chair noted that Dr Jagan John was no longer a member of the Board owing to the transition from CCGs to ICBs. The Chair thanked Dr John for his contribution to the Board and his support as Deputy Chair and wished him well in future.

HEALTH AND WELLBEING BOARD

8 November 2022

Title:	**Covid-19 update in the Borough**
Report of the Director of Public Health	
Open Report	**For Information**
Wards Affected: All	**Key Decision: No**
Report Author: Richard Johnston Performance & Intelligence Analyst	**Contact Details:** E-mail: Richard.johnston@lbbd.gov.uk
Sponsor: Matthew Cole, Director of Public Health, London Borough of Barking and Dagenham	

Summary:

The Board will be presented with the latest information regarding the Covid-19 situation in the borough, including the geographic and demographic spread of the virus, the latest mortality figures and progress made with the vaccination programme.

Recommendation(s)

The Health and Wellbeing Board is recommended to:

1. Review and provide feedback on the presentation.

Reason(s)

Keeping the Health and Wellbeing Board informed of the current Covid-19 situation in the borough.

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Coronavirus (COVID-19) Situation Report for the Health and Wellbeing Board

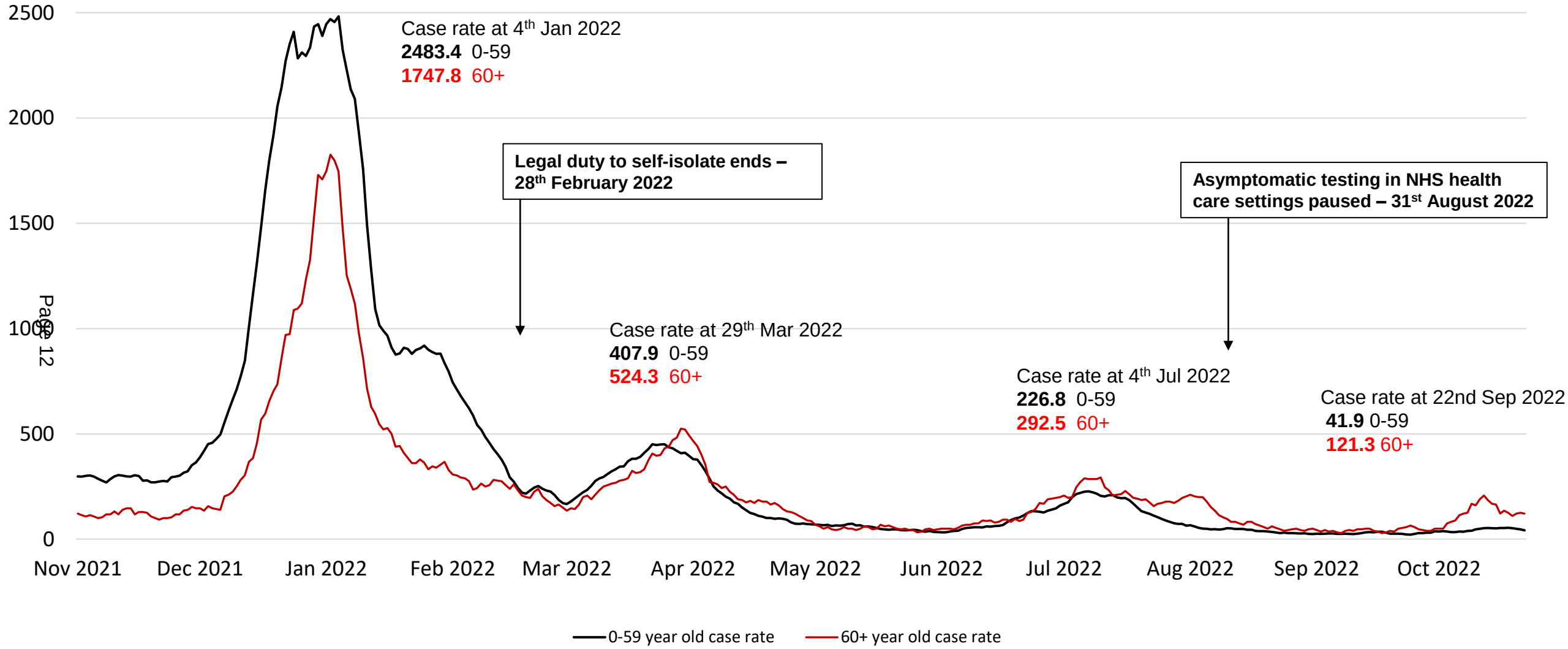
Barking & Dagenham

8th November 2022

one borough; one community; no one left behind

Covid-19 Cases in Barking and Dagenham

LBBD Case Rate per 100k Residents, November 2021 to October 2022

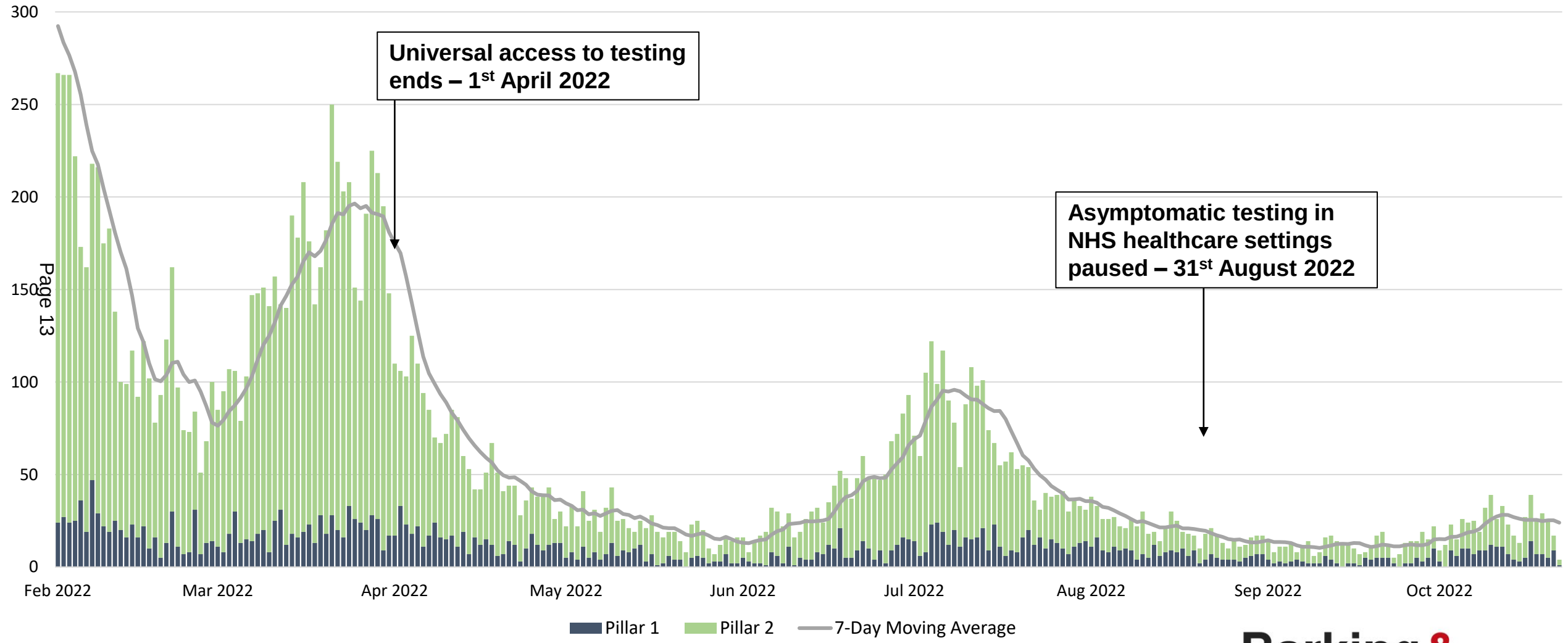


Barking & Dagenham

Covid-19 Testing in Barking and Dagenham

Residents tested for COVID-19 February to October 2022

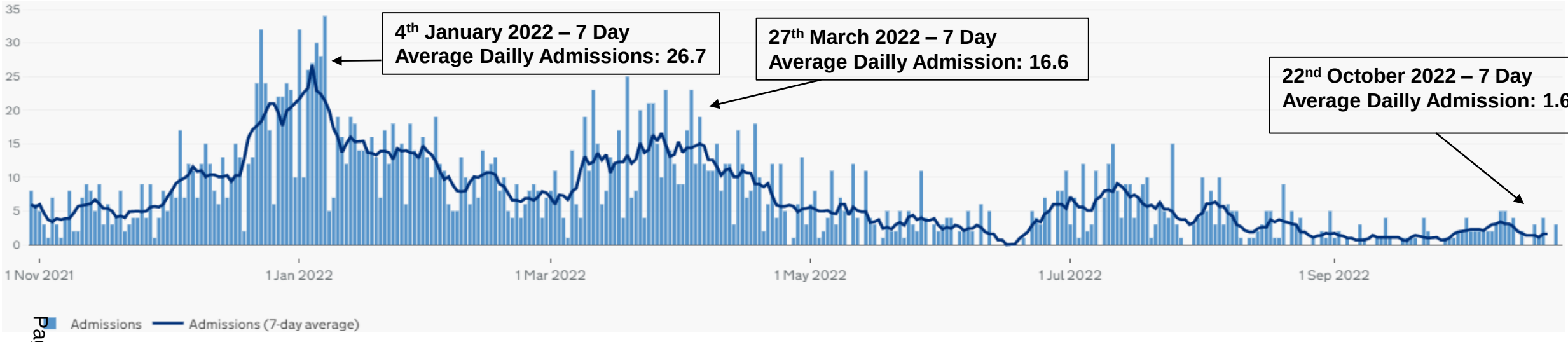
To October 2022 (UKHSA), 4 most recent days are provisional



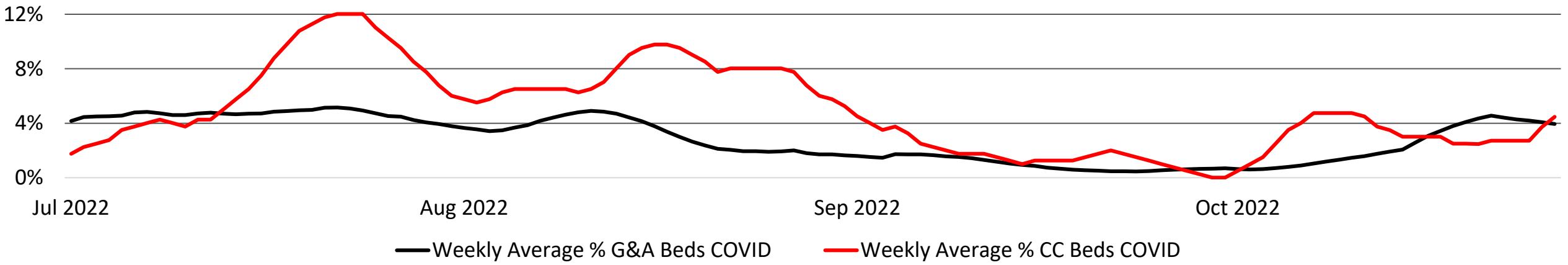
Barking & Dagenham

Covid-19 Hospitalisations in Barking and Dagenham

Hospital admissions testing positive for COVID-19 November 2021 to October 2022

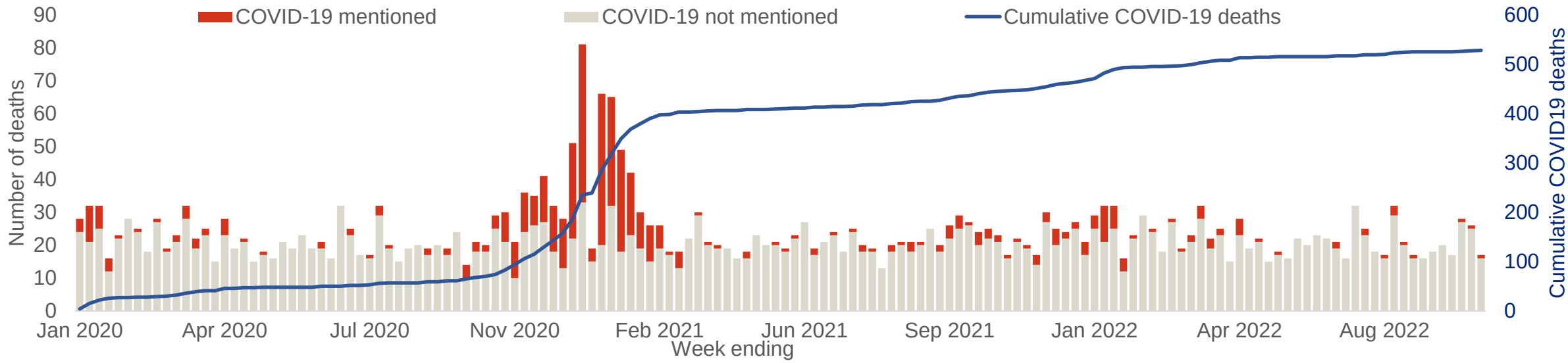


% BHRUT Hospital Beds Occupied by COVID-19 Positive Patients July 2022 to October 2022

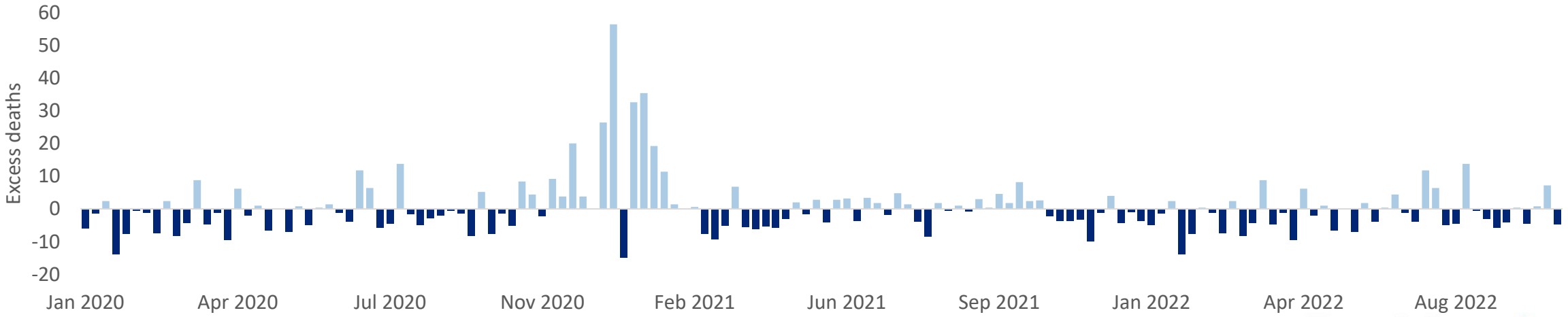


Covid-19 Mortality in Barking and Dagenham

Trend in deaths that occurred to October 2022



Excess deaths that occurred to October 2022



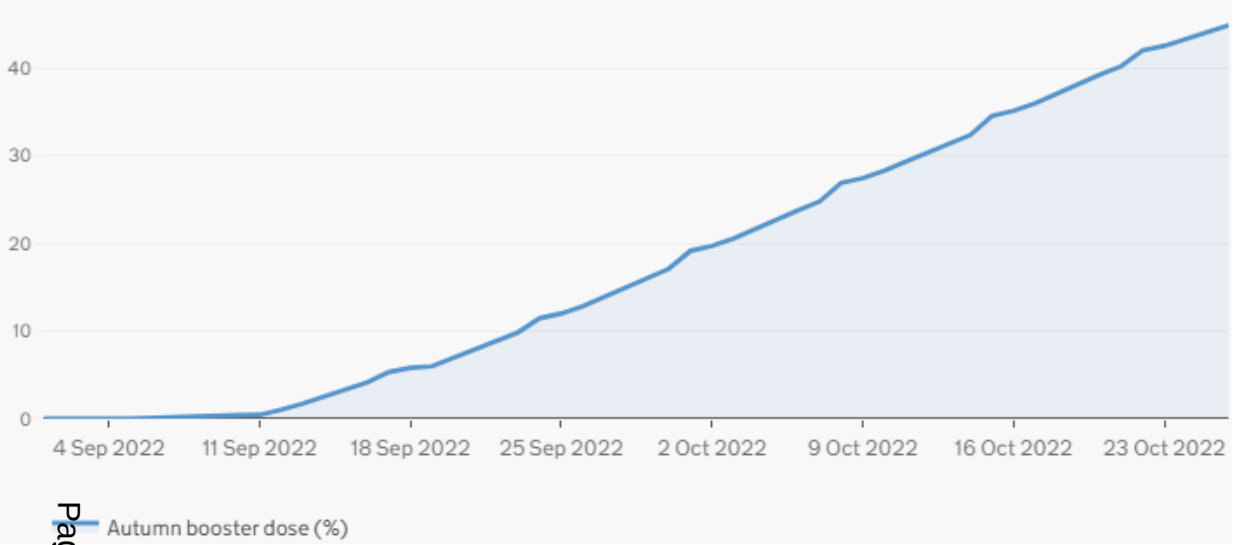
Greater than the 5 year average Week number Less than the 5 year average

one borough; one community; no one left behind

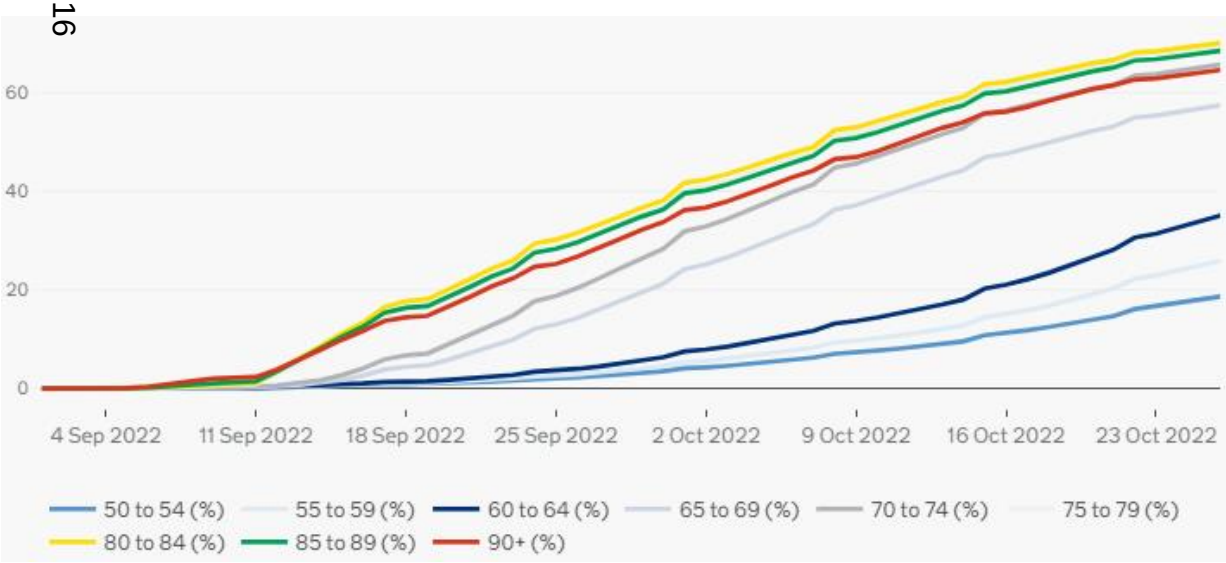
Barking & Dagenham

Vaccination

Autumn Booster Vaccination uptake (50+) October 2022

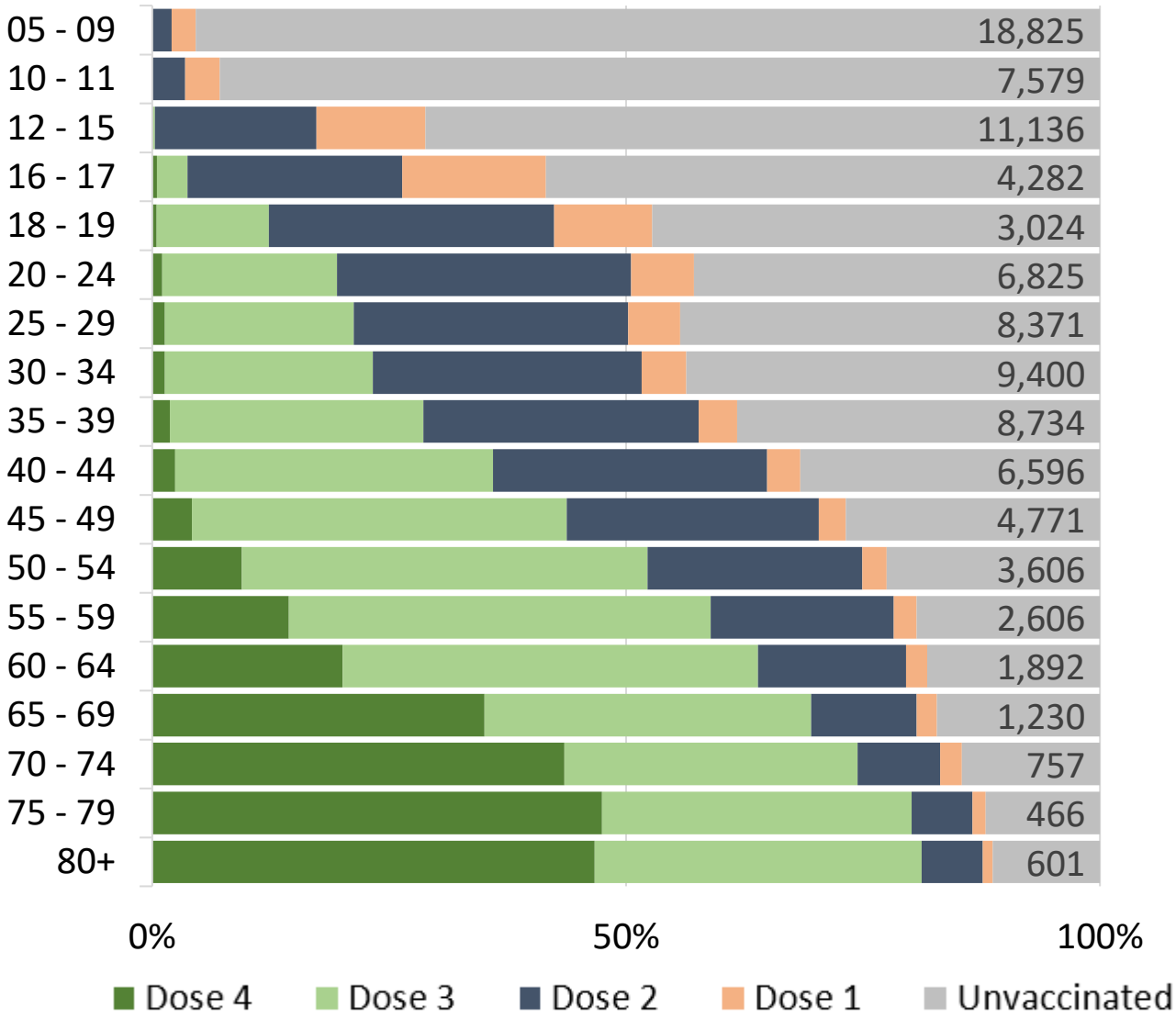


Autumn Booster Vaccination uptake by age band 50+) October 2022



Data source coronavirus.data.gov.uk

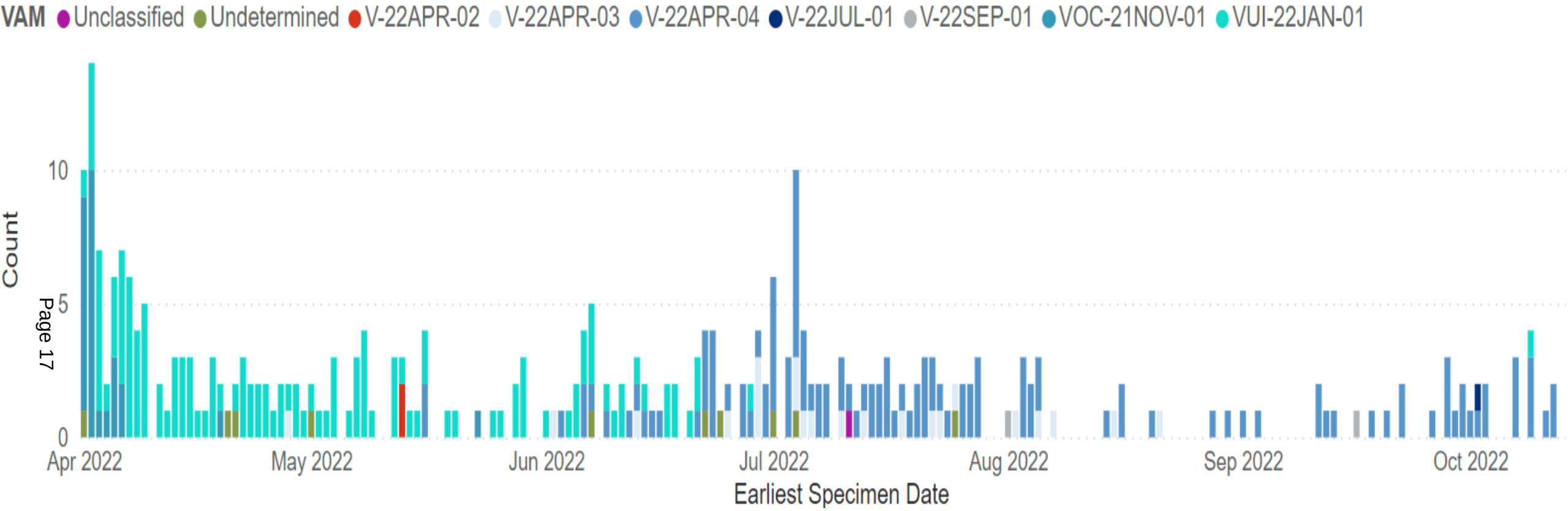
Vaccination uptake by age group October 2022



Data source: UKHSA

Variants and mutations

COVID-19 variants and mutations, Barking and Dagenham, April 2022 – October 2022



It is not always possible to establish whether a positive case is a variant or mutation. Not all positive cases are submitted for genotyping and not all specimens are of high enough quality for genotyping.

Image and data source: Covid-19 Situational Awareness Explorer

Covid-19 in London, 13th October to 19th October 2022.

Case rate

Weekly case rate (per 100,000)

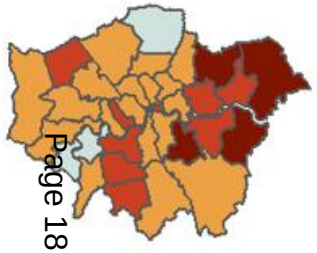
- > 1000
- 600 - 1000
- 400 - 599
- 200 - 399
- < 200

Case rate change

7-day change in weekly case rate

- >100% increase
- 51 to 100% increase
- 10 to 50% increase
- Under 10% change
- 10 to 50% reduction
- 51 to 100% reduction

Positivity



Weekly percentage positive

- >10%
- 7.51% - 10%
- 4% - 7.5%
- < 4%

Hospitalisations*

Weekly average hospital admissions

- 30
- 20
- 10
- 0

- The week to 19th October saw a reversal of the capital-wide rate increases seen in the week to 12th October. 25 London boroughs saw an all-age case rate decline over the week to 19th October. The London average rate fell from 62.4 cases per 100k residents to 56.1 cases, a 10.1% decline. Havering finished the week with the highest case rate in London, of 86.3 cases per 100k residents. Barking and Dagenham saw its case rate fall from 71.0 cases per 100k residents to 57.9 cases, a 18.5% decline.
- In the week to 19th October, the declines seen in all-age case rates across London were also seen in 60+ case rates. 25 London boroughs saw their 60+ case rate fall over the week. The London average rate fell from 119.1 cases per 100k residents to 105.1 cases. Excluding the City of London, Barking and Dagenham saw the largest percentage decline in its 60+ case rate, of 50.0% as its rate fell from 206.9 cases per 100k residents to 103.4 cases. Hillingdon finished the week with the highest 60+ case rate of 163.9 cases per 100k residents.
- Over the week to 19th October, the rate of people taking a PCR test per 100k residents fell in Barking and Dagenham from 35.5 tests per 100k residents to 27.6 tests. This moved the boroughs rate below the London average rate, which remained unchanged at 33.7 tests per 100k residents over the week to 19th October.
- The percentage of residents receiving a positive result after taking a PCR test in Barking and Dagenham fell from 12.0% to 8.2%. The boroughs positivity remained rag rated red. The London average fell from 7.5% to 6.8% over the same week.

Case rates, 7-day change, weekly mortality rate, weekly positivity, and 7-day moving daily average testing rates by Local Authority are for the period 13th October to 19th October.

Barking & Dagenham

HEALTH AND WELLBEING BOARD

8 November 2022

Title:	Annual Report of the Director of Public Health 2022- 'People, Partnerships, Place Seizing new opportunities to improve health'

Report of the Director of Public Health

Open Report	**For Information**
Wards Affected: All	**Key Decision: No**
Report Author: Matthew Cole, Director of Public Health, LBBD	**Contact Details:** E-mail: matthew.cole@lbbd.gov.uk

Sponsor:

Elaine Allegretti, Strategic Director Childrens and Adults, LBBD

Summary:

The Director of Public Health Annual Report provides an opportunity for the Director of Public Health to give an independent assessment of the health of the population and focus on priority areas that the Council and its partners need to consider individually and collectively.

This years report focusses on providing professional perspective that informs an integrated care approach. Observations within chapters act as a starting point for identifying 'where to look' before 'what to change' and finally how to change, with the introduction sets context as we recover from the pandemic and manage the impact of the cost-of-living crisis.

Chapter 1 continues with previous themes of using the opportunities provided by population health management to advance the design and delivery changes by learning from residents, the frontline and building a roadmap to 'spread, scale, and sustain'.

The second chapter follows on to explore the opportunities to improve outcomes for children and families through the lens of the 0-19 Healthy Child programme and national initiatives such as Start for Life and Family Hubs, including 'what good looks like'.

Chapter 3 shares the steps we have taken to address health inequalities through population level interventions using borough assets to promote healthy lives and highlights areas where we need to do more.

Lastly, the final chapter discusses the scale of health protection work to protect residents from the impacts of COVID-19 and what should be considered for its ongoing management.

Recommendation(s)

The Health and Wellbeing Board is recommended to:

(i) Approve the content of the full report

(ii) Endorse the future considerations and conclusions within each chapter

Reason(s)

The Director of Public Health has a statutory responsibility to publish an annual report with content decided on an annual basis.

3 Consultation

Key stakeholders and partners reviewed the report and provided input and suggestions to the content.

Additionally, the report was taken to the following Governance groups: People and Resilience Management Group, Business As Usual; Portfolio and Corporate Strategy Group.

List of Appendices:

Appendix A - B&D ADPHR 2022 full. PDF

People, Partnerships, Place

Seizing new opportunities to improve health

Barking & Dagenham

Foreword

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

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

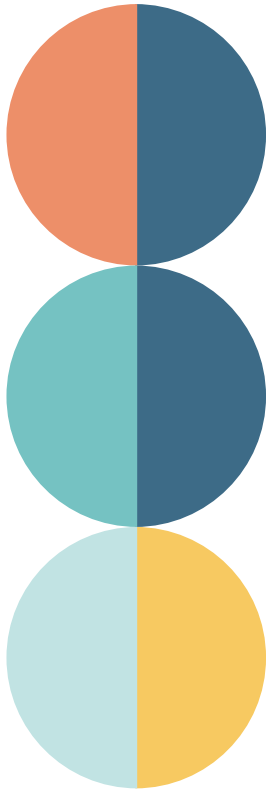
Consequently, residents young and old too often receive disjointed care from services that are not effectively co-ordinated around their needs. This can negatively impact their experiences, lead to poorer outcomes, create duplication and inefficiency. To deliver support that better meets needs of the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

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

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

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

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



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

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

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

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

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

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

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

Contents

Introduction

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

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

Getting Back to Business

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

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

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

Common Language and Focus

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

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

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

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

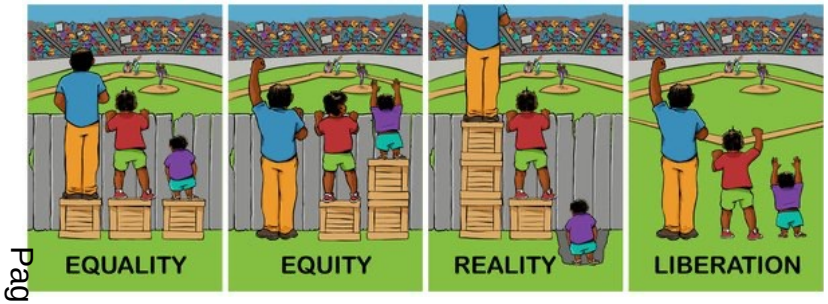


Figure 2: Equality, Equity, Reality and Liberation

Current Context: COVID Recovery and the Cost of Living Crisis

COVID-19 Legacy on Health and Service Demand

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

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

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

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

Impacts of the Cost of Living Crisis

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

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

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

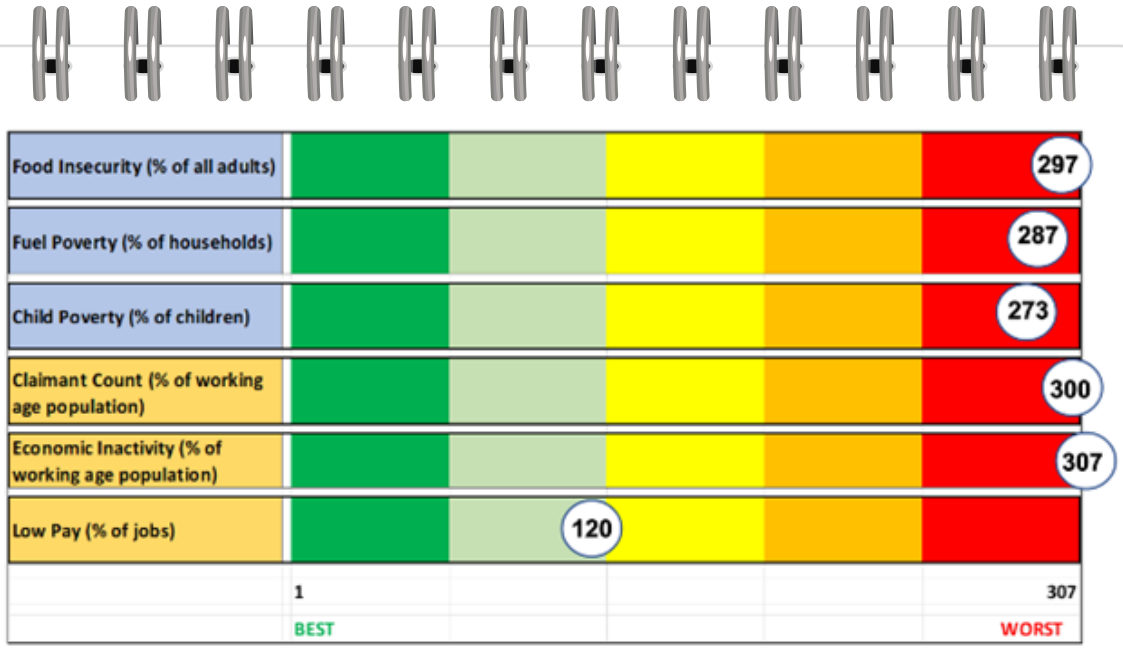


Figure 3: Vulnerability of B&D residents to cost of living crisis compared to 307 other English local authorities

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

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

Food insecurity

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

Fuel poverty

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

Debt

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

Lessening the Health Impacts

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

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

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

Chapter 1: 'Population Health' and the Population's Health

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

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

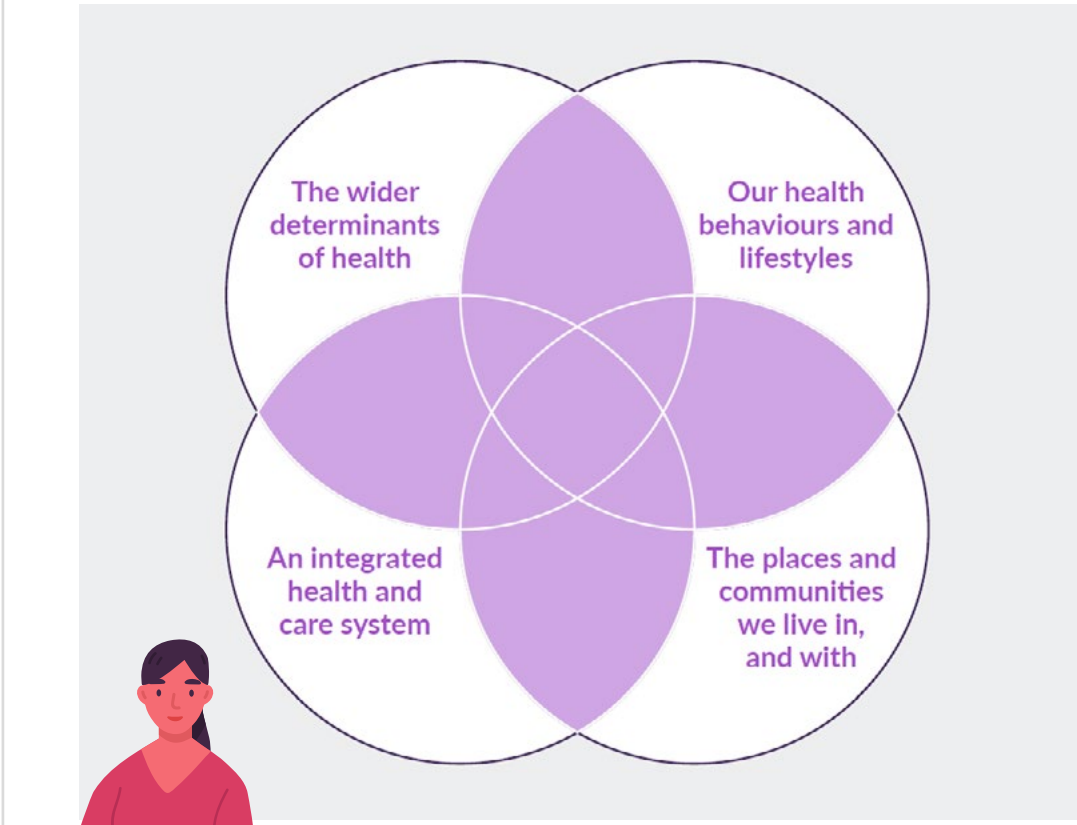


Figure 4: Pillars of Population Health

Predicting and Addressing Preventable Needs

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

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

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

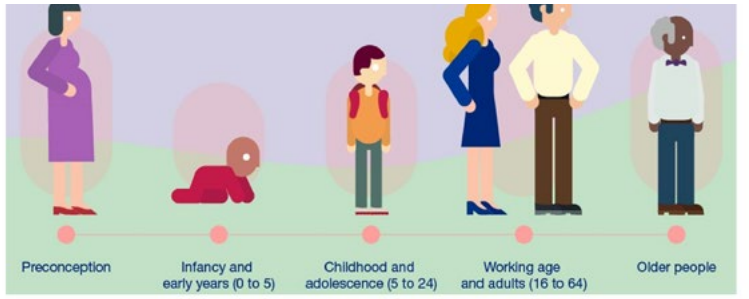
Analysing what causes this low healthy life expectancy highlights how we have the highest rates of some cardiovascular disease (CVD) (heart disease and stroke); respiratory conditions (chronic obstructive pulmonary disease (COPD)) and cancer (lung) in London (see table 1).

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

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

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

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



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

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

Delivering with Communities and Maximising Community Assets

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

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

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

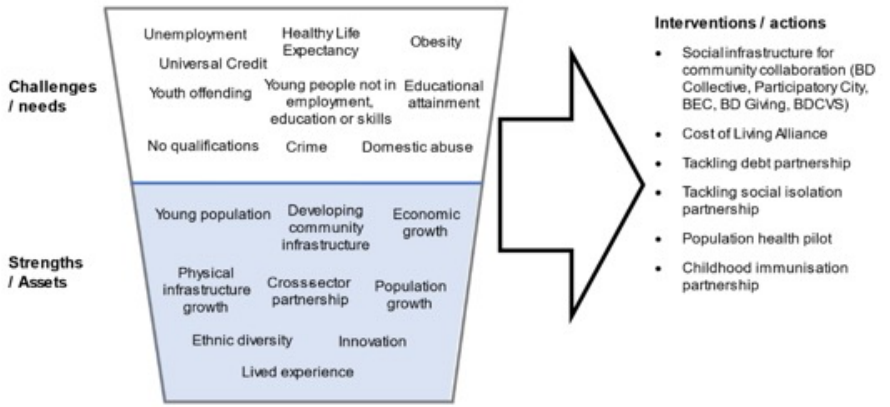


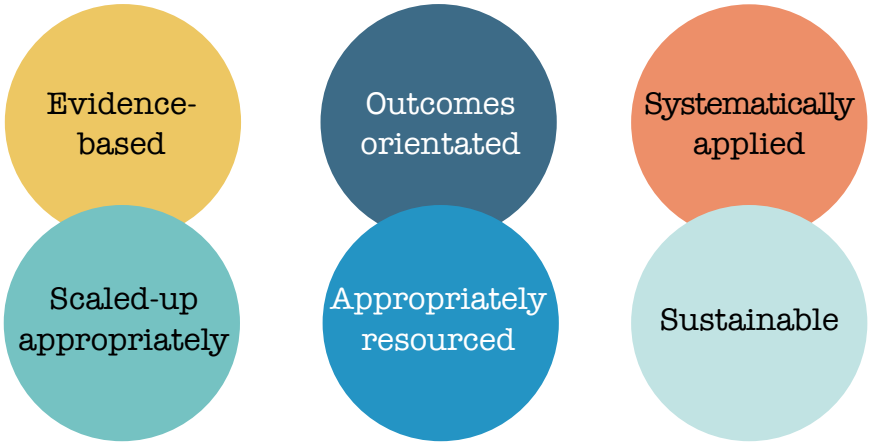
Figure 6: Using community assets to develop solutions to B&D challenges ('glass half full')

Delivering health improvement through place based/locality working

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

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

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



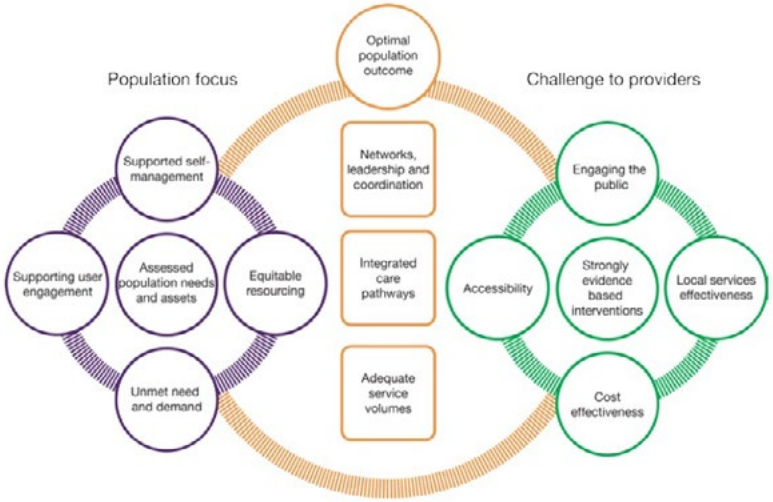


Figure7: The Population Outcomes Through Services (POTS) framework

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

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

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

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

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

Case Study: Frailty Transformation Board

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

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

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

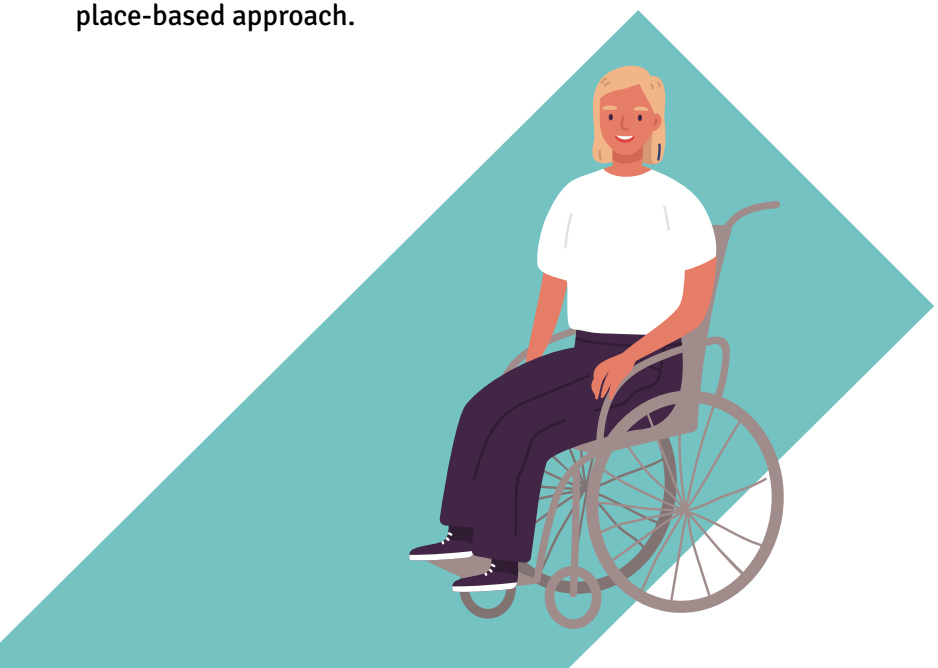
- The most important aspects of care (1) maintaining independence (2) feeling respected (3) advice and guidance whilst waiting for a referral
- Communal strength and balance exercise were a necessity, as it combined physical activity with a shared experience
- A need for improved access to medication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

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

Table 2: Moving From Traditional To Place-based Health

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

There are already some examples (these two case studies) of taking a place-based approach.



Conclusions

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

Considerations for the Future

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

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

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

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

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

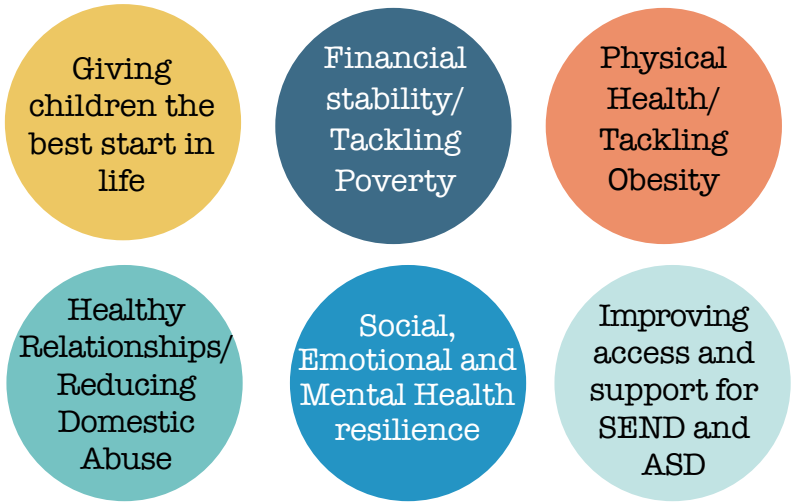
This provides an opportunity to 'get it right' from the earliest time in a child's life, making sure that they are school ready; supported to achieve; find fairly paid, good quality employment and have better financial stability in their adulthood. Developing healthy foundations also reduces the risk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

Babies, Children and Young People's Plan

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

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

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



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

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

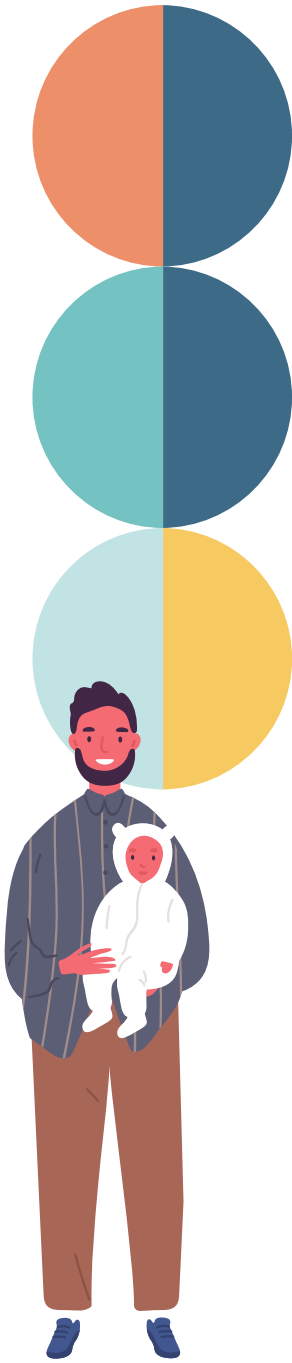
To achieve the 'Best Start for Life' Marmot objectives and deliver the outcomes in the BCYP Plan, the Council and partners will be implementing the national 'Start for Life' programme, building on delivery of the Healthy Child Programme and setting up three locality-based Family Hubs as the focus for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

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

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

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

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



Opportunities and Ways of Working

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

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

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

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

Ensuring Success

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

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

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

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

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

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

SPOTLIGHT ON CHILDHOOD VACCINATIONS:

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

Intended outcome:
Increased childhood vaccination coverage

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

How will we know if Family Hubs have been successful?

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

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

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

Future Considerations

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

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

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

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

Conclusions

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

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

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

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

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

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

Key Questions:

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

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

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

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

Chapter 3:

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

Introduction

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

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

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

- **Unhealthy weight** – In 2019/20, 26.5% reception aged children, 46.3% of year 6 aged children and 44.7% of children aged 10-11 were above a healthy weight.
- In 2020/21, it was estimated that 64.5% of adult residents (aged 18+) live with overweight or obesity, which is the 3rd highest percentage when compared to all London boroughs.
- **Smoking** – Almost 1 in 5 (18.1%) of our adults smoke, contributing to our higher levels of diseases such as COPD; cancers; earlier death and the worst outcomes in hospital admissions linked to smoking compared to other London boroughs.

Most people start smoking and become addicted to nicotine when they are still young. Children whose parents or siblings smoke are around four times more likely to smoke than those in non-smoking households.

- The Smoking status at time of delivery provides information on the number of women smoking at time of delivery (childbirth). In 2020/21, 7.6% of our pregnant women were smoking at the time of delivery - the highest in London but lower than the England average of 9.6%.
- Smoking has a huge economic impact in addition to the impact on smokers' health. An analysis of the impact of smoking on productivity estimates that smoking costs £77.84m a year, as seen in table 3.

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

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

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

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

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

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

Equity at Scale in Services

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

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

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

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

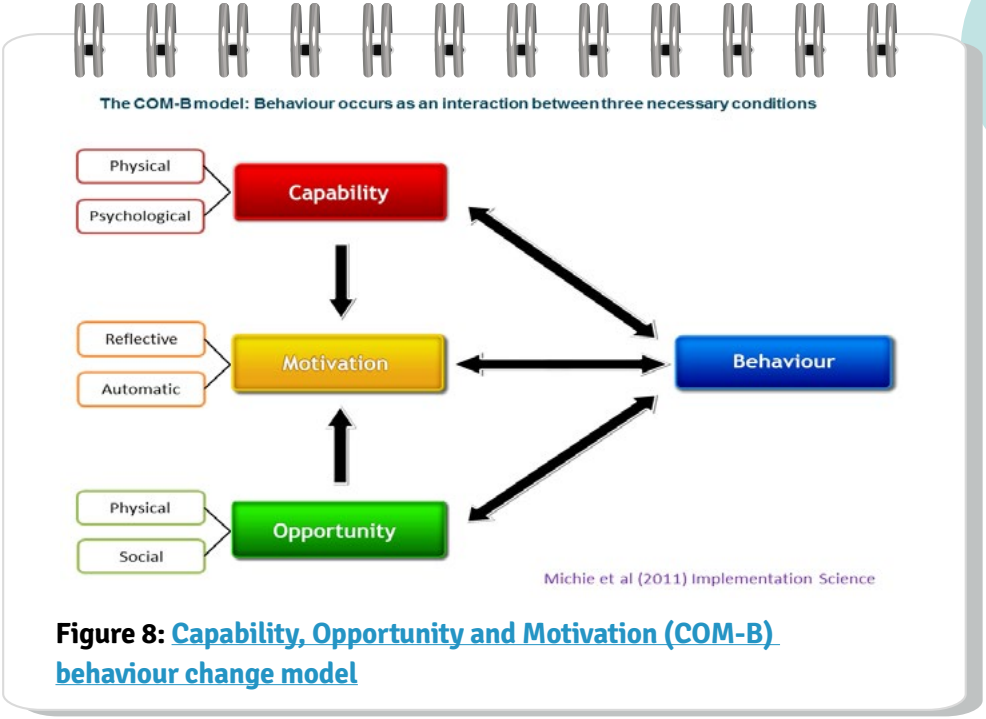


Figure 8: Capability, Opportunity and Motivation (COM-B) behaviour change model

Considerations for the Future

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

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

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

Delivering Weight Management Services

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

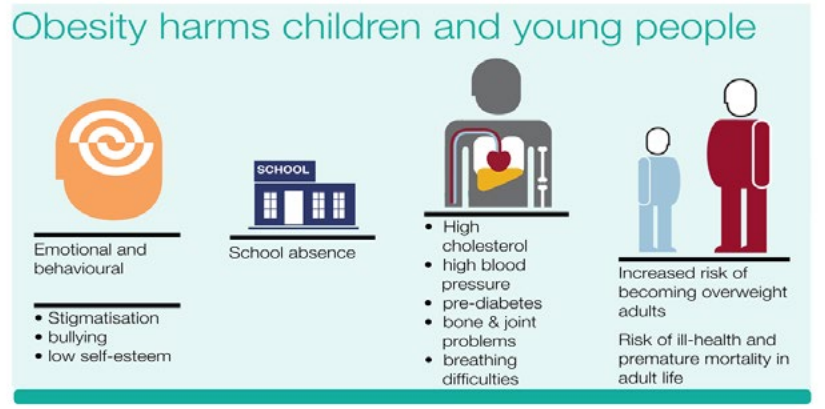


Figure 9: The ways in which obesity can harm children and young people

Figure 10: The ways in which obesity can harm adults

What are We Doing?

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

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

Adult Weight Management	
Service	**Delivery**
Momenta	Culturally appropriate cardiovascular disease (CVD) prevention project to 2 PCNs (North and New West) Training community voluntary Services to deliver culturally appropriate CVD prevention project in the community
Harmony House Al Madina	Culturally appropriate CVD prevention project in the community
MoreLife	Pre-pregnancy/post-natal support-exploring the approach
Community Solutions	Exercise on referral, Weight Management service

Role of Social Prescribing in Weight Management

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

The NHS Five Year Forward View, the General Practice Forward View and the NHS Long Term Plan all highlight the value of social prescribing and for building effective networks with partners[5]. This work is being led by the primary care networks (PCNs) and Community Solutions, with the current GP framework contract providing funding for one social prescribing link worker per PCN.

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

Conclusions

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

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

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

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

Examples of related outcomes:

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

Public Health Outcomes Framework

Delivering Stop Smoking Services

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

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

Figure 11: Stop smoking – what works?

What are We Doing?

Our specialist stop smoking service is provided by Community Solutions, the Council's integrated 'front door' to support. Unlike other stop smoking services, this is not a stand-alone service. As added value, it is completely integrated into Community Solutions, and service users are offered a wide range of support in addition to healthy lifestyle advice. Service users are connected with other Community Solutions and wider Council/voluntary sector services that may meet their needs such as housing advice, support with money and debt issues, access to a community food club and support with social isolation and loneliness using a Make Every Contact Count ("MECC"[5]) approach, reflecting the often complex needs of people who wish to quit. The service utilises existing and emerging Community and Family Hubs, with all staff trained to use carbon monoxide monitors and refer into the specialist service.

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

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

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

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

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

Preventing Uptake of Smoking – The Role of Schools

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

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

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

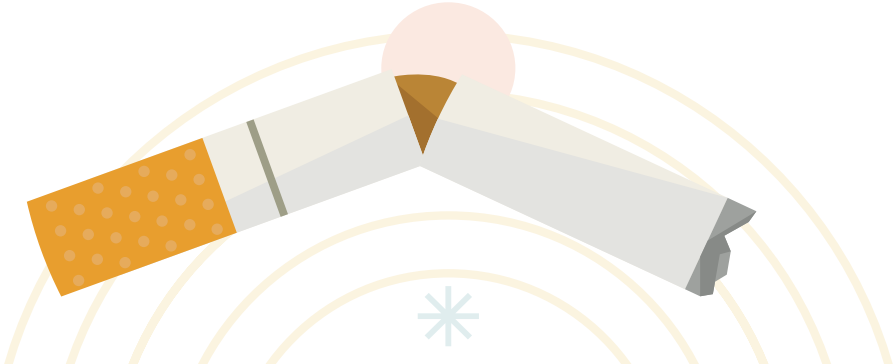
Conclusions

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

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

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

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



Considerations for the Future

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

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

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

Delivering the NHS Health Check Programme

Figure 13: The NHS Health Check

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

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

Wider Costs

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

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

What are We Doing?

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

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

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

NewMe healthy lifestyle services

Free local support with stopping smoking, healthy eating and exercising

Exercise on referral

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

Eat Healthier

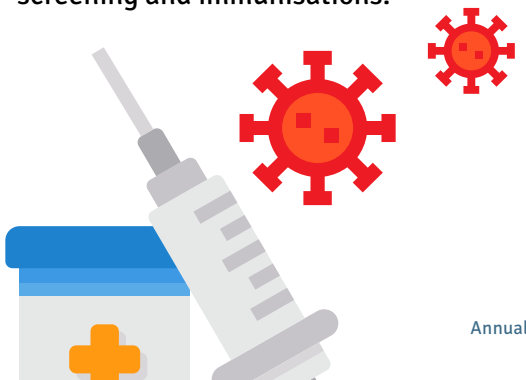
A 12-week programme to improve awareness of food and drink (including alcohol) consumption

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

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

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

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



How Can We Improve Uptake?

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

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

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

Conclusions

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

Considerations for the Future

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

Chapter 4:
COVID-19

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

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

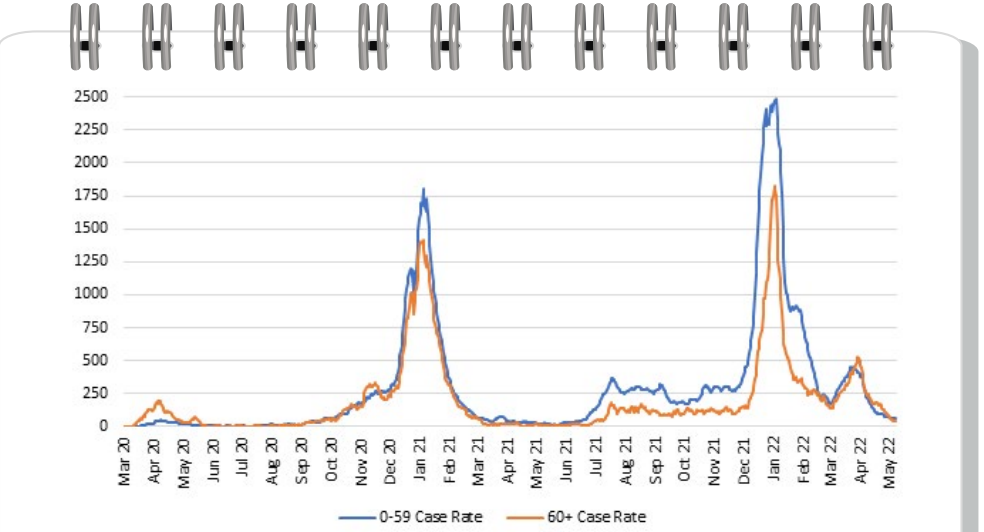


Figure 14: B&D COVID-19 case rates per 100,000 residents

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

Impacts of COVID-19

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

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

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

What are We Doing?

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

Testing

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

Contact Tracing

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

BD-CAN Plus

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

Infection Prevention and Control (IPC) Support

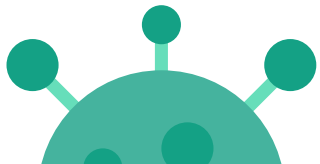
– the pandemic highlighted the critical role of specialist IPC support to social care. UKHSA and North East London Foundation Trust (NELFT) IPC team supported adult social care, but NELFTs capacity was stretched and they could only support care homes. The role of social care within the healthcare system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

Vaccination

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

Long COVID Service

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



What Actions are Most Effective?

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

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

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

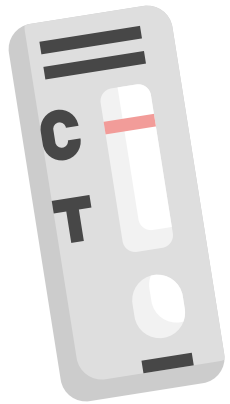
Conclusions

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

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

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

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



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

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

Considerations for the Future

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

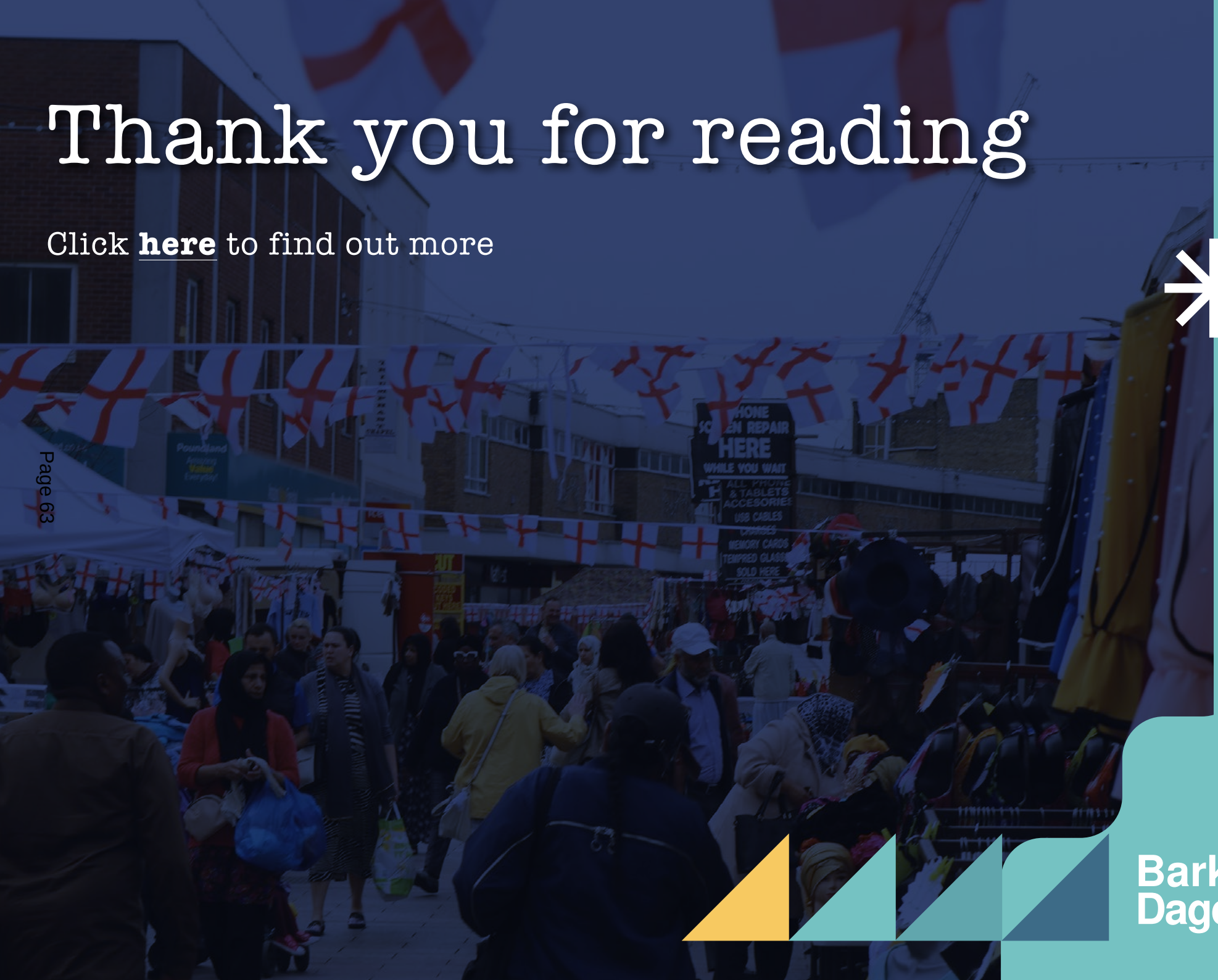
Acknowledgments

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

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

Thank you for reading

Click **here** to find out more



Barking & Dagenham

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HEALTH AND WELLBEING BOARD

8 November 2022

Title:	North East London Integrated Care Strategy Development
Open Report	**For Information**
Wards Affected: ALL	**Key Decision: No**
Report Author: Emily Plane, Head of Strategy and System Development, NELFT	**Contact Details:** e.plane.nhs.net
Lead Officer: Hilary Ross, Director of Strategic Development	

Summary

Considerable progress towards integration has taken place across North East London. Places have been working with their health and wellbeing boards, through preparation of Better Care Fund plans, or the previous non-statutory Integrated Care Systems (prior to the Health and Care Act 2022) to develop strategies and approaches that support more integrated health and care.

The Health and Care Act 2022 amends the Local Government and Public Involvement in Health Act 2007, and requires integrated care partnerships (ICPs) to write an integrated care strategy.

The Integrated Care Partnership strategy will need to set out how the assessed needs (building on place joint strategic needs assessments) can be met through the exercise of the functions of the integrated care board, partner local authorities or NHS England (NHSE).

The development of the integrated care strategy can be used to agree the steps that partners, working closely with local people and communities, will take together to deliver system-level, evidence-based priorities in the short-, medium- and long-term. These priorities should drive a unified focus on the challenges and opportunities to improve health and wellbeing of people and communities throughout the area of the integrated care partnership.

This paper provides an update on the approach and proposed content of the development of the North East London Integrated Care System Strategy.

Recommendations

The Health and Wellbeing Board is asked to:

- Consider, discuss and comment on the proposed approach to develop the North East London Integrated Care Strategy

- Support identification of your key priorities and challenges locally, particularly based on your local knowledge and insights, to feed into development of the strategy

Reasons for report

Development of the North East London Integrated Care System Strategy is an opportunity for us to articulate the key population health and inequalities challenges that we have across the system, ensuring a strong focus and committeemen going forward to addressing these.

This report aligns to the following aims:

- To improve outcomes in population health and healthcare
- To tackle inequalities in outcomes, experience and access
- To support broader social and economic development

1. Introduction/ Context/ Background/ Purpose of the report

1.1 Considerable progress towards integration has taken place across North East London. Places have been working with their health and wellbeing boards and local partners, through preparation of Better Care Fund plans, or the previous non-statutory Integrated Care Systems (prior to the Health and Care Act 2022) to develop strategies and approaches that support more integrated health and care.

1.2 The Health and Care Act 2022 amends the Local Government and Public Involvement in Health Act 2007, and requires integrated care partnerships (ICPs) to write an integrated care strategy.

1.3 The Integrated Care Partnership strategy will need to set out how the assessed needs (building on place joint strategic needs assessments) can be met through the exercise of the functions of the integrated care board, partner local authorities or NHS England (NHSE). It will build on existing work and momentum to further the transformative change needed to tackle challenges such as reducing disparities in health and social care; improving quality and performance; preventing mental and physical ill health; maximising independence and preventing care needs, by promoting control, choice and flexibility in how people receive care and support.

1.4 The integrated care strategy will set the direction of the system across the area of the integrated care board and integrated care partnership, setting out how commissioners in the NHS and local authorities, working with providers and other partners, can deliver more joined-up, preventative, and person-centred care for their whole population, across the course of their life. It presents an opportunity to firmly ground the approaches of our Place based Partnerships to do things differently to before, such as reaching beyond 'traditional' health and social care services to consider the wider determinants of health or joining-up health, social care and wider services.

1.5 This paper provides an update on the approach and proposed content of the development of the North East London Integrated Care System Strategy.

2.Proposed approach to develop the North East London Integrated Care Strategy

2.1 We are proposing to sign off the interim North East London Integrated Care System Strategy at a full meeting of the integrated care partnership in January 2023.

2.2 To achieve this tight deadline, we will work closely with the North East London Place based Partnerships, Health and Wellbeing Boards, Overview and Scrutiny Committees and partners over the next several months to co-develop the content of the strategy, building on the significant engagement work that has already taken place across the system to identify our key priorities (babies, children and young people; mental health; long term conditions; and workforce and employment).

2.3 There is a requirement for the strategy to be refreshed annually and we intend for the strategy to support an ongoing process of system development, learning and improvement

as opposed to production of a one-off static document.

2.4 **Appendix 1** sets out a proposed timeline for engagement over the next several months with key groups and partners. We are in the process of engaging with key groups within each Place based Partnership to get slots on agendas.

2. Proposed content of the strategy

3.1 We are in the process of establishing several workstreams to develop the content of the strategy. There is a workstream on data and analytics which is meeting fortnightly with whole system representation. In addition to producing a Population Health Profile for NEL, we have undertaken rapid reviews of local JSNAs and health and wellbeing strategies. The Healthwatch team has also undertaken an analysis of insights in relation to the four ICS priorities which will inform the workshops.

3.2 A series of stakeholder workshops are currently taking place aimed at progressing the four Integrated Care System priorities. Stakeholder events are planned during October and November focusing on our priorities of babies, children and young people; mental health; long term conditions; and workforce and employment. Over 120 people from across the system attended a workshop on our system response to the cost of living increase on 6 October.

3.3 **Appendix 1** sets out in more detail the proposed content of the strategy, which we are keen to seek feedback and input from partners on to further shape.

4.Risks and mitigations

4.1 Timescales are short ahead of the submission of the first draft of the strategy, however, the Partnership is dedicated to developing the content of the strategy locally with our Places, Health and Wellbeing Boards and partners and are keen for them to shape and own it, ensuring that it reflects our key challenges, and agreed direction of travel. Our intention for this to be an ongoing process, rather than a one off document, should help to mitigate the risk around the short timeframe that we have to develop the initial draft.

5. Impact on Finance and Performance Quality

5.1 There are no additional resource implications/revenue or capitals costs arising from this report at this stage.

6. Risks

6.1 Timescales are short ahead of the submission of the first draft of the strategy, however, the Partnership is dedicated to developing the content of the strategy locally with our Places, Health and Wellbeing Boards and partners and are keen for them to shape and own it, ensuring that it reflects our key challenges, and agreed direction of travel. Our intention for this to be an ongoing process, rather than a one off document, should help to mitigate the risk around the short timeframe that we have to develop the initial draft.

7. Attachments

7.1 **Attachment 1 -** North East London Integrated Care Strategy development update

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North East London Health & Care Partnership

NHS North East London

North East London Integrated Care Strategy development

Barking and Dagenham Health and Wellbeing Board

November 2022

Summary of key points

- The Department for Health and Social Care has issued **guidance for integrated care strategies** with a suggestion that partnerships might aim to produce an interim strategy around December 2022 ahead of further guidance in June 2023.

- A per the timeline in the next slide, the intention in NEL is to **sign off the interim strategy** at a full meeting of the integrated care partnership in **January 2023** following a period of engagement. There is a requirement for the strategy to be refreshed annually and we are keen to position the strategy in NEL as an **ongoing process of system development, learning and improvement** as opposed to production of a one-off static document.

- The current focus is on **developing content** for the strategy. There is a workstream on data and analytics which is meeting fortnightly with whole system representation. In addition to producing a Population Health Profile for NEL, we have undertaken rapid reviews of local JSNAs and health and wellbeing strategies. The Healthwatch team has also undertaken an analysis of insights in relation to the four ICS priorities which will inform the workshops.

- A series of **stakeholder workshops** are currently taking place aimed at progressing the four ICS priorities. Stakeholder events are planned during October and November focusing on our priorities of *babies, children and young people; mental health; long term conditions;* and *workforce and employment.* Over 120 people from across the system attended a workshop on our system response to the cost of living increase on 6 October.

- The **engagement plan** in North East London will include discussions with local health and wellbeing boards and joint overview and scrutiny committees ahead of sign off by the partnership in January 2023.

Integrated Care Strategy

North East London Health & Care Partnership

- The integrated care strategy is an opportunity to work with a wide range of people, communities and organisations to develop evidence-based system-wide priorities that will improve the public's health and wellbeing and reduce disparities.
- The integrated care strategy must set out how the assessed needs (identified in the joint strategic needs assessments) of the integrated care board and integrated care partnership's area are to be met by the exercise of functions by the integrated care board, partner local authorities, and NHSE.
- These commissioners must have regard to the relevant integrated care strategy when exercising any of their functions, so far as relevant.

Statutory Requirements – Must do's

1. Must set out how the 'assessed needs' from the joint strategic needs assessments in relation to its area
2. Must consider whether the needs could be more effectively met with an arrangement under section 75 of the NHS Act 2006
3. Must have regard to the NHS mandate in preparing the integrated care strategy
4. Must involve local Healthwatch organisations and people who live and work in the area
5. Must consider revising the integrated care strategy whenever they receive a joint strategic needs assessment

Localising the strategy beyond just national requirement

1. Further insight outside of just JSNAs with including resident feedback and local insights into our population
2. Demand forecasting based on population size and growth
3. Focusing on our four key NEL system priorities
4. Inequalities a thread across our strategy

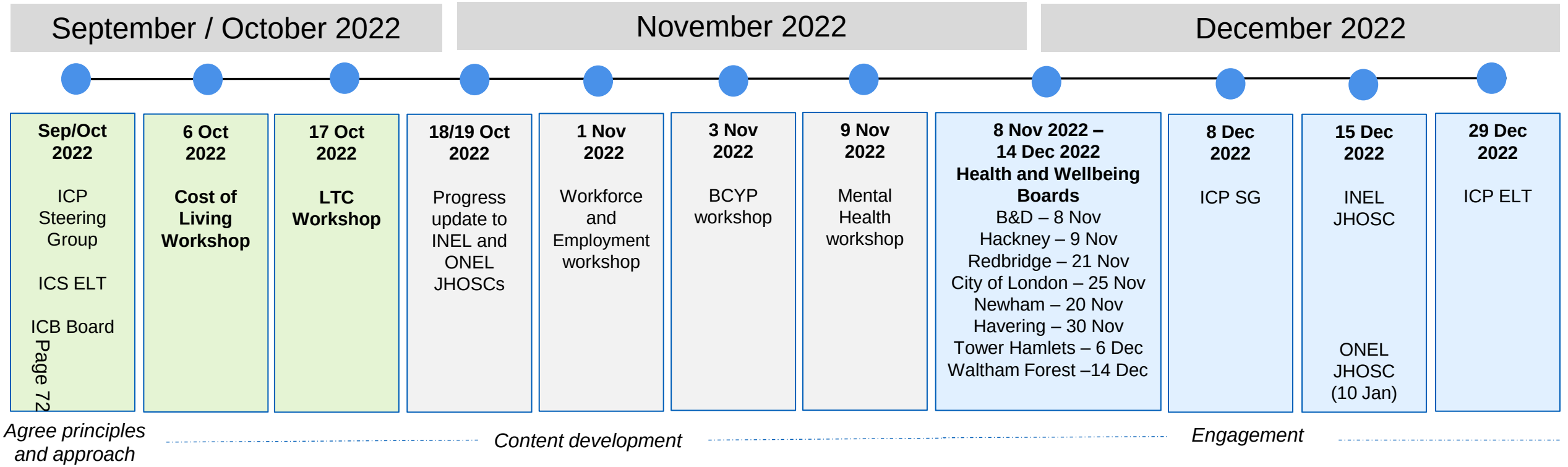
Key risk and issues:

- JSNAs across NEL are not always consistent in approach.
- Some of our JSNAs are significantly out of data and have not been updated.

Mitigation:

- Engage with our place based partnerships to determine their key priorities

Integrated care strategy timeline and key milestones



Interim Integrated Care Strategy Sign Off:

Full Meeting of Integrated Care Partnership 11 January 2023

Alignment to:

- 2 year system intentions development
- Joint Forward Plan development (guidance due Oct 22)
- 2 year operational planning

The ICB Board will be meeting on 25 January 2023 and will need to consider the Integrated Care Strategy in development of the NHS Joint Forward Plan due before April 2023

Developing content for the strategy – key themes and actions from the Cost of Living Workshop

Over 120 stakeholders from all parts of our system attended a workshop on 6 October – attendees represented a wide range of backgrounds and seniority.

Stakeholders across the system in NEL share motivation and a sense of urgency to address this key issue for staff and residents.

There was broad agreement on some key priorities that would benefit from urgent action at the system level as well as recognition of the need for sustained action.

Next steps will be agreed at the next meeting of the NEL Clinical Advisory Group on 12 October.

Key themes / priorities from the workshop

- Develop platform / mechanisms for sharing practice and ideas across the system
- Establish system wide group to share and develop workforce initiatives – potential priorities discussed included opening up work places across NEL to wider groups of staff across the partnership, increasing access to support for care staff, support for emotional wellbeing
- Use our collective voice to influence regional and national policy (eg travel concessions/support for health and care staff)
- Sustained support for community and voluntary sector through the new collaborative
- Development of proposals to support people with cost of prescriptions, particularly those with multiple long term conditions
- Identification and targeted support for those most vulnerable and/or at risk of hospital admission in our communities

We will be engaging with Health and Wellbeing boards, Place based Partnerships, Overview and Scrutiny Committees and other partners over the coming weeks and months, and are particularly keen to get their input on the following:

North East London Health & Care Partnership

Based on your JSNA's and local insights what are your top five priorities?

What are your key wider determinants of health that are impacting on poorer outcomes for your residents?

What are you doing to address your top five priorities and the wider determinants of health at place?

HEALTH AND WELLBEING BOARD

8 November 2022

Title:	Barking and Dagenham Place-based Partnership Winter Summit: Report of the *How do we keep people well and safe in their homes and out of hospital?*
Open Report	**For Information**
Wards Affected: All Wards	**Key Decision: No**
Report Author: Melody Williams	**Contact Details:** Tel: 0300 555 1201 E-mail: melody.williams@nelft.nhs.uk
Sponsor: Melody Williams Director of Integrated Care, NELFT	

Summary:

The Barking and Dagenham Winter took place on 20th October 2022. The slides used for the summit are being presented to the Board for comment.

Recommendation(s)

The Health and Wellbeing Board is asked to note the report.

Reason(s)

NELFT is committed is ensuring that the Health and Wellbeing Board is kept up to date on its activities that come under the Board's responsibilities.

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Barking and Dagenham Place-based Partnership Winter Summit:

How do we keep people well and safe in their homes and out of hospital?

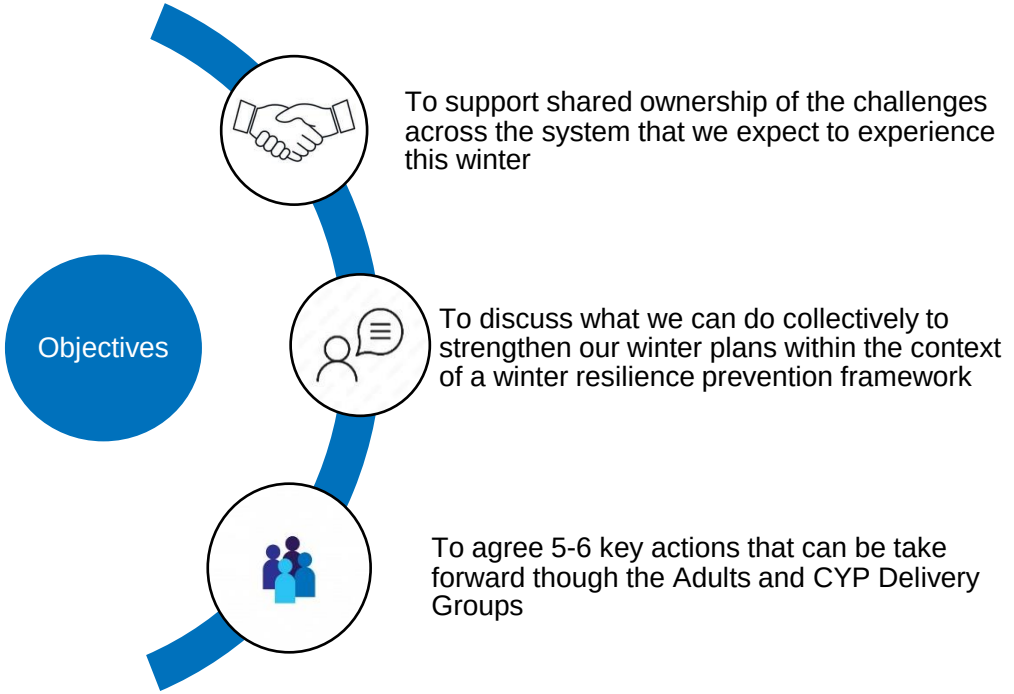
Output slides

Overview

The Barking & Dagenham Winter Summit took place on Thursday 20th October and was attended virtually by representatives from across the partnership.

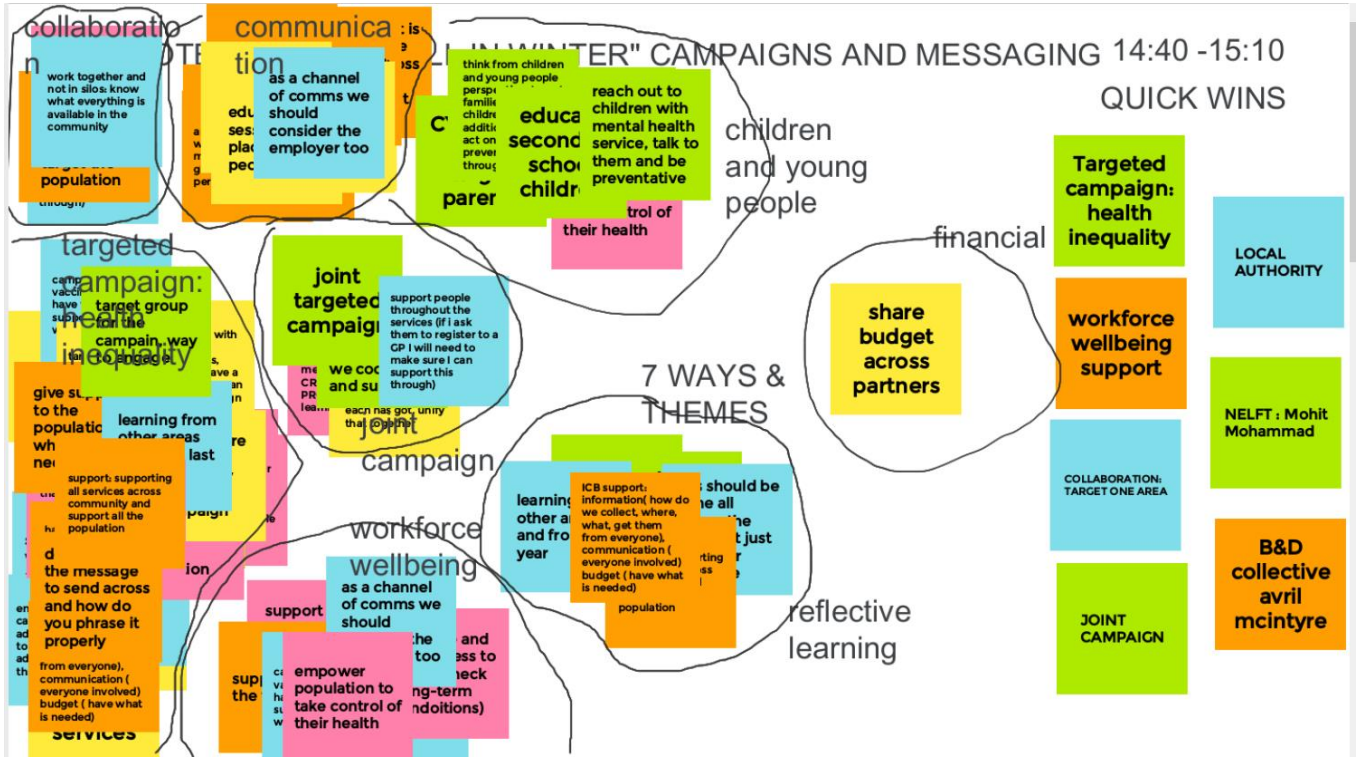
Time		Lead
14:00pm	Introduction, agenda and objectives	Dr Rami Hara
14:10pm	Outlining the challenges of keeping people in their homes and out of hospital	Sharon Morrow
14:20pm	Developing a place-based approach to health and wellbeing this winter	Matthew Cole
	Breakout room workshops	
14:35 - 14:40	Introduction to breakout rooms: **1) Prevention:** promote " staying well in winter" campaigns and messaging **2) Proactive Care:** Optimise case finding, diagnosis and management of long-term conditions **3) Workforce:** How do we support the health wellbeing and resilience of the health and care workforce?	Giulia Ponza/ Lara Dobbie/ Kouroush Sharifi-BHRUT, QI
14:40-15:10	Idea Generation on defined themes	
15:10-15:30	Refining Ideas and Generating Quick Wins	
15:30-15:45	Volunteers and Time Scales	
	Return to main meeting	
15:45pm	Feedback from groups	Facilitators
15:55pm	Summary and next steps	Dr Rami Hara

Organisation	Representation
BHRUT	4
Care provider voice	2
Community Pharmacy	1
NEL ICB	13
B&D GP Federation	1
Healthwatch	1
LAS	2
LBBD	10
NELFT	4
PELC	1
Primary Care	6
Public Health	1
Red Cross	1
NHS Camden	1



Breakout Discussion1

The session was broken into 3 discussion workshops, facilitated by the QI team at BHRUT. The idea was to generate as many ideas as possible, theme them, then agree on a set of actions for the short, medium and long term that the group could work together on to implement.



Group 1 was on the theme of ‘Prevention: promote “staying well in winter” campaigns and messaging’.

Some ‘quick win’ actions that were agreed by the group were:

- To run a targeted campaign on health inequalities – Local Authority colleague (TBC)
- Promote workforce wellbeing support - Local Authority colleague (TBC) and Mohammed Mohit from NELFT
- Collaboration: target one area – Mohammed Mohit from NELFT and Avril McIntyre, B&D Collective
- Holding joint campaign - Avril McIntyre, B&D Collective

Volunteers to carry these actions forward have been identified above.

Promote staying well in winter campaigns- key themes

Collaboration

- Need to move away from silo working – understand the range of services available in the community and make every contact count

Targeted campaigns

- Co-ordinated joint campaigns targeted at underserved groups, informed by an understanding of what the community needs with clear messaging and using a variety of communication tools
- Joint campaigns focused on workforce wellbeing

Young people

- Reach out to CYP with mental health issues
- Education of secondary school children – action on prevention through schools
- Target families with children who have additional needs

Breakout Discussion 2

Group 2 was on the theme of ‘Proactive Care: Optimise case finding, diagnosis and management of long-term conditions’.

Quick win actions agreed in this session:

- Targeted intervention and collaborative working
- A systematic approach powered by data sharing
- Early intervention

A short term action was:

- Improved community communication engagement and patient empowerment

Matthew Cole, Public Health, Shanika Sharma, GP and Ronan Fox, CYP Lead ICB- volunteered to bring these items for discussion at the next adults and children’s delivery group meetings respectively.

Proactive care – key themes

Systematic approach powered by data sharing

- Take a systematic approach to early identification and treatment using data/intelligence to identify vulnerable groups and those who slip through the net
- Better use of technology e.g. apps to support care and treatment

Targeted interventions and collaborative working/early intervention

- Proactive case finding across primary care and the voluntary sector – including HIU, unsafe discharges
- Ensure patient and carer reviews are taking place and review MDT working
- Set up dedicated clinics/hubs across PCN footprints that enable co-location of services and engagement with the voluntary sector, aligning resources and support to improve care; condition themed community support
- Review the respiratory pathway for CYP and support required through winter, including transition

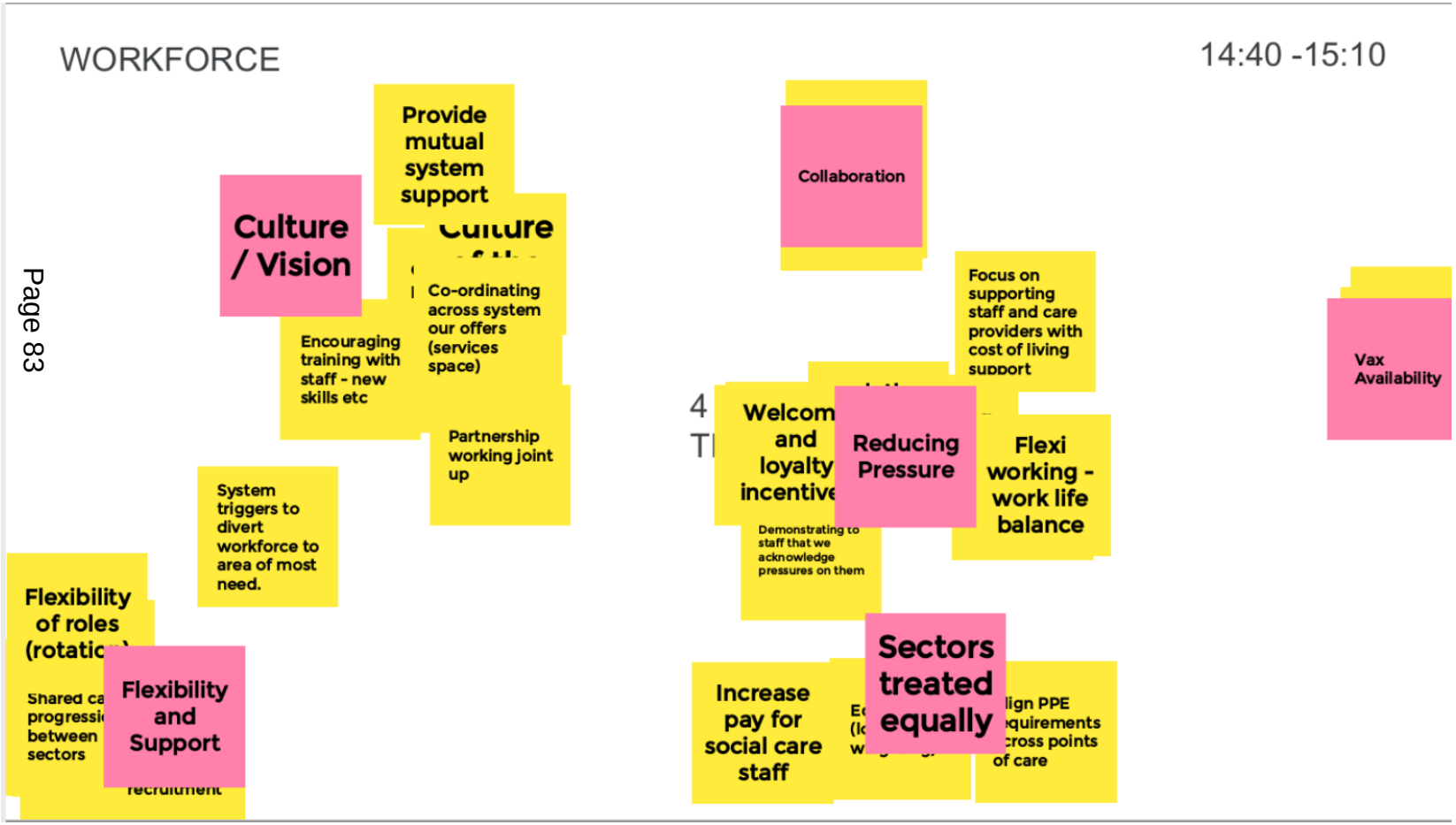
Improve community engagement and patient empowerment

- Clear messaging on why it is important for people to have their health checked in culturally appropriate language
- Better use of community champions to engage and empower residents

Workforce

- Ensure support for our own staff who have LTC

Breakout Discussion 3



Group 3 was on the theme of 'Workforce: How do we support the health wellbeing and resilience of the health and care workforce?'

Some 'quick win' actions identified:

- Culture/vision: 'launch' the partnership to establish values and direction
- Vaccine availability for staff: strengthen comms about where to go, outreach for those who are hesitant

Mid-term:

- Collaboration- e.g. working with schools and training organisations

Long term:

- Sectors treated equally
- Culture change
- Reducing pressure via flexibility/support: link in HR to enable staff to move around system

Ann Hepworth, BHRUT, agreed to start conversations towards launching the partnership in order to promote values/organisational identity

Workforce – key themes

North East London Health & Care Partnership

Culture and vision
- Co-ordinate the service offer across the system and spaces where people work from
- Staff training – to support core training to achieve outcomes and encourage new skills development

Reducing pressure
- Demonstrate to staff that we acknowledge pressures on them; ask them what we can do support
- Support staff and care providers with the cost of living pressures
- Consider welcome and loyalty incentives to improve recruitment and retention

Collaboration
- Making best use of volunteers
- Collaboration with schools to promote training into health and care roles

Vaccine availability
- Build confidence in, and provide access to COVID and flu vaccines for staff

Sectors treated equally
- Equality of pay – aligning London weighing across NEL; increasing pay for social care staff
- Align PPE requirements across points of care

Summary and actions

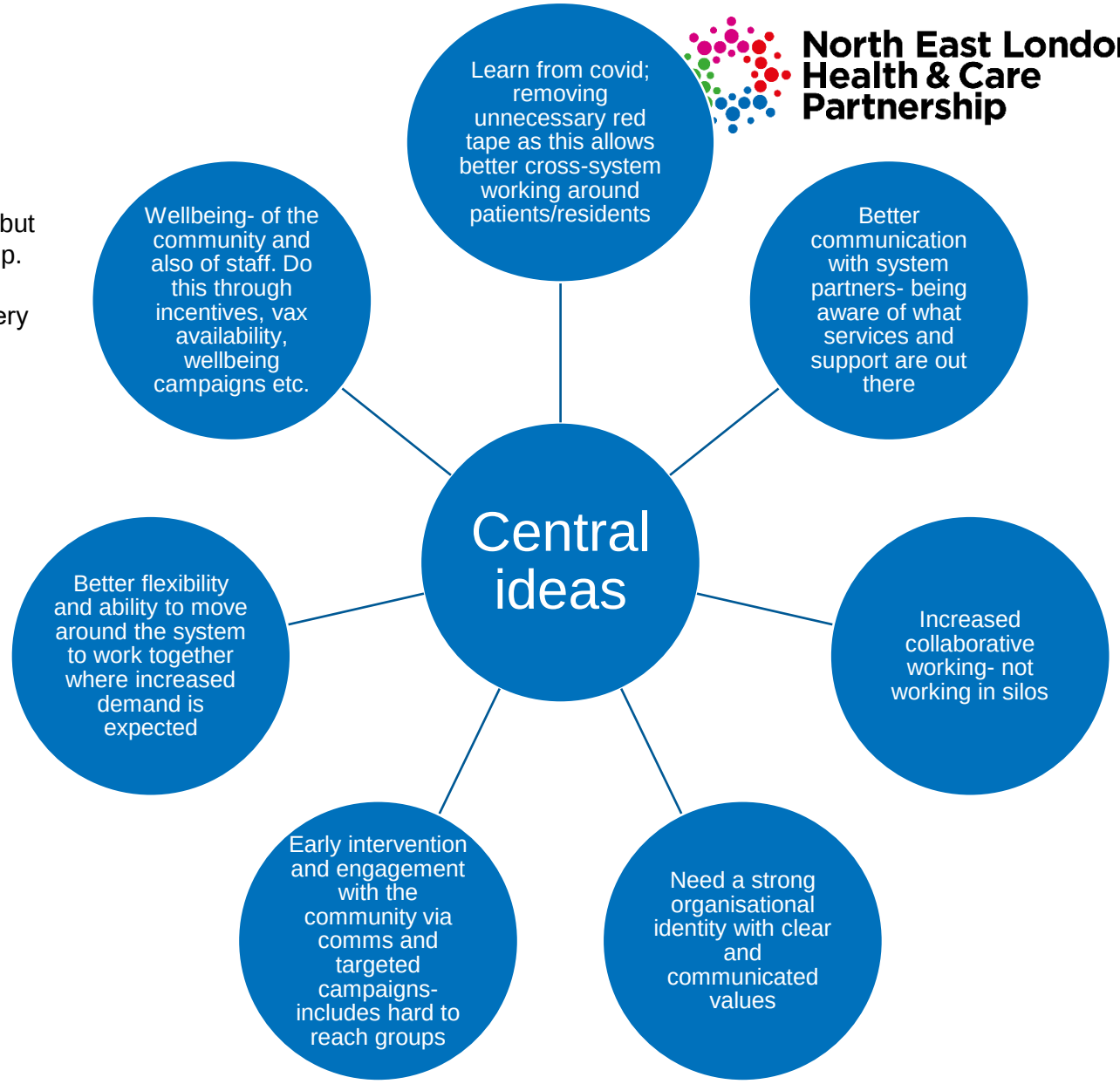
It was widely recognised in breakout discussions that this winter will be extremely challenging due to a ‘perfect storm’ of factors, namely: covid/flu, the ongoing cost of living crisis and workforce and capacity issues.

Volunteers have been identified from each breakout session to pick up short term actions but task and finish groups may be needed to progress these with support from a working group.

Outputs from these discussions will be shared at the next B&D adults and children’s delivery groups and the B&D Partnership Board.

Session	Actions
1) Prevention: promote “staying well in winter” campaigns and messaging	Need all partners to discuss how to coordinate a targeted campaign- will need more work to ensure all organisations give the same message to the population on health inequalities and promoting workforce wellbeing support in particular. Mohammed Mohit from NELFT and Avril McIntyre, B&D Collective volunteered to feedback names on who will be part of the group/support set up
2) Proactive Care: Optimise case finding, diagnosis and management of long-term conditions	Matthew Cole, Public Health, to share themes of targeted intervention and collaborative working, systematic approach powered by data sharing, and early intervention to the next adult’s delivery group on 17/11/22 to gather feedback/ideas. Ronan Fox, CYP Lead ICB, will also share at the next children’s delivery group- date TBC. Invites to groups will be extended to colleagues in the breakout session.
3) Workforce: How do we support the health wellbeing and resilience of the health and care workforce?	Ann Hepworth, BHRUT, agreed to start conversations (with Sharon) towards launching the partnership in order to promote values/organisational identity. Individual organisations to strengthen their comms messaging around vaccine availability for staff and staying well.

North East London Health & Care Partnership



Next steps

Volunteers have been identified from each breakout session to take forward several actions, which will aim to fulfil collective system objectives in the respective areas of discussion. Quick wins to be scoped further over the next 2 weeks and worked up through:

BCYP winter planning session – 15th November
Adults Delivery Group – 17th November
Executive Committee – 18th November

Winter planning update required for the Health Scrutiny Committee on 14th November.

BHR System Command and Oversight Group (SOCG) has been reconvened and will meet weekly for escalation – first meeting 27th November.

HEALTH AND WELLBEING BOARD

8 November 2022

Title:	**Healthwatch programme of work – 22/23 Progress Report**
Report of the Programme of work for Healthwatch Barking and Dagenham	
Open Report	**For Information**
Wards Affected: ALL	**Key Decision:** No
Report Author: Manisha Modhvadia, Manager Healthwatch Barking and Dagenham, LifeLine Projects	**Contact Details:** Tel: 020 8597 2900 E-mail: Manisha.Modhvadia@healthwatchbarkinganddagenham.co.uk
Sponsor: Nathan Singleton, CEO, LifeLine Community Projects	
Summary: In summary, this paper aims to: - Update the Health and Wellbeing Board about the areas of work scheduled and undertaken by Healthwatch Barking and Dagenham (HWBD) (from 1st April – 30th September 2022.	
Recommendation(s) The Health and Wellbeing Board is recommended to: (i) Consider the report noting the progress made to date	
Reason(s) To bring to the attention of the Board trends in public opinion with regard to health and social care services of Barking and Dagenham. To advise the Board of any identified gaps in service provision and to be able to influence commissioning in a timely way.	

1 Introduction and Background

1.1 Healthwatch is an independent champion for the public for both health and social care. It exists at both a national level – Healthwatch England and a local level – Healthwatch.

1.2 The aim of Healthwatch (local) is to give citizens and communities a stronger voice to influence and challenge how health and social care services are provided within their borough. Local Healthwatch also provides information and signposts individuals to services that might assist them or further information.

1.3 Under the Health and Social Care Act 2012, the Local Authority (in this case, London Borough of Barking and Dagenham) has a duty to commission a local Healthwatch organisation. National guidance establishes some of the services that Healthwatch must deliver, but local specification is up to local authorities and the local Healthwatch Board.

1.4 All work that is undertaken by Healthwatch has to be driven by feedback from residents of that Borough.

1.5 LifeLine Projects were awarded the contract for the provision of Healthwatch Barking and Dagenham for a period of 3 years from 1st April 2022

1.6 The contract length is three years with an opportunity to extend the period for one year subject to review, with an opportunity to extend a subsequent year, again subject to review.

2 Work plan

2.1 The work plan this year has been designed by the feedback of residents through the staff working on Healthwatch. It has been authorised by the Healthwatch Board and the Borough.

Enter and View visits

2.2 Enter and View visits are carried out under section 221 of the Health and Social Care Act 2012. It imposes duties on certain health and social care providers to allow authorised representatives of local Healthwatch organisations to enter premises and carry out observations for the purposes of Healthwatch activity.

2.3 Healthwatch can enter certain health and social care premises to view the care being provided. This includes premises such as hospitals, care homes and doctors' surgeries etc. All Enter and View locations are identified through feedback from residents of the borough and those that use the services.

2.4 Enter and Views can be announced or unannounced. This is determined by the project team. During visits authorised representatives, who have received training designed by Healthwatch England, will observe and speak to service users about their experiences of the visited location in order to collect evidence on the quality and standard of the services being provided. Representatives also speak to staff and relatives.

2.5 The results of all Enter and View visits are made available in reports which give evidence-based feedback to organisations responsible for delivering and commissioning services. Those responsible for the service are expected by law to respond back in 21 working days. Reports are then made public on the Healthwatch website and sent to Healthwatch England, CQC, London Borough of Barking and Dagenham and others.

2.6 This year, Healthwatch Barking and Dagenham will be carrying out two Enter and View visits in quarter four (January to March 2023), these will be undertaken at social care settings based in the borough. Locations have not yet been decided.

2.7 All completed reports from Enter and View visits are available on http://www.healthwatchbarkinganddagenham.co.uk/enter-and-view

Raising awareness of Healthwatch Barking and Dagenham

2.8 A focus of this year continues to be on raising awareness of Healthwatch to residents of Barking and Dagenham. This includes doing street engagement and having a larger presence on social media. From these things, we will engage more residents in our programmes, including Enter and View, as well as gaining evidence about services locally.

2.9 This work has already begun. All the Healthwatch team have received training from LifeLine's communication department on how to best use social media and how to run an event.

2.10 This year Healthwatch Barking and Dagenham have planned to carry out 50 engagement sessions in a variety of places across the borough. We have undertaken 30 sessions so far in various venues across the borough including libraries, Children's Centres, leisure centres and visiting voluntary and community groups. In this way our volunteers and staff can approach a wide variety of people to give them information about Healthwatch and ask people for their experiences of services.

2.11 We continue to provide monthly e-bulletins. These have so far been sent out August and October to those who have signed up to the Healthwatch mailing list. This will bring individuals up to date with our latest work as well as informing them on consultations that are currently taking place.

2.12 Healthwatch Barking and Dagenham has taken over 120 calls and emails from the public requesting advice and signposting. The calls consisted of individuals wanting to know how to make a complaint, where to go for benefit advice, issues relating to GP practices, and where to access dental care.

Healthy Living Project – highlight findings

2.13 Healthwatch Barking and Dagenham undertook a research project to understand the needs of local people when it comes to maintaining a healthy lifestyle. The focus of the report was primarily on healthy eating, exercise, understanding of BMI and healthy living services.

2.14 The survey drew a total of 126 responses from residents across the London Borough of Barking and Dagenham. We also received an additional 40 pieces of information from individuals.

2.15 More than 50% of respondents agreed that it makes a difference if healthcare professionals understand issues relating to their race/culture when providing support relating to healthy living and weight management.

2.16 A quarter of all respondents do not know their BMI but consider themselves to be overweight.

2.17 Most respondents showed an awareness of their health in relation to weight and BMI, although much of this appears to be based on personal perception, with 49% of respondents selecting statements including the words 'believe' or 'consider' next to 51% who selected statements including the words 'I am.' This highlights the need to educate individuals how to check their BMI and the importance of knowing their BMI, not having a true reflection of their weight could influence an individual's decision on accessing healthy lifestyles services and relevant health care support.

2.18 Two thirds of respondents told us that they had successfully lost weight in the last 3 years.

2.19 Overall, respondents are keen to make positive changes, and know what they would like to do. However, busy schedules, high levels of stress and low income appear to be the main drivers that are preventing people from living healthier lifestyles.

2.20 Employers need to be more aware of their employees' difficulties regarding staying healthy, and more flexible with regards to their needs in this respect.

2.21 Results show that the most respondents have not heard of or engaged with the healthy lifestyles services listed in the survey. This highlights the need to focus on raising awareness of local services.

2.22 Individuals from BAME backgrounds also commented on the need for the healthy lifestyles team to be more culturally friendly.

2.23 HWBD made nine recommendations based on the findings. A meeting was held between the council, the healthy lifestyles team and public health, after a proactive discussion of the findings a positive response to the recommendations was provided from partners who were involved in the initial discussion.

Pre- Frailty Workshops

2.24 Two workshops run by Healthwatch as a part of the Population Health Pilot in the borough. The aim of these workshops was to design interventions from the bottom up that would prevent the pre-frailty from advancing into actual frailty with these interventions being proposed and designed by the cohort themselves. Participants were drawn from a cohort of those identified as pre-frail in the borough, and particularly those aged over 50 and diagnosed with hypertension.

2.25 Facilitation of two interactive workshops, each lasting around 2.5 hours delivered in July 2022 with 8 patients in attendance. The project was based on an inclusive,

qualitative methodology which prioritises listening to and drawing out the experiences and perspectives of NHS patients in a pre-frail cohort.

2.26 The principle aim of the workshops was to gain a rich understanding of the experiences and view of this cohort and the healthcare provision they currently access and would like to access in the future. Ultimately, the focus of each session was on understanding from the user perspective how services are preventing and could better prevent people moving from pre-frailty to frailty

2.27 Each participant shared that they had at least one current health condition which related to the definition of pre-frailty, with almost all sharing that they have two or more.

2.28 HWBD are pleased to report that the pre-frailty report has been shared with stakeholders in London working on Anticipatory Care, to help other places with their implementation. The report has been displayed on the London NHS Future page for Anticipatory Care.

2.29 At a local level the findings from the workshops are being used to develop a pilot model of care for pre - frailty in Barking and Dagenham. HWBD have a role to ensure that patients are involved in plaining and designing of health and care services, this is a prime example of how it could be done.

Maternity project in collaboration with NEL Healthwatch

2.30 North East London (NEL) has four of the ten most diverse Local Authorities in England and Wales. As such, women living in NEL are more likely to experience health inequalities when accessing maternity services. The National Health Service England (NHSE) has asked Local Maternity Systems (LMS) to focus on their five priorities to improve equitable maternal and neonatal care. NEL Healthwatch were asked to get involved and seek the voice of women from the BAME and look to understand the experiences of patients from minority or marginalised groups when accessing and experiencing maternity services.

2.31 Healthwatch Barking and Dagenham undertook 36 interviews, and 35 surveys were completed in Barking and Dagenham.

2.32 A North East London wide report has been shared with the ICS maternity lead and NHS England. Once this has been approved, the team will be able to share the report more widely.

GP website reviews

2.33 A review of 33 GP practice websites has been undertaken after receiving feedback from the public. Healthwatch reviewed the 33 GP surgeries websites within Barking and Dagenham. The research was undertaken as our residents were concerned about:

- Not being able to clearly find out who to complain to at their GP practice.
- The opening times for their surgery were not clearly displayed
- Being unclear regarding the process of making a complaint, and who to complain to

- Not knowing if their surgery had a Patient Participation group and how they could become part of it.
- Unsure about whether their surgery offered the E-consult service

2.34 All 33 websites were reviewed. The questions used for the research were formulated to review the online presence of each surgery and included the following areas:

- whether the practice had a website,
- the details most likely to be searched by patients,
- if the website made it clear how to register as a patient
- the process of getting an appointment,
- the complaints procedure,
- the process for requesting repeat prescriptions.
- Further questions also included accessibility for patients with a range of sensory loss or learning disabilities.

2.35 A report will be sent to the ICS and a full response will be shared with the board once a response has been received.

Volunteers

2.36 Healthwatch Barking and Dagenham has a volunteer base of 17 ad hoc volunteers; we are therefore currently running a campaign to recruit local volunteers to become supporters and advocates who will expand capacity in the coming years.

2.37 In order to recruit and increase volunteers Healthwatch Barking and Dagenham have been advertising through face to face engagement, utilising social media, sharing opportunities with voluntary and sector community groups and sharing opportunities with colleges and the local university.

Current and future projects for 2022-23 (November 2022- 31st March 2023)

2.38 **Education, Health, and Care Plan (EHCP) –** The council has duties to monitor provision and arrangements for each child with an EHCP. Healthwatch have been asked by the local authority to undertake an independent project focusing on the voices of parents of children who have EHCP or are waiting for EHCP and engaging with children and young people. Engagement for this piece of work will commence mid-November with a report complete by 31st January 2023.

2.39 **Health visiting project –** Healthwatch Barking and Dagenham have recently launched this project. According to NELFT NHS Foundation Trust the health visiting service provides a community public health service to children, young people, and their families with a focus on early intervention and prevention, as well as promotes physical, emotional, and social wellbeing. However, the latest annual health visiting

survey that has been completed by 1,291 practitioners from across the UK has revealed that coronavirus pandemic and staff shortages have left health visiting services extremely stretched and that only the “tip of the iceberg of need is being met for some families”. As a result, for many families’ routine health and development reviews, that are mandated by the government, have not been carried out.

2.40 Healthwatch Barking and Dagenham have launched an independent project to explore what the local picture is with the aim of reporting what is working well and what needs to improve within the health visiting service. The project is anticipated to be completed by February 2023.

2.41 Each year, local Healthwatch’s are tasked to do an annual survey to assess the impact of Healthwatch in the local borough. This year’s annual survey will run from November 2022 to January 2023 - with the aim of gaining a range of feedback from the local population.

Challenges

2.42 Recruitment of staff has been a challenge for Healthwatch Barking and Dagenham, sessional officers were recruited to support the service in delivering the workplan. After three recruitment rounds two officers have been employed.

Representation

2.43 Healthwatch continues to be represented on the following groups and board:

- Health and Wellbeing Board
- Safeguarding Adults Board
- Barking and Dagenham Place
- NEL Healthwatch meeting
- BHRUT Healthwatch leads meeting
- Local Quality Surveillance Group
- Health and Adult Social Care Scrutiny Committee
- Joint Health Overview Scrutiny Committee
- Carers Strategy Group

3 Mandatory Implications

Joint Strategic Needs Assessment

3.1 When developing our annual plan, Healthwatch Barking and Dagenham have been mindful of the content and data of the Joint Strategic Needs Assessment

Joint Health and Wellbeing Strategy

3.2 When developing our annual plan, Healthwatch Barking and Dagenham have been mindful of the content and priorities of the Joint Health and Wellbeing Strategy.

Integration

3.3 Healthwatch Barking and Dagenham continue to have discussions and work closely with NEL Healthwatch and the Integrated Care System.

Financial Implications

3.4 The contract with LifeLine Projects began in April 2022 and LifeLine is funded to deliver the programme for two years with an opportunity to extend the period for one year subject to review, with an opportunity to extend a subsequent year, again subject to review.

(Implications completed by: Manisha Modhvadia, Manager for Healthwatch Barking and Dagenham)

Legal Implications

3.5 Under the Health and Social Care Act 2012, the Local Authority (in this case, London Borough of Barking and Dagenham) has a duty to commission a local Healthwatch organisation.

3.6 Under the Health and Social Care Act 2012, local Healthwatch organisations can undertake announced or unannounced 'Enter and View' visits to both health and social care settings.

(Implications completed by: Manisha Modhvadia, Manager for Healthwatch Barking and Dagenham)

Risk Management

3.7 All those undertaking services for Healthwatch Barking and Dagenham (especially Enter and View visits) have undertaken the correct level of DBS clearance and training by an authorised member of staff.

3.8 The safeguarding procedure follows the process and procedures established by LifeLine Projects. Healthwatch Barking and Dagenham staff have received training.

3.9 Risks are managed monthly through LifeLine's 'scorecard' process, which is an internal process to register the risks related to the contract.

Patient / Service User Impact

3.10 Healthwatch Barking and Dagenham's work is built solely on the feedback of residents and the wider public. This feedback is either gathered from service users themselves (through engagement events, social media, or signposting services), or via meetings held by/within the borough where Healthwatch has representation.

3.11 Published Healthwatch reports are designed to reflect the views of the users of health and social care services in the Borough.

4 Non-mandatory Implications

Crime and Disorder

4.1 None

Safeguarding

4.2 All staff have updated DBS checks and have received training on the safeguarding policy and safeguarding issues that they may face in their roles. Each member of staff is formally asked each month whether they have encountered any safeguarding issues. The expectation is that safeguarding issues are raised through the agreed procedure immediately they are discovered.

Property / Assets

4.3 Healthwatch Barking and Dagenham are now based at LifeLine House, Neville Road, Dagenham, Essex RM8 3QS.

Customer Impact

4.4 Healthwatch Barking and Dagenham's work is built solely on the feedback of residents and the wider public. This feedback is either gathered from service users themselves (through engagement events, social media, or signposting services), or via meetings held by/within the borough where Healthwatch has representation.

4.5 Published Healthwatch reports are designed to reflect the views of the users of health and social care services in the Borough.

Contractual Issues

4.6 LifeLine Projects is contracted to deliver Healthwatch Barking and Dagenham for three years until 31st March 2025. There will be an opportunity to extend the period for one year subject to review, with an opportunity to extend a subsequent year, again subject to review.

4.7 Healthwatch Officers are also supported by the Healthwatch Barking and Dagenham Board which is made up of five Barking & Dagenham board members and a Chair from LifeLine Projects. The Board meets every quarter to receive an update and raise any concerns to the project team. The Board is contacted about other issues during the quarter but may not formally meet.

Public Background Papers Used in the Preparation of the Report:

- Healthwatch Healthy living report
- Healthwatch Pre frailty report

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Population Health Management: Pre-Frailty July 2022

healthwatch Barking and Dagenham

Contents

Introduction

This report presents a summary of the findings from 2 workshops run by Healthwatch as a part of the Population Health Pilot in the borough. The aim of these workshops was to design interventions from the bottom up that would prevent the pre-frailty from advancing into actual frailty with these interventions being proposed and designed by the cohort themselves.

Participants were drawn from a cohort of those identified as pre-frail in the borough, and particularly those aged over 50 and diagnosed with hypertension.

The outcomes from these workshops, along with suggestions for improving future levels of engagement, are presented here under thematic headings requested by NHS North East London.

Methodology

The project is based on an inclusive, qualitative methodology which prioritises listening to and drawing out the experiences and perspectives of NHS patients in a pre-frail cohort. The principle research method is the facilitation of two interactive workshops, each lasting around 2.5 hours. The principle aim of the workshops was to gain a rich understanding of the experiences and view of this cohort and the healthcare provision they currently access and would like to access in the future. Ultimately, the focus of each session was on understanding from the user perspective how services are preventing and could better prevent people moving from pre-frailty to frailty. It has a wide-ranging focus aiming to elicit novel and revelatory responses.

Recruitment, Sampling and Generalisability

The workshop brought together participants fitting the definition of pre-frailty to discuss their experiences. Participants were selected using a mixture of purposive and convenience sampling. GPs local to the Borough reached out to a large number of current patients who have a diagnosis connected to pre-frailty – for the most part, this was patients with chronic hypertension. Each GP service called between 30 and 60 people in the days leading up to the workshop, asking if they would be interested in attending, leading to 8 patients attending (5 in session 1, 3 in session 2). Each participant shared that they had at least one current health condition which related to the definition of pre-frailty, with almost all sharing that they have two or more. Whilst participants were not asked to disclose their condition or any medical history and were advised that this was not necessary for the discussion, all chose to share aspects of this at points of the workshops. This is a highly positive sign that people felt comfortable with the research process.

In qualitative data collection, there is often not a clearly defined required sample size: qualitative research is concerned with the richness of data and human experiences shared rather than statistical weightings. In the data and experiences provided by the 8 participants, there are clear commonalities which are indicative of themes and shared experiences across the cohort. Whilst 8 is a relatively low number in comparison to the population size (e.g. everyone with hypertension in the Borough), the evident commonalities emerging allowed the researchers to draw out a strong set of limited findings which are likely representative of many in the pre-frail cohort. In the analysis presented below, caveats are provided to demonstrate any limitations of the data and the tone of the findings is one of occasional caution (e.g. it seems that…) rather than declarative certainty, as expected in this type of community research.

Method: Facilitated Interactive Workshops

It is common for focus groups to be used in community engagement and community research, particularly on areas of broad interest such as healthcare. The principle method used in this piece has much in common with focus groups but aims for greater level of discussion between participants (rather than only between participants and

researchers). The facilitation element of the workshop also places significantly more emphasis on the conditions of discussion, aiming to create a less-formal, more relaxed environment for people to not only feel comfortable in sharing their views and experiences but to enjoy the discussion, too. Community research, in our view, should aim to provide a benefit to participants rather than be entirely extractive.

The interactive workshops are based on principles of inclusive dialogue in which the voice and interests of participants are given outright priority. Whilst there is an overarching structure, there is significant scope provided for participants to lead conversation, open up tangential areas, provide anecdotes, pose their own questions, etc. The facilitators are present to support good, inclusive conversation, mitigate any tensions or unhelpful dynamics and to keep time – the rest is down to the participants. This is a qualitative difference to the traditional focus group and is especially helpful when discussing sensitive topics with people who do not usually speak in public or share personal experiences with strangers.

Distinctively in these two workshops, the patient-participants were joined by a small number of healthcare professionals, mostly GPs. This allowed any medical or NHS-focused questions to be dealt with by experts as and when they arose (e.g. does the NHS have a service for XXXX in the Borough?). It also provided the opportunity for the healthcare professionals to listen first-hand to the perspectives of patients in an environment which was non-transactional and outside of their usual workplace dynamic. The professionals were informed that their role in this would be limited to specific aspects such as asking questions and any other contribution made should be provided as 'patients' rather than representatives of the NHS. The feedback afterwards was that the experience was interesting, new and useful for many of the GPs taking part and helpful to the participants' conversation.

Workshop Flow

The workshops ran in 3 linked phases:

1. Information and icebreaker: people were provided with a clear introduction to the project, key definitions (e.g. pre-frailty), information on people's roles in the room and to the ethos of the project. Participants then took part in an informal icebreaker activity.
2. Exploring people's views and experiences: people were asked to list and discuss the services they access or have accessed and the barriers to accessing these services, prompting wide-ranging discussions of the groups' experiences.
3. Practical activity: people were asked to consider one of the services or approaches they have encountered and develop a logic for how it could better prevent frailty. Participants developed a basic Theory of Change for a specific intervention, proposing an activity or change they would like to see and showing logically how it would help people who are in a pre-frail state to improve their quality of life or healthcare outcomes. These were purposely developed without critique or sense-checking from healthcare professionals, in order to illicit novel and less-restricted responses and avoid statements such as 'well that's not really how it works…'.

Data and Reporting

Two types of data were collected during the workshops. Firstly, the verbal contributions made by participants collected in fieldnotes by researchers and secondly, the written contributions on post-it notes and flipchart paper. This data was then analysed by the researchers, coded into themes and reported in a structure which blends the needs of the NHS-practitioner audience and the ground-up themes from the voice of participants. This is what is presented below.

Summary Findings

The findings in this report are presented in 4 thematic areas as requested by NHS North East London.

1. Service and Provisions Accessed in the Borough and Barriers to Access

To set the context for the session and to better understand the needs of the participants in the room, the first interactive activity asked participants to list all of the health provision that they currently access, or have recently accessed. This also served as an effective exercise in steadily opening the group up to dialogue with each other, as all participants use the NHS and related services on a regular basis, and so had this in common.

Participants initially listed lots of primary and secondary NHS provision (there were a couple of passing references in discussion to tertiary care such as overnight stays in hospitals) as shown below:

GP	A&E	999
111	Dentist	Optician
Outpatient clinic	NHS website	Walk in centre

Widening Conceptions of Healthcare Interventions

With some group discussion and facilitator prompting, participants were able to widen their input to include an array of wider preventative and supportive community and voluntary sector provision too. Most of the examples given by participants were still reactive (i.e. in response to an event) and specialised to presenting needs (related to an existing aspects of pre-frailty), but did include some more general preventative activities such as fitness classes or gym attendance. For many, it appeared that this was the first time that they had fully considered the question of what constitutes health provision, providing the opportunity to positively frame their own choices and extant activities and consider the much wider picture of activities which enhance their wellbeing. Examples of the feedback include:

Fitness classes	Gym	Physio
Smoking clinic	Pharmacy	Community sessions

Widening Conceptions of Healthcare Provider

Over the course of the discussion there was also a clear recognition that unpaid carers such as family and friends comprise a critical element of health provision for participants, and in the Borough more generally. Many participants hold the dual role of provider and recipient of unpaid care. Crucially, the discussion in the first session became much richer and relaxed as unpaid care became recognised by the group, including the healthcare professionals in the room, as a legitimate and valued healthcare function. It was highlighted and discussed in the first of the two sessions that greater training for and recognition of unpaid carers could have a range of positive outcomes for both carers and recipients of care. This was especially felt to be the case with the introduction of “novel” terminology, like frailty and pre-frailty, with which the carers and those that they care for are unlikely to be familiar. It was felt that a clear recognition from local statutory services that unpaid carers are a central part in pre-frailty interventions provides an opportunity to highlight and reinforce the value added by this oft-hidden and excluded cohort: a chance to bring them into the fold.

Telephone and Online

Nearly all participants in both groups used the telephone to access and receive services and provision. This was often as a matter of necessity rather than preference, especially with regards to consultations with GPs and clinical specialists – participants were begrudgingly making do with the only option provided. All participants were aware of at least some form of online health content and support, such as the NHS website, but most were reticent to use this and saw it as a minor part of their care. There are close links here to barriers to accessing services, and these were discussed next in the sessions.

Barriers and Hurdles

When asked to list the barriers that they face in accessing, or attempting to access, services and provision, participants responded much more readily and in a greater level of detail than they did in response to being asked which services and provision they use. There was a clear split in how participants in the first session saw barriers with some barriers being seen as being large, almost insurmountable issues whilst others were smaller problems or hold-ups that caused disruption and/or discontent and make accessing services seem harder and less achievable. These latter, smaller, and often recurrent, issues were classified as being hurdles, but it was recognised by participants that repeated hurdles had led to individuals missing out on or opting out of healthcare.

Commonly cited barriers included:

Language	Transport	Systems
Internet access	Waiting times	Work

There was a great deal of crossover between barriers and hurdles in many cases, but where hurdles were discussed, these were often more in the form of personal experience, and often quite emotive. Key examples include:

Repeat prescriptions not working	Notes and files not being shared	Long wait times to book appointments
Long gaps between making an appointment and seeing a GP	Referrals not being made	Not being aware of what is available

Overall, there was a very wide range of both barriers and hurdles discussed and listed in both sessions and additionally there was a good recurrence of the same barriers and hurdles across all participants in both sessions. This, coupled with the already developed levels of understanding of barriers to access in Barking and Dagenham, suggests that the data gathered is reliable and indicative of the wider picture for this cohort of service users.

2. Participant Designed Interventions

The main part of each workshop was participants being asked to design an intervention which they feel would help slow or prevent people who are pre-frail from moving into frailty. To guide participants and to give logical structure to their interventions, they were asked to use a template of a vertical logic model that is based on a single pathway of a Theory of Change. This template can be seen below:

Activity	This is what the new intervention or approach is.
SO THAT	
	What is the first thing that it helps with? EG: - Are you able to see a specialist/GP/any health provider quicker? - Are you physically fitter? - Are you better able to make decisions about your health and lifestyle? - Do you have more information about aging?
SO THAT	
	What is the second thing that changes here in the chain as a result of the below? EG: - Does seeing someone quicker stop health issues deteriorating? - Are your health conditions improving as a result of increased physical fitness? - What are these informed decisions changing? - Do you feel better prepared for aging? - Are you more motivated or bought in?
SO THAT	
	Is there are third (and fourth) thing that happens?
SO THAT	
Aim	People in the pre-frailty cohort are prevented from moving into frailty

By using this model, with a clearly defined aim which was understood by participants, and the prompting of participants with *"So that?"* questions, each group was able to draw a logical link between the intervention that they proposed and the aim of the intervention with key, measurable steps in between. Where possible participants were asked to define what success looked like or how it could be measured at each stage in the logic model.

In all 5 interventions were designed with varying degrees of complexity and detail. From these 5 interventions, 4 are documented here with commentary detailing common linkages between them and other relevant outputs from the workshop. One participant who created an intervention did not wish to present this back to others in the workshop or for it to be shared as it was personal to her. The content of this was very similar to that of Intervention 2 though and so no completely unique data or insights have been omitted.

<u>Intervention 1: The provision of more fitness and hobby clubs</u>

This group acknowledged that there is provision in the borough, such as exercise classes, which can be accessed by everyone, but felt that much of it was not suitable to them personally because of their age, fitness levels and their interests. One participant

commented that she is not excluded from provision in any formal way but that she self-excludes because she would feel uncomfortable in certain situations, such as a spin class.

The group which co-designed this intervention feel that a wider range of activities including hobby clubs, such as sewing and model making, as well as more fitness based provision would help to create a virtuous circle of people doing more, feeling better and then doing even more.

Activity	More age, health and interest appropriate fitness and hobby clubs are run in the borough	
	"So that?"	
	There are more suitable things for pre-frail people in the borough to do.	Measurement: Increased amount of provision
	"So that?"	
	Pre-frail people in the borough get out more and do more	Measurement: Number of activities taken up and time spent moving each day increasing
	"So that?"	
	People feel more confident and improve their physical fitness and continue to do more.	Measurement: Increased confidence, mental and physical health.
	"So that?"	
Aim	People in the pre-frailty cohort are prevented or slowed from moving into frailty	

<u>Intervention 2: Improving access to existing provision and prioritising at risk cohorts.</u>

This group recognised that there is provision that already exists in the borough and that much of this is good and suitable. However, many times this provision is at full capacity and people in the pre-frail group are unable to access it because of barriers.

The specific example from the workshop was of a lady who has had a double knee replacement who would like to regularly take part in a water aerobics class that runs at a local leisure centre. These sessions though fill up very quickly and are typically only available to book online. This lady does not use the internet and so is reliant on what availability is left. This is often none and so she does not take part in the classes and is not managing her knee pain.

This group independently articulated the same virtuous circle as those in Intervention 1, but also felt that it was important that pre-frail people are able to set their own goals. For the individual here this was to be able to play fully with her grandchildren. This would be a big motivating factor for her and something that she could qualitatively assess.

Activity	Improving access to existing provision and prioritising at risk cohorts.	
	"So that?"	
	More provision is prioritised for pre-frail people in a way that they are able to book and access.	Measurement: Being able to book onto classes over the phone or in person and quotas being ring-fenced for those at risk/ in need.
	"So that?"	
	People are able to do more and improve their fitness, pain management and confidence.	Measurement: Physical outcomes, including less reliance on painkillers, and loneliness indicators.
	"So that?"	
	Quality of life improves and people carry on do more of what they want to do	Measurement: Should be defined by the individual as part of an action plan. EG: Being able to play properly with grandchildren
	"So that?"	
Aim	People in the pre-frailty cohort are prevented or slowed from moving into frailty	

Intervention 3: Creation of a single point of access for provision in the Borough.

This intervention recognised that many pre-frail people, including those in the session, often have several and/or complex needs and that accessing several forms of provision through different providers and channels can lead to missed opportunities for interventions and patient drop out.

Much like interventions 1 and 2, this also focusses on increased motivation and subsequent behavioural change, but it aims to bring it about in a slightly different way.

An important, parallel strand, of work emerged from this group in the workshop too around better and more file sharing between hospitals and GPs. A patient needing to repeat their health problems and issues is seen was seen by the group as a significant hurdle to those with several need and so minimising the amount of times that a person needs to tell their story to health professionals would minimise this. It was also felt that this could lead to a better standard of care health professionals will be better briefed and more efficient in using their time with patients.

Activity	Creating a single, user-friendly point of access for patients in the borough	
	"So that?"	
	People have more and better awareness of, provision in the Borough.	Measurement: Increased knowledge of provision including support groups, voluntary sector provision and exercise classes.
	"So that?"	
	People feel empowered to make their own health choices and take up more provision	Measurement: Increased uptake of provision including support groups, voluntary sector provision and exercise classes.
	"So that?"	
	People feel themselves getting healthier and are better able to manage their own conditions	Measurement: Physical and mental health indicators
	"So that?"	
Aim	People in the pre-frailty cohort are prevented or slowed from moving into frailty	

Intervention 4:Greater continuity in provision

This intervention was designed in the second workshop but has a strong overlap with Intervention 3, which was designed in the first workshop. The recurrence of the theme of patient repetition being felt to be problematic is suggestive of this being a widespread issue and cause of patient discontent.

This proposed intervention recognises that one to one care and patients always seeing the same GP or other relevant health professional is not possible. However, where there are smaller at risk cohorts, such as those classed as pre-frail with a number of longer-term and more complex needs, this could be an aspiration. It is felt that by building stronger relationships and having greater continuity in care here that patients will receive better care and be more inclined to access provision when they need it.

Activity	Providing greater continuity of in care for people with long-term, complex conditions	
"So that?"		
	Patients are, where possible, seen and treated by the same healthcare professionals	Measurement: More and better relationships between the patient and the professional
"So that?"		
	More continued conversations and more trust between the patient and the professional	Measurement: Less repetition and less dropping out of provision
"So that?"		
	More confidence and inclination to access healthcare when needed	Measurement: Greater uptake of provision and more early interventions
"So that?"		
Aim	People in the pre-frailty cohort are prevented or slowed from moving into frailty	

3. Delivering Quality Services and Managing Expectations

In both sessions, there was a wide-ranging discussion between participants, added to by the healthcare professionals in the room, on the distinctiveness of the NHS and the role it can play in contemporary society. This was not a predetermined focus of the workshops or part of the outline structure – it arose somewhat organically and became a useful tangent to the more practical discussion of specific services in the Borough. In order to do justice to the workshops in this report, an overview of this discussion is captured in this short section, providing an indication of the nuance of the discussion around service provision.

At points, the discussion of services and the future of NHS provision pivoted to a wider, background issue of what citizens can and should expect of NHS services. Is it reasonable for people to expect immediate, on-demand services from the NHS? Are prevailing norms from other sectors exacerbating people's frustrations? Are patients asking too much? Are healthcare professionals too busy to care about the journey of individual patients beyond specific transactions?

The first point to note is that there is no fixed conclusion here. The discussion was highly nuanced and not focused on blame or judgement at all. It was felt that many of the issues discussed underpin much of the conversation about on services for pre-frail and frail groups.

Some of the discussion was based around the analogy of popular subscription delivery services such as Amazon Prime and how a society which now relies on these services for consumer goods and a wide range of services in everyday life are perhaps expecting a similar standard of service from the NHS. This was a multi-faceted discussion. For some, the focus was on speed and immediacy of provision: perhaps citizens now expect to access healthcare straightaway because more people can obtain a greater speed of service in other areas of life. A clear commonality between participants was the high degree of frustration with waiting for GP surgeries to answer the phone or waiting times in hospital emergency departments, for example.

Another facet was 'choice'. For many people and in many other areas of life, there are increasing expectations about having a range of options in transactions and being permitted to choose between those for an option that best suits one's needs: bespoke, customised products and services are increasingly the norm in many other areas of life, from the weekly shop to buying insurance. It was suggested by some that people's experience of choice offered in other areas was affecting their expectations of the NHS in a way that was not realistic in the current system, and not desirable for a public service.

Finally, related to both speed and choice, the weight of customers' opinions and perspectives was also felt to have increased in other sectors. People are asked for feedback immediately after online purchases and people's freedom to choose means that they are in the driving seat of consumption. It was suggested that this is increasingly leading to patients demanding a more significant role in dictating what care they receive, what medical interventions are relevant and the terms of their engagement with medical professionals. People's access to Google provides more access to information but not necessarily a more appropriately-informed patient cohort. The example of someone demanding an intervention that was entirely inappropriate for their condition because they had seen it used on television or in popular culture was used for illustration here.

The discussion of the societal factors behind our expectations of the NHS began in one session with the statement from a GP: 'I just think that some patients expect too much: we're not Amazon Prime'. To the facilitators, this felt as much a declaration of personal

frustration as a substantive social commentary. Over the course of a discussion, this statement and others like it were deconstructed and more nuance was brought to the conversation. There was a useful discussion of how, in the experiences of both patients and professionals, the structural challenges in the NHS were preventing them from meeting some of the most basic expectations, such as being able to get an appointment. It was felt by some that expectations for some people used to priority services in other facets of life, were too high. But, more pressingly for the aim of this research, health and social care services were not able to effectively prioritise provision for those soon to be most in need: the frail and pre-frail groups.

The analogy of Amazon Prime came up repeatedly and the difference between Amazon Prime and the NHS was drawn out through the conversation. With a Prime membership, the customer is given priority in exchange for subscription fees – money. In a free-at-point-of-use NHS, money is or should not relevant to the care received. It was felt in both groups that prioritisation should be based on need and vulnerability and for a pre-frail group, prioritisation should be on those factors which, when combined, hinder ones resilience to recover from illness and maintain wellbeing.

The discussion in both groups ultimately turned to the limits of the current healthcare system. These ranged from IT systems not being adept in prioritising care needs to the reliance on digital services not accounting for digital poverty and exclusion. As discussed above, for the pre-frail cohort representative in both groups, these were both significant barriers to preventing frailty.

Ultimately, it was felt that expectations of NHS services are likely to be rising at a time when services are under almost-unprecedented demand. This is a challenging dynamic for the population at large. In relation to this research, though, pre-frail patients and healthcare professionals are subject to similar pressures within the same system. There are some obvious barriers and hurdles to provision that are not related to patients' expectations or healthcare professionals care, they are caused by a structure under significant pressure which, for many of those attending these workshops, was felt to be under-resourced. The preventative measures suggested here, and the many more that could be developed, are likely to save on NHS pressure in the long-term providing the funding can be made available to invest upfront, which is a clear aim of Population Health Management.

One common theme across this discussion was that perhaps the most promising way of overcoming these expectations and services pressures was to have more contact between patients and healthcare professionals, to allow the highlighting of simple interventions that could make a big difference to pre-frail groups and to build understanding between both healthcare professionals and patients in a constructive way.

Conclusion

This report commends the efforts of NHS North East London and the healthcare professionals who gave their time to take part in the workshops and the exercises in them. This, very genuine, enthusiasm for bringing about positive change in the way that healthcare is provided in Barking and Dagenham makes the change that much more likely to happen.

Though this work is only comprised of 2 workshops with a relatively small cohort of participants, broad thematic areas of findings did emerge and Healthwatch recommend that NHS North East London take these into account when planning future engagement and service delivery.

Firstly, participants were able to articulate very clearly the big barriers and smaller hurdles that stop them, or slow them, from accessing healthcare. None of these barriers or hurdles were new, but the consistent articulation of them suggests that they should be taken into account when planning future works. Mitigating for language barriers, a lack of understanding of NHS systems and the online/offline divide will be key to involving patients in planning their own services and consulting with them around these.

Secondly, it is likely no coincidence that 3 of the 4 patient designed interventions independently proposed the creation of a virtuous circle whereby the NHS make it easier people to make positive choices about their healthcare and lifestyle which leads to people doing more and better things for themselves. Kicking off this positive loop should feature prominently in planning in the borough for slowing or stopping the move from pre-frailty to frailty. Similarly, 2 of the 4 participant designed interventions recognise that not all cohorts of patients are the same and call for specialist provision and allocations for those with the greatest need. If building resilience against frailty is a health priority in the borough, then prioritising and working with those in danger of becoming frail is an obvious first step.

Finally, though the desire to engage with patients and to have them playing an active role in designing health interventions in the borough is both admirable and genuine, there are challenges in getting patients around the table to engage. It is hoped, and recommended, that the suggestions for widening engagement listed in Section 4 of this report are acted upon. Building grassroots engagement from scratch, or a very low level, is a huge task and, where possible, NHS North East London should look to work with trusted community, voluntary and faith sector groups to reach patients and residents in as wide a variety of ways as is possible and practicable.

Recommendations on Future Engagements

The level of engagement of participants in the two sessions was very good and the support from local GPs was excellent in both. The number of people recruited was, however, lower than was hoped or expected. This may, in part, be due to both unseasonably warm weather and the on-going risks and fears associated with Covid-19.

Therefore, Healthwatch make the following practical suggestions to increase engagement in future, similar events:

- Widening the cohort beyond those aged over 50 and with hypertension. People with other indicators of pre-frailty could also be included so as to widen the pool of potential recruits.
- Running engagements at different times of the day could be explored. Both of the sessions in this work were run in the early evening on a weekday and this may exclude people with caring responsibilities, certain work patterns or those who do not feel safe in later in the day.
- Tagging future engagement sessions onto existing provision or events should be explored. One participant in the second session suggested that attendance may have been negatively impacted by a Zumba class that runs nearby at a similar time and so running an engagement session at the same venue as the Zumba class but directly after may widen uptake.
- Participants could be incentivised to take part, or have their travel costs refunded to them. For participants too, being made aware that they will be able to spend time face to face with their GP in the sessions could be a good incentive for them to take part. If GPs continue to play an active role, then this aspect could be used in recruitment and promotion.
- Anecdotally, the participants in the session held at the GP surgery appeared more comfortable in the environment than those at the Learning Centre. This may be related to familiarity with the venue. It may be that holding the engagements in venues which participants are not familiar with and comfortable in creates a barrier to attending.
- The approach to the ethos of the workshops appears to have been a significant factor in the richness of data created. The focus in future ventures should remain on discussion in a comfortable, enjoyable, participant-led environment facilitated under the ethos of inclusive dialogue.

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healthwatch
Barking and
Dagenham

Healthy Living in Barking and Dagenham

The resident perspective

August 2022

healthwatch Barking and Dagenham

Contents

Summary of Findings

- The survey drew a total of 126 responses from residents across the London Borough of Barking and Dagenham. We also received an additional 40 pieces of information from individuals. This was a reasonable outcome although not as strong as some of our previous research. The offer of a free prize draw with the chance of winning £25 worth of vouchers for anyone who completed the survey may have helped with this.
- More than 50% of respondents agreed that it makes a difference if healthcare professionals understand issues relating to their race/culture when providing support relating to healthy living and weight management.
- A quarter of all respondents do not know their BMI but consider themselves to be overweight.
- Two-thirds of respondents told us that they had successfully lost weight in the last 3 years
- Overall, respondents are keen to make positive changes, and know what they would like to do. However, **busy schedules, high levels of stress and low income** appear to be the main drivers that are preventing people from living healthier lifestyles.
- Employers need to be more aware of their employees' difficulties regarding staying healthy, and more flexible with regards to their needs in this respect.
- Majority of the respondents had not heard of or engaged with the healthy living services listed in the survey.

Background to the report

Obesity is on the rise in the UK. Since 1946, every generation has been heavier than the previous one. The more of their lives people spend overweight or obese, the greater their risk of developing chronic health conditions such as coronary heart disease, type 2 diabetes, high blood pressure and arthritis. The obesity 'epidemic' is projected to cost the UK's National Health Service £22.9 billion per year by 2050.[1] We are also facing rising mental health challenges, with an estimated one in five adults saying they experienced some form of depression during the coronavirus pandemic, and cases of adult depression are making up a larger percentage of overall diagnoses by GPs than pre-pandemic. As a percentage of all diagnoses, depression in adults rose by 1.3 percentage points to 15.6% compared to the corresponding 2019 period.[2]

At the start of 2022 Healthwatch Barking and Dagenham undertook a research project to understand the needs of local people when it comes to maintaining a healthy lifestyle. This continued for a few months to ensure we could speak to as many people as possible.

We are aware that so much of our lives have been disrupted by the COVID pandemic these past two years and that it has changed the way we think, the way we feel, and what we are able to do.

It is also clear that the pandemic has had a major impact the food that we eat, the exercise that we get, and the state of our mental health.

We decided to find out more about how these changes have affected people that live and work in the borough. We conducted a survey, asking people about ways of staying healthy that have worked for them, the services that they feel need to improve or are missing full stop, and any other feedback they may have had on services related to healthy living across the borough.

The following report is a result of our findings, and recommendations moving forward.

[1] Bradshaw, R. (2017), 'The Rise of the Obesity Epidemic'. Accessed: 13/5/22. <https://www.ucl.ac.uk/ioe/research-projects/2022/jan/rise-obesity-epidemic>

[2] Vizard, T and Joloza, T. (2021). 'Are we facing a mental health pandemic?' Accessed: 13/5/22. <https://blog.ons.gov.uk/2021/05/05/are-we-facing-a-mental-health-pandemic/>

Methodology

The research was conducted via a survey, for which we used SurveyMonkey. We also had face to face discussions with residents where possible. The team used a targeted social media campaign and face-to-face engagement at Dagenham Library and active age clubs to gather responses. We asked participants questions to ascertain their own awareness of their general level of health, what they are doing to stay healthy, whether they feel there is anything holding them back from living healthily, which health services in the borough they had heard of, and their experiences if they had used them. We also gathered general data on the overall demographics of the survey participants, such as gender, age, sexual orientation, ethnic origin, faith background, and disability level. We were particularly interested in gathering responses from carers. The survey was anonymous, and we did not gather any personal data. Participants were encouraged to share as much as they felt able to.

Demographics

Age	
15-17	1
18-24	15
25-29	13
30-34	38
45-59	30
60-64	11
>65	18
Prefer not to say	1

Gender	
Male	35
Female	81
No gender information given	3

Sexuality	
Heterosexual/Straight	106
Gay man	6
Gay woman/Lesbian	4
Bi-sexual	1
Prefer not to say	5

Religion	
Christian	55
Jewish	3
Hindu	8
Muslim	30
Sikh	3
No religion	31
Prefer not to say	4

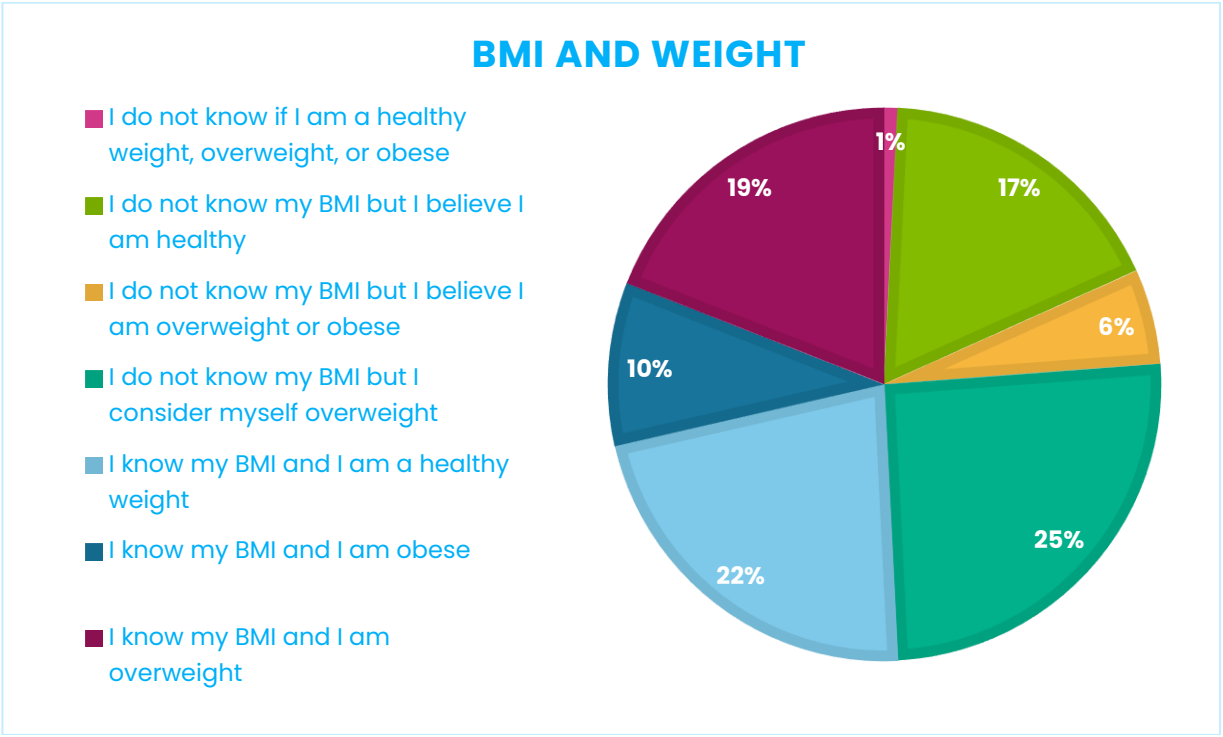
Ethnicity	
White British	61
Irish White	1
Any Other White	4
Asian/Asian British - Pakistani	30
Asian/Asian British - Chinese	1
Asian/Asian British - Bangladeshi	2
Asian/Asian British - Indian	8
Black/Black British - African	11
Black/Black British - Caribbean	7
Any Other Black	1
Mixed – White/Black African	1
Gypsy/ Irish Traveller	1
Prefer not to say	4
Other	5 (South African, Kosovan, Mixed Black/White British, Mediterranean)

- From this information we can deduce that most of our respondents were White British, heterosexual, and Christian, within the age range 30-59.

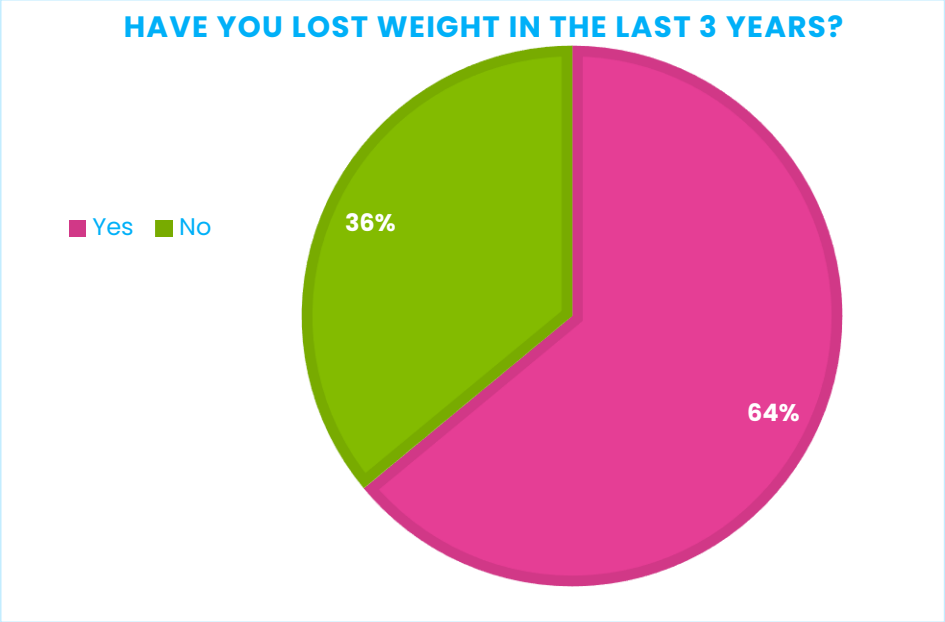
- Eighty of the survey respondents have successfully lost weight within the last 3 years, compared to 45 who have not.

- 28 of the survey respondents were also carers.

Survey responses and analysis



The above pie chart shows that over a quarter of respondents (32%) do not know their BMI but consider themselves to be overweight. Encouragingly, only 1% of respondents had no awareness at all of their level of health in relation to weight or BMI. Most respondents showed an awareness of their health in relation to weight and BMI, although much of this appears to be based on personal perception, with 49% of respondents selecting statements including the words 'believe' or 'consider' next to 51% who selected statements including the words 'I am.' This highlights the need to educate individuals how to check their BMI and the importance of knowing their BMI, not having a true reflection of their weight could influence people's decision as to what actions they need to take to be of a healthy weight.



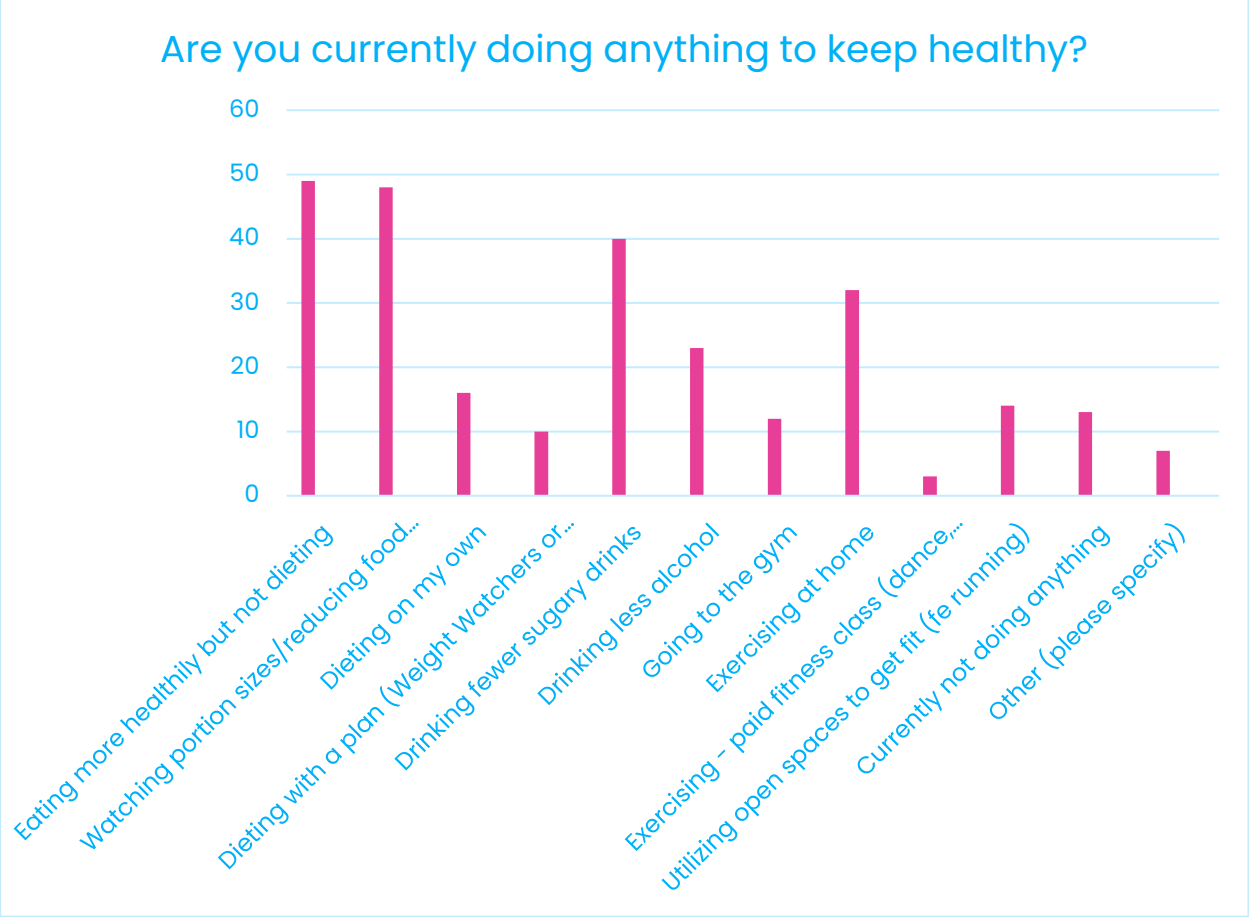
From the individuals who shared their views with the team, 64% said they have successfully lost weight in the last three years.

According to the responses below, the things that worked for those who have lost weight in the last three years appeared to be: routine, guidance from professionals/a formal support group (such as Weight Watchers), realistic goals, and a combination of healthy eating habits with regular exercise. For all the survey responses please see Appendix A.

What worked for you/did not work for you? *Top responses*

"I have lost weight for the following reasons: I am back in employment, having not worked for nearly 2 years, I walk to work and back 4 miles round trip, I eat less snack food"
"Self-discipline was the biggest thing that worked for me. Poor mental health did not work"
"Sensible eating and lots of exercise"
"I did lots of jogging and intermittent fasting"
"Just cutting back on snacks"
"Working out in advance what to eat. Avoiding stress was a problem"
"Intermittent Fasting worked, counting calories was not effective"
"Dieting and having a dietician helping me"
"Diet shakes"
"Planning what to eat and when worked for me"
"Calorie counting, exercise (at home) both worked."
"I used the treadmill and watched what I ate"
"Exercise, walking and eating healthy snacks."

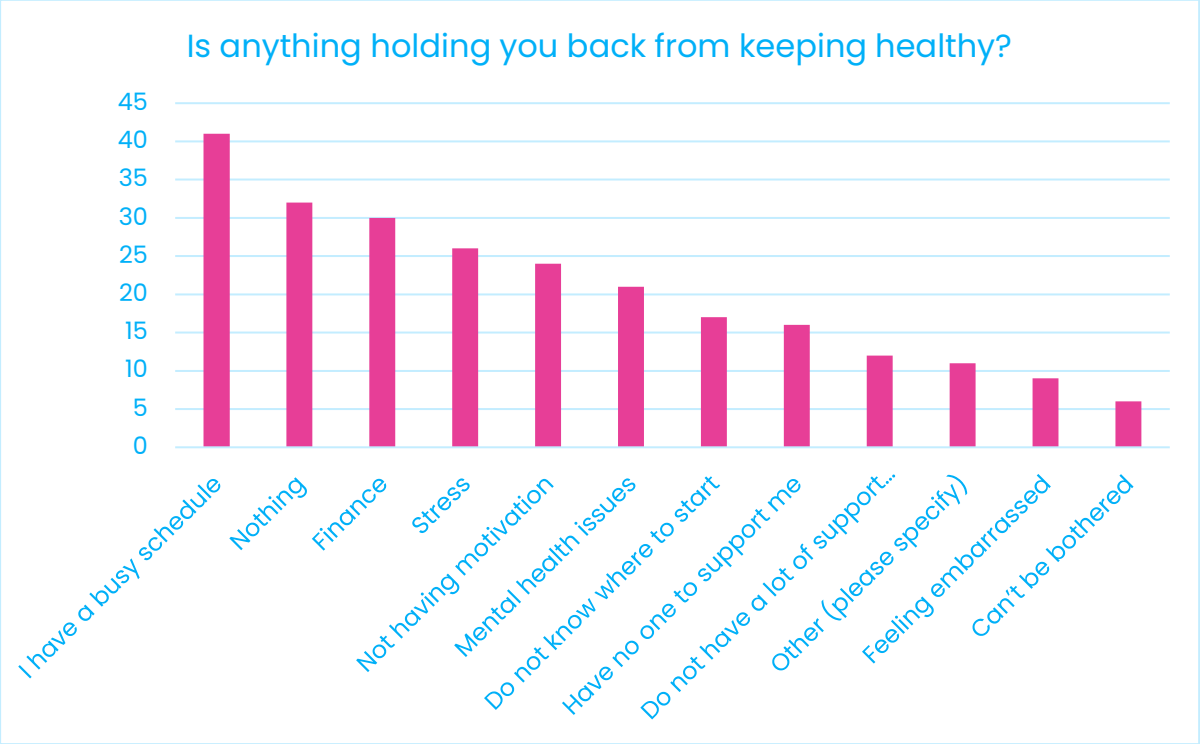
"Increasing veg from 50% to about 70% of my plate; swapping lean chicken for cheese in my lunch salad; drinking more water/sugar free squash; eating a larger lunch and a slightly smaller dinner stopped evening snacking"
"Originally meal replacement (750 calls per day) to get the weight off and then to maintain I do a 3/4 fast, 3 days @ 600 calories and 4 days at 1000calories"
"Weight watchers"
"Portion control"
"Having access to a gym"
"Tablets I received from Dr"
"Slimming club"
"Following a GP referral Healthy Eating Plan through Weight Watchers Slimming World and Calorie Deficit"
"Following a GP referral indicated healthy eating plan through weight watchers"
"Having a routine, cutting out most, but not all things like sweets and crisps"



Other category includes the below:
"Drinking lots of water"
"My job is physical work I'm on my feet all day and walk over 10,000 steps so I class that as my exercise"
"Following CKD diet mostly"
"Walking"
"I take part on Tai Chi lessons once a week"
"I practice and teach Tai Chi"

"Watching Instagram posts that give tips about keeping healthy"

Most responses to this question appear to revolve around food intake, food quality and dieting. Very few respondents are currently attending paid-for exercise classes, which may be due to financial strain or anxiety about returning to group classes following successive lockdowns (especially given the number of respondents who have said they are exercising at home). Combined with the data from the previous question, where more than a quarter of respondents said they considered themselves to be overweight, it would appear there is a high level of understanding that a combination of healthy eating and exercise contributes towards positive health outcomes. However, as we will go on to discuss, there needs to be more support around helping people to access exercise opportunities, incentivisation to eat healthily and clear guidance on *how* to combine healthy eating with exercise to achieve the desired results.



The most cited reason for not managing to maintain the level of health respondents would like to be 'I have a busy schedule.' This is unsurprising, as anecdotally, the vast majority of people will empathise with the time and energy pressures of working, running a household and looking after family. Healthy habits slip further and further down the priorities list as people are busier and more stressed, which is evidenced by the open-ended responses given below (for all the responses detailed in the survey, please see Appendix B).

Please tell us more about the above points, what do you feel needs to happen in order to support you? What would make a difference to you? *Top responses*

'I feel that more needs to be done workplaces could do a lot more in terms of healthy eating. The healthy eating team within public health should send out healthy workstyle's notices to all employers in the borough to share with their employees. Should be done for mental health etc as well. I work and have never seen any encouragement. Also, council and NHS staff get more benefits and access to reduced costs of items, but other sectors do not.'
'A guide to starting the healthy options. Step by step tips'
'Rewards from the government'
'Help with childcare and a routine'
'More help for disordered eating'
'Guidance on how I should utilise my time in a way that I am able to relax, study and exercise sufficiently'
'Nothing - I have already taken steps to lose three stone in weight and am now focussing on maintaining a healthy BMI/Weight. Thinking about the past it would be helpful I think if annual health checks, via GPs were available to all, a BMI, weight, blood pressure and blood test would enable the individual to get the right advice hopefully before too much damage is done.'
'Good food costs more money being a single mum of four makes it hard to feed myself better'
'Maybe having free access to swimming pools or gyms'
'Larger green spaces in Barking Riverside - for example making the river walk more of a path'
'Advertise availability more widely. Link information to wider Borough advertising. Get it into GP surgeries'
'Local gym/swimming focuses on healthy people or families, children. Do not seem supported for older people with complex health'
"Workplaces should do more"

Do you feel culture or race influences healthy living?

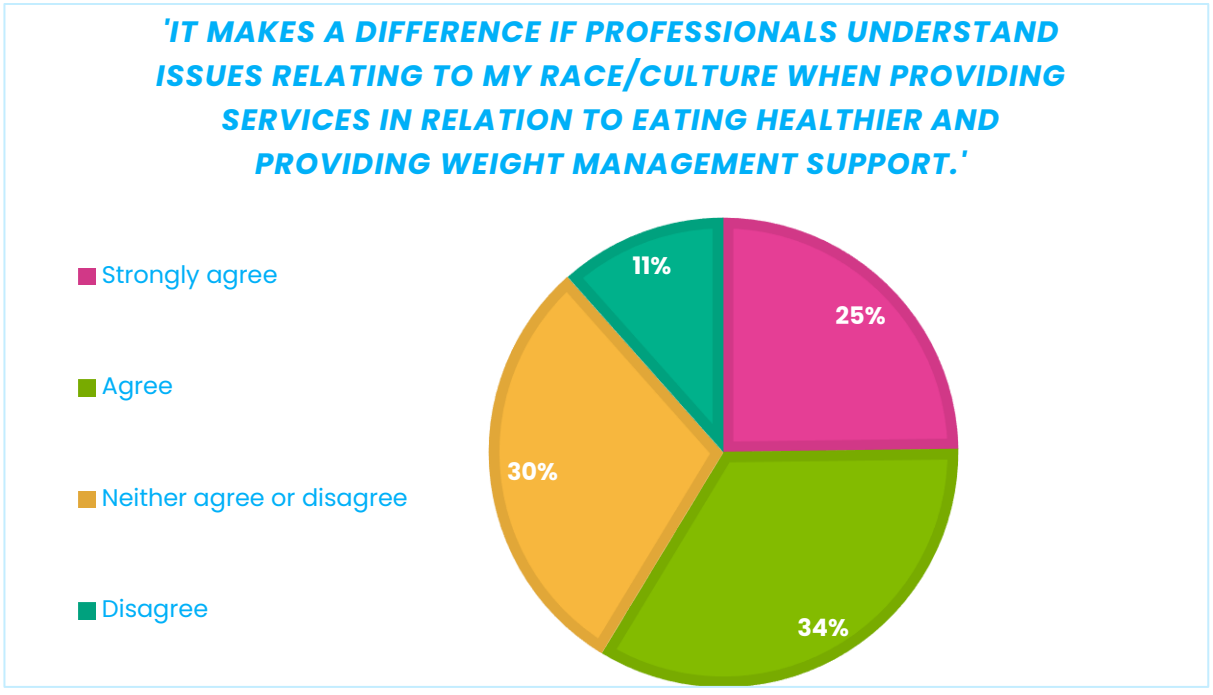
When asked if they feel there are certain aspects of their culture or race that influence them keeping fit, a larger proportion of respondents from Global Majority backgrounds said there were, compared with those from White backgrounds (detailed below), who were less likely to reference their race or culture, although familial practices did play a part in some of these responses. For full survey responses please see Appendix D.

Do you feel there are certain aspects of your culture/race that influences you keeping fit? If so, please tell us about them. *Top responses.*

"Yes! Asian families expect a lot from each other, cooking for big families so may not always have time to cook a separate meal for oneself" (Asian/ Asian British – Bangladeshi)
"Yes, I dress modestly so will only use a female only gym which is staffed by females only" (Asian/ Asian British – Bangladeshi)
"Eating is seen as showing respect to those who have invited you around to their home" (Asian/ Asian British – Bangladeshi)
"A sweet dish is always a must" (Asian/ Asian British – Pakistani)

"The traditional dishes in my culture" (Black/ Black British – African)
"Yes, we eat a lot of starchy food" (Black/Black British – African)
"I think the fact that African people who live in cold country and still eating the food they used to eat in a warm country might be an issue" (Black/ Black British – African)
"Having a bit of a healthy weight is seen as a positive" (Black/ Black British – African)

"No none I just love fatty foods" (White British)
"I hide my eating" (White British)
"I was brought up on a high cholesterol diet" (White Irish)

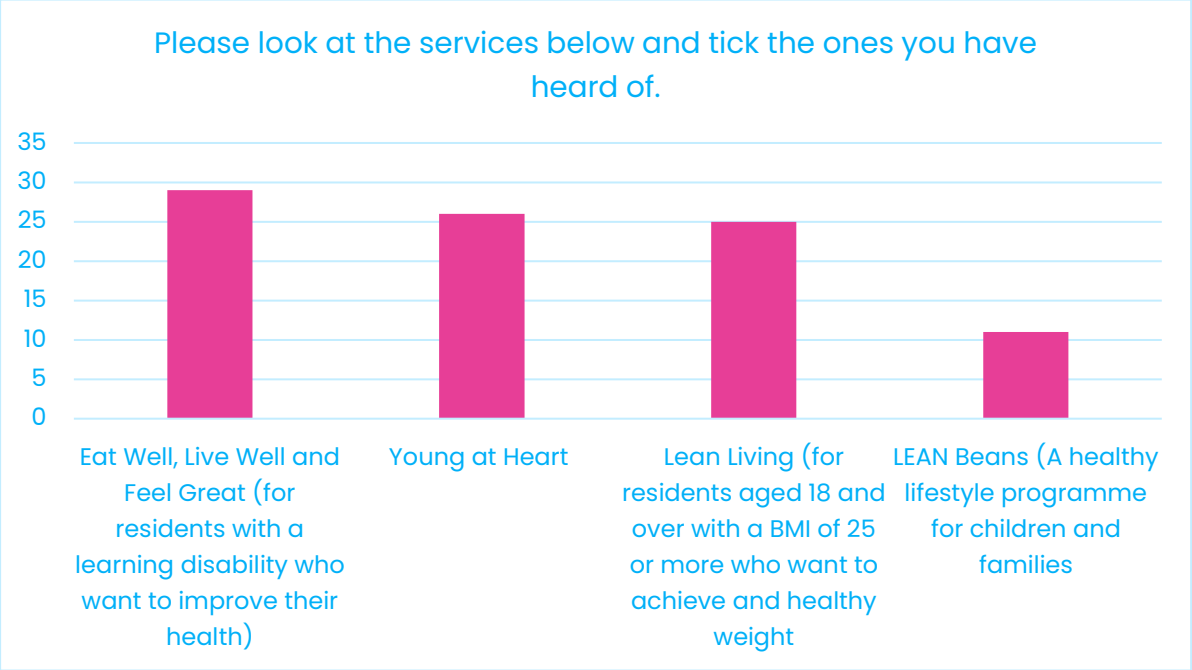


59% of respondents believe that it makes a difference if professionals understand issues relating to their race and culture when providing services in relation to healthy eating and weight management support. This also came across very strongly in the open-ended responses, which are detailed below. Those who are carers have all said

that they feel professionals need to be more understanding of the issues they face. For all of the survey responses, please see Appendix C.

What kinds of issues do you feel health professionals and those who are supporting you to keep fit and healthy need to be aware of? What would make a difference to you? *Top responses*

"That I have no one to support me"
"To be more compassionate"
"Family background, mental health issues"
"That it is simply not possible for some people to follow the "healthy" diet recommended by the practitioner, as they do not have the means to finance it.
Information to control cravings you may have"
"How pregnant women should exercise safely"
"That society in general tends to be overworked, with most people being unable to survive unless they work 5+ days per week, leaving them with no time or motivation to exercise and keep up with healthy habits"
"My cultural food habits"
"I do not have any specific cultural differences that a health professional would need to know. What would make a difference is if the professional was up front and asked if there was anything they should of aware regarding your race/ culture that should be considered"
"Not to have an overweight professional telling me I am overweight"
"They need to be more aware of the benefits that practicing Tai Chi and yoga can do and help people"
"That everyone's body is different & so should also be specific to body types"
" Address mental struggle and other such factors that affect health and diet.
Someone who understands age"
"Prescribing fitness classes, rather than drugs and medication. Social exercise sessions"
"Cost of healthy foods, initiatives to get them cheaper"
"Motivating me, giving me tips that could work for me"
"A GP that you can see and one that understands the menopause and the need to work"
"After surgery there needs to be more advice and help available to give you more confidence to do more things and not stay indoors"
"I do not receive any support, but I do feel that just being aware of different cultures and what their beliefs are could really help. Also, there is more emphasis on those who are overweight than those who are underweight. My sister is underweight and there is not a lot of support or information about how to put on a healthy weight"
"I am a carer and I do not have a lot of time"
"Carers have limited time"
"I need support to look after my mum to be able to go out, maybe a free online session to help, and make plans to keep healthy"



At least 35 people did not respond to this question, which tells us that around a quarter of respondents at the very minimum had not heard of any of these services. However, the question clearly stated, *"please tick the services you have heard of"* and most people did not tick any service which indicates they have not heard of any of the services. We have no way of knowing how many people selected multiple answers, so this figure could be a lot higher. We also do not know how many of them engaged with these services, although the numbers who gave feedback on them were very low.

Please note the Eat Well, Live Well and Feel Well service is for residents with a learning disability who want to improve their health. Individuals who responded to the survey may have indicated they have not heard of the service as this is a specific service.

Interestingly these findings show that although these services are available more work needs to be undertaken to raise the profile. One way could be for social prescribers to be sharing this information more widely and the healthy lifestyles team could plan and lead on an event that focuses on healthy living.

Of those who have engaged with these services, most of the individuals were satisfied (17), with eight reporting that they were Partly Satisfied and two reporting that they were dissatisfied.

We investigated the feedback from our discussions and survey responses to gain a better understanding of what would improve the experience of those of have accessed the service and what worked.

Women from South Asian backgrounds highlighted the importance of professionals understanding the service users background for example although women are the main individuals who cook and they make some of the decisions about what is made, it does not necessarily mean this is based on what they see as individual feel I healthy as the preference of what to cook is also influenced by a number of other factors such as, big family's, what their husband prefers meat of veg, what extended family may like to eat.

Quotes from individuals

"I love cooking, but a lot of what I cook is made from what my family around me like to eat" (Asian- Asian British Indian)

"There doesn't seem to any in depth knowledge to how my background impacts my health, eating together is seen as a very positive aspect to our culture, my family, everyone from my dad's side and mums side gets together at Eid, and lots of traditional food is made, the healthy living service was excellent, but it doesn't really look at things in a wholesome way, just having that understanding from professionals would make a very big difference, I know they can't do anything about the situation, but just knowing they know it can be very hard would make a difference". (Asian- Asian British Pakistani)

"Be realistic, change will take time, even a small change is a big change, especially when you come from another country, I adapted to the way of life here very quickly, but I find it hard to change the way I cook my food. The lady I spoke to did not really understand what I was trying to explain to her, but if I could explain maybe she could have helped me" (Asian- Asian British Bengali)

(This indicates other underlying issues, Healthwatch are not in a place to comment if other women feel the same way, but working in a holistic way has been mentioned by others, therefore the healthy lifestyles team need to consider, how they improve the service to be more holistic, this can be simple things like signposting, being proactive and mentioning or asking if they are any cultural barriers etc)

"Have not used the service, if I was to, then I would hope that anyone working with me to lose weight or stay healthy would see that sometimes it's hard to chance the mentality of the older generation, and not eating food that is offered, even a little is seen quite defensive, this is changing but we have a very long to go, my children are very open and will tell me and their dad and grandparents, but I am from a different generation. Things are slowly changing" (Asian- Asian British Pakistani)

"I like my traditional Nigerian food, if someone tells me it's not good for you, tell me how to make it better, but taste as good" (Black-Black British African)

"We tend to eat less fruits and veg, red meat is eaten a lot in our house, and I know we need to eat less of it as a family, but how can I make food spicier and tastier, but still make it taste like food I am used to, we have been eating this type of food for many years, from my parents to there, it goes back and back" (Black-Black British African)

"Men in our culture, well some men like their women big, so I could lose weight, but it is not as easy as that, what about how that will make me feel? The service was very good, and I did lose weight, but I felt not myself from inside and now I have gone back to eating the way I use to." (Black-Black British Caribbean)

"Every service needs to remember that we all eat different foods and making food is different for everyone, when your pregnant, your encouraged to eat everything because it will keep the baby healthy, and that is a pressure." (Black-Black British African)

Feedback received from respondents shows that eating together brings a sense of belonging for certain communities particularly South Asian families, eating, and feeding people is not seen as a chore but more of a happy occasion. However, feedback from some individuals shows that this impacts how they make changes to live a healthy lifestyle and their experience would be improved by the following:

- A better understanding that one individual is trying hard to make changes, but surrounding environment makes it a challenge.
- Self-confidence and motivation do not come easily, and professionals need to always remember and show that you can slowly work towards motivation.
- Professionals also need to ensure that where an individual is struggling with mental health or other health concerns, the service they provide will only make a difference if the service user is receiving a package to support with other areas that they need support with.
- Professionals Training staff to ensure they are aware of more then just cultural foods and religious beliefs. More awareness of how other factors can impact an individual trying to live a healthy life or trying to change their lifestyle.

Those who had heard of the services but had not yet engaged with them reported either that the service did not appeal to them, or that they had not been sure how to. **We asked people what they felt could be done to help with promotion of the services. Some of the main themes highlighted are listed below:**

- Advertisement of services more widely – does not need to cost a lot, focus on places where people go.
- More for pregnant women- in terms of exercise

Quotes from respondents

"Not sure what the service offers, would love to lose weight, but I can check what is available on the internet, I would love to go to a class where women of similar cultures got together to give each other ideas, the internet is really good, but I prefer to meet and chat"

"It does not appeal to me because I don't think I need it"

"Don't need these services"

"I can't speak English very good and that makes me less confident in going anywhere"

Recommendations

Who the recommendation applies to	Recommendation
Public health teams in councils and NHS North East London to provide information about keeping healthy to employers in the borough to share with their employees.	Obesity working group to explore what can be in a resourceful way to support those working in the borough who would like to improve their lifestyles. Public health teams in councils and NHS North East London to provide information about keeping healthy to employers in the borough to share with their employees.
Community Solutions: Healthy living team	An updated summary of all services available to be shared with all organisations in the boroughs. Healthwatch will also share this on their website, promote through social media and face to face engagement.
Community Solutions: Healthy living team	Refresh and provide training and information for professionals on the racial and cultural challenges that might be faced by their service users. Relook at how the service can meet the needs of those from different cultures. Healthwatch are happy to come and present findings to the team about the kind of feedback we have heard and what would be helpful to service users. Devise a communications and engagement plan about how the team will raise awareness using already available resources about the services that are on offer to residents. And then implement the plan.
Campaign on Health Living and a face-to-face event- lead by Healthy	Public health should support this event The event should enable individuals to

Lifestyles team with support and input from other partners.	come and find out more about options and services available. Taster sessions of exercise, healthy eating services, healthy living services can be promoted. VCS organisations should be involved and so should NHS North East London. The obesity working group and partners should explore this as a joint venture as all partners offer different services and support community solutions in delivering this event.
Community Solutions	To explore what can be made available to pregnant women specifically exercises to keep healthy and look at offering these to women in the borough.

Appendix A: What worked for you/did not work for you?

What does not work, is being busy and trying to find time to slot exercise in. Maybe more 20 minutes quick videos for people to use at home
My friends motivated me, we started off by saying let us focus on keeping fit and being healthy rather then we are overweight- we want to be able to round the block without being out of breath. Setting a small goal and celebrating the goal and then sitting another goal a more challenging one, start small and get big!
Cutting out bread and eating more healthy but worried that this will not be possible with all the price increases
Going walking with my daughter
Being part of the walking group and the social part of that - I am still eating what I want to
Being part of the walking group and the social part of that. Getting motivated to do it regular was difficult
Good exercise regime
Online App
People need to begin with something that is not hard, people seem to think that aiming to run a marathon within a week will happen, all health and care professionals and anyone involved with people who are trying to lose weight need to bring people back to basics and encourage small steps.
When I have time and decide to focus, I lose weight easily.
Did WW for a few months, used Fitbit, started walking
Taking into consideration is my life, my health.
Being more active
Keeping my mind balanced
Culture and confidence people look at you like your just fat and do not try.

Appendix B: What do you feel needs to happen in order to support you? What would make a difference to you?

Stress is playing a major part in holding me back from a lot of my goals. There never seems to be enough time in the day, but there is plenty of worries and concerns.
I need to take more off-days, I usually take overtime almost every day.
A timetable that I stick to, more motivation
Living in a cramped place and we need to move. Saving money to move to a bigger house. Have not been able to get financial help.
More time for exercise and more opportunities
if I had more me time
I would be interested in an online forum.
I need to make the effort to set aside time to plan healthy meals.
More information about fitness

My work schedule can be chaotic so finding time in between would be useful to go gym and signing up
to a gym closer to home
MORE MONEY
Getting a higher hourly wage, so I could work less hours and have more free time to exercise.
Motivation from my family and friends maybe
I need to have a less hectic schedule and need someone to look after the kids while I exercise and unwind
There is not an answer to this problem, it is ongoing
Better work meals no snacking
Support with family
Less stressful problems in my life
Limited time to exercise due to classes and work. Limited time to cook as well so easier to just have food delivered. More shops around the area that sell fresh vegetables and can deliver healthier but affordable meals.
A better night sleep so I feel more energised and motivated to do exercise.
I am encouraging myself to keep healthy.
Not sure. Comfort eating!
I feel quite a lot of stress, so I tend to comfort eat. There is no easy solution in terms of eating something healthy when I want a sweet treat.
Living healthy is a good way of structuring your life to be fit and stay safe. I do not need support because all that is necessary to fit and healthy is available within my reach.
Nothing - I have already taken steps to lose three stone in weight and am now focussing on maintaining a healthy BMI/Weight. Thinking about the past it would be helpful I think if annual health checks, via GPs were available to all, a BMI, weight, blood pressure and blood test would enable the individual to get the right advice hopefully before too much damage is done.
I need to plan my time wisely.
Support system to motivate me
Local health schemes and activities for my age group
Give me more advice and motivation
Need to eat more healthy
I need to be able to help myself
Not having to work so do not have to tired
I am a vivid walker and love walking partly everywhere. I have a strong family tie with my children and grandchildren.
With the high rise in petrol prices, can get stressful with obviously driving to various service users & vulnerable shops & no pay rise in many years
I have thyroid problems and since then I have struggled with my weight, and I also cannot afford to go to the gym
I need to lose some weight by myself as its not doing my joints any good due to having rheumatoid arthritis and osteoarthritis
I just do not seem to have enough hours in the day to take care of myself

Cheaper leisure facilities and better health
Due to the high level of service we provide to the community package it leaves little time for our mental wellbeing also with pricing going up i.e., food, petrol, rent/council tax, and our pay stay the same means less holiday and not being able to pay for the gum if we had time in our busy work schedule
I just need motivation to do it
I am doing slimming world for my weight and am happy with how it is going I do not need any help
Grief. Stress at work running a small team
Prices of food have gone up and must work more hours
Certain times of the day for pension age people to use gym, as very embarrassing to use with younger people
Waiting for GP referral - to start routine exercises once hip bone injury has healed
I need to take initiative, but some of my medicines make it more difficult to lose weight. I have arthritis so exercise - other than walking is difficult
A group more sensitive to my needs
Having someone and more places to go in the area to help me to build my courage up to do this.
Something in this area being opened like a leisure centre
Time
Having more time for myself
I am self-sufficient, but I do feel that I need to speak to my GP about health and weight, but that is already a barrier!
My wife died a couple of months back it has been difficult to cope with. I accept that counselling might help me.
Having a good social circle of friends
I am on my own, so I eat for comfort not much going on in my life.
I am obese… my GP has been good… in my culture being big is healthy… it is when I got to being too big that it became an issue. My husband is also big, he still wants tasty food sometimes unhealthy. This does not help. If someone from my family would have encouraged me to reduce my weight earlier, then this would not be the case now.
My medication makes me put weight on. There is not anywhere I know of where there is direct support just for those who are much heavier than others… This would make me feel more comfortable as other people are in the same situation as me. There may be places, but I have not been given with any information for them.
Support from my doctors would be great. More affordable gym prices
I feel down quite a lot about my weight. I am unemployed so cannot afford classes and gym. There is no support I have and feel alone.
I am on medication, and I tried to lose weight but had no success. I feel too overweight to go to the gym or running feels like everyone is watching hence I have stopped.
Less pressured life
More time for myself

Supermarkets should have an aisle of "superfoods" and healthy snacks! Instead, they are filled with high sugar but low-fat content items.
Healthy food prices need to be lowered. Working Monday to Friday with a child, and not much access to childcare means I cannot go to the gym, and I feel burned out.
To have more time to do these things other than continually working to pay the bills
Going with someone else to exercise with - my daughter does this to help me
Finding ways to lose weight
My husband has been encouraging me to get out walking more after hospital surgery
Target age groups- motivation- highlight the value of the social aspects of exercising with groups.
A group more sensitive to my needs.
Waiting for a GP referral - start routine exercises once hip bone injury has healed
I need to take initiative, but some of my medicines make it more difficult to lose weight. I have arthritis so exercise (other than walking) is difficult.
I must survive in terms of a small budget from benefits. People do not understand that my medicine is what is making me put weight on, and it is hard to shift. People assume that people who are overweight cannot be bothered to do anything.
I feel that more needs to be done workplaces could do a lot more in terms of healthy eating.
I have recently lost my job, so I do not have money but before I would go to the gym. Also not having someone to motivate me or come with me for a walk or something really does make me not want to go for walk.
Need to have things to do as a family at a reduced cost
Reduced family healthy eating and exercise
I do not think my weight is much overweight so there is nothing that the doctor will do, prevention needs to start now not once it is a problem.

Appendix C: What kinds of issues do you feel health professionals and those who are supporting you to keep fit and healthy need to be aware of? What would make a difference to you?

If the person needs to be encouraged more
Motivation.
They do not understand my problem
I tend to have days where I have no appetite.
LOW INCOME
The kind of food my culture eats.
Ability to exercise due to medical conditions
knowing more about mental health
not body shaming
Mental health could be an important issue, some of which may be undiagnosed.
I do not have much time to exercise
mobility issue and time management
Fat legs

History and all current concerns
BMI, they used for example. What race are they basing that from? Because different race would have had their tolerance body mass index, wouldn't they?
mental health is an issue - I suffer from a bit of stress and anxiety, and even though it is mild, it still impacts my eating habits
They need to aware of diet.
Knowing that health checks could be incorporated into the advice given
Different jobs require different fitness levels.
Mentally stable factors
More activeness from doctors and health officials
My race
People give up
Possibility if I was overweight and short, then professionals would be involved in supporting me, but I am neither
No face-to-face appointments
My health issues and what I am able to do to keep fit and healthy.
Social issues
More healthy options
Gyms to be cheaper childcare to attend fitness would help
For me getting outside
Consider the mental health
Where I suffer with mental health issues, sometimes it is very difficult to even get out of bed, let alone keep fit - I often relapse
Not so many fast foods - not enough healthy living food places
I have dark moments when I feel down - get emotional. Having people around me like this group helps me with my thoughts.
That medication can impact your weight it is not as simple as changing diet and exercise. I tired that. Is it all about losing weight or me keeping healthy too even if I do not lose weight?
Understanding Complex health issues that are stigmatising
Cultural cooking, family
Health restrictions relating to exercise
There needs to be more information to help make choices
More information about the health benefits and what the health implications might be given the food that I eat
My age dictates the kind of exercise I can do
That they know about community clubs that promote healthy living i.e., walking clubs
Prescribing fitness classes - social exercise sessions - rather than drugs and medication.
To a certain extent yes, it is hard for people from other cultures to relate to each other fully. It is like I am from an Indian background, so what would someone else from a different background know about my food? Professionals need to be given a background on culture and background to understand what and how different cultures cook, and how to make their food tasty without using lots of oil etc.… also

educating the younger population will help to ensure future generations pick up cooking culturally food in a healthy way
My GP does not do much. Cannot even see him so trying to get help is difficult as GP is your first port of call.
Health professionals need to be aware that some people have never exercised and its extremely difficult to start when they do not know how to
Culture Food Recipes.
That I have a busy, stressful life and do not enjoy much time for myself. Gyms are expensive and money is tight
Healthy food is sometimes more difficult or longer to put together or more expensive to buy.
Doctors rarely give out Slimming World memberships and Fit4Life when people need it.

Appendix D: Do you feel there are certain aspects of your culture/race that influences you keeping fit? If so, please tell us about them.

I do not think my race or culture has anything to do with myself keeping fit
No none I just love fatty foods
Yes, having to be skinny
Laziness
Eating healthy cultural foods
Race has nothing to do with this, but generally speaking black people are stronger and healthier than Caucasian people
Yes, if you are skinny, you are told you should eat! Being too fat is not seen as good either. You are encouraged to eat more, or sometimes a sweet dish when you go are guests, but the culture is to feed guests, so rather than saying, would you like a sweet dish etc… your encouraged to eat a little bit even if you have said no., I don't think this helps.

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Barking & Dagenham

LBBD response to healthwatch's *"Healthy Living in Barking and Dagenham" Report*

September 2022

one borough; one community; no one left behind

Background

At the start of 2022 Health Watch undertook research into the needs of residents regarding maintaining a healthy weight lifestyle covering:

1. What worked for you/didn't work for you?
2. What do you feel needs to happen in order to support you? What would make a difference to you?
3. What kinds of issues do you feel health professionals and those who are supporting you to keep fit and healthy need to be aware of? What would make a difference to you?
4. Do you feel there are certain aspects of your culture/race that influences you keeping fit?

Views from 126 respondents were received, with characteristics including:

- most respondents were White British, heterosexual and Christian, within the age range 30-59.
- 80 respondents successfully lost weight within last 3 years
- 28 respondents were carers

LBBD welcomes this report, which - together with other data and evidence - will make a valuable contribution to ongoing work to improve our action to support healthier weight for Barking and Dagenham residents.

Healthy weight services in Barking & Dagenham

Commissioned Weight Management Services

Check full eligibility criteria & suitability for programme

Tier 1: Eat Well, Live Well, Feel Great
- B&D residents with learning disabilities

Tier 1: NHS Weight Loss Pan app
- B&D residents with overweight/obesity

Tier 2: Lean Living
- B&D adults with overweight/obesity

Tier 2: HENRY 'Right from the Start' & 'Growing Up'
- B&D parents with children 0-5
- B&D parents with children aged 5-12 with overweight/obesity

Tier 3: Not currently commissioned

Tier 4: Not currently commissioned, referred across London.

Diabetes Prevention/Programmes for Patient with Type 2 Diabetes

Check full eligibility criteria & suitability for programme

Diabetes Prevention Programme
- Pre-diabetes or previous gestational diabetes

Low Calorie Diet Programme
- Diet/tablet-controlled type 2 diabetes diagnosed within past 6 years

NHS Digital Weight Management
- Type 2 diabetes with overweight/ obesity and/or hypertension for programme

UNIVERSAL SERVICES

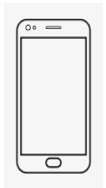
Local Sports & Leisure Facilities

Everyone Active: Abbey Leisure Centre, Becontree Heath Leisure Centre, Jim Peters Stadium.

School Leisure facilities: Barking Abbey School Leisure Centre, Barking and Dagenham College Leisure Centre, Castle Green Leisure Centre, Robert Clack School Leisure Centre, Sydney Russell Leisure Centre.

Online Resources & Apps

- NHS 12 Week Weight Loss Plan
- NHS Live Well
- Couch to 5K
- Active 10
- Her Spirit
- This girl can
- Green outdoor gym



Other Fitness Opportunities

- Parkrun: Barking
- Health Walks
- Good Gym
- Green Gym
- Young at Heart for adults 60+
- A-Life in schools and Schools Out Get Active
- Community exercise in community hubs

Discounted Gym Memberships

1. Through Better Health Campaign with free online library of health resources
2. Through Exercise Referral Scheme

Barking & Dagenham

Responses to recommendations (1 of 4)

Who the recommendation applies to	Recommendation	Responses
Public Health team, and North East London NHS	1. Obesity working group to explore what can be in a resourceful way to support those working in the borough who would like to improve their lifestyles. 2. Public health teams in councils and NHS North East London to provide information about keeping healthy to employers in the borough to share with their employees.	This is part of a whole systems approach to obesity, which we are currently reviewing. It is also relevant to the work currently underway on a B&D Food Strategy. This will be considered within work by the Inclusive Growth Team, who have excellent links with local businesses. Already businesses are pointed towards the London Mayor's Good Work Standard and encouraged to accredit and we will consider what more can be done to facilitate employers to promote and support healthy behaviours in staff. Community Solutions will share information on services with Healthwatch to aid distribution of information and marketing

Responses to recommendations (2 of 4)

Who the recommendation applies to	Recommendation	Responses
Public Health (and Community Solutions)	3. Public health should undertake a healthy living event to enable individuals to come and find out more about options and services available. Taster sessions of exercise, healthy eating services, healthy living services can be promoted. Obesity working group and partners should explore this as a joint venture as all partners offer different services.	Promotion at smaller community events and via community hubs have been agreed as a better approach to marketing and promotion and a list of community events will be included in the comms and engagement plan and shared with healthwatch. Embedding health promotion and awareness raising for services within pop-up and community events increases reach and engagement, particularly for those suffering from inequalities. Hence it is felt is a more effective approach than a single health focussed event. Community-led HENRY Growing Up weight management service pilots are already under way with a number of community 'trusted voice' organisations. Community Solutions will continue to share information on all new events with healthwatch to aid marketing

Community Solutions	4. Create an updated summary of all services available to be shared with all organisations in the area. HealthWatch will aid in marketing.	One page summary of services being developed with links to New Me web page with further detail. It will also promote in community hubs and religious spaces. Community Solutions will create a meeting with healthwatch to develop an integrated communications approach when new staff member begins.
Community Solutions and Public Health	5. To explore what can be made available to pregnant women specifically exercises to keep healthy and look at offering these to women in the borough.	Following a competitive tender process we are appointing More Life to pilot their MUMS2B service for women during pregnancy and 4MUMS for women up to 24 months after giving birth. Community Solutions will promote exercise programmes that are available to pregnant women in the borough.
Community Solutions	6. Refresh and provide training and information for professionals on the racial and cultural challenges that might be faced by their service users.	Staff facilitating programmes will take internal training in three areas (Diversity, Race and Cultural Awareness) to address this need

Responses to recommendations (4 of 4)

Who the recommendation applies to	Recommendation	Responses
Community Solutions	7. Relook at how the services can meet the needs from different cultures	Working with Momenta to look at the current LEAN living programme and how it can be adapted to meet the needs of people from different cultures- currently recruiting additional community health champions that can support programme participants to think about different foods and appropriate swaps. A number of HENRY Growing Up weight management pilots are already under way with a number of community organisations, enabling the use of 'trusted voices'. Meetings have already been set up to look at best practice in other local authorities on delivery of programmes to a particular target group. This includes a potential pilot of a weight management model coproduced with people of Black African or Caribbean heritage. A 'Deep Dive' analysis of weight management services considered how services are working for different genders and ethnicities and will be used together with this report to support improvement and development. Discussions will be undertaken with commissioners about creation of relevant service changes where required
Community Solutions	8. Healthwatch are happy to come and present findings to the team about the kind of feedback we have heard and what would be helpful to service users.	Healthwatch presented findings at a Healthy Lifestyles Team away day in September 2022
Community Solutions	9. Devise a communications and engagement plan about how the team will raise awareness using already available resources about the services that on offer to residents. And Implement the plan and share with healthwatch	A communication and engagement plan is being developed and will be shared with healthwatch.

Other reflections on report

1. *Service transformation* – Report is timely and valuable and together with other evidence (e.g. 'Deep Dive analysis' on weight management services) will support Service transformation planning to improve equity and effectiveness of services

2. Wider 'whole systems approach' – Services play an important role, but addressing the obesogenic environment is critical and as evidences by 2/3 respondents losing weight through diverse support, services will be developed as part of our wider 'whole systems approach to obesity'

3. Embedding in wider resilience support – It was noted that "busy schedules, high levels of stress and low income" were identified as primary drivers of unhealth behaviours, which supports new targeted debt support pilot that will incorporate social prescribing alongside debt support

4. *Use of trusted voices* – The report highlighted key groups were tailored messages by trusted voices are most effective (e.g. people with long term conditions, people from some ethnic minority backgrounds), which our increasing focus on partnership and communities (e.g. community weight management pilots, developing community health and wellbeing infrastructure) will help

5. *Systematic approach to what works, for who and why* – Feedback that *"Those who had heard of the services but had not yet engaged with them reported either that the service didn't appeal to them, or that they hadn't been sure how to"* will be addressed by work to consider issues of access (including awareness), experience and outcomes across the population

Areas for potential collaboration with healthwatch

1. *Further communications with partners* – Partnership and collaboration will be key to progressing opportunities highlighted in report and it could be useful for Healthwatch to join us / lead discussion in sharing the messaging and engaging partners in solution through the year.

2. *Healthcare professionals* – The report suggested perceived lack of support and encouragement from healthcare professionals and it would be helpful to work together on this. In addition to increasing awareness and access to services, the scale of need and limitations of services dictates it is important that HCPs plays a role through an 'every contact counts' approach, including brief interventions. This would support NICE guidance and quality standards, and could include processes and training (e.g. HEE/ELfH Health Weight Coach training and OHID/Sport England Physical activity Clinical Champions). LBBD would welcome working with Healthwatch in engaging NHS colleagues.

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Barking & Dagenham

HEALTH and WELLBEING BOARD
FORWARD PLAN

THE FORWARD PLAN

Explanatory note:

Key decisions in respect of health-related matters are made by the Health and Wellbeing Board. Key decisions in respect of other Council activities are made by the Council's Cabinet (the main executive decision-making body) or the Assembly (full Council) and can be viewed on the Council's website at http://moderngov.barking-dagenham.gov.uk/mgListPlans.aspx?RPId=180&RD=0. In accordance with the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012 the full membership of the Health and Wellbeing Board is listed in Appendix 1.

Key Decisions

By law, councils have to publish a document detailing "Key Decisions" that are to be taken by the Cabinet or other committees / persons / bodies that have executive functions. The document, known as the Forward Plan, is required to be published 28 days before the date that the decisions are to be made. Key decisions are defined as:

(i) Those that form the Council's budgetary and policy framework (this is explained in more detail in the Council's Constitution)
(ii) Those that involve 'significant' spending or savings
(iii) Those that have a significant effect on the community

In relation to (ii) above, Barking and Dagenham's definition of 'significant' is spending or savings of £200,000 or more that is not already provided for in the Council's Budget (the setting of the Budget is itself a Key Decision).

In relation to (iii) above, Barking and Dagenham has also extended this definition so that it relates to any decision that is likely to have a significant impact on one or more ward (the legislation refers to this aspect only being relevant where the impact is likely to be on two or more wards).

As part of the Council's commitment to open government it has extended the scope of this document so that it includes all known issues, not just "Key Decisions", that are due to be considered by the decision-making body as far ahead as possible.

Information included in the Forward Plan

In relation to each decision, the Forward Plan includes as much information as is available when it is published, including:

- the matter in respect of which the decision is to be made;
- the decision-making body (Barking and Dagenham does not delegate the taking of key decisions to individual Members or officers)
- the date when the decision is due to be made;

Publicity in connection with Key decisions

Subject to any prohibition or restriction on their disclosure, the documents referred to in relation to each Key Decision are available to the public. Each entry in the Plan gives details of the main officer to contact if you would like some further information on the item. If you would like to view any of the documents listed you should contact Yusuf Olow, Senior Governance Officer, Ground Floor, Town Hall, 1 Town Square, Barking IG11 7LU (email: yusuf.olow@lbbd.gov.uk)

The agendas and reports for the decision-making bodies and other Council meetings open to the public will normally be published at least five clear working days before the meeting. For details about Council meetings and to view the agenda papers go to https://modgov.lbbd.gov.uk/Internet/ieDocHome.aspx?Categories=-14062 and select the committee and meeting that you are interested in.

The Health and Wellbeing Board's Forward Plan will be published on or before the following dates during 2022/23:

Edition	Publication date
November 2022 Edition	10 October 2022
January 2023 Edition	21 December 2022
March 2023 Edition	13 February 2023

Confidential or Exempt Information

Whilst the majority of the Health and Wellbeing Board's business will be open to the public and media organisations to attend, there will inevitably be some business to be considered that contains, for example, confidential, commercially sensitive or personal information.

This is formal notice under the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012 that part of the meetings listed in this Forward Plan may be held in private because the agenda and reports for the meeting will contain exempt information under Part 1 of Schedule 12A to the Local Government Act 1972 (as amended) and that the public interest in withholding the information outweighs the public interest in disclosing it. Representations may be made to the Council about why a particular decision should be open to the public. Any such representations should be made to Yusuf Olow, Senior Governance Officer, Ground Floor, Town Hall, 1 Town Square, Barking IG11 7LU (email: yusuf.olow@lbbd.gov.uk).

Key to the table

Column 1 shows the projected date when the decision will be taken and who will be taking it. However, an item shown on the Forward Plan may, for a variety of reasons, be deferred or delayed. It is suggested, therefore, that anyone with an interest in a particular item, especially if he/she wishes to attend the meeting at which the item is scheduled to be considered, should check within 7 days of the meeting that the item is included on the agenda for that meeting, either by going to https://modgov.lbbd.gov.uk/Internet/ieListMeetings.aspx?CId=669&Year=0 or by contacting Yusuf Olow on the details above.

Column 2 sets out the title of the report or subject matter and the nature of the decision being sought. For 'key decision' items the title is shown in **bold type** - for all other items the title is shown in normal type. Column 2 also lists the ward(s) in the Borough that the issue relates to.

Column 3 shows whether the issue is expected to be considered in the open part of the meeting or whether it may, in whole or in part, be considered in private and, if so, the reason(s) why.

Column 4 gives the details of the lead officer and / or Board Member who is the sponsor for that item.

Decision taker/ Projected Date	Subject Matter Nature of Decision	Open / Private (and reason if all / part is private)	Sponsor and Lead officer / report author
Health and Wellbeing Board: 18.1.23	**SEND Green Paper, SEND Inspection, & SEND Area Committee** The Government undertook a consultation as part of its Green Paper on Special Education Needs and Disabilities (SEND). The Green Paper follows the review of SEND reforms introduced in 2014 which found that, whilst there had been improvements, navigating the SEND system and alternative provision was not a positive experience for many children, young people and their families. The review also found that outcomes for children and young people with SEND or in alternative provision were consistently worse than their peers across every measure and that the system was not financially sustainable. The Board will be updated on the Green Paper and NELFT's response. • Wards Directly Affected: All Wards		Elaine Allegretti Strategic Director, Children and Adults elaine.allegretti@lbbd.gov.uk
Health and Wellbeing Board: 18.1.23	**The Barking and Dagenham Best Chance Strategy - Our partnership plan for babies, children, young people and their families** This is the plan for whole-system working on improving outcomes for babies, children and young people and their families in the borough. It includes a co-created vison, ambitions and outcomes, and a proposed governance structure for the future of children's work in Barking & Dagenham (sitting under the new Place Based Partnership). The Best Chance Strategy is the Council's partnership plan for babies, children, young people and their families. This will guide our partnership work, provide a sound baseline for our ambitions and makes clear the outcomes we are working on together – to give our babies, children, young people and families, the best chance. • Wards Directly Affected: All Wards		Rebecca Nunn, Consultant in Public Health rebecca.nunn@lbbd.gov.uk

Health and Wellbeing Board: 18.1.23	**Covid-19 update in the Borough** The Director of Public Health will provide the Board with an update on the effects of that Covid-19 is having on Borough residents and the Council's response to dealing with the challenge of Covid-19. • Wards Directly Affected: All Wards		Matthew Cole, Director of Public Health (Tel: 020 8227 3657) (matthew.cole@lbbd.gov.uk)
Health and Wellbeing Board: 18.1.23	**Annual Report of the Safeguarding Adults Board 2021/2022** The finalised report of the Chair of the Safeguarding Adults Board, covering 2021/2022 will be presented to the Committee for approval. • Wards Directly Affected: All Wards		Anju Ahluwalia (anju.ahluwalia@lbbd.gov.uk)
Health and Wellbeing Board: 14.3.23	**Covid-19 update in the Borough** The Director of Public Health will provide the Board with an update on the effects of that Covid-19 is having on Borough residents and the Council's response to dealing with the challenge of Covid-19. • Wards Directly Affected: All Wards		Matthew Cole, Director of Public Health (Tel: 020 8227 3657) (matthew.cole@lbbd.gov.uk)

APPENDIX 1

Membership of Health and Wellbeing Board:

Cllr Maureen Worby (Chair), LBBD Cabinet Member for Social Care and Health Integration
Dr Ramneek Hara NHS North East London Integrated Care Board
Elaine Allegretti, LBBD Strategic Director, Children and Adults
Cllr Jane Jones, LBBD Cabinet Member for Children's Social Care & Disabilities
Cllr Syed Ghani, LBBD Cabinet Member for Enforcement & Community Safety
Cllr Elizabeth Kangethe, LBBD Cabinet Member for Educational Attainment & School Improvement
Melody Williams, North East London NHS Foundation Trust (NELFT)
Elspeth Paisley, BD Collective
Matthew Cole, LBBD Director of Public Health
Louise Jackson, Metropolitan Police
Kathryn Halford, Barking Havering and Redbridge University Hospitals NHS Trust
Sharon Morrow, NHS North East London Integrated Care Board
Nathan Singleton, Healthwatch Barking and Dagenham (CEO Lifeline Projects)

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