Barking & Dagenham

Notice of Meeting

HEALTH SCRUTINY COMMITTEE

Wednesday, 19 July 2023 - 7:00 pm
Council Chamber, Town Hall, Barking

Members: Cllr Paul Robinson (Chair), Cllr Michel Pongo (Deputy Chair), Cllr Muhib Chowdhury, Cllr Irma Freeborn, Cllr Manzoor Hussain and Cllr Chris Rice

By Invitation: Cllr Maureen Worby

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AGENDA

1. **Apologies for Absence**

2. **Declaration of Members' Interests**

   In accordance with the Council's Constitution, Members 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 held on 24 May 2023 (Pages 3 - 8)**

4. **Update on Salisbury Avenue General Practice (Pages 9 - 18)**

5. **Joint Local Health and Wellbeing Strategy 2023-28 Refresh Framework for Delivery - Final (Pages 19 - 72)**

6. **Joint Health Overview and Scrutiny Committee Appointments Report (Pages 73 - 84)**

7. Work Programme (Pages 85 - 87)

The Health Scrutiny Committee is asked to agree the draft Work Programme for 2023-24.

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

9. To consider whether it would be appropriate to pass a resolution to exclude the public and press from the remainder of the meeting due to the nature of the business to be transacted.

Private Business

The public and press have a legal right to attend Council meetings such as the Assembly, except where business is confidential or certain other sensitive information is to be discussed. The list below shows why items are in the private part of the agenda, with reference to the relevant legislation (the relevant paragraph of Part 1 of Schedule 12A of the Local Government Act 1972 as amended). ***There are no such items at the time of preparing this agenda.***

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

Barking & Dagenham

Our Vision for Barking and Dagenham

ONE BOROUGH; ONE COMMUNITY; NO-ONE LEFT BEHIND

Our Priorities

- Residents are supported during the current Cost-of-Living Crisis;
- Residents are safe, protected, and supported at their most vulnerable;
- Residents live healthier, happier, independent lives for longer;
- Residents prosper from good education, skills development, and secure employment;
- Residents benefit from inclusive growth and regeneration;
- Residents live in, and play their part in creating, safer, cleaner, and greener neighbourhoods;
- Residents live in good housing and avoid becoming homeless.

To support the delivery of these priorities, the Council will:

- Work in partnership;
- Engage and facilitate co-production;
- Be evidence-led and data driven;
- Focus on prevention and early intervention;
- Provide value for money;
- Be strengths-based;
- Strengthen risk management and compliance;
- Adopt a “Health in all policies” approach.

The Council has also established the following three objectives that will underpin its approach to equality, diversity, equity and inclusion:

- Addressing structural inequality: activity aimed at addressing inequalities related to the wider determinants of health and wellbeing, including unemployment, debt, and safety;
- Providing leadership in the community: activity related to community leadership, including faith, cohesion and integration; building awareness within the community throughout programme of equalities events;
- Fair and transparent services: activity aimed at addressing workforce issues related to leadership, recruitment, retention, and staff experience; organisational policies and processes including use of Equality Impact Assessments, commissioning practices and approach to social value.

MINUTES OF
HEALTH SCRUTINY COMMITTEE

Wednesday, 24 May 2023
(7:03 - 9:10 pm)

Present: Cllr Paul Robinson (Chair), Cllr Michel Pongo (Deputy Chair), Cllr Muhib Chowdhury, Cllr Irma Freeborn, Cllr Manzoor Hussain and Cllr Chris Rice

Also Present: Cllr Maureen Worby

1. Declaration of Members' Interests

There were no declarations of interest.

2. Minutes - To confirm as correct the minutes of the meeting held on 29 March 2023

The minutes of the meeting held on 29 March 2023 were confirmed as correct.

3. Health Inequalities Programme

The Consultant in Public Health introduced an update on the 2023 Health Inequalities Programme. In 2022, the Council had received six months' worth of funding from the North East London Integrated Care Board (NEL ICB) to work on addressing health inequalities. The Council was committed to using this funding as an opportunity to build the partnership approach in Barking and Dagenham, to ensure that this was place-based, co-produced and co-delivered across the place partners, and to influence the wider system in terms of its working styles and culture. This update also provided context as to:

- Inequalities challenges in Barking and Dagenham, across the life course;
- The types and principles of interventions that were proven to reduce health inequalities and increase health equity; and
- The eleven Barking and Dagenham health inequalities programme workstreams.

The Health Lead (HL) for Community Resources then updated the Committee as to partnership working that had been undertaken as part of the programme, as well as the importance of community power and community agency in the prevention of ill-health. The update also provided context as to the work that had been taking place as part of the localities approach, such as mapping with residents in terms of assets that they identified as connecting places in the community, and future work that was to be undertaken, such as a podcast starting in June 2023, which would ask residents who they turned to when they faced difficulties in their lives. Much work was being undertaken in this space, with the HL highlighting the importance of joint-working and innovation.

The Chief Operating Officer (COO) at the Together First Community Interest Company (TFCIC) reiterated the importance of partnership working, as well as highlighted issues within the health system, such as people in Barking and Dagenham getting older age frailties up to two decades before people in non-

deprived boroughs, yet funding to GP surgeries in the Borough was not reflecting this and resulting in the Community Sector often needing to pick up the gaps. He highlighted numerous positive examples of partnership working in addressing health equalities and detailed some of the workstreams relating to these.

The Chair of the TFCIC then highlighted the extent to which the Covid-19 pandemic had made visible the challenges faced by residents, as well as the need to work differently. She detailed some of the work undertaken by the Borough's Health Inequalities Leads, such as community pop-up clinics and winter coat appeals, and work being developed, such as breast screening programmes for those patients with serious mental illness or learning disabilities, as well as work to support young carers with their caring roles. She emphasised the need to work innovatively to address issues, with the Place-based Partnership essential in collaboratively building on infrastructure. The Programme Director of the TFCIC also highlighted the benefits of close partnership working with the GP leads and their enthusiasm, and the innovative nature of the work being undertaken.

In response to questions from Members, officers stated that:

- Through the TFCIC and Public Health working collaboratively, officers had been able to compare the ethnic makeup of each borough ward against the different cohorts that were coming forward for Covid-19 vaccinations during the pandemic. They were then able to look to improve the figures for uptake through targeted communications, and encouraging community leaders to send out vaccination uptake messaging to their communities. This method had proved to be very successful in improving vaccination rates. They had also created risk lists of those residents with the highest risk of decline should they contract Covid-19, and worked to encourage their vaccination uptake, such as through having nurses call them in their native languages, to arrange their vaccination appointments.
- A further success story had been through encouraging patients with learning disabilities to attend Covid-19 vaccination appointments at the Vicarage Fields site, which was familiar to them and enabled them to have confidence in attending.
- From a community perspective, it had been noted that there was a big issue in terms of trust and building trust; there had been nearly 2,000 conversations with local residents, from a wide range of ages and ethnicities, and this theme of trust had featured frequently. The sector had helped to link an Eastern European lady, whose son had autism, with other parents of children with autism, to mutually support and connect with each other, with the group starting out at 8 parents and now spanning 40. Whilst services did often need to be involved in providing support, it was important to note that connecting individuals with local neighbourhood support networks could be just as vital.

The Cabinet Member (CM) for Adult Social Care and Health Integration noted that whilst it was recognised at a North East London level that work needed to be undertaken around health inequalities, the formula used by NEL ICB, as was the case nationally for allocating funding, was based on the previous census and not the current one. Whilst the first year of the funding allocations had been based on a bidding process, the funding this year had returned to the national formula, which meant that Barking and Dagenham had lost out on £400,000 worth of funding.

Provisions had been made in the Council's Public Health Grant for this year to account for this £400,000 funding, so that funding could continue for identified projects for another year. As the commitment from NEL ICB was for three years, the Council knew that it would receive another £700,000 over the next two years, which enabled it to plan, and by making up the £400,000 shortfall, this would give all the capacity to jointly lobby for an additional allocation going forward.

The COO at TFCIC explained that Barking and Dagenham was let down in terms of funding, with GP practices in the Borough being paid for around 20,000 fewer patients than it actually had due to the weighting formula. The reason for this issue was due to the younger average age of the Borough. Furthermore, other national and London funding weightings also meant that Barking and Dagenham was frequently let down in its allocations, which exacerbated health inequalities in the Borough, particularly as residents tended to suffer from health conditions at an earlier age that those in other parts of the country.

The Chair of TFCIC stated that these challenges were faced by GPs on a daily basis and were also evident through workforce retention. Whilst positive news had been received that 5,000 more GPs were to be trained, with 100 of these likely to come to London, there was an issue whereby GPs had been trained in the Borough, but then moved elsewhere due to the lack of an inner London weighting pay. The CM stated that these issues were well acknowledged by NEL ICB and it had given a commitment to look to address these. There was also now a commitment from the three inner London Boroughs (Tower Hamlets, Newham, and City and Hackney) to receive a standstill to their funding allocations, whilst the outer London Boroughs caught up; positively, there was an acknowledgement that funding needed to be evened out. The Health Lead for Community Resources stated that a systems approach needed to be taken, working together differently to address inequality and the Programme Director for TFCIC stated that staff retention issues were also due to the tough working conditions across London.

In response to further questions from Members, officers stated that:

- One of the projects that Public Health had commissioned the TFCIC to undertake had been around health checks for those aged 30-39 in the BAME community, as Public Health had recognised a need for this through data. This project had been particularly successful in encouraging those who may not normally approach Health services, to receive health checks.
- TFCIC was also looking into how services could be provisioned differently, within the community hubs through pop-up clinics. It was also working on childhood immunisation uptake, and targeting its public communications messages differently to increase this, as well as encouraging uptake through using health checks to begin these conversations. It was also looking into targeted clinics, such as for veterans, and into increasing GP registration.
- A pop-up clinic at the Borough's Coronation Festival had been successful in enabling 102 people to receive a health check, who otherwise would not have gone to their GP to have this; however, health check information would be passed to each individual's local GP, to enable conversations to continue.
- Colleagues were working to ensure messaging around GP registration was becoming widespread, to ensure that all communities knew that they were

able to use GP services for free at the point of access.

- To ensure long-term change, colleagues were focusing on changing infrastructure and how all partners worked together in practice.
- The CM stated that colleagues were about to join the place system with the Council's Health and Wellbeing Board, to become a "Committee-in-common". This would further increase partnership working, and would also include representatives from the Metropolitan Police, further increasing the depth of debate and expertise.

The Chair requested that colleagues return in six-months' time, to update the Committee as to the progress of the Health Inequalities Programme.

4. Mental Health Transformation Programme Update - One Year On

The Integrated Care Director (ICD) at North East London NHS Foundation Trust (NELFT) delivered a one-year programme update on the progress of the Barking and Dagenham Community Mental Health Transformation Programme, the background behind this and the challenges. In 2019, all areas across the country had been required to submit their plans around a new framework for community mental health services, with the bid submitted by NELFT and its partners being ranked as one of the most positive bids and transformation programmes. The update also provided context as to:

- The vision and principles of the Mental Health and Wellness Teams;
- The progress as of May 2023, with a particularly positive element being the development of Peer Support Workers who were now embedded within Mental Health and Wellness Teams and who were employed by MIND, further highlighting the importance of partnership working and the fact that statutory organisations were not always best placed to employ and develop peer support, which worked best through the Voluntary and Community sector;
- The training of all staff in different approaches and modalities, such as in trauma-informed care and open dialogue (an approach involving the people who were around an individual);
- The introduction of more point of care testing, to support more physical health monitoring, as physical health issues tended to be higher in those with mental health conditions;
- Increased engagement with the Voluntary and Community sector;
- The next steps to be undertaken, such as developing the service offer for young adults, and developing more Peer Support Workers across the life course;
- The fact that transformation work was being undertaken, as caseloads and demand continued to increase.

In response to questions from Members, the ICD stated that:

- The programme had a number of measures relating to aspects such as recruitment, staff training and individuals with severe and enduring mental health issues accessing physical health checks. It also had outcomes measures around individuals' social engagement and ability to move into employment opportunities, as there were lower rates of employment amongst those with mental health issues. These measures were being

worked through with the wider system and the mental health collaborative.

- There had been some very sad cases involving young people and knife crime in Barking and Dagenham, which often had a ripple effect across young people in schools. Recently, NELFT had ensured that there were Mental Health Support teams in schools to support with the impact of these incidents, running workshops around mental resilience, working from a trauma-informed perspective and looking to create whole schools' approaches around mental health and wellbeing.
- Before the Covid-19 pandemic, the Integrated Mental Health team (between NELFT and Barking and Dagenham Council) had been disaggregated, which had been followed by investment from the Council in terms of social care capacity. The disaggregation had enabled Health to focus on health care, and social care to focus on social care issues. Through the transformation programme, social care colleagues were working collaboratively with NELFT as part of a steering group with local resident and lived experience representation; whilst this had all been a large change, there was now a very productive way of working.
- Whilst there were bed flow issues in terms of mental health beds at Goodmayes Hospital, with the lowest bed base for mental health beds in Northeast London and the second lowest bed base in the country, it did not have significant delayed transfers of care as in other areas of Northeast London. There was also frequent praise for the collaborative work between social care and the Health community team, in terms of supporting people to move on, and move on with a care package.
- Whilst the Mental Health and Wellness Teams were not physically co-located, there were a range of different workers within the service, and social workers and health workers were part of ongoing reviews and joint care plans, as part of more integrated working.
- There were always challenges around workforce retention. Whilst the NELFT workforce had increased, NELFT did not have the workforce whole time equivalent that was now dealing with the increased demand. A percentage of the workforce was also agency and locum.
- Caseloads per worker were monitored to ensure that these were not unmanageable, particularly for cases around those who had more severe mental health diagnoses.
- All health agencies were working through a degree of backlog; for example, certain assessments had had to be suspended for a period of time during Covid-19 and this had increased waiting lists. NELFT was working through recovery plans to reduce these waiting lists, and it also worked within national targets for assessment, based on the risk stratification. The vast majority of patients who came through to NELFT came through its Access team, and were seen within 18 weeks.
- NELFT was part of a national quality improvement programme along with the Royal College of Psychiatry, specifically looking at the Autism Spectrum Disorder (ASD) service and how patient flow could be improved.
- Services were now much more linked than previously. Barking and Dagenham had also not received a Regulation 28 report (whereby a coroner would look into the death of an individual receiving treatment and whether this had been preventable) for a number of years.
- NELFT worked very closely with the police in terms of domestic abuse. There was a Mental Health Liaison Police Officer and NELFT did lots of case-by-case joint working with this officer. NELFT received MERLIN

reports when there was a domestic abuse incident, and it also undertook dash risk assessments, with staff upskilled to be able to undertake these and refer into MARAC and other support agencies. NELFT was also part of the Violence Against Women and Girls' group (VAWG). It was able to share information with the Police in terms of those individuals who came to the attention of the Police due to being unwell, as well as was able to work with other agencies in supporting those individuals who frequently used emergency services, known as "frequent fliers". NELFT also worked with the Police in terms of reducing the potential risk to staff and the public, in terms of those individuals who were particularly aggressive, to promote a zero-tolerance approach.

- NELFT staff were trained in smoking cessation skills, and would refer patients on to further specialist services as appropriate. Quite often, many accessing NELFT services had quite ingrained smoking habits and as such, staff used the 'making every contact count' approach in their service delivery. Healthy eating and increased physical activity approaches were also used, for example, employing Support, Time and Recovery workers to accompany individuals to access healthy living programmes as necessary.
- Supporting residents with their mental health in the community was the goal, rather than in an entirely hospital-based setting. This would be achieved through infrastructure such as the community hubs and new health centres, encouraging a community-based model and greater flexibility for residents. Support was also being provided in schools, such as through the Schools' teams, and the Thrive approach, ensuring a whole life course approach.
- In terms of risks relating to delivering the model, workforce recruitment and retention, high population growth and the parity of funding as to this, and the long-term impact of the Covid-19 pandemic were all cited as factors.
- Improving Access to Psychological Therapies (IAPT) services had been renamed nationally as 'Talking Therapies'.
- Around 40 to 60% of all GP consultations related to mental health. It was hoped that the Talking Therapies Practitioners could be linked to each GP Practice and the relevant Primary Care Network (PCN), to enable them to look into the residents seeking help, troubleshoot any issue and ensure multi-disciplinary working at a PCN level. This would also mean that individuals presenting to their GP with lower level needs could be seen by Talking Therapies or the PCN mental health practitioner, those with high-level needs could be seen by secondary care services in crisis response services and inpatient units, and then those who did not fall into the criteria of low-level need and the areas that Talking Therapies would benefit, could be seen and supported by the Mental Health and Wellness Team.

5. Joint Health Overview and Scrutiny Committee

It was noted that the minutes of the last meeting of the Joint Health Overview and Scrutiny Committee could be accessed via the link provided on the front sheet of the agenda pack for this meeting.

6. Minutes of Barking and Dagenham Partnership Board

The minutes of the last meeting of the Barking and Dagenham Partnership Board were noted.

HEALTH SCRUTINY COMMITTEE

19 July 2023

Title: Update on Salisbury Avenue General Practice	
Report of the NHS (North East London)	
Open Report	**For Information**
Wards Affected: Abbey	**Key Decision:** No
Report Author: Communications and Stakeholder Manager, NHS North East London	**Contact Details:** laura.fratczak@nhs.net

Summary

- The Care Quality Commission (CQC) carried out a site inspection at the Salisbury Avenue Practice on 1 December 2022, followed by remote inspections on 15 and 22 December 20222 and 9 January 2023.
- The report was published on 11 May 2023.
- Following inspections, the CQC changed the rating for Salisbury Avenue Healthcare from Good to Inadequate.
- The Health Scrutiny Committee was notified of this in May 2023 and requested an updated on the actions being taken to improve the Practice.
- A representative will deliver the update presentation at Appendix 1 at the meeting which will be followed by an opportunity for questions by Members of the Committee may.

Recommendation(s)

The Committee is recommended to note the update at Appendix 1.

Reason(s)

It is important that the Health Scrutiny Committee is kept updated on CQC inspection results of practices in the Borough and the actions being taken to improve them, if required.

Financial Implications, Legal and Other Implications

As this report is not for decision, there are no direct implications arising from it.

Public Background Papers Used in the Preparation of the Report: None.

List of appendices:

Appendix 1: Update Presentation on CQC Inspection of Salisbury Avenue Practice

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Appendix 1

NHS
North East London

Update on Salisbury Avenue practice

Barking and Dagenham Health Overview Scrutiny Committee

19 July 2023

Background

- The Care Quality Commission (CQC) carried out a site inspection at the Salisbury Avenue practice on 1 December 2022, followed by remote inspections on 15 and 22 December 20222 and 9 January 2023.
- The report was published on **11 May 2023.**
- Following inspections, the CQC changed the rating for Salisbury Avenue Healthcare from **Good** to **Inadequate.**
- Practice were instructed to make a number of improvements.
- Arrangements were put in place for a new practice manager to run the practice following the CQC inspections.
- Patients continue to be seen/treated as normal while improvements are being made.

Response

- Immediate action taken by NHS North East London.
- Team of experts specialising in care quality, safeguarding, medicines management and primary care supporting with addressing the issues.
- Stakeholders were notified in May when CQC report released.
- Practice website was updated to carry the statement.
- Practice patient group was notified.

Improvement plan

- An infection control audit was completed on 19 June 2023. The summary of this report outlined that the practice showed compliance with standards of IPC (infection prevention and control) Essential Quality Requirements. However, there are a number of recommendations are made in the action plan with time frame for actions to be completed.
- All patients highlighted by the CQC have been reviewed.
- Independent staff wellbeing consultation has been completed – this has shown the practice as having scored above average for peers in all 7 domains. The practice has said that despite this they will continue to strive to improve further.
- Safe domain and medicine management policies were reviewed and systems implemented to improve medicines management.

Medicines Management update

Practice is working closely with the NEL ICB Medicines Management team to identify improvements in search and routines including:

- Ensuring that there is drug monitoring of all appropriate patients on high risk medications.
- New ways of working adopted for repeat and acute prescription requests.
- Increased support for practice Clinical Pharmacists and PCN support.
- 40/50% of patients opted for a medicines review. Ongoing plan is for the practice to ensure they develop and run searches frequently in-house to ensure all monitoring is up to date.

Medicines Management update – cont.

- Clinicians, when re-authorising/issuing warfarin prescriptions, are now required to indicate on the prescription when the next date for their international normalised ratio (INR) blood test is due.
- All patients prescribed repeat medications will receive a medication review every 12 months as a minimum.
- Practice encouraged to reach out to medicines management team for support as and when required.

Safeguarding Children and Adults update

- Safeguarding Policy in place.
- Laminated copies of the full safeguarding contacts list located throughout the surgery.
- The policy document is supported by a more user-friendly aide memoire called vulnerable patients and GP protocols. This is to embed the “safeguarding is everyone's business” process.
- There is also a guidance document put in place on writing high quality, measurable patient care plans. This is also on the practice meeting agenda so that quality is embedded in practice routines.

Safeguarding Children and Adults

- Monitoring of Safeguarded/Vulnerable patients is now taking place on a regular basis.
- A central list (log) of all vulnerable/safeguarded patients and their carers is maintained.
- Sign off of compliance by safeguarding experts expected to be completed by second week in July.

HEALTH SCRUTINY COMMITTEE

19 July 2023

Title: Joint Local Health and Wellbeing Strategy 2023-28 Refresh Framework for Delivery – Final	
Report of the Director of Public Health	
Open Report	**For Noting**
Wards Affected: All	**Key Decision:** No
Report Author: Jane Leaman, Consultant in Public Health, LBBD Jess Waithe, Public Health Specialist, LBBD	**Contact Details:** Jane.leaman@lbbd.gov.uk Jess.waithe@lbbd.gov.uk
Accountable Director: Matthew Cole, Director of Public Health, LBBD	
Accountable Strategic Leadership Director: Elaine Allegretti, Strategic Director-Children and Adults, LBBD	

Summary

The current Barking and Dagenham Health and Well Being Strategy (HWBS) ends in 2023. In the context of the new place-based partnership and integrated working, this refreshed strategy sets out a renewed vision for improving the health and wellbeing of residents and reducing inequalities at every stage of residents' lives by 2028. It provides a framework for action, drawing on a range of other relevant local strategies.

The Health and Wellbeing Board approved the Strategy refresh at Junes Committees in Common meeting.

Recommendation(s)

The Committee is recommended to:

(i) Note the content of the Strategy and its relationship with other strategic documents, such as the and the Corporate Plan.

Reason(s)

This item is for noting only, as the previous meeting of the Committee received a report on Joint Local Health and Wellbeing Strategy 2023-28 Refresh where it was discussed.

1. Introduction and Background

The Health and Social Care Act 2012 requires each local council area to have a Health and Wellbeing Board (HWB), which brings together key leaders from local health and care organisations to work together to improve the health and wellbeing of local people and to reduce inequalities that are the cause of ill health.

The HWB must produce a Health and Wellbeing strategy (now known as Joint Local Health and Well Being Strategy (JLHWBS)) that describes the key local health and care issues and explains what the board is going to do to make improvements to these issues.

The JLHWS sets out the vision, priorities and action agreed by the HWB to meet the needs identified within the JSNA and to improve the health, care and wellbeing of local communities and reduce health inequalities.

1.1 NHS NEL Integrated Care Strategy

The NHS NEL's Integrated Care Strategy has now been published and should be considered by the HWB in agreeing this JLHWBS to ensure that they are complementary. However, there are no expectations that a JLHWBS is re-written in the light of the ICB Integrated Care Strategy.

The Integrated Care Strategy built on the existing HWBS (2019- 2023) and is complement to the draft JLHWSs, identifying where needs could be better addressed at the system level. It will also bring learning from across the system to drive improvement and innovation.

System partners across North East London Health and Care Partnership have reached collective agreement on NHS NEL's ICS purpose and four priorities to focus on together as a system. The priorities and cross-cutting themes (see below) will set a clear direction for the development of the new NHS Joint Forward Plan.

Priorities:

- To provide the best start in life for the Babies, Children and Young People of North East London
- To support everyone at risk of developing or living with a long- term condition in North East London to live a longer and healthier life
- To improve the mental health and wellbeing of the people of North East London
- To create meaningful work opportunities and employment for people in North East London now and in the future

Cross-cutting themes describing 'how' NHS NEL will work differently as an integrated care system:

- Working together as a system to tackle health inequalities including a relentless focus on equity.

- Greater focus on prevention
- Holistic and personalised care
- Co-production with residents
- A high trust environment
- Working as a learning health system

1.2 Other Relevant Plans and Assessments

1.2.1 LBBD Corporate Plan

The newly published Council Corporate Plan sets out how and what the Council will deliver against agreed priorities – many of which directly or indirectly impact on the health of residents, as well as good health of residents it will also enable the achievement of all. Therefore, the Health and Well Being Strategy is a key overarching strategy for this plan.

The relevant Corporate Plan's priorities are that residents:

- Are supported during the current cost of living crisis
- Are safe, protected and supported at their most vulnerable
- Live healthier, happier, independent lives for longer
- Prosper from good education, skills development and secure employment

LBBDs equality objectives for 2023-27, and the action that sits below the objectives, have been developed in line with the Corporate Plan priorities for the same period. The key relevant objective is:

- **Addressing structural inequality:** activity aimed at addressing inequalities related to the wider determinants of health and wellbeing, including unemployment, debt, and safety. Intersection between poverty, racism and structural inequality.

1.2.2 ICB Joint Forward Plan (JFP)

NEL's ICB, with its partner NHS Trusts and NHS Foundation Trusts, must prepare a 5-year joint forward plan, to be refreshed each year. The plan sets out any steps on how the ICB proposes to implement any JLHWS that relates to the ICB area, and the ICB must have regard to the Integrated Care Strategy when exercising any of its functions.

The plan itself must describe how the ICB proposes to implement this JLHWSs, and the NHS NEL ICB and partner trusts will send a draft of the JFP to the HWB when initially developing it or undertaking significant revisions or updates. The HWB must respond with its opinion and may also send that opinion to NHS England, telling the ICB and its partner trusts it has done so. If NHS NEL ICB and its partner trusts subsequently revises a draft JFP, the updated version will be sent to the HWB, and the consultation process described above repeated. The JFP must include a statement of the final opinion of the HWB.

Barking and Dagenham are also producing a Local Forward Plan which will set out how the partnership will deliver the JLHWBS.

1.2.3 Performance Assessments

In undertaking its annual performance assessment of an ICB, NHS England must include an assessment of how well the ICB has met the duty to have regard to the relevant JSNAs and JLHWSs within its area. In conducting the performance assessment, NHS England must consult each relevant HWB for their views on the ICB's contribution to the delivery of any JLHWS to which it was required to have regard.

2. Proposal and Issues

The current Barking and Dagenham Health and Well Being Strategy ends in 2023. However, on review following the publication of the refreshed JSNA, and the Babies, Children's' and Young Peoples Plan, and as recommended in the Director of Public Health's report 2021-22, it is proposed the strategy remains but refreshed in the aftermath of the COVID- 19 pandemic and the current 'cost of living crisis', for the period 2023 -2028.

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.

In the context of the new place-based partnership and integrated working this refreshed Strategy will set out a renewed vision for improving the health and wellbeing of residents and reducing inequalities at every stage of residents' lives by 2028, aspiring to the development of a 'system of health'.

The vision is: "By 2028, residents in Barking and Dagenham will have improved physical and mental health and wellbeing, with a reduction in the gap in health inequalities between Barking and Dagenham residents and people living elsewhere. Our residents will benefit from coproduction and partnerships around their needs and priorities."

It sets out three thematic outcome areas:

<u>Best start in life</u>
We want babies, children, and young people in the borough to:

- Get the best start, be healthy, be happy and achieve
- Thrive in inclusive schools and settings, in inclusive communities
- Be safe and secure, free from neglect, harm, and exploitation
- Grow up to be successful young adults

<u>Living well</u>
We want to ensure residents live well and realise their potential, and when they need help they can access the right support, at the right time in a way that works for them.

Ageing well

We want residents to live healthily for longer and:

- Be able to manage their health, including health behaviours, recognising and acting on symptoms and managing any long-term conditions
- Have increased opportunities to have an early diagnosis of health conditions and be provided with appropriate care to manage a condition before it becomes more serious
- Their health and wellbeing is improved to support better opportunities (educational, employment, social) and independent living for as long as possible

3. Consultation –

3.1 Final consultation between March and April 2023 was carried out with the following overarching groups:

- Residents
- Internal Council stakeholders
- External Council partners and colleagues

There was general agreement with vision, themes and principles overall. Comments that were summarised and incorporated into the final version around delivering priorities include a focus on:

- SEND provision/special needs support; safety; support with transitions & developing skills for adulthood (Best start in Life).
- Prevention and support for earlier adoption of healthier lifestyles; Emotional wellbeing and mental health; the environment, particularly safety and housing (Living Well).
- Earlier intervention and improved awareness of support available; Improving connection, cohesion and loneliness (Ageing Well).
- Listening to people; making sure the feedback loops are closed and impact of involvement is clear; involving young adults more; making involvement easier/more accessible (Co-production)

4. **Financial Implications, Legal and Other Implications**

None.

5. **Corporate Policy and Equality Impact –** The Health and Wellbeing Strategy is a key overarching strategy for the Council's Corporate Plan.

An Equalities Impact Assessment was approved by LBBDs Strategy Team and is attached as Appendix B for reference.

6. **Health Issues –** The aim of the Strategy is to set the direction for improving health issues, reducing health inequalities, and ensuring services are provided in an integrated manner. The delivery plans that will be formed with residents

underpinning the strategy will be developed to have a positive effect on local communities.

Public Background Papers Used in the Preparation of the Report: None

List of appendices:

Appendix A: LBBD JHWS 2023-2028

Appendix B: JLHWS Equalities Impact Assessment

BARKING AND DAGENHAM

Joint Local Health and Wellbeing Strategy

2023-2028

Improving and protecting health, wellbeing and reducing health inequalities.

Barking & Dagenham

Foreword

I am pleased to introduce our refreshed Joint Local Health and Wellbeing Strategy. This strategy provides a clear, concise and convincing explanation of what we need to do, and what impact we aim to have for the next 5 years, as a 'framework for action'. It includes the vision of how we can achieve this, and the outcomes and actions required to reduce health inequalities at every stage of residents' lives.

The health and care needs of our residents are unique, but so are the assets within our communities which need support to enable them to succeed, and this strategy reflects this. The challenge is clear in our Borough Manifesto – we need to get to the root cause of problems. Much of Barking and Dagenham's ill health is linked to social, economic, and environmental factors and most of them can be well addressed. Yet, our local health and care system continues to focus on ill-health and illnesses rather than focussing on promoting good health. Establishing a sustainable model of integrated health and social care requires using all resources to influence the wider determinants of health.

The combined impacts of the pandemic, cost of living crisis and demographic change further show the need for a difference in the way we design and deliver services.

The combined impacts of the pandemic, cost of living crisis and demographic change further show the need for a difference in the way we design and deliver services. We cannot meet the rising needs of our population by spending more money on the kinds of services we currently provide. Instead, we need to re-focus what we do so that we identify the root cause of need and tackle it so that residents have a better chance of living more independently now and in the future.

By truly co-producing with residents, particularly those who experience the poorest health, we can understand the root causes of ill heath, the ways we can best meet needs and ensure communitunites are supported and empowered. Through working at a level closest to individuals and families and creating an infrastructure which move us from providing reactive/ transactional services which often intervene too late, to ones that are relational and create social capital to enable residents to live happier, healthier lives.

Good health is vital to an enjoyable and meaningful life free from avoidable illness and, in the worst cases, early death. But the importance of good health needs to be considered, particularly in our aspirational and developing borough, as a crucial factor of economic prospects, both at an individual and a system level. We want residents at all ages to engage and not be compromised by poor health – both physical and mental. To allow all residents to benefit from the new opportunities within Barking and Dagenham we need to ensure health is core to everything we do.

We would like to thank everybody that has been involved in this strategy refresh. Residents for offering their lived experiences; the Health and Wellbeing Board; elected members and individuals who demonstrate their commitment to this important agenda - but the success of any plan is in its delivery.

Cllr Maureen Worby
Cabinet Member for Adult Social Care and Health Integration and Chair of the Health and Wellbeing Board

INTRODUCTION

Welcome to the Barking and Dagenham plan for improving and protecting health, wellbeing and reducing health inequalities.

This strategy sets out a renewed vision for improving health and wellbeing of residents and communities and reducing inequalities by 2028. It reamplifies key themes and outcomes from the 2019-2023 strategy – which are still relevant – and defines how we can deliver these over the next 5 years. It recognises and harnesses our new partnerships, with a particular focus on ensuring communities are central to coproduction and delivery.

Local health services have a key role to play in delivering this vision but many issues impacting health are outside of the health service. Therefore the heart of this strategy is to tackle the wider determinants of health. It recognises the need for equity by targeting those with the poorest health and wellbeing and therefore those who would benefit the most from support working with residents to ensure actions meet individual needs and characteristics of our communities.

Following the publication of the refreshed JSNA (2022) and the Barking and Dagenham Best Chance Strategy - a partnership plan for babies, children, young people and their families, it was agreed that the key themes within the current HWB strategy (2019 -2023) remain but are refreshed in the context of the new NHS Integrated Care System (ICS) and after the COVID-19 pandemic and the current 'cost of living crisis', for the period 2023 -2028 (as recommended in the Director for Public Health's report 2021-22).

This strategy has been produced at a time of significant transformation to the NHS and wider health and care system, with organisations responsible for health and care services coming together to form a Place-Based Partnership. This will have a key role in delivering wider programmes to promote health and wellbeing and integrating services to improve health and experience of care for local people.

An initial programme of community engagement was undertaken to help outline 'what good looks like' against the agreed priorities; and following this we further engaged with residents through an online survey, through Healthwatch and with partner organisations as key stakeholders, to establish what actions we should focus on in our plan.

The strategy sets out an indication of the health needs in the borough, what we want to achieve and key areas for action needed to get there.

This strategy sets out a renewed vision for improving health and wellbeing of residents and communities and reducing inequalities by 2028.

WHERE ARE WE NOW:
OUR POPULATION AND ITS HEALTH CHALLENGES

Barking and Dagenham is the most deprived borough in London, based on Index of Multiple Deprivation score (32.8)[1] and is ranked 5th in London on the related Income Deprivation Affecting Children Index (IDACI) score, which measures the percentage of all children aged 0 to 15 years who live in income deprived families (23.8%).[2] Furthermore, B&D had the highest percentage of children aged under 16 living in absolute low income families in London (21.2%) in 2020/21.[3]

Around 218,900 people live in Barking and Dagenham (B&D) and although the local population is the 10th lowest in the London boroughs, it has seen the 2nd highest growth in numbers in recent years. Between 2011 and 2021, the population size of the borough increased by 17.7%, from around 185,900 to 218,900.[4]

Our local population is young, with an average age of 33 years old, and the highest proportion aged under 18 within England and Wales (28.9%).

Our local population is young, with an average age of 33 years old, and the highest proportion aged under 18 within England and Wales (28.9%). The borough also has the highest proportion of under 5s in the UK (8.8%), nearly a quarter (23.6%) are aged between 5-19 years old and almost a third (31.5%) are aged 19 and under. This younger population has also showed considerable growth in the number of residents aged 5-9 (28%), 10-14 (43%) and 15-19 years old (20%), in the decade leading up to the 2021 Census.[5]

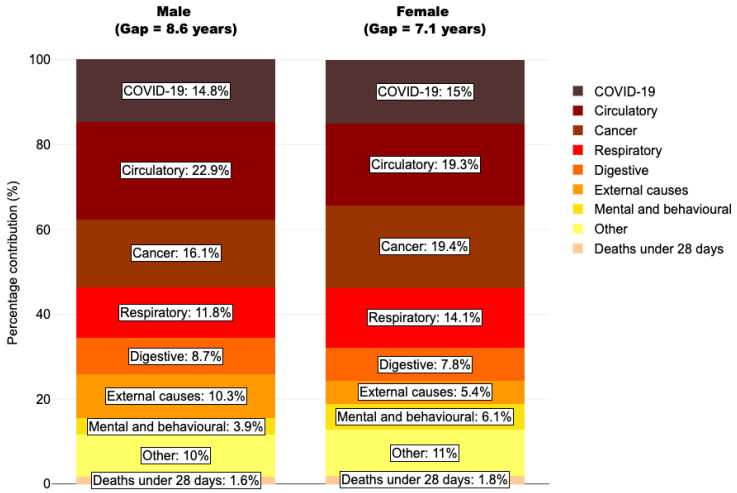
Although nearly six in ten local residents (c.128,500 people) were born in the UK (58.7%), the borough has a **diverse population**, in which 44.9% are White, 25.9% Asian, 21.4% Black, 4.3% Mixed and 3.6% of Other ethnic groups.[5] The last Census data also told us 8.4% of the borough population are migrants (i.e. had a different address on Census day to the same day one year before) and a quarter of the local population had lived in the UK for 10 years or more.

In 2018-2020, **life expectancy** in the borough for both men (77.0 years)[6] and women (81.7 years)[7] was reduced and is significantly worse than the national averages. We also had the highest rate of **premature mortality** in London in 2021, with 511.9 deaths per 100,000 people aged below 75, compared to 358.9 for London overall.[8]

Similarly, healthy life expectancy for males in 2018-20 was 58.1 years, which was the lowest of the London local authorities and significantly worse than both London (63.8 years) and England (63.1 years).[9] Healthy life expectancy for females in the borough for 2018-20 was 60.1 years, which was the 3rd lowest of the London local authorities and significantly worse than both London (65.0 years) and England (63.9 years).[10]

Both **cancer and cardiovascular disease** (CVD) remain major killers in B&D and contribute to the gap in life expectancy for residents. However, many of these cases are caused by avoidable and essentially preventable lifestyle choices and behaviours linked to smoking, alcohol and obesity.[11]

The diagrams below show the greatest contributors to the life expectancy gap by cause of death for males and females in B&D for 2020/21.



We also had the highest rate of **premature (<75 years) mortality from cardiovascular diseases** in London for 2021, with a rate of 117.6 per 100,000, which was also significantly higher than both London (74.3 per 100,000) and England (76.0 per 100,000).[12]

Barking and Dagenham has some of the worse outcomes for **long term conditions (LTCs)** in London. For example, in 2021, we had the 2nd highest rate of premature (under 75) mortality from respiratory disease in London, with a rate of 38.1 per 100,000, which is significantly higher than the rates for both London (22.5 per 100,000) and England (26.5 per 100,000).[13]

However, the number of people with **long term conditions (LTCs)** is substantially lower than expected, which may be related to our young population, but also indicates that many cases currently go undiagnosed and untreated.

For adults, the borough had the 3rd highest rate of emergency hospital admissions for **COPD** in 2019/20, with a rate of 597 per 100,000, which was significantly higher than both London (358 per 100,000) and England (415 per 100,000).[14] It also had the 2nd highest mortality rate from COPD in London at 59.9 per 100,000, which was significantly worse than both London (34.8 per 100,000) and England (39.8 per 100,000), in 2021.[15]

Smoking is the leading preventable cause of ill health and mortality in B&D and although there has been a national decline in smoking prevalence since the 1950s, 11.3% of adults in 2021 **smoked**, which is similar to both London (11.5%) and England (13.0%).[16] However, higher smoking prevalence is found within the more deprived communities in the borough, as well as those people with severe mental illness, contributing significantly to health inequalities.

The percentage of women in the borough smoking at the time of delivery has also shown a significant decrease over the last decade falling from 13.1% (in 2011/12) to 4.5% in 2021/22, which is significantly lower than in England overall (9.1%).[17] In contrast, smoking attributable mortality, as well as smoking attributable deaths from cancer, in Barking and Dagenham, have in recent years been the highest in London at 280.9 per 100,000 and 115.7 per 100,000 respectively.[18,19]

Smoking is also linked to the delivery of low birth weight babies and premature births. For premature births (i.e. those less than 37 weeks gestation), we have the 3rd highest rate in London (89.1 per 1,000), and is significantly worse than London (76.4 per 1000) and England (79.1 per 1,000).[20] In addition, our borough is significantly worse than England on low birth weight of term babies with a rate of 3.8%, compare with 2.8% nationally.[21]

In 2021, Barking & Dagenham had the highest percentage of its economically active population unemployed of all the London boroughs (7.6%).

The borough had the highest prevalence of **obesity** in London for Reception Year (14.8%)[22] and Year 6 children (33.2%), in 2021/22[23] both of which are significantly higher than regional and national averages. Similarly, the borough had the 3rd highest proportion of obese adults (28.6%) within the London local authorities for years 2020/21.[24]

In the year ending March 2023, there were 3,568 **domestic abuse offences** recorded by the Metropolitan Police for Barking and Dagenham, representing a rate of 16.7 per 1,000, which is the highest rate within the London boroughs. This rate is a 2.7% increase on the previous year and a 10.5% rise on the previous month although some of this is due to good reporting. Of these offences, 798 were domestic abuse violence with an injury.[25]

It is estimated that 75.43 per 1000 children aged 0-4 years old live in households where a parent is suffering domestic abuse, compared with the national rate of 71.33 per 1000.[26]

Overall, in the year ending March 2023, there were 116.3 crimes per 1,000 people locally, which is higher than the rate for London (109.7 per 1,000 population).[27]

Similarly, for 2021, the borough had the 5th highest rate of first-time entrants into the youth justice system in London, with a rate of 256.0 per 100,000, which was significantly higher than the national rate (146.9 per 100,000).[28]

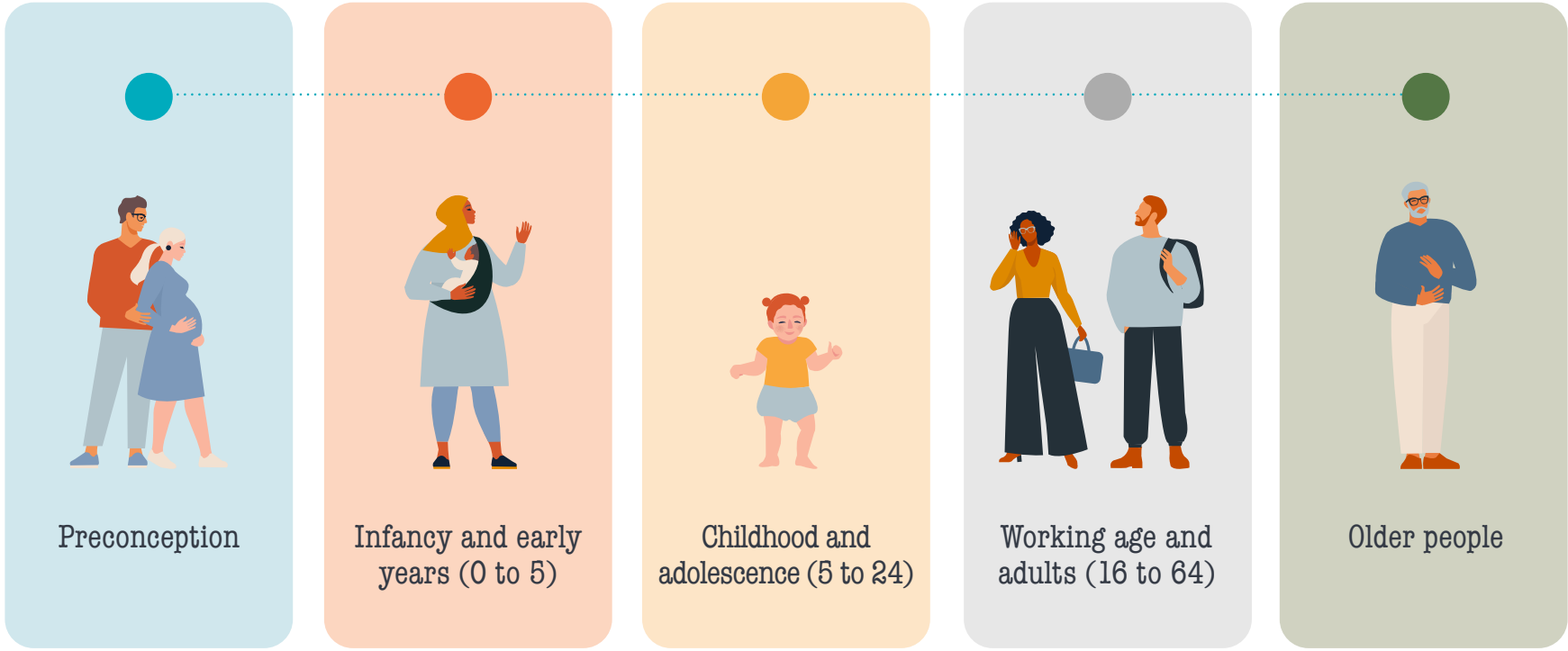
In recent years (since 2019) there has been an increase in the number of children and young people with Education Health and Care Plans (EHCPs) in B&D with the most common primary needs identified in 2022 being Autistic Spectrum Disorder (ASD) (31.9% of EHCPs) and Speech, Language and Communication needs (18.3%).

Between 2019/20 and 2021/22, the rate of households in **temporary accommodation** in B&D fell significantly from 20.7 to 17.8 per 1,000. However, the borough still had a significantly higher rate than both London (16.3 per 1,000) and England (4.0 per 1,000), on this measure of homelessness.[29]

Fuel poverty here was the worst in London, with nearly 14,000 households in the borough (18.6%) experiencing this form of economic challenge, in 2020.[34] In 2021/22, the borough also had the 7th highest percentage of the working population claiming out of work benefits (8.7%) in England.[35]

In 2021, Barking & Dagenham had the **highest percentage of its economically active population unemployed of all the London boroughs** (7.6%).[30] During 2021/22, the borough also had the 3rd lowest percentage in London of people in employment (67.6%).[31] However, we also had the second highest economic inactivity rate (30.2%) of all the London boroughs in 2021/22, which is significantly higher than both London (20.5%) and England (21.2%).[32] Defined as the proportion of the working age population (16-64 years old) who are economically inactive (i.e., neither employed nor unemployed), this measure is associated with negative health outcomes.[33]

Action is required across the life course



	Obesity in Pregnancy % (2018/19)	Low Birth Weight at Term (2021)	Good Development at 2-2.5 yrs (2021)	Children Living in Absolute or Relative Poverty (2022)	Unhealthy Weight at 10/11 yrs (2021/22)	Economic Inactivity 16-64yrs (2021/22)	Domestic Abuse Incidents per 1,000 population (2021/22)	Healthy Life Expectancy M/F (2018/20)	Life Expectancy at Birth M/F (2021)
Barking and Dagenham	27.4%	3.8%	56.0%	49.0%	49.1%	30.2%	35.4	58.1/60.1 yrs	75.6/80.3 yrs
London	17.8%	3.3%	79.9%	29.5%	40.5%	20.5%	35.4	63.8/65.0 yrs	78.8/83.4 yrs
England	22.1%	2.8%	81.1%	37.0%	37.8%	21.2%	30.8	63.1/63.9 yrs	78.8/82.8 yrs

WHAT ARE WE TRYING TO ACHIEVE?

Our Vision:

By 2028, residents in Barking and Dagenham will have improved physical and mental health and wellbeing, with a reduction in the gap in health inequalities between Barking and Dagenham residents and people living elsewhere.

Our residents will benefit from coproduction and partnerships around their needs and priorities.

Themes

The strategy will be based on three themes:

- Best Start in Life
- Living Well
- Ageing Well

Outcomes

The following sets the long-term outcomes for each of the three themes within the strategy, but this strategy will focus on the actions for the Health and Well Being Board over the next five years:

Best start in life

We want babies, children, and young people in the borough to:

- Get the best start, be healthy, be happy and achieve
- Thrive in inclusive schools, settings and communities
- Be safe and secure, free from neglect, harm, and exploitation
- Grow up to be successful young adults

Living well

We want to ensure residents live well and realise their potential, and when they need help they can access the right support, at the right time in a way that works for them.

Ageing well

We want residents to live healthily for longer and:

- Be able to manage their health, including health behaviours, recognising and acting on symptoms and managing any long-term conditions
- Have increased opportunities to have an early diagnosis of health conditions and be provided with appropriate care to manage a condition before it becomes more serious
- Their health and wellbeing is improved to support better opportunities (educational, employment, social) and independent living for as long as possible

HOW ARE WE GOING TO GET THERE?

Core to the strategy is addressing health inequalities by taking a place-based approach, with a fully engaged community.

To help us to do this we have referred to a number of frameworks which exist[36], which help us to deliver through system and at scale, depending on audiences contexts and priorities. Drawing on this evidence, the strategy is under pinned by the following principles:

- Coproduction with Communities
- Integrated Care
- Taking Place-Based Action
- Addressing Health Inequalities
- Acting on What Makes Us Healthy

Principles

The following principles underpin this strategy:

Coproduction with Communities

At the forefront of action is a genuine commitment to the value of relationships and coproduction with residents in designing or discovering changes to meet the needs of our communities. Building a connected, effective community infrastructure, where healthy life expectancy is improved, takes commitment and discipline by the whole system. The work being developed around geographical areas known as localities, is building a system where:

- Resources are maximised and organisations are released to do what they do best.
- Referrals to formal services are accurate and appropriate.
- Residents are empowered – getting what they need, when they need it and from the right place (e.g.: a neighbour; a friend; a social sector organisation; place of worship; the local authority; or primary or secondary care).
- The value of relationship (connection, trust and belonging within the community) is recognised as essential to health and wellbeing as are council and health services.

This will take the form of working with the following range of community-centred approaches[37] for health and wellbeing:

- **Strengthening communities** – Building on community capacities to act together on health and the social determinants of health.
- **Volunteer and peer roles** – Focus on increasing an individuals' capabilities to provide advice, information and support or organise activities around health and wellbeing in their or other communities.
- **Collaborations and partnerships** – Involve communities and local services working together at any stage of the planning cycle, from identifying needs through to implementation and evaluation.
- **Access to community resources** – Connect people to local resources, practical help, group activities and volunteering opportunities to meet health needs and increase social participation.

Integrated Care

We will work to ensure that residents can access the right support, at the right time in a way that works for them. This requires understanding of assets and roles across sectors, as well as within our communities. 'Shifting the centre of gravity' to make place-based, person-centred health and care a reality can be supported by the following principles:

Building on what already works locally

Expanding the partnership already working effectively to plan and deliver joined-up, person-centred services.

A person-centred approach

Co-production to plan and deliver care and support with individuals and, where they wish, with their families, to achieve the best outcomes. As well as empowering communities to manage their own health and wellbeing.

A preventative, assets-based population health approach

Maximising health and wellbeing, independence, and self-care in or as close to people's homes as possible to reduce their need for health and care services.

Achieving best value

Working together to ensure delivery of care and support represents the best value, including, of securing the best possible health and wellbeing outcomes using safe and high-quality services, while ensuring the sustainable use of resources.

Taking Place-Based Action

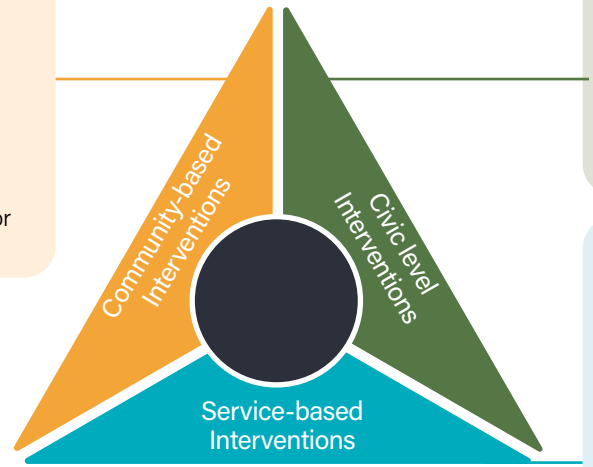
To make a difference, effective action is required at civic, service and community levels as shown by the population intervention triangle. System leadership and planning through our new partnership arrangements will ensure action is effective and is meeting needs of our residents.

This will be done by making sure interventions are:

1. Evidence based
2. Outcomes orientated
3. Systematically applied
4. Scaled-up appropriately
5. Appropriately resourced
6. Sustainable

Population Intervention Triangle

- The assets within communities, such as the skills and knowledge, social networks, local groups and community organisations, as building blocks for good health.



- Legislation; regulation; licencing; by-laws
- Fiscal measures: incentives; disincentives
- Economic development and job creation
- Spatial and environmental planning
- Welfare and social care
- Communication; information; campaigns
- Major Employer

- Delivering intervention systematically with consistent quality and scaled to benefit enough people.
- Reduce unwarranted variation in service quality and delivery
- Reduce unwarranted variability in the way the population uses services and is supported to do so.

Addressing Health Inequalities

Addressing avoidable and unjust differences in health between residents is a key underpinning principle in all our work to deliver this strategy.

These differences are a result of health events across the life course from pre-birth, and over 80% are unrelated to access to health services.

In Barking and Dagenham, residents are exposed to more negative risks to health than those in other local areas, i.e., the highest percentage of households suffering multiple deprivations (68%; Census 2021). This will be worsened by the 'cost-of-living crisis', with B&D residents having the fourth highest vulnerability to it out of 307 local areas[33].

Acting on What Makes Us Healthy

Services have an important role in enabling us to be healthy, however improving health and reducing health inequalities requires us to also act on the 80% of health determinants outside of healthcare. Working across partnerships which places the assets and needs of individuals and communities at the centre can enable us to make a real change on 'what makes us healthy' (Health Foundation, 2019).

WHAT ACTIONS ARE NEEDED OVER THE NEXT 5 YEARS?

Priorities

The JSNA has been complemented by other important sources (such as the 2021 Census) to create a set of key priorities agreed by the Place-Based Partnership. These relate to:

- **Improving outcomes for people with long term conditions in children and adults.**
- **Addressing unhealthy weight and smoking in children and adults.**
- **Providing the best start in life for our babies, children, and young people.**
- **Preventing and addressing domestic abuse.**
- **Preventing exposure to and the consequences of adverse childhood experiences.**
- **Addressing wider determinants of health- for example unemployment, poor housing, low level of training, education and skills development.**

Proposed Actions

Strategic Leadership

For a place to be effective in delivering systematic, system wide place or population action to address health inequalities, the following needs to be in place[36]:

1. A vison and strategy with measurable goals, coordinating targeted action at all levels
2. System leadership and accountability for action on health inequalities
3. A system approach to data linkage and data and evidence driven policy and intervention development and implementation
4. Building on the evidence base of what works
5. Improved system capability for action on health inequalities and wider determinants of health
6. Use of systematic assessment tools to drive multi-agency cross system action
7. Comprehensive engagement to magnify community voice

Co-production

Working in partnership to design and deliver support together

The strategy's focus includes a core commitment to working in creative partnerships with communities to achieve our aims - to reduce health inequalities so no-one is left behind.

We know communities know best about having access to the right services, in the right place, at the right time and whether services are accessible for the people who need them.

We want to work with communities who face the most inequalities to achieve lasting change – releasing the power of communities to participate in change-making, bring challenge and lead where appropriate.

We want to develop ways that will best help our residents and communities to take part in thinking and developing solutions together for improving health and well-being in B&D and to help us understand progress made with delivery.

To help do this we are proposing that we will focus in year one on:

- Finding new and creative ways of bringing people together to share experiences, ideas and voices
- Developing a new approach to maximise the unique positioning of residents and community organisations to build resilience and where needed, early help when issues arise- which includes their collaboration with statutory services
- Using data, to understand our population - particularly our underserved communities better and consider the relevant approaches required for working together
- Co-creating and co-developing specific actions to deliver this strategy, ending in a co-produced action plan

Our long-term aim is to develop approaches that better enable and empower local communities to shape and contribute to how the strategy tackles health inequalities and improves health and well-being on an ongoing basis.

We know we cannot do this alone.

Developing our approach to co-production

We want to develop our approach to co-production in partnership and to work with a wide range of people, professionals and organisations. We are committed to making this work and the following principles will be part of how we do this:

- Involve everyone who will be taking part in co-production from the start.
- Value and reward people who take part in the co-production process.
- Ensure that there are resources to cover the cost of co-production activities.
- Ensure that co-production is supported by a strategy that describes how things are going to be communicated.

We would like to find the best way with residents and our communities for them to strengthen our approach to co-production; better contribute to the development of the strategy and monitor progress of delivery over time. By doing this we want to build co-production into the following activities as part of what we do:

- **Co-design,** including planning of services and support
- **Co-decision making** in the allocation of resources and funding
- **Co-evaluation** of services and performance

Delivering Priorities

Providing the best start in life for our babies, children, and young people. To be healthy, be happy and achieve by:

- Increasing access to services including maternity, health visitors and early help provision.
- Tackling early causes of childhood neglect.
- Improving poor perinatal mental health and domestic abuse.
- Improving uptake of breastfeeding, immunisations and two-year-old checks.
- Improving school readiness, education outcomes and standards.
- Supporting healthy weight.

To grow up to be successful young adults by:

- Accessing good quality youth support.
- Increasing feelings of safety through reducing serious violence, offending and reoffending.
- Proving supportive pathways into adult services.
- Improving a strong training and local employment offer, especially for care leavers and those with SEND.
- Providing positive diverse and inclusive role models.
- Supporting with transitions & developing skills for adulthood.
    - To thrive in inclusive schools and settings, in inclusive communities by:
        - Accessing Early Help and Support for children, young people, and families with SEND.
        - Providing a better offer for those with social, emotional and mental health needs, including timely access to CAMHS.
    - To be safe and secure, free from neglect, harm and exploitation, by:
        - Supporting good child protection and Child Death Overview Panels decisions and outcomes.
        - Developing contextual safeguarding approaches.
        - Caring for children in care and care leavers.

Preventing the exposure to and the consequences of adverse childhood experiences (ACEs).

Action will include:

- Building resilience through, e.g. parenting programmes/strengthening families; mentoring opportunities; school-based programmes to develop life skills; psychological support to deal with negative impacts of ACEs; community-based programmes that strengthen local resources and relations.
- Raising awareness of behaviour norms and environments that contribute to ACEs.
- Developing Trauma Informed practice within communities and settings.

Delivered through:

- Implementing the national 'Start for Life' programme,
- Strengthening the delivery of the 0-19 Healthy Child Programme
- Setting up three locality-based Family Hubs and a Family Hub Network as the channel for integrated working across the system in the borough.

Living Well

Addressing unhealthy weight and smoking in children and adults

Action will include:

- Development of a system wide approach needed to address unhealthy weight including joined up support for those living with unhealthy weight; increasing access to safe open spaces for play, walking and cycling; opportunities for physical activity and enabling healthier diets.
- Developing a system wide approach to reducing smoking – including stopping children starting and providing access to evidence-based stop smoking services.

Preventing and addressing domestic abuse

Action will include:

- Delivering the Barking and Dagenham Domestic Abuse Improvement Programme.
- Leading the delivery of a broader public health approach to addressing domestic abuse.

Addressing wider determinants of health for example employment (including unemployment, under employment and employment quality), poor housing, low level of training, education, and skills development

Action will include:

- Delivering a health in all policies approach (linking to the themes[38] identified within the Barking and Dagenham Together vision document 2017 – 2237) with all partners responsible, to allow opportunities for people through training, education, skills development, and good employment.
- Supporting housing policy to improve health and wellbeing.
- Acting on air quality to improve health.
- Public sector partners developing their roles as 'anchor institutions.'
- Delivering the Serious Violence Duty to reduce child exploitation and crime.

Ageing Well

Improving health and wellbeing for residents, particularly those with long term conditions.

Action will include:

- Improving health behaviours such as smoking and physical inactivity.
- Improving connection, cohesion and reducing loneliness.
- Providing appropriate and accessible services and support for residents to prevent development of health conditions.
- Supporting residents to understand when and how to access services for the assessment and management of long-term conditions.
- Ensuring more residents with health conditions are assessed, identified and provided with condition management as early as possible.
    - Development of integrated teams that allow residents to receive the support and care needed to live independently for as long as possible.
    - Development and delivery of a digital transformation strategy for care and support.

HOW WILL WE KNOW WE HAVE BEEN SUCCESSFUL?

Outcomes

Each priority/ theme will have several outcomes (short, medium and long term- up to 5 years).

1

Performance Indicators

Performance indicators will be identified against which progress with be tracked, to deliver improvements to health and wellbeing and reduce health inequalities.

2

Delivery Plans

A detailed set of delivery plans will be developed to describe activity to achieve the agreed measures.

3

Accountability

Responsibility for delivering these plans will sit with our Place Executive Group with implementation of the plans by our system partners through both the Adult, and Best Chance for Babies, Children and Young People Delivery Groups.

4

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THANK YOU FOR READING

To find out more information on our strategies, policies and plans click here.

Barking & Dagenham

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Community and Equality Impact Assessment

As an authority, we have made a commitment to apply a systematic equalities and diversity screening process to both new policy development or changes to services.

This is to determine whether the proposals are likely to have significant positive, negative or adverse impacts on the different groups in our community.

This process has been developed, together with **full guidance** to support officers in meeting our duties under the:

- Equality Act 2010.
- The Best Value Guidance
- The Public Services (Social Value) 2012 Act

COMMUNITY AND EQUALITY IMPACT ASSESSMENT	

About the service or policy development

Name of service or policy	Joint Health & Wellbeing Strategy Refresh 2023-28
Lead Officer Contact Details	Jess Waithe, Public Health Specialist Jess.waithe@lbbd.gov.uk

Why is this service or policy development/review needed?
The Joint Health and Wellbeing Strategy is a statutory document. The current Strategy, running from 2019 is due to expire this year and the refreshed version will build on this, setting out a renewed vision for improving the health and wellbeing of residents and reducing inequalities at every stage of people's lives for 2023- 2028 . The priorities in the document will underpin delivery plans and outline how London Borough of Barking Dagenham and partners will work together to deliver the proposed priorities.

1. Community impact (this can be used to assess impact on staff although a cumulative impact should be considered).

What impacts will this service or policy development have on communities?
Look at what you know. What does your research tell you?

Please state which data sources you have used for your research in your answer below

Consider:

- National & local data sets
- Complaints
- Consultation and service monitoring information
- Voluntary and community organisations
- The Equality Act places a specific duty on people with 'protected characteristics'. The table below details these groups and helps you to consider the impact on these groups.
- It is Council policy to consider the impact services and policy developments could have on residents who are socio-economically disadvantaged. There is space to consider the impact below.

COMMUNITY AND EQUALITY IMPACT ASSESSMENT	

Demographics

Barking and Dagenham (B&D) is the most deprived borough in London, based on Index of Multiple Deprivation score and is ranked 5th in London on the related Income Deprivation Affecting Children Index score- which measures the percentage of all children aged 0 to 15 years who live in income deprived families (23.8%). We also had the highest percentage of children aged under 16 living in absolute low-income families in London (21.2%) in 2020/21.

Around 218,900 people live in the borough and although the local population is the 10th lowest in London, it has seen the 3rd highest growth in numbers in recent years. Between 2011 and 2021, the population size of the borough increased by nearly 33,000 (17.7%).

Our local population is young, with an average age of 33 years old, and the highest proportion aged under 18 within England and Wales (28.9%). B&D also has the highest proportion of under 5s in the UK (8.8%). Nearly a quarter (23.6%) of the borough's population are aged between 5-19 years old and almost a third (31.5%) are aged 19 and under. This younger population has showed considerable growth in the decade leading up to the 2021 Census.

Although nearly six in ten residents (c.128,500 people) were born in the UK (58.7%), the borough has a diverse population, in which 44.9% are White, 25.9% Asian, 21.4% Black, 4.3% Mixed and 3.6% of Other ethnic groups. The last Census data also told us 8.4% of the borough population are migrants (i.e. had a different address on Census day to the same day one year before) and a quarter of the local population had lived in the UK for 10 years or more.

In 2018-2020, life expectancy in the borough for both men (77.0 years) and women (81.7 years) was reduced and is significantly worse than the national averages. We also had the highest rate of premature death in London in 2021 for people aged below 75.

Similarly, healthy life expectancy for males in B&D in 2018-20 was 58.1 years, which was the lowest of the London local authorities and worse than both London (63.8 years) and England (63.1 years). Healthy life expectancy for females in the borough for 2018-20 was 60.1 years, which was the 3rd lowest of the London local authorities and significantly worse than both London (65.0 years) and England (63.9 years).

Potential impacts	Positive	Neutral	Negative	What are the positive and negative impacts?	How will benefits be enhanced and negative impacts minimised or eliminated?
Local communities in general	X			The aim of the Health and Wellbeing Strategy is to improve the health of all residents, but also focus where inequalities exist and	The importance of involving local communities has been outlined within this refresh, with the ambition that more strategic and ongoing

				where action will have the greatest impact. The refreshed strategy will continue to address issues for specific groups within each of its themes.	approaches to engagement will be undertaken throughout the lifetime of the strategy. The development of these approaches will be formed as part of next steps, we will seek input from residents, so they decide how this should be done.
Age	X			We have: The highest proportion (26.1%) of residents aged 16 and under across England & Wales. 65.2% of residents aged 16-64 and the remaining aged 65+. The greatest changes by age group (increases in those aged 0-64 and decreases in those 65+) compared to both England and London.	The refresh takes a life course approach addressing issues under the three themes: Best Start; Living Well; Ageing Well and will look to act on issues that are most relevant to residents at each stage of life. Children, young people and family specific engagement was undertaken as part of the 'Best Chance Strategy' development which this refresh has reflected on. Engagement with adults will be carried out by the delivery group when forming delivery/action plans and specific approaches to doing this will be directed by residents.
Disability	X			We have the highest proportion of households in London where at least one person identified as disabled (29.8%). 13,700 (6.3%) Barking & Dagenham residents considered themselves to be disabled under the Equality Act and considered their day -to -day activities to be limited a lot and 15,300 (7.0%) said a little.	One of the Strategy priorities is to address long term conditions, including the identification of those at risk; support early diagnosis and treatment to prevent long term serious issues and avoidable admissions. The ways in which groups and communities will be involved in agreeing specific actions to address this will be the responsibility of the delivery groups. This

				The last Census also shows after age standardisation we have a higher proportion compared to London and England in terms of residents with fair, bad and very bad health. Cancer, cardiovascular disease (linked with preventable causes such as smoking, alcohol and obesity) are major killers and contribute to the gap in life expectancy and residents from Black and Asian backgrounds developing long term conditions earlier than White British. A higher smoking prevalence is found within our more deprived communities in the borough, as well as those people with severe mental illness. We also have one of the highest adult obesity rates within London for years 2020/21, with inequalities locally for residents who are Black, women and/or in lower socioeconomic areas.	development will begin once the strategy is published.
Gender reassignment		X		Based on the latest Census data for those aged 16 and over: 9 in 10 residents' gender identity was the same as sex registered at birth (90.4%). Of all English & Welsh local authorities, for those aged 16+, B&D had the highest proportion of trans women (0.25%) and the 3rd highest proportion of trans men (0.24%). We also had the 5th highest proportion of people whose	Previously, views of the LGBTQ+ communities and relevant professional stakeholders were accounted for and represented through engagement on the initial Strategy (2019-23), which included those who have undergone gender reassignment. Focus groups were held with Flipside LGBTQ+ members to formulate statements for inclusion in the previous strategy,

				gender identity was different, but no specific identity given (0.64%).	outlining what good health means for residents.
Marriage and civil partnership		X			
Pregnancy and maternity	X			A theme within the strategy is 'Best Start in Life' which focuses on health and wellbeing from the pre- natal period into young adulthood (to positively impact mother and child) and includes healthy pregnancy; developmental support; support for SEND children and young people; mental health as well as domestic violence and addressing adverse childhood experiences. One area of focus within is on obesity and smoking. Our rates for obesity in pregnancy (2018/19) were 27.4%, which is higher than both London and England. High rates of obesity in reception aged children are also greater than regional and national figures. However positively, rates of those smoking at time of delivery (which is linked to low-birth-weight babies and premature births) was 4.5% (in 2021/22), which is much lower than England (9.1%), but the rates of low birth rate babies and premature births still remains poor compared to London and England.	Forums and workshops were conducted in 2022 with stakeholders (multi-agency; children and young peoples voice; education; VCSE; health) to develop the 'Best Chance Strategy' outputs from this inform aims, priorities and outcomes within this document. Engagement will be an ongoing process and the Best Chance Delivery Group will look to address needs- which include those during pregnancy and maternity.
Ethnicity		X		We had the greatest increase in ethnic diversity between 2011-21 and 151,300 residents are non-White British. Of all English & Welsh local authorities, we have the	There are differences in health outcomes and variation across ethnic groups and health conditions. Data will be used to take a targeted approach to ensure

				highest proportion of Black African residents and 4th highest proportion of Asian Bangladeshi residents. Romanian (4.5%) is the highest national identity of residents who do not identify as British or English.	views of different ethnicities are accounted for and relevant actions/approaches are taken to improve equity and inequalities where they exist.
Religion or belief		X		Our borough has a higher proportion of Muslims compared to London and England. The proportion of Christians in Barking & Dagenham has dropped below half since the previous census but is higher than London. A fifth of Barking & Dagenham residents have no religion – lower than both London and England.	
Sex	X			Life expectancy in the borough reduced for both sexes in recent years and is worse than national averages. Although women still outlive men, they live longer in poorer health resulting in poor quality of life and greater need/reliance on services.	The Best Start in Life theme/focus will have a positive impact for women (although equally for both sexes of the child). Areas of action as part of the Best Chance Strategy will seek to uncover any variation between sexes relating to young peoples health issues.
Sexual orientation		X		On Census Day, nearly 9 in 10 Barking & Dagenham residents described their sexual orientation as Straight or Heterosexual (88.6%), which is higher than London (86.2%), but lower than England (89.4%). Of all authorities in England and Wales, we had the 4th highest proportion who described their sexual orientation as all other sexual	Previously, views of the LGBTQ+ communities and relevant professional stakeholders were accounted for and represented through engagement on the initial Strategy (2019-23), which this is a refresh of.

				orientations (0.07%) and 23rd highest proportion who described their sexual orientation as Pansexual (0.38%).	
Socio-economic Disadvantage	X			62.4% households were deprived in at least one dimension (education, employment, health, housing) - the highest in England & Wales. Of all English & Welsh wards, 11 B&D wards were in the highest 10% for deprivation and 5 were in the highest 20%. <u>Households</u> 62.4% households were deprived- the highest in England & Wales 12.8% households were lone parents with dependent children – the highest in England & Wales And 8.6% households were multi-family households with dependent children – 2nd highest in England & Wales <u>Housing</u> Of all English and Welsh local authorities, in terms of households we had the: 3rd highest proportion who rent their home from the Council/Local Authority (24.5%). 2nd highest proportion living in a property without enough bedrooms (17.8%).	An area of action within the strategy is for 'anchor institutions' to develop there roles as such and to deliver a health in all policies approach with partners. This relates to training, education, skills development and housing to help address the wider/social factors that contribute to disadvantage and ultimately impact on health.

				7th highest proportion living in a property without enough rooms (20.4%). <u>Education</u> B&D (2.29) has the lowest Qualification Index score of all London boroughs – and is one of only 4 London boroughs whose index score is below the English average. 22.7% residents aged 16 and over had no qualifications - highest proportion of all London boroughs. 33.3% residents aged 16 and over had Level 4 qualifications- the 3rd lowest proportion of all London boroughs.	
Any community issues identified for this location?		X		Language: 5.1% of residents aged 3 and over cannot speak English well or at all. Romanian (4.8%) is also the most common language of residents whose main language is not English, followed by Bengali and Lithuanian. 41.3% of residents were born outside of the UK – 16th highest in England & Wales. This is 10.4% higher than 2011 Census and the 2nd highest percentage point change in England & Wales. Transience: 14% of residents arrived in the UK between 2001 and 2010, which is the 2nd highest proportion in England & Wales.	

				9/10 residents were living at the same address one year before Census Day, however it's important to note the pandemic limited people's movement.	

2. Consultation.

Provide details of what steps you have taken or plan to take to consult the whole community or specific groups affected by the service or policy development e.g. on-line consultation, focus groups, consultation with representative groups. If you have already undertaken some consultation, please include: • Any potential problems or issues raised by the consultation • What actions will be taken to mitigate these concerns
Broad consultation took place to create the initial Strategy (2019-23) (consultation with 16 teams and partnerships and 12 resident focus groups with 128 attendees), upon which this refresh is based. This refresh has considered the engagement with children, young people, families and relevant professional stakeholders in the creation of the 'Best Chance Strategy' in 2022 and feeds directly into the 'Best Start in Life' aims, priorities and outcomes within this. It has also considered the extensive engagement undertaken and outputs from the Boroughs Domestic Abuse Commission Report, 2021. Engagement with residents via a One Borough Voice survey was undertaken to 'sense check' the previous priorities and capture any emerging issues; Health Watch also undertook engagement by asking key questions relating to priority areas- long term conditions; healthy lifestyles and employment and education. Consultation between March and April 2023 was carried out regarding the vision, aims, principles and themes in the framework with the following overarching groups: • Residents • Internal Council stakeholders • External Council partners and colleagues Feedback received has been summarised and incorporated into the final version of the strategy.

3. Monitoring and Review

How will you review community and equality impact once the service or policy has been implemented? *These actions should be developed using the information gathered in **Section 1 and 2** and should be picked up in your departmental/service business plans.*		
Action	**By when?**	**By who?**
Form and review plans outlining actions and methods of measurement to achieve outcomes specified in the strategy.	Quarterly	Best Chance Delivery Group Adults Delivery Group
Monitor the outcomes of the strategy.	Annually	Health and Wellbeing Board

4. Next steps

It is important the information gathered is used to inform any Council reports that are presented to Cabinet or appropriate committees. This will allow Members to be furnished with all the facts in relation to the impact their decisions will have on different equality groups and the wider community.

Take some time to summarise your findings below. This can then be added to your report template for sign off by the Strategy Team at the consultation stage of the report cycle.

Implications/ Customer Impact
A renewed vision for improving the health and wellbeing of residents is being set out for the period of 2023-28 is based on key themes and outcomes of the previous Strategy 2018-23, although it has a greater focus on coproduction with communities: • Best Start in Life • Living Well • Ageing Well Once the Strategy refresh is approved at June's health and wellbeing board, specific action plans will be co-created and developed with residents, led by the Adults Delivery Group and Best Chance for Children and Young People Delivery Group to deliver against the priority themes- as part of next steps. The delivery groups will work to establish the best way to involve residents and communities in an ongoing approach to improving co-production, decision making and evaluation.

5. Sign off

The information contained in this template should be authorised by the relevant project sponsor or Divisional Director who will be responsible for the accuracy of the information now provided and delivery of actions detailed.

Name	Role (e.g. project sponsor, head of service)	Date
Jane Leaman	Consultant in Public Health	June 2023

HEALTH SCRUTINY COMMITTEE

19 July 2023

Title: Appointments to the Outer North East London Joint Health Overview and Scrutiny Committee	
Report of the Chief Strategy Officer	
Open Report	**For Decision**
Wards Affected: None	**Key Decision:** No
Report Author: Masuma Ahmed, Principal Governance Officer	**Contact Details:** Tel: 020 8227 2756 E-mail: masuma.ahmed@lbbd.gov.uk
Accountable Director: Alex Powell, Chief Strategy Officer	

Summary

This report is to:

i. Inform the Health Scrutiny Committee (HSC) of the local arrangements for joint health scrutiny; and
ii. Ask the Committee to confirm the appointment of three HSC members to the Outer North East London (ONEL) Joint Health Overview and Scrutiny Committee (JHOSC) for the 2023/24 municipal year.

This report and the Terms of Reference at Appendix 1 explain local joint health scrutiny arrangements amongst the boroughs of Barking and Dagenham, Havering and Redbridge.

Recommendation(s)

The HSC is recommended to:

(i) Note the Terms of Reference for the JHOSC; and
(ii) Agree the appointment of three HSC members to the JHOSC for 2023/24.

Reason(s)

To accord with joint health scrutiny arrangements.

1. Powers of Health Scrutiny in general

Regulations under the National Health Service Act 2006 state that local authorities in England have the power to:

- "Review and scrutinise matters relating to the planning, provision and operation of the health service in the area. This may well include scrutinising the finances of local health services;
- Require information to be provided by certain NHS bodies about the planning, provision and operation of health services that is reasonably needed to carry out health scrutiny;
- Require employees including non-executive directors of certain NHS bodies to attend before them to answer questions;
- Make reports and recommendations to certain NHS bodies and expect a response within 28 days;
- Set up joint health scrutiny committees with other local authorities and delegate health scrutiny functions to an overview and scrutiny committee of another local authority; and
- Refer NHS substantial reconfiguration proposals to the Secretary of State if a local authority considers:
    - The consultation has been inadequate in relation to the content or the amount of time allowed;
    - The NHS body has given inadequate reasons where it has not consulted for reasons of urgency relating to the safety or welfare of patients or staff; and
    - A proposal would not be in the interests of the health service in its area".[1]

2. Joint Health Scrutiny Arrangements

2.1 The Department of Health Guidance ('the Guidance') issued in June 2014 describes two types of joint scrutiny committees; discretionary and mandatory. Discretionary joint committees are set up by local authorities by choice to scrutinise health matters that cross local authority boundaries. Mandatory joint committees are required by regulation to be set up when a relevant NHS body or health service provider consults more than one local authority's health scrutiny function about substantial reconfiguration proposals.

2.2 In such circumstances, the regulations state that:

- "Only the joint committee may respond to the consultation (i.e. rather than each individual local authority responding separately);
- Only the joint committee may exercise the power to require the provision of information by the relevant NHS body or health service provider about the proposal; and
- Only the joint committee may exercise the power to require members or employees of the relevant NHS body or health service provider to attend before it to answer questions in connection with the consultation." [2]

[1] Department of Health, Local Authority Health Scrutiny Guidance, 27 June 2014, p12
[2] Department of Health, p17

2.3 Individual councils or departments would still be able to respond informally to any consultations but the responsibility to give a formal response would lie with the mandatory JHOSC.

3. Referrals to the Secretary of State for Health

3.1 The Guidance makes it clear that the above restrictions do not apply to referrals to the Secretary of State. "Local authorities may choose to delegate their power of referral to the mandatory joint committee but they need not do so. If a local authority had already appointed a discretionary committee, they could even delegate the power to that committee if they choose to. If the local authority has delegated this power, then they may not subsequently exercise the power of referral. If they do not delegate the power, they may make such referrals."[3]

3.2 The London Borough of Barking and Dagenham's Constitution delegates the power of referral to the Secretary of State to the HSC.

4. The Outer North East London Joint Health Overview and Scrutiny Committee

4.1 The ONEL JHOSC consists of three members from each of the following boroughs:

- Barking & Dagenham;
- Havering; and
- Redbridge.

The London Borough of Waltham Forest used to be represented on the ONEL JHOSC via three of its health scrutiny members. However, following a meeting of its Council on 25 April 2019, it agreed to reduce its membership of the ONEL JHOSC from three members to one, and transfer its main membership to the Inner North East London JHOSC, to reflect changes in the local health commissioning landscape.

The Essex County Council may nominate one full Member for the JHOSC. Thurrock Borough Council's Health Overview and Scrutiny Committee may nominate an observing Member to the Joint Health Overview and Scrutiny Committee. The councils of the Borough of Brentwood and District of Epping Forest may also each nominate an observing Member.

4.2 Background to the JHOSC

The Outer North East London JHOSC was established by the health overview and scrutiny committees of the above boroughs, exercising their powers under section 7 of the Health and Social Care Act 2001 and the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002. This legislation, together with directions issued by the Secretary of State for Health in 2003, required all local authorities affected by what they considered to be 'substantial variations' in local health services to form a 'joint health overview and scrutiny committee' to consider those changes.

[3] Department of Health, p17

5. Further information regarding the JHOSC and Appointment of Members

5.1 The Terms of Reference at Appendix 1 describe the remit and governance of the JHOSC.

5.2 There are typically four JHOSC meetings a year with the boroughs taking turns to host the meetings. The chair of the health scrutiny committee from the hosting borough chairs the JHOSC meeting.

5.3 The first JHOSC meeting of 2023/24 will be held at 4.00pm on Thursday 27 July 2023. The remaining JHOSC meetings for the year will take place on:

- Tuesday 17 October 2023;
- Tuesday 9 January 2024; and
- Tuesday 16 April 2024.

5.4 In Barking and Dagenham, the Chair and Deputy Chair of the HSC are usually appointed to the JHOSC as a matter of standard practice. This year the HSC Chair and Deputy Chair are Cllr Paul Robinson and Cllr Michel Pongo respectively. It is therefore recommended that Cllrs Robinson and Pongo are appointed to sit on the JHOSC for the 2023/24 municipal year, with the third Member appointment to be put forward at today's meeting.

6. Financial Implications

6.1 This report is largely for information and seeks to confirm the appointment of three Health Scrutiny Committee (HSC) members to the Outer North East London Joint Health Overview and Scrutiny Committee, for the 2023/24 municipal year. As such, there are no direct financial implications arising from the report.

7. Legal Implications

7.1 Under section 21 of the Local Government Act 2000 the Heath Scrutiny Committee has specific responsibilities about health functions in the Borough. Such Health Scrutiny Committees shall carry out health scrutiny in accordance with Section 244 (and Regulations under that section) of the National Health Services Act 2006 as amended by the Local Government and Public Involvement in Health Act 2007 relating to local health service matters. The Health Scrutiny Committee in its work has all the powers of an Overview and Scrutiny Committee as set out in section 9F of the Local Government Act 2000, Local Government and Public Involvement in Health Act 2007 and Social Care Act 2001 (including associated Regulations and Guidance).

7.2 Furthermore health matters can and do have cross borough implications and in some matter as identified in the body of this report only a Joint Health Scrutiny Committee can respond. To address this issue a multi borough health scrutiny committee covering Barking & Dagenham; Havering; Redbridge and Waltham Forest has been established (although Waltham Forest is now lesser represented as explained in the main report). It exercises its powers under section 7 of the Health and Social Care Act 2001 and the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002. This report seeks agreement to make appointment of three HSC members to the Outer North East

London (ONEL) Joint Health Overview and Scrutiny Committee (JHOSC) for the 2023/24 municipal year.

Background Papers Used in the Preparation of the Report: None.

List of appendices:

Appendix 1: Joint Health Overview and Scrutiny Committee's Terms of Reference

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TERMS OF REFERENCE FOR
OUTER NORTH EAST LONDON
JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Establishment of the JHOSC

1. The Outer North East London Joint Health Overview and Scrutiny Committee (the JHOSC) is established by the Overview and Scrutiny Committees having health responsibilities of the London Borough Councils of Barking & Dagenham, Havering, Redbridge and Waltham Forest ("the borough OSCs") in accordance with s.190-191 of the Health and Social Care Act 2012 and consequential amendments and the Local Authority (Overview and Scrutiny Committees Healthy Scrutiny Functions) Regulations 2002.

Membership

2. The JHOSC will consist of three Members appointed of each of the Borough OSCs.

3. In accordance with section 21(9) of the Local Government Act 2000, Executive Members may not be members of an Overview and Scrutiny Committee.

4. The Essex County Council may nominate one full Member for the Joint Health Overview and Scrutiny Committee. Thurrock Borough Council Health Overview and Scrutiny Committee may nominate an observing Member of the Joint Health Overview and Scrutiny Committee. The Councils of the Borough of Brentwood and District of Epping Forest may also each nominate an observing Member.

5. Appointments made to the JHOSC by each participating London borough OSC or Council will reflect the political balance of the borough Council, unless a participating borough OSC agrees to waive the requirement and this is approved by the JHOSC.

Attendance of Substitute Members

6. If a Member is unable to attend a particular meeting, he or she may arrange for any appropriate Member of the borough Council to attend as substitute, provided that a Member having executive responsibilities may not act as a substitute. Notice of substitution shall be given to the clerk before the commencement of the meeting.

Role and Function of the JHOSC

7. The JHOSC shall have the remit to review and scrutinise any matter, including substantial variations, relating to the planning, provision and operation of health services that affect two or more boroughs in Outer North East London. The JHOSC will have the right to respond in its own right to all consultations on such matters, both formal and informal.

8. In fulfilling its defined role, as well as reviewing documentation, the JHOSC will have the right to do any or all of the following:

    a. Request information or to hold direct discussions with appropriate officers from each of the following organisations or their successor bodies:

    Barking and Dagenham Clinical Commissioning Group (CCG)
    Havering CCG
    Redbridge CCG
    Waltham Forest CCG
    Barking, Havering and Redbridge University Hospitals NHS Trust
    Barts Health NHS Trust
    Care Quality Commission
    East London Health and Care Partnership
    London Ambulance Service NHS Trust
    NHS England
    NHS Improvement
    North East London Commissioning Support Unit
    North East London NHS Foundation Trust

    as well as any other NHS Trust or other body whose actions impact on the residents of two or more Outer North East London Boroughs;

    b. Co-operate with any other Joint Health Overview and Scrutiny Committee or Committees established by two or more other local authorities, whether within or without the Greater London area;

    c. Make reports or recommendations to any of the NHS bodies listed above and expect full, written responses to these;

    d. Require an NHS or relevant officer to attend before it, under regulation 6 of the Regulations, to answer such questions as appear to it to be necessary for the discharge of its functions in connection with a consultation;

    e. Such other functions, ancillary to those listed in a to d above, as the JHOSC considers necessary and appropriate in order to fully perform its role.

    Although efforts will be made to avoid duplication, any work undertaken by the JHOSC does not preclude any individual constituent borough Overview and Scrutiny Committee from undertaking work on the same or similar subjects

Co-optees

9. The JHOSC shall be entitled to co-opt any non-voting person as it thinks fit or appropriate to assist in its debate on any relevant topic. Each borough Healthwatch organisation for Barking & Dagenham, Havering, Redbridge and Waltham Forest shall be entitled to nominate one co-opted (non-voting) member of the JHOSC.The power to co-opt shall also be available to any Working Groups formed by the JHOSC.

Formation of Working Groups

10. The JHOSC may form such Working Groups of its membership as it may think fit to consider any aspect or aspects of its work. The role of such Groups will be to consider the matters referred to it in detail with a view to formulating recommendations on them for consideration by the JHOSC. The precise terms of reference and procedural rules of operation of any such Groups (including number of members, chairmanship, frequency of meetings, quorum etc) will be considered by the JHOSC at the time of the establishment of each such Group; these may differ in each case if the JHOSC considers it appropriate. The meetings of such Groups should be held in public except to the extent that the Group is considering any item of business from which the press and public could legitimately be excluded under the Access to Information legislation. The extent of available resources and the existence of relevant ongoing work at a borough level will also be considered by the JHOSC when considering whether to establish a working group.

Meetings of the JHOSC

11. The JHOSC shall meet formally at such times, at such places and on such dates as may be mutually agreed, provided that five clear days' notice is given of the meeting. The Committee may also meet informally as and when necessary for purposes including, but not limited to, visiting appropriate sites within the boroughs or elsewhere.

12. The JHOSC will meet on a minimum of four occasions per year with any variation to be agreed by the Committee. Meeting venues will normally rotate between the four Outer North East London boroughs.

13. Meetings shall be open to the public and press in accordance with the Access to Information requirements. No tape or video recorders, transmitters, microphones, cameras or any other video recording equipment shall be brought into or operated by any person at a meeting of the JHOSC unless the Chair of the meeting gives permission before the meeting (this exclusion will not apply to the taping of the proceedings by officers responsible for producing the minutes). When permission is given, a copy of any tape made must be supplied to the London Borough of Havering, in its role as Administrator.

Attendance at Meetings

14. Where any NHS officer is required to attend the JHOSC, the officer shall be given reasonable notice in advance of the meeting at which he/she is required to attend. The notice will state the nature of the item on which he/she is required to attend to give account and whether any papers are required to be produced for the JHOSC. Where the account to be given to the JHOSC will require the production of a report, then the officer concerned will be given reasonable notice to allow for preparation of that documentation.

15. Where, in exceptional circumstances, the officer is unable to attend on the required date, and is unable to provide a substitute acceptable to the JHOSC, the JHOSC shall in consultation with the officer arrange an alternative date for attendance.

16. The JHOSC and any Working Group formed by the JHOSC may invite other people (including expert witnesses) to address it, to discuss issues of local concern and/or to answer questions. It may for example wish to hear from residents, stakeholders and members and officers in other parts of the public sector and shall invite such people to attend.

17. The JHOSC shall permit a representative of any other authority or organisation to attend meetings as an observer.

Quorum

18. The quorum for the JHOSC shall be four, provided there is present at least one Member from at least three of the London borough OSCs. For meetings involving the writing or agreeing of a final report of the Committee, the quorum shall comprise at least one representative from each of the four London borough OSCs.

Chair and Vice Chair

19. Each meeting will be chaired by a Member from the host borough on that occasion.

Agenda items

20. Any member of the JHOSC shall be entitled to give notice to the Clerk of the Joint Committee that he/she wishes an item relevant to the functions of the JHOSC to be included on the agenda for the next available meeting. On receipt of such a request (which shall be made not less than five clear working days before the date for despatch of the agenda) the relevant officer will ensure that it is included on the next available agenda.

Notice and Summons to Meetings

21. The Clerk of the Joint Committee will give notice of meetings to all members. At least five clear working days before a meeting the relevant officer will send an agenda to every member specifying the date, time and place of each meeting and the business to be transacted, and this will be accompanied by such reports as are available.

22. Any such notice may be given validity by e-mail.

23. The proper officer of each Council shall ensure that public notice of the meeting is displayed in accordance with the customary arrangements of that Council for giving notice of Committee etc. meetings.

Reports from the JHOSC

24. Where required, for any reviews that require recommendations, the JHOSC will prepare a formal report and submit it to the relevant bodies. In accordance with the Department of Health Guidance on the Overview and Scrutiny of Health dated July 2003, the JHOSC should aim to produce a report representing a consensus of the views of its members. If consensus is not reached within the JHOSC, minority views will be included in the report.

25. In undertaking its role the JHOSC should do this from the perspective of all those affected or potentially affected by any particular proposal, plan, decision or other action under consideration.

Formal Consultations and Referrals to Secretary of State

26. Under guidance on Local Authority Health Scrutiny issued by the Department of Health in June 2014, only the JHOSC may respond to a formal consultation on substantial variation proposals covering health services in more than one constituent Council area. This power also extends to the provision of information or the requirement of relevant NHS officers to attend before the JHOSC in connection with the consultation.

27. The JHOSC may only refer matters directly to the Secretary of State on behalf of Councils who have formally agreed to delegate this power to it.

Procedure at JHOSC meetings

28. The JHOSC shall consider the following items of business:

(a) minutes of the last meeting;
(b) matters arising;
(c) declarations of interest;
(d) any urgent item of business which is not included on an agenda but the Chair, after consultation with the relevant officer, agrees should be raised;
(e) the business otherwise set out on the agenda for the meeting.

Conduct of Meetings

29. The conduct of JHOSC meetings shall be regulated by the Chair (or other person chairing the meeting) in accordance with the general principles and conventions which apply to the conduct of local authority committee meetings.

30. In particular, however, where any person other than a full or co-opted member of the JHOSC has been allowed or invited to address the meeting the Chair (or other person chairing the meeting) may specify a time limit for their contribution, in advance of its commencement which shall not be less than five minutes. If someone making such a contribution exceeds the time limit given the Chair (or other person chairing the meeting) may stop him or her.

31. The Chair (or other person chairing the meeting) may also structure a discussion and limit the time allowed for questioning by members of the JHOSC.

Officer Administration of the JHOSC

32. The London Borough of Havering will be the Lead Authority for clerking and administering the JHOSC. The Clerk of the Committee will be the Principal Committee Officer, London Borough of Havering. Costs of supporting the JHOSC will be shared, in proportion to their representation on the Committee, by the London Boroughs of Barking and Dagenham, Havering, Redbridge, Waltham Forest and by Essex County Council, in cash or in kind.

Voting

33. Members may request a formal vote on any agenda item by informing the Clerk of the Joint Committee at least five working days before a meeting. If it is not possible to give this notice, Members have the right to request a vote at a meeting itself, provided they explain to the meeting why it has not been possible to give the standard notice of this request. The decision on whether to allow a vote, if the standard notice has not been given, will rest with the Chairman of that meeting.

34. Any matter will be decided by a simple majority of those members voting and present in the room at the time the motion was put. This will be by a show of hands or if no dissent, by the affirmation of the meeting. If there are equal votes for and against, the Chair or other person chairing the meeting will have a second or casting vote. There will be no restriction on how the Chair chooses to exercise a casting vote. Co-opted members will not have a vote.

Public and Press

35. All meetings of the JHOSC shall be open to the public and press unless an appropriate resolution is passed in accordance with the provisions of Schedule 17 of the National Health Service Act 2006.

36. All agendas and papers considered by the JHOSC shall be made available for inspection at all the constituent authority offices, libraries and web sites.

Code of Conduct

37. Members of the JHOSC must comply with the Code of Conduct or equivalent applicable to Councillors of each constituent Local Authority.

General

38. These terms of reference incorporate and supersede all previous terms of reference pertaining to the JHOSC.

Work Programme 2023/24 *(This is a live document which is subject to late changes)*

Relevant Cabinet Member: Councillor Worby, Adult Social Care and Health Integration

Health Scrutiny Committee Chair: Councillor Paul Robinson			
Meeting	**Agenda Items**	**Officer/ Organisation**	**Deadline to send to Governance Services**
18 September 2023	Healthwatch report on Maternity Services (presentation) (Note: it may be helpful to add a general report on progress over last 12 months, and future goals until March 2024?)	Manisha Modhvadia, Healthwatch Lead	Monday 4 September
	Corporate Plan targets re health outcomes & inequality (e.g., healthy life expectancy) – ask Performance team to present on progress/ challenges / is this getting the right kind and level of investment. Winter Planning Minutes of the last JHOSC meeting	Neha Shah, Consultant in Public Health Sharon Morrow (NEL ICB)/ Susanne Knoerr (Operational Director, Adult's Social Care) Cllr Paul Robinson, Chair of Health Scrutiny Committee -	

	Minutes of the last NEL ICB meeting		
29 November 2023	Update on new 12 month shadow arrangements which launched from 26 June – review if this has improved accountability and engagement? DRAFT HSC Review Report on The Potential Voluntary Sector Community Diagnostic Centre (is this on track?) Minutes of the last JHOSC meeting Minutes of the last NEL ICB meeting	Fiona Taylor (Accountable Officer for Place), jointly with NHS representatives Rhodri Rowlands, Director of Community Participation and Prevention Anne Hepworth, BHRUT Cllr Paul Robinson, Chair of Health Scrutiny Committee -	Monday 13 November
7 February 2024	NELFT CQC inspection – progress update Minutes of the last JHOSC meeting Minutes of the last NEL ICB meeting	Melody Williams, Integrated Care Director, NELFT Cllr Paul Robinson, Chair of Health Scrutiny Committee -	Monday 22 January

27 March 2024	Screening – cervical, breast, bowel, lung (this is a check) cancer? Minutes of the last JHOSC meeting Minutes of the last NEL ICB meeting	Cancer Alliance – (Matthew Cole to coordinate) Cllr Paul Robinson, Chair of Health Scrutiny Committee -	Monday 11 March
5 June 2024	Community Diagnostic Centre – update Minutes of the last JHOSC meeting Minutes of the last NEL ICB meeting	Anne Hepworth, BHRUT Cllr Paul Robinson, Chair of Health Scrutiny Committee -	Monday 20 May

Notes:

TBC – Healthwatch upcoming projects/priorities

ICB programme of planned service changes?

Chris Bush – changes to Adult Social Care services

Next year- heart disease

Health Inequalities Programme- to be scheduled in six months' time from 24 May 2023 (following the presentation of the item to this Committee).

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