Barking & Dagenham

Notice of Meeting

HEALTH SCRUTINY COMMITTEE

Wednesday, 7 February 2024 - 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

Date of publication: 30th January 2024

Fiona Taylor
Chief Executive

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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 29th November 2023 (Pages 3 - 8)**

4. **Scrutiny Review into the potential of the Voluntary and Community, Faith and Social Enterprise (VCFSE) Sector (Pages 9 - 43)**

5. **NELFT CQC inspection - progress update (Pages 45 - 65)**

6. **CQC Report on Together First (Pages 67 - 86)**

7. Joint Health Overview and Scrutiny Committee

The agenda reports pack and minutes of the last meeting of the Joint Health Overview and Scrutiny Committee can be accessed via: Browse meetings - Joint Health Overview & Scrutiny Committee | The London Borough Of Havering

8. Work Programme (Pages 87 - 88)

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

10. 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.***

11. 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, 29 November 2023
(7:02 - 9:02 pm)

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

Also Present: Cllr Maureen Worby

Apologies: Cllr Manzoor Hussain

21. Declaration of Members' Interests

There were no declarations of interest.

22. Minutes (18 September 2023)

The minutes of the meeting held 18 September 2023 were confirmed as correct.

23. Appointment of Tony Chambers as Interim Chief Executive

The Chief Executive (CE) of Barking, Havering and Redbridge University Trust (BHRUT) provided a verbal update on the appointment of Tony Chambers as Interim Chief Executive BHRUT following the investigation and subsequent sentencing of Lucy Letby.

The CE advised that throughout the multi-stage recruitment process for Tony Chambers, all measures were followed regarding the interview and pre-employment procedures, however there were no findings in relation to misconduct during his time at Chester Hospital (CH). Amongst the 11 applicants for the post, four applicants were shortlisted and interviewed, including Tony Chambers who briefly mentioned his experience and some of the challenges he faced at CH.

Tony Chambers' experience at BHRUT was dominated by Covid-19, with him being only ten weeks in-post when the pandemic began. There had been an external review on the key decisions regarding safety and equality during the time of his appointment, for which there had been a clear governance process and there were no concerns raised. In April 2020, a whistleblowing measure was put in place as an independent guardian policy for staff who were potentially concerned that their issues were not dealt with effectively. Issues raised in relation to management, safety, work and bullying increased between April to October 2020, which signified a positive trend as staff openly proceeded with complaints without anonymisation. This worked to support a changing BHRUT workplace culture as staff could attempt to resolve issues before escalation.

The appointment of CE and Directors was also discussed. In line with the Fit and Proper Persons framework, there was transparency across an individual's career at BHRUT. From pre-employment checks, appraisals, references, exit interviews, enhanced DBS checks and a formal completion of assessment, all senior staff experienced the same procedures. A leader competency framework was also in

place; also based on transparency, the CE commented that Tony Chambers would have met the Trust standards today, although based on the media, his image was flawed.

The criminal trial focussed on the actions of Lucy Letby and did not analyse the conduct of the NHS Trust and therefore, media coverage on the topic of conduct was highly speculative.

A series of questions were asked to the CE BHRUT regarding their responses and reflections on the Letby case. On a question on the Trust's plans for prevention of such cases in the future, the CE suggested that the Letby case was considered an isolated case which was not ideal to inform policy changes. He also ensured that there were no characteristics which would have indicated that Letby was involved in such criminal activity, where it was further noted that the potential role of race could have misinformed the response of the Senior Leadership Team at CH.

The CE outlined the progress of policy change in response to a question on rebuilding trust from the perspective of the public. A focus on behavioural characteristics alongside seeking external critical reviews and independent bodies of scrutiny would be used to improve transparency and responses to future cases. It was highlighted again that there was no concern surrounding the Trust's decision at the time of Lucy Letby's employment at CH.

The CE stressed the importance of the clinical voice in leadership especially where data is involved. It was noted that the public board published positive information on factors such as mortality rates in both Queen's Hospital (QH) and King George's Hospital (KG), both of which performed well. Other trends regarding pressures on the Emergency Department in hospitals had been address and there were several positive changes made, which in turn contributed to reducing waiting times at KG. Such improvements represented BHRUT's ongoing progress following policy changes.

A question was asked regarding the NHS England Fit and Proper Persons Framework for board members, and whether issues around bullying were considered on the risk register. The CE mentioned that as part of the NHS open environment principle, all staff were actively involved in a training programme to manage situations should concerns arise. Following this, a Member raised a question regarding the increase in staff raising concerns using the existing guardian policy and grievance policy in place. It was noted that in consideration of the large scale of the organisation, the number of cases was not problematic, nor should actions be taken to reduce it at the time. All staff were encouraged to follow the implemented procedures should they raise any concerns about the workplace, although staff were also given active bystander training which dealt with issues without engaging in the formal procedure.

A further question was asked in relation to staff wellbeing at BHRUT, and the support measures in place to maintain a standard of welfare amongst staff. With increases in staff raising concerns about the workplace, the CE mentioned that staff were less willing to so do if bullying was experienced with senior staff. The CE explained that whilst it was difficult to change the culture in an organisation, it continued to be a work in progress. Interventions included dismissals for inappropriate behaviour; targeted action for some areas; and improving the staff

survey response rate which displayed improvements more recently. Other support services included formal therapy for staff, as well as supervision and more security staff to support staff, especially on the frontline. Examples included an increase in security staff at KG from two to four staff for frailty services in the Emergency Department and reductions in abusive interactions between sonographers and the public in the Maternity ward as a result.

The CE was asked for information on further areas for improvement at BHRUT. Improvements at both QH and KG were outlined; changes to specialist services, a virtual ward for care and support for the elderly and reduced waiting and admission times at KG were highlighted. Following the previous Care Quality Commission inspection which rated KG as 'inadequate', the interventions placed contributed to the most recent inspection which suggested significant improvement had been made with a high standard of clinical care and outstanding patient feedback. Other interventions such as reducing agency staff had aided the retention of staff, thus improving productivity and efficiency among the workforce. This allowed for the progression of staff instead of having restricted roles on certain pathways at the Trust.

The CE also encouraged the idea that more services should be introduced in Barking Community Hospital or shopping centre facilities for better accessibility amongst the wider community. This would consequently reduce the strain on hospitals as the pressure on services resulting from higher cancer rates being identified post-pandemic, for example, would require staff to work harder and longer hours.

The Committee noted the update.

24. Community Diagnostic Centre

The Chief Operating Officer (COE), BHRUT, the Clinical Cancer Lead (CLL) and the Programme and Service Development Lead – Community Diagnostics (PSDL), presented a report on the progress of the new Community Diagnostics Centre (CDC) at Barking Community Hospital (BCH).

As part of a national programme since the beginning of the pandemic, CDCs were to be introduced as a means to increase the capacity for patient investigations. By working with community providers for staff and facilities, alongside gaining funding to carry out the project, the development of this innovative service would work to reduce delays for patient services. Especially as a Borough which does not have an acute hospital to support its growing population would contribute to a 21% increase in demand for services, this would reduce deprivation levels overall, by contributing to the reduction of health inequalities in the Borough.

The PSDL highlighted the importance of engagement with the local population who supported the development of the CDC. Their suggestions were considered throughout the development and reflected the needs of service users in the Borough.

As a result of service user feedback, the BCH CDC would include:

- Free parking for patients;
- Calm pastel and pale colours throughout to make it more relaxing for all

patients;
- Floor to ceiling windows;
- Ramps, lifts and accessible changing rooms run throughout, and all patient services available on ground floor;
- Landscaped outdoor space;
- Increasing ways to book appointments;
- Staff to be trained on how to communicate with all patients; and
- Continuous improvement of care and experience gathered through patient and staff survey before and after the CDC opens

With various facilities at the CDC, the PSDL explained that an extra 72,000 scans would be possible every year. Scanning equipment such as MRI, CT and ultrasound would be housed at the CDC alongside consultation rooms for a range of other tests. Early diagnoses for some cancer types would also be available as well as innovative tests such as cystosponge, colon capsules, transnasal endoscopy and a rapid asynchronous triage clinic for oral lesions. Included with this were public facilities for waiting and changing and hearing induction loops for patients with hearing impairments. Such advancements would also provide job opportunities amongst the local population, for example, where nursing staff would benefit from an expanded scope of practise when the CDC opened.

The progress of the CDC for 2024 was then outlined. Whilst the BCH CDC would open in Spring 2024, there would be ongoing engagement with stakeholders, patients and staff including site visits and a patient trial run in order to understand their first-hand experience at the centre. Furthermore, there would be collaboration with Healthwatch on accessible information standards training for staff to further improve patient care. The opening of a new CDC in St George's (Hornchurch) embedded in the St George's Health and Wellbeing Hub was proposed.

On a question regarding staff communication with patients of differing abilities, the PSDL explained that all staff would be trained to communicate effectively with patients to give them the best experience during their visits. The use of accessible information with posters, portable hearing booths for deaf patients and interpreting services would be available for patients who faced a language barrier due to not speaking English. A question following up on communication services was brought forward, regarding whether frontline staff were trained in interpreting skills or British Sign Language (BSL), for example. It was highlighted that external providers would provide services, for both BSL and telephone interpreting for referral patients with language barriers due to the short appointment times that the CDC would enable. A member suggested that staff demographic based on diversity and equality would be beneficial, not only for the staff but also as a cost-effective means for interpreting services for patients facing a language barrier.

In consideration of patients with learning disabilities, it was noted that one-and-a-half years ago, a system was put in place to identify such patients to ensure they received proper care in collaboration with the learning disabilities team as a means to reduce health inequalities.

In response to questions regarding the appointment booking system, specifically for groups such as the elderly who may be technologically excluded, the PSDL explained that various methods of communication were available for patient use; these included already existing e-referrals, a patient call service, email system and an online booking system which would be introduced in the future. It was

recognised that in order to create connections and maximise engagement with patients, Do Not Attends (DNAs) were monitored frequently and a need to push for telephone communications to discuss appointments instead of automatic text messages was desirable.

The CLL was asked about the range of cancer diagnoses that were tested at the CDC, and whether these were inclusive of factors such as age, cancer type or gender.. The CLL outlined that breast, prostate and lung cancers were increasingly identified at Stage 1 and Stage 2 from patient screening services. Contributory to this was the targeted lung health checks within the Borough which promoted screening for a quicker diagnosis. The CDC enabled a secondary preventive measure which focused on the top five cancers in the Borough. The importance of world-class technology was indeed costly, however effective where the CDC could provide a cancer diagnosis within 7-10 days in comparison to the standard 28-day time frame. In relation to this, a Member asked why only some cancer types were detectable at the CDC. The CLL explained that some cancer types were commonly detectable at a later stage, such as pancreatic cancer, so the CDC as a means of early diagnosis was not applicable. On the other hand, blood cancer was diagnosed with blood tests, so patients would be diverted to haematology clinics at acute hospital sites. Other cancers would require sedation or other interventions which may not be facilitated at the CDC.

Further, the CDC's proposed for an extra 72,000 scans per year was raised. In consideration of the pressure on staff, the COE suggested that selective staff would be recruited to deliver services, where a phased roll out of additional staff would improve efficiency for the CDC. Throughout the CDC, the COE and PDSL stressed the value of recruiting local staff to further develop the Borough. However, a question was then raised on the available staff training to meet the expectations of the increased capacity for services across old and new CDCs. The CLL highlighted that a radiology academy would be in place to improve training for junior staff; by encouraging staff to rotate between sites and use different facilities, these experiences helped to create better patient services as staff are well-developed on programmes which provide a breadth of insight into various departments. This would also help to generate a new workforce amongst the local population.

The Committee noted the report.

(Standing Order 7.1 (Chapter 3, Part 2 of the Council Constitution) was suspended at this juncture to enable the meeting to continue beyond the two-hour threshold).

25. Joint Health Overview and Scrutiny Committee - 19th October 2023

The minutes of the last Joint Health Overview and Scrutiny Committee (JHOSC) were noted.

26. Minutes of the last HWBB/ICB (Committees in Common) meeting - 12 September 2023

The minutes of the last Health & Wellbeing Board and ICB Sub-Committee were

noted.

27. Work Programme

The Committee requested that a report on the impact of the financial savings due to be considered by the ICB be presented to the next meeting of the Committee.

The work programme was noted.

HEALTH SCRUTINY COMMITTEE

7 February 2024

Title: Scrutiny Review into the potential of the Voluntary and Community, Faith and Social Enterprise (VCFSE) Sector	
Report of: Director of Community Participation and Prevention	
Open Report	**For Decision**
Wards Affected: None	**Key Decision:** No
Report Author: John Dawe, Senior Governance Officer	**Contact Details:** Tel: 020 8227 2135 E-mail: john.dawe@lbbd.gov.uk
Accountable Director: Rhodri Rowlands, Director of Community Participation and Prevention	
Accountable Strategic Leadership Director: Fiona Taylor, Chief Executive	

Summary

The Health Scrutiny Committee agreed to undertake an in-depth scrutiny review into the Voluntary and Community, Faith and Social Enterprise (VCFSE) Sector's provision of health inequalities work within communities and the ways in which the Council can contribute to a helpful work environment, enabling the VCFSE to play an active role in service delivery.

This report provides an update on the progress of the review and presents the final draft for comment and approval.

Recommendation(s)

The Health Scrutiny Committee is recommended to:

1. Agree the final report and the recommendations contained within,
2. Ask the Director of Director of Community Participation and Prevention to develop an Action Plan describing how the recommendations will be implemented, and
3. Receive an update report on progress in six months.

Reason(s)

The Health Scrutiny Committee must agree the final review to enable an action plan to be developed.

1. Introduction and Background

1.1 At the meeting of the Committee on 21 September 2022, the Chair presented a draft work programme for 2022/23, following previous discussions with the Director of Public Health, the Operational Director for Adults Social Care and the Cabinet Member for Social Care and Health Integration (now Adult Social Care and Health Integration), as to what the priorities should be for the year. In approving the work programme, Members agreed to undertake an in-depth scrutiny review into the Voluntary and Community Sector's provision of health inequalities work within communities and the ways in which the Council can contribute to a helpful work environment, enabling them to play an active role in service delivery. (Minute 53 refers).

1.2 Members considered various areas which could be considered as part of the Review which included:

2. Terms of Reference for the Scrutiny Review

2.1 The Committee agreed the following Terms of Reference for the Review, in addition to which a number of key lines of enquiry were developed and agreed as set out in italics below:

How is the VCFSE helping to reduce health inequalities within communities, both separately and in partnership with the statutory sector?

- *What is the unique role of the VCFSE in improving health and wellbeing (i.e. how does it differ to statutory services, how can it compliment statutory services, what can it do that statutory services cannot),*
- *When should or shouldn't the statutory sector (local authority and NHS) partner with the community sector (i.e., it is not there to deliver statutory service on the cheap), and*
- *Within those appropriate functions, what is the VCFSE currently doing and what is it not doing to improve health, prevent ill health, improve outcomes for those with health conditions and reduce health inequalities.*

How can we (the Council) work better at 'place' (Barking and Dagenham) and sub-borough levels to ensure that the VCFSE and residents have an active and meaningful role in informing and shaping future strategy / service delivery?

- *What are the enablers and barriers for the VCFSE in undertaking this work (e.g., the "V" in VCFSE does not mean it comes for free as resources are required),*
- *What is working to enable and empower VCFSE organisations and reduce barriers, and how can these be scaled up, and*
- *What levels (e.g., borough, locality, and community) is this support required and how can it best be delivered.*

2.2 These questions were to be asked with a view to making recommendations around what the statutory and VCFSE partners could do in the near future to realise opportunities and remove barriers.

2.3 During the discussions, the Chair formed the view that it was also very important to consider what the Partnership could do to ensure equitable and early access to health services; however, as the Review would need to be concluded in this municipal year (2023/24), it was felt that to include this issue as part of the Review would not be feasible in terms of time and resources. It is therefore suggested that this matter be further reviewed as part of the development of the action plan.

3. Process

3.1 In accordance with standard practice a project plan was drawn up, and forming part of the scrutiny review process, Members were required to attend a number of fact-finding sessions outside of the Committee's formal meetings structure, to collate sufficient information to answer the Review's terms of reference. This included separate sessions with statutory health partners and voluntary and community sector partners, as detailed in the final scrutiny report.

4. Recommendations

4.1 The Review has now concluded, and the following recommendations are being proposed:

Continue to foster relationship with the voluntary and community sector and social enterprise (VCFSE) that focuses on commissioning, collaborating and co-designing together.

1. Consideration to be given in all commissioned services / tenders to the qualitative evidence on overall impact on individuals and communities e.g. via case examples and stories.

2. Work with civil society groups to facilitate more consortium approaches to funding bids that promote collaboration rather than competition and increase reach and breadth of the VCFSE contribution.

3. Commit to using the community locality leads model as a platform to draw learning and to help shape the emergent locality model being developed by council and partners.

Developing community capacity and connections.

4. Review existing grant and commissioned funding to ensure its reach is fair and supports the contribution and role of the VCFSE in addressing health Inequalities.

5. Work with the VCFSE sector to develop clear and shared consensus of the role of the sector in co-design and delivery of system priorities e.g. the emergent locality model.

6. Commit to utilising the VCFSE sector to support activity aimed at increasing voice and reach of services to seldom heard.

Sharing information across the VCFSE.

7. Establish training sessions for groups across the Borough to upskill and build capacity in bid writing.

8. Ensure that bid applications only ask the questions that need directly answering, reducing the time and resources required for groups to spend on drafting them.

9. Ensuring the VCFSE sector are aware of key developments within health and care and are able to respond appropriately.

Developing common culture and language.

10. Establish joint training sessions and working groups between the VCSE sector, NHS, and the Council to allow for genuine collaboration and to develop stronger relationships between organisations.

11. Ensure VCFSE representation in co-design and subsequent implementation of Barking and Dagenham Committee in Common (Place Partnership) Engagement Strategy and Co-Production principles.

Ensuring longevity of funding.

12. Contracts should aim to allow time for the VCSE to create sustainable workstreams where staff members can develop projects before funding is cut prematurely.

5. Next Steps

5.1 If the recommendations are accepted, the Director of Community Participation will be asked to draw up an Action Plan describing how the recommendations will be implemented. This report will be shared with the Cabinet Member for Adult Social Care and Health Integration and the Voluntary Community and Faith Social Enterprise (VCFSE) as it is now known and referred to in the final report.

5.2 In six months' time, the Health Scrutiny Committee will request a monitoring report setting out the progress of the implementation of the recommendations and whether anything could be said of the early impact they have had on outcomes.

6. Consultations

6.1 In addition to consultation with officers and the Cabinet Member for Adult Social Care and Health Integration, the VCFSE were consulted and provided input to the final report as presented. Whilst the outcomes and recommendations arising from the review were supported by the sector and reflected feedback and input, one of the learning points for any future reviews is to ensure a full co-designed approach is taken from the outset to maximise mutual benefit and buy-in.

7. Legal Implications

Implications completed by: Dr Paul Feild Principal Governance Solicitor

7.1 The Health Scrutiny Committee 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 terms of reference establish its function to ensure that the providers of health and social care services work in their delivery in an integrated manner.

7.2 The Health and Social Care Act (2012) conferred the responsibility for health improvement to local authorities. In addition, as a best value authority under the Local Government Act 1999 there is a duty on the Council to secure continuous improvement.

7.3 The Equality Act 2010 outlaws certain discrimination against persons with the following protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation. The Equality Act 2010 requires the local authority to observe the public sector equality duty in the exercise of its functions, having due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

7.4 The report and its recommendations advance the delivery of the legal duties on the Council and its partners to improve the health and wellbeing of the local community.

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

List of appendices: Draft final in depth scrutiny review by the Health Scrutiny Committee into better supporting the Voluntary and Community Sector to play an active role in service delivery.

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Scrutiny Review 2024

Barking & Dagenham

An in-depth scrutiny review by the Health Scrutiny Committee into better supporting the Voluntary and Community Sector to play an active role in service delivery.

Foreword by Councillor Paul Robinson, Chair of the Health Scrutiny Committee

The Health Scrutiny Committee is one of two scrutiny committees of the London Borough of Barking and Dagenham. The Committee scrutinises health and social care outcomes for the Borough's residents to improve outcomes. We do this by working with partners to improve services and hold decision makers to account.
This year as the Chair of the Committee, I oversaw an extensive scrutiny review into how the Council and its partners can better support the Voluntary and Community, Faith and Social Enterprise (VCFSE) Sector and enable the sector and residents to have a more meaningful role in shaping future strategy/service delivery. The VCFSE plays an integral role in delivering health and care services for residents (both independently and on behalf of the NHS and local councils) and its importance, value and support to residents cannot be underestimated.

Health inequalities between wealthy and deprived areas are longstanding and worsening in England as a whole. It is of particular note that Barking and Dagenham has amongst the greatest health inequalities in North East London (NEL), London and England. However, health inequalities by their very definition are avoidable, unfair and systemic differences in health between different groups of people.
As Integrated Care Systems (ICS) are now responsible for planning and funding health and care services and as health inequalities continue to worsen in Barking and Dagenham due to factors such as the COVID-19 pandemic and the cost-of-living crisis, I regard this review as timely.

During the course of the review, the Committee met with representatives of the VCFSE to discuss their role in supporting residents and tackling health inequalities, to hear about the barriers as they perceived them to the wider system of joint working through the BD Collective, as well as what improvements and support, in their view, were needed. The Committee also learnt about a number of community-based health projects making a real difference to local communities and residents. There were also separate discussions with statutory health services partners to gain a greater understanding of the challenges they faced and how working with the VCFSE could be improved.

In conclusion, I hope that the recommendations from this review can build upon recent ICS governance changes, to enable the VCFSE and residents to have a greater voice in tackling local health issues.

Finally, I would like to thank all those persons who have contributed to this review including in particular Elspeth Paisley, Community Resources Health Lead and Member of the BD Collective along with others from the voluntary sector and our health partners, together with all the Members of the Health Scrutiny Committee, the Cabinet Member for Adult Social Care and Health Integration and those officers who presented evidence and contributed to the report.

Councillor Paul Robinson
Chair of Health Scrutiny Committee

Members of the Health Scrutiny Committee 2022/23 and 2023/24

The Health Scrutiny Members who carried out this review were:

Cllr Paul Robinson (Chair)

Cllr Donna Lumsden (Deputy Chair)

Cllr Irma Freeborn

Cllr Muhib Chowdhury

Cllr Michel Pongo

Cllr Manzoor Hussain

Cllr Chris Rice

Contents

List of Recommendations arising from this Review

For ease of reference, the recommendations are set out below. The Committee as part of good scrutiny practice, will receive a monitoring report on the progress of all the recommendations approximately six months after the report is complete and shared with stakeholders and specific actions are developed as appropriate in response to the recommendations.

For ease of reference, the key recommendation themes and initial high-level actions arising from this Review are provided below **under 5 key headings**.

The Health Scrutiny Committee (HSC) recommends:

Continue to foster relationship with the voluntary and community sector and social enterprise (VCFSE) that focuses on commissioning, collaborating and co-designing together

1. Consideration to be given in all commissioned services / tenders to the qualitative evidence on overall impact on individuals and communities e.g. via case examples and stories.

2. Work with civil society groups via the BD Collective (which includes all the infrastructure organisations to facilitate more consortium approaches to funding bids that promote collaboration rather than competition and increase reach and breadth of the VCFSE contribution.

3. Commit to working with the community locality leads model as a platform to draw learning and to help shape the emergent locality model being developed by the Council and partners.

Developing community capacity and connections

4 Review existing grant and commissioned funding to ensure its reach is fair and supports the contribution and role of the VCFSE in addressing health inequalities.

5 Work with the VCFSE sector to develop clear and shared consensus of the role of the sector in co-design and delivery of system priorities e.g. the emergent locality model.

6 Commit to utilising the VCFSE sector to support activity aimed at increasing voice and reach of services to seldom heard.

Sharing information across the VCFSE

7 Establish training sessions for groups across the Borough to upskill and build capacity in bid writing.

8 Ensure that bid applications only ask the questions that need directly answering, reducing the time and resources required for groups to spend on drafting them.

9 Ensuring the VCFSE sector are aware of key developments within health and care and are able to respond appropriately and together discover and shape the best way to do this.

Developing common culture and language

10 Establish joint training sessions and working groups between the VCFSE sector, NHS, and the Council to allow for genuine collaboration and to develop stronger relationships between organisations, inviting the VCFSE to lead when and where appropriate.

11 Ensure VCFSE representation in co-design and subsequent implementation of Barking and Dagenham Committee in Common (Place Partnership) Engagement Strategy and Co-Production principles.

Ensuring longevity of funding

12 Contracts should aim to allow time for the VCFSE to create sustainable workstreams where staff members can develop projects before funding is cut prematurely.

1. Background to the Review

Why did the Health Scrutiny Committee choose to undertake an in-depth review on the potential of the Voluntary and Community Sector?

1.1 The Council's scrutiny committees decide what topic to undertake an in-depth review on based on the **'PAPER'** criteria. The section below explains why according to these criteria 'the potential of the Voluntary and Community Sector' was a good topic to review:

PUBLIC INTEREST	Health inequalities are avoidable, unfair and systematic differences in health between different groups of people. Health inequalities are longstanding and worsening in England (e.g., the health gap is growing between wealthy and deprived areas, improvements in life expectancy have stalled for men and declined for women in the most deprived areas)[1]. It is particular note that Barking and Dagenham has amongst the greatest health inequalities in North East London (NEL), London and England. The VCFSE plays an integral role in delivering health and care services for local residents (both independently and on behalf of the NHS and local councils) and its importance, value and support to residents cannot be underestimated. As Integrated Care Systems (ICS) become responsible for planning and funding health and care services (from 1 July 2022) and as health inequalities continue to worsen in Barking and Dagenham due to factors such as the COVID-19 pandemic and the cost-of-living crisis, a review into how the Council and its partners can best support the VCFSE and enable the sector and residents to have a more meaningful role in shaping future strategy/service delivery is timely. Under the Public Sector Equality Duty outlined by the Equalities Act 2010, the Council also has a duty to advance equality of opportunity for all residents.	✓

[1] February 2020, Institute of Health Equity, Health Equity in England: The Marmot Review 10 Years On.

ABILITY TO CHANGE	Whilst positive work is underway to amplify the voices of local residents and the VCFSE, as well as to increase partnership working, it is clear that much more still needs to be done to address health inequalities within the Borough. Alongside recent ICS governance changes, the recommendations presented in this Review can be used by the VCFSE and residents to enable a greater voice in tackling local health issues.	✓
PERFORMANCE	Health inequalities and life outcomes continue to worsen within the Borough. The Health Scrutiny Committee wished to investigate the actions that both the Council and its partners could take to improve the life outcomes of its residents, as well as to best support the VCFSE and amplify the positive work that it is undertaking.	✓
EXTENT OF THE ISSUE	It is clear that health inequalities disproportionally affect residents living in Barking and Dagenham, and that there is a great need to continually consider how best to address these and improve partnership working in order to improve the life outcomes of our residents.	✓
REPLICATION	Whilst the means of best addressing health inequalities and how to improve partnership working have been under monitor and review internally, the Health Scrutiny Committee felt it was necessary to provide an overview of the current context, positive work that has already been undertaken and to provide a platform for itself, partners and the VCFSE to best work together in future.	✓

2. Scoping and Methodology

2.1 Scoping

2.1.1 This section outlines the scope of the review which includes the areas the Health Scrutiny Committee wished to explore and the different methods used to collate evidence for potential recommendations.

2.1.2 Having received a scoping report at its meeting on 14 November 2022, the Health Scrutiny Committee agreed the following key lines of enquiry:

(i) How is the VCFSE helping to reduce health inequalities within communities, both separately and in partnership with the statutory sector?

- What is the unique role of the VCFSE in improving health and wellbeing (i.e., how does it differ to statutory services, how can it compliment statutory services, what can it do that statutory services cannot),
- When should or shouldn't the statutory sector (local authority and NHS) partner with the community sector (i.e., it is not there to deliver statutory service on the cheap), and
- Within those appropriate functions, what is the VCFSE currently doing and what is it not doing to improve health, prevent ill health, improve outcomes for those with health conditions and reduce health inequalities.

(ii) How can we work better at 'place' (Barking and Dagenham) and sub-borough levels to ensure that the VCFSE and residents have an active and meaningful role in informing and shaping future strategy / service delivery?

- What are the enablers and barriers for the VCFSE in undertaking this work (e.g. the "V" in VCFSE does not mean it comes for free as resources are required),
- What is working to enable and empower VCFSE organisations and reduce barriers, and how can these be scaled up, and
- What levels (e.g. borough, locality, and community) is this support required and how can it best be delivered.

2.2 Overview of Methodology

2.2.1 The review gathered evidence during the Committee's meetings. Details of stakeholders and their contributions to this review are outlined below:

19 December 2022

Overview presentation from Rhodri Rowlands, Director of Community Participation and Prevention: National and local health context, the existing VCFSE landscape in Barking and Dagenham, strategic context and outcomes for action.

15 March 2023

First Evidence Gathering Session with VCFSE Partners:

- Community Resources
- Dagenham and Redbridge Football Club Community Trust
- Ekota Academy
- Future Molds Communities
- Harmony House
- Lifeline Projects
- St Chads

3 April 2023

Second Evidence Gathering Session with Health Partners:

- Adults' Services, London Borough of Barking and Dagenham
- Clinical Care Director, Barking and Dagenham Place-Based Partnership
- North East London Integrated Care Board (NEL ICB)
- North East London Local Pharmaceutical Committee (NEL LPC)
- North East London NHS Foundation Trust (NELFT)

11 July 2023

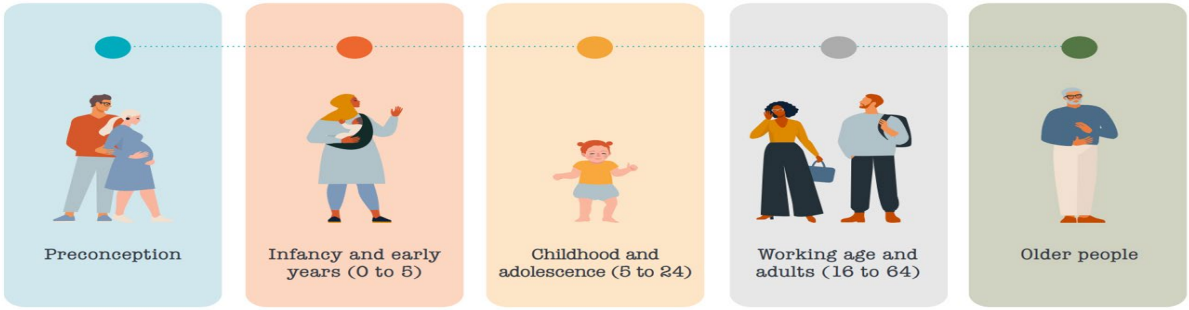
Third Evidence Gathering Session with VCFSE Partners including:

- LBBD Members
- Adults' Services, LBBD
- Public Health, LBBD
- Community Resources
- Thames Life
- Harmony Community Project
- St Chads
- Independent Living Agency

3. Introduction

What do we mean by health inequalities and why are these important to address?

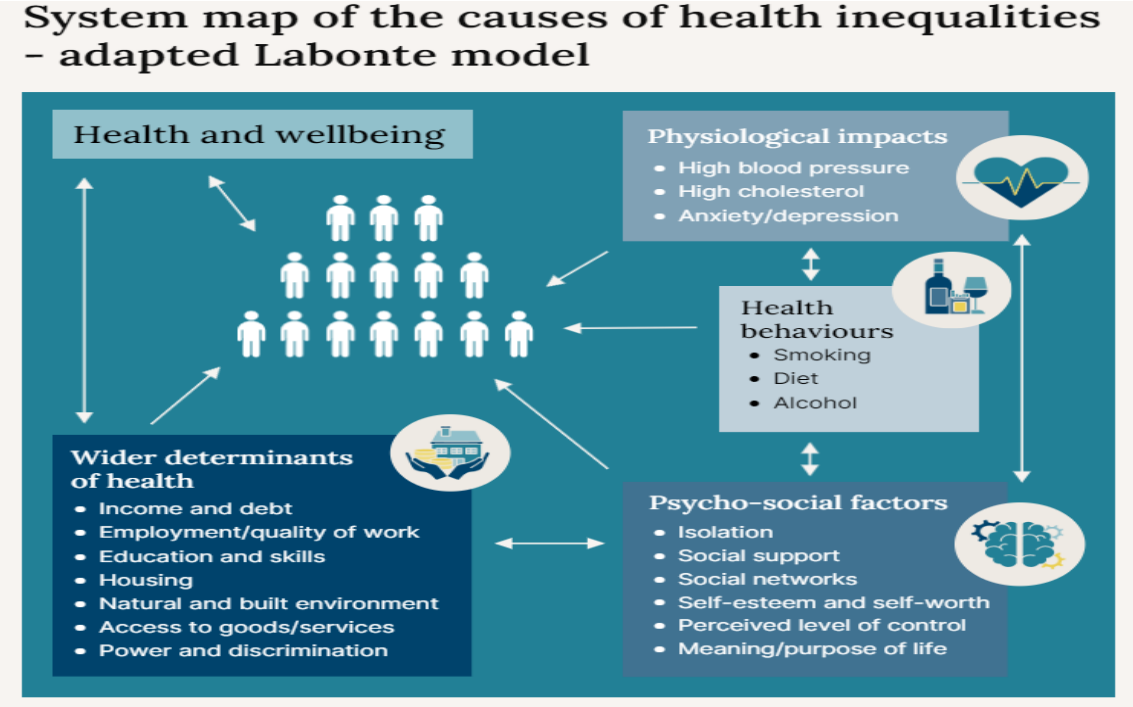
3.1 Health inequalities are avoidable, unfair and systemic differences in health between different groups of people. It can be a broad term, in that it refers to unjust differences in overall health outcomes, measured by, for example, life expectancy or healthy life expectancy (HLE) – the number of years an individual can expect to live in "full health" by taking into account years lived in poor health – as well as contributing factors to health.



	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

3.2 The above diagram identifies stark health inequality for B&D residents in all contributors of health and wellbeing in comparison to London figures. In relation to services, health inequalities are impacted by individuals' access, experience and outcomes of the service, relative to their needs. Behavioural risks may further impose health inequalities – smoking, alcohol consumption, diet and physical activity (lack of) are included in this. It is evident that B&D performs much worse in the latter two behavioural risks, as shown in the diagram.

3.3 Health outcomes are greatly influenced by social determinants of health; these include social, economic and environmental factors. The exposure of inequality within these factors consequently contributes to health inequalities amongst the population. Below is an adapted Labonte model displaying the causes of such health inequalities – this model which is also used by the UK Government neatly maps the causes of health inequalities.[2]



[2] NICE NICE and health inequalities | What we do | About | NICE

3.4 The King's Fund notes that health inequalities can include differences in:

- Health status, for example, life expectancy;
- Access to care, for example, availability of given services;
- Quality and experience of care, for example, levels of patient satisfaction;
- Behavioural risks to health, for example, smoking rates; and
- Wider determinants of health, for example, quality of housing[3].

3.5 Furthermore, it notes that health inequalities can also be experienced by individuals grouped by a range of factors, such as:

- Socio-economic factors, for example, income;
- Geography, for example, region or whether urban or rural;
- Specific characteristics including those protected in law, such as sex, ethnicity or disability; and
- Socially excluded groups, for example, people experiencing homelessness.

3.6 These often overlap, meaning individuals may experience a combination of the above factors, and this can compound the severity of the health inequalities experienced. It is important to note that no experience is universal; for example, not all individuals living in unstable housing conditions will experience the same health needs and outcomes. Nonetheless, at a population level, certain risk factors, such as smoking and disadvantages such as poor-quality housing or being of a racially minoritized group, are closely linked to poor health outcomes and such drivers often intersect. Structural inequalities will overlap and compound, particularly, as the stark disparities in the impact of the Covid-19 pandemic between different ethnic groups showed, the dynamic between ethnicity, racism, and deprivation[4].

3.7 Estimates of the factors around health frequently place great emphasis on the social determinants of health. Whilst the exact percentage in different analyses of the relative contribution of the determinants may differ, all are agreed that health services, or clinical care, make a lesser contribution to overall health, frequently cited to be 20% of what makes health.[5] It follows that the factors that contribute most to health inequalities follow a similar pattern; inequities in quality and access to healthcare are significant, but socio-economic factors explain health inequalities more. The European Health Equity Status Report by the World Health Organisation concluded that income insecurity is the largest contributor to health inequalities, and consistently contribute to the largest portion of the gap in people's self-reported health, mental health and life satisfaction.[6]

[3] What are health inequalities? | The King's Fund (kingsfund.org.uk)
[4] Nuffield Trust (2022) Review of the Mayor of London's Health Inequalities Test 1667818147_nuffield-trust-mayor-of-london-s-health-inequalities-test-web.pdf (nuffieldtrust.org.uk)
[5] LGA (2016) Health in all policies: a manual for local government health-all-policies-hiap--8df.pdf (local.gov.uk)
[6] WHO (2019) Healthy, prosperous lives for all: the European Health Equity Status Report Healthy, prosperous lives for all: the European Health Equity Status Report (who.int)

3.8 More recently health inequalities have been exacerbated by the COVID-19 pandemic and the cost-of-living crisis. Whilst much positive work has already been undertaken to address this, continued action is needed to ensure that individuals have the best possible life chances and outcomes. The additional strain of the rising cost of living means the need to ensure that action on the social determinants of health alongside sufficient healthcare provision and services for health and wellbeing that work best for residents only grows more imperative.

4 Health in Barking and Dagenham

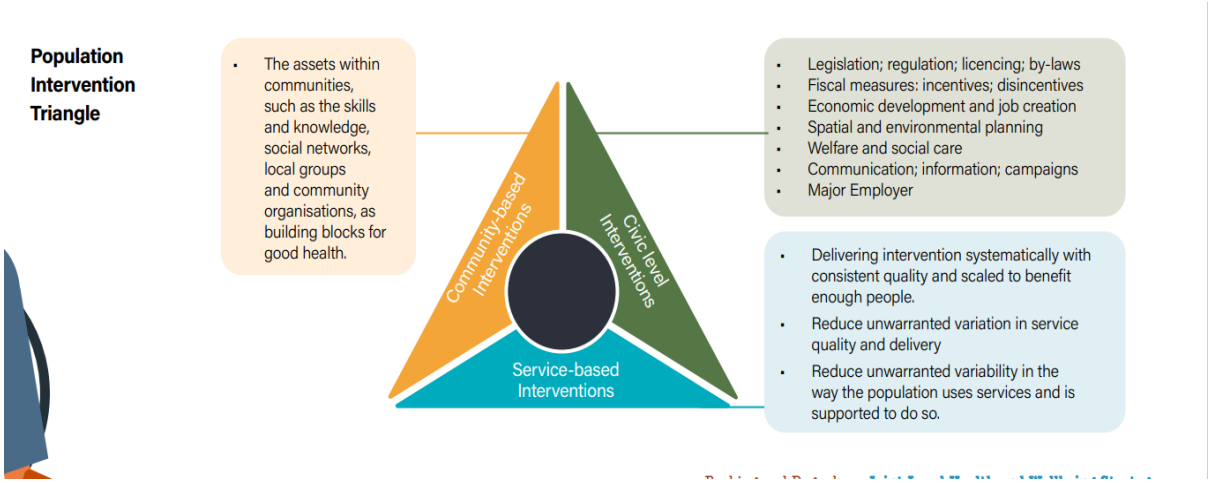
4.1 The Borough is ranked the fifth most deprived local authority in England, and the most deprived in London. The Index of Multiple Deprivation (IMD 2019) measures the lack of necessities individuals in a neighbourhood have. Factors including income, employment and education are used as Quantifiable measures. The IMD shows that some neighbourhoods in the Borough experience from higher levels of national income deprivation and a lack of education, skills and training. Moreover, the majority of B&D neighbourhoods are categorically in the most deprived 10% of neighbourhoods in England when considering barriers to housing and services. Barriers expand to the impact of housing affordability, overcrowding, homelessness, and distance to amenities including GP surgeries and supermarkets to measure deprivation.

4.2 Health is bound up with deprivation as evidence shows that there is a social gradient in health: the more deprived an area of residence, the lower an individual's socio-economic position, which generally equates to poorer health and shorter life expectancy. Unsurprisingly, on several health metrics, Barking and Dagenham has poor outcomes and there are significant differences with wealthier areas of London short distances away. Some disparities in health outcomes within the Borough may also follow this social gradient. National analysis of NCMP data shows that there is a strong relationship between deprivation and childhood obesity[7]. Locally, Barking Riverside, the ward with the highest percentage of obesity amongst children in Reception year, contains some of the most deprived neighbourhoods in the Borough.

4.3 Barking and Dagenham has amongst the greatest health inequalities in North East London (NEL), London and England. This can be clearly seen in The measure of healthy life expectancy - the year a person has "good" or "very good" health, based on how people perceive their general health. In Barking & Dagenham, healthy life expectancy is just 58.1 for males and 60.1 for females, around 5 years less than the average for London. The prevalence Of unhealthy weight (including obesity) of children and adults is significantly higher than the national average. 49.1% of Barking and Dagenham children in Year 6 were classified as overweight or obese during the academic year 2021/22 - the highest proportion of all local authorities in the country.

[7] Part 4: Deprivation - NHS Digital

5. What role does the Voluntary and Community Sector play in supporting residents?



5.1 Community partners play a critical role in supporting and improving the health and wellbeing of residents, including but not limited to navigating services. Many residents may have little contact with or trust in the Council and statutory partners, but frequent contact and trust in community and faith groups close to them and their families (i.e. trusted voices). These organisations maintain close, trusted connections with those that they help and hold knowledge of the needs and demands of their specific communities. To help as many local people as possible from a diverse range of backgrounds, we must listen to these groups, partners, and indeed, residents themselves.

5.2 The North East London NHS Joint Forward Plan[8] recognises the opportunities which closer working between health, social care and the Voluntary Community and Faith Sector and Social Enterprise (VCFSE) organisations can achieve and that these are essential to the planning of care and to supporting a greater shift towards prevention and self-care. The VCFSE work closely with local communities and are viewed as key system transformation, innovation, and integration partners of equal value with other statutory partners.

5.3 Health and wellbeing remains a key priority for the Council and the Borough, as outlined in both the Joint Health and Wellbeing Strategy[9] and the 2022 Joint Strategic Needs Assessment (JSNA)[10], where a gap of meeting the demands of those with greatest need is identified. The review recognises that a refocusing of services and transformation of those undergoing challenges in capacity and funding may be required to bridge this gap.

[8] https://www.northeastlondonhcp.nhs.uk/wp-content/uploads/2023/06/NEL-Joint-forward-plan-June-2023-vFINAL.pdf
[9] https://www.lbbd.gov.uk/sites/default/files/2023-06/LBBD%20JHWS%202023-28.pdf
[10] https://www.lbbd.gov.uk/sites/default/files/2022-10/BHRJSNA2022_LBBD_Final_%20version.pdf

5.4 The Borough Manifesto[11] includes a theme on health and social care which recognises that the local community face long-term challenges because of unhealthy lifestyles. Consequently, the Manifesto includes targets to improve male and female health life expectancy, outcomes where, as already stated, B&D suffers inequalities and targets to determinants of health inequalities. To buck these trends, the approach to health and care must be viewed differently; health and care services need to work more closely together being fully integrated and seamless, reducing the barriers that currently exist. By embracing and driving this transformation, the Council aspires for B&D to become a place which supports residents to achieve independent, healthy, safe and fulfilling lives.

5.5 Highlighting the work already provided by the VCFSE and further establishing better relationships between community groups and statutory partners will be key to achieving this. Put simply, the VCFSE can play a role in providing what statutory partners cannot.

5.6 Recent NHS Confederation reports[12] and guidance[13] show how integral the voluntary sector is to achieve integrated care in health and care services.

6. The existing VCFSE landscape in Barking and Dagenham

6.1 The capacity of the VCFSE in Barking and Dagenham has grown significantly over the last few years. Participation and Engagement became a priority in the 2020-22 Corporate Plan and a new social infrastructure contract was commissioned to the BD Collective - a values driven movement focussed on creating an environment that facilitates collaboration. The movement does this via a network of networks, seeking to redress the balance of power sharing between the state and civil society.

6.2 At the beginning of the COVID-19 pandemic, a collaborative model of support was set up between the Council and the BD Collective, coordinating local volunteers, voluntary and faith groups to deliver a support system for the community, by the community. This model catalysed a pattern of undertaking work with the VCFSE, having conversations as equal partners and making decisions together.

6.3 The Council's collaborative work with partners enabled the setting up of the participatory grant funding organisation, BD Giving. The organisation seeks to make it easier for local people and organisations to fund what matters to them, using participative grant-making processes directly involving residents.

6.4 Most recently, Community Resources on behalf of the BD Collective, worked alongside the Council in setting up the Community Locality Leads Model to address health inequalities and provide cost-of-living support. During the first discovery year five VCFSE organisations acted as Locality Leads across six geographical areas, providing local connections in communities and triaging

[11] https://www.lbbd.gov.uk/sites/default/files/2022-09/Barking-and-Dagenham-Together-Borough-Manifesto.pdf
[12] The voluntary sector: a game-changer in integrated care systems | NHS Confederation
[13] The voluntary sector – the secret weapon for integrated care? | NHS Confederation

support with a network of community partners, to ensure that residents in need can access the most appropriate support.

6.5 Addressing the issue of health inequalities and enabling wellbeing has proved successful for the B&D Partnership with the inclusion of the VCFSE. However, to further improve, it is essential that we continue to work with the VCFSE to produce better outcomes for all, so that together we enable residents to make informed decisions, shape services and create a supportive system so as to work together effectively in an environment of collaboration.

7. What is the role of the new Integrated Care Systems (ICS) in amplifying the voice of the VCFSE?

7.1 On 1 July 2022, Integrated Care Systems (ICS) became statutorily responsible for planning and funding health and care services. These are led by two related entities at system level: an 'Integrated Care Board' (ICB) and an 'Integrated Care Partnership' (ICP), which are collectively referred to as the ICS. Their purpose is to integrate care across different organisations and settings, joining up services and leading the following on behalf of their population footprint:

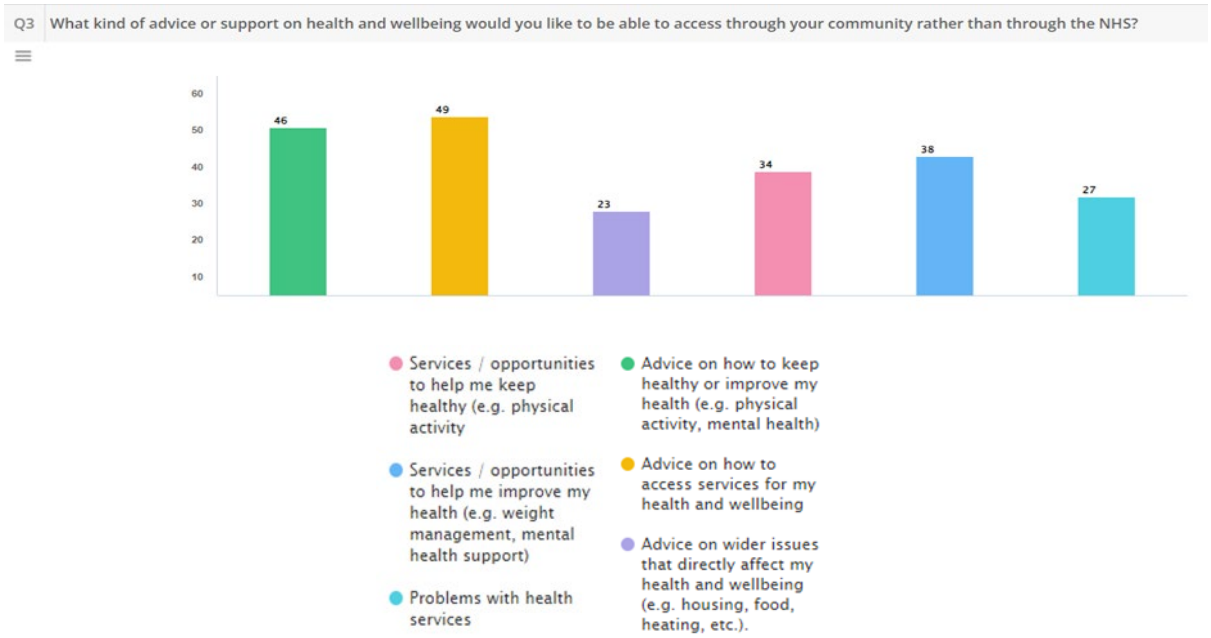
- Improve outcomes in population health and healthcare,
- Tackle inequalities in outcomes, experience, and access,
- Enhance productivity and value for money; and
- Help the NHS support broader social and economic development.

7.2 The ICP, which brings together key system partners for health and social care, including VCFSE organizations', represents an opportunity for the VCFSE sector to become more embedded in-service design and decision-making for health and wellbeing. This will also be strengthened through VCFSE representation on the ICB Place Sub-Committee and on the Partnership Board, enabling the sector to have a greater voice in health planning and service delivery.

8. Resident Engagement

8.1 In a local survey completed by 83 people online support was shown for community-led healthcare and for more involvement of community organisations in shaping services. Most people felt that community organisations should have a role in seeking the views of local people and working with the NHS to inform health and wellbeing services. There was overwhelming support for the VCFSE to provide advice on health and wellbeing issues and improvement, more than doing so through the NHS.

8.2 Most respondents felt that they had never been able to influence health services. Given the response to question 3 set out below, the VCFSE could play a significant role in changing this sentiment.



9. Feedback and Findings from Sessions

9.1 First Evidence Gathering Session with VCFSE Partners: 15 March 2023

9.1.1 Members of the Health Scrutiny Committee met with partners from a range of Voluntary and Community Sector organisations on 15 March 2023, to discuss their perspectives as to:

- The role of the VCFSE in supporting residents and each other in tackling health inequalities;
- The current barriers between the VCFSE and the wider system in joint working, and how colleagues felt that all partners could begin to navigate challenges such as differences in culture and language, to be able to work better together;
- How the relationship between all partners could be strengthened;
- The best means of placing people and communities at the heart of decision-making regarding services and community-centred approaches to health and wellbeing; and
- The support needed by the VCFSE as a sector, to be able to have a more meaningful and active role in shaping future strategy and service delivery.

9.1.2 During the session, Members also learnt more about the establishment of the BD Collective, which had been created four years prior, as a response to a report by Julia Unwin on the future of civil society. The values of connection, trust, accountability and power sharing, as endorsed by Julia Unwin, were adopted by the BD Collective as the defining ethos of its model, creating an open and welcoming environment, for VCFSE partners to come together as a network.

9.1.3 The BD Collective model marked a crucial change in the operation of the VCFSE; Members learnt that previous commissioning models had encouraged the VCFSE to compete against each other, rather than to work

collaboratively to realise their collective strengths. As such, the BD Collective presents an innovative and new space for VCFSE partners to collaborate around aspects such as service delivery and consortia funding bids.

Key Messages from the session

- VCFSE service advertisement could prove difficult; colleagues struggled with their time and capacity to promote their work and often did not know how best to get messages out to the local community. Furthermore, increased service take-up could also create issues in terms of the necessary staffing to support additional service delivery.

- Working in silos acts as a barrier. Working together on issues like commissioning is more productive to the VCFSE, as is having direct relationships with people in the Council and social sector (e.g. NHS) – more willingness to work together and keep each other updated.

- Colleagues struggled to navigate the wider systems. Joint training and doing more things together would help each other's worlds, especially understanding the integrated care system and of equal importance, helping statutory colleagues to understand the strength and diverse nature of the VCFSE sector.

- Colleagues struggled to get the message out to the local community about what their groups were offering/activities they were running. They also found it difficult to find the right person to talk to, to support them with getting the messages out. There doesn't seem to be a central point at the Council either- e.g., Council website is not very good.

9.2 Second Evidence Gathering Session with Health Partners: 3 April 2023

9.2.1 Members of the Health Scrutiny Committee and officers met with statutory Health Partner colleagues on 3 April 2023, to hear their thoughts and learn ideas as to:

- ***The role of statutory health and care system and the VSFCE sector***

9.2.2 Since the ICB was established, Place has had a strong presence in the way the statutory system works and has expanded the remit of health formally beyond healthcare. The Place-based Partnership has a remit around addressing health inequalities.

9.2.3 Work has started at the Place-based Partnership that has highlighted it cannot achieve anything without the VCFSE. Currently with the involvement of the VCFSE, five Locality Leads have been established across six localities, allowing on the ground connections to over 500 VCFSE groups which are co-producing ways of addressing health inequalities with residents. Whist this is producing some short-term benefits, in order to make a real difference, it will take 4-5 years.

9.2.4 The emergent system led priority to establish a more coherent locality model and approach, offers further potential to draw on the learning and impact of the locality leads in working with and alongside system partners to address health inequalities in and around our neighbourhoods.

- ***Commissioning the VSFCE***

9.2.5 Barking and Dagenham has many small voluntary community- based groups. However, the reality is that in the main the statutory services are unable to commission and/or fund them as these groups in the main do not have the necessary governance arrangements in place that would merit/allow public funds to be allocated. This is incredibly challenging and frustrating at a time when trying to grow and develop the voluntary sector locally.

9.2.6 There does exist the Social Prescribing Community Chest Fund, financially supported through the Health Inequalities Grant which could be used to support the community to grow its capacity. Whilst a level of due diligence/governance is required, it is set much lower and there is also support available to assist with bid writing. The BD Collective is actively exploring becoming an entity. This would be advantageous in the governance of the distribution of funding to smaller community groups.

- ***How can the statutory system better support the VCFSE***

9.2.7 The Statutory system has a lot of estate. Partners can act as an enabler, looking at shared assets with the community. As an example, the Council is about to open its first two Community Hubs within health-owned buildings.

- ***Barriers to joint working***

9.2.8 The NHS is not a single cohesive organisation, just like the VCFSE is not. Understanding how organisations relate to one another, and what services are available is a challenge. Other more practical challenges include the limited ability of the community to volunteer when their working environment is either insecure, unsociable hours and/or longer hours.

- ***Culture and language barriers***

9.2.9 The use of language and terminology and jargon in the NHS needs to be reviewed with a particular issue around the use of acronyms. There is merit in the NHS arranging training for the voluntary sector about terminology. Also using the voluntary sector to directly engage with the communities on behalf of the NHS can have a real positive impact as they have the experience of working at that level.

- ***Beyond funding and resources, what support does the VCFSE need as a sector to be able to have a more meaningful and active role in shaping future strategy and service delivery***

9.2.10 The key for the statutory services is about transparency and honesty and having the voluntary sector at the table at every opportunity. It is about giving the likes of community groups the opportunity to be heard and the influence to create change instead of the statutory partners just telling them what to do.

- ***How to improve communications with the VCFSE to enable them to have a greater voice***

9.2.11 The BD Collective is important as a network of networks to help identify what is out there. There is not yet one place to go to know what is going on, when it operates, and who is who. The Collective serves as a conduit and communication channel, given the ever-changing sector of the VCFSE.

9.2.12 Technology can play a vital role. An example being the Joy app, a social prescribing software application which is being rolled out and enables health and social care professionals to link clients to local services and demonstrate outcomes.

Key Messages from the session

- Often people arrive at statutory health and care services in a place of need, which in practice makes the statutory system more of a "sickness service". Whilst the statutory system does have a preventative element, we need to think about how a person might manage a condition or live with it in a manner that prevents further sickness. In that sense prevention means addressing further deterioration and that is where the VCFSE can play a vital role in addressing health inequalities.
- Greater use of technology to improve communications.
- Better signposting opportunities re voluntary and community groups that can support residents.
- Produce welcome packs for all new residents specifically, around the locality and the services available in them.
- Better support through the Council and the BD Collective for smaller organisations to enable them to bid for contracts.
- Use the VCFSE to directly engage with communities on behalf of the NHS.

9.3 Third Evidence Gathering Session with VCFSE Representatives: 11 July 2023

9.3.1 Members of the Health Scrutiny Committee together with a number of officers met for a second time with partners from a range of voluntary and community sector organisations on 11 July 2023. The session was introduced by Rhodri Rowlands, Director of Community Participation and Prevention and led by Elspeth Paisley, Community Resources Health Lead and member of the BD Collective Leadership Team.

9.3.2 The presentation outlined the background and role of the BD Collective, bringing the social sector of Barking & Dagenham together in partnership with others. By doing this, it seeks to build trust between people and organisations

through shared challenges and accountability, and importantly aims to shift power to devolve decision making for those most impacted by those decisions.

9.3.3 The combined efforts of the networks aim to shift the balance in the Borough from individual organisations to collective endeavour, moving away from traditional public service commissioning which pits groups and individuals against one another and does not allow the collective benefit to come through, to a model of shared accountability and power. Thoughts and comments from the session included:

- Do we really see what the value of the voluntary and community sector is?
- There are circa 5,000 groups in the Borough; the value of what they do is huge and often untapped.
- Positive bias towards residents doing small projects.
- 40% of people presenting to a GP did not actually need to see a doctor – they can be better helped and supported in the community.
- Building friendships when activities are in groups – this provides extra benefit to health support.
- Residents can find solutions themselves; they are creative. Statutory providers need to put their trust in them.
- The aim should be to steer a path away from becoming another bureaucracy – the sector offers different opportunities.
- To improve healthy life expectancy, we must have a long-term vision.
- Funding: ideally, this would be longer-term as well, so as not to lose good people on short-term contracts.
- It is important to be willing to fail and try again. Change doesn't happen overnight, and we can't work out what works well that quickly.
- We need to make sure that we're measuring the right things. Impact is important but needs to be thoughtfully measured.
- We need to be open to continuous learning – there's still much more to learn, and,
- It can never be just about numbers and how many people, but case studies of the journeys and quality of programmes, examples of which were presented as follows:

9.4 Independent Living Agency

9.4.1 Mr A was a 65-year-old gentleman who was discharged from hospital on a Friday. On return home he was taken back to hospital as his home was in a state of disrepair. We were asked by the LBBD hospital discharge team to support the gentleman as soon as possible, as they wanted him discharged from hospital due to bed shortages. We visited him in Queen's Hospital within an hour of the referral and agreed to start work. The gentleman told us that he had money but needed to get cash out. He was keen to go home so agreed for us to access his home and get his card. On entering the premises, we realised it needed cleaning. We sent photos to the social work team who agreed to fund the clean the following day.

9.4.2 Our support worker went to hospital on the Friday night with the gentleman's bank card, and he gave us permission to buy a bed and fridge. On Sunday,

we went back to hospital and the gentleman allowed us to get new bedding and household items and cooking items plus a new microwave and curtains. He was due to be discharged on Monday and called his support worker when leaving the hospital at 6pm. We met him at his flat to support his move and liaised with the care agency to ensure they were aware that he had arrived home. We went shopping for food and items he needed.

9.4.3 By using our local connections and knowledge that we have built up over twenty-five years, we were able to secure a quick discharge into a safe home space.

9.5 Harmony Clinic (HCP)

9.5.1 Alex (not his real name) first encountered Harmony Clinic in the last quarter of 2022 when he dropped in for a free health check at the Dagenham Library (Community Hub) where health care volunteers from Harmony Clinic offer fortnightly health checks.

9.5.2 During the consultation, it was found that Alex's blood pressure was over 190 systolic and over 100 diastolic. He smoked 20 or more cigarettes a day, enjoyed coffee, Coca-Cola, and regularly had takeaway lunches. Alex rarely did any physical activity. Alex was strongly encouraged to see his GP due to his high blood pressure. He was also given health advice regarding diet and exercise and was told to visit the clinic in two weeks' time.

9.5.3 Alex returned a month later and informed Harmony Clinic that he had seen his GP. He started treatment on amlodipine and had started going to the gym, taking packed lunches to work, but was struggling to give up coffee. After another blood pressure check, Alex's result had improved (140/86). He was advised to continue checking his blood pressure regularly. On his third visit, he had stopped smoking and his coffee intake had decreased. He substituted coca cola with sparkling water. Alex described feeling much better in himself as a result.

9.6 Thames Life Community Development Trust

9.6.1 Matt Scott, CEO and Lucy Lee, Locality Health Lead from Thames Life provided an overview of the Group's Community Drop-In Clinic, a new model of care. In the absence of a purpose-built Health Clinic in the Barking Riverside ward and as the existing clinic in Thames View is overwhelmed with patients, the waiting times for GP appointments are long. As a result, Matt and Lucy were invited towards the end of last year to look at a new model of care. As part of the consideration Dr John (Aurora Medicare) and Zoinul Abidin (Head of Universal Services & Community Solutions, LBBD) brought their thoughts to the conversation and suggested that a drop-in session on a Friday be established facilitated by Thames Life with support from the likes of paramedics, GP's, massage therapists etc. A pilot drop-in session took place at Thames Community Hub on 17 March 2023.

9.6.2 The pilot was a great success and despite only three days of leafleting and marketing, hundreds of people attended and commented as to how great it was. People were happy to not only get a free massage, but to also be able to

get in front of a doctor and have their minds put at ease, which positively impacted the community. So much so, that in partnership with Thames Life, Zoinul and Dr John and now supported by Barking Riverside Ltd (BRL), the drop-in sessions are now taking place once a month in various locations/venues, now partnered with local community groups and organisations.

Key Messages from the session

- How can we scale what we know can make a real difference? This is an opportunity for both the Council and NHS.
- Can we start doing more in more locations e.g., near stations?
- How can we build sustainability within these projects and how can we shift resource from statutory partners to the sector in the future?

Looking to the next steps:

1. Engage and design **WITH**, rather than do to. Harness collective knowledge of variety of groups.
2. Focus on discovering what works: we know that some things aren't fit for the 21st century.
3. Commit to commissioning via consortia (opening door to wider range of providers) to benefit from collective wisdom.
4. Release community power. By doing so, you improve wellbeing of the community, and
5. Invest in the long-term. Focus on what we collectively want to see in Barking and Dagenham.

10. Key themes and recommendations from all sessions

10.1 Continue to foster relationships with VCFSE that focuses on commissioning, collaborating and co-designing together

10.1.1 Members of the VCFSE described deeply entrenched ways of working in a service-delivery model rather than one of working in collaboration. Rather than being there to support the Council or statutory partners in delivering their services, the VCFSE offers something different and deserves a place at the table to work in collaboration with those partners. More willingness to work together and share power between partners offers the possibility of harnessing the best of every sector. It is the Council (and NHS) that holds the responsibility of relinquishing some of their resources and power to allow the community to do what it does best.

10.1.2 As a requirement to providing services to statutory partners, the VCFSE are regularly asked to work towards specific metrics and outcomes. It was felt that sometimes, these targets were not realistic, particularly within short timeframes. These targets force groups to respond in more of a business style than that of a VCFSE organisation. Groups argued that VCFSE organisations focus more on connections and improved quality of life rather than on quantitative measures around process, such as how many contacts their

organisation had with individuals, which may not communicate the full picture of how their work helps people. In addition to this, VCFSE representatives argued that reporting to specific numerical targets may detract from the values of the organisation and what the programme really aims to achieve. Allowing groups to showcase their work through more qualitative measures such as case studies and testimonials would help to reveal the impact of their work in a less restricted manner.

10.1.3 One knock-on effect of this service delivery model is that groups feel they act in competition for access to funding pots, instead of working together towards shared goals. This often means that smaller organisations are unsuccessful at securing funding bids while in competition with larger organisations, despite both having similar aims. Consortium approaches to funding pots allow more groups to access funding, leading a step closer to fully utilising the unique potential and expertise of every group.

Recommended actions:

- *Consideration to be given in all commissioned services / tenders to the qualitative evidence on overall impact on individuals and communities e.g. via case examples and stories.*

- *Work with civil society groups to facilitate more consortium approaches to funding bids that promote collaboration rather than competition and increase reach and breadth of VCFSE contribution.*

- *Commit to using the community locality leads model as a platform to draw learning and to help shape the emergent locality model being developed by council and partners.*

10.2 Developing community capacity and connections

10.2.1 We all need to work in collaboration, recognising that we need each other and that each sector has something to offer. It is important to have more open conversations between the different sectors, discussing issues and encouraging greater collaboration.

10.2.2 Often people aren't aware of the other groups that are operating in the same spaces as them, especially if these other groups are booking independently. How can we publicise the offer more and help groups to make those connections?

Recommended actions:

- *Review existing grant and commissioned funding to ensure its reach is fair and supports the contribution and role of VCFSE in addressing health inequalities.*

- *Work with VCFSE sector to develop clear and shared consensus of the role of the sector in co-design and delivery of system priorities e.g. emergent locality model.*

- *Commit to utilising the VCFSE sector to support activity aimed at increasing voice and reach of services to seldom heard.*

10.3 Bid writing and sharing information across the VCFSE

10.3.1 The competitive nature of bid writing means that it is often the larger groups and organisations that are successful. Those smaller groups tend to have less access to the resources and capacity needed to draft lengthy funding bids and fall short of those where an employee with specific bid-writing expertise wins the funding. Frequently, the organisation must weigh up the time spent completing a lengthy bid application and the potential of being successful or not, with focusing that time elsewhere. This may result in fewer organisations feeling compelled to apply to pots of funding, in turn encouraging a pattern of the same, larger groups being successful.

Recommended actions:

- *Establish training sessions for groups across the borough to upskill and build capacity in bid writing.*
- *Ensure that bid applications only ask the questions that need directly answering, lessening the time and resource required for groups to spend on drafting them.*
- *Ensuring the VCFSE sector are aware of key developments within health and care and are able to respond appropriately.*

10.4 Developing common culture and language

10.4.1 There was an acknowledgment that the VCFSE does not always speak in the same language as the NHS, and that the worlds both sectors operate in can vary significantly. Currently the VCFSE feel that there are not enough opportunities to have joint conversations and there is a lack of knowledge about who to contact at the Council for support unless there is an existing direct relationship. Of course, we cannot rely on direct relationships, for when that person leaves, the relationship between organisations ceases to exist.

10.4.2 Joint training sessions and conversations where colleagues from all sectors can work together would help to mitigate against these obstacles to partnership working. These conversations would help all sides understand how other sectors operate, and what they're working on. It should be noted that the VCFSE seldom has the resources to lead things like joint training sessions but would be keen to join such things if the Council or NHS were willing to set these up.

Recommended actions:

- *Establish joint training sessions and working groups between the VCFSE sector, NHS, and the Council to allow for genuine collaboration and to develop stronger relationships between organisations.*
- *Ensure VCFSE representation in co-design & subsequent implementation of B&D Committee in Common (Place Partnership) Strategy & co-production principles.*

10.5 Ensuring longevity of funding

10.5.1 Groups expressed frustration at the “stop-start” nature of funding. Short contracts and pilot projects mean that often organisations recruit staff on short-term contracts with uncertainty as to whether they will be able to retain that member of staff post contract completion. The knock-on effect of this is that it becomes more difficult to recruit staff in the first place with only a fixed-term position available, and staff morale is hampered when turnover is high, and projects are cut before much work can develop.

10.5.2 Strong relationships take time to fully develop, and when organisations are commissioned to do this with local people, one or two years to do this thoroughly is rarely enough. One representative from the VCFSE concluded that “the community are tired of being experimented on”.

Recommended actions:

- *Contracts should aim to allow time for the VCFSE to create sustainable workstreams where staff members can develop projects before funding is cut prematurely.*

11. Acknowledgements

11.1 The Health Scrutiny Committee would like to extend its thanks to the following Voluntary and Community Sector Partners, Health Partners and Council officers for contributing to this review:

Voluntary and Community Sector

- Elspeth Paisley, Community Health Lead, and Member of the BD Collective Leadership Team
- Ronke Olulana, Director Harmony Community Projects
- Terry Miller, Chief Officer, Independent Living Agency
- Matt Scott, CEO and Lucy Lee, Health Outreach Worker, Thames Life
- Sarah Robertson, CEO Future M.O.L.D.S Communities
- Belinda Ramsey, Anne Foster & Carol Welsby Toddler Group, & Nursery leads, St Chads Church
- Ian Kane, Adults Services Manager, LifeLine Projects
- Mizan Rahman, CEO Ekota Academy
- Denis Lawrence, Community Trust Manager, Daggers Community Trust
- Kendrick Morris, Locality Lead Manager, Harmony House

Health

- Melody Williams, Integrated Care Director (Barking and Dagenham), North East London NHS Foundation Trust (NELFT)
- Sangita Lull, Assistant Director, Adults' Services (Barking and Dagenham) NELFT
- Shilpa Shah, CEO, North East London Local Pharmaceutical Committee (NEL LPC)
- Emily Plane, Head of Strategy and System Development (Barking and Dagenham, Havering and Redbridge), North East London Integrated Care Board (NEL ICB)
- Dr Ramneek Hara, Clinical Lead, Barking and Dagenham Place-Based Partnership

London Borough of Barking and Dagenham Council

- Rhodri Rowlands, Director of Community Participation and Prevention
- Monica Needs, Head of Community Participation and Engagement
- Claire Brewin, Policy Officer
- Mike Brannan, Consultant in Public Health Primary Care and Transitions
- Sophie Keenleyside, Strategy and Programme Officer
- Susanne Knoerr, Operational Director, Adults' Services
- Mahira Chowdhury, National Management Trainee
- Masuma Ahmed, Claudia Wakefield and John Dawe, Governance Services

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HEALTH SCRUTINY COMMITTEE

7th February 2024

Title: NELFT CQC Inspection Update February 2024	
Report of the Chief Executive NELFT: Paul Calaminus	
Open Report	**For Information**
Wards Affected: None	**Key Decision:** No
Report Author: Suzanne Sutton, Associate Director of Nursing & Quality (Barking & Dagenham) NELFT NHS Foundation Trust	**Contact Details:** Tel: 0300 5551201 x 53100 E-mail: Suzanne.sutton@nelft.nhs.uk

Summary

NELFT is registered with the CQC to deliver safe, effective, responsive, caring and well led care. The Trust places patients and staff central to all it strives to achieve as required by the NHS Constitution. Non-compliance with the regulations including the fundamental standards may impact on the quality of care provided to the people served.

NELFT has retained a rating of Good following the 2022 Well led inspection which also comprised of short notice announced inspections of acute wards for adults of working age, psychiatric intensive care units, mental health crisis services and health-based places of safety. They also carried out a focused inspection of specialist community mental health services for children and young people in Kent.

Following the 2022 inspection of specialist community mental health services for children and young people in Kent, CQC made a further 2 “must do” recommendations in addition to one existing “must do” risk which had remained open from 2019 and 6 new “should do” recommendations. 9 Trust wide recommendations were made, 10 for mental health acute wards for working age adults and 3 which relate to mental health crisis services and health-based places of safety.

The current Trust position at time of writing is that a total of one “must do” risk and 8 “should do” risks remain open.

The one “must do” risk remaining open is ‘The Trust must continue to work to ensure children and young people in Kent have access to treatment within 18 weeks of referral’. Significant work has been undertaken to progress this risk from the initial 22 actions across the neurodevelopment pathway to a position whereby just one action remains.

Currently 4 out of the 12 trustwide “should do” risks remain open. The 6 “should do” risks for specialist mental health services for children and young people in Kent have closed. 4 out of 13 risks for the acute and rehabilitation directorate (ARD) remain open. For the remaining risks, actions and trajectories are in place to close by end of March 2024.

The overall action plans for each recommendation and risk were presented at the Trust’s engagement meeting on 21st September 2024 and the updated ARD action plan was presented on 8th December 2024.

One “must do” action has remained open since the 2019 inspection, this was in relation to waiting times for the neurodevelopment service in Kent. A total of 22 actions have been put in place to address the risk since then, with significant progress leading to only one remaining action.

The “must do” action ‘The Trust must ensure that staff complete all mandatory training within Kent CYPMHS’ was successfully closed in July 2023. Weekly monitoring of mandatory training compliance is in place through a quality dashboard which Heads of Service use to support supervision compliance with the operational managers. Monthly monitoring for assurance continues through directorate leadership meetings. Compliance has consistently maintained 85% target and above for Mandatory Training across all services.

The “must do” action ‘The Trust must ensure that there are systems to identify & address changes in risk for young people waiting and these are consistently applied across teams” was also closed in July 2023, the Lead Nurse for Patient Safety continues to report to operational managers around risk compliance. Any risk assessments that are not in date are captured through the quality dashboards to enable managers to have this information accessible and to enable them to address any lapses. The new standard operating procedure has been reviewed to reflect changes and processes to manage risk, including the duty system.

The remaining “must do” and “should do” recommendations have been added to the Trust’s risk register in the form of an overarching improvement plan which is monitored and updated to ensure timely progression of actions.

There are monthly updates on the CQC improvement plan at the CQC Assurance Group meeting which is chaired by the Chief Nurse and is attended by Directors of Nursing, Associate Directors of Nursing & Quality, Director and Assistant Director of Governance, Integrated Care Directors, Corporate Leads and the CQC Compliance Team.

A monthly update is presented to the Quality and Safety Committee (QSC), who in July 2023 carried out a deep dive into the open “must do” and “should do” risks and the progression to date. In addition, the Executive management team (EMT) is provided with regular updates as well as the NELFT board. The board reports are public domain reports and are available on Board papers | NELFT NHS Foundation Trust .

In November 2023 a review of the closed risks took place via the Trust’s CQC Compliance team to seek assurance that actions remain embedded for sustained change. This is also monitored through existing audit cycles, quality support visits, governance and individual meeting agendas.

This report is to provide the health and scrutiny committee with an update on progress since the last presentation and an outline of the progression of the improvement plan since the 2022 inspection.

Recommendation

The Committee is recommended to:

(i) Note the content of this report
Reason This report is for noting and allows the Committee to put questions to the officer presenting the report.

1. Introduction and Background

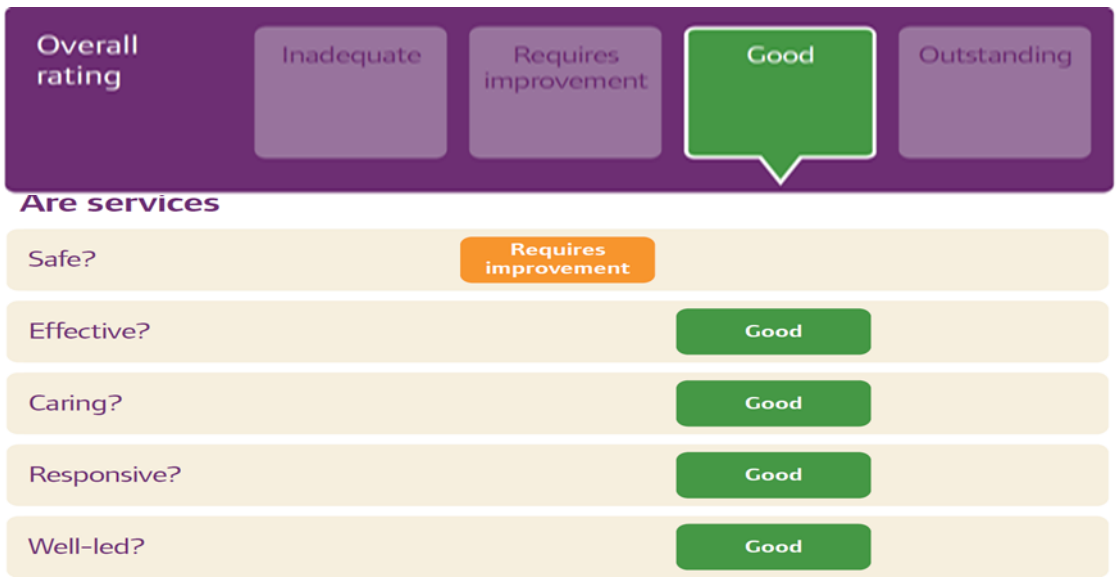
1.1 Following the last presentation to the Committee it has requested a further update in respect of the CQC Improvement Plan developed in 2022. This report and accompanying presentation give a headline progress review.

1.2 By way of background the Care Quality Commission (CQC) inspected NELFT from April to June 2022. The CQC undertook a repeat Well Led review following the previous 2019 inspection and in addition inspected the following core services:

- Acute wards for adults of working age and psychiatric intensive care units;
- Mental health crisis and health-based places of safety; and
- Specialist community mental health services for children and young people Kent.

1.3 The inspection report produced by CQC following the conclusion of the inspection describes their judgement on the quality of services provided by the Trust. This report is published on the CQC website - North East London NHS Foundation Trust - Overview - Care Quality Commission (cqc.org.uk).

1.4 The overall inspection result for 2022 was a rating of 'Good'.



1.5 NELFT's overall rating remains 'Good' as of January 2024. In November 2023 NELFT's psychiatric liaison team were part of a wider CQC inspection of the North East London Mental Health Crisis pathway which focused on Barking Havering and

Redbridge University Hospital. There were no immediate actions for NELFT and the draft report is anticipated shortly.

2. Issues and Actions

2.1 Following the 2022 Well led inspection 28 “should do” recommendations were made. The previous remaining recommendations from the 2019 inspection of Community Mental Health services for adults of a working age and Community Mental Health services for adults with learning disabilities have all been closed.

2.2 The current Trust position is 1 “must do” and 8 “should do” recommendations remain open. All are progressing within expected timescales and with the exception of the remaining “must do” which will close in the first quarter of 2024.

2.3 Each identified action has an assigned executive lead to oversee progress and an operational/corporate director to lead the delivery. The Trust is in the process of moving over from Datix to InPhase which includes a risk management module that enables all risks/action plans to be viewed in live mode and therefore track progress accordingly. The risks are then monitored at directorate leadership team level, monthly at the CQC Assurance Group and at the Quality and Safety committee. Progress is also reported to the Trust board.

2.4 One “must do” action has remained open since the 2019 inspection; this is in relation to waiting times for the Neurodevelopment service in Kent. A total of 22 actions have been put in place to address the risk since then, with significant progress leading to only one remaining action. Following the pandemic, this service has experienced a further increase in referrals, despite actions and progress to reduce this, which has had a continued impact on this service’s overall waiting times. There is a plan in place at locality level to address waiters alongside system wide workstreams which have commenced with all Kent providers to develop a new shared clinical model around ADHD/ASC assessment (Attention Deficit Hyperactivity Disorder/ Autistic Spectrum Condition) and to continue the work around long waitlists.

2.6 The main themes of the remaining trust wide “should do” recommendations relate to supervision and appraisal compliance being consistently maintained above 85% and to have an appropriate team in place to support medical staffing. Robust plans are in place to address these from both a corporate and operational perspective.

2.7 New supervision and appraisal training has been launched by the Trust’s Training and Development team to support staff and their managers. There is daily refresh of compliance data on the Trust’s dedicated performance platform (Power BI) and all mangers have access to compliance figures. Locality business managers and service leads escalate non-compliance, and a weekly updated position is monitored via the directorate level risk meetings.

2.8 The remaining “should do” recommendations are for the Acute and Rehabilitation directorate.

- **The Trust should ensure planned works to extend patient call alarm system are progressed** - this is being progressed with a completed completion time frame of end of March 2024, in the meantime mitigations remain in place to ensure the safety of patients whilst waiting for the installation of call alarms.

- **The Trust should ensure that all wards promote a therapeutic environment by maintaining good standards of decoration and cleanliness-** there is a dedicated programme of works underway to progress this recommendation and an ongoing process in place to promptly address any ongoing concerns.

- **The Trust should ensure that recognised ratings scales are used to monitor patient outcomes –** The Trust is rolling out DIALOG across all acute mental health wards of working age and psychiatric intensive care, a project manager is supporting wards with the implementation which is expected to be completed by end of February 2024.

2.79 Alongside progression of the "must do" and "should do" recommendations, the Trust continues to embed a culture of compassionate leadership and sustaining CQC compliance as part of business-as-usual activities. The directorate leadership teams for NELFT alongside the corporate teams remain committed to adherence to the CQC quality standards and this is robustly monitored via the following processes:

- Increased visibility of leaders – both operational, professional, and clinical leadership roles;
- Programme of Quality Support Visits (QSV) led by the Associate Directors of Nursing & Quality. Compliance of required actions is monitored at both a Trust wide and directorate level; and
- Following a successful business case, a dedicated CQC Compliance team are in place comprising of CQC Compliance Lead, a CQC Compliance facilitator and a project support officer. The team works closely with corporate and operational staff to support them by providing training.

Public Background Papers Used in the Preparation of the Report:

https://www.cqc.org.uk/provider/RAT

List of Appendices:

Appendix 1 – NELFT CQC Inspection Feedback

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Appendix 1

NELFT NHS
NHS Foundation Trust

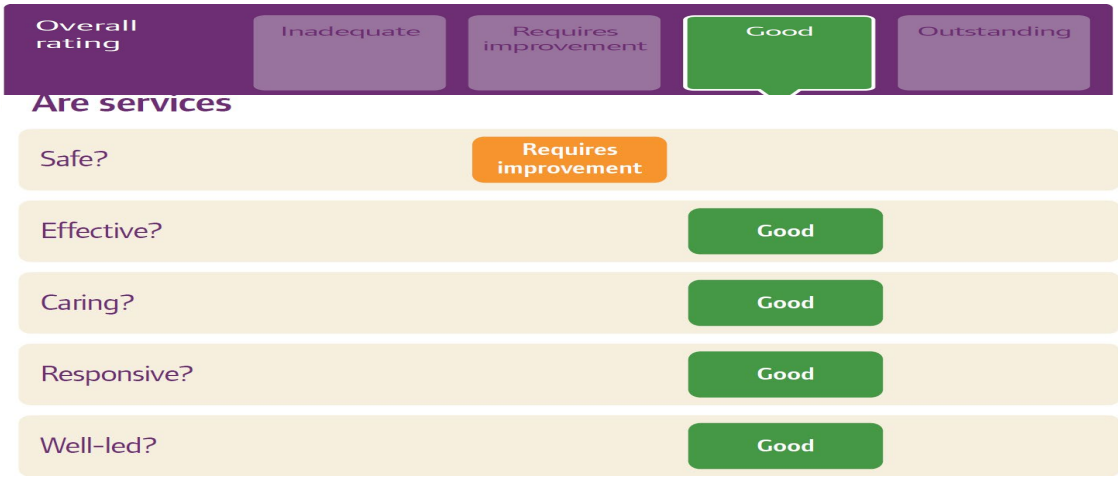
NELFT CQC Improvement plan

January 2024

Best care by the best people

CQC Inspection activity 2023

- NELFT has retained a rating of Good following the 2022 Well led inspection which also comprised of short notice announced inspections of acute wards for adults of working age, psychiatric intensive care units, mental health crisis services and health-based places of safety. They also carried out a focused inspection of specialist community mental health services for children and young people in Kent.



CQC Recommendations

- Following the 2022 Inspection there were a total of 2 new MUST do recommendations and one existing MUST do from the previous inspection and 28 new Should do recommendations.
- All recommendations were added to the Trust's risk register for organisational oversight monitoring and progression
- Currently only 1 MUST do recommendation remains open for Kent specialist mental health services for children and young people
- 2 Trust wide recommendations (split into 3 Directorate risks)
- 4 recommendations for the Acute mental health wards for adults of a working age.

Progression of MUST Do's

"The Trust must ensure that systems to identify and address changes in risk for young people who are waiting are consistently applied across all teams – relating to neurodevelopmental pathway (Regulation 12 (1)(2)(a)(b))".

- Significant progression has taken place in 2022 and 2023
- The Quality Safety Committee, Trust Board and CQC are well sighted on the system wide challenges that impact upon the closure of this risk.
- Only one action now remains out of the 22 initial actions that relates to the neurodevelopmental pathway waiting list.
- Work through a dedicated project group continues to address the remaining waiters, caseload stratification has been undertaken, communication is in place for those on waiting lists, an online referral form with additional information for effectives screening has been introduced, locality reviews and assessments by both locality consultants and neurodevelopmental consultants.
- System wide workstreams have commenced with all Kent providers to develop a new shared clinical model around ADHD/ASC assessments and to continue the work around long waitlists. This includes services are working with the ICB including using a multidisciplinary approach between health care providers, targeting early support packages of care in collaboration with schools and the primary care networks.

Progression of MUST Do's

The Trust must ensure that staff complete all mandatory training (Canterbury and Maidstone) (Regulation 12(2)(c)).

- Risk was closed in July 2023
- Local basic life support and clinical moving and handling training sessions have been put in place locally.
- Training compliance is monitored weekly by the leadership team and follow up action taken around any changes in compliance by the service leads.
- Training for the Kent teams has been maintained constantly above 85% and organisationally 90%

The Trust must ensure that systems to identify and address changes in risk for young people who are waiting are consistently applied across all teams (Regulation 12 (1)(2)(a)(b)).

- Risk was closed in July 2023
- A standard operating procedure and multidisciplinary process is in place across all teams for identification, discussion, escalation and management of changing level of risk. Any risk assessment that does not meet compliance standards are captured via the trust's quality dashboard.

Progression of Key Trust wide recommendations and organisation developments

- During 2022 and 2023 significant work has taken place around several key areas within the Trust further progressed as part of the CQC Improvement plan and should do recommendations.

These include:

- Quality Improvement
- Staff engagement with Mental Health Transformation
- Co-production and service user involvement
- Recruitment and retention
- Supervision and Appraisal compliance

Quality Improvement (QI)

The Trust should ensure that following the pandemic, QI is reinstated across the Trust.

- Risk Closed in July 2023.
- A total of 1075 new staff (since April 2023, launch of 3year QI strategy) have had a QI awareness session
- A total of 139 existing staff (since April 2023) have completed the half day QI foundation training – training and tools to start approaching problems using QI.
- A total of 9 existing staff (since April 2023) have completed the QI facilitation training – real world application through a QI project and share learning to help others in their teams use QI to approach problems.
- Trust wide sharing and learning event celebrating improvement work has resulted in QI projects being presented at every trust board and also every quarter at the trust's all staff webinar. From 2024 each directorate will have their own QI sharing and learning event at least once a year.
- Each directorate has a nominated improvement advisor from the QI team to help with any training, project advice as well as sharing and learning events.
- Since April 2023 there are currently 92 active QI projects with support from the QI team. Ongoing work is progressing with the patient involvement and experience team, to develop a model that will enable users of service to be involved in, lead and contribute to QI projects across the Trust.

Quality Improvement initiatives Barking and Dagenham(QI)

Recent QI Initiative projects include:

- Barking and Dagenham Integrated Children's Service – resulting in a reduction in the number of complaints about the service from an average of three per week to zero

- The B&D Adult Autism service as part of the QI collaborative being run by the National Collaborating Centre for Mental Health at the Royal College of Psychiatrists – aim of the project is to increase the discharge rate following specialist assessment.

Co-production with users of service

The Trust should continue its work in developing new patient participation structures in each locality.

- **Risk Closed in July 2023**.
- Monthly Strategic Patient and Carer experience partnership group meetings now in place attended by Integrated Care Directors of each directorate who provide feedback on the co-production occurring in each directorate and with external collaboratives.
- Young people's network has been set up with regular network meetings.
- Patient Partner advocate roles in place and have been recruited to.
- Integrated patient and carer experience partnership (IPCEP) groups now have now been formed in each directorate.
- T&F group to review and ensure the patient experience strategy is co-produced.
- Several engagement events across all localities during 2023 included in these were a number that were delivered in collaboration with key partners.

Recruitment and Retention

The Trust should ensure work continues around Recruitment and retention in Kent CYPMHS/Medway and continue its work to recruit to vacant posts in the MH Acute inpatients.

- **Risk Closed in July 2023.**
- From June 2022 to date the Acute Rehab Directorate (ARD) initiated continuous recruitment, successfully filling 101.1 vacancies within inpatient mental health wards.
- There are several initiatives in place to support recruitment of posts through Just R campaigns and retention of staff through an appreciative inquiry pilot.
- There has been an increase in applications in Kent in the past three months which has resulted in three appointments and four additional posts at interview stage.

Ongoing recruitment and retention remains a risk for the Trust. Actions in place to address this include:

- Dedicated retention and recruitment group
- Trust-wide recruitment and retention plan, including the Zero Vacancy initiative.
- Successful international recruitment programme (22 nurses placed in MH Inpatients)
- Recruitment events

Supervision and Appraisal Compliance

The Trust should ensure staff receive regular supervision and appraisals and these are recorded on STEPS.

Separated into 3 risks relating to directorates.

Significant improvement has been made in compliance throughout the Trust.

- Barking and Dagenham Directorate above the Trust standard of 85% for appraisal and 75% for supervision with a trajectory in place to meet compliance.
- Weekly monitoring of appraisal and supervision compliance is now in place through a Quality Dashboard which Heads of Service use to support appraisal with the operational managers. Monthly monitoring for assurance continues through leadership team and Assistant director meetings.
- New supervision software tool STEPS implemented.
- Supervision guidance refreshed and available for all staff.
- Video examples for staff available, updated web pages and user guides, direct support to managers and staff, Power Bi reporting

Staff involvement in MHS Transformation

- The Trust should ensure that all staff are supported to engage in (mental health) transformation programmes that affect their teams.
- Closed in July 2023
- Ongoing staff engagement work has continued in 2023.
- Task and finish groups were implemented for Transformation
- Co-production workshops regularly attended by users of service, carers and staff.
- MH Transformation Newsletters are produced and shared.
- MH Transformation Intranet and webpages were set up and updated.
- Regular Programme Delivery Group Meetings are in place and attended.

Acute MHS wards for working age adults

There are currently 3 remaining recommendations:

The Trust should ensure that all wards promote a therapeutic environment by maintaining good standards of decoration, cleanliness and maintenance.

- There is a dedicated programme of works underway to progress this recommendation, on track for completion date 29.02.24 and an ongoing process in place to promptly address any ongoing concerns.

The Trust should ensure planned works to extend patient call alarm system are progressed and call alarms in young people's bedrooms (Brookside).

- This is being progressed with a completed completion time frame of end of March 2024, in the meantime mitigations remain in place to ensure the safety of patients whilst waiting for the installation of call alarms.

The Trust should ensure that recognised ratings scales are used to help assess patient outcomes.

- The Trust is rolling out Dialog across all acute mental health wards of working age and psychiatric intensive care and a project manager is supporting wards with the implementation which is expected to complete by end of February 2024.

It is anticipated these remaining recommendations will have closed by end of March 2024.

Monitoring of Improvement plan

NELFT NHS
NHS Foundation Trust

- Monthly directorate CQC meeting where any matters arising to CQC are monitored including ongoing assurance regarding the CQC implementation plan.
- Assurance of embedding of actions continues to be monitored at a monthly CQC Assurance group meetings.
- Progress of the implementation plan is reported to the Quality and Safety Committee in line with the cycle of business.
- Audit cycles are in place to monitor compliance of actions relating to quality and patient safety and record keeping
- A monthly Quality support visit programme provides ongoing assurance around CQC compliance.

Quality Support Visits

- Embedding of ongoing CQC compliance continues to be monitored by NELFT's internal Quality support visit programme which is conducted using an assessment framework based on the CQC Key lines of enquiry Safe, Effective, Responsive, Caring and Well Led.
- Changes to the questions are being implemented to incorporate the new CQC quality statements and single assessment framework
- Teams are being encouraged to carry out their own self- assessment around quality and patient safety and CQC compliance.
- Actions from Board member visits to services are incorporated into the process.
- Associate Directors of Nursing & Quality support local changes from learning and embedding of ongoing CQC compliance.
- Quality support visits actions are monitored at NELFT's CQC Assurance group meeting and directorate level CQC monthly.
- Good news stories and areas of good and outstanding practice are identified as part of the visits and shared to the wider trust through and "All staff webinar" and communications briefing, the Trust's social media platforms and internet pages.

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HEALTH SCRUTINY COMMITTEE

7 February 2024

Title: CQC Report on Together First	
Report of the Chief Operating Officer, Together First CIC, Barking & Dagenham GP Federation	
Open report	**For Information**
Wards Affected: None	**Key Decision:** No
Report Author: Craig Nikolic, Chief Operating Officer Together First CIC, Barking & Dagenham GP Federation	**Contact Details:** Tel: 07947 887722 E-mail: craig.nikolic@nhs.net
Accountable Director: Craig Nikolic, Chief Operating Officer Together First CIC, Barking & Dagenham GP Federation	
Summary Craig Nikolic, Chief Operating Officer, Together First CIC, Barking & Dagenham GP Federation and Sandeep Sharma of The White House Surgery will be attendance to present a CQC Report on Together First to the Committee.	
Recommendation(s) The Health Scrutiny Committee is recommended to note the report.	

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

List of appendices:

- Appendix 1 – The Care Quality Commission report on Together First

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Barking Hospital

Inspection report

Upney Lane
Barking
IG11 9LX
Tel:
www.togetherfirst.co.uk

Date of inspection visit: From the 7 to 19 December 2023
Date of publication: 30/01/2024

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Outstanding
Are services well-led?	Good

Overall summary

This practice is rated as Good overall. (Previous inspection 10 October 2018 the service was rated overall Good)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Outstanding

Are services well-led? – Good

We carried out an announced comprehensive inspection at Barking Hospital from the 7 to 19 December 2023 as part of our inspection programme.

How we carried out the inspection.

This inspection was carried out in a way which enabled us to spend a minimum amount of time on site.

This included:

- Conducting staff interviews using video conferencing.
- Reviewing patient records to identify issues and clarify actions taken by the provider.
- Requesting evidence from the provider.
- A site visit.

Our findings

We based our judgement of the quality of care at this service on a combination of:

- what we found when we inspected
- information from our ongoing monitoring of data about services and
- information from the provider, patients, the public and other organisations.

At this inspection we found:

We rated the service as outstanding for providing responsive services because:

- People can access services and appointments in a way and at a time that suits them.
- Technology was used innovatively to ensure people have timely access to treatment, support, and care.
- The service identified people's health inequalities and needs and provided services in response.
- The service improved on commissioned services to provide better outcomes for patients.
- People's individual needs and preferences were central to the delivery of tailored services.

We have rated safe, effective, caring and well-led as good because:

Overall summary

- Staff involved and treated patients with compassion, kindness, dignity and respect.
- The service had systems to keep people safe and safeguarded from abuse.
- Technology and equipment were used to improve treatment and to support patients' independence. The service was able to access the patients GP NHS records to ensure they had enough information when making care and treatment decisions.
- Staff worked together and worked well with other organisations to deliver effective care and treatment.
- The service had a vision and strategy to deliver quality care and promote good outcomes for patients.
- Leaders had the capacity and skills to deliver quality sustainable care.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

The areas where the provider should make improvements are:

- Act to risk assess any Disclosure and Barring checks that are not current and from a previous employer.
- Improve the recording and guidance for the audit of clinician's patient consultations reviews.
- Review policies and procedure to check they fully reflect the services practices.
- Act to record verbal complaints to enable the identification of any reoccurring issues.
- Seek further assurance that all staff have completed the necessary training for their roles.

Dr Sean O'Kelly BSc MB ChB MSc DCH FRCA

Chief Inspector of Health Care

Our inspection team

Our inspection team was led by a CQC lead inspector supported by a GP specialist adviser.

Background to Barking Hospital

The provider of Barking Hospital is Together First CIC, which was a GP Federation formed in 2014 and reformed as a Community Interest Company (CIC) in 2020 to partner with its GP shareholders with a focus on service development and delivery of services for their local communities.

The address is Barking Hospital

Upney Lane

Barking

Essex

IG11 9LX

The premises are a small reception area and some consultation rooms at Barking Hospital but operated by Together First CIC.

The service is operated by a Board with a chairperson and four elected members and a chief officer who are supported by directors, including a clinical director, business managers and an administration team. They support a clinical team who work across the services.

The service is commissioned by the Primary Care Network (PCN) and North East London Integrated Care Board (ICB) for the residents of Barking and Dagenham who are registered with a local GP practice. The service is commissioned for:

An extended hours service open from Monday to Friday 6.30pm to 10pm and Saturday and Sunday 10am to 10pm. This was for patients who were assessed as having an urgent primary care need. The service provided GP face to face and telephone appointments. It did not provide a service for patients who required on going treatment for long-term conditions, palliative care, and maternity care. Patients could access the service by contacting the service directly, through their NHS GP service, or NHS111 or urgent care services.

An enhanced access service, which commenced in October 2022 offered cervical screening, vaccination, and long-term health condition monitoring appointments to patients within the different PCNs. The service was subcontracted from the PCNs who were commissioned by the local Integrated Care Board (ICB). The service operated from Monday to Friday 9:30am to 6.30pm and Saturdays and Sundays 9am to 5pm.

A simple wound care service for patients, which was carried out by practice nurses. The service was open from 9am to 5pm from Monday to Friday.

A spirometer service. The service was open on Tuesday 2.30pm to 7.30pm, Friday 10am to 7:30pm and Saturday and Sunday 9am to 10pm.

The provider Together First Ltd is registered with the CQC to provide the regulated activity treatment of disease, disorder and injury.

Good

Are services safe?

We rated the service as good for providing safe services.

Safety systems and processes

The service had systems to keep people safe and safeguarded from abuse.

- The service had systems to safeguard children and vulnerable adults from abuse. This included providing staff with the necessary information to ensure safeguarding protocols were followed. In addition, any safeguarding incidents were logged and followed up to ensure the patients NHS GP and safeguarding teams were notified.
- The staff had access to patients GP NHS records which provided information and assurance that an adult accompanying a child had parental authority.
- On the first day of the inspection, the service demonstrated clinical staff had completed children's and adults safeguarding level 3, and non-clinical staff had completed level 1 training. As many of the non-clinical staff were patient facing the service was advised to review the safeguarding intercollegiate guidance which recommends level 2 training for all non-clinical patient facing staff. During the inspection process non-clinical staff completed level 2.
- The provider had a human resource manager who was responsible for staff recruitment and training. The recruitment policy was last reviewed in December 2022. The provider employed permanent staff and staff who worked out of normal hours that were described as locums.
- The human resource manager explained all staff had an enhanced Disclosure and Barring Service check (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). A review of a sample of staff files found that for some staff the service had accepted DBS checks carried out by a previous employer but had not carried out a risk assessment regarding the length of time between their employment with the service and the DBS check.
- Documents reviewed demonstrated proof of identity, address, a curriculum vitae, a DBS check, immunisation status and an induction form for locum clinical staff. The human resource manager explained they normally did not conduct an interview because most of the clinical staff worked within the local area. However, this was not reflected in the recruitment policy last reviewed in 2022. The non-clinical staff had evidence of identity, address, a curriculum vitae, a DBS check, immunisation status, an induction form and references, the human resource manager explained interviews were held for these staff.
- The premises were part of Barking Hospital, which was operated by NHS property services. The site managers had an overview of their premises and infection prevention and control risk assessments. The infection control lead carried out an infection prevention and control risk assessment every three months and the site was checked monthly by the site managers. The service used Barking Hospitals waste management system. All call handlers and administration and most clinical staff had completed annual infection control training.
- Barking Hospitals NHS services were responsible for the fire safety equipment. The fire risk assessment was last carried out in April 2023, the equipment was checked in August 2023, and the most recent fire drill was in October 2023. We saw there was fire information on the notice boards. The health and safety compliance audit was last carried out by the provider in November 2023 with a review date of November 2024.
- The provider had evidence of health and safety and fire training for all staff except for out of hours GPs who were already working in a GP NHS service and where they believed they would have completed this training already.
- The provider had carried out annual equipment calibration checks on the 12 November 2023. Clinical staff were not allowed to use their own equipment.
- The staff carrying out the spirometry service provided evidence of their weekly calibration checks.

Risks to patients.

There were systems to assess, monitor and manage risks to patient safety.

Good

Are services safe?

- There were arrangements for planning and monitoring the number and mix of staff needed. There was an effective system in place for dealing with surges in demand. Senior staff were easily identifiable and available for staff to escalate their concerns.
- There was an effective induction system for temporary staff tailored to their role.
- The leaders explained staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention and sepsis had been discussed at various meetings.
- There were suitable medicines and equipment to deal with medical emergencies which were stored appropriately and checked regularly. These were checked daily by staff and monthly by the site managers.
- Following patients booking an appointment the service's staff would call the patient to check what type of appointment they would like, whether the appointment was appropriate and advised patients what to do if their condition got worse.
- When there were changes to services or staff, the service assessed and monitored the impact on safety**.**

Information to deliver safe care and treatment.

Staff had the information they needed to deliver safe care and treatment to patients.

- Clinical staff had access to the patients NHS clinical records. All clinical consultations were documented directly into the patients records during the consultation. In addition, the patients GP was provided with a discharge letter within 24 hours of the consultation.
- We reviewed a sample of patients care records and we saw that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- At the time of the inspection, the service did not carry out direct referrals to secondary care, the clinician would complete a proforma making a recommendation of a referral to the patients GP practice. The administrative staff would follow up the referrals to ensure the NHS GP practice had reviewed them.
- The service had a system in place to retain medical records in line with Department of Health and Social Care (DHSC) guidance in the event that they cease trading.

Safe and appropriate use of medicines.

The service had systems for appropriate and safe handling of medicines.

- The systems and arrangements for managing medicines, including medical gases, emergency medicines and equipment, and controlled drugs and vaccines, minimised risks.
- The service kept prescription stationery securely and monitored its use. Arrangements were in place to ensure medicines and medical gas cylinders carried in vehicles were stored appropriately.
- Staff prescribed, administered, and gave advice to patients on medicines in line with legal requirements and current national guidance.
- We were provided with an audit of co-amoxiclav carried from October to end of November 2023. The conclusion found that clinicians needed to update their knowledge on the appropriate use of broad-spectrum antibiotics previous audits. A second audit was planned in six months.
- Processes were in place for checking medicines and staff kept accurate records of medicines.

Track record on safety.

The service had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.

Good

Are services safe?

- Service level agreements were in place which detailed the provider and hub site responsibilities in relation to premises, health and safety and infection prevention and control.
- The service monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.
- The staff explained that most clinical staff received safety alerts in their main place of work. In addition, the service emailed out safety alerts to clinicians and were implementing a new computer management system which would enable them to record that staff had read them.

Lessons learned and improvements made.

The service learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The service learned and shared lessons, identified themes and took action to improve safety in the service.
- The provider took part in end-to-end reviews with other organisations. Learning was used to make improvements to the service.
- The provider was aware of and complied with the requirements of the Duty of Candour.

Good

Are services effective?

We rated the service as good for providing effective services.

Effective needs assessment, care and treatment

- Technology and equipment were used to improve treatment and to support patients' independence. The service was able to access the patients GP NHS records to ensure they had enough information when making care and treatment decisions.
- The provider had systems to keep clinicians up to date with current evidence-based practice.
- We saw evidence that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.
- Patients' immediate and ongoing needs were fully assessed. Where appropriate this included their clinical needs and their mental and physical wellbeing.
- The extended hours service provided same-day general practitioner appointments for the local primary care network patients, operating in the evenings and weekends every day of the year, including public holidays. Patients could access appointments through the call centre or their GP or 111 or the urgent treatment centre. When an appointment was made, patients were contacted to ensure the appointment was suitable for their needs. For example, whether they preferred face to face or a telephone appointment. The service was for patients who were assessed as having an urgent primary care need. The service did not see patients with severe mental illness or patients who required palliative care.
- The service had an enhanced access service commenced in October 2022; this was subcontracted from the primary care networks, who were commissioned by the local Integrated Care Board (ICB). The service offered cervical screening, vaccination, and long-term health condition monitoring appointments to patients with in the different PCNs. The enhanced service staff included advanced nurse practitioners (ANP), practice nurses, nurse prescribers and health care assistants. The service acted on behalf of GPs to recall patients for their long-term health condition reviews.
- The service had a spirometry service to help diagnose and monitor certain lung conditions commissioned by the local integrated care board, which was provided at Barking hospital patients were referred to the service by their NHS GP.
- The service offered simple wound care for patients operated by practice nurses, commissioned by the local ICB.

Monitoring care and treatment

- For the extended hours service the provider reported monthly to the local integrated care board the number of appointments completed for each practice and the age range of the patients. The provider also submitted the number of complaints each month.
- The provider submitted October 2023 figures which demonstrated they had completed a total of 2,085 appointments. The providers quality report for 2022 to 2023 stated they had provided 25,000 appointments. For quarter 2 of 23/24 year the practice had exceeded all the commissioners' targets for the minimum number of hours. This demonstrated they were meeting and sometimes exceeding their local targets
- The clinical lead explained for the extended hours service they carried out annual consultation reviews of three patient records consultations for each GP partly against the Royal College of General Practitioners guidance and if they had any concerns the GP would be informed by email or by telephone, contact.
- However, we found the audit system and data was inconsistent, because although GPs were informed of any failings, their records were not audited again until the following year. In addition, the guidelines for clinical auditors stated that audits of new GPs should be completed as soon as possible after they started shifts, however we were not provided with any written evidence that this was followed. The clinical lead GP explained that they did audit new doctors when they started working in the service, but this was not reflected clearly in the data. During the inspection, the clinical lead clinical GP agreed to review the system and guidance.

Good

Are services effective?

- The enhanced service, which commenced in October 2022 offered cervical screening, vaccination, and long-term health condition monitoring appointments to patients within the different PCNs. The service was subcontracted from the PCNs who were commissioned by the local Integrated Care Board (ICB). The service provided unverified data of the PCNs submissions to the ICB to demonstrate for quarter two in 2023/2024 they had carried out slightly more appointments than required.
- The enhanced service staff included advanced nurse practitioners (ANP), practice nurses, nurse prescribers and health care assistants. The clinical lead supported an ANP to carry out the clinical audits for the nursing staff. We saw audits were carried out in April, May and June 2023, but these did not cover all the staff and it was unclear what processes were followed. Also, the service did not have guidance for the staff to follow. During the inspection, the clinical lead clinical GP agreed to review the system and guidance.
- The service provided information to demonstrate that audits had been carried out for staff working in the respiratory hubs.
- The service carried out medicines audit to ensure prescribing was in line with best practice guidelines for safe prescribing. We were provided with an audit of co-amoxiclav carried from October to November 2023. The conclusion found that clinicians needed to update their knowledge on the appropriate use of broad-spectrum antibiotics previous audits. A repeat audit was planned for six months' time.
- The service monitored the frequency of attenders to report back to the patients GP services.

Effective staffing

- The provider had a learning and development policy for staff which was last reviewed in October 2022, this did not reflect the information the provider held regarding the mandatory training for all staff. For example, the policy stated staff should complete regarding Autism awareness, mental health, DOLS, moving and handling and prevent training but the provider did not have evidence of this training.
- All the staff worked in other NHS services and completed their training as part of their full-time work. The provider would seek some assurances from the staff that training had been completed.
- The provider had evidence staff working in the enhanced service and the spirometer service had completed mandatory training.
- For non-clinical staff, the service had evidence of mandatory training and a site admin competency framework check list that they had to complete prior to commencing work.
- The service had evidence the GPs working in the extended hours service had completed safeguarding and basic life support training, however at the start of the inspection, it did not require staff to provide evidence of other mandatory training, such as infection control training, health and safety and information governance. During the inspection process the provider sought assurance from staff that this training had been completed.
- The provider had an induction programme for all newly appointed staff.
- The registered manager recognised the need for review of their clinical supervision process so that they clearly documented how they ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.
- The provider explained that all of the Directors had received a full Institute of Directors training to Certificate level, which they intended to expand to diploma levels.

Coordinating care and treatment

Staff worked together and worked well with other organisations to deliver effective care and treatment.

- The chief executive represented the service within the Integrated Care Board (ICB) to ensure the improvement of services to the local population of Barking and Dagenham.

Good

Are services effective?

- We saw a sample of records that showed that all appropriate staff, including those in different teams, services, and organisations, were involved in assessing, planning, and delivering care and treatment.
- The services had access to the patients NHS GP records and recorded their consultation within them which enabled coordinated and person-centred care.
- The services also provided discharge letters to the patients GPs following each consultation.
- There were clear and effective arrangements for booking appointments, all referrals to other services were made through the patients NHS GP and the services had plans in place to commence direct referrals to secondary care.

Helping patients to live healthier lives.

Staff were consistent and proactive in empowering patients and supporting them to manage their own health and maximise their independence.

- The service identified patients who may need extra support. Staff had access to the patients NHS records which enabled them to see alerts which identifying any patients' specific needs.
- Where appropriate, staff gave people advice so they could self-care. Systems were available to facilitate this.
- Where patients need could not be met by the service, staff redirected them to the appropriate service for their needs.
- The services website included information about self-care.

Consent to care and treatment

The service obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.

Good

Are services caring?

We rated the service as good for caring.

Kindness, respect and compassion

- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- The service gave patients timely support and information. Call handlers gave people who phoned into the service clear information.
- The service sought patient feedback following each consultation and collated them monthly and provide this feedback to the commissioners. For 2022 to 2023, 823 patients responded to the satisfaction survey, this asked the patients to rate the courtesy of the reception staff 79.4% stated they were very helpful and 20.3% stated they were helpful and 99.9% stated they would recommend the service to their family or friends.

Involvement in decisions about care and treatment

- Interpretation services were available for patients who did not have English as a first language. Patients were also told about multi-lingual staff who might be able to support them.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- The service sought patient feedback following each consultation, collated them monthly and provided this feedback to the commissioners. For 2022 to 2023, 823 patients responded to the satisfaction survey, this asked patients to rate the explanation given by the GP. 49.3% of respondents stated it was outstanding and 49.2% stated it was good and when asked how well did the healthcare professional include you in making the decision about your care 43.5% stated it was outstanding and 51.3% stated it was good.

Privacy and dignity

The service respected and promoted patients' privacy and dignity.

- Staff respected confidentiality.
- Staff understood the requirements of legislation and guidance when considering consent and decision making.
- Staff supported patients to make decisions.
- Patients had access to a chaperone.

Outstanding ☆

Are services responsive to people's needs?

We rated the service as outstanding for providing responsive services because:

- People could access services and appointments in a way and at a time that suits them.
- Technology was used innovatively to ensure people had timely access to treatment, support, and care. For example, in response to Core20 Plus5 reducing healthcare inequalities for children and young people. The service had developed a data snapshot of the children 0 to 17 years, which enabled them to carry out targeted prevention and interventions at an early age to improve health outcomes, which was shared with the ICB.
- The service identified people's health inequalities and needs and provided services in response. For people with long-term conditions the service identified patients across the primary care networks who had not had their reviews and targeted their enhanced service to meet the unmet need.
- The service improved on commissioned services to provide better outcomes for patients.
- People's individual needs and preferences were central to the delivery of tailored services.

Responding to and meeting people's needs

- Together First CIC was a GP Federation formed in 2014 and reformed as a Community Interest Company (CIC) in 2020 to partner with its GP shareholders with a focus on service development and delivery of services for their local communities. The provider understood the needs of its population and tailored services in response to those needs. The provider engaged with commissioners to secure improvements to services where these were identified. Examples where the provider improved services where possible in response to unmet needs were: -
- An extended hours service open from Monday to Friday 6.30pm to 10pm and Saturday and Sunday 10am to 10pm. The service was commissioned by the local primary care networks (PCN) for the residents of Barking and Dagenham who were registered with a local GP practice in the networks. It was commissioned for patients who were assessed as having an urgent primary care need. The service provided GP face to face and telephone appointments. To support NHS 111, A&E, GP practices and urgent care centres. It did not provide a service for patients who required on going treatment for long-term conditions, palliative care, and maternity care. Patients could access the service by contacting the service directly, through their NHS GP service, or NHS111 or urgent care services.
- The provider explained they ensured the full take up of all appointments by contacting each patient by telephone to check the type of appointment they required (face to face or telephone appointment) and to make sure the appointment was appropriate for their needs. This helped them to ensure the service was effective and efficient. The provider explained that by ensuring the service was efficient they had been able to extend the service above the contracted hours of 8pm up to 10pm each evening within the existing budget increasing access for local patients.
- The service provided appointments for working people and children who could not attend during normal working hours and was available at Barking Hospital and a second location.
- The provider stated in their 2022/23 quality report that they provided 25,000 appointments.
- In addition, to meet patient need during the winter period they had structured the service to provide more appointments towards the winter months, where they typically offer 40-60% more appointments per day than in the quieter summer months. They had also provided 778 extra appointments on commissioner request to assist 111 during the January to March 2023. Throughout the year the practice had met the commissioners' targets and the patient survey carried out by the provider demonstrated this had prevented patients from attending accident and emergency and urgent care services. The unverified patient survey demonstrated for 2022 to 2023 where they had 823 responses that if the service was not available 297 would have contacted NHS 111, 222 patient would have gone to accident and emergency services and 77 would have used other out of hours services such as urgent care and 146 would have waited to see their own GP.
- The enhanced service, which commenced in October 2022 offered cervical screening, vaccination, and long-term health condition monitoring appointments to patients with in the different PCNs. The service was subcontracted from the PCNs who were commissioned by the local Integrated Care Board (ICB). The service operated from Monday to Friday 9:30am to 6.30pm and Saturdays and Sundays 9am to 5pm.

Outstanding ☆

Are services responsive to people's needs?

- The provider explained how they would meet regularly with the primary care networks to establish which practices would benefit from their support to increase the number of patients long-term health reviews were completed. With the agreement of the practice, they would review the patient record system and invite patients who were due an annual review to the enhanced access appointments. From October 2022 to October 2023, the quality report states that they had provided 243 asthma, 865 diabetes and 57 chronic obstructive pulmonary diseases annual patient reviews.
- The provider reviewed this service following the first six months and improved by changing offering specific clinics to generic patient condition clinics which meant patients had more choice about appointment times.
- Alongside the enhanced service the provider offered childhood immunisations and stated in their quality report they had completed 264 childhood immunisations of patients from hard-to-reach groups. As part of this service, they had been involved in pop up clinics where they advised and encouraged immunisation to patient guardians.
- The service offered simple wound care for patients at Barking Hospital, which was carried out by practice nurses. Unverified feedback from the provider where 772 patients provided feedback found 94% found it very good or good service.
- A spirometer service from Barking Hospital which the quality report stated had provided 639 appointments from 2022 to 2023. The service was open on Tuesday from 2.30 to 7.30pm, Friday 10am to 7.30pm and Saturday and Sunday 9am to 10pm. Unverified feedback from the provider, which demonstrated out of 144 patients 133 had confidence in the service and trust in the nurses treating them. 134 were satisfied with the outcome of the service.
- During the winter months from 5 January to 31 March 2023 the service was commissioned to promptly set up acute respiratory infection hubs for 12 weeks to help relieve the pressure on urgent care and GP practice. The annual quality report stated they offered 6,632 appointments using different staff skills. The service provided same-day independent prescriber appointments for the borough, running in the daytime core hours every day of the contracted period, including public holidays.

  Appointments were booked in GP practices directly from Monday to Friday and 111 or the urgent treatment centre booked directly on a Saturday and Sunday; also, the practices had access to any unused appointments on Monday to Friday. This service was not operating at the time of the inspection.

- The practice followed and leaders were focused on delivering plans aligned to Core20 Plus5 reducing healthcare inequalities for children and young people. The service had developed a data snapshot of the children 0 to 17 years, reviewed ethnicity by indices of multiple deprivation, the number of children by ward and the number of patients with asthma, epilepsy, obesity, diabetes and severe mental illness. This enabled them to carry out targeted prevention and interventions at an early age to improve health outcomes. For example, the enhanced access service. Following the initial success of this service the commissioners have commended funding it.
- The data was shared with all of the ICB partners and voluntary sector organisations and was being used to develop the targeted commissioning for 2024/5.
- The service was also collating data for adults over the age of 18 years. The provider was aiming for this to be used to identify health inequalities, treat unmet need, and provide targeted prevention and intervention within the ICB.
- Previous examples of the service respondence to patient needs were: -

  From the 1 April to 21 May 2022, the provider was commissioned to provide COVID vaccinations to residential home patients and those who were unable due to illness to leave their homes and children aged 5 to 15 years. The quality report states that the service delivered 3080 doses in total, including 481 at home and in care homes settings.

Outstanding ☆

Are services responsive to people's needs?

Following the pandemic, the service was awarded the safeguarding star for the Covid vaccination programme they provided. This included running post-dusk Ramadan clinics and using local engagement campaigns to target specific groups, such as Eastern European younger people and school-age children.

In addition, the provider recognised that people with a learning disability or severe mental illness were not presenting for their vaccinations and in response made reasonable adjustments to the service. For example, reduced noise and stimulus in the location had fewer appointments, increased the length of the appointment to approximately 30 minutes and added quiet areas for patients to relax and de-stress. This resulted in 341 patients with a learning disability or severe mental illness receiving their first Covid dose and 280 receiving their second does. In addition, their carers were offered the vaccine at the same time which resulted in 184 doses.

- The provider recognised that different community groups were affected more by health inequalities, in response they provided the data to secure funding from the commissioners to provide 3706 health checks for patients aged 40 to 74 years for these groups.
- The service had a system in place that alerted staff to any specific safety or clinical needs of a person using the service.
- The facilities and premises were appropriate for the services delivered.

Timely access to the service

Patients were able to access care and treatment from the service within an appropriate timescale for their needs.

- Patients access to appointments was dependent upon the service the needed.
- The extended hours service were booked by the patient GP practice, through NHS111 or by the urgent care center.
- The enhanced access service offered all appointments to the GP practices two weeks in advance and in the last week would use their own generated patient lists and offer appointments directly by direct text message to the patient. Patients could then book in via an online one-time booking link. The appointments were based on identified needs, usually quality outcomes framework or investment and impact fund targets.
- Patients accessed the spirometry service by their GP referral.
- Patients were given a link to the self-booking service for the wound care service.
- The service had revised their appointment booking system to be more reflective of patient's needs. They had invested in secure technology to allow patients to remotely choose their appointment, book it, cancel it, and choose their preferred site and time. Patients could also securely book through their GP practice or 111 for many services. The system allowed a choice of appointment for many services, for example health checks and vaccinations.
- Patients were able to access care and treatment at a time to suit them. The extended hours service was open from Monday to Friday 6.30pm to 10pm and Saturday and Sunday 10am to 10pm. The enhanced access service operated from Monday to Friday 9:30am to 6.30pm and Saturdays and Sundays 9am to 5pm.
- The wound care service was open from 9am to 5pm from Monday to Friday.
- The spirometry service was open on Tuesday 2.30 to 7.30pm, Friday 10am to 7:30pm and Saturday and Sunday 9am to 10pm.
- The extended hours service was run by the provider from 8pm to 10pm each day of the week outside of the commissioning agreement in response to patient's needs.
- Patients could access the service by directly calling the service or via the NHS 111 service or their NHS GP and from urgent care centres. The patients were called by the administration team to check that the appointment was appropriate and met their needs.
- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- We were provided with data submitted to the commissioners that demonstrated the targets were met and sometimes exceeded for all of the services.

Outstanding ☆

Are services responsive to people's needs?

- Where patient's needs could not be met by the service, staff redirected them to the appropriate service for their needs.
- The appointment system was easy to use.

Listening and learning from concerns and complaints

- The service had a complaints policy which was last reviewed in October 2023 and information about how to complain was available on the services website.
- The service had received one complaint since October in 2023. We reviewed the complaint and found it had been responded to by the member of staff the complaint was about. The registered manager agreed that they would consider the response being sent from a person who was not involved in the complaint in future.
- The staff explained that some complaints were verbal, resolved at the time and not recorded.

Good

Are services well-led?

We rated the service as good for leadership.

Leadership capacity and capability

Leaders had the capacity and skills to deliver quality sustainable care.

- Leaders had the experience, capacity, and skills to deliver the service strategy and address risks to it. The directors had completed the Chartered Institute of directors training to enable them to continue to carry out their role as the Federation developed.
- The service had increased the management team with a business manager, to support leadership and governance.
- The Chief Operating Officer and Executive Director were clear about the challenges to the organisation and the community it served.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership. Although staff were home based, we saw that the administration staff held monthly meetings, the senior leaders and the management team held weekly meetings.
- Senior management were accessible throughout the operational period, and staff said there was an effective on-call system that they were able to use. The service had an escalation system in place for staff who worked out of hours where staff could escalate any concerns to the senior leaders.

Vision and strategy

The service had a vision and strategy to deliver quality care and promote good outcomes for patients.

- There was a clear vision and set of values. The provider's vision was to support the general practice members, work in partnership with the primary care networks, act in strategic partnership with their health and social care partners, be innovative and make working life better for all staff. There values included that they act in the best interests of their patients. The values were evidenced in their commitment to improving primary health care in Barking and Dagenham.
- The service developed its vision, values and strategy jointly with patients, staff and external partners. The provider explained how they worked with the primary care networks and the Integrated Care Board to develop service for patients in Barking and Dagenham.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them. Staff we spoke with were aware of the visions and values of the service and their roles in achieving them.
- The strategy was in line with health and social care priorities across the region. The provider regularly reviewed the information about the practice population and planned the service to meet the needs of the local population.
- The provider monitored progress against delivery of the strategy. The provider reported their delivery regularly to the commissioners.
- The provider ensured that staff who worked away from the main base felt engaged in the delivery of the provider's vision and values.

Culture

The service had a culture of high-quality sustainable care.

- Staff felt respected, supported, and valued. They were proud to work for the service. The staff we spoke with and three whom completed staff questionaries all confirmed they felt they worked with a supportive team.
- The service focused on the needs of patients. The service had access to the patients NHS records this enabled them to review of the data to identify and respond to health inequalities.
- The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.

Good

Are services well-led?

- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- The provider stated that all staff had received regular annual appraisals in the last year.
- Clinical staff, including nurses, were considered valued members of the team.
- There was a strong emphasis on the safety and well-being of all staff.
- Staff had received equality and diversity training. Staff felt they were treated equally.
- Staff reported positive and supportive relationships between staff and teams.

Governance arrangements

- The provider of Barking Hospital is Together First CIC, which was a GP Federation formed in 2014 and reformed as a Community Interest Company (CIC) in 2020 to partner with its GP shareholders with a focus on service development and delivery of services for their local communities. This is operated by a Board with a chairperson and four elected members and a chief officer who are supported by directors, including a clinical director and business managers. The managers had regular meetings and all issues were discussed and escalated to the Board.
- There were clear responsibilities, roles and systems of accountability to support good governance and management. Together First was a non-profit organisation, with a board of trustees and a chief executive who was responsible for the day-to-day management of the service. They were supported by human resources and improvement, two operational, nursing and corporate and finance and information directors. Who were responsible for the management of the service team leaders. The service worked with the GP members to meet unmet need and improve patient care. Structures, processes, and systems to support good governance and management were mostly, understood, and effective.
- Staff were clear on their roles and accountabilities regarding safeguarding and infection prevention and control.
- Leaders had established policies, procedures and activities to ensure safety. However, we found some policies did not reflect working practices. Such as recruitment, learning and development and audit guidance.

Managing risks, issues and performance

There were processes for managing risks, issues and performance.

- The providers had plans in place and had trained staff for major incidents. The service had a business continuity plan in place which was last reviewed in October 2023 and included escalation, identifying the problem and the alerting process and the contact numbers of staff and local contacts.
- The leaders had business continuity exercise review for four days in March 2023 where the entire executive team were removed from management and the organisation was left to operate without them. This found that prior training and development had equipped the second tier of management with the necessary skills, competencies, and confidence to handle even the most senior tasks of the federation.
- The provider had processes to manage current and future performance of the service.
- The recording system regarding the performance of employed clinical staff through audit was not fully effective at the time of the inspection. The registered manager reviewed the system after this inspection.
- Leaders had oversight of incidents, and complaints.
- Performance of the organisation was regularly discussed at senior management and board level. Performance was shared with staff and the local commissioners as part of contract monitoring arrangements.
- The provider implemented service developments and where efficiency changes were made this was with input from clinicians from the local primary care networks to understand their impact on the quality of care.

Appropriate and accurate information

- The service collated patient data monthly to ensure they were meeting patient demands.

Good

Are services well-led?

- The service used information technology systems to monitor and improve the quality of care. The provider had access to the primary care networks patients' medical records this enabled them to review patient data and respond to patients needs and improve their own performance.
- The service submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

- The service offered all patients the opportunity to provide feedback following their consultation. They collated and reviewed this information monthly and annually. For 2022 to 2023 823 patients responded to the survey and 99.6% of respondents were satisfied with the outcome of their consultations and 99.8% would recommend the service to family and friends.
- The service reviewed their friends and family feedback, we were provided with the feedback for October and November 2023 where most of the patients said they would be likely to recommend the service.
- The provider reported regularly to the commissioners about the service. The Chief Operating Officer represented the organisation at ICB meeting and other meetings with external partners to feedback their health inequality findings.
- The service worked alongside the primary care networks to identify and meet patient needs.
- Staff said they were able to provide feedback and the management team held regular meetings at all levels to discuss changes to the service.
- The service was transparent, collaborative, and open with stakeholders about performance.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement at all levels within the service. For example, the directors had completed Chartered Institute of Directors training to enable them to continue to carry out their role as the federation developed.
- Staff knew about improvement methods and had the skills to use them. The management team reviewed patient data to identify patient needs and service gaps.
- There was a strong culture of innovation evidenced by:
- The service was contracted to facilitate the development the new PCN Health Inequalities GP Leads, by providing programme direction, learning sets and delivery to equip them for their roles.
- The service worked with the community sector locality leads to develop an understanding of and relationships with their community to support community engagement in decision-making about the development of services.
- The service held GP practice managers meetings, providing speakers for fortnightly remote meetings.
- The service provided administration support for when ICB staff undertook protected training.
- Monthly updates were provided to GP practices on Investment and Impact Fund(IIF) measures and the best way to maximise performance to achieve their targets. The Investment and Impact Fund (IIF) was an incentive scheme focussed on supporting PCNs to deliver high quality care to their population, and the delivery of the priority objectives articulated in the NHS Long Term Plan and in Investment and Evolution, a five-year GP contract framework.
- The service held sub-contracts to support the local primary care networks. For example, to aid recruitment, assist with data analysis and business intelligence
- The service reported updates on changes of national policy to ensure PCNs were always ahead of the information curve.

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**
27 March 2024	Screening – cervical, breast, bowel, lung cancer	Cancer Alliance – (Matthew Cole to coordinate)	Monday 11 March
	Impact of ICB Financial Savings	Sharon Morrow	
	Update on new 12-month shadow arrangements which launched from 26 June	Fiona Taylor	
	Minutes of the last JHOSC meeting	Cllr Paul Robinson, Chair of Health Scrutiny Committee	
	Minutes of the last HWBB/ICB (Committees in Common) meeting	Leanna McPherson	

5 June 2024	Community Diagnostic Centre – progress update Stroke Neuro rehabilitation and prevention NEL update Minutes of the last JHOSC meeting Minutes of the last HWBB/ICB (Committees in Common) meeting – Date TBC	Anne Hepworth, BHRUT Sharon Morrow Cllr Paul Robinson, Chair of Health Scrutiny Committee Leanna McPherson	Monday 20 May