Appendix 1

NHS
Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups

Barking & Dagenham

NHS
Barking, Havering and Redbridge University Hospitals NHS Trust

Together First CIC
Barking & Dagenham Federation

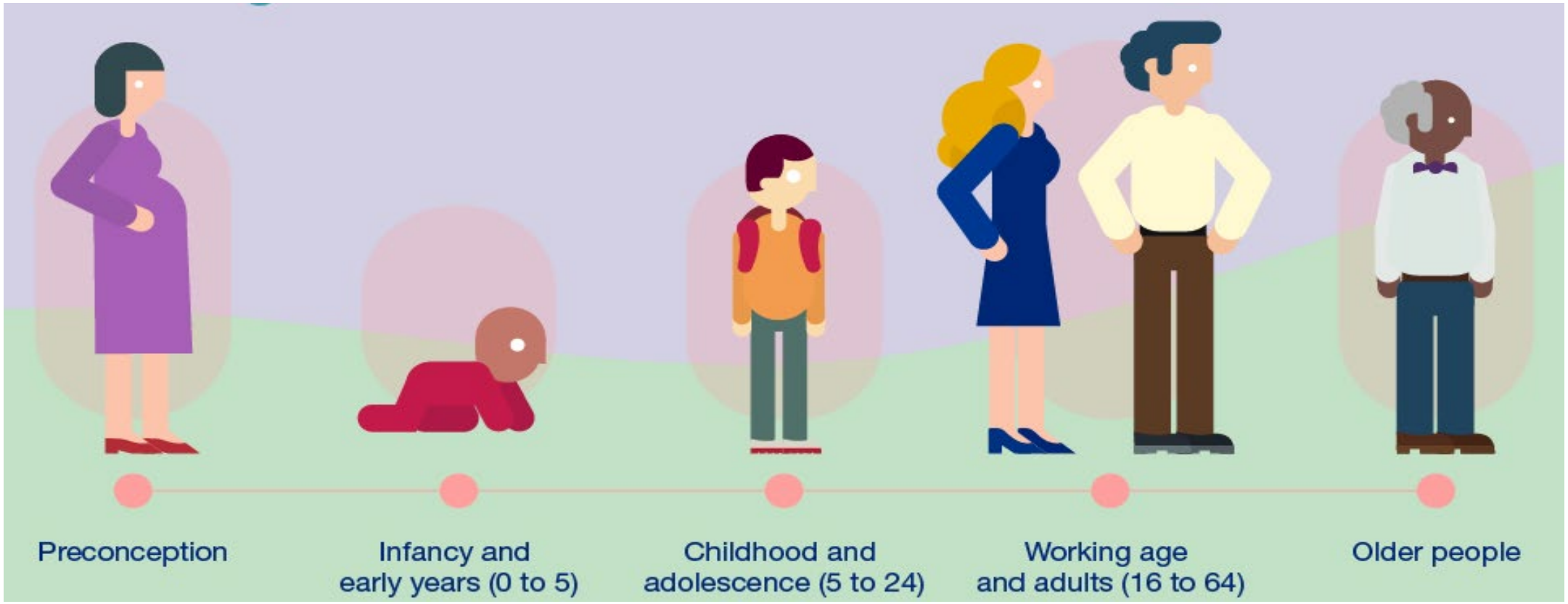
NELFT NHS
NHS Foundation Trust

BD COLLECTIVE

B&D Health Inequalities Programme 22/23

Health Scrutiny Committee, 14 November 2022

B&D residents face worse health at all life stages



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

B&D Health Inequalities programme 22/23

Following allocation of National NHSE funding, NEL HCP called for local place-based bids for FY22/23 funding to address:

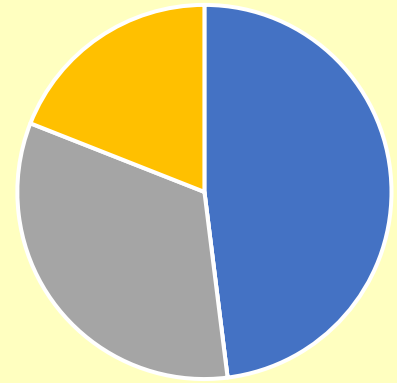
1. Leadership, partnership working, capacity development; Pot A - £0.5m per borough
2. Local health inequalities challenges; Pot B – up to £0.6m

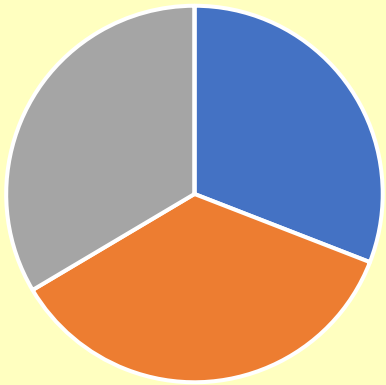
LBBD Public Health lead a rapid coproduction process across the Barking and Dagenham partnership and secured then highest allocation in NEL of £1.1m (20-140% more than other boroughs for funding Pot B)

Funding accessible from November 2022 for delivery to be completed by end-March 2023

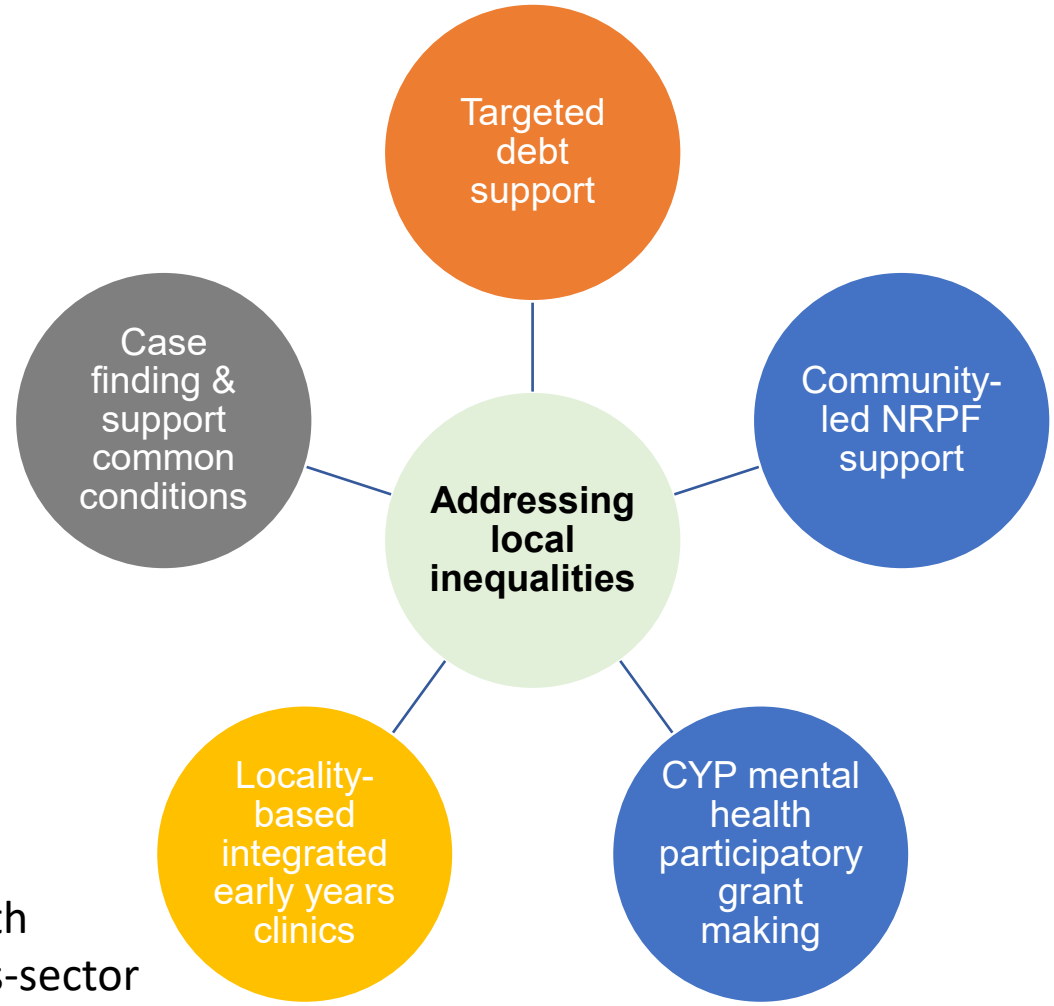
Funding / delivery

(% funding per sector)





B&D Health Inequalities Programme Workstreams



Community
Council
Health
Cross-sector

Benefits of programme – System and people

Barking & Dagenham

- Better, common knowledge & skills
- Better data
- Integrated, inequalities-focussed planning
- Better understanding of community
- Community focussed services
- Earlier identification (vulnerable 0-5, adults with LTCs)
- Greater accountability

- Voice to professionals
- Culturally appropriate support
- Funds for projects
- Access to social prescribing
- Debt support
- Better access to support
- Services tailored to needs (what, where, when)

Workstream#1: Locality Leads model

Aim

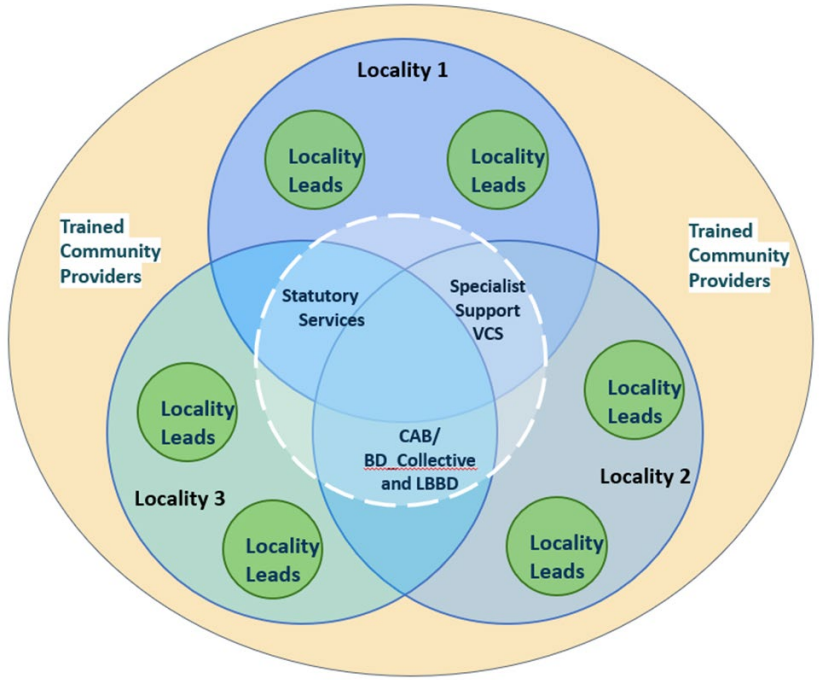
Establish focal point for CVS organisations within each locality to provide leadership, coherence and support cross-sector working

Outputs

- Named Community Locality lead in each locality
- Triage and referral process to ensure people get the most appropriate support (statutory or community)
- Coproducing and prototyping solutions to resident identified issues

Outcomes / benefits

- Interface between community and statutory services
- Building connection, trust and belonging in communities
- Better access to support for residents
- Services tailored to community need and preferences

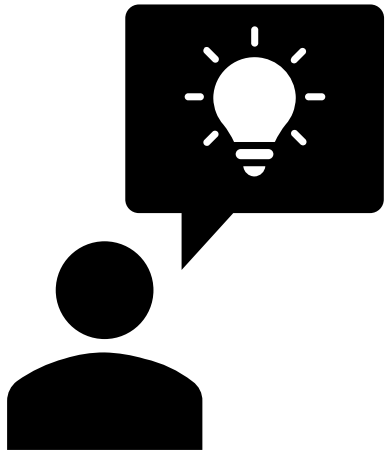


Progress to date:

- Six Locality Leads live as of 10 October
- Locality Leads connecting with residents, community organisations and PCNs

Workstream#2: Knowledge and skills development

Aim
Enhanced understanding of health inequalities and ability to act on them across the partnership



Outputs
- Partners in Practice workshop series for those instrumental in realising Family Hubs
- Action Learning Set for PCN Health Inequalities Leads
- System-wide learning offer on health inequalities in B&D

Outcomes / benefits
- Family Hubs partners understand how they individually and collectively impact on health inequalities
- Strengthened leadership on health inequalities within PCNs
- Shared understanding and narrative of what health inequalities
- Improved staff knowledge and skills on addressing health inequalities

Progress to date:
- First workshop held with practice leads around Family Hubs
- Specification developed for PCN Action Learning Set

Workstream#3: Community Chest for Social Prescribing

Aim

Pilot a ‘community chest’ approach to improve the provision and resourcing of community-based socially prescribed services

Outputs

- Coproduction of community chest model with VCSE
- Piloting ‘community chest’ process and funding round

Outcomes / benefits

- Better data on social prescribing needs, pathways, outcomes, demand and capacity
- Additional capacity in the social prescribing system to meet residents’ needs
- Participating VCSE organisations can leverage additional opportunities

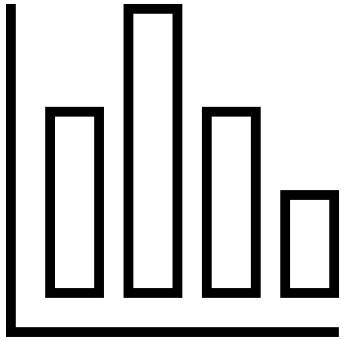
Progress to date:

- LBBD and VCSE working group are developing a “consortium” model for the funding

Workstream#4: Scoping system data needs

Aim

Co-produce cross-sector health inequalities indicator set/ dashboard to create a common data for planning and delivery



Outputs

- Analysis of datasets used across B&D partnership
- Scoping health inequalities data needs of partners
- Pilot a dashboard providing timely, appropriate health inequalities information for partners based on common data

Outcomes / benefits

- Partnership has a common health inequalities data
- Common, recognised data across partnership for monitoring, planning and delivery

Progress to date:

- Specification developed for LBBD to commission provider

Workstream#5: Planning NHS services in B&D Hubs

Aim

NHS participation in planning for Community/Family Hubs and support transition of relevant services into Hubs

Outputs

- A Strategic framework for integrating services
- Structured approach for how NHS Enhanced Access will work with Family and Community Hubs
- Fully consulted model for future planning and commissioning
- Model for sharing aggregated and anonymised data between the services

Outcomes / benefits

- Systematic approach for identifying and transitioning relevant NHS services into community/family hubs
- Integrated NHS services for residents accessible in the Community Hubs infrastructure

Barking & Dagenham Community Hubs

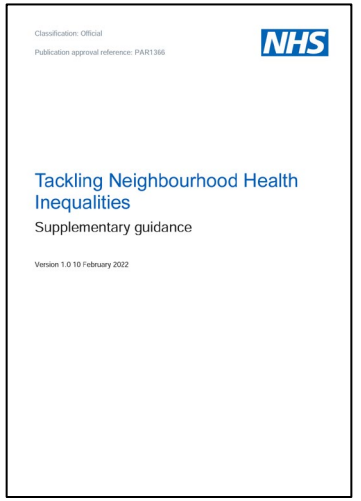
Progress to date:

- Project plan in development with Together First

Workstream#6: NHS PCN Health Inequalities Leads capacity

Aim

Develop PCN HIL roles to utilise local and national opportunities (e.g. integrated neighbourhood teams)



Outputs

1day / week PCN HIL in each PCN (6x)

1 day / month Programme Clinical Director (across B&D HI Programme)

Outcomes/benefits

- Community involvement in service planning / delivery
- ‘Hard wired’ link between NHS and community through PCN HILs and Community Locality leads
- Services more responsive to local needs
- Interventions coproduced with residents

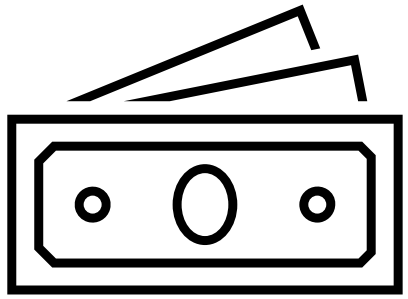
Progress to date:

- PCN HILs appointed
- Clinical Director appointed
- HILs & Community Locality leads relationships

Workstream#7: Debt and health proactive outreach

Aim

Pilot proactive and preventative approach to support residents with their debt and wider health and wellbeing



Outputs

- Identification of residents falling into doubt with likely mental health issues
- Targeted proactive supportive offer
- Provision of specialist debt advice and wider health and wellbeing social prescribing to residents taking up offer

Outcomes/benefits

- Participating residents' debt reduced and income maximised
- Participating residents' mental health and wider wellbeing improved
- Systems benefits in earlier intervention before needs escalate
- Development of evidence based approach to secure further funding

Progress to date:

- Cohort of residents identified
- Process flow for support intervention scoped

Workstream#8: Community-led support for people with No Recourse to Public Funds

Aim

Increase understanding and access to eligible services across professionals and volunteers and individuals with NRPF

Outputs

- Brief guidance for workforces (statutory and voluntary)
- Culturally competent communications of the support offer
- More GP practices with Safe Surgeries status
- Partnership briefed on scale, profile and lived experience of B&D population with NRPF

Outcomes/benefits

- Improved access to support to avoid financial and health crises
- Build community resilience
- Partners can better plan for NRPF population

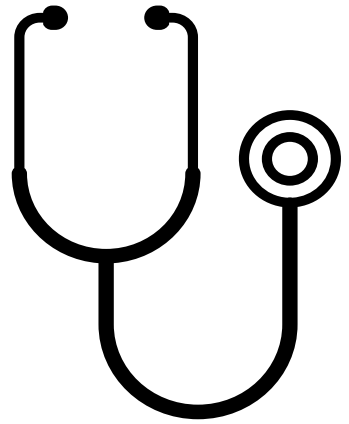
Progress to date:

- Ultimate Counselling appointed as lead community organisation
- Mapping of community organisations in the borough supporting people with NRPF
- Focus group of B&D residents with lived experience informing where barriers are

Workstream#9: Case finding

Aim

Pilot novel approaches to identify people with common manageable health conditions (CVD, COPD and diabetes) not currently identified and in treatment



Outputs

- Provide new engagements for the population most likely to have unrecorded CVS, COPD or diabetes
- Share analysis of how programme has improved health engagement

Progress to date:

- Unmet needs analysis conducted
- Scoping of project underway

Outcomes / benefits

- Health improvements for those with otherwise undiagnosed CVD, COPD or diabetes
- Improved knowledge base of providers in what works to improve case finding

Workstream#10: Participatory grant making for CYP mental health

Aim:
Pilot community-led grant giving process to deliver ‘grass roots’ community delivered interventions to address low level mental health issues in children and young people

Outputs:
- Coproduce community participatory grant making process
- Pilot process to select community-prioritised interventions
- Community-led interventions to tackle low-level emerging mental health issues in children and young people

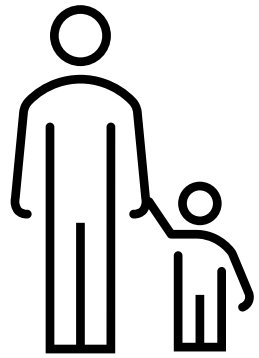
Outcomes / benefits
- Funding process supports small community organisations and collaboration
- Testing of innovative solutions to improve children and young people’s mental health and practitioner resilience

Progress to date:
- EOI conducted for community organisations to be involved in participatory process
- BD Giving facilitated workshops with community organisations to determine grant making process

Workstream#11: Locality-based 0-5yr Vulnerable Hot Clinics

Aim

Pilot partnership approach to support families of children aged 0-5 years at risk of developmental delay and / or physical or mental harm



Outputs

- Interventions put in place by VHC to improve outcomes related to health inequality indicators (e.g. school readiness)
- Interventions put in place by VHC tackle drivers of health inequalities such as poverty, poor housing and debt

Progress to date:

- Information Sharing Agreement drafted
- First VHC held with 5 cases

Outcomes / benefits

- Improved partnership working and communication
- Interventions put in place to support improved outcomes for vulnerable under 5s
- Tested model for roll out to other localities

Next steps

Embedding programme management

Programme governance through place-based structure

Linking to NEL opportunities – *Quality Improvement collaborative, cross-borough discussions*

Discussions with NEL ICB on 23/24 funding / planning