Barking & Dagenham

Notice of Informal Meeting

HEALTH & WELLBEING BOARD

Wednesday, 12 January 2022 - 6:00 pm
Meeting to be held virtually

Date of publication: 4 January 2022

Claire Symonds
Chief Executive

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Membership

Cllr Maureen Worby (Chair)	LBBD (Cabinet Member for Social Care and Health Integration)
Dr Jagan John	North East London Clinical Commissioning Group
Elaine Allegretti	LBBD (Strategic Director, Children and Adults)
Cllr Saima Ashraf	LBBD (Cabinet Member for Community Leadership and Engagement)
Cllr Sade Bright	LBBD (Cabinet Member for Employment, Skills and Aspiration)
Cllr Evelyn Carpenter	LBBD (Cabinet Member for Educational Attainment and School Improvement)
Melody Williams	North East London NHS Foundation Trust
Matthew Cole	LBBD (Director of Public Health)
Kimberly Cope	Metropolitan Police
Sharon Morrow	North East London Clinical Commissioning Group
Kathryn Halford	Barking Havering & Redbridge University NHS Hospitals Trust
Nathan Singleton	Healthwatch - Lifeline Projects Ltd.

Standing Invited Guests

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

AGENDA

1. **Apologies for Absence**

2. **Declaration of Members' Interests**

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

3. **Minutes - To note the minutes of the meeting on 9 November 2021 (Pages 3 - 8)**

4. **Proposed Appointment to the Health and Wellbeing Board (Page 9)**

5. **Covid-19 Update in the Borough (Page 11)**

6. **Urgent Action: Better Care Fund (Pages 13 - 84)**

7. **Maternity Services Report (Pages 85 - 94)**

8. **Maternity Services-Equity and Equality Needs Assessment (Pages 95 - 228)**

9. **BHR Joint Strategic Needs Assessment 2021-22 Update (Pages 229 - 242)**

10. **Carers Charter and Action Plan (Pages 243 - 256)**

11. **Forward Plan (Pages 257 - 262)**

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

13. **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 Health and Wellbeing Board, 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.***

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

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Barking & Dagenham

Our Vision for Barking and Dagenham

ONE BOROUGH; ONE COMMUNITY; NO-ONE LEFT BEHIND

Our Priorities

Participation and Engagement

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

Prevention, Independence and Resilience

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

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

Inclusive Growth

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

Well Run Organisation

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

MINUTES OF
HEALTH AND WELLBEING BOARD

Tuesday, 9 November 2021
(6:00 - 8:00 pm)

Present: Cllr Maureen Worby (Chair), Dr Jagan John (Deputy Chair), Elaine Allegretti, Cllr Sade Bright, Cllr Evelyn Carpenter, Sharon Morrow and Melody Williams

Also Present: Brian Parrott

Apologies: Cllr Saima Ashraf, Matthew Cole, Nathan Singleton and Cllr Paul Robinson

22. Declaration of Members' Interests

There were no declarations of interest.

23. Minutes (9 March, 15 June and 14 September 2021)

The minutes of the formal meeting held on 9 March 2021and informal meetings held on 15 June and 14 September 2021 were confirmed as correct.

24. Covid-19 Update in the Borough

The Senior Intelligence and Analytics Officer (SIAO) disclosed that the Delta variant remains the most prevalent in the borough. There was a new variant, designated as Delta Plus, discovered in October that was presently under investigation but only fourteen cases had been detected in the borough so far.

The SIAO also stated that since the last Board meeting

- Average daily hospital admissions had increased from five to seven
- As of 2nd November, there were 64 Covid-19 patients from the borough in Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT)which represented an increase from 51 patients
- The number of patients requiring mechanical ventilation was reduced from 15 to eight.

In addition to this, the SIAO explained that 33.4% of residents aged 18+ were still unvaccinated and persons aged 40 and under had the lowest vaccination rate. Barking and Dagenham had the 16th highest case rate in London which was an improvement on September where it was 9th. Longbridge ward continued to have the highest cumulative case rate. Since the pandemic began, there has been 583 Covid-19 related deaths.

In response to questioning, the SIAO clarified that the low rate of testing, relative to other parts of London and England, did impose limitations on the data but until people agree to be tested there was no way to discern infection rates and variants among such persons.

The Chair expressed concern at the levels of people unvaccinated, noting that vaccinations among persons aged 12 and above was only 54%. The Chair also requested that, going forward, the Board be provided with data on booster injections in the borough. Additionally, the Chair also requested how many staff at care homes were relieved of their position due to their refusal to be vaccinated.

In response, the Strategic Director-Children and Adults (SDCA) disclosed that work was ongoing to ensure that care home staff were fully vaccinated by the 16th December deadline set by the Government. Only two care homes were run by the Council with the remainder being privately run. Work was focused on four care homes were more than five staff members had still not received their first dose. There had been issued with data accuracy on vaccines however, take up was 90% and the SDCA was confident that there would be no impact on service delivery.

The Deputy Chair explained that 100% of all patients in intensive care had not been vaccinated whilst 7% of those aged 16 or under had been vaccinated which was skewing the figures. Concern was also expressed that few members of the public were wearing masks.

The Integrated Care Director (ICO) at North East London Foundation Trust (NELFT) said that communications were ongoing to encourage unvaccinated groups to book an appointment and these communications would utilise social media. However, given the differences in group profiles, there could not be a one size fits all strategy therefore communications would need to be tailored.

The Board noted the update.

25. Healthwatch Tender

The Lead Commissioner for Health (LCH) presented a report to the Board on the tender of the Healthwatch contract which expired on 31st March 2022. An engagement event would be taking place and would include two service users who would be involved in the design of the new service as well as being part of the tender panel. The Council wanted Healthwatch to be more visible in the community and to give voice to residents.

In response to questioning, the LCH clarified that Healthwatch would be expected to undertake more collaborative work across Barking and Dagenham, Havering and Redbridge with more tri-borough investigations, research and programmes.

The Board agreed to delegate the contract tendering process to the Chair and the Director of Public Health. The Board also agreed that the tender proposal would be brought back to the Board for the final decision.

26. Barking and Dagenham (B&D) Update Report on 2021/22 Adult Mental Health Investment and Long Term Plan Progress

The Mental Health Transformation Programme Director (MHTPD) at the North East London Foundation Trust (NELFT) presented to the Board on NHS England's long term plan in relation to mental health.

The aim was to develop an evidence-based skills development programme in

order to facilitate long term resilience to the challenges that would be faced in the coming years. This would be done by:

- Increasing access to psychological therapy;
- Promote continuity of care and avoid patients being dealt with by several teams;
- Develop a primary care model based around the primary care networks;
- Greater use of apprentices, recruitment of persons with lived experience to develop the future workforce and implement new ways of working as well as training existing staff: and
- Work with the third sector to develop community mental health resilience and support.

The MHTPD set out what had already been achieved including:

- Model of care and interfaces;
- Barking and Dagenham locality steering group;
- Open dialogue training commencement;
- Training matrix developed to facilitate staff development; and
- Contracts were developed with the third sector for the peer support worker service;

The MHTPD then clarified that the immediate priority for NELFT was to;

- Address service pressures;
- Produce new systems and processes in cooperation with key stakeholders using feedback from service users; and
- Complete recruitment and staff training.

The MHTPD disclosed that, whilst the aim was to begin implementation in December 2021 in at least two boroughs there had been technical issues. It was now expected that the plan relating to Barking and Dagenham would go live in March 2022.

The Integrated Care Director (ICD) updated the Board on actions taken to resolve issues with the crisis pathway including;

- Hospital beds closer to the patient's home with an improved support network;
- Reduction in hospital stays required for patients;
- No use of private sector beds since November 2020 when the Clinical Decision Unit was established;
- The Integrated Crisis Assessment Hub, introduced in November 2020, had achieved a patient satisfaction rating of 80%; and
- Improved joint working with the police and ambulance services enabling a quicker response and handover.

In relation to those aged between 18 and 25, the ICD stated that further research was required on this age group. An external organisation, called 'At Scale' had been commissioned to carry out research in order to assist NELFT in meeting the needs of 18 to 25 years olds. The ICD identified sub-groups at risk:

- Care leavers/children in care;
- Those on edge of youth justice services;
- Those with special educational needs; and
- Young carers and children separated from their families.

In relation to perinatal services, staff recruitment was ongoing and staffing resources were providing to be the biggest challenge in meeting the targets set out in the long-term plan. 80% of additional required staff had been recruited for the eating disorder service.

The 'Improving Access to Psychological Therapies' (IAPT) had been ranked among the two highest performing within seven IAPT services across North East London Integrated Care Services. The ICD also confirmed that the 'Keeping Well NEL' had been launched to support employees.

The Director of Integrated Care (DIC) at North East London Clinical Commissioning Group (NELCCG) responding to questioning, outlined how the three year mental health investment plan was being drawn up by NELFT and NELCCG. A Finance and Performance Group was established consisting of staff from both organizations. This was to ensure that investment was more closely aligned to service development, delivery and anticipating potential shortfalls, such as staff shortages, so that investment can be swiftly aligned to address any issue that arose. DIC acknowledged the complexities and the challenges that come from sudden increases in demand.

The Chair requested that a further update be given in six months as this would enable the Board to hear the feedback from service users and to further discuss the plan's development and challenges.

The Board noted the update

27. Safeguarding Adults Board Annual Report 2020-21

The Independent Chair of the Safeguarding Adults Board (ICSAB) presented to the Board.

There were issues of mental health and emotional wellbeing that were challenging to quantify as was domestic violence. Covid-19 had placed pressure on care homes and the 'care at home' scheme however ICSAB praised the Council for its response.

ISCAB highlighted his concern that a disproportionate number of adults with learning disabilities had died of Covid-19 in the borough. It was therefore important to acknowledge that gaps existed in knowledge. ICSAB cited, as an example, the gap in experience of people who have had safeguarding undertaken on their behalf and highlighted this as an area requiring improvement.

ICSAB discussed the new North East London partnership arrangements that come into force on 1st April 2022 disclosing that he had met with the Chief Nurse and that the meeting was productive. A proposed adult safeguard partnership assurance tool was discussed with ICSAB. Further discussions would take place.

The Strategic Director, Children and Adults (SDCA) clarified the definition of 'known persons' that was alluded to in the report. SDCA explained that data improvement exercises had been undertaken and that this likely resulted in changes to the number of known cases owing to such improvements. SDCA also stressed that the Council was largely responsible for producing such data despite other agencies also being responsible for dealing with adults at risk. The SDCA indicated that this would need to change.

The Board noted the update.

28. BHR Health and Care Academy Launch

The Chief Nurse (CH) at Barking, Havering and Redbridge University Hospitals (BHRUT) updated the Board on the BHR Academy. The Academy was launched in response to challenges with the workforce in terms of required numbers and qualifications.

Programmes have been implemented to address this including working with Barts Health and NELFT to increase the size of the workforce and upgrade skills. The BHR Academy aims to broaden this work and to involve more stakeholders. The CH stressed that, in addition to recruitment, moving existing employees to new positions, following training, is also part of the process and to create a pool of skilled staff in sufficient numbers.

The CH highlighted problems with health visitors, mental health nurses and allied health professionals. In terms of employment, a pilot was undertaken in the Summer of 2020 where care leavers were offered apprenticeships and whilst the numbers of care leavers were relatively low, this was a programme that could be expanded.

The Consultant in Public Health (CPH) raised the importance of reflecting the public health role of all health and care staff when workforce needs are looked at

The CH concluded by stating that the improvement plan was ongoing and further updates would be given.

The Board noted the update

29. Forward Plan

The Board noted the forward plan.

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

NHS England (NHSE) intended to implement changes to the rules regarding the administration of the Better Care Fund. The Board is required to sign off on the changes, however NHSE had indicated that the changes would need to be signed off before the next meeting of the Board which was in January 2022.

Therefore, the Chair of the Board or the Chief Executive would be required to sign off the changes on the Board's behalf. The nature of the changes would be presented to the Board at the next meeting.

The Board noted the update.

HEALTH AND WELLBEING BOARD

12 January 2022

Title:	Proposed Appointment to the Health and Wellbeing Board
Report of the Cabinet Member for Social Care and Health Integration	
Open Report	**For Decision**
Wards Affected: All	**Key Decision: No**
Report Author: Yusuf Olow. Senior Governance Officer	**Contact Details:** Tel: 020 3911 7919 E-mail: Yusuf.Olow@lbbd.gov.uk
Sponsor: Councillor Maureen Worby, Cabinet Member for Social Care and Health Integration	
Accountable Strategic Leadership Director: Elaine Allegretti, Strategic Director, Children and Adults	

Summary:

The Health and Wellbeing Board seeks to be representative of the health and social care sector.

Reimagining Adult Social Care Network, part of the B&D Collective, has requested to join the Board. The Chair supports their request as this would increase the involvement of the social care sector in the review and decision-making process.

Elspeth Paisley, from Community Resources, has been nominated to represent the B&D Collective.

As the meeting of the 12 January 2022 will be an informal meeting, the Board will not be able to formally approve Ms Paisley's appointment. However, the Board can request that the Assembly amend the Board's membership at their next meeting which takes place on 26 January.

Recommendation(s)

The Health and Wellbeing Board is recommended to agree:

1. That the Chair submit a report to the Assembly that a representative from the B&D Collective be added to the membership of the Health and Wellbeing Board.

Reason(s)

The inclusion of B&D Collective will widen the Council's engagement with stakeholders.

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HEALTH AND WELLBEING BOARD

12 January 2022

Title:	**Covid-19 update in the Borough**
Report of the Director of Public Health	
Open Report	**For Information**
Wards Affected: All	**Key Decision: No**
Report Author: Bianca Hossain, Senior Intelligence and Performance Officer.	**Contact Details:** E-mail: bianca.hossain@lbbd.gov.uk
Sponsor: Matthew Cole, Director of Public Health, London Borough of Barking and Dagenham	
Accountable Strategic Leadership Director: Elaine Allegretti, Strategic Director, Children and Adults	

Summary:

Since the beginning of the pandemic over 40,000 borough residents have tested positive for Covid-19 and there have been more than 590 Covid-19 related deaths.

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

Recommendation(s)

The Health and Wellbeing Board is recommended to:
1. Review and provide feedback on the presentation.

Reason(s)

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

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HEALTH & WELLBEING BOARD

12 January 2022

Title: Urgent Action: Better Care Fund 2021/22	
Report of the Strategic Director, Children and Adults	
Open Report	**For Information**
Wards Affected: None	**Key Decision:** No
Report Author: Louise Hider-Davies, Head of Commissioning, Adults' Care and Support	**Contact Details:** E-mail: louise.hiderdavies@lbbd.gov.uk

Accountable Strategic Leadership Director: Elaine Allegretti, Strategic Director, Children and Adults

Summary:

Local authorities and CCG's were issued with guidance on 30 September 2021 regarding Better Care Fund (BCF) submissions for 2021/22 and given just six weeks to make their respective submissions. Working closely with colleagues from Havering and Redbridge Councils and the CCG, LBBD officers completed the narrative document and planning template required by NHS England and submitted the Barking, Havering and Redbridge BCF submission for 2021/22 by the initial 16 November 2021 deadline.

Due to the extremely tight timescale, it was not possible to present the proposed submission to the last meeting of the Health & Wellbeing Board and NHS England had set a deadline of 11 January 2022 for the formal sign-off by HWBBs, which was the day before the next scheduled meeting of the HWBB.

In the circumstances, the Council's Chief Executive agreed that it would be appropriate to approve the BCF 2021/22 under the Urgent Action provisions of Part 2, Chapter 16, paragraph 4 of the Council's Constitution. It was also necessary to apply the General Exception provision set out in Part 2, Chapter 17, paragraph 14 of the Constitution as the matter qualified as a 'key decision' but had not been publicised in advance on the Forward Plan in accordance with the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012.

In line with the Urgent Action and General Exception provisions, the Chair of the HWBB and the Chair of the Health Scrutiny Committee were consulted prior to the Chief Executive taking the action. The BCF submission was also circulated to all Members of the HWBB for comment prior to approval.

The report and supporting documents which formed the basis of the Chief Executive's decision are set out at Annex 1 to this report.

Recommendation(s)

The HWBB is asked to note the action taken by the Council's Chief Executive, in accordance with the Urgent Action procedures set out in Part 2, Chapter 16, paragraph 4 and the General Exception provision under Part 2, Chapter 17, paragraph 14 of the Council Constitution, in relation to approving the BHR Better Care Fund submission for 2021/22.
Reasons To accord with the requirements of the urgency procedures contained within the Council Constitution.

Public Background Papers Used in the Preparation of the Report:

- Letter signed by LBBD Chief Executive dated 21 December 2021 entitled "Urgent Action under Part 2, Chapter 16, paragraph 4 of the Constitution – Better Care Fund 2021/22" (https://modgov.lbbd.gov.uk/Internet/ecCatDisplay.aspx?sch=doc&cat=14752)

List of appendices:

- **Annex 1** - Report and supporting papers entitled "Better Care Fund 2021/22"

HEALTH AND WELLBEING BOARD

December 2021

Title:	**Better Care Fund 2021/22**
Report of the Strategic Director, Children's and Adults	
Open Report	**For Decision**
Wards Affected: All	**Key Decision: Yes**
Report Author: Louise Hider-Davies, Head of Commissioning, Adults' Care and Support	**Contact Details:** E-mail: louise.hiderdavies@lbbd.gov.uk
Sponsor: Elaine Allegretti, Strategic Director, Children's and Adults	

Summary:

The Better Care Fund (BCF) provides financial support for councils and NHS organisations to jointly plan and deliver local services. Every year the local authority and the CCG are required to submit a template and/or narrative to NHS England to set out how the BCF is delivered in Barking and Dagenham. This year we were given 6 weeks to produce the template and narrative, alongside partners in LBH, LBR and the CCG, showing how the plan meets the metrics and requirements of the BCF. The plan was submitted on 16 November but now requires formal ratification by the Health and Wellbeing Board.

Recommendation(s)

The Health and Wellbeing Board is recommended to approve the BHR Better Care Fund submission for 2021/22, as detailed in appendices 1 and 2 to the report.

Reason(s)

The Better Care Fund enables the local authority and NHS organisations to jointly plan and deliver local services to support Barking and Dagenham residents. The BCF funds projects and services that are delivered by stakeholders from across the system, designed to improve health and social care outcomes, prevent re-admission to hospital, maintain and improve independence and support hospital discharge. The BCF works to deliver the Council's vision and priorities.

1. Introduction and Background

1.1 The Better Care Fund (BCF) provides financial support for councils and NHS organisations to jointly plan and deliver local services. It brings together ring-fenced budgets from Clinical Commissioning Group (CCG) allocations, and funding paid directly to local government, including the Disabled Facilities Grant (DFG), the improved Better Care Fund (iBCF) and the Winter Pressures grant.

1.2 In summary, this encompasses:

1) **Minimum CCG (Min CCG):**

- CCG funding including s256 proportion to LAs to support out-of-hospital services such as Reablement funding to maintain reablement capacity in LAs, community health services, independent/voluntary sectors
- Care Act monies to support the implementation of the Care Act 2014
- Carers' Break funding so carers can have a break

2) **Disabled Facilities Grant (DFG) paid directly to LAs:** for home adaptations and technologies to support people to live independently at home

3) **Winter Pressures (WP):** support the local health and care system to manage demand pressures including interventions that support people to be discharged from hospital, with the appropriate social care support in place, and promote people's independence.

4) **Improved Better Care Fund (iBCF) paid directly to LAs for Social Care Funding:**

- Meeting adult social care needs
- Reducing pressures on the NHS, including seasonal winter pressures
- Supporting more people to be discharged from hospital when they are ready
- Ensuring that the social care provider market is supported.

1.3 We have a Section 75 that governs the arrangement between us, BHR CCGs, Havering and Redbridge. An executive group steers the development of the BCF and in terms of governance, this group feeds up into the Joint Commissioning Board (JCB).

Preparation for BCF 21/22

1.4 This year the executive group reviewed our local schemes and how they fit together across the three Boroughs in order that we could determine our areas for future integration and development. One of our key priorities for this year has been hospital discharge and discharge to assess in line with the new Hospital Discharge planning requirements, which has included a focus on disaggregating the JAD, transferring staff back to the local authority, implementing the Single Point of Access (SPA) and embedding our longer-term Home First and Discharge to Assess arrangements.

1.5 The group agreed that our previous overarching schemes were out of date, particularly in light of changing guidance, metrics, terminology and of course the ongoing impact and recovery from the pandemic. Each Borough will now adopt the following four overarching schemes which encompass all of our work. This will be reflected in our future narratives in relation to the Better Care Fund for Barking and Dagenham, Havering and Redbridge:

i) **Hospital Discharge Planning & Support:** Ensuring effective discharge & increasing patient independence

ii) **Targeted Out-of-Hospital Care:** Supporting people with higher care needs in the community

iii) **Community Wellbeing, Care & Support:** Prevention & early intervention for low level care & support needs.

iv) Integration, market stabilisation and Covid recovery: Strategic joint working to support integration and borough partnerships; essential market and provider support to ensure services are available; reducing the risk of provider failure and to minimise the impact of recent effects of the COVID 19 pandemic and beyond.

2. Proposal and Issues

2.1 Guidance for this year's BCF was released on 30 September 2021 (two quarters into the year's spend) and a planning template and narrative was required by the regional and national team for submission by 16 November.

2.2 Attached at Appendix 1 and Appendix 2 is our BCF narrative, produced by the three BHR Boroughs and the CCG, as well as our Borough-based financial and metrics template.

2.3 Local areas were not required to submit BCF plans in 2020-21, given the exceptional pressures on systems due to the COVID-19 pandemic. The requirements for 21/22 focus on continuity and require systems to agree plans for integrated care that support recovery from the pandemic and build on the closer working arrangements that have developed over the previous 2 years.

2.4 The requirements echo previous years and conditions are as follows:

- A jointly agreed plan between local health and social care commissioners and signed off by the Health and Wellbeing Board.
- NHS contribution to adult social care to be maintained in line with the uplift to CCG minimum contribution.
- Invest in NHS commissioned out-of-hospital services.
- Plan for improving outcomes for people being discharged from hospital.
- Plans must have involvement from providers, VCS and housing colleagues.

What's changed since previous years?

2.5 **Metrics:** The BCF Policy Framework sets national metrics that must be included in BCF plans in 2021-22. The framework retains two existing metrics from previous years:

- older adults whose long-term care needs are met by admission to residential or nursing care per 100,000 population (Metric 1)
- effectiveness of reablement – the proportion of older people still at home 91 days after discharge from hospital into reablement or rehabilitation (Metric 2)

2.6 The previous measure on non-elective admissions will be replaced with a measure of avoidable admissions (unplanned hospitalisation for chronic ambulatory care sensitive conditions – Metric 3). Areas should agree expected levels of avoidable admissions and how services commissioned through the BCF will minimise these.

2.7 Finally, a new discharge indicator set has also been given as a new metric 4. This sets out that local systems should agree a plan to improve outcomes across the HWB area for the following measures:

- reducing length of stay in hospital, measured through the percentage of hospital inpatients who have been in hospital for longer than 14 and 21 days
- improving the proportion of people discharged home using data on discharge to their usual place of residence.

2.8 BCF plans should include stretching ambitions for improving outcomes against the national metrics for the fund.

2.9 **5.3% increase in CCG minimum contribution:** The CCG's minimum contribution to social care has increased by 5.3% since last year (in line with previous years). The local authority and the CCG have agreed that this will be spent on packages and placements as this is where pressure is currently being felt following the pandemic.

2.10 **Sign-off requirements:** The national and regional teams required the BCF to be signed off formally by the Health and Wellbeing Board by the time that approval letters were to be sent by the regional teams. Due to the fact that the next HWB meeting is 12 January and after this assurance letter is due to be published, delegated authority has been sought for the Chief Executive to sign this report off via urgent action following consultation with Board members. Prior to initial submission the Chair of the Health and Wellbeing Board, the CCG, the DASS and the Chief Executive signed off the BCF narrative and financial template.

Financial summary

2.11 The below table is a summary of the pooled budget that will make up the BCF in 21/22. The DFG, iBCF and Winter Pressures Grant are all directly given to the local authority.

2.12 It should be noted that, as in previous years, all BCF money is allocated for 21/22 against schemes and activities. Any changes in spend in future years would require early planning and engagement with all partners to enable changes to be made as a large majority of spend pays for packages, placements, services and teams that support the delivery of the national conditions/metrics.

Funding Sources	Income
DFG	**£1,856,901**
Minimum CCG Contribution	**£16,517,375**
iBCF	**£10,392,182**
Additional LA Contribution	**£0**
Additional CCG Contribution	**£0**
Total	£28,766,458

2.13 To provide some context to the above and the financial template in Appendix 2, the below list outlines the key areas that are funded by the Better Care Fund:

- Community Health Services
- Locality multi-disciplinary and integrated case management teams across the community, integrated care and mental health
- The Single Point of Access (SPA) that coordinates hospital discharge and the Community Health and Assessment Team (CHAT) of social workers within the local authority that supports discharge and assessment
- The British Red Cross Home, Settle and Support Service
- Home First discharge process to facilitate same day and next day discharge
- Ageing Well urgent care and 2 hour response bridging services
- Packages and placements within extra care, domiciliary care, supported living, residential and nursing care
- Crisis intervention packages for the first six weeks of an individual leaving hospital
- Commissioning and safeguarding resource and systems
- Care Act implementation support
- Mental health and learning disabilities supported employment
- Admiral nurses
- Carers services
- Support for the Personal Assistant market
- Falls prevention
- Equipment, adaptations and care technology
- Support to strengthen user and carer voice and prevent social isolation
- Support to stabilise the market and respond to demand

Next Steps

2.14 As discussed, the submission was approved by key stakeholders within the local authority and the CCG for the 16 November provisional submission date. Once the Board has approved the submission via delegated authority, the authority will be provided to NHS England colleagues. The narrative and template will go through a scrutiny process and we will be hoping to receive assurance in early

January as per the table below. Once the BCF is approved, the Section 75 arrangement between the three local authorities and the CCG will be updated.

Activity	Date
Submission	16 November
Scrutiny of BCF plans by regional assurers, assurance panel meetings, and regional moderation	16 November to 7 December 2021
Approval letters issued giving formal permission to spend (CCG minimum)	From 11 January 2022
All Section 75 agreements to be signed and in place	By 31 January 2022

3 Consultation

3.1 As stated in the narrative at Appendix 1, stakeholders, providers and residents are engaged in the BCF development and delivery throughout the year.

4 Implications

4.1 Financial Implications

(Implications completed by Philippa Farrell, Head of Service Finance)

BCF is integral to funding Adult Social Care Budget. This funding needs to be retained and utilised. If this funding is lost there would be a significant gap in the Council's finances that would result in deeper cuts. In addition there would be significant detriment to the outcomes for service users and partnership working.

4.2 Legal Implications

(Implications completed by: Kayleigh Eaton, Senior Contracts and Procurement Solicitor, Law & Governance)

This report is seeking approval to sign off the Better Care Fund submission for 2021/2022. Once approved the arrangements will be formulated into a section 75 agreement.

Section 75 of the National Health Service Act 2006 gives powers to local authorities and clinical commission groups to make certain joint arrangements, including pooling resources and delegating certain NHS and local-authority health related functions to the other partners if it would lead to an improvement in the way those functions are exercised. Such arrangements are referred to as section 75 agreements.

The Law & Governance team are on hand to assist in the drafting and updating of a section 75 agreement before it is finalised.

4.6 Risk Management

The sign off of the BCF must be undertaken by the Health and Wellbeing Board otherwise NHS England will not assure our BCF narrative and plan.

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

List of Appendices:

Appendix 1 - Better Care Fund BHR Narrative
Appendix 2 - Better Care Fund Barking and Dagenham Funding and Metrics Template

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BHR Integrated Care Partnership

Better care, better lives, together

Barking & Dagenham, Havering & Redbridge (BHR)

Joint Better Care Fund Plan 2021-22

London Borough of Barking & Dagenham
London Borough of Havering
London Borough of Redbridge
NEL CCG

Contents

SECTION HEADINGS

BHR Better Care Fund Plan 2021-22

This joint plan consists of the following Health & Wellbeing Boards:

- Barking & Dagenham
- Havering
- Redbridge

This consists of the following local organisations, submitting the plan:

- London Borough of Barking & Dagenham
- London Borough of Havering
- London Borough of Redbridge
- North East London Clinical Commissioning Group

Collectively the this forms the North East London Integrated Care Partnership with our other partners that includes:

- Barking, Havering & Redbridge University Hospital Trust (BHRUT)
- Barts University Hospital Trust (Barts)
- North East London Foundation Trust (NELFT
- Primary Care Networks
- Emergency Services
- Commissioned services health and social care provider reps
- Patient and Service User reps
- VCS organisations

Summary of National Conditions

Our BHR BCF plan sets out how we will meet these requirements.

National Conditions		Covered in Sections
1	**Jointly agreed plan between local health and social care commissioners, signed off by the HWBs** - or delegated authority if there is no HWB board. Reports will all go to the respective borough HWBs informing them of the plan. Plans should set out a joined-up approach to integrated, person-centred services across local health, care, housing and wider public services. They should include arrangements for joint commissioning, and an agreed approach for embedding the current discharge policy in relation to how BCF funding will support this.	Sections 1, 2, 3 &4
2	**NHS contribution to adult social care to be maintained in line with the uplift to CCG minimum contribution**	BHR Expenditure Templates
3	**Invest in NHS-commissioned out-of-hospital services** Narrative plans should set out the approach to delivering this aim locally, and how health and local authority partners will work together to deliver it. Expenditure plans should show the schemes that are being commissioned from BCF funding sources to support this objective.	BHR Expenditure Templates Sections 2,3,5 & 6
4	**A plan for improving outcomes for people being discharged from hospital** • Support improvement in outcomes for people being discharged from hospital, including the implementation of the hospital discharge policy, and continued implementation of the High Impact Change Model for Managing Transfers of Care. • Focus on improvements in the key metrics below: i. Reducing length of stay in hospital, measured through the percentage of hospital inpatients who have been in hospital for longer than 14 and 21 days ii. Improving the proportion of people discharged home using data on discharge to their usual place of residence	BHR Expenditure Templates - Metric Tab Section 3

*All detail and data contained within this plan was correct at the time of submission.

Executive Summary

Our Joint Priorities

Across the Barking & Dagenham, Havering and Redbridge Better Care Fund plan for 2021-22, we have agreed the following priorities:

Priority 1: Hospital Discharge Planning & Support

- **To support safe and timely discharge from hospital and support a home first approach**

Priority 2: Targeted Out-of-Hospital Care

- **To support people with higher care needs to get as great a level of independence as possible**

Priority 3: Community Support & Independence

- **To support people to remain well in the community - maximise their independence and reduce admissions**

These priorities are key to deliver the ambitions of the BCF programme and deliver the standard and quality of health and care services to meet the needs of our residents.

Key Changes

1. The development of a Single Point of Access (SPA) which includes the Hospital Discharge Service (HDS). The previous joint assessment and discharge service was disbanded in August 2021 and phase one of the move to an SPA for all discharge commenced with referral and discharge co-ordination offer moving to a single team and managed the North East London Foundation Trust. Phase 2 to merge the HDS with the SPA will commence in January 2022. Further scoping is underway to determine the full remit of the SPA going forward from April 2022 and beyond.

2. The roll out of the Home First model of care which was piloted in Havering in 2021-22. The CCG has funded additional therapy staff to extend the Havering services and also roll out to B&D and Redbridge from quarter 3 in 2021-22.

3. Funding for the first four weeks of care post discharge pathway continues to be funded from the Hospital Discharge Fund in 2021-22.

4. To reduce the rate of admissions where individuals could be supported better in the community through anticipatory care and admission avoidance.

5. The CCG has commissioned additional capacity from the NELFT Community Treatment Team as part of the Ageing Well priority to achieve the national requirement that by 31st March 2022, all systems should have universal coverage of a 2-hour crisis response at home service operating 8am to 8pm 7 days a week at a minimum, and using a model in line with national guidance.

6. Preparation for the new place-based Borough Partnership arrangements across the three boroughs.

7. The impacts of COIVD on the care market – financial sustainability, workforce issues and service delivery moving away from building based to more virtual services.

8. Increase in care needs and complexity of conditions due to restrictions in accessing primary care services and people now requiring a higher level of care when entering the system.

9. The impact of COVID on our vulnerable residents with long-term health conditions and BANE communities.

10. Younger people being admitted to hospital with COVID due to a reluctance in uptake of the vaccine.

11. Stronger governance arrangements and closer working as result of the pandemic.

Section 1: Governance (National Condition 1)

1. BHR BCF Governance & Ambitions

Our overarching vision for BHR is to:

'Accelerate improved health and wellbeing outcomes for the people of Barking and Dagenham, Havering and Redbridge and deliver sustainable provision of high-quality health and wellbeing services.'

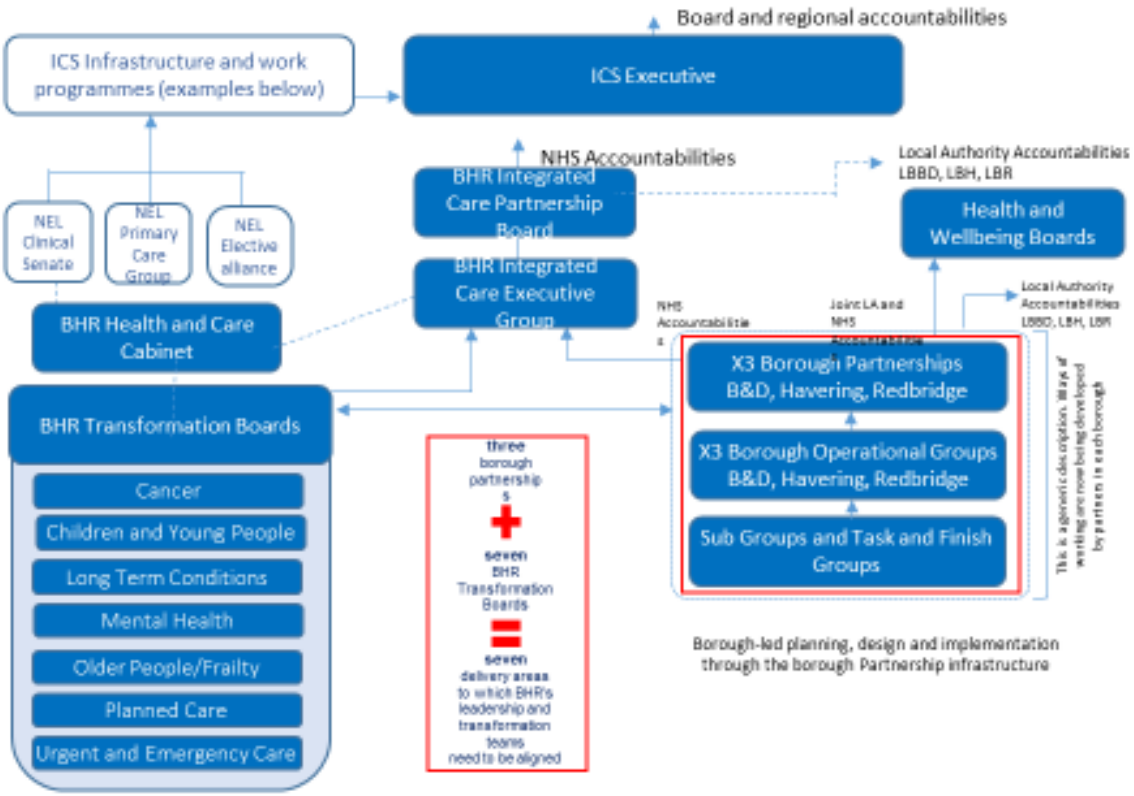
- **Create an environment that encourages and facilitates healthy and independent lifestyles** by enabling and empowering people to live healthily, to access preventive care, to feel part of their local community, to live independently for as long as possible and to manage their own health and wellbeing

- **Organise care around the individual's needs**, involving and empowering them, integrating across agencies, with a single point of access, and providing locally where possible. It will meet best practice quality standards and provide value for money.

- **Ensure organisations work collaboratively**, sharing data where appropriate, and maximise effective use of scarce/specialist resources (e.g. economies of scale).

- **Remove artificial barriers that impede the seamless delivery of care**, bringing together not only health and social care, but a range of other services that are critical to supporting our population to live healthy lives.

The diagram below sets out the BCF Governance within the BHR structure.



Joint BHR S75 Agreement
Overall strategic oversight of partnership working between the Partners is vested in the respective Borough Health and Wellbeing Boards.

The Partners have agreed that the Joint Commissioning Board (JCB) will be responsible for the review of performance and oversight of the partnership agreement. The JCB is a working group of representatives of Barking and Dagenham, Havering and Redbridge Councils and North East London CCG. At least one member from each of the Partners has individual delegated responsibility from their host organisation to make decisions which enable the JCB to carry out its duties and functions. In addition, each partner has secured internal reporting arrangements to ensure the standards of accountability and probity required by each Partner's own statutory duties and organisation are complied with.

The BCF programme of schemes are governed through our Joint Commissioning Board, which is part of the Integrated Care Partnership structure, the JCB provides the strategic direction of the development and application of the Better Care Fund across BHR. From our BCF 2017-19 plan we developed a joint BHR S75 with the BHR LAs and CCGs, which was completed and signed back in July 2018. This set out the foundation to strengthen the work across the partners to deliver health and care services across the BHR region using the BCF as a key lever for support integration where this brings efficiencies of quality and sustainability. The S75 sets out three 'BCF aligned pooled funds' for each HWB area, and in addition incorporates the option of utilising a fourth 'pot' to facilitate joint pooled commissioning arrangements between partners.

The JCB consists of representation between the BHR LAs and CCGs. The chair alternates between CCG and local authorities with representation consisting of the respective DASSs, DPHs, CCG Leaderships, finance representatives and Commissioner Leads as members of the Board. A BCF Operations & Finance group support the JCB in undertaking its decision making and setting strategic direction. It is exploring opportunities for further development in relation to integrated services and joint commissioning opportunities. Therefore, it is expected that the BCF plans will continue to develop and evolve as the JCB is a forum to which the key commissioning partners can bring forwarded new initiatives to align with local and regional needs and demands.

Jointly Agreed Plan Approval
Below sets out the key officers from each organisation responsible for plan sign off and the dates of the Health & Wellbeing Boards for plan agreement.

Barking & Dagenham	
Chair of the HWB	Cllr Maureen Worby, Cabinet Member for Social Care & Health Integration
DASS	Elaine Allegretti, Strategic Director for Children's & Adults
Section 151 Officer	Philip Gregory, Director of Finance
Date of HWB Agreement	30th November 2021

Havering	
Chair of the HWB	Councillor Jason Frost, Lead member for Adults Social Care & Health
DASS	Barbara Nicholls, Director Adult Social Care & Health
Section 151 Officer	Jane West, Chief Operating Officer
Date of HWB Agreement	16th November 2021 (24th November for HWB formal sign off)

Redbridge	
Chair of the HWB	Cllr Mark Santos, Cabinet Member for Adult Social Care & Health
DASS	Adrian Loades, Corporate Director of People
Section 151 Officer	Maria Christofi, Corporate Director of Resources
Date of HWB Agreement	30th November 2021 (EGM on 7th December 2021 to be ratified)

NEL CCG & BHR ICP	
Accountable Officer	Henry Black, NEL CCG (Interim) & Ceri Jacob, Managing Director, BHR ICP
Finance Director	Steve Collins, Chief Finance Officer, NEL CCG & Ahmet Koray, Director of Finance, BHR ICP
Senior Responsible Officer	Sharon Morrow, Director of Integrated Care & SRO BHR ICP

Section 2: Approach to Integration

1. Summary

An integrated care system (ICS) is one that brings together local health and care organisations to deliver the 'triple integration' of primary and specialist health care, physical and mental health services and health with social care. Redbridge, Havering & Barking & Dagenham Local Authorities and the NEL CCG are part of the BHR Integrated Care System, which serves a population of around 780,500 people.

The key underlying principles of an ICS are to (a) shift care from the hospital to the community where it is appropriate to do so, (b) provide place-based care through more integrated working across health, social care and the voluntary sector at a neighbourhood level and (c) provide person-centred care by breaking down traditional barriers between organisations and the functions within them, placing a greater focus on the delivery of better outcomes for local people.

Joint commissioning, service model development and pathway redesign in BHR are managed through a number of commissioners, provider boards and working groups. This is led by the Integrated Care Partnership Board (ICPB) and the Integrated Chief Executive Group (ICEG), who lead the strategic direction and decision making for the BHR area. Others key boards include the A&E Delivery Board - led by the acute trust; a Discharge Improvement Working Group (DIWG) - chaired by local authority and NHS community services directors, it reviews and manages flow in and out-of-hospital. The Older Peoples and Frailty Transformation Board is led by the CCG and a Joint Commissioning Board (JCB) consisting of BHR LAs and CCGs functions at a more strategic level where a range of collaborative commissioning initiatives are developed and negotiated, which includes the BCF. Commissioners across the three boroughs are also working together on a number of themed programmes and service developments.

Primary Care Networks (PCNs) are one of the key building blocks and the focus of integrated care delivery. PCNs are groups of general practices and social and community care providers that serve areas with populations of about 30,000-50,000 people (although can be larger), and aim to provide person-centred, community-based care through multi-disciplinary teams (MDTs). The formation of PCNs was directed by the NHS Long Term Plan in 2019.

2. Integration Approaches & Joint Commissioning

Embedding Integration - Joint and Collaborative Commissioning
Our vision is to accelerate improved health and wellbeing outcomes for the people of Barking and Dagenham, Havering and Redbridge and deliver sustainable provision of high- quality health and wellbeing services. This plan sets out a clear determination that the BHR area will move increasingly towards that vision with a new model of care, building upon the history and experience we have together to meet the challenges of increasing demand, demographic change and financial constraint. We have defined, and agreed, a series of themes. Each of them is important to the BHR health & care system and all are central to the Better Care Fund. The plan overall is expected to deliver against the key requirements as set out in the National Guidance and Policy Framework, including the High Impact Change Model, market capacity and sustainability, supporting the acute hospitals' 'flow' and ensuring that social care services are protected wherever possible, which in turns supports the whole health and care system. The system is working together to achieve the following aims:

- To enable and empower people to live a healthy lifestyle, have access to preventative care, to feel part of their local community, to live independently for as long as possible, to manage their own health and wellbeing, which creates an environment that encourages and facilitates healthy and independent lifestyles.

- Where care and support is organised around the individual's needs, involves and empowers the service user, is integrated between agencies, with a single point of access, is provided locally where possible, meets best practice quality standards and provides value for money.

- In which organisations share data where appropriate, work collaboratively with other agencies and make more effective use of scarce resources (e.g., economies of scale).

- Where organisational barriers that impede the seamless delivery of care are removed, bringing together not only health but social care, but a range of other services that are critical to supporting our population to live healthy lives.

Through working in partnership, the local authorities, NHS partners, primary care and the VCS have an ambitious transformation agenda for older people and those who are frail. Through the integration of health and social care, streamlining pathways around

the person and by supporting older people to be healthy; preventing hospital admission (both in the community and at the hospital front door), supporting safe effective discharge, preventing people in care homes from being hospitalised and enabling a good end of life experience in a person preferred place of death - we can enable people to be safe and well in community settings.

Having invested in the development of our locality models, bringing greater levels of integration and co-location of teams, we are developing this further, as a part of our ambition for Place Based (Borough) Partnerships to take a greater role in the commissioning and provision of services. Increasingly this will draw in the wider range of services than our current community models deliver, such as housing, general practice, voluntary sector services and so on.

The commissioning and monitoring of BCF plans is overseen by the BCF Executive Group, which reports to the Joint Commissioning Board. The executive group agrees the BCF plan and commissioning arrangements.

Joint commissioning, service development and pathway redesign in BHR are managed through a number of multiple commissioner and provider boards. These include the Discharge Improvement Working Group (DIWG) reviewing and managing flow in and out of hospital chaired by local authority and NHS community services directors, a number of themed change boards: Older Peoples and Frailty, Mental Health and Long-Term Conditions led by the CCG and a Joint Commissioning Board (JCB), where a range of collaborative commissioning initiatives are developed and negotiated, which includes the BCF.

Improving outcomes for frail and older people is a priority for the BHR Integrated Care Partnership (ICP). The planning and delivery of a transformation plan to achieve this has been co-ordinated through a BHR system wide transformation programme for older people and those who are frail. This was established in June 2018 with the aim of improving quality and patient outcomes and ensuring that services are as efficient as possible and integrated around the patient.

The transformation programme provides programme support to the delivery of the BCF outcomes. A number of system workstreams have been established reporting to a transformation board to take forward service transformation through collaboration and shape the BCF plans.

The Older People and Frailty Transformation Programme was approved by the ICP which set out priority areas for improvement. This brought all the work together to describe the entirety of the transformation programme across a pathway of care, the investment requirement to enhance capacity on primary/community care and savings opportunities resultant from a reduction in avoidable hospital activity. It was intended that transformation would be delivered over 3 years – the first year focused on building the foundation, moving to full scale transformation in year 2 and delivery through an ICS in year 3. The Board is planning a refresh of the strategy in late 2021-22.

The partnership approach involves the CCG, NHS provider trusts and Local Authorities across the three boroughs, Havering, Barking and Dagenham and Redbridge. As part of the governance structure a Joint Commissioning Board has been formed to take opportunities for joint commissioning. Many initiatives and objectives are shared and delivered, and the strategic goals of prevention, integration and partnerships and personalisation resonate across all organisations. The partnership has been in place in various forms over some time and, through lessons learned from the three authorities and through demographic and demand profiling, has developed a localised model for delivery of services based upon Primary Care Network partnerships established within the borough.

Borough Partnerships

All three boroughs are working towards an integrated care system along with its system partners. Intrinsic to that is the development of the place-based partnerships for each area. For example, the Havering Borough Partnership includes system partners including GPs, social care and NHS providers, the voluntary sector, health watch, the CCG and the local authority. The partnership has identified early priorities and will need to continue to develop aligned with the model of delegation that is ultimately agreed. The Joint Health and Wellbeing strategy and many organisational cross overs and governance groups set out the already established partnership approach between the Havering and system partners. The membership of the Redbridge Borough Partnership is similar to that of Havering. The Redbridge partnership has agreed its governance arrangements and identified three priority areas (Children's Health, Adult Mental Health and the health impact of overcrowding) which it will use to develop the working of the partnership as well as improving outcomes for residents. The Partnership is undertaking a series of developmental workshops in addition to its regular meetings in order to establish future ways of working. Progress is reported to the HWB at its regular meetings. Redbridge is also developing its Borough partnership approach and priorities and been undertaking a range of workshops to develop this. Progress is reported to the HWB at its regular meetings.

Within B&D it has been agreed that the Partnership Board will be supported by a programme structure that supports delivery across separate pathways of care for children and adults. Delegated authority will be sought for responsibility for pooled health and care budgets, managed under a Section 75 partnership arrangement. An organisational development (OD) session 'bringing the B&D

Borough Partnership to life' will take place in November. The session is aimed at Delivery Group members and executive-level decision makers who will be involved in the Partnership on behalf of their organisation.

Borough Partnerships Visions

Locality Models

All three broughs operate the community heath and/or social care services on a 'locality model basis'. The localities have populations within them of a size that are largely equal populations though with potentially different needs. The move to a localities model has to be designed so that end users get better services. The concept means that the response to local needs will deliver more value for the residents in that area, because services are aligned with those local needs.

Our Joint Priorities

Priority 1: Hospital Discharge Planning & Support

- **To support safe and timely discharge from hospital and support a home first approach**

Priority 2: Targeted Out-of-Hospital Care

- **To support people with higher care needs to get as great a level of independence as possible**

Priority 3: Community Support & Independence

- **To support people to remain well in the community - maximise their independence and reduce admissions**

Priority 4: Market Stabilisation & COVID Recovery

- **To support the stabilisation of the care market and Winter pressures**

Primary Care Networks

BHR has a number of Primary Care Networks (PCNs) operating as part of a wider joint approach to primary care across north-east London. As part of the localities model, we will explore the establishment of 'community hubs' within each borough which will aim to co-locate a number of health and care services including GP and community nursing walk-in clinics, health and wellbeing programmes, employment support, housing support, healthy living prevention activities, and education services for adults and children. GP Federations are at borough level and are a key platform to expand the benefits of PCNs and enable further joint

commissioning and economies of scale at both a borough level and across BHR. They are a key part of the changing way health and care services are working together to support people in community settings.

Direct Enhanced Services provided by PCNs

Direct Enhanced Service	Service Outline	PCN Workforce Service Support
Structured Medication Reviews	• Aims to optimise use of medicines for some people (such as those who have LTCs or who take multiple medicines) • Can identify medicines that could be stopped or need a dosage change, or new medicines that are needed. • Can lead to a reduction in adverse events.	Clinical Pharmacist
Enhanced health in care homes	• Access to consistent, named GP and wider primary care services • Medicines review • Hydration and nutrition support • Access to out-o-f hours / urgent care when needed	Clinical Pharmacist Community Paramedic
Anticipatory care with community services	• Thinking ahead and understanding the health needs of individual people • Knowing how to use services better • Helps people make choices about their future care. Those with LTCs or chronic health problems can benefit from having an Anticipatory Care Plan.	Social Prescriber Clinical Pharmacist Physician Associate Community Paramedic PCN Physiotherapists
Personalised care	• Care tailored to the needs of people and what matters to them • Prevention embedded • Personal Health budgets • Shared decision making	Social Prescriber Clinical Pharmacist Physician Associate Community Paramedic PCN Physiotherapists
Inequalities	• Reducing inequalities between patients in access to, and outcomes from, healthcare services and in securing those services that are provided in an integrated way where this might reduce health inequalities	Social Prescriber Clinical Pharmacist Physician Associate

Section 3: BHR BCF Scheme Summary Overview

1. Summary

This section provides a summary preview of our scheme for the BCF 2021-22. Since the impact of COVID many of our services have had to adapt and amend their delivery models and within commissioning teams across NEL we are now looking at these services going forward and how revised or new models need to be designed and implemented. This is particularly linked to hospital discharge, the sustainability of homecare, residential care, the care workforce and our prevention and early intervention offer.

2. Schemes & Metrics

BCF National Metrics

Metric 1:	**Discharge** i) Reducing length of stay in hospital, measured through the percentage of hospital inpatients who have been in hospital for longer than 14 and 21 days ii) Improving the proportion of people discharged home using data on discharge to their usual place of residence
Metric 2:	**Avoidable admissions to hospital**
Metric 3:	**Reduction in admissions to residential and care homes**
Metric 4:	**Effectiveness of reablement**

Other Related Metrics
Many of our services contained within the BCF plan also deliver to a wide range of other outcome measure under ASCOF and NHSOF, such as those supporting carers. For example:

ASCOF Related Domains
1. Enhancing quality of life for people with care and support needs
2. Delaying and reducing the need for care and support
3. Ensuring people have a positive experience of care and support
4. Safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm

Example ASCOF indicators include:
- 1D. Carer-reported quality of life
- 1I: The proportion of people who have as much social contact as they would like.
- 3D. Proportion of people who use services and carers who find it easy to find information about support
- 4B. Proportion of people who use services who say that those services have made them feel safe and secure

PHOF Related Domains
1. Improving the wider determinants of health: Improvements against wider factors which affect health and wellbeing and health inequalities
2. Health improvement: People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities
3. Health protection: The population's health is protected from major incidents and other threats, whilst reducing health inequalities
4. Healthcare public health and preventing premature mortality: Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities

NHSOF Related Domains
1. Enhancing quality of life for people with long-term conditions
2. Helping people to recover from episodes of ill health or following injury
3. Ensuring that people have a positive experience of care

BHR BCF Plan Schemes
Our plan priority schemes for 2021-22 are set out below. The scheme types are those models and/or services that will deliver the priority scheme ambitions.

ID	SCHEME	SCHEME TYPES*
1	**PRIORITY: Hospital Discharge Planning & Support** **AMBITION: To support safe and timely discharge from hospital and support a home first approach**	• High Impact Change Model for Managing Transfer of Care • Integrated Care Planning and Navigation • Enablers for Integration • Home First (other) • Hospital Discharge Service (other)
2	**PRIORITY: Targeted Out-of-Hospital Care** **AMBITION: To support people with higher care needs to get as great a level of independence as possible**	• Bed based intermediate Care Services • Reablement in a person's own home • Residential Placements • Home Care or Domiciliary Care • Housing Related Schemes
3	**PRIORITY: Community Support & Independence** **AMBITION: To support people to remain well in the community - maximise their independence and reduce admissions**	• Prevention / Early Intervention • Personalised Budgeting and Commissioning • Assistive Technologies and Equipment • Care Act Implementation Related Duties • Carers Services • Community Based Schemes • DFG Related Schemes • Community Treatment Team expansion (other)

ID	SCHEME	SCHEME TYPES*
4	**PRIORITY: Market Stabilisation & COVID Recovery** **AMBITION: To support the stabilisation of the care market and Winter pressures**	• Provider uplifts • Fee increase • Winter pressures

*The scheme types often deliver in more than one priority schemes area to delivery care services in a variety of ways. For example, DFG monies can be used to support hospital discharge and community support and independence in the community.

Scheme Delivery & Management
BCF Scheme delivery will be overseen by the BHR BCF Executive Group and BCF Operations & Finance group which ultimately reporting into our Joint Commissioning Board. Progress reports on the health and care models delivery and spend will be presented to the Executive group. However, Commissioners from all three boroughs and the NEL CCG work closely together on a regular basis in relation to discharge models, system changes, and transformational and commissioning work. Our s75 agreement sets out the governance for these groups.

Approach to Risk
All partners are facing great financial pressures in the life of this plan and continuing to work to addressing ongoing sustainability. Partners to continue to be responsible for overspends on their respective budgets within the BCF. COVID and increased demand across all client groups is placing significant risk on the health and care system and financial landscape across BHR. This is impacting our NHS, social care and provider workforce. Within the local authority, social work and brokerage teams are often severely stretched to meet caseloads and demand and key workforce areas are struggling to meet the demand, for example the number of therapists available at a regional and national level. The system is working to mitigate these workforce issues with agency usage, the new BHR Academy and new apprenticeships through Care City, but these longer-term solutions will take a while to trickle through and mitigate these risks.

Further governance detail to Risk is set out in our joint BHR BCF s75 agreement. A detailed **Risk Log** can be found in **Appendix 1.**

Section 4: Supporting Discharge & Plan Priorities (National Condition 4)

1. Summary

All of our priorities above are designed to provide a range of services and supporting outcomes to meets the needs and demand of patients, service users and carers within the flow of the health and care system and support the maintenance of people to stay, well and supported within community and home settings – only needing acute settings when necessary. Therefore, our BCF monies are targeted towards our priorities in supporting this flow. As set out in schemes and expenditure plans.

We work towards embedding key improvement outcomes around, independence, support and mental health and care within service design and to ensure we meet the national outcome frameworks of the NHS, Adult Social Care Outcomes Framework (ASCOF) and PHOF.

Key to supporting hospital discharge is partnership working between social care and our acute providers BHRUT & Barts, and community health provider NELFT - in developing discharge policies and processes around flow out of hospital in the community and home. Key to this is the Discharge Improvement Working group where engagement was vital to ensure that the new discharge models of our SPA, D2A and Home First can be implanted and delivered. Working groups are in place to ensure that these are being constantly monitored and refined between all partners.

Winter Pressures Support across BHR
Although the Winter Pressures is contained within the BCF (and not subject to ring-fencing) we will use the monies across BHR to support key services and capacity to ensure patient flow through discharge planning, and to ensure there is sufficient capacity to support move on from hospital to other care services (with our Brokerage teams) to fund extra residential placements (residential/nursing care/extra care/supported living); homecare packages; home, settle and support service and reablement (our default offer pathway for hospital services). Further detail is set out in the BHR individual expenditure plans.

2. Models of Care

Social care continues to support getting people out of hospital. This approach however of investing to support discharge has led at times to localised market capacity issues and budget pressure (overspends). Greater use of residential care and residential with nursing care places across the boroughs might destabilise those markets locally or push prices up for Local Authorities but there is opportunity to work together to minimise any impact.

Barking & Dagenham, Havering and Redbridge are adjacent boroughs in outer north east London. We share a single major acute provider, Barking Havering and Redbridge University Trust, and a large community and mental health Trust, NELFT NHS Foundation Trust. This creates a natural alignment for health and local authority partners to work together to achieve the best outcomes for the whole population

Hospital Discharge Policy
All three boroughs and have used the BCF to work to support discharges and improve outcomes for our residents when they come out of hospital.

We have worked across all discharge pathways to improve the experience and outcomes for our residents and also to support the local acute hospital system with the demand increases for their bed base. Internally within the health system the BCF has supported the creation of community-based discharge team which has driven care decisions into the community rather than keeping them based in a hospital setting. Developing a single point of access (SPA) for discharges across BHR aims to streamline discharge processes and give local authorities a greater degree of management over care packages from their start. Key to the success of the SPA is the trusted assessor model which situates trusted assessors of care needs on the hospital wards to increase the efficiency of assessments for placements across care settings.

The BCF is crucial in supporting our pathway 0 offer with respect to providing people support in their home at point of discharge. This includes our home settle and support service provided by the British Red Cross. This is a particular example of joint commissioning; the service being jointly commissioned by all three boroughs and the CCG.

Pathway one is supported through the home first pilot which has been referenced above alongside the BCF supporting general crisis intervention from our homecare agencies. In the B&D Crisis Intervention is our free service provided for a period of up to 6 weeks at point of discharge. The BCF supports both the initial 6 weeks as well as a further capacity and support throughout domiciliary care provision. Social care in the community, including a DOLs assessments are also supported through the BCF to ensure that we have the capacity to meet the demand from hospital discharges. Similarly, for Havering & Redbridge we use reablement as our default offer for this pathway and also Home First sits within these providers. These dedicated reablement services have been modelled around home first principles and is fundamental to ensuring the flow from hospital is maintained.

Pathway 2 and 3 are supported through our jointly commissioned discharge pathways include the discharge to assess pilot referenced earlier. This pathway places individuals into nursing home beds that have a rehabilitation team supporting the residents for a six-week period. The aim is that these residents will then be able to have their long-term care package reduced after the six-week period. The pathway works with contracted nursing home beds which also eases the discharge process as for those who are eligible for the pathway there are pre-arranged beds available. This initiative, piloted in Havering, was evaluated and has been effective in improving outcomes and cost effectiveness.

The BCF supports a wide range of other services in B&D that support discharges that are safe and effective. This includes our community treatment team and social care capacity and a Blitz Cleaning and decluttering service provided by the ILA, a voluntary sector organisation. Redbridge also provides a service to help those who hoard to enable them to be able to live safely and return home with care. Havering ensures that its commissioned voluntary sector services are joined up with reablement and 'home settle and support' discharge pathways to enable connection with appropriate services depending on needs.

While Barking & Dagenham and Havering have BHRUT as the one main acute provider, Redbridge also has Barts Health NHS Trust (Barts) in addition to BHRUT through Whipps Cross University Hospital, situated in the north west of Redbridge serving approximately one third of the population and is the provider of choice for a number of residents due to access with Redbridge CCG commissioning services with Barts. Therfore, the LA works very closely with both acute providers in supporting its discharge process. Home First is Redbridge will be moving into its next phase which will include developing this with Barts.

The narrative below for our key priorities provides an overview and highlight of the key models of health and care, and key services delivering our ambitions within our BCF plan for 2021-22. This not an exhaustive list of every service provided by every borough and CCG as many of these are the same across the patch, but an illustration of the key components working across BHR. Full details of what is funded is provided within the individual **HWB Borough Expenditure templates**.

SCHEME 1: Hospital Discharge Planning & Support

The interface between hospital and the community is vitally important in the relationship between health and social care, both for the individual and for the organisations concerned.

The ICS subsystem partners, as the pandemic eases over the next 18 months, must return to its relentless focus on avoiding admissions to the acute hospitals. This will require understanding of vulnerability and early responses to issues without creating dependency. Imaginative approaches to reablement prior to hospitalisation, continued focus on assistive technology, high quality homecare, personalisation of services will all contribute to sustaining people in the community rather than escalating to acute or long-term care.

Developing Discharge Options
Over the past 12 months, there have been a number of key developments around discharge. These are:

- **Discharge to Assess:** Particularly piloting targeted care homes with a wrap-around therapy team, has shown outcomes to support 23% of the patients to be discharged home.

- **Home First:** Each borough now has a Home First approach including a therapy team, reablement care and access to equipment. Havering now have Home First as the default model for discharge:
    - Reablement / Crisis Intervention
    - Homecare
    - Residential and Nursing Care

- **Trusted Assessor (TA):** The TA model has really supported the range of discharges required during the pandemic to care homes including discharge to assess, designated provision and alternative rehab stepdown. The service will be sustainably funding from Q3 with two assessors to work across BHR.

When people do go into hospital and come out with a new or on-going need for support there is a need for a quick and effective response, putting in place all the necessary support mechanisms that will re-able and rehabilitate the person back to independent living as soon as possible. We are committed to the principles of 'Discharge to Assess', the idea of getting people out of the acute setting as soon as they are medically fit, ideally back home, where prompt assessment of needs leads to support in place quickly, in whatever form necessary, to enhance chances of rehabilitation and independence. There are a significant number of dependencies on this happening effectively.

- Understanding as soon as possible the point at which clinical need in an acute setting ends, so that the person is identified as ready to go home
- Once this point is understood the rapid transportation home of the person with required support in place (be that equipment or support from a therapist, care worker or an adjustment to the home environment)
- Getting the right assessment of need for the person, recognising that the assessment will be different if done:
    - At the point of crisis in hospital
    - Immediately after the person gets home
    - After a period of reablement and/ or rehabilitation at home.
- Other influencing factors will be whether the assessment is a joint one, with multi-disciplinary input and whether there is a full understanding and application of the principles of personalisation, developing support plans that focus on outcomes.
- How quickly, from the point of return home, the application of high quality reablement and/ or rehabilitation is put in place
- The quality and intelligence applied in determining need for home care
- The messages that are given to the person concerned around dependency and the ability to get them back to independence
- The family response to the situation
- The ability of informal carers to take responsibility for meeting the needs of the person they are caring for
- The quality and appropriateness of the housing situation of the person concerned

All these dependencies, and others, play out in deciding whether or to what extent and how quickly the person might be capable of being fully independent. If the services do not coordinate, the likelihood of recovery being sustainable for the person concerned will be diminished.

Where commissioned services are part of this, they need to be enabled to play their part in contributing to the desired outcome. This needs to be considered in the design of such services, ensuring that integration is designed as an end to end process and not as an individual, segregated service. Commissioners and providers from different organisations must continue to join up where possible

to design across the end to end process, with the benefit to the end user in mind, and not in silos with the achievement of narrow targets as the measure of success.

Our strategic approach will look to approach things from this perspective and our system design will actively avoid the development of solutions in isolation of partners crucial to the design of an effective end to end process.

One unintended consequence of the nationally prescribed Hospital Discharge Policy, with its 'Trusted Assessor' element is that the borough is seeing far too many patients discharged into care home settings, who then stay there permanently. Whilst on paper it makes complete sense for any assessment of long term need to take place out of the hospital setting, without the right community offer in place (such as access to rehabilitation), the consequence for the patient can be catastrophic, in that they further decondition, become institutionalised and remain in that care home permanently. As a system, we need to review our investments to refocus on keeping people out of hospital in the first place, but where they do have to be admitted, that there are the right services to pull patients back out into community settings not care homes

BHRUT are currently refreshing their Clinical Strategy, and patients and partner organisations are being widely consulted. BHRUT recognise that central to the refresh, is that it must look more outward and play its part in supporting the right health outcomes for people in out of hospital settings.

Single Point of Access
A key priority across and health and social care is to development a robust and sustainable 'Single Point of Access' (SPA). The BHR health and social care discharge teams have been brought together under the management of NELFT as a single team that will manage all hospital discharges for pathways 2-3. The operating model for integrated working is being embedded over quarters 1-3 in 2021-22 and is expected to operate as a fully functional service in quarter 4 of 2021-22.

The NEL CCG has commissioned some external support to work with the system to review the discharge process which will support informing the development of the SPA model.

All partners have used the BCF to support the integrated commissioning across hospital discharge pathways. The discharge to assess pathway and the home first pathway are both supported by the BCF and commissioned across the local authority and the CCG. Both pathways seek to increase the efficiency of discharges from our acute settings while improving the longer-term outcomes of our patients. The home first pathway uses therapist support to carry out discharge assessments at home where a more accurate package of care can be put in place. This also encourages home as being a default discharge setting.

The discharge to assess pathway sees residents discharged into a named nursing home which has a rehabilitation team wrapped around the nursing homes normal service. This increases the chances of a decrease in long term care needs. The CCG and Local Authority are commissioning 8 beds for the discharge to assess pathway with a rehabilitation team to support these beds. The aim is to improve discharge outcomes in the long term for these residents.

Home First
Whilst the home first pilot in Havering described above initiated a different approach, this is now being rolled out, adapted to meet local needs in B&D and Redbridge.

B&D is currently undertaking a number of hospital discharge pilots which are seeking to improve the hospital discharge pathway for our residents. Therefore, many of these are also focused on supporting our residents to remain at home and with a great level of independence. Chiefly is the Home First pathway pilot which is seeking to ensure that as default the first choice for discharge is back home. This pilot then puts in place a more accurate care package that has been assessed in the home of the resident. This aim is that these residents will be more able to remain at home with an accurate care package suited to their needs. With this more accurate care package there will also be a reduction in readmission to hospital.

Redbridge has also been piloting its Home First model which is embedded into our Reablement service. It is now seeking to increase its number of Home First slots and will be hosting the Occupational Therapists for both Barking & Dagenham and Redbridge. The business case has now been approved and recruitment is underway.

System Improvements
The pandemic has prompted even closer partnership working and has led to initiatives to improve all aspects of the care system, including discharge pathways. An example is the insight that provider markets, both residential and home care, have provided in regard to quality of discharge perspectives at their end. With improved dialogue across the system this has now led to a review of the pathway with engagement from the local authorities, the hospital, CCG and provider markets to learn from these experiences,

to include service user perspectives, with a view to improving the quality of discharge as a partner initiative. The governance of this sits in DWIG and illustrates how that is working in practice to improve outcomes for local people.

SCHEME 2: Targeted Out-of-Hospital Care

Rehabilitation
The CCG continue to commission from NELFT a range of rehabilitation services. There are 61 community rehab beds available to support discharge with rehab and step down. 27 stroke specialist rehab beds are also commissioned to offer step down rehab from the acute stroke wards. Hybrid models working with care homes to offer step down from hospital and rehab beds have also been developed.

The Intensive Rehab Service (IRS) continues to offer 21-day intensive rehab at home post discharge. Longer term rehab is then continued via integrated care teams in the community. Stroke and Neuro rehab is offered with an Early Supported Discharge team at BHRUT and Community Rehab Services offer slow stream rehab.

Discharge to Assess block booked beds were piloted in Havering for 6 months in 2021-22. The pilot provided very successful with 23% of patients who went through the block booked bed base with a wraparound rehab team returning home. The scheme has been extended to the end of the financial year. B&D are also commencing a block booked beds pilot from December 2021 until March 2022. The long-term plan is to have a BHR wide facility/facilities from April 2022.

Reablement
Redbridge recommissioned and implemented its default Reablement offer with NELFT for hospital inpatient discharge services across both its acute providers - BHRUT and Barts, as well as actively encouraging referrals from community teams. Built into our existing 'Community Health & Social Care Service' S75 agreement where MDTs are co-located within our four locality areas. This provides a platform for the Redbridge Reablement Service (RRS) to deliver a preventative element through the health and adult social care pathway and to proactively interface with the operational service, building on our integrated partnership model which will continue to shape the service in line with service needs. This new default offer is provided using a Trusted Assessor model with our provider and will support discharge and provides a quality service to ensure we maximise the goals and outcomes that service users can achieve reduce the need for long-term care packages and enabling to still be at three months after receiving support. We doubled our investment from £700k to over £1.4m a year to deliver a higher quality outcome focussed Reablement service with increased capacity.

Havering's commissioned service provided by Essex Cares Limited has been in place since 2019 and is a fundamental part of Havering's preventative offer. Demand on the service has exceeded what was expected when the service was commissioned. This has been exacerbated by the pandemic, but demand continues to be at unprecedented levels. If the demand continues the system as a whole will have to consider how the service, which supports hospital flow and allows for delivery of home first principles and outcomes, can be funded. It is a significant challenge but in terms of quality, the service is providing very positive outcomes, which presents at the same time an opportunity for the system to come together to design and deliver a highly effective reablement model that links in with all other aspects of the preventative model. A key priority for health and social care from here on forward is to focus on how reablement services can be funded and tilt towards admission avoidance, in collaboration with CTT, LAS and utilising technological opportunities (such as virtual reality) to stop patients being admitted in the first place.

Crisis Intervention
B&D currently implements a crisis intervention model in which homecare agencies provide support to residents for the first six weeks after discharge into the community to support individuals to live independently at home and prevent re-admission to hospital. We are currently reviewing whether we implement a commissioned reablement approach with stakeholders from across the partnership. We have worked with Care City, an innovation centre for healthy ageing and regeneration in North East London, to support us to research and review international and national reablement models to inform our thinking and we are currently developing an options appraisal in order to pilot a reablement approach in 2022.

Designated Beds
During the pandemic the BHR health and care commissioners worked together to develop the designated beds offer. The settings identified were in Havering and Redbridge and accounted for more than 35 beds for positive patients to be discharged to. There was a robust process around the admission and discharge of patients from these settings, and additional infection control measures were overseen by the NELFT Infection and Prevention Control Nursing Team.

Home, Settle & Support
The BHR British Red Cross Home, Settle and Support service commissioned by the local authorities and the CCG has continued to support residents on their arrival home from hospital. The service primarily supports residents who live on their own and a large proportion of the people accessing the service have been 70-89 years old. The main goals of the service are to help people feel more safe and secure when they get home from hospital, reduce their anxiety, and increase their ability to manage day to day things when they get home. The British Red Cross staff and volunteers have picked up medication, delivered shopping and signposted residents to onward services during the pandemic. The service has helped residents feel safe when they get home and has often been delivered remotely or in a COVID-19 secure way, again to reduce the risk of transmission.

Accommodation Based Care
We offer a range of specialist accommodation options, including supported living and extra care, and the shared lives programme. Supported living accommodation is commissioned for people assessed as requiring a supported living environment, including people living with or recovering from mental illness or crisis, people with a learning disability, physical disability, at risk of domestic violence, homelessness and for care leavers. Supported living is similar to extra care provision although rather than being based in sheltered housing schemes it tends to be based in shared housing/accommodation. It can also include floating support services where people live independently and receive external support. This housing related support is predominantly provided by registered social landlords that in some cases also provide care to those individuals.

Extra care services provide an alternative approach/model to traditional home care services in people's own homes and to residential and nursing care placements. The transitional service also provides opportunities to individuals who require a higher level of care following hospital discharge to convalesce before returning home when their require level of care improves.

Housing designed to meet needs of individuals and their parents/carers will delay and prevent the need for care. It is essential, therefore, that the dialogue between Housing and commissioning is an active one to ensure provision is responsive to community needs.

Social care for various groups requires a property element that is, however, more diverse than general housing. The designs vary depending on what service is being provided. A supported living facility for people with learning disabilities will differ from a residential home for older people. It is often the case that the market will provide properties and have care linked to the property that they own. Whilst this has advantages it also means it is difficult to change providers if similar property is not available. In other cases, property is owned by different agencies from the care provider, creating complications with compatible timelines and strategic objectives of different organisations. Over a period of time, if the Council has none of these properties and do not control where they are based, it can cause problems with finding provisions and costs can escalate.

Where this has happened, or is happening, the issue will be articulated and possibilities around providing Council owned properties or working with other providers to ascertain interests in providing property assets needs to be brought to decision makers attention, jointly from Housing and Social Care.

Property as a means of responding to people's needs, with social care attached in some form, means the two are inextricably linked. This needs a joined-up response formulated that both protects the financial interest of the council but also means people are in the right places and localities to meet their needs.

Within B&D we are currently piloting some extra care assessment flats. These flats are designed to support hospital discharge for those over 55 who have lower level care needs and need time and support to establish a longer-term housing arrangement or who may be interested in extra care longer-term. If the commissioned assessment flats are successful, we will make this a long-term arrangement to support discharge.

As part of its out-of-hospital transition provision Redbridge also operate a number of step-down beds for people being discharge for hospital before going home where people can stay for up to 2 weeks. There are 7 in total across two sites.

End of Life Care Satellite Service
We are currently introducing a new end of life care satellite service at Kallar Lodge, a residential care home owned by B&D. This will see seven end of life care beds added to the market which will enable older people to live as comfortably as possible at the end of their life in a supportive setting and will ease pressure on the hospital trust, St Francis Hospice and palliative care teams. This is a jointly commissioned service by the local authority and the CCG.

SCHEME 3: Community Support & Independence

Protecting adult social care services recognises that people's health and wellbeing are generally managed best where people live, with very occasional admissions to acute hospital settings when necessary. Without the full range of adult social care services being available, including those enabling services for people below the local authority's eligibility criteria for support, the local health system would quickly become unsustainable. Adult social care services are fundamental to the delivery of our ambition to deliver the right care and support, in the right place, first time. Protecting adult social care will allow the local health economy to deliver 'care closer to home' and, whenever possible, in people's own homes.

Admission Avoidance
The key local service for Rapid Response intervention (Community Treatment Team) was comprehensively reviewed in 2021-22. This indicated that with increased demand throughout the day, a larger response team was required and particularly telephone triage capacity. This has led to a considerable investment (£1.2m FYE from Ageing Well) to increase nurses and allied health professionals to meet the new two-hour urgent care response. A 'Bridging Service' will also be commissioned alongside the additional capacity from quarter 3 (recruitment and mobilisation in quarter 2).

Anticipatory Care (AC)
By supporting people differently in the community, including tackling the wider determinants of health, we can prevent some individual's needs escalating or address them in the community rather than in acute services. Ahead of the fill guidance in 2022 and the DES PCN arrangements expected in the autumn of the same year, BHR will be working the borough partnerships, NELFT and the work Population Health Management pilots in B&D and Redbridge to develop the concept and model. This would include identifying cohorts, care planning and co-ordination.

Homecare & Double Handed Care
B&D are also running a pilot which is seeking to reduce the numbers of double handed care packages across the borough. In this project we are working with occupational therapists to upskill our domiciliary care providers in correct use of equipment and in techniques that can increase independence. The aim of this pilot is to improve the chances in a reduction of care needs and an increase in independence in the community.

Redbridge is now 2 years into its revised Homecare Framework model. This is a locality-based model with lead providers, back-up and specialist providers for children, LD and mental health. This enables areas to provide improved personalised care for service users to reduce hospital admission; position the market to deliver an enhanced health and social care home care service that reflects our integrated community care service and deliver improved efficiencies and reduce the need for long-term higher needs care.

In Havering a long established 'Active Homecare Framework' based on a Dynamic Purchasing system has established a set of providers that have passed high quality criteria where relationships are based on long term partnership. It has reduced the need for spot contracting to less than 10% from 50% before the framework was established. Recently the market has joined up in an association model, which is now operating its own forums with the LA as a partner. Continuously improving dialogue has led to initiatives and high quality partnership working.

Supporting people to remain independent at home, including strengths-based approaches and person-centred care
Improving the quality of people's lives and reducing the years of disability and illness will increase the length of time people can continue to live independent lives and reduce the need for and dependence on health and social care services. Retaining a level of independence supports both psychical and mental health through empowering and maintaining those close community links within a familiar environment.

Supporting people in their own homes is an important part of ensuring that people retain their independence. The retention of links to family and community, in places where they are familiar, results in better health and wellbeing outcomes, as well as reducing the need for costly residential care.

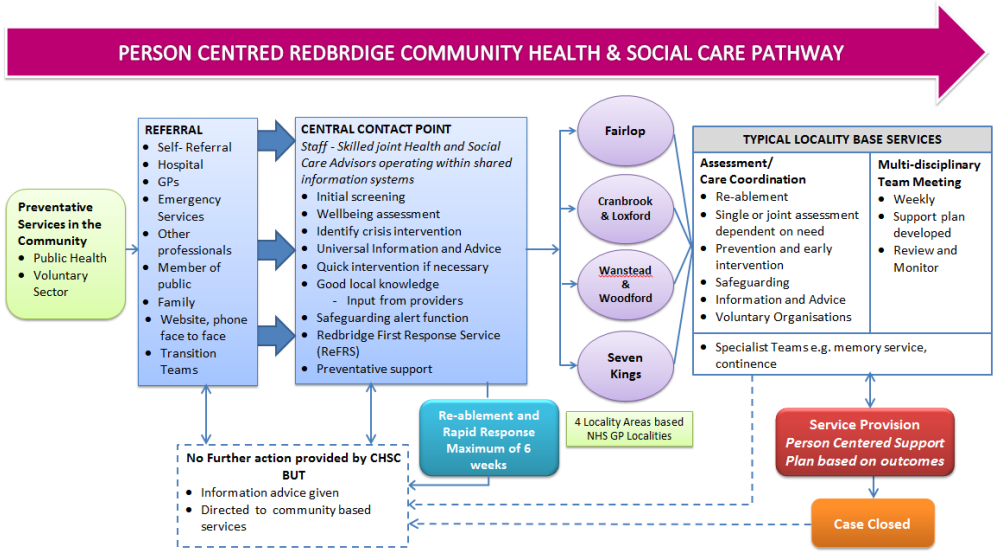
Further to placed based care approaches investigated in 2019-20 and with Anticipatory Care workstream as part of the Ageing Well agenda, BHR will be working though the borough partnerships to development very localised approaches at a neighbourhood and Primary Care network level. Planning work is commencing in the second half of 2021-22, which will include the recruitment of a borough-based project lead, with some pilot schemes in Q3.

Urgent Care Rapid (UCR) Response is the key approach to supporting people who are at risk of presenting at the emergency department and potentially being admitted to an acute setting. UCR will assess a patient within two hours if required and provide

nursing, AHP and medic input (and prescribing) in the persons home. This is for three days. A 'Bridging' service will hold a person for a slightly longer period if they are still at risk of hospitalisation.

Strength-based Model

The Redbridge First Contact team use 'People Matter - Three Conversations' as the default model of social care across all localities in the borough replacing the traditional 'formal' based assessment model. By putting the person at the centre of the conversation as the best placed person to understand their needs, it uses a conversational approach with the person to find out what is really important to them; what they would like to achieve and how they can best maintain their independence, health and wellbeing for as long as possible. By using this approach people feel their lives are improved and has led to a significant reduction in the number of long-term support packages. It supports the promotion of choice, independence and personalised care - through the use of Direct Payments, Self-directed support and complements personalised health budgets. The personalisation agenda will form part of a key workstream for LA commissioners going forward.



B&D have adopted a strengths-based approach as their social work practice model supported by a delivery model and framework which sets out Care and Support Services' intent over the next three years to develop and introduce a 7 strength and asset-based approach that informs our professional and management practice: and organisational culture across adult services. It will be reflected in our service structures and commissioning intentions; our partnership approaches; and most importantly our engagement and relationships with communities and the Third Sector going forwards. The framework represents a fundamental change to how we engage with each other within Care and Support and the Council; and across the whole system with health and social care stakeholders and partners; and fundamentally with the Third Sector and with residents and communities, and how we support community led new and improved ways of working that will deliver greater community resilience and better outcomes.

Modern 21st century social work and social care in B&D seeks to move away from Care Management and a 'deficit' model, away from 'problems and issues' and how professionals can 'solve' this. Instead, we want to improve practice and support better outcomes through true collaboration with people and communities who use services and those who care for and about them. To drive this forward, we recognise that to maximise empowerment and outcomes for and with people and communities the whole system needs to change, moving from a system built around the assumption that formal services are always the solution, and recognising we are partners in a wider system of relationships and support networks. In B&D, our strength is that we are an ethnically and culturally diverse workforce and population. We do however face significant challenges. On average, communities have less access to resources than the national average. At the same time the population in is growing faster than in any other area in the UK. By moving to a strengths and asset-based model we will seek to be bold, build on our diversity and the knowledge and experience in our communities; and deliver shared community and organisational benefits.

Havering are encouraging the use of all available assets is essential in ensuring that public services continue to support those most vulnerable in our communities. Almost every activity, engagement, communication and discussion between actual and potential service users and their carers, and those who are part of the social care and health system should look to utilise and enhance available assets and abilities as, at least, an implicit aspect of the conversation.

This approach is enshrined in Havering's 'Better Living' approach, whereby social care practice looks to have conversations with service users that first look to find their own or community assets that can address the problems faced without creating a dependency on statutory services. To provide the infrastructure that supports this approach services are commissioned that are

complementary. The system we want should support people staying fit and well and keep people out of long-term care as much as possible through interventions that are designed to facilitate people to live as independent a life as possible.

We will use data and establish systems that provide evidence to ensure an understanding of preventative models and to inform where future investment will be best placed. It is important that public health and commissioners work together where there are needs for data and evidence bases to support the delivery of improved health and well-being. Getting to grips with Population Health management is critical to ensure the best outcomes for people over the medium and longer term.

Mental Health & Carers Support

Mental health is a key area that has been impacted upon by the pandemic and a number of local providers are commissioned to provide befriending to reduce social isolation for service users and their carers, therefore complimenting and supporting the more clinically based models of care for mental health.

As part of long-established BCF schemes, the BHR boroughs commission employment support for people with mental health needs and a Carers Support Service. The latter service is commissioned from a voluntary sector organisation and delivered in a variety of health and community settings. The service also helps to lead the delivery of the joint health and social care Carers Strategy.

We continue to implement its duties as outlined in the Care Act 2014, through promoting wellbeing, prevention, advice and information on care services, and providing strengths-based person-centred care - including support for Carers. Our Carers offer is being reviewed in order to explore ways in which we can provide better support to carers and reduce incidents of carer breakdown. Through working with our providers and carers themselves, we will be able to co-produce an improved model to ensure more flexible support is available when needed. B&D are developing a new Carers Charter to improve services and support to carers in the Borough.

Redbridge is developing a Carer Friendly Borough by aiming to support carers better through meeting the following strategic priorities:

- Identification and recognition: Support those with caring responsibilities to identify themselves as carers at an early stage, recognising the value of their contribution and involving them from the outset in designing local care provision and in planning individual care packages.
- Realising and releasing potential: Support people with caring responsibilities to fulfil their educational and employment potential.
- A life alongside caring: Ensure that support for both carers and those they care for is personalised, enabling them to have a family and community life.
- Supporting carers to stay healthy: Support carers to remain mentally and physically well.
- Supporting young carers: Protect children and young people from inappropriate caring roles and ensure they have the support they need to learn, develop and experience positive childhoods.

Havering has invested BCF in re-commissioning its dedicated carers service and works directly with the provider, integrating the service as an important part of Havering's wider preventative offer.

Community Provision

Redbridge LA has a long-established history of working closely with its VCS partners by commissioning and contracting many prevention and early intervention services with VCS providers who are highly experienced in meeting the needs of our diverse community. They provide lower-level cost effective provision, such as our Falls Prevention model provided by Age UK which is now looking to be replicated across the other LAs. Our CVS has been instrumental in both development and delivery of our social prescribing models. In addition, as part of the NHS long-term plan, NEL CCG have been developing their role and commissioning of the VCS over the last year. The VCS are key partners - being key contributors into boards, steering and task and finish groups. This has been particularly the case with the older people and frailty agenda, where a number of new developments will be funded via the BCF, and the VCS have been key in driving these agendas forward. This includes care home trusted assessors to support patients to be assessed for a care home place in hospital for more rapid discharge; funding additional care navigators to enhance supported discharge and the expansion of Redbridge Falls prevention classes as part of a strategic approach to falls prevention approach across primary, community, secondary care and the VCS.

Community, social connections and having a voice in local decisions are all factors that make a vital contribution to health and wellbeing. These community determinants of health build resilience and can help buffer against disease and influence health-related behaviour. Involving and empowering local communities, and particularly disadvantaged groups, is central to local and national strategies in England for both promoting health and wellbeing and reducing health inequalities. All communities have assets that

can contribute to the positive health and wellbeing of residents, including the skills, knowledge, social competence and commitment of individuals, and local community and voluntary groups and associations (both formal and informal

There has been an increased focus on community resilience and social isolation both locally and nationally in the last few years, leading to the rise in practices such as social prescribing. Social prescribing involves GPs, nurses and other health professionals referring patients to non-medical services, typically provided by voluntary and community sector organisations, including, for example, volunteering, arts activities, group learning, gardening, befriending, cookery, healthy eating advice and physical activities.

For example, in Redbridge:

- Voluntary Sector: The Borough commissions a number of voluntary sector organisations to support prevention and early intervention including befriending and support for carers to help reduce social isolation. This sis currently being reviewed in light of the COVID pandemic to understand how needs have changed.
- Redbridge Social Prescribing: The Borough and CCG commission a social prescribing service which reaches 42 GP surgeries, the service supports people with low level mental health problems, type 2 diabetes or who were socially isolated with a Health and Wellbeing buddy.
- Day Opportunities: These services, provided both directly by the Borough, and by external agencies promote independence, improve quality of life, and support individuals to socialise and play an active part in their community and provide vital breaks and support for carers of those with LD & MH disabilities.

In Havering, the voluntary and community sector is an important part of the market. Extensive engagement with both commissioned and non-commissioned voluntary sector services co-produced a set of outcomes important in the Havering context. We will work with providers to ensure outcomes are delivered. We will look to integrate the services with the wider system where necessary. The required outcomes include:

- High quality information and advice
- Ensuring people are supported in their journey from hospital to home
- Low level support in the community for vulnerable people that prevents escalation to statutory services

However, the process also identified three other outcomes that are particularly important in the Havering context:

- Social inclusion – informed by the identification of social isolation as a major driver for demand in Havering.
- Carers, both young and old, supported in their role – informed by the demographic of Havering and the identification in the 2011 census of 25,000 carers within the borough. The Carers Strategy identifies more detailed outcomes for the voluntary sector to respond to.
- Development of self-sustaining peer support networks – responding to the need for the community to use all its assets to provide support to people.

A further development has been the introduction of community hubs that are designed to provide support to communities, linking them with voluntary sector services and to other preventative initiatives such as Local Area Coordinators.

Within B&D, our front door service, Community Solutions continues to provide essential frontline support to mitigate hardship for residents with specific concerns and support requirements such as finance, debt, rent, benefits, housing and employment. Community Solutions are also commissioned to provide the Borough's social prescribing service.

We have an increasingly vibrant voluntary sector which is an essential part of our Care and Support Provider market and provides a number of our key services such as Carers Support, Handyman service and the Home, Settle and Support service. During the pandemic, the voluntary sector provided essential support to shielding and vulnerable residents. Through the BD Collective there are now a number of groups which bring together Care and Support staff and VCSE colleagues:

- Re-imagining Adult Social Care
- Early Help
- Joining the dots

Alongside the development of Community Hubs and neighbourhood networks in the Borough, these groups offer an opportunity moving forward for professionals from both sectors to come together and better support our residents and work up ideas collaboratively. Social isolation is a key priority and will become a focus for all partners in 2022.

Local Area Coordination

Local Area Coordination is an essential part of Havering's approach to preventative and personalised services. It is a model of supporting people that is embedded in the community. Local Area Coordinators work within a population of around 12,000 people. They get to know the people and local assets in the area. They are based in the community and work on the basis of introductions. If a person has something they want to change, their Local Area Coordinator will walk alongside them to help them achieve it. Local Area Coordination is a strengths-based approach that focuses on the strengths of the individual and the capacity they have and the contribution they can make, reconnecting people into their community. The service is being actively rolled out as a partnership initiative.

Local Area Coordinators form trusting relationships with people and look at all aspects of their lives, focusing on what is good and motivating people to be in control, building their capacity to take control of their life. Local Area Coordination is actively delivering good outcomes, working with people in the community who face a range of challenges including mental health, issues related to debt, housing or feeling isolated. Building community resilience and linking support with local community assets is central to the aims of Local Area Coordination.

We are piloting this approach in Havering and although management of the team sits within the Council structure, Local Area Coordination will support outcomes from all public sector partners and therefore the pilot is jointly funded by a range of partners and from the BCF. An evaluation of the service is being developed and, when it has been operational for a sufficient amount of time, evidence will allow partners to make informed decisions about rolling out the service across Havering. Our ambition is that the LAC offer is expanded to cover the whole borough.

Personalisation

Havering is committed to increasing the scope and scale of personalisation and the infrastructure that supports it. There are many issues to be understood, solutions identified and implemented through a programme of change in partnership with service users and their parents/ carers. To build a solid infrastructure for a sustainable system, the activities and approaches needed include:

- Engagement and inclusion of those who are potential and current recipients of self-directed support so that they can shape the model moving forward
- Clear and specific commitment at a leadership level
- Engagement with the market – outlining the drive toward personalisation and the implications, which will include:
    - The opportunities for developing services designed to meet the needs of individual budget holders.
    - Micro commissioning and the need for growth in personal assistants and/or micro commissioned services that meet particular needs
    - Review of levels of payment to direct payment budget holders
- A culture developed across the system that understands and appreciates the power of personalisation, promoting the thinking that is needed to move from the perception of dependent service users and patients to empowered ones
- Use of external information and learning to promote ways of developing personalised services
- Committing to making processes as easy as possible to access and purchase services
- A proportionate and explicit approach to risk around safeguarding and quality within the context of directly commissioned services
- Draw on cross borough initiatives where they are supportive of market development, quality etc.
- Communicate and work with providers to develop the range of services and the support needed to respond to the demand generated for such services
- Have a clear and documented policy framework as the basis for design and decision making
- Clear set of outcome-based measures ensuring movement towards increasingly personalised services for users
- Commissioning services to allow them to be flexible and responsive to individual and family needs

B&D is currently undertaking a direct payment reviews project to ensure that service users have the support available to them in their role as an employer and that they have a Personal Assistant or other service that meets their needs. The Borough's direct payment support service, run by Vibrance, is working closely with social workers to ensure that service users have the right advice and support when they are thinking about choosing a direct payment and can help a service user to find and employ a PA and put the right documentation in place. This service is being used across adults and children's services and the wider project is also reviewing processes and training needs to support the Care and Support workforce.

Integrated Community Equipment Service

Redbridge is the commissioning lead for the Integrated Community Equipment Service (ICES) with its partner - Havering, BHRUT (acute provider), NELFT community health services and the NEL CCG and implemented through a S75 agreement using one equipment provider commissioned via a framework arrangement. The service has just been re-tendered for a new contract and

includes sharing management costs and a recycle equipment pool across all partners. This does not currently include B&D who are part of a pan-London community equipment arrangement.

Assistive Technology
Havering invests significantly in Assistive Technology, helping people to stay at home as independently as possible. Whilst current offers support people it is also our intention to look at innovative solutions as they develop to look to use the most effective solutions available. A pilot is being implemented with technology that monitors movements within the home to ascertain the level of support that is needed with the aim of minimising dependency. There is also interest in virtual reality providing the opportunity for remote monitoring and identification of need without the need for face to face personal interactions.

Redbridge currently has a transformation workstream around its approach and investment in assistive technology. It has been working on a app called 'Multi-me' which enables and supports people with LD to networks with services, carers and friends in relation to their care and needs.

Care Technology
B&D is currently procuring an Innovation Partner for the management and delivery of an all-age Care Technology solution our residents. This service will deliver in three key areas:

1. Innovation and development of technological or digital services to residents which complement their own support and networks. This will also include flexibility and future projects based around arising technology throughout the contract.
2. Facilitate a cultural change by establishing and embedding a 'Technology First' approach within Care and Support services to include a Care Technology learning and development programme.
3. Manage and deliver the service to embed an innovative new operating model for leveraging care technologies and data to support better outcomes in care and support and deliver significant financial benefits. This will include a flexible proactive and reactive response-based service pertinent to both support planning and the immediate welfare of our residents.

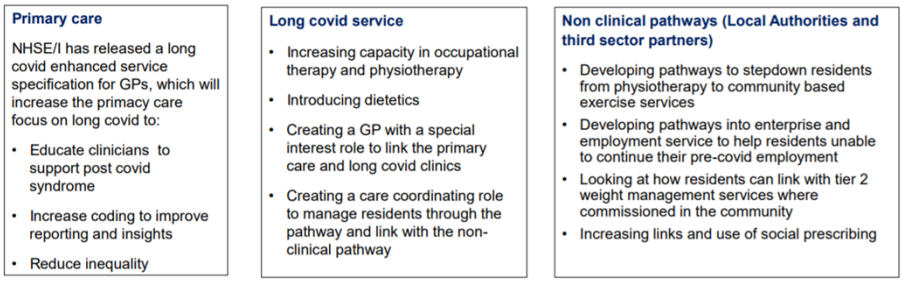
This service will move away from the traditional reactive models of assistive technology centred around a conventional monitoring and response alert-based service, to transformed health and social care systems and services centred around technology to achieve better outcomes for residents, fully harnessing the role of the wider community and support networks. This will mean embracing the full suite of technological advancement available now and throughout the contract term ranging from artificial intelligence and machine learning to augmented and virtual realities to offer a truly personalised experience for our residents.

Impact of COVID
COVID drove forward system working across health, social care and the voluntary sector. An ever-changing environment meant the system had to flexible and very quickly respond and develop to the pandemic. Examples of this were NELFT developing a hospital discharge service from existing services in 3-4 weeks and re-purposing bed bases very quickly to respond to changing needs. Projects such as Home First and D2A quickly developed and have become business as usual as we reach the tail end of 2021-22.

What do we know about Long COVID residents?
- 95% of people require physiotherapy support
- 100% are being supported with their shortness of breath
- 100% can benefit from exercise, however the team need to targeting supporting people back to work and fatigue first 75% of people require occupational therapy support
- 100% suffer from fatigue
- 75% will have difficulties with activities of daily living; dressing, eating etc.
- 40% have financial difficulties
- 50% require support will return to work 60% of people require clinical health phycology support
- 50% will receive neuropsychological interventions
- 50% will receive long COVID specific psychological therapy

What are the differences between first and second wave of COVID?
Wave one residents had more deconditioning due to the length of hospitalisation and/or waiting for the long COVID service to be commissioned and mobilised. More of the sickest in residents were treated by being nursed prone (nursed on their fronts) which has increased long term physical effects. In wave two, BHR were some of the hardest hit parts of London, coined 'the COVID triangle'. There are higher numbers of wave two resident who are developing long COVID, which could be associated with a decrease in mortality and increase in morbidity as the NHS learnt more about how to treat these residents.

What are we doing to address the long-term impacts of long COVID?



SCHEME 4: Market Stabilisation & COVID Recovery

Care Market

Social care in particular faces a number of challenges including necessary steps to stabilise the local market and related inflationary pressures, alongside demand pressures. The impact of COIVD has been significant in de-stabilising a number of key care markets – Residential, Homecare and the voluntary sector. This is due to a number of factors:

- Workforce issues relating to care staff leaving the sector to work in other areas where pay is higher. This is proving a huge area of concern for Homecare agencies reducing their ability and capacity to deliver high-quality safe care for people at home and take on new packages.
- An increase in the complexity of care needed in people being discharged from hospital including the need for double-handed care packages, larger care packages with more hours and more care packages for younger older adults - exacerbated by the shortage in workforce.
- Staff not agreeing to have the COVID vaccine and therefore being made redundant and unable to work in place-based care settings.
- The impact of the COVID pandemic on people's choice to go into care homes given their mortality rate during the pandemic periods and concern over safety and levels of care. Providers seeing a reduced income as a result leaving them financially less stable and in some cases closing care settings.
- Carer breakdowns due to people being looked after at home as a result of building-based services not being open and operating more restricted services. Also, the increased number of hidden carers due to the impact of the pandemic on people heath.
- However, on the flip side, as people have returned to work and are less able to care for relatives as home, we are now seeing an increase in demand again for care services such as Homecare.
- Increase of insurance costs to providers as a result of the increased risk the COIVD pandemic brought with it.
- Voluntary sector providers unable to deliver building-based care and moving towards more virtual models and losing people as they are being cared for at home, as building based services were closed and the increase on the number of hidden carers as a result income generated from this.
- The impact of compulsory vaccination on the care market and just recently NHS front line staff.

Demand for services is predicted to continue to rise across almost all conditions and service user groups across BHR especially in Havering with older people. Demand for services, even though demand management initiatives have been introduced, are therefore likely to rise. Care services are largely people based and it therefore follows that the number of people we will need to provide care in future is likely to increase. This is already manifesting itself in markets like the home care market where across the country the deficit in recruitment is causing shortages in provision. This has had a direct knock on effect on transfers of care from hospital and the challenges around ensuring quality of service. All boroughs are continuing to respond to this by ensuring that investment in the system is targeted where it can make most impact.

Within B&D we are seeing an increase in the acuity and number of placements within nursing and residential care and homecare e.g., in August we saw a doubling of nursing and residential placements and a doubling in the number of homecare packages in comparison to the previous month.

Additionally, the B&D Mental Health service continues to see rising demand with many new referrals considered to be COVID-related. The service is aware of a high number of hospital admissions relating to ill mental health (up by 1/3). Especially young people up to the age of 24 are affected and those who had been discharged from Mental Health services and had remained well in the community for several years. This continues to have an impact on the Services provided by our health colleagues in NELFT and in the longer term will impact on activity levels in our Social Care service. Additionally, the Disabilities service is witnessing significant

demand with caseloads above acceptable levels, particularly in young people with disabilities. There are a number of drivers for this additional demand namely that the pandemic has put families under enormous pressure over a prolonged period of time. Additionally, we have seen a rise in families from neighbouring boroughs moving to B&D, with children with complex Learning Disability presentations.

Equipment and Adaptations is being closely monitored due to an increase in demand. This is thought to be a combination of package and placement increases and equipment market pressures due to COVID and Brexit.

The challenges of COVID have proved to be many and on-going as services and staff responded rapidly to ensure people continue to receive care and support and that new demand is met. Despite the challenges faced, the overall performance of social care has been largely maintained.

There are of course other aspects to maintaining a sustainable market. Dialogue with providers is a key element of the strategic approach in this area. The dialogue, through provider forums, through a web portal and through co-production exercises, will be a key factor in the overall strategic approach. It is not only engagement but the tenor of the discussions that are had that is important. The commitment is to operate from an assumption that the Council and providers have a shared objective; to provide high quality services to vulnerable people in a cost-effective way.

BHR as a subsystem is now taking forward joint work on developing an approach for local suppliers to position themselves to bid for procurement opportunities to deliver and supply to Council and NHS services. There is also the development and launch of the BHR health and social care academy (launched in September), to address workforce shortages in the NHS and social care, as well as create opportunities for local people to start and develop their careers in the local care system, including maximising apprenticeships.

BHR System Challenges

BHR faces a number of system challenges. Given the high population, the impact of COVID within the area, the long-term health conditions and complexity of population challenges, we can identify the following:

1. Our rapidly increasing and changing population profile means we need a new approach to preventing ill health, targeting people who are more likely to require health and social care in the future.

2. Social care in particular faces a number of challenges including necessary steps to stabilise the local market and related inflationary pressures, alongside demand pressures. The impact of COIVD has been significant in de-stabilising a number o key care markets – Residential, Homecare and the voluntary sector. This will only become more acute with the increase in the National Living Wage / London Living Wage, as well as inflationary uplift.

3. Resources required per head increase with age therefore any new service model and resource allocation must be appropriately designed to address these challenges given that Havering has one of the oldest populations in the country, as well as a Redbridge receiving a low allocation per head within the BCF.

4. The BHR system has significant challenges to tackle including poor health and inequalities, care and quality and financial sustainability. We have a diverse, highly mobile and in some cases very deprived population – all with unique health and wellbeing needs and in some cases poor health outcomes. Demand is expected to be highest in more deprived localities.

5. Barking and Dagenham is the 3rd most deprived area nationally with both a prevalence of long-term conditions, below average life expectancy alongside an increasing population specific and marked increases in key groups; an example is a projected increase in Older People over the next 20 years.

6. Redbridge has an increasing prevalence of long-term conditions in an ageing population and the combined effect of this and demographic is projected to result in an increased demand for hospital care of with more elective admissions and emergency admissions, plus an additional increase in demand for long term social care by 2030 if the model of care does not change.

7. Havering has the oldest resident population in London and has seen a large inflow of children. It is estimated to have one of the highest rates of serious physical disabilities among London boroughs and one of the largest proportions of the population in the country with dementia and it is estimated that around half of people living with dementia are as yet undiagnosed.

8. Patients have often found it challenging to access the right service, in the right place, at the right time. Our acute provider has seen significant improvement in emergency flow, staff engagement and financial performance, however, broader system wide partnership is needed to address longstanding access issues, including increasing A&E attendances, admissions and waiting

times for elective care. Whilst discharge and LOS have vastly improved, the system needs to embed learning and good practice and review and develop services to maximise flow.

9. Primary care also faces significant challenges with a large proportion of GPs nearing retirement age, difficulty in attracting new talent and increasing demand.

10. External inflationary pressures impact significantly on social care providers and currently inflation is rising, and it is uncertain whether and for how long these inflationary pressures will continue. To meet the local authority obligation to keep the market sustainable the local authority has to listen and respond to the care market. At some point, however the two priorities, to sustain the care market and to protect local authority budgets, could become incompatible. This needs to be part of the system wide understanding of pressures and not seen as a local authority issue alone.

Section 5: Disabled Facilities Grant (DFG) & Wider Services

1. Summary

Statutory Disabled Facility Grants (DFG) will continue to be delivered via the Better Care Fund which significantly contributes towards helping older and vulnerable homeowners remain in their properties; this meets one of the key aims of the BCF to prevent people from being admitted into hospital or residential care.

The boroughs have a significant population of elderly residents (over 65), particularly Havering, and as such have seen a steady increase in the demand for disabled facility grants. As a system there has been an increasingly joined up approach across health, social care and housing to help deliver adaptations to support people remaining in their own homes.

Traditionally disabled facility grants pay for a range of adaptations to people homes, including Level Access Showers, Ramps, Stairlifts and extensions to provide ground floor bedrooms and bathrooms. However, we are aware that the incorporation of the DFG within the Better Care Fund is to encourage the Council and CCG to think strategically about the use of home aids/adaptations and the use of technologies to support people in their own homes.

Within B&D, an Older People's Housing taskforce has been set up to strategically shape the future of housing and planning for older people. This group combines stakeholders from across Care and Support, Housing, Community Solutions, Inclusive Growth, Landlord Services, Adaptations team and Be First, our regeneration company. The group is focused on the future of sheltered housing, extra care, bungalow provision, site regeneration, referral processes and adaptations across Council, private and housing association housing.

Redbridge People services are working closely with Housing colleagues with those people who experience mental health, addiction homelessness and those with other long-term conditions – including LD and physical disabilities. This includes feeding into the Local Plan and housing strategies.

2. BHR Area DFGs

Barking & Dagenham
Barking and Dagenham utilise the DFG for adaptations and social care projects in line with guidance. The majority of the DFG (approx. 75%) is spent on adaptations for individuals with disabilities across the life course and the team administering the DFG sits within our all-age Brokerage and Markets service.

Home adaptations and assisted living enable disabled, vulnerable and older people to maintain their quality of life and improve their ability for independent living and self-care in their home. Adaptations can also reduce health and social care costs, help to reduce the risk of injury from falls, enable faster discharge from hospital, delay admission to residential care and reduce care costs.

As well as the Mandatory DFG (as detailed in the Housing Grants, Construction & Regeneration Act 1996, subsequent amendments and the associated 2002 RRO), Barking and Dagenham offers a discretionary DFG to 'top up' mandatory works on a case-by-case basis at management discretion. This allows us to ensure that adaptations are designed to meet both current and anticipated needs, thus avoiding the need for more costly interventions e.g., high-cost packages of care /nursing home accommodation.

In many homes with a disabled resident there are also other repairs that are needed to make the home safer to live in. As part of the DFG process officers will consider all aspects of the home (using the parameters of the Housing Health and Safety Rating System)

and will recommend other works to reduce hazards like cold homes, and trips and falls and refer to other services such as the Handypersons Scheme.

The Council's aim for 2021-22 is to revise our DFG Policy to utilise the flexibility to use the DFG as set in the Regulatory Reform Order 2002 and we are working with Foundations in order to do this. In the last year we have begun to use a proportion of the DFG more flexibly to meet the increasing demands to support people to live independently in their homes for longer, keep individuals safe and decrease levels of falls and reduce hospital admissions. We have begun to finance Housing, Health & Social Care initiatives such as the hoarding and decluttering scheme, a double to single handed care reviews project and will be expanding the handypersons service to encompass DFG as well as iBCF funding. The DFG has also been used to finance Assisted Technology services such as 'Breezie' which provides older people with a personalised tablet to be more independent in tasks such as communicating with friends and family and linking in with managing their environment with a touch of a button e.g., adjusting the heating or seeing who is visiting them at the front door. Additionally, it will support the new All-Age Care Technology service as described above.

Havering
Havering Council has an overarching vision that is focused around the Borough's Cleaner & Safer, Prouder, Together and Value for Money strategic themes. By embracing both statutory and discretionary powers that are available to us via the Regulatory Reform Order 2002 the Authority aims to improve the health and well-being of residents (both adults and children) by helping them maintain independence, whilst having a focus on preventative work which will contribute to improving the quality of life of our vulnerable residents.

We will continue to drive up the visibility and take up of the Disabled Facilities Grant (DFG) to applicable residents. We work across social work teams in both Children's and Adults departments, with our Local Area Coordinators, departmental colleagues in Housing, Health, Environment and Public Protection. We also work with housing associations, their tenants, homeowners, private tenants and/or landlords who are able to apply directly.

In Havering the responsibility for the DFG sits within the Strategic Commissioning function which strengthens our understanding of the end user need and demand. We are able to plan, review and analyse demand for services and provisions as well as offer signposting to the DFG as part of a suite of services, available through a variety of providers including the voluntary sector. Through the analysis of demand, we are able to align commissioned and non-commissioned services and identify opportunities for expansion, for example we plan to review the Handyperson Scheme and the use of Assistive Technology (AT).

We provide advice, information and support on repairs, maintenance, adaptations of properties across the Borough and offer a health-based framework of assistance to vulnerable groups and households including those with long term health conditions. Whilst it is recognised that it is the homeowner's responsibility to maintain their own properties the Council will target limited resources to support vulnerable adults and children who are not able to achieve this themselves and will support families to provide safe and effective care to enable vulnerable loved ones to remain at home.

In addition to the mandatory DFG Havering offer a discretionary Housing Assistance Grant, this includes:

- DFG top up - top up of mandatory DFG which exceeds grant limit.
- Discretionary adaptation assistance - financial assistance for those who fail the mandatory means test.
- Moving on assistance - financial assistance to move to a more suitable accommodation.
- Hospital discharge assistance – to prevent delayed transfers of care associated with housing disrepair or access issues.
- Safe warm and well - to provide a safe and warm house for older and disabled people to promote health, wellbeing and independence.
- Dementia aids, adaptations and assisted technology - to enable people with a diagnosis of dementia manage their surroundings and retain their independence.
- Sanctuary Scheme - to provide occupiers at risk of domestic abuse with improved security.

The BCF enables us to aim to reduce delayed transfers of care, minimise avoidable hospital admission, and facilitate early or timely discharge from hospital by tackling housing related matters. We support vulnerable households to ensure they are able to heat their homes at reasonable cost and assist disabled people with adaptations to facilitate their movement in and around their home thereby improving their quality of life.

Havering Council's DFG plan for 2021-22 includes a programme of digitalisation, expansion and promotion. The first steps will be to expand the use of the recently procured Dynamic Purchasing System (DPS), a review of end to end processes and recruitment of additional staff (Technical Officer and DFG Officer). These activities will provide a more robust foundation from which we can expand the reach of the service whilst also seeking more innovative, preventive and personalised applications of the funding.

Redbridge

Home adaptations and assisted living enable disabled and vulnerable people to maintain their quality of life and continue independent living in their home environment. Adaptations can also reduce health and social care costs, help to reduce the risk of injury from falls, enable faster discharge from hospital, delay admission to residential care and reduce care costs. In Redbridge adaptations are carried out using the BCF funded Disabled Facilities Grant (DFG) in a variety of ways.

As well as the mandatory DFG (as detailed in the Housing Grants, Construction & Regeneration Act 1996, subsequent amendments and the associated 2002 RRO), Redbridge offers a discretionary DFG to top up mandatory works where the cost exceeds the maximum mandatory allowance of £30k. This allows us to ensure that adaptations are designed to meet both current and anticipated needs, thus reducing the need for hospital stays and residential care. The discretionary DFG is particularly relevant for children's cases as adaptations need to be designed to meet the ongoing complex needs of a growing child and their family.

In some cases, it is not possible to adapt the current home of a disabled resident. This could be because of the size, layout or planning restrictions in place. In such instances Redbridge also offers a Relocation Grant to assist with the cost of moving to a more suitable property.

In many homes with a disabled resident there are also other repairs that are needed to make the home safer to live in. As part of the DFG process officers will consider all aspects of the home (using the parameters of the Housing Health and Safety Rating System) and will recommend other works to reduce hazards like cold homes, and trips and falls. These works are then carried out using other funding set aside for Home Repairs Grants. Alternatively, a referral may be made to the Redbridge Handyperson Scheme for minor repairs.

While the Handyperson Scheme is funded from another budget, we are looking at options to expand on this service using DFG funding through the BCF. Priority is already given to residents about to be discharged from hospital where they need help with moving furniture, fitting of key safes, home security and minor adaptations. Discussions are also taking place with our current provider to expand this service to include things like a home from hospital service which would further contribute to quicker hospital discharge. To support this DFG funding has been used in part to fund our Lifeline and Telecare systems (assistive technology) which allow vulnerable residents to remain independent in their own homes.

Redbridge has developed a Private Sector Housing Renewals Policy which includes major reviews of the provision of adaptations and repairs for vulnerable residents. This reduces processing times for DFGs by including:

- An increase in the available top-up grant for Mandatory adaptations in excess of £30,000.
- An alternative disabled facilities grant to the current mandatory grant.
- A simplified means test and application process to enable speedier processing.
- An increase in the available Relocation Grant to reflect the increased costs of moving in London.
- A minor works grant to supplement social care equipment budgets with minor adaptations that cannot be covered by those budgets.
- Partnership working with neighbouring authorities in the Healthcare Trust to develop lists of competent contractors to work with us to provide quicker adaptations under a framework agreement.
- Partnership arrangements to enable rapid 'off the shelf' adaptations from stock.

Section 6: BHR BCF Finance Summary

1. Summary

This section shows the highly level overview of the Better Care funding across the Barking, Havering and Redbridge areas. Further detail of schemes and services funded by the programme elements (CCG minimum, iBCF and DFG) are detailed in each of the boroughs Expenditure Plans for 2021-22.

2. High Level Funding Overview

The tables below set out the high-level summary in more detail.

Table 1: Total BCF Funding across BHR

B&D	Havering	Redbridge	BHR Area Total
£28,766,458	**£29,951,938**	**£32,706,462**	**£91,424,858**

Table 2: Breakdown by Fund

Fund	B&D	Havering	Redbridge	Area Total
CCG Minimum	£16,517,375	£20,397,102	£20,492,322	**£57,406,799**
iBCF	£10,392,182	£6,624,304	£9,784,945	**£26,801,431**
DFG	£1,856,901	£2,056,802	£2,429,195	**£6,342,898**
Additional LA	£0	£873,730	£0	**£873,730**
Additional CCG	£0	£0	£0	**£0**

Table 3: Required Spend for National Conditions 2 & 3

Allocations	B&D	Havering	Redbridge	Area Total
NHS Commissioned Out of Hospital spend from the minimum CCG allocation	£4,693,770	£5,796,278	£5,823,336	**£16,313,384**
Adult Social Care services spend from the minimum CCG allocations	£6,120,163	£7,683,932	£8,044,889	**£21,848,984**

Table 4: Spend per head of population (no additional funding included)

Borough	LA Boundary ONS Population UK mid 2020 (Estimated)	Spend per head (£) (no additional contributions included)
Redbridge	305,658	**£107.00**
Havering	260,651	**£111.55**
B&D	214,107	**£134.35**
Total Area Estimated Population	**780,416**	Area average: **£116.02**

The table above shows clearly that Redbridge's spend per head of population is significantly below the area average along with Havering.

Section 7: Equality & Health Inequalities

1. Summary

Our BCF draws together a range of strategies and policies which have, in their development been subject to an assessment of their impact upon key groups within our population. In addition, the BCF is driven by national policy, designed to positively impact upon both the health and social care system and importantly, upon individuals improved health, self-care and wellbeing, seeking to address inequalities and improve outcomes informed by our Joint Strategic Needs Assessments.

All reports to our Health & Wellbeing Boards are required to consider the implications of the protected characteristics under the Equalities Act and similarly as part of our work in understanding demand and need of our populations, we ensure that we undertake Equalities Impact Assessments when undertaking to design and commission services and these will be subject to ongoing review to consider the EIA implications. Within Redbridge we a Disability Charter – which set out a number of core principles to support service

users and carers with all disabilities to being involved within our Commissioning process – from co-production, contract tendering and contract monitoring.

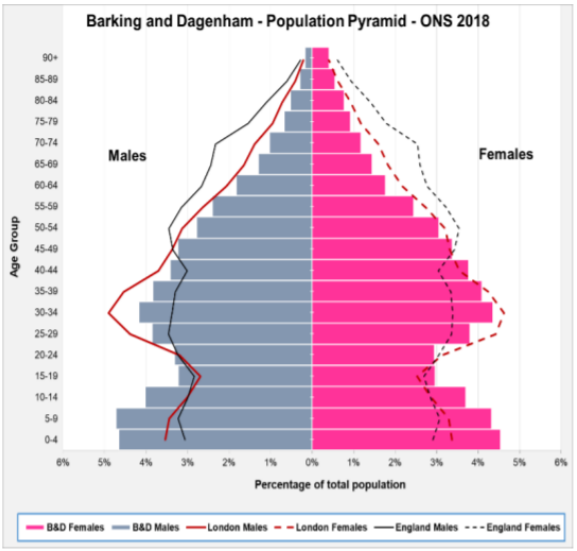
The three boroughs have distinctive populations: Barking and Dagenham has a younger and ethnically diverse population which is the third most deprived in the country; Havering an older, largely white population; and Redbridge an ethnically diverse, majority Asian, median income population. The section below highlights key data on local areas.

3. Local Area Summary

The detail below provides a highlighted snapshot of the three boroughs. Further details about each borough profiles can be found on the respective websites with their Joint Strategic Needs Assessments (JSNA). As stated, all detail and data contained within this plan was correct at the time of submission.

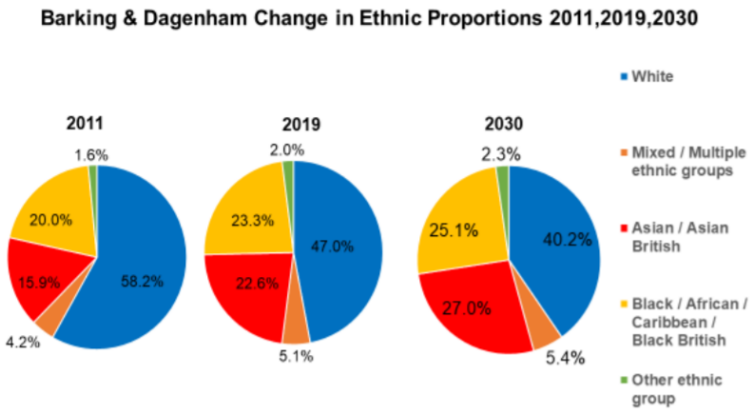
Barking & Dagenham
As health and care commissioners we seek to co-produce the design and implementation of our services based on the evidence of our local population needs.

The population of Barking and Dagenham is relatively young in comparison to the rest of London and the BHR ICS. Of 16,000 people aged 85 and older living in the three boroughs comprising the BHR ICS, only 19% live in Barking and Dagenham. Nevertheless the age profile of the Barking and Dagenham population is projected to change with proportionally greater growth amongst those aged 60-69 e.g. the number of people aged 60-69 living in Barking and Dagenham will increase by 6K (44.8%) from 13.5k in 2018 to 19.5K by 2030. Overall impact of demographic change: If age specific rates of attendance remain unchanged, the demographic change described above will result in a 24% increase in unplanned hospital admissions of Barking and Dagenham residents by 2030.



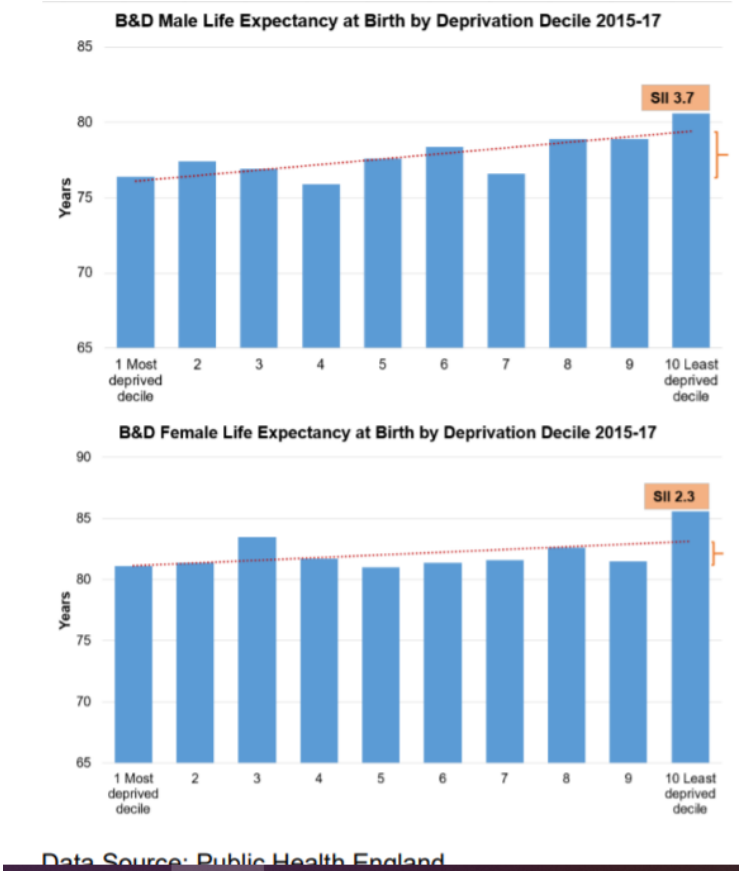
Data Source: ONS mid-2018 population estimates

Ethnic diversity in Barking and Dagenham has increased in the recent past. An estimated 53% of Barking and Dagenham residents are from a Black, Asian or Minority Ethnic (BAME) background compared to 44% for London. This proportion is predicted to increase to 60% by 2030.



Source: GLA Ethnic Group Projections (2016-based central trend)

Life expectancy in Barking and Dagenham has increased steadily over recent decades but remains lower than the national average. The additional years of life achieved in recent decades are often impaired by ill health and disability resulting in poor quality of life and significant need for health and social care services. There is a significant social gradient in life expectancy such that residents living in the most deprived decile of the borough have a lower life expectancy (3.7 years for men and 2.3 years for women) than peers in the least deprived decile. As well as lower life expectancy, people living in deprivation have a proportionally lower healthy life expectancy than less disadvantaged peers.



The Index of Multiple Deprivation (IMD) combines many different facets of disadvantage into a single measure. According to IMD 2019, Barking and Dagenham is the fifth most deprived local authority in the country and the most deprived borough in London.

Levels of deprivation are high in Barking and Dagenham compared to other London boroughs; 19.4% of the population live in income deprived households compared to 12.1% in Redbridge, 10.8% for Havering and an average of 13.8% for London. 20 BHR JSNA profile: LB Barking & Dagenham 2019-20 Work is good for physical and mental health, in part due to the association with higher income. The rate of employment in Barking and Dagenham (69.0%) is lower than the London (74.2%) and England (75.6%) average. The proportion of working age adults in Barking and Dagenham who are economically inactive (26.8%) is correspondingly higher than

the London (21.9%) and national averages (21.1%). However, 5,900 Barking and Dagenham residents are economically inactive and want a job.

In the London Borough of Barking and Dagenham inequalities is at the heart of everything that the Council does, with a corporate strategy focusing on ensuring that no one is left behind.

Havering

Geographical Profile:

- The London Borough of Havering is the 3rd largest borough in London (43 miles2) and contains 18 electoral wards.
- It is mainly characterised by suburban development, with almost half of the area dedicated to open green space, particularly to the east of the borough.
- The principal town (Romford) is densely populated and is an area of major metropolitan retail and night-time entertainment.
- The southern part of Havering is within the London Riverside section of the Thames Gateway redevelopment area and will be an area of increasing development and population change.
- Havering is a relatively affluent local authority but there are pockets of deprivation to the north (Gooshays and Heaton wards) and south (South Hornchurch) of the borough.

Population Profile:

- The estimated population of the London Borough of Havering is 257,810.
- It has the oldest population in London with a median age of approximately 39 years old.
- The Borough experienced a net population loss of 6.3% from 1983 to 2002 but the population has increased year on year from 2002, with a 14.5% increase from 2002 to 2018.
- As well as increases in the number of births in Havering, there has been an increase in the general fertility rate from 58 (per 1,000 women aged 15-44) in 2004 to 68 in 2017. This equates to an additional 10 births per 1,000 women aged 15-44 within the period.
- From 2012 to 2017, Havering experienced the largest net inflow of children across all London boroughs. 4,343 children settled in the borough from another part of the United Kingdom during this six-year period.
- It is projected that the largest increases in population will occur in children (0-17 years) and older people age groups (65 years and above) up to 2033.
- The life expectancy at birth for people living in Havering is 79.6 years for males and 84.2 years for females.
- The life expectancy at age 65 years in Havering is 18.5 years for males and 21.6 years for females.
- Havering is one of the most ethnically homogenous places in London, with 83% (census 2011) of its residents recorded as White British, higher than both London and England.
- About 90% of the borough population were born in the United Kingdom.
- It is projected that the Black African population will increase from 4.4% in 2019 to 5.3% in 2034.
- About 19% of working age people living in Havering disclosed that they have a disability or long-term illness.

Household Profile:

- There are 107,933 households in Havering, according to the Council Tax List (as at 10th July 2019).
- Households are mainly composed of pensioners and married couples with dependent children.
- All adults in 52% of households (40,722 households) are working and no adults are working in 16% of households (12,256 households).
- In 2011, there were 7,224 one-adult households with children under 16 in Havering. This is an increase from 2001 when there were 4,005 lone parent households. There has also been an increase in the number of one-adult households with no children.
- About 73% of the population in Havering are homeowners. This is one of the highest proportions across London boroughs.
- Housing in the borough is mainly Victorian and Edwardian. Houses are generally large with an average of 2.8 bedrooms per household (higher than both London and England).
- The rate of homeless households in temporary accommodation (8.9 per 1,000 households) is lower than London (14.9 per 1,000) but higher than England (2.7 per 1,000).
- The rate of statutory homelessness (eligible people not in priority need) in Havering (0.5 per 1,000 households), in 2016/17, is lower than both London (1 per 1,000) and England (0.9 per 1,000).
- The borough has a rate of short-term international migrants of 165 per 100,000 population, the second lowest of all London local authorities.
- Almost all (99%) of the traveller caravans in Havering were on authorised sites, as at January 2018.
- 32% (13,449) of the population aged 65 years and above are living in one-person households. Almost half (48%) of all one person households in Havering are occupied by persons aged 65 years and over, which is the highest proportion in London

Economic Profile:

- The average gross income per household in Havering (£44,430, as measured in 2012/13) is low in comparison to the London average (£51,770) and slightly higher than the England average (£39,557).
- 77% of households in Havering have at least one car and compared to other local authorities in London, Havering has the second highest proportion of households (32.8%) with 2 or more cars.
- Majority of children in Havering are not poor, but around 8,800 live in income-deprived households. Gooshays and Heaton wards have the highest proportion of children living in poverty.
- About 77.9% of working age residents in Havering were in employment between April and June 2018. Overall employment rate in Havering is higher than London (74.6%) and England (75.9%)
- The proportion of working age residents in Havering claiming out-of-work benefits (6.8%) is significantly lower than England (8.4%).

Redbridge

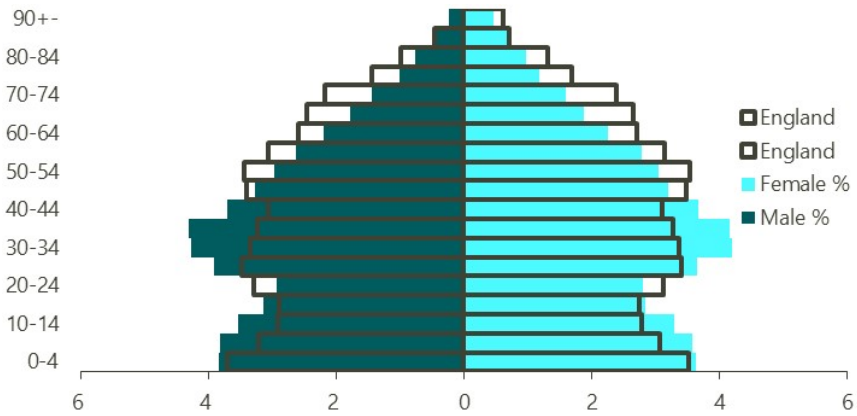
As health and care commissioners we seek to co-produce the design and implementation of our services based on the evidence of our local population needs. This is based a range of data sources including our Annual Public Health Reports, JSNA, health and social data from client management systems, as well as performance outcomes frameworks (including ASCOF, PHOF, NHS outcomes) in the design of services. Undertaking Equality Impact Assessments will ensure we are meeting these needs and our duties to reduce health inequalities for those with protected characteristics under the Equality Act. Redbridge is a very diverse borough with 64% of residents from a BME groups with Indian and Pakistani minority ethnic groups representation the largest proportion of this. In terms of population health 15% of people have a limiting long-term illness compared with 14% across London. Redbridge also has one of the highest prevalence of Diabetes in the country and is expected to increase to 11.9% by 2035. This is due to a high proportion of residents from South Asian ethnicities, prevalence of obesity and low physical activity rates. We are expecting to see increases in the 65-74 and 85+ populations with the proportion of the population aged 65 and over rising from 12% to 14%.

Redbridge has co-produced a 'Disability Charter' with our CCG, local Cllrs, and VCS partners, that sets out a number of principles to inform commissioning processes across the Council and CCG and to improve the quality of life for residents with a disability or mental ill-health. It will ensure that our services are person centred, designed with people who use them and promote independence, choice and control. It has four key areas covering: (1) Working in partnership; (2) Understanding disability; (3) Improving outcomes; (4) Monitoring impact. This will be agreed by our HWB and Cabinet in Dec 2018 and Jan 2019.

Population Overview

Between 2010 and 2019, the population increased by 11.2% and is projected to increase by a further 15% by 2035. Redbridge has a younger population compared to England with the proportion of residents between the ages of 0 and 19 years (28%) and between 25 and 44 years (32%) is higher than the national average (25% and 26% respectively). In contrast, it has a lower proportion of older adults aged 65 years and over (about 12%), compared to nationally (17%).

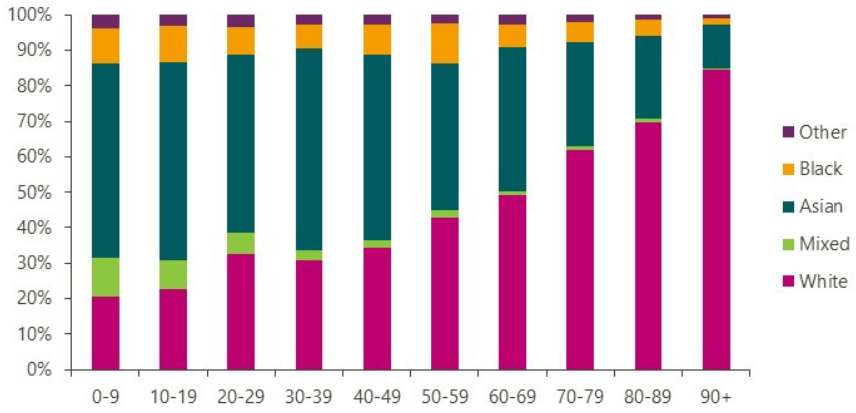
Redbridge's population, in five-year age bands, by age and sex, 2019



Diversity

With over 100 languages spoken on the Borough's streets, Redbridge's population is both culturally and ethnically diverse. In 2019, almost 50% of the population were from Asian ethnic groups and 35% of the population were from White ethnic groups. The proportion of Redbridge residents from White ethnic backgrounds increases among older age groups, while the proportion of Redbridge residents from Asian ethnic backgrounds is higher among younger age groups.

Redbridge's population, in ten-year age bands, by age and ethnicity, 2019

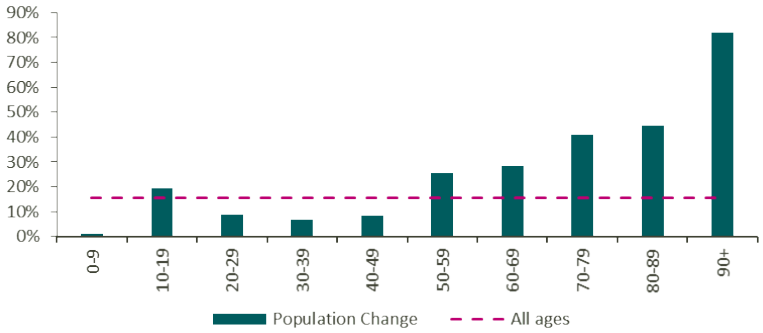


Population Change

Redbridge's population is both increasing and ageing; between 2019 and 2035 the local population is projected to increase by around 15%. Its population is projected to increase the most among those above the age of 50, with the number of people aged 65 years and over in the Borough is expected to grow by 40% between 2019 and 2035.

Older people disproportionately require more health and social care than their younger counterparts. Therefore, we need to ensure the population of Redbridge age as healthily as possible in order to mitigate impacts on individuals, families and local services.

Projection population change in Redbridge between 2019 and 2035, by age



- Asthma, chronic kidney disease, diabetes mellitus, hypertension and coronary heart disease are the most prevalent LTCs in Redbridge.
- The most common LTC in Redbridge is hypertension. The local hypertension prevalence is 11.6%, which is higher than London (11.0%) but remains lower than England (14.0%).
- The second most prevalent LTC in Redbridge is diabetes. In 2018/19, 9% of residents had the condition; the local prevalence is 2.1% higher than the national average
- National statistics estimate that in 2015, 54% of individuals aged over 65 lived with multi-morbidity. This figure rises to 90% for those aged over 85. As the population ages, LTCs will place an even greater burden on the health and social care system.
- The number of people with dementia in Redbridge is set to grow by nearly 36% from 2,838 people in 2019 to 3,853 people in 2030, due to both growth in prevalence and growth in the older population.
- In Redbridge, social care accounts for the largest proportion of the cost of dementia, and this is expected to grow by nearly 70% from £66.6 million in 2019 to £113 million in 2030. The value of unpaid care is expected to grow by nearly 63% from £44.3 million in 2019 to £72.1 million in 2030. Healthcare costs, which account for the smallest proportion of the cost of dementia locally, are expected to grow by 56% from £15.8 million in 2019 to £24.6 million in 2030.
- In 2018, 51% of jobs in Redbridge paid at or above the London Living Wage. This was the lowest rate in London, and significantly lower than the rate for London as a whole (80%). London Borough of Redbridge is an accredited London Living Wage (LLW) employer and, in the Borough Partnership Plan for 2025, has committed to encouraging public services and private employers to achieve LLW status.

*All data used for the borough profiles has been pulled from the respective borough Joint Strategic Needs Assessment (JSNAs) which can be found on the website in section 9 of this plan.

What has changed since our last plan?
There are two cohorts of patients/residents that will be presenting needs to both health and social care going forward. Firstly, People affected by Long-COVID with respiratory and mobility issues. This is not age defined and is requiring some targeted interventions from local services. There is an increase in care and support needs for those who are below 65 years old which is part of the changing face of health and social care in a post COVID-19 era. This increasing level of demand of the younger cohort is presenting as an issue in a market where the registrations of care providers are, in the vast majority, for over 65s.

Secondly, many older people have been more negatively impacted by the pandemic than other groups. With self-isolating and shielding services are starting to see people who have decondition both physically causing mobility problems and mentally with depression and increased impacts of dementia causing more severe behaviour problems. This is also had a marked impact on informal carers and their ability to cope.

What are we doing to make difference and address this imbalance?
Throughout the COVID pandemic and over 2021-22 the BHR health and social care system have been working in tandem through integrated commissioning and joint decision making. This joint working, which is enabled by the BCF, is a different approach from the past 5 years and will pay dividends in the outcomes for our residents across BHR. Removing silo working across local authority boundaries and providing equitable acute and community services can reduce the risk of inequalities increasing across our system. A joint BHR JSNA is currently underway and will support the future demand management and planning of services across the patch. Close working with colleagues from Public Health and housing is crucial to understanding the changing needs and impact of wider determinants on both our current and future populations.

The focus on personalised responses to people suffering from experience of inequalities has given insight into the problems faced and the development of responses to them. The clearest example is the development of local area coordination, where people are 'walked with' to understand the scope and scale of their problems before jointly devising solutions to change lives. Case studies are illustrating how complex people's lives are and are not necessarily solved by an isolated service intervention, such as responding to something identified, for example, as a 'hoarding' issue if in fact the issue is a result of another more deep-rooted problem. Clearing a house without responding to the root cause of the problem will lead to a repetition rather than a solution. The efficacy of this approach has been recognised and funded, through the BCF, by system partners. Although this is an example the wider philosophy across the partnership is that people's needs are to be understood and their assets used to devise tailored solutions that are sustainable. The thrust of our commissioning and operational approaches is compatible with this thinking. For those with protected characteristics this approach will identify the issues they face and deal with them in a personalised way.

Engagement with our service users, carers and providers and local community groups is a key component of understanding the issues at both a service delivery level and grass roots level – the lived experience. Feedback and consultation with our communities is a cornerstone that is and will be embedded in our commissioning work. For example, we know that within Redbridge the Bangladeshi community was particular impacted by the COVID pandemic. By listening to our local community, we are beginning to understand the reasons behind this (such a lifestyle and dietary choices) and therefore provide the targeted support to mitigate the impact of this happening again.

Section 8: Stakeholder Engagement

1. Summary

Providing and delivering services in the current climate is challenging and we know that we cannot work in isolation. To maximum the opportunities for achieving the best outcomes for those who use our services, we need to work with and engage those same people in the design and development of services for the future. With an increasing population and growing demand for services, it is essential that service providers and stakeholders work together to ensure that there is maximum benefit for every service commissioned in achieving the best outcomes possible.

Through this we will:

- Ensure all people have an equal opportunity to have their voices heard by increasing the accessibility of consultation and engagement activity
- Measure the impact of consultation on service development, commissioning and provision to ensure that it has a genuine influence
- Ensure that good quality, timely feedback is provided to consultees so that they know how their views have made a difference

- Improve communication between, and increase collaboration by, partners on engagement activity to make best use of limited resources
- Increase community engagement skills among Adult Care, Health and Wellbeing's workforce to improve the quality of consultation and engagement activity

Levels of Engagement & Co-production

LEVEL 1: Doing to	LEVEL 2: Doing for	LEVEL 3: Doing with
Passive recipients	**Engaging & involving people**	**Equal & reciprocal partnership**
• Education • Coercion	• Engagement • Consultation • Informing	• Co-production • Co-design

Diagram of 'Participation hierarchy', developed by the New Economic Foundation

2. Engagement Activity

Both the LAs and CCG constantly undertake a wide range of engagement activities throughout the year. These form part of the Commissioning Cycle and partnership work, market development and engagement and contract and provider relationship work. The work delivered by the BCF fund is a key theme throughout our engagement activities. The section below outlines some of the key area activities.

Service User & Carers
Barking and Dagenham and Havering have commissioned the British Red Cross to a undertake piece of research to understand the experience of residents who have gone through each of the four overarching hospital discharge pathways (0-3) as outlined in national guidance. We want to understand the experience of residents who go through hospital discharge and use this feedback to improve pathways, support, communication and information and advice. The BRC are undertaking 40 interviews of Barking and Dagenham and Havering residents, concluding in Autumn 2021 and the outcome of this work will inform our BCF schemes, pathways and joint commissioning activities.

Within B&D the Provider Quality and Improvement Team ring round a random pool of recipients of care and support each month services to understand their experience and any areas for improvement or feedback.

The new Barking and Dagenham Carers Charter engaged over 100 carers, as well as carer groups and system stakeholders between February and August 2021 to develop the Charter's key principles and to inform the action plan. This is being signed off at Cabinet and the Health and Wellbeing Board in January 2022.

Redbridge constantly engages both service users and carers. We have recently updated out Carers offers and engaged our Carers Service to lead on the engagement for us. During our commissioning work we are now embedding service users as part of the commissioning workstream work from beginning to end – service design through to procurement. Our Quality Assurance teamwork with service users to discuss their care and quality of care and feed this back to contacts and safeguarding and locality social work teams where necessary. This ensures that we are providing a consistent quality of care across providers.

In Havering homecare recipients are contacted directly to understand their experience of care and this is now established as a corporate indicator reported to councillors. 'Carers Voice' was a group that met regularly but was inhibited as a result of the pandemic but is looking to be re-energised giving a voice for carers that feeds into the Carers Partnership Board, the delivery mechanism for our carers strategy.

Provider Engagement
- Older People and Frailty Transformation Board (OPF): The board is system wide and oversees and directs the older people and frailty transformation, the contribution to the Integrated Sustainability Plan to reduce pressures on the system and the developing Ageing Well agenda.
- Operational Working Groups (OWG) for the OPF Transformation including acute frailty, Falls, End of Life, discharge improvement working group, prevention. These OWGs sit under the transformation board and deal with the detail of developing business cases to transform services and then mobilise, operationalise and monitor the progress and impact
- Care Provider Forum - established during the pandemic to support providers to manage outbreaks to developing good practice across services. The forum has both care home and community care providers and continues to develop and support services.

- Redbridge hold a number of provider forums throughout the year for service providers and partners to provide updates and listen to issues and share ideas on delivery services.
- B&D have monthly provider forums with care homes and home care providers to share good practice, information and support for providers.
- The BCF has been used to support discharge pathway pilots, which have been developed with providers and partners across health and social care. Particularly important has been the contribution of therapy services in the development of community-based discharge services.
- The large care market in Havering has put significant pressure on both the market and the local authority's relationship with it through the pandemic. However, the response has included extensive communications, information guidance and support and increased communication directly to the market through meeting technology and an online communications hub. This has led to a much closer and improved relationship with the market and has enabled an understanding of issues faced by all sections of the community served by the care market. It has led to a range of initiatives and responses and has meant that stakeholder engagement has been an ongoing and active part of all the developments and initiatives outlined within this plan.

The British Red Cross Psychosocial and Mental Health Team provide group reflective practice and clinical supervision to partners across frontline sectors to support their work. The British Red Cross have been undertaking sessions with providers particularly focusing on Covid-19, to support social care staff who have faced very tough and challenging times since March 2020.

Voluntary Sector Engagement

BHR CCGs have been developing the role and commissioning of the VCS over the last year. The VCS are now key players in the transformation agendas being key contributors into boards, steering and task and finish groups. This has been particularly the case with the older people and frailty agenda, where a number of new developments will be funded via the BCF and the VCS has been key in driving this forward. This includes care home trusted assessors to support patients to be assessed for a care home place in hospital for more rapid discharge, funding additional care navigators to enhance supported discharge and the expansion of Falls prevention classes as part of a strategic approach to falls prevention approach across primary, community, secondary care and the VCS.

The VCS are commissioned to deliver a number of services including the home from hospital and carers support service and front door services within the local authority are signposting service users to VCS services and support as part of their discharge and social prescribing work.

Reconnections have also been actively supporting older residents in Barking and Dagenham and Havering since January 2020. It is a two-year pilot in Barking and Dagenham and Havering, joint funded by Independent Age, the two local authorities and the CCGs. Reconnections is a service that supports over-65s in rediscovering their love of life in the communities where they live. They introduce friendly local volunteers to lonely older residents and invite them into local activities, gatherings and events ranging from regular chats over coffee to bucket-list experiences that provide meaningful social connections that help break the cycle of isolation and loneliness.

Although the pilot's first year ran during the pandemic, they reconfigured their service in order to provide support to older people in a COVID secure way. This included weekly phone calls with a volunteer and support to residents to access and use digital technology to connect with loved ones, undertake shopping and listen to their favourite music. They also encouraged wellbeing walks, step challenges and dog walks. They did virtual coffee mornings, online cook-a-long's and friendly postcards sent through the post. Volunteers supported hundreds of residents across the two Boroughs and the pilot received high rates of satisfaction. The Boroughs are working to review the pilot which comes to an end in December 2021 and will determine the next steps for the project.

Within Redbridge we are currently undertaking a review of our VCS services with a view to developing a new model to better understand the needs of communities and how these have changed over the past few years and also how providers have developed services and seen needs change to adapt their services throughout the COVID period. This is key to our prevention and early intervention model. This also includes our external Day Opportunities providers. There has also been a strong VCS within Redbridge although this has been impacted by COVID.

In Havering, voluntary sector services have been re-commissioned, enabled by BCF funding. The focus of this voluntary sector commissioning has been on achieving particular outcomes including sustaining carers in their roles and looking to minimise social isolation and develop peer support groups for those facing particular issues. There is a tailored approach to support for those facing issues, for example carers of people with dementia will face different issues to carers of people with learning disabilities. Those facing physical disability will face different problems to those facing mental health issues. The range of organisations commissioned reflects the different issues faced and the specific needs of different groups.

Representatives of the voluntary sector join up with the local authority and the CCG to communicate about issues and initiatives that the voluntary sector can respond to at a regular 'compact' meeting. This has enabled the VCS to be intrinsically involved in the development of the borough partnership, where the VCS has established a more joined up means of engaging with the partnership and providing the particular insights they can bring.

Clinical Engagement
Primary care, the acute trust and community trust continue to be involved as a system in the development of services through operational working groups, transformation boards and other task groups as stated above. Each transformation area has CCG clinical directors allocated to drive the agenda forward and link to primary care and PCNs.

Patient or Service Users Groups
Operational Working Groups (OPF) have patient involvement links which maybe actioned through a patient (and or carer reference group), patient reps on the working group or wider consultation through Age UK and or other forums. Healthwatch's across BHR also engage patient and service user representatives and each of the Borough Healthwatch's provided important reviews of the impacts of COVID across patient, service user, family and provider groups which were used to improve COVID pathways and services. The outcome of the Havering and Barking and Dagenham commissioned patient experience work with British Red Cross will be used to improve and/or redesign pathways across BHR in relation to hospital discharge.

BHR Leadership Health & Wellbeing Boards
The local Health and Wellbeing Board provides system leadership for our health and care economy, including overseeing the implementation of each areas Health & Wellbeing Strategy and how we work to reduce health inequalities. The Redbridge Our 'Caring for Redbridge: Strategic Commissioning Framework for People' is the Redbridge LA strategic plan that provides an overview of our vision, ambitions and aims for the commissioning of services. Our Redbridge CVS have been a key member of the HWB since its inception and represent the views of VCS in Redbridge. This provides the opportunity to ensure that our voluntary sector partners, who we work closely with, are engaged alongside other system leaders in health and social care programmes and services across the borough.

We have also engaged through the ICP Board, JCB and Health and Wellbeing Boards for sign-off.

Section 9: Links to other Plans

BHR Area Key Strategies & Plans

- Annual Public Health Reports
- Barts Plans
- BHR End of Life Strategy
- BHRUT Clinical Strategy
- Discharge strategy
- Falls Strategy
- Health & Wellbeing Strategy's
- Integrated Sustainability Plan
- JSNAs
- Market Position Statements
- Older People and Frailty Business Case
- Prevention Strategy
- Primary Care Plans
- Redbridge Commissioning Framework
- Redbridge Disability Charter
- Redbridge Good Practice Commissioning Charter (Draft)
- Urgent Care

Websites:

www.lbbd.gov.uk
www.havering.gov.uk
www.redbridge.gov.uk
www.northeastlondonccg.nhs.uk
www.nelft.nhs.uk
www.bhruthospitals.nhs.uk
www.bartshealth.nhs.uk

APPENDIX 1

BCF Risk Log

	IDENTIFIED RISK	RISK MITIGATION	LIKELIHOOD	IMPACT	RISK SCORE	RAG
1.	Demographic and need demand - increasing numbers of Older People (over 85s and over 65s), people with long term conditions, low number of healthy life years, deprivation etc. raise specific challenges. Complexity of conditions and increase in children and young people with LD transiting in adulthood These budget pressures sit alongside corporate financial pressures faced by the partners	Investment in prevention and managing demand and use of the social care grant to support and protect social care, pending solutions to longer term funding solutions to social care funding. Best use of existing community capital and signposting. Encouragement of population to take responsibility for their own health, self-management Upstream preventative / early intervention investment Better planning and management of the Transition process for CYP	4	4	High	
2.	Costs and benefits fall unevenly across the system and inequitably to the investing partner for areas of change	• Review and transparency of impact and outcomes achieved. • Affordability to be a determinant of further steps. • Risk share remains an option for consideration. • Protection of social care services and consideration of pooled budgets. • Ongoing monitoring of impacts.	4	3	Medium	
3.	Resources locked into current contracts/ activity cannot be effectively unlocked to support activity where positive evidence of improved outcomes are drawn.	Engagement across commissioners and providers with service contracts having sufficient flexibility to allow for adjustments, contract review schedules are considered through governance alongside activity. Effective contract management and the right level of governance.	2	2	Medium	
4.	Three borough complexity slows progress because of differing democratic leadership, priorities and indeed financial values into specific /shared schemes	We have mitigated the challenge posed by taking an iterative approach to our deepening the reach of the BCF plan and improved governance and working relationships. COVID was a cornerstone in demonstrating the necessity of working together to support the system under a period if extreme pressure.	2	3	Low	

	IDENTIFIED RISK	RISK MITIGATION	LIKELIHOOD	IMPACT	RISK SCORE	RAG
		Integrated Care Partnership is responsible for ensuring these tensions are understood and managed. Ensuring effective information and clarity of decision points.				
5.	Elections at both a local level result in changes to administration(s) and policy direction.	'Watching brief' on policy and guidance changes	1	2	Low	
6.	Local authority budgetary deficits and cost of COVID	Impact of costs of COVID are very high. Monitoring of demand and costs in relation to funding to be closely monitored and any remedial action to be agreed and implemented where necessary.	5	5	High	
7.	Commissioning capacity and staffing resources	Improving joint and or lead commissioning across BHR will seek to reduce the burden of individual organisational activity, alongside our intention through the BCF plan to achieve a greater level of integration and available resource utilisation.	3	2	Medium	
8.	Service demand continues to increase for social care	Review of prevention and early interventions services to provide earlier intervention, passporting to alternative, community and universal services is expected to improve management of demand.	High	High	High	
9.	Increasing costs faced by service providers, insurance, wages increases and workforce issues	BHR commissioners to work closely together and with partners to help stabilise the current market and develop a joint protocol around provider concerns and failure - adjusting rates where it can (if available) and taking a proactive approach to managing demand. Use all available initiatives such as Skill for Care funding to support workforce issues.	High	High	High	
10.	Community health services are commissioned under a block contract – lack of transparency regarding service line budgets limits the joint commissioning opportunities	BHR CCGs and NELFT have escalated this for formal resolution through the contractual process.	Medium	Medium	Medium	

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Better Care Fund 2021-22 Template

1. Guidance

Overview

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

For a more optimal view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance sheet for readability if required.

The details of each sheet within the template are outlined below.

Checklist (click to go to Checklist, included in the Cover sheet)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be completed before sending to the Better Care Fund Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'

3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover (click to go to sheet)

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net
(please also copy in your respective Better Care Manager)

4. Income (click to go to sheet)

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2021-22. It will be pre-populated with the minimum CCG contributions to the BCF, Disabled Facilities Grant (DFG) and improved Better Care Fund (iBCF). These cannot be edited.
2. Please select whether any additional contributions to the BCF pool are being made from local authorities or the CCGs and as applicable enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources when planning expenditure. The fields for Additional contributions can be used to include any relevant carry-overs from the previous year.
3. Please use the comment boxes alongside to add any specific detail around this additional contribution including any relevant carry-overs assigned from previous years. All allocations are rounded to the nearest pound.
4. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net

5. Expenditure (click to go to sheet)

This sheet should be used to set out the schemes that constitute the BCF plan for the HWB including the planned expenditure and the attributes to describe the scheme. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting and to particularly demonstrate that National Conditions 2 and 3 are met.

The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and CCG minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:

1. Scheme ID:

- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.

2. Scheme Name:

- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.

3. Brief Description of Scheme

- This is a free text field to include a brief headline description of the scheme being planned.

4. Scheme Type and Sub Type:

- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 5b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important to our understanding of how BCF funding is being used and levels of investment against different priorities.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.

5. Area of Spend:

- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where 'Social Care' is selected and the source of funding is "CCG minimum" then the planned spend would count towards National Condition 2.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.

6. Commissioner:

- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3.
- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and CCG/NHS and enter the respective percentages on the two columns.

7. Provider:

- Please select the 'Provider' commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

8. Source of Funding:

- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the CCG or Local authority
- If the scheme is funding across multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

9. Expenditure (£) 2021-22:

- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)

10. New/Existing Scheme

- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

This is the only detailed information on BCF schemes being collected centrally for 2021-22 and will inform the understanding of planned spend for the iBCF grant and spend from BCF sources on discharge.

6. Metrics (click to go to sheet)

This sheet should be used to set out the HWB's performance plans for each of the BCF metrics in 2021-22. The BCF requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for the last two quarters of 2021-22.

The previous measure of Non Elective Admissions is being replaced with a measure of Unplanned Admissions for Chronic Ambulatory Care Sensitive Conditions. Performance data on this indicator up to 2019-20, by local authority can be found at:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/february-2021/domain-2-enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

A data pack showing breakdowns of data for new metrics (discharge and avoidable admissions) is available on the Better Care Exchange.

For each metric, systems should include a narrative that describes:

- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- how BCF funded schemes and integrated care will support performance against this metric, including any new or amended services.

1. Unplanned admissions for chronic ambulatory sensitive conditions:

- This section requires the area to input a planned rate for these admissions, per hundred thousand people for the year. This is the current NHS Outcomes Framework indicator 2.3i.
- The numerator is calculated based on the expected number of unplanned admissions for ambulatory sensitive conditions during the year.
- The denominator is the local population based on Census mid year population estimates for the HWB.
- Technical definitions for the guidance can be found here:
https://files.digital.nhs.uk/A0/76B7F6/NHSOF_Domain_2_S.pdf

2. Length of Stay.
- Areas should agree ambitions for minimising the proportion of patients in acute hospital who have been an inpatient for 14 days or more and the number that have been an inpatient for 21 days or more. This metric should be expressed as a percentage of overall patients.
- The ambition should be set for the HWB area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions. Ambitions should be set as the average percentage of inpatient beds occupied by patients with a length of stay of 14 days and over and 21 days and over for Q3 2021-22 and for Q4 2021-22 for people resident in the HWB.

- Plans should be agreed between CCGs, Local Authorities and Hospital Trusts and areas should ensure that ambitions agreed for 21 days or more are consistent across Local Trusts and BCF plans.

- The narrative should set out the approach that has been taken to agreeing and aligning plans for this metric
3. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay.

- The ambition should be set for the healthand wellbeing board area. The data for this metric is obtained from the Secondary Uses Service database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions. Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.

4. Residential Admissions (RES) planning:
- This section requires inputting the information for the numerator of the measure.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care) for the Residential Admissions numerator measure.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.
5. Reablement planning:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

7. Planning Requirements (click to go to sheet)

This sheet requires the Health & Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2021-22 for further details.
The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.
The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.
1. For each Planning Requirement please select ‘Yes’ or ‘No’ to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is ‘No’, please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

Better Care Fund 2021-22 Template

2. Cover

Version 1.0

HM Government

NHS

Please Note:
- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.
- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided. Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".
- Please note that national data for plans is intended for release in aggregate form once plans have been assured, agreed and baselined as per the due process outlined in the BCF Planning Requirements for 2021-22.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Barking and Dagenham
Completed by:	Louise Hider-Davies
E-mail:	Louise.HiderDavies@lbbd.gov.uk
Contact number:	07976 302019

Please indicate who is signing off the plan for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	Chair of the Health and Wellbeing Board
Name:	Councillor Maureen Worby

Has this plan been signed off by the HWB at the time of submission?	No	
If no, or if sign-off is under delegated authority, please indicate when the HWB is expected to sign off the plan:	Mon 20/12/2021	<< Please enter using the format, DD/MM/YYYY Please note that plans cannot be formally approved and Section 75 agreements cannot be finalised until a plan, signed off by the HWB has been submitted.

	Role:	Professional Title (where applicable)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Councillor	Maureen	Worby	maureen.worby@lbbd.gov.uk
	Clinical Commissioning Group Accountable Officer (Lead)		Ceri	Jacob	cerijacob@nhs.net
	Additional Clinical Commissioning Group(s) Accountable Officers		Sharon	Morrow	sharon.morrow2@nhs.net
	Local Authority Chief Executive		Claire	Symonds	claire.symonds@lbbd.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)		Elaine	Allegretti	elaine.allegretti@lbbd.gov.uk
	Better Care Fund Lead Official		Louise	Hider-Davies	louise.hiderdavies@lbbd.gov.uk
	LA Section 151 Officer		Philip	Gregory	philip.gregory@lbbd.gov.uk
*Please add further area contacts that you would wish to be included in official correspondence -->					

**Only those identified will be addressed in official correspondence (such as approval letters). Please ensure all individuals are satisfied with the information entered above as this is exactly how they will appear in correspondence.*

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Template Completed

	Complete:
2. Cover	Yes
4. Income	Yes
5a. Expenditure	Yes
6. Metrics	Yes
7. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2021-22 Template

3. Summary

Selected Health and Wellbeing Board: Barking and Dagenham

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£1,856,901	£1,856,901	£0
Minimum CCG Contribution	£16,517,375	£16,517,375	£0
iBCF	£10,392,182	£10,392,182	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£0	£0	£0
Total	**£28,766,458**	**£28,766,458**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum CCG allocation

Minimum required spend	£4,693,770
Planned spend	£9,858,780

Adult Social Care services spend from the minimum CCG allocations

Minimum required spend	£6,120,163
Planned spend	£6,658,595

Scheme Types

Assistive Technologies and Equipment	£760,000	(2.6%)
Care Act Implementation Related Duties	£927,380	(3.2%)
Carers Services	£177,340	(0.6%)
Community Based Schemes	£6,200,786	(21.6%)
DFG Related Schemes	£1,856,901	(6.5%)
Enablers for Integration	£301,000	(1.0%)
High Impact Change Model for Managing Transfer of	£4,343,287	(15.1%)
Home Care or Domiciliary Care	£913,062	(3.2%)
Housing Related Schemes	£0	(0.0%)
Integrated Care Planning and Navigation	£6,340,635	(22.0%)
Bed based intermediate Care Services	£0	(0.0%)
Reablement in a persons own home	£1,853,957	(6.4%)
Personalised Budgeting and Commissioning	£80,000	(0.3%)
Personalised Care at Home	£1,072,000	(3.7%)
Prevention / Early Intervention	£1,392,500	(4.8%)
Residential Placements	£2,547,610	(8.9%)
Other	£0	(0.0%)
Total	**£28,766,458**	

Metrics >>

Avoidable admissions

	20-21 Actual	21-22 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	1,089.7	1,079.9

Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients	LOS 14+	9.7%	11.0%
	LOS 21+	5.0%	5.4%

Discharge to normal place of residence

	0	21-22 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence	0.0%	95.4%

Residential Admissions

		20-21 Actual	21-22 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	621	674

Reablement

		21-22 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	80.8%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	PR1	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	PR4	Yes
NC3: NHS commissioned Out of Hospital Services	PR5	Yes
NC4: Plan for improving outcomes for people being discharged from hospital	PR6	Yes
Agreed expenditure plan for all elements of the BCF	PR7	Yes
Metrics	PR8	Yes

Better Care Fund 2021-22 Template

4. Income

Selected Health and Wellbeing Board: Barking and Dagenham

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Barking and Dagenham	£1,856,901
DFG breakerdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc iBCF)	**£1,856,901**

iBCF Contribution	Contribution
Barking and Dagenham	£10,392,182
Total iBCF Contribution	**£10,392,182**

Are any additional LA Contributions being made in 2021-22? If yes, please detail below	No

Local Authority Additional Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional Local Authority Contribution	**£0**	

CCG Minimum Contribution	Contribution
NHS Barking and Dagenham CCG	£16,517,375
Total Minimum CCG Contribution	**£16,517,375**

Are any additional CCG Contributions being made in 2021-22? If yes, please detail below	No

Additional CCG Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional CCG Contribution	**£0**	
Total CCG Contribution	**£16,517,375**	

	2021-22
Total BCF Pooled Budget	**£28,766,458**

Funding Contributions Comments Optional for any useful detail e.g. Carry over

See next sheet for Scheme Type (and Sub Type) descriptions

Better Care Fund 2021-22 Template

5. Expenditure

Selected Health and Wellbeing Board: Barking and Dagenham

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£1,856,901	£1,856,901	£0
Minimum CCG Contribution	£16,517,375	£16,517,375	£0
iBCF	£10,392,182	£10,392,182	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£0	£0	£0
Total	**£28,766,458**	**£28,766,458**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum CCG Contribution (on row 31 above).

	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum CCG allocation	£4,693,770	£9,858,780	£0
Adult Social Care services spend from the minimum CCG allocations	£6,120,163	£6,658,595	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes

Sheet complete

						Planned Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
1	Hospital discharge, planning and	Care - Coordination to support discharge	Community Based Schemes	Integrated neighbourhood services		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£5,944,435	Existing
1	Hospital discharge, planning and	Various community based services	High Impact Change Model for Managing	Multi-Disciplinary/Multi-Agency Discharge		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£3,335,417	Existing
2	Targeted out of hospital care	Supported Employment	High Impact Change Model for Managing	Other	Other approaches	Mental Health		CCG			NHS Community Provider	Minimum CCG Contribution	£259,760	Existing
3	Community support and independence	CCG Contribution to the local carers organisation	Carers Services	Other	Carer Advice and Support	Community Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£39,840	Existing
1	Hospital discharge, planning and	Home from Hospital - Home, Settle and Support Service (British Red Cross)	Integrated Care Planning and Navigation	Other	Care Planning, Assessment and Review	Community Health		CCG			Local Authority	Minimum CCG Contribution	£32,715	Existing
1	Hospital discharge, planning and	Home First same & next day discharge - AHPs.	Reablement in a persons own home	Reablement to support discharge - step down		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£55,262	New
3	Community support and independence	Urgent Care 2 Hour response and Bridging services (Ageing Well)	Community Based Schemes	Multidisciplinary teams that are supporting		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£191,351	New
1	Hospital discharge, planning and	Services and support to ensure timely discharge from hospital and	High Impact Change Model for Managing	Multi-Disciplinary/Multi-Agency Discharge		Social Care		LA			Local Authority	Minimum CCG Contribution	£715,610	Existing

2	Targeted out of hospital care	Crisis Intervention/ Reablement/Homecare	Reablement in a persons own home	Reablement to support discharge - step down		Social Care		LA			Local Authority	iBCF	£579,700	Existing
2	Targeted out of hospital care	Crisis Intervention/ Reablement/Homecare	Reablement in a persons own home	Reablement to support discharge - step down		Social Care		LA			Local Authority	Minimum CCG Contribution	£1,218,995	Existing
3	Community support and independence	Care Bill Implementation to support prevention, integration, independence	Care Act Implementation Related Duties	Other	Care Act fee increases and safeguarding	Social Care		LA			CCG	Minimum CCG Contribution	£622,380	Existing
2	Targeted out of hospital care	Managing homecare and additonal demand over winter in particular within	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Local Authority	iBCF	£913,062	Existing
2	Targeted out of hospital care	Support to manage safeguarding of Adults and DoLS	Care Act Implementation Related Duties	Other	Deprivation of Liberty Safeguards	Mental Health		LA			Local Authority	iBCF	£175,000	Existing
4	Market Stabilisation & COVID Recovery	Market Development /Fee increases and COVID Recovery	Residential Placements	Other	Fee increase to stabilise the care provider market	Social Care		LA			Private Sector	iBCF	£1,600,000	Existing
3	Community support and independence	Care technology, equipment and adaptations	Assistive Technologies and Equipment	Community Based Equipment		Social Care		LA			Private Sector	iBCF	£680,000	Existing
3	Community support and independence	Supporting people to remain in their homes through the provision of	DFG Related Schemes	Adaptations, including statutory DFG		Social Care		LA			Local Authority	DFG	£1,856,901	Existing
1	Hospital discharge, planning and	Home is best	High Impact Change Model for Managing	Home First/Discharge to Assess - process		Social Care		LA			Local Authority	Minimum CCG Contribution	£24,000	Existing
2	Targeted out of hospital care	Additional Care Navigators, investment in Mental Health, transforing care	Integrated Care Planning and Navigation	Care navigation and planning		Social Care		LA			Local Authority	iBCF	£1,514,420	Existing
2	Targeted out of hospital care	Integrated case management delivered through cluster multi	Integrated Care Planning and Navigation	Care navigation and planning		Social Care		LA			Local Authority	Minimum CCG Contribution	£1,748,500	Existing
2	Targeted out of hospital care	Develop joint commissioning to achieve the outcomes of the BCF	Integrated Care Planning and Navigation	Assessment teams/joint assessment		Social Care		LA			Local Authority	iBCF	£2,980,000	Existing
2	Targeted out of hospital care	Supporting adults of working age with mental health problems to live	Personalised Care at Home	Mental health /wellbeing		Social Care		LA			Local Authority	Minimum CCG Contribution	£572,000	Existing
2	Targeted out of hospital care	Supporting adults of working age with mental health problems to live	Personalised Care at Home	Mental health /wellbeing		Mental Health		LA			Local Authority	iBCF	£500,000	Existing
2	Targeted out of hospital care	Supported Employment	Prevention / Early Intervention	Other	Other approaches	Mental Health		LA			Local Authority	iBCF	£100,000	Existing
2	Targeted out of hospital care	Resource and systems to support integration, better processes and provider	Enablers for Integration	Data Integration		Social Care		LA			Private Sector	iBCF	£100,000	Existing
2	Targeted out of hospital care	Resource and systems to support integration, better processes and provider	Enablers for Integration	Data Integration		Social Care		LA			Local Authority	Minimum CCG Contribution	£201,000	New
3	Community support and independence	Care Bill Implementation to support prevention, integration, independence	Care Act Implementation Related Duties	Other	Safeguarding Adults	Social Care		LA			Local Authority	Minimum CCG Contribution	£130,000	Existing
3	Community support and independence	LD Demand growth and Transitions	Prevention / Early Intervention	Other	Placements	Social Care		LA			Local Authority	iBCF	£1,100,000	Existing
3	Community support and independence	LD Employment and NEETs	Prevention / Early Intervention	Other	Employment support	Social Care		LA			Local Authority	iBCF	£150,000	Existing

1	Hospital discharge, planning and	Care Home Trusted Assessors	High Impact Change Model for Managing	Home First/Discharge to Assess - process		Social Care		LA			Local Authority	Minimum CCG Contribution	£8,500	Existing
3	Community support and independence	Preventative services to prevent falls and promote health & wellbeing	Prevention / Early Intervention	Risk Stratification		Social Care		LA			Private Sector	Minimum CCG Contribution	£30,000	Existing
3	Community support and independence	Care technology, equipment and adaptations	Assistive Technologies and Equipment	Community Based Equipment		Social Care		LA			Private Sector	Minimum CCG Contribution	£80,000	Existing
3	Community support and independence	Reconnections - social isolation pilot	Prevention / Early Intervention	Other	Social Isolation Pilot	Social Care		LA			Local Authority	Minimum CCG Contribution	£12,500	Existing
2	Targeted out of hospital care	Developing joint commissioning to achieve the outcomes of the BCF	Residential Placements	Care home		Social Care		LA			Local Authority	Minimum CCG Contribution	£947,610	Existing
3	Community support and independence	Support for the Personal Assistant market	Personalised Budgeting and Commissioning			Social Care		LA			Local Authority	Minimum CCG Contribution	£80,000	Existing
3	Community support and independence	Support for service users with dementia and their informal carers	Community Based Schemes	Multidisciplinary teams that are supporting		Social Care		LA			Local Authority	Minimum CCG Contribution	£65,000	Existing
3	Community support and independence	Support for carer support organsitons.	Carers Services	Other	Support for carer support organsitons.	Social Care		LA			Local Authority	Minimum CCG Contribution	£75,000	Existing
3	Community support and independence	Strengthening User and Carer Voice	Carers Services	Other	Strengthening User and Carer Voice	Social Care		LA			Local Authority	Minimum CCG Contribution	£62,500	Existing
1	Hospital discharge, planning and	Home from Hospital - Home, Settle and Support Service (British Red Cross)	Integrated Care Planning and Navigation	Other	Care Planning, Assessment and Review	Social Care		LA			Local Authority	Minimum CCG Contribution	£65,000	Existing

2021-22 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Telecare 2. Wellness services 3. Digital participation services 4. Community based equipment 5. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Carer advice and support 2. Independent Mental Health Advocacy 3. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the CCG minimum contribution to the BCF.
3	Carers Services	1. Respite services 2. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services shoukld be recorded under the specific scheme type 'Reablement in a person's own home'
5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG - including small adaptations 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate
6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. Community asset mapping 7. New governance arrangements 8. Voluntary Sector Business Development 9. Employment services 10. Joint commissioning infrastructure 11. Integrated models of provision 12. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.

7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Domiciliary care workforce development 4. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.
10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
11	Bed based intermediate Care Services	1. Step down (discharge to assess pathway-2) 2. Step up 3. Rapid/Crisis Response 4. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups. Four service models of intermediate care are: bed-based intermediate care, crisis or rapid response (including falls), home-based intermediate care, and reablement or rehabilitation. Home-based intermediate care is covered in Scheme-A and the other three models are available on the sub-types.
12	Reablement in a persons own home	1. Preventing admissions to acute setting 2. Reablement to support discharge -step down (Discharge to Assess pathway 1) 3. Rapid/Crisis Response - step up (2 hr response) 4. Reablement service accepting community and discharge referrals 5. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible

13	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.
14	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
15	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
16	Residential Placements	1. Supported living 2. Supported accommodation 3. Learning disability 4. Extra care 5. Care home 6. Nursing home 7. Discharge from hospital (with reablement) to long term residential care (Discharge to Assess Pathway 3) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
17	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Better Care Fund 2021-22 Template

6. Metrics

Selected Health and Wellbeing Board: Barking and Dagenham

8.1 Avoidable admissions

	19-20 Actual	20-21 Actual	21-22 Plan	Overview Narrative
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	Available from NHS Digital (link below) at local authority level. Please use as guideline only	1,089.70	1,079.9	Plan to maintain the pre-covid rates, if not improve on.

>> link to NHS Digital webpage

Please set out the overall plan in the HWB area for reducing rates of unplanned hospitalisation for chronic ambulatory sensitive conditions, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

8.2 Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan	Comments
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients (SUS data - available on the Better Care Exchange)	Proportion of inpatients resident for 14 days or more	9.7%	11.0%	We are utilising 19/20 Performance as the plan for 21/22.
	Proportion of inpatients resident for 21 days or more	5.0%	5.4%	

Please set out the overall plan in the HWB area for reducing the percentage of hospital inpatients with a long length of stay (14 days or over and 21 days and over) including a rationale for the ambitions that sets out how these have been reached in partnership with local hospital trusts, and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.

8.3 Discharge to normal place of residence

	21-22 Plan	Comments
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	95.4%	We are utilising 19/20 Performance as the plan for 21/22.

Please set out the overall plan in the HWB area for improving the percentage of people who return to their normal place of residence on discharge from acute hospital, including a rationale for how the ambition was reached and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.

8.4 Residential Admissions

		19-20 Plan	19-20 Actual	20-21 Actual	21-22 Plan	Comments
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	738	677	621	674	Extrapolation and straight forecasting, based on current data and seasonal trends from previous years, indicate we will likely exceed our 2020/21 outturn of 123. This is due to the fact that mortality was higher for these service users in 20/21 and that during 20/21 residents and families sought community-based alternatives to
	Numerator	150	134	123	135	
	Denominator	20,316	19,780	19,807	20,044	

Please set out the overall plan in the HWB area for reducing rates of admission to residential and nursing homes for people over the age of 65, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		19-20 Plan	19-20 Actual	21-22 Plan	Comments
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	88.2%	85.0%	80.8%	This target has been set taking demand, mitigating actions and performance from our statutory performance returns into account. Currently Barking and Dagenham has Crisis Intervention in place as a reablement offer, which is delivered by the Council's Commissioned home care providers and is working well.
	Numerator	97	102	84	
	Denominator	110	120	104	

Please set out the overall plan in the HWB area for increasing the proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Please note that due to the splitting of Northamptonshire, information from previous years will not reflect the present geographies. As such, all pre-populated figures above for Northamptonshire have been combined.

For North Northamptonshire HWB and West Northamptonshire HWB, please comment on individual HWBs rather than Northamptonshire as a whole.

Better Care Fund 2021-22 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Barking and Dagenham

Theme	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it
NC1: Jointly agreed plan	**PR1**	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between CCG(s) and LA; been submitted? Has the HWB approved the plan/delegated approval pending its next meeting? Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned?	Cover sheet Cover sheet Narrative plan Validation of submitted plans	Yes	See narrative		
	PR2	**A clear narrative for the integration of health and social care**	**Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes:** • How the area will continue to implement a joined-up approach to integrated, person-centred services across health, care, housing and wider public services locally. • The approach to collaborative commissioning • The overarching approach to support people to remain independent at home, and how BCF funding will be used to support this. • How the plan will contribute to reducing health inequalities and inequalities for people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered, - Changes to local priorities related to health inequality and equality, including as a result of the COVID 19 pandemic, and how activities in the BCF plan will address these	Narrative plan assurance	Yes	See narrative		
	PR3	**A strategic, joined up plan for DFG spending**	**Is there confirmation that use of DFG has been agreed with housing authorities?** • Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home? • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory Disabled Facilities Grants? or - The funding been passed in its entirety to district councils?	Narrative plan Confirmation sheet	Yes	See narrative		
NC2: Social Care Maintenance	**PR4**	**A demonstration of how the area will maintain the level of spending on social care services from the CCG minimum contribution to the fund in line with the uplift in the overall contribution**	Does the total spend from the CCG minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)?	Auto-validated on the planning template	Yes	See expenditure tab		
NC3: NHS commissioned Out of Hospital Services	**PR5**	**Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the CCG minimum BCF contribution?**	Does the total spend from the CCG minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC4: Plan for improving outcomes for people being discharged from hospital	**PR6**	**Is there an agreed approach to support safe and timely discharge from hospital and continuing to embed a home first approach?**	• Does the BCF plan demonstrate an agreed approach to commissioning services to support discharge and home first including: - support for safe and timely discharge, and - implementation of home first? • Does the expenditure plan detail how expenditure from BCF funding sources supports this approach through the financial year? • Is there confirmation that plans for discharge have been developed and agreed with Hospital Trusts?	Narrative plan assurance Expenditure tab Narrative plan	Yes	See narrative		

Agreed expenditure plan for all elements of the BCF	**PR7**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	• Do expenditure plans for each element of the BCF pool match the funding inputs? (auto-validated) • Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (see paragraphs 32 – 43 of Planning Requirements) (tick-box) • Has funding for the following from the CCG contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement?	Expenditure tab Expenditure plans and confirmation sheet Narrative plans and confirmation sheet	Yes	See narrative and template		
Metrics	**PR8**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	• Have stretching metrics been agreed locally for all BCF metrics? • Is there a clear narrative for each metric describing the approach locally to meeting the ambition set for that metric, including how BCF expenditure will support performance against each metric? • Are ambitions across hospital trusts and HWBs for reducing the proportion of inpatients that have been in hospital for 21 days aligned, and is this set out in the rationale? • Have hospital trusts and HWBs developed and agreed plans jointly for reducing the proportion of inpatients that have been in hospital for 14 days or more and 21 days or more?	Metrics tab	Yes	See narrative and template		

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HEALTH AND WELLBEING BOARD

14 September 2021

Title:	CQC Maternity Services Report
Open Report	**For Information**
Wards Affected: ALL	**Key Decision: No**
Report Author: John Mealey, Senior Communications Officer -Stakeholder and Community Engagement	**Contact Details:** Email; john.mealey@nhs.net Tel: 01708 504 135
Lead Officer: Sue Lovell, Director of Midwifery and Divisional Director of Nursing for Women's Health, Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT)	

Summary

The Care Quality Commission (CQC) carried out an unannounced inspection in June 2021 at Queens Hospital and King George Hospitals focusing their inspection on two specific areas; 'safe' and 'well lead.'

The CQC published their report on 1st October 2021 and, whilst many areas of good practice were highlighted, the CQC expressed concern in regard to relations between senior staff and the divisional management team. The CQC also questioned the sustainability of improvements that had been made as key members of the midwifery team had left.

As a result, the CQC downgraded BHRUT's rating for 'safe' and 'well lead' from 'Good' to Requires Improvement.'

The Report highlights the issues the CQC raised and BHRUT's plans to address them.

Recommendations

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

Reasons for report

BHRUT is committed to keeping all stakeholders informed of its plans and objectives and to invite comment and discussion on all aspects of its activities.

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MATERNITY SERVICES REPORT

Barking & Dagenham HWBB
January 2022

Sue Lovell
Director of Midwifery and Divisional Director of Nursing for Women's Health

TAKING PRIDE IN OUR CARE

NHS
Barking, Havering and Redbridge University Hospitals NHS Trust

OUR MATERNITY SERVICES

- Queen's Hospital (QH) has the largest single site maternity unit in north east London (NEL), with capacity to care for all women across Barking and Dagenham, Havering and Redbridge

- We provide a full range of antenatal and postnatal services to our residents. At QH, we can care for 8,000 women a year in total – 6,500 women on our labour ward and an additional 1,500 low risk births in our Birth Centre. Our level two Neonatal Intensive Care Unit (NICU) is also located at QH

- At King George Hospital (KGH) we run scanning and high-risk clinics, which include mental health, diabetes and birth options clinics

- We also provide a number of joint obstetric and medical clinics as part of maternity services, including cardiac, rheumatology, blood disorders, endocrinology, smoking and twins

CQC INSPECTION

- In 2018, the Care Quality Commission (CQC) inspected our maternity department and we received an overall rating of Good
- Returning earlier this year in June 2021, the CQC completed an unannounced inspection of our maternity services, focusing on two specific areas – Safe and Well-led
- We're pleased that during the inspection, several areas of good practice were highlighted
- Initial feedback received following the visit found that staff were welcoming and fully engaged, staff were able to escalate concerns and senior leadership had developed an action plan to address issues previously raised
- However, they also found there was a disjoint between senior staff and the divisional management team, and with key members of the midwifery team leaving, concerns were raised that improvements were not sustainable

CQC RATING

- The CQC published its report on 1 October
- Our rating for Safe did not change, however, our rating for Well-led was downgraded from Good to Requires Improvement
- As a result, the overall rating for our maternity service was downgraded to Requires Improvement
- The CQC did not review other aspects of the service, so our ratings for Effective, Caring and Responsive remain Good

KEY FINDINGS

- Members of staff raised concerns about poor culture and bullying within the department, and not all staff felt respected, supported and valued
- Leaders were not always effective in implementing meaningful changes to improve safety
- The systems in place to manage performance were not always effective and did not always identify risks and issues
- Effective governance processes were not always followed
- The report also included details where we have not fully met regulations 12 (Safe Care and Treatment) and 17 (Good Governance) of the Health and Social Care Act 2008
- To meet these regulations, there are six ‘Must do’ requirements we must undertake, as well as a number ‘Should do’ actions

‘MUST DO’ REQUIREMENTS AND ‘SHOULD DO’ ACTIONS

‘Must Do’ requirements:

- The Trust must ensure that staff accurately score women using the Maternity Early Obstetric Warning Scoring, designed to recognise women at risk of deterioration *(Regulations 12 (2)(a)(b))*
- The Trust must ensure staff share all necessary information at handovers and that staff follow a situation, background, assessment, recommendation (SBAR) type handover *(Regulations 12 (2)(b))*
- The Trust must ensure that the holistic needs of women are consistently considered during handover. *(Regulations 12(2)(b)).*
- The Trust must ensure all guidelines and policies are up to date *(Regulations 17(2)(f))*
- The Trust must ensure effective systems are in place to ensure incidents are managed within the 20 days Trust target *(Regulations 17(2)(f))*
- The Trust must ensure the risk register accurately reflects the risks to the service (Regulations 17 (2)(f))

‘Should Do’ actions:

- The Trust should ensure that data on the quality of care board is recorded and up to date
- The Trust should ensure fire evacuation plans specifically mention babies, and babies are referenced in drills and skills training performed by staff
- The Trust should review the latest guidance from the Royal College of Obstetricians and Gynaecologists issued in June 2021, Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology, to ensure postpartum haemorrhage guidance reflects latest updates
- The Trust should consider taking minutes to record triumvirate meetings, actions and outcomes
- The Trust should ensure minutes and guidelines are correctly dated
- The Trust should ensure that thromboprophylaxis (VTE) assessment are carried out at each stage of the maternity pathway to help keep women them safe

IMPROVING OUR SERVICE

- The safety of women and children is our ultimate priority and we are working hard to make sure women continue to be confident to give birth at QH
- Action is being taken to improve the cultural and operational issues that have been highlighted
- Safety is a priority – its discussed at every meeting and staff are encouraged to speak up about any risks they see, either with their manager or through an independent Guardian service
- Incidents are discussed weekly, to ensure learnings are implemented across the department immediately
- We've also reviewed our process for monitoring and updating maternity guidelines
- We're a member of NHSE/I's Maternity Safety Support Programme (MSSP)

IMPROVING OUR SERVICE – CONTINUED

- Our maternity department has engaged with staff to develop an action plan, to improve culture and address the report findings
- Our CQC action plan and all other plans will feed into one master Improvement Plan, which will report via the Maternity Governance Process, to our Trust Board, to ensure its delivered
- We're recruiting a new Divisional Director for Women and Child Health
- We've added to our clinical leadership team, which includes a new obstetric lead and a second Head of Midwifery to oversee good governance. We're also adding to the number of consultant obstetricians within the department
- We're working with our newly formed Maternity Voices Partnership (MVP) to ensure our service is reflective of women's requirements

HEALTH AND WELLBEING BOARD

14 September 2021

Title:	Maternity Services-Equity and Equality Report
Open Report	**For Information**
Wards Affected: ALL	**Key Decision: No**
Report Author: Diane Jones, Chief Nurse and Caldicott Guardian at North East London Clinical Commissioning Group (NELCCG)	**Contact Details:** Email; diane.jones11@nhs.net Tel: 07341135004
Lead Officer: Diane Jones, Chief Nurse and Caldicott Guardian at North East London Clinical Commissioning Group (NELCCG)	

Summary

The Equity and Equality Assessment report contains useful metrics on health outcomes, community assets and staff experience. The report will be used to produce an action plan to bring services into alignment with the integrated care system. The aim will be to improve neonatal care by ensuring equity for mothers and babies from Black, Asian and Mixed ethnic groups and those living in the most deprived areas.

The report will also be used to produce a plan to improve race quality among maternity staff.

Recommendations

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

Reasons for report

BHRUT is committed to keeping all stakeholders informed of its plans and objectives and to invite comment and discussion on all aspects of its activities.

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North East London
Clinical Commissioning Group

Maternity Services
Equity and Equality needs assessment

North East London Local Maternity System

November 2021

Contents of this report

Note: Throughout this report we have used the terminology Black, Asian and Minority Ethnicity (BAME) or Black and Minority Ethnicity (BME) in line with the context from the National policies and guidelines where it has been used.

We have also used 'pregnant women' for brevity in our section 4 analysis, the data represents all pregnant people, whatever their gender identity. On an individual basis, pregnant people are referred to using the language of their choice.

Foreword

By Diane Jones, Chief Nurse and Caldicott Guardian at North East London Clinical Commissioning Group

North East London is a community of over two million people, living across eight boroughs. It's the second largest health economy in the UK with one of the fastest growing populations. Four of our boroughs are within the top ten most diverse Local Authorities in England and Wales, and five of our boroughs are in the twenty most deprived.

Our two million people demonstrate a real richness in diversity; diversity of ethnicity, culture, experience and thought. And with this diversity, there needs to be equity. Understanding what access, experience and expectation means for pregnant people in North East London. It's about meeting their needs to ensure we respond to each person's unique health and social situation, so that care is safe and personal for all.

East London has the highest birth rate in the UK. Our health and care services must cope with this growth and continue to ensure the best possible outcomes for mothers and babies. We know from the women and families we see, there are health, social and economic inequities and inequalities for women of Black and Minority Ethnic (BME) backgrounds and those from the most deprived areas when accessing and experiencing maternity services.

As a Local Maternity System (LMS), we are working in partnership with local women and their families, health partners and community groups to determine how maternity and neonatal services need to respond to each person's situation, remaining regardful of their diversity.

This Equity and Equality assessment provides data and findings for health outcomes, community assets (anything that can be used to improve the quality of community life) and staff experience, forming part one of a two-step process. All the discoveries and outcomes from the assessment will inform the second step; to co-produce an equity and equality action plan, ensuring it is aligned with the health inequalities work of the Integrated Care System (ICS). Both pieces of work combined aim to improve maternity and neonatal care by; ensuring equity for mothers and babies from Black, Asian and Mixed ethnic groups and those living in the most deprived areas, and also race equality for staff.

Alongside this Equity and Equality assessment and action plan, we are working with maternity units on the Ockenden priorities, one of which focuses on the needs of BME women feeling supported and listened to by health care professionals to ensure that women have their voices heard. We are also working on supporting and strengthening the workforce to ensure all our BME women receive continuity of carer, alongside the rest of our population, by 2023.

Good care and positive experiences for all those who use maternity services will influence long-term health and educational outcomes. We are committed to progressive change regarding equity and equality so that care is safe for all pregnant people and their babies.

2.0 Introduction

2.1 Our area

North East London (NEL) is a vibrant, diverse and distinctive area of London steeped in history and culture.

The 2012 Olympics regenerated much of Stratford (Newham) and the surrounding area, bringing a new lease of life and enhancing the reputation of this exciting part of London. This has brought with it an increase in new housing developments and improved transport infrastructure and amenities.

Additionally, the area is benefiting from investment in health and care facilities with a world class life sciences centre in development at Whitechapel (Tower Hamlets) and confirmed funding for a new health and wellbeing hub in Redbridge, making it an exciting time to live and work in North East London.

2.2 Our people

North East London (NEL) Clinical Commissioning Group (CCG) is co terminus with eight local authorities:

City of London | Hackney | Tower Hamlets | Newham | Waltham Forest | Redbridge | Barking and Dagenham | Havering

Population

- With a population of over 2 million, it is the second largest health economy in England.
- Our population is predicted to increase by 13% to 2.2 million by 2028.
- This growth is faster than the London average with the greatest growth at 20% expected in Newham.

Ethnicity

- Our local communities are richly diverse with over 50% identifying as Black, Asian and Minority Ethnic groups.
- Four of our boroughs in the top ten most diverse Local Authorities in England and Wales.

Deprivation

- Five of our boroughs are in the 20 most deprived in England.
- Many local people: rely on benefits, experience fuel poverty, unemployment and live in poor housing. There are significant variations across our boroughs in terms of health and care outcomes, population, services & quality, relationships between organisations and resources.

2.3 Our local health structure

Within North East London there are five NHS Trusts - three acute and two community/mental health:

- Barts Health NHS Trust
- Barking, Havering and Redbridge University Hospitals NHS Trust
- Homerton University Hospital NHS Foundation Trust
- East London NHS Foundation Trust
- North East London NHS Foundation Trust

- In April 2022 NEL CCG will become an Integrated Care Board (ICB), working with partners to form the Integrated Care System (ICS) in enabling transformation of health and care systems for all our communities. The North East London ICS will be underpinned by place based partnerships in each borough.

- At a local place level, providers work collaboratively through strategic partnerships and provide services at scale. Each of our local areas has been built on strong place-based partnerships and have grown organically to respond to the need to shift the emphasis and settings of care from the hospital to the community.

2.4 Our health and care partners

5
NHS Trusts
3 acute and 2 community/mental health

47
Primary care networks

7
GP federations

8
Healthwatch organisations

272
GP practices

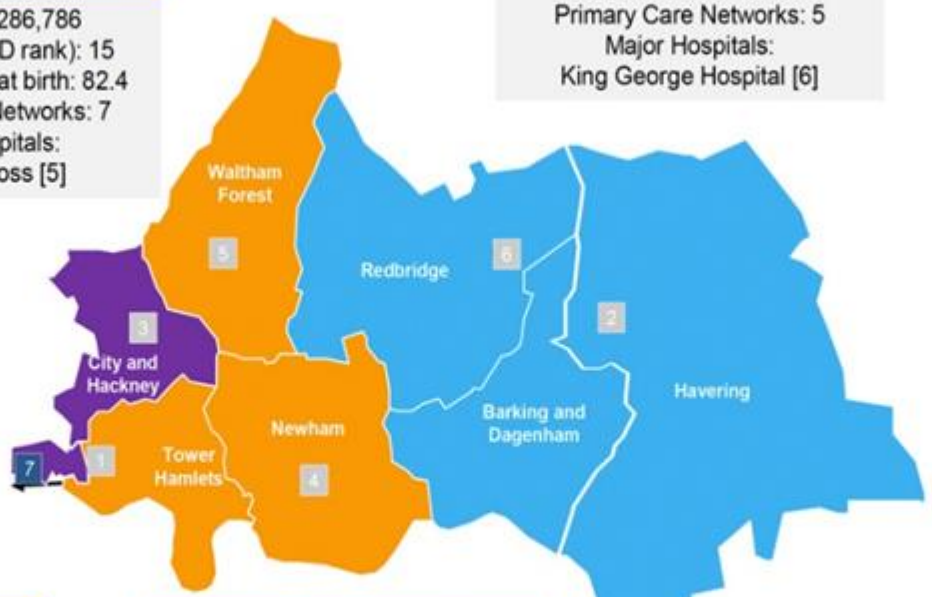
320
Dental surgeries

250+
Care Homes

2100+
Community assets and voluntary sector organisations

- At a neighbourhood level, our 47 primary care networks work across practices and health and social care services, supporting a systems approach to population.
- NEL Integrated Care System (ICS) will support and transform the health of our local population by addressing and tackling health inequalities.

2.5 Our local health network



Waltham Forest

Population: 286,786
Deprivation (IMD rank): 15
Life Expectancy at birth: 82.4
Primary Care Networks: 7
Major Hospitals:
Whipps Cross [5]

Redbridge

Population: 307,861
Deprivation (IMD rank): 119
Life Expectancy at birth: 82.7
Primary Care Networks: 5
Major Hospitals:
King George Hospital [6]

City and Hackney

Population: 283,600
Deprivation (IMD rank): 2 (Hackney) & 226 (City of London)
Life Expectancy at birth: 80.9 (Hackney)
Primary Care Networks: 8
Major Hospitals:
Homerton[3]
St Bartholomew's [7]

Havering

Population: 258,676
Deprivation (IMD rank): 166
Life Expectancy at birth: 81.9
Primary Care Networks: 4
Major Hospitals:
Queen's Hospital [2]

Tower Hamlets

Population: 323,704
Deprivation (IMD rank): 6
Life Expectancy at birth: 81.0
Primary Care Networks: 8
Major Hospitals:
Royal London [1]

Newham

Population: 359,467
Deprivation (IMD rank): 8
Life Expectancy at birth: 81.3
Primary Care Networks: 10
Major Hospitals:
Newham University Hospital [4]

Barking and Dagenham

Population: 214,864
Deprivation (IMD rank): 3
Life Expectancy at birth: 80.0
Primary Care Networks: 5

2.6 Our Local Maternity System

High quality, *safe*, *equitable* and *personalised care*

NEL Local Maternity System (LMS) has a responsibility and duty to listen to all women and their families accessing maternity and neonatal services across NEL.

We want to continuously and actively collaborate, with all those who interact with our service, to improve access and health outcomes for mothers and babies, using their experiences to transform services with providers and other stakeholder.

East London has the highest birth rate in the UK. Our health and care services must cope with this growth and continue to ensure the best possible outcomes for mothers and babies. We want to make sure that all babies born in North East London have the best possible start in life and that their parents experience the best possible pregnancy and birth.

There are three providers working over five acute sites for maternity services, each with an obstetric labour ward and a midwifery led unit. There are also two freestanding midwifery led birth units.

Barts Health Trust

- The Royal London Hospital
- Newham University Hospital
- Whipps Cross Hospital

Barking, Havering and Redbridge University Trust

- Queen's Hospital

Homerton University NHS Foundation Trust

- Homerton University Hospital

NEL LMS is accountable to NEL CCG/Integrated Care Board (ICB) delegated to the Quality committee and the London Maternity Perinatal Board. NEL LMS has a representative membership from sector-wide stakeholders to ensure clinical, system level and service user input is used to inform and direct targeted service improvement interventions.

3.0 Equity and Equality Needs Assessment process

The Equity and Equality needs assessment has been conducted in direct response to the recently published 2021/22 priorities and operational planning guidance. Supplementing the Local Maternity Transformation plans developed in 2017 with a co-produced equity and equality analysis that follows a two-step process:

1.Submitting an equity and equality analysis (covering health outcomes, community assets and staff experience) and a co-production plan – **by 30 November 21**

2.Co-producing equity and equality actions plans setting out how the NHS will work in partnership to ensure equity for women and babies and race equality for staff – **by 28 February 22**

This report forms step 1, the Equity and Equality needs assessment.

The two aims:	The two-step process:	Step 1 needs assessment	Step 2 action plan
• *equity for mothers and babies from Black, Asian and Mixed ethnic groups and those living in the most deprived areas* • *race equality for staff*	• *Step 1 - an equity and equality assessment covering health outcomes, community assets and staff experience* • *Step 2 - Co-produce equity and equality action plan, ensuring it is aligned with the health inequalities work of Integrated Care Systems*	• *population needs analysis* • *outline of our community assets* • *summary of our staff experience data* • *approach to co-production*	• *Co-produce equity and equality action plan, ensuring it is aligned with the health inequalities work of Integrated Care Systems*

North East London
Clinical Commissioning Group

4. Analysis of inequalities across the NEL Local Maternity System (LMS)

4.1 Background and aim of this analysis

MBRRACE-UK reports about maternal and perinatal mortality show **worse outcomes** for those from **Black**, **Asian** and **Mixed ethnic groups** and those living in the most deprived areas. In September 2021, NHSE responded to those findings by issuing guidance to Local Maternity Systems (LMS). This guidance is structured around the **five health inequalities priorities** described in the *20/21 priorities and operational planning guidance: Implementation guidance.*

- The aim of the analysis in section 4.0 and 8.0 is to **support the** *equity and equality needs assessment covering health outcomes, community assets and staff experience* (excluding community assets) using the available data. The scope of this analysis includes:
    - an initial high level analysis of the scale and scope of possible inequalities for women and babies in NEL in health outcomes and across wider factors that are known to be linked to these.
    - An identification of the major gaps in the analysis - e.g. due to time constraints and/or lack of available/good quality data;
    - A list of recommendations for possible further analysis based on our initial findings to help the inform and target co-produced action plans.

4.1 Our approach

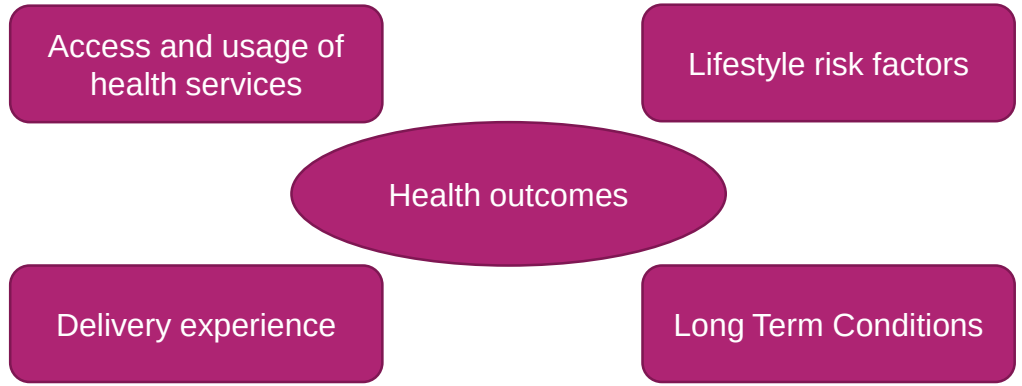
- Our analysis focuses **only** on those pregnant women that **gave birth in NEL in 20/21**. It focuses on identifying potential inequalities across **4 main ethnic groups** of pregnant women and babies (**Black, Asian, Mixed, Other**) relative to White women and across the **5 deprivation quintiles**.

- At NEL we understand the importance of adopting inclusive language in our perinatal services. We acknowledge that social disadvantage and marginalisation contribute to poorer health outcomes, as do barriers to quality healthcare. At NEL we are committed to promoting the use of language that reflects and represents the diversity of our population, so that no one is excluded. This will also be further reflected in our Equity and Equality Plan. Whist in this report we have used the term 'pregnant women' for brevity, the data represents all pregnant people, whatever their gender identity. On an individual basis, pregnant people are referred to using the language of their choice.

- We have looked at a vast range of metrics covering health outcomes and other relevant indicators that we know may have an important influence not only on health outcomes but also on the overall experience of women and babies.

- **Hospital Episode Statistics** (**HES**) and **Secondary Uses Service** (**SUS**) have been our two primary data sources for this analysis. While there is a **Maternity Services Data Set (MSDS),** our high level assessment of this data suggested that for many of our indicators of interest, the data are not sufficiently complete to base the analysis on. Data from the MSDS has been limited therefore to a very small set of indicators.

- The full list of metrics, sources and definitions are set out in Annex **1** of this report.



- We have also analysed the nationally available data on the 9 **Workforce Race Equality Standard** (**WRES**) indicators and nationally available data on the profile of victims of **Female Genital Mutilation** (FGM) in NEL.

4.1 Key caveats and limitations of the data & analysis (1)

1. Our pregnant population only include those that **gave birth** in 2021	• This analysis of inequalities only covers women that gave birth in 20/21. Metrics calculated on this population are therefore based on the c.9 months up to delivery (this means, for example, that for some women, an A&E attendance 'during pregnancy' may have taken place in 19/20 (i.e. if the delivery happened before Q3 in 20/21).
2. City of London not included in this analysis	• The profile (both ethnicity and deprivation) is significantly different to that of Hackney. It also has a relatively small population compared with the overall population of Hackney. To avoid risks of this area skewing the overall results and therefore potentially providing misleading averages for Hackney as a whole, we were asked to exclude it from our analysis.
3. Differences have not been tested for **statistical significance**	• Testing for statistical significance is important as it provides confidence that observed differences are real, reliable and not due to chance. Given the complexity in testing for statistical significance and the scale of metrics covered in our analysis, we have not been able to test for significance within the scope of this work. To mitigate against risk of drawing spurious conclusions, we have limited references to differences to those we think are more likely to be significant.
4. Differences in **ages** have not been taken into account	• Rates are not age standardised so the variation between ethnicity or deprivation could be age-driven in part. The importance in this may vary by indicator and some outcomes may be influenced greatly by the woman's age and therefore any variation in population age structures may have a confounding effect.
5. Variations in the completeness and consistency of coding across the main data sources	• Trusts may interpret guidance differently or have differing coding completeness. This may skew the borough results. There may also be a number of patients which have not been matched to an address and these will not be reported within the borough numbers (and some of these patients could be in high risk groups) or assigned to a deprivation quintile (as this is based on patients resident address). • Further information on this by metric is included Annex 2 of this report

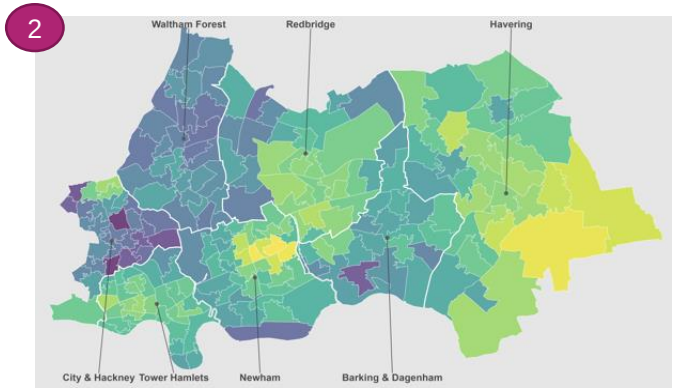
4.1 Key caveats and limitations of the data & analysis (2)

6. Findings based on **very low numbers** may be misleading	• In small samples, even small 'random' differences can lead to unreliable conclusions about 'true' differences between groups. This is relevant to two three main indicators in this analysis: (1) Still birth rates (2) postnatal mortality and the (3) prevalence of epilepsy. This is due to the incidence/prevalence of these outcomes being relatively rare in the overall population in England.
7. We have not investigated the distribution of women of **Mixed ethnicity**	• While women in this group make up a relatively small proportion of the 'pregnant' population in NEL (i.e. **2%** on average) there are a number of indicators at both the NEL and borough level in which this group appears to be an very notable outlier. As we do not know the make up nor distribution of this group of women, we have not been able to make any assessment of whether there may be one or more sub-groups within this category that disproportionately experience adverse outcomes than White or other ethnicities, nor whether they are more at risk of poor outcomes given differences in prevalence rates across risk factors for example.
8. Our analysis has only looked at **one year** of data – and coincides with the height of the Covid pandemic	• We have not analysed time trends for any of the metrics included in this analysis. In the absence of looking at patterns both within and across years, we are unable to conclude at this stage whether the differences between ethnicities and deprivation status that we have observed in this analysis also apply over different time periods or if Covid has affected trends over time.
9. Not all boroughs have LSOAs in the **4th and 5th IMD quintile**	• All NEL boroughs have at least 1 Lower Layer Super Output Area (LSOA) within their boundary in each of 1st, 2nd and 3rd (i.e. the most deprived) quintiles in England. Not all, however, have at least 1 LSOA in the 4th and 5th (i.e. the least deprived) quintile. This included Barking and Dagenham, Hackney (neither have any LSOAs in the 4th or 5th quintile), and Newham (no LSOAs in the 5th quintile).
10. Observed differences across ethnic groups have **not been controlled** for differences in deprivation and vice versa	• Where differences between ethnicities have been observed, we have not assessed the extent to which it may be deprivation (or indeed other factors such as age) that are driving these observed differences rather than ethnicity alone. Controlling for differences in deprivation status would enable us to better assess us for example, whether Asian women living in the most deprived areas have the same outcomes as White women in the most deprived areas?

4.1 NEL has among the most ethnically diverse and deprived boroughs in England

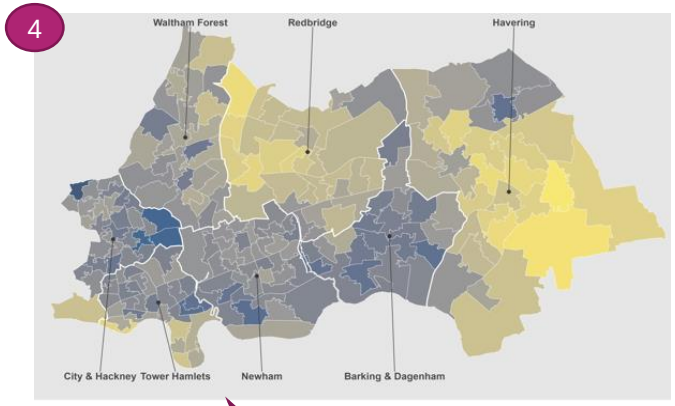
This map shows the prevalence and concentration of people of **Asian** ethnicity by neighbourhood - darker colours indicate higher %

2



This map shows the prevalence and concentration of people of **Mixed** ethnicity by neighbourhood - darker colours indicate higher %

4



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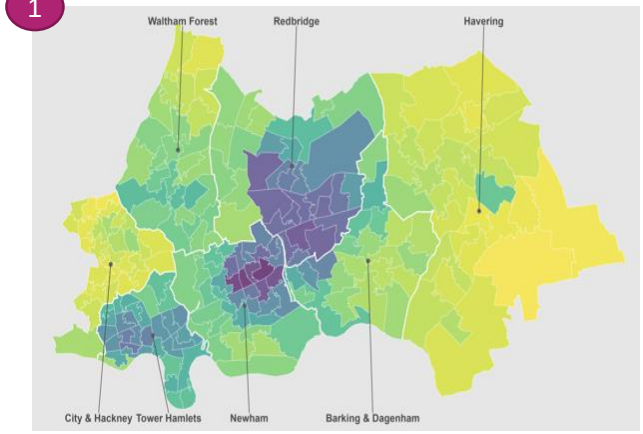
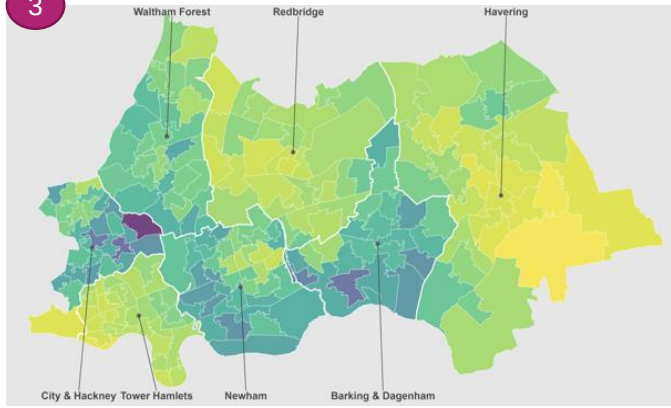


This map shows the prevalence and concentration of people of **Black** ethnicity by neighbourhood - darker colours indicate higher %

3



This map shows the IMD score - darker colours indicate higher deprivation

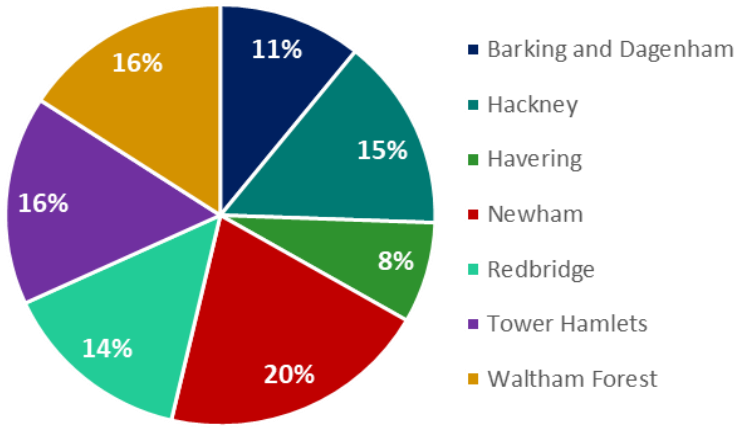
4.1 This diversity means that the effects of any inequalities are amplified as they impact more people

There were 25,950 babies born in NEL in 2020/21

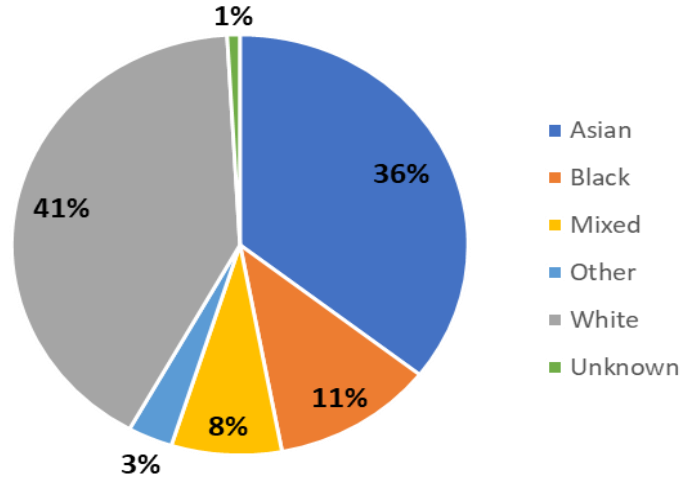
58% of those babies were born to Black, Asian, Mixed and Other ethnicity women

72% of those babies were born to women in two most deprived quintiles

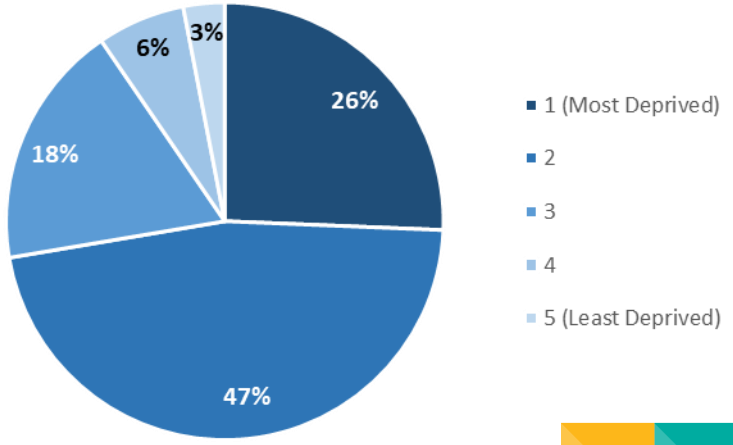
% of babies born by borough in 2020/21



% of babies born by ethnicity in NEL (2020/21)



% of babies born by deprivation quintile in NEL (2020/21)



Source: Hospital Episode Statistics (HES)

4.2 Key findings from our analysis – NEL level (1)

1. The stillbirths among babies born to Black and Asian women are concentrated in 3 boroughs with rates markedly higher than for babies born to White women

- Overall across NEL, there were **90** stillbirths in 20/21. While we have calculated the rates across each ethnicity, without further analysis, the size of the sample means that any conclusions on the 'true' differences between ethnicities based on these numbers alone may not be reliable.
- Across NEL, the rate of babies born stillbirth was higher for babies born to Black women (**3.8 per 1000)** and Asian women (**4 per 1000**) compared to the rate for those both to White women (**2.6 per 1000**). This compares with the national average of **3.8 per 1000** babies.
- Stillbirths to Asian and Black women tend to be concentrated **in 3 boroughs** – Hackney, Newham and Waltham Forest – with the rates for babies born to Asian women (**6.5 per 1000**) and Black women (**9 per 1000**) being highest in Newham. The rate for Other ethnicities was even higher at **12.7 per 1000.**
- In contrast, there were stillborn babies born to White women **across all NEL boroughs** with the exception of Newham.

2. Babies born to Black and Asian women are more likely to have had a neonatal admission than those born to White women

- On average, nearly a quarter of babies born in NEL were admitted to neonatal care **(24%)** although there is a much higher degree of variation between boroughs. Havering and Barking and Dagenham had the highest proportion of admissions **(48% and 39%)** which was over 3 times the percentage of admissions in Hackney **(11%)**, Tower Hamlets **(16%)** and Waltham Forest **(12%).**
- On average at NEL level, Asian and Black ethnicities had the highest percentage of babies admitted to neonatal care **(27% for both)**, compared with **22%** for babies born to White women.

3. Babies born to Black and Asian women are also nearly twice as likely to have a low birth weight than those born to White women

- Across NEL, **11%** of babies born to Black and Asian women had a low birth weight – nearly **double the rate** for babies born to White women (**6%**). This disparity is largest within Hackney where the percentage of babies born with low birth weight of Black and Asian ethnicity is nearly **three times as high** as the percentage found for White ethnicities. In Waltham Forest and Tower Hamlets this difference is **twice as high**.

4. In total across NEL there were 5 women that died within 42 days of delivery (i.e. direct deaths)

- Concerns around Information Governance (IG) - in terms of risks around re-identification - mean that we are not able to provide a ethnic breakdown of this group of women
- Also, without further analysis (e.g. looking across a larger number of years) we are unable to draw any reliable conclusions on potential disparities across ethnicities on this sample alone.

4.2 Key findings from our analysis – NEL level (2)

5. We have been unable to collect and validate data at this stage on neonatal deaths or infant mortality

- It has not been possible within the time frame allowed for this analysis to collect, validate and analyse data on these outcomes and how they vary by ethnicity and deprivation status. This will be covered within the scope of the proposed next steps of our analysis into maternity inequalities.

6. Black women are more likely to have attended A&E than White women within 6 months of delivery

- On average across NEL, Black ethnicities **(11%)** had the highest percentage of women attending A&E within 6 months of delivery, compared to White **(7%)** and Other ethnicities **(7%)** who had the lowest percentage.

7. Women in Black, Mixed and Other groups tend to present to healthcare services at least 2 weeks later into their pregnancy than White women

- On average across NEL, Mixed women take an average of **11 weeks** into their pregnancy to present, Black women **11 weeks**, and women from Other ethnicities **10 weeks**, compared **8 weeks** for White women.
- In Newham, for example, the average gestational age at first contact was approximately **twice as high** for Black and Mixed ethnicities than White ethnicities (i.e. **9, 10** and **4 weeks** respectively). In Tower hamlets, Black and Mixed women made first contact between **3 and 4 weeks later** than White women.

8. Black and Asian women are also more likely to have attended A&E during their pregnancy than White women

- On average across NEL, **37%** of Black women **and 31%** of Asian women had at least **one attendance to A&E** during their pregnancy compared with **23%** among White women. This pattern is consistent at the borough level, with Black women having **the highest percentage of women** with an A&E attendance during pregnancy in all 7 NEL boroughs.
- The differences between rates among Black and White women are largest in Tower Hamlets and Newham. In Tower Hamlets, for example, the rates for these same two ethnicities are **42%** compared with **26%** and in Newham are **48%** compared with **35%.** Similarly, in Havering the rate among Black women (**23%**) is more than twice that for White women (**11%).**

9. Black women are also more likely than White women to have been admitted to hospital during their pregnancy

- On average across NEL, **38%** of Black women had at least one admission to hospital during their pregnancy compared with **29%** among White women.
- Hackney (as well as having the highest overall proportion of women with an admission), has the largest variation between ethnicities with **65%** of Black women having an admission compared with **50%** for White women.

4.2 Key findings from our analysis – NEL level (3)

10. Black pregnant women are almost twice as likely to be obese than White women

- On average across NEL, **36%** of Black women giving birth in 2021 were obese compared with **19%** of White women and **22%** of Asian women. The difference between White, Asian and Mixed women are relatively less marked.
- At the borough level, Black women also have the highest rates of obesity across every NEL borough with the exception of women of **Mixed ethnicity** in Barking & Dagenham where the rate is as high as **45%**

11. Asian pregnant women are more than 3 times - and Black women more then two times –likely to have diabetes than White women

- **26%** of Asian women had diabetes (T1/T2/gestational) compared with **15%** of Black women and only **7%** of White women. This is despite their having comparatively lower obesity rates than other ethnicities.
- Variations between ethnicities looks to be highest within Newham and Tower hamlets. Prevalence rates among Asian women in these two boroughs are **27-28%** compared with **17-19%** among Black women and **7%** among White women.

12. Black pregnant women tend to have higher rates of hypertension than White women

- Across NEL, the prevalence rate of hypertension among Black women is **higher** compared with all other ethnicities. On average **8%** of Black women that gave birth in 2021 have hypertension compared with **5%** among White women. And this disparity is a trend across all 7 NEL boroughs. In Havering the prevalence among Black women is by far the highest at **11%** and more than double that of White women at **5%**

13. Black and Asian women are less likely than White women to be taking folic acid in pre/early pregnancy although deprivation is potentially the more important driver underlying differences

- On average across NEL, the rate among White women is relatively higher than those among both Asian and Black women (i.e. **44%, 37% and 37%** and respectively)
- On average across NEL, deprivation appears to be **more closely correlated** with the likelihood of women having a (good) folic acid status. On average across NEL, the rate among women in the l**east deprived** quintile is **67%** which is **almost twice as high** as for those in the **most deprived quintile** (**36%).** This closely linked correlation may – in part – be explained by the cost associated with taking folic acid supplements for which women in the least deprived areas may be more able to afford.

14. Black pregnant women are more likely to be out of employment compared with all other ethnicities

- On average, **a higher proportion** of women in ethnic minority groups are not in employment compared with White women (i.e. **10-13%** across **BME** groups compared with **8%).** On average, the rate is highest among Black women at **13%.**
- As expected, deprivation appears to be strongly linked to the likelihood of being out of employment with **13%** of women **in** the most deprived areas not being in employment compared with **4%** in the least deprived **(i.e. more than three times the rate).**

4.2 Key findings from our analysis – NEL level (4)

15. There are no consistent trends in the rates for 'complex social factors' but this may be due to lack of reporting consistency

- **Redbridge** (**15%)** and **Barking & Dagenham** (**13%)** have much higher rates of women that gave birth in 2021 having complex social factors, with the rate in **Tower Hamlets (2%)** being the lowest. On average, the proportion of White women with complex social factors (**8%)** is either **very similar** or even **slightly higher** than compared with all ethnic minority groups **(6-8%)** with the exception for women of Other ethnicity **(9%).**
- However, the accuracy of these findings may be undermined by inconsistent reporting practices both within and across boroughs due to the relatively large scale and variety of factors that make up this indicator.

16. The likelihood of a vaginal delivery is relatively similar across ethnicities, with larger variations in unplanned C-section deliveries

- Across and between boroughs, the rates for Asian, Black and White women for vaginal deliveries (which do not include assisted vaginal deliveries) are **relatively consistent** at approximately **57%.**
- While the average rate of vaginal delivery for Mixed women across NEL is only slightly higher at **59%,** the rate among this group this **markedly** higher than in any other ethnicity in three of the boroughs: Newham **(71%),** Redbridge **(67%)** and Havering **(65%).**
- In contrast, average unplanned C-sections rates vary much more across borough from **4%** in Hackney to **24%** in Havering.

17. Black and Asian women are more likely to have an unplanned C-section compared with White women

- Overall across NEL, approximately **30%** of deliveries take place via C-sections (planned/unplanned)
- On average across NEL, Asian women **are twice as likely** as Mixed or Other women to have an unplanned C-section (**19**% compared with **9%)** and are also more likely than White women to give birth in this way **(13%) .**
- On average, Black women **are also more likely** than White women (and compared with other non-Asian ethnicities) to have an unplanned C-section **(i.e. 18%** compared with **13%).**

18. White women are twice as likely to deliver via forceps compared to Black women

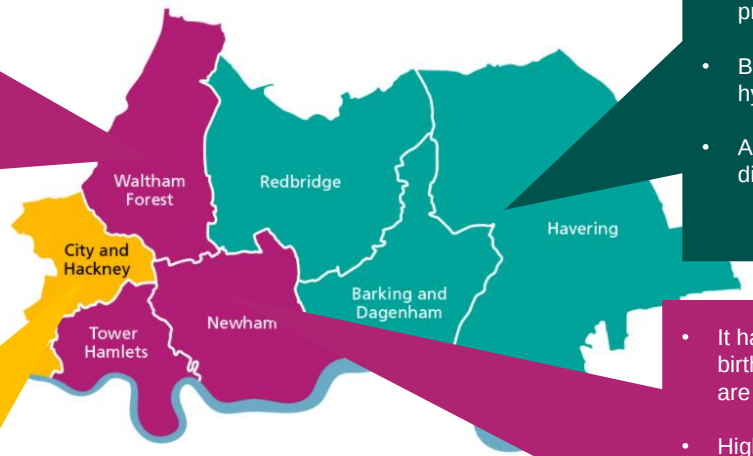
- On average across NEL, **8%** of white women had deliveries via forceps' compared with **4%** among Black women.
- In contrast the average rates among Asian **(7%)**, Mixed **(7%)**, Other **(7%)** and White **(8%)** women are relatively similar.

19. Asian women are more likely than White women to have a second or third degree tear

- More than a quarter of women in all boroughs had a second degree tear**. 30%** of Asian women had a second degree tear compared with **25%** among White women and **19%** among Black women.
- Third degree tears are significantly more rare, with less than **3%** of women across NEL suffering from this. On average, the rate among Asian women is **3%,** higher than for White women **(2%)** and Black women (**1%).**

4.2 Key findings from our analysis – Borough level (1)

- Overall stillbirth rate of 3.4 in 1000 and one of the 3 boroughs in which stillbirths to Black and Asian women are concentrated
- Babies born to Asian (10%) and Black (11%) women twice as likely as babies to White women (5%) to have a low birth weight.
- Black women (16%) **twice as likely** than White women (**8%**) to have had an unplanned C-section
- Black and Mixed women tend to present to healthcare services c.4 weeks later into their pregnancy than White women.
- Black, Asian and Mixed women more likely than White women to have attended A&E or been admitted to hospital with 6 months of delivery than White women
- Black and Mixed women are two times more likely that White women to be obese and Black women twice as likely to have hypertension



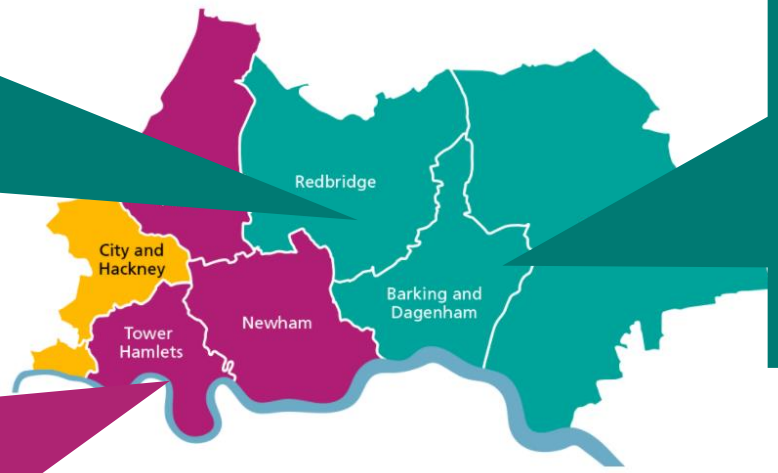
- Overall stillbirth rate of 1 in 1000 and lowest in NEL
- Has the highest average rate across NEL of women having an unplanned C-section (24%) with rates for Black (32%) and Asian (28%) women are markedly higher than for White women (22%)
- Black women tend to present to healthcare services c.4 weeks later into their pregnancy than White women.
- Black women (11%) more than twice as likely as White women (5%) to have hypertension
- Asian women (25%) more than twice as likely as White women (10%) to have diabetes

- Overall still birth rate of 3 in 1000 It was one of the 3 boroughs in which stillbirths to Black and Asian women are concentrated
- Babies born to Black (14%) and Asian (15%) women nearly three times as likely than those to White women (5%) to have a low birth weight
- Babies born to Black women (20%) twice as likely to be admitted to neonatal care than those to White women (**10%)**
- More than half of women admitted to hospital during pregnancy with rates much higher among Black (65%) than White (50%) women
- Highest average rate of planned C-section across NEL (26%) with rates much higher for Black (37%) and Asian (30%) women than for White (22%)

- It has one of the highest rates of stillbirths across NEL at almost 5 in every 1000 births and one of the 3 boroughs in which stillbirths to Black and Asian women are concentrated.
- Highest rates in NEL of stillbirths among Black, Asian and Other ethnicity women (**6.5 per 1000** among Asian women, **9 per 1000** among Black women, and **12.7 per 1000** among Other ethnicities)
- It has the **highest average proportion** of women giving birth to babies with **low birth weight** in NEL (c.1 in 10)
- Black and Mixed women tend to present to healthcare services more than 4 weeks later into their pregnancy than White women.
- Has among the largest disparities between Black and White women in attending A&E during pregnancy (and the largest average rate across NEL overall). Also has one of the largest disparities between Black, Asian and White women in diabetes prevalence

4.2 Key findings from our analysis – Borough level (2)

- Overall stillbirth rate of 2.5 in 1000
- Babies born to Asian (37%) and Black (34%) women much more likely those born to White women to be admitted to neonatal care (25%)
- Black women are twice as likely and Asian women are three times more likely to have diabetes than White women.
- Black women (9%) are three times more likely than White women (3%) to have hypertension
- Black women (35%) are much more likely to be obese than White women (20%)



- Overall stillbirth rate of 2.2 in 1000
- Second highest average rate across NEL of babies admitted to neonatal care (40%)
- Black women twice as likely than White women to have attended A&E and been admitted to hospital within 6 months of delivery
- Second highest average rate across NEL of women having an unplanned C-section (23%) with rates higher among Black (29%) and Mixed (29%) women compared with White women (21%)
- Mixed ethnicity women tend to present to healthcare services c.4 weeks later into their pregnancy than White women.
- Highest average prevalence rate of obesity (27%) across NEL with rates for Mixed (45%) and Black (35%) women markedly higher than among White women (25%)
- Prevalence of hypertension twice as high among Black and Mixed women compared with White women

- Highest overall stillbirth rate in NEL at 6.2 in 1000 and is based mainly by stillbirths to White women and those Unknown ethnicity – who have a very high rate at 12 per 1000 births
- Babies born to Black (12%) and Asian (11%) women are **twice as likely** to have a low birth weight than those born to White women (**5%**)
- It has one of the largest difference in rates between Black (42%) and Mixed (40%) women compared with White (26%) women attending A&E during pregnancy
- It is has the **highest** average rate across NEL of women attending A&E with 6 weeks as well as 6 months after delivery (7% and 10%)
- It has the highest average rate across NEL of diabetes prevalence (**21%) and has one of** the largest differences in rates between Asian (28%) and Black (19%) women compared with White women (**7%)**

4.2 Key findings – Barking & Dagenham

- **2,805** births in 20/21 (**11%** of total NEL births)
- **50%** of women that gave birth in 20/21 are BME
- Average age of pregnant women is **30 years**

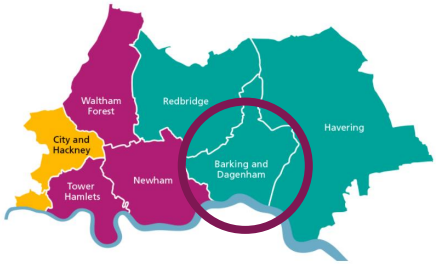
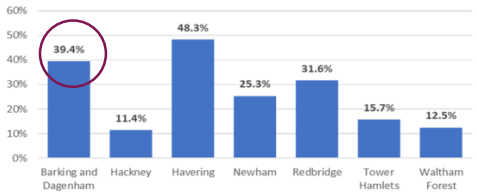


Figure 17: % of admissions to neonatal care – by borough (2020/21)



- It is has the **second highest** average rate across NEL of women giving birth to babies that are admitted to neonatal care

- It is has the **second highest** average rate across NEL of women having an unplanned C-section (22%) with rates among Black (24%), Asian (24%) and Mixed (24%) women higher than those among White women (20%)

Chart 1 | % of unplanned C section deliveries | rates by Borough | 2020-21

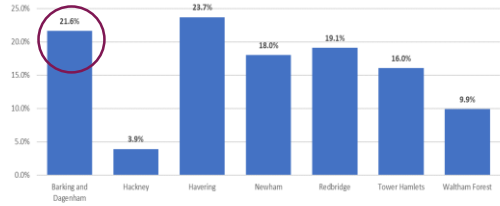
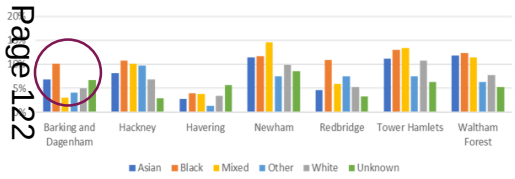


Figure 10: % of pregnant women with an A&E attendance within 6 months of delivery – by ethnicity and borough (2020/21)



- It has the **highest** average rate of pregnant women that are obese (27%) across NEL and rate among Mixed and Black and women in particular are much higher than those among White women (**45%** and **35%** compared with **25%)**
- It also has the **third highest** average prevalence rate across NEL of **diabetes** (18%) as well as the highest rate among Asian women compared with all other boroughs at almost 30%. This rate is also three times higher than the rate for White women (10%)
- The prevalence of **hypertension** is also **much higher** among Black and Mixed women compared with White women (7% and 7% compared with 3%)

Figure 4: % of pregnant women with an admission within 6 months of delivery - by ethnicity and borough (2020/21)

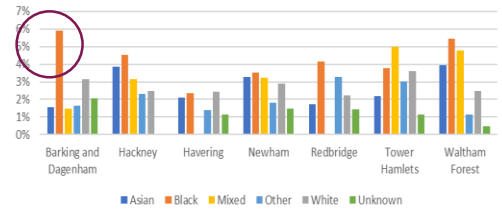
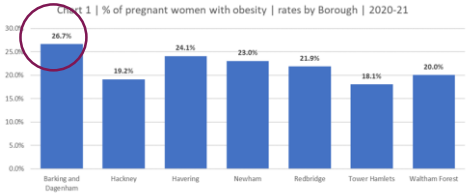


Chart 1 | % of pregnant women with obesity | rates by Borough | 2020-21



- Black women **twice as likely** than White women to have **attended A&E** within in 6 months of delivery (**10%** compared with **5%)** and to have been admitted to hospital within in 6 months of delivery (**6%** compared with **3%)**

Chart 2 | % of pregnant women with diabetes | rates by borough and ethnicity | 2020-21

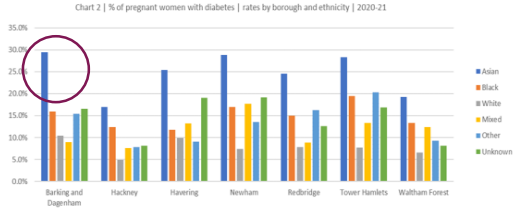
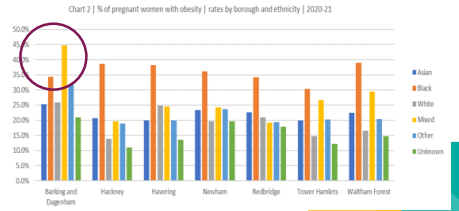


Chart 2 | % of pregnant women with obesity | rates by borough and ethnicity | 2020-21



4.2 Key findings - Hackney

- **3,830** births in 20/21 (**15%** of total NEL births) - HES
- **41%** of women that gave birth in 20/21 are BME
- Average age of pregnant women is **31 years**

Figure 21: Rate per 1000 of babies born stillbirth - by ethnicity and borough (2020/21)

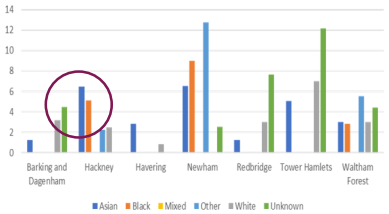
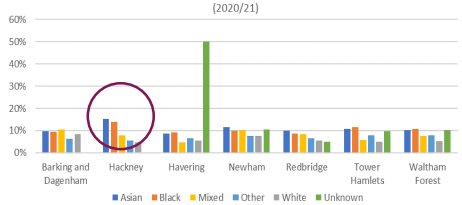


Figure 8: % of babies born with low birth weight – by ethnicity and borough (2020/21)



- It is one of the 3 boroughs in which stillbirths to Black and Asian women are **concentrated – 3** per **1000** births and mainly to Black and Asian ethnicity women – stillbirths to women of Asian ethnicity highest at **6.5** in every **1000** births
- The proportion of babies born with low birth weight born to Black and Asian women is nearly **three times as high** as for White women (**14%** and **15%** versus **5%)**
- Babies born to Black women are twice as likely to be admitted to neonatal care than those to White women (**20%** versus **9%)**

Figure 15: % of admissions to neonatal care – by ethnicity and borough (2020/21)

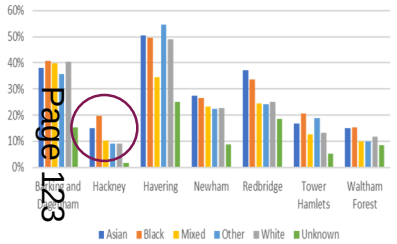


Figure 9: % of pregnant women with an admission during pregnancy - by borough (2020/21)

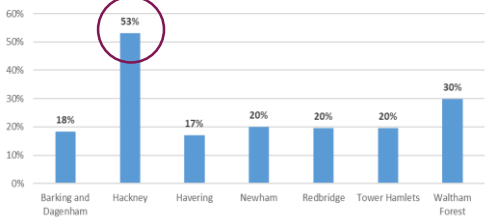
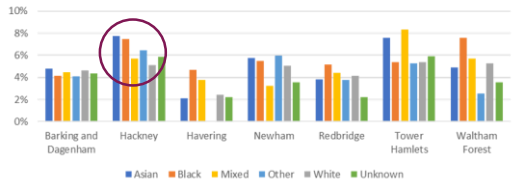
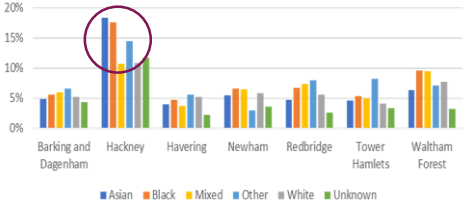


Figure 7: % of pregnant women with an A&E attendance within 6 weeks of delivery – by ethnicity and borough (2020/21)



- On average **more than half** of women are **admitted to hospital during pregnancy** (highest across NEL) with rates higher among Black and Asian women compared with White women **(65% and 58%** versus **50%)**
- Black and Asian women were also **more likely to attend A&E within 6 weeks** of delivery compared to White women (**8%, 7%** versus **5%)**
- Black and Asian women are also **much more likely** than White women to be **admitted to hospital** within 6 weeks of delivery (**18%** and **18%** compared with **11%)**

Figure 1: % of pregnant women with an admission within 6 weeks of delivery – by ethnicity and borough (2020/21)



- Black women more than **twice as likely** to be **obese** than White women
- It has the **highest average** proportion of women with **hypertension** in pregnancy (**6%)** across NEL with rates among Black women **highe**r than among White women (**9%** versus **5%)**

Chart 2 | % of pregnant women with obesity | rates by borough and ethnicity | 2020-21

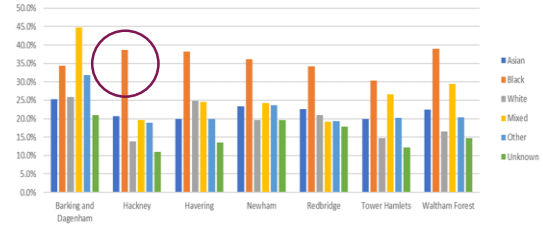
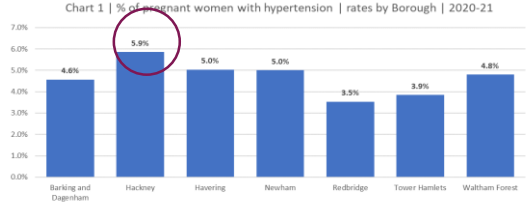


Chart 1 | % of pregnant women with hypertension | rates by Borough | 2020-21



- It has by far the highest overall average rate of planned C-sections across NEL (**26%)**
- Black and Asian women much more likely to give birth this way than White women (**36%** and **27%** compared with **22%)**

Chart 1 | % of planned C section deliveries | rates by Borough | 2020-21

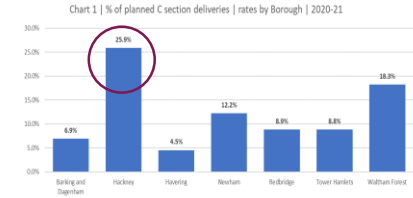
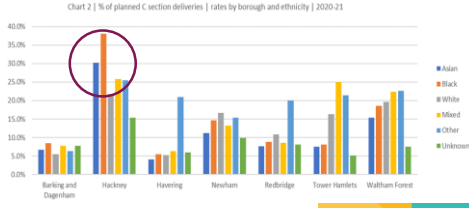


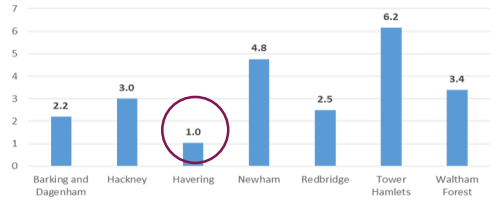
Chart 2 | % of planned C section deliveries | rates by borough and ethnicity | 2020-21



4.2 Key findings – Havering

- **2,010** births in 20/21 (**8%** of total NEL births)
- **31%** of women that gave birth in 20/21 are BME
- Average age of pregnant women is **31 years**

Figure 23: Rate per 1000 of babies born stillbirth – by borough (2020/21)



- While it has the **lowest** rates of stillbirths per 1000 births overall, **nearly half** of women (49%) have babies that are admitted to neonatal care – although no notable differences across ethnicities with rates for BME babies either the same of less than for those born to White women.

Figure 17: % of admissions to neonatal care – by borough (2020/21)

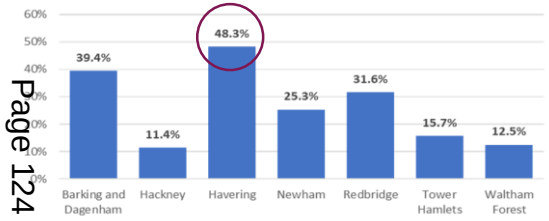


Chart 1 | % of unplanned C section deliveries | rates by Borough | 2020-21

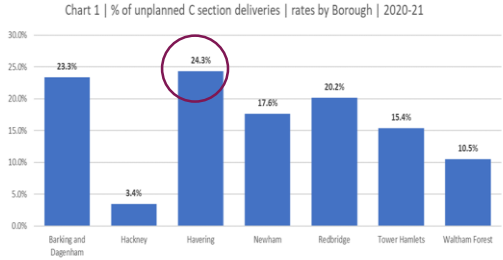
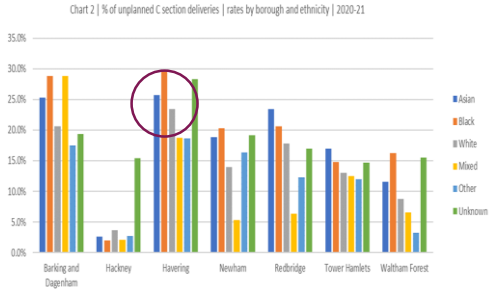


Chart 2 | % of unplanned C section deliveries | rates by borough and ethnicity | 2020-21



- It has the **highest average** rate across NEL of women having an **unplanned C-section** (**24%**) with rates for Black and Asian women are **markedly higher** than for White women (**32%** and **28%** compared with **22%**)

Chart 2 | % of pregnant women with diabetes | rates by borough and ethnicity | 2020-21

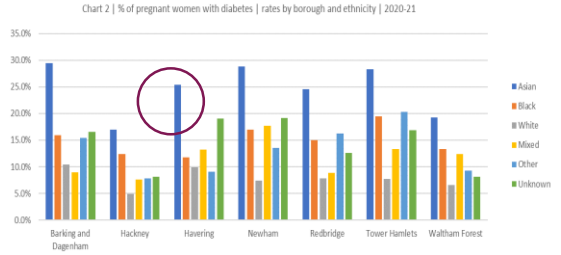
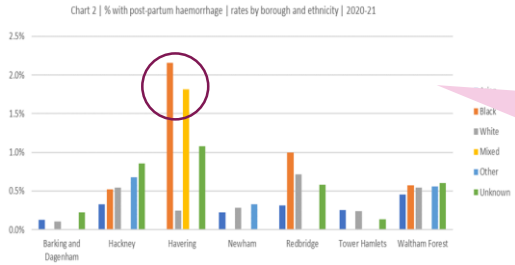


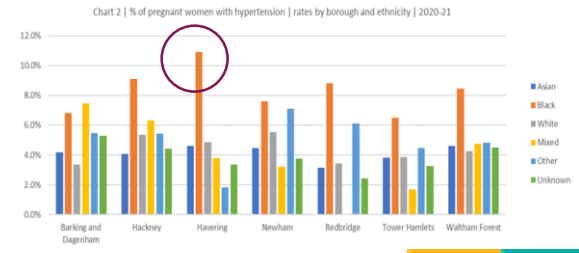
Chart 2 | % with post-partum haemorrhage | rates by borough and ethnicity | 2020-21



- Black women are **10 times** more likely and Mixed women **9 times** more likely than White women to suffer **post partum haemorrhages** (**2.2%** and **1.8%** compared with **0.2%)**

- Black women more than twice as likely as White women to have hypertension (11% compared with **5%)**
- While it has one of **the lowest** overall average prevalence **of diabetes** across NEL (**13%)** the rate among Asian women is more than **twice as high** as for White women (**25%** compared with **10%)**

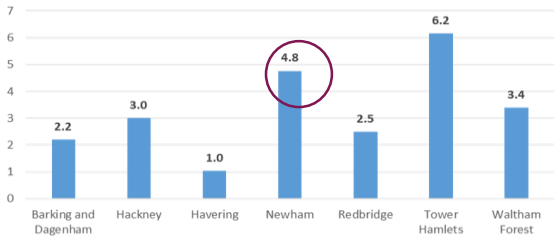
Chart 2 | % of pregnant women with hypertension | rates by borough and ethnicity | 2020-21



4.2 Key findings – Newham

- **5,282** births in 20/21 (**20%** of total NEL births)
- **55%** of women that gave birth in 20/21 are BME
- Average age of pregnant women is **30 years**

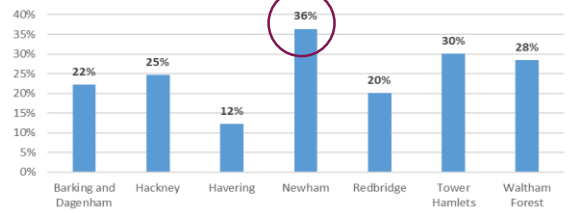
Figure 23: Rate per 1000 of babies born stillbirth – by borough (2020/21)



- It has one of the **highest rates** of **stillbirths** across NEL at almost **5** in every **1000** births.

- Largest average rate across NEL of women attending A&E during pregnancy
- It is one of the two boroughs with the **largest difference** in rates between Black and White women (**48%** versus **35%)**

Figure 10: % of pregnant women with an A&E attendance during pregnancy - by borough (2020/21)



- It is one of the 3 boroughs in which stillbirths to Black and Asian women are **concentrated** – and also has the **highest rates** for these two groups at **6.5 per 1000** among Asian women and **9 per 1000** among Black women. The rate found for Other ethnicities was even higher at **12.7 per 1000.**

Figure 21: Rate per 1000 of babies born stillbirth - by ethnicity and borough (2020/21)

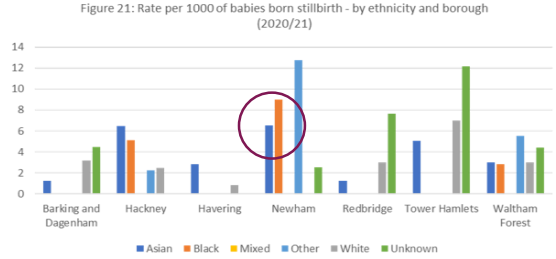
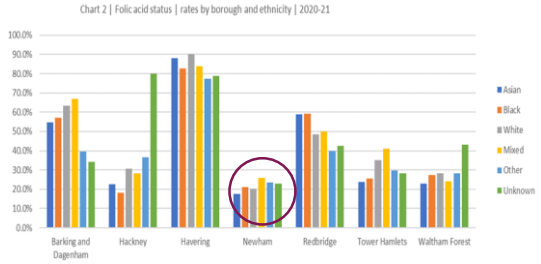
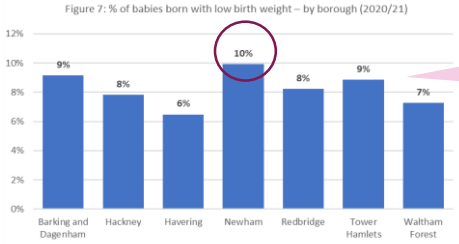


Chart 2 | Folic acid status | rates by borough and ethnicity | 2020-21



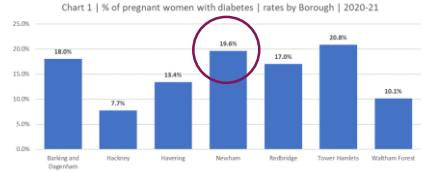
- While rates within ethnicities of 'good' folic acid stats are very similar, it has the **lowes**t average rate across all women among all the NEL boroughs at **20%**.

Figure 7: % of babies born with low birth weight – by borough (2020/21)



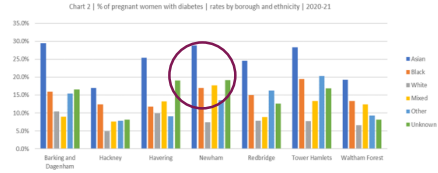
- On average, has the **highest proportion** of women giving birth to babies with **low birth weight** in NEL – around **1 in 10**

Chart 1 | % of pregnant women with diabetes | rates by Borough | 2020-21



- It has one of the **highes**t average rates of diabetes **(20%)**
- It is one of the two boroughs with the **largest differences** in rates among Asian, Black and White women **(28%, 17%** and **7%)**

Chart 2 | % of pregnant women with diabetes | rates by borough and ethnicity | 2020-21



4.2 Key findings – Redbridge

- **3,757** births in 20/21 (**14%** of total NEL births)
- **59%** of women that gave birth in 20/21 are BME
- Average age of pregnant women is **31 years**

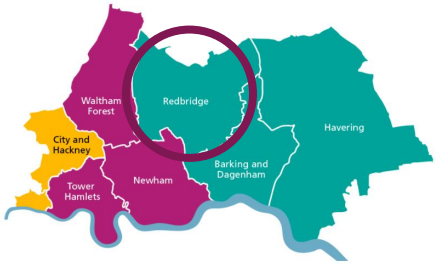
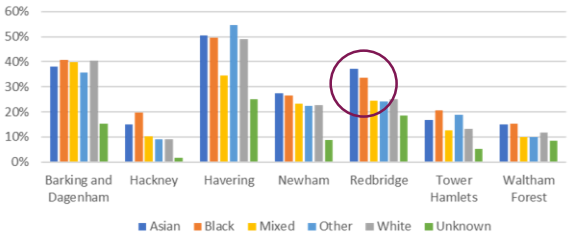


Figure 15: % of admissions to neonatal care – by ethnicity and borough (2020/21)



- It is has the **third highest** average rate across NEL of women giving birth to babies that are admitted to neonatal care.
- Rates among babies born to Asian and Black women are much higher than those born to White women (**37%, 34%** compared with **25%)**

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Black women are **twice as likely** to have **attended A&E** within 6 months of delivery compared with White women (**11%** compared with 5**%)** and are **twice as likely** to have been admitted to hospital over the same time frame **(4%** compared wit**h 2%)**

- Black women are much more likely to be **obese** than White women (**34%** compared with **21%).**
- Black women are **twice as likely** and Asian women are three **times more likely** to have **diabetes** than White women.

- Black women are also more than twice as likely than White women to have hypertension (**9%** compared with **3%)**

Figure 4: % of pregnant women with an admission within 6 months of delivery - by ethnicity and borough (2020/21)

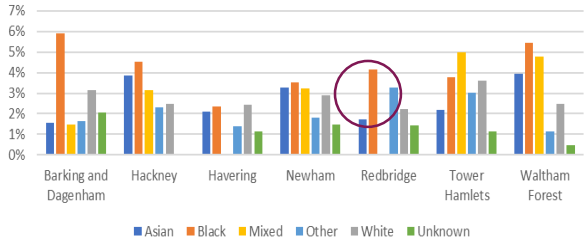
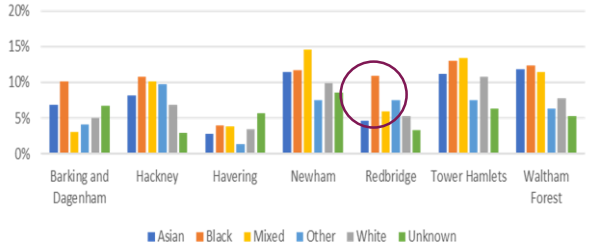
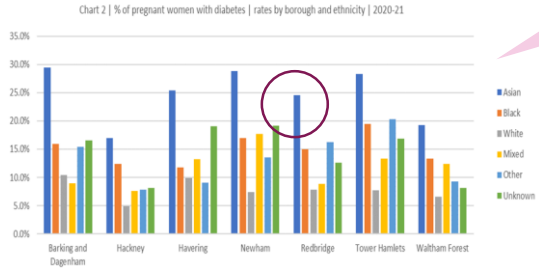


Figure 10: % of pregnant women with an A&E attendance within 6 months of delivery – by ethnicity and borough (2020/21)

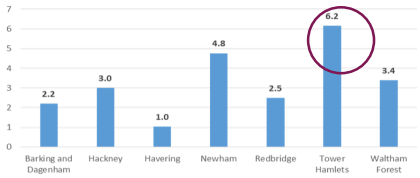




4.2 Key findings – Tower Hamlets

- **4,166** births in 20/21 (**16%** of total NEL births)
- **61%** of women that gave birth in 20/21 are BME
- Average age of pregnant women is **31 years**

Figure 23: Rate per 1000 of babies born stillbirth – by borough (2020/21)



- It is one of the 3 boroughs in which stillbirths to Black and Asian women are **concentrated** (and has the highest overall rate in NEL at **6.2** per **1000)**
- This rate is based mainly by stillbirths to White women and those Unknown ethnicity – who have a **very high** rate at **12** per **1000** births

Figure 21: Rate per 1000 of babies born stillbirth - by ethnicity and borough (2020/21)

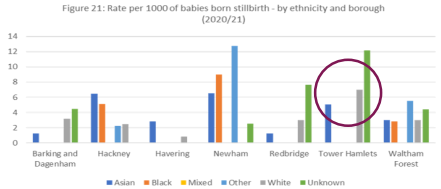
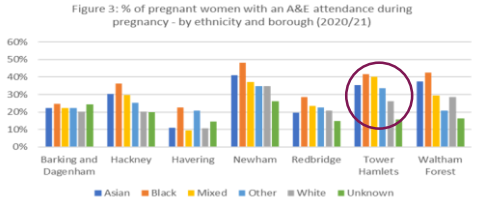


Figure 3: % of pregnant women with an A&E attendance during pregnancy - by ethnicity and borough (2020/21)



- It is has the **second highest** average rate of women attending A&E during their pregnancy
- It has one of the largest differences in rates between Black and Mixed women compared with White women (**42**%, **40**% compared with **25**%)

Figure 9: % of pregnant women with an A&E attendance within 6 weeks - by borough (2020/21)

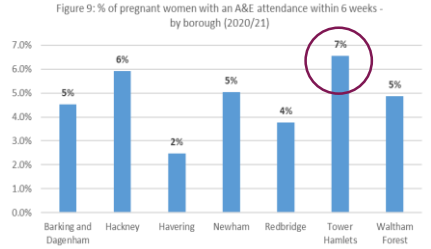
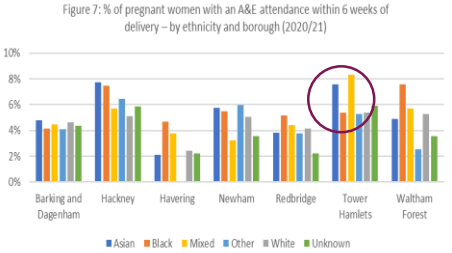


Figure 7: % of pregnant women with an A&E attendance within 6 weeks of delivery – by ethnicity and borough (2020/21)



- It is has the **highest** average rate across NEL of women attending A&E within 6 weeks as well as 6 months after delivery (7% and 10%)
- Asian and Mixed women tend to have higher rates of within 6 week attendances compared with White women

Figure 12: % of pregnant women with an A&E attendance within 6 months - by borough (2020/21)

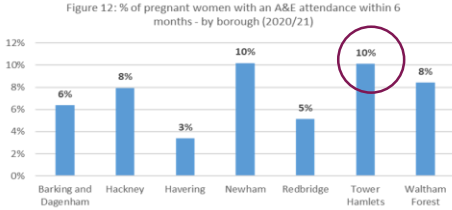
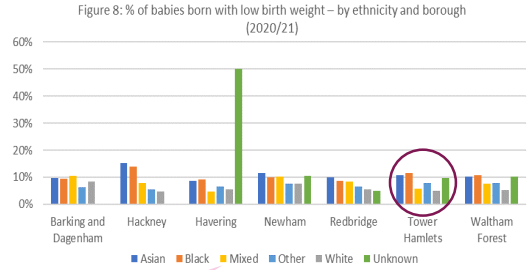
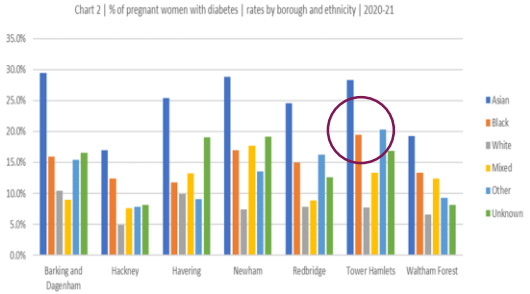


Figure 8: % of babies born with low birth weight – by ethnicity and borough (2020/21)



- Babies born to Black and Asian women are **twice as likely** to have a low birth weight than those born to White women (**12%** and **11%** versus **5%**)

Chart 2 | % of pregnant women with diabetes | rates by borough and ethnicity | 2020-21

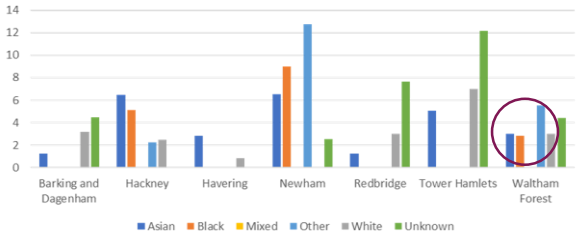


- It has the highest average rate across NEL of diabetes prevalence (**21%)**
- It also has one of the largest differences in rates between Asian and Black women compared with White women (**28%** and **17%** compared with **7%)**

4.2 Key findings – Waltham Forest

- **4,100** births in 20/21 (**16%** of total NEL births)
- **39%** of women that gave birth in 20/21 are BME
- Average age of pregnant women is **32 years**

Figure 21: Rate per 1000 of babies born stillbirth - by ethnicity and borough (2020/21)



- It is one of the 3 boroughs in which stillbirths to Black, Asian and Other women are **concentrated** (and has **3.4** per **1000** across all ethnicities**)**
- It has one the largest disparities in low birth weight – with the rates for Asian and Black women twice as high as for White women (**10%** and 1**1%** compared with **5%)**

Figure 8: % of babies born with low birth weight – by ethnicity and borough (2020/21)

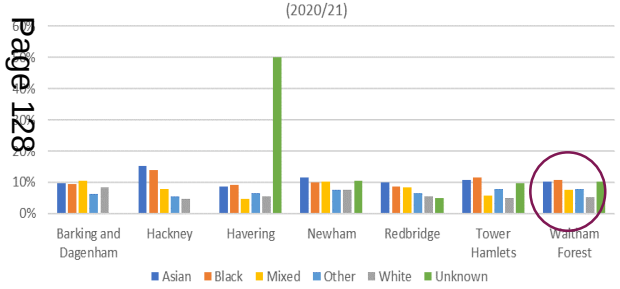
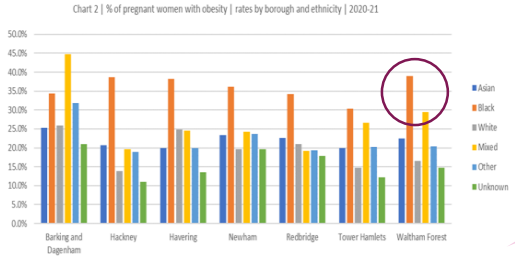


Chart 2 | % of pregnant women with obesity | rates by borough and ethnicity | 2020-21



- Black and Mixed pregnant women are **more likely** to be obese than White women (**39%, 29%** compared with **16%)** and Black women are twice as likely as White women to have hypertension (**8%** compared with **4%)**

Figure 10: % of pregnant women with an A&E attendance within 6 months of delivery – by ethnicity and borough (2020/21)

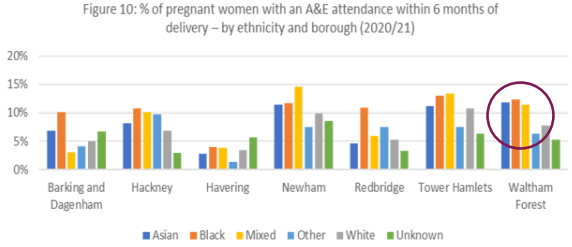
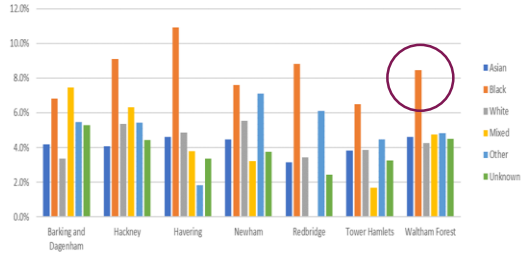
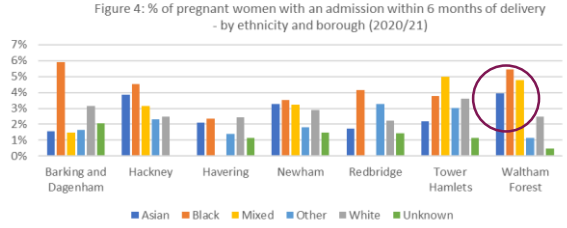


Chart 2 | % of pregnant women with hypertension | rates by borough and ethnicity | 2020-21



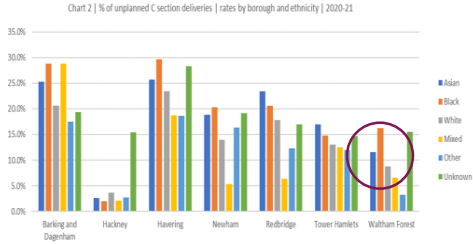
- Black, Asian and Mixed women are **more likely** to have **attended A&E** within 6 months of delivery compared with White women (**12%, 12%** and **11%** compared with **8%)** and are also **more likely** to have been admitted to hospital over the same time frame **(5%, 4%** and **5%** compared wit**h 2%)**

Figure 4: % of pregnant women with an admission within 6 months of delivery - by ethnicity and borough (2020/21)



- Black women are near **twice as likely** than White women to have an unplanned C-section (**15%** compared with **8%)**

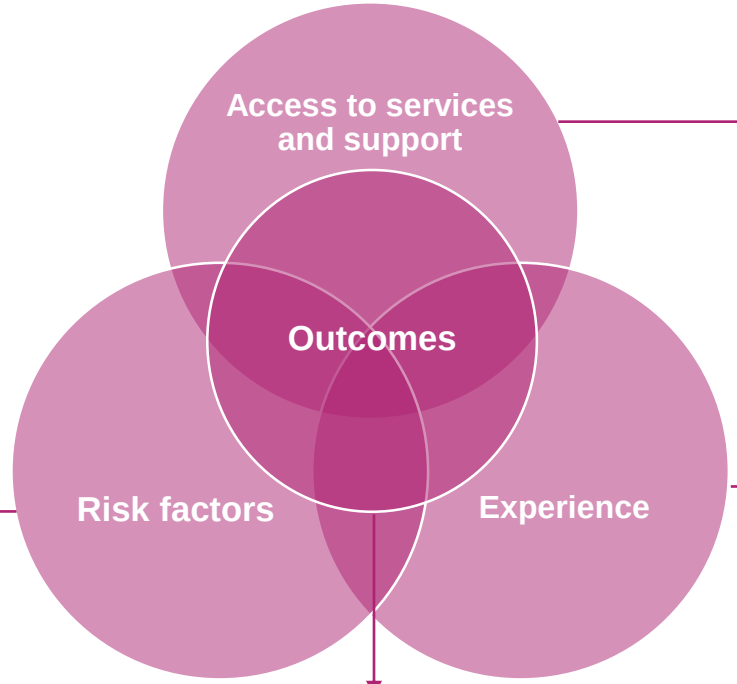
Chart 2 | % of unplanned C section deliveries | rates by borough and ethnicity | 2020-21



4.3 Key indicators not covered in this analysis

As this analysis is an **initial** assessment of inequalities for women and babies using data that is (readily) available in the time frame given for this analysis. There are a number of metrics (examples listed here) that have not been included but should be considered as part of any further more comprehensive/in-depth analysis.

Further work would be needed to assess the current availability and quality of data on these indictors and the feasibility of collection by system partners.



- DNA rate of hospital appointments
- Ultrasound bookings and DNA rates
- Enrolment on LTC related management programmes
- Usage of postnatal mental health services
- Post-natal home health visits
- Referrals to hospital by GPs
- Rates of GP registration
- Rates of GP appointments

- Smoking rates
- Rates of substance abuse
- Prevalence of co-morbidities
- Prevalence of diabetes by type
- Prevalence of significant mental health issues (SMI)

- Premature labour
- Rate of babies born with a disability
- Neonatal mortality (1st year of life)
- Maternal mortality
- Rate of admission to ITU post delivery
- Postnatal depression diagnosis

- Survey data from women by ethnicity on lived experience of health care services – pre and post natal
  - Access to interpreters
  - Cultural sensitivity
  - Listening to preferences and concerns

Annex 1 – Demographic profile of women in NEL accessing Maternity services

Key notes and data caveats

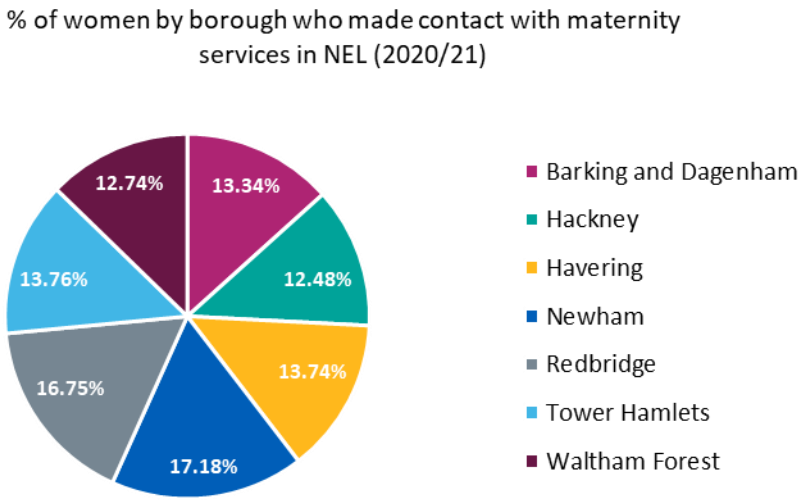
- Unless otherwise specified, the data has been sourced from **Secondary Uses Services (SUS)** and refer to the financial year **20/21**
- The population we have extracted from SUS - on which this demographic profile is based - includes **all** women who had **contact with Maternity services in 20/21 regardless of whether they went on to become pregnant or give birth**.
- This means that the population considered here is **much broader** than the population of pregnant women that went on to give birth in 20/21 (i.e. the population of women on which our initial analysis of inequalities is based).
- It does, however, provide a helpful and boarder view of the number and profile women **overall** in NEL accessing these services. Further, this population will also account for pregnant women that used these services who may have gone on to have a miscarriage or a termination (and who therefore will not have been included the population sample for our inequalities analysis).
- Overall, **c.15%** of the NEL women included in our demographic profile did not have an ethnicity in their record (when extracted from SUS) and we have no way of estimating whether the distribution of this 15% are skewed towards a particular ethnicity. If they are however, this could skew the findings presented in this report so the analysis should be treated with some caution.

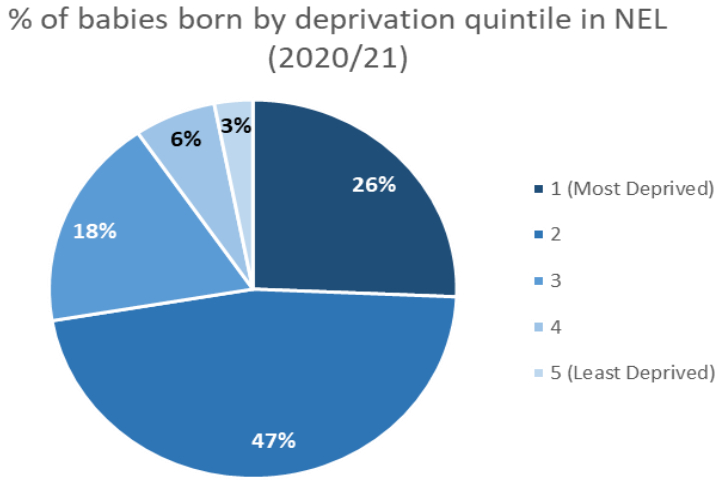
Size and distribution of the women making contact with NEL Maternity services in 20/21

Total of 61,215 women in NEL made contact with these NEL Maternity services in 20/21[1]

25, 950 (42%) of these women went on to give birth in the same year[2]

72% of those babies were born to women in two most deprived quintiles

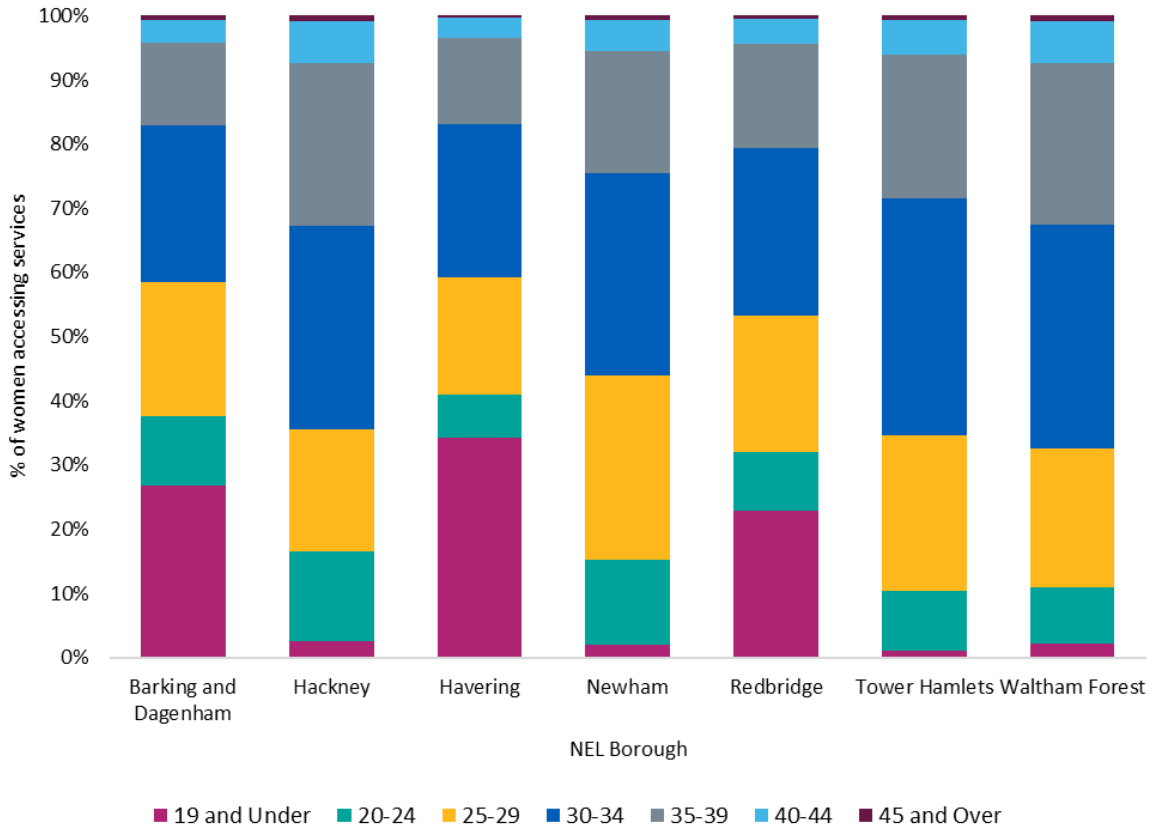




(1)Source: Secondary Uses Services, (2)Source: Hospital Episodes Staticstics

Age profile of women accessing Maternity services

Figure 1: Breakdown (%) of all women accessing Maternity services by age (20/21)



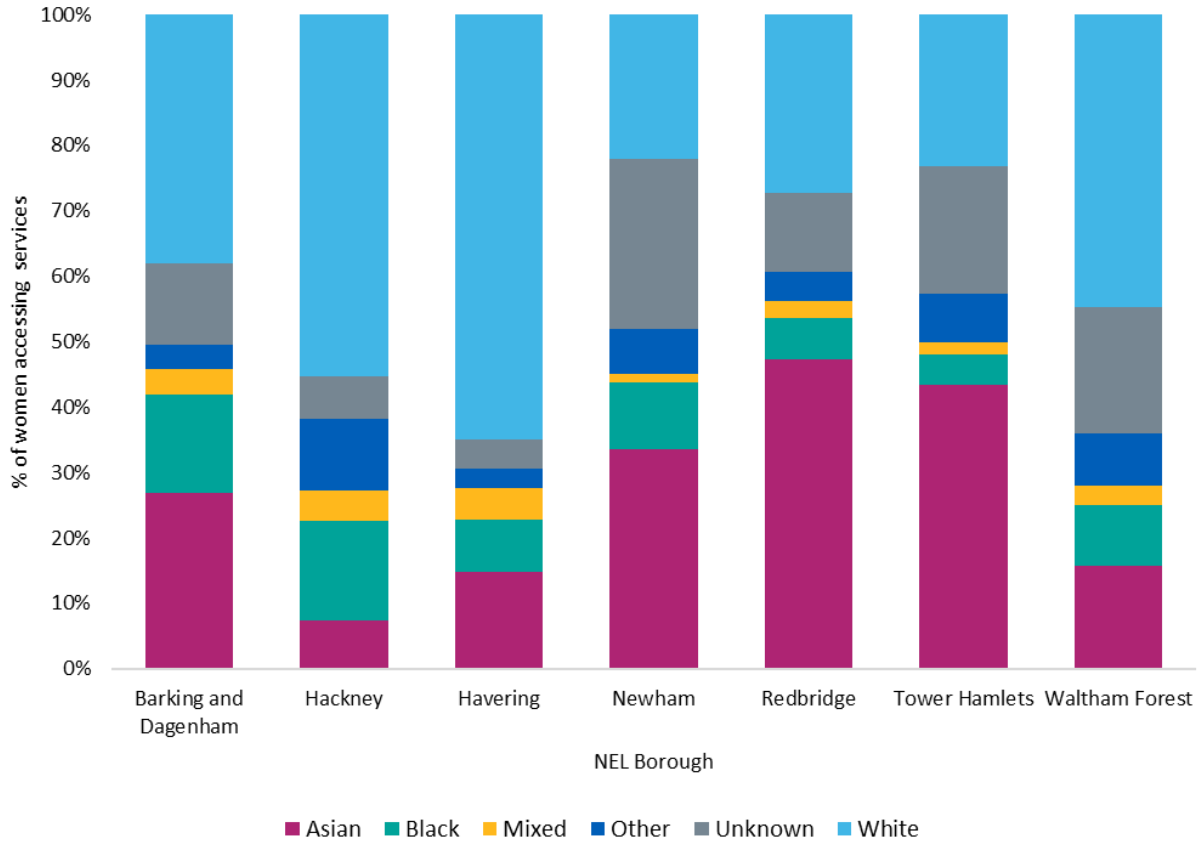
Source: Data from SUS

Key findings:

- The average proportion across NEL of women aged 19 or under that accessed these services is **13%** compared with **10%** for those aged 20-24, **22%** for those aged 25-29, and **55%** for those aged 30 and above.
- These NEL averages do, however, mask relatively large differences at the borough level. Variations in age vary most in relation to the proportion of women aged 19 or under. The population accessing these services in Barking and Dagenham, Havering and Redbridge is much younger than in other NEL boroughs. In Havering, for nearly **35%** of the women are aged 19 and under and in Barking and Dagenham this rate is **27%**. This is a stark difference to other NEL boroughs, where the proportion is less than **5%.**
- In contrast, the profile of women in Tower Hamlets, Waltham Forest and Hackney are much older with between **65-68%** of women over 30 compared with the **41-56%** across the other boroughs.

Ethnicity profile of women accessing Maternity services

Figure 2: Breakdown (%) of all women accessing Maternity services by ethnicity (20/21)



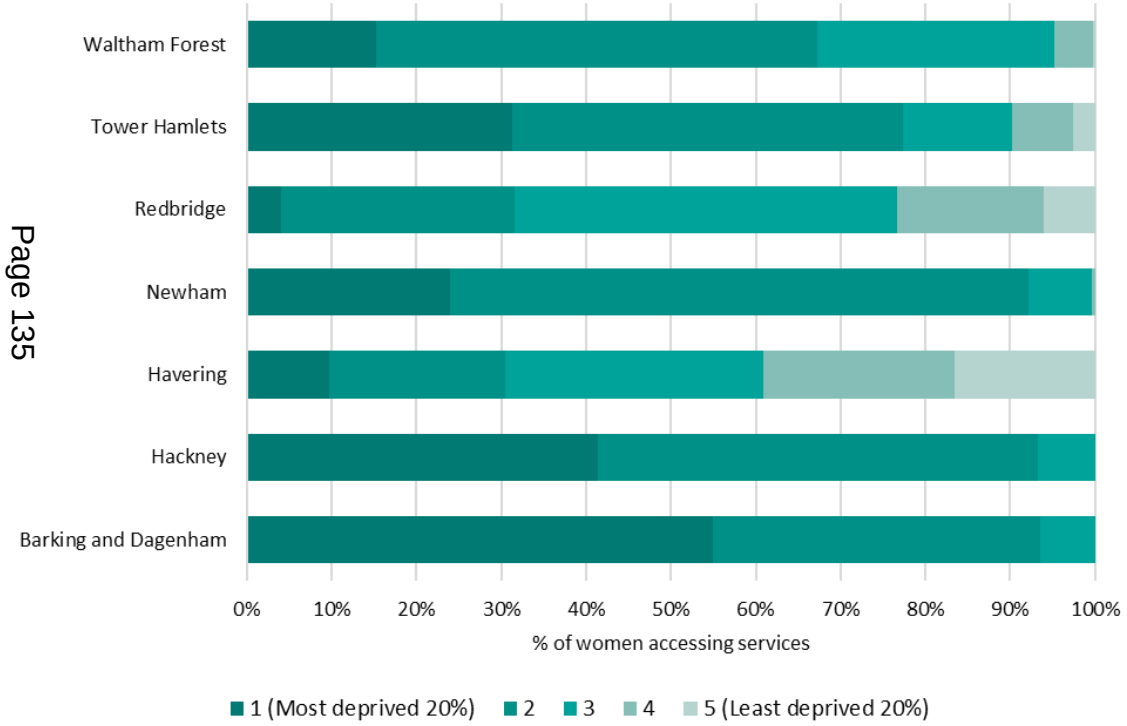
Source: Data from SUS

Key findings:

- On average across NEL, just under half (**47%)** of women accessing these services were of Asian, Black, Mixed or Other background.
- As with age, NEL averages do, however, mask relatively large differences at the borough level. Newham, Redbridge and Tower Hamlets have the most diverse populations with , Black, Asian, Mixed and Other women, accounting for between **52-61%** of population of women accessing these services compared with **31%** in Havering and **36%** in Waltham Forest.
- Both these latter boroughs have the highest proportion of White women **65%** and **45%** respectively.
- With the exception of Hackney – in which Black women make up the majority of the BME population (i.e. **15%** out of the overall **38%** BME proportion of this specific population) - Asian women tend to represent the largest proportion of the BME population compared with either Black or women of Mixed ethnicity.
- Tower Hamlets and Redbridge have particularly high proportion of Asian women (**43%** and **47%** respectively) compared with the other NEL boroughs where less than a **quarter (25%)** are in this group.
- Newham has the smallest proportion of this population with White ethnicity at **22%** and Redbridge has the largest Asian proportion across NEL at just under half (**48%**).

Deprivation profile of women accessing Maternity services

Figure 3: Breakdown (%) of all women accessing Maternity services by deprivation - IMD quintile (20/21)



Source: Data from SUS

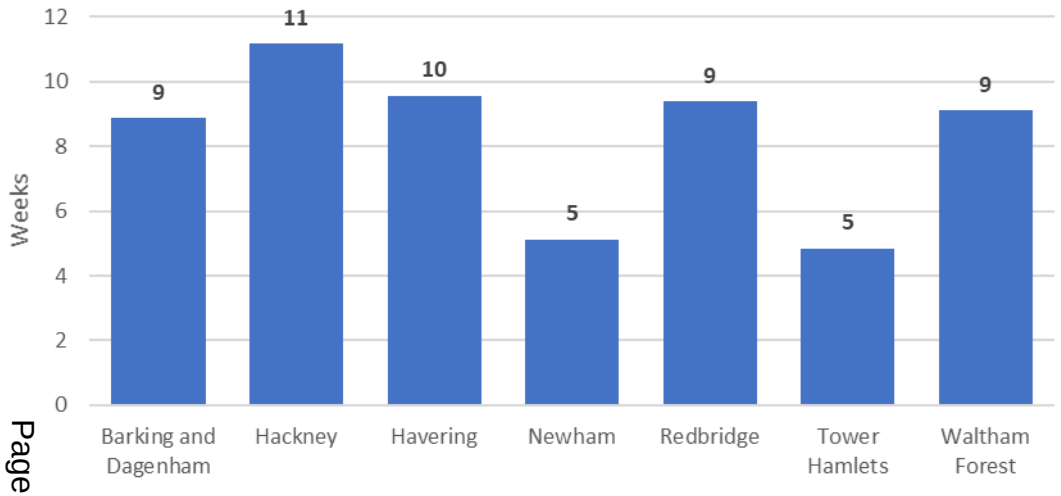
Key findings:

- Overall, the population of women in NEL accessing this services is **highly skewed** towards the most deprived quintiles with an average of **67%** of women living in areas in the two most deprived quintiles.
- As with both age and ethnicity, however, this masks a lot of variation at the borough level, with over **half** of the women in this population in Barking and Dagenham living in the most deprived quintile compared with **under 5%** in Redbridge and **10%** in Havering. These two boroughs also have the highest proportion of women living in areas that are in the two least deprived quintiles (**23%** and **39%** respectively).
- Further, neither Barking and Dagenham, Newham nor Hackney, include within them any LOSAs in the two least deprived quintiles (i.e. 4 and 5) which suggests the populations in these boroughs are particularly deprived relative to the other boroughs. It does not imply, however, that there are no women in these boroughs in higher income groups.
- There do not appear to be any other obvious similarities however between these two areas in relation to their age and ethnic profiles.

Annex 2 – Access and usage of healthcare services during pregnancy

Gestational age at first contact with NHS services

Figure 1: Average gestational age at first contact – by borough (2020/21)



Key findings

- Across NEL, women tend on average to first present at before **12** weeks, with **9-10** weeks being the range for four of the seven boroughs. Of the other three boroughs, women in Newham and Tower Hamlets tend to present a **lot sooner** than the other boroughs across NEL (**5** weeks). In contrast, women in Hackney tend to present **a lot later** than in the other boroughs at **11** weeks gestational age.
- On average across NEL, women of Mixed (**11** weeks), Black (**11** weeks) and Other (**10** weeks) ethnicity made first contact around **2** weeks **later** into their pregnancy than White women (**8** weeks). Asian ethnicities had the **earliest average gestational age** at first contact at around **7** weeks.
- At borough level, Newham and Tower Hamlets appear to have the largest disparity between ethnic minorities (excluding Asian ethnicities) and White women (and as above, are also the two boroughs with the youngest average gestational age at first contact). In Newham, for example, the average gestational age at first contact was more than **twice as high** for Black and Mixed ethnicities than White ethnicities (i.e. **9, 10** and **4** weeks respectively). In Tower hamlets, Black and Mixed women made first contact between **3 - 4** weeks later than White women and between **6-7** weeks later than Asian women..
- While White ethnicities in the other boroughs also tended to have the lowest average gestational ages at first contact compared with all other ethnicities, the differences – while potentially material – are not as stark as above.
- Across NEL, women in the **most deprived** quintile (**8** weeks) first made contact on average around a week earlier than women in the **least deprived** quintile (**9 weeks**). At the borough level, however, the picture is more mixed.
- Interestingly, the average gestational age at first contact **for the most deprived** pregnant women in Tower Hamlets (**3** weeks) was **at least 2 times** earlier than in Newham (**7** weeks) and Barking & Dagenham (**8** weeks), and at **least 3 times earlier** than the rest of the boroughs. Further, the difference between women in the most and least deprived areas **(i.e. 3** weeks versus **11** weeks) is much larger within Tower Hamlets than observed within all the other boroughs.

Figure 2: Average gestational age at first contact – by ethnicity and borough (2020/21)

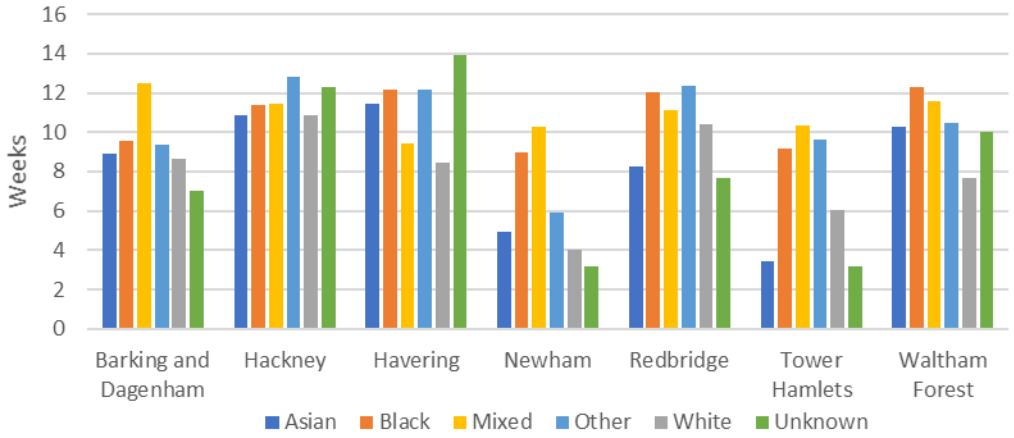
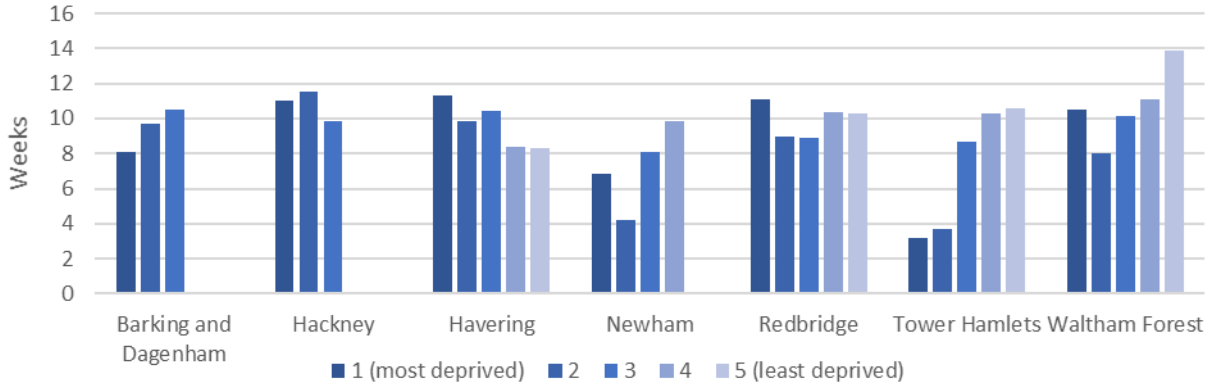


Figure 3: Average gestational age at first contact – by deprivation and borough (2020/21)



Outpatient appointments during pregnancy

Figure 4: Median no. of outpatient appointments during pregnancy - by borough (2020/21)

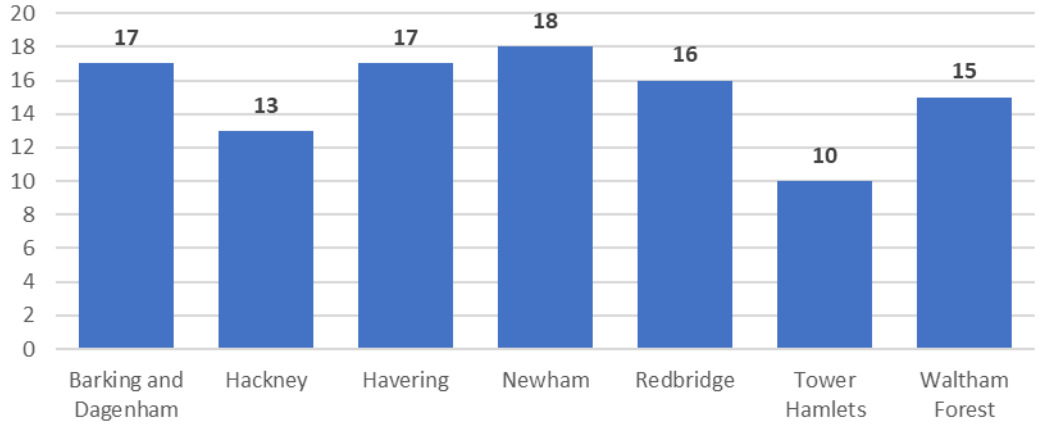
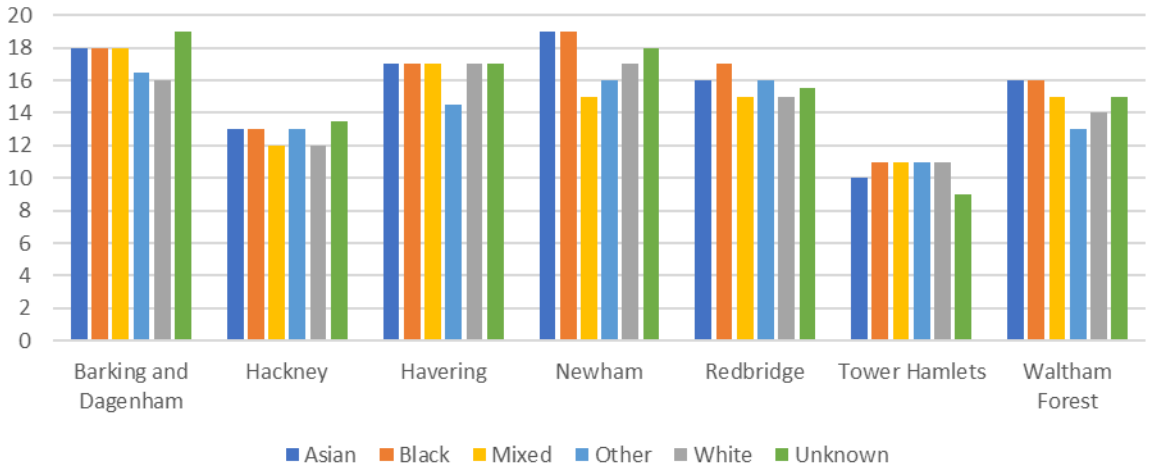


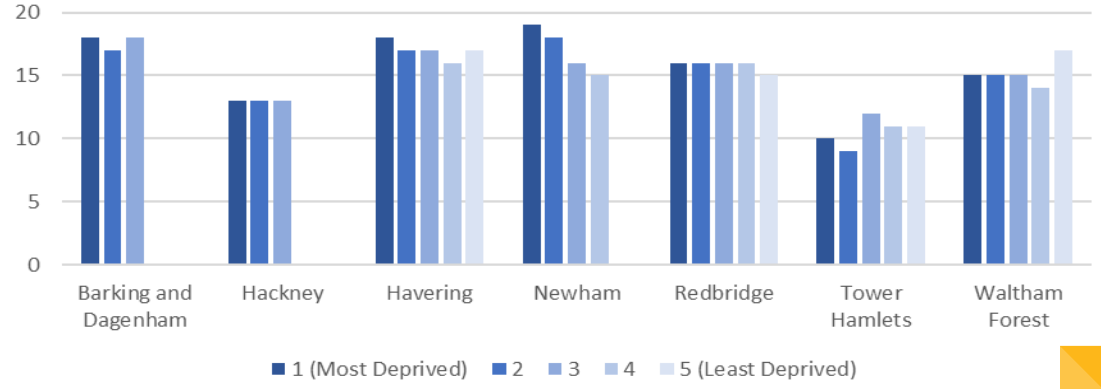
Figure 5: Median no. of outpatient appointments during pregnancy - by ethnicity and borough (2020/21)



Key findings

- Across the NEL boroughs, the average number of outpatient appointments per woman that gave birth in 2021 was **15**, with no large variations observed at the borough level. The main outlier is Tower Hamlets in which the average number per woman is **10** compared with **15-18** across the other boroughs.
- There also appears to be relatively little variation within boroughs across ethnicity and therefore does not suggest any significant inequalities at this level.
- Similar to the findings on ethnicity, there does not appear to be a significant variation by deprivation status and where there is variation, this tends to be larger across than within boroughs.
- Of the boroughs, Newham had the largest variation between both ethnicities and deprivation quintiles. Women in the **most deprived** quintile had on average **19** outpatient appointments compared with **15** in the **least deprived** quintile. Similarly, Black and Asian women in Newham had **19** outpatient appointments compared with **17** for White women and **15** for Mixed ethnicities.

Figure 6: Median no. of outpatient appointments during pregnancy - by deprivation and borough (2020/21)



A&E attendances during pregnancy

Figure 7: % of pregnant women with an A&E attendance during pregnancy - by borough (2020/21)

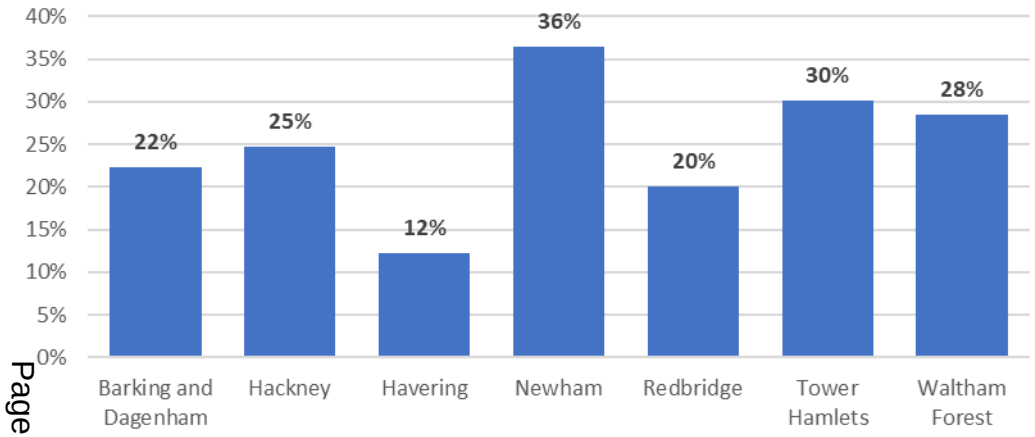
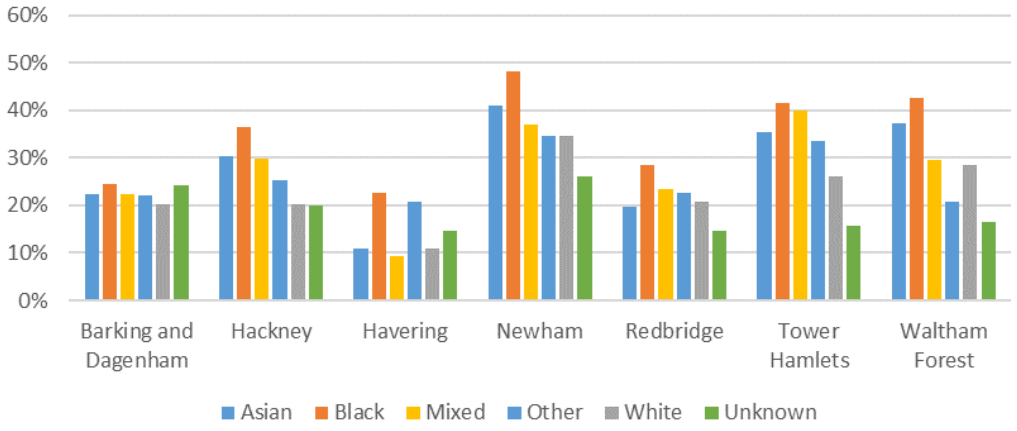


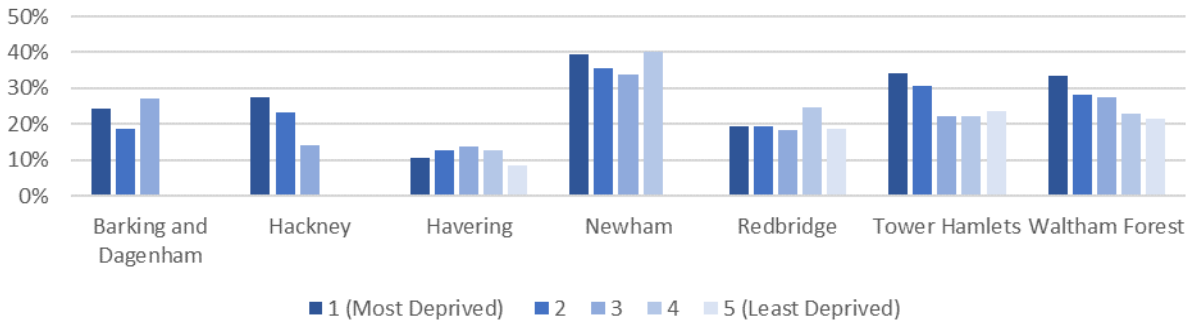
Figure 8: % of pregnant women with an A&E attendance during pregnancy - by ethnicity and borough (2020/21)



Key findings

- On average across NEL, **27%** of the women that gave birth in 2021 were admitted to A&E **at least once** during their pregnancy. There are, however, two notable outliers – i.e. Newham, who has the largest proportion of women attending A&E attendance (**36%**) and Havering with the lowest at **12%**.
- On average across NEL, Black women and Asian women tend to be **more likely** to have attended A&E during their pregnancy than White women with rates among these groups at **38%**, **31%** and **23%** respectively. This pattern is consistent at the borough level, with Black women having the **highest percentage** of women with an A&E attendance during pregnancy in all 7 NEL boroughs.
- The differences between rates among Black and White women are largest in Tower Hamlets and Newham. In Tower Hamlets, for example, the rates for these same two ethnicities are **42%** compared with **35%** and in Newham are **48%** compared with **37%.** Similarly, in Havering the rate among Black women **(23%)** is **more than twice** that for White women **(11%).**
- Barking and Dagenham and Redbridge appear to be the two main exceptions, with the differences across ethnicities within these boroughs much smaller than compared to those within the others.
- A clear trend exists between deprivation and A&E attendances across NEL, the proportion of women with an A&E attendance in the most deprived quintile (**30%) was double the proportion** for the least deprived quintile (**15%**)
- Focusing on boroughs, deprivation seems to be closely linked to A&E attendances across Hackney, Tower Hamlets and Waltham Forest as the most deprived quintiles have much higher percentages of women with an A&E attendance during pregnancy, compared to their least deprived quintiles (**28%** vs **15%** for Hackney, **34%** vs **24%** for Tower Hamlets, and **33%** vs **21%** for Waltham Forest).

Figure 9: % of pregnant women with an A&E attendance during pregnancy - by deprivation and borough (2020/21)



Admissions to hospital during pregnancy

Figure 10: % of pregnant women with an admission during pregnancy - by borough (2020/21)

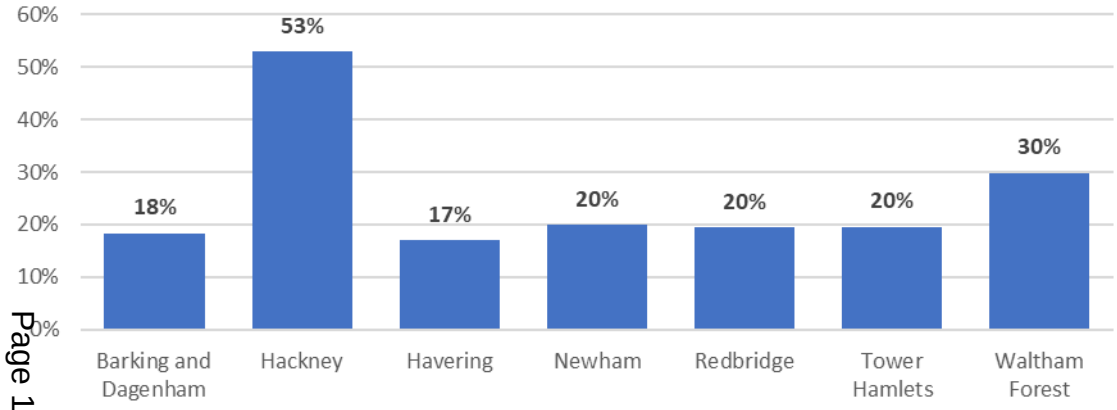
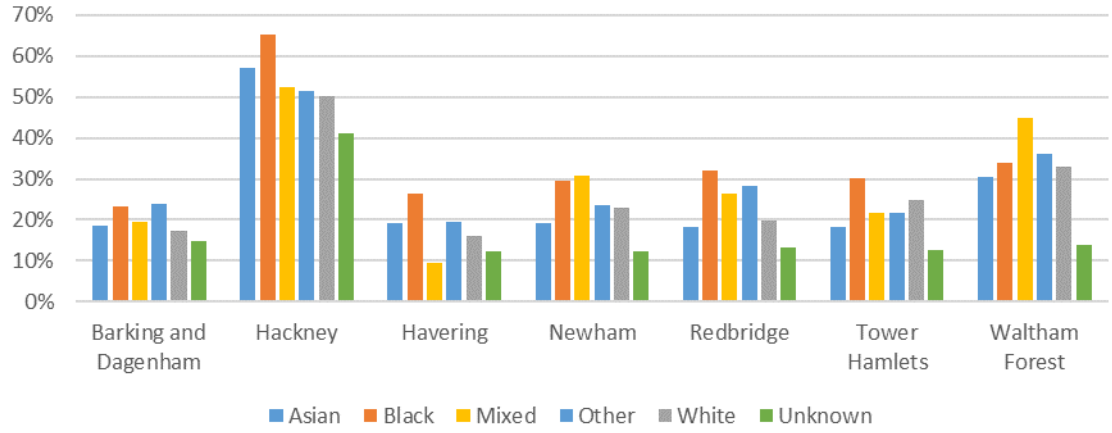


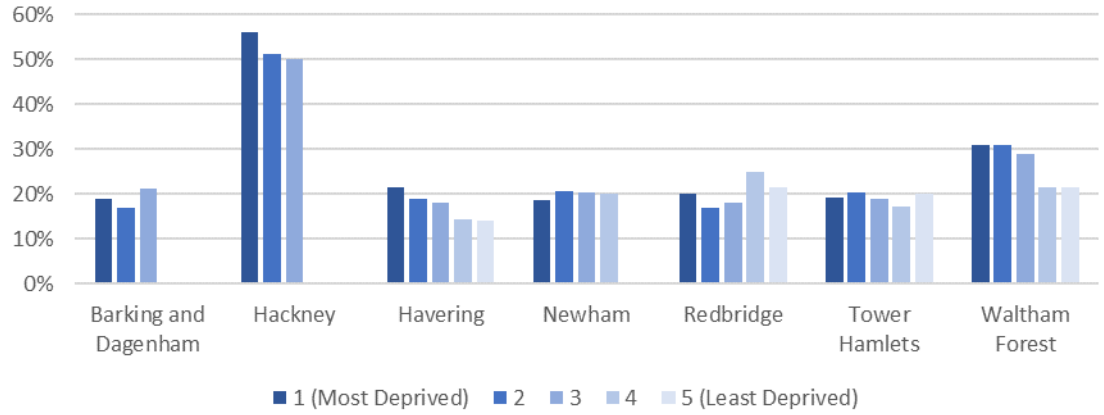
Figure 11: % of pregnant women with an admission during pregnancy - by ethnicity and borough (2020/21)



Key findings

- On average across NEL, **26%** of women that gave birth in 2021 had an admission to hospital during their pregnancy. The main outlier is Hackney at **53%** which is **more than double than** all other boroughs with the exception of Waltham Forest in which the rate is **30%** (and is also still higher than compared with the other five boroughs across whom rates are relatively similar at **18-20%**).
- When looking at differences in ethnicity in NEL, Black women **(38%)** had nearly double the percentage of women admitted to hospital compared to Asian women **(21%)** and **9%** more than White women **(29%).**
- With the exception of Waltham forest, Black women are more likely than White women to be admitted to hospital during their pregnancy across all of the boroughs. Hackney, as well as having the highest overall proportion of women with an admission, has the largest variation between ethnicities with **65%** of Black and **57%** of Asian women having an admission compared with **50%** for White women.
- When looking at differences in deprivation across NEL, the proportion of pregnant women with an admission decreases from the most deprived quintile **(29%)** to the least deprived quintile **(18%).**
- At the borough level, however, the correlation appears to be largest in Hackney, Havering and Waltham Forest – where the difference in rates across the two groups is larger compared with the other boroughs. Of these, Waltham Forest had the largest difference in rates between the most deprived quintiles and the least deprived (**31%** versus **21%).**

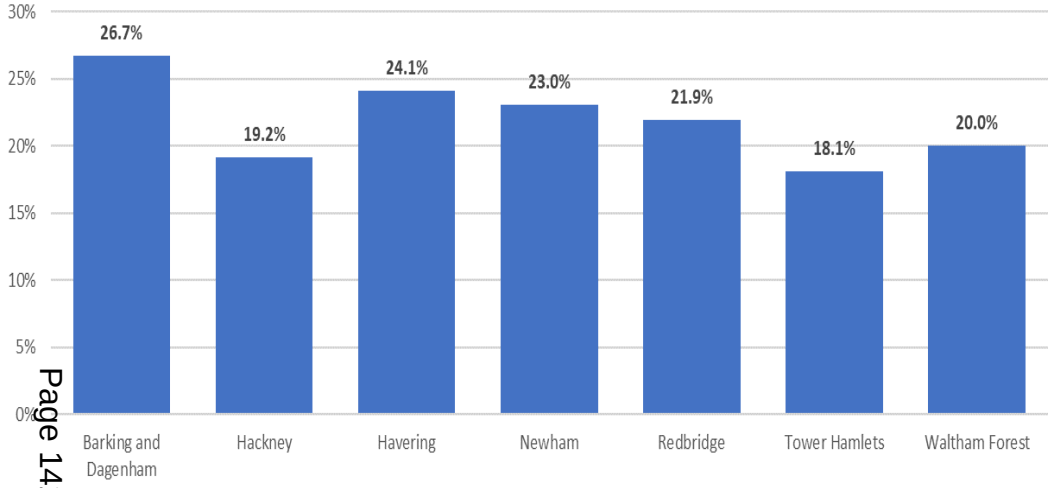
Figure 12: % of pregnant women with an admission during pregnancy - by deprivation and borough (2020/21)



Annex 3 – LTCs and other risk factors during pregnancy

Prevalence of obesity

Figure 1 | % of pregnant women with obesity | rates by Borough | 2020-21



Key findings

- Overall at the NEL level, around a **fifth** of women that gave birth in 2021 are classed as obese. Barking and Dagenham has the highest prevalence rate (**26.7%**) and Tower Hamlets the lowest (**18.1%)**
- On average across NEL, **36.4%** of Black women are obese, which is **twice as high** as the average across White women (**19%).** The difference between White, Asian and Mixed women are relatively less marked.
- At the borough level, Black women also have the highest rates of obesity across every NEL borough with the exception of women of **Mixed ethnicity** in Barking & Dagenham where the rate is as high as **45%**
- Deprivation appears to be a strongly correlated with obesity, with rates among the **most deprived** quintile at **25%** which is **far higher** than among those in least deprived which is **15%** on average. At the borough level, both Having and Newham have **the largest difference** between rates in the most and least deprived group. The difference in Having is **35%** vs **16%** and in Newham it is **26%** vs **13%.**

Figure 2 | % of pregnant women with obesity | rates by borough and ethnicity | 2020-21

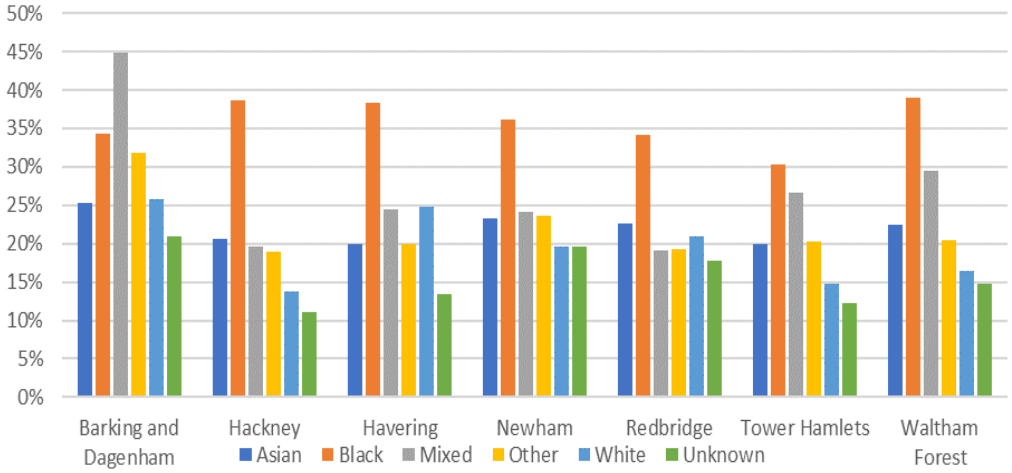
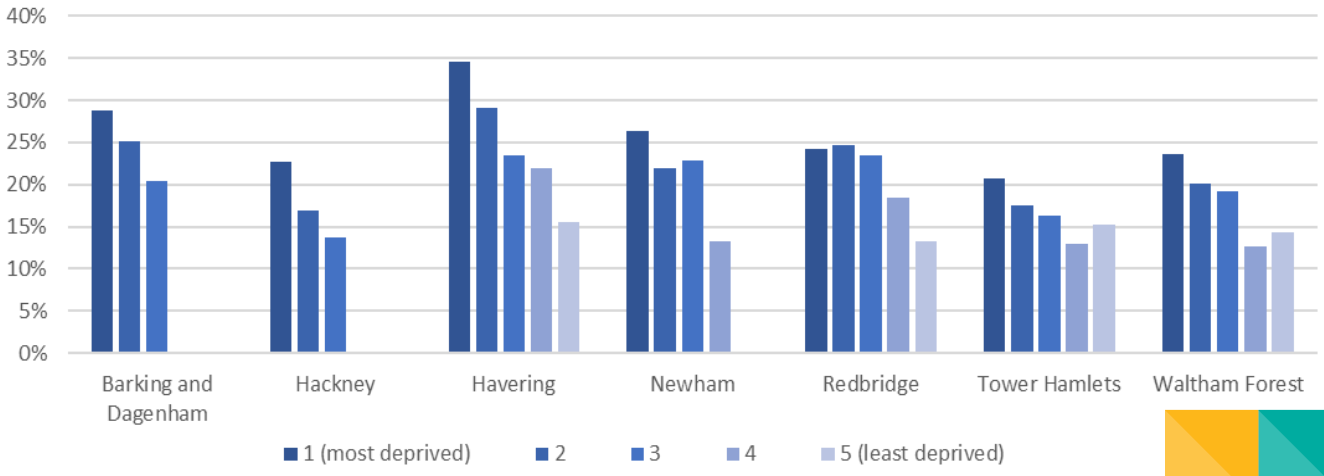


Figure 3 | % of pregnant women with obesity | rates by Borough and Deprivation Quintile | 2020-21



Prevalence of diabetes

Figure 4 | % of pregnant women with diabetes | rates by Borough | 2020-21

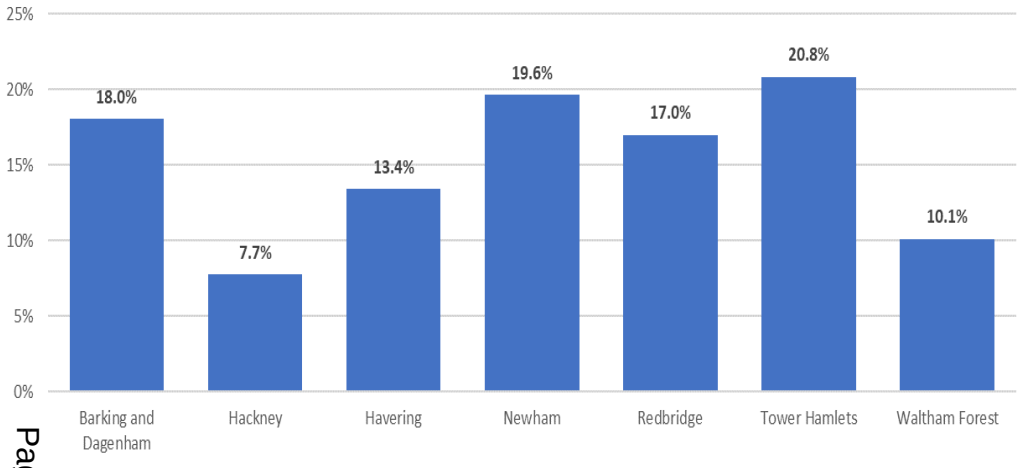
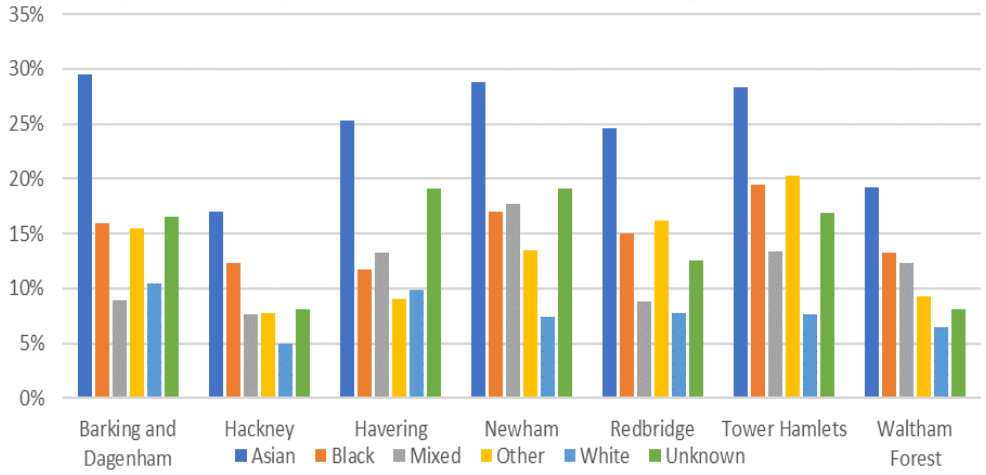


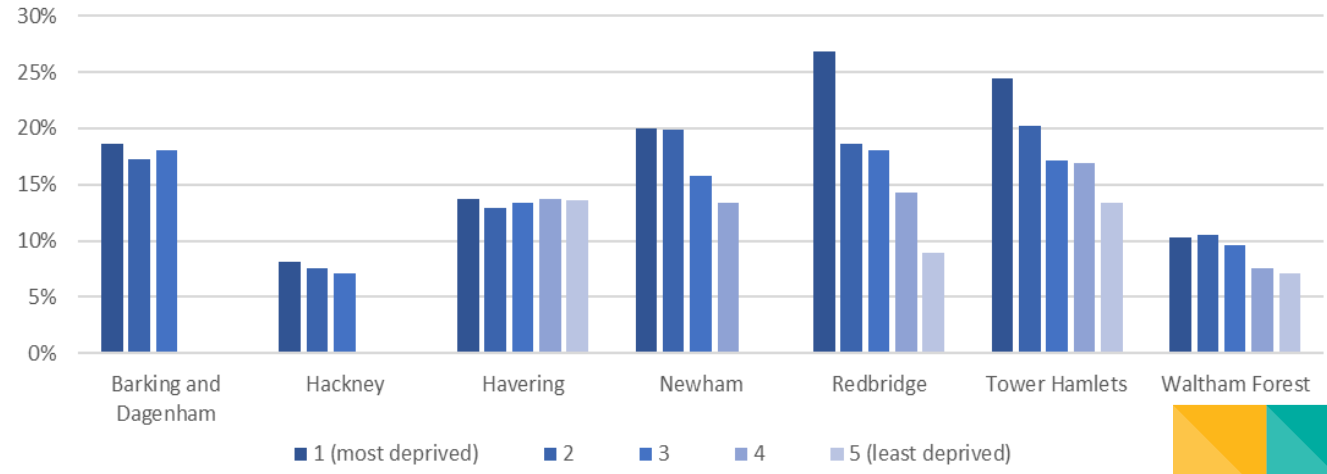
Figure 5 | % of pregnant women with diabetes | rates by borough and ethnicity | 2020-21



Key findings

- This metric combines all diabetes types – i.e. T1, T2 and gestational diabetes
- There is a relatively wide variation in prevalence rates for diabetes across NEL boroughs among women that gave birth in 2021 - ranging from **around 20%** in Tower Hamlets and Newham to as low as **10%** in Waltham Forest and **8%** in Hackney.
- Overall across NEL, there is a large variation across ethnicities with prevalence rates among all ethnic minority groups **much higher than** those among White women. Rates among Asian and Black ethnicities - in particular- are **markedly higher** than for White women. Rates among Asian women are more then **three times higher** than rates among White women (i.e. **26%** compared with **7%)** and **twice as high** among Black women (**15%).**
- There is evidence that Asians may be more predisposed than other ethnicities to becoming diabetic which may – in part – explain this otherwise significant difference. However, the variation is sufficiently large to warrant further analysis .
- Variations between ethnicities looks to be highest within Newham and Tower Hamlets. Prevalence rates among Asian women in these two boroughs are **27-28%** compared with **17-19%** among Black women and **7%** among White women.
- **Deprivation also appears to be strongly correlated** with prevalence rates. Overall across NEL **17%** of women in the most deprived quintile have diabetes compared with **12%** in the least deprived.
- This correlation appears especially strong for Newham, Redbridge and Tower Hamlets where the prevalence rate is between **20-26%** among those in the **most deprived** groups compared with **7-13%** among the **least deprived**.

Figure 6 | % of pregnant women with diabetes | rates by Borough and Deprivation Quintile | 2020-21



Prevalence of epilepsy

Figure 7 | % of pregnant women with epilepsy | rates by Borough | 2020-21

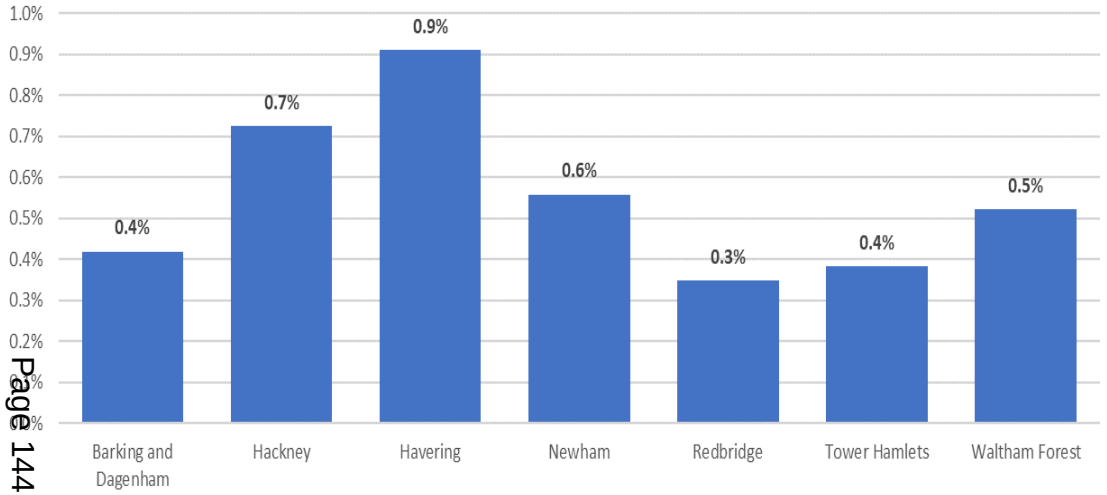
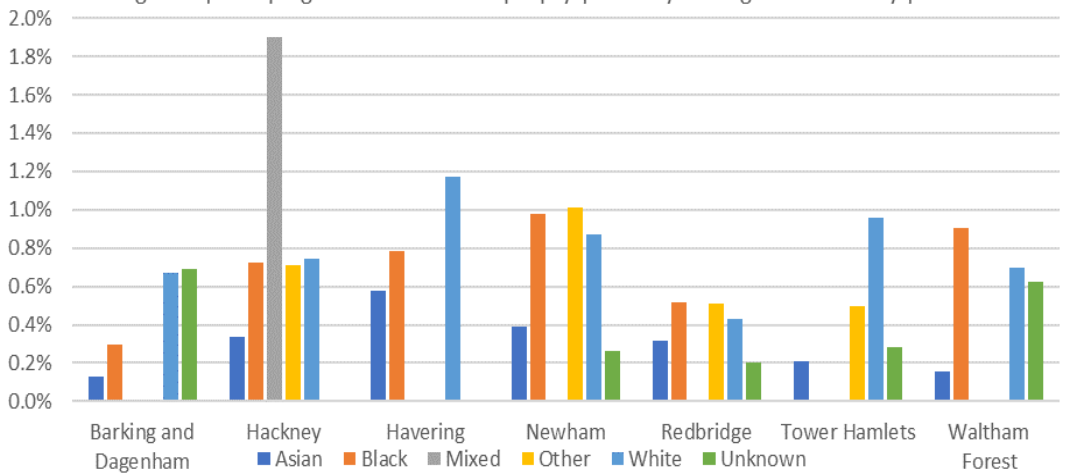


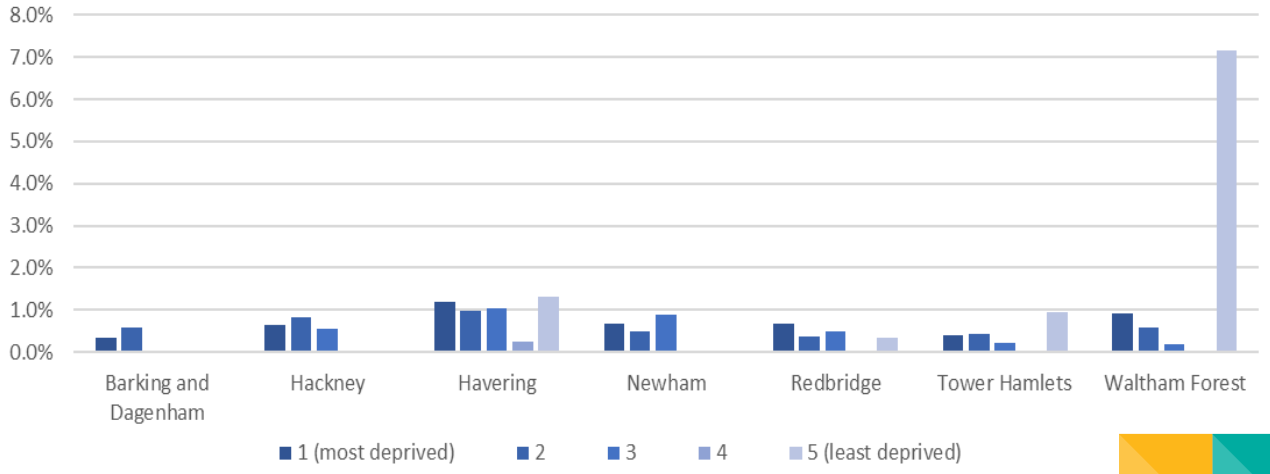
Figure 8 | % of pregnant women with epilepsy | rates by borough and ethnicity | 2020-21



Key findings

- On average across NEL, prevalence rates among women that gave birth in 2021 are very low across all NEL boroughs - at less than **1%.** There is, however, large variation at the borough level with Havering and Hackney with the highest rates at **0.9%** and **0.7%** respectively which is over **twice the rate** in other boroughs including Redbridge and Tower Hamlets.
- Overall, prevalence across Asian, Black and White women are **very similar** with rates among White slightly higher (**0.5% 0.5%** and **0.6%** respectively) and unlikely to be statistically significant.
- Only Hackney appears to have women of Mixed ethnicity with epilepsy giving birth that year and this group also has the highest recorded rate at the borough level at **1.9%.**
- Deprivation appears to have a stronger relationship with prevalence rates with rates among women in the **least deprived** areas **six times higher** than those in the least deprived (i.e**. 0.6%** versus **0.1%).**
- **The relatively small overall numbers for this indicator means the above findings should be treated with caution because a small degree of 'random' variation in the data can have a disproportionate impact on the observed finding/trend.**

Figure 9 | % of pregnant women with epilepsy | rates by Borough and Deprivation Quintile | 2020-21



Prevalence of hypertension

Figure 10 | % of pregnant women with hypertension | rates by Borough | 2020-21

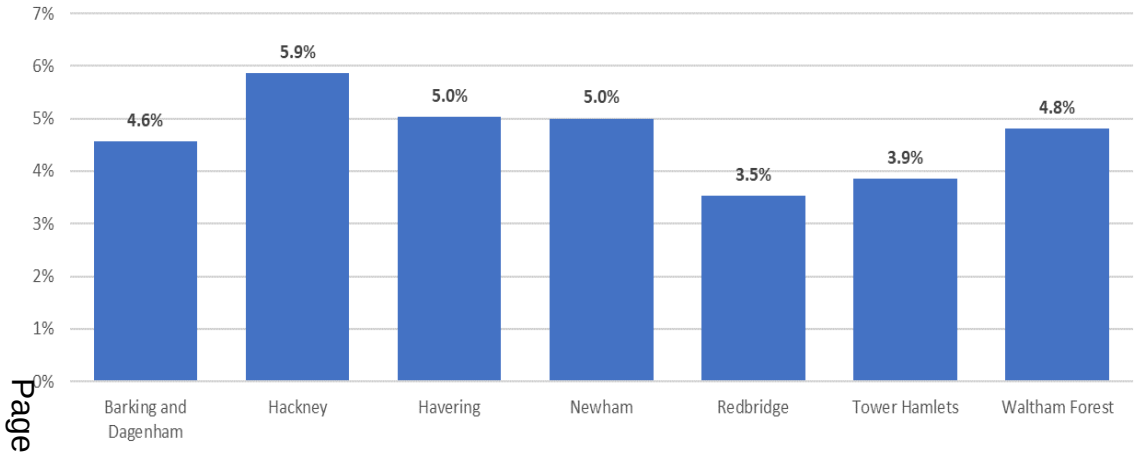
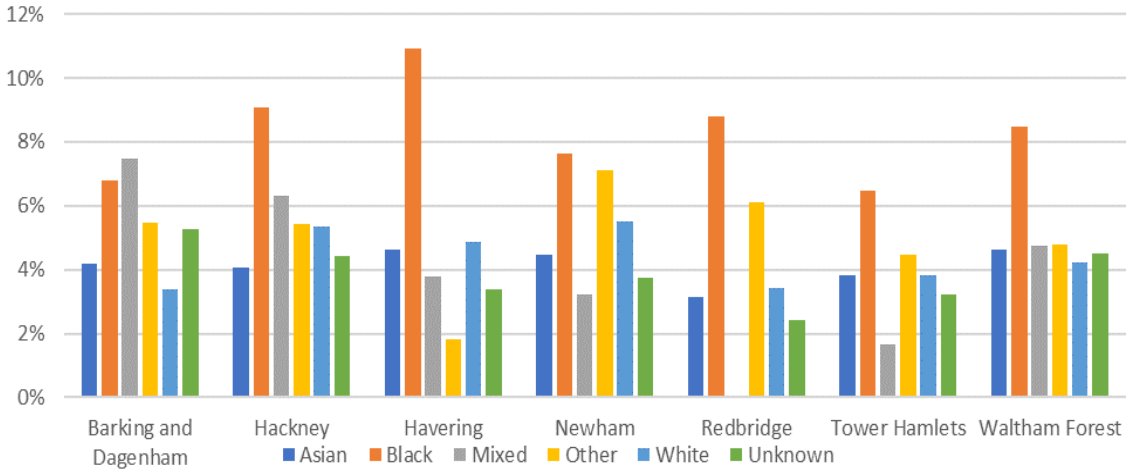


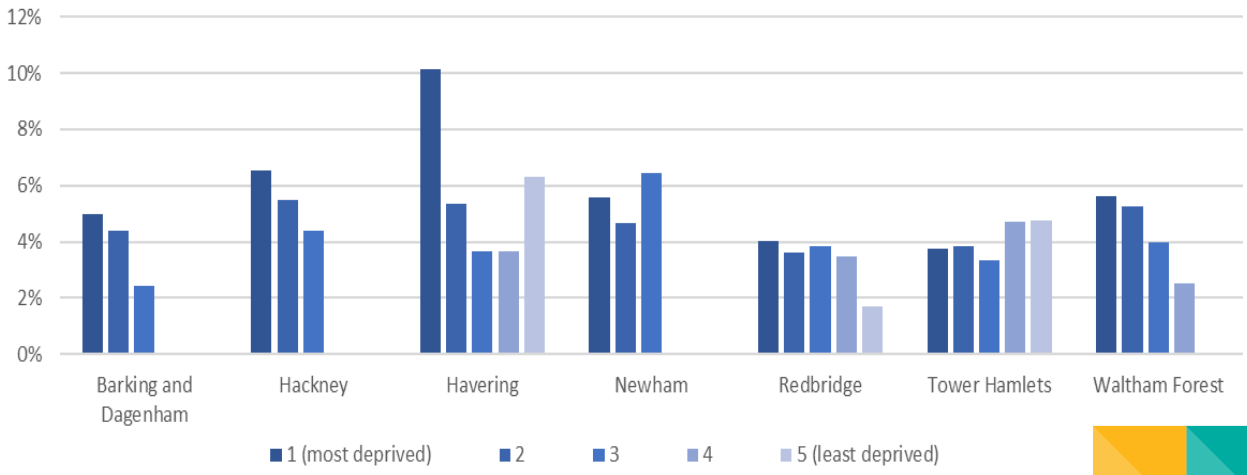
Figure 11 | % of pregnant women with hypertension | rates by borough and ethnicity | 2020-21



Key findings

- On average, the rate of hypertension across the majority boroughs is around **5%. Hackney** has highest prevalence (**6%)** and **Redbridge lowest (3.5%)**
- Across NEL, the prevalence rate among Black women is **higher** compared with all other ethnicities. On average **8%** of Black women that gave birth in 2021 have hypertension compared with **5%** among White women. This disparity is a trend across all 7 NEL boroughs. In Havering, the prevalence among Black women is by far the highest at **11% and is more than double the rate** among White women **(5%)**
- In contrast, the average rates at the NEL level among women in other ethnic minority groups are **relatively similar** with those among White women (i.e. **4-5%** compared with **5%).**
- On average across NEL deprivation does not appear to be strongly correlated with prevalence rates – with the average prevalence at **4-5%** of women across all quintiles. However, the **very high prevalence** rate among women in Waltham Forest living in the least deprived areas **(at 11%)** is skewing this average as for some boroughs the data does suggest high levels of deprivation may be a key factor. Havering, for example, has the largest variation – with **10%** of women in the most deprived having epilepsy compared with **6%** in the least deprived areas. Similarly, in Redbridge the rate drops from **4%** in the most deprived areas to **1.7%** in the least.

Figure 12 | % of pregnant women with hypertension | rates by Borough and Deprivation Quintile | 2020-21



Folic acid status

Figure 13 | Folic acid status | rates by Borough | 2020-21

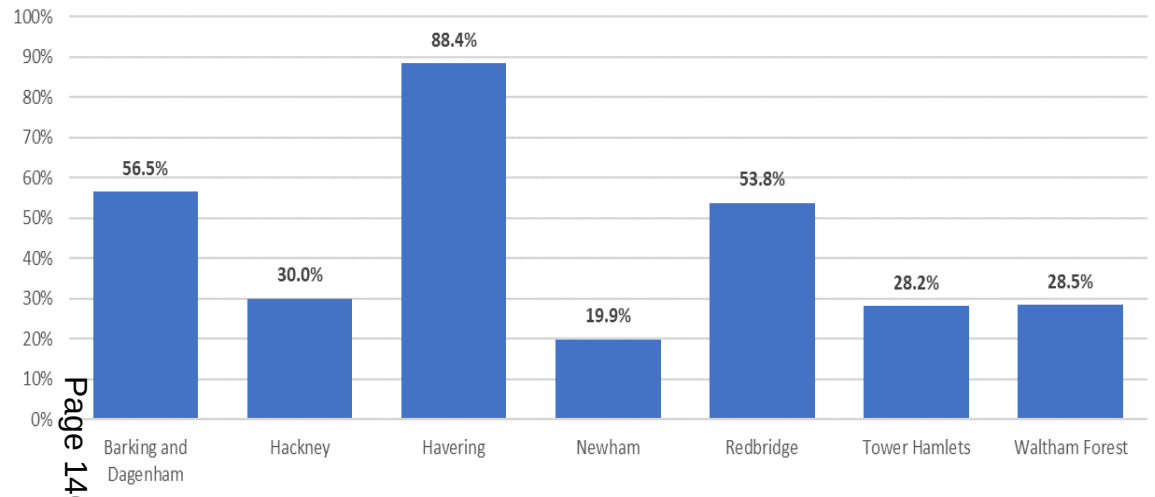
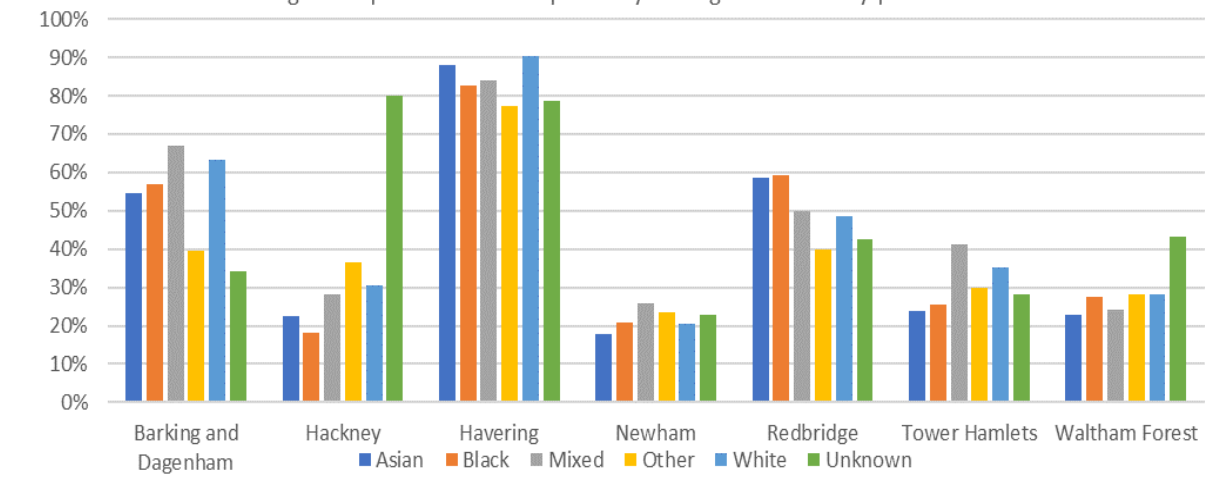


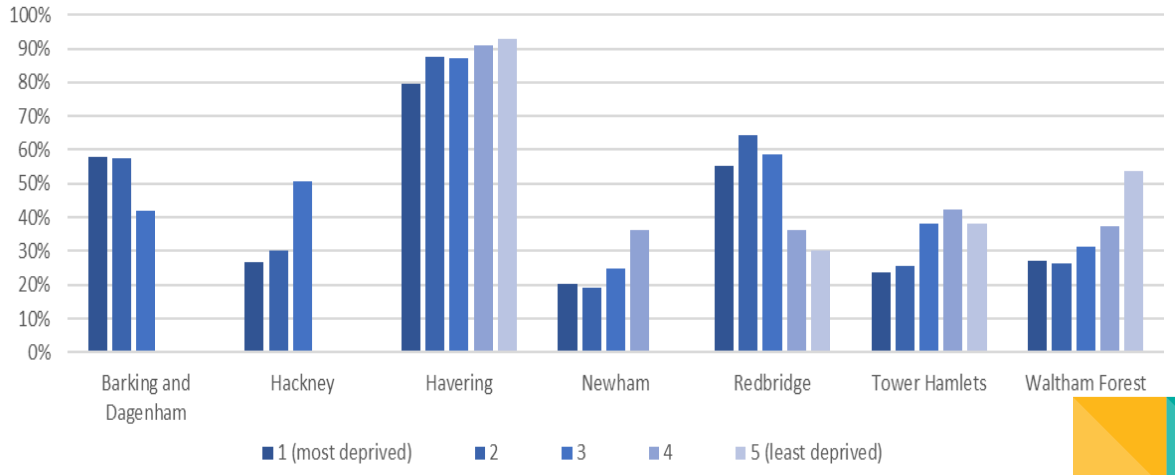
Figure 14 | Folic acid status | rates by borough and ethnicity | 2020-21



Key findings

- This relates to the prevalence of women that are know to have been taking Folic acid supplements in early pregnancy.
- Overall, there is a lot of variation across NEL boroughs. The proportion of women with a (good) folic acid status is highest in Havering at **88%** and is **substantially higher** than the rates across the others which vary between **20%** in Newham and **57%** in Barking and Dagenham.
- On average across NEL, the rate among White women is relatively higher than those among both Asian and Black women (i.e. **44%, 37% and 37%** and respectively). While this difference is perhaps not as large as those observed for other indicators, it is known to have a direct link on outcomes for babies.
- On average across NEL, deprivation appears to be **more closely correlated** with the likelihood of women having a (good) folic acid status. On average across NEL, the rate among women in the l**east deprived** quintile is **67%** which is **almost twice as high** as for those in the **most deprived quintile** (**36%).** This closely linked correlation may – in part – be explained by the cost associated with taking folic acid supplements for which women in the least deprived areas may be more able to afford.

Figure 15 | Folic acid status | rates by Borough and Deprivation Quintile | 2020-21



Prevalence of complex risk factors

Figure 16 | Complex social factors indicator | rates by Borough | 2020-21

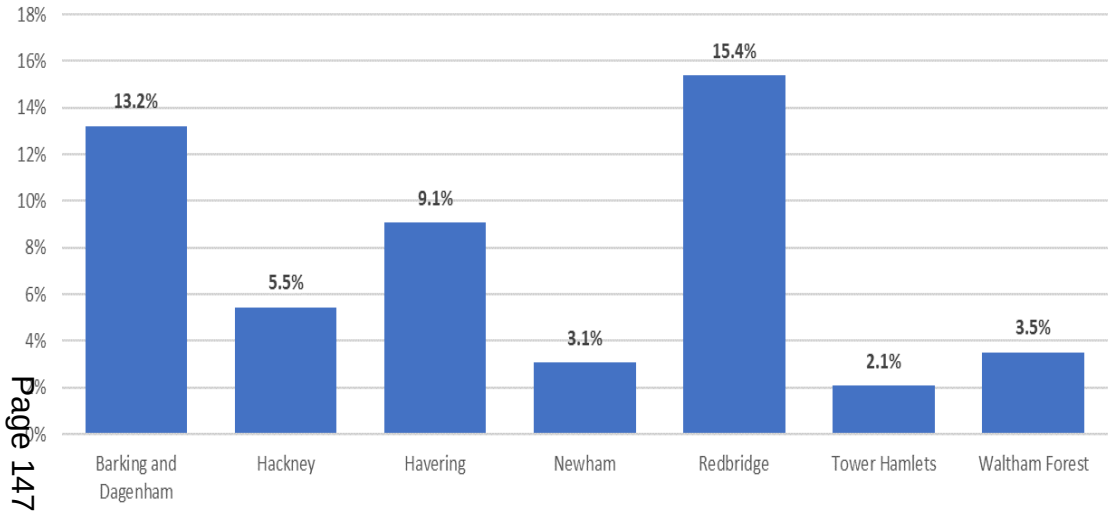
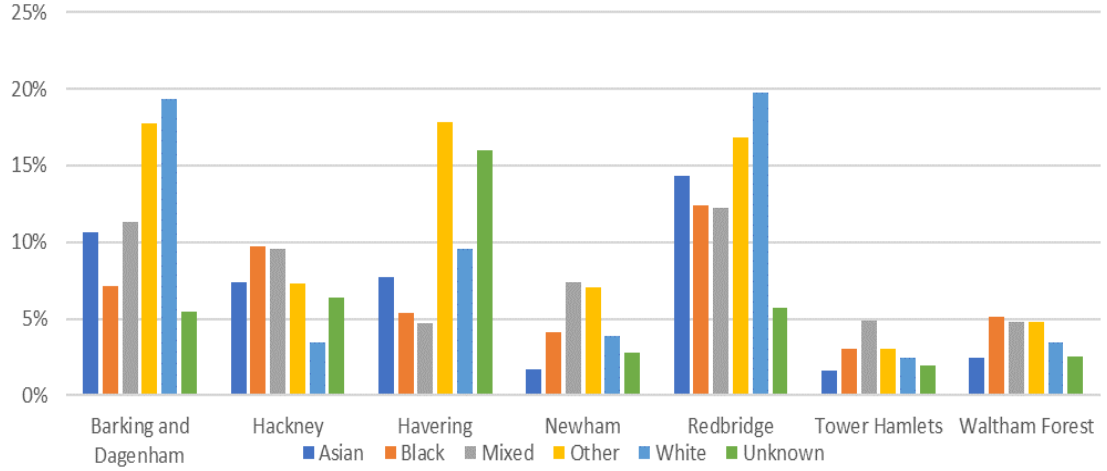


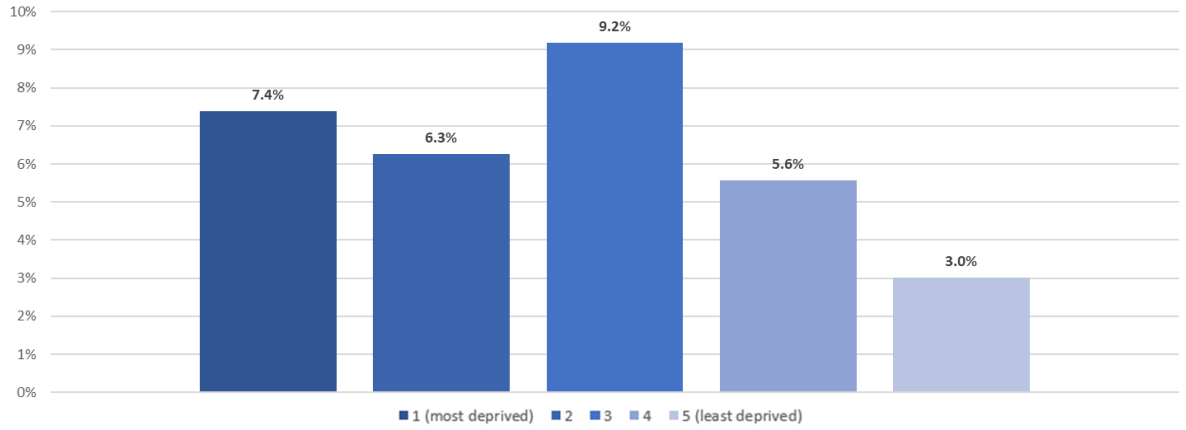
Figure 17 | Complex social factors indicator | rates by borough and ethnicity | 2020-21



Key findings

- Midwifes record whether one or more 'social complex' factors are present. This list both large and varied and includes, for example women who are aged under 20, experience domestic abuse, misuse substances, or recent migrants for example (see slide **87** for the complete list).
- **Redbridge** (**15.4%)** and **Barking & Dagenham** (**13.2%)** have much higher rates of women that gave birth in 2021 having complex social factors, with the rate in **Tower Hamlets (2.1%)** being the lowest.
- On average, the proportion of White women with complex social factors (**8%)** is either **very similar** or even **slightly higher** than compared with all ethnic minority groups **(6-8%)** with the exception for women of Other ethnicity **(9%).**
- This, however, masks a lot of variation both across and between boroughs – particularly in Redbridge and Barking and Dagenham in which the rates among White women are **much higher** than for ethnic minority groups. In Barking and Dagenham for example, the rate among White women is **19%** compared with **7-10%** for Black and Asian women.
- On average across NEL, deprivation appears to be closely correlated with this indicator with women in the least 40% having had much lower rates than the most deprived 60% (i.e. **5%** compared with **8%)**
- **Given the range of factors included in this list, there is potentially high risk of this metric being interpreted differently by Midwives both within and between boroughs. Without further information on local recording practices for this metric, this risk around consistency of recording means that the findings above should be treated with caution**

Chart 18 | Complex social factors indicator | rates by IMD 2019 Deprivation Quintile | 2020-21



Disability status

Figure 19 | % disabled | rates by Borough | 2020-21

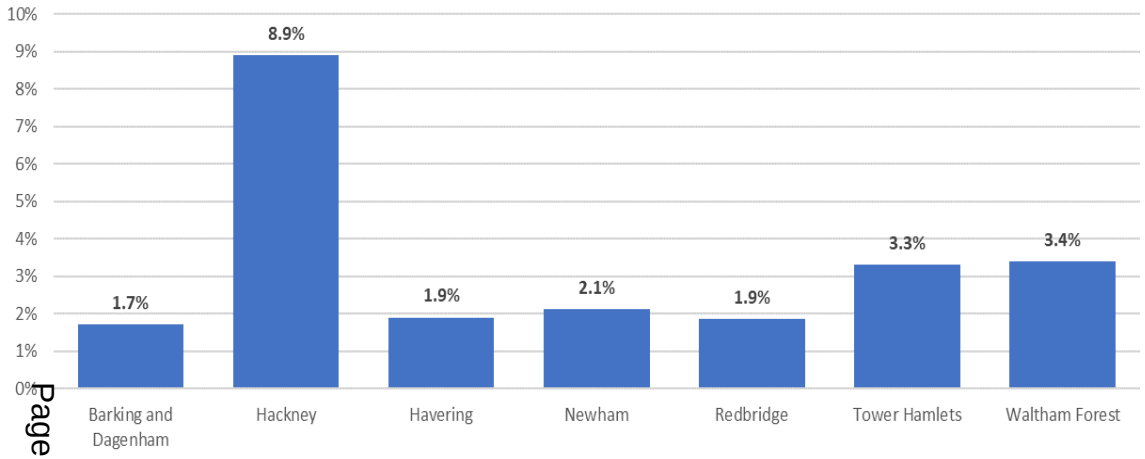
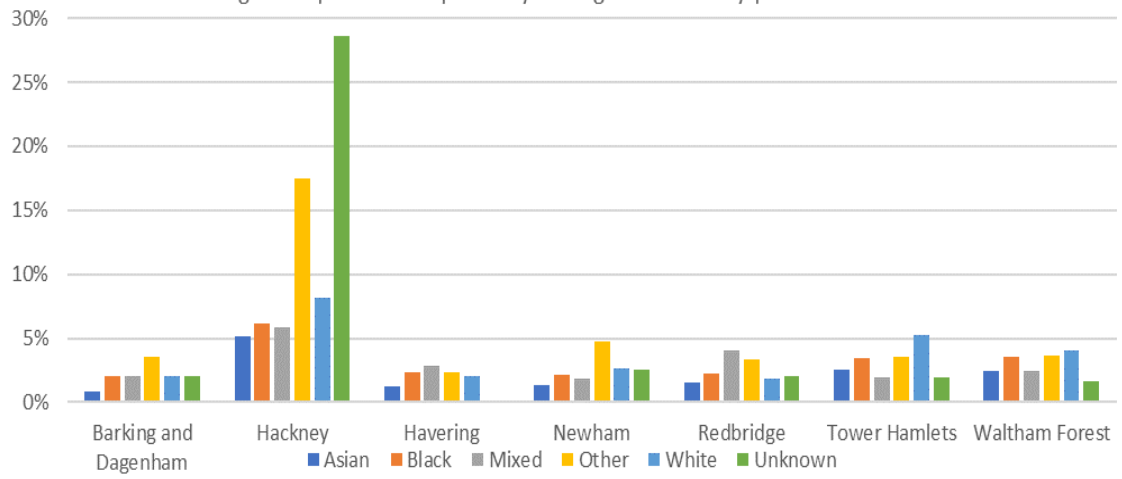


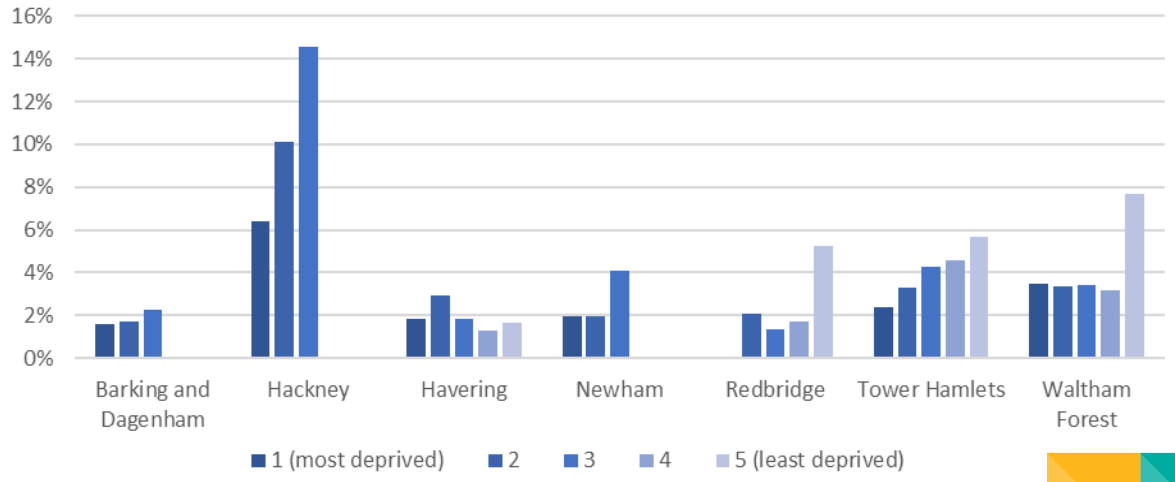
Figure 20 | % disabled | rates by borough and ethnicity | 2020-21



Key findings

- Across the NEL boroughs between **2-3%** of women that gave birth in 2021 are disabled. The notable exception is Hackney, with **9%** of women having a disability – which is more **than three times** the rate across most of the other boroughs.
- On average, the rate of disability tends to be **higher** for White women than for women in most ethnic minority groups (i.e. 4% for White women compared with **2-3%** across Black, Asian and Mixed women). The exception is women in the **Other** ethnicity group for whom the average rate is **7%** - however, this average rate is heavily skewed by Hackney in which the rate for this group is exceptionally high relative to all other ethnicities at **18%.** This variance warrants further analysis.
- As with ethnicity, deprivation does not appear to be highly correlated to disability rates, with the average rate for women in the most deprived area the same as for those in the least deprived (i.e. **3%** across both)

Figure 21 | % disabled | rates by Borough and Deprivation Quintile | 2020-21



Employment status

Figure 22 | % unemployment or long term sick or disabled | rates by Borough | 2020-21

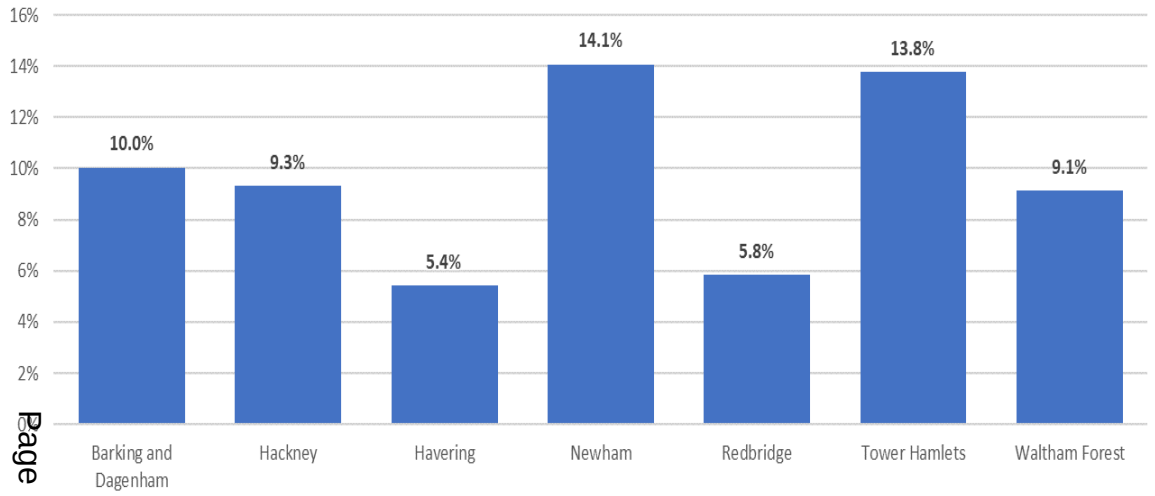
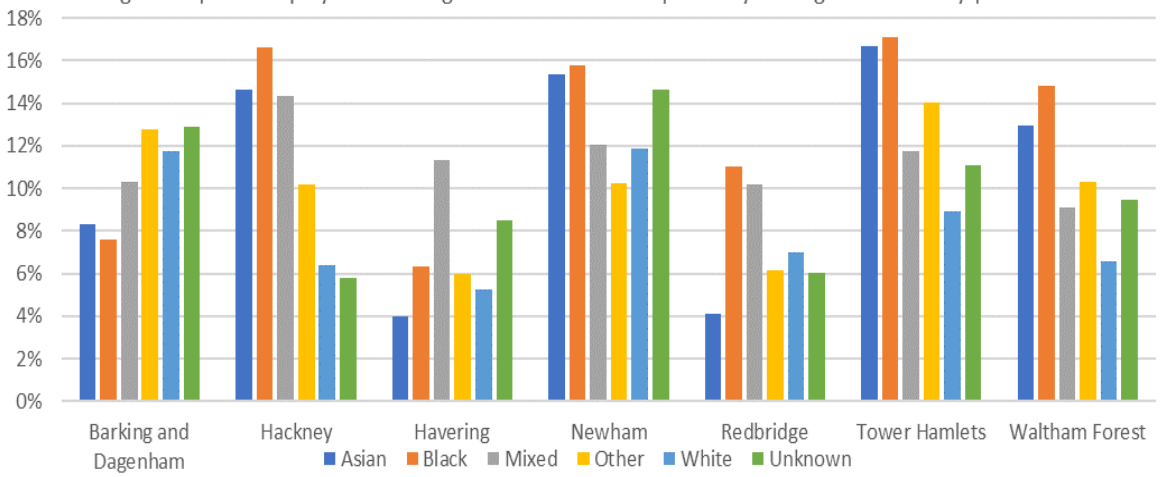


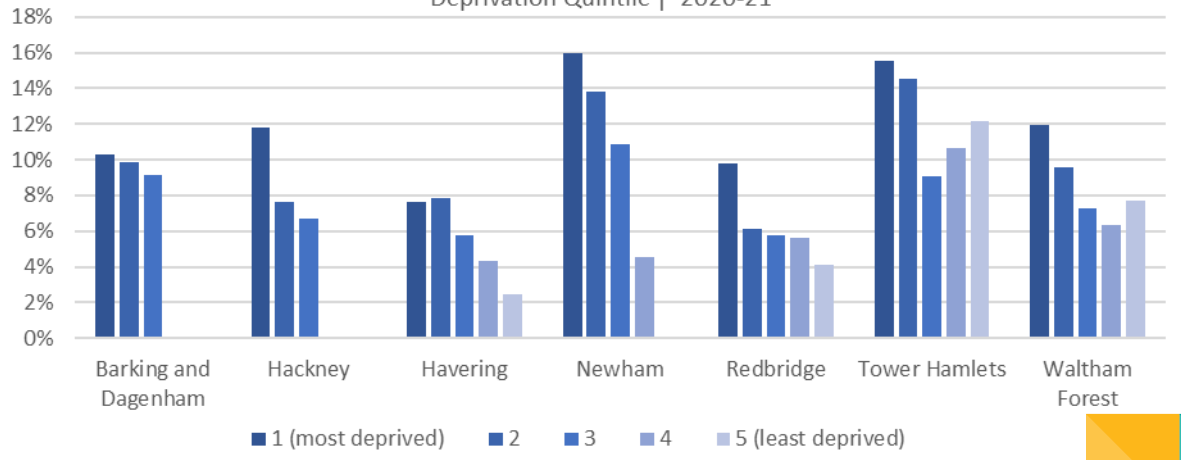
Figure 23 | % unemployment or long term sick or disabled | rates by borough and ethnicity | 2020-21



Key findings

- This indicators shows the rate among women that gave birth in 2021 who are not in employment, due to unemployment, long term sickness or disability.
- Overall, Newham and Tower Hamlets have a much higher proportion of women not in employment. Both have rates at **14%** which are **more than twice** the rate in Havering and Redbridge at **5%** and **6%** respectively.
- On average, **a higher proportion** of women in ethnic minority groups are not in employment compared with White women (i.e. **10-13%** across ethnic minority groups compared with **8%).** On average, the rate is highest among Black women at **13%.**
- Hackney and Tower Hamlets have the **largest relative difference** in rates between Asian and Black women compared with White women. In Hackney, for example**, 14%** of Asian Women and **17%** of Black women are not in employment which is at least **twice the rate** as that for White women at **7%**.
- As expected, deprivation appears to be strongly linked to the likelihood of being out of employment with **13%** of women **in** the most deprived areas not being in employment compared with **4%.**

Figure 24 | % unemployment or long term sick or disabled | rates by Borough and Deprivation Quintile | 2020-21



Annex 4 – Delivery methods

Vaginal Births

Figure 1 | % of vaginal deliveries | rates by Borough | 2020-21

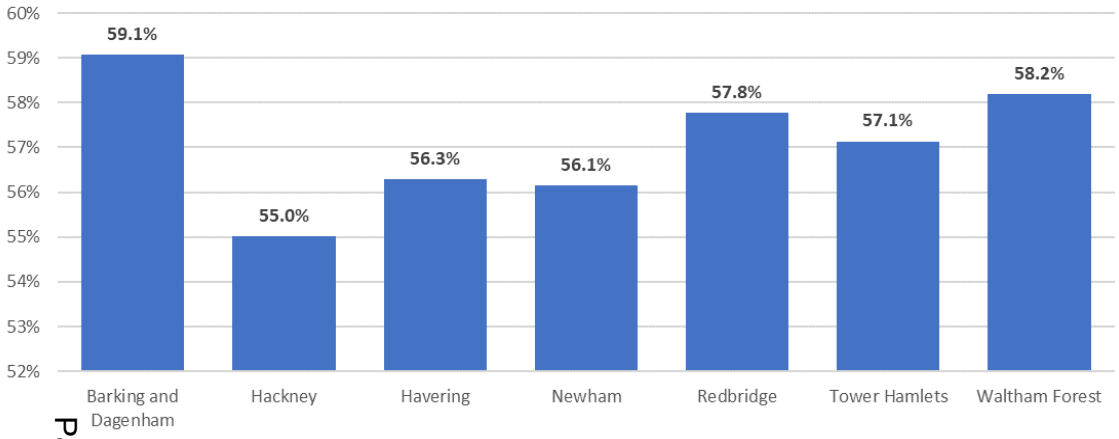
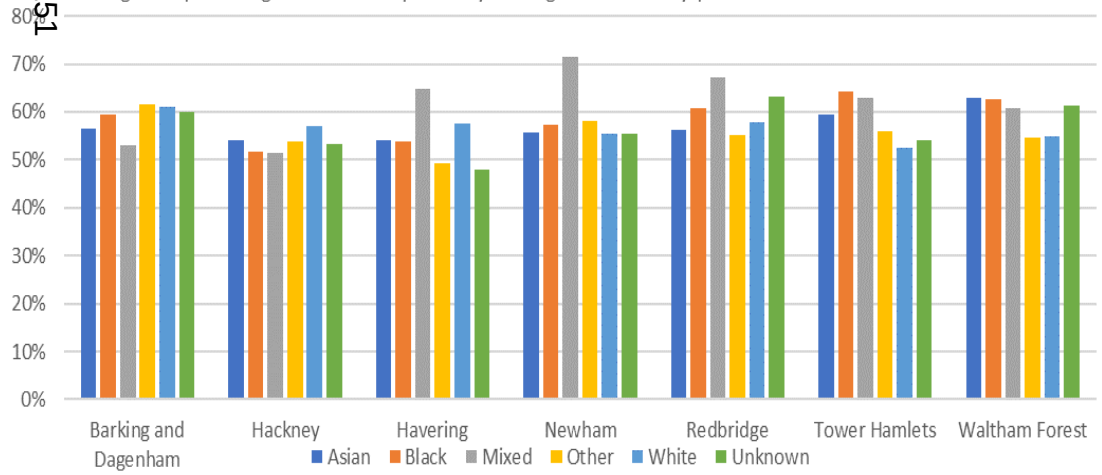


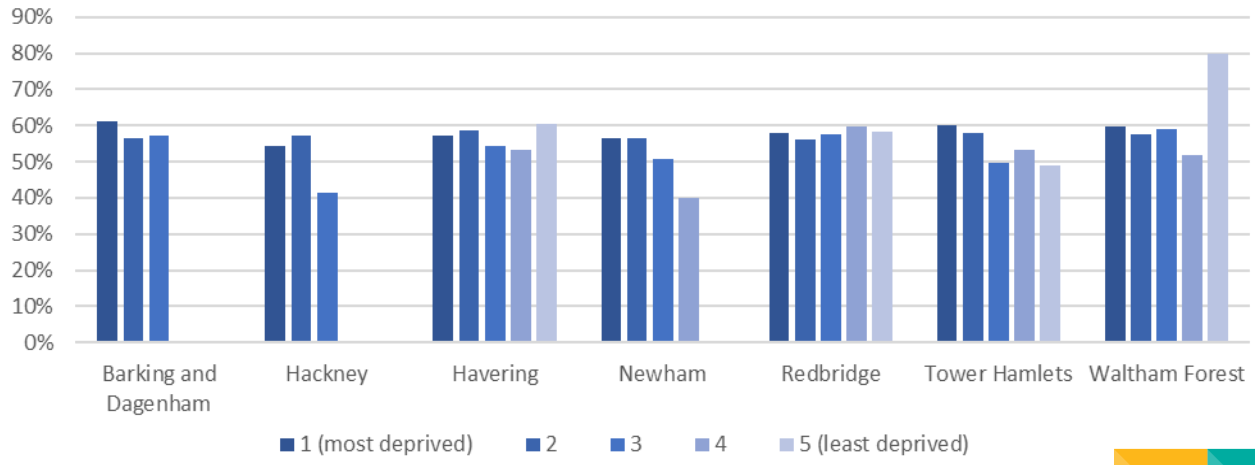
Figure 2 | % of vaginal deliveries | rates by borough and ethnicity | 2020-21



Key findings

- This includes (a) spontaneous Vertex and (b) Spontaneous Other Cephalic births.
- Overall, just over half of the women across of the NEL boroughs that gave birth in 2021 had a vaginal delivery. The variance across individual boroughs is relatively low with the lowest rate in Hackney (**55%)** and the highest in Barking & Dagenham **(59%).**
- Across and between boroughs, the rates for Asian, Black and White women are **relatively consistent** at approximately **57%.** While the average for Mixed women across NEL is only slightly higher at **59%,** the rate among this group this markedly higher than in any other ethnicity in three of the boroughs: Newham **(71%),** Redbridge **(67%)** and Havering **(65%)**
- There does not appear to be a strong link to deprivation, with the average NEL rate among women in the most deprived areas at **58%** being comparative for those in the least deprived (**58%).** At the borough level, the main outlier is Waltham Forest in which **60%** of women in the least deprived area had a vaginal birth compared with **80%** among those in the least deprived.

Figure 3 | % of vaginal deliveries | rates by Borough and Deprivation Quintile | 2020-21



Forceps births

Figure 4 | % of forceps deliveries | rates by Borough | 2020-21

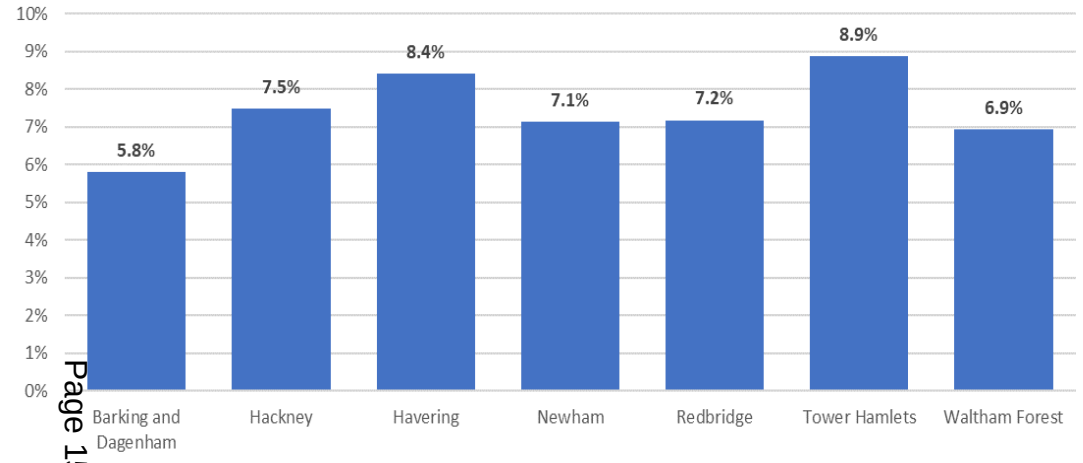
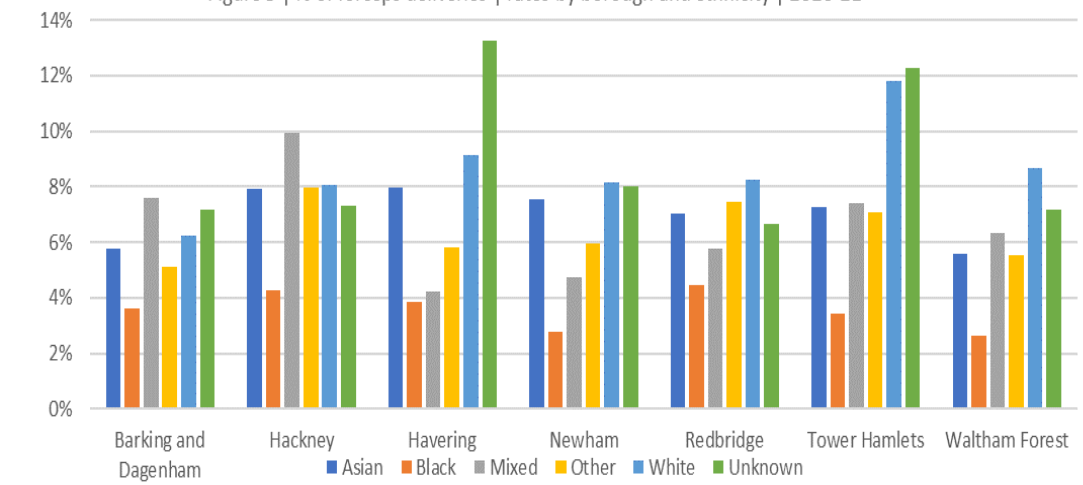


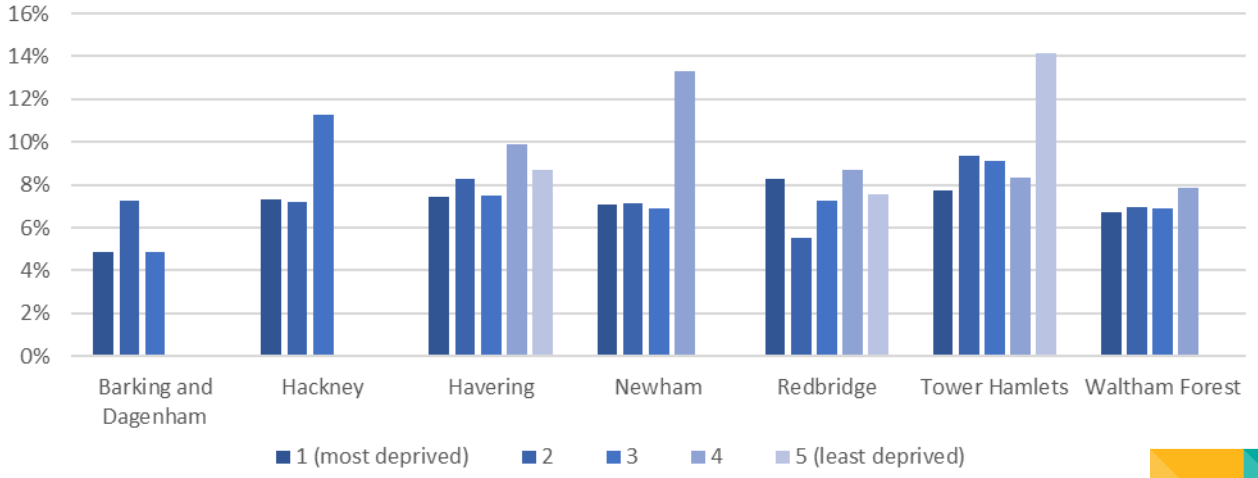
Figure 5 | % of forceps deliveries | rates by borough and ethnicity | 2020-21



Key findings

- On average across NEL, **7%** of women that gave birth in 2021 did so via forceps although this ranges from **9%** in and Tower Hamlets to **6%** Barking & Dagenham.
- On average across NEL, White women are **2 times as likely** to deliver via forceps compared to Black women **(i.e. 8% versus 4%).** In contrast the average rates among Asian **(7%)**, Mixed **(7%)**, Other **(7%)** and White **(8%)** women are relatively similar. These patterns at the NEL level are relatively consistent at the borough level – with no major outlier boroughs.
- There appears to be a relatively small correlation with deprivation with **7%** of women in the most deprived areas giving birth in this way compared with **9%** for those in the least deprived. At the borough level, however, there are two key outliers: Newham and Tower Hamlets where the rate for those the **least** deprived areas are almost twice as high as for those in the **mos**t deprived.

Figure 6 | % of forceps deliveries | rates by Borough and Deprivation Quintile | 2020-21



Unplanned C-Sections

Figure 7 | % of unplanned C section deliveries | rates by Borough | 2020-21

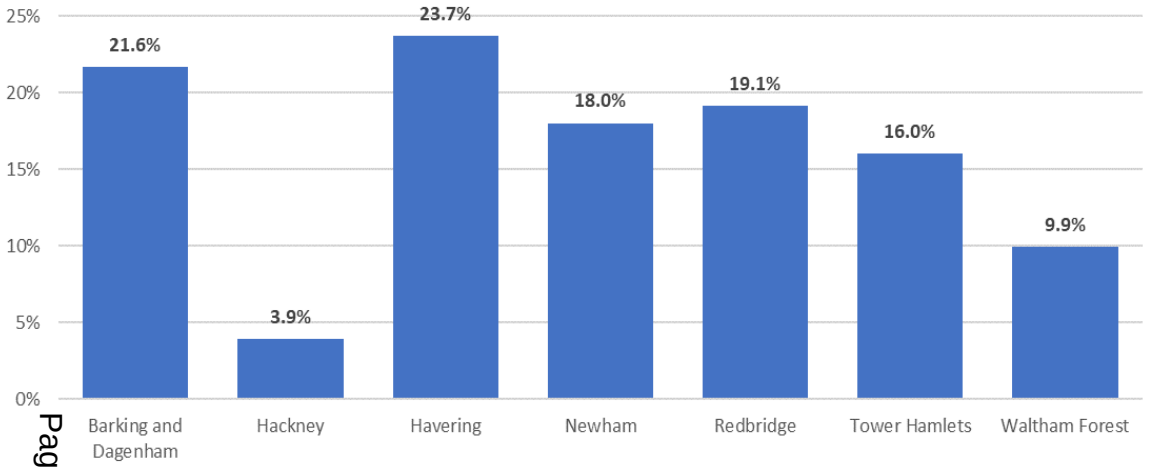
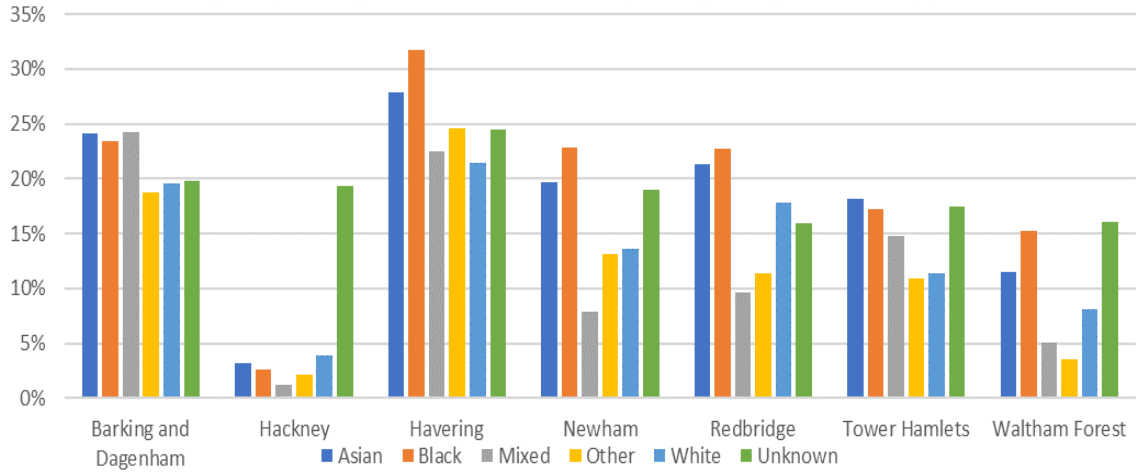


Figure 8 | % of unplanned C section deliveries | rates by borough and ethnicity | 2020-21



Key findings

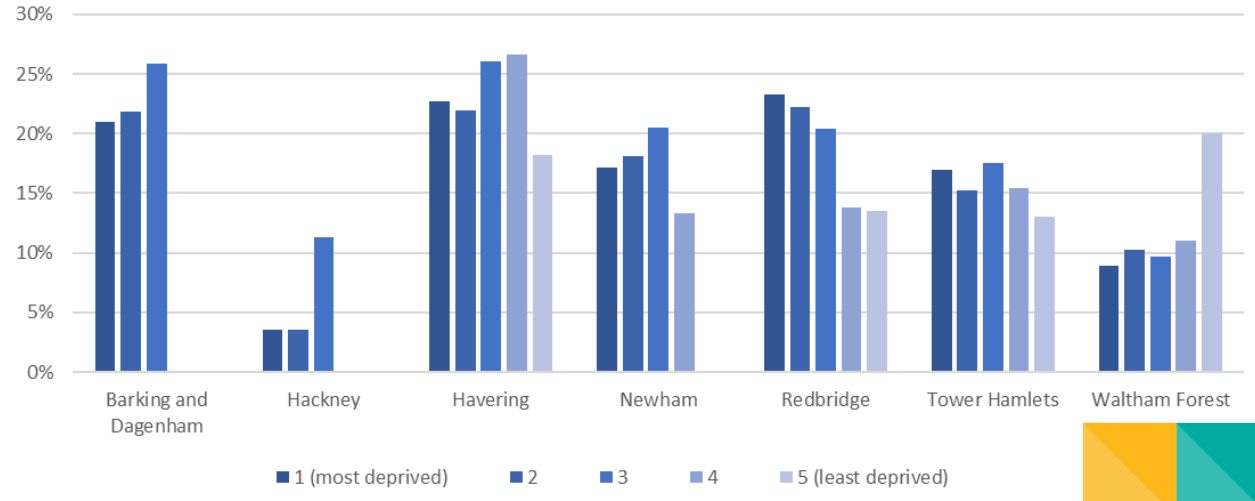
- Overall, there is a lot of variation in the rate of women having unplanned C-sections of those that gave birth in 2021. Two boroughs had over a **fifth** of women giving birth in this way: Baking and Dagenham (**22%)** and Havering **(24%)** compared with **10-19%** across Newham, Tower Hamlets and Waltham Forest. Hackney is the main outlier with a substantially smaller rate **at 4%.**

- On average across NEL, Asian women **are twice as likely** as Mixed or Other women to have an unplanned C-section (**19**% compared with **9%)** and are also more likely than White women to give birth in this way **(13%) .** On average, Black women are also more likely than White women (and compared with other non-Asian ethnicities) to have an unplanned C-section **(i.e. 18%** compared with **13%).**

- At the borough level, differences between rates for Asian and Black women compared with White women are largest in Newham, Havering and Redbridge**.** In Newham, for example, the rate among Black and Asian women is **23%** and 20**%** compared with 14% for White women. Similarly, the rate among Black and Asian women in Redbridge is **21%** and **23%** compared with **18%** for White women. In Havering, the rate among Black and Asian women is **32%** and **28%** compared with **22%** for White women

- At the NEL level, deprivation seems to be much correlated to rates of un-planned C-sections than ethnicity**,** with less deprived areas having only slightly higher rates than those in the least deprived (i.e. **15%** compared with **16**%). At the borough level both Redbridge and Waltham Forest are the main outliers. In Waltham Forest, for example, just under **10%** of those in the **most** deprived areas had an unplanned C-section compared with **20%** among those in the least deprived. The finding is reversed for Redbridge, however, in which the rate is **23%** among women in the **most** deprived areas compared with 14% in the **least** deprived.

Figure 9 | % of unplanned C section deliveries | rates by Borough and Deprivation Quintile | 2020-21



Planned C-Sections

Figure 10 | % of planned C section deliveries | rates by Borough | 2020-21

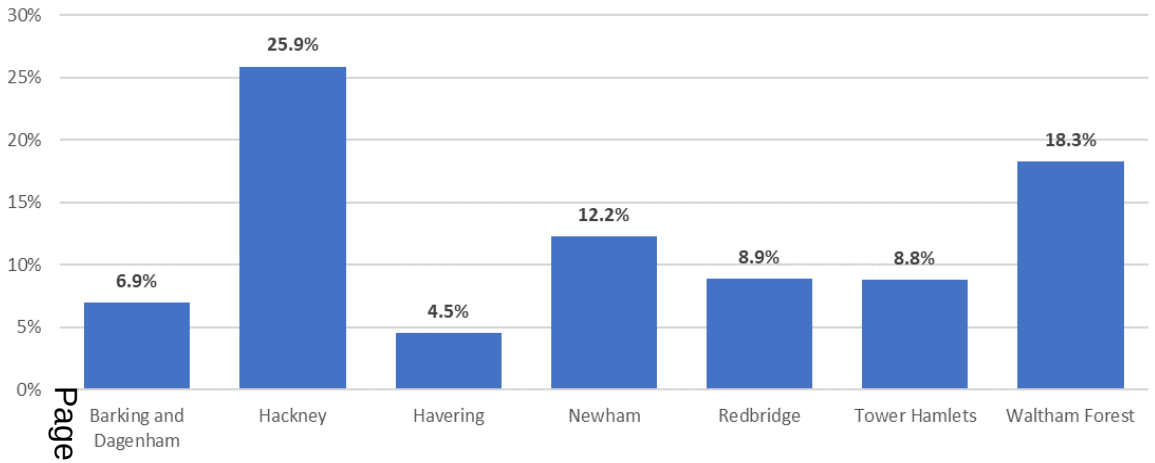
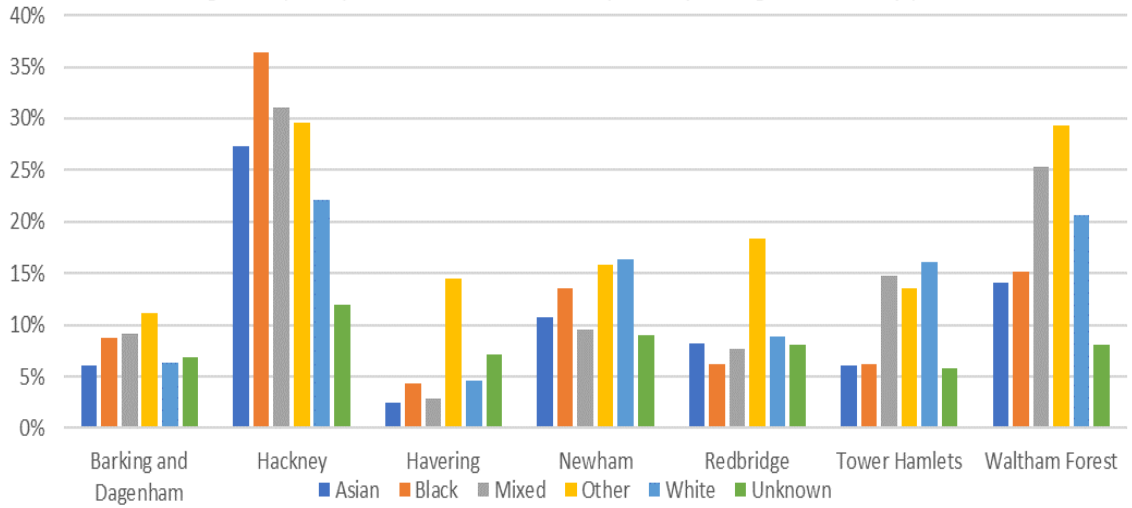


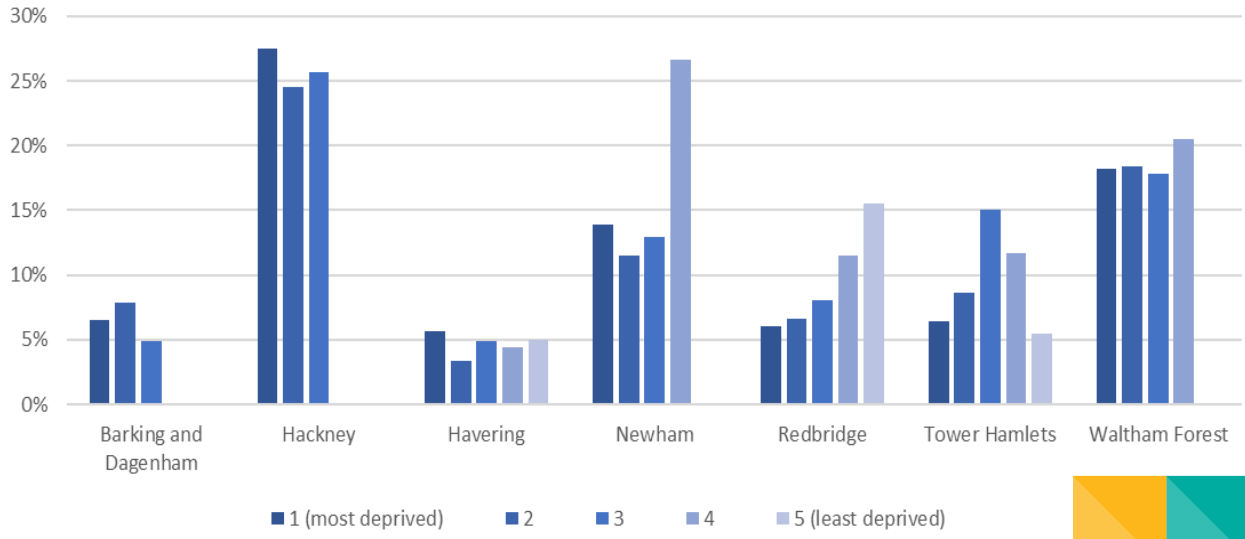
Figure 11 | % of planned C section deliveries | rates by borough and ethnicity | 2020-21



Key findings

- As with unplanned C-sections, there is a lots of variation across boroughs and this appear to be closely linked to rates of unplanned C-sections. Those boroughs that have the **highest rates** of unplanned C-sections (i.e. Barking and Dagenham, Havering and Redbridge) also have the **lowest rates** of planned-C-section (i.e. at **7%, 5%** and **9%** respectively). Similarly, Hackney - who by far had the **lowest rate** of unplanned C-section compared with all other NEL boroughs - also has the **highest planned** C-section rate by far – with a **quarter of women** giving birth in this way.
- On average across NEL, Black and Mixed women have the highest rates at **16**% and **18%** respectively and higher than the rate for both Asian and White women which are **9%** and **14%** respectively.
- The differences are, however, being driven largely by the relatively large disparities between ethnicities in Hackney in particular where **37%** of Black women and **30%** of Asian Women have both via planned C-section compared with **22%** among White women.

Figure 12 | % of planned C section deliveries | rates by Borough and Deprivation Quintile | 2020-21



Ventouse deliveries

Figure 13 | % of planned C section deliveries | rates by Borough | 2020-21

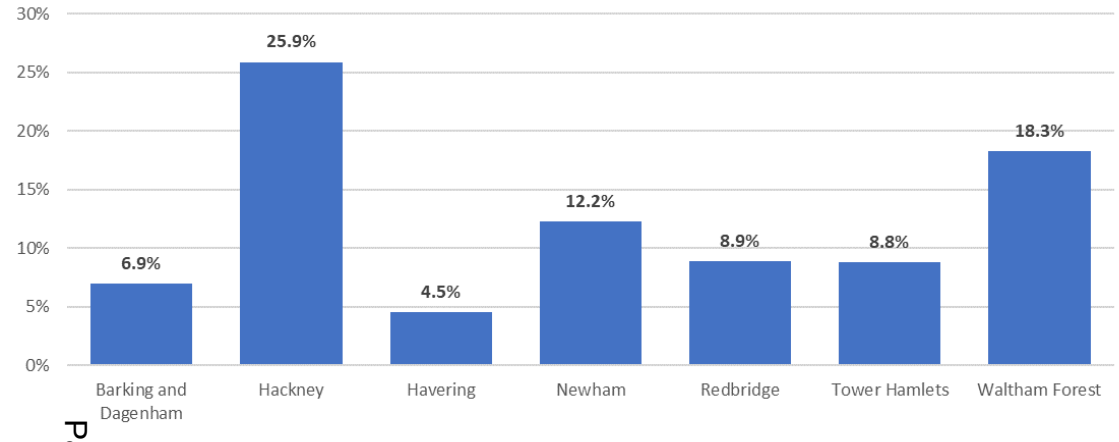
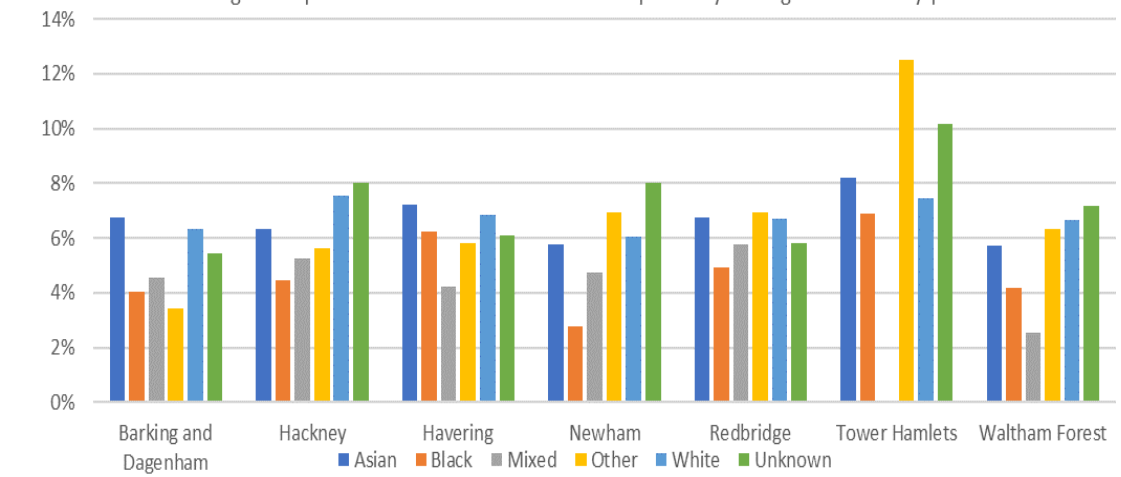


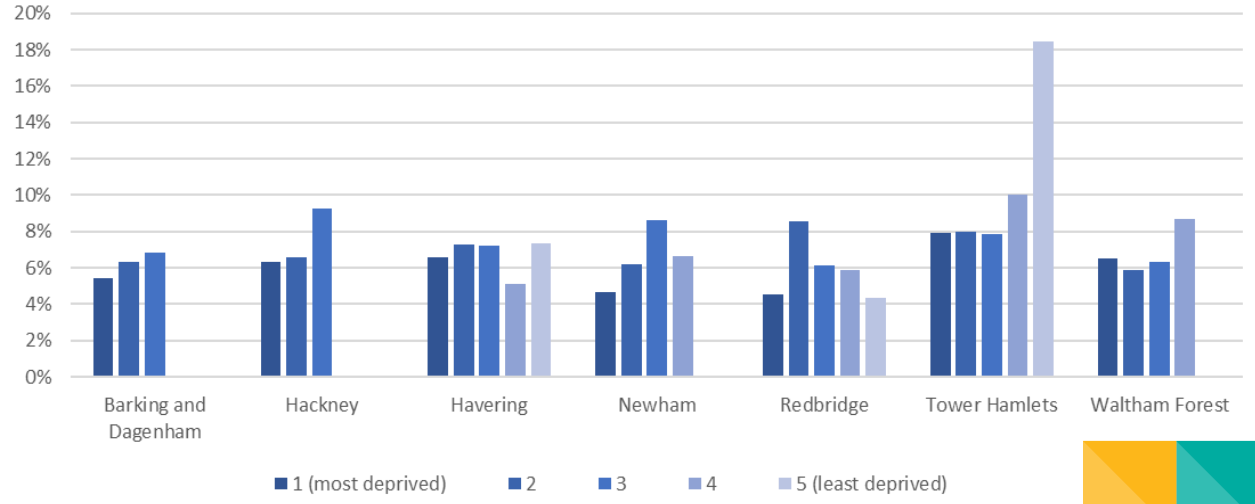
Figure 14 | % of ventouse or vacuum deliveries | rates by borough and ethnicity | 2020-21



Key findings

- Overall across NEL, there does not appear to be a lot variation in the rate of women having ventouse deliveries, with the rate ranging from **6%** in Barking and Dagenham to **8%** in Tower Hamlets.
- On average across NEL, the rates are almost identical for Asian, White and Other women (at **7%** in each group) and are higher then those among Black and Mixed women (**4%** among both groups).
- Two boroughs had over a **fifth** of women giving birth in this way: Baking and Dagenham **(22%)** and Havering **(24%)** compared with **10-19%** across Newham, Tower hamlets and Waltham Forest. Hackney is the main outlier with a substantially smaller rate **at 4%.**
- On average across NEL, the correlations appears to be relatively mild with **6%** of women in the **most** deprived areas giving birth in this was compared with 8% for those in the **least** deprived.

Figure 15 | % of ventouse or vacuum deliveries | rates by Borough and Deprivation Quintile | 2020-21



Post-partum haemorrhages

Figure 16 | % with post-partum haemorrhage | rates by Borough | 2020-21

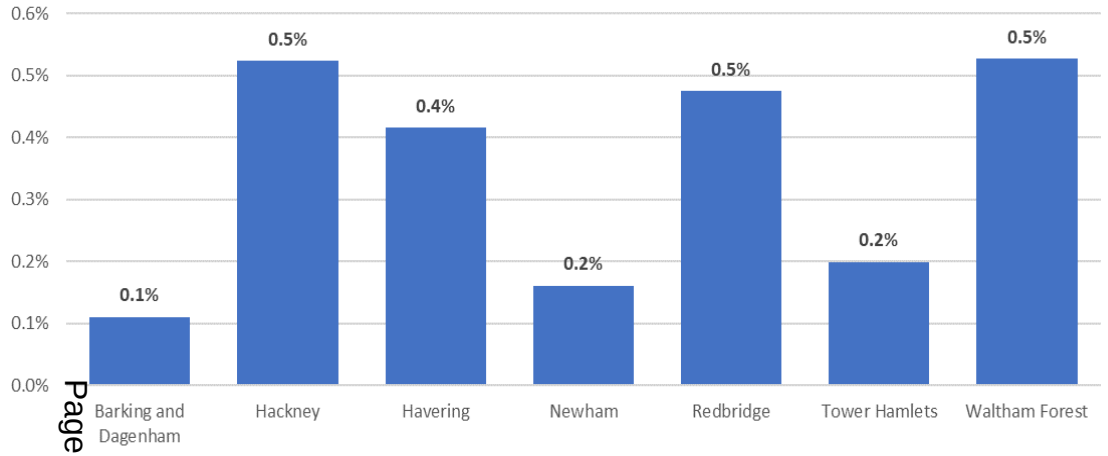
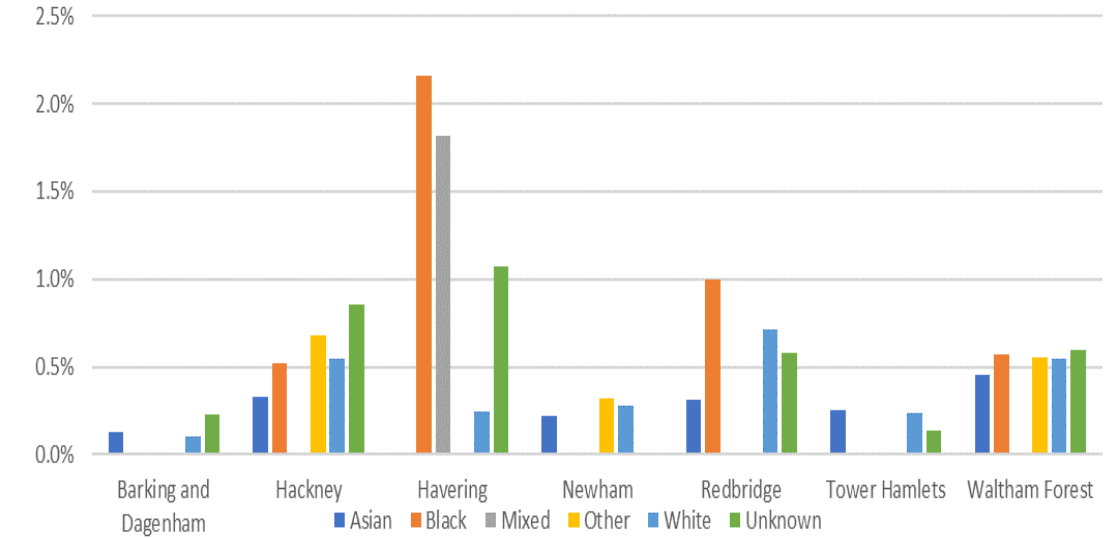


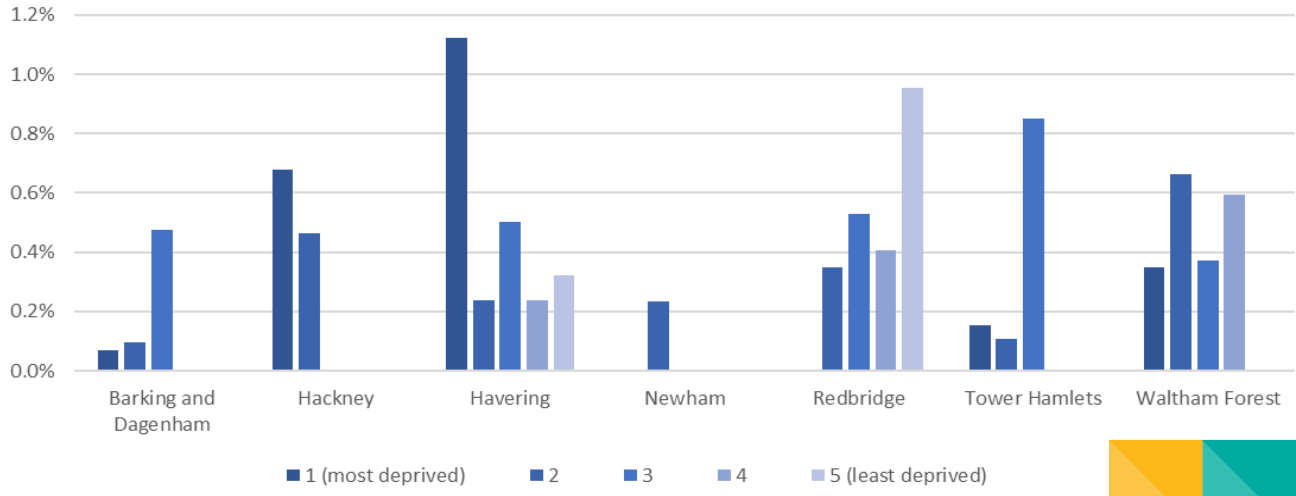
Figure 17 | % with post-partum haemorrhage | rates by borough and ethnicity | 2020-21



Key findings

- On average across NEL, less than **0.5%** of the women that gave birth in 2021 had a post-partum haemorrhage.
- On average across NEL, rates are highest among Black (**0.4%)** and lowest among Mixed women (**0.2%).** The average rate for Black women is, however, driven mainly by Havering which compared to all the other boroughs has highest rates for Black (2.2%) and Mixed (1.8%) women
- On average, the link with deprivation status appears relatively small.
- ***Note: the low numbers in this cohort may be too small on which conclude meaningful (and statistically significant) differences and in the absence of further analysis of the data, trends presented here should be treated with caution.***

Figure 18 | % with post-partum haemorrhage | rates by Borough and Deprivation Quintile | 2020-21



First degree tears

Figure 19 | % of women with 1st degree tears | rates by Borough | 2020-21

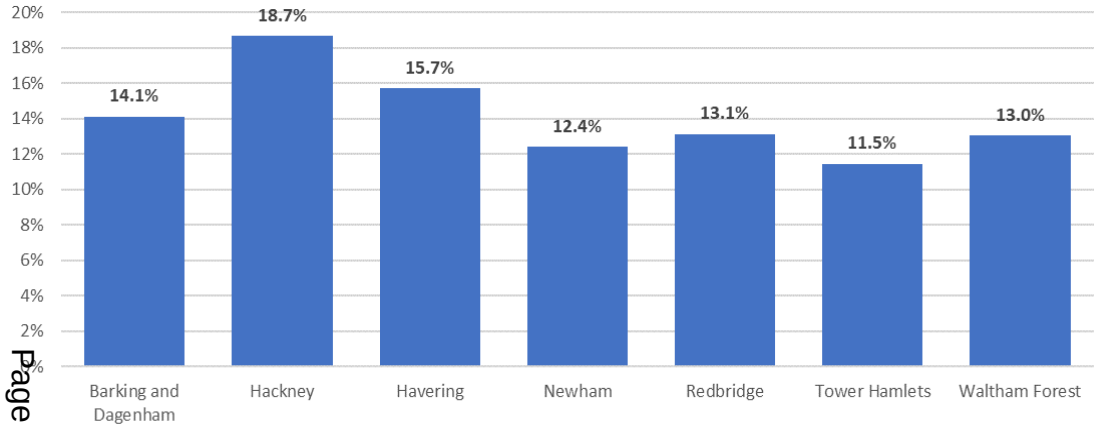
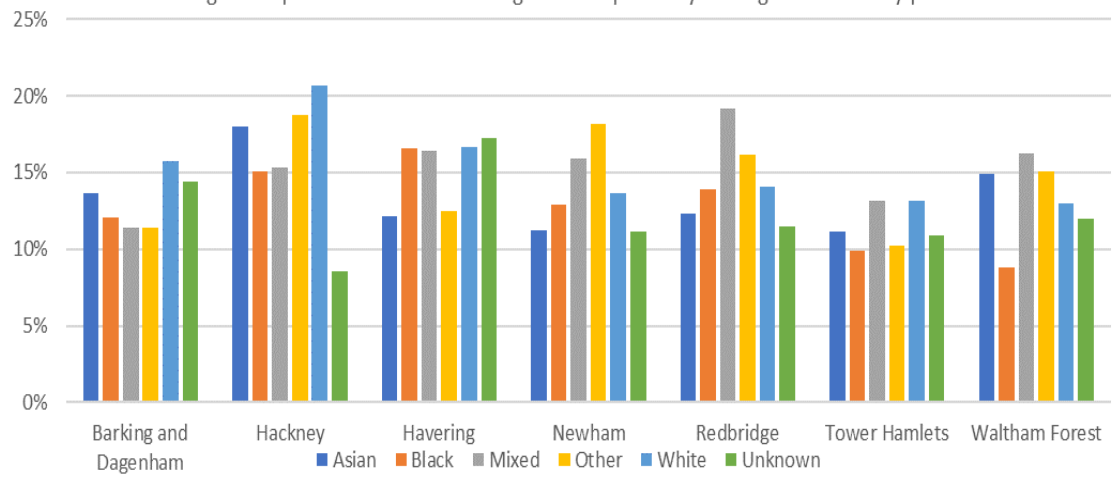


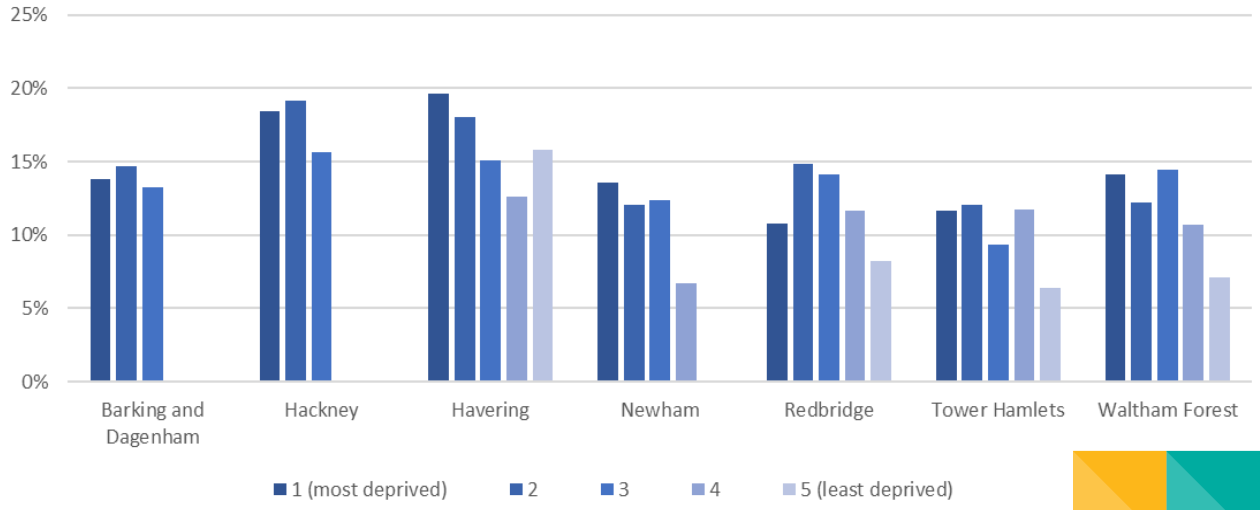
Figure 20 | % of women with 1st degree tears | rates by borough and ethnicity | 2020-21



Key findings

- These refer to small, skin-deep tears which usually heal naturally.
- Overall across the NEL boroughs, the rate of women with first degree tears ranges from 1**2%** in Tower Hamlets to 19% in Hackney. On average, White women tend to have higher rates of 1st degree tears that women in other ethnic groups (i.e. **16%** compared to between **12-15%** for ethnic minority women).
- On average at the NEL level, there does appear to be a potentially stronger correlation with deprivation with **15%** of women living in the **most** deprived areas having a first degree tear compared with **11%** in the **least** deprived.

Figure 21 | % of women with 1st degree tears | rates by Borough and Deprivation Quintile | 2020-21



Second degree tears

Figure 22 | % of women with 2nd degree tears | rates by Borough | 2020-21

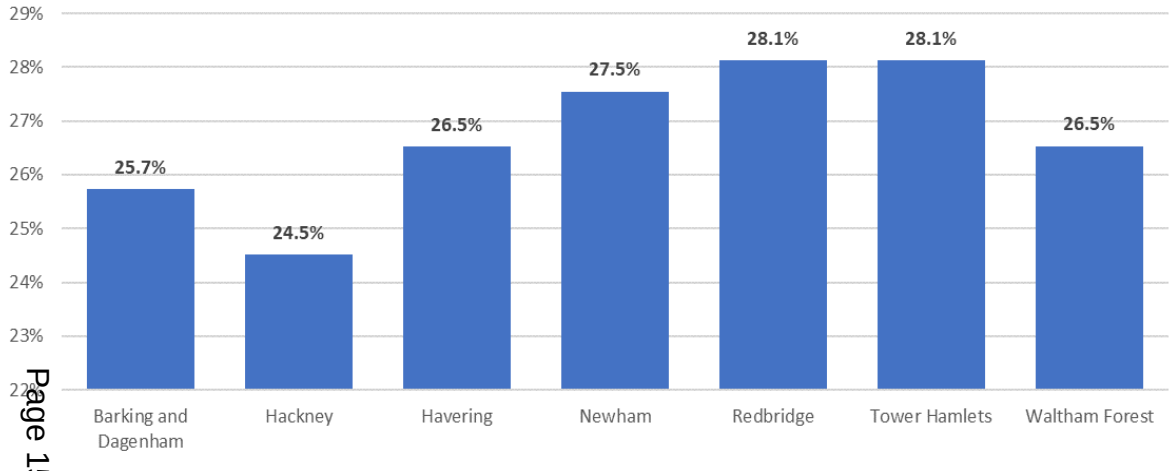
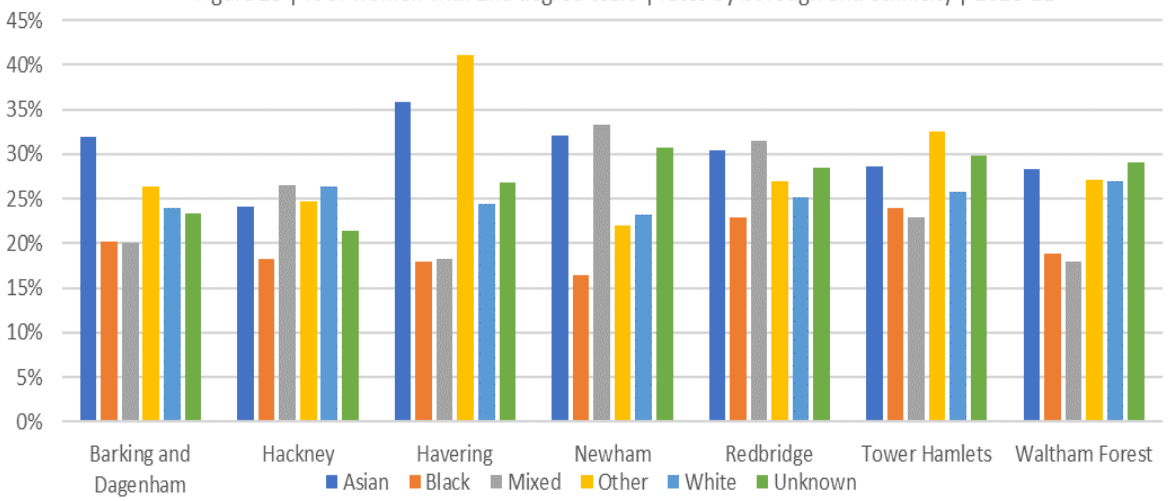


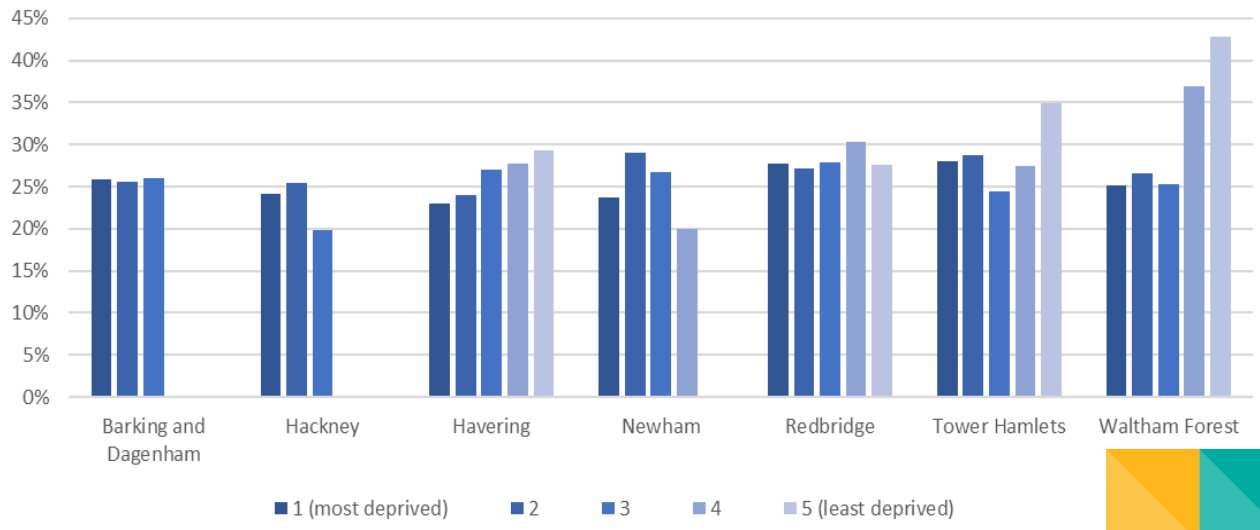
Figure 23 | % of women with 2nd degree tears | rates by borough and ethnicity | 2020-21



Key findings

- Second degree tears are deeper tears which affect the muscle of the perineum as well as the skin. These usually require stitches.
- Overall at the NEL level, **more than a quarter** of women in all boroughs had a second degree tear. This rate ranges from **25%** in Hackney to **28%** in Redbridge and Tower Hamlets.
- On average across NEL, Asian women **are much more likely** than White women to have a second degree tear (e.g. **30%** compared with **25%).** In contrast, the rate among Black women was markedly lower at **19%** (and also lower than the rates for Mixed and Other women for whom the rate **is 24%** and **27%** respectively). The rate Asian women is highest in Havering at 35%
- In contrast to first degree tears, on average across NEL the correlation with deprivation appear to be more marked (and of the opposite direction) with women in the **most** deprived area **much less likely** to have a second degree tear than those in the least deprived (i.e. **25%** versus **30%**).

Figure 24 | % of women with 2nd degree tears | rates by Borough and Deprivation Quintile | 2020-21



Third degree tears

Figure 25 | % of women with 3rd degree tears | rates by Borough | 2020-21

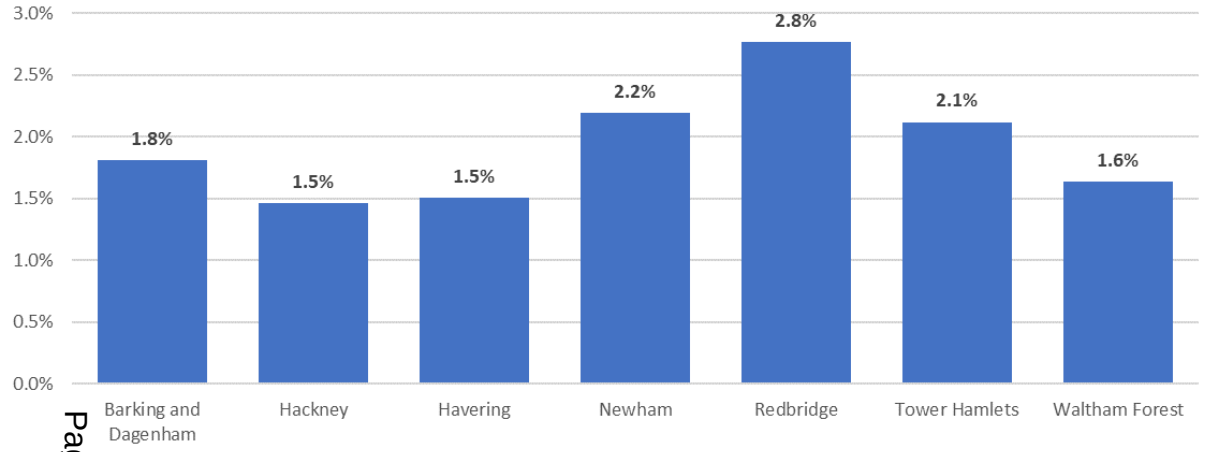
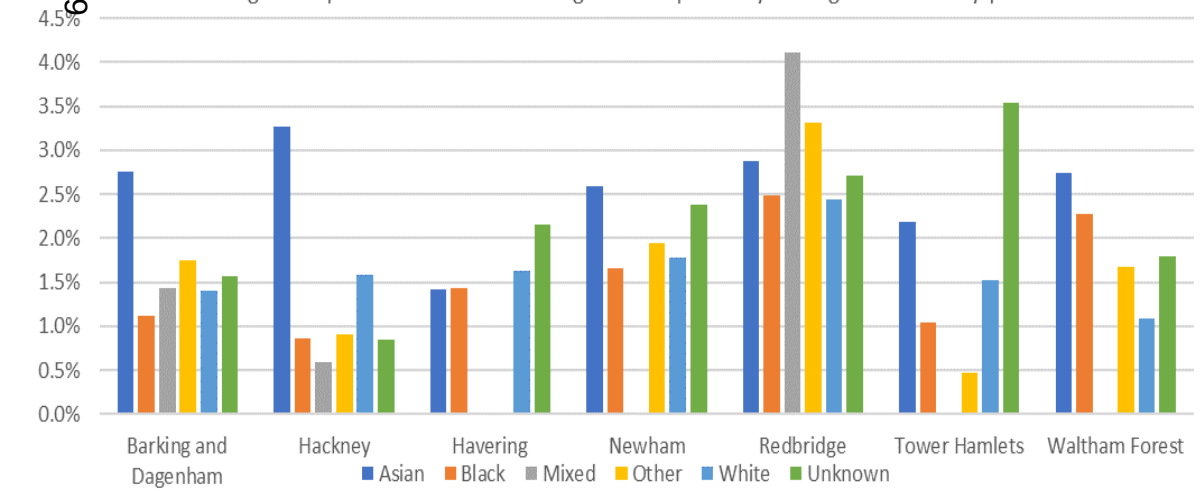


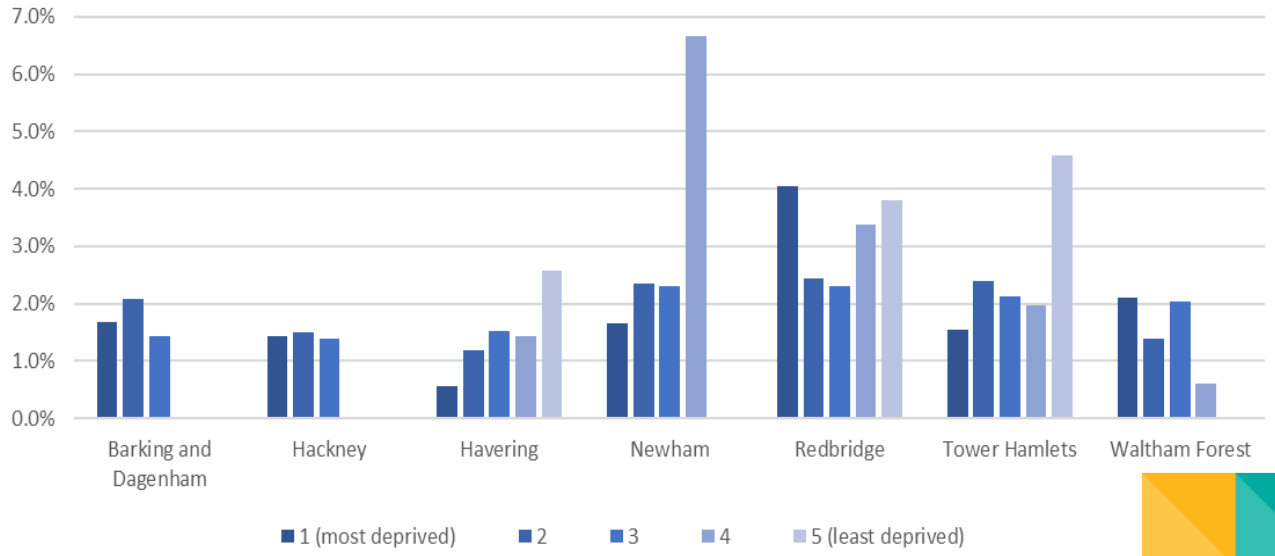
Figure 26 | % of women with 3rd degree tears | rates by borough and ethnicity | 2020-21



Key findings

- Third-degree tears are those which extend away from the vaginal wall, towards the perineum to the anal sphincter.
- Overall at the NEL level, third degree tears are significantly more rare than either first or second degree tears with less than **3%** of women experiencing across each of the boroughs. The rate does, however, rage from **1.5%** in Hackney and Havering to **2.8%** Redbridge – which is almost **double.**
- On average across NEL, Asian women are more likely to suffer third degree tears than White women (**3%** versus **2%).** In contrast, the rate among Black women is **1%,** lower than for women in those same ethnic groups.
- As with second degree tears, women in the **most** deprived appear to be **less likely** to have a third degree tear than those in the **least** deprived (i.e. **1.6%** versus **3.3%**).
- ***NOTE: as with other metrics that are based on relatively low numbers, without further analysis, these findings should be treated wit caution.***

Figure 27 | % of women with 3rd degree tears | rates by Borough and Deprivation Quintile | 2020-21



Annex 5 – Outcomes for women and babies

Stillbirths

Figure 1: Rate per 1000 of babies born stillbirth - by borough (2020/21)

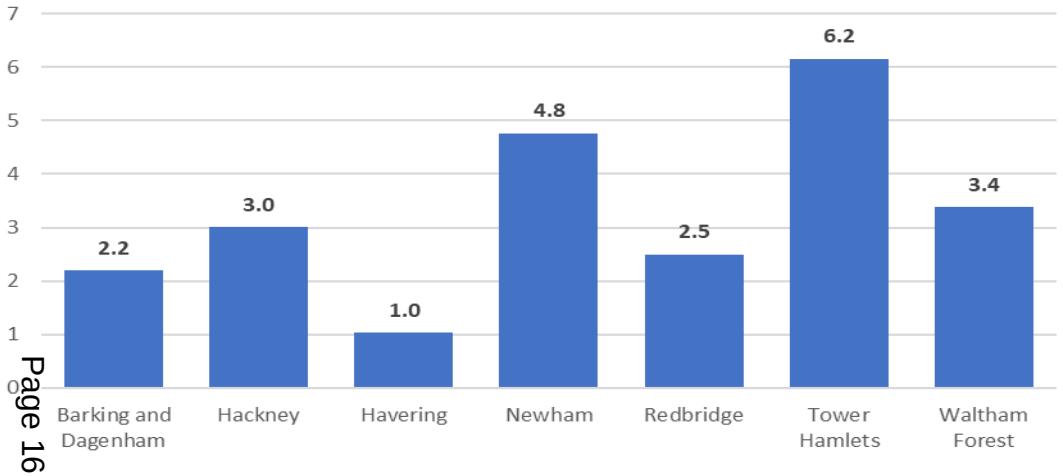
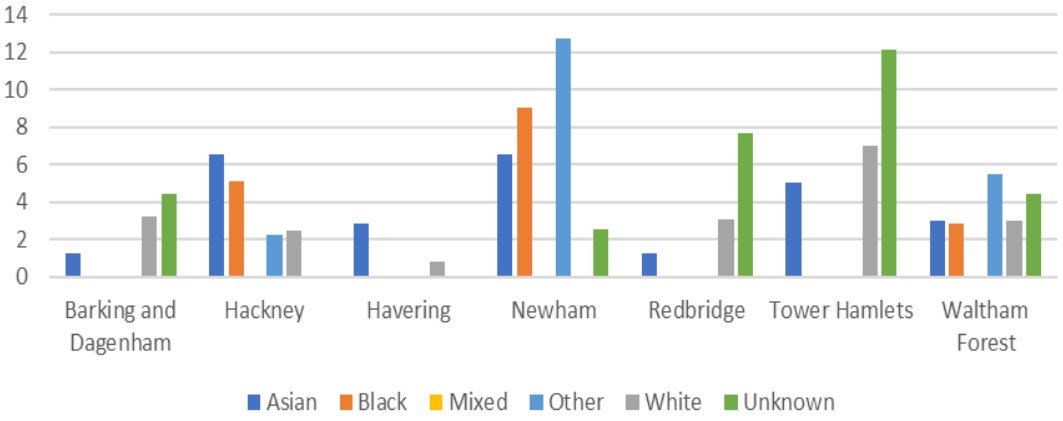


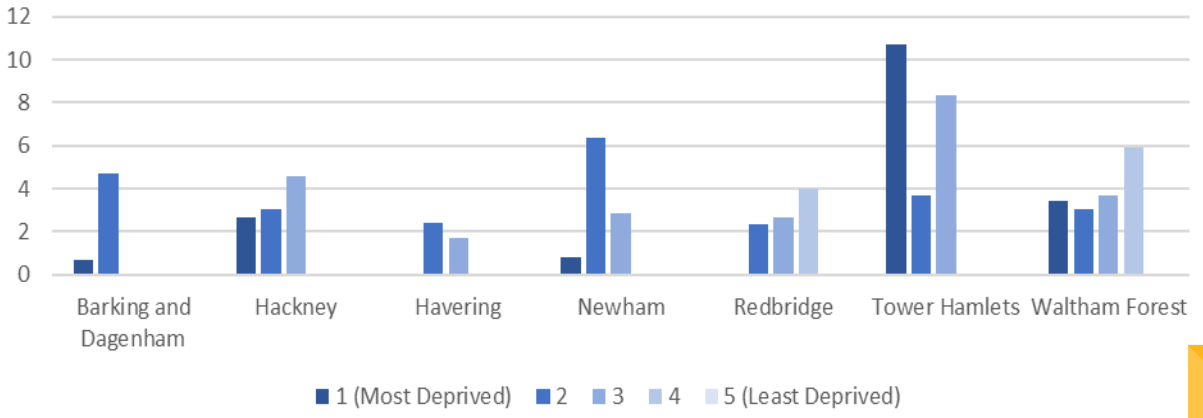
Figure 2: Rate per 1000 of babies born stillbirth - by ethnicity and borough (2020/21)



Key findings

- Overall there were **3.6 babies per 1000** born stillbirth in NEL. Tower Hamlets had the **highest rate** per 1000 of babies born stillbirth at **6.2 per 1000**, this was 6 times higher than the rate found in Havering (i.e. at **1 per 1000**).
- Across NEL, the rate of babies born stillbirth was higher for Black (**3.8 per 1000**), Asian (**4 per 1000**) and Other ethnicities (**4.1 per 1000**) compared to the rate for White (**2.6 per 1000**) and Mixed ethnicities (**0**).
- Stillbirths to Asian and Black women tend to be concentrated in 3 boroughs – Hackney, Newham and Waltham Forest – with the rates for Black (**6.5 per 1000**) and Asian women (**9 per 1000**) being highest in Newham.
- In contrast, there were stillborn babies to White women across all NEL boroughs with the exception of Newham. There were also no stillbirth babies to Mixed women across all NEL boroughs.
- Two notable outliers are Other ethnicities (**12.7 per 1000**) in Newham and Unknown (**12.1 per 1000**) in Tower Hamlets for whom the rate was higher than for all groups in all boroughs.
- Across NEL, the rate of babies born stillbirth was highest among women living in areas within the second most deprived quintile at **4.2 per 1000**, compared to those living in areas within the least deprived quintile were **0** babies were born stillbirth.
- Across the NEL boroughs, Tower Hamlets had the highest rate of babies born as stillbirth in their most deprived quintile (**10.7 per 1000**), this was at least **3 times greater** than the rate found in the most deprived quintile in the other boroughs across NEL.
- **As the numbers are very low for this outcome measure, the findings should be treated with a high degree of caution ahead of further analysis (in Phase 2)**

Figure 3: Rate per 1000 of babies born stillbirth - by deprivation and borough (2020/21)



Admissions to neonatal care

Figure 4: % of admissions to neonatal care – by borough (2020/21)

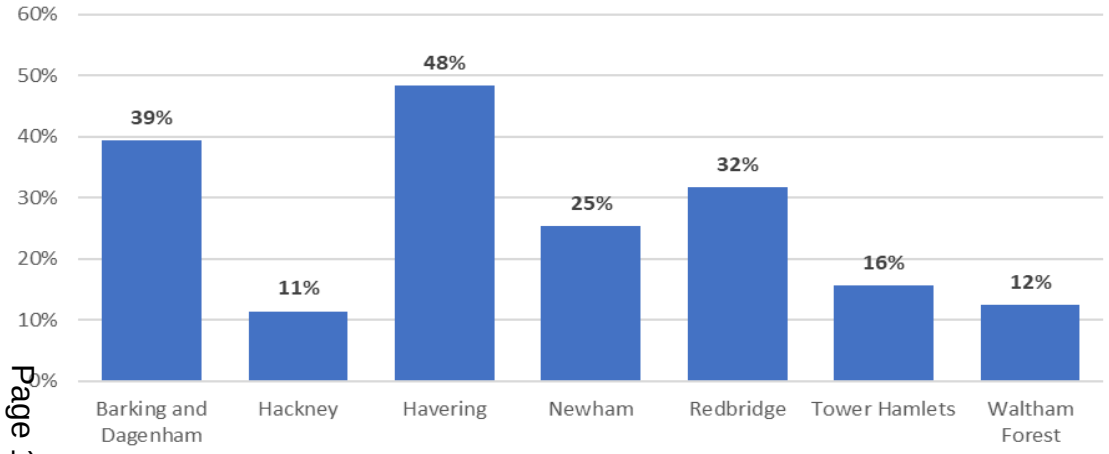
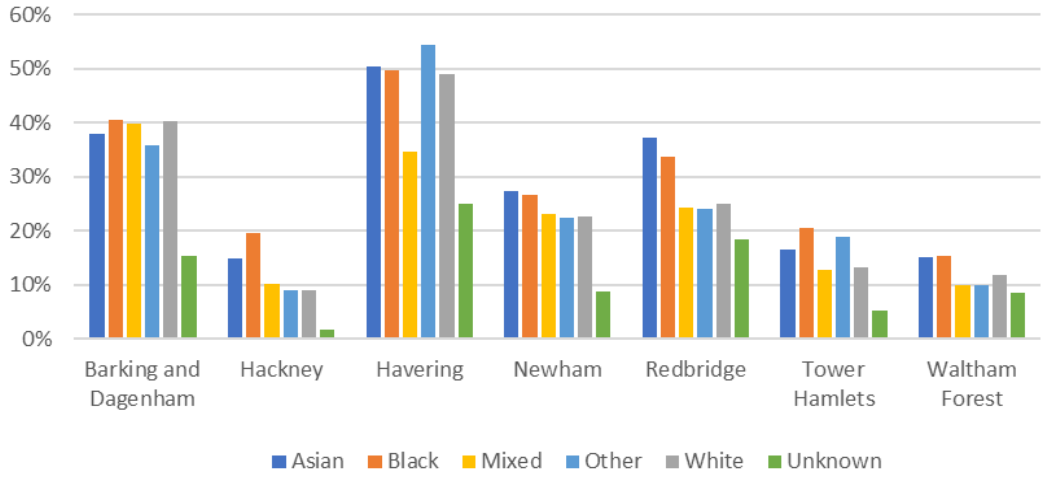


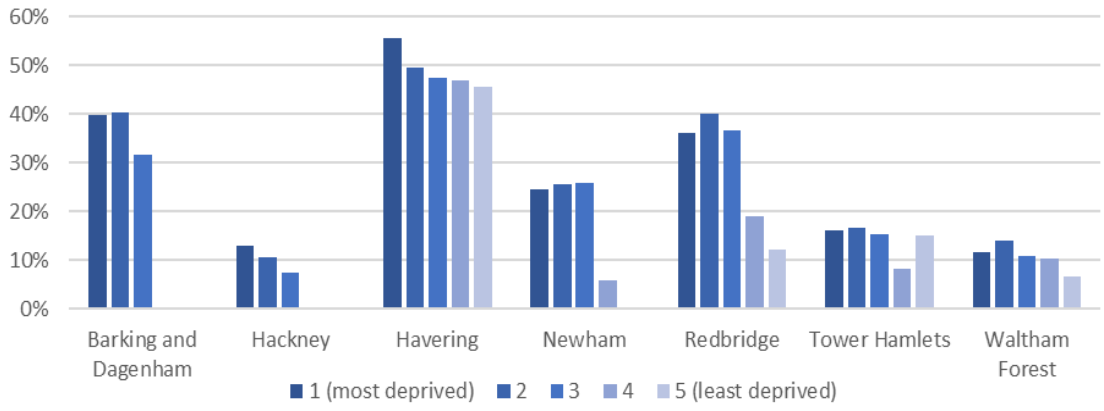
Figure 5: % of admissions to neonatal care – by ethnicity and borough (2020/21)



Key findings

- On average, nearly a quarter of babies born in NEL were admitted to neonatal care (**24%**) although there is a lot of variation between boroughs. Havering and Barking and Dagenham had the highest proportion of admissions (**48% and 39%**) which was **over 3 times** the percentage of admissions in Hackney (**11%**), Tower Hamlets (**16%**) and Waltham Forest (**13%**).
- On average at NEL level, Asian and Black ethnicities had the highest percentage of babies admitted to neonatal care (**27%** for both), compared with **22%** for babies born to White women and **18%** for babies born to Other ethnicities..
- The variation between Black and White women is **highest** in Hackney with **20%** of babies born to Black women admitted to neonatal – which is over double the rate for White ethnicities (**9%**) as well as Mixed (**10%**) and Other (**9%**).
- On average across NEL, differences between deprivation quintiles appear relative small, i.e. ranging from **23%** for those living in the **most deprived** areas to **26%** in the least.
- At the borough level however, there appears to be a correlation between deprivation and admissions, most prevalent in Havering and Redbridge where the rates for those in the **most deprived** areas are at **36-56%** compared with **12-45%** for those living the **least deprived** areas**.**

Figure 6: % of admissions to neonatal care – by deprivation and borough (2020/21)



Low birth weight

Figure 7: % of babies born with low birth weight – by borough (2020/21)

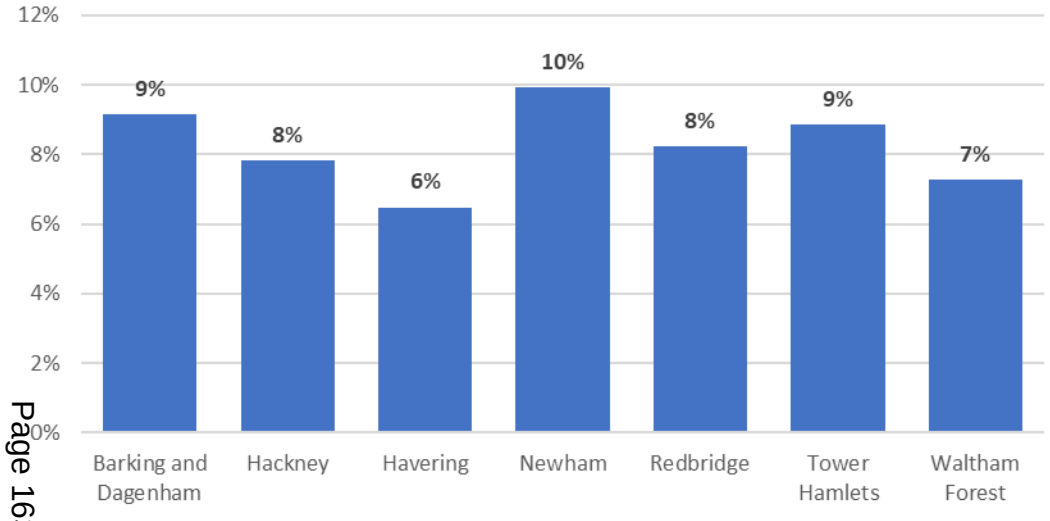
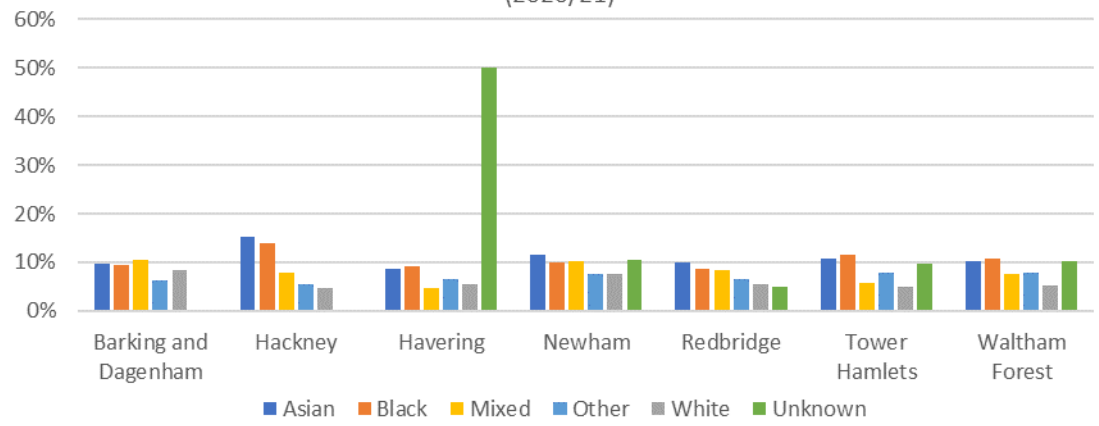


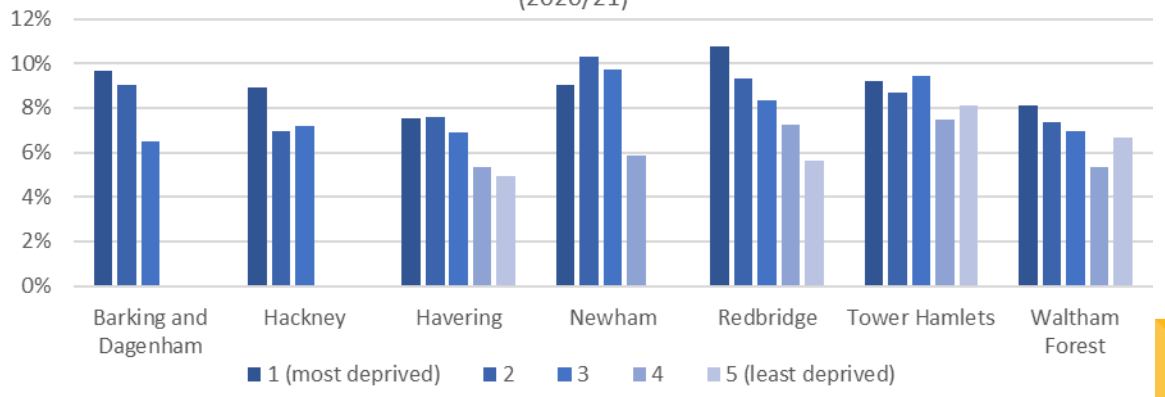
Figure 8: % of babies born with low birth weight – by ethnicity and borough (2020/21)



Key findings

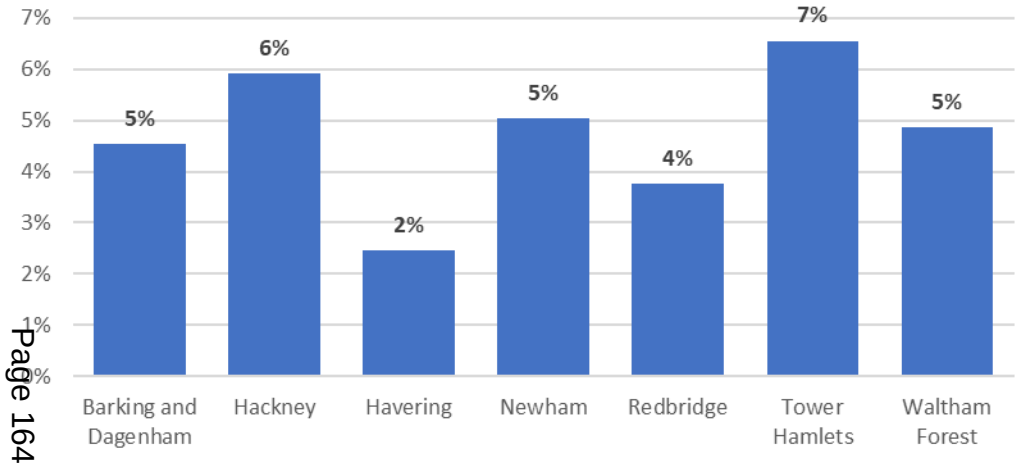
- Across NEL, **8%** of babies were born with low birth weight – with some variation across this average (**6-10%**).
- Havering, despite having the **highest percentage** of babies admitted to neonatal care, had the **lowest percentage** of babies born with low birth weight relative to all other NEL boroughs. Though it looks like Havering has a very high rate of low birth weight for Unknown ethnicity babies, there are only 4 babies with unknown ethnicity for Havering, and 2 of them had low birth weight.
- Approximately **1 in 10** babies born (**10%**) in Newham had a low birth weight.
- Across NEL, **11%** of babies born to Black and Asian women had a low birth weight – almost **double the rate** for babies born to White (**6%**).
- This disparity is largest within Hackney, Tower Hamlets and Waltham Forest. In Hackney, the percentage of babies born with low birth weight of Black and Asian ethnicity is **nearly three times as high** (between **14-15%**) as the percentage found for White ethnicities (**5%).** In Tower Hamlets and Waltham Forest this difference is **twice as high** (**10-12% vs 5%** for both boroughs).
- For the majority of boroughs, the percentage of babies born with low birth weight increases with deprivation with **9%** of babies in the **most deprived** group in NEL with a low birth weight compared with **6%** for the **least deprived** group.

Figure 9: % of babies born with low birth weight – by ethnicity and borough (2020/21)



A&E attendances within 6 weeks of delivery

Figure 10: % of pregnant women with an A&E attendance within 6 weeks - by borough (2020/21)



Key findings

- On average across NEL, **5%** of women had an A&E attendance within 6 weeks of delivery. Havering had the lowest percentage of women with an A&E attendance (at **2%**) which is at least twice as low as the average rate within the other boroughs.
- On average, there was little variation in the rates found between ethnicities in NEL (**5-6%** for all ethnicities). This does, however, mask key differences at the borough level.
- In Havering, for example, Black ethnicities (**4%**) and Mixed ethnicities (**4%**) had approximately **double the rate** of women with at least one A&E attendance than White (**2%**) and Asian ethnicities (**2%**).
- Across NEL, the percentage of women with an A&E attendance living in the most deprived areas was twice as high as those in the least deprived (i.e. **6%** versus **3%**).
- The link appears to be largest in Redbridge and Havering. In Redbridge the percentage for the most deprived quintile (**5%**) **is more than double** the percentage for the least deprived quintile (**2%**). Similarly, in Havering the rate is **5%** versus **3%.**

Figure 11: % of pregnant women with an A&E attendance within 6 weeks of delivery - by ethnicity and borough (2020/21)

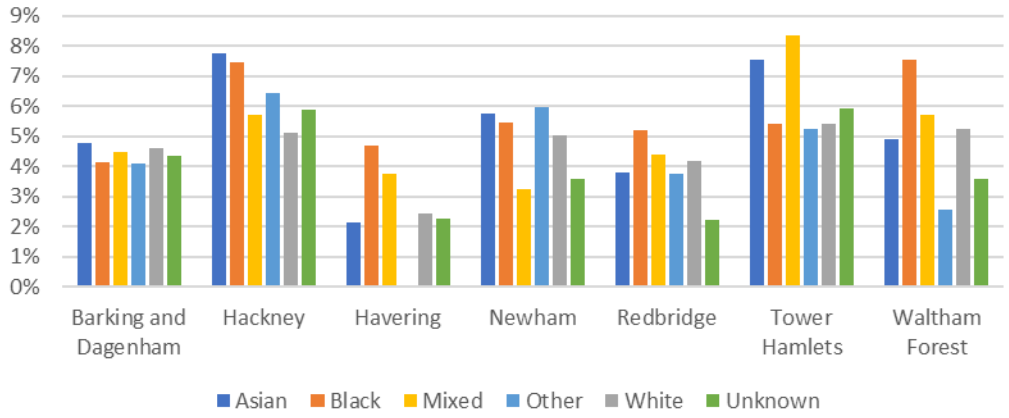
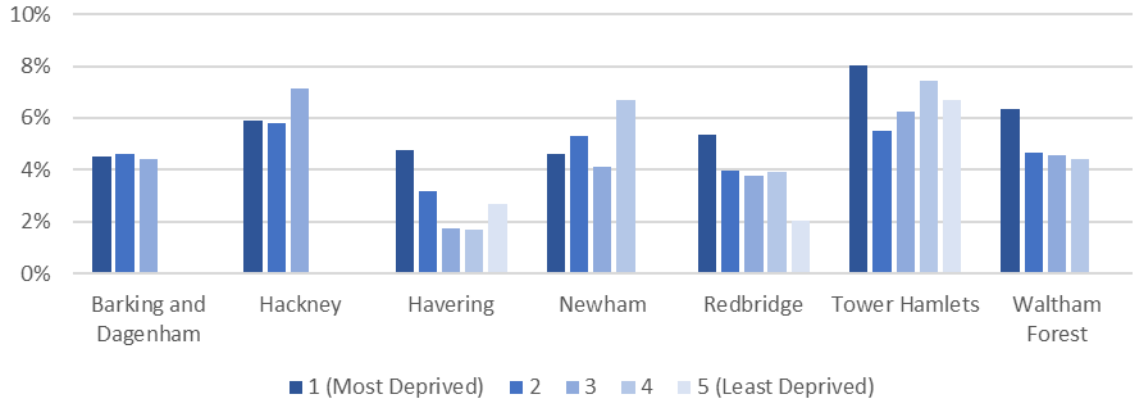
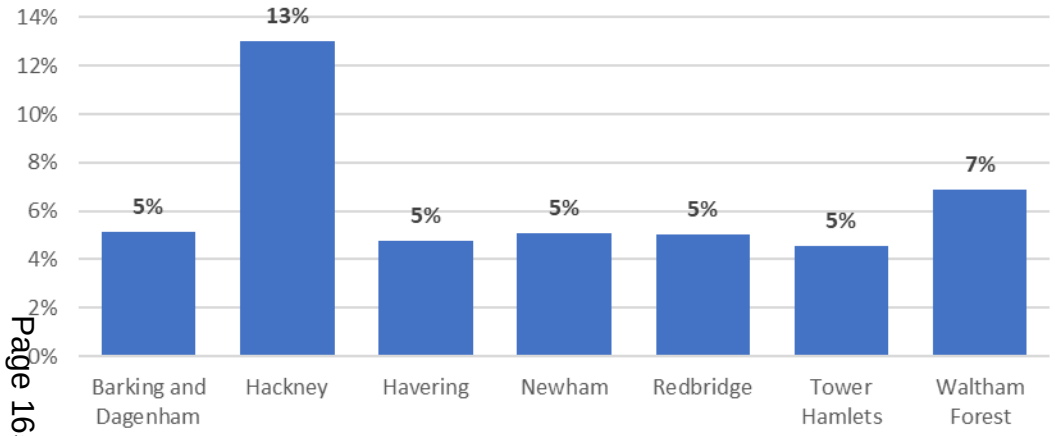


Figure 12: % of pregnant women with an A&E attendance within 6 weeks of delivery - by deprivation and borough (2020/21)



Admissions to hospital within 6 weeks of delivery

Figure 13: % of pregnant women with an admission within 6 weeks of delivery - by borough (2020/21)



Key findings

- On average across NEL, **6%** of women were admitted to hospital within 6 weeks of delivery. Hackney (**13%**) had the largest percentage of women with an admission, this was more then **twice as high** as the value found for other boroughs across NEL.
- When focusing on ethnicity across NEL, differences between ethnicities relatively minimal. At the borough level, Hackney is the one notable exception – with a **large observed disparity** in rates among Black and Asian women (at **18%** for both) compared with those among White women **(11%).**
- Across NEL, the percentage of women with an admission to hospital fell from the most deprived quintile (**7%**) to the least deprived quintile (**4%**), however these differences do not appear overly marked.
- However, as with ethnicity Hackney is also the outlier here, with the largest difference in rates between the most deprived (**14%**) and least deprived quintiles (**10%**) – although Hackney does not have any of its LSOAs in the top two least deprived quintiles (and may therefore understate the 'true' scale of the difference).

Figure 14: % of pregnant women with an admission within 6 weeks of delivery - by ethnicity and borough (2020/21)

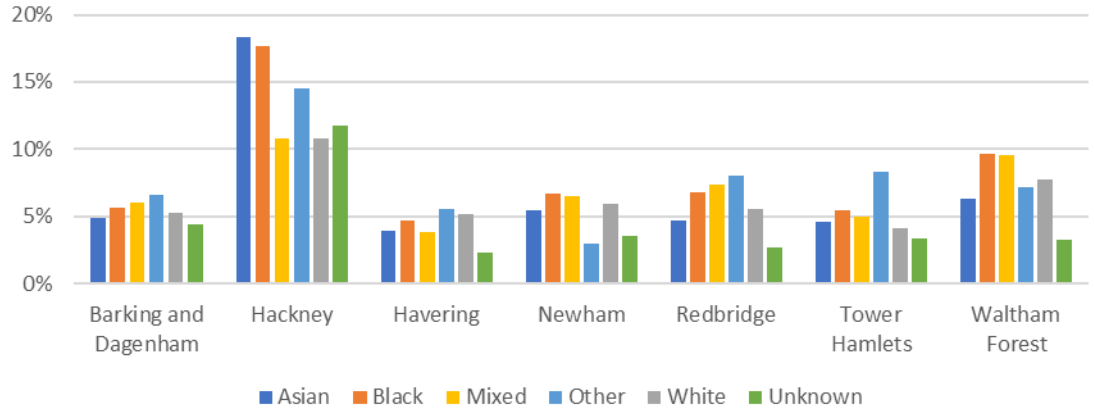
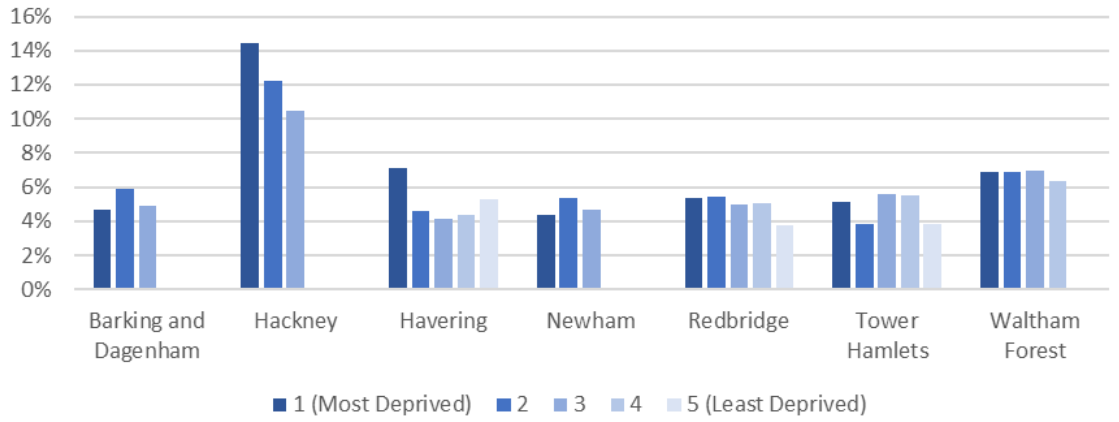


Figure 15: % of pregnant women with an admission within 6 weeks of delivery - by deprivation and borough (2020/21)



A&E attendances within 6 months of delivery

Figure 16: % of pregnant women with an A&E attendance within 6 months of delivery - by borough (2020/21)

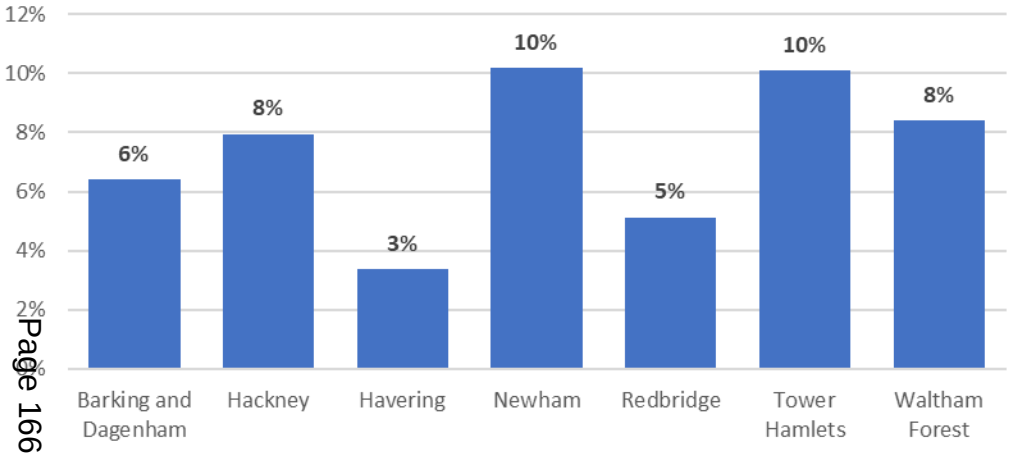
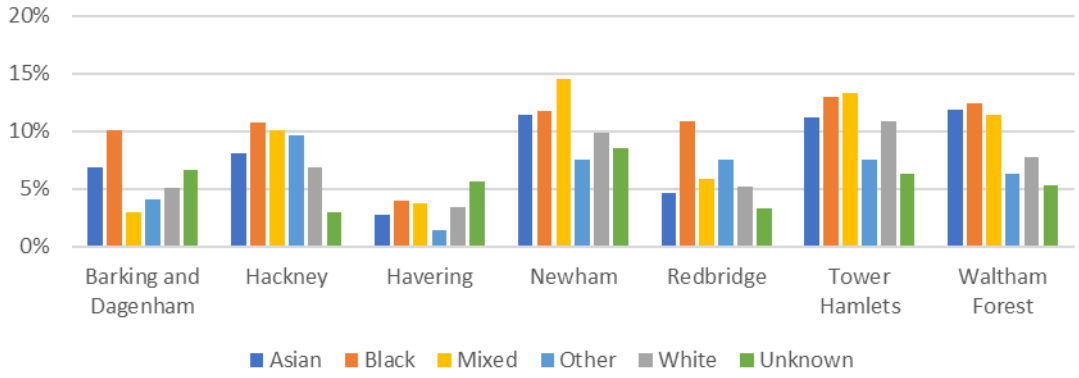


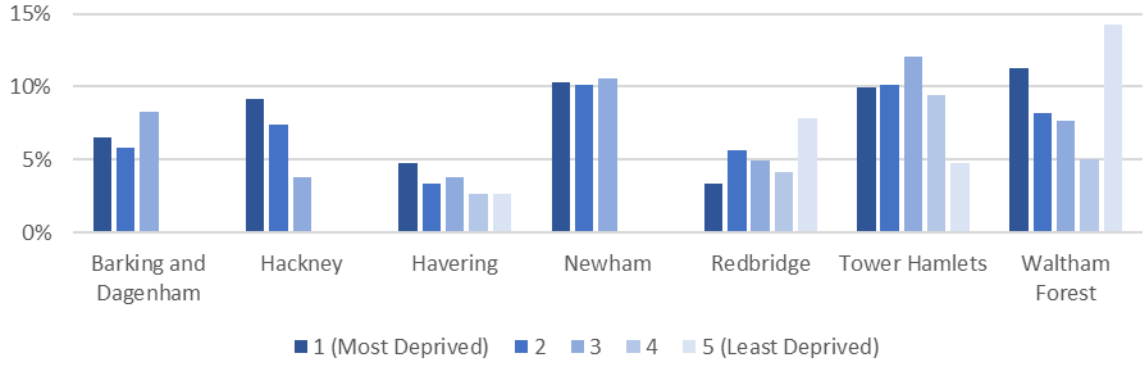
Figure 17: % of pregnant women with an A&E attendance within 6 months of delivery - by ethnicity and borough (2020/21)



Key findings

- On average across NEL, **8%** of women had an A&E attendance within 6 months of delivery (excluding the first 6 weeks). The percentage of women with an A&E attendance within 6 months varies between the NEL boroughs, with the rates in Newham (**10%**) and Tower Hamlets (**10%**) **double that** in Redbridge (**5%**), and **three times** greater than the rate in Havering (**3%**).
- On average across NEL, Black ethnicities (**11%**) had the highest percentage of women attending A&E within 6 months of delivery, compared to White (**7%**) and Other ethnicities (**7%**) who had the lowest percentage.
- Both Black and Mixed ethnicities had the highest percentage of pregnant women with an A&E attendance in all of the boroughs. In Barking and Dagenham and Redbridge, for example, the percentage of Black women (**10%** in both) with an A&E attendance was **double the** percentage found for White women (**5%** in both).
- On average across NEL, the percentage of women with an A&E attendance is **almost double** among those in the **most deprived** quintile compared with the least deprived (i.e. **9%** compared with **5%**), suggesting a strong link between deprivation and A&E attendances.
- In Hackney and Tower Hamlets, for example, the percentage of women with an A&E attendance for the most deprived quintile is double the percentage for the least deprived quintile (**8%** vs **4%** for Hackney, and **10%** vs **5%** for Tower Hamlets). Redbridge is the main outlier to this as the percentage found for the **least deprived** quintile (**8%**) is **double the value found** for the most deprived quintile (**4%**).

Figure 18: % of pregnant women with an A&E attendance within 6 months of delivery - by deprivation and borough (2020/21)



Admission to hospital within 6 months of delivery

Figure 19: % of pregnant women with an admission within 6 months of delivery - by borough (2020/21)

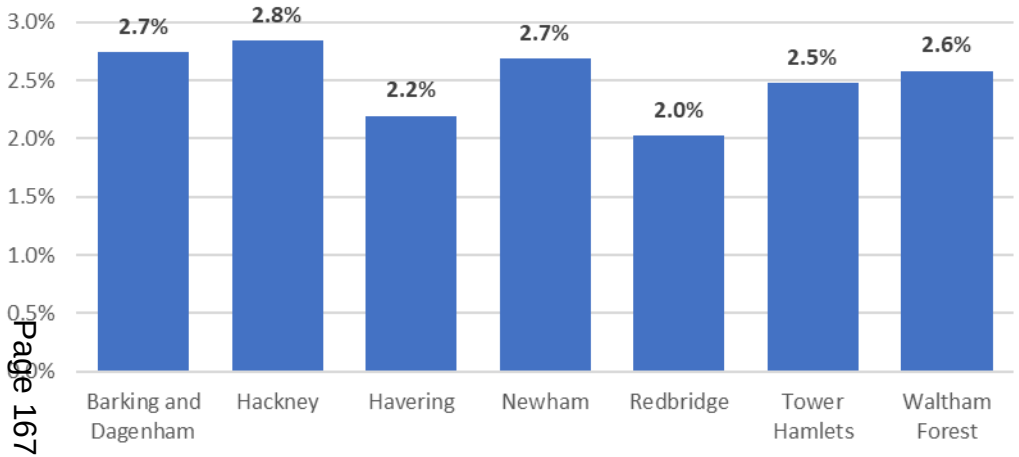
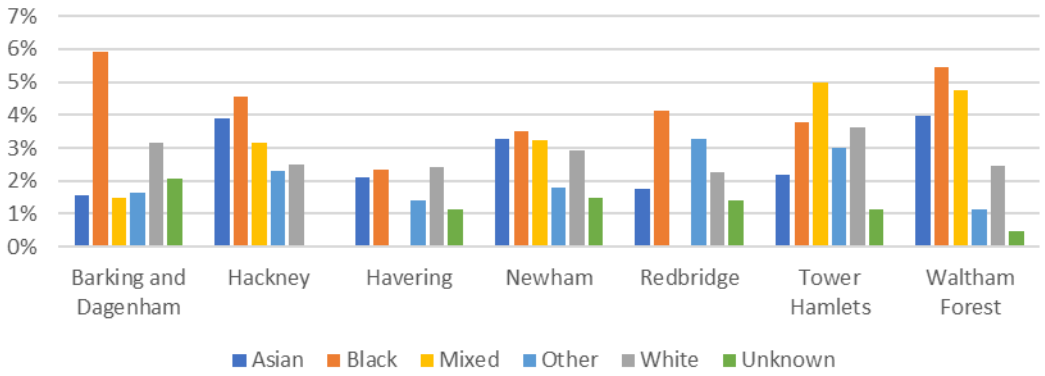


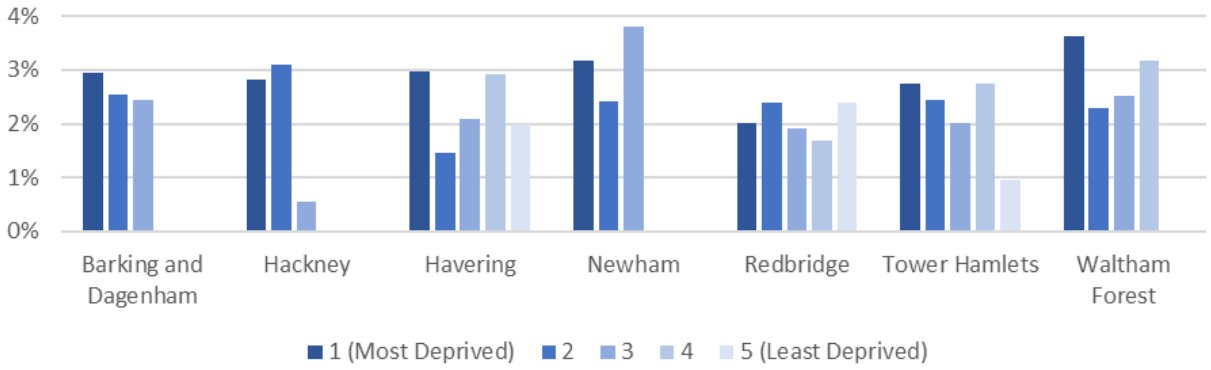
Figure 20: % of pregnant women with an admission within 6 months of delivery - by ethnicity and borough (2020/21)



Key findings

- On average across NEL, **3%** of women that gave birth in 2021 were admitted to hospital within 6 months of delivery (excluding the first 6 weeks).
- On average across NEL as a whole, differences between ethnicities were minimal. However, Black ethnicities had the highest percentage of women with an admission within 6 months of delivering for all boroughs, other than Tower Hamlets where Mixed ethnicities had the highest.
- This average does, however, mask much large variations observed within individual boroughs.
- In Barking and Dagenham, for example, Black ethnicities (**6%**) had **more than double** the rate of women admitted compared with those for White women **(3%).**
- On average across NEL, differences between deprivation quintiles in NEL are relatively small, with **3%** of women in the most deprived quintile having an admission compared to **2%** for those in the least deprived. This finding appears to be relatively consistent at the borough level with Hackney and Tower Hamlets the two notable outliers. In Tower Hamlets and Hackney the percentage of women with an admission in their most deprived quintile is at **least 2 times greater** than the percentage found in their least deprived quintile (**3%** vs **1%** for both boroughs) .

Figure 21: % of pregnant women with an admission within 6 months of delivery - by deprivation and borough (2020/21)



Outpatient appointments within 6 weeks of delivery

Figure 22: Median no. of outpatient appointments within 6 weeks of delivery - by borough (2020/21)

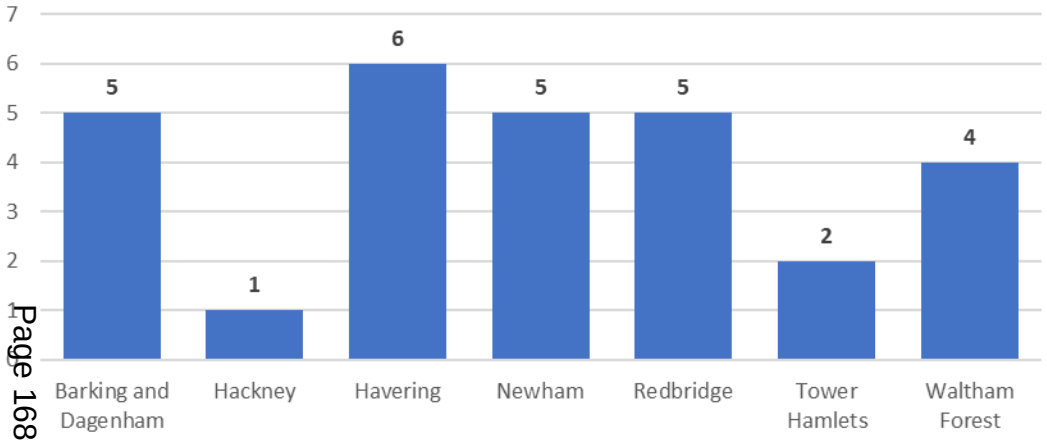
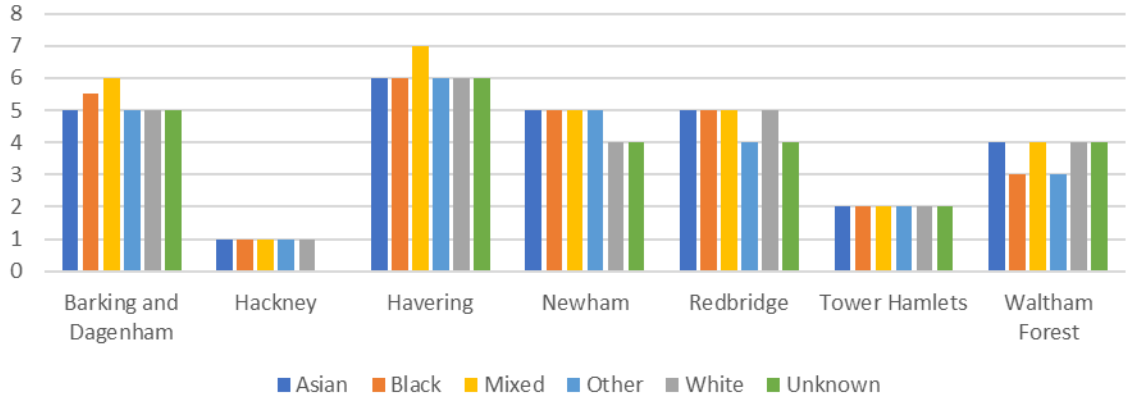


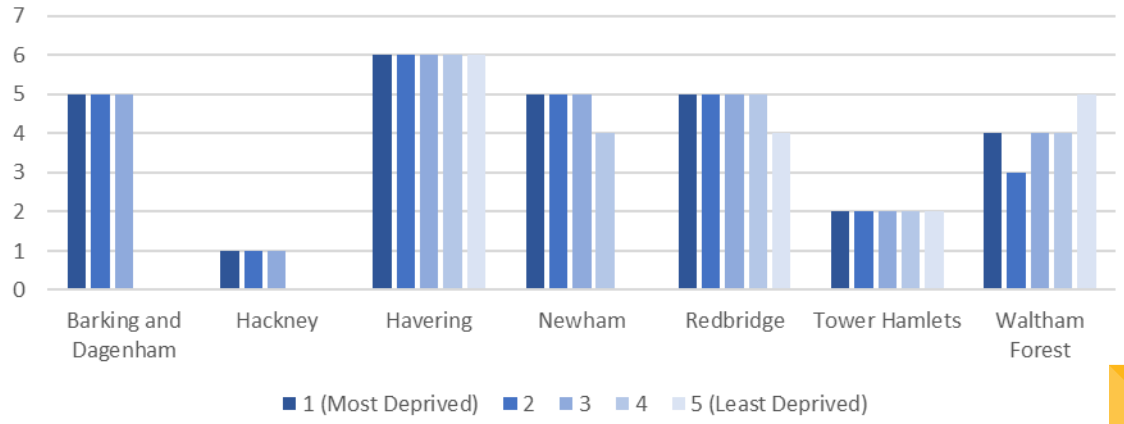
Figure 23: Median no. of outpatient appointments within 6 weeks of delivery - by ethnicity and borough (2020/21)



Key findings

- In NEL, the median number of outpatient appointments within 6 weeks was **4**, although there is a lot of variation across boroughs. Similar to outpatient appointments during pregnancy, Tower Hamlets (**2** appointments) and Hackney (**1** appointment) had less than **half the median number** of outpatient appointments within 6 weeks of delivery, compared to the other boroughs in NEL (**4-6** appointments).
- Across NEL, the median number of appointments between ethnicities was broadly the same (**3-4** appointments).
- Across NEL, the median number of outpatient appointments for the most deprived quintile is **3** appointments, compared to a median of **5** appointments for the least deprived quintile.
- It seems that number of outpatient appointments is consistent within boroughs (across ethnicity and deprivation) but varies mainly between boroughs across NEL.

Figure 24: Median no. of outpatient appointments within 6 weeks of delivery - by deprivation and borough (2020/21)



Annex 6 – Overview of the FGM population

Overview of the National FGM Enhanced Data set

- The data analysis in this section are drawn from the Female Genital Mutilation (FGM) Enhance Data Set covering the period 20/21. Anonymised borough level data are made publically available by NHS Digital.

1.What is the FGM enhanced data set?

- It is a repository for individual level data collected by healthcare providers in England - including acute hospital providers, mental health providers and GP practices - about patients who have had FGM.
- It is mandatory for acute hospital providers, mental health providers and GP practices to submit to the FGMED (SCCI 2026 Information Standards Notice)
- This enhanced data set supports the DHSCs FGM prevention programme by presenting an national picture of the prevalence of FGM in the NHS in England.
- This submission in managed and published on a quarterly basis by NHS Digital and collects information.
- It builds on the FGM Prevalence Dataset which collected data from acute trusts between April 2014 and March 2015. The Enhanced Dataset began collecting data on 1 April 2015 in Trusts and GP practices in October 2015.
- There are **19** different data fields that are included in the dataset (see table)

2. What indicators have we included in this report?

- Overall for the period 20/21, the completeness of a large majority of data field was extremely low with many being less than **35%** complete and in some cases as low as **15%** (see table for coverage rates). We have, therefore, limited our analysis of FGM women in the 20/21 data set to indicators **No. 1** (Total women with FGM), **No. 2** (FGM type), **No. 4** (Age at attendance), and **No. 12** (Identification method) as they have the best completion % .
- The trends on low completeness rates apply across all boroughs with Hackney being the exception' having the 'best' data coverage, with having approx. **90%** coverage for some of the indicators. This could be a potential further area for exploration to understand whether there is any good practice within Hackney that could be shared across the other boroughs.

No.	Indicator	% unknown/not reported (NEL)	% unknown/not reported (London)
1	Total no. women/girls with FGM (2015-21 and 2020-21)	N/A	N/A
2	No. individual women by FGM Type	29%	43%
3	No. individual women with FGM Type 4 by Subtype	57%	54%
4	Age of Attendance	0%	0%
5	No. Newly recorded women	N/A	N/A
6	Age at which FGM was carried out	85%	54%
7	Region of Birth	66%	45%
8	Region of Origin	70%	61%
9	Country where FGM Carried Out	82%	61%
10	No. of Daughters Under 18	85%	59%
11	Referring Organisation Type	72%	44%
12	FGM Identification Method	2%	17%
13	Treatment Function Area	69%	26%
14	Pregnant at Attendance	71%	34%
15	Average no. of attendances per woman	N/A	N/A

Key data caveats, notes and definitions

1. High proportion of 'unknown' and/or 'not reported' data

- This is the case for most of the indicators for FGM women in the 20/21 dataset which is why we have limited our analysis to the data on (1) FGM type and (2) age at attendance – both of which had the highest completion rates. However, the (average) completion rates across NEL for these two indicators is still below the level that we would normally require to be able draw reliable and meaningful conclusions so even the findings on these two metrics should be interpreted with caution.
- Further, it is unclear whether - and to what extent – the pressure on the system due to Covid has impacted the completeness of reporting against data fields by NHS staff and if completeness rates were better in previous years (and indeed whether they may improve going forward as Covid pressure subside).
- While on average, the data coverage for 20/21 is relatively poor across both the London region and England, overall, data quality across NEL appears to be **worse** than compared with London and England overall

2. Data suppression

- Where numbers are low, NHSD has suppressed the data to minimise the risk of individuals being identified. This means that:
  - all values from 1 to 7 have been coded as 5, and numbers above that have been rounded to the nearest 5)
  - This means that both overall values and averages presented in this analysis may be skewed due to the rounding conventions applied to the published dataset.

3. Risks of underreporting numbers due to Covid

- NHSD notes that the reporting period 20/21 coincides with the increased pressure on NHSE services dues to Covid and that 'fewer individuals continue to be reported making FGM related attendances'. NHSD notes that it is unclear whether this reflects (1) a reduction in the number of women and girls seen by NHS services at attendances related to their FGM and/or (2) a reduction the capacity of NHS services to report all the FGM-related attendances that have taken place.

4. We are unable to accurately estimate the % of FGM women pregnant in 20/21

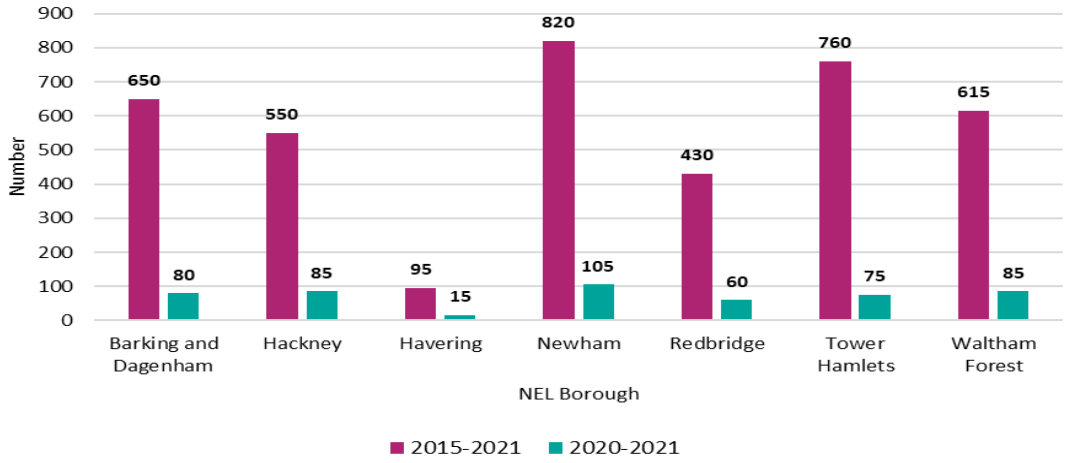
- This Data set records FGM victims regardless of whether they are or have been pregnant in the past. It does, however, include a field to indicate whether women were pregnant at the time of attendance. However, for the reasons relating to completeness – this data not been included in this analysis.

5. "Individuals"

- Note: Chart 1 refers to the total of "individuals"; i.e. referring to all patients in the reporting period where FGM was identified or a procedure for FGM was undertaken. **Each patient is only counted once**.

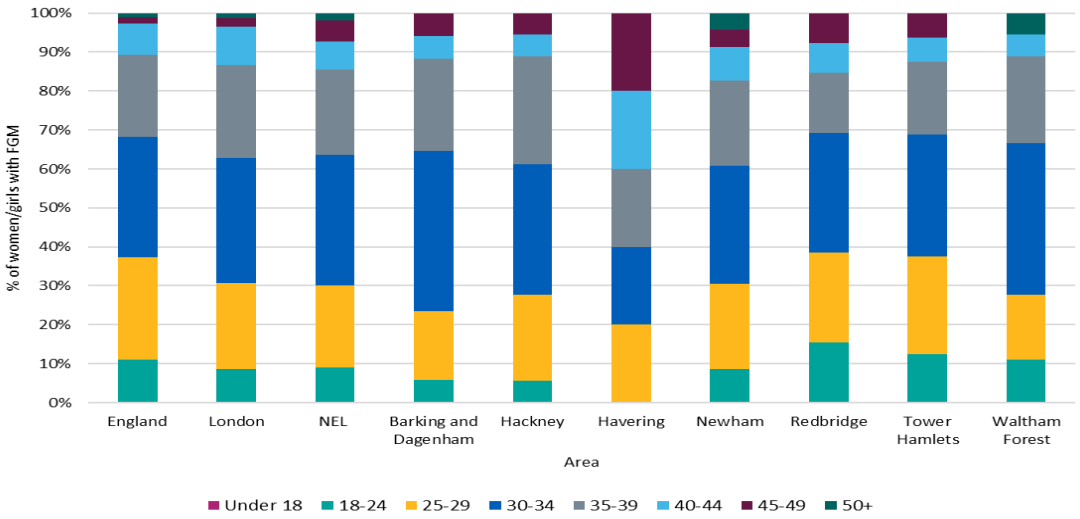
Overview of FGM population

Figure 1: Total no. of women/girls with FGM (2015-21 and 20-21)



Note: 20/21 numbers are a subset of the 2015-2021 data

Figure 2: Breakdown (%) of women/girls with FGM by age of attendance (20/21)



Key findings

- Overall, Newham, Tower Hamlets and Barking and Dagenham, have the highest number of unique women identified with FGM over the last six years. (See Chart 1). Newham and Tower Hamlets are also the two boroughs with the highest proportion of ethnic minority women. Newham had 105 women, and both Waltham Forest and Hackney had 85 women who either had FGM identified or a treatment for FGM in 20/21. This compares with **15-80** across the other 4 boroughs.

- Overall, the distribution at the NEL level across age groups is relatively consistent when compared with both London and England (See Chart 2). The age distribution across all boroughs tends to be skewed more towards women in the 30+ age groups with an average of **60%** reported as being in this age group in NEL overall.

Overview of FGM population (2)

Figure 3: Breakdown (%) of women/girls with FGM by Type (20/21)

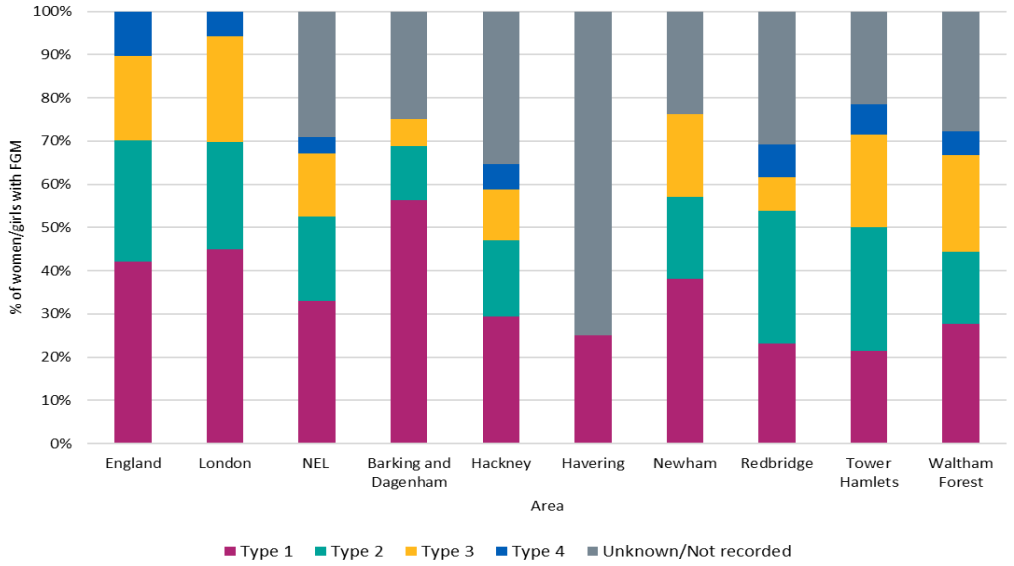
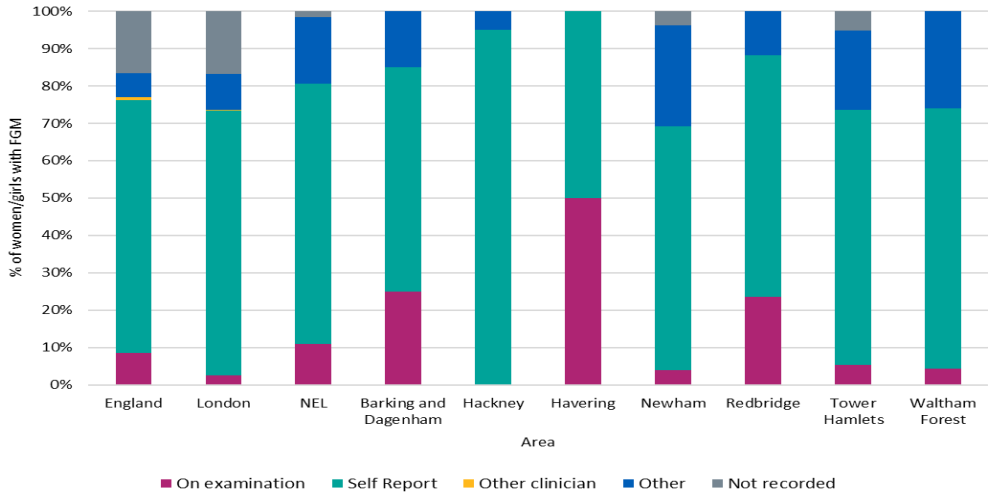


Figure 4: Breakdown (%) of women/girls with FGM by their FGM identification method (20/21)



Key findings

- Similarly to London and national trends, Type 1 is the **most common** FGM type across NEL **(21-56%)** and Type 4 is the least common, with the highest proportion of Type 4 FGM are Redbridge (**8%)** and Tower Hamlets (**7%).** Barking and Dagenham has a much lower proportion of women with the more severe Type 2 and 3 FGM compared to the other NEL boroughs (as well as London and England averages) and has no reported cases of Type 4. (See Chart 3)

- In line with London and national trends, 'Self Report' is the most common method of identification for women and girls with FGM across NEL (**50-95%),** Hackney having the greatest proportion of almost all (**95%)** methods of identification being Self Report. This is different to Havering where only half identify through 'Self Report'. The other **50%** are identified 'On examination', which is unique both across NEL as well as England and London, where 'On examination**'** figures are **9%** and **3%** respectively. (See Chart 4)

Annex 7 – Covid-19 infections & admissions

COVID-19 Infections by ethnicity and deprivation

Figure 1: % of pregnant women infected with COVID-19 - by borough (2020/21)

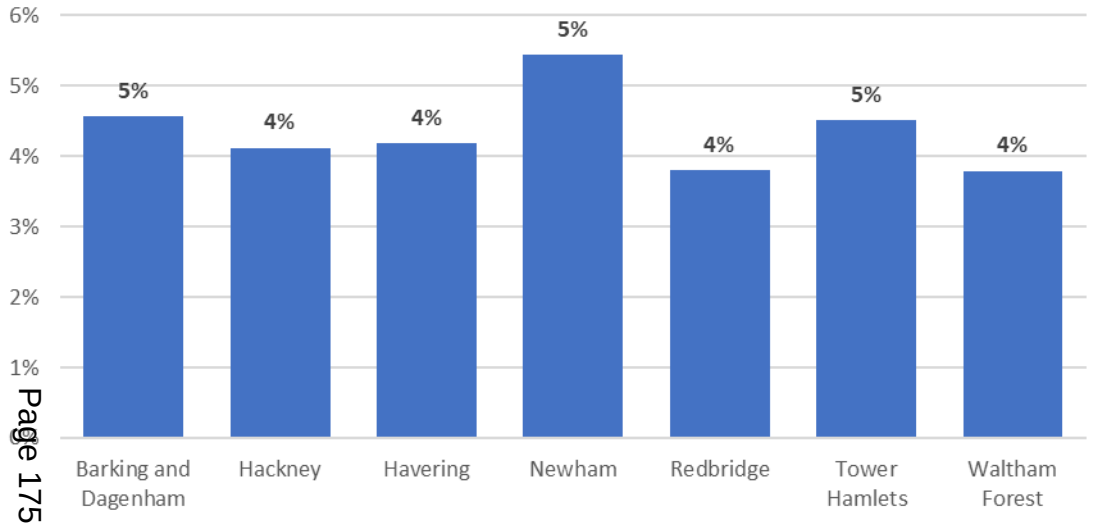
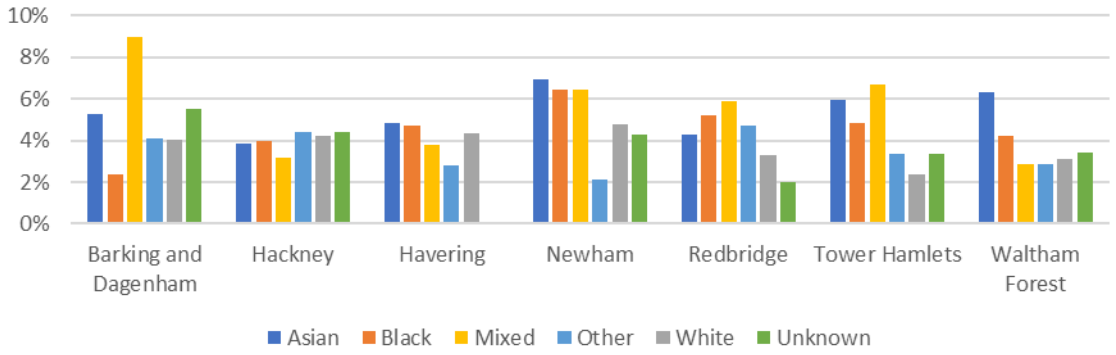


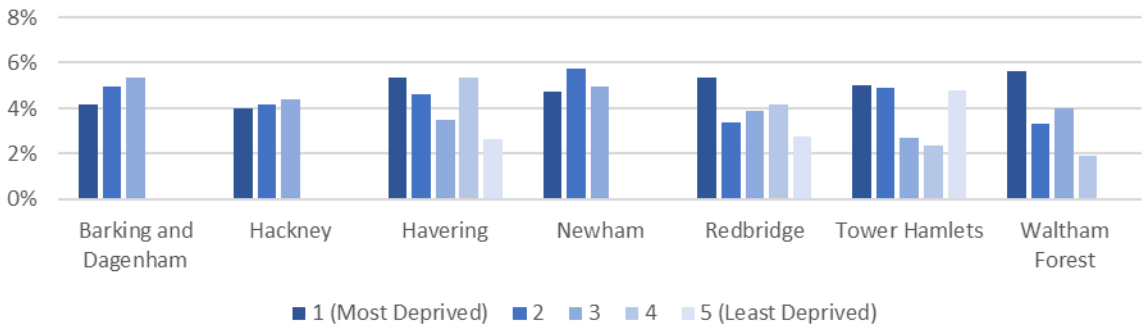
Figure 2: % of pregnant women infected with COVID-19 - by ethnicity and borough (2020/21)



Key findings:

- Across NEL, **4%** of pregnant women were infected with COVID while pregnant. There were only small differences between boroughs, with all boroughs having an admission percentage between **4-5%**.
- With the exception of Hackney and Havering, in general women in ethnic minority groups across all boroughs were more likely to be infected with COVID than White women
- Within some boroughs, the rates of infection for women among Black, Asian and Mixed groups were **double** those among White women :
    - In Waltham Forest, the percentage of Asian women infected with COVID while pregnant was **two times higher** than for White ethnicities (**6%** compared with **3%).**
    - In Barking and Dagenham and Redbridge the percentage of women from a Mixed background infected by COVID was **twice** that for White women. In and Tower Hamlets the rate is **three times** as high.
- In addition to the inequalities within boroughs, there are some key inequalities across boroughs:
    - The percentage of pregnant women infected with COVID-19 of Black ethnicity is **three times** higher in Newham than in Barking and Dagenham (**6%** compared with **2%).**
    - The percentage of pregnant women infected with COVID-19 of Mixed ethnicity **is over two times** higher in Barking and Dagenham than in Hackney and Waltham Forest.
- Across NEL, although differences between deprivation quintiles appear relatively small, the percentage of women infected with COVID while pregnant fell from the most deprived quintile (**5%**) to the least deprived quintile (**3%**).
- This trend is most apparent in Havering, Redbridge and Waltham Forest, where the percentage of women with COVID while pregnant is **2 times higher** for the **most deprived** quintile than the **least deprived** quintile.

Figure 3: % of pregnant women infected with COVID-19 - by deprivation and borough (2020/21)



COVID-19 Admissions by ethnicity & deprivation

Figure 4: % of pregnant women admitted to hospital with COVID-19 - by borough (2020/21)

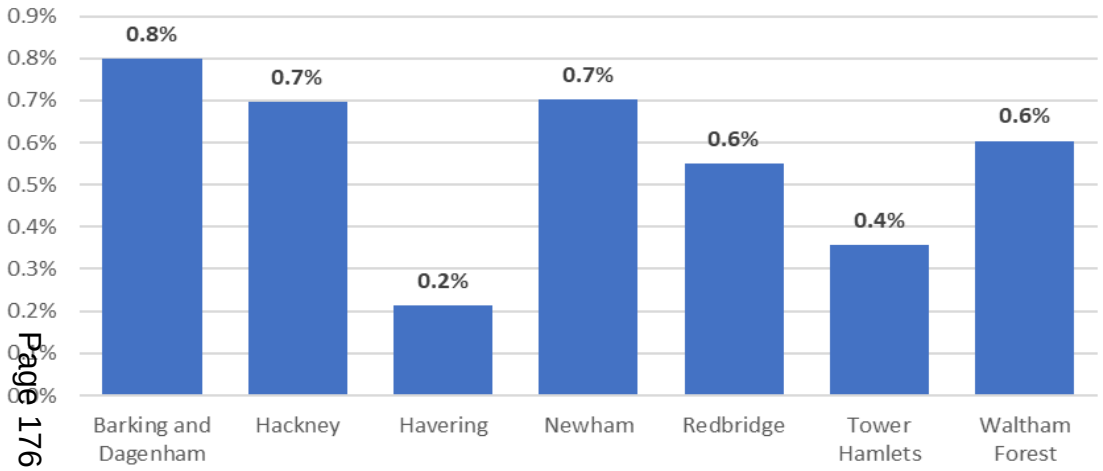
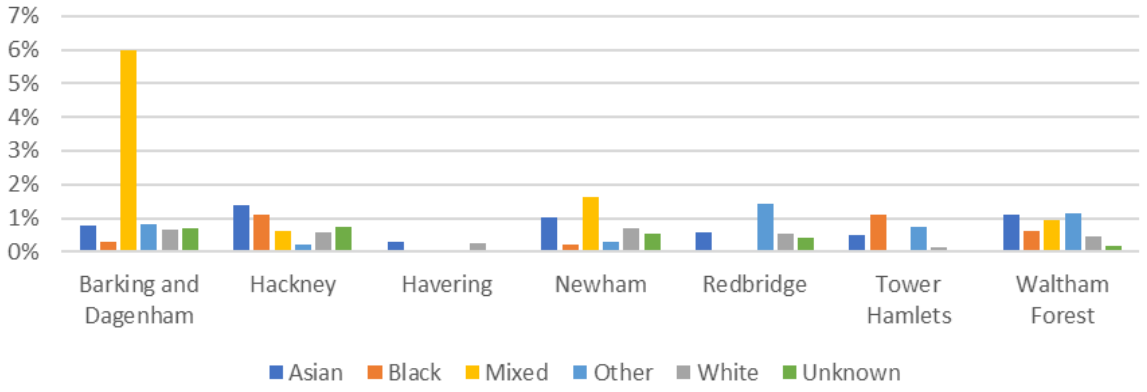


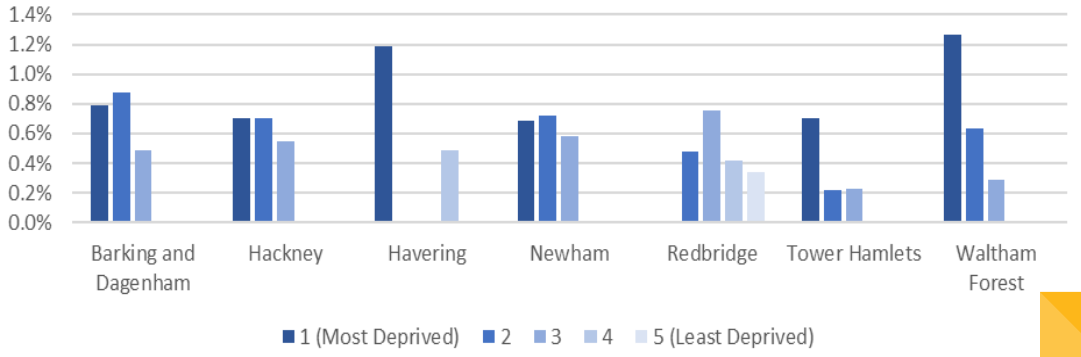
Figure 5: % of pregnant women admitted to hospital with COVID-19 - by ethnicity and borough (2020/21)



Key findings:

- Across NEL, **0.6%** of women were admitted to hospital with COVID while pregnant. Havering had the lowest percentage of women admitted to hospital at **0.2%** while the percentage for Barking and Dagenham (**0.8%**) was 4 times greater.
- In general, the proportion of pregnant women admitted into hospital with Covid across all ethnicities tended to be higher than for White women. In Hackney for example, while the proportion of infections across ethnicities was broadly similar, the opposite is true for admissions, with the rate among Black women (**1.1%**) nearly **twice** that of White women (**0.6%**)
- Similarly, in Barking & Dagenham, the percentage of pregnant woman admitted to hospital with COVID-19 of Mixed ethnicities (**6%**) is **6 times higher** than the value for all other ethnicities in the borough (less than **1%** for all).
- As with infections, deprivation also appears to be related to the probability of admission. Across NEL as a whole the rate for the most deprived quintile (**0.8%**) was **8 times greater** than the rate for the least deprived (**0.1%**).
- Although the percentage of pregnant women admitted to hospital with COVID-19 by deprivation quintile is low for all boroughs, the percentage admitted falls from the most deprived quintiles to the least deprived in all boroughs except Redbridge. Rates for women the most deprived quintiles ranged between **0.7-1.3%** compared with **0-0.5%** among those in the top two least deprived quintiles.

Figure 6: % of pregnant women admitted to hospital with COVID-19 - by deprivation and borough (2020/21)



Annex 8 – Metrics, data sources & definitions

Outcomes – data sources & definitions

Metric	Year	Source	Definitions/Notes
% of women with an admission within 6 weeks after delivery	2020/21	SUS	This metric focuses on the percentage of women who had at least one admission within 6 weeks of delivery. Both elective and non-elective admissions are included.
% of women with an admission within 6 months after delivery	2020/21	SUS	This metric focuses on the percentage of women who had at least one admission within 6 months of delivery, excluding the first 6 weeks. Both elective and non-elective admissions are included.
% of women with an attendance within 6 weeks after delivery	2020/21	SUS	This metric focuses on the percentage of women who had at least one A&E attendance within 6 weeks of delivery.
% of women with an attendance within 6 months after delivery	2020/21	SUS	This metric focuses on the percentage of women who had at least one A&E attendance within 6 months of delivery, excluding the first 6 weeks.
Median number of outpatient appointments within 6 weeks of delivery	2020/21	SUS	This metric focuses on the median number of outpatient appointments for women with all specialties within 6 weeks of delivery
% of babies born with extremely low birth weight by ethnicity and deprivation	2020/21	HES	This metric focuses on the percentage of babies born with low birth weight, where low birth weight is defined as less than 2500g. For ethnicity it is the mothers ethnicity that is captured rather than the baby's.
% of babies admitted to neonatal critical care	2020/21	HES	This metric focuses on the percentage of babies admitted to neonatal critical care. For ethnicity it is the mothers ethnicity that is captured rather than the baby's. A baby is considered in the neonatal period if they are within the first 28 days of their birth date.
Stillbirth rate	2020/21	HES	This metric focuses on the rate per 1000 of babies born stillbirth. For ethnicity it is the mothers ethnicity that is captured rather than the baby's.

Access and use of services – data sources & definitions

Metric	Year	Source	Definitions/Notes
% of women with at least 1 inpatient admission during pregnancy	2020/21	Secondary uses service (SUS) dataset	This metric focuses on the percentage of pregnant women who had at least 1 admission during pregnancy. Both elective and non-elective admissions are included.
% of women with at least 1 A&E attendance during pregnancy	2020/21	Secondary uses service (SUS) dataset	This metric focuses on the percentage of pregnant women who had at least one A&E attendance during pregnancy
Median number of outpatient appointments by Midwifery and Obstetrics during pregnancy	2020/21	Secondary uses service (SUS) dataset	This metric focuses on the median number of outpatient appointments for pregnant women with the midwifery and obstetrics specialties.
Average gestational age at first contact	2020/21	Maternity services (MSDS) dataset	This metric focuses on the average gestational age at first contact where first contact is defined as the date the women first contacted the NHS for antenatal/pregnancy care. This is either GP appointment or direct access to maternity services.

LTCs & risk factors – data sources & definitions

Metric	Year	Source	Definitions/Notes
Prevalence of Epilepsy (%)	2021	SUS	The rate of women giving birth in 2021 that have an ICD-10 diagnosis of epilepsy
Prevalence of diabetes (%)	2021	SUS	The rate of women giving birth in 2021 that have an ICD-10 diagnosis of type 1 or 2 diabetes
Prevalence of high blood pressure/hypertension (%)	2021	SUS	The rate of women giving birth in 2021 that have an ICD-10 diagnosis of hypertension
Prevalence of High BMI/ Obesity (%)	2021	SUS	The rate of women giving birth in 2021 that have a BMI of 30 or above
Folic Acid status	2021	HES	This records whether or not the woman has been taking folic acid supplements, as identified at First Contact or Booking Appointment. It combines national codes 01 (has been taking prior to pregnancy & 02 (started taking once pregnancy confirmed)
Disability indicator (%)	2021	HES	The rate amongst women that gave birth in 2021 who have a listed disability
Employment Status (%)	2021	HES	the rate among women that gave birth in 2021 who are not in employment, due to unemployment, long term sickness or disability.
Complex social factors (%)	2021	HES	Complex social factors include women aged under 20, women who experience domestic abuse, women who are recent migrants, asylum seekers or refugees, or who have difficulty reading or speaking English or women who misuse substances including alcohol.

Delivery methods – data sources & definitions

Metric	Year	Source	Definitions/Notes
% Babies born by delivery Method – Vaginal Birth	2020-21	MSDS	The rate of babies being delivered by the method of Spontaneous Vertex, or Spontaneous other delivery
% Babies born by delivery Method – Forceps	2020-21	MSDS	The rate of babies being delivered by the method of Low forceps cephalic delivery or Other Forceps delivery
% Babies born by delivery Method – Planned C-Section	2020-21	MSDS	The rate of babies being delivered by the method of Elective Caesarean Section
% Babies born by delivery Method – Unplanned C-Section	2020-21	MSDS	The rate of babies being delivered by the method of Emergency Caesarean Section
% of women having a episiotomy	2020-21	HES	At present this derivation will always be NULL. This is a placeholder derivation, pending further discussion with subject matter experts within NHS Digital on the construction logic. This construction logic will be confirmed in a future release of the Technical Output Specification.
Post Partum Haemorrhage	2020-21	HES	Post-partum haemorrhage (PPH) is excessive bleeding from the vagina at any time after the baby's birth, up until 6 weeks afterwards. PPH is a complication that can occur during the third stage of labour after a baby's born
% of women with 1st/2nd/3rd degree tears	2020-21	HES	Women who receive a tear during delivery 1st degree involves skin 2nd degree involved perineal muscles 3rd degree with partial anal sphincter involvement

Annex 9 – Data completeness and coverage by NEL borough and trust

Difference in population sizes by data source

- Our analysis has had to drawn on a mix of **three main data sources**: **Secondary Uses Services (SUS), Hospital Episode Statistics (HES**) and the **Maternity Data Set (MSDS).** While similar, there are differences in the total numbers of births and deliveries that each of the sources reports for 20/21 which means that in some cases, the denominators for some calculations will be difference depending on the source used.

20/21 cohort description	Data source		
	SUS	HES	MSDS
Total deliveries (i.e. unique women)	23,790	24,640	23,559
Total births	24,904	25,590	23,812

Outcomes– data coverage and completeness of metrics [by Borough]

Metric	Source			Coverage of records as NEL level 20/21	Coverage of records as NEL level						
	SUS	HES	MDS		TH	N	WF	BG	R	HV	HK
% of women with an admission within 6 weeks after delivery	x			*N/A. Trusts will only record this for a an individual if they have ether attended or been admitted. If they did not have an attendance/admission there will be nothing recorded for this in their record (i.e. they would not record that the individual did not attend A&E). This means that we are unable to tell for any of those individuals that have not been flagged as having had an attendance/admission whether do they do in fact have one (or more) it but this has not been recorded for them.*							
% of women with an admission within 6 months after delivery	x										
% of women with an attendance within 6 weeks after delivery	x										
% of women with an attendance within 6 months after delivery	x										
Median number of outpatient appointments within 6 weeks of delivery	x										
% of babies born with extremely low birth weight by ethnicity and deprivation		x		94%	96%	98%	92%	97%	95%	93%	84%
% of babies admitted to neonatal critical care		x		90%	100%	99%	94%	79%	82%	59%	95%
Stillbirth rate		x		94%	97%	98%	92%	97%	95%	93%	84%

*Based on recording of events in SUS, as not every woman will have an event we cannot accurately say if there are secondary care events missing.

Outcomes – data coverage and completeness of metrics [by Trust]

Metric	Source			Coverage of records as NEL level 20/21	Coverage of records as NEL level		
	SUS	HES	MDS		Barts	BHRUT	Homerton
% of women with an admission within 6 weeks after delivery	X			*N/A. Trusts will only record this for a an individual if they have ether attended or ben admitted. If they did not have an attendance/admission there will be nothing recorded for this in their record (i.e. they would not record that the individual did not attend A&E). This means that we are unable to tell for any of those individuals that have not been flagged as having had an attendance/admission whether do they do in fact have one (or more) it but this has not been recorded for them*			
% of women with an admission within 6 months after delivery	X						
% of women with an attendance within 6 weeks after delivery	X						
% of women with an attendance within 6 months after delivery	X						
Median number of outpatient appointments within 6 weeks of delivery	X						
% of babies born with extremely low birth weight by ethnicity and deprivation		X		*NB. Our current data extract does not provide this information at trust level and due to the short timescale we are unable to extract trust level data for these metrics.*			
% of babies admitted to neonatal critical care		X					
Stillbirth rate		x					

Access to services – data coverage and completeness of metrics [by Borough]

Metric	Source			Coverage of records as NEL level 20/21	Coverage of records as NEL level						
	SUS	HES	MDS		TH	N	WF	BG	R	HV	HK
% of women with at least 1 inpatient admission during pregnancy	x			100%*	100%*	100%*	100%*	100%*	100%*	100%*	100%*
% of women with at least 1 A&E attendance during pregnancy	x			100%*	100%*	100%*	100%*	100%*	100%*	100%*	100%*
Median number of outpatient appointments by Midwifery and Obstetrics during pregnancy	x			100%*	100%*	100%*	100%*	100%*	100%*	100%*	100%*
Average gestational age at first contact			x	100%**	100%**	100%**	100%**	100%**	100%**	100%**	100%**

*Based on recording of events in SUS, as not every woman will have an event we cannot accurately say if there are secondary care events missing.

**Based on recording of events in MSDS, any woman with any contact during their pregnancy will by necessity have a first contact, but those without any first contact will not be recorded at all

Access to services – data coverage and completeness of metrics [by Trust]

Metric	Source			Coverage of records as NEL level 20/21	Coverage of records as NEL level		
	SUS	HES	MDS		Barts	BHRUT	Homerton
% of women with at least 1 inpatient admission during pregnancy	x			100%*	100%*	100%*	100%*
% of women with at least 1 A&E attendance during pregnancy	x			100%*	100%*	100%*	100%*
Median number of outpatient appointments by Midwifery and Obstetrics during pregnancy	x			100%*	100%*	100%*	100%*
Average gestational age at first contact			x	100%**	100%**	100%**	100%**

*Based on recording of events in SUS, as not every woman will have an event we cannot accurately say if there are secondary care events missing.

**Based on recording of events in MSDS, any woman with any contact during their pregnancy will by necessity have a first contact, but those without any first contact will not be recorded at all

LTCs & risk factors – data coverage and completeness of metrics [by Borough]

Metric	Source			Coverage of records as NEL level 20/21	Coverage of records as NEL level						
	SUS	HES	MDS		TH	N	WF	BG	R	HV	HK
Prevalence of Epilepsy (%)	X			*N/A. Trusts will only record this for a an individual if they have been diagnosed with the condition. If they do not have the condition there will be nothing recorded for this in their record (i.e. they would not record that the individual does not have the condition). This means that we are unable to tell for any of those individuals that have not been flagged as having this condition, whether do they do in fact have it but this has not been recorded for them*							
Prevalence of diabetes (%)	X										
Prevalence of high blood pressure/hypertension (%)	X										
Prevalence of High BMI/ Obesity (%)	X										
Folic Acid status			X	71%	53%	46%	68%	75%	78%	97%	97%
Disability indicator (%)			X	98%	95%	97%	98%	99%	98%	98%	99%
Employment Status (%)			X	91%	87%	93%	91%	95%	95%	98%	81%
Complex social factors (%)			X	86%	76%	76%	80%	87%	89%	98%	99%

LTCs & risk factors – data coverage and completeness of metrics [by Trust]

Metric	Source			Coverage of records as NEL level 20/21	Coverage of records as NEL level		
	SUS	HES	MDS		Barts	BHRUT	Hommerton
Prevalence of Epilepsy (%)	X			*N/A. Trusts will only record this for a an individual if they have been diagnosed with the condition. If they do not have the condition there will be nothing recorded for this in their record (i.e. they would not record that the individual does not have the condition). This means that we are unable to tell for any of those individuals that have not been flagged as having this condition, whether do they do in fact have it but this has not been recorded for them*			
Prevalence of diabetes (%)	X						
Prevalence of high blood pressure/hypertension (%)	X						
Prevalence of High BMI/ Obesity (%)	X						
Folic Acid status			X	71%	41%	100%	99%
Disability indicator (%)			X	98%	97%	100%	100%
Employment Status (%)			X	93%	93%	100%	100%
Complex social factors (%)			X	86%	71%	100%	100%

Delivery methods – data coverage and completeness [by Trust]

Metric	Source			Coverage of records as NEL level 20/21	Coverage of records as NEL level		
	SUS	HES	MDS		Barts	BHRUT	Hommerton
% Babies born by delivery Method			x	99%	100%	98%	100%
Post Partum Haemorrhage		x		*Diagnosis codes do not exist in a flagged system. There is no way of telling if a diagnosis code doesn't exist because it wasn't recorded, as opposed to the patient not being diagnosed with a particular item*			
% of women with 1st/2nd/3rd degree tears		x					

Delivery methods – data coverage and completeness [by Borough]

Metric	Source			Coverage of records as NEL level 20/21	Coverage of records as NEL level						
	SUS	HES	MSDS		TH	N	WF	BG	R	HV	HK
% Babies born by delivery Method			x	99%	99%	100%	99%	99%	99%	99&	99%
Post Partum Haemorrhage		x		*Diagnosis codes do not exist in a flagged system. There is no way of telling if a diagnosis code doesn't exist because it wasn't recorded, as opposed to the patient not being diagnosed with a particular item*							
% of women with 1st/2nd/3rd degree tears		x									

Coverage rates across of all MDS metrics (1)

MDS metric	1. % of women included in the relevant data tables/columns	2. % of women included in the data table with a known ethnicity recorded (Black, White, Mixed, Asian or other
Gestational age at booking	92%	91%
Mental health prediction indicator (Whether or not the recommended questions for prediction and detection of mental health issues were asked.)	91%	96%
Disability indicator	91%	91%
Support status (Whether or not the mother feels she is supported in pregnancy and looking after a baby, from partner, family or friends.)	91%	91%
Employment Status	88%	92%
Complex social factors	80%	92%
Folic acid status	78%	92%
Language code (The language the patient prefers to use for communication with a Health Care Provider.)	55%	95%
Continuity of care (An indication of whether a mother has been booked onto a continuity of carer pathway, as defined by the Better Births recommendations)	43%	94%
Antepartum care plan	40%	94%

Coverage rates across of all MDS metrics (2)

MDS metric	1. % of women included in the data table	2. % of women included in the data table with a known ethnicity recorded (Black, White, Mixed, Asian or other
Personalised antepartum care plan	39%	93%
Baby first feed breastmilk	31%	92%
Skin to skin contact	22%	98%
Alcohol units at booking	9%	95%
Smoking status at booking*	0%	0%

Note – This is a selection of indicators, the MSDS contains over 40 possible metrics.

*In MSDS specification it states this column is in as a placeholder pending further discussions

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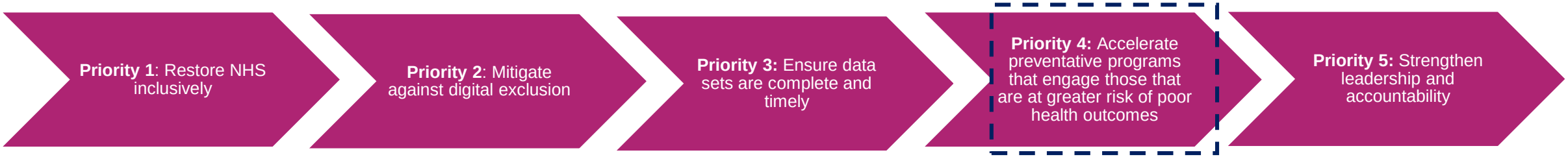
6. Community assets mapping

Prepared by Women's Health and Family Services: Maternity Mates

6.1 Aim of community assets mapping



The COVID-19 pandemic repeatedly demonstrated that-harnessing effective**, local community assets** is integral to **reducing inequalities and improving health outcomes.**

Community assets are: almost always people centred, should have cultural competence at the heart of their services and are provided from accessible and trusted locations and build on the unique strengths of our local communities

The **purpose of mapping** our community assets is to:

- Build our knowledge of what services are available across NEL within each borough
- Determine what is effective and has proven to meet the needs of Black, Asian and Mixed ethnicity pregnant women and their babies, and those living in areas with high levels of deprivation
- Understand whether there is a consistent offer across NEL
- Identify what assets are missing from areas/boroughs
- Inform a 5 year development strategy

The **Guidelines suggest**, we should put into place a directory of services for health professionals which:

- Aid or enhance personal care plans
- Provide a platform for integration and partnerships between community assets and maternity systems to improve equity for women from Ethnic Minorities backgrounds and those living in areas with high levels of deprivation.

6.2 Our approach

We used research, third sector evidenced reports and outreach to identify those assets and resources supporting populations most likely to experience Health inequalities within maternity care.

Assets and resources are categorised around Social Determinants of Health, recognising the vital role they play in addressing wider issues that can improve health outcomes particularly for those experiencing intersectionality.

Women's Voices	•Support/service delivery •Informal conversations •Interviews and focus groups from third sector report
Clinical Commissioning Group; Local Public Health, Maternity Teams	• Commissioned local services
Council for Voluntary Services	•Members and individuals •Community Centres •Associations and faith groups •Formal and informal entities
Local third and private sectors	•Charities and the Charities Commission •Companies •Housing Associations

Reference: Public Health England, Health Guidance Matters, 28 February 2018

6.3 Key caveats to asset mapping

1. Volume of local assets

- We identified approximately 2104 community assets across NEL comprising of formal and mostly informal entities offering a service that is or could be relevant to pregnant women/new mothers from Ethnic Minorities living in areas with high levels of deprivation.

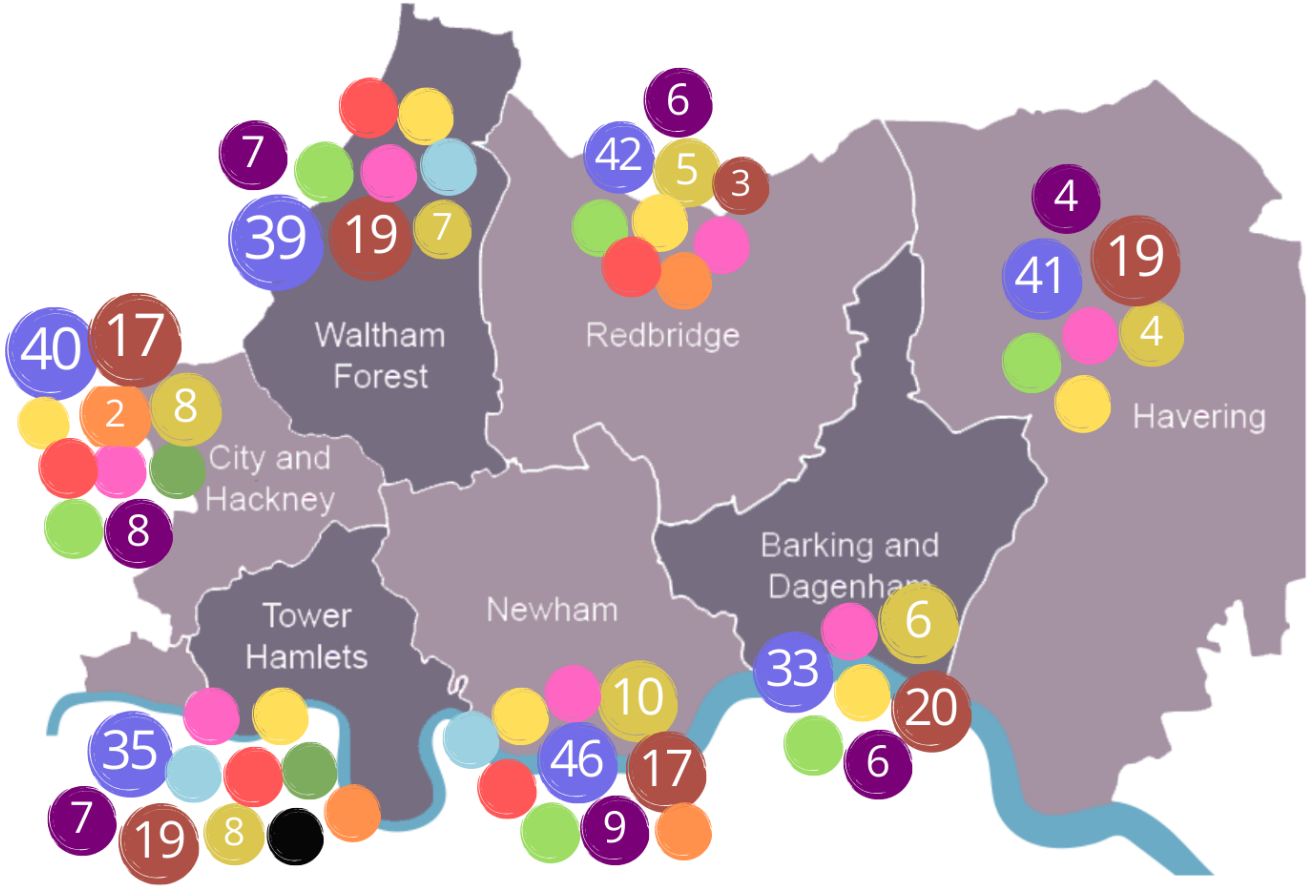
2. Quality Assurance Impact Assessment and Governance

- We recognise that, once all local community assets have been captured, it will be necessary to quality assure organisations contained within a directory (for example, Safeguarding, Governance structures and financial practices) to ensure that Maternity Services can make connections with confidence. This has not been possible within the time restraints of Stage 1 and could form a key part of Stage 3.

3. Incompleteness

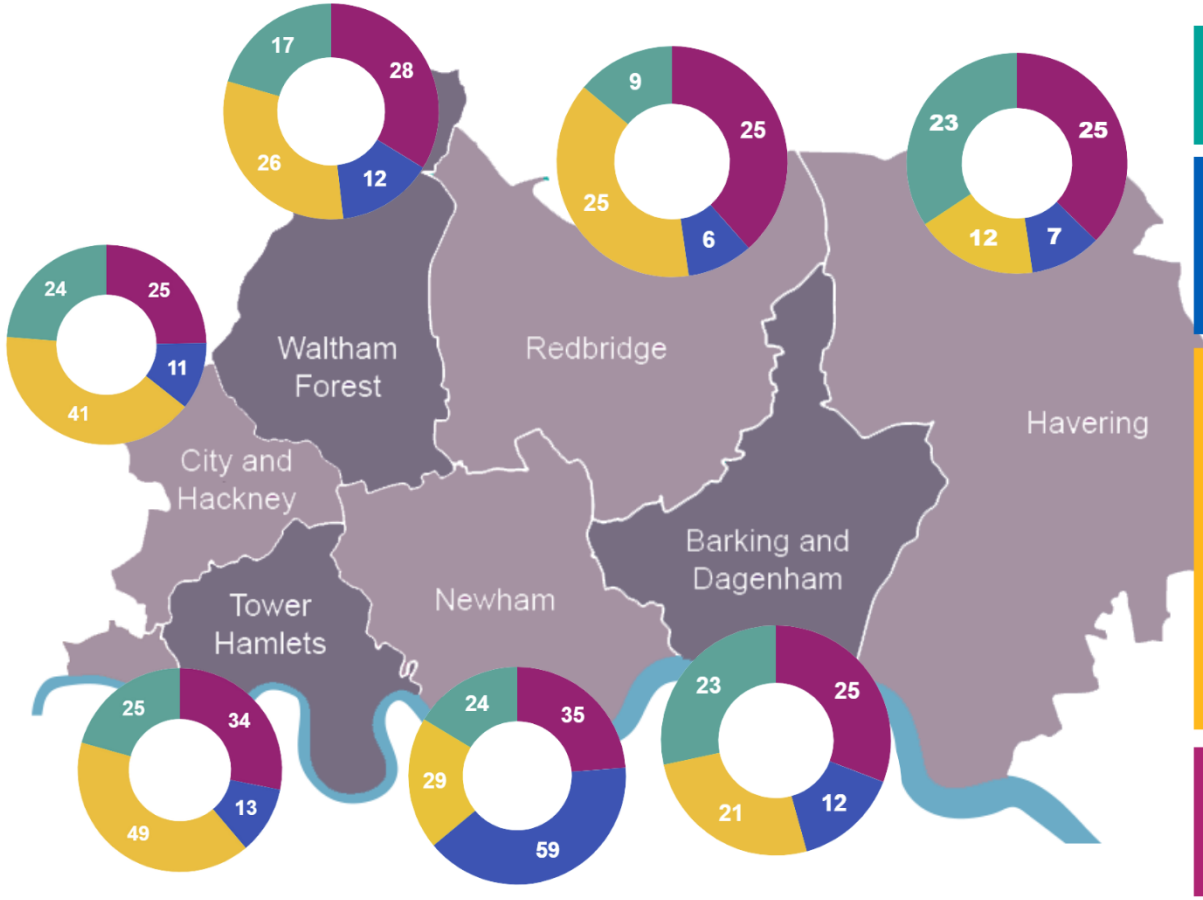
- This Stage (1) is not an exhaustive, complete picture of all existing community assets. Has instead focussed on beginning the process by highlighting 'visible' assets to inform Stage 2's coproduction with local communities.
- Time limit, to concentrate on capturing community assets, our beneficiaries
- We have also not yet cross-referenced our identified assets with those held by local Social Prescribers who represent a valuable source of information
- We also recognise the need to enhance the level of information held against each asset to understand the precise offer of support available

6.4 NEL: Statutory and Commissioned Assets



- Pharmacies
- GPs
- Primary Care Networks
- Social Prescribers
- Preconception care for pregnant women with long-term conditions
- Peer support for vulnerable pregnant women
- Family Nursing Partnership
- Women's Health Hub
- Culturally-centred Antenatal classes
- MVPs
- Healthwatch
- Bereavement and Birth Trauma Support

6.5 Asset overview categorised around social determinants of health



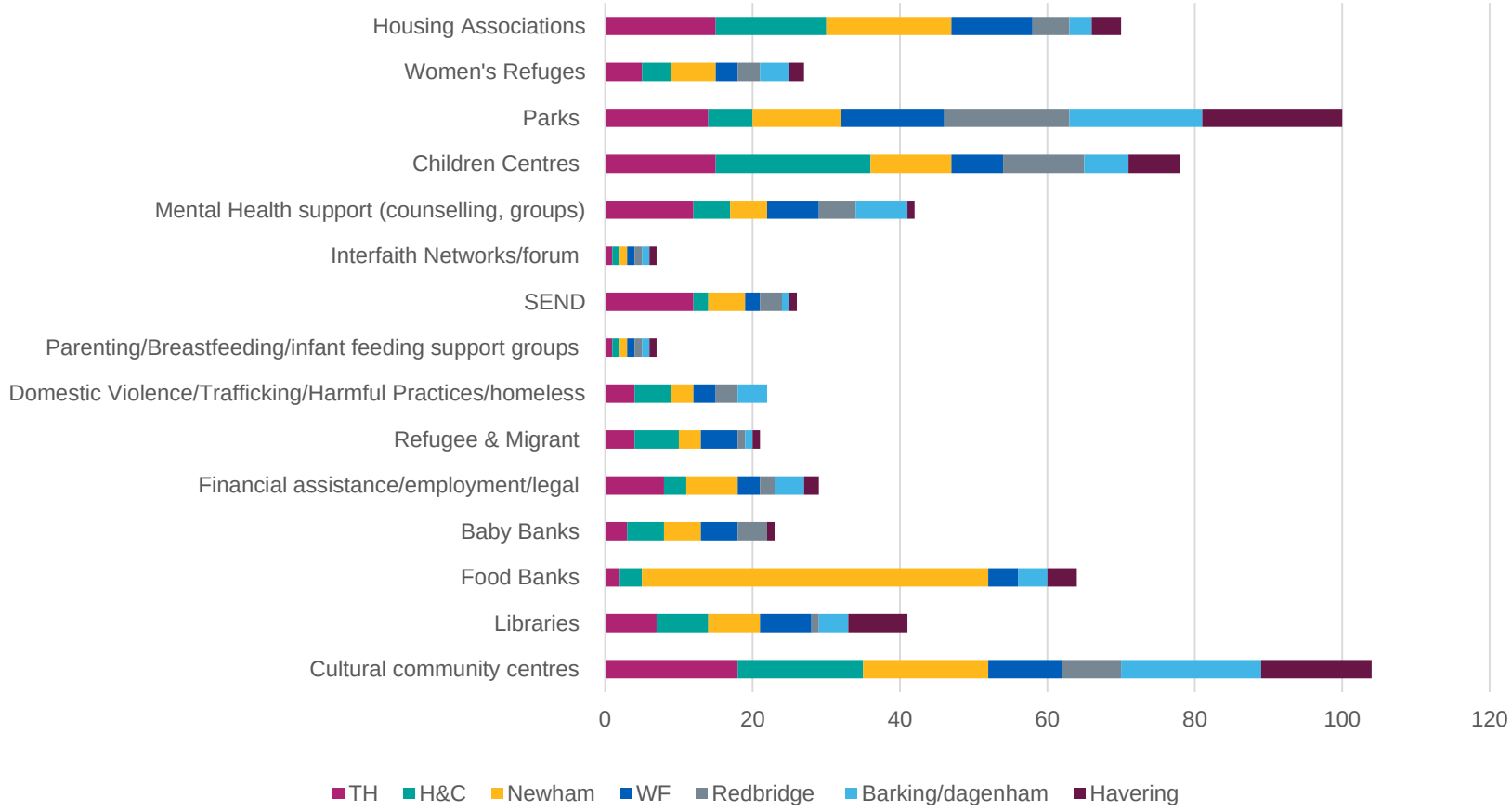
Education, language, culture
- Cultural centres
- Libraries

Poverty/Economic stability
- Food banks
- Baby Banks
- Financial Assistance
- Employment/Legal support

Social and Community
- Refugee, migrant, asylum support
- Domestic violence, trafficking and harmful practices
- Parenting, breastfeeding and infant feeding support groups
- SEND
- Interfaith networks and forum
- Mental health support
- Befriending, coffee mornings, walking groups

Housing and Neighbourhood
- Parks
- Refuges
- Housing Associations

6.6 Community Asset comparison by borough



Education, language, culture
- Cultural centres
- Libraries

Poverty/Economic stability
- Food banks
- Baby Banks
- Financial Assistance
- Employment/Legal support

Social and Community
- Refugee, migrant, asylum support
- Domestic violence, trafficking and harmful practices
- Parenting, breastfeeding and infant feeding support groups
- SEND
- Interfaith networks and forum
- Mental health support
- Befriending, coffee mornings, walking groups

Housing and Neighbourhood
- Parks
- Refuges
- Housing Associations

6.7 Key findings from our community mapping

1. Over 2100+ community assets	• Our local communities have a huge and diverse range of assets to draw upon and ensuring positive connections between these community assets and Maternity services will be hugely valuable.
2. Disparity across Boroughs	• The mapping exercise has revealed large differences between available local assets across boroughs. Whilst these differences may, at least in part, be explained by the distinct needs of the communities contained within each respective Borough, further analysis will be needed to fully understand where the most significant gaps are and how these can be best addressed as part of a future development strategy.
3. Multiple organisations have commenced community asset mapping	• Through this exercise, we have become aware of a number of other local services (E.g. social prescribing) that have taken preliminary steps to identify, map and navigating or directing women and their families to other services. We will look to co-ordinate our work with these agencies to avoid duplication and share resources wherever possible, this includes health care professionals making every contact count.
4. Perinatal Mental Health	• Perinatal Mental Health is one critical area of enormous importance to our LMS given the level and complexity of local need, nuances of intersectionality. Hence, where data analysis has not been possible at this stage. The work continues to echo trends of inequalities in health. It critically illuminates the need for maternity and perinatal mental health services to be re-built through the lenses and lived experiences of minoritised ethnic groups and communities. Co-production must be at the core of what we do.

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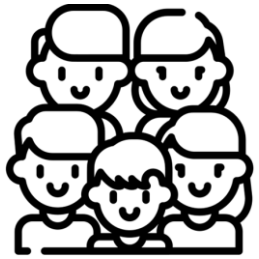
7. Case Studies across NEL LMS

Showcasing partnerships between health care professionals and community assets for pregnant people and their families:

7.1 Holistic support for an entire family: Children's Centre, The Magpie Project and the Alternatives Trust
7.2 Pregnant and substance reliance: Homerton University Hospital Foundation Trust, Hackney Orbit and Comet
7.3 Hearing from all communities: BHRUT and local faith communities
7.4 Vulnerable Pregnant Women: Bart's Health NHS Trust and Maternity Mates

7.1 Holistic support for an entire family: Children's Centre, The Magpie Project and the Alternatives Trust



Family: Pregnant mother (30), father (31) and, three children under 6, Bangladeshi.

Referral: Referral from older children's School as family are new to the area, no English, mother is pregnant, and father lost his job. Signposting for universal sessions and access to services.

Overview: Family relocated to Newham with no support network. Father is on a spouse Visa with NRPF and recently lost his job. They live in a private rented property at a cost of £1800 a month. In need of financial support.

Financial worries were affecting Mothers health and wellbeing, alongside arthritis and migraines. Referral was initially made for a low-income family with financial support needed. However, during assessment it was clear Mother needed counselling support as she has been feeling low with her pregnancy and was worried about baby and finances. Both parents needed ESOL (English to Speakers of Other Languages) classes as this was affecting their ability to access support. Father was limited with his employment search, as he had no English.

The Magpie Project: we provide a safe and fun place for mums and under-fives suffering in temporary or insecure accommodation. We believe all children have the right to a secure, safe place to play, healthy food, engaged, informed parents, and access to support, no matter what their family circumstances.

Alternatives Trust: empowers vulnerable families in the London Borough of Newham to transform their lives. A small dedicated team gives long-term, intensive support to over 100 women and their children each year through the We Are Family (WAF) programme. This is centred on a weekly therapeutic group which offers early intervention through parenting and life skills to 25-30 families each week.

Intervention and signposting

Mother

- ESOL class
- Referral to Talking Therapies for mother
- Access to Positive Parenting as mother needed support around boundaries
- Referral to Magpie and Alternatives for essentials, food and baby bag for the hospital
- Weaning webinars for baby
- New baby support with liaising with Health Team, BCG and breast feeding
- PIP completed for mother

Father

- ESOL class
- Advocacy and letter of access to clients Solicitor as father was applying to extend his Visa. Fee waiver of £2000 was granted

Whole family

- Shelter referral for family
- Referral to Newham Money for £250 vouchers
- Support with Homeless application made
- Referral to Newham Food Alliance for weekly food delivery
- Family Fund application made for Fridge Freezer which was granted
- Support with Child Benefit application
- Weekly £15 Vouchers from Alternatives during the lockdown for nappies and wipes
- Children's Centre provided bottles, bottle brush, clothes, nappies and wipes for family.
- Supported family to access Early Education for 2 year old funding for Child A
- Advocacy with universal Credit to sort out the payment as Child C was on DLA (UC was able to adjust the payment and family got higher payment)
- Supported family with DLA and carers allowance for Child C
- Liaised with School for Child C for EHCP

Outcomes

- Family were not aware about the Early Help support available when they were referred to the Children's Centre. This support has enabled mother to improve mental health and wellbeing as she has now completed all her Talking Therapy sessions. She is now able to contact the Children Centre herself and book in the play sessions for baby.
- New baby has accessed the Sensory baby sessions and mother understands the importance of tummy time and early communication with baby. Mother feels empowered within the community as she now has made new friends and confident to arrange GP appointment for herself. Father has completed his online ESOL classes.
- Child A has accessed the 15 hours nursery and is happy, thriving and there are no concerns with their developmental milestones.

7.2 Pregnant and substance reliance: Homerton University Hospital, Hackney Orbit and Comet

From **Hackney Orbit's** launch in 2015, the service has provided robust and sustained support for its service users. Strong relationships have been developed between the service users and the professionals, and a trusting and open dialogue has been created. Honest, and at times challenging conversations take place but always within a safe environment.

From the formal sessions that started in January 2016 there have been many successes and challenges within our work. There has continued to be a core group of service uses and the children have greatly benefited from the crèche sessions that are led by Comet early years practitioners. They are offered a range of resources, play equipment and experiences that are rich, challenging, stimulating and fun, therefore supporting the child's development and the parent-child relationship.

I enjoy socialising and the activities

It helped me grow comfortable with my baby's development

I feel safe and comfortable there

I like the non-judgmental environment

It helps with my anxiety

I was happy with the support I received and how welcoming the group was

Hackney Orbit: provides antenatal, postnatal and holistic support to women experiencing current or historical substance and alcohol dependency. In addition to the support provided for women, the sessions are accessible to their partners and family members; parents, carers of children aged 5 or under where a person in the family is experiencing the effects of substance / alcohol use whether engaged in treatment or not.

7.3 Hearing from all communities: BHRUT and local faith communities

The role of **Midwife for Multi-Ethnic Empowerment** was introduced for the trust to proactively seek out and implement changes and solutions that will work towards reducing the health inequalities and disparities faced by Black, Asian and Minority Ethnic women during pregnancy and childbirth, both in their outcomes and experiences.

The Midwife currently in the role reported *'the solutions and answers already exist, the women who bear the brunt of these stark statistics can tell us exactly what we need to do to make immediate and sustainable changes, we just need to listen and act on what they tell us'.*

It was felt asking women to fill in surveys about their maternity experience at the point of leaving the hospital was not always the right time to gain their meaningful, detailed contributions to improving care. This method also excluded women who were not fluent in English from providing their feedback.

Instead, as part of her role, the midwife for Multi-Ethnic Empowerment undertakes targeted outreach work, working in partnership with faith and community groups representing the local communities, meeting and consulting with women during their mother and baby group sessions at local centres. Meeting with women in their own spaces, gives a sense of safety and familiarity, providing optimum environments for honest conversations amongst groups of women who already know each other and are able to provide peer support when needed.

To date, women have shared their positive experiences as well as constructive feedback regarding the aspects of their maternity care that they felt were unsafe, unkind or did not meet the expected standard of care. To ensure that women's voices are heard, consenting mothers will record their stories so they can be shared to the wider team and inform the changes that need to be made.

7.4 Vulnerable Pregnant Women: Bart's Health NHS Trust and Maternity Mates

The COVID-19 pandemic was an incredibly challenging period for our marginalised people who were already extremely isolated and facing unimaginably difficult circumstances that were only exacerbated by the crisis.

Case study 1: Mum was referred at 8 months pregnant, suffering from depression and anxiety. At the first introduction meeting, by video call due to Covid-19, the Maternity Mate (MM) reported mum seemed disengaged and disinterested. Alia opened up by text and explained that she couldn't speak freely as she shared her home with her husband and his large family. She felt isolated, had no friends or family and said her husband was verbally abusive and controlling. MM worked closely with mum's social worker and accompanied mum to her perinatal mental health appointments. Maternity Mates funded mum's taxi to these appointments when her husband refused to help.

At birth, MM helped mum manage pain through walking and massage. She also helped mum call her sister after the birth, as her husband had blocked mums contact with her family. Maternity Mates Support Assessors visited mum on the postnatal ward, and supported her wish to breastfeed. Mum told MM her husband's family kept taking the baby from her to give them formula. MM took Alia to the East London Sling Library so she could wear a sling with baby in to prevent them being taken. At the height of the pandemic, MM also arranged with the local Children's Centre a space for her and mum to meet weekly, in private, so mum could speak freely. MM also accompanied mum to baby massage classes and referred her to a culturally relevant support network for women who had been in similar situations.

Case Study 2: Mum was referred at 4 months pregnant as a single mum with no support from family and friends. She disclosed being raped in her home country. She was now in the UK as an asylum seeker, her level of English was very limited, and she did not feel prepared for the arrival of her baby.

Due to limited income, she needed support fulfilling her basic needs. Mum's Maternity Mate (MM) accompanied her to a food bank and helped her find affordable baby items online, since mum felt apprehensive about the pandemic and did not want donated second hand items. Maternity Mates Support Assessors supported her with a heater for the winter. Mum attended online antenatal class. It was difficult in the beginning since she did not have enough data credit to attend Zoom calls for the length of the course and her understanding of English was quite limited. Maternity Mates provided phone credit and found an Arabic interpreter so mum was able to attend and participate in the sessions.

The property where mum lived was in a terrible condition. Both the MM and Programme Coordinator liaised with the property manager on taking actions towards repair. To encourage exercise and get to know Newham, the MM and mum would go to different shops and compare prices, engaging in conversations around diet and healthy eating, since mum was not eating well.

Mum was taken to the hospital and induced due to low foetal activity. She was very scared but the same interpreter and the MM talked to her and the doctors to translate. Neither were allowed in the induction due to COVID-19 restrictions but they followed up closely with mum once the baby was born. On her leaving hospital, we arranged a taxi for her to get home.

A **Maternity Mate** is a female volunteer trained by Women's Health and Family Service, to provide practical and emotional support to women during pregnancy, childbirth and the early weeks of motherhood.

North East London
Clinical Commissioning Group

8. Staff Experience
WRES indicators

8.1 Overview of the National WRES dataset

- The analysis presented in this report is based on nationally collected data on the Workforce Race Equality Standard (WRES). Our analysis of these data is confused on the three NEL acute trusts: Homerton University Hospital NHS Foundation Trust, Barts Health NHS Trust and Barking, Havering and Redbridge University Hospitals NHS Trust.

1.What is the WRES dataset?

The WRES programme was established in 2015 and requires NHS commissioners and NHS organisations (including private providers) to report yearly against 9 indicators of race equality. The WRES is mandated through the NHS standard contract. The annually published WRES Report and supporting data is intended to:

- enable organisations to compare their performance with others in their region and those providing similar services: and to
provide a national picture of WRES in practice, to colleagues, organisations and the public on the developments in the workforce race equality agenda.

The latest WRES Report and data covers the period 20/21.

- *Link: https://www.england.nhs.uk/publication/workforce-race-equality-standard-2020-supporting-data/*

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2. Which of the WRES indicators have we included in this report?

- This analysis covers all **nine** of the WRES indicators (see table to the right]
- *[Note: I = Indicator]*

	Workforce indicators For each of the four workforce indicators, ***compare the data for white and BME staff***
1	Percentage of staff in each of the AfC Bands 1-9 or medical and dental subgroups and VSM (including executive board members) compared with the percentage of staff in the overall workforce disaggregated by: • Non-clinical staff • Clinical staff, of which – Non-medical staff – Medical and dental staff *Note: Definitions for these categories are based on Electronic Staff Record occupation codes with the exception of medical and dental staff, which are based upon grade codes.*
2	Relative likelihood of staff being appointed from shortlisting across all posts *Note: This refers to both external and internal posts*
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation *Note: This indicator will be based on data from a two-year rolling average of the current year and the previous year.*
4	Relative likelihood of staff accessing non-mandatory training and CPD
	National NHS Staff Survey indicators (or equivalent) For each of the four staff survey indicators, ***compare the outcomes of the responses for white and BME staff***
5	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
6	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
7	KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion
8	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues
	Board representation indicator For this indicator, ***compare the difference for white and BME staff***
9	Percentage difference between the organisation's board membership and its overall workforce disaggregated: • By voting membership of the board • By executive membership of the board

8.2 Key caveats and limitations of the WRES data and assumptions

1.Some of the indicators include in this analysis covers all staff groups (i.e. not split by specialty)	• The data reported nationally is not split by specialty. However, NHSD have been able to provide us with data for some indicators covered by the standard for Midwifery staff only (i.e. 1, and 5-7). This means that the data with the exceptions of indicators 2 - 9 (which covers all specialty). It is unclear how far the findings on the latter type of indicators will be representative of the experience of midwifery staff specifically.
2. The breakdown of ethnic groupings are limited	• The ethnicity groupings are limited to **White, BME and Null.** This is means that we are unable to see inequalities across sub-groups (for whom inequalities may vary) in the way we are for the border analysis of maternity inequalities in which this analysis is part.
3. The published data does not also include information on gender split	• The data does not provide this split which means we cannot identify whether staff in ethnic minority groups may be at a particular disadvantage due to their gender. This is particularly relevant for this analysis as we know that a large majority of maternity staff will be made up of women.
4. The published data does not include the overall distribution of staff employed by ethnicity	• The publicly available data does not provide the overall split of staff by ethnicity group which means that we cannot directly assess for either over or under representation for those indicators that do not take account of differences in the absolute numbers of staff within each grouping (i.e. Board representation). This does not apply to the indicators for which NHSD has supplied data for midwifery staff (in which they also included data on the overall distribution of this staff type by ethnicity).

8.3 Overall distribution of Midwifery staff by ethnicity 2020/21

Figure 1: Breakdown (%) of Midwives in BHRUT by ethnicity (20/21)

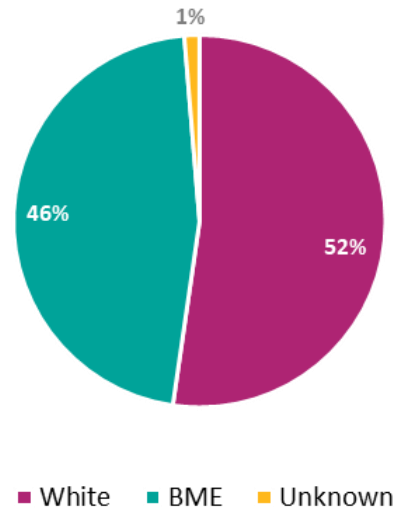


Figure 2: Breakdown (%) of Midwives in Bart's Health NHS Trust by ethnicity (20/21)

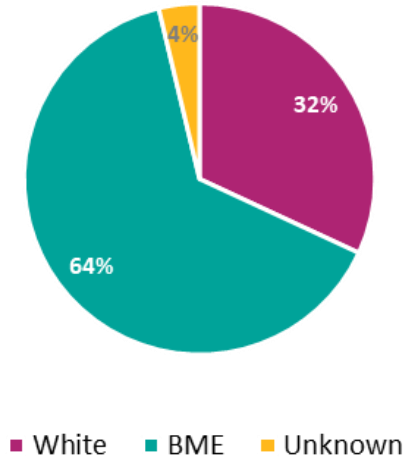
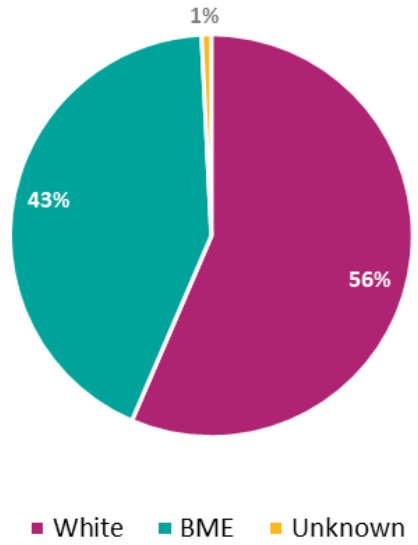


Figure 3: Breakdown (%) of Homerton University Hospital NHS Foundation Trust by ethnicity (20/21)



National distribution of Midwifery staff by ethnicity		
White	BME	Unknown
85%	11.7%	3%

- BME Midwives make up close to or more than half of the total number of midwives in NHS trusts, ranging between **43-64%**. Bart's is the only trust with White midwives as the minority (**32%).**

I1: Distribution of staff by ethnicity and Afc pay band (Midwifery only)

Figure 4: Breakdown (%) of midwives by pay band and ethnicity across Homerton (2020/21)

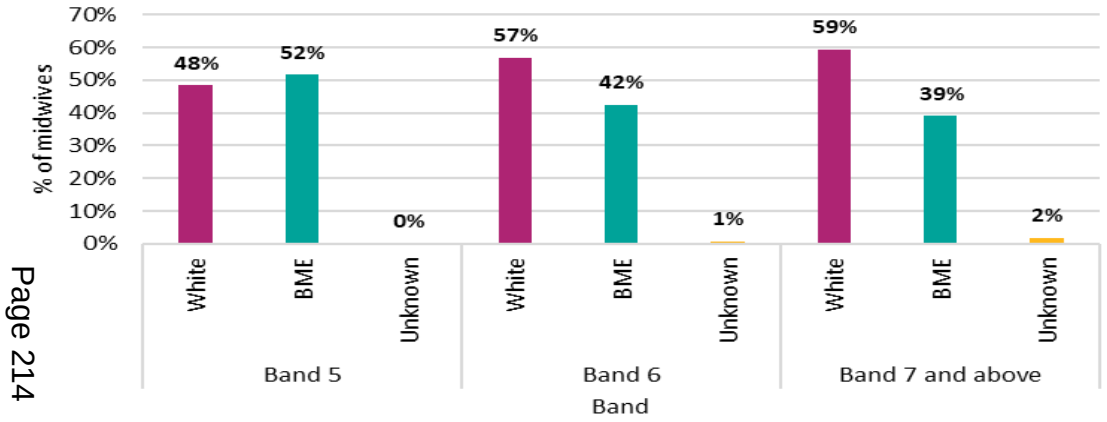


Figure 5: Breakdown (%) of midwives by pay band and ethnicity across BHRUT (2020/21)

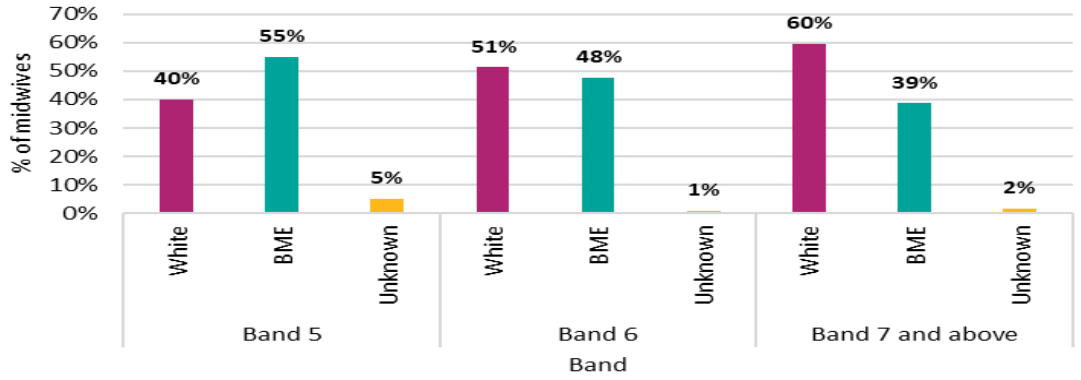
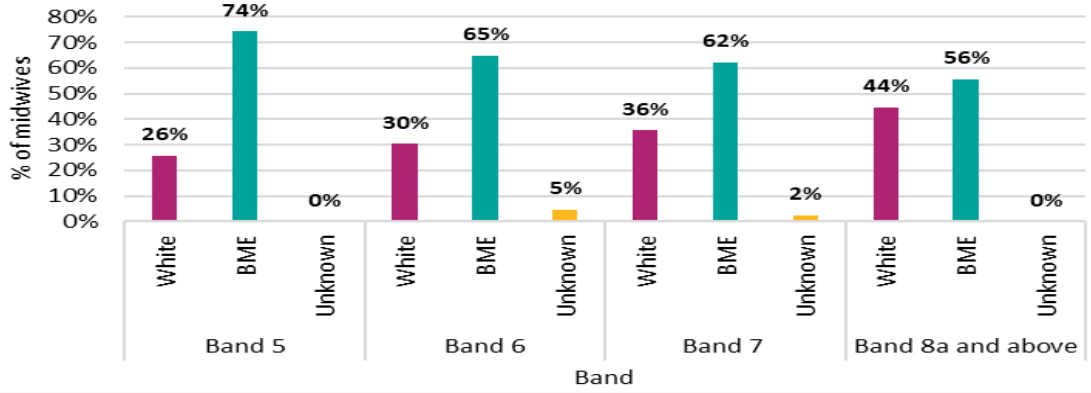


Figure 6: Breakdown (%) of midwives by pay band and ethnicity across Barts (2020/21)

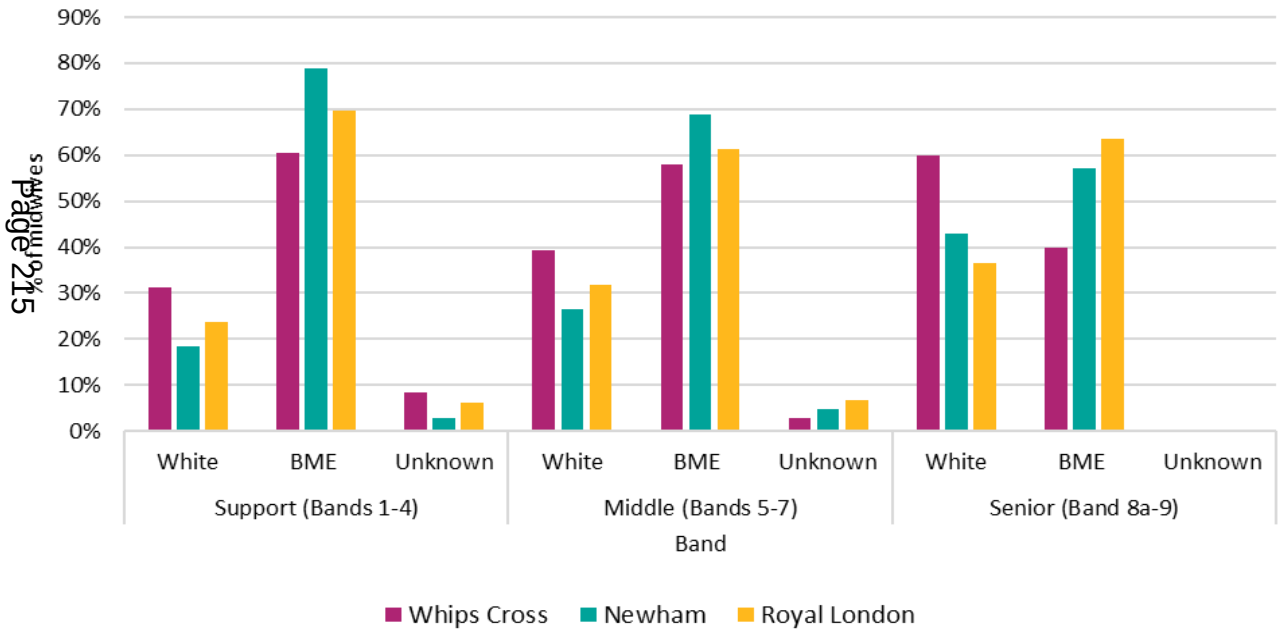


Key findings

- Relative to the overall distribution of staff across ethnic groups all ethnic minority staff are underrepresented at band 7 and above: e.g.
  - BHRUT – **39%** of BME staff at band 7 and above compared with **46%** BME staff overall
  - Homerton **- 39%** of BME staff at band 7 and above compared with **43%** BME staff overall
  - Barts - **56%** of BME staff at band 8a and above compared with **64%** BME staff overall
- These differences are the opposite of what we observe at the national level – where BME staff were slightly overrepresented at band 8a and above in 20/21 (i.e. **16%** at band 8a and above compared with **11%** BME staff overall)
- Note that there are inconsistent groupings regarding pay bands. NHDS were unable to provide separate data at the more senior levels due to IG rules governing low numbers. For Barts, however, – from whom we also received data at the site level - we know they have no midwifery staff at the VSM level.

I1: Distribution of staff by ethnicity and Afc pay band: Barts site level (Midwifery only)

Figure 7: Breakdown (%) of Barts clinical (non-medical) Maternity staff by pay band and ethnicity (2020)



Key findings

- Across all trust sites, there is a stark majority of midwives in ethnic minority groups in Bands 1-4 (between **60-79%),** compared to White maternity staff (**18-31%)**
- As pay band increases, the gap between proportions of ethnic minority and White midwives decreases i.e. the proportion of ethnic minority staff decreases as seniority increases.
- As pay band increases, the proportion of White midwives increases, although ethnic minority maternity staff still remain the majority. The exception is Whips Cross, where midwives in ethnic minority groups are the minority at **40%** in Band 8a-9, compared to White maternity staff at **60%**
- The following data refers to a different data source, data that we have received directly from Barts trust by their three sites, for 2020.
- ***Note that we do not have the overall breakdown of staff by ethnicity at the site level to assess for over/under representation as we have done for the trust level data provide by NHSD.***

I2 & I3: Relative likelihood of being appointed from shortlisting & entering formal disciplinary process*

Note: Data on I2&3 has not been provided for midwifery staff only and applies to staff groups across all specialties

Table 1: Relative likelihood of White staff being appointed from shortlisting compared to BME staff across NEL boroughs (2020)

Trust	Relative likelihood of White staff being appointed from shortlisting compared to BME staff:
Homerton University Hospital NHS Foundation Trust	1.58
Barts Health NHS Trust	1.63
Barking, Havering and Redbridge University Hospitals NHS Trust	1.73

Table 2: Relative likelihood of BME staff entering the formal disciplinary process compared to White staff across NEL boroughs (2020)

Trust	Relative likelihood of BME staff entering the formal disciplinary process compared to White staff:
Homerton University Hospital NHS Foundation Trust	1.18
Barts Health NHS Trust	1.25
Barking, Havering and Redbridge University Hospitals NHS Trust	1.26

Key findings:

- **Relative likelihood of White staff being appointed from shortlisting compared to BME staff (table 1):**
  - Across all NEL trusts, White staff are more likely to be appointed from shortlisting, compared to BME staff, varying between **58-73%** more likely.
  - This inequality is most present in Barking, Havering and Redbridge University Hospitals NHS Trust (**73%** more likely)
- **Relative likelihood of BME staff entering the formal disciplinary process compared with White staff (table 2):**
  - Across all NEL trusts, BME staff are more likely to enter formal disciplinary processes, compared to White staff, varying between **18-26%** more likely.
  - Although, these differences in relative likelihood is very small and according to the four-fifths rule**, only BHRUT has a difference large enough to conclude risks of adverse impacts on BME staff.

***Four-fifths rule:** It is important to note the NHSD report's use of the four-fifths rule in accessing inequalities. According to such guidelines, if a relative likelihood falls inside four-fifths i.e. **within 0.8-1.25**, it is concluded that the **difference is not big enough** for an organisation to have adverse effects on an identified group.

I4: Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff*

Note: Data on I4 has not been provided for midwifery staff only and applies to staff groups across all specialties

Table 3: Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff across NEL boroughs (2020)

Trust	Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff:
Homerton University Hospital NHS Foundation Trust	1.25
Barts Health NHS Trust	0.98
Barking, Havering and Redbridge University Hospitals NHS Trust	0.74

Key findings:

- In both Homerton University Hospital NHS Foundation Trust and Barts Health NHS Trust, White staff were **slightly less likely** to access non mandatory training and CPD compared to BME staff.
- This is similar to London, where the relative likelihood of White staff accessing non mandatory training and CPD compared to BME staff is **0.9**
- This is the reverse for Barking, Havering and Redbridge University Hospitals NHS Trust, where BME staff are more likely to access such training compared to White staff, by a more significant amount.
- According to the **four-fifths rule****, none of the NEL trusts show adverse inequality within likelihood of White staff accessing non-mandatory training and CPD compared to BME staff.

****Four-fifths rule:*** It is important to note the NHSD report's use of the four-fifths rule in accessing inequalities. According to such guidelines, relative likelihood that falls inside four-fifths i.e. **within 0.8-1.25**, it is concluded that the **difference is not big enough** for an organisation to have adverse effects on an identified group

I5&I6: Staff experiencing harassment, bullying or abuse from patient, relatives, public or staff [Midwifery only]

Figure 8: % of midwives experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months (2020)

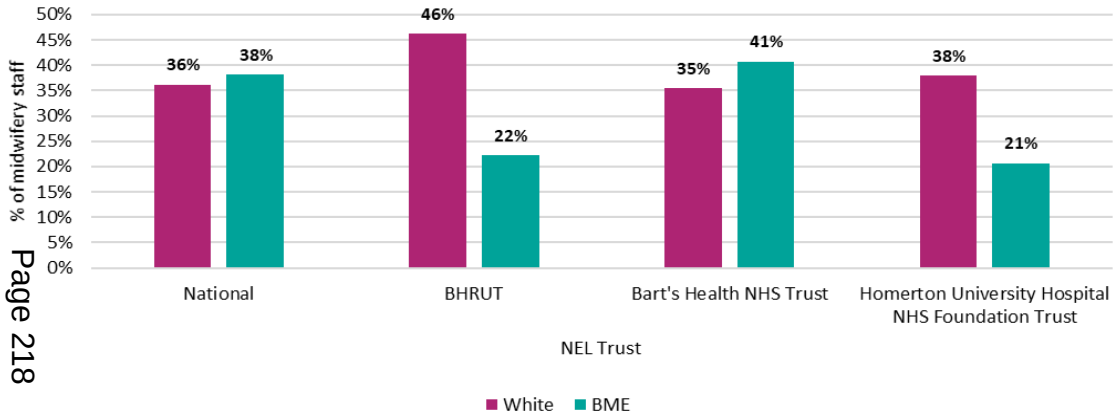
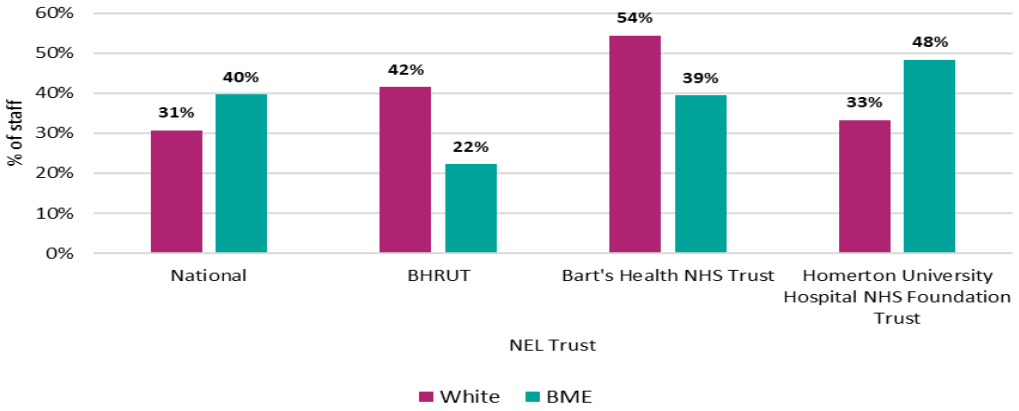


Figure 9: % of midwives experiencing harassment, bullying or abuse from staff in last 12 months (2020)



Key findings:

- **Staff experiencing harassment, bullying or abuse from <u>patients, relatives or the public</u> (chart 5)**
  - In BHRUT and Homerton, more White staff experience harassment, bullying or abuse from patients, relatives or the public (**46%** and **38%** respectively), compared to BME staff (**22%** and **21%** respectively)
  - The reverse is true for Barts (i.e. with BME staff being more likely to have experienced harassment) although the difference is much smaller, at around **6%.**
- **Staff experiencing harassment, bullying or abuse from <u>staff</u> (chart 6)**
  - Only Homerton has a larger proportion of BME staff experiencing harassment from other staff (**48%)** compared to White staff **33%.** This is also higher than the national rate for BME staff at **40%**.
  - There is a larger proportion of White midwives experiencing harassment from other staff in BHRUT (**42%**) and Barts (**54%**), compared to BME staff (**22%** and **39%** respectively).

I5&I6: Staff experiencing harassment, bullying or abuse from patients, relatives, public or staff: Barts site level [Midwifery only]

Figure 10: % of Barts midwives experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months (2021)

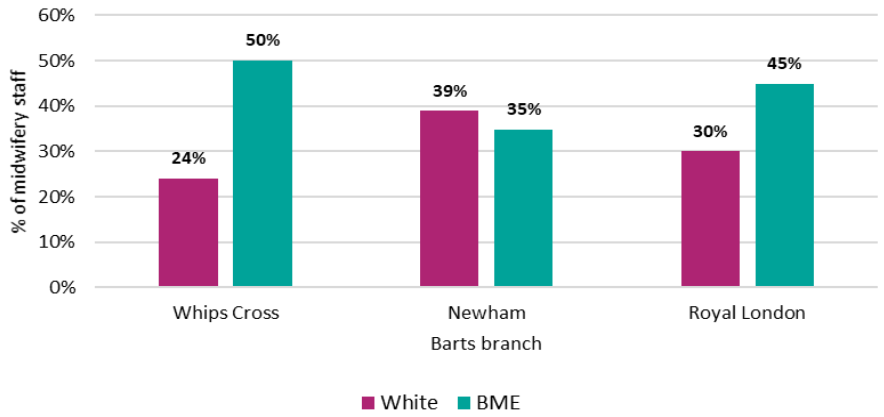
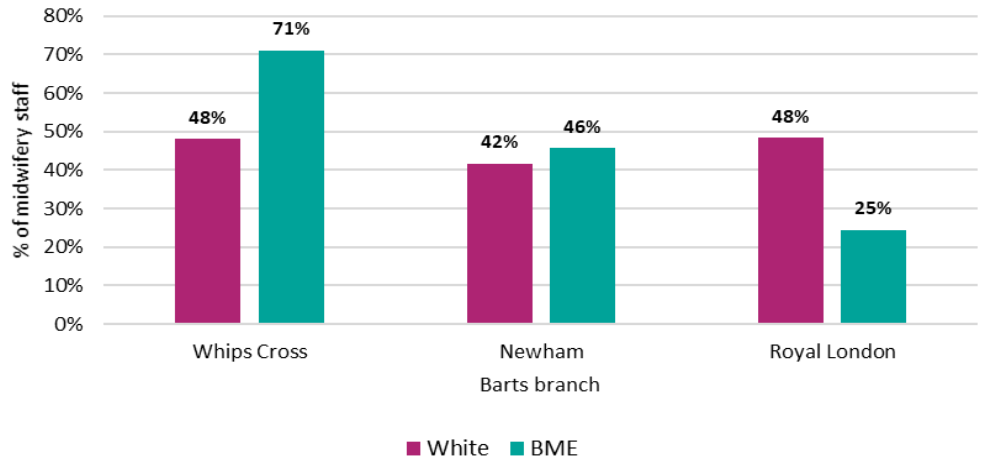


Figure 11: % of Barts midwives experiencing harassment, bullying or abuse from staff in last 12 months (2021)



Key findings:

- ***Note: This site level data from Barts is based on 2021 survey responses and therefore not directly comparable to the 2020 survey results at the trust level that is presented in the previous slide***
- **Staff experiencing harassment, bullying or abuse from patients, relatives of the public (chart 14)**
  - For Whips Cross and Royal London, more BME maternity staff experienced harassment, bullying or abuse from patients, relatives or the public (**50%** and **45%** respectively) compared to White maternity staff (**24%** and **30%** respectively).
  - The reverse is true for Newham, although the difference is much smaller at **4%**.
  - The biggest inequality exists in Whips Cross, where there were **two times** as many BME maternity staff (**50%**) who experienced harassment from patients, relatives or the public, than White maternity staff (**24%**).
- **Staff experiencing harassment, bullying or abuse from staff (chart 15)**
  - Harassment, bullying or abuse from other staff varies across the Barts sites. For Whips Cross and Newham, more BME maternity staff experienced harassment from other staff (**71%** and **46%** respectively), compared to White maternity staff (**48%** and **42%** respectively)
  - The reverse was true for Royal London, where **48%** of White maternity staff experienced harassment from other staff, compared to **25%** of BME staff.
  - The biggest difference observed is at Whips Cross, where there were **71%** of BME maternity staff experiencing harassment from other staff, compared to **48%** of White staff.

I7&I8: Trust on equal opportunities for career progression and experience of discrimination (Midwifery only)

Figure 12: % of midwives believing trust provides equal opportunities for career progression or promotion (2020)

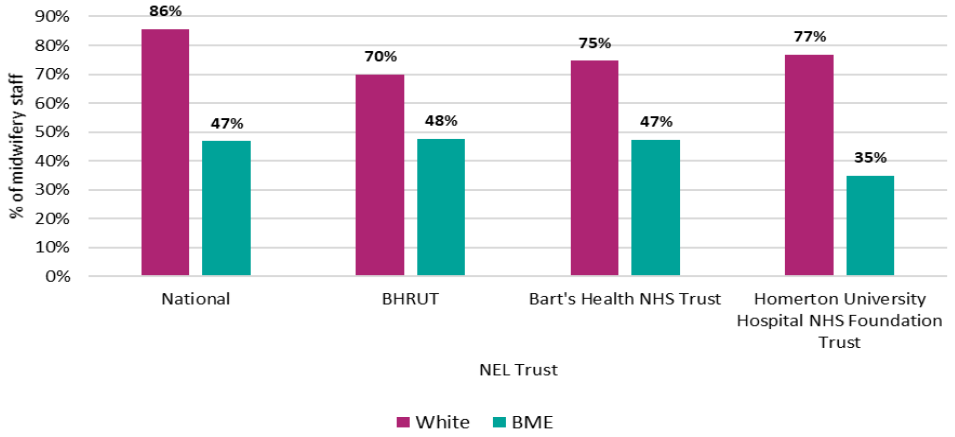
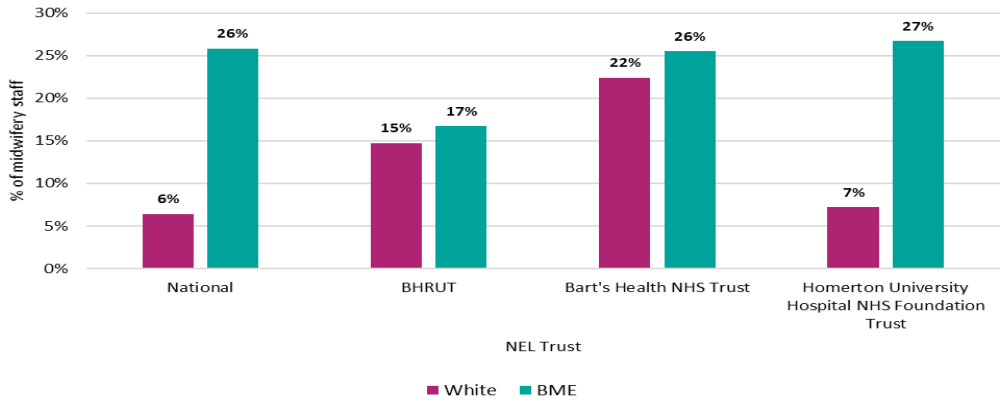


Figure 13: % of midwives personally experiencing discrimination at work from manager/team leader or other colleagues (2020)



Key findings:

- **Staff believing that the trust provides equal opportunities for career progression and promotion (chart 7):**
  - Across all three NEL Trusts, more White staff believed that their relative trust provides equal opportunities for career progression or promotion **(70-77%)**, compared to BME staff **(35-48%).**
  - This trends are replicated nationally with a slighter bigger inequality, where **86%** of White midwives believed that their relative trust provides equal opportunities for career progression or promotion compared to **47%** BME midwives.

- **Staff personally experiencing discrimination at work (chart 8)**
  - Across all three NEL trusts, a greater proportion of BME staff have personally experienced discrimination at work from a manager/team leader or other colleagues, however there is significant variation between the trusts.
  - BHRUT and Barts have a small percentage difference (**2-4%** respectively) between White and BME midwives who have personally experienced discrimination at work from a manager/team leader or other colleagues
  - Homerton, however, has a significantly greater inequality, with **27%** of midwives who have experienced discrimination at work from a manager/team leader or other colleagues are BME compared to **7%** who are White.
  - This larger inequality is also replicated at national level, where **26%** of midwives who have experienced discrimination at work from a manager/team leader or other colleagues are BME compared to **6%** who are White.

I7&I8: Trust on equal opportunities for career progression and experience of discrimination: Barts site level (Midwifery only)

Figure 14: % of Barts midwives believing trust provides equal opportunities for career progression or promotion (2021)

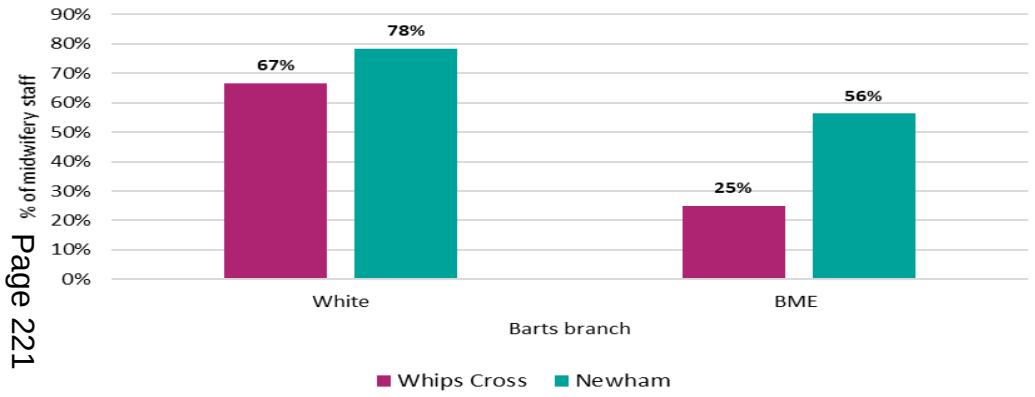
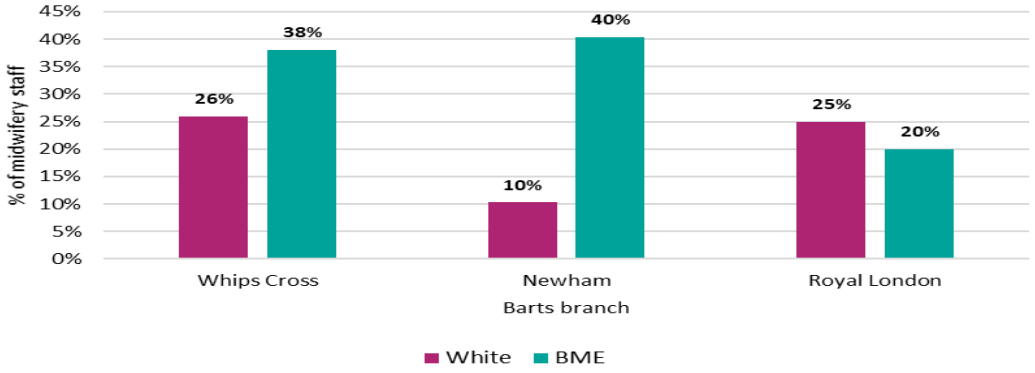


Figure 15: % of Barts midwives personally experiencing discrimination at work from manager/team leader or other colleagues (2021)



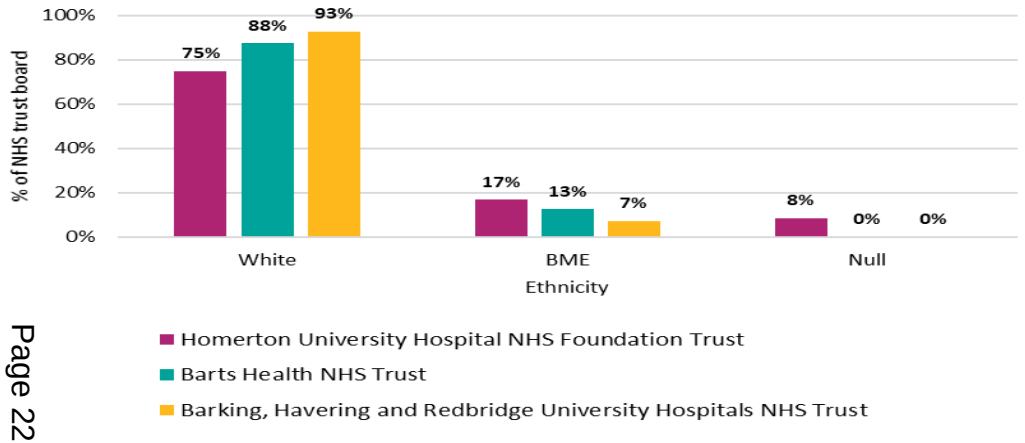
Key findings:

- ***Note: This site level data from Barts is based on 2021 survey responses and therefore not directly comparable to the 2020 survey results at the trust level that is presented in the previous slide***
- **Staff believing that the trust provides equal opportunities for career progression and promotion (chart 16):**
  - Both Newham and Royal London have a greater proportion of White maternity staff believing trust provides equal opportunities (**66.7%** and **78.3%** respectively) compared to BME maternity staff (**25.0%** and **56.3%** respectively)
  - The biggest inequality exists at Whips Cross, where White midwives were **over two times** more likely to believe trust provides equal opportunities than BME midwives.
  - ********Due to too few survey responses, Royal London has been excluded from this chart.*
- **Staff personally experiencing discrimination at work (chart 17)**
  - For Whips Cross and Newham, more BME staff personally experienced discrimination at work from a manager/team leader or other colleague (**38%** and **40%** respectively) compared to White staff (**26%** and **10%** respectively).
  - The reverse is true for Royal London, but for a smaller percentage difference: more White midwives experiences discrimination (**25%)** compared to BME midwives (**20%**).
  - The biggest inequality exists in Newham, where there were four BME maternity staff personally experiencing discrimination, to every one White maternity staff.

I9: NHS Trust Board Representation by Ethnicity*

Note : Data on I9 has not been provided for midwifery staff only and applies to staff groups across all specialties

Figure 16: Breakdown (%) of NHS Trust board representation by ethnicity (2020)



Key findings

- Across all three NEL Trusts, there is a significant majority of White representation (**75-93%)** and stark minority BME representation (**7-17%)** on NHS Trust boards. This difference is largest in BHRUT, where the Board is made up by approx. **93%** White staff and only **7%** by BME staff. The national figure of BME board representation is at **10%** and London figure at **20%.**
- Across all three NEL Trusts, there is a greater proportion of White executive members (**71-100%**) compared to BME executive members (**0-29%**), This inequality is again worst in BHRUT, where there are **no BME** board members who have executive membership.
- Across all NEL trusts, there is a significant greater proportion of White board members who have voting membership (**75-92%**) compared to BME staff (**8-17%**). This inequality is again worst in BHRUT, where only **8%** of voting board members are BME.
- ***Note**: in contrast to the data on AFC pay band for which we are able to compare representation at pay band level with overall representation across the trusts – we do not have the equivalent data to compare in the same way for these data at the pooled staff level.*

Figure 17: Breakdown (%) of NHS Trust board representation by ethnicity and executive/ non executive membership (2020)

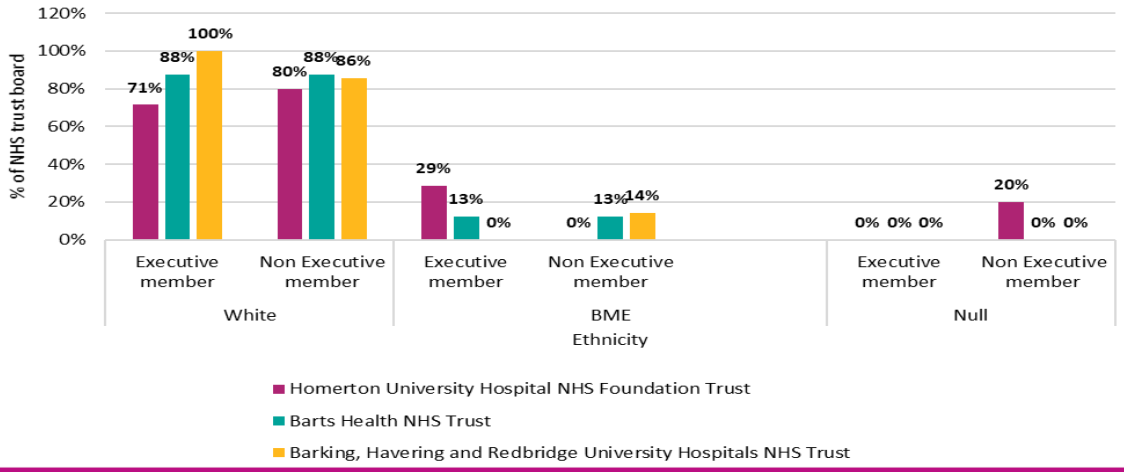
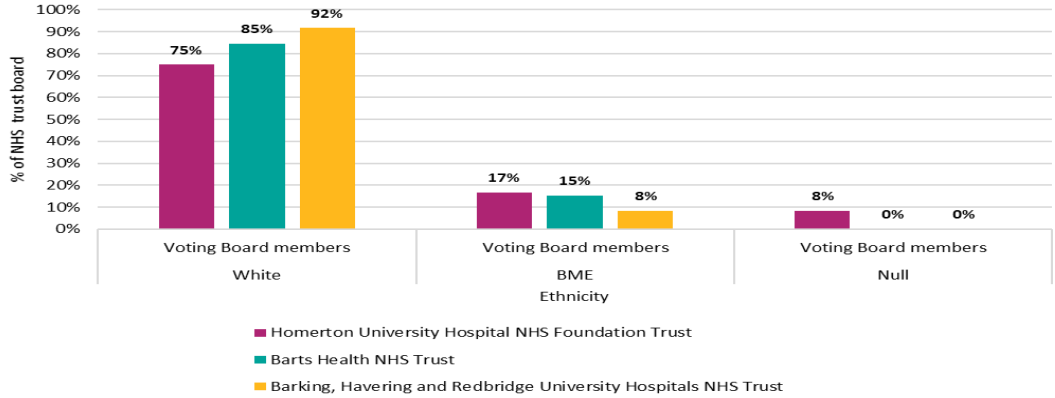


Figure 18: Breakdown (%) of NHS Trust board representation by ethnicity and voting/non voting membership (2020)



NHS
North East London
Clinical Commissioning Group

9. Action Plan

9.1 Action Plan next steps

NEL LMS are committed to improving equity and equality for women from Ethnic Minority backgrounds, including staff within maternity services.

Action plan next steps are detailed in sections 9.2 and 9.3, relating to recommendations for further data analysis and further community asset mapping and co-production.

Summary of next steps:

1. Recommendations for further data analysis

2. Recommendations for further community asset mapping and co-production
    - This will include gathering and assuring data from wider sources by conducting a programme of outreach and participatory community co-production with local partners and women, to:
        - Determine the validity of our asset mapping by local women in their communities
        - Add less ‘visible’ assets seen as critical by local women
        - Understand women’s direct experiences of engaging with these assets to determine quality, impact and cultural appropriateness
        - Create a comprehensive database supported by a digital map by borough for health professionals (this work will include ensuring that the database can be maintained and regularly refreshed to ensure the quality of the content).

3. To co-produce a five year strategy based on the needs of our population, aligning to the ICS planning guidance. This will include:
    - a presentation to our wider stakeholders on our findings
    - 2-3 workshops on how we will co-produce meeting the needs of women
    - a consultation and stakeholder and women’s survey

9.2 Recommendations for further data analysis

- To support with **evidenced-base** decision making on the prioritisation and targeting of action plans, we proposed this initial analysis be supplemented by a further project that is split into **four phases** of work. **NOTE: these are indicative recommendations and would require further discussion and scoping before any work is commenced**.

Phase	Area of focus	What would we do?	What questions will this help answer?	Key issues
Phase 1	Confirming observed differences in health outcomes included in our initial analysis across ethnicities and deprivation status – and extending the analysis to cover more outcome measures	Carrying out a statistical analysis to estimate differences in health outcomes across : • Ethnicity (controlling for differences in age and deprivation status) • Deprivation status (controlling for differences in age and ethnicity status) Explore make up of *Mixed* ethnic groups	• For which outcomes are there *genuine* differences across ethnicity and deprivation? • Which outcomes are these differences the largest and for which category of women? • How specific are these differences to individual boroughs? Which ones are NEL wide?	Data availability and quality for extended set of outcome measures Outcome measures with low numbers will need multiple years data to improve the reliability of findings. Time required by trusts to provide relevant data (if not currently reported on in SUS etc.) and quality checking by team may be considerable.
Phase 2	Assessing the relative importance of health status, wider risk factors and access to maternity services in determining outcomes for women and babies	Carrying out statistical analysis to estimate the relative impact on outcomes of factors independent of ethnicity, deprivation and age - at NEL and borough level – including: • LTCs (including type and number) and other risk factors (e.g. smoking rates) • Access to maternity services • The trust in which delivery takes place	• What other factors drive difference in outcomes regardless of ethnicity or deprivation? • Which of these are potentially easier to prevent and/or mitigate against the adverse impacts than others? • How much do trusts themselves influence outcomes (e.g. quality or care)	Data availability and quality on broader potential drivers on outcomes Unclear whether we can link PC data with secondary data for al boroughs Time required by trusts to provide relevant data (if not currently reported on in SUS etc.) and quality checking by team may be considerable.
Phase 3	Confirming observed differences between ethnicities and deprivation status across the most 'important' drivers	Carrying out statistical analysis to understand whether any of the factors identified in Phase 2 vary by ethnicity or deprivation.	• For the 'most' important drivers, are women of different ethnicity and/or deprivation status disproportionately affected?	No major issues for this phase if those in P1&2 are addressed.
Phase 4	Analysis of (large sample) survey data (e.g. if commissioned by trusts) of lived experience which also records ethnicity and deprivation status	Assess themes in survey by women in different categories and whether differences in experience between them are statistically significant Triangulate findings with findings from the data analysis	• To what extent do women's lived experience validate/confirm what we are seeing in the data? • What does it tell us about other inequalities (e.g. in how women are treated) that data on outcomes alone cannot reveal but are very relevant to health, wellbeing and experience?	Existing surveys on Maternity services do not split results by ethnicity/deprivation so likely that a more tailored survey would need to be commissioned by trusts.

9.3 Recommendations for further community asset mapping and co-production

The lenses and lived experiences of women and birthing people must be given precedence to reshape maternity and perinatal health services. We must provide an audience to ensure 'All voices must be heard' from all communities in the process of reshaping services.

Tasks	What would we do?	What questions do we want answered?	Key issues
Stage 2 Community-engaged asset mapping January, early February 2022	**Where** • Children's Centres • Community hubs and networks • Stakeholder engagement events • Online surveys • Workshops to consolidate community assets **How** • Workshops with stakeholders to consolidate community assets e.g. Social Prescribers, Early Years and children's services in each borough. • Map assets onto deprivation maps for further co-production work. • Outreach into each borough with local partners who provide culturally and gender centred support, access to language translations. • Collaborating efforts across diverse stakeholders to improve equity and to tackle social determinants of health as part of an ICS, this will include housing opportunities, transport and infra-structure	• Which community assets listed have you used? • What have we missed from our mapping that is important to you? • Which ones do you have to travel outside of your borough to access? What transportation links are available to you to access these? • Grade the assets based on personal experiences to determine quality of support? • What else is missing from our community that would make a difference to you and your family • Are there any other gaps in our asset mapping used by these teams?	• COVID 19 restrictions on stakeholder engagement • Ensuring hard to reach voices are heard. • Data viability • Time to complete action plan • Identify Resource to support Action plan

Stage 3 Co-production of Five Year Strategy
 	
January, early February 2022
	• Set up co-production opportunities for community representatives and other diverse stakeholders, ensuring barriers are removed – accessibility, digital divide, safe spaces, cultural appropriateness, language support and transportation.
	• As part of the Core20PLUS5 approach to reducing health inequalities by ensuring continuity of care for 75% of women from Black, Asian and minority ethnic
	• In addition to local communities, other stakeholders to be included:
	  ○ ICS Digital and data support
	  ○ ICS Workforce planning
	  ○ Early Years Steering Groups
	  ○ ICS Housing and Population plans
	  ○ Infrastructure and Transportation
	  ○ Population Health
	  ○ Children/family Hubs
		What are the interventions and innovative solutions to:
		• Improving inequalities and equity to maternity care for ethnic minorities
		• To achieving continuity of care for 75% of ethnic minority communities living in the most deprived areas of North East London
		• Address the challenges – delivery, reach and access
		• Staffing and workplace challenges to meet service demands, diversity and cultural competence
			• COVID 19 restrictions on stakeholder engagement
			• Ensuring hard to reach voices are heard.
			• Data viability
			• Time to complete action plan
			• Identify Resource to support Action plan

10. Acknowledgements

We wish to thank and acknowledge the following team, organisations and individuals for their contributions to this piece of work:

NEL LMS team

NEL CCG Financial Strategy Analytics team

NEL CCG Children and Young People Services

Trust representatives and Perinatal Mental Health Services

Maternity Mates – a commissioned organisation the LMS has a strong partner relationship with

Thank you to all the community organisations who have been approached and contributed as part of this assessment

Thank you to all those individuals who consented to sharing their story as part of our case studies

NHS
North East London
Clinical Commissioning Group

HEALTH AND WELLBEING BOARD

12 January 2021

Title:	BHR Joint Strategic Needs Assessment 2021-22 (Update)
Report of the Cabinet Member for Social Care and Health Integration	
Open Report	**For Information**
Wards Affected: All	**Key Decision:** No
Report Authors: Wassim Fattahi-Negro, Principal Manager Performance and Intelligence Jane Leeman, Interim Public Health Consultant	**Contact Details:** **E-mail:** Wassim.FattahiNegro@lbbd.gov.uk Jane.Leaman@lbbd.gov.uk
Sponsor: Chris Bush, Commissioning Director for Children's Care and Support; Matthew Cole, Director of Public Health	
Accountable Strategic Leadership Director: Elaine Allegretti, Strategic Director, Children and Adults	

Summary:

A report to apprise the board on the delivery of BHR Joint Strategic Needs Assessment 2021-22, where the London Boroughs of Barking and Dagenham, Havering and Redbridge collaborate to meet this statutory requirement via the production of three individual needs assessments, each of which mirror each other in format and content whilst offering a localised and detailed view of the health needs in each borough.

The production of the BHR Joint Strategic Needs Assessment is further enhanced by an online mapping tool that allows stakeholders to further interrogate and access relevant data.

This update offers the board an advanced overview of the JSNA prior to publication in March 2022.

Recommendation(s)

The Health and Wellbeing Board is asked to:

1. note the report and
2. feedback considerations on the current development framework and provide directions if required.
3.

Reason(s) Offering an update on the delivery of the BHR JSNA 2021-22

1. Introduction and Background

1.1 The Health and Social Care Act 2012 amends the: Local Government and Public Involvement in Health Act 2007 to introduce duties and powers for health and wellbeing boards in relation to Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs).

1.2 In the Act, the Government sets out a vision for the leadership and delivery of public services, where decisions about services should be made as locally as possible, involving people who use them and the wider local community. The Act supports the principle of local clinical leadership and democratically elected leaders working together to deliver the best health and care services based on the best evidence of local needs.

1.3 Local authorities and clinical commissioning groups (CCGs) have equal and joint duties to prepare JSNAs and JHWSs, through the health and wellbeing board. The responsibility falls on the health and wellbeing board as a whole.

1.4 JSNAs are assessments of the current and future health and social care needs of the local community. Such needs could be met by the local authority, CCGs, or the NHS. JSNAs are produced by health and wellbeing boards and are unique to each local area.

1.5 In 2019 the Directors of Public Health in Barking and Dagenham, Havering and Redbridge led on the project of delivering a Joint Strategic Needs Assessment for the BHR area where each Local Authority delivered in 2020 a unique JSNA to their areas that at the same time gave full regards to the other areas, offering a comparative approach and delivering a JSNA that is both local to the individual areas and to the BHR area at the same time.

1.6 The published JSNAs incorporated, and were complemented by, an online tool called Local Insight that which allowed detailed interrogation of data referred to in the JSNA along with a package of analytical reports that can be downloaded by the public.

2. Proposal and Issues

2.1 The successful collaborative approach taken by the three local authorities last year, which culminated in the production of a modern, easy to use and detailed JSNA at BHR level, endorses a continuation of such work and the production of a BHR JSNA in 2021 that is complemented with an online tool to facilitate both the interrogation and further exploration of useful data, reports, and maps by interested stakeholders.

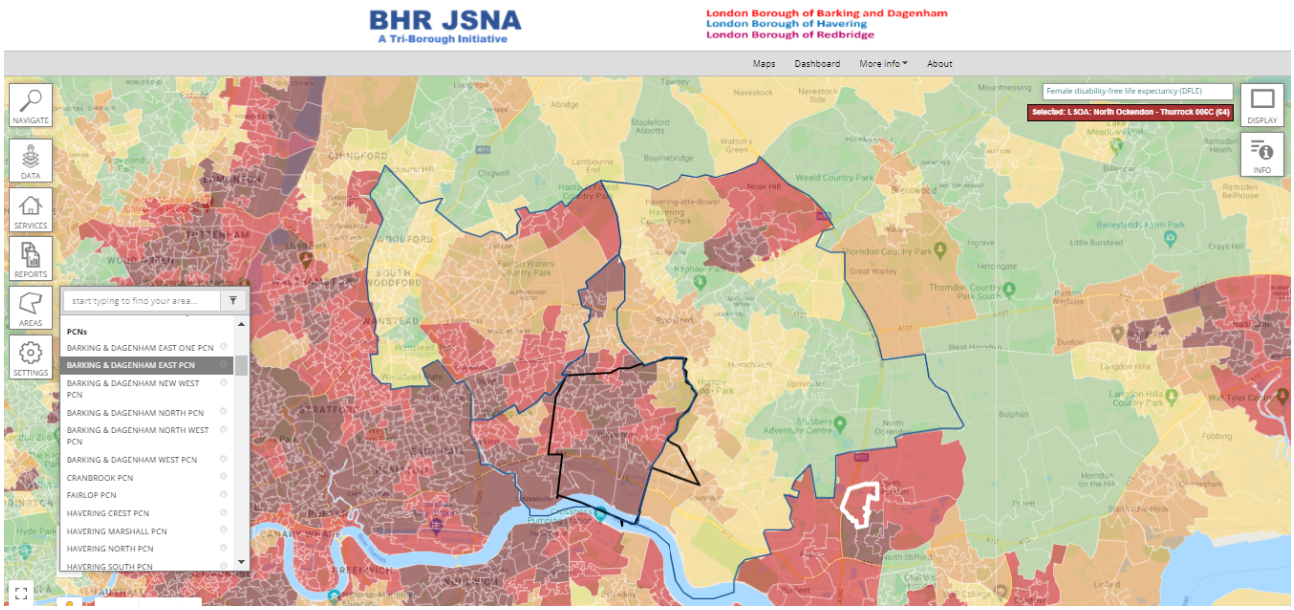
2.2 The delivery of the 2021-22 BHR JSNA is progressing well and is now in the advanced concluding stages of drafting with the intention to present the final document for Barking and Dagenham to the HWBB in March 2022 ready for sign off and publication by the end of the financial year.

2.3 The next stage of the delivery of this BHR JSNA 2021-22 will focus on the completion of the three JSNA documents; where the first document will be the delivery of the London Borough of Havering local version of the JSNA followed by two mirrored, but localised, versions for The London Boroughs of Barking and Dageham and Redbridge.

2.4 The delivery and maintenance of the online tool remains a crucial part of the process and production of the BHR JSNA, as going digital is very important to reaching wider audiences including commissioners, commercial entities, professionals and other stakeholders.

The Local Insight online platform already procured for, accessible online and made available for the public to make use of for at least a further year. The BHR JSNA 2021-22 iteration of the Local Insight tool includes a much larger set of data and gives regard to newer geographies such as ones that could mirror primary care networks.

Link to BHR online Local Insight tool: https://bhrjsna.communityinsight.org/map/



Snapshot of the online tool showing the *Female disability-free life expectancy (DFLE)* data for the area with a particular highlight of an individual Primacy Care Network (Source: https://bhrjsna.communityinsight.org/?indicator=dfle_f_v_20090101#)

2.5 The BHR JSNA steering group have successfully engaged and continue to do so with transformation teams to ensure the 2021-22 JSNA includes all relevant and key intelligence where data is available.

2.6 The current aim is to finalise the writing of the various chapters that form the BHR JSNA 2021-22 during the months of January 2022 so that final documentation is complete by the end of February 2022 in readiness for sign off at the respective Health and Well Being Boards in the following month.

According to this timetable, the current intention is to present the JSNA to the respective Health and Wellbeing Board for approval in March 2022, and if approved publish it shortly after.

Challenges:

2.7 Whilst considerable improvements have been included in this year's BHR JSNA some challenges were confirmed and others remained such as the intelligence

teams' inability to have access to primary care data. This is an impasse that prevents the teams from offering an analysis at a greater granularity in support of service delivery and the overall locality/PCN population health agenda. As such, the JSNA is likely to recommend a need to continue to pursue access to such data with colleagues across various services such as CCG.

3 Timeline

3.1 Timelines to March 2022

BHR JSNA Chapters reviewed and shared (Havering)	Mid January
Completion of the draft BHR JSNA – LBBD version	Mid February
Finalise documentation (JSNA and Online tool)	End of February
Presenting JSNA to HWBB	March HWBB
Publication of JSNA	End of March

3.2 Link to most recent BHR JSNA profiles:

https://bhrjsna.communityinsight.org/custom_pages?view_page=43

Link to BHR online Local Insight tool:

https://bhrjsna.communityinsight.org/map/

4 Mandatory Implications

4.1 Joint Strategic Needs Assessment

Meeting obligations as per statutory requirements set above.

4.2 Health and Wellbeing Strategy

To apprise the board with the development and delivery of the BHRJSNA.

4.4 Financial Implications

None

4.5 Legal Implications

None

BHR JSNA 2021-22

Progress Update

bhrjsna.communityinsight.org

Barking & Dagenham

Performance & Intelligence Unit

12th January 2022

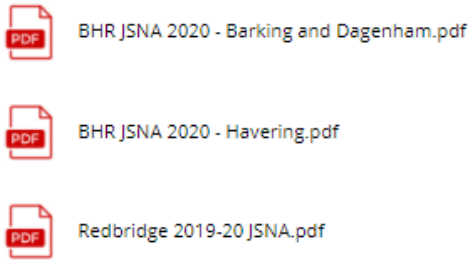
one borough; one community; no one left behind

What is a JSNA?

- A Process by which Local Authorities and Clinical Commissioning Groups assess the health, care and wellbeing needs in their local communities (current and future needs).
- Historically, JSNAs are produced in a format of detailed report and is used to:
  - Strengthen joint working between the NHS and local authorities.
  - Inform strategic and operational decision making at specific footprints.
  - Reduce inequalities.
  - Commissioning and planning local services such as direct planning of services in community hubs in LBBD.
  - Planning future services.
  - Monitor important health, care and wellbeing agenda such as obesity, smoking, and long term conditions..

BHR JSNA
A Tri-Borough Initiative

Tri-borough profiles:



Barking & Dagenham, Havering and Redbridge
Joint Strategic Needs Assessment Profiles

London Borough of Barking & Dagenham

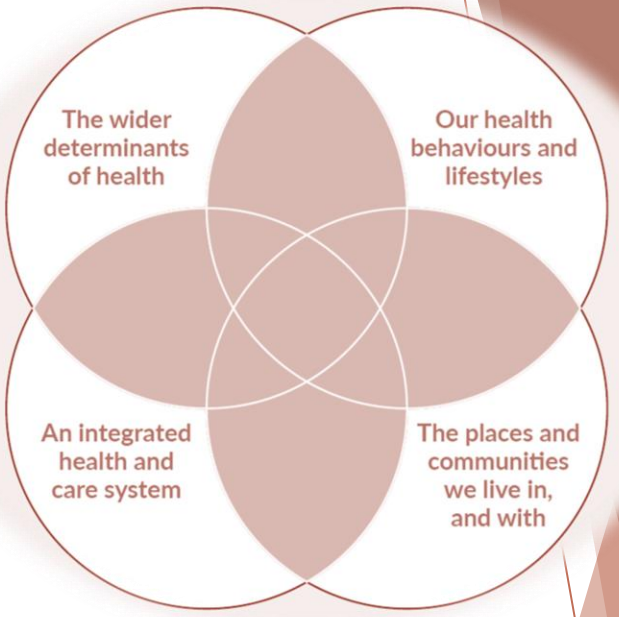
The board's vital role

Local authorities and clinical commissioning groups (CCGs) have equal and joint duties to prepare JSNAs through the Health and Wellbeing Board.

The responsibility falls on the Health and Wellbeing Board as a whole to ensure the duty is met.

2021-22 JSNA includes chapters on:

- Children & Young People
- Maternity
- Cancer
- Long Term Conditions
- Older People
- Mental Health



Also addresses:

- Urgent & Emergency Delivery

The chapters cover the BHR footprint, and will be centred around the framework for population health and based on these four pillars (first identified by the Kings Fund):

wider determinants of health; our health behaviours and lifestyles; places and communities we live in; and an integrated health and care system.

BHR JSNA
A Tri-Borough Initiative

Tri-borough profiles:

- BHR JSNA 2020 - Barking and Dagenham.pdf
- BHR JSNA 2020 - Havering.pdf
- Redbridge 2019-20 JSNA.pdf

2021-22 improvements

- The 2021-22 BHR JSNA is a follow on the first joint endeavor that resulted in the production of the 2020 BHR JSNA.
- Colleagues from Public Health and Intelligence teams in the respective Local Authorities collaborate and cooperate.
- Havering leads on the overall Project Management of the needs assessment and Barking and Dagenham leads on the delivery of the online platform.
- The 2021-22 BHR JSNA is richer in both: data and recommendations and is complemented by an easy-to-use online tool.
- Includes consideration of health protection issues covering COVID-19.
- Further collaborative endeavours, including the delivery of a Joint Pharmaceutical Needs Assessment in 2022.

BHR JSNA
A Tri-Borough Initiative

Tri-borough profiles:

- BHR JSNA 2020 - Barking and Dagenham.pdf
- BHR JSNA 2020 - Havering.pdf
- Redbridge 2019-20 JSNA.pdf

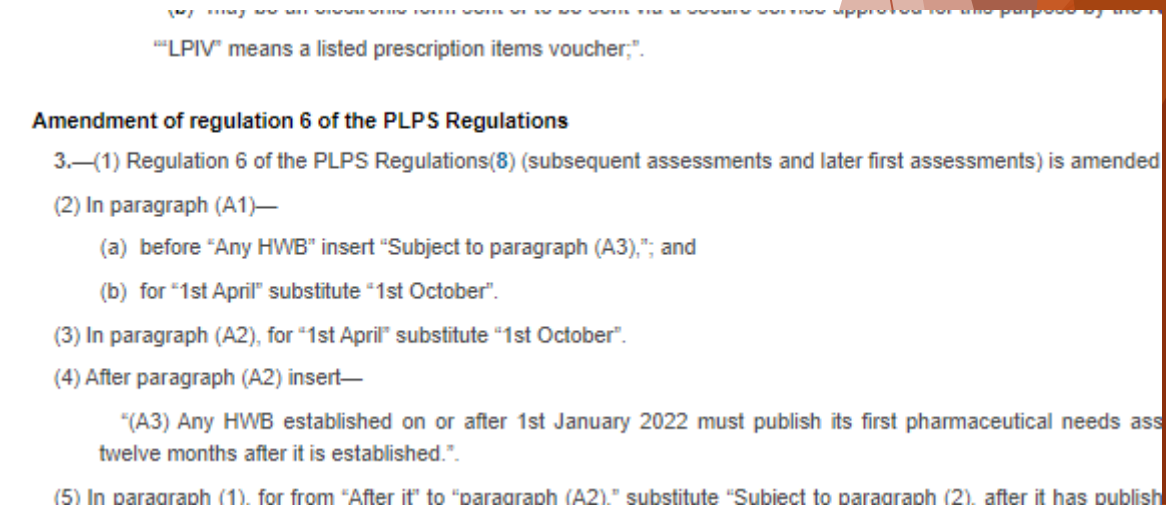
Pharmaceutical Needs Assessment

- Barking and Dagenham along with Havering and Redbridge have opted to further their association and jointly produce a Pharmaceutical Needs Assessment in 2022.
- Deadline was initially set for March 2022; However, on 21st December 2022 an act of parliament amended the Statutory Instrument regulation and changed the deadline to October 2022*.
- LBBD is leading on behalf of BHR on the procurement process and is takes a leading role along with Havering in project managing the delivery of the needs assessment in the coming months.
- Consultation process has started and the aim to deliver a richer PNA that is more responsive to wants and needs of both residents, patients, and pharmacies.

* The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 UK Statutory Instruments2013 No. 349 PART 1 as amended SI 2021/1346, laid on 30 November 2021

https://www.legislation.gov.uk/uksi/2021/1346/made

https://statutoryinstruments.parliament.uk/instrument/xswmNv65/timeline/K9j0j8A8/



""LPIV" means a listed prescription items voucher;".

Amendment of regulation 6 of the PLPS Regulations

3.—(1) Regulation 6 of the PLPS Regulations(8) (subsequent assessments and later first assessments) is amended

(2) In paragraph (A1)—

(a) before "Any HWB" insert "Subject to paragraph (A3),"; and

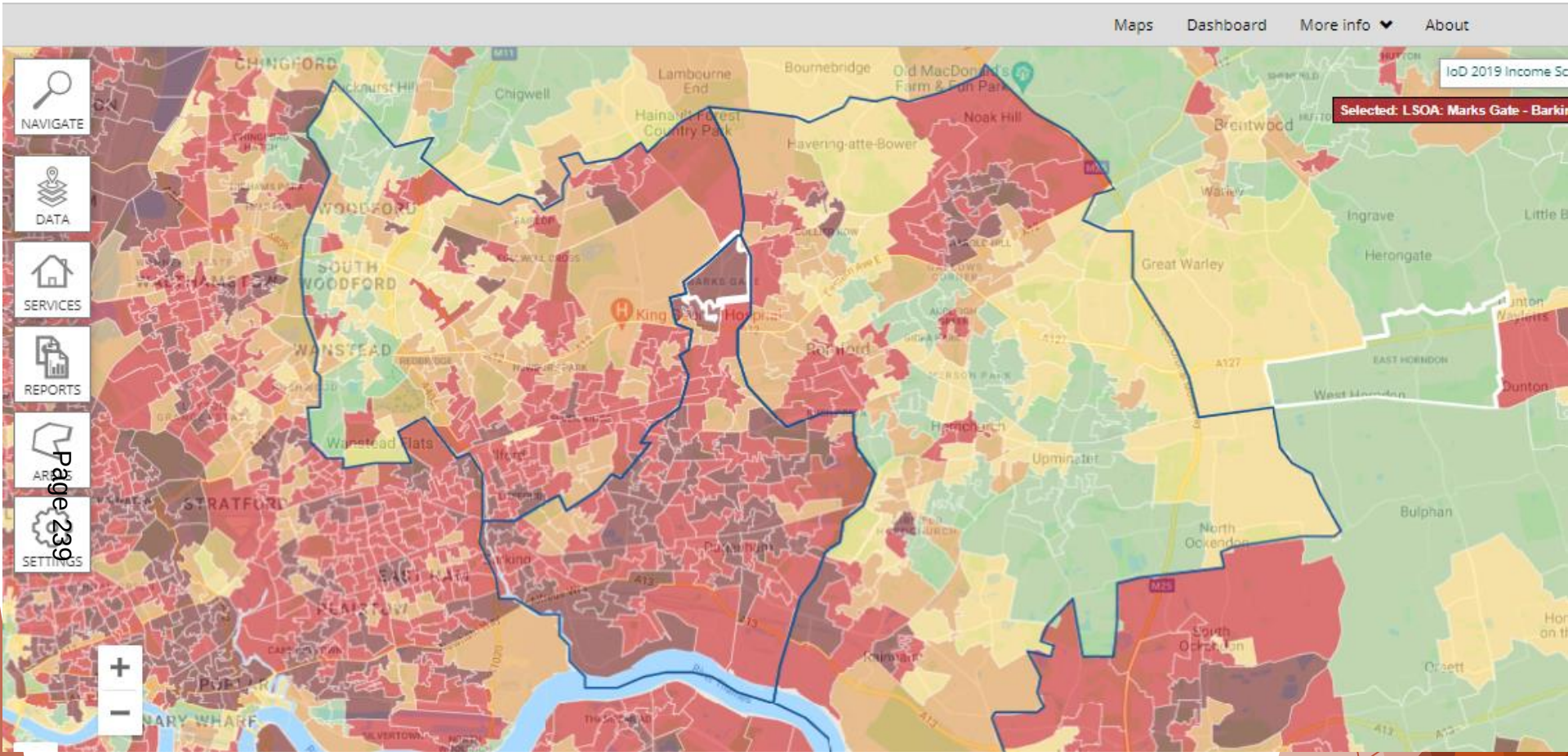
(b) for "1st April" substitute "1st October".

(3) In paragraph (A2), for "1st April" substitute "1st October".

(4) After paragraph (A2) insert—

"(A3) Any HWB established on or after 1st January 2022 must publish its first pharmaceutical needs ass
twelve months after it is established.".

(5) In paragraph (1), for from "After it" to "paragraph (A2)," substitute "Subject to paragraph (2), after it has publish



Screenshot of the Local Insight landing page

bhrjsna.communityinsight.org

Area Dashboard

AREAS

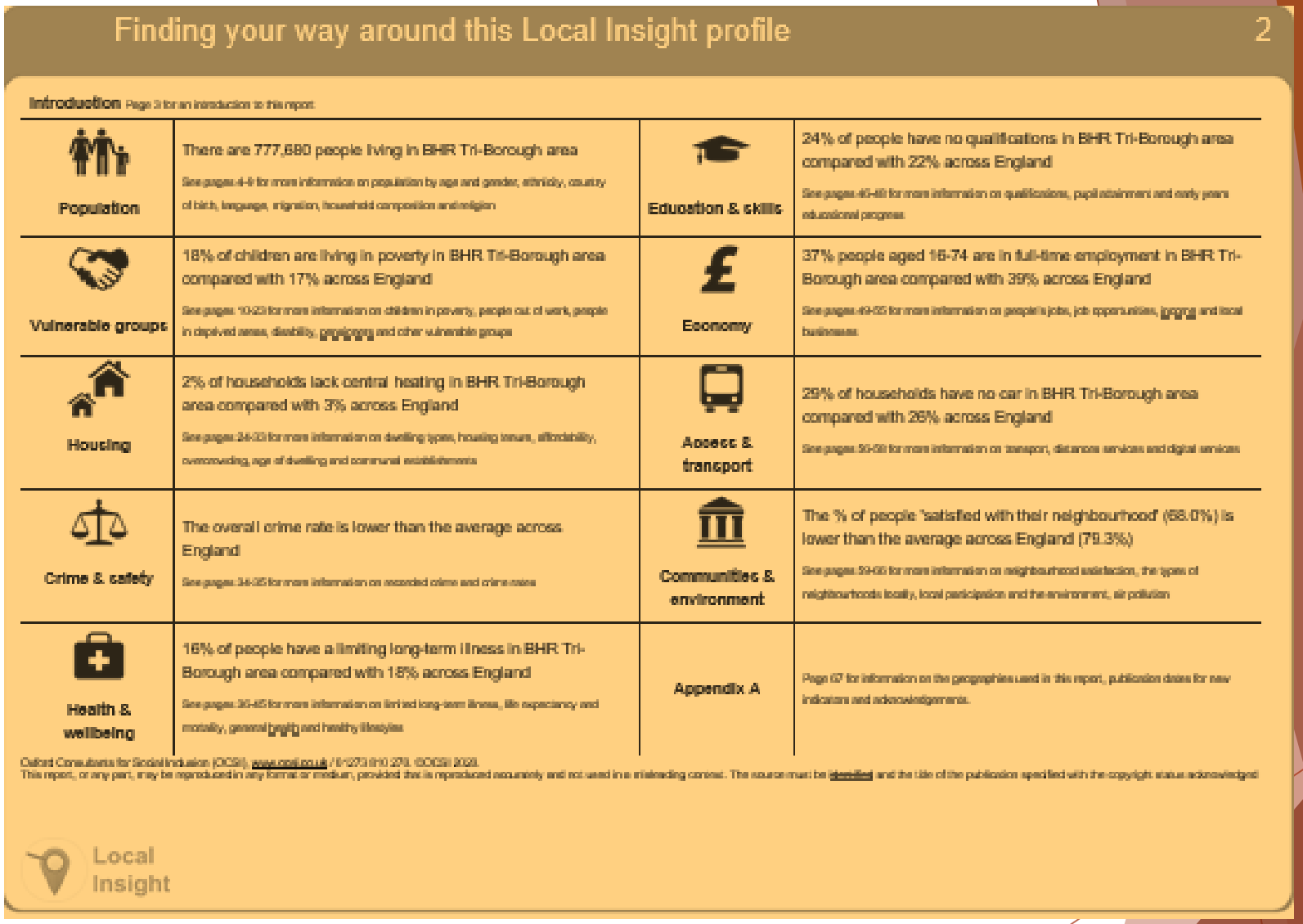
EXPORT

The colours on the dashboard show how your areas compare with each other

High | Medium | Low

	Aged 0-15	Aged 16-64	Aged 65+	Total population	IoD 2019 Income Scor	Fuel poverty	IDAOPI Score	Diabetes	Coronary Heart Disease	Emergency admission
National Comparator										
England	19.2	62.4	18.4		12.9	10.3	14.2	6.8	3.2	
Local Authorities and partnerships										
Barking and Dagenham	27.2	63.5	9.3		19.4	12.3	26.1	7.8	1.8	
BHR Tri-Borough area	23	63.4	13.5		13.6	11.2	17.4	7.7	2.3	
East London Health and Care Partnership STP	21.9	67.9	10.2		16.1	12.3	25.7	7.3	1.9	
Havering	20.3	61.7	18		10.8	9	11.7	6.8	2.7	
Redbridge	22.4	64.8	12.7		12.1	12.7	19.5	8.4	2.3	
Localities										
Barking and Dagenham East Locality	25.8	63.3	10.8		19.3	11.5	24.5	7.5	1.8	
Barking and Dagenham North	27.2	62.7	10.1		19.6	12.4	25.7	8	2	

Screenshot of the Local Insight Dashboard



Finding your way around this Local Insight profile

2

Introduction Page 3 for an introduction to this report

Population	There are 777,680 people living in BHR Tri-Borough area See pages 4-9 for more information on population by age and gender, ethnicity, country of birth, language, migration, household composition and religion	**Education & skills**	24% of people have no qualifications in BHR Tri-Borough area compared with 22% across England See pages 40-48 for more information on qualifications, pupil attainment and early years educational progress
Vulnerable groups	18% of children are living in poverty in BHR Tri-Borough area compared with 17% across England See pages 10-23 for more information on children in poverty, people out of work, people in deprived areas, disability, gypsies and other vulnerable groups	**Economy**	37% people aged 16-74 are in full-time employment in BHR Tri-Borough area compared with 39% across England See pages 49-55 for more information on people's jobs, job opportunities, jogging and local businesses
Housing	2% of households lack central heating in BHR Tri-Borough area compared with 3% across England See pages 24-33 for more information on dwelling types, housing tenure, affordability, overcrowding, age of dwelling and communal establishments	**Access & transport**	29% of households have no car in BHR Tri-Borough area compared with 26% across England See pages 56-59 for more information on transport, distances services and digital services
Crime & safety	The overall crime rate is lower than the average across England See pages 34-35 for more information on recorded crime and crime rates	**Communities & environment**	The % of people "satisfied with their neighbourhood" (68.0%) is lower than the average across England (79.3%) See pages 59-69 for more information on neighbourhood satisfaction, the types of neighbourhoods locally, local participation and the environment, air pollution
Health & wellbeing	16% of people have a limiting long-term illness in BHR Tri-Borough area compared with 18% across England See pages 36-45 for more information on limited long-term illness, life expectancy and mortality, general health and healthy lifestyles	**Appendix A**	Page 67 for information on the geographies used in this report, publication dates for new indicators and acknowledgements.

Local Insight

Screenshot of the area reports.

Thank you

HEALTH AND WELLBEING BOARD

12 January 2022

Title:	Carers Charter 2022-2025 and Action Plan
Report of the Cabinet Member for Social Care and Health Integration	
Open Report	**For Decision**
Wards Affected: All	**Key Decision: Yes**
Report Author: Arabjan Iqbal, Commissioning Manager, Commissioning Care and Support	**Contact Details:** Tel: 020 8227 5731 E-mail: Arabjan.iqbal@lbbd.gov.uk
Accountable Strategic Leadership Director: Elaine Allegretti, Strategic Director, Children and Adults	

Summary:

This report puts forward the Carers Charter for approval covering the period of 2022-2025 and associated Action Plan to act as a framework for the delivery and development of services, working practices, identification and support of unpaid or informal carers in the borough through a partnership approach.

The Carers Charter comprises of statements that have been co-produced with carers in the borough alongside key stakeholders from health, social care and the community and voluntary sector. The Carers Charter will be used as a basis for the action plan that identifies key deliverables and will be refreshed annually.

Recommendation(s)

The Health and Wellbeing Board is recommended to:

1. Agree the Carers Charter (Appendix A) and adopt this as a framework and use it as a basis to develop and refresh the Action Plan (Appendix B).

2. Recommended that all Partner organisations formally adopt the Carers Charter and its Action Plan and take forward the actions over the next 12 months.

3. Receive an annual update on the delivery of the Carers Charter from the Carers Strategy Group.

Reason(s)

The Carers Charter will deliver the Council's priority of enabling social responsibility by supporting residents to take responsibility for themselves and their loved ones and become more resilient.

The Carers Charter supports participation and engagement with residents and partners through the co-production of the Carers Charter. The outcomes defined in the I statements of the Carers Charter and Action Plan will enable carers and their loved ones to thrive and live independent and healthy lives. This is accomplished through joint working across the partnership and bringing carers to the forefront of service delivery.

Building on existing partnerships with health and the community and voluntary sector the Charter will work towards developing effective pathways with health, social care and the community and voluntary sector to identify 'hidden carers'. Hidden carers are carers who do not recognise themselves as a carer or are not known to services as providing an informal, unpaid, caring role.

By accessing timely support and developing a carer friendly community, carers can be identified early and provided with the support they need to thrive alongside their caring role.

1. Introduction and Background

1.1 The Care Act 2014 brought carers to the forefront of service delivery in health and social care, by putting them on an equal footing to the cared for. Informal carers make up a significant number of the population with an estimated 1 in 8 people providing unpaid or informal care.

1.2 There are a number of carers who provide care and support that are known to services however a large number of these are not known to services and are known as 'hidden carers'. It is worth noting that not all carers will require support but access to timely information and advice is valuable to supporting carers and preventing a crisis. Carers provide valuable one to one support to vulnerable residents who can include family and friends.

1.3 The Care Act 2014 put in statute for the first time the needs of carers and their right to be recognised for the work that they do. The Care Act and the Children and Families Act 2014 introduced measures to improve the rights of adult and young carers.

1.4 Barking and Dagenham's Carers Strategy, Let's Care for Carers 2015-2018 brought together the key elements of the Care Act, Children and Families Act and the National Carers Strategy 2008 to 2018 and provided an important framework in the design and delivery of carers services in the borough.

1.5 In 2016, the Government launched a carers' Call for Evidence consultation. The call for evidence showed that carers felt pride and satisfaction in their caring role, but also highlighted the many practical frustrations and difficulties they face, and the profound impact caring can have on their own health, employment and lives outside of caring.

1.6 The Carers Action Plan: Supporting Carers today[1] published in June 2018, builds on the National Carers Strategy and was developed following the Carers' Call for Evidence. This was put in place in anticipation of the Green Paper on Health and Social Care and the new National Carers Strategy when it is published. The action plan works to focus on the following five primary themes to improve the health and wellbeing of carers:

(a) Services and systems that work for carers

(b) Employment and financial wellbeing

(c) Supporting young carers

(d) Recognising and supporting carers in the wider community and society

(e) Building research and evidence to improve outcomes for carers.

1.7 The Health and Care Bill (2021)[2] outlines closer working together of Health and Social Care and other partners in delivering services and to support post COVID-19 pandemic recovery. The Bill introduces Integrated Care Systems whose aim is to integrate care across different organisations and settings, joining up hospital, community-based services and health and social care. It is hoped that the Integrated Care Systems will act as a vehicle in improving population health and health inequalities. This step change brings more collaboration and a focus on places and local populations as the driving forces for improvement. This provides an opportunity for carers to be involved in the delivery of NHS services through the wider public consultation.

COVID-19 Pandemic

1.8 The value of carers has been brought to the forefront during the pandemic lockdowns. Carers have picked up a lot of the pressure from health and social care when services were challenged the most, for example by reducing presentations at hospital for the cared for and taking up the pressure from social care when day centres were closed due to Government guidance. This was done alongside working from home and other caring responsibilities such as young children. With the continued challenges on their time carers often put their own needs on hold whilst prioritising the needs of the cared for person. This can sometimes result in lost opportunities of early intervention for health and wellbeing.

1.9 A report released by Carers UK, Caring behind closed doors: six months on[3] (October 2020) reviewed the impact that the pandemic had on carers, the findings of which have been incorporated in the development of the charter. Some of the findings from the report are detailed below;

[1] Carers Action Plan 2018 to 2020: Supporting carers today (publishing.service.gov.uk)
[2] newbook.book (parliament.uk)
[3] Caring_behind_closed_doors_Oct20.pdf (carersuk.org)

- 4 in 5 unpaid carers (81%) are currently providing more care than before lockdown.
- More than three quarters (78%) of carers reported that the needs of the person they care for have increased recently.
- Most carers (64%) have not been able to take any breaks at all in the last six months.
- More than half (58%) of carers have seen their physical health impacted by caring through the pandemic, while 64% said their mental health has worsened.
- Despite government intervention in the labour market 11% reported reducing their hours and 9% had given up work because of caring.

1.10 The COVID-19 pandemic has put increased pressure on carers, with several facing financial instability due to increases in the numbers of hours that they provide care and juggling working from home and their caring responsibilities.

Carers Support Service in Barking and Dagenham

1.11 Carers of Barking and Dagenham provide the local carers support service and is commissioned jointly by the London Borough of Barking and Dagenham and NHS North East London Clinical Commissioning Group (NEL CCG). The services are delivered to all carers and comprise of a service for adult carers and one for young carers.

1.12 Adult carer support service includes:

- Information, Advice and Guidance
- Peer support including groups for specific communities
- Signposting to other services including health, social care and voluntary sector services
- Training
- Income maximisation
- Access and maintaining employment, training and education opportunities
- Accessing Personal Protective Equipment
- Through the pandemic the service has adapted its delivery model to support carers especially during the lockdowns so that carers can access food medication and necessary supplies
- Attend strategic and partnership meetings to promote, influence and develop carers support

1.13 Young carer support service includes:

- Support services for young carers in the borough up to the age of 18
- Activities for young carers including training, sports, days out
- 1:1 support for individual carers where they need more support
- Signposting to various services including careers services, CAMHS, Drug and alcohol services, sexual health and other council and voluntary services the young carers may benefit from
- Homework club for the young carers
- The opportunity to share their experiences with other young carers
- Peer support to help other young carers within schools

Carers Strategy Group

1.14 The Carers Strategy Group works as a partnership to deliver outcomes from the Carers Strategy. The group is made up from representatives from Social Care, NEL CCG, Healthwatch, DWP JobCentre Plus. NELFT End of Life, Employment and Skills, Public Health, Carers of Barking and Dagenham, Community Solutions, Commissioning and LBBD Performance and Intelligence Team as well as a Carer representative. The Carers Strategy Group meets quarterly to monitor delivery of the strategy, raise awareness of the challenges faced by carers, discuss new initiatives that are being delivered and bringing carers to the forefront of service delivery.

2 Carers Charter and Action Plan

2.1 The Carers Charter was developed to build on the work delivered as part of the Carers Strategy as well as to include Young Carers and to reflect the carers needs in the evolving COVID-19 landscape. The Carers Charter and initial Action Plan once agreed provide a framework for the partnership to deliver support to carers.

Structure of the Charter

2.2 The Carers Charter is made up of four areas:

- Working together for Carers
- Carers Wellbeing and Employment
- Supporting Young Carers
- Carers in the wider community

2.3 A Carers Charter and Action Plan was put in place to provide an accessible document that outlined our commitments to carers and a supporting document that had deliverable actions that could be monitored and updated as work progresses.

2.4 Initial discussions were started with stakeholders, residents and carers prior to COVID but the majority of the work and development for the charter has been developed during 2021; and takes into account the challenges and life experiences of carers as well as changing working practices of partners in reflection of the pandemic and the impact this has had on carers.

3 Co-production and Engagement

1.1 To engage as widely across the Borough as possible and provide genuine opportunities for carers to be involved in the development of the Carers Charter, consultation took place through virtual events, meetings and via the Council's consultation and engagement website, One Borough Voice.

1.2 The consultation process was designed to take place in stages. This best practice approach allowed us to maintain continuous dialogue with carers throughout the development process, ensuring their input led to a Carers Charter that was co-produced and truly reflective of their priorities and aspirations. The consultation on the Carers Charter has been identified as an exemplar piece of work, bringing carers along the journey and adapting the method and format of the consultation, so that all carers' voices can be heard. Carers of Barking and Dagenham, as the carers support service provider, alongside development of the consultation material, also supported the workshops and focus groups, facilitating representation from a cross range of carers. A small number of carers preferred to complete hard copies of the consultation questions which was supported by Carers of Barking and Dagenham and sent through to be uploaded.

1.3 The Carers Charter consultation took place between February 2021 and August 2021 through three separate stages.

Stage 1: 48 Participants (One Borough Voice consultation)

Stage 2: 21 Participants (virtual workshop via Zoom)

Stage 3: 22 Participants (One Borough Voice consultation)

1.4 Aside from the initial focus groups and the workshops, there were 337 visits to the Carers Charter page on the One Borough Voice portal with 70 engaging in completing the consultation.

1.5 Questions for the initial stage were developed with carers focus groups, based on the local and national policy and their lived experience, and were put on the One Borough Voice portal for consultation. Alongside this, work was done with stakeholders in health, social care and the community and voluntary sector to identify areas that are important to carers and building on the positive work that has already been undertaken to support carers in their caring role. From the analytics of One Borough Voice there was a lot of interest in each stage of the consultation but not all visits resulted in a completed questionnaire.

1.6 In addition to the questions, carers were given an opportunity to include things that they would like to be included or considered as part of the development of the Carers Charter. This provided a platform for more discussion in the absence of face-to-face workshops and forums, where discussion points could be teased out further or carers could approach the facilitator for a separate discussion. Following on from feedback from carers, a workshop was put in place to discuss the Carers Charter further and to develop I statements with the carers.

1.7 The Carers Charter uses the principles of 'Think Local Act Personal' and includes the co-produced I statements by the carers that talk about the outcomes that Carers identified and we will deliver as part of the Carers Strategy Group and the partnership. Triangulation of all the information, feedback and policy context was used to develop the Carers Charter, with a long list of I statements put out for consultation and subsequently shortlisted down to four in each area by the carers.

1.8 The Carers Charter informed the development of the Action Plan and how partners would support the delivery of this shown in Appendix B. The Action Plan will be monitored through the Carers Strategy Group and updated annually through consultation with carers and the Carers Strategy Group to make this a reflective document monitoring the achievements delivered in this space and joint future areas of work that need to be focused on. In essence these two documents will outline our vision and priorities in supporting carers in their caring role across the partnership.

1.9 Feedback received from Carers of Barking and Dagenham on the development of the Carers Charter is as follows;

"The document is a well thought out and user-friendly piece of work that has clearly identified the issues that carers face. Carers of Barking and Dagenham have been heavily involved in the consultation process and carers have expressed how they appreciated having their views listened to. The commissioner has worked very hard to ensure that all voices were heard, and the charter is presented in a way that is easily read and understood. This has been a good example of joint working and we look forward to receiving the final document."

1.10 Previously, young carers were not included in the Carers Strategy, the work to support Young Carers has however been incorporated in the work of the Carers Strategy Group. A young carer within legislation is defined as someone who is under the age of 18 with caring responsibilities. Young carers take on various responsibilities, including washing and dressing the person they are caring for which could be a parent or other family member, looking after younger siblings, undertaking domestic chores such as cooking, cleaning, and shopping. Young carers maybe supporting a family member with a disability, mental health issues or drug and alcohol dependency.

1.11 Consultation with young carers took place via the young carers' subgroup and ambassadors' workshop, where they were asked to develop I statements they felt were significant to them. We worked with the provider Carers of Barking and Dagenham to consult with young carers in the borough. Young carers were given the option of taking part in the carers survey, which was advertised widely and on the One Borough Voice website, at each of the stages.

1.12 Alongside this work, the Carers Charter and Action Plan were developed with members of the Carers Strategy Group including NEL CCG, NELFT End of Life, Social Care, Carers of Barking and Dagenham. Alongside the focus groups, the Carers Strategy Group provided the themes of the initial consultation questions, development of the I statements and subsequent Action Plan. All our partners have been promoting the consultation process locally and supporting carers to have equity in developing the Carers Charter.

1.13 There is also a Tri-Borough Carers Network Group which includes Barking and Dagenham, Havering and Redbridge carers leads, carers commissioned services alongside NEL CCG lead and the BHR Integrated Care Partnership (ICP) clinical lead for Carers. The group meets quarterly to discuss ideas, innovation and joint working to better support carers in their caring role across the tri-borough footprint.

This group along with representatives from Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) have also been involved in developing the Carers Charter and Action Plan.

1.14 The Community and Voluntary Sector are an important partner in delivering the Carers Charter and are often the first point of contact for carers including 'hidden carers' in the community. BD Collective, through the Re-imagining Adult Social Care Forum have also contributed to the development of the Carers Charter and Action Plan. In addition to this, consultation and development has also been undertaken with the Metropolitan Police and informed the Carers Charter and Action Plan.

1.15 The Carers Charter and Action Plan promote a joined up and co-ordinated response across the partnership and allow services to provide a holistic support response. The Carers Action plan will be monitored through the Carers Strategy Group through measurable outcomes.

4 Mandatory Implications

4.1 Joint Strategic Needs Assessment

The Joint Strategic Needs Assessment makes recommendations for several areas that impact on the lives of both young and adult carers. This can range from the impact of young people not realising their potential through education and employment due to their caring roles as well as the impact of being a carer on the mental health of carers of all ages. Financial resilience alongside health and wellbeing of the cared for contributes to the impact on the carer. Carers are often caring for individuals with complex needs which means that they do not address their own health and wellbeing needs as the cared for person is prioritised.

The needs identified in the JSNA all impact on carers as they support individuals with varying needs and different stages of the life course. Positive outcomes for the cared for including timely support, access to services including prevention services and providing a carer friendly community will contribute to supporting carers in their caring role. An example of this is accessing COVID-19 vaccinations and identifying carers locally. The Carers Charter and Action Plan will support bringing carers to the forefront of service delivery across the partnership.

4.2 Joint Health and Wellbeing Strategy

The Joint Health and Wellbeing Strategy aims are aligned with the Carers Charter and Action Plan. Through early diagnosis and intervention both the cared for and the carer can be supported through timely diagnosis and intervention. Carers and the cared for can have health and wellbeing support needs, which when addressed early on can decrease or slow down the need for further support from health and social care.

Becoming a carer can often happen overnight and have far reaching multifaceted impacts on the lives of the carer, especially when a person does not identify themselves as a carer or equally are not given the information to come to that conclusion, thereby, are unable to access the right support. Building resilience and improving health and wellbeing outcomes using trauma-informed intervention models will enable carers to practice self-care as well as enable carers of all ages to participate in opportunities such as employment, education, and training.

Better Care Fund

It is important that everyone works together to improve the lives of carers in Barking and Dagenham. The partnership between health and social care is of particular importance and as such, the local authority and NEL CCG have agreed that support to carers should be one of the key themes of the Better Care Fund (BCF). This includes the joint commissioning of the carers support service delivered by Carers of Barking and Dagenham.

In particular, the BCF plan sets out that we will:

• Improve the support available to carers, recognising their key role in helping people to remain in their own homes, which will in turn support planned reductions in rates of avoidable admissions to hospitals and care homes;

• Identify additional services required for carers and supporting commissioning activities to develop these services;

• Target carers at risk of breakdown and positively increasing the number of carers supporting people in their own homes for as long as possible;

• Meet the requirements of the Care Act;

• Improve the experience of carers and service users by ensuring that their needs and priorities are reflected in provision.

4.3 NHS Long Term Plan

The NHS Long Term Plan launched in January 2019 echoes the commitment to carers including better recognition and support of carers, especially from vulnerable communities, and improve outcomes. Carers being support through emergencies and not having to manage on their own by understanding access to and signposting to out of hours options, contingency planning and specific support for young carers. There is also an increased focus on social prescribing in primary care and a co-ordinated, proactive approach to the delivery of the service to enable a more differentiated support offer.

4.4 Borough Partnership

To achieve partnership goals and tackle the health inequality challenges of boundaries, the Partnership Board is being proposed to lead on strategy development to develop place-based care that addresses whole population needs. Commissioning plans would include commissioning services in the preventative space and the integration of the social sector into models of care so that there is a ground up connection with communities. The Board will be supported by a programme structure that supports delivery across separate pathways of care for children and adults. Delegated authority would be sought for responsibility for

pooled health and care budgets that are managed under a Section 75 partnership arrangement.

4.5 Financial Implications

Implications completed by: Murad Khan (Finance Manager)

There are no direct financial implications to this report, this sets out the carers support framework and charter for the approval of the Health and Wellbeing Board.

The health and wellbeing of our carers is of paramount importance as stress or poor working conditions can lead to sickness, absence or resignation, this could lead to significant financial pressures in the future in the form of increased care costs.

4.6 Legal Implications

Implications completed by: Dr Paul Feild (Senior Governance Lawyer)

The Care Act 2014 contains provisions relating to adult care and support and health and is intended to give effect to the policies requiring primary legislation that were set out in the White Paper *Caring for our future: reforming care and support*, to implement the changes put forward by the Commission on the Funding of Care and Support, and to meet the recommendations of the Law Commission in its report on Adult Social Care to consolidate and modernise existing care and support law. Furthermore, it establishes a fund for the integration of care and support with health services, to be known as the *Better Care Fund* and made provision for additional safeguards around the general dissemination of health and care information. While the Care Act is adult focused the important role that young carers and their need for support is addressed by the Children and Families Act 2014 and it shall working in conjunction with the Care Act.

Local Authorities responsibilities are set out in the Care Act including care and support roles. There is an overriding principle that that local authorities must promote the well-being of the adult when carrying out their functions under the Act.

As set out in the body of this report the Council is under a duty to assess carers. It requires a local authority to carry out an assessment, known as a “carer’s assessment”, where it appears that a carer may have needs for support at that time, or in the future. The aim of the assessment is to determine whether a carer has support needs either currently or, possibly, in the future and what those needs may be.

4.7 Public Background Papers Used in the Preparation of the Report:

Detailed within the footnotes of the body of the report.

List of Appendices:

Appendix A - Carers Charter 2022-25
Appendix B - Carers Charter Action Plan

Carers Charter 2022-25

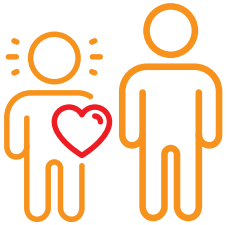
This Carers Charter has been developed with unpaid carers in Barking and Dagenham who provide valuable support to loved ones. The charter outlines the commitment to carers across the borough including our partners and how we will help them in their caring role.

Working together for carers

1. I have help at an early stage.
2. I want friendly professionals who understand my role as a carer and listen to me.
3. I am recognised as an expert and equal partner of care with my views and opinions valued and respected.
4. I want to access a range of support, including breaks from my caring responsibilities, to help me live my life and continue to carry on with my caring role.

Carers wellbeing and employment

1. I have access to information and advice to help me look after my own mental and physical health.
2. I can access an effective response from health and social care to address changes in my loved ones needs, for instance increase in care package so that I can return to work quickly.
3. I am supported to maximise my income including accessing benefits.
4. I am supported with my caring responsibilities so that I can continue to work or study.



Supporting young carers

1. I can attend carers support groups and activities with young carers that understand what I am going through.
2. I can access help to support me with my mental health and wellbeing.
3. I am able to focus on my future and my studies without impacting on my caring role, including university training and employment options.
4. My school understands my caring role and I feel supported.

Carers in the wider community

1. I recognise I may need help both in my caring role and in maintaining my own health and well-being.
2. I can access a carers needs assessment when I need it.
3. I want to be able to find out information about what services are available in the community.
4. Information is shared with me and other professionals to raise awareness and signposted appropriately.

Barking & Dagenham

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Appendix B

Carers Charter Action Plan					
Carers Charter Area					
Working together for Carers	**Objective**	**Action**	**Owner**	**Reporting time**	**Measure**
•I have help at an early stage. •I want friendly professionals who understand my role as a carer and listen to me.	Promote identification of hidden carers.	Training to identify carers/hidden carers and understand their contribution to health and social care for all frontline staff within the partnership.	All	Quarterly	% of staff completed training (target 60% per annum)
	Develop a referral pathway at hospital discharge to the Carers Centre.	Referral pathway developed and promoted to staff at BHRUT to refer carers to Carers of Barking and Dagenham.	CHAT	Mar-23	Quarterly % increase in the number of referrals once pathway in place
	Promote identification of hidden carers by GPs.	Training and pop up reminder on GP system to promote recording of carers by GPs. Promote identification and recording of carers by GPs through GP intranet and PTI and links to signposting.	NEL CCG (BHR ICP)	Quaterly	Number of additional patients recorded as carers.
•I am recognised as an expert and equal partner of care with my views and opinions valued and respected.	Involve Carers in cared for health and wellbeing planning.	Involve carers in the assessment and development of support plans for the cared for.	LBBD Social Care	Quarterly	Case studies of carers supported
	Develop Carers Champions	Identify champions in the workforce to drive the delivery of the carers charter and bring carers to the forefront of service delivery.	All	Annually	Number of carers champions and successful initiatives
. •I want to access a range of support, including breaks from my caring responsibilities, to help me live the life; and continue to carry on with my caring role.	Support carers in a culturally competent approach to deliver person centred outcomes.	Increase awareness of support requirements for carers of different cultural and racial backgrounds by meaningfully considering race and identity of carers through training and shared learning.	All	Quarterly	Number of training and shared learning sessions that reflect culturally competent practice. Survey of carers experience of service (annual)
	Carers access support and breaks through direct payments.	Development of Carers Market for carers to use direct payments.	LBBD Commissioning Carers of Barking and Dagenham LBBD Social Care	Annually	Number of carers accessing support and breaks through direct payments.
Carers wellbeing and employment	**Objective**	**Action**	**Owner**	**Reporting time**	**Measure**
•I have access to information and advice to help me look after my own mental and physical health.	Maximise income for carers	Training to identify hidden carers Maximise income through employment, training and benefits.	LBBD Community Solutions DWP Job Centre Plus Carers of Barking and Dagenham	Quarterly	% of staff completed training (target 60% per annum) -accessing employment, including initiatives like Kickstart, Jets, Sector-based work Academy programmes (SWAPS) DEA Direct support, DWP Apprenticeships, volunteering opportunities and employment programmes run by DWP -increased engagement with Homes and Money Hub, including support with budgeting - wellbeing courses with a view to employment (confidence/motivation) -training -additional benefits -% increase of Carers Allowance from baseline.
	Increase screening and referrals for carers (prevention/early intervention)	Link worker to work with GPs and promote social prescribing carer referral.	LBBD Community Solutions/ NEL CCG	Quarterly	2% increase in carers accessing social prescribing
•I can access an effective response from health and social care to address changes in my loved ones needs, for instance increase in care package so that I can return to work quickly.	Increase awareness of working carers and impact of timely intervention for social care and health staff.	Work with health and social care partners to raise awareness.	Carers of Barking and Dagenham	Six monthly	Case studies of carers supported
•I am supported to maximise my income including accessing benefits.	Increase employment/training opportunities.	Work with Carers to access employment/training and utilise experience gained as a carer.	LBBD Community Solutions/ Job Centre Plus	Quarterly	% increase in number of carers accessing employment/training and volunteering. % carers engaging with JobShop and Adult College
	Increase uptake of NHS health checks and screening for eligible carers.	Promote uptake of health checks to carers	NEL CCG/ LBBD Public Health	Quarterly	No. of healthchecks accessed by carers.
•I am supported with my caring responsibilities so that I can continue to work or study.	Increase uptake of COVID and Flu vaccinations amongst carers	Continue to promote vaccinations to carers amongst partner organisations.	LBBD Public Health	Annually	% of identified carers vaccinated for COVID % of identified carers vaccinated for Flu
	Support older carers of adult children with disabilities to access advance care planning for cared for.	Plans for adult children with disabilities to be put in place to be implemented after parent passes away.	End of Life Care Service LBBD Social Care	Annually	Number of advance care plans in place
Supporting Young Carers	**Objective**	**Action**	**Owner**	**Reporting time**	**Measure**
•I can attend carers support groups and activities with young carers that understand want I am going through.	Young carers are able to attend activities and meet with peers who understand their situation, and they receive a break from their caring responsibilities.	Activities and regular groups take place to support young carers.	Carers of Barking and Dagenham	Quarterly	Number and type of online and face to face activities.
•Increase awareness and support for young carers.	Increase awareness and referral pathways for young carers	Safeguarding Board Partners are aware of the young carers services	Carers of Barking and Dagenham Disability Services Voluntary Sector Drugs and Alcohol Services Education Safeguarding	Quarterly	Partners are referring into services.
•I can access help to support me with my mental health and wellbeing.	Increase access to mental health and wellbeing support services.	Work with health partners to increase awareness of young carers and access support. Signpost young carers to mental health support	Carers of Barking and Dagenham, Education and all NHS partners	Quarterly	% increase from baseline young people accessing mental health support.
	Promote awareness of young carers	Work with Carers of Barking and Dagenham and Young Carers to promote carers in the young people's space.	Carers of Barking and Dagenham	Quarterly	Number of assemblies with schools.
•I am able to focus on my future and my studies without impacting on my caring role, including university training and employment options.	Support young people to continue in education, training and employment	Develop partnerships with schools to increase awareness of young carers and how schools/colleges can build on this work.	LBBD Education, Carers of Barking and Dagenham LBBD Community Solutions	Quarterly	Number of new initiatives delivered/ developed. - % increase in NEET young carers accessing advice services for training and employment.
•My school understands my caring role and I feel supported.	Schools where possible are able to work with and help young carers to meet their potential	Increase awareness of support requirements for carers in schools	Carers of Barking and Dagenham LBBD Social Care LBBD Education/ Designated Safeguarding Leads	Six monthly	Number of referrals from schools.
Carers in the wider community	**Objective**	**Action**	**Owner**	**Reporting time**	**Measure**
•Recognise I may need help both in my caring role and in maintaining my own health and well-being.	Identify carers and provide onward referral to Carers of Barking and Dagenham.	Increase awareness of support requirements for carers including providing culturally competent support by meaningfully considering race and identity of all age carers.	All	Quarterly	Breakdown and number of referrals received from partners by Carers of Barking and Dagenham -Case studies of carers supported

•I can access a carers needs assessment when I need.	Increase uptake of carers needs assessments.	All actively promote the carers needs assessment and referral to the Intake Team.	All LBBD Social Care LBBD Performance and Intelligence Team Carers of Barking and Dagenham LBBD Community Solutions Healthwatch	Quarterly	% increase in Carers Assessments from baseline.
•I want to be able to find out information about what services are available in the community.	Develop a carer friendly community.	Work with the all partners and local businesses and employers to develop a carer friendly community.	All Local businesses/ LBBD Community Solutions	Six monthly	Report initiatives and processes developed including service user feedback. - increase in number of flexible employment roles available for carers
	Identify and support carers at incidents or in contact with Police.	Increase awareness of all age carers and appropriately refer to carers support service.	Metropolitan Police	Quarterly	No of referrals received by Carers of Barking and Dagenham.
•Information is shared with me and other professionals to raise awareness and signposted appropriately.	Promote services to carers and partners including signposting and referral pathway.	Promote services through GP intranet, partner websites, faith forums, community and voluntary sector organisations.	All, BHRUT BD Collective End of Life Care Service Healthwatch Carers of Barking and Dagenham Community Solutions Community Hubs	Quarterly	Monitor referral source to Carers of Barking and Dagenham Strong culture on feedback form referrals and areas where improvements can be made/best practice No of information and training sessions delivered. No of forums attended.

Barking & Dagenham

HEALTH and WELLBEING BOARD FORWARD PLAN

January 2022 Edition

Publication Date: 14 December 2021

THE FORWARD PLAN

Explanatory note:

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

Key Decisions

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

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

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

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

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

Information included in the Forward Plan

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

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

Publicity in connection with Key decisions

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

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

The Health and Wellbeing Board's Forward Plan will be published on or before the following dates during 2020/21:

Edition	Publication date
June 2021 Edition	17 May 2021
September 2021 Edition	16 August 2021
November 2021 Edition	11 October 2021
January 2022 Edition	14 December 2021
March 2022 Edition	14 February 2022

Confidential or Exempt Information

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

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

Key to the table

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

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

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

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

Decision taker/ Projected Date	**Subject Matter** Nature of Decision	**Open / Private** (and reason if all / part is private)	**Sponsor and Lead officer / report author**

Health and Wellbeing Board: 15.3.22	**Child and Adolescent Mental Health Services Review** • Wards Directly Affected: All Wards		Elaine Allegretti, Strategic Director, Children & Adults (Tel: 020 8227 3567) (elaine.allegretti@lbbd.gov.uk) Elaine.Allegretti@lbbd.gov.uk
Health and Wellbeing Board: 15.3.22	**Covid-19 Update in the Borough** • Wards Directly Affected: All Wards		Matthew Cole, Director of Public Health (Tel: 020 8227 3657) (matthew.cole@lbbd.gov.uk) Matthew.Cole@lbbd.gov.uk
Health and Wellbeing Board: 15.3.22	**Integrated Care System/Local Borough Partnership Proposals and Governance** • Wards Directly Affected: All Wards		Jess Waithe, Interim Health Improvement Lead (jess.waithe@lbbd.gov.uk) jess.waithe@lbbd.gov.uk

APPENDIX 1

Membership of Health and Wellbeing Board:

Cllr Maureen Worby (Chair), LBBD Cabinet Member for Social Care and Health Integration
Dr Jagan John (Deputy Chair), NHS North East London Clinical Commissioning Group
Elaine Allegretti, LBBD Director of People and Resilience
Cllr Saima Ashraf, LBBD Deputy Leader and Cabinet Member for Community Leadership and Engagement
Cllr Sade Bright, LBBD Cabinet Member for Employment, Skills and Aspiration
Cllr Evelyn Carpenter, LBBD Cabinet Member for Educational Attainment and School Improvement
Melody Williams, North East London NHS Foundation Trust
Matthew Cole, LBBD Director of Public Health
Kimberley Cope, Metropolitan Police
Kathryn Halford, Barking Havering and Redbridge University Hospitals NHS Trust
Sharon Morrow, NHS North East London Clinical Commissioning Group
Nathan Singleton, Healthwatch Barking and Dagenham (CEO Lifeline Projects)