Barking & Dagenham

Notice of Meeting

HEALTH SCRUTINY COMMITTEE

Wednesday, 23 March 2022 - 7:00 pm
Council Chamber, Town Hall, Barking

Members: Cllr Paul Robinson (Chair) Cllr Donna Lumsden (Deputy Chair); Cllr Abdul Aziz, Cllr Peter Chand, Cllr Adegboyega Oluwole and Cllr Chris Rice

By Invitation: Cllr Maureen Worby

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Claire Symonds
Chief Executive

Contact Officer: Claudia Wakefield
Tel. 020 8227 5276
E-mail: claudia.wakefield@lbbd.gov.uk

Please note that this meeting will be webcast and members of the press and public are encouraged to view the proceedings via this method. Those wishing to attend the meeting in person must provide evidence of a negative Lateral Flow Test on arrival and are encouraged to wear a face mask at all times, including while seated in the public gallery on the second floor of the Town Hall. To view the webcast click here and select the relevant meeting (the weblink will be available at least 24-hours before the meeting).

AGENDA

1. Apologies for Absence

2. Declaration of Members' Interests

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

3. Minutes - To confirm as correct the minutes of the meeting held on 3 November 2021 (Pages 3 - 8)

4. Minutes - To confirm as correct the minutes of the meeting held on 19 January 2022 (Pages 9 - 13)

5. Minutes - To confirm as correct the minutes of the meeting held on 23 February 2022 (Pages 15 - 20)

6. **Children's Community Health Services (Pages 21 - 37)**

7. **NELFT CQC Inspection Update (Pages 39 - 56)**

8. **The Integrated Care System/Local Borough Partnership Proposals and Governance- Position Update (Pages 57 - 68)**

9. **Joint Health Overview and Scrutiny Committee**

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

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

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

Private Business

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

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

Barking & Dagenham

Our Vision for Barking and Dagenham

ONE BOROUGH; ONE COMMUNITY; NO-ONE LEFT BEHIND

Our Priorities

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

Barking & Dagenham

- 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 SCRUTINY COMMITTEE

Wednesday, 3 November 2021
(7:00 - 8:58 pm)

Present: Cllr Paul Robinson (Chair), Cllr Donna Lumsden (Deputy Chair), Cllr Abdul Aziz, Cllr Adegboyega Oluwole and Cllr Chris Rice

Also Present: Cllr Maureen Worby

Apologies: Cllr Peter Chand

14. Declaration of Members' Interests

There were no declarations of interest.

15. Minutes - To confirm as correct the minutes of the meeting held on 10 February 2021

The minutes of the meeting held on 10 February 2021 were confirmed as correct.

16. Minutes - To confirm as correct the minutes of the meeting held on 30 June 2021

The minutes of the meeting held on 30 June 2021 were confirmed as correct.

17. Minutes - To confirm as correct the minutes of the meeting held on 22 September 2021

The minutes of the meeting held on 22 September 2021 were confirmed as correct.

18. Healthwatch's Key Reports/ Findings 2020/21

The Healthwatch Officer (HO) from Healthwatch Barking and Dagenham delivered a presentation on the following three reports that had arisen from key projects undertaken by the organisation during 2020/21:

- ‘Dental Services in Barking & Dagenham during COVID-19’;
- ‘Care Home and Domiciliary Care – Staff Wellbeing during COVID-19’ and
- ‘Community insights on Disabled Residents and the Covid Vaccine in North East London’.

The presentation outlined the context behind each project, its key aims, the methodology and the information gathered.

In response to questions in relation to the ‘Dental Services in Barking & Dagenham during COVID-19’ report, the HO stated that:

- Following the restricted dental services that were put in place from 6 June 2020, residents had experienced many issues with dental practices either

not registering new patients, or not offering appointments to them until after weeks or months, due to being fully booked. Dental practices were referring residents back to NHS 111, which was supposed to be used in emergencies, or requesting that residents try a different practice. Dental practices were also using voice messages as first points of contact.
- These issues had been experienced across other areas of London, and colleagues from the NHS England Dental Commissioning team had listened to these issues at the Pan-London Healthwatch network. After discovering that these issues were taking place on a national level, Healthwatch England ran a national campaign to build a fuller picture. Local dental committees were not involved at this point and work was currently underway to establish connections between these and Healthwatch, so that both could work together in future to improve services and ensure better data sharing.
- Local dental committees had since found engaging with Healthwatch to be a positive experience. As a consequence, the Chair of Healthwatch England and the Chair of the British Dental Association had written a letter to the Chancellor of the Exchequer on 21 October 2021, urging him to provide more funding for dental services nationally.
- Whilst dental care and GP services were both primary care services, the commissioning for the former was undertaken by NHS England, with the latter undertaken by Clinical Commissioning Groups (CCGs).
- Healthwatch was currently the first point of contact for residents who were having issues with their dental services.
- Healthwatch Barking and Dagenham (BD) had received many more complaints and concerns from residents in relation to dental services since the pandemic.

The Cabinet Member for Social Care and Health Integration (CM) noted that there were a higher number of NHS dentists operating in the Borough, than surrounding boroughs; but there were still issues in getting dental services to operate face-to-face again, and in getting appointments for the Borough’s looked after children.

In response to questions in relation to the ‘Care Home and Domiciliary Care – Staff Wellbeing during COVID-19’ report, the HO stated that:

- During their interviews, some care home and domiciliary care staff had said that their employers had encouraged them to take time off when they were struggling; however, the question of whether they had to take annual leave for this was not directly explored as part of the interviews.
- The ‘disparity between the social care services’ referred to on page 78 of the agenda pack, referred to the disparity between care home and domiciliary care staff, and other healthcare services.
- The HO had not yet received any feedback on the pilot undertaken by the Council, whereby frontline care workers from across the sector could discuss their challenges and seek support from each other. However, he intended to attend meetings with local care homes and domiciliary care providers and would raise this point at future meetings. The CM stated that the Council had taken on board all recommendations from the report; however, the Council was dependent on the owners of the care home and

domiciliary care home services to release their staff to attend these forums and this was part of the difficulty with the pilot and gathering information. Whilst the pilot had worked, the continued pressures of Covid-19 and the winter period would mean continued stresses for care home and domiciliary care staff, likely translating into increased staff sickness. As such, the Council had said that it would review the pilot again after six months, when it would revisit how it could strengthen opportunities for frontline staff to have a voice in its forums. The Council would feedback to Healthwatch at an appropriate time.

- Healthwatch BD was currently discussing how it could better engage with people from other cultural backgrounds within the Borough, as it felt that it needed to personalise its communication, for example, in terms of the messaging around Covid-19 vaccinations.
- In their interviews, staff often expressed concern as to what their peers may think of them if they were not able to attend work; however, they had felt comfortable in sharing their experiences with Healthwatch.

The CM stated that BD had an 80% vaccination rate in terms of its care home and domiciliary care staff.

In response to questions in relation to the 'Community Insights on Disabled Residents and the Covid Vaccine in North East London' report, the HO stated that:

- This was the first stage of this particular piece of work. When the insights gained as part of the report were presented to the North East London Clinical Commissioning Group (NEL CCG), GPs were highly positive about the work and the local information and insights gathered. Healthwatch would be continuing this piece of work for the next two years.
- As a consequence of being involved in this work, Healthwatch BD had been nominated for a national award.
- The next stage of this work would focus on how Healthwatch would communicate the issues that disabled residents were facing, as well as the demography of the local population and how this changed over time. Healthwatch would update the Committee as to the next stage of the project.

The Committee praised the work delivered by Healthwatch BD. The HO stated that Healthwatch BD were currently waiting for sign-off on two other projects that it had completed, namely, one on exercise and activity for young people in the Borough, and the other on sexual health services. Looking forward, it would be undertaking a vast project on obesity in BD.

19. Managing Our Planned Care

The Acting Chief Operating Officer (ACOO) for Elective Care at BHRUT delivered a presentation on managing planned care at the Trust, which included the impact of Covid-19 on key planned care measures and actions taken to mitigate this, current service performance and future plans.

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

- Inequalities between different populations had become much more manifest as a result of the Covid-19 pandemic. Whilst this topic was still fairly new, BHRUT had noted that there did not appear to be any trust level differences between different ethnic groups, or in different socio-economic groups in accessing care; however, this finding could change once BHRUT started to look at the data in more detail. There were also not currently any obvious differences in the waiting times between different socio-economic, ethnic, or age groups; however, much more work needed to be undertaken to understand the data and the questions to be asked.
- There were, however, differences in waiting times between different specialities. Surgical services tended to have longer waiting times than medical specialities, as they required patients to have a number of outpatient and diagnostic appointments, as well as to wait to come into theatre. About half of the waiting list was currently within six different specialities and BHRUT knew that it needed to focus on its surgical specialities, in particular certain paediatric services such as Ear Nose Throat (ENT), where it knew that there were longer waiting times than other areas.
- There were also some cancers that took longer to diagnose, such as colorectal cancers. These diagnostics were also stopped for a longer period during the pandemic, meaning that there was a greater need to catch-up on these diagnostics to reduce waiting times back to pre-covid levels. BHRUT was also dependent on tertiary providers for treatment in relation to more complex cancers. As these complex surgical services stopped during the initial phase of Covid-19 and as BHRUT was dependent on these providers, there was a lot of catch-up work and longer waiting times. Unmet need within the community was also unknown, in terms of patients not being referred into services.

The CM also highlighted that a higher proportion of the Borough's residents presented to services when their cancers were already at stage three or four. One of the priorities at the North East London Integrated Care System (ICS) level, was to encourage individuals to come forward earlier, as the combined impact of long waiting times and presenting late, meant that outcomes for these individuals were poor. There were also issues around how different cultural groups perceived cancer, so the ICS had been working with faith and cultural leaders as to how this message could be relayed appropriately for each cultural group.

In response to further questions, the ACOO stated that:

- National awareness campaigns were taking place on a rolling programme, with a lung cancer campaign taking place in November 2021. Big increases in referrals were also experienced following the deaths of prominent public figures. Whilst there was limited capacity in secondary care, it was hoped that awareness campaigns would identify unmet need. Whilst awareness campaigns and increased investments in diagnostics were positive, the system needed to ensure that patients accessed services in the first place.
- In regards to patients waiting over 63 days from referral to treatment, the

Trust had two measures, one of which was a 'backlog'. Pre-covid, there were approximately 200 patients waiting over 63 days due to complex reasons, and currently this figure stood at 350 patients. BHRUT's plan was to return to pre-covid levels by the end of the financial year.

- BHRUT was in a position to run more super clinics; however, it was less able to encourage patients to access care in the first place, as the first point of contact for patients was with GP practices. Work needed to be undertaken with primary care as to whether more could be done jointly to encourage patients to access care.
- There was an intention to invest in cancer diagnostic pathways with the investment that BHRUT was expecting from the Government, locating diagnostics within the community to make these easier to access, such as through Barking Community Hospital and the St. Georges Hub.
- BHRUT was focused on ensuring that it had a sufficient workforce to deliver services. During the pandemic it had moved staff treating patients in theatres, to critical care wards to manage a greater emergency demand. There was an additional challenge in that BHRUT was having to catch-up on work that could not be undertaken during Covid-19, alongside current demands, with the same workforce. Whilst technology, such as virtual appointments, could mitigate some issues, it would take a long time to catch-up on this work.
- There was ongoing work into potential missed cancers during the pandemic, and the Trust knew that it needed to run at around 120 percent of its pre-covid levels to undertake this work. The NEL Cancer Alliance was also exploring whether there was evidence of inequalities between particular communities in terms of missed cancers. The Trust received financial incentives to recover its lost work and had not received any penalties.

The Director of Commissioning and Performance (DCP) at BHR ICP and NEL CCG also confirmed that a large amount of work had been undertaken across Phlebotomy over the last six to twelve months, addressing the closure of services during the first pandemic. The backlog was now under control and residents could go online and book blood tests for the following day. BHRUT did not use the blood test tube bottles that had been impacted by the global shortage and was therefore not significantly affected.

20. Engagement On St George's Hospital Development

The Director of Commissioning and Performance (DCP) at BHR ICP and NEL CCG delivered a presentation on the engagement plans for the new St. George's Hospital development, which would aim to integrate a range of health, care and wellbeing services into one hub in South Hornchurch. The engagement period was proposed to run between 22 November 2021 and 13 February 2022, with a variety of engagement both online and in-person.

In response to questions, the DCP stated that the ICP and CCG wished to give as wide a range of residents within Havering, Redbridge and BD, the opportunity to comment on the proposals. There was also lots of ongoing work around the health

aspects of the Barking Riverside development, and the organisations wished to ensure that the models of care being developed were consistent with each other. Whilst the St Georges Hub was not a facility in BD, the way that the Hub was set up and run could help to inform what the ICP and CCG were doing in Barking Riverside as part of that development.

The CM positively acknowledged the benefits of the scheme for residents of Havering; however, expressed dismay that a Hub was being developed in Havering, when she believed many of the services it would offer were already available to Havering residents. She urged the DCP to consider implementing wider health, care and wellbeing services at Barking Community Hospital as opposed to more minor facilities, especially considering the high levels of deprivation and poverty experienced by BD residents, who did not already have these services available to them within their own borough. BD had already lost three hospitals over the years. She stated that it would prove difficult to engage BD residents in the consultation, as they would likely question the benefits for them.

In response to a question, the DCP stated that any patient identified as being impacted by the transfer of the renal dialysis unit from Queens Hospital to the St George's Hub would be consulted.

The DCP answered some further questions around the health and wellbeing needs that the services within the Hub would meet and confirmed that as far as he was aware, there were currently no plans to charge for car parking at the Hub and discussions had centred more around ensuring sufficient parking.

21. Joint Health Overview and Scrutiny Committee

The Committee noted the minutes from the Joint Health Overview and Scrutiny Committee.

22. Work Programme

The Committee agreed to accept the changes to the Work Programme as outlined in the report. It also requested that officers look into the possibility of NELFT attending the 23 February 2022 Committee meeting, to provide and explain the figures as to how many children were on the Child and Adolescent Mental Health Services (CAMHS) waiting list, for talking therapies and for diagnosis.

MINUTES OF
HEALTH SCRUTINY COMMITTEE

Wednesday, 19 January 2022
(7:00 - 9:15 pm)

Present: Cllr Paul Robinson (Chair), Cllr Donna Lumsden (Deputy Chair), Cllr Abdul Aziz, Cllr Peter Chand, Cllr Adegboyega Oluwole and Cllr Chris Rice

Also Present: Cllr Maureen Worby, Cllr Margaret Mullane and Cllr Andrew Achilleos

23. Declaration of Members' Interests

There were no declarations of interest.

24. Minutes - To note the minutes of the meeting held on 3 November 2021

The minutes of the meeting held on 3 November 2021 were noted.

25. Annual Director of Public Health Report- Equalities Challenges in Barking and Dagenham

The Director of Public Health (DPH) presented his Public Health Annual Report for 2020-21, which focussed on the health inequalities in the Borough, that had been made further stark by the Covid-19 pandemic. The report provided a snapshot of inequalities at a borough population-level and summarised the consultation feedback from key stakeholders on how to collectively reduce them and improve the health and wellbeing of all residents.

The DPH summarised some of the key health inequalities and challenges faced by black and minority ethnic (BAME) groups residing in the Borough, whilst also highlighting the deficiencies within local systems in collating accurate, reliable data. He emphasised the importance of noting that inequalities were worse than they were before the pandemic, which had severely impacted diagnostic tests and increased waiting lists for a number of conditions. Some of the challenges were very nuanced, and frequently changing; for example, the current Omicron wave of the pandemic had led to more younger groups occupying general acute medicine beds, which could potentially be attributed to issues such as vaccine hesitancy within particular BAME groups. His report did not have all the answers, but it did provide a starting point for understanding the impacts of inequalities on different groups and raised the key areas of exploration to address these challenges. It would also form the basis of the inequalities work that the Council was undertaking to inform its Corporate Plan and the future refresh of the Equality and Diversity Strategy.

In response to questions, the DPH stated that:

- More could certainly be done to engage harder to reach groups at the earlier stages of service development to ensure new services would have the desired impact. Examples of this were the development of services for

those with long Covid and the community hubs, which aimed to work with residents facing a range of issues impacting their health and wellbeing, such as domestic violence;

- Those living in 'houses in multiple occupation' (HMOs) were a difficult to reach group and adding to this challenge was the high churn in families moving in and out of the Borough, particularly in certain wards such as Abbey;
- One of the reasons the Borough was disproportionately hit by the pandemic was the higher number of HMOs in the Borough, as well as the higher proportion of residents who were employed in industries which exposed them more to the virus, such as hospitality and catering;
- NHS Partners faced real challenges going forward and it was of paramount importance that they addressed the impact of the pandemic on waiting lists and services. Simultaneously, they had to adapt their services to meet future demand. This would be against the backdrop of limited resources and workforce challenges; and
- Whilst it was true that many of the health issues faced by residents, like obesity and smoking, were preventable, these were often linked to the wider determinants of health such as deprivation and mental health problems, which were difficult to overcome in the short-term.

The Cabinet Member for Community Safety and Enforcement stated that it was important for all partners to realise that the way they responded to issues in the community would have an impact on overall health and wellbeing outcomes – for example, she and her fellow Cabinet Members had made it clear to the Police that drug taking in the streets must be dealt with, and not just seen as a low level crime, due to the impact it had on the individual but also, communities.

Members expressed frustration that health inequalities had been an issue that the Borough had been facing for a number of years and asked what it would take to see a real difference. The Cabinet Member for Social Care and Health Integration (CMSCHI) stated that she too shared the same frustration, explaining that historically, the Borough had been significantly and continually underfunded, which meant that the challenges it faced in improving residents' health had worsened over time. However, the Northeast London system, which the Borough was now a part of, along with six other boroughs, offered a glimmer of hope in that the commissioning of resources was now more transparent, and new governance arrangements meant that the Board had a real say, giving the Borough more leverage over health funding.

In response to Members expressing concern in relation to reports that nationally, some children had not returned to school following the lockdowns to prevent the spread of Covid-19, and the risks this could present to some children, the CMSCHI stated that the Council was aware of such cases and did encourage the parents of these children to put their child back into school; however, under the current legislation, parents had the choice to home school their children and in some cases, the Council was unable to change their minds.

In response to questions in relation to the struggles some families were facing in accessing speech and language therapies for children with Special Education Needs and/or Disabilities (SEND), the Director for Commissioning, stated that a medium-term solution was to try and bring professionals other than speech and

language therapists in to address the less complex cases. The long-term solution, and the one that would be tougher to deliver, was to work with partners in education to encourage and influence the future workforce to go into career pathways that would help meet demand, as there simply were not enough speech and language therapists.

Members referred to the statements within the DPH's report that multi-morbidity (having two or more long-term conditions) was experienced eight years earlier by the African and Caribbean groups as compared to the White British/White Other group and asked why this was and what could be done to address this. The DPH stated that there was potentially a myriad of reasons behind this, such as not accessing primary care and lifestyle issues. Communication tailored to these groups, which came from a source they trusted, was shown to be effective- for example, a huge increase in the Covid-19 vaccine take-up was seen in certain groups when messages about vaccine safety was delivered via local mosques. The CMSCHI stated that it was difficult to fully understand why some national health programmes that had worked elsewhere, had not worked in the Borough. She hoped that the new community hubs would play a crucial role going forward in this regard; however, she wanted the hubs to grow organically to fully understand local issues faced by residents, which would take time.

In response to a Member citing an example of a local Sikh temple which facilitated a very successful session between worshippers and doctors, the CMSCHI stated that she agreed that the Borough needed better programmes that were culturally specific and accessible; however, due to the challenges within funding, she had to think carefully before making too many promises around this.

26. Update on the impact of the expansion of the Ultra-Low Emission Zone (ULEZ) in Barking and Dagenham, and how children and young people in Barking and Dagenham are being affected by air pollution following the recent case in Lewisham

The Service Manager for Environmental Health (SMEH) presented a report on the expansion of the ULEZ in the Borough and the impact on young people of air pollution. The report also provided an update on the main actions being progressed as part of the Council's Air Quality Action Plan (AQAP), as well as outlining the key recommendations arising from a Coroner's report on the death of a nine-year-old girl in 2013 who resided in Lewisham, who was the first person to have air pollution as a cause of death on her death certificate. The SMEH emphasised that the AQAP was not delivered by the Environmental Health team alone; a range of partners both within the Council (such as Public Health) and outside (such as BeFirst) all played an active part and were key to its success. One of the main aims of all partners was to drive behavioural changes in those residing and working in the Borough, via a good communications strategy and other initiatives, which would reduce air pollution.

In response to Members' questions, the SMEH stated that:

- There were two monitoring stations and 30 diffusion tubes in the Borough which measured PM 2.5 and PM10 (polluting particles) and Sulphur Dioxide to help the Council determine local air quality over a period of time;
- A key aim was to reduce pollution concentration levels near schools by

introducing low emission zones and the Street Schools project, which aimed to create pedestrian and cycle-only zones in the immediate vicinity of schools. The Council was also looking to introduce a level of enforcement near schools to tackle the issue of car idling, as this behaviour contributed to poor air quality; and
- In relation to the A13 dual carriageway, there would be a consultation on this as the Mayor of London was looking to extend the ULEZ to cover further areas linked to it. Reducing pollution on the A13, which spanned across several boroughs, would require the Council to work with other local authorities on projects and campaigns, and any effect of such joint working would only be seen in the long term.

The Cabinet Member for Enforcement and Community Safety expressed concern that the Government had withdrawn plans for a train station at Beam Park, which would mean increased levels of car usage in this area. This example demonstrated the importance of a good public transport offer in local communities and the role it played in improving air quality.

The Council's Member Champion for Climate Change (MCCC) stated that air quality and climate change were of the most important issues the world faced, particularly when considering that Covid-19 had thus far, caused serious respiratory illness. He raised a number of issues, as follows:

- The locations of the two monitoring stations in the Borough (Scrattons Farm and Rush Green) were away from the metropolitan centres of the Borough where there was a higher density of residents and more construction work taking place. Therefore, they were not best placed to give an accurate picture of the Borough's overall air quality. The diffusion tubes mitigated this to some extent, but they did not provide as detailed data as the monitoring stations;
- He had been in discussions with BeFirst regarding the potential for utilising Section 106 payments (payments made by developers as part of agreements with the Council).) to contribute towards the cost of further monitoring stations for the Borough;
- There was data that showed a higher concentration of particulates on the western boundary of the Borough (which could in part be attributed to the easterly wind) that gradually faded out as they reached Eastbrook and Havering. He felt strongly that the Council should consider the creation of a 'green ward' near Barking Creek by tree planting and other natural solutions, which would 'catch' the particulates;
- There was some fantastic work taking place in relation to promoting active travel and electrical vehicles. In 9 years' time, when the Government was planning to phase out petrol and diesel, the market would be more competitive, making it cheaper for residents to purchase electrical cars - it was important that the Council put in place the infrastructure for these changes in advance and he very much welcomed the decision by the Cabinet to approve the delivery of 250 electric vehicle charge-points across the Borough;
- The Walking and Cycling Strategy Steering Committee had a number of priorities for the coming year, including reducing traffic in the route from the north to the south of the Borough, and making streets more attractive to cycle and walk, to help cut down on the number of short car journeys;

- He congratulated the SMEH and his team for the School Streets project as it had been a broad success, when the same could not be said of other boroughs across London. More ‘School Streets’ were planned to expand these across the Borough; and
- 41% of particulates in the Borough came from construction work and BeFirst and the Council were pioneering new ways to reduce this by looking at new methods of construction. BeFirst had won awards for their work on modular developments; this, essentially, was ‘flat packing’ a property so that much of the construction took place off-site, and whilst it did not sound very attractive, it was more energy efficient, cost effective and less polluting, which would have a beneficial impact on the environment and residents’ health.

In relation to the point that the two monitoring stations were not enough to obtain a detailed understanding of the pollution levels across the Borough, the SMEH stated that there was some good news, as the Greater London Authority had recently provided the Borough with two further sensors; one was located near Jo Richardson School and the other near Barking Station. These sensors collected data which went directly to a data management consultant at Imperial College, who provided the Council with regular updates on air pollution levels. This data also formed part of the annual data set submitted to the Department for Environment, Food and Rural Affairs (DEFRA). Further good news was that a company was sponsoring four additional sensors with the latest technology, which would be in place in appropriate locations by March this year and would provide an even fuller understanding of pollution levels in the Borough.

In response to a question, the MCCC confirmed that in the two years that he had been in the role, he had worked closely with internal officers, park rangers, Cabinet Members, conservation volunteers, the local community and external partners, all of whom had been extremely positive to work with. He highlighted some of the Council’s achievements, including a new community woodland in St Chads Park, 32,000 trees planted in a ‘forest of thanks’ in Parsloes Park (to commemorate key workers and those who had lost their lives in the pandemic) and the ‘wild and free in LBBD’ project which aimed to increase participation within the Borough’s country parks. He very much hoped to continue with this work if re-elected.

The Chair thanked the MCCC and the SMEH for their attendance and updates on this very important area of work.

27. Health and Care Bill (House of Commons Bill 2021-22)

The report was noted.

28. Joint Health Overview and Scrutiny Committee

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

29. Work Programme

The changes to the Work Programme, as detailed in the report, were agreed.

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MINUTES OF INFORMAL
HEALTH SCRUTINY COMMITTEE

Wednesday, 23 February 2022
(7:02 - 8:48 pm)

Present: Cllr Paul Robinson (Chair), Cllr Donna Lumsden (Deputy Chair), Cllr Abdul Aziz, Cllr Peter Chand, Cllr Adegboyega Oluwole and Cllr Chris Rice

Also Present: Cllr Maureen Worby

30. Declaration of Members' Interests

Cllr Paul Robinson declared a non-pecuniary interest in agenda item 5, as he was a Senior Clinical Trial Practitioner on the SUMMIT study, which was referenced on page 39 of the agenda.

31. Minutes - To note the minutes of the meeting held on 19 January 2022

The minutes of the meeting held on 19 January were noted.

32. What is the community access to healthcare post-Covid-19?

The Director of Primary Care Transformation (DPCT) at Barking, Havering and Redbridge Integrated Care Partnership (North East London Clinical Commissioning Group) delivered a presentation on the community access to healthcare post-Covid-19, focusing on primary care access. The presentation detailed:

- The contact types and volumes of consultations pre-/throughout the pandemic (for all clinical consultations, and for GPs);
- Task and finish group work to test the new models of care with GP practices, residents and local stakeholders;
- Work being undertaken through the Winter Access Fund;
- Work to support the community access into primary care and the PCN Strategic Infrastructure planning programme;
- Means to improve digital access and work to support patients to better manage their own care (for example, through remote consultations for long-term conditions);
- Digital consultations; and
- Patient:workforce ratios and means to recruit and develop more clinical staff.

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

- As part of the Winter Access Fund, the CCG was using a programme called Equip to look at trends in terms of GP appointment bookings, as well as the staff that were available and how they could be differently matched across the system. It was also using a programme called Time for Care, which was looking at appointments, in terms of improving access. The CCG was supporting all 16 GP practices in Barking and Dagenham to look into this

work, as appointments needed to be booked via a flexible system, that was able to adapt to booking trends.

- Demand was currently very high, which was why the CCG was commissioning additional capacity in its GP practices and hubs. As part of the new ways of working, practices were working to triage patients appropriately, with appointments booked according to what was deemed clinically appropriate by GPs. This meant that those who needed an urgent appointment, were able to receive one, and it did not depend on which individuals were able to get through to the practice first on the telephone. The practices would then telephone less urgent patients back, to assign them an appointment. Most patients were understanding of this, as long as they did hear back from the practice within the time that they needed to. Practices also checked with the patient that they had the right phone number and would use their mobile numbers to contact them.
- Normal blood test results were filed, and it was then up to the patient to contact the practice to receive these, due to the high volume that GPs needed to deal with. GPs received blood test results every day and had a system to review these, to see who needed to be called back for further testing. If a patient needed a follow-up, they would be contacted by their practice.
- Two-way text messaging could also be used by practices, to contact patients with their blood test results, and the DCPT would take Committee feedback to the task and finish group, to consider whether patients could be messaged about their blood test results, when these were within the normal range.
- Practices were also trying to move more towards a self-management system, particularly for long-term conditions, and from April 2022, practices would enable patients to access more of their patient records; however, patients would not be able to see everything, particularly where it would be better for their results to be explained to them.
- Whilst clinical triage meant that some patients telephoned their practice, only to be told to be come in, this helped GPs to prioritise more urgent cases; however, GPs often did not take any risks with the elderly and the under-fives, and would ask them to come in regardless.
- The CCG wanted to work with Healthwatch, local residents and stakeholders to look into and improve the new ways of working, such as for people with learning disabilities, who may struggle with virtual consultations.
- The CCG was to receive around £8-9 million, in three pots of money. All practices across North East London would get an equal share of the first pot, which was for additional capacity and would be funded at £1.16 per patient. The second pot would be used to support certain practices with access issues. The third pot of money would be for the benefit of all general practice, in relation to the primary care family (such as urgent care into primary care, community pharmacies and GP practices).
- The NHS was still managing infection control and it maintained some measures as Covid-19 was still in circulation, to help keep staff and patients safer.

In response to questions from Members regarding concerns around patients not receiving appointment letters, the Director of Transformation (DoT) at NEL CCG stated that she received feedback quickly from GPs if there were lots of patients who were stating that they had not received appointment letters, and that they had

been discharged as a result. She had only been notified of this happening three times in the last few months; however, she would monitor this issue, and would pick this up with the Deputy Chief Operating Officer (COO) at BHRUT (Barking, Havering and Redbridge University Trust), as the Committee had notified her of this happening on two recent occasions.

In response to further questions, the Associate Director of Communications and Engagement (ADCE) at NEL CCG stated that NEL CCG was undertaking some work with Healthwatch, looking into the barriers and issues that patients had in terms of understanding how to get help from their GP practice. Digital exclusion was a growing issue, particularly as digital means were becoming more relied upon, and Healthwatch and the CCG were working to look at what this meant for different parts of the community. The next step of the work was to work with practices, Healthwatch and stakeholders to think about means to improve the issues and ensure that people were getting access to their care, in the way that they needed.

The Cabinet Member for Social Care and Health Integration expressed her concern that the triage system could result in the later detection of cancers within Barking and Dagenham, with late presentation already being a major issue within the Borough, and that take-up rates could get worse when the community perceived an additional 'hurdle' in accessing care. As such, she stated that work needed to be undertaken around these potential behavioural issues and high-priority health conditions. The DPCT agreed, acknowledging that telephone consultations and triaging would not work for everybody. It was important to pick up on the cues that someone was displaying in terms of their health, and work needed to be done to support this. Work also needed to be undertaken locally with practices and with receptionists to keep their training up to date, as they acted as a gateway into GP practices.

33. BHR Transformation Boards 21/22 Key Progress and Achievements to Date

The Deputy Director of Recovery and Planning (DDRP) at NEL CCG delivered a presentation on the key progress and achievements of the BHR Transformation Boards. Whilst the work of the Boards had been paused in 2021, owing to the need to redeploy staff during the Covid-19 pandemic, priorities had been reset since the Boards had resumed. The DDRP detailed some examples of key progress against the eight Transformation Boards in BHR, which comprised:

- Cancer;
- Children and Young People;
- LD and Autism (NEL Board);
- Long Term Conditions;
- Mental Health (NELFT/NEL System wide Board);
- Planned Care;
- Older People/ Frailty; and
- Unplanned Care.

The BHR Transformation Boards were monitoring the impact of the transformation activity, noting that data and key information were showing that over the past year, A&E activity and admissions had decreased in general and were on a continual downward trajectory. The BHR Transformation Boards would continue to review

the impact of the transformation activity, and continue to invest and develop services that helped the population, and create sustainability over the longer term.

In response to questions from Members, the DoT at NEL CCG stated that:

- The Cancer Board had a wide remit, including patient experience, the early identification of cancer screening targets and overall targets that the Trust had been asked to achieve. The Faster Diagnosis (FDS) standard (patients being informed of their cancer status within 28 days of their referral) had been achieved for the last three months across three of its key specialities, where it had the most referrals in to BHRUT. Whilst this did not remove concerns around the late presentations of cancers and the impact of Covid-19, this was a very positive step in the right direction.
- BHRUT were in a very good position in terms of treating cancer patients, and it had gained funding from the North East London Cancer Alliance. Funding was being offered for the purchase of dermatoscopes, which would help in terms of skin cancer identification, which had been offered in recognition of the fact that other parts of North East London already had this equipment, whereas BHRUT did not.

The Council's Director of Public Health (DPH) stated that his team was undertaking active case finding for missing cancers due to the pandemic, and was restarting this for other chronic diseases such as COPD and diabetes. The team was also recovering the Health Check programme, working to ensure that patients could be screened early for any conditions. The DoT stated that there was currently a particular surge in breast referrals, which whilst not positive in terms of the management needed for this, was very positive in terms of patients coming forward.

In response to further questions, the DoT stated that:

- The development of the BHR Workforce Academy over the past year, had been a positive step in working to address gaps in recruitment, particularly focusing on therapists and on Allied Health Professionals (AHPs) as these had the largest shortages. The Academy was looking into changing the offer so that more people were attracted to these posts locally, such as through having posts that enabled employees to rotate through community services, the hospital and primary care. She recommended that the Head of the Workforce Academy attend a future meeting of the Committee, to talk about this area, as BHR were leading on this. BHR had also developed a tool that showed it where the current workforce was coming from, linking into its anchor organisation work, particularly around BHRUT and NELFT.
- There was currently a review being undertaken within the Mental Health Transformation Board to consider how the Board would work moving forward and how it would integrate on a North East London level, acknowledging that there was a very high demand on mental health services post-pandemic, and that the service model needed to change to be able to accommodate this.

34. Barking and Dagenham Smoking Cessation Service

The Cabinet Member (CM) for Social Care and Health Integration delivered a

presentation on the Barking and Dagenham Smoking Cessation service. The presentation began by highlighting the particular context within Barking and Dagenham, with the seventh highest smoking attributable hospital admissions in London, the highest percentage of women smoking at the time of delivery in London and a smoking attributable mortality higher than London and England. It detailed:

- The current service provided to residents;
- The health impacts of smoking;
- Inequalities in relation to the Smoking Cessation service (such as age, ethnicity and gender);
- The number of residents supported by the service and current success rates;
- The current issues and work already underway to address these issues; and
- Future areas of work.

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

- It was important that frontline staff were able to have brief initial conversations with residents about smoking cessation advice, referring them into the right part of the service that was able to provide them with more guidance.
- Whilst she did not want to stop the service, it was not having the desired impact and as the service received nearly half a million pounds in funding, she wanted this to be more effective for residents. As such, she felt that targeting the service via programmes to specific groups, such as those who were pregnant, young people, and ethnic communities within the Borough, for at least a couple of years, could result in more cost effectivity and better health outcomes, making a real difference to these groups. This method would require co-production with these target groups. Residents that did not fall into the target groups would be offered a service via the GP referral route.
- Whilst it would be difficult to enforce a Borough-wide outdoor smoking ban, she could look into this possibility for certain areas, such as playgrounds.

In response to a question from the CM, the DPH stated that the London Borough of Havering had decommissioned their smoking cessation service a few years ago, and that their cessation rates had actually improved. A number of other boroughs had also decommissioned their services over the past few years, with Barking and Dagenham being in the minority of those councils in London who had kept their service. Many boroughs had also moved to a digital service offer. As such, the CM wanted to review how the Council was targeting its service, and come back to the Committee with proposals as to how to move forward, as addressing only two percent of smokers in the Borough as currently, was not value for money.

In response to further questions from Members, the Public Health Strategist (PHS), the Integrated Care Director at NELFT and the DPH stated that:

- The vast majority of referrals came from GPs, with a negligible number coming from self-referrals.
- Mental Health service staff were trained in terms of level one service

support, having active conversations with patients around their smoking status. Smoking cessation conversations were also part of the annual health check for those with serious mental illnesses, with signposting into this service as necessary. Smoking prevalence was much higher in those with serious mental illness, in comparison to other cohorts of the population. Patients at Goodmayes Hospital were also supported to access free nicotine replacement therapy (NRT) and smoking cessation support, as well as vaping (due to the increase in aggression incidents when restrictions on smoking were put in place around NHS property), as an alternative.

- Whilst the price of Champix (a medication used in smoking cessation) had increased, the service was able to provide this due to low service usage. Champix was not suitable for many, and had to be prescribed by a clinician.
- The Council's Licensing team was working on a project to tackle shisha use and to work with shisha bars, due to start in April 2022. The programme would initially focus on education, rather than enforcement. The team was also working in conjunction with the Smoking Cessation service.
- The Smoking Cessation service was accessed by some Havering residents, as they lived on the Barking and Dagenham/Havering border, and were on the GP practice lists for Barking and Dagenham. Havering Council also bought in to Barking and Dagenham's smoking cessation maternity offer.

The CM acknowledged that smoking was an addiction and that the Council and its partners needed to get better at supporting individuals. She, along with the Committee, questioned whether the Improving Access to Psychological Therapies (IAPT) service could ask patients more about smoking, to increase referrals into the Smoking Cessation service and to help individuals before they needed more extensive support. The CM would also discuss with the Council's HR team, what the Council could be doing to offer smoking cessation support to its employees.

35. Joint Health Overview and Scrutiny Committee

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

36. Work Programme

The Work Programme was noted.

HEALTH SCRUTINY COMMITTEE

23 March 2022

Title: Children's Community Health Services	
Report of the NELFT – North East London NHS Foundation Trust	
Open Report	**For Information**
Wards Affected: All	**Key Decision:** No
Report Author: Melody Williams, Integrated Care Director, NELFT and Doug Tanner, Children's Commissioner, NEL CCG for BHR	**Contact Details:** Tel: 03005551200 x 65075 E-mail: melody.williams@nelft.nhs.uk
Summary This report and presentation provide key insight into the challenges that Children's Community Services experience.	
Recommendation(s) The Health Scrutiny Committee is recommended to note the update provided by NELFT, NEL CCG and LBBD and following the information provided, to discuss any issues that need further exploration with presenting officers.	
Reason(s) This report is for noting and allows the Committee to put questions to the officers presenting the report.	

1. Introduction and Background

1.1 The Committee has asked for a presentation from the North East London NHS Foundation Trust (NELFT), North East London Clinical Commissioning Group (NEL CCG) and the London Borough of Barking and Dagenham (LBBD) around the area of Children's Community Health Services, with particular reference to Child and Adolescent Mental Health Services (CAMHS), Children's Therapy Services and Specialist Nursing services.

1.2 NELFT is the lead provider of community services for children and young people and adults, including older adults, in Barking and Dagenham.

1.3 NELFT provides the following services for the children and young people of Barking and Dagenham:

Community-based:

- Universal 0-19 Services (Health Visiting and School Nursing);
- Community Paediatric Medical services;

- Community Speech and Language Services (SLT);
- Community Children's Physiotherapy Services (PT);
- Community Children's Occupational Therapy Services (OT);
- Community Children's Nutrition and Dietetic Services (N&D);
- Community Children's Audiology Services;
- Child and Adolescent Mental Health Services (CAMHS);
- Looked After Children's Team; and
- BCG Childhood Immunisation Service.

1.4 All services have remained open to referrals during the Covid pandemic and have had to develop different ways of working in order to continue delivery through the pandemic period. Services have also had to account for requirements around infection prevention and control (IPC) measures, access to personal protective equipment (PPE), lockdown impact and patients requesting alternative means of contact and support, as opposed to traditional methods.

1.5 Referrals to these services during key lockdown periods reduced significantly and we saw spikes in referrals post-lockdown. This has led to challenges in waiting times and this has heightened the previously known and recognised sufficiency gap, particularly for paediatric therapy services.

1.6 Acuity of patients' needs has increased, resulting in the need to increase the amount of contact per referral now required. This was especially acute for children and young people as the impact of Covid and lockdown was experienced differently. We know that the impact was compounded through less visibility as schools and other services remained closed or operated in reduced delivery.

1.7 The accompanying presentation provides both pictorial and trend analysis, and we welcome further discussion and questions.

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

List of appendices:

- Appendix 1: NELFT, NEL CCG & LBBD PowerPoint Presentation (Data)

NELFT NHS

NHS Foundation Trust

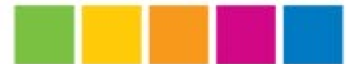
Appendix 1

Health Scrutiny Committee

NELFT, NEL CCG & LBBD

Presentation

Best care by the best people



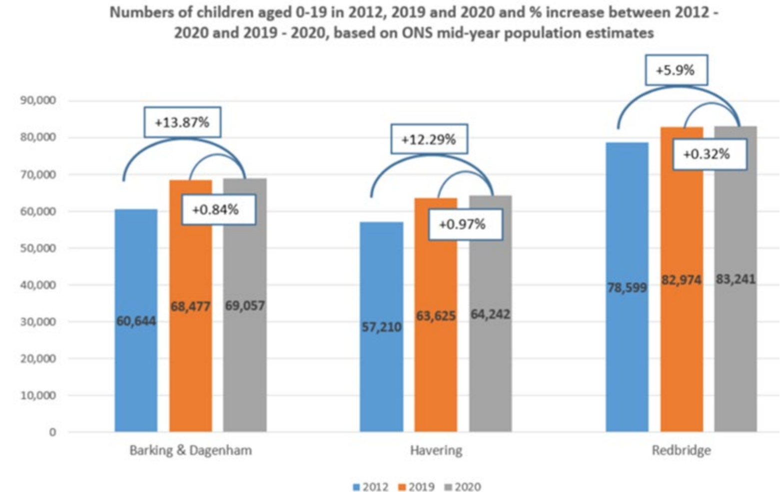
Children's Community Health Services

NELFT NHS Foundation Trust

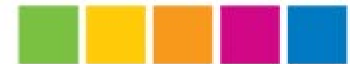
- NELFT delivers the following Children and Young People (CYP) services in Barking & Dagenham:

Childrens Universal 0-19 Services	Childrens Specialist Targeted Services
Heath Visiting	CAMHS
School Nursing	CYP Speech & Language Therapy
	CYP Occupational and Physio Therapy
	BCG
	Health YOS & Exploitation
	Community Medical Service
	Specialist School Nursing Service
	Child Development Team
	LAC
New Services	
MHST- Mental Health Support Team	
BHR ASD Service	

CYP Population Growth

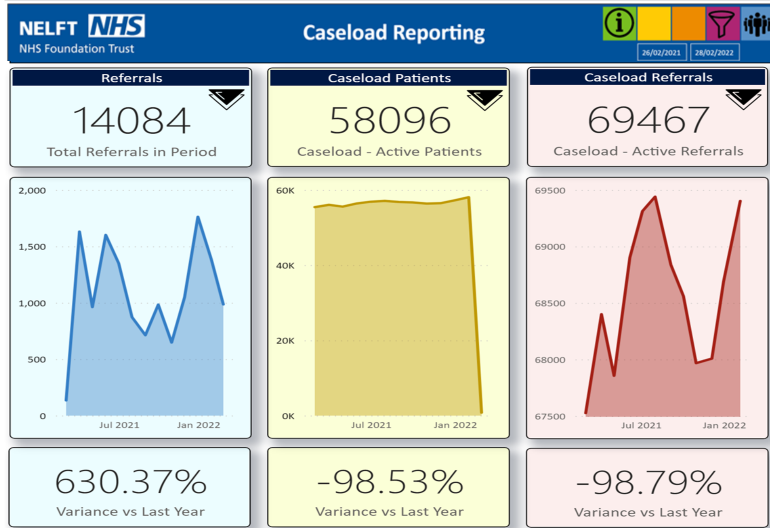


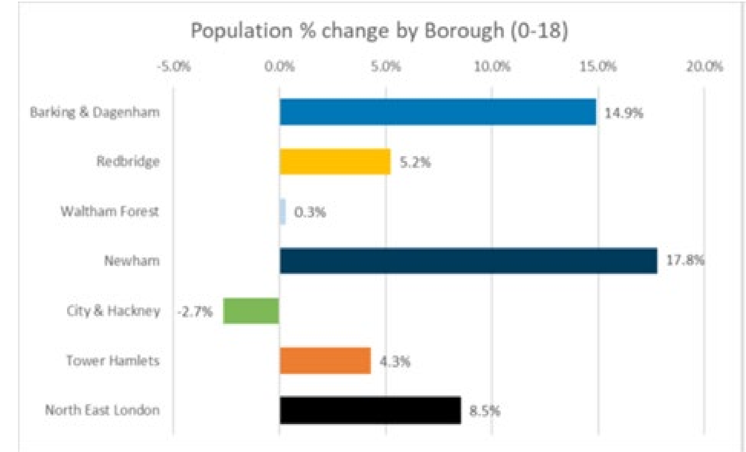
High proportion of CYP across BHR (32.2% B&D, 27.2% Redbridge, 24.6% Havering), prevalence rate of 1.1% in general population (2% males; 0.3% females https://www.bma.org.uk/media/2056/autism-briefing.pdf), CYP population growth (B&D 13.87%, Havering 12.29%, Redbridge 5.9%) and CYP numbers (Redbridge >80,000, B&D close to 70,000 and Havering approx. 65,000).



Caseloads and Waiting Times

NELFT NHS
NHS Foundation Trust

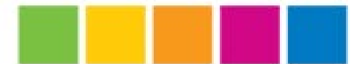




The population of 0-18 year olds across NEL is expected to increase by over 41,000 children between 2020 and 2030. This represents an increase of 8.5%.

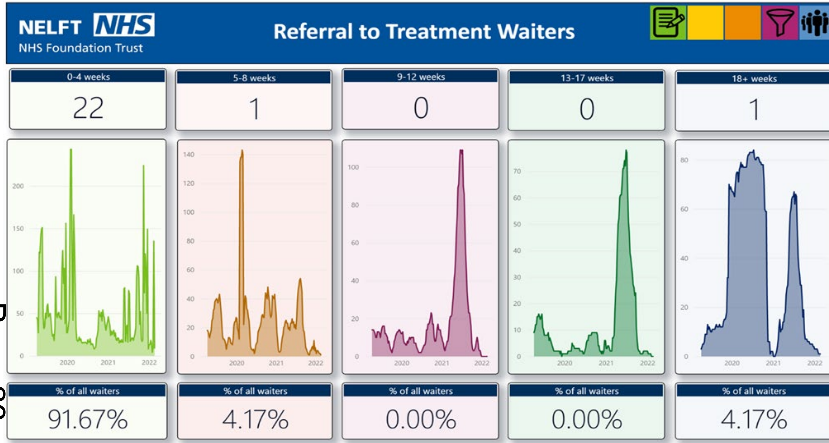
Within Barking and Dagenham, there is an increased level of redevelopment and regeneration, including more housing. This is not fully factored into the Greater London Authority (GLA) figures and therefore the prediction growth of 14.9% may be higher with the 0 -18 cohort, due to many young families moving in the Borough. It is expected for the overall caseloads and referrals to increase significantly.

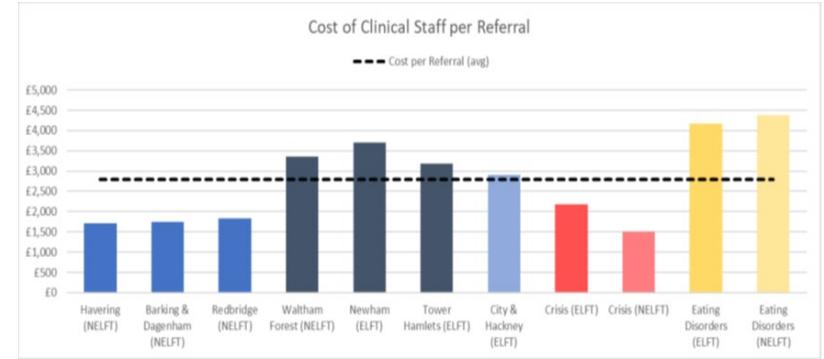
Known to have a significant number of housing units with multiple families occupying them – this has been an increasing trend seen in some of the new development areas and therefore understanding this market and impact to population numbers is also key in planning growth and capacity of services.

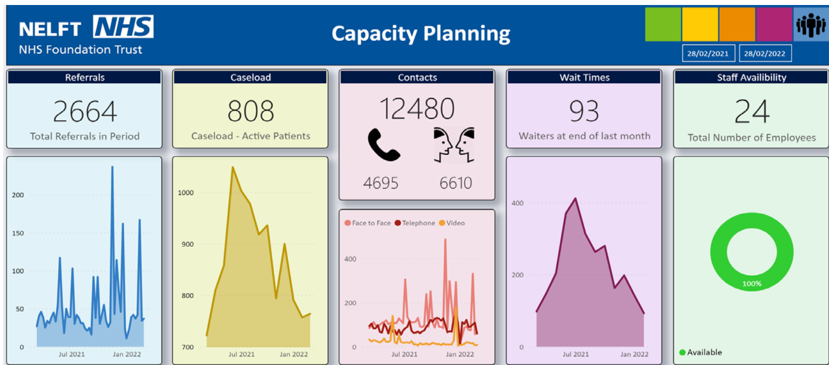


CAMHS Waiting Times

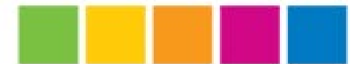
NELFT NHS
NHS Foundation Trust







Best care by the best people



Mental Health Support Team- MHST

NELFT NHS
NHS Foundation Trust

B&D MHST is being established to provide support for 4 schools in the Borough in 2022/23 (**Wave 5 implementation**)
Further expansion will follow with the intent for each MHST to support schools across the Borough, following completion of the EMHP training.

The B&D Education Mental Health Support Service has 3 core functions:

- Provision of early intervention psychological support
- Support for the school's Whole-School Approach to wellbeing
- Signposting to specialist services

The team consist of:

- ✓ 1 Admin staff
- ✓ 8 trainee Educational Mental Health Practitioners (EMHPS),
- ✓ 4 Senior EMHP's
- ✓ 2 Senior Therapists
- ✓ 1 Clinical and Service Lead

Work closely with Education and LBBD to select schools (Phase 1):

- ✓ Robert Clack School
- ✓ Jo Richardson Community School
- ✓ Hunters Hall Primary
- ✓ Rose Lane Primary

December 21- February 2022 Phase 1	Operationalising of service • Initial meetings/relationship building with key partners and services • Referral routes, pathways discussed and implemented with school leads and CAMHS, Triage, Charities, Universal Services etc • Allocation of team members to schools/colleges • Promotion of our service in the form of presentations
February – March 2022	• Introduction meetings (EMHP, MHST Senior Mental Health Practitioners/Supervisor, School Link person and other key staff) • Formal Inductions (in person or remotely, MHST Induction Checklist, School-Specific Induction) • School & MHST signed the 'Partnership Agreement' • EMHP have met key members of pastoral team • Set up regular meetings between EMHP & School Link person is in place and allocated team members are attending • Relevant group meetings, team meetings are underway • EMHP have shared 'Course Overview for Schools' with School Link person • EMHP's and overall service has been and will be distributing information from 'Implementation Toolkit' (information for staff, parents, CYP about the service) via email, assemblies, PSHE, school council meetings, etc.

Caseloads and Waiting Times

NELFT NHS
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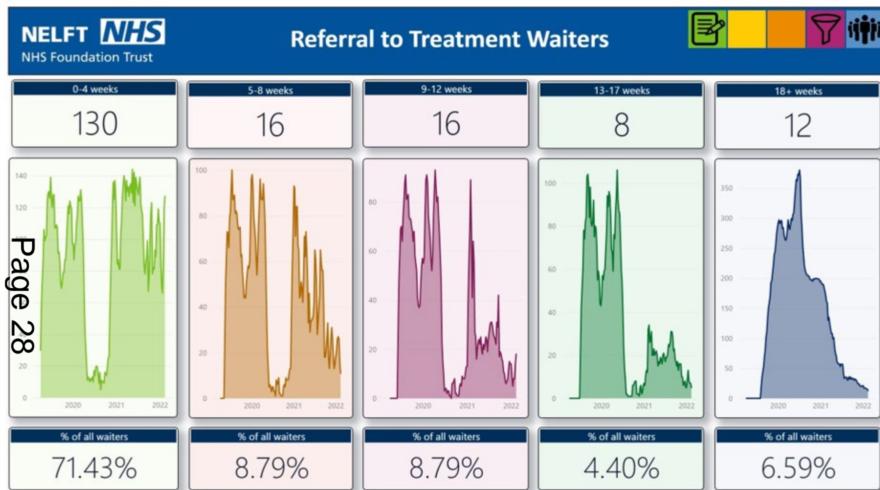
Speech & Language Therapy



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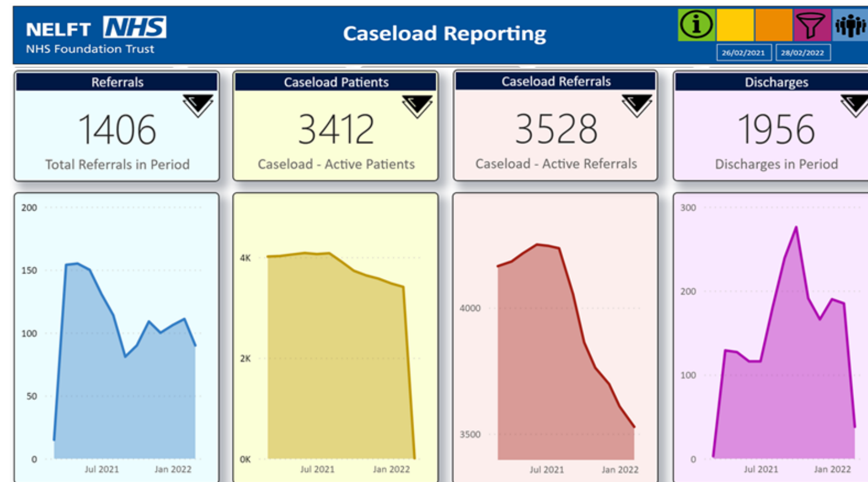
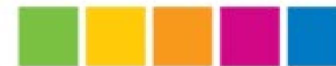


Long waiters cleared - 12 CYP are out of borough (OOB)
The Service has streamlined its processes and moved into clinical pathways in order to support patient flow and maximise the capacity in the team
Increased needs, higher demand and acuity impacting on current resources
Increased universal interventions - developing training packages for schools, regular SENCO meetings, use of more digital applications to support care plans (clinical developments in this area)



Caseloads and Waiting Times

NELFT NHS
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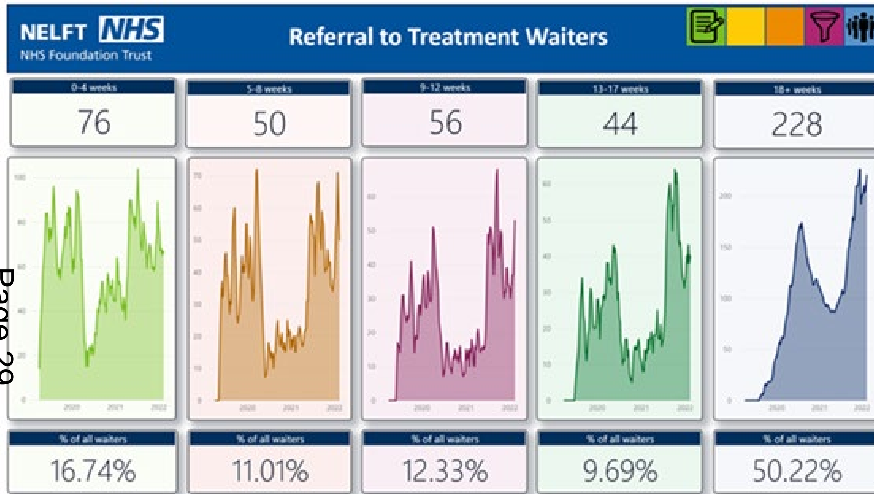
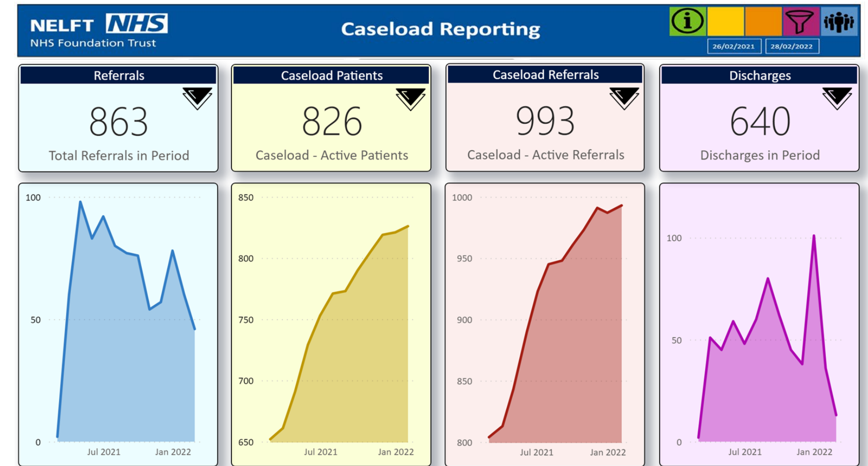
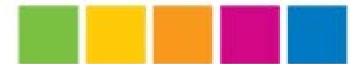
Occupational and Physio Therapy





- Recognised to be under resourced compared to the population, population growth and complexity of needs
- Result is High caseloads, acuity and complexity
- Very small OT/PT team (5WTE) compared to the 0-18 populations/per capita population growth rate.
- Average caseloads of nearly 200 patients per staff WTE
- Challenges with recruitment



School Nursing (5-19) and Specialist School Nursing

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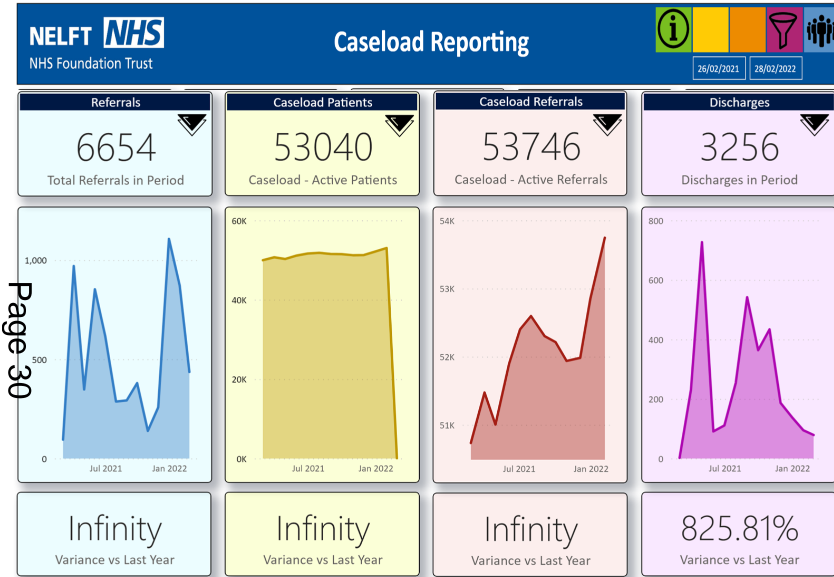
School Nursing



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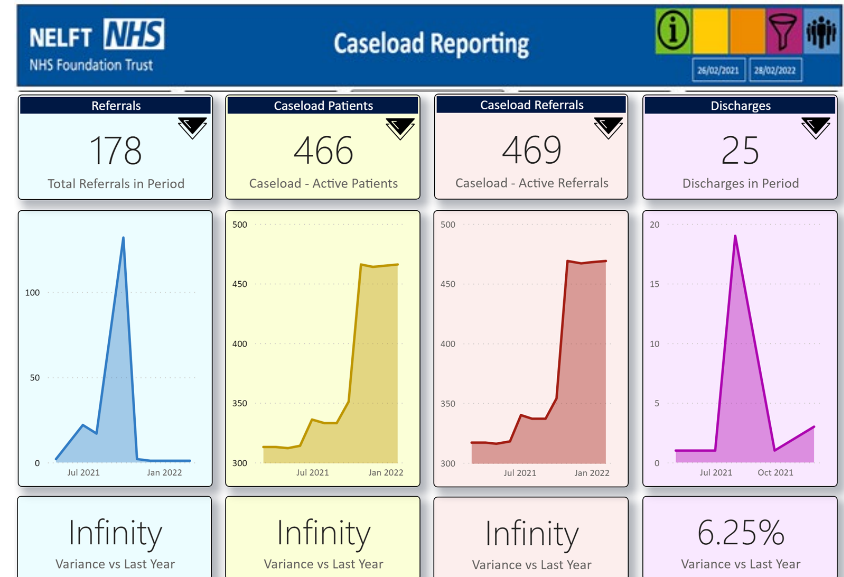
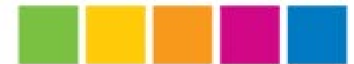
10 WTE Qualified Specialist Community Public Health Nurses and 6 WTE Community Staff Nurses focus on the public health priority areas in LBBD across the 3 localities. These staff oversee large caseloads. Increasing the capacity of school nurses will maximise their contribution in supporting health and wellbeing and raising attainment of the school-age population, and will contribute significantly to preventing ACE (Adverse Childhood Experience); reducing the effects of health inequalities and ensuring a focused and targeted approach to promoting health and wellbeing for children and young people.

Special school Nursing



3 WTE Specialist School Nurses support Trinity and Riverside Bridge Schools.

Best care by the best people



School Nursing (5-19) Caseload Stratification (Risk Management)

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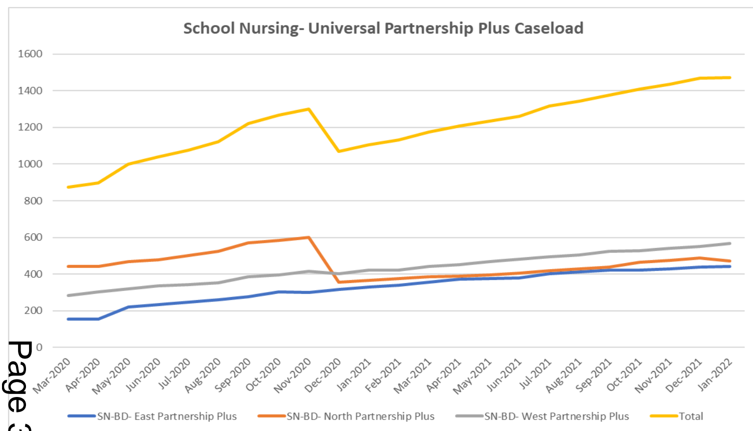
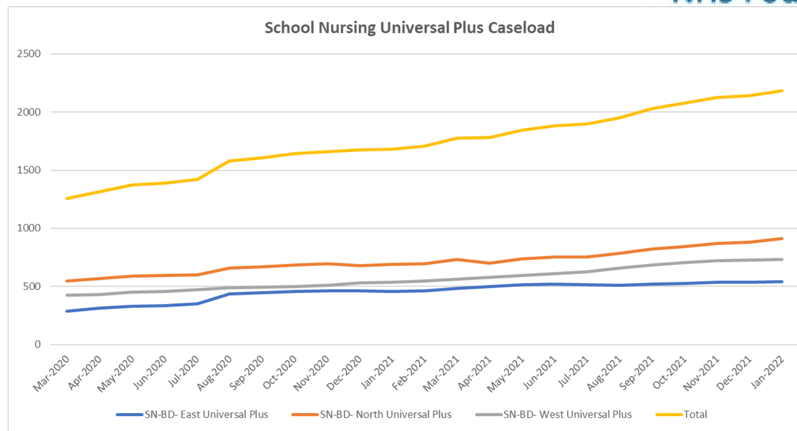
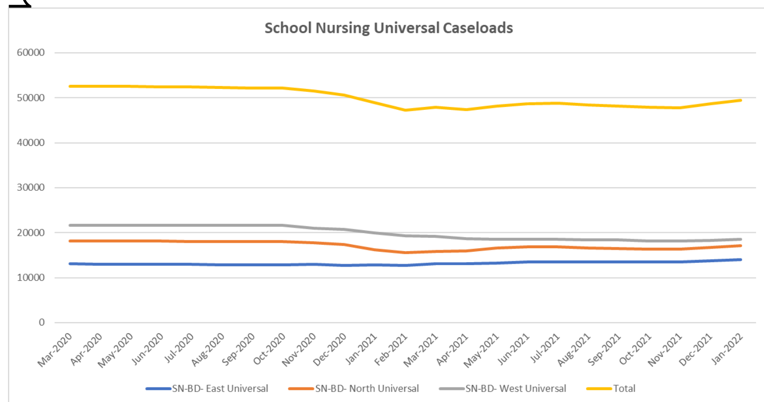
NHS Foundation Trust

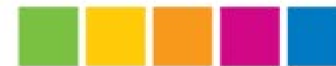






- Increase trend of UP and UPP cases over the years
- Lack of investment within the School Nursing team to meet population growth and increased demand
- Increase demand on the service to support the numbers of safeguarding
- Higher caseload with an impact on the delivery of the public health agenda
- There are 5 infant schools, 5 junior schools, 35 primary schools, 4 all-through schools, 8 secondary schools, 1 technical and training school, 1 secondary tuition centre (referral unit) and 3 special schools serving the community in Barking and Dagenham

Best care by the best people



Paediatric Integrated Nursing

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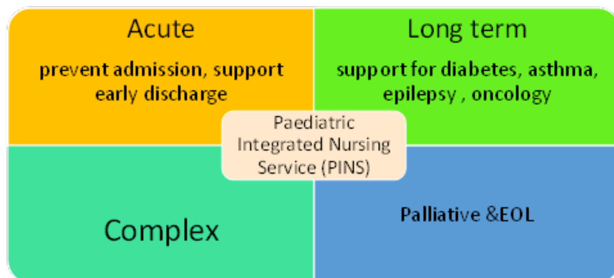
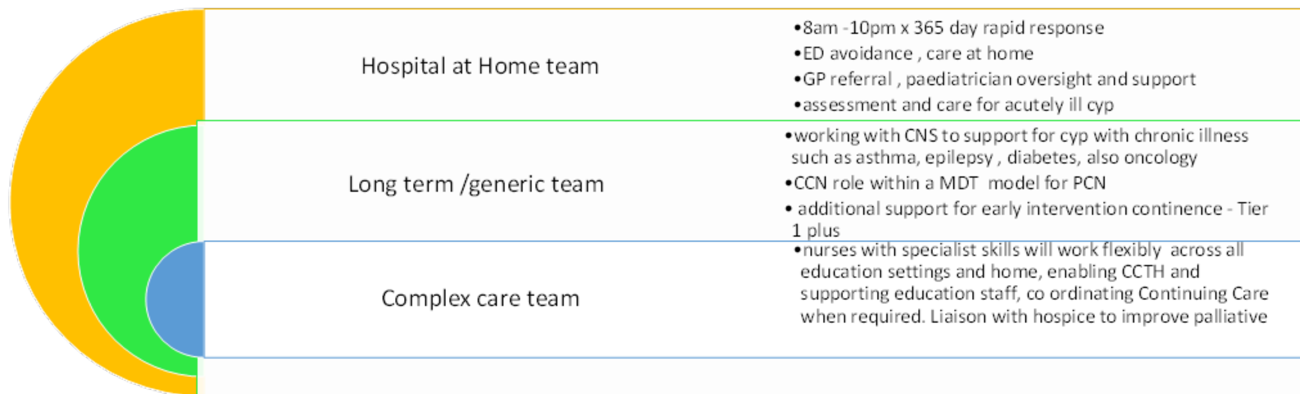
*A project team have been revising CYP community nursing across BHR over past 18 months using 4 Pathway model (DoH 2012,RCN 2020)



*Project remit is to redesign services to meet the CYP needs of each pathway . This will take a teams within a team approach (below) working from Borough bases linked to PCN and Family hubs



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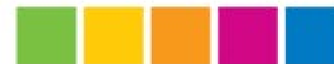

Funding

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2020/21 CAMHS Spend	B&D CCG
Spend by Category	**Actual Spend**
Children & Young People's Mental Health (excluding LD)	£3,895
Children & Young People's Eating Disorders	£225
Perinatal Mental Health (Community)	£417
Early intervention in psychosis 'EIP' team (14 - 65yrs)	£1,017
Health and Justice	£53
TOTAL	**£5,607**

Parity of Service and Levelling Up

Parity of funding for CYP and CAMHS provisions remain an issue across the NEL system.

- The needs and variances across NEL have been presented in great detail in such documents as the following:
- The Healthy London Partnership CYP MH Programme with the intention of 'supporting local systems to address inequalities'. This 2021 publication provided 'ICS Data Snapshots' which are informing priority setting and spending
- The joint BHR Strategic Needs Assessment providing system recommendations for the CYP agenda and that take advantage of the opportunities provided by working with an integrated system
- The 'Attain' Report. Commissioned by providers to deliver a detailed analysis of current and future CAMHS provision and funding equity and reporting in early 2022. This report has provided detailed comparison on funding inequities between boroughs which will inform the future 'levelling up' actions

Recommendations 1

Funding of CAMHS teams varies across the ICS. This is impacting access and care provision

The CAMHS community services are stretched and caseloads are increasing in all teams. The investment across NCL has significant variance that is not related to demand. The investment is impacting on access and care. In BHR where the investment per new referral across borough teams is the lowest and contacts shortest. In BHR concerns for staff wellbeing were voiced. As well as BHR having smaller CAMHS community teams, the interviews indicated that the BHR localities had less community assets to support lower-level need.

Recommendations

1. ICS-level review of total all age investment (commissioner (CCG and LA), Lottery and other sources) and how that funding has been deployed by providers to identify best strategies to increase access to resources for CYP.
2. Share the different workforce models being employed across the ICS
3. If additional finance is made available, the most expedient approach to provide increased resource is considered to invest in proactive prevention capacity (inc schools) that can also be used to step CYP down into.

Eating Disorder services are particularly pressurised. The demand for specialist eating disorder services has in increased between 2% and 69%. This concern was echoed within the Eating Disorder teams where the demand has put the Eating Disorder teams into a critical position. It was reported that there are concerns about staff well being and staff working excessive hours.

Recommendations

1. Urgently review investment and workforce within the eating disorder teams
2. Share learnings between the teams of how they responded to the Covid pandemic
3. Fund an Intensive Pathway for Eating Disorders for both NELFT and ELFT

Recommendations 3

Communication

There is no common language used across the ICS or within a place to describe CYP need for mental health support. The Thrive Framework is at best used by the CAMHS community team and some partners. Eating Disorder teams and crisis teams do not use Thrive. A common language can help support job planning for clinicians and the involvement of other resources providing lower level support.

Recommendations

1. A common language is established across the ICS to enable a consistent and meaningful approach to describing services that can support children with emotional and mental health issues.
2. Share how Havering and Waltham Forest community teams have used The Thrive Framework to provide clarity for job planning
3. Agree and roll out a standard lexicon for labelling the different teams and the different pathways against which activity is recorded

Access

The pathway of a CYP from birth to adulthood is artificially fragmented. Access to services is complicated without a health and care single point of access for all children's services. Access for those in crisis needs to be simple, widely understood to support interventions to reduce attendance at hospital.

Recommendations

1. Review Front door models and establish consistency building on good practice e.g. Newham award winning service could clinical network look at this?
2. Create a joint CYP commissioning strategy
3. Establish an ICS approach for CYP access to work in an integrated way that can be delivered at a Borough level - ? Clinical network focus
4. Promote the 24/7 crisis lines linked to 111 press2
5. Commission crisis teams 24/7 to deliver intensive home treatment type offer from ELFT
6. Establish model for social prescribing and a digital catalogue of support that is periodically refreshed and updated social prescribing moving forward
7. Review and share the varied non-standard staffing models to inform local team workforce planning

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Recommendations 4

Partnership

It is clear that where services are coproduced they can better address issues of stigma, promote access and meet a communities need. There is significant variation across localities of experience around coproduction

Recommendations

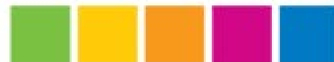
1. The Kooth contract is reviewed for commissioning at an ICS level. Kooth insights are shared to the teams on the ground as well as commissioners. Kooth coproduction and engagement resources are quantified to consider where Kooth can best lead coproduction to release locality team resources.
2. Recommendation: Create regular "summits" where insights, knowledge and support can be shared

Proactive prevention

Where proactive prevention resources are in place this can help manage demand into and out of the specialist CAMHS services. It is important to have an integrated approach in each Borough. Across the system a principle is that there is no wrong front door. In Hackney, there is a First Steps service that has no lower threshold of need, for the Getting advice and Getting help part of the system. The most common outcome of this service is step down to the universal offer. These services can also support stepping down from the CAMHS community teams. This can reduce the numbers of clients the CAMHS community services hold onto post intervention.

Recommendations

1. Consider the benefits and costs of commissioning mental health support in primary care. This should review the opportunity to access the Additional Roles Reimbursement Scheme. This scheme provides funding to PCNs for roles that include social prescribing link workers, physicians' associates, care coordinators, heath and wellbeing coaches, occupational therapists and mental health practitioners
2. Establish a social prescribing strategy for the ICS that ensures a richer source of community-based voluntary and third sector organisations able to provide support for mild mental health issues (See UCL and Anna Freud – led project)
3. Across schools including Academy schools establish an approach to identify all the resources that can work alongside and strengthen the interventions across all schools, for example school nurses
4. Establish the capacity to provide brief interventions within the community mental health teams
5. Consider the Barking and Dagenham team multi organisation approach for supporting routine referrals SPA workstream



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HEALTH SCRUTINY COMMITTEE

23 March 2022

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

Summary

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

NELFT was inspected by the CQC in June 2019 and the results were made publically available via the CQC website in September 2019. As a result of the inspection, there were 22 “Must Do” actions identified.

Since the inspection results, a significant workstream to address concerns has been instigated, with only 1 “Must Do” action remaining open. This action is in relation to waiting times for the Neurodevelopment and Learning Disability service in the Kent services. Due to the pandemic, there has been a further significant impact on this service’s overall waiting times, despite actions and progress to reduce this. The CQC are fully aware and assured that appropriate mitigations are in place.

There are monthly updates on the CQC Improvement Plan via the Quality and Safety Committee (QSC) and Executive Management team (EMT), with regular updates to the NELFT board. The Board reports are public domain reports and are available on https://www.nelft.nhs.uk/about-us-board-papers.

This report is to provide the Health Scrutiny Committee with an update on progress since the last presentation, as well as an outline of the preparation the Trust is making in respect of the next CQC Inspection, which is anticipated to take place in 2022.

Recommendation

The Health Scrutiny Committee is recommended to note the update provided by NELFT and following the information provided, discuss any issues that need further exploration with presenting officers.

Reason

This report is for noting and allows the Committee to put questions to the officers presenting the report.

1. Introduction and Background

1.1 Following the last presentation to the Health Scrutiny Committee by the Chief Executive of NELFT (minute 10, 21 October 2020 refers), it was requested that NELFT provide a further progress update in respect of the CQC Improvement Plan that it had developed to address the "Must Do" and "Should Do" findings. This report and accompanying presentation give a headline progress review.

1.2 By way of background, the Care Quality Commission (CQC) inspected NELFT from 14 May 2019 to 27 June 2019. As part of the CQC's checks on the safety and quality of healthcare services, eight core services were inspected.

The core services inspected were:

- Acute wards for adults of working age and psychiatric intensive care units;
- Community-based mental health services for adults of working age;
- Forensic inpatient/secure wards (low secure);
- Wards for people with a learning disability or autism;
- Mental health crisis and health-based places of safety;
- Community-based mental health services for people with a learning disability or autism;
- Specialist community mental health services for children and young people; and
- Urgent Care.

1.3 The inspection report produced by CQC following the conclusion of the inspection describes their judgement on the quality of services provided by the Trust. This report is published on the CQC website at https://www.cqc.org.uk/provider/RAT.

The overall inspection result for 2019 was one of 'requires improvement'.

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ➡⬅ Aug 2019	Good ➡⬅ Aug 2019	Good ➡⬅ Aug 2019	Good ➡⬅ Aug 2019	Requires improvement ⬇ Aug 2019	Requires improvement ⬇ Aug 2019

1.4 Despite the NELFT response to the COVID-19 pandemic, work around the CQC Improvement Plan has continued across all our services. It is recognised that some actions were understandably delayed; however, all priority and 'Must Do' actions were progressed and with the exception of one "Must Do" action relating to the Kent services, all have now been closed down following significant changes.

2. Issues and Actions

2.1 In February 2021, NELFT undertook an internal audit to review the design of processes and controls in place to respond to the 2019 CQC inspection. This audit

provided an overall assessment of “significant assurance with minor improvement opportunities” which was in line with management expectation. The assessment outcome was driven by evidence of a robust and risk-based approach to develop and agree an action plan to respond to “Must Do” areas within the CQC report, and which is subject to regular review, update and governance.

2.2 Although the audit recognised that the Trust has taken steps to prioritise the “Must Do” actions, it was recommended that:

- The “Should Do” actions be reviewed at the Quality & Patient Safety Committee focus meeting to understand whether any of them represent an increasing level of risk to the Trust since the publication of the CQC report; and
- Once the “Must Do” actions have been signed off, to progress “Should Do” actions as per current process.

2.3 The CQC found 34 areas that the Trust should improve to comply with either a minor breach that did not justify regulatory action, to prevent breaching a legal requirement or to improve service quality.

2.4 Following review of the CQC “Should Do” actions by EMT, it was identified that 12 such actions had already been completed with supporting evidence of compliance and 5 “Should Do” actions could be added as additional actions, to a “Must Do” risk. The result of this review and realignment left a total of 17 CQC “Should Do” actions to place on the CQC “Should Do” Improvement Plan dashboard. These CQC “Should Do” actions were presented at the Quality and Safety Committee on 14 April 2021, and following agreement at EMT, they were opened as separate risks with associated actions on the Trust monitoring system (Datix).

2.5 Progress against the original 22 “Must Do” areas involved the implementation of 129 separate actions. These have been monitored for completion at the monthly CQC Trust wide oversight meeting. An improvement plan has progressed in relation to both the 22 “Must Do” and 17 “Should Do” areas. The current Trust position at time of writing is one “Must Do” risk remains open and five “Should Do” risks remain open.

2.6 Each identified action has an assigned Executive Lead to oversee progress and an Operational/Corporate Director to lead the delivery. The Trust uses a system called Datix, which includes a risk management module that enables all risks/action plans to be viewed in live mode and therefore track progress accordingly.

Significant actions have included:

- Ensuring post-dose physical health monitoring takes place after patients have received medication by rapid tranquilisation, in line with NELFT’s Rapid Tranquilisation Policy.

- Ensuring all Mental Health inpatient staff complete mandatory training in the prevention and management of violence and aggression.

- Significant progress on staff morale, with the development of a Junior Doctors' Forum and procedures in place to support junior doctors in raising concerns.

- Commitment to the health and wellbeing of staff and service users within our inpatient wards by moving to therapeutic engagement, seeking regular feedback from patients and staff. Ensuring service users are fully involved in their care planning and risk management plans.

- Since January 2021, the Acute Crisis Assessment Team (ACAT) form part of the Integrated Crisis Assessment Hub (ICAH), with a designated area for service users to attend, and provides a diversion service from Emergency Departments, London Ambulance, and the Police. ICAH has been transformational in regard to the experience of patients requiring safe assessment and admission to the mental health wards where necessary.

- An independent review of the Executive Management Team was undertaken, resulting in creation of a dedicated Chief Nurse role and Director of Partnerships.

- Implementation of a Trust-wide performance data system to ensure access to accurate data to monitor performance which is accessible to all staff.

- Increased staffing establishment and leadership roles within the Clinical Pharmacy service, improved Medicines Governance through a revised audit programme to support the revised Medicines and Controlled Drugs Policy.

- Deployment of Electronic Prescribing Medicines Administration (ePMA) and Automated Dispensing Cabinets (Omnicell) across all inpatient wards, to promote safe systems for storing, prescribing, administering, and recording medicines.

- A refreshed approach and increase in the capacity of the Freedom to Speak up Guardian team (FTSU) that is accessible across the Trust, including the creation of an online anonymous form for staff to raise concerns which are then acted upon by the FTSU Guardian.

- Revised Trust-Wide Learning Strategy which has since been embedded into the Trust Quality and Patient Safety Strategy, established monthly patient safety and learning meeting to ensure learning is shared across all services and teams.

2.7 NELFT has had some CQC inspection activity: During December 2020, the Redbridge Community Care Advice Centre Reablement Service (provision of personal care to people seeking independence after injury or accident) was inspected under section 60 of the Health and Social Care Act (2008) as part of CQC regulatory functions and in July 2021, CQC carried out a focused inspection of the Child and Adolescent Mental Health ward at Kent and Medway Adolescent Hospital. These services did not receive an overall rating (in line with the type of inspection carried out); however, where improvements were identified these were addressed via an accompanied action plan.

2.8 The Trust will be inspected in the future as part of the planned work of the CQC; therefore, the current rating for the Trust will remain until such time as the next inspection period has concluded. The Trust continues to embed a culture of compassionate leadership and sustaining CQC compliance as part of business as usual activities. All of the leadership teams for the locality areas that NELFT serves alongside the corporate teams remain committed to adherence to the CQC quality standards and this is robustly monitored via the following processes:

- Increased visibility of leaders – both operational, professional, and clinical leadership roles;
- Clinical Professional Advisory Group overseeing Integrated Adult and Integrated Babies, Children, and Young People forums;
- Programme of Quality Support Visits (QSV) led by the Directors of Nursing; and
- CQC Self-Assessment tools completed via all core services with associated improvement action plans.

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

List of appendices:

- Appendix 1: CQC – Improvement Plan Progress

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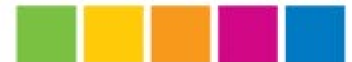
Appendix 1

CQC – Improvement Plan Progress

23 March 2022

Best care by the best people



CQC Must do/ Should do Risks and CQC Improvement plan

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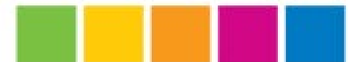
- Following the CQC Well Led inspection in 2019, the Trust progressed an improvement plan in relation to the MUST do actions and SHOULD do actions. In relation to:
- 12 Trust-wide MUST Do's
- 2 Essex & Kent MUST Do's
- 8 Acute and Rehabilitation Directorate

22 MUST do risks and **17 should do risks** were added to the risk register.

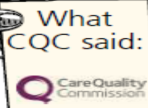
The MUST Do and Should do risk progress are fortnightly at the CQC Trust wide oversight meeting.

1 MUST Do risk remains open

5 Should do risks remain open and these have all been added to our CQC Compliance Dashboard which is monitored at our CQC Trust wide Oversight meeting fortnightly.



Improvement plan actions taken in response of Essex & Kent Directorate MUST Do Risks identified



The provider must continue to work to ensure children and young people in Kent have access to treatment within 18 weeks of referral to the service

WHAT WE DID:

- Created a single Neurodevelopment and Learning disability (NDLD) triage administration team based in Single Point of access (SPA) delivering a co-ordinated front of house response to children, young people, and their families
- Implemented a process whereby the main SPA triage all referrals for potential Neurodevelopment and Learning disability cases, requests appropriate additional documentation from the child/young person and family after which a NDLDS clinician reviews all returned documentation to support next steps
- Implemented electronic prescribing in all NDLD clinics
- Increased the number of senior staff that could run clinics to reduce number of children and young people awaiting Autistic Spectrum Conditions
- Extensively cleansed the waiting lists so that appropriate discharge could take place of young people now transitioned to adult services and discharge of those no longer meeting the threshold for this service.
- Ensured that while young people and their families awaited assessment, they receive good communication, signposting and support by completing the 5 by 5 survey with them monthly and acting on feedback.

The provider must ensure that work to improve the Kent single point of access continues. The provider must also ensure that all referrals in Kent are screened in a timely fashion and prioritised for follow up by the correct team

WHAT WE DID:

- Completed a full-service review and implemented a new procedure to ensure all systems and processes are understood by staff
- Monitored the number of referrals for triage daily and employed agency staff to support substantive staff in the week and at weekends to achieve appropriate triage of referrals where risk is identified within 24 hours and routine referrals within 48 hours.

Improvement plan actions taken in response of Essex & Kent Directorate MUST Do Risks identified

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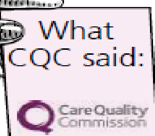

The trust must ensure governance systems are strengthened to provide assurance that services are safe and effective

WHAT WE DID:

- Ensured that the Child and Adolescent Mental Health Service (CAMHS) was embedded trust wide
- Learning cascades in relation to thematic reviews of serious incidents into the suicides of young people was developed and cascaded to all staff working in Specialist Community MHS services for CYP.

The provider must ensure that staff complete Intermediate Life support mandatory (ILS) training

WHAT WE DID:

- Directorate Assistant Medical Directors review ILS training figures monthly and follow up directly with the member of staff to ensure training is either in date or a confirmed training date has been booked.

Best care by the best people

Must Do Risks 2098 – The provider must take steps to ensure children and young people in Kent have access to treatment within 18 weeks of referral to the service.

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- Actions being implemented in the coming months:

- Funding for additional medical staff has been secured from April 2022.
- The overall model is being transformed via a phased mobilisation plan. Young people on the waiting list for the ADHD pathways and young people already in receipt of treatment will move from the central team into the locality teams. The South Kent team will be the pilot team for this transformation. The locality team will carry out assessment, review, treatment, and prescriptions which will enable young people to have care closer to home. The locality team will have additional staffing resource, including a consultant pharmacist to support prescriptions and oversee the safety aspect of medication management. If successful, this model will be rolled out to other locality teams throughout the coming year.

- Wider system work is planned with Care Navigators within the Primary Care Networks who will work with families to look at additional support needed.

- CQC has been kept informed through reporting and updates at the CQC Oversight group meeting.

Improvement plan actions taken in response of Acute and Rehabilitation Directorate MUST Do Risks identified for MH Acute wards of working age adults and PICU

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The Trust must ensure post-dose physical health monitoring takes place after patients have received medication by rapid tranquilisation in line with the trust's rapid tranquilisation policy.

WHAT WE DID:

- Senior oversight of all rapid tranquilisation on a weekly basis
- Carried out quarterly audits of Physical Health Monitoring post rapid tranquilisation
- Review of the rapid tranquilisation policy post audit
- Supported staff with training.

The Trust must ensure that all MH inpatient staff complete mandatory training in the prevention and management of violence and aggression.

WHAT WE DID:

- Ensured each ward met a training compliance rate of 85% for prevention and management of violence and aggression training through monthly monitoring and reporting to the leadership team.

The Trust must work to address the concerns raised by junior doctors to ensure a good working relationship and safe.

WHAT WE DID:

- Junior doctors' concerns are heard and acted upon at a Junior Doctors Forum
- Put in place a procedure to support junior doctors in raising any concerns
- An additional junior doctor is now on call on the twilight shift since July 2019.

The Trust must develop a governance system to effectively monitor the use of restrictive interventions across the wards.

WHAT WE DID:

Made a commitment to the health and wellbeing of staff and patients by moving from restrictive interventions to therapeutic engagement by:

- Using technology for the safer monitoring of patients at a distance, introduced the wearing of body cams
- Ensure we seek regular feedback from patients and staff using the 5-question respect approach
- Ensure service users are fully involved in their care planning and risk management plans
- Staff work with patients during community meetings to review any blanket rules in place on the wards.
- Implemented zonal observations, safety huddles and safe ward intervention to support early intervention.

Improvement plan actions taken in response of Acute and Rehabilitation Directorate MUST Do Risks identified for Forensic inpatient/secure wards

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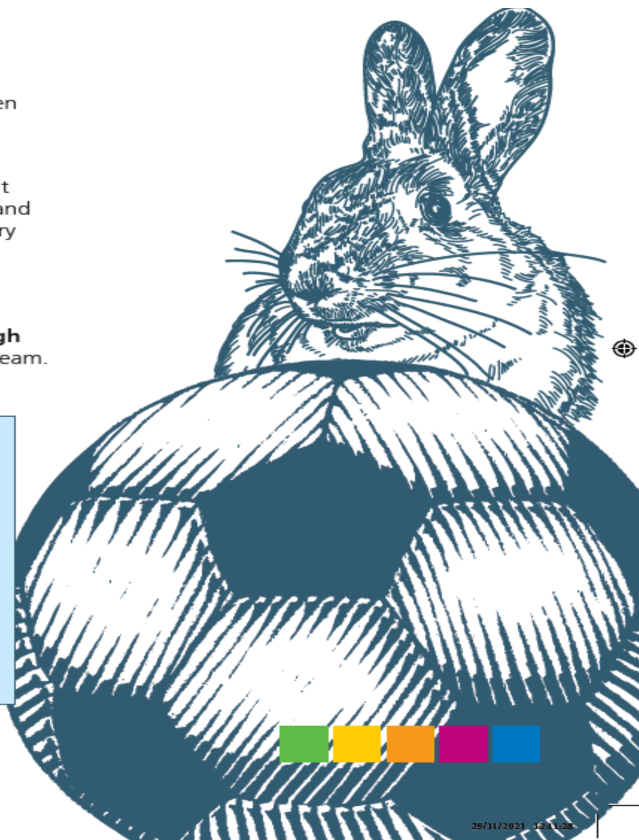
- **Carers** had co-produced with staff an information leaflet about psychosis
- **Innovative plans** to develop and staff a professional kitchen were in hand and capital funding had been applied for
- Since the last inspection the ward had **developed** one its **gardens** to provide an innovative programme where patient looked after a range of small livestock, including **chickens** and **rabbits**. This therapeutic activity supported patient's recovery
- The ward continued to **maintain excellent links** with the **community** and **engaged patients** in a range of activities seven days a week. This included local college attendance, work experience on a farm and attending a '**coping through football programme**' with the local professional football team.

The Trust must develop a governance system to effectively monitor the use of restrictive interventions across the wards.

WHAT WE DID:

- Implemented an individual risk assessment on every patient which included vital sign monitoring, adjustment of level of safe and supportive observation based on physical and mental health risks.
- Call bell system fully implemented throughout the ward.



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Improvement plan actions taken in response of Acute and Rehabilitation Directorate MUST Do Risks identified for Mental health Crisis and Health – based places of safety

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The Trust must ensure that patients attending out of hours at Sunflowers Court for assessment by the acute crisis assessment team (ACAT) or waiting to be admitted to wards after their ACAT assessment, are appropriately supervised and cared for. A policy and procedure to govern this process must be developed.

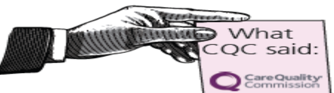
WHAT WE DID:

- Installed CCTV in the main reception area and reception corridors with live feed to ACAT reception
- Carried out a staffing and skill mix review of ACAT undertaken with dedicated out of hours medical cover
- Since Jan 2021 ACAT forms part of the Integrated Crisis Assessment Hub (ICAH) which has a designated area for patients to attend and is used for diversion from Emergency Department, London Ambulance Service and police. This avoids patients coming to Sunflowers Court to be seen. When arriving at the hub patients are with staff throughout their stay
- A standard operating procedure was implemented and all reception staff completed training which included running through scenarios.

The Trust must ensure that effective arrangements are in place for the acute crisis assessment team to work with other professionals and teams, especially medical staff, to ensure patients receive comprehensive assessments and where clinically required an inpatient admission in a timely manner.

WHAT WE DID:

- Enhanced the monitoring of assessment times and outcomes by recording specific information in the Electronic patient record system Rio.
- Ensured leadership attendance at the Junior doctor's forum.
- Designated Consultant Psychiatrist in the team to support assessment and liaison with other professionals as required.



The Trust must ensure that leaders of all levels listen to feedback from staff and take appropriate action to address the safety, risk, and multidisciplinary working issues in the acute crisis assessment team

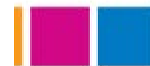
WHAT WE DID:

- Out of hours escalation procedures for clinical and non-clinical escalation were reinforced
- Bite size training was rolled out to all the MHS inpatient wards with pre and post training feedback collated
- Additional incident reporting (Datix) training was provided to medical and nursing staff. Trends and themes are reported weekly.
- Change to Datix trends and themes are identified through the Incident reporting group which meet weekly
- Staff continue to be encouraged to report concerns and patient safety issues through to the Trusts Freedom to Speak Up Guardian (FTSUG) and issues identified are acted upon
- An audit of the daily duty doctor handover was undertaken.

The provider must ensure that all staff complete mandatory training in the prevention and management of violence and aggression.

WHAT WE DID:

- Ensured each ward meet a training compliance rate of 85% for PAMOVA training
- Training report for PAMOVA monitored monthly and reported to Leadership meeting.



Improvement plan actions taken in response of Trust wide MUST Do Risks identified

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The Trust must take steps to ensure the senior executive leadership team work together in a cohesive manner to ensure they work together to address issues that impact on the safety of patients and staff.

WHAT WE DID:

- An independent review of the Executive Management Team was undertaken, this has resulted in the creation of a dedicated chief nurse role and a director of partnerships to build capacity into the nursing directorate and to ensure executive oversight of the Essex and Kent services. An Executive management team development programme was initiated leading to more cohesive and joined up team dynamics. This programme is ongoing.
- A team compact (how the team would work together) was signed by all members of the executive team.

The Trust must ensure that the culture of the trust is improved so that medical staff, particularly in the mental health services, can raise concerns without a blame culture and feel confident that staff will work together to make the necessary changes.

WHAT WE DID:

- Health Education England review undertaken with actions including, ensuring new starters receive shadowing opportunities, ensure there is a clear procedure for how learners raising concerns can receive feedback on actions.
- Implemented actions as a result of the staff survey to include:
  - Roll out of Health and wellbeing initiatives, Increased medical support to HTT's
  - Improved staff confidence in the incident reporting process through guidance, talks and support to staff

The Trust must ensure that staff understand the decision processes within the trust especially the role of the Chief Nurse Group. They must also review the split chief operating officer role

WHAT WE DID:

- Following extensive consultation, a new Governance Structure was put in place. Which helps to articulate how the 'ward to board' approach can be facilitated in our trust
- The Chief Nurses group was removed from the governance structure
- Appointment of Executive Chief Nursing Officer/Executive Director AHP & Psychological Professions to strengthen clinical leadership in the trust
- Appointment of Executive Director of Partnerships

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Improvement plan actions taken in response of Trust wide MUST Do Risks identified

The Trust must understand that all staff understand lone working practices.

WHAT WE DID:

- A buddy system was implemented in all teams
- Allocated SMART phones to staff who work in front line services
- Implemented a revised lone worker protocol to accompany the policy which can be found on the policy section of the internet under Health and Safety policies.

The Trust must ensure that the systems in place to identify and address risk is robust, consistent, and effective.

WHAT WE DID:

- Ensured all clinical staff undertook Clinical Risk Assessment and Management mandatory training and that training compliance was 85% or above
- Carried out a review of the Risk assessment and clinical harm review process which included implementing a revised risk assessment template in the patient electronic records (Rio).

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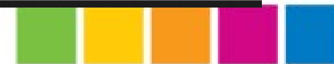

Improvement plan actions taken in response of Trust wide MUST Do Risks identified

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The Trust must ensure managers and leaders have access to accurate data to monitor their performance.

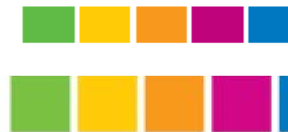
WHAT WE DID:

- Implemented a Trust wide performance data system called Power BI which is being rolled out trust wide and is accessible to all staff.

The Trust must ensure safe systems for storing, prescribing, administering and recording medicines.

WHAT WE DID:

- Increased staffing establishment and leadership positions to strengthen the clinical pharmacy service provided and support the wider MDT.
- Increased specialists support within the community, inpatient and crisis pathway services.
- Introduction of the lead medicine safety nurse role to bridge the gap between pharmacy and nursing.
- Deployment of EPMA (WellSky) and Automated Dispensing Cabinets (Omnicell) across all inpatient wards.
- Implemented wireless temperature monitoring across the Trust to provide greater visibility and improved processes for management of temperature breaches in medicine areas.
- The development of a Medicines Safety Training which is being launched as essential to role for all clinical staff
- Ensured closer working with the patient safety team, clinical effectiveness team and service leads to improve communication of safety messages, quality initiatives and shared learning from incidents.
- Improved Medicines Governance, through revised audit programme to support the revised Medicines and Controlled Drugs Policy
- Reviewed all medicines related policies, documents rationalised and new guidance produced where gaps in knowledge and skills were identified.
- A dedicated Pharmacy and Medicines Improvement QI Programme which has delivered a number of improvements.
- Re-tendering of the out-sourced pharmacy supply service and plans to re-locate on site with a view to strengthening service provision and collaborative working.



Improvement plan actions taken in response of Trust wide MUST Do Risks identified

NELFT NHS
NHS Foundation Trust

The Trust must ensure staff are appropriately supported to raise concerns.

WHAT WE DID:

- Created an online anonymous form for staff to raise concerns which are then acted upon by the Freedom to Speak up Guardian (FTSU)
- Members of the board and of the operational leadership teams carries out a programme of visits to teams at all locations to listen to the feedback of staff
- Implemented FTSU online training
- Implemented at FTSU strategy
- Continue to promote the FTSU culture with the trust through newsletters, screen savers and regular reports to Board.

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The Trust must ensure systems to ensure consistency from learning.

WHAT WE DID:

- Implemented a serious incident twitter page and intranet page
- Refreshed the Trust wide learning strategy that has since been embedded in the Trust Quality and Patient Safety Strategy.
- Established a monthly patient safety and learning meeting, that includes the directorate ADoN for quality and patient safety in it's membership. This enables learning to be shared across all services and teams.
- Carried out a review of the Serious Incident policy
- Commenced quarterly Trust wide learning events to share learning and best practice more widely
- Use screen savers and IT pop ups to update staff on learning information
- Undertook a thematic review of all unexpected deaths over a two-year retrospective process to benchmark against the National Confidential enquiry report into suicides and homicides.
- Created a shared learning desktop icon where staff can access learning cascades and patient safety information
- Recruited to the lead patient safety role that supports learning across the organisation.
- Created the patient safety learning champion role, with representation from all directorates.

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HEALTH SCRUTINY COMMITTEE

23 March 2022

Title: The Integrated Care System/Local Borough Partnership Proposals and Governance- Position Update	
Report of the Director of Public Health	
Open Report	**For Information**
Wards Affected: All	**Key Decision:** No
Report Author: Jane Leaman, Interim Consultant in Public Health and Jess Waithe, Interim Health Improvement Lead	**Contact Details:** jane.leaman@lbbd.gov.uk jess.waithe@lbbd.gov.uk
Accountable Director: Matthew Cole, Director of Public Health	
Accountable Strategic Leadership Director: Elaine Allegretti, Strategic Director for People and Resilience	

Summary

The appended presentation is intended to provide a high-level outline of the Integrated Care System (ICS) that is set to be established from July 2022, provide an overview of the current context, provide an update on the current proposal and on any next steps.

Recommendation(s)

The Health Scrutiny Committee is recommended to:

1. Consider the content of the report; and

2. Note the proposal to establish the B&D Delivery Board as the Place Based Partnership Board; an ICB place committee running alongside the Health & Wellbeing Board. This would be provided with delegated authority to make decisions about NHS service planning and delivery (a final agreement is still to be made with all relevant partners and a final full paper will be brought back to the Health Scrutiny Committee (HSC) in September).

Reason(s)

A mutual agreement between partners needs to be established providing the final proposal for the governance structure of a place-based partnership for 2022/23 onwards as part of the overall NEL ICS.

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

List of appendices:

Appendix 1: Integrated Care System and Borough Partnership Proposals and Governance Update

Barking & Dagenham

Appendix 1

Health Scrutiny Committee

23 March 2022

one borough; one community; no one left behind

Background

Integrated Care Systems (ICSs) are partnerships bringing together providers, commissioners, local authorities and other local partners to plan services meeting local needs.

In July 2022, ICSs will become statutory (subject to the passing of the H&SC Bill) and led by two related entities at system level: an '**Integrated Care Board' (ICB)** and an **'Integrated Care Partnership' (ICP).** Together referred to as the ICS.

Their purpose is to **integrate care across different organisations and settings**, joining up services and to lead the following on behalf of their population footprint:

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

In addition to the two governing bodies, there will be three other core components of the ICS system:

- Provider Collaboratives
- **Place-based Partnerships**
- Primary Care networks

Current Context

- Moving a three-borough arrangement to 1 & 7 borough arrangements
- Many decisions being worked through
- Our basic premise - as much at LBBD level as possible (budgets, power, services)
- Huge financial and resource inequity, masked by BHR footprint arrangements

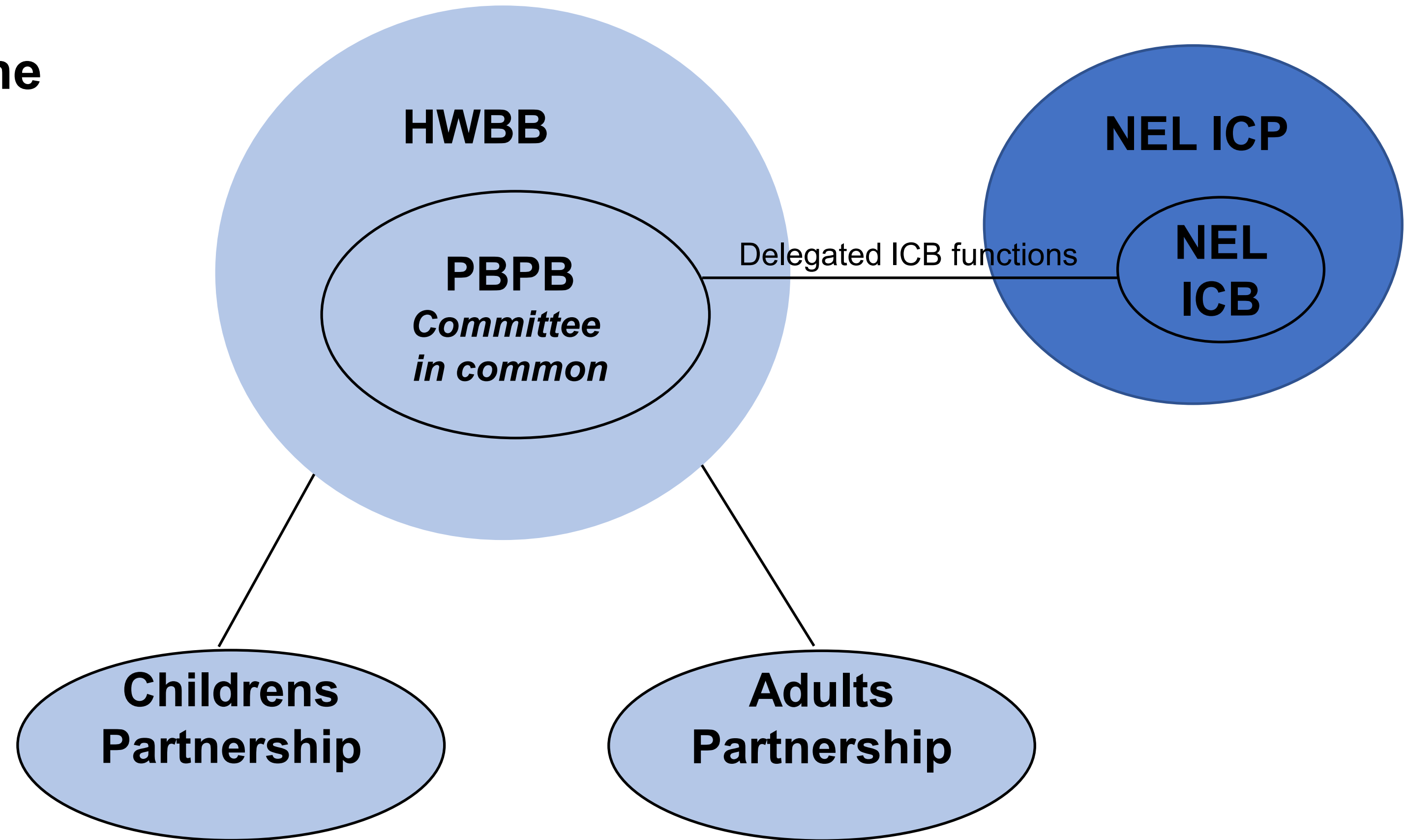
Health Vs. Local Authority (LA) landscape

- Health dominated guidance and bias so far
- LA statutory duties continue and increasing
- No clarity from national guidance re role of LA in all terms
- No clarity, in addition to health and social care – how we want local arrangements to build on ComSol approach, VCS and other partners who are not in health guidance statue so far, e.g. schools

Place Based Partnership (proposal)

Addressing needs through more locally determined and integrated health services, alongside action to address the wider community and social factors which impact the health of our community, will be done through:

- More democratic involvement
- Delegated NHS budgets
- Locally agreed priorities and service delivery plans
- Joint commissioning e.g. to improve mental health support
- Shared use of local estate
- Increased involvement of local people, local service providers and the voluntary sector in service planning and delivery



ICP = Integrated Care Partnership
ICB = Integrated Care Board
PBPB = Placed Based Partnership Board

Areas Of Development

- Joint commissioning, pooling money and delivering more locally (like with schools and VCS)

- Delivery at locality/ward/community hub level - joined up around residents, ease of access and them “telling their story once”

- Developed two distinct workstreams (children and adults), actively working to embed manifesto in developments (best chance for children, living well and Barking Hospital)

- Significant disentanglement needed at all levels, this will not be the case in other LAs of NEL, London or country - although many of the challenges of governance role LA are the same

Next Steps

Agree the planned governance model for place including:

- Membership
- Place-level decision-making arrangements, including any joint arrangements for statutory decision-making functions between the NHS and local government
- Agree the final proposal with partners and obtain sign off for each organisation
- Leadership roles, for convening the place-based partnership, as well as any individuals responsible for delegated functions
- Clinical and care leadership
- Representation on, and reporting relationships with, the ICP and ICB
- Strategy/plan and outcomes at place (CYP and adults)

‘Joining Up Care For People, Places And Populations’

The Government's proposals for health and care integration

- Published 9 February 2022

one borough; one community; no one left behind

Summary

- Sets out approach to designing **shared outcomes** between councils and local NHS organisations
- Introduces an expectation for a **single person accountable for the delivery of shared outcomes and plans** at local level across health and social care (H&SC)
- Breaks down the barriers that separate our **health and care workforces**
- It is part of a wider set of mutually reinforcing reforms: **our Adult Social Care Reform white paper, People at the Heart of Care; the Health and Care Bill and reforms to the public health system**
- Advocates for **health and well-being as a key priority**, with a greater emphasis on prevention
- Whilst children's social care is not directly within scope of the paper, places are encouraged to consider the integration between and within children and adult health and care services wherever possible***

****The **Independent Review of Children's Social Care** is taking a fundamental look at the needs, experiences and outcomes of the children supported by children's social care. Government is championing the continued join up of services, expanding family hubs to more areas across the country, and funding key programmes such as Supporting Families and supporting the implementation of the Early Years Healthy Development Review. At the recent Budget, a £500m package for these services was announced, to provide more support for families so that they can access the help and care that they need.*

Headlines

- Shared Outcomes
- Agreed plan – demonstrating delivery against outcome – role of Care Quality Commission (CQC)
- Single leadership role across health and social care
- Simplify pooling funding arrangements – working towards normal way of working
- Increase use of digital technology – for community and workforce
- Improved use of shared data for understanding needs and service planning
- Integrated health and care workforce – e.g. joint training and development, delegation framework of healthcare interventions, career passport
- Place-based governance model
- Emphasis on health and wellbeing and addressing health inequalities

Key Milestones

- Winter 2021/22: publish a final version of the Data Strategy for Health and Care
- End of 22: Develop a standards roadmap
- April 2023: Implementation **of shared outcomes** will begin
- Spring 2023: All places should **adopt a model of accountability and provide clear responsibilities for decision making**
- Autumn 23: Develop a co-designed suite of standards for adult social care
- By 2024: Ensure all professionals have access to a functionally single health and adult social care record for each citizen
- By 2025: Ensure each ICS implement a population health platform with care coordination functionality