Barking & Dagenham

Notice of Meeting

HEALTH SCRUTINY COMMITTEE

Wednesday, 1 February 2023 - 7:00 pm
Council Chamber, Town Hall, Barking

Members: Cllr Paul Robinson (Chair) Cllr Donna Lumsden (Deputy Chair); Cllr Muhib Chowdhury, Cllr Michel Pongo and Cllr Chris Rice

By Invitation: Cllr Maureen Worby

Date of publication: 24 January 2023

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AGENDA

1. **Apologies for Absence**

2. **Declaration of Members' Interests**

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

3. **Minutes - To confirm as correct the minutes of the meeting held on 14 November 2022 (Pages 3 - 10)**

4. **NHS North East London - Severe Weather System Response (Pages 11 - 21)**

5. **Annual Report of the Director of Public Health 2022- 'People, Partnerships, Place Seizing new opportunities to improve health' (Pages 23 - 67)**

6. **Shaping the Refresh for the Joint Local Health and Wellbeing Strategy 2023-28 (Pages 69 - 80)**

7. North East London Integrated Care Strategy Development (Pages 81 - 97)

8. Scrutiny Review on the potential of the Voluntary and Community Sector 2022/23 (Pages 99 - 114)

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. Work Programme (Pages 115 - 117)

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

12. 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.***

13. 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

- 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

Monday, 14 November 2022
(7:00 - 9:13 pm)

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

Apologies: Cllr Olawale Martins

54. Declaration of Members' Interests

There were no declarations of interest.

55. Minutes - To confirm as correct the minutes of the meeting held on 21 September 2022

The minutes of the meeting held on 21 September 2022 were confirmed as correct.

56. Updates relating to Winter Pressures, Vaccinations and the Cost of Living

The Director of Integrated Care (DIC) at North East London Integrated Care Board (NEL ICB) presented an update on the approach that the Integrated Care System (ICS) was taking to managing winter pressures in 2022/23, as well as an update on a recent winter summit that was held by the Barking and Dagenham Partnership, to consider actions that could be taken locally to keep people safe and well at home.

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

- Workforce was always a risk area; however, the ICS had received some additional funding over winter, which had been directed to providers such as Barking, Havering and Redbridge University Hospitals Trust (BHRUT), North East London NHS Foundation Trust (NEFLT) and the local authority, for these to invest in workforce capacity. Support also needed to be streamlined: in terms of Barking and Dagenham, funding needed to be streamlined to support social work in A&E and to increase capacity in emergency response services.
- Whilst the ICB did not employ frontline staff (as these were employed by the NHS providers), it was working to develop a Workforce Strategy so that each of the provider organisations would have its own Workforce Development Strategy around recruitment and retention, with some of this being related to training and skills development. There was also a constant review around caseloads and capacity. It was also considering career opportunities and new models of care, such as through looking at new roles and rotations across organisations to encourage people to work in Barking and Dagenham.
- Work was also being undertaken across the Partnership to consider care provider resilience and to undertake scenario planning to best respond to any issues, such as where care providers were no longer able to operate.

- The Barking, Havering and Redbridge (BHR) Workforce Academy was working to understand where there were gaps in recruitment and to provide recruitment opportunities.
- There were a number of services in the community that focused on proactive care; through general practice, NEL ICB had commissioned an enhanced health care home scheme, which provided multidisciplinary support to residents in care homes who had complex needs. This was a collaboration between Primary Care and community services, with links through to Rapid Response teams as necessary.
- The Barking and Dagenham Partnership had recently piloted a population health management approach to keeping people well at home, which was exploring a greater collaboration between the Health and Voluntary sectors. This had shown that a number of factors that impacted on health were sometimes best addressed by other services not provided by the NHS, meaning that greater integration between Primary Care, community care and voluntary services was essential.
- The ICB had commissioned capacity in community urgent care services. The Community Treatment team, which had had significant investment over recent years supported by system development funding, was designed to ensure that people could receive a rapid community response if their health deteriorated more rapidly, to avoid an ambulance trip into hospital. Generally, these services were for people with long-term conditions who were on the practice caseload for integrated case management and were generally maintained, fit and well; however, at times their health would deteriorate and they would not be able to get access to an urgent community service.
- Across the BHR system, the ICB had commissioned an Integrated Discharge Hub, which was hosted by NELFT; it also had the local authority discharge functions integrated into the team, so that health and care were working together to support hospital discharge. This was primarily for people who required health or care support following discharge, to ensure that they received an assessment when they were discharged to their home and that they had an ongoing care package in place.
- The system had a very good partnership arrangement around discharge, which was very much strengthened during the Covid-19 pandemic. There was a two-weekly discharge working improvement group, which was chaired by the Director of Adult Social Care at Havering Council, which brought together all partners in BHRUT, NELFT, and Barking, Havering and Redbridge Councils, to look at pathways around discharge and discuss opportunities for improving these. At an operational level, there was a daily discharge call, which involved Health and Care and looked specifically at individual patients and which actions needed to be taken to facilitate their discharge.
- A number of ideas had arisen from the Winter Summit in relation to children and young people, such as through empowering secondary school pupils to take more control of their health, as well as improving immunisation rates for flu, to address respiratory viruses in the youngest cohorts.

In response to questions from Members, the Integrated Care Director (ICD) at NELFT stated that:

- Whilst it was a peak time for NELFT in terms of working through bank and

agency staff requests, there was a range of different staff. Its Workforce Development Plans were also looking at increasing workforce capacity and developing a new workforce, such as through Clinical Associate Psychologist (CAP) roles, to create more substantive posts.
- In terms of staffing shortfalls, NELFT was in a similar position as to other NHS Foundation Trusts nationally.

The Council's Director of Public Health highlighted the importance of supporting both the clinically vulnerable, and those affected by the cost-of-living crisis through the winter, as well as the need for close collaborative working between the NHS, the Voluntary sector and the Council through the place-based arrangements to deliver this support. There had also been a number of changes in general practice and primary care in terms of supporting residents without them needing to go to A&E. Going forward, it would be vital that residents understood the help they could receive for conditions and when to seek support, so that they did not need to present to A&E.

The Council's Acting Chief Executive and Place Partnership Lead (ACEPPL) then presented an update on the approach that was being taken by the Council to support residents through the current cost-of-living crisis. This provided a summary of key engagement with partners and residents, as well as actions being taken to mitigate against difficulties, such as through the establishment of the Barking and Dagenham Cost of Living Alliance and a warm spaces network.

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

- There was lots of support that could be accessed by the Health workforce within the Borough.
- She would request a detailed written response as to the Leeds Credit Union and the APR of 42.6%, which would then be provided to the Committee.
- Residents could access additional information as to the warm spaces network, from the Barking and Dagenham website. The Council would also provide an update as part of its December newsletter, which would be circulated to all residents who had signed up to this via email.
- The Council had very successfully taken part in the Cosy Homes Scheme, which helped eligible residents stay warm, save energy and lower their energy bills through subsidised energy-saving improvements. The ACEPPL would request a more detailed written response as to the number of homes that the Council hoped to be able to insulate moving forward.
- Many positive comments had been received as to the leaflets that had been circulated to residents regarding support that they could receive around the cost-of-living. If any resident had not received this for any reason, they could get in contact with the Council to request a copy.

57. Place-Based Partnership Update

The Council's Director of Public Health (DPH) introduced an update on the place-based partnership governance arrangements, outlining the structure and roles involved as part of this.

The Council's Acting Chief Executive and Place Partnership Lead (ACEPPL), the Clinical Director for Barking and Dagenham, the Director of Integrated Care (DIC)

at NEL ICB and the Integrated Care Director (ICD) at NELFT each outlined their vision for their roles as part of the Place-Based Partnership arrangements, as well as the importance of working collaboratively to address issues across the Borough.

In response to questions from Members, the ACEPPL and the DPH stated that:

- The Health Scrutiny Committee would continue to have a key role in governance and the oversight of decision-making in future. Going forward, it would be important that the Committee's work programme align with some of the decisions that were to be taken across the ICS; as such, there was still some work to be undertaken around the governance of the Committee.
- Going forward, the Committee would no longer solely scrutinise the decisions of Health partners, but of all partners across place, which included all system leaders, such as the NHS, the Voluntary and Community sector, the Council and provider collaboratives. A challenge would be for officers to ensure that all key decisions were able to be brought to the Committee, to ensure that it would be able to deliver its statutory duties around service changes.
- It was very likely that going forward, the terms of reference for the Committee would need to be amended to account for its wider role. It was likely that the attendance for each meeting would also need to be widened, to include additional key partners.
- The Council was embracing governance changes and was working very closely with its partners.
- Partners had worked very collaboratively to address Covid-19 issues within the community and this continued close collaboration would be vital going forward to address health inequalities issues within the Borough. It would be essential to work as 'one system' in the future.

In response to further questions, the ACEPPL and the DIC at NEL ICB stated that:

- Ongoing and open dialogue would be essential to collaborative working.
- In terms of the decision-making process, there would be a "conflict of interest" policy; however, the majority of the work that would be undertaken through the Partnership Board would not require contractual decisions or any decisions that could have any material impact on any of the partners. The focus would be around quality improvement and improving ways of working within allocated resources, rather than considering commissioning decisions.

58. New Moorfields Hospital Eye Hub at Stratford, London

The Chief Operating Officer (COO) and the Divisional Director and Glaucoma Consultant (DDGC) at Moorfields Eye Hospital NHS Foundation Trust delivered a presentation on the proposal to provide additional eye care at a new site in Stratford from Spring 2023, which would bring together in one place a range of eye services for the local community including glaucoma, medical retina and cataracts, a specialist pharmacy, diagnostics, face-to-face and surgical treatments. The existing site at Barking would become a centre offering diagnostic tests for eyes, jointly operated by Moorfields, BHRUT and Barts Health. All face-to-face eye clinics provided at Barking would relocate to the new Stratford facility.

The presentation detailed the case for change, the proposals and feedback from patients. In response to questions, the COO and the DDGC stated that:

- Whilst there was an eligibility criteria, the Trust did provide patient transport, which would continue under the new proposals and those eligible would be able to be transported from their homes to Stratford. Nevertheless, the Trust's aim was to support the majority of patients who currently received their care at Barking, to remain at Barking for their care. It was looking to expand the number of patients that it could see at Barking, where patients wished to be seen there. Whilst there was a small number of patients that would have to go to Stratford for their care, the Trust would assess each patient on an individual basis to look at how it could support them.
- The Trust had a close working relationship with colleagues at BHRUT and Barts; in the future, it may be possible for patients who lived near to one of these sites, to receive their care there.
- The Stratford site would provide better and additional facilities for patients. The Trust was also hoping to offer some low visual aid appointments, so that patients did not need to travel outside of the Borough for these.
- The proposal would enable patients to receive a range of diagnostics within the community, through a separate pathway that meant that they would not need to travel to a hospital site.
- The Trust hoped to operate the Barking Ophthalmology Community Diagnostic Centre (CDC) five days a week, seeing around 21,000 patients per year. This was significantly higher than the 8,000 currently seen at Barking.
- The Stratford site would be based at the former MIND charity offices, which was a four-floor 13,000 square foot building and a four-to-five-minute walk from Stratford train and bus stations.
- Cataracts patients were currently seen at Barking for the initial part of their patient pathway and would then need to travel to St. Ann's for their surgery, outside of the Northeast London area. The proposal would enable a "one-stop" model for cataracts patients, who would be able to receive all of their care and treatment at the Stratford site.
- Medical retina and glaucoma patients would have periods of stability where no intervention was required, with these patients being able to continue to receive care at Barking during this. If they were found to require injections or had queries about changing their treatment, then they would go to the Stratford site to meet the clinicians face-to-face. Once the patients had stabilised, they would be able to return to Barking. As such, the new proposal would have a mixed pathway for patients, based on their need.
- Patients were currently having to travel much further for surgery than proposed under the new model. The Trust had mapped out parking areas for the Stratford site; whilst this was not as straightforward as for Barking, there was parking available due to the proximity of local shopping centres.
- Ophthalmology was generally an outpatient or day patient service. Whilst there were currently six inpatient beds at the City Road site, these were for overnight-stay patients with a co-morbidity.
- The Trust was currently looking at exploring its emergency care model of delivery. It was piloting a model that enabled it to triage patients that had been referred to its A&E, which had been developed at its City Road site. The Trust was looking into how it could roll this model out to the other areas

that it served. Patient feedback had been received as to having emergency support at the Stratford site and the Trust would look into this in future years.

- Diagnostics was divided into lanes, with each service designing the investigations that were required to make a decision about the patient's stability. No clinical decision would be made at this point, with the patient receiving a letter at a later date as to the findings of their diagnostic tests.
- The Glaucoma service ran across various sites; however, all staff had service meetings and received the same service teachings, so that the same standard of care was kept across all of the sites. The Trust worked hard to offer the same standards, with the same imaging devices, diagnostic tests and set-up.
- The Trust had undertaken a lot of work around 'Did Not Attends' (DNAs). This had peaked at 30 percent during the Covid-19 pandemic, with the Trust now striving to reduce this to ten percent. A lot of work was being done to improve the patient portal, in order to digitise reminder letters and guarantee that patients received these. The Trust was also starting to aim for a more predictive model to show which patients were most likely to not attend appointments and to reach out and work in partnership with them. Where there were spikes in DNAs, the Trust was working to understand the reasons for these, such as through socio-economic circumstances.

59. Health Inequalities Funding

The Council's Consultant in Public Health Primary Care and Transitions (CPHPCT) delivered a presentation on the Barking and Dagenham Health Inequalities Programme 2022/23, which provided context as to health inequalities in the Borough in comparison with London and nationally, how the funding was secured for the programme, programme workstreams and the benefits of the programme.

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

- In terms of the debt and health pilot, the Council was identifying adults who were falling into debt, such as those who were failing to pay Council Tax, as well as those whose social care records showed that they had low level mental health problems, as it was aware that debt could exacerbate mental health issues and that mental health issues could make it more challenging to manage debt. This was a pilot that had previously been undertaken, with the Council looking to scale this up, as well as make this more effective through linking it to the NHS. Those identified would be approached and offered the opportunity to access social prescribing, with social prescribers being trained to signpost and support these residents with expert advice on debt and health.
- Currently, no referrals into Talking Therapies or IAPT would be made, as there was no medical diagnosis or clinical assessment as part of the programme. The debt workstream was focusing on reaching those residents who were falling into debt before the issue started to escalate; however, referrals could be a future iteration of the programme.
- The Council was going to look into the data that all partners held, to ensure that all across the system had the same understanding of health inequalities within the Borough. This data could then be used to better support planning

delivery, through the creation of a data indicator set or dashboard that all partners could refer to. The Council was also working closely with its Data Insight Hub to support this work.

The DIC at NEL ICB stated that there was an opportunity to look at how residents could be better signposted to NHS services, and that confirmation had also recently been received that the funding for the debt workstream would become recurrent, which would help with long-term planning. Residents could also self-refer into IAPT services if they had any concerns.

The Clinical Director for Barking and Dagenham also stated that each of the Primary Care Networks (PCNs) had Inequality Clinical Leads; each PCN would likely have different prevalence rates for different conditions and the Leads would be able to identify these and concentrate resources in a tailored way to that area.

In response to further questions, the CPHPCT stated that there was a work stream which aimed to identify interventions for children and young people who were starting to develop low-level mental health issues, to provide them with support within the community to build their resilience. The ICD at NELFT stated that self-referrals could be made into the Barking and Dagenham CAMHS service; there was a phone number and a website and residents were able to make use of these. The Clinical Director for Barking and Dagenham also emphasised the importance of raising awareness amongst young people for them to come forward to their school counsellors if they had any concerns, as well as ensuring that GP practices were young people-friendly. Signposting in libraries and Community Hubs would also be key in promoting services; work was also being undertaken at Riverside to encourage conversations around mental health amongst young people.

In response to a question from a Member, the ICD at NELFT stated that NELFT worked in conjunction with social care colleagues at the Council to support patients who were eligible for Freedom Passes, to make these applications.

Owing to the number of questions around the health inequalities work, the Committee agreed to bring this item back to a future meeting of the Committee, where it could explore this topic in increased detail.

60. Scrutiny Review on the potential of the Voluntary and Community Sector 2022/23

The Chair presented the proposed terms of reference for the Committee's Scrutiny Review on the potential of the Voluntary and Community Sector 2022/23. The Committee agreed the terms of reference and noted that officers would draft a project plan, with a timeline for completion. This project plan would then be circulated to the Committee in advance of the next formal meeting for agreement.

61. Joint Health Overview and Scrutiny Committee

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

62. Work Programme

The Committee agreed the Work Programme.

HEALTH SCRUTINY COMMITTEE

1 February 2023

Title: NHS North East London – Severe Weather System Response	
Report of the Director of Integrated Care at NEL ICB	
Open Report	**For Information**
Wards Affected: None	**Key Decision:** No
Report Author: Claudia Wakefield, Senior Governance Officer	**Contact Details:** Tel: 020 8227 5276 E-mail: claudia.wakefield@lbbd.gov.uk
Accountable Strategic Leadership Director: Sharon Morrow, Director of Integrated Care at NEL ICB	

Summary

The appended presentation is intended to provide an update on the severe weather system response of NHS North East London, as previously requested by the Committee.

Recommendation(s)

The Health Scrutiny Committee is recommended to note the update provided and following the presentation, discuss any issues that need further exploration with the NEL ICB representatives.

Reason(s)

The themes in the appended presentation relate to the Council's priority of Prevention, Independence and Resilience.

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

List of appendices:

- Appendix 1: NHS North East London – Severe Weather System Response Presentation

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Appendix 1

NHS
North East London

NHS North East London – Severe weather system response

Review of summer 2022 and future actions to address severe weather

Barking & Dagenham HSC

Context

- Severe weather presents a multitude of risks to the health of patients and the provision of healthcare.
- The main risks to the NHS and to patients during severe weather are a) significant increase of activity with patients suffering ill health or death due to heat, b) estates issues relating to overheating of equipment, c) safety of patients throughout clinical settings and d) safety of staff.
- The NHS must work with its health and social care partners to respond to the risks posed as a result of severe weather. This includes planning for severe weather, responding to severe weather, and ensuring that there is an ongoing learning process to incorporate actions and outcomes.
- The National Heatwave Plan 2022 outlines that the climate is changing and the current analysis in the national UK climate change risk assessment suggests that summers will progressively get hotter. Services across the nation must ensure that they are equipped to respond to heatwaves and do their part to reduce climate change where possible.

NHS EPRR planning

- Under the NHS EPRR (Emergency Preparedness, Resilience and Response) Framework 2022 and the Civil Contingences Act 2004, NHS organisations are required to plan for a variety of incidents and scenarios that could potentially impact the provision of services to patients.

- Planning for such incidents must take in to account the specifications as noted in the CCA 2004, the Health and Safety Act 1974, the Health and Social Care Act 2022 and other supporting documents. In addition, NHS organisations must adhere to national guidance, plans and best practice and incorporate these in to their plans. An NHS organisation's approach is assessed by NHS England in a yearly assurance process whereby a compliancy rating is given.

- Each NHS organisation will have its own plan which governs its response to incidents and their causes. An overarching incident response plan will be supported by items such as a) business continuity for estates and facilities, IT infrastructures, wards and whole sites, b) severe weather which must cover floods, cold and hot weather, and c) pandemic plans.

- It is important to note that each NHS organisation is a statutory body, and is therefore responsible for their individual planning approach. However, there is a requirement for NHS organisations to plan and act in a multi-agency way with other frontline responders and Borough partners, and all plans must be shared and reviewed by stakeholders to ensure that health and social care services are coordinated in response.

Severe weather planning overview

- The North East London Integrated Care Board (NEL ICB) currently collate cold and hot weather plans in to one plan, entitled the Severe Weather Plan.
- The Severe Weather Plan is based off of new guidance (such as the Heatwave Plan) and is reviewed yearly in order to ensure that it is current and reflective of new ways of working and best practice. The plan was last reviewed in June and is currently in the process of another review after the ICBs assurance meeting with NHS England.
- Trusts also have a Severe Weather Plan (sometimes split between a hot and cold weather plan), which governs their response to severe weather. All severe weather plans must be in line with the latest heatwave and cold weather guidance.
- Multi-agency planning for events such as heatwaves are required to take place at the Borough Resilience Forum, which in Barking and Dagenham is led by Barking and Dagenham Council (LBBD).
- LBBD hold exercises yearly on a number of issues in order to test multi-agency arrangements. The ICB will also lead ICS-level incident exercises to test arrangements across a NEL footprint. The first to take place was a nationally mandated exercise in December 2022, which incorporated severe weather (snow). The ICB will be leading an exercise in April 2023 (topic TBC).

What the NEL Severe Weather Plan covers

The NEL severe weather plan, currently under review, covers:

- Risk assessment for patients and services;
- Nationally identified patient groups at risk;
- Level of response required per Alert level, plus any supporting actions;
- Command and Control arrangements;
- Communications and Media guidance including ICB-led cascades;
- Managing Excess Deaths guidance;
- Data sharing and intelligence gathering;
- Training Requirements; and
- Testing Requirements (also covered by the NHS NEL EPRR Policy).

The above stipulations are all required as per the National Heatwave Plan 2022.

2022 summer – record temperatures

- The UK experienced a brief but unprecedented extreme heatwave from 16 to 19 July 2022, reaching heights of 40C. The Met Office issued its first red warning for extreme heat and the UK Health Security Agency issued a level 4 alert. This resulted in the Government declaring a national emergency.

- The NHS prepared for the heatwave by invoking their severe weather plans and reviewing their business continuity arrangements. Trusts also reviewed their estates risk assessments to understand potential issues which could arise (such as roof-top generators breaking down) and prepared for an increase in patients or acuity challenges. Trusts were required to 'report by exception' issues relating to the heatwave and advise of potential risk to NHS services, including estates, staff, supply chain and patient safety. The ICB stood up Incident Management meetings with Directors on Call.

- NHS England released a communications package for ICBs to cascade to frontline providers (including Primary Care). This communications package outlined staff communications and public health messaging regarding keeping cool. Communication leads worked with their local authority counterparts to reiterate local public health messaging.

- London Boroughs stood up additional BRFs (Borough Resilience Forums) or Tactical coordination groups in order to respond to the heatwave or incidents caused by hot weather such as fires. These were joined by the Director on Call.

- A number of fires broke out across London, including in Barking & Dagenham and Havering. Rest centres stood up by LBBD as part of the response required enhanced support form healthcare colleagues, which was provided by North East London NHS Foundation Trust (NELFT) and local primary care services (including mental health support, prescriptions and general healthcare needs). There were limited casualties to the fires and few patients were conveyed to hospital.

NHS learning from summer 2022 heatwave

Trusts followed their heatwave plans, resulting in NHS services remaining resilient. There were no NHS organisations who reported issues regarding the impacts of heat (on patients, staff or facilities). However, there were a number of lessons learnt due to the response to fires regarding multi-agency working. This included:

1. **Establishing a silver on-call rota for North East London;**
2. **Ensuring emergency preparedness cascades are followed;**
3. **Ensuring all levels of ICB management are trained in Emergency Response;**
4. **Health to run ICS-level and Borough-level exercises, created with advice/support from Local Authority Resilience Leads;**
5. **Ensure widespread understanding of the ICBs new evacuation plan; and**
6. **Joint planning between the ICBs Climate/Green Team and EPRR.**

2023 Heatwave Planning

The ICBs Severe Weather Plan already incorporates the requirements of the national Heatwave Plan in 2022. However, there are a number of areas that the ICB is working on to ensure that it is satisfied with the system response for health. These include:

- The long-term goal of adapting and reducing the impact of climate change to the NHS in NEL. This requires working together across the system in incident teams, Green Teams and facilities teams to address issues which the NHS faces. Engagement with these groups, which will be conducted via several routes – the NHS Green Team Working Group (all partners), ICBs Resilience Group (ICB Leads) and the NHS NEL Resilience Forum (all NHS NEL stakeholders with an interest in resilience);
- Improving the understanding of level of vulnerable patients in the community, noting that many stakeholders hold similar but differing lists (Housing Association, Council, NHS Primary Care and NHS Trusts);
- Ensuring that all organisations going through the procurement process have their climate and resilience plans reviewed, with a direct link to seek support and information from the NEL ICB EPRR Team;
- Ensure that there is appropriate planning in place and enhanced support for non-NHS settings, such as care homes;
- Reviewing the resilience of primary care and community service estates (both currently and long-term);
- Continuing to review all plans on an annual basis to incorporate new guidance and best practice;
- Ensuring the above areas are underpinned by strategies such as the Greener NHS Plan, the NHS EPRR Framework and the NHS NEL Estates strategy; and
- Promote the heatwave plan and its requirements with new staff and leadership, and ensure continuous engagement with the plan outside of EPRR and Climate teams.

For more information

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HEALTH SCRUTINY COMMITTEE

1 February 2023

Title: Annual Report of the Director of Public Health 2022- 'People, Partnerships, Place Seizing new opportunities to improve health'	
Report of the Director of Public Health	
Open Report	**For Information**
Wards Affected: All	**Key Decision:** No
Report Author: Matthew Cole, Director of Public Health	**Contact Details:** E-mail: matthew.cole@lbbd.gov.uk
Accountable Strategic Leadership Director: Elaine Allegretti, Strategic Director Childrens and Adults	

Summary:

The Director of Public Health Annual Report provides an opportunity for the Director of Public Health to give an independent assessment of the health of the population and focus on priority areas that the Council and its partners need to consider individually and collectively.

This year's report focuses on providing professional perspective that informs an integrated care approach. Observations within chapters act as a starting point for identifying 'where to look' before 'what to change' and finally how to change, with the introduction setting context as we recover from the pandemic and manage the impact of the cost-of-living crisis.

Chapter 1 continues with previous themes of using the opportunities provided by population health management to advance the design and delivery changes by learning from residents, the frontline and building a roadmap to 'spread, scale, and sustain'.

The second chapter follows on to explore the opportunities to improve outcomes for children and families through the lens of the 0-19 Healthy Child programme and national initiatives such as Start for Life and Family Hubs, including 'what good looks like'.

Chapter 3 shares the steps we have taken to address health inequalities through population level interventions using borough assets to promote healthy lives, and highlights areas where we need to do more.

Lastly, the final chapter discusses the scale of health protection work to protect residents from the impacts of COVID-19 and what should be considered for its ongoing management.

Recommendation(s)

The Health Scrutiny Committee is recommended to note the report provided and to discuss any issues that need further exploration with the Director of Public Health.

Reason(s)

The Director of Public Health has a statutory responsibility to publish an annual report with content decided on an annual basis.

1 Consultation

Key stakeholders and partners reviewed the report and provided input and suggestions to the content.

Additionally, the report was taken to the following Governance groups: People and Resilience Management Group, Business As Usual; Portfolio and Corporate Strategy Group. The report was also approved at the Health and Wellbeing Board on 8 November 2022 (item 29 refers).

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

List of Appendices:

- Appendix 1: Annual Report of the Director of Public Health 2022- 'People, Partnerships, Place Seizing new opportunities to improve health'

People, Partnerships, Place

Seizing new opportunities to improve health

Barking & Dagenham

Foreword

Welcome to my public health report for 2022, in what continues to be unique times, as we go on to manage and recover from the pandemic. COVID-19 has shone a light on inequalities within our communities and has deeply changed our lives. This, combined with the cost of living crisis and the extraordinary demands on our health and care services, will have a major long-term impact on Council services, residents, and local businesses.

Over the years my Annual Reports have argued for the development of integrated care approaches focused on population health need. Many of our older residents are living longer with multiple, complex, long-term conditions and increasingly need longterm support from many different services and professionals. Also, the focus can't just be about older adults, prevention and delivering early intervention services for parents, children and families is as important in breaking the generational cycle of health inequalities to support children and young people to enjoy good health across their life course.

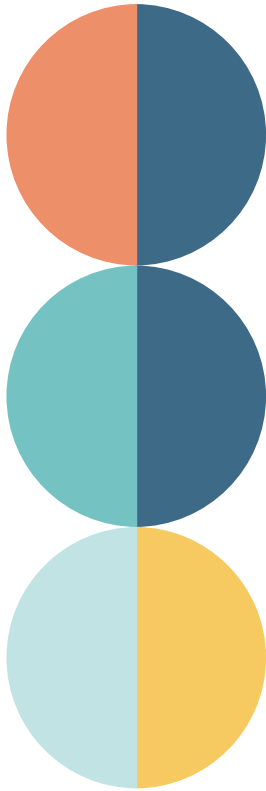
Consequently, residents young and old too often receive disjointed care from services that are not effectively co-ordinated around their needs. This can negatively impact their experiences, lead to poorer outcomes, create duplication and inefficiency. To deliver support that better meets needs of the population, different parts of the NHS, voluntary sector, schools, social care and wider Council services need to work in a much more joined-up way.

This is a fundamental principle of Integrated Care Systems (ICSs), which, following the passage of the 2022 Health and Care Act have been formalised as legal entities with statutory powers and responsibilities. However, it is important to recognise its limitations. It is not possible to legislate for collaboration and co-ordination of local services; this requires changes to behaviours, attitudes and relationships among staff and leaders right across the system. However, stronger local decision making is central to completely changing the relationship between our residents, the NHS and the Council, in deciding the delivery approaches we take to achieve the best outcomes, at the right cost.

We are therefore refreshing our Joint Local Health & Wellbeing Strategy for the period 2023 -2028 to give a vision and clarity to outcomes the ICS needs to improve. But, as most issues impacting on people's health are outside of the health service, the heart of this will be tackling health inequalities supported by the value of relationships and connecting with residents in designing or delivering changes in services, to meet the individual needs and characteristics of our communities.

My report gives a professional perspective that informs this approach based on sound epidemiological evidence and analysis taken primarily from our Joint Strategic Needs Assessment 2022. I hope my observations in the following chapters act as a starting point for identifying 'where to look' before 'what to change' and finally how to change, with the introduction providing a context setting as we recover from the pandemic and manage the impact of the cost of living crisis.

Chapter 1 continues my theme over the years of using the opportunities provided by population health management to advance the design and delivery changes by learning from residents, the frontline and building a roadmap to 'spread, scale, and sustain'. I make the case for using the delegated NHS responsibilities for Barking & Dagenham to speed up integrated care delivery at locality level by using population



health management to drive real change. To achieve this, we need to be outcome and quality driven and place-based focused, with multidisciplinary teams working together in localities to maintain unified care, which meet needs to effectively manage demand. This should be supported by data transparency and sharing to ensure streamlined care.

Chapter 2 follows on to explore the opportunities to improve outcomes for children and families through the lens of the 0-19 Healthy Child programme and national initiatives such as Start for Life and Family Hubs. I consider 'what good looks like' and how this can be developed to benefit residents through the new arrangements for the ICS and locality working.

Chapter 3 shares the steps we have taken to address health inequalities through population level interventions using borough assets to promote healthy lives and highlights areas where we need to do more. Effective place-based action requires action based on civic, service and community interventions, along with system leadership and planning, indicating more can be done system wide through our new partnership arrangements.

In the final chapter I discuss the scale of health protection work to protect residents from the impacts of COVID-19. The UK COVID-19 Inquiry has been set up to examine the UKs response, impact experienced and to learn lessons for the future. The Inquiry's work is guided by its Terms of Reference and in response to the Inquiry, I reflect on how we successfully managed through the first three waves of the pandemic, learn to adapt our ways of working, live with restrictions, and prepare for its ongoing management.

As we approach the challenge of winter, we know that vaccine hesitancy remains a significant issue. For flu, the personal risk perception is likely to have reduced following limited case numbers in recent seasons. For COVID-19, learning to live with the 'new normal' may also lead to lower interest. Together with the UK Health Security Agency we will be putting significant efforts into promoting the importance of vaccination, mainly amongst groups with the lowest uptake, greatest vulnerability, and lowest vaccine confidence. National and local advertising campaigns will begin shortly, and there will be regular briefings available on the epidemiology of both viruses and vaccine uptake data.

I hope you find the 2021/22 Report of the Director of Public Health for Barking and Dagenham of interest and value. Comments and feedback are welcome and should be emailed to **matthew.cole@lbbd.gov.uk**.

Matthew Cole
Director of Public Health
London Borough of Barking and Dagenham

Contents

Introduction

Last year's Report was written in the middle of the pandemic and its clear the indirect impacts of COVID-19 will have a greater and lasting impact on health and wellbeing across our communities, and our own commitment of *"one borough; on community; no-one left behind"*.

I highlighted how our residents were more impacted and at greater risks of COVID-19 infection due to the poor health many of our residents' face, the same is true of the current threats to our health and wellbeing. In this report I look at what those threats are, what we are doing and how by working on evidence-based, collaborative action we can reduce the risks and improve the health of our residents.

Getting Back to Business

This annual report signals a start of a new period when we get 'back to business' with addressing inequalities and putting equity at the heart of all we do.

The Health Foundation and Institute of Health Equity published Building Back Fairer as an evidence-based approach to putting health equity at the centre of post-pandemic recovery. It suggested that long standing issues of poor health and widening health inequalities were a basic reason for the UK doing worse than other countries during COVID-19, in respect to infections, deaths and economic damage. We need to place the following 'Marmot Principles' (see figure 1) and associated indicators at the heart of what we do, including our new Joint Health and Wellbeing Strategy in 2023.

Figure 1: 'Marmot Principles' for a fairer, healthy society

Common Language and Focus

Over the last year major work has been undertaken to develop the emerging Integrated Care Systems and the elements that sit within the borough (e.g. the Place Based Partnership). A key learning from the process has been- even with the same aim there is a lack of common language, focus or approach across the health sector.

Key terms that are used regularly are used to mean different things. So, it is important we are clear on key concepts that provide the basis of our work (figure 2 describes some of these pictorially):

- **Deprivation** – Lack of the usual resources often considered necessary for life (e.g. unemployment, poor housing, social isolation, etc.)
- **Poverty** – Lack of the usual financial resources often considered necessary for life
- **Health inequalities** - Avoidable and unfair differences in the health and wellbeing of groups and individuals which are avoidable and can be reduced

- **Health equity** – Everyone has a fair opportunity to be as healthy as possible
- **Proportionate universalism** – Using resources to benefit everyone (universal) and giving them relative to need (i.e. those with the greatest need get the most access)
- **Social justice** – Removal of the barriers that create inequalities ('liberation')

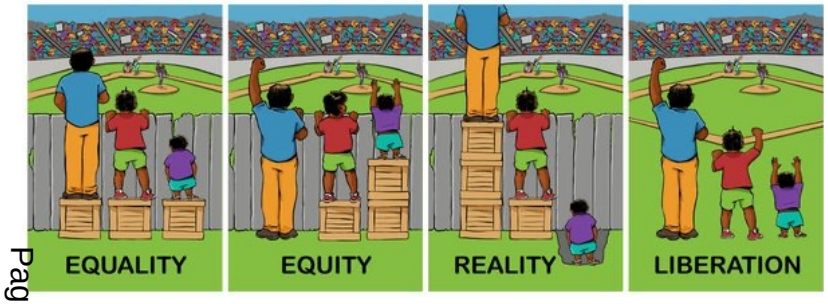


Figure 2: Equality, Equity, Reality and Liberation

Current Context: COVID Recovery and the Cost of Living Crisis

COVID-19 Legacy on Health and Service Demand

The 'direct' impacts of COVID-19 on health and health services have reduced, but not disappeared and indirect impacts have worsened. The Health Foundation's 'year on' study shows that death for COVID and 'long COVID' ill health continues, with deaths 3 to 4 times higher in the most deprived areas. Indirect impacts include mental health and well-being, which is well below pre-COVID levels and includes lower levels of resilience. The report also suggests three wider key risks to health and wellbeing and health inequalities: lost learning and educational attainment; economic inactivity; and family finances and income.

Services have also seen extraordinary (and unmanageable) increases in demand. Waiting lists for NHS services have reached previously unseen levels, but these increases are much higher in deprived areas (55% compared to 36%) due to greater demand and unequitable offer of services. Local authority delivered social care services also face unrealistic demand. It is estimated that an almost 300,000 waiting list for an assessment of care needs would hit 400,000 by November 2022 - double the 2021 total. Action is required across the systems to manage this increasing need.

However, as we work on recovery from the consequences of the COVID pandemic we also now face a cost of living crisis which could have equally devastating consequences on the health of our community. Because of the rise in cost of living, nationally over half (55%) of people feel their health has been negatively impacted. People are unable to make healthy choices and even before the pandemic the poorest fifth of UK households would need to spend 40% of their disposable income to meet healthy eating guidelines.

This current crisis adds to the recognised scale and challenge of long-standing economic deprivation, identified in a bold and necessary ambition following the independent Growth Commission of *"one borough; one community; no-one left behind"*. However, the commission also recognised the opportunity that record population growth offered.

Impacts of the Cost of Living Crisis

Even before the crisis, after adjusting for inflation, average weekly pay in London was 5.9% below 2010 levels in 2019, with lower paid sectors seeing a greater gap (e.g. hospitality, retail and construction). Average rents are rising faster in London than other regions, with new tenancies 15.7% more expensive in May 2022 than May 2021. The National Institute for Economic and Social Research (2022) estimated 1 in 200 (6.5%) of London households could face food and energy bills greater than their disposable income in 2022-23.

These numbers would be much greater across our community where poverty and deprivation are high. Barking and Dagenham (B&D) was the fifth most deprived area in England in 2019, up from the 20th in 2004 and community concerns raised include:

- Being unable to pay for medicines and care (e.g. 'prescription poverty', dental poverty)
- Poverty and deprivation (e.g. 'eat or heat' decisions, increasing debt)
- Mental health and wellbeing of children and young people
- Social isolation
- Unhealthy weight and obesity
- Generational unemployment

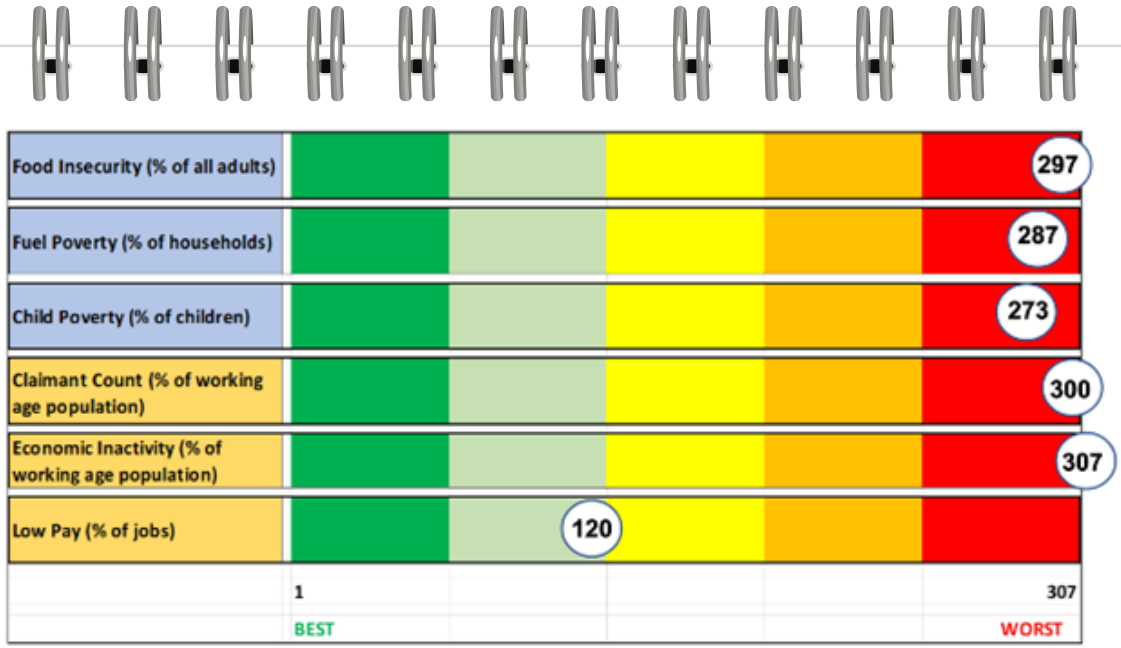


Figure 3: Vulnerability of B&D residents to cost of living crisis compared to 307 other English local authorities

Looking at data can be misleading as it appears we have similar or even less of a challenge than other boroughs (e.g., new tenancy rental cost increases was the second lowest in London at 3.3% versus the 15.7% average). But that is not the case, data provided by the Councils Insight Hub indicates that our residents have fewer financial resources to provide resilience and are more vulnerable to these changes. Figure 3 shows a greater exposure amongst our residents to risk factors that make them more vulnerable to the crisis.

Further data from our Insight Hub also highlighted areas of particular concern, such as:

Food insecurity

Over half of our residents (53.7%) live in the 20% most deprived areas in the country and a healthy diet is likely to become unaffordable. An unhealthy diet is one of the leading causes of disease in England, including an unhealthy weight, heart disease and some cancers.

Fuel poverty

Pre-crisis almost 1 in 4 (22.5%) of our households lived in fuel poverty compared to 13.5% nationally and 15.2% across London. Cold homes are associated with increased respiratory and CVD, minor ailments such as flu and poor mental health.

Debt

Higher levels of existing debt and lower levels of economic assets means our residents are at greater risk of debt and associated poor health (e.g. poor mental wellbeing, poor social wellbeing, developing unhealthy behaviours and health-harming changes in the wider factors e.g. housing).

Lessening the Health Impacts

Although as much as possible should be done to reduce the impacts of current living costs, negative impacts on health are unavoidable. So, it is important that we lessen those impacts.

Prof' Sir Michael Marmot's Institute of Health Equity undertook an evidence review of The impact of the economic downturn and policy changes on health inequalities in London before the previous recession in 2008. Its recommendations included action to assess and respond to an area's need by:

- Ensure sufficient and affordable housing, including reducing fuel poverty
- Ensure an adequate supply of good jobs, including stimulating employment and encouraging 'good' work
- Local measurement, monitoring and cross-sector working
- Ensure sufficient incomes, including financial incentives to work and good quality, affordable childcare
- Sufficient provision of services to cope with likely issues, including advice and information services; mental health services; schools places; GP services, inter-borough safeguarding and coordinated provision of services for rough sleepers and the homeless

Chapter 1: 'Population Health' and the Population's Health

My Annual Report 2015/16 focussed on the needs of the whole population (population health) and integrated care that predicts and addresses preventable needs (population health management). With the Integrated Care System (ICS) now in place, it is timely to review how this approach works locally.

Taking a population health approach means moving from a focus on illness to one that promotes wellbeing, prevention of ill-health and reduction of health inequalities across a whole population (rather than just focusing on individuals). The King's Fund identifies four pillars of population health, (see figure 4) which need to be considered when developing any programme to improve health and reduce health inequalities at locality level and wider.

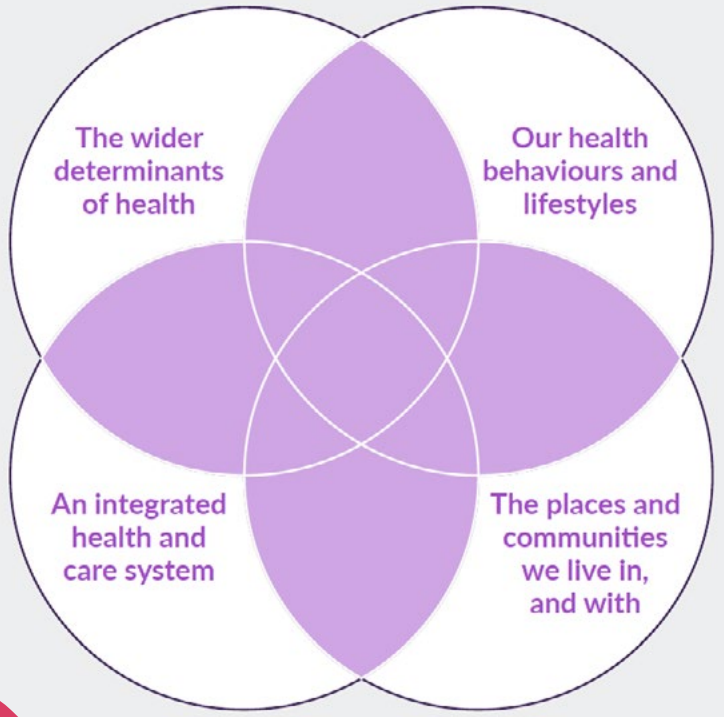


Figure 4: Pillars of Population Health

Predicting and Addressing Preventable Needs

The lived reality for residents is that at each stage of life they experience inequalities in health and wellbeing compared to people living in other parts of London and England. These disadvantages add up across a lifetime leading to early avoidable ill health that impacts our life opportunities and overall outcomes such as healthy life expectancy.

Therefore, to address these inequalities and with a population growing as quickly as that of ours, predicting and addressing preventable needs is critical. For health and wellbeing, it is possible to find trends in the causes of/risks to ill health, which can predict and allow you to prevent later impacts. It is important to consider not just levels of disease, but how health (good and bad) impacts wellbeing and how we live our lives.

Nationally, health and wellbeing has been on the decline and health inequalities on the increase for over a decade. Healthy life expectancy describes the number of years a baby born can expect to live in self-assessed good health. In B&D healthy life expectancy is just 58.1 and 60.1 years of age for males and females. These are the lowest and third lowest respectively in London, and below England averages. Across the borough 49,357 years are 'lost' annually through ill health, disability, or early death (termed Disability Adjusted Life Years).

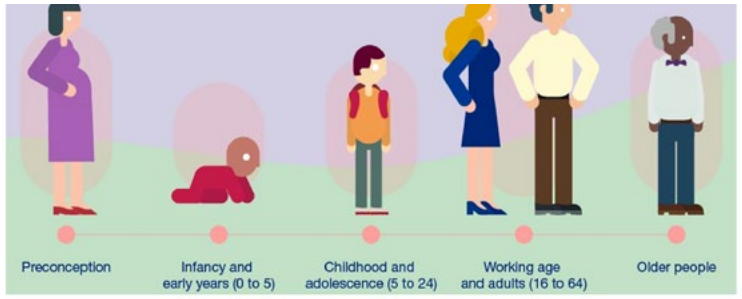
Analysing what causes this low healthy life expectancy highlights how we have the highest rates of some cardiovascular disease (CVD) (heart disease and stroke); respiratory conditions (chronic obstructive pulmonary disease (COPD)) and cancer (lung) in London (see table 1).

Table 1: Ranking of 'top 10' health conditions in Barking and Dagenham in London and England (2019)

Cause			
	Rate	***London rank (out of 32)***	***England. Rank (out of 150)***
Ischemic heart disease	1,343	*1*	*34*
Low back pain	1,093	*5*	*124*
Chronic obstructive pulmonary disease	902	*1*	*15*
Lung cancer	878	1	18
Depressive disorders	725	13	18
Headache disorders	705	13	17
Diabetes mellitus	676	18	65
Stroke	543	1	80
Falls	519	7	67
Neonatal disorders	507	13	58

Many of these diseases are preventable. An 'unmet needs' analysis has been started to estimate the number of undiagnosed people with these common conditions (CVD; COPD; diabetes and dementia) that could be receiving treatment, before the condition develops into more serious disease. This can be used to help focus work to find cases and provide support to manage conditions.

Figure 5 below, provides further data on key facts which impact on health and result in health inequalities.



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

Figure 5: Health inequalities for our residents across the life course

Delivering with Communities and Maximising Community Assets

As part of the North East London (NEL) ICS, a Place-based Partnership (PbP) has been set up which will allow a place-based approach to delivering services and programmes which puts people and communities in the centre of decision making rather than services being 'done to' people, which supports the locality service model already in development in the borough. However, this approach requires a change in culture as well as practice, with collaboration between people; communities; services and commissioners at its heart.

Considering the 'needs' of individuals and communities helps inform how we shape support, services and investment. But whilst considering health care needs, it is important to recognise that, the majority of health – around 80% - is defined by wider issues (e.g. socioeconomics, environment and health behaviours). A Population Health Management approach can help us achieve this.

Our residents and communities are an 'asset' and putting trust and control in the hands of communities is critical for improving and sustaining good health, wellbeing and reducing inequalities. A 'glass half full' underpinned the response to COVID-19 and is being built on by developing changes such as community locality leads and neighbourhood networks. Figure 6 uses the image of a glass to show how the borough is full of assets as well as challenges / needs (i.e. half full and half empty) and we have put in place interventions using these assets to address the needs.

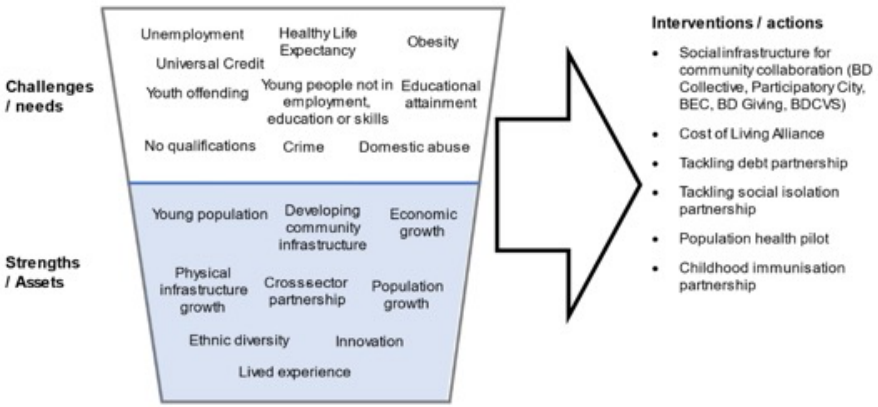


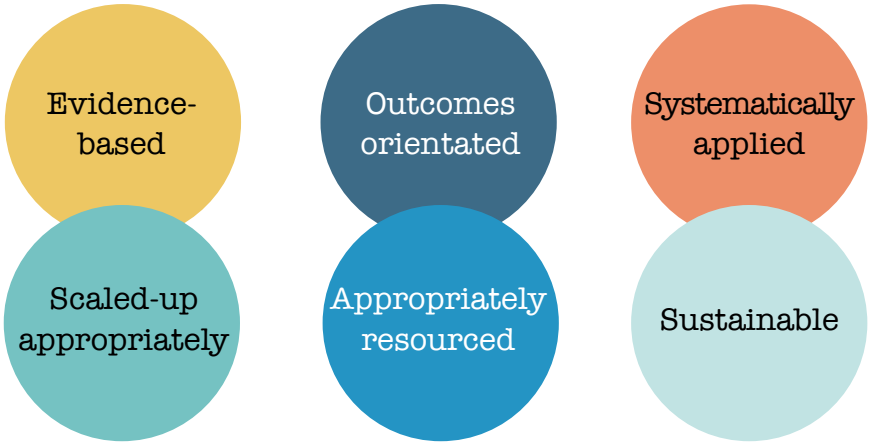
Figure 6: Using community assets to develop solutions to B&D challenges ('glass half full')

Delivering health improvement through place based/locality working

A place-based approach delivered through locality working can achieve population-scale change if the following three types of interventions (i.e. the Population Intervention Triangle) are considered:

- Civic-level interventions
  (e.g. licensing, economic development)
- Community-based interventions
  (e.g. using and building assets within communities)
- Services-based interventions
  (e.g. quality and scale, reducing variation)

The Population Outcomes through Services (POTS) Framework (see figure 7) is an evidence-based model through which the new PbP/ locality leadership can make a real difference to address health inequalities. Interventions delivered within this model, to be effective should consider the following six principles:



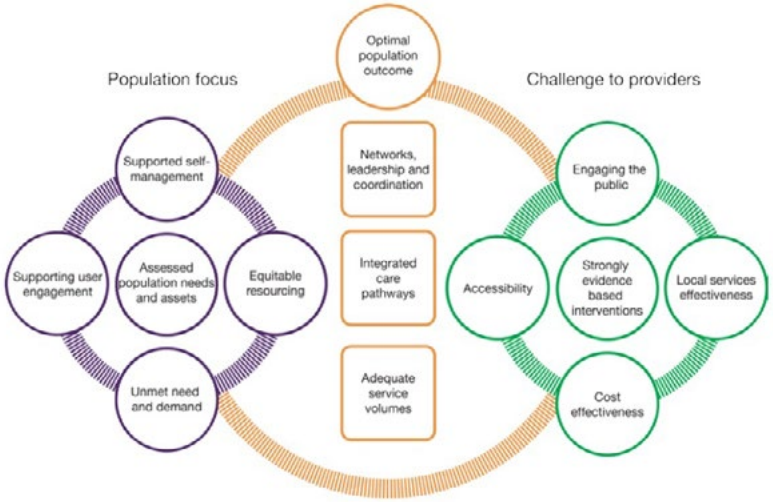


Figure7: The Population Outcomes Through Services (POTS) framework

Case Study: Targeted Debt Support and Prevention for Vulnerable Residents Pilot

A review of our Support and Collections services showed the Council was too quick to begin legal proceedings when residents fell in to rent arrears. Therefore, a preventative approach was tried to support people in debt. The aim was to encourage people (who could) to set up a payment plan, support residents that couldn't pay, avoid costly recovery processes, and improve engagement with residents. A group of residents with multiple debts, and more than one vulnerability were identified and sent them personalised texts offering support. The Homes and Money Hub then called and worked with them.

By measuring outcomes of this group against a control (5 interventions as business as usual) we achieved:

- 26% engagement
- Delivered 127 support interventions e.g., setting up payment plans, awarding Discretionary housing payment and other benefits support
- Improved collections status
- Lower rates of legal and bailiff action
- Improved recording of wider issues e.g., mental health and domestic violence (11% improvement vs control)

This pilot approach showed better outcomes for residents as well as improving revenue for the Council and is now being built into business as usual.

Case Study: Frailty Transformation Board

Compared to pre-pandemic times, referrals into falls treatment teams in the over 65 years of age, have seen a percentage increase of 80%. For this reason, 2021/22 the Frailty Transformation Board invested £1.2M, in the delivery of the fall's strategy across the next two years so residents could access evidenced based falls prevention education, strength and balance activities related with preventing musculoskeletal conditions, improving bone health and overall psychological wellbeing.

The Barking, Havering and Redbridge falls prevention working group reported successful delivery against the falls recovery action plan and services managed to *'turn around'* the referral to treatment time that was nearly 18 weeks in December 2021. Now, the average wait to be seen by the Falls Community Team, is between 0-4 weeks, alongside reductions in A&E attendances and admissions. Also, 95% of residents attending strength and balance exercise, reported an improvement in their balance and self-confidence with 15% reporting a recurrent fall.

In August 2022, residents fed back their views and experiences and highlighted:

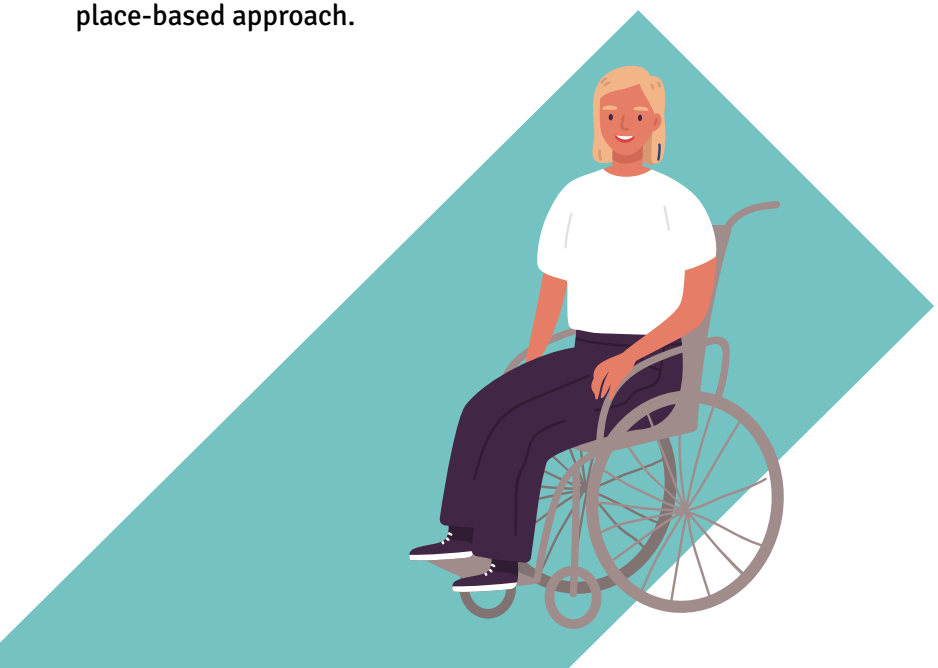
- The most important aspects of care (1) maintaining independence (2) feeling respected (3) advice and guidance whilst waiting for a referral
- Communal strength and balance exercise were a necessity, as it combined physical activity with a shared experience
- A need for improved access to medication reviews, a contributing factor for falls
- Consent for GPs to share care records, encouraging pro-active prevention (case finding) and reducing the need to repeat stories

This feedback will form part of the continuous improvement cycle of the falls pathway under the prevention strategy.

Table 2: Moving From Traditional To Place-based Health

Current system	Place-based health
Closed	Open
Separate service silos	Whole system approach
Vertical top down model	Horizontal model across places
Institution led	Person centred
Largely reactive	Largely preventative
Focussed on treating ill health	Focussed on promoting wellbeing
Health in a clinical setting	Wider determinants of health in communities
Services 'done to' citizens	Balance of rights and responsibilities

There are already some examples (these two case studies) of taking a place-based approach.



Conclusions

Table 2 describes the differences between a traditional approach and a place based approach which help us to understand the principles we need to build into this way of working. Development of the PbP as part of the NEL ICS will accelerate the place-based approach introduced through the locality model way of working, to improve the population's health and deliver a population health management programme i.e., to deliver primary and secondary preventative approaches (preventing the development of ill health and early identification and treatment of a condition to prevent or delay its progression).

Considerations for the Future

How can the ICS and specifically the PbP, through the localities support coordination and collaboration for all four pillars of population health and lead the coordination of the Population Outcomes through Services (POTS) Framework for the area.

How can we take a systematic approach to early identification and treatment for health conditions causing the greatest problem to individuals, communities and the care system?

How can we create shared understanding based on data and evidence of need to develop community, civic and services-based interventions?

Chapter 2:
A New Approach for Improving The Health and Wellbeing of Children and Young People

As described in our JSNA, we have a rapidly growing, young and diverse population as well as having the highest birth rate and rates of child poverty in London. The 2010 Marmot Review explained how social determinants of health play a huge role in a child's overall health and wellbeing and can influence health outcomes and inequalities experienced.

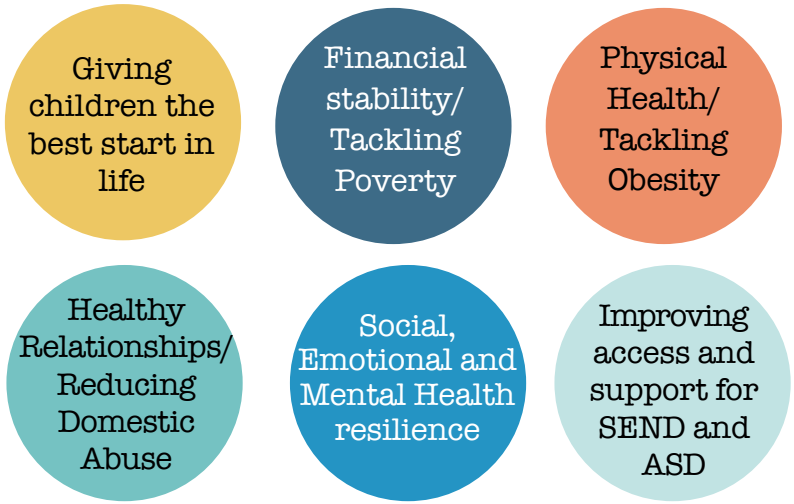
This provides an opportunity to 'get it right' from the earliest time in a child's life, making sure that they are school ready; supported to achieve; find fairly paid, good quality employment and have better financial stability in their adulthood. Developing healthy foundations also reduces the risk of long-term health conditions (like diabetes and heart disease), mental ill health and poor physical health leading to early frailty – all of which can impact their ability to work and remain financially resilient.

Babies, Children and Young People's Plan

A borough Babies, Children and Young People's (BCYP) strategic plan is due to be published in Autumn 2022. This plan will use a multi-agency collaborative partnership approach to address the issues and concerns currently faced by our BCYP.

The plan's vision is ***"Working together to give the best chance in life to babies, children, young people and their families..."***, achieved by focusing on 5 key ambitions:

Within this, 6 priority areas for action have been identified, which are:



The action plan will take these ambitions and priority areas, define clear and measurable outcomes and, as a system, develop and commit to clear actions which are underpinned by the latest data, evidence and best practice and will be delivered within the context of the new Place-based Partnership (PbP) governance structure.

Delivering the BCYP Plan – the Role of the Start for Life programme, Family Hubs and Family Hub Networks

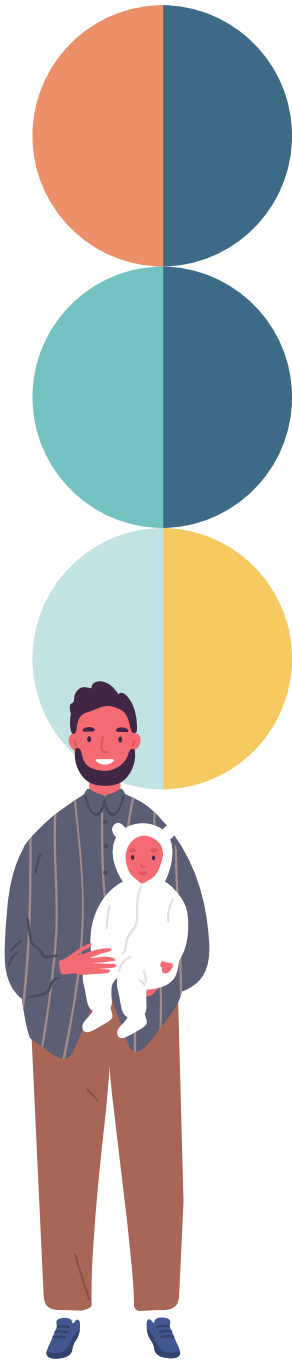
To achieve the 'Best Start for Life' Marmot objectives and deliver the outcomes in the BCYP Plan, the Council and partners will be implementing the national 'Start for Life' programme, building on delivery of the Healthy Child Programme and setting up three locality-based Family Hubs as the focus for integrated working across the system and Family Hub networks in the borough.

SEND: Special educational needs and disabilities **ASD:** Autism spectrum disorder

There is a strong evidence base for Family Hubs presented by the Family Hubs Network and the National Centre for Family Hubs and the Start for Life funding has specified that the offer must include support for parenting, parent- infant relationships, perinatal mental health, infant / breast feeding, and home learning environment. This will be a new way of working for our local BCYP services, so it is important the new model is developed in line with evidence base, best practice, and local need.

For midwifery, health visiting and school nursing, best practice includes a focus on the high impact areas for different life stages – maternity, early years and school-aged years. These include breast feeding; mental health; healthy weight; parenting support; child development; emotional resilience and reducing inequalities. These areas line up with the aspirations and outcomes in the BCYP plan, so the system should ensure that delivery aims to follow best practice set out in the high impact area guidance.

Family Hubs aim to be more accessible, better connected and relationship centred. They will be a central access point to services and support within a locality, connected to all other delivery sites in the area. Therefore to ensure that services match the needs of families who need them most, and are accessible for them, a needs assessment is needed to ensure they offer the right services and are situated in areas of greatest need within a locality (for example high birth rates and under 5s populations), a needs assessment would help to determine where hubs would be best situated and whether there are additional needs in certain areas which need provision for.



Opportunities and Ways of Working

The new Start for Life offer, and Family Hubs model gives an opportunity for innovation, a chance to change the way we work and who we work with, to meet the needs of families. The Family

Hubs model gives more opportunity to work with the community and voluntary sector to outreach into communities and engage families who are not currently being reached.

Therefore, it is essential to use all opportunities to engage with families and connect them with support, using a 'one front door' and 'making every contact count' model. Therefore, services don't all have to be delivered in the Family Hubs, significant outreach from hubs to engage families will also be important. This should include spokes in other areas within the locality (such as community hubs, GP surgeries and VCS premises) to connect with families in places they access and feel comfortable in. Working with the community, faith and voluntary sector to shape pathways and develop services using a co-production approach is essential to reach communities, allow for local innovation, and for sustainability. For example, linking with the Council's Community Hubs programme.

Family Hubs are an opportunity for NHS, local authority and community and voluntary organisations to work together in an integrated and collaborative way and wrap around families to ensure that important opportunities- such as vaccinations, are not missed and to reduce disconnect between services and make strong links between maternity; primary care; 0-19; Early Help; community and voluntary; homes; money advice and any other services used. It is also an opportunity to shift from a crisis intervention system into one of early intervention, to prevent the escalation of need into costly statutory services.

Ensuring Success

To successfully implement Start for Life and the Family Hubs model, strong strategic leadership at both an organisational and 'place' level is vital to allow a new integrated model to be developed and delivered to make a sustainable change to the way we provide services and improve outcomes. This level of transformation also requires robust governance arrangements to support a whole system change and monitor progress against the outcomes in the BCYP plan and the 6 action areas highlighted in the Vision for the 1001 Critical days report (including an empowered workforce, continual improvement, and leadership for change).

Clear strategic vision and system wide strategic collaboration will secure join-up with other large programmes, such as Community Hubs, to prevent duplication, maximise our limited resources, and ensure that families are clear on what is being offered.

To help this joined-up working, there is a need for better data sharing across the system – both in terms of sharing information on individuals, and sharing large scale data for service planning, evaluation and quality improvement. This will improve spotting of risks/ vulnerabilities; ensure all agencies have necessary information to support families; allow for better planning and targeting of services; facilitate stronger collaboration and allow the tracking of progress towards shared outcomes.

Links to Universal Services, including the 0-19 Healthy Child Programme

Maternity services have a unique connection with parents, so it is essential they give out the right information, assess risk, and work with other services to meet family needs. Perinatal mental health and infant feeding are key focus areas of Family Hubs, and these are both areas where maternity services can have huge impact on outcomes if the right immediate support and referral pathways are in place. We have 2 main maternity sites and providers – Queen's Hospital (BHRUT) and Barking Birthing Centre (Barts) which presents an additional challenge with joining up with other services. Family Hubs may be able to help with this challenge and strengthen join-up between maternity services and other partners such as primary care, the voluntary sector and health visiting.

A 6-8 week check for all babies and mothers in the borough performed by GPs in primary care. This includes checks for both mother and baby around feeding, mental health, healing and general health and discussion on future vaccinations. There is huge opportunity here to identify issues, provide correct advice, reassurance and/or connection to appropriate services – so it is important that the workforce is given appropriate information and training to allow them to keep up to date with guidance, useful information and services available. Having primary care linked into Family Hubs allows for them to work in an integrated way with other universal and targeted services to ensure families can access help when they need it.

SPOTLIGHT ON CHILDHOOD VACCINATIONS:

Nationally, there has been a steady decline in childhood immunisation rates over the last decade, and now there is significant risk to children from vaccine-preventable diseases such as polio, measles and meningitis. B&D shares this downward trend, currently having over 20% of 2 year olds with no MMR vaccination, but has a strong desire to reverse it. Planning is underway for primary care outreach to improve uptake of childhood immunisations and address the inequalities that this may bring for unvaccinated children.

Intended outcome:
Increased childhood vaccination coverage

The 0-19 Healthy Child Programme, funded by the public health grant and delivered by NELFT, will form a core part of the Family Hubs and Family Hub Networks offer. This includes the health visiting and school nursing services, and the National Child Measurement Programme (NCMP). Included in this provision are antenatal contacts; new birth visits; 6-week, 1 year and 2.5 year checks; infant feeding advice and support; public health support for schools and safeguarding activities. This provision is universal (for all families) with extra targeted and specialist support for those families with additional needs. Changing this service to meet the needs of our children and families by delivering the Family Hubs model, the Start for Life agenda, and the requirements of the Healthy Child Programme is a priority for the coming year.

How will we know if Family Hubs have been successful?

The following measures would be a good way of measuring the impact of Start for Life and Family Hubs on the outcomes for local families:

1. Increased rates of breastfeeding (initiation and continuation)
2. Families being more aware of how to access medical care – evidenced by a reduction in children's A&E attendance rates
3. Improved rates of childhood immunisations
4. Improved uptake of the 1 year and 2-2.5 year checks – especially in groups which do not currently attend them (and groups with worse school readiness)
5. All children achieving developmental milestones (Physical, emotional and social) and a Good Level of Development at the 2-year check
6. Families with children with SEND happy that special educational needs are being met, and school/ early years settings are providing adequate support
7. A reduction in exposure to Adverse Childhood Experiences (particularly domestic abuse, parental conflict, and parental mental health conditions)
8. Reduced rates of childhood overweight and obesity, and increased rates of physical activity
9. Early identification of risk and issues, with more families receiving 'Early Help' rather than social care interventions
10. A reduction in inequalities within all the above outcomes (by improving outcomes of those who are below average)
11. Improved mental health in children and young people (measured by WEMWBS[1] score)
12. Reduced incidents of school exclusions and serious youth violence

1. Warwick-Edinburgh Mental Wellbeing Scales (measuring mental wellbeing in the general population)

Future Considerations

The CYPs population has increased, but investment and capacity has largely remained the same. Further increases in need will continue, so we have an opportunity to carry out the JSNAs recommendation of 'reviewing universal service capacity to ensure that it is suitable to the pace and scale of change in the CYP population in recent years'. This would allow a better understanding of the current and predicted need; the best model to meet this, give improvements in outcomes and understand the costs. It is possible more funds will be needed for any future model, so in the spirit of a levelling up agenda, it is important to look at ICS funding to ensure our borough receives a share appropriate to the need and challenges faced.

We know that we have a high need population, but we don't have an in-depth understanding of how this need affects service priorities or restrictions. There is a need for an in-depth review of our 0-5 (health visiting) and 5-19 (school nursing) services, working with commissioners, providers, local organisations, schools, and families to determine what is being done well; where there are gaps, shortfalls and pressures; what can be done to improve outcomes; how the service can adapt to provide this and what additional investment or input might be needed.

Current 0-19 services are not providing the level of improvement in outcomes which our babies, children and young people need. Informally, reasons that the service is stretched include funding challenges, national staff shortages, an increasing population including more families with high and complex needs (including higher than average needs for additional support and high safeguarding caseloads), and a shortage in specialist school nursing provision for pupils with SEND meaning that mainstream public health school nurses are having to cover this workload. It is likely that both additional investment, service change and innovation is needed to adjust the outcomes that we are getting from our 0-19 services.

In the short term, there is also a need for the system to invest in additional specialist school nursing provision for the additionally resourced provision to allow the public health school nurses in the 0-19 programme to fulfil their role as public health leaders within the mainstream schools system. They need to have dedicated public health school nursing capacity to help them to understand their data; determine what might work for them; plan and implement health and wellbeing policies and activities and facilitate partnerships with the wider support offer, especially provision from the community, faith and voluntary sector (e.g. SW!TCH Futures Advocate Mentor programme). This will provide the support outline in the Healthy Child Programme to assist our schools to help keep their pupils safe, resilient, healthy, and provide additional support where necessary.

Conclusions

To give the best start in life, the following key areas should be focused upon in the implementation of Start for Life and Family Hubs:

Strong Strategic Leadership and Governance –both at organisational and place to join up agendas, models, programmes and services.

Joined-up and Outcomes-Based Commissioning and Provision – the need for shared outcomes (provided by the BCYP plan), system commitment to delivery and continuous monitoring of progress against outcomes with commissioners working together.

A Stronger Focus on Inequalities of Provision and Outcomes – we need to improve and close the gaps between outcomes. We need to better understand our population's needs, how they utilise services and what outcomes they get.

Better Joining Between Organisations, Programmes and a Whole Family Approach to Delivery – all organisations involved in delivery need to be engaged, working collaboratively and supported to flex their services to meet need. The family should be at the heart with focus on supporting the whole family to maximise health and wellbeing.

Improved Data Sharing – The system and all stakeholders need to facilitate this to plan, evaluate and quality improve services.

Key Questions:

How can we achieve the aspirations in the BCYP plan? What do we need to do to get there? And how can we work together as a system to do this?

Based upon the data for outcomes in our population, which additional areas should our Family Hubs focus on?

What can the Council and system do to help CYP recover from the impacts of COVID-19? (e.g. poor mental wellbeing; time away from schools; increased obesity and lack of access to services for 2 years).

How will our key BCYP and families' services (including the 0-19 Healthy Child Programme) change their arrangements to deliver the BCYP plan ambitions through a joined up Start for Life offer and Family Hubs model?

Chapter 3:
'Equity' in services that improve health – providing healthy lifestyle services to those who need them most

Introduction

'Health inequalities' are avoidable differences in the health and wellbeing of groups and individuals caused by opportunities (or lack of) to lead a healthy life and were a focus of last years report. One of the key questions was *'How can we ensure that our resources, time, people and assets are targeted and balanced to the needs of our community'*. In the last year we have explored this question across key Council health improvement services that address key causes of health inequalities:

- **Weight Management Services –** Children living in low-income areas are more than twice as likely to live with obesity than those living in the highest income areas, and 80% of children with obesity in childhood will live with it in adulthood, without help. Weight management services help individuals and families understand and change behaviours that cause unhealthy weight.
- **Stop Smoking Services** – People in routine/manual jobs are 2.5 times more likely to smoke than those in managerial jobs and those with a lower income are 20% less likely to plan to quit. Using a stop smoking service makes it three times more likely a quit will be successful.
- **The NHS Health Check** – People living in low income areas of England are almost four times more likely to die from CVD than those in high income areas. Everyone aged between 40 and 75 years of age is invited every five years to an 'NHS Health Check' to spot early signs of stroke, kidney disease, heart disease, type 2 diabetes and dementia and provide support to lower risks.

These services are particularly important for both reducing health inequalities and improving health across the population as we are more impacted from the issues they address.

- **Unhealthy weight** – In 2019/20, 26.5% reception aged children, 46.3% of year 6 aged children and 44.7% of children aged 10-11 were above a healthy weight.
- In 2020/21, it was estimated that 64.5% of adult residents (aged 18+) live with overweight or obesity, which is the 3rd highest percentage when compared to all London boroughs.
- **Smoking** – Almost 1 in 5 (18.1%) of our adults smoke, contributing to our higher levels of diseases such as COPD; cancers; earlier death and the worst outcomes in hospital admissions linked to smoking compared to other London boroughs.

Most people start smoking and become addicted to nicotine when they are still young. Children whose parents or siblings smoke are around four times more likely to smoke than those in non-smoking households.

- The Smoking status at time of delivery provides information on the number of women smoking at time of delivery (childbirth). In 2020/21, 7.6% of our pregnant women were smoking at the time of delivery - the highest in London but lower than the England average of 9.6%.
- Smoking has a huge economic impact in addition to the impact on smokers' health. An analysis of the impact of smoking on productivity estimates that smoking costs £77.84m a year, as seen in table 3.

Table 3: Estimated annual costs of smoking to B&D

Area		Cost
1. Smoking related loss of productivity		£65.27m
2. Healthcare costs due to smoking related illnesses	Hospital admissions	£2.76m
	Primary care	£3.69m
3. Social care costs due to smoking related illnesses	Residential care	£2.23m
	Domiciliary care	£2.47m
4. Cost of smoking related fires		£1.42m
Total		£77.84m

- **Cardiovascular Disease (CVD)** – We have the highest levels of early death from CVD and CVD deaths considered preventable in London.

We looked at who uses these services to understand if they met the needs of our community and those who would benefit from them most. In other words, were they 'equitable' by giving those who need the most support an equal chance of a healthy life. We did this for the three characteristics where inequalities are most seen: age, gender and ethnicity.

Within the smoking service, we found very low numbers of under 18s accessing support; a higher number of male smokers (22.8%) compared to females (10.1%), but more females accessed the service and successfully quit (63% in 20/21) and an over representation in White British service users (65%) compared to the groups estimated smoking numbers (23%). This group also overrepresented in outcomes, as 77% of users successfully quitting (20/21) were White British.

For weight management services, we found low numbers of referrals for children aged 12 and under; high numbers of referrals (69%) to weight management programmes for females (mostly aged 35-54) compared to males and higher percentage of White ethnicities (male and female) being referred onto programmes, even though higher numbers of Black males and females are above a healthy weight by comparison.

Equity at Scale in Services

Without a proactive focus on targeting greatest need, inequality - or inequity in services is unavoidable, this can be seen in funding, demand, and level of need. Nationally GP Practices in deprived areas see 10% more patients (as people in poor areas develop poor health earlier, with an 18 year gap in disability-free life expectancy), but receive around 7% less funding per need-adjusted patient than those in the most affluent areas.

However, providing services alone is not enough to reduce barriers for those in greatest need. Services need to consider and address barriers to access and should be informed by the target population. This is best done through community-centred approaches involving communities at all stages from identifying needs through to implementation and evaluation. The Population Outcomes Through Services (POTS) framework (Figure 7) illustrates this well. Three key factors: access, experience and outcomes (identified by NHS England's National Healthcare Inequalities Improvement Programme) also looks to ensure health equity in delivering services.

In understanding unhealthy behaviours and linked inequalities, it also is important to consider that we do not have equal risk of unhealthy behaviours. A Kings Fund analysis of four key unhealthy behaviours – smoking, excessive alcohol consumption, poor diet and low levels of physical activity – found 'clustering' of these behaviours. Those in deprivation are more likely to undertake unhealthy behaviours (often multiple) and have multiple needs.

And when supporting change to reduce risk, behaviour change science tells us that behaviour (and success of change) is determined by three things: capability; motivation and opportunity (see figure 8). Therefore, services should take a person focused perspective to identify which behaviour the individual is more open to change and provide the appropriate support.

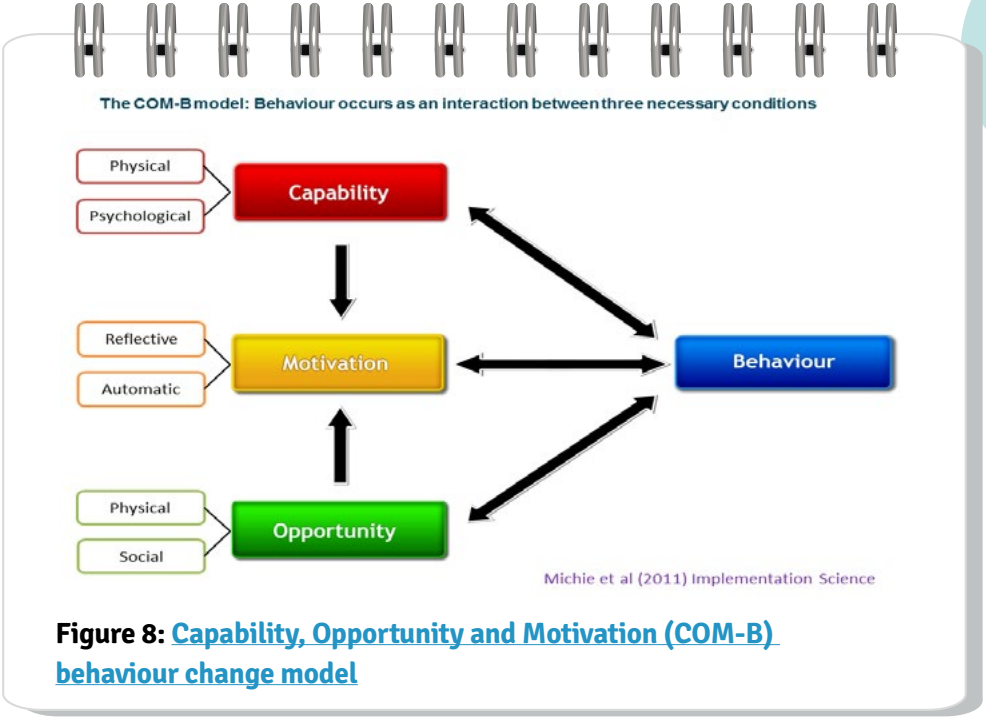


Figure 8: Capability, Opportunity and Motivation (COM-B) behaviour change model

Considerations for the Future

How do we ensure a person-centred approach that identifies the right time and service to support an individual to make a positive change to behaviour, working across services and community?

How can we 'hardwire' equity in access, experience and outcomes into delivery and monitoring to ensure services are working and resources are being used well?

A Look at Weight Management Services, Stop Smoking Services and Health Checks

Delivering Weight Management Services

Overweight and obesity does not affect all groups equally and can lead to physical and mental health issues across the life course into old age (see figures 9 and 10). Addressing this issue is complex and no single solution alone can support people to reach or maintain a healthy weight at population or individual level because of the multi-factorial causes and contributors.

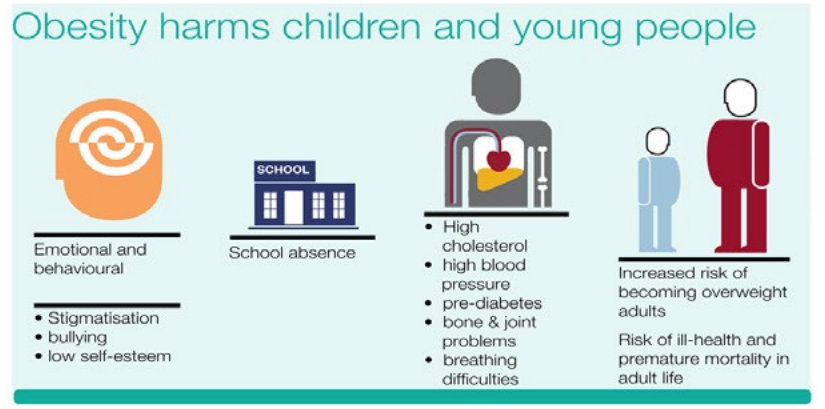


Figure 9: The ways in which obesity can harm children and young people

Figure 10: The ways in which obesity can harm adults

What are We Doing?

Below outlines our current children, young peoples and adult weight management offer. This is delivered by multiple partners and is funded by the Office for Health Improvement and Disparities (OHID).

Children Weight Management	
Service	**Delivery**
HENRY	HENRY training and support; HENRY programme to the family
Community Solution	Extended Brief Intervention (EBI)
Al Madina Redeemed Christian Church of God Creative Wellness Wonder	HENRY Healthy Families: Growing up Programme
Harmony House	HENRY Healthy Families: Right from the Start" programme
Thames View Community Project	Delivery of 6 activities (Boxfit, football, tennis, gardening, cooking, walking) targeting both physical health and nutrition to approximately 200 children aged 5-12 years

Adult Weight Management	
Service	**Delivery**
Momenta	Culturally appropriate cardiovascular disease (CVD) prevention project to 2 PCNs (North and New West) Training community voluntary Services to deliver culturally appropriate CVD prevention project in the community
Harmony House Al Madina	Culturally appropriate CVD prevention project in the community
MoreLife	Pre-pregnancy/post-natal support-exploring the approach
Community Solutions	Exercise on referral, Weight Management service

Role of Social Prescribing in Weight Management

Social prescribing is when health professionals (often in primary care) refer people to a range of local non-clinical interventions or services (for social, emotional, physical or practical needs), typically provided by voluntary and community sector organisations.

The NHS Five Year Forward View, the General Practice Forward View and the NHS Long Term Plan all highlight the value of social prescribing and for building effective networks with partners[5]. This work is being led by the primary care networks (PCNs) and Community Solutions, with the current GP framework contract providing funding for one social prescribing link worker per PCN.

Evidence suggests social prescribing can deliver meaningful benefits to wellbeing, health and reductions in use of health services. There is no current evidence of direct benefits around weight loss, but social prescribing can form a key part of a personalised, preventive support offer to people with long-term conditions. This could include increased levels of physical activity; greater engagement with health advice and increased self-esteem and confidence which will support efforts to make lasting health behaviour changes.

Conclusions

Obesity is one of the key health priorities which requires urgent attention.

Weight management services need to be provided in a way which are accessible and appropriate to the populations who need them most. The use of health technologies could be useful to explore as set out in recent NICE guidance as part of a suite of service offers.

Weight management services, whether online or face to face should highlight a complete approach to health and well-being instead of only losing weight. Programmes should focus on social relations; daily activities; habit change and positive success as part of a daily balanced life and ensure they are:

However, weight management services are only part of the system wide approach needed to address obesity. Leadership of this approach to achieve agreed outcomes, needs to surround a culture where staff understand the importance of talking to people about their weight and ensure consistent up to date knowledge of the local weight management offer and opportunities/services to help get people active, alongside addressing related environmental and social issues. Increasing access to safe open spaces for walking and cycling, allowing opportunities for physical activity and promote wellbeing are important contributions to a thorough obesity strategy.

Examples of related outcomes:

- **Proportion of the population meeting recommended '5-a-day' on a 'usual day'**
- **Percentage of adults (aged 18 and over) classified as overweight or obese**
- **Percentage of physically active adults**
- **Percentage pf physically inactive adults**

Public Health Outcomes Framework

Evidence based and fulfil guidance (e.g. NICE)

Delivered in an equitable way (access, experience, outcomes)

Part of an integrated approach (e.g. Across health behaviours, across services, etc.)

Coproduced with and meet the needs of our population

Appropriately monitored and adopt a quality improvement approach, where possible

Delivering Stop Smoking Services

Stopping smoking at any time has significant health benefits, even for people with a pre-existing smoking-related disease. Providing a combination of behaviour change and pharmacotherapy increases a smoker's likelihood of quitting three-fold, compared to no support (see figure 11).

The most effective way to quit smoking is the use of stop smoking aids with expert behavioural support from local stop smoking services, as shown below. These include prescription medication, nicotine replacement therapies and e-cigarettes. This package of support is 3 times as successful compared to quitting unaided or with over-the-counter nicotine replacement therapy.

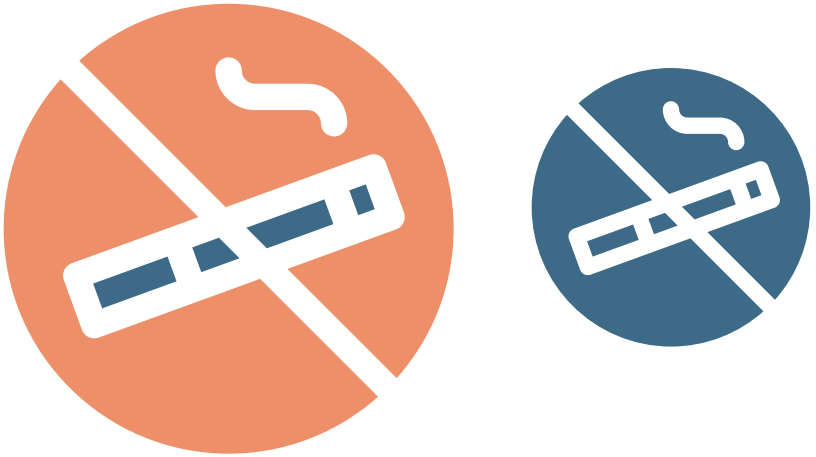


Figure 11: Stop smoking – what works?

What are We Doing?

Our specialist stop smoking service is provided by Community Solutions, the Council's integrated 'front door' to support. Unlike other stop smoking services, this is not a stand-alone service. As added value, it is completely integrated into Community Solutions, and service users are offered a wide range of support in addition to healthy lifestyle advice. Service users are connected with other Community Solutions and wider Council/voluntary sector services that may meet their needs such as housing advice, support with money and debt issues, access to a community food club and support with social isolation and loneliness using a Make Every Contact Count ("MECC"[5]) approach, reflecting the often complex needs of people who wish to quit. The service utilises existing and emerging Community and Family Hubs, with all staff trained to use carbon monoxide monitors and refer into the specialist service.

The stop smoking service is training many frontline staff within the Council and partner agencies, including the Trading Standards team, so they can offer Very Brief Advice and embed smoking cessation within their work. Trading Standards continue to carry out test purchases to identify and tackle under-age and illicit tobacco sales. In addition, all planning applications for shisha premises will be considered by Trading Standards and Environmental Health before approval and representations are submitted where structures or placement is considered undesirable.

Vaping and shisha use among young people are the biggest challenges currently. Our stop smoking service is working with partners across NEL to develop a shisha campaign particularly targeting young people. Additionally, the Trading Standards teams are working with local businesses to encourage tobacco retailers and shisha operators to sign up to a voluntary code of conduct and a series of regulatory compliance pledges. This includes safeguarding young people and supplying only electronic shisha, signposting customers to smoking cessation services and operating transparently and legally. As shisha use among young people is one of the biggest challenges, there is a need to work with schools to address all forms of tobacco use among children and young people.

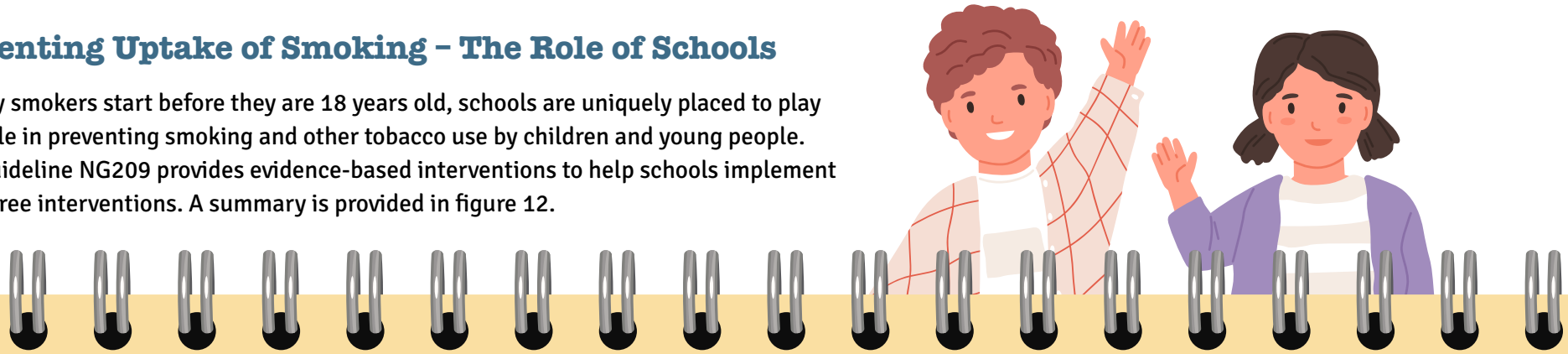
Tackling the Social, Structural and Policy Context in Relation to Smoking Cessation

Targeted individual intervention will have greater impact if it is done within a context of wider social and structural changes including:

All these measures have been applied in this country and played some part in the overall reduction of smoking prevalence, however, there is more work to do. For example, illicit tobacco is cheaper, which makes it more affordable especially for young people and in areas of deprivation. The current cost of living crisis may make illicit tobacco even more attractive, therefore enforcement agencies must be watchful.

Preventing Uptake of Smoking – The Role of Schools

As many smokers start before they are 18 years old, schools are uniquely placed to play a key role in preventing smoking and other tobacco use by children and young people. NICE guideline NG209 provides evidence-based interventions to help schools implement smoke free interventions. A summary is provided in figure 12.



1. **Ensure smoking prevention interventions in schools are:**
   - Part of a local tobacco control strategy
   - Consistent with regional and national tobacco control strategies
   - Integrated into the curriculum
2. **Develop a whole-school smokefree policy with young people and staff:**
   - Include smoking prevention activities (led by adults or young people)
   - Include staff training and development
   - Take account of cultural, special educational or physical needs
3. **Ensure the policy forms part of the wider strategy on wellbeing, relationships education, relationships and sex education (RSE), health education, drug education and behaviour**
4. **Apply the policy to everyone using the premises (grounds and buildings), always. Do not allow any areas in the grounds to be designated for smoking (apart from caretakers' homes, as specified by law).**
5. **Combine information about the health effects of tobacco use and the legal, economic, and social aspects of smoking, into the curriculum. E.g., create relevance when teaching subjects such as biology; chemistry; citizenship; geography; mathematics and media studies**
6. **Tobacco use should be discussed and challenged, aim to develop decision-making skills through active learning techniques. Include strategies for enhancing self-esteem and resisting the pressure to smoke from the media, family members, peers and the tobacco industry**
7. **As part of the curriculum discourage children, young people and young adults who do not smoke from experimenting with or regularly using e-cigarettes**
8. **Make it clear why those who do not smoke should avoid e-cigarettes to avoid accidentally making them desirable**
9. **Encourage parents and carers to become involved. E.g., let them know about classwork or ask them to help with homework assignments**

Figure 12: School-based interventions for preventing smoking and other tobacco use.

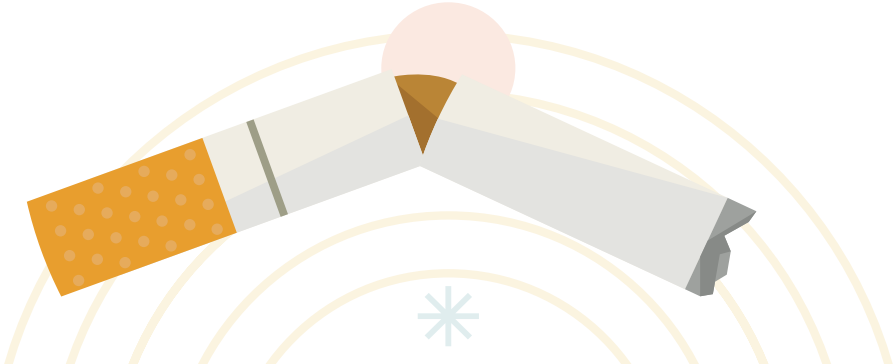
Conclusions

Smoking is the leading preventable cause of illness, early death and health inequalities. Schools have a vital role to play in preventing children and young people from smoking. The roll out of the NHS tobacco dependency service will help address some of the barriers to accessing stop smoking services when in hospital, as all inpatient smokers will be assessed and offered support to quit smoking. Therefore, NHS services need to work with local stop smoking services to complement each other and avoid duplication.

Given the ethnic composition of the borough, it is essential that the stop smoking service increases access to smokers from all communities including Black, Asian and Eastern European to help address existing inequalities that have been worsened by the COVID-19 pandemic.

Smoking at time of delivery is reducing. However, more needs to be done, as we continue to have the highest proportion of women smoking at time of delivery in London. This is particularly important, as smoking during pregnancy puts the unborn child at a disadvantage even before they are born. It increases the risk of still births, threatens the child's best start to life and supports health inequalities. The NHS tobacco dependency service will be addressing this as it continues to be rolled out across NHS Trusts.

Our goal should be to work towards the Government's ambition for England to be smokefree by 2030 - when smoking is no longer normalised in society. This has been defined as when smoking rates are 5% or less.



Considerations for the Future

- As we move forward, we need to think about the improvements we'd like to see locally, below highlights some key outcomes to work towards:

Short term	Medium term	Long term
Improve recording of ethnicity data to ensure more accurate data on smokers Increase number of smoking quitters year on year, in particular men, Black and Asian minority groups, eastern Europeans Reduce rates of smoking in: • pregnant women • routine and manual workers • people with severe mental illness Reduce vaping and shisha use in young people Continue low uptake of smoking in children and young people Minimise the proliferation of Shisha outlets and illegal tobacco sales	Reduce smoking attributable hospital admissions and mortality	Smoke free society by 2030 (5% or less people smoking)

- What more needs to be done working with communities, to make local smoking cessation services more accessible to males and the borough's diverse ethnic groups?
- How will smoking cessation services respond to the emerging NEL ICS and tobacco dependency treatment being rolled out in NHS Trusts as part of the NHS Long Term Plan?
- What role can the new Place-based Partnership play in delivering a system side approach to preventing uptake and helping people to stop smoking?

Delivering the NHS Health Check Programme

Figure 13: The NHS Health Check

Cardiovascular disease (CVD) is the leading cause of death globally and causes 38% of all non-communicable premature deaths. World Health Organization states 75% of all CVD deaths take place in low- and middle-income countries and communities, which is supported by research emphasising the strong correlation between levels of deprivation and CVD mortality.

The high CVD death rate is evidenced by our under 75 mortality rate from all cardiovascular diseases being the highest in the country, matched by the latest deprivation scores showing us as the third most deprived borough in London.

Wider Costs

CVD and its related diseases place great strain on the NHS and accounts for nearly £9 billion a year in healthcare costs across the UK. Between 2015 and 2018, by improving treatment and preventative action for atrial fibrillation and hypertension, the NHS was able to prevent 9,710 heart attacks and 14,500 strokes, saving £72.5 million and £201.7 million, respectively. Treating high risk atrial fibrillation patients prevented 14,200 strokes within the three years accounting for a total of £241.6 million saved.

NHS Health Check has provided a form of early diagnosis and intervention for those at risk and has saved over £3 million in costs that would have been spent on CVD related admissions within the borough (see figure 13).

What are We Doing?

The NHS Health Check service is available at GP surgeries across the borough and before the pandemic some community pharmacies were also delivering this. Though, the pharmacy offer was suspended during the pandemic and is currently in the process of being re-established.

In quarter 4 of 2021/22s financial year, a total of 1,321 health checks were offered locally making up 2.5% of the eligible population, similar to London (2.5%) and England (2%). Out of the 1,321 residents offered an NHS Health Check in that quarter, 972 (73.6% of invites) took up the offer which was higher than the London average of 48.2% England average of 40.7%.

Once a resident has had their Health Check, there are several supportive health and lifestyle services that residents can use/ join if required, such as:

NewMe healthy lifestyle services

Free local support with stopping smoking, healthy eating and exercising

Exercise on referral

A 12-week programme to increase physical activity and make lifestyle choices aimed at reducing CVD risk

Eat Healthier

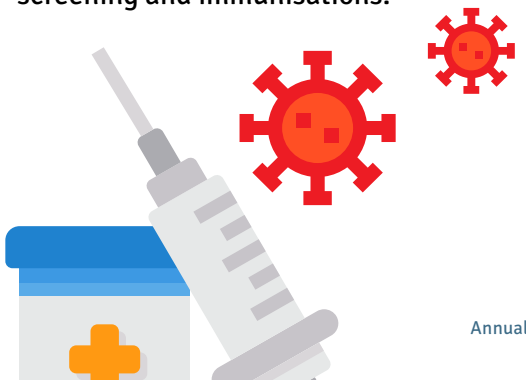
A 12-week programme to improve awareness of food and drink (including alcohol) consumption

The B&D Black, Asian and Minority Ethnic Inequalities Profile, as demonstrated in the most recent JSNA highlights that these communities are being diagnosed with long term conditions before the age of 40 and with a lower age of multimorbidity (the presence of two or more chronic conditions in a person at the same time) in the Black community compared to White populations, which means they are missing vital preventative interventions, as the NHS Health Checks targets people from age 40.

To address this, an inequalities pilot project has been set up to deliver Health Checks to individuals within the Black, Asian and Minority Ethnic communities aged between 30 and 39. This £80,000 pilot is being delivered by Together First CIC, the GP Federation, who will use their existing relationships with GP practices and patients to invite those eligible to attend a Health Check. The pilot aims to understand:

- **Effectiveness of a targeted programme in populations with earlier development of CVD risk factors**
- **'What works' to encourage people from key minority ethnic populations to undertake a Health Check**

The pilot will explore delivery of Health Checks, alongside other interventions such as vaccination in community locations to improve access amongst the underserved. Learning from this pilot will help address inequalities in uptake of other services such as cancer screening and immunisations.



How Can We Improve Uptake?

On a national level, higher uptake has been found among older people, individuals in deprived areas and people with a family history of CVD; as well as higher uptake amongst Bangladeshi, Caribbean and Indian ethnic groups compared to their White and Chinese counterparts, when checks are delivered in familiar settings such as places of worship or local community hubs.

However, a survey conducted to understand what local models are used to deliver the NHS Health Check in 2019/20 across local authorities found that 93% of local authorities commission General Practices (GPs) to deliver some of the health checks compared to community outreach providers (27%) and pharmacists (19%). This is because GP clinical patient records are the main method to check for eligibility whereas community outreach and pharmacists are more likely to take an opportunistic identification approach. This can be seen in Kent County Council, where it was found that sending text message reminders to patients and IT prompts to clinical staff are effective ways of increasing uptake.

Page 60

Financial incentives have also been found to be a motivation for GP practices to target priority groups for the NHS Health Check. In Wigan, equality monitoring showed that the working age population were less likely to attend, due to GP working hours being a barrier. A new contract included weighted payments for patients based on age (younger patients attracted higher payments), alongside a requirement for 20% of appointments to be offered outside of 9-5 working hours for ease of access.

Conclusions

Models introduced elsewhere such as home blood pressure monitoring and digital NHS Health Check assessments may help to provide more accessible service. Although, the Health Check services needs to be better focused to tackle health inequalities experienced by the underserved groups such as the homeless and individuals not registered with GPs. The programme should also be provided in a wider context of CVD prevention addressing smoking, weight management and the wider determinants of health.

Considerations for the Future

- There is a need for the Place-based Partnership to prioritise improvements in early detection, management and prevention of CVD and its linked illnesses. Utilising recent analysis identifying the level of undiagnosed disease, interventions need to focus on bridging this gap and ensure those from underserved groups can access the Health Check service.
- Based on guidance, evidence and existing good practice, the following outcomes should be considered by the Partnership:
    - Increased number of health checks offered to the Black and minority ethnic groups and reduce the gap between the White British and minority ethnic groups for those offered and receiving health checks
    - Greater Health Check accessibility for underserved groups
    - B&D to rank below the national and regional averages for under 75-year-old mortality rate from all cardiovascular diseases
    - Residents equipped with knowledge to better manage their health
    - Increase in the number of residents using health and wellness initiatives
    - Reduce the health inequalities experienced by residents
- How can we strengthen the referral pathways to services especially amongst underserved groups?
- What more can be done to improve accessibility to service amongst the Black, Asian and Minority Ethnic and other underserved groups?
- How can we involve community leaders to ensure the importance of the NHS Health Check is understood? (i.e., amongst Black and Asian groups)
- Is there an opportunity to create more tailored lifestyle services to the most at-risk groups?
- How do we adopt the most effective methods of inviting residents for a health check?

Chapter 4:
COVID-19

COVID-19 had a shocking impact and affected some communities more than others. At the beginning of June 2022 nearly 70,000 residents had tested positive for Coronavirus and up to 8,000 of those could have developed into Long COVID. The pandemic has had other indirect impacts such as delayed appointments because of reduced access to healthcare, potentially contributing to avoidable deaths.

Figure 14 sets out the COVID-19 case rates from the beginning of the pandemic, with peaks showing the different waves. Case rates at the beginning were underestimated, as testing was extremely limited during that period and testing levels, along with case rates across London have fallen following the Omicron wave. The closure of local testing sites and the end of free universal testing on 1 April 2022 contributed to the fall.

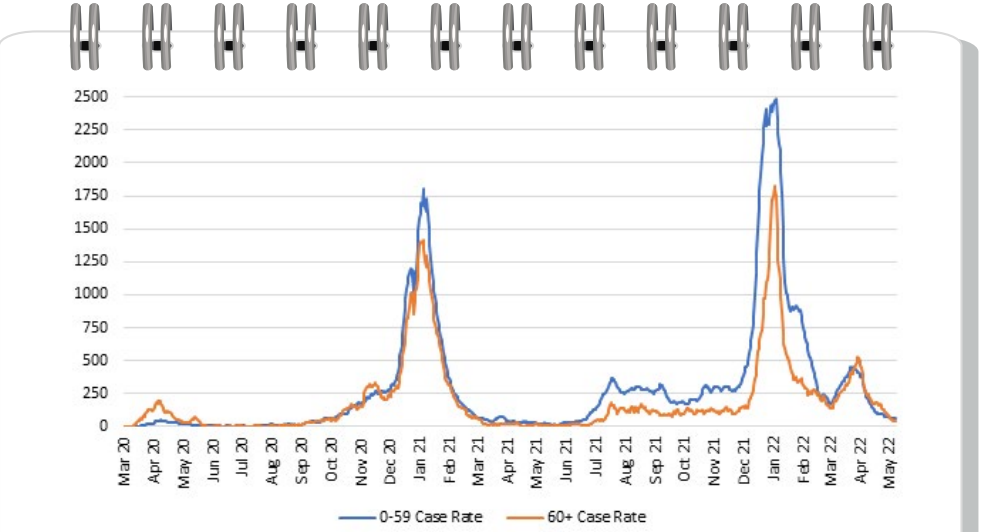


Figure 14: B&D COVID-19 case rates per 100,000 residents

Source: [Cases in B&D | Coronavirus in the UK (data.gov.uk)]

Impacts of COVID-19

At the height of the pandemic, many health services were suspended. In addition, fear of catching COVID-19 led to people not accessing health services that were available. As a result, the pandemic has and will continue to have an impact on health and livelihoods, worsening existing inequalities. Some of these are summarised below:

- **Missed opportunities for early detection of cancers, cardiovascular disease risks and dental health problems due to interruption of services**
- **A rise in vaccine preventable illnesses due to missed childhood immunisations**
- **Development or worsening of existing mental health issues, smoking and drug and alcohol issues**
- **Increase in obesity due to continued inactive lifestyles**
- **Increased workload for health services due to a backlog, following reduced access**
- **Workplace and business closures, leading to redundancies**
- **School closures affecting children's education and in some cases wellbeing**
- **Non-contact of support services, 'hidden harms' e.g., domestic abuse, children's safeguarding issues**

2. https://coronavirus.data.gov.uk/details/cases?areaType=ltla&areaName=Barking%20and%20Dagenham

What are We Doing?

Initially, testing and isolation were the main ways of managing COVID-19, along with other infection prevention and control measures (hands-face-space-fresh air). The introduction of vaccination in December 2020 saw the development of local initiatives to vaccinate all eligible groups. This included dedicated teams visiting care homes and housebound residents, setting up community-based vaccination centres and several hyper local pop-up clinics to increase access to under-served communities. Other new initiatives were also developed in the borough to support residents.

Testing

- testing played a key role in our efforts to contain and lessen the impact of the pandemic by identifying infected individuals, to help prevent further person-to-person spread. With support from Department of Health and Social Care (DHSC) and UK Health Security Agency (UKHSA), we set up PCR and LFT test sites across the borough, targeting areas of highest need and where variants of concern were initially identified. Learnings from this will enable us to set up further test sites quickly when needed.

Contact Tracing

– our local service complemented the national service. This enabled us to follow up people by telephone or home visit, offering advice and support to those required to isolate due to testing positive or being identified as close contacts. This service ended when the requirement to self-isolate ended. With the experience that we gained; we can reinstate a local contact tracing service rapidly if needed.

BD-CAN Plus

– our community and social sector mobilised to work with the Council to help our vulnerable residents. The Council was able to rapidly organise a network of support; linking together council services, voluntary sector and residents to form the BD CAN Plus network. This network coordinated and delivered a range of support on jobs, homelessness, debt advice and other practical support including delivery of food and medicines to shielding and other vulnerable residents. The network of volunteers also played a crucial role in the running of the COVID-19 vaccination site.

Infection Prevention and Control (IPC) Support

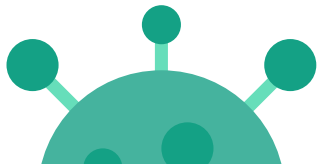
– the pandemic highlighted the critical role of specialist IPC support to social care. UKHSA and North East London Foundation Trust (NELFT) IPC team supported adult social care, but NELFTs capacity was stretched and they could only support care homes. The role of social care within the healthcare system is important and its most important the future of IPC support to settings across NEL is reviewed. It is essential any future service should have both a proactive and reactive role with enough capacity to manage the demand of high-risk areas such as care settings including other settings outside care homes.

Vaccination

- vaccination has been shown to reduce the transmission of COVID-19 and contribute to reducing severe illness and deaths. We developed good partnerships with the NHS, schools, community and faith groups to help improve access to vaccinations, but we still have a challenge- with one of the lowest COVID-19 vaccination rates among children and young people in London. We continue to share intelligence on areas of low uptake with relevant community groups to help with more targeted interventions involving community champions.

Long COVID Service

- while many of those who have COVID-19 fully recover, many people also suffer long-term effects, including fatigue, breathing difficulties, depression and difficulty concentrating. Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT), in collaboration with NELFT set up and continue to provide a Long COVID clinic to support those who may be struggling with long-term effects.



What Actions are Most Effective?

Non-pharmaceutical interventions (NPIs) are the most effective public health interventions against COVID-19 after vaccination. They can be applied to different degrees and combinations, however, NPIs restrict people's lives and may have a negative impact on the economy and peoples wellbeing. Evidence based NPIs for managing COVID-19 include:

- Promoting and facilitating social distancing in all settings
- Using well-fitting masks appropriately, in public
- Avoiding crowded places, especially indoors
- Testing
- Isolation
- Regular cleaning of frequently touched surfaces
- Appropriate ventilation of indoor spaces
- Limiting the size of gatherings

These interventions have now stopped since being enforced at scale and it would be challenging to continue local operation for some, without national authority.

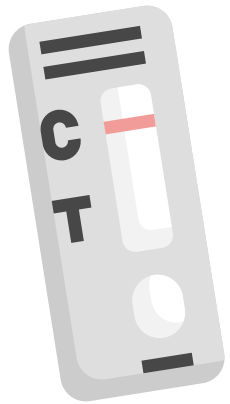
Conclusions

The worst of the pandemic has passed for now, but it is not over. As social contact returns there is likely to be a reappearance in influenza activity in winter 2022/23 to levels like or higher than before the pandemic. More recently the rise of Monkeypox has led the World Health Organisation to declare it a public health emergency of international concern. In some cases, it has also created a larger pool of susceptible children to common childhood infections, leading to outbreaks such as norovirus, chickenpox, and scarlet fever. There is also potential for co-circulation of respiratory viruses and for circulation to be longer than usual.

The pandemic highlighted gaps in IPC within social care, schools, workplaces, and other settings. We worked to support settings and embed enhanced IPC measures, but it is important to continue support, as good IPC helps prevent all infections.

Schools were severely affected by the pandemic and worked hard to manage outbreaks and implement control measures. However, more can be done. Ventilation is important because of how the virus spreads, therefore schools need to review ventilation systems to ensure rooms have adequate ventilation to lower the risk of COVID transmission and other infections. Continuing to support the mental health and wellbeing of children is also an important role within a school setting.

Schools play a central role in ensuring good uptake of childhood immunisations and a multi-agency approach is needed to restore confidence and increase uptake of the COVID-19 vaccine and other immunisations. This is more urgent, following the detection of vaccine derived polio virus in sewage and reported cases of other vaccine preventable illnesses like measles in London.



High risk settings such as care homes were overly affected during the pandemic and many care homes closed to visitors, damaging residents' wellbeing and caused delays in the COVID-19 vaccine roll out. With support, care homes enhanced their IPC practices. An important enabler was the DHSCs Adult Social Care Infection Control Fund, which helped care homes to implement enhanced IPC measures and support backfilling staff absences due to self-isolation. As this funding has stopped, care homes need to find ways of maintaining adequate IPC as needed.

Current and future Long COVID cases will potentially require care from health and/or social care services. Occupations of those reporting such symptoms are overrepresented in health care, social care and teaching or education, meaning on top of direct impacts, Long COVID may also disrupt delivery of key services.

Considerations for the Future

- Inadequate IPC support to high-risk settings is under consideration across NEL and needs to be resolved as a matter of urgency.
- There is a need for the Council and partners to maintain the ability to rapidly re-establish control measures (e.g. testing, contact tracing, enhanced cleaning and supporting the vulnerable to self-isolate) in response to increasing cases, outbreaks, or variants of concern.
- Local intelligence (e.g. case rates in small areas) helps identify community outbreaks quickly and is important in a targeted and effective response. In the absence of universal testing, we need to work with UKHSA to identify outbreaks early.
- We need to build on and replicate excellent partnership working (to uptake of immunisations; cancer screening; tackling inequalities and in the distribution of cases and vaccination uptake). Data sharing arrangements must be implemented across different providers and the emerging Integrated Care Boards and Place-based Partnerships could facilitate this.
- We need to continue to increase the COVID-19 vaccination, working with communities where uptake is lowest, alongside other 'competing' immunisation programmes. This should include new approaches to addressing low uptake in some age, ethnic groups and localities.
- To recognise and address the health inequalities exacerbated by the pandemic, through all Place-based Partnership programmes.

Acknowledgments

I'd like to thank many colleagues who have provided input, information, advice and guidance:

Andrew Stock; Benhildah Dube; Carys Rees; Craig Nikolic; Dr Jackie Chin; Ellen Bloomer; Elspeth Paisley; Erik Stein; Fiona Noah; Jacquie Hutchinson; Jane Hargreaves; Jane Leaman; Jenny Houlihan; Jess Waithe; Julia Cory; Julia Kanji; Julia Pearson; Justine Henderson; Mike Brannan; Nathan Singleton; Pauline Starkey; Paul Starkey; Rebecca Nunn; Richard Johnston; Sandeep Sharma; Sarah Addiman; Sophie Keenleyside; Yaccub Enum; Zoinul Abidin.

Thank you for reading

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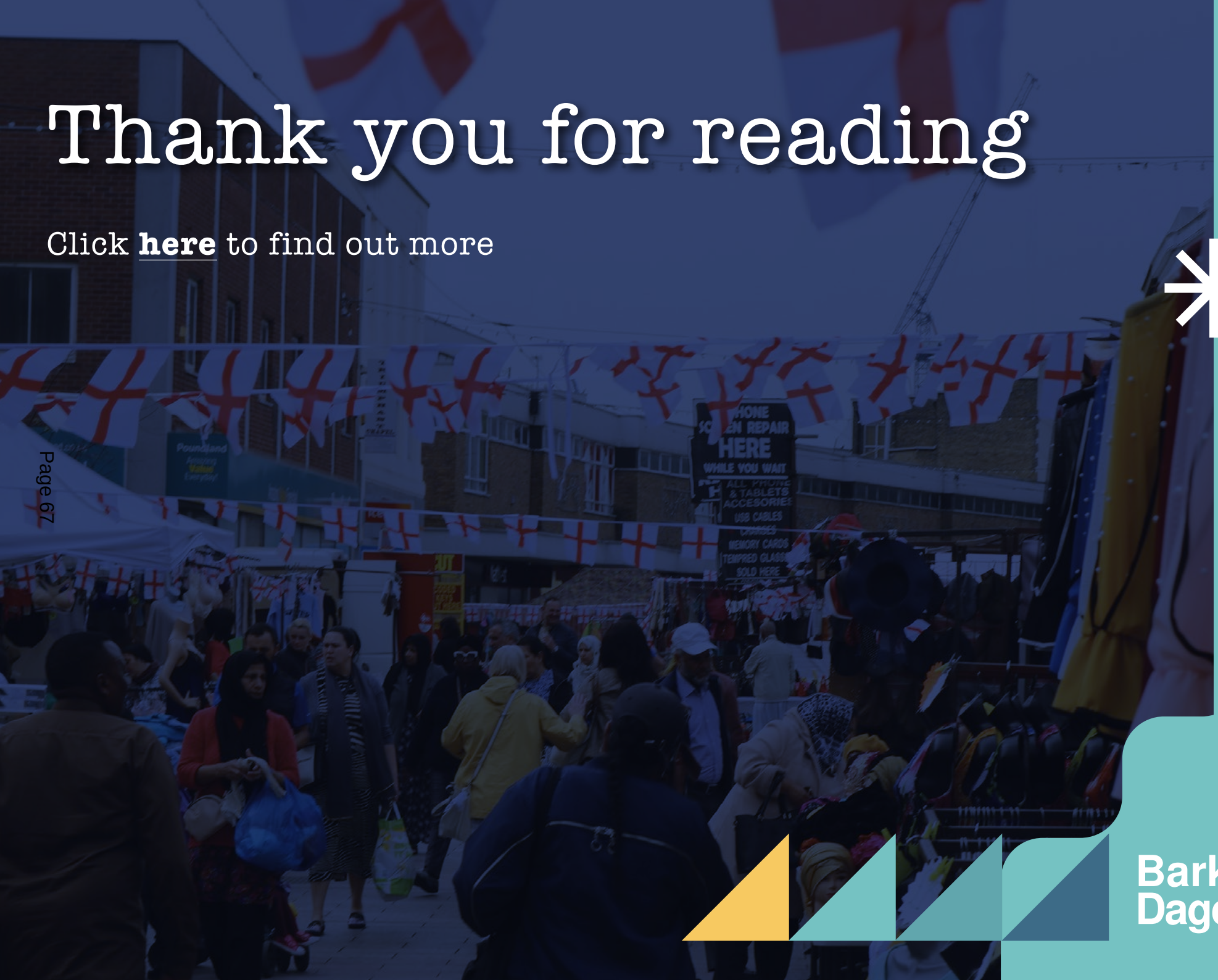

Barking & Dagenham

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HEALTH SCRUTINY COMMITTEE

1 February 2023

Title: Shaping the Refresh for the Joint Local Health and Wellbeing Strategy 2023-28	
Report of the Director of Public Health	
Open Report	**For Information**
Wards Affected: All	**Key Decision:** No
Report Authors: Jane Leaman, Consultant in Public Health Jess Waithe, Public Health Specialist	**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 Childrens and Adults	

Summary

The current Barking and Dagenham Health and Well Being Strategy (HWBS) ends in March 2023. On review, following the publication of the refreshed Joint Strategic Needs Assessment (JSNA) and the Babies, Childrens' and Young Peoples' Plan, it is proposed that the strategy (now known as the Local Joint Health and Well Being Strategy (JLHWBS)) remains but is refreshed in the context of the new Integrated Care System (ICS) and in the aftermath of the COVID Pandemic and the current 'cost of living crisis' for the period 2023 -2028 (as recommended in the Director of Public Health's report 2021-22).

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

The Health and Wellbeing Board (HWBB) will need to consider the NHS NEL Integrated Care Strategy when refreshing the JLHWBS to ensure that they are complementary. Conversely, the Integrated Care Strategy should build on and complement the JLHWSs, identifying where needs could be better addressed at the system level. Recent guidance on the publication of the ICB Joint Forward Plan (JFP) specifies ICBs and their partner Trusts must involve relevant HWBs in preparing or revising the JFP. The 23/24 JFP needs to be published by 30 June 2023.

A Local Delivery Plan for Place will also be published setting out how the JLHWBS will be delivered in Barking and Dagenham. The Adult and Children and Young People's delivery groups will be responsible for delivery, accountable to the Barking and Dagenham Executive Group.

Recommendation(s)

The Committee is recommended to:

1. Note and comment on the direction of travel for refreshing the Joint Local Health and Wellbeing Strategy, in the context of the newly established Place-based Partnership and Integrated Care System.
2. Discuss how the Committee will utilise the Health and Wellbeing Strategy to scrutinise the planning, provision and operation of health and health services in the Borough.
3. Note a full discussion will be had on the draft Joint Local Health and Wellbeing Strategy at its next meeting on 29 March 2023, before it is finalised by the Health and Wellbeing Board at its meeting on 13 June 2023.

Reason(s)

The themes in the report relate to the Council's priority of Prevention, Independence and Resilience.

1. Introduction and Background

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

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

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

2. Role of the Joint Strategic Needs Assessment and Joint Local Health and Wellbeing Strategy

2.1 These are vehicles for ensuring that the needs and the local determinants of the health of the local population are identified and agreed. The JSNA provides the evidence base for the health and wellbeing needs of the local population and should be kept up to date regularly. The JLHWS sets out the agreed priorities and joint action for partners to address the health and wellbeing needs identified by the JSNA. They are not an end in themselves, but a regular process of strategic assessment and planning.

2.2 Local authorities and ICBs must have regard to the relevant JSNAs and JLHWSs so far as they are relevant when exercising their functions, including NHS England in exercising any functions in arranging for the provision of health services in relation to the geographical area of a responsible local authority.

3. Recent guidance on Health and Wellbeing Boards (HWBBs) (Nov 2022)[1]

3.1 HWBBs continue to be responsible for:

- Assessing the health and wellbeing needs of their population and publishing a joint strategic needs assessment (JSNA);
- Publishing a joint local health and wellbeing strategy (JLHWS), which sets out the priorities for improving the health and wellbeing of its local population and how the identified needs will be addressed, including addressing health inequalities, and which reflects the evidence of the JSNA;
- The JLHWS should directly inform the development of joint commissioning arrangements (see section 75 of the National Health Service Act 2006) in the place and the co-ordination of NHS and local authority commissioning, including Better Care Fund plans; and
- Developing a pharmaceutical needs assessment (PNA) for their area.

a. Local Joint Health and Well Being Strategy and Integrated Care Strategy

NHS NEL's Integrated Care Strategy will need to be considered when preparing the JLHWBS to ensure that these are complementary and HWBBs should be active participants in the development of the Integrated Care Strategy.

The JLHWBS has greater significance under the new arrangements; not only will this influence the NEL Integrated Care Strategy, but the strategy will inform a Local Delivery Plan at Place (see 1.9 below). This plan will outline how Partnership priorities link with that of NELs and how they will be delivered locally, through place governance.

JSNAs will be used by Integrated Care Partnerships (ICPs) to develop the Integrated Care Strategy, identifying where the assessed needs within the JSNA can be met by local authorities, ICBs or NHS England in exercising their functions.

The Department for Health and Social Care has issued guidance for integrated care strategies[2] with a suggestion that partnerships may wish to develop interim strategies to influence system planning for 23/24 ahead of further strategy guidance expected in June 2023.

b. NHS NEL Integrated Care Strategy Proposal

System partners across North East London Health and Care Partnership have reached collective agreement on NHS NEL's ICS purpose and four priorities to focus on together as a system. The priorities and cross-cutting themes (see below) will set a clear direction for the development of the new NHS Joint Forward Plan due end March 2023 (see Appendix A for what good looks like against the cross-cutting themes).

[1] https://www.gov.uk/government/publications/health-and-wellbeing-boards-guidance
[2] https://www.gov.uk/government/publications/guidance-on-the-preparation-of-integrated-care-strategies/guidance-on-the-preparation-of-integrated-care-strategies

The interim strategy document will be completed taking on board any further feedback from the Integrated Care Partnership on 11 January 2023. The strategy will not however be a one–off process, more a dynamic dialogue across all parts of the system and with local people.

Priorities:

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

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

- Working together as a system to tackle health inequalities including a relentless focus on equity;
- Greater focus on prevention;
- Holistic and personalised care;
- Co-production with residents;
- A high trust environment; and
- Working as a learning health system.

Other Relevant Plans and Assessments

c. LBBD Corporate Plan

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

d. ICB Joint Forward Plan (JFP) (replacing commissioning plan)

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

Recent guidance[3] specifies that systems have flexibility to determine their JFP's scope as well as how it is developed and structured. Legal responsibility for developing the JFP lies with the ICB and its partner Trusts. However, it is encouraged that systems use the JFP to develop a shared delivery plan for the Integrated Care Strategy and the JLHWS that is supported by the whole system,

[3] https://www.england.nhs.uk/wp-content/uploads/2022/12/B1940-guidance-on-developing-the-joint-forward-plan-december-2022.pdf

including local authorities and voluntary, community and social enterprise partners. As a minimum, the JFP should describe how the ICB and its partner Trusts intend to arrange and/or provide NHS services to meet their population's physical and mental health needs. This should include the delivery of universal NHS commitments, address ICSs' four core purposes and meet legal requirements.

ICBs and their partner trusts must involve relevant HWBBs in preparing or revising the JFP. This includes sharing a draft with each relevant HWBB and consulting relevant HWBB's on whether the JFP takes proper account of each relevant joint local health and wellbeing strategy (JLHWS).

The guidance specifies ICBs and their partner trusts have a duty to prepare a first JFP before the start of the financial year 2023/24 – i.e. by 1 April. For this first year, however, the date for publishing and sharing the final plan with NHS England, their Integrated Care Partnerships and Health and Wellbeing Boards, is 30 June 2023. Therefore, it is expected that the process for consulting on a draft (or drafts) of the plan, should be commenced with a view to producing a version by 31 March, but consultation on further iterations may continue after that date, prior to the plan being finalised in time for publication and sharing by 30 June 2023.

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

e. ICB Annual Reports

The ICB is required as part of their annual report to review any steps they have taken to implement the NEL borough's JLHWS. In preparing this review, the ICB must consult each relevant HWB.

f. Joint Outcomes Framework[4]

A framework will be developed nationally with a focused set of national priorities, and an approach for prioritising shared outcomes at a local level, focused on individual and population health and wellbeing. The implementation of shared outcomes will begin from April 2023.

The national Government will set some delivery standards for organisations, to ensure that the public receive a consistent standard of care, via setting a Mandate for NHS England. The outcomes will sit alongside - and complement - systems' and organisations' statutory responsibilities and wider regulatory frameworks.

[4] https://www.gov.uk/government/publications/health-and-social-care-integration-joining-up-care-for-people-places-and-populations

g. Local Delivery Plan for Place

A local delivery plan will be published which demonstrates how the Barking and Dagenham Partnership will deliver the priorities identified within the JLHWBS. Delivery will be led through the Children and Young People (CYP) and Adult Delivery Groups, accountable to the Barking and Dagenham Executive Group.

h. Performance Assessments

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

3.2 **The Care Quality Commission** (CQC) will consider outcomes agreed at place level as part of its assessment of ICSs. The CQC will also continue to develop its assessment of individual providers, to ensure their contribution to plans that improve outcomes at place and ICS level are assessed as part of the overall oversight framework. In addition to its current role in regulating and inspecting health and care providers, the CQC will also review integrated care systems including NHS care, public health, and adult social care and assess local authorities' delivery of their adult social care duties.

4. Shaping the Health and Wellbeing Strategy

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

4.2 But, as most issues impacting on people's health are outside of the health service, the heart of this will be tackling health inequalities supported by the value of relationships and connecting with residents in designing or delivering changes in services, to meet the individual needs and characteristics of our communities.

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

i. Proposed Framework for the 2023 – 2028 Strategy

Vision

By 2028 as Barking and Dagenham (B&D) continues to grow, our residents will have improved health and wellbeing, with less health inequalities between Barking and Dagenham residents and the rest of London: no-one will be left behind.

Our residents will have increased resilience, empowered to not just survive, but to thrive. Residents will benefit from a place-based system of care, where partners across the Barking, Havering and Redbridge system work together to get upstream of care and improve the health of the population. Partners will increasingly focus on outcomes and impact, rather than outputs with outcomes-based commissioning working effectively to improve outcomes for residents.

The strategy will place the 'Marmot Principles' and associated indicators at the heart of what it says as an evidence-based approach to putting health equity at the centre of post-pandemic recovery.

It will also consider the impacts of the 'cost of living' crisis which nationally has resulted in over half (55%) of people feeling their health has been negatively impacted. These numbers will be much greater across our community where poverty and deprivation are high, given we were the fifth most deprived area in England in 2019, up from the 20th in 2004.

The strategy will be built around the following four pillars of population health[5] :

- The wider determinants of health;
- Our health behaviours and lifestyles;
- An integrated health and care system; and
- The places and communities we live in, and with.

And will reflect the current priority themes of:

Priority Theme 1: Best Start in Life;
Priority Theme 2: Early Diagnosis and Intervention; and
Priority Theme 3: Building individual and community strength.

The following partnership priorities will be reflected within these themes:

- **Addressing long-term conditions** (adults and children) (early diagnosis and treatment preventing long-term serious health conditions including serious mental health problems, avoidable admissions and reducing demand on social care services);
- **Addressing obesity and smoking;**
- **Best start in life** including healthy pregnancy, developmental support, diagnosis and support for SEND;
- **Domestic violence and addressing adverse childhood experiences;**
- **Health in all Policies/anchor institutions; and**
- Including training, education and skills development, employment, housing and inclusive growth.

These will be underpinned by addressing health inequalities with a focus on the Core20Plus5 (adults and children) priorities. The strategy will take a place-based approach delivered through locality working, involving three types of interventions:

- Civic-level interventions (e.g. licensing, economic development);

[5] https://www.kingsfund.org.uk/publications/vision-population-health

- Community-based interventions (e.g. using and building assets within communities); and
- Services-based interventions (e.g. quality and scale, reducing variation).

j. Developing Outcomes and Delivery Plans

Coproduced with residents:

- Each theme will reflect the relevant partnership priority and will have outcomes (short medium and long term) associated to them;
- A detailed set of delivery plans (included in the Local Delivery Plan for Place) will be developed to describe activity to achieve the agreed measures;
- All interventions will be evidence-based, outcomes orientated, systematically applied across the borough, scaled-up appropriately and appropriately resourced to meet needs, and sustainable;
- Responsibility and accountability for delivering these plans will be both the Adult and Best Chance for Children and Young People Delivery Groups; and
- Measures (performance indicators) will be identified against which progress will be tracked.

5 Consultation and Engagement

This process has been broken down into three phases:

5.1 Phase one included gathering relevant insight from Partnership Board members (as well as internally) relating to recent and related engagement undertaken that could help to identify gaps, newly emerging themes- such as the ‘cost of living crisis’, or feed into the development of the delivery plans. It also included a survey hosted on One Borough Voice, where residents were asked to ‘sense check’ the relevance of current strategy priorities that fall with current themes.

5.2 Phase two is currently being formulated and focuses on working with LBBD’s Participation and Engagement Team to develop a plan for engagement with communities and existing groups/organisations, with input being sought from partners within the community and voluntary sector. The intention is to engage with underserved groups and within key geographic areas (by linking in with Locality Leads) that have the greatest need/are impacted most by the issues outlined within the partnership priorities listed in 2.1 above.

5.3 This is expected to be undertaken through different approaches (including workshops) to seek views, mainly on ‘what good looks like’ which will inform measures for the refresh as well as potentially feeding into outcome development and actions within the delivery plans.

5.4 Due to the extensive engagement work recently undertaken during the development of the Babies, Childrens and Young Peoples Plan, engagement for this strategy refresh will be focused on engagement with adult populations only.

5.5 The final phase will be to write a refreshed draft of the strategy and provide an opportunity for residents (via One Borough Voice), partners and colleagues (throughout the internal governance process) to revise the document during final stages of consultation, ahead of its finalisation and publish.

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

List of appendices:

Appendix 1: What success will look like for The NHS NEL Integrated Care System

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What success will look like for The NHS NEL Integrated Care System

Health Inequalities
In addition to the specific health inequalities measures set out in relation to our four priorities below:

- Across North East London we are reducing the difference in access, outcomes and experience with a focus on people from black and minority ethnic communities, people with learning disabilities, people who are homeless, people living in poverty or deprivation and for carers.
- Healthy life expectancy is improved across NEL and the gap between our most and least deprived areas / those living in poverty and the wealthiest is reduced.
- We have improved ethnicity data collection and recording across health and care services and deliver inclusive, culturally competent, and trusted health and care services to our population.
- Our staff have access to training on health inequalities and we routinely measure and address equity in NHS waiting lists.
- We are mitigating against digital exclusion.
- Tackle racism and increase cultural competence and cultural awareness in services.

Prevention
In addition to the specific prevention measures set out in relation to our four priorities:

- We invest more in prevention as a system to reduce prevalence of long-term conditions and mental health equitably across all of our places.
- We identify and address unmet need including diagnosing more people early and increasing access to care and support particularly for our most vulnerable or underserved groups.
- We invest in our community and voluntary sector to support prevention and early intervention in a range of ways to suit our diverse population.
- Through our role as anchor institutions, we support economic development by employing local people and prioritising social value in procurement.
- We share and use data to identify the most vulnerable people living locally including those not using services and those frequently using services to provide more targeted and proactive support which better meets their needs.

Personalisation

- Staff have access to all the information they need in one place to enable them to provide seamless care to local people and can share this information safely through our IT systems.
- Local people including carers only need to tell their story once through their health and care journey.
- Local people are asked what matters to them in setting their treatment or care goals and can access a wide range of non-medical support in the community.
- Particularly vulnerable residents are identified and given additional support to access services ensuring their experience and outcomes of care are equitable.

- Our staff are equipped to deliver trauma-informed care based on the principles of physical and psychological safety; trust; choice; collaboration; empowerment; and cultural competence.
- We aim for at least one Primary Care Network (PCN) in each place-based partnership to have a CYP social prescribing service, in line with local needs.

Coproduction

- We can evidence how decisions taken by our boards are informed by the views of local people.
- We helped establish a community and voluntary sector collaborative and actively support and resource its development.
- We train a wide range of health and care staff in co-production and power sharing approaches.
- We can demonstrate how we have identified and engaged underserved groups and the full diversity of our local population.
- We use existing sources of insight from local people including carers to shape our strategies and plans and resist repeatedly asking the same questions.
- We close the loop when we seek the views of carers and local people by feeding back.

High Trust environment

- Partners in the ICS feel actively engaged.
- Partners have adopted an ‘open book’ approach including how we spend our money.
- We challenge each other constructively without blame.
- We are open to new ways of working and share risk as a system.

Learning System

- We use data, evidence, and insights to build our understanding of our population and to drive our ambitions, priorities, transformation and improvements.
- We regularly review the impact we are having through evaluation of our services and transformation programmes and make changes based on this learning.
- We innovate and enable shared learning to accelerate adoption of innovation, research and best practice throughout our system.
- We support and encourage research that is focused on improving health and care for local people and involve more local people in research.

HEALTH SCRUTINY COMMITTEE

1 February 2023

Title: North East London Integrated Care Strategy Development	
Report of the Director of Strategic Development, NHS North East London	
Open Report	**For Information**
Wards Affected: None	**Key Decision:** No
Report Author: Claudia Wakefield, Senior Governance Officer	**Contact Details:** Tel: 020 8227 5276 E-mail: claudia.wakefield@lbbd.gov.uk
Accountable Strategic Leadership Director: Hilary Ross, Director of Strategic Development, NHS North East London	

Summary

The appended presentation is intended to provide an update on the North East London Integrated Care Strategy Development, as delivered to the Outer North East London Joint Health Overview and Scrutiny Committee (ONEL JHOSC) on 10 January 2023.

Recommendation(s)

The Health Scrutiny Committee is recommended to note the update provided by the Chair, following the presentation of the item to the ONEL JHOSC on 10 January 2023.

Reason(s)

The themes in the appended presentation relate to the Council's priority of Prevention, Independence and Resilience.

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

List of appendices:

- Appendix 1: North East London Integrated Care Strategy Development Presentation

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Appendix 1

North East London Health & Care Partnership

NHS North East London

North East London Integrated Care Strategy development

Joint Overview and Scrutiny Committee

Hilary Ross, Director of Strategic Development, NHS North East London

December 2022

Introduction

- In July our **Integrated Care Partnership** was formally established. This is a statutory committee that brings together a broad set of system partners (including local government, the voluntary, community and social enterprise sector, NHS organisations and others) to develop an **integrated care strategy** for the area.

- The Department for Health and Social Care has issued **guidance for integrated care strategies** with a suggestion that partnerships may wish to develop interim strategies in order to influence system planning for 23/24 ahead of further strategy guidance expected in June 2023.

- System partners across North East London Health and Care Partnership have already reached collective agreement on **our ICS purpose and four priorities** to focus on together as a system . These priorities will be at the heart of our integrated care strategy in NEL.

- Broad system-wide engagement including a series of well attended system-wide stakeholder workshops, and discussions with Health and Wellbeing Boards and place based partnerships has shaped our plans for progressing the four system priorities. Our engagement has also identified six cross-cutting themes describing ‘how’ we will work differently as an integrated care system. The priorities and cross-cutting themes will set a clear direction for the development of the new NHS Joint Forward Plan due end March 2023.

- While the strategy has been informed by discussions with local people and existing insights via Healthwatch, the key messages, priorities and success measures will be tested further with local people through a ‘Big Conversation’ planned to take place in Spring 2023.

- The interim strategy document will be completed taking on board any further feedback from the Integrated Care Partnership on 11 January. The strategy will not however be a one–off process, more a dynamic dialogue across all parts of the system and with local people.

Following the next slide where we have suggested some questions for discussion, we have included draft content in development on the four system priorities and six cross-cutting themes. We are continuing to develop the other sections of the strategy which include the introduction and context, overview of our population, and a section at the end on the foundations of a well-functioning integrated system.

Questions for discussion

1. Are there any key areas missing from our priorities or cross-cutting themes or anything we need to emphasise differently particularly at this stage in order to influence the NHS Joint Forward Plan?

2. Have we set the right level of ambition and scope in our success measures for the new system strategy?

Draft content

Improving outcomes and tackling inequalities - our four system priorities

To provide the best start in life for the Babies, Children and Young People of North East London

Our context and case for change-

- Babies, children and young people comprise one quarter of our population.
- In all our places except Hackney and Havering we have a higher proportion of babies born with a low birth weight than the England average. Low birth weight increases the risk of childhood mortality and of developmental problems for the child and is associated with poorer health in later life.
- In all our places except Havering, we have a higher percentage of children living in poverty than the England average (15.6%). This is likely to have been exacerbated by recent challenges including the pandemic and cost of living pressures. There is a strong link between childhood poverty and poorer health outcomes including premature mortality. There is also evidence to show that children who live in poverty are exposed to a range of risks that can have a serious impact on their mental health.
- Assessments indicate that 38,000 pupils in north east London need special educational support. 13,600 of these pupils have Educational, Health and Care Plans which outline the support they receive and these numbers are increasing.
- In all places in NEL, overweight and obesity in children is higher than the England average (35%). Barking and Dagenham and Newham respectively have the highest and fifth highest rates in England. Dental decay in 5-year olds is also higher in all our places compared to England.
- We saw physical and mental health outcomes deteriorate during the Covid-19 pandemic, particularly for vulnerable children and those with long term conditions within disadvantaged communities. In north east London at least 18,099 children and young people have asthma, 1,370 have epilepsy and 925 have type 1 diabetes.
- We are currently seeing substantial pressures on child health urgent care services which is likely to be connected to the recent pandemic and cost of living pressures.
- Currently there are 3,343 babies, children and young people in north east London with life limiting conditions requiring palliative and end of life care, and this number is gradually increasing.

Key messages we heard through our engagement

Support for young people feels unequal, and varies depending on stage of life.

I want to be involved in decisions about my care, and I don't always feel that my needs are understood.

The care I receive feels rushed and impersonal, and has varied in quality across services and at different stages of my life.

What we need to do differently as a system

Create the conditions for our staff to do their best possible work including creating a safe multi-disciplinary learning environment spanning teams across north east London, provider collaboratives and place-based partnerships with a focus on co-production, quality improvement and trauma-informed care.

Focus on tackling health inequalities by working with our place-based partnerships to increase support for our most vulnerable children and their families, developing an enabling programme of work which addresses workforce challenges, supports data capture and benchmarking, and promotes better communication.

Develop clearly defined prevention priorities supporting place-based partnerships to focus on the most deprived 20% of the population and other underserved groups, as well as a focus across north east London on prevention priorities including obesity and oral health.

Develop community-based holistic care, building community capacity, aligning to family hubs and strengthening adolescent healthcare. Through social prescribing and multi-disciplinary teams we will enable links to community assets including the community and voluntary sector and put health inequalities at the heart of our work

Prioritise our children and young people's mental health, recognising the importance of support, and timely access to information, advice and care. We will harness the potential of the digital offer and work with children and young people to design and deliver high quality, accessible services in a range of settings.

Improve prevention and support for babies, children and young people with long term conditions such as asthma, diabetes and epilepsy, by supporting greater personalisation of care and prevention activities across north east London.

What success will look like for local people

- *I have the same experiences and range of support for my development, health and wellbeing, no matter where I grow up in north east London*
- *I have the opportunity to access healthcare, education and care in ways that suit me and my goals*
- *I receive high quality and timely personalised care at a place of my choice*
- *I am treated with kindness, compassion, respect, information and communication is accessible and understandable*
- *I have opportunities to share my experience and insight, and seen change that I have influenced*
- *I have people who treat and look after me care as I move through the different stages of my life*
- *I am involved in decisions about my care*

What success will look like as outcomes for our population

- Reduce proportion of babies born with low birth weight in north east London
- Identify children living in poverty within our communities and ensure they are receiving the support they need to live a healthy life including equitable access to and outcomes from our health and care services
- Strengthen our focus on prevention, reducing levels of childhood obesity and dental decay and increasing uptake of childhood immunisation
- Strengthen our support for children living with long term conditions and address health inequalities by reducing the number of asthma attacks, increasing access to prevention and self-management for children and young people with diabetes (particularly those living in poverty or deprivation and those from black and ethnic minority backgrounds), increasing access to specialist epilepsy support for children, including those with learning disabilities and autism
- Improve access to children and young people's mental health services, and support young people better through the transition to adult mental health services
- Reduce the number of young people reporting that they feel lonely and isolated
- Collaborate between education, health and social care to meet the needs of children with special educational needs and disability

To support everyone at risk of developing or living with a long term condition in north east London to live a longer and healthier life

Our context and case for change

- 31% of our residents have a long term condition. Living with a long term condition can impact on many aspects of a person's life, including their family and friends and their work. People with a long term condition are more likely to suffer from further conditions or complications over time, including poor mental health.
- Long terms conditions account for half of GP appointments, 70% of inpatient bed days and 70% of the acute care budget.
- Long term conditions cannot be cured but when managed effectively, the impact the condition has on a person and their life can often be alleviated or delayed. Some long term conditions can also be prevented completely through healthier behaviours.
- People living in deprived neighbourhoods and from certain ethnic backgrounds are more likely to have a long term condition and to suffer more severe symptoms. For example, the poorest people in our communities have a 60 per cent higher prevalence of long term conditions than the wealthiest and 30 per cent higher severity of disease. People of South Asian ethnic origin are at greater risk of developing Type 2 Diabetes, and people with an African or Caribbean family background are at greater risk of sickle cell disease.
- Our population has a higher prevalence of type 2 diabetes, and several other conditions including hypertension and chronic kidney disease as well as a higher mortality rate for cardiovascular disease in the under 75s. One in five of our residents has respiratory disease. Further, there are likely to be high levels of unmet need – highest in our 'underserved' communities - that are not showing in the data but require proactive identification and better management.
- Two-thirds of people with at least one long term condition have more than one mental health problem, including depression and/or anxiety, and there is a growing connection between living with a long term condition, social isolation and low self-esteem.

Key messages we heard through our engagement

Care for people with long term conditions feels unco-ordinated and fragmented.

I am not always clear who I can turn to with a problem, where I can access non-medical support in my local community or support with my emotional and psychological wellbeing.

I do not want to be asked to repeat my story to different professionals and I want my transition from service to service to be much better co-ordinated and supported.

What we need to do differently as a system

Better coordination of care, including between mental and physical health, and better transitions between different services, such as between child to adult services.

Empower and resource local communities and voluntary organisations to increase support for prevention and self-management, de-medicalising and destigmatising day to day support for long term conditions through social prescribing, increasing access to emotional and psychological support and widening peer support.

More consistent communication with people living with long term conditions and their carers, including in relation to their end of life care. Ensuring that people are at the heart of every conversation and that we focus on their holistic needs and strengths (not just their care).

Support health creation within local communities, increasing opportunities and support for making healthier choices, including starting health and well-being conversations in early years and working together to reduce the number of people in north east London living with risk factors such as obesity or smoking.

Lead by example as a large employer across north east London. Through our priority on workforce and local employment we will identify what more we can do as employers to encourage healthy behaviours and to support colleagues with long term conditions. We will also do more to value and support informal carers in recognition of the significant contribution they make to the health, wellbeing and independence of local people.

More intelligent identification of those with long term conditions or risk factors to support those affected to take earlier and more proactive action particularly among 'underserved' communities where there are high levels of unmet need.

What success will look like for local people

- *I receive the support I need to make healthier life choices, increasing my chances of a long and healthy life*
- *If I develop a long term condition, it will be identified early and I will be supported through diagnosis; with my individual needs taken into account*
- *I feel confident to manage my own condition, and there is no decision about me without me*
- *I am able to access timely care and support from the right people in the right place*
- *I feel my quality of life is better because of the care and support I received*
- *I am able to care for my loved one, my contribution is recognised and valued and help is there for me when I need it*

What success will look like as outcomes for our population

- Reduce prevalence of obesity and we will be smokefree by 2030
- Reduce the number of people with long term conditions diagnosed in an urgent care setting and increase early diagnosis of cancer
- Increase uptake of vaccines for people with chronic respiratory conditions to prevent more emergency hospital admissions
- Increase hypertension case finding in primary care to minimise the risk of heart attack and stroke within our population
- Increase the proportion of local people who say that they are able to manage their condition well
- Increase the proportion of local people who are able to work and carry out day-to-day activities whilst living with a long term condition
- Improve the mental health and wellbeing of people with long term conditions and their carers

To improve the mental health and wellbeing of the people of north east London

Our context and case for change

- Mental health affects how we think, feel and act, and has a profound impact on our day-to-day lives. It is strongly linked with wider health outcomes and therefore improvements here impact our overall ambition to improve the lives of people living in north east London.
- We are seeing a growing number of people in need of our mental health services. Recorded rates of depression have increased year-on-year in every borough in north east London over the past 5 years.
- The Covid-19 pandemic and cost of living crisis has brought new challenges, exacerbated inequalities, and often it has been those who were struggling before that are now being hit hardest. The number of referrals received across North East London Foundation Trust Mental Health Services has steadily increased since the pandemic began in early 2020 and is currently up 18.5% on the previous year.
- There has been a steady increase in demand for crisis support for children and young people by 82% between July 2020 and July 2022. Children and Young Adults Mental Health Services (CAMHS) have started to see crisis presentations stabilise, although referrals across most services continue to be higher than pre-pandemic levels.
- We still have further to go to ensure that people with mental and physical health conditions, including across their life course and people with dementia, get the right integrated support, as early as possible.

Key messages we heard through our engagement

I want those providing my support to consider me as a whole person

I want to access support in different ways that suit me and my goals, not just what is available and not when it is too late

I want to tell my story once and be involved in deciding what support will suit me and my family's, goals and needs

What we need to do differently as a system

Prioritising what matters to service users, carers and people with lived experience, so that service users and carers have an improved quality of life, with joined-up support around the social determinants of health.

Delivering local priorities for mental health, including the assets, wishes and aspirations of our communities, and the unmet needs and inequalities facing specific groups.

Improving access and integration, reducing inequality of access, and improving people's first contact with mental health services including ensuring that local people can access the support they need in the place that best placed for addressing their needs.

Enabling and supporting patient leadership at every level in the system so that service users are equally valued for their leadership skills and experience as clinicians, commissioners and other professionals.

Embedding and standardising our approach to peer support across north east London so that it is valued and respected as a profession in its own right, and forms part of the multi-disciplinary team within clinical teams and services.

Improving cultural awareness and cultural competence across north east London so that people with protected characteristics feel they are seen as individuals, and that staff are not making assumptions about them based on those characteristics.

Valuing the contribution of carers and providing more and better support to them so that they are able to provide better support for others as well as improve their own health and wellbeing.

What success will look like for local people

- *I feel happy and healthy in my life*
- *I have the same chances in life as my peers without adversity or vulnerability, we aren't hard to reach*
- *I am supported to get involved and see changes that I have influenced*
- *I have the same experience and access to a range of support regardless of where I live or go to school*
- *I am able to see all support available to me, my family and friends in one place*
- *I feel I have ownership of maintaining and improving my resilience and wellbeing*

What success will look like as outcomes for our population

- Increase the number of people diagnosed with dementia and improve support to people and their carers before and after diagnosis
- Address under-representation of people from black, Asian, and minority ethnic communities in talking therapy services
- Improve the physical health and premature mortality of people with a serious mental illness including ensuring annual health checks for at least 60%
- Increasing the availability and timely access for preventative mental health and wellbeing services for children and young people, particularly within schools and including increasing the number of schools covered by a Mental Health Support Team
- Increase the number of carers referred to IAPT services
- Create new peer support roles and increase the number of paid peer support workers
- Increase training for non-mental health specialists including receptions staff
- Reduce the gap in employment rate for people with long term mental health needs.

To create meaningful work opportunities and employment for people in north east London now and in the future

Our context and case for change

- North east London has almost one hundred thousand staff working in health and care, with over 4,000 in general practice, 46,000 in social care, and around 49,000 within our trusts. Our workforce are the heart of our system and play a central role in improving population health and care.

- Alongside our paid workforce, our thousands of informal carers play a pivotal role in supporting family and friends in their care, including enabling them to live independently. Analysis undertaken by Healthwatch shows inequalities of experiences for carers who have poor experiences in accessing long term conditions (51%) and mental health services (70%), between 61% and 73% did not feel involved and supported.

- Our employed workforce has grown by 1,840 people in the last year. Investment in primary care workforce has seen numbers grow by 3.7% in the last year, as well as a growth in training places for GPs.

- Retention and growth are a key part of all our workforce plans but we still have a number of challenges to overcome. We have an annual staff turnover rate of 23%, and we have heard from staff that burnout has been a growing problem after the Covid-19 pandemic.

- The interplay of increased workload and stress due to the pandemic is still having an effect. Sickness rates for north east London were higher than the national average of 4%, at 4.9%. Although we have the second lowest sickness rate in London, we know that mental health issues are the second highest reason for sickness, behind musculoskeletal problems.

- To achieve our ambitions as an integrated care system we need our workforce to be equipped with the right skills, values and behaviours to deliver our health and care services. To meet rising demand as our population grows and their health and care needs become more complex, we will also need staff to work in different ways, potentially in new roles, as models of care are adapted and improved.

Key messages we heard through our engagement

I value flexibility and work life balance over traditional rewards such as pensions

I want career development and career growth opportunities available to me locally

I felt over-worked before the pandemic and now it's really affecting my ability to work

I'm a local person with transferable skills but I don't feel local health and care jobs are accessible to me

I want the informal care I provide valued and supported

What we need to do differently as a system

Employ more local people supported by efficient, streamlined, and accessible recruitment processes, promoting diversity and ensuring that under-represented groups have the opportunity to be employed in our services. We will contribute to the local economy by upskilling and employing local people who are unemployed or at risk of unemployment as well as investing in growing our own workforce from within, creating a consistent pipeline in partnership with our education institutions, and utilising system-wide approaches for all sectors.

Work collaboratively to develop one workforce across health and care in north east London. We will work together to develop a deal that all employers will offer with a focus on flexible career development and improved access to a consistent wellbeing and training offer shared across providers.

Work together to progress the London Living Wage commitments across north East London.

Prioritise retention of our current workforce, and create the opportunities for development across organisations to ensure that we have a stable and high performing workforce in all services. We will develop system approaches to career pathways, leadership and development.

Support the health and wellbeing of our staff, with a consistent offer of support for staff which recognises the challenges brought by the Covid-19 pandemic and current cost of living crisis.

Develop and recognise our social care and voluntary workforce and prioritise specific retention programmes, ensuring that they have support when needed.

Value the contribution of carers and provide more and better support to them so that they are able to provide better support for others as well as improve their own health and wellbeing.

What success will look like for our people

- *Working in health and care in north east London, I feel valued and respected*
- *I have meaningful work and am able to support myself and my family financially*
- *I have access to training and career development opportunities whichever part of the local health and care system I am currently working within*
- *I feel I have local employment and volunteering opportunities across a range of health and care settings, regardless of my background*
- *I am able to care for my loved one, my contribution is recognised and valued, and help is there for me when I need it*

What success will look like as outcomes for our people

- Increase the number of local residents working in health and social care, ensuring that our workforce is representative of the community it serves.
- Our carers feel supported, valued and provided with the skills to deliver personalised care to meet the needs of our residents.
- Consistent and joint financial approach between health and care to avoid inequity across health and care sectors.
- Staff will be able to transfer easily between employers in health and care
- All staff in all sectors will have access to a consistent health and well-being offer, building on our Keeping Well NEL platform that supports staff retention.
- As part of our employment deal, a consistent offer of development, flexibility and mobility that all organisations in north east London sign up to, including recognition of skills across sectors and professions.
- We are increasing the ethnic diversity of board level and senior leadership to reflect the make-up of the population in NEL

Draft content

How we work as an integrated care system – our 6 cross cutting themes

Equity

Working together as a system to tackle **health inequalities** including a relentless focus on equity underpinning all that we do

What success will look like for our system

In addition to the specific health inequalities measures set out in relation to our four priorities above:

- Across north east London we are reducing the difference in access, outcomes and experience with a focus on people from black and minority ethnic communities, people with learning disabilities, people who are homeless, people living in poverty or deprivation and for carers.
- Healthy life expectancy is improved across NEL and the gap between our most and least deprived areas / those living in poverty and the wealthiest is reduced.
- We have improved ethnicity data collection and recording across health and care services and deliver inclusive, culturally competent and trusted health and care services to our population.
- Our staff have access to training on health inequalities and we routinely measure and address equity in NHS waiting lists.
- We are mitigating against digital exclusion.
- Tackle racism and increase cultural competence and cultural awareness in services

Prevention

A greater focus on prevention and **health creation** across the whole of our system including **primary** and **secondary prevention** and the wider determinants of health.

What success will look like for our system

In addition to the specific prevention measures set out in relation to our four priorities:

- We invest more in prevention as a system to reduce prevalence of long term conditions and mental health equitably across all of our places.
- We identify and address unmet need including diagnosing more people early and increasing access to care and support particularly for our most vulnerable or underserved groups.
- We invest in our community and voluntary sector to support prevention and early intervention in a range of ways to suit our diverse population.
- Through our role as anchor institutions, we support economic development by emplying local people and prioritising social value in procurement.
- We share and use data to identify the most vulnerable people living locally including those not using services and those frequently using services to provide more targeted and proactive support which better meets their needs.

Personalisation

We will deliver health and care that is **holistic, personalised and trauma–informed** supported by seamless integration across service and organisational boundaries.

What success will look like for our system

- Staff have access to all the information they need in one place to enable them to provide seamless care to local people and can share this information safely through our IT systems.
- Local people including carers only need to tell their story once through their health and care journey.
- Local people are asked what matters to them in setting their treatment or care goals and can access a wide range of non-medical support in the community.
- Particularly vulnerable residents are identified and given additional support to access services ensuring their experience and outcomes of care are equitable.
- Our staff are equipped to deliver trauma-informed care based on the principles of physical and psychological safety; trust; choice; collaboration; empowerment; and cultural competence.

Co-production with local people and all partners, particularly drawing on the **strengths and assets** of individuals and communities, rebalancing power.

What success will look like for our system

- We can evidence how decisions taken by our boards are informed by the views of local people.
- We helped establish a community and voluntary sector collaborative and actively support and resource its development.
- We train a wide range of health and care staff in co-production and power sharing approaches.
- We can demonstrate how we have identified and engaged underserved groups and the full diversity of our local population.
- We use existing sources of insight from local people including carers to shape our strategies and plans and resist repeatedly asking the same questions.
- We close the loop when we seek the views of carers and local people by feeding back.

High trust We will endeavour to develop a high trust environment supporting **partnership working, collaboration** and **integration** across the whole of our system, with the contribution all partners valued equally.

What success will look like for our system

- Partners in the ICS feel actively engaged
- Partners have adopted an ‘open book’ approach including how we spend our money
- We challenge each other constructively without blame
- We are open to new ways of working and share risk as a system

Learning system We will work as a learning health and care system making the best use of **data, evidence, research** and **insight** to drive continuous development and **improvement,** encourage **innovation** and accelerate progress through shared learning.

What success will look like for our system

- We use data, evidence and insights to build our understanding of our population and to drive our ambitions, priorities, transformation and improvements.
- We regularly review the impact we are having through evaluation of our services and transformation programmes and make changes based on this learning.
- We innovate and enable shared learning to accelerate adoption of innovation, research and best practice throughout our system.
- We support and encourage research that is focused on improving health and care for local people and involve more local people in research

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HEALTH SCRUTINY COMMITTEE

1 February 2023

Title: Scrutiny Review on the potential of the Voluntary and Community Sector 2022/23	
Report of the Director of Community Participation and Prevention	
Open Report	**For Information**
Wards Affected: All	**Key Decision:** No
Report Author: Claire Brewin – Policy Officer (Communities) Sophie Keenleyside – Strategy and Programme Officer	**Contact Details:** E-mail: claire.brewin@lbbd.gov.uk
Accountable Director: Rhodri Rowlands, Director of Community Participation and Prevention	
Accountable Strategic Leadership Director: Fiona Taylor, Acting Chief Executive, LBBD and Place Partnership Lead	

Summary

The key lines of enquiry for the Health Scrutiny Committee's scrutiny review into the potential of the Voluntary, Community and Social Enterprise (VCSE) sector and health locally are:

(i) How is the VCSE helping to reduce health inequalities within communities, both separately and in partnership with the statutory sector; and
(ii) How can we work better at 'place' (Barking and Dagenham) and sub-borough levels to ensure that the VCSE and residents have an active and meaningful role in informing and shaping future strategy / service delivery?

This report provides the context for a scrutiny review into the Voluntary and Community Sector's provision of health inequalities work within communities and the ways in which the Council can contribute to a helpful work environment, enabling the VCSE to play an active role in service delivery.

The report outlines key data, summarises the existing landscape of VCSE delivery in the context of health inequalities and provides a methodology and timeline for the review, which will take place in early 2023.

Recommendation(s)

The Committee is recommended to:

- Note the existing VCSE healthcare landscape and current health data relevant to the Borough; and
- Note the proposed timeline (as it stands) for consultation with statutory partners, the VCSE, and residents.

Reason(s)

To enable well-functioning VCSE healthcare provision that helps every resident to take pride and responsibility over their health and wellbeing, and to allow the VCSE and residents to play a meaningful role in shaping future health service delivery.

1. Introduction and Background

1.1 Barking and Dagenham remains one of the most economically-deprived boroughs in London. Health is bound up in inequalities and those in less financially prosperous positions are less likely to access the proper healthcare, medicine, and nutrition that they require. The Borough continues to witness rising levels of obesity and cardiovascular diseases, both of which result in lifelong consequences. As the rising cost of living puts additional strain on the Borough, the need to ensure sufficient healthcare provision that works best for residents only grows more imperative.

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

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

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

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

1.6 The Terms of Reference that were agreed by the Committee are as follows:

1) How is the VCSE helping to reduce health inequalities within communities, both separately and in partnership with the statutory sector; and

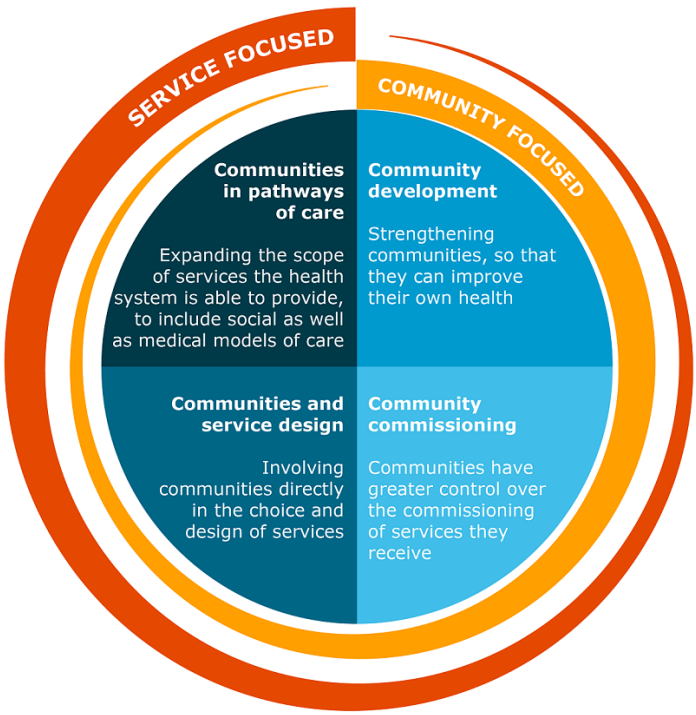
2) How can we work better at 'place' (Barking and Dagenham) and sub-borough levels to ensure that the VCSE and residents have an active and meaningful role in informing and shaping future strategy/service delivery?

1.7 The scrutiny review will be concluded by the end of this municipal year.

2 National and Local Health Context

2.1 Health inequalities are longstanding and worsening in England (e.g. the health gap is growing between wealthy and deprived areas, improvements in life expectancy have stalled for men and declined for women in the most deprived areas)[1]. Addressing health inequalities at scale requires a place-based approach of interventions across systems: civic-level interventions, service-based interventions and community-based interventions (the 'Population Intervention Triangle')[2].

2.2 The Barking and Dagenham Annual Director of Public Health Report 2021/22 highlights the need to both put people and communities at the centre of decision-making on services and developing community-centred approaches to health and wellbeing. This will involve doing "with" not "to" people" though an approach that supports and maximises community assets to harness the 80% of health determined outside of health services. The below figure from the King's Fund illustrates a model for supporting communities to improve their health[3].



[1] February 2020, Institute of Health Equity, Health Equity in England: The Marmot Review 10 Years On.
[2] 2020, Public Health England, Community Centred Public Health
[3] May 2021, Kings Fund, Communities and Health

2.3 Local government is the primary funder of VCSE organisations at 68% of VCSE contracts[4]. This contrasts with 13% of contracts from Central Government, and just 11% from the NHS. Barking and Dagenham Council maintains a strong relationship with its VCSE, but more could be done to explore how the Council can best support health and wellbeing in the community, alongside the social care commissioning contracts that are already in place.

2.4 There are several challenges outlined in 'the Role of the Voluntary, Community, and Social Enterprise (VCSE) Organisations in Public Procurement'[5] report that VCSE organisations are facing. These include, in brief:

- Payment timelines and prompt payments;
- Awareness of opportunities and access to tenders;
- Technological barriers;
- Skills and capacity issues, particularly in smaller organisations;
- Contract design as a barrier to engagement; and
- Exclusion from project tender specification due to scale and price.

2.5 Local engagement and co-production are recommended by the report to explore how to support the VCSE in public sector procurement, to address capacity concerns and contract readiness.

2.6 Integrated Care Systems (ICS) became statutory in England on 1 July 2022. The Integrated Care Partnership component of the ICS, which brings together key system partners for health and social care, including VCSE organisations, represents an opportunity for the VCSE sector to become more embedded in service design and decision-making for health and wellbeing.

3 The existing VCSE landscape in Barking and Dagenham

3.1 The capacity of the VCSE in Barking and Dagenham has grown significantly over the last few years. Participation and Engagement became a priority in the 2020-22 Corporate Plan and a new social infrastructure contract was commissioned to the BD_Collective – a network of networks – sharing power between the state and civil society.

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

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

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[4] August 2022, Department for Digital, Culture, Media and Sport, The role of Voluntary, Community, and Social Enterprise (VCSE) organisations in public procurement

[5] August 2022, Department for Digital, Culture, Media and Sport, The role of Voluntary, Community, and Social Enterprise (VCSE) organisations in public procurement

3.4 The Council also partnered with Participatory City Foundation to develop Every One Every Day, a local project and the biggest peer-to-peer participation programme in the country, with a network of activity project shops across the Borough.

3.5 Most recently, the local partner Community Resources worked alongside the Council in setting up the Locality Model to address health inequalities and provide and cost-of-living support. Five VCSE organisations act as Locality Leads across six geographical areas, providing local connections in communities and triaging support with a network of community partners, to ensure that residents in need can access the most appropriate support.

3.6 There is still more that we can do to work more effectively with the VCSE in the context of addressing health inequalities and enabling wellbeing, but what has worked well over the last few years can provide Public Health with the confidence that working together can produce better outcomes for all, allow residents to make decisions and shape services and create a supportive system where, rather than working in competition with each other, we work together.

4 Strategic context and outcomes for action

4.1 The co-produced, long-term vision for Barking and Dagenham through the Borough Manifesto outlines a range of ambitious cross-partnership targets to be achieved by the year 2037. In relation to health inequalities, the Borough Manifesto sets goals that by 2037:

- Healthy weight will be better than the East London average;
- Personal wellbeing and happiness will be above the London average;
- Healthy Life Expectancy will be better than the London average; and
- The rate of regular physical exercise will be higher than the East London average.

4.2 The long-term vision of the Borough Manifesto is translated into medium-term priorities in the Council's current Corporate Plan. Refreshed at a time of upheaval with the pandemic and associated financial challenge, the Corporate Plan 2020-2022 sets out "5 giants" on the road to social progress for Barking and Dagenham:

1) Domestic abuse;
2) Social isolation;
3) Unemployment;
4) Debt; and
5) Neighbourhood crime.

4.3 The Corporate Plan outlines the programmes of work that the Council and wider partnership are undertaking to address the "5 giants" - all of which are areas that drive health inequalities. It is boldly stated in the Corporate Plan that unacceptable levels of health inequalities hold many Barking and Dagenham residents back. Through addressing the 5 giants as a system, the Borough will make traction in reducing health inequalities.

4.4 Achieving the health inequalities-related goals in the Borough Manifesto requires input from partners beyond the local authority and NHS, and a focus on prevention

of ill-health. Much of the Borough's relatively poor health outcomes are driven by deprivation and the wider determinants of health. The Joint Health and Wellbeing Strategy 2019-2023 therefore has a strong emphasis on prevention. Priority themes in the Strategy comprise:

- Best Start in Life;
- Early Diagnosis and Intervention; and
- Building Resilience.

5 Methodology and consultation

5.1 The review will entail a series of evidence sessions with statutory and VCSE partners as well as residents across January and February 2023. These sessions will explore the health infrastructure already in place, the challenges, and relationships between statutory and VCSE partners, as well as what could be done to facilitate more meaningful health inequalities work whereby residents and the VCSE play an active role in shaping future service delivery.

5.2 The sessions will include both presentation-style scoping and discussion as well as question and answer opportunities and action planning, culminating in a final report which will be produced at the end of March 2023, detailing the findings from the evidence gathering period and recommendations for future health strategy and collaboration work with the VCSE.

5.3 The Terms of Reference will be explored in the evidence sessions, and are as follows, with more detailed points to explore below; these are shared at this stage as examples. We expect that these will evolve as the Committee hears evidence:

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

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

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

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

6 Work Plan and Timeline

6.1 The below indicates an estimated timeline of the evidence gathering sessions and report for early 2023.

Month	Title	Details
November	Health Scrutiny Committee	Terms of Reference agreed by Committee on 14 November 2022
December	HSC Scrutiny Review: Context Setting	Report to outline proposed workplan and timeline, as well as context-setting presentation to Committee on 19 December 2022
February	Evidence Session 1: VCSE Introduction Session	Introductory session with key VCSE organisations and leads to consider exploring the current health infrastructure, remit, and context to inform and shape the review
February	Evidence Session 2: Session with key health and social care system partners	Session with key health and system partners to understand how the statutory health and social care system works and its role in strategy, commissioning, and funding
March	Evidence Session 3: Good practice showcase and learning	Delivery showcase and Q&A (range of stakeholders) to reveal good practice, case studies, how to build on current context, and scale and embed good ethos
March	Evidence Session 4: Action planning	Action planning with statutory partners with a focus on how we can work better at ensuring that the VCSE and residents have an active and meaningful role in informing and shaping future strategy and service delivery
April	Evidence Session 5: Action planning	Action planning with the VCSE on the above
TBC	Final report and presentation	A report drafted including the findings from the evidence gathering sessions and recommendations for the future

7 Background information

7.1 Members are recommended to familiarise themselves with the reading materials listed in Appendices 1 to 4, which will be referred to throughout the preparation of the scrutiny report.

Public Background Papers Used in the Preparation of the Report:

- Kings Fund Community and Health Blog: Communities and health | The King's Fund (kingsfund.org.uk)

- New Local's Community Powered NHS: A Community-Powered NHS - New Local
- PHE's Community Centred Public Health: Community-centred public health: Taking a whole-system approach (publishing.service.gov.uk)

List of appendices:

- Appendix 1: Health Scrutiny Committee: Scrutiny Review on the potential of the Voluntary and Community Sector 2022/23 (Presentation)

Appendix 1

Barking & Dagenham

Health Scrutiny Committee:

Scrutiny Review on the potential of the Voluntary and Community Sector 2022/23

one borough; one community; no one left behind

Introduction

Barking and Dagenham remains one of the most economically-deprived boroughs in London, and subsequently has some of the greatest health inequalities in London and England.

The need to ensure sufficient healthcare provision that works best for residents only grows more imperative, especially in light of the challenges faced by residents due to the cost-of-living crisis.

Community partners play a critical role in supporting our residents with their health and wellbeing. These organisations maintain strong connections with those that they help and uphold knowledge of the needs and demands of their specific communities. These groups are particularly helpful for residents who are harder to contact or those who have little trust in the Council or statutory partners.

In the 2022 Joint Strategic Needs Assessment (JSNA), a gap of meeting the demands of those with greatest need was identified – health and wellbeing remains a key priority for the Council and Borough. A transformation of existing services will be needed to bridge this gap, whilst also highlighting the work already provided by the Voluntary Community and Social Enterprise (VCSE) sector and establishing better relationships between statutory partners and community groups.

The VCSE can play a role in providing what statutory partners cannot.

Key Lines of Enquiry

The Terms of Reference agreed by the Committee that the scrutiny review will seek to evaluate are as follows:

i. How is the VCSE helping to reduce health inequalities within communities, both separately and in partnership with the statutory sector; and
ii. How can we work better at 'place' (Barking and Dagenham) and sub-borough levels to ensure that the VCSE and residents have an active and meaningful role in informing and shaping future strategy / service delivery?

The scrutiny review will be concluded by the end of this municipal year.

National and Local Health Context

- Health inequalities have widened in England. Addressing health inequalities at scale requires a place-based approach of interventions across systems.

- There is now a greater focus on placing people and communities at the heart of decision-making regarding services and community-centred approaches to health and wellbeing.

- Local government is the primary funder of VCSE organisations (68% of contracts). LBBD has an existing strong relationship with this sector, but more can be done to explore how best to support health and wellbeing in the community alongside the social care commissioning contracts that are already in place.

- VCSE organisations face several challenges regarding public sector procurement. Local engagement and co-production are recommended by the report to explore how to support the VCSE in public sector procurement, to address capacity concerns, and with contract readiness.

- Since Integrated Care Systems (ICS) became statutory in England in July 2022, there is greater opportunity for the VCSE sector to become more embedded in service design and decision-making for health and wellbeing.

The existing VCSE landscape in Barking and Dagenham

- The capacity of the VCSE in LBBD has grown massively over the past few years.

- Some of the projects we have been working on include:
  - **BD Collective** – commissioning of a new social infrastructure contract and the development of a collaborative model of support for each other and residents.
  - **BD Giving** – the setting up of a participatory grant funding organisation, allowing residents to get involved with funding what matters to them.
  - **Every One Every Day** - a partnership with Participatory City Foundation to grow the biggest peer-to-peer participation programme in the country, with a network of activity project shops across the Borough.
  - **Community Resources** – the development of a locality leads model which has helped to address health inequalities and provide support in regards to the cost-of-living crisis.

Strategic context and outcomes for action

- Borough manifesto goals regarding health and wellbeing to be achieved by 2037:
  - Healthy weight will be better than the East London average
  - Personal wellbeing and happiness will be above the London average
  - Healthy Life Expectancy will be better than the London average
  - The rate of regular physical exercise will be higher than the East London average

- There are 5 priorities or 'giants' for social progress in LBBD – these drive health inequalities and so we aim to challenge these:
  - Domestic abuse
  - Social isolation
  - Unemployment
  - Debt
  - Neighbourhood crime

- The focus of the Joint Health and Wellbeing Strategy 2019-2023 is the prevention of ill-health. Priority themes mentioned in this Strategy are:
  - Best Start in Life
  - Early Diagnosis and Intervention
  - Building Resilience

Methodology and timeline

- The evidence sessions will include presentation-style scoping and discussion as well as Q&A opportunities and action planning.
- A final report will be produced, detailing the findings from the evidence gathering period and recommendations for future health strategy and collaboration work with the VCSE.
- The key lines of enquiry mentioned previously will be explored at these sessions.

Month	Title	Details
February	Evidence Session 1	Introductory session with key VCSE organisations and leads, exploring the current health infrastructure, remit, and context to inform and shape the review
February	Evidence Session 2	Session with key health and system partners to understand how the statutory health system works and its role in strategy, commissioning, and funding
March	Evidence Session 3	Delivery showcase and Q&A to reveal best practice, case studies, how to build on current context, and scale and embed good ethos
March	Evidence Session 4	Action planning with statutory partners with a focus on how we can work better at ensuring that the VCS and residents have an active and meaningful role in informing and shaping future strategy and service delivery
April	Evidence Session 5	Action planning with the VCS on the above
TBC	Final report and presentation	A report drafted including the findings from the consultation sessions and recommendations for the future

Questions

HEALTH SCRUTINY COMMITTEE

14 November 2022

Title: Work Programme 2022/23	
Report of the Acting Chief Executive, LBBD and Place Partnership Lead	
Open Report	**For Information**
Wards Affected: None	**Key Decision:** No
Report Author: Claudia Wakefield, Senior Governance Officer	**Contact Details:** Tel: 020 8227 5276 E-mail: claudia.wakefield@lbbd.gov.uk
Accountable Director: Alan Dawson, Head of Governance and Electoral Services	
Accountable Strategic Leadership Director: Fiona Taylor, Acting Chief Executive, LBBD and Place Partnership Lead	

Summary

This report details two proposed amendments to the Health Scrutiny Committee's Work Programme, since the Committee's last meeting on 14 November 2022:

- Finalised Governance Arrangements for Place-Based Partnership: It is now proposed that this item (due to be presented to the Committee on 29 March 2023) also includes an update on the Joint Forward Plan (JFP), to provide additional context and as a draft of the JFP is due by 1 April 2023.
- Draft Joint Local Health and Wellbeing Strategy: It is proposed that this item be added to the 29 March 2023 agenda, to enable the Committee to provide any comments before the Strategy is approved at the Health and Wellbeing Board meeting on 13 June 2023.

Recommendation(s)

The Health Scrutiny Committee is recommended to agree the amendments to the Work Programme, as set out in this report.

Reason(s)

It is good practice to inform the Health Scrutiny Committee of any amendments to the Work Programme and to ask the Committee to agree these.

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

List of appendices:

Appendix 1: HSC Work Programme 2022/23

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Work Programme 2022/23 *(This is a live document which is subject to late changes)* **Appendix 1**

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

Health Scrutiny Committee Chair: Councillor Paul Robinson			
Meeting	**Agenda Items**	**Officer/ Organisation**	**Deadline to be:**
29 March 2023	NELFT CQC Inspection Update	Melody Williams, Integrated Care Director (NELFT)	Monday 13 March
	Health Inequalities Funding (Full Presentation)	Mike Brannan, Consultant in Public Health; Sophie Keenleyside, Strategy and Programme Officer; Elspeth Paisley, Community Chest; Dr Shanika Sharma, GP; Justine Henderson, Interim Early Help Programme Lead	
	Finalised Governance Arrangements for Place-Based Partnership and Joint Forward Plan	Fiona Taylor, Place Partnership Lead for Barking and Dagenham	
	Draft Joint Local Health and Wellbeing Strategy	Matthew Cole, Director of Public Health	
24 May 2023	Mental Health Transformation Grant	Melody Williams, Integrated Care Director (NELFT)	Monday 8 May

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