Barking & Dagenham

Notice of Meeting

HEALTH SCRUTINY COMMITTEE

Wednesday, 24 May 2023 - 7:00 pm
Council Chamber, Town Hall, Barking

Members: Cllr Paul Robinson (Chair) Cllr Michel Pongo (Deputy Chair); Cllr Muhib Chowdhury, Cllr Irma Freeborn, Cllr Manzoor Hussain and Cllr Chris Rice (subject to confirmation at Annual Assembly)

By Invitation: Cllr Maureen Worby

Date of publication: 16 May 2023

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Acting Chief Executive

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Please note that this meeting will be webcast via the Council's website. Members of the public wishing to attend the meeting in person can sit in the public gallery on the second floor of the Town Hall, which is not covered by the webcast cameras. To view the webcast online, click here and select the relevant meeting (the weblink will be available at least 24-hours before the meeting).

AGENDA

1. Apologies for Absence

2. Declaration of Members' Interests

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

3. Minutes - To confirm as correct the minutes of the meeting held on 29 March 2023 (Pages 3 - 10)

4. Health Inequalities Programme (Pages 11 - 25)

5. Mental Health Transformation Programme Update - One Year On (Page 27)

6. 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

7. Minutes of Barking and Dagenham Partnership Board (Pages 29 - 33)

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

9. 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.***

10. 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

Wednesday, 29 March 2023
(7:00 - 9:11 pm)

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

72. Declaration of Members' Interests

There were no declarations of interest.

73. Minutes - To confirm as correct the minutes of the meeting held on 1 February 2023

The minutes of the meeting held on 1 February 2023 were confirmed as correct.

74. NELFT CQC Inspection Update: March 2023

The Associate Director of Nursing and Quality (ADNQ) at the North East London NHS Foundation Trust (NELFT) and the Integrated Care Director (ICD) for Barking & Dagenham at NELFT presented an update on the NELFT Care Quality Commission (CQC) Inspection as of March 2023. This provided context as to:

- The CQC Well-Led inspection of NELFT between April to June 2022, with NELFT subsequently being issued with a new rating of “Good”;
- Overall Well-Led feedback that NELFT had received from the inspection;
- Positive feedback that had been received as to safeguarding at NELFT;
- The Well-Led Improvement Plan, including the nine “Should Do” recommendations that had the CQC had made following the Well-Led review, and the monitoring and progressing of the Improvement Plan; and
- The Quality Support Visit programme at NELFT.

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

- During the Covid-19 pandemic, complaint response times had decreased, as well as investigations around the most serious incidents; as such, there had been some delays and some increased 90-day responses for complaints and increases around the 45-day response for serious incidents being completed.
- Since the pandemic, this response backlog had improved. NELFT had a very robust process in terms of incidents being reviewed on a daily basis through Datex, which was an electronic system used by NELFT for incident reporting and complaints monitoring. NELFT’s acknowledgement rate of complaints within three days was now at 90%, with the close-down of complaints in terms of the 28-day framework being dependent as to the complexity of the complaints themselves.
- Some of the Inspectorate team that had inspected NELFT in 2022, had also inspected NELFT in 2019. The Lead Inspector had praised NELFT for its cultural and behavioural changes, with many of the challenges previously

identified in the 2019 inspection, such as around senior leadership, having been addressed, such as through different Chief Executive arrangements and embedding a more just and compassionate culture.

- NELFT aspired to become an “Outstanding” Trust; the Trust would use its CQC action plan and the number of quality improvement workstreams within this, to meet the requirements in order to achieve this “Outstanding” rating.
- NELFT faced a number of challenges, such as operating in an area of significant population growth and the continued impact of the Covid-19 pandemic. The new place-based arrangements would present a different opportunity around how NELFT planned and organised health provision to help address some of these challenges.
- NELFT had a number of staff recruitment and retention programmes, with the recruitment process having an induction and speed-dating for new recruits. NELFT also had one of the best staff survey results in London. It had a number of accolades in terms of its work around recruiting staff from Black Asian Minority Ethnic (BAME) backgrounds; in Barking and Dagenham, 60% of its workforce came from a BAME background.
- NELFT’s staff had voiced that they came to work for NELFT due to its inclusivity, agile working and flexibility, having won awards around family friendly practices, workforce race equality standards and disability standards.
- There was a national workforce shortage; whilst some disciplines were harder to recruit to, NELFT was working to recruit in these specialisms. NELFT had also recruited over 240 internally educated nurses this year and was working to nurture this staff group.
- The diversity of NELFT’s senior leadership team was increasing. In terms of the local leadership team of 14 colleagues, 11 were from a BAME background. The NHS was composed of more females than males, with the Senior Leadership team reflective of this.
- There were no 18-week breaches in terms of people accessing community learning disability services in Barking and Dagenham; however, there were 18-week breaches in the Adult’s Autism, Paediatric Autism and Paediatric Speech and Language pathways. During the pandemic, Autism assessments were suspended as the physical assessment had to be completed without a mask; NELFT was currently addressing the backlog through a new pathway around Paediatric Autism, autism assessments and diagnostic services.
- In terms of managing waiting lists, this depended on the service; in some services, staff had been refocused to provide assessment and initial treatment, as opposed to longer-term treatment. The amount of one-to-one service provision had decreased and group provision had been increased, so that more people were able to be seen by NELFT in a shorter time frame. Whilst group treatment worked well for some individuals, it did not for others; digital applications were also being employed to enable people to undertake one-to-one work.
- NELFT had also looked at different skill mix models, such as through utilising Assistant Psychologists to provide lower intensity programmes, to ensure that service users were not left without treatment. Clinical Harm reviews had also been introduced for waits of over 18 weeks, to ensure that service users were not declining whilst waiting for treatment.
- Whilst NELFT had received a small amount of funding to help address

backlog waiting lists due to the pandemic, this funding would not be recurring.
- The Governance structure was to be restructured following a recommendation from the CQC and from Deloitte, who NELFT had commissioned to undertake an internal well-led review; this would enable NELFT to better support the delivery of organisational objectives and to free up more capacity to support the emerging collaborative agenda.
- An area for future improvement was around Quality Improvement (QI) and being able to evidence the involvement of QI and quality improvement projects within the organisation, reviewing data and ensuring that NELFT's projects and improvements made were evidenced in this data. This would help to pinpoint the areas for improvement going forward.
- There was a QI team at NELFT, with a dedicated director for this, and there was also a dedicated QI Advisor for each locality. All staff were also able to undertake QI training.

75. Early Pregnancy Assessment Unit (EPAU)

The Consultant Obstetrician and Gynaecologist (COG) at Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) delivered a presentation on the Early Pregnancy Assessment Unit (EPAU), which provided context as to:

- The service itself and how it could be accessed;
- Care and support for people who miscarry;
- How the Trust worked to decrease the risk of repeat miscarriages; and
- How patient feedback was addressed by the Trust.

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

- It was recognised as best practice for an Early Pregnancy Unit to have a quiet room, where patients and their families could receive bad news and where staff could break this bad news. Prior to the pandemic, the Emergency Gynaecology Unit and the Early Pregnancy Unit were located on a different hospital ward; however, during Covid, the use of the wards was changed, with Gynaecology moving to a different ward and the new physical environment not being as bespoke for the service. As such, BHRUT was working to re-establish the quiet room which was present on the previous ward.
- In the new ward, women and families that received bad news would be taken to a quiet area in a side room; however, this was not currently bespoke.
- In regards to the decreased miscarriage rate in 2022/23 in comparison to during the pandemic, the birth rate had also recently dropped, with a direct link between a lower miscarriage rate and lower birth rate.
- There were some staff who were trained in mental health first aid, to support both staff members and patients. The staff that worked within the Early Pregnancy Unit were expected to have communication skills training, including around breaking bad news and in recognising patients who were in mental health distress.
- BHRUT had links with SANDS (a bereavement charity) and its Bereavement midwives did provide close support in terms of links with the Adults and Perinatal mental health services. The vast majority of this staff

also had experience of working within the maternity service; as there were close links with the perinatal mental health service, it was very easy to make a direct referral into these clinics. BHRUT also had the facility for inpatient referral to the Adult mental health services, for mental health crises as a result of an early pregnancy problem.
- There were referral criteria into the Perinatal mental health unit, with all midwives having a certain level of training in looking after patients who did have mental health concerns. There were two levels of the perinatal mental health service, with one being midwife-led and one being for women with more severe mental health illnesses, with these women being eligible to be seen within the joint consultant and perinatal psychiatric service. There was no waiting list to be seen in the joint clinic, with the service also being recognised as being a best practice model.

The Integrated Care Director (ICD) for Barking & Dagenham at NELFT stated that NELFT was the provider of the perinatal infant mental health services (PIMS), which operated across all four London areas in the outer northeast London programme. Delivery was across the community and in the acute service. There was also a maternal mental health specific pathway, known as the Tulip service. The PIMS service was essentially the first point of access into the perinatal mental health remit, with patients either being managed within the PIMS service or through the Tulip service. The Tulip service was commissioned during the pandemic and extended the reach agreement of the perinatal infant mental health service.

In response to further questions from Members, the COG stated that:

- One of the areas of quality improvement work was around flow through the service; the service was well known through social media advertising and BHRUT did not want to delay people's presentation with an early pregnancy problem. The COG also detailed the patient journey and flow through the service and the possible routes that this could take depending on the patient's needs. For those who had experienced a miscarriage, the COG also detailed their patient journey and support received, dependent on the type of miscarriage that they had experienced.
- There was a range of risk factors for early pregnancy problems, with miscarriage being a very common occurrence and arising in 30% of pregnancies. The COG detailed these risk factors, such as having had a previous miscarriage, a previous ectopic pregnancy, predisposing medical conditions, being older in age, smoking and some previous predisposing sexually transmitted infections. The service encouraged women to either see their GP early or to present themselves early to the Early Pregnancy Unit in these instances, or where these women had any concerns, anybody could present themselves to the service through self-referral. The COG also detailed some of the advice and guidance that was provided in these circumstances, as well as reassurance that the vast majority of women who had early pregnancy loss would go on to have a healthy pregnancy in the future. The COG also discussed the criteria around whether somebody was considered to have a recurrent miscarriage and the patient journey and support that would be provided in these cases.
- Ideally, women would present themselves for midwifery care at around nine weeks, in order that there was time for the screening tests that needed to

be undertaken as part of the antenatal service, and in line with national targets for presentation to maternity services. At this point, a woman would be risk assessed, which would also include history of previous pregnancies and pregnancy loss. Unless somebody had been diagnosed with an underlying medical condition, there was usually no additional antenatal treatment or care that was recommended for somebody who had had early pregnancy loss or somebody who had had a pregnancy loss in the second trimester previously. From around 13 weeks to 20 weeks, there was some additional support that would be put in place, but for under 12 weeks, the vast majority of women would not need anything additional in their antenatal care; however, community midwives would discuss this as part of a person's antenatal care and provide tailored advice. People could also approach the Early Pregnancy Unit if they were unsure about anything.

- Individuals who had experienced recurrent miscarriage could be offered genetic testing, to help identify if there were any genetic causes for miscarriage. Screening for other genetic conditions could also be undertaken during first trimester screening, with these women being looked after within the Fetal Medicine Unit; the COG detailed the various means of support provided and diagnostic means through this. The Fetal Medicine Unit worked very closely with King's College and had developed links with the fetal medicine network across the local maternity system, such as with Barts and the Homerton.
- If young people had experienced miscarriages but did not want to present to the service, whilst they should be encouraged to access the service, they could also talk to a trusted adult, or approach their school nurse, GP or wellbeing services within sexual health services. It would also be important to consider safeguarding, as well as their ability to access contraception services, for example, if they had experienced an unplanned pregnancy.
- Caring for staff was essential, particularly as obstetrics and gynaecology as a speciality had a very high attrition rate, with one of the reasons for this being the stress involved in the job. Within the Fetal Medicine Unit, there were regular debriefing sessions led by a Bereavement team; the Trust was looking to extend this into the Early Pregnancy Unit as it was now recognising more and more the emotional burden that could impact staff within this unit.
- The pandemic had brought more recognition of the need for more emotional wellbeing services for staff; BHRUT also had quite extensive psychological support services and if it was recognised that staff were in distress, the Trust could also arrange for events where staff could discuss any concerns that they had. BHRUT had implemented "Schwartz Rounds" during the pandemic, where staff could share their stories and where collective learning could take place. Much support during the pandemic had been modified to take place online and the Trust was now thinking about how it could run this face-to-face. The Trust was rolling out nursing advocates, who were trained in delivering psychological support and who could be accessed by staff for support.
- Compassion fatigue was a very well recognised phenomenon. There were different ways that the Trust could identify this, such as through complaints and incident reports; for example, if an individual was identified on a recurrent basis, this would be flagged up early, or if there was a particularly emotionally difficult complaint, then the COG would intervene directly to find out what was happening and ensure that support could be provided.

- The Trust could also monitor burnout and compassion fatigue, through means such as monitoring staff sickness levels, absenteeism, staff being late and staff cancelling shifts. If an individual had been identified as being particularly at risk, a conversation would be had with their line manager through a supportive route, ensuring that the individual was signposted to the necessary services to support their wellbeing. As a last resort and if the individual needed a break from working in their area, the Trust also had the facility to do this. Teams were also very close knit and were able to identify and provide support to their team members who may be suffering from burnout.

The Committee recommended that more work be undertaken to support fathers and partners during miscarriages and pregnancy loss, as it affected the whole family unit. It also recommended that more work be undertaken to support EPAU access for more vulnerable populations, including teenagers.

76. Proposed Governance for Place-Based Partnerships

The Council's Director of Public Health (DPH) delivered an update on the developing place-based partnership arrangements, which the Council had to agree with the North East London Integrated Care System (NEL ICS) and partners such as BHRUT and NELFT and which would come into place from 1 April 2023. The DPH stated that:

- All had been in discussions and wished to streamline processes; often there were too many meetings, with the same agenda items. As such, it was agreed that a joint Committee of the Health and Wellbeing Board meeting at the same time as the Integrated Care Board Sub-Committee would be a useful approach. This would assist in speeding up the decision-making process and help all partners to address health inequalities issues at a much quicker rate.
- Between now and July 2023, all partners would need to consider how this approach would operate, in terms of aspects such as administration. It may also consider whether membership of the Health and Wellbeing Board (HWB) would need to be refined; for example, Primary Care Networks (PCNs) and the GP Federation were not currently on the HWB or the ICB Sub-Committee.
- A report would be presented to the 13 June 2023 HWB and the June 2023 NEL ICS Board, asking all to agree to these arrangements in shadow-form for the next 12 months.
- Public Health would return to the Committee's 24 May 2023 meeting, to enable the Committee to ask any further questions that it had around the arrangements.
- It was hoped that the arrangements would bring issues closer to local politicians and residents, so that they could have a bigger say in decision-making around resources and how issues were addressed, so that services were more accountable to local people and were more tailored to their needs.

77. Joint Local Health and Wellbeing Strategy 2023-28 Refresh Framework for Delivery - Consultation

The DPH delivered a presentation on the Joint Local Health and Wellbeing Strategy 2023-28 refresh framework for delivery and consultation. This detailed:

- The statutory duty of the Council to produce a Health and Wellbeing Strategy, which sat with the Council's Health and Wellbeing Board. It set out the health and wellbeing needs of residents and mapped out what was needed to be undertaken over the next three to five years to improve health outcomes;
- The context, intended vision and key principles behind the Strategy;
- How the Joint Health and Wellbeing Strategy interlinked with other strategies and delivery plans;
- The consultation dates for the Strategy, which was open for comment between 30 March and 30 April 2023; and
- How it was intended for the Strategy to be monitored in terms of progress.

The Committee requested an informal consultation session between itself, the Cabinet Member for Adult Social Care and Health Integration and Public Health, for Members to provide wider Committee feedback on the Strategy.

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

- The consultation was available online, for residents and interested partners to provide comment. The consultation was also being complimented with various focus groups, working with specific partners that the Council had networks with. The Council was also engaging with professionals, partners and the wider community through social media, digital media through the website and the Council's newsletter.
- Consultation had also recently being undertaken around the Council's Best Chance in Life Strategy for prenatal conception care through to age 25; the outcomes of which were also being factored into the Health and Wellbeing Strategy.
- The Council was engaging with typically "harder-to-reach" patient groups, such as the homeless, asylum seekers and emerging communities, such as the growing Romanian community, through its existing networks, partners and Healthwatch.
- One of the most difficult aspects of delivering medical and mental health care was communication. There were various barriers to being able to communicate with people, such as where an individual had a learning disability or a language issue, or due to technical medical language. When new communities came to the Borough, there was also often a need to explain how they could access primary care, registering with a GP and what an individual was entitled to through the health system.
- The Council was investing more in interpretation services, as it had found that leaflets were often ineffective in assisting those who were not fluent in English.

The Integrated Care Director at NELFT stated that NELFT had a contract with the Language Shop, which provided interpretation services across a range of London boroughs and health providers, for both sign and spoken languages, in telephone and in-person formats. Whilst it recognised that many families would translate for other family members, it did not rely on this as a source of translation, as it acknowledged that family members could mistranslate information, as well as due to challenges in the Borough around issues such as domestic violence and coercion. If an individual had an access need, they were able to highlight this prior to their appointment, so that NELFT was able to provide interpretation services.

The DPH also stated that in many languages, there was often not a direct translation for some medical diagnoses or conditions, which could prove difficult in explaining certain terms to individuals; the Council was investing in learning and work around this through its Health Inequalities project work, investing in community advocates and by co-locating community hubs within faith community spaces.

In response to further questions from Members, the DPH stated that the Council was engaging well with well-established partners from the LGBTQ+ community and with children and young people. The Borough was also continuously assessing the needs of its children and young people through its annual school health survey, in conjunction with the University of Bristol.

A Member stated that the needs of the Lithuanian community needed to be better considered, with many not understanding where to go when they had speech and language problems. The Member had had to signpost these individuals to services in Newham, as they were able to liaise with services in their native language there. The DPH stated that this would be factored into the consultation, ensuring that further work would target this group to improve their access to services.

78. 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.

79. Minutes of Barking and Dagenham Partnership Board

It was noted that the minutes of the last meeting of the Barking and Dagenham Partnership Board were included from pages 69-80 of the agenda pack.

80. Work Programme

The Work Programme was agreed.

HEALTH SCRUTINY COMMITTEE

24 May 2023

Title: Health Inequalities Programme	
Report of the Consultant in Public Health	
Open Report	**For Information**
Wards Affected: None	**Key Decision:** No
Report Authors: Dr Mike Brannan, Consultant in Public Health and Sophie Keenleyside, Public Health Strategy and Programme Officer: London Borough of Barking and Dagenham (LBBD) Craig Nikolic, Chief Operating Officer; Dr Shanika Sharma, Chair and Brinda Sinclair, Programme Director: Together First Community Interest Company (CIC) Elspeth Paisley, Health Lead: Community Resources	**Contact Details:** mike.brannan@lbbd.gov.uk sophie.keenleyside@lbbd.gov.uk
Accountable Director: Matthew Cole, Director of Public Health	
Accountable Strategic Leadership Director: Elaine Allegretti, Strategic Director Childrens and Adults	

Summary

The appended presentation provides an update on achievements of the funding allocated by NHS North East London to the London Borough of Barking and Dagenham on behalf of the Barking and Dagenham Place-based Partnership in 2022/23 to address health inequalities at the Place level. It outlines the jointly developed place-based approach to health inequalities, an overview of partnership projects within the programme, achievements to date and an outline of 'next steps' for the year 2023/24.

Recommendation(s)

The Health Scrutiny Committee is recommended to:

(i) Note the workstreams and project achievements/deliverables within the programme; and
(ii) Note timelines and next steps for the programme for the financial year 2023/24.

Reason(s)

The Health Scrutiny Committee requested partners delivering the projects funded with the health inequalities funding from the NHS North East London Integrated Care Board to

report to the Committee at the end of the financial year 2022/23. Furthermore, 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: B&D Health Inequalities Programme 22/23 Presentation
- Appendix 2: North East London Health & Care Partnership Health Inequalities Programme Funding Criteria
- Appendix 3: The Core20PLUS5 Approach

Appendix 1

NHS North East London

Barking & Dagenham

NHS Barking, Havering and Redbridge University Hospitals NHS Trust

Together First CIC Barking & Dagenham Federation

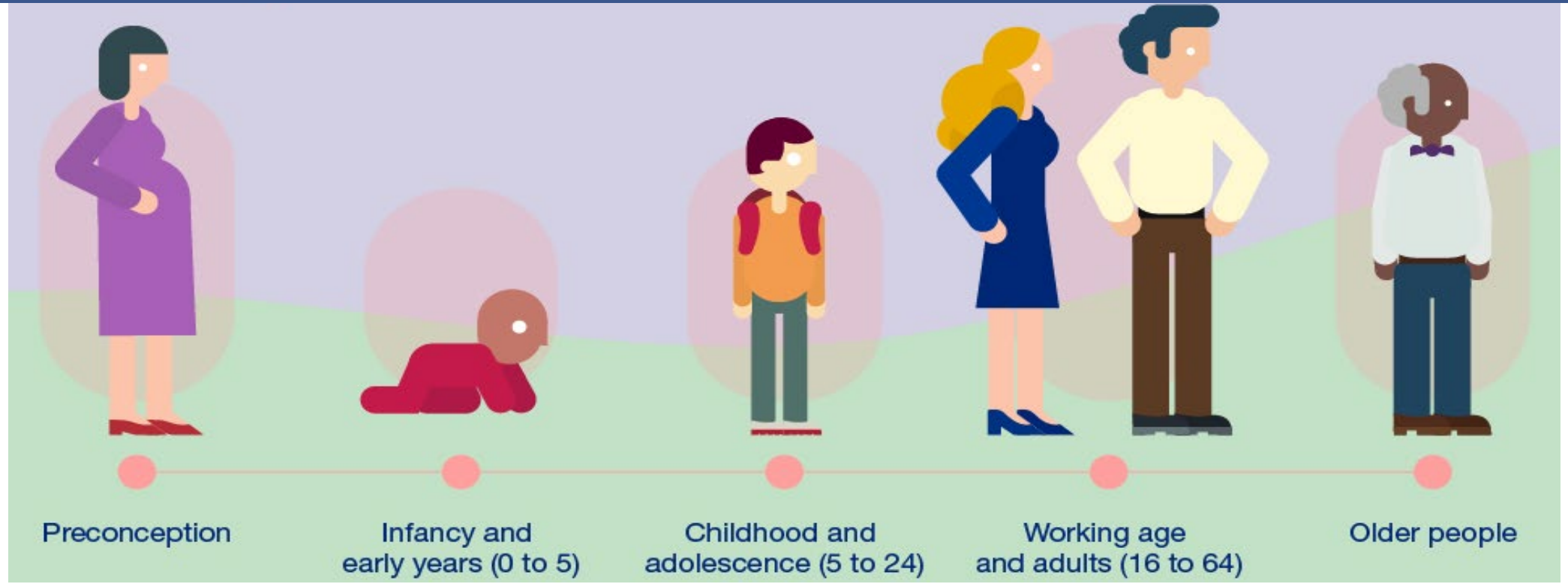
NELFT NHS NHS Foundation Trust

BD COLLECTIVE

B&D Health Inequalities Programme 22/23

Health Scrutiny Committee, 24 May 2023

B&D Inequalities Across the Life Course



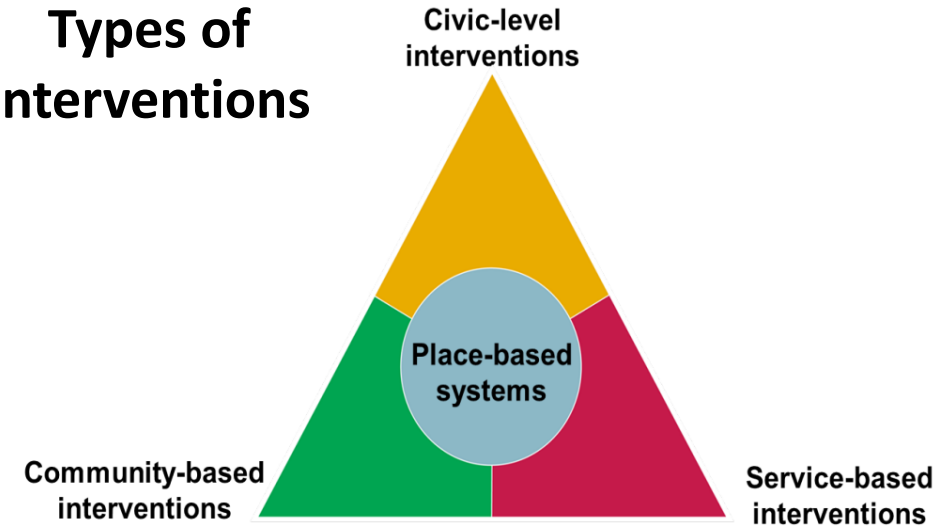
	Obesity in Pregnancy % (2018/19)	Low Birth Weight at Term (2021)	Good Development at 2-2.5 yrs (2021)	Children Living in Absolute or Relative Poverty (2022)	Unhealthy Weight at 10/11 yrs (2021/22)	Economic Inactivity 16-64yrs (2021/22)	Domestic Abuse Incidents per 1,000 population (2021/22)	Healthy Life Expectancy M/F (2018/20)	Life Expectancy at Birth M/F (2021)
B&D	27.4%	3.8%	56.0%	49.0%	49.1%	30.2%	35.4	58.1/60.1 yrs	75.6/80.3 yrs
London	17.8%	3.3%	79.9%	29.5%	40.5%	20.5%	35.4	63.8/65.0 yrs	78.8/83.4 yrs
England	22.1%	2.8%	81.1%	37.0%	37.8%	21.2%	30.8	63.1/63.9 yrs	78.8/82.8 yrs

What Works To Reduce Health Inequalities

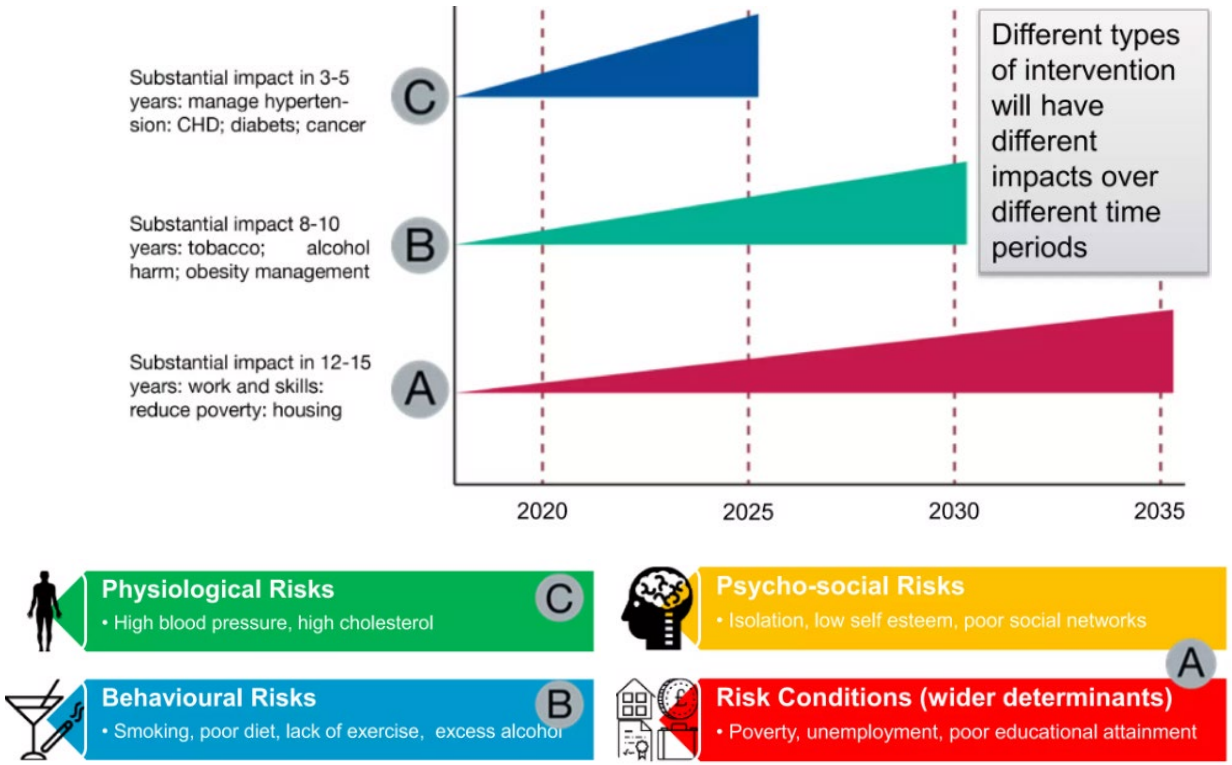
Principles of effective interventions

1. Evidence based
2. Outcomes orientated
3. Systematically applied
4. Scaled-up appropriately
5. Appropriately resourced
6. Sustainable

Types of interventions



Timescales of interventions



Health Inequalities Funding 2022/23

Following NHS England (NHSE) funding to the Integrated Care System (ICS), the North East London Health and Care Partnership (NEL HCP) called for local place-based bids for FY22/23 funding to address:

- *Leadership, strengthen partnership working* – £0.5m allocation per borough
- *Local health inequalities challenges* – up to £0.6m

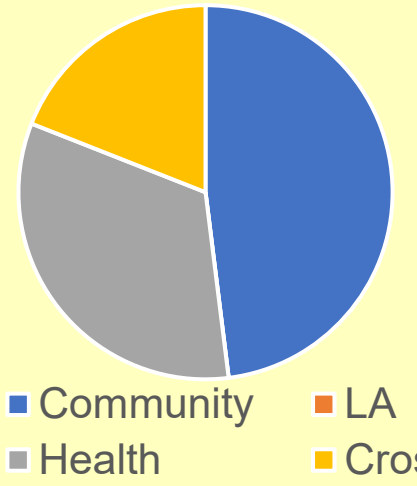
Rapid co-production process across the full Barking and Dagenham partnership

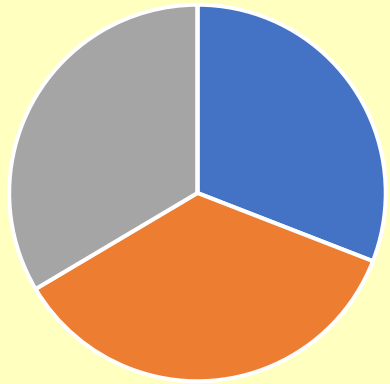
Barking & Dagenham partnership approach recognised as a strength by the NEL Panel (and demonstrated since)

Secured the highest allocation in NEL of £1.1m (20-140% more than other boroughs for competitive element)

Funding / delivery

(% funding per sector)





B&D Health Inequalities Programme Workstreams

Community
Council
Health
Cross-sector

Leadership, partnership working, capacity development

- Community Infrastructure: Locality Leads model
- Primary Care Network (PCN) Health Inequalities Leads capacity
- Knowledge & skills development
- Planning NHS services in Hubs
- Social prescribing 'Community Chest'

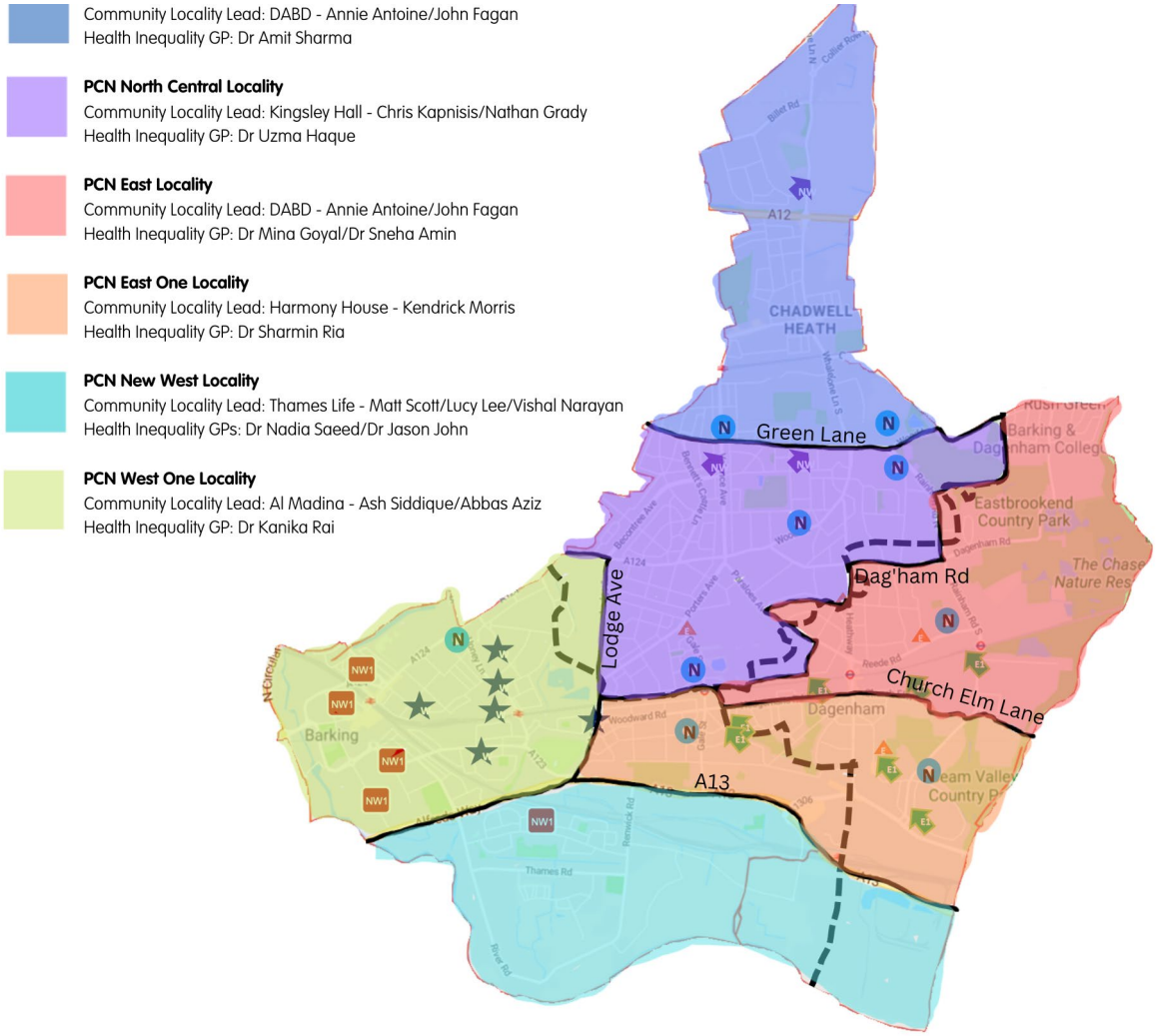
Addressing local inequalities

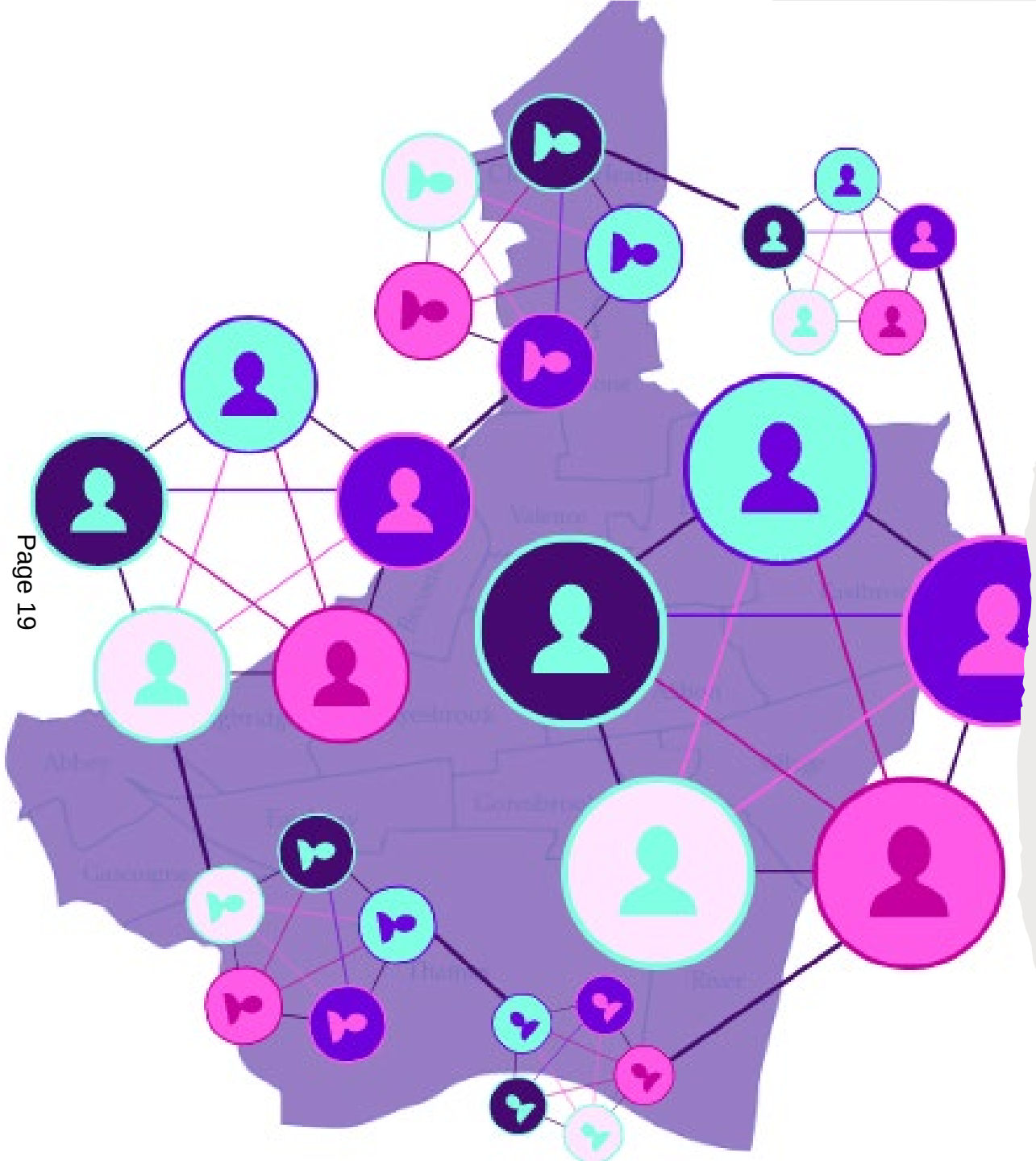
- Targeted debt support
- Case finding & support common conditions
- Community-led No Resource to Public Funds (NRPF) support
- Children's Early Intervention Panel 0-5s
- Children and Young People (CYP) mental health participatory grant making

Partnership Working

Community Locality Leads and PCN Health Inequality Leads

- Swiftly established a foundation to which community sector and health partners work together
- PCN Health Inequality Leads and Locality Leads co-designing with residents
- Resident-driven
- Learning fundamental to this way of working (that did not exist before)





Localities: Testing A New Approach

- Locality working: moving away from a single organisation/service delivery model, to facilitating a connected network of support
- Public sector and civil society working together
- Learning how to have real conversations with civil society – making help easier to access and the giving of help a favourable option
- Discovering how to re-build connection, trust and belonging (or ‘community’) - improving our health & wellbeing
- Unveiling the breadth and depth of community assets, and how best to join the dots
- Prototypes vs projects: learning how to learn again

Achievements

Improved place working & action on health inequalities

- Community Locality Leads
- PCN Health Inequalities
- Place-based CYP Early intervention Panel
- Workforce knowledge, skills & practice (e.g. Trauma-informed practice, support for residents with No Recourse to Public Funds)
- Framework for NHS services within community / family hubs

Services-led health improvement & inequalities reduction

- Targeted case finding of undiagnosed / unmanaged health conditions
- Targeted, proactive and holistic support on debt for residents with low level mental health issues
- Faster, holistic support for families through CYP Early Intervention Panel

Community-led health improvement and reduction

- Participatory grant making for children and young people's mental health
- Community Locality Lead-led co-production & prototyping
- Community chest for social prescribing

Next Steps

Health Inequalities Workshop

- Session held with Place-Based Partnership (PBP) Board and wider on 27 April to share and develop consensus on the ICB-funded health inequalities programme and wider place-based approach

Plan for Health Inequalities Programme 2023/24

- Plan coproduced through Place Partnership Workshop and Place Working Group
- To ICB for review on 14 June

Evaluation of 2022/23

- Projects of 2022/23 Health Inequalities Programme evaluated by August 2023
- Learning to help inform next round of programme, live from September 2023

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North East London Health & Care Partnership Health Inequalities Programme Funding Criteria

Funding objectives:

- Supports leadership and partnership working and builds capacity for tackling health inequalities locally.
- Supports improved understanding of health inequalities affecting local communities.
- Maximises and accelerates local plans to tackle inequalities across health and care that takes a life course approach including babies, children and young people, as well as adults.
- Enhances community resilience and widens participation.

Proposals should address the following funding criteria:

- Align to the ICS purpose, approach and priorities; the Core20Plus5 framework and/or the NHS Operating Plan health inequalities priorities[1].
- Be based on clear evidence that health inequalities exist, that the projects are needed and will deliver an impact.
- Focus on reducing inequalities by targeting deprived neighbourhoods and/or underserved groups.
- Demonstrate community/ service user participation in development and delivery of the programme.
- Contribute to strengthened partnership working for health inequalities particularly with the community and voluntary sector.
- Demonstrate how the work will be sustained post-22/23 to support the delivery of longer-term outcomes.
- Include a clear outcomes and robust evaluation plan.
- Provide value for money.

[1] 1. Restore NHS services inclusively. 2. Mitigate against digital exclusion 3. Ensure datasets are complete and timely 4. Accelerate preventative programmes & proactively engage those at greatest risk 5. Strengthen leadership & accountability

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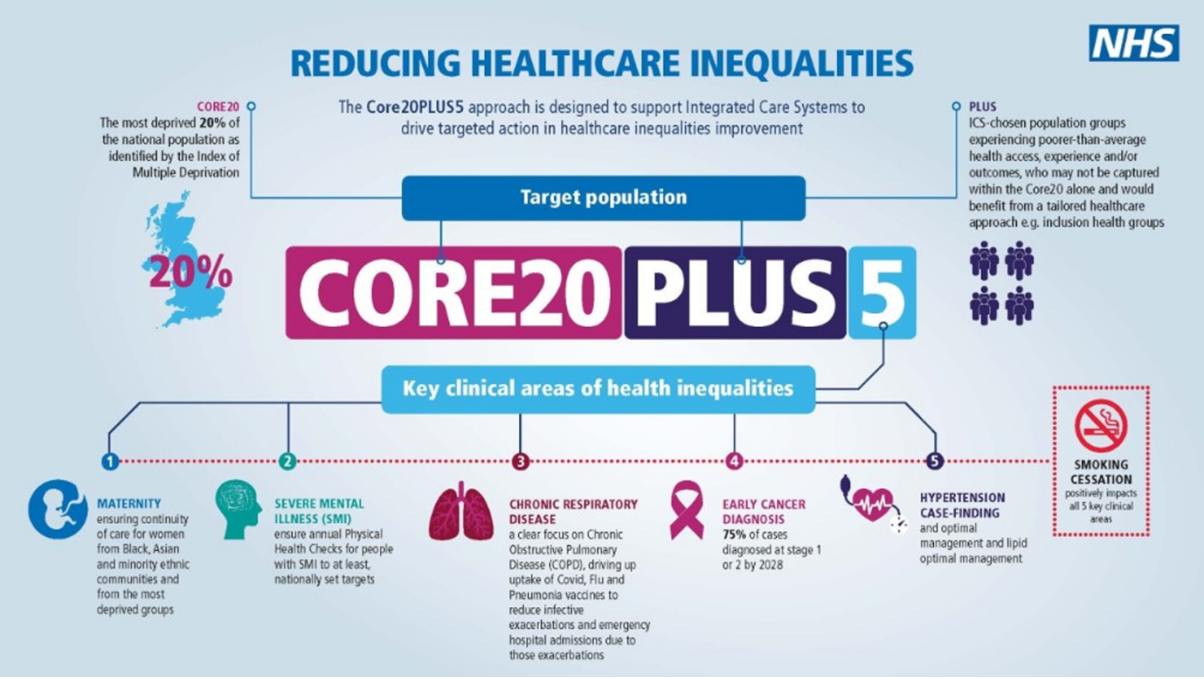
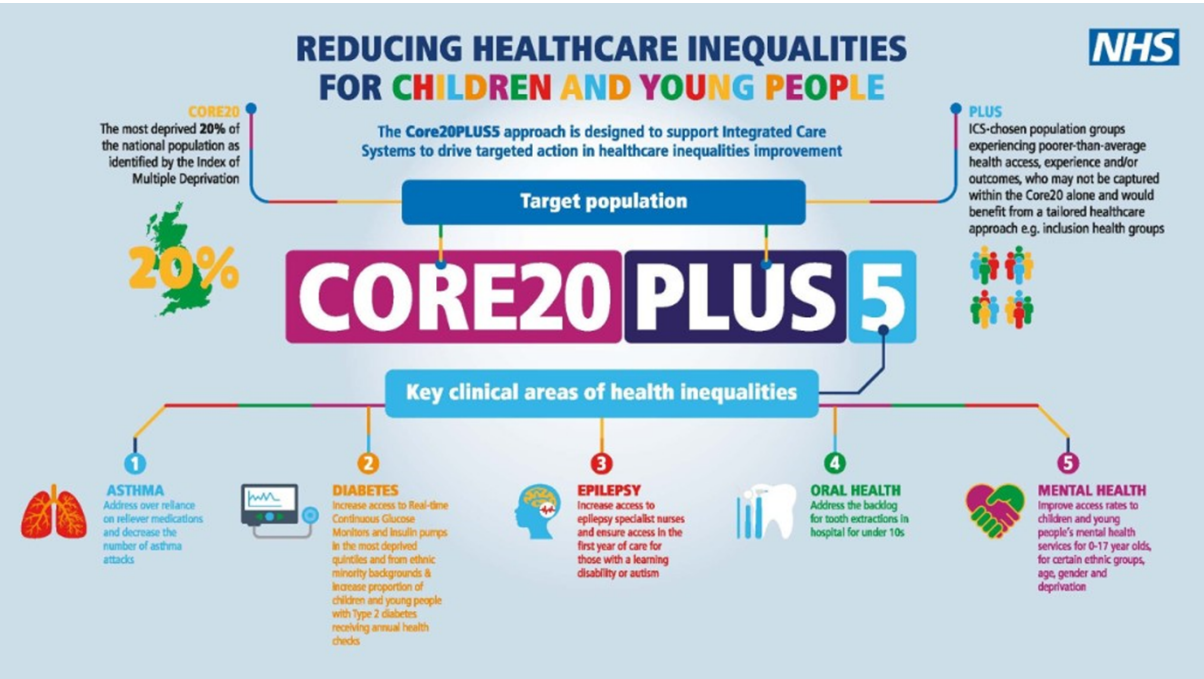
The Core20PLUS5 Approach

Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level. The approach defines a target population – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement.

The approach, which initially focussed on healthcare inequalities experienced by adults, has now been adapted to apply to children and young people. The infographics below provide a summary for both.





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HEALTH SCRUTINY COMMITTEE

24 May 2023

Title: Mental Health Transformation Programme Update – One Year On	
Report of the Integrated Care Director (Barking & Dagenham) at NELFT	
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: Melody Williams, Integrated Care Director (Barking & Dagenham) at NELFT	

Summary

The presentation (to follow) is intended to provide a one-year update as to NELFT's Mental Health Transformation Programme. As previously requested by the Committee, the item will focus on:

- How has NELFT implemented the mental health transformation investment?; and
- What outcomes, in terms of improving the health of the community, have been achieved?

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 NELFT representative.

Reason(s)

The themes in this item 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: None

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NHS North East London Integrated Care Board

North East London Health & Care Partnership

DRAFT
Barking and Dagenham Partnership Board
Thursday 30 March 2023
Committee Room 2, Barking and Dagenham Town Hall and Via Microsoft Teams

Members:	
North East London ICB	
Dr Rami Hara (RH)	Clinical/Care Director, NHS North East London
NHS Trusts	
Melody Williams (MWi)	Integrated Care Director, NELFT
Ann Hepworth (AH)	Director of Strategy & Partnerships, BHRUT
Local Authorities	
Cllr Maureen Worby (MWo) Co-Chair	Councillor, London Borough of Barking & Dagenham
Matthew Cole (MCo)	Director of Public Health, LBBD
Rhodri Rowland (RR)	Director of Community Participation and Prevention – ComSol, LDDB
Charlotte Pomery (CP)	Chief Participation and Place Officer, NHS North east London (Standing for Sharon Morrow)
Together First CIC, B&D GP Federation	
Primary Care	
Dr Shanika Sharma (ShaS) Co-Chair	Primary Care Network Director, West One
Dr Kanika Rai	GP Provider/ PCN representative
BD Collective	
Elspeth Paisley (EPa)	Health Lead, Lifeline Community Resources
Georgina Alexiou (GA)	Founder & Project Manager, BDYD
Healthwatch	
Agne Pilkauskiene (AP) Rep for Manisha Modhavia	Healthwatch, Engagement and Project Officer
Care Provider Voice	
Pooja Barot (PB)	Director, Care provider Voice
Attendees:	
Jane Leaman (JLe)	Consultant in Public Health (interim), LBBD
Debbie Harris (DH)	Governance Officer, NHS North east London
Dotun Adepoju DA)	Senior Governance Manager, NHS North east London
Matt Cridge (MCr)	Head of Borough Partnerships, LBBD
Susanne Knoerr (SK)	Head of Service, Integrated Care
Apologies:	
Dr Narendra Teotia (NT)	Primary Care Network Director, North
Fiona Taylor (FT)	Acting Chief Executive, LBBD
Sharon Morrow (SM)	Place Director, NHS North East London
Sunil Thakker (ST)	Finance, NHS North East London
Elaine Allegretti (EA)	Strategic Director Children and Adults, LBBD
Dalveer Johal (DJ)	Pharmacy Services Manager, NEL LPC
Dr Jason John (JJ)	Primary Care Network Director, New West
Dr Afzal Ahmed (AA)	Primary Care Network Director, East

Dr Bhawnesh Liladhar (BL)	Dental Lead
Dr Kashyap (dG)	Primary Care Network Director, North West
Craig Nikolic (CN)	CEO, Together First CIC, B&D GP Federation
Manisha Modhvadia (MM)	Healthwatch Acting Manager
Selina Douglas (SD)	Director of Partnerships, NELFT
Dr Natalya Bila (NB)	Primary Care Network Director, East One

Item	
1.0	**Welcome, introductions and apologies**
	The Chair welcomed members/attendees to the meeting. All members/attendees joined the meeting in person. Apologies were noted as above.
1.1	**Declarations of conflicts of interest**
	Members were reminded to complete their Declaration of Interest form if they had not already done so. No additional Conflicts of Interests were noted.
1.2	**Minutes of the meeting held on 27 October 2022**
	Notes from the previous meeting were agreed as an accurate record.
1.3	**Action Log**
	The action log was discussed and noted.
2.0	**Community based localities**
	Elspeth Paisley (EP) presented the Community based localities paper that outlines the rationale, learning and outcomes behind BD_Collective's/civil society's approach to building community system resilience in Barking & Dagenham after six months. Highlights included: • The Board/Committee is asked to consider their contribution to this 10-year piece of work to build a connected, effective infrastructure, where resources are maximised, residents are empowered and healthy life expectancy is improved by 5 years. • A well-established evidence base shows us that relationships are as important to our health as hospitals and council services, and that powerlessness is a killer. • BD Collective is a network of networks of the social sector in B&D. Its values of connection, trust, accountability and power-sharing drive the localities work, the heart of which is creating environments for collaboration, placing the citizen in the driving seat. • The localities work is measuring connection, trust and belonging as a means of evaluating the depth of relationships that are being established across the borough, and the journey of moving from an 'I' lens to a 'we' lens across all organisations. Comments from the Board: • How are you ensuring that we are reaching the groups in the community that are not currently accessing your services? • We have previously tried working with the Voluntary sector but they are not set up to work within our governance framework, so what is the offer from BD_Collective to be the overarching governance framework for these smaller groups? • There is a need to look at the delivery element too along with what is meant by Commissioning. • There is a need to be aware of our changing population. • Are we linking in with Social Care Co-Ordinators as practices will be aware of their patients who are isolated and suffering from loneliness but with no medical conditions? Is there a plan to get these residents out of their homes to socialise them? • Can we utilise our Health Inequalities funding to help us identify lonely residents? • There is a need to do a commissioning piece of work on 'what does it look like in the New world'.

	• Do we have any data on how many people we manage to support back into work? **Action:** BD_Collective to bring quarterly updates back to the Board. The Board noted the update.
3.0	**Acute Collaborative update**
	Ann Hepworth (AH) presented the Acute Collaborative paper that provides an update on the development of the acute provider collaborative across NEL. Highlights included: • The NEL Acute Provider Collaborative will sit alongside four other NEL collaboratives (community health, primary care, mental health and VCSE organisations) within NELs integrated care systems. • The collaboratives will work at scale across multiple places, with shared purpose and effective decision-making arrangements, to: - Reduce unwarranted variation and inequality in health outcomes, access to services and experience, and: - Improve resilience by, for example, providing mutual care. • A framework, based on national guidance has been produced that articulates the overarching purpose and benefits of the Collaborative focusing on the Why, How and What. • How we work together will be developed through discussions on core principles of Why/How with a proposal for learning partner to support us through this process as the Acute Provider Collaborative (APC) develops and matures. Comments from the Board: • The Thames Gateway growth in population was mentioned, with a challenge that the acute sector would not be prepared to look at what 'has to be' provided in hospitals. We built LIFT buildings to take services out into the community, also looking to ease pressure on General Practice with other referral routes into specialist, either based in the community or hospital. • A challenge for Barking and Dagenham residents is that we do not have a Trust in our Borough. Residents have to attend different Trusts for different treatments with no communication between the two resulting in duplication. However, a procurement process is in place for Queens and King Georges for an electronic patient record system. • Newham have a portal that allows GPs to see all investigations that have taken place for a patient but this is not the case in Barking and Dagenham. • It was felt that innovation happens at Barts leaving BHRUT as a standalone Trust which makes it a challenging place to work and for career development. How will the Collaboratives ensure that Barking and Dagenham residents have access to all treatments that are available in NEL? • Where we have taken some services out into the community there is a need to double check the pathway to ensure patients are not being put back to the beginning of the process. • A need to look at reconfiguring Barking Hospital space for out-of-hospital services to use. The Board noted the update.
4.0	**Health and Wellbeing Strategy refresh Consultation**
	Jane Leaman (JL) provided an update on the Health and Wellbeing Strategy refresh Consultation. Highlights included: • The current Barking and Dagenham Health and Well Being Strategy (HWBS) ends in 2023. • This draft refreshed strategy sets out a renewed vision for improving the health and wellbeing of residents and reducing inequalities at every stage of residents' lives by 2028.

	• The Strategy provides a framework for action, drawing upon a range of other relevant strategies including the NEL Integrated Care Strategy; LBBD Corporate Plan (currently in production); LBBD equality and diversity policy statement and B&D's Best Chance Strategy. • The Strategy is being developed alongside the evolving ICB joint forward plan (JFP) which needs to be published by June 30th 2023. A Local Forward Plan will be produced which will include actions required to deliver this strategy. • There is an emphasis on co-production with residents being part of decisions and development. • There is a need to develop some common indicators to measure our collective endeavour. • We have begun the consultation on this draft and are inviting feedback from residents and other stakeholders until the 16th April. • Rhodri Rowlands (RR) to produce a follow up note for the Board that sets out the steps in the consultation which includes a link to an On-Line survey. There is an ask for this group to utilise their networks and groups to support and promote this consultation. • We will also be hosting a Q&A open session as part of the consultation. Comments from the Board: • Will delivery metrics be available? • Will this strategy be aligned to other strategies e.g. Diabetes? • In terms of turning the strategy into provision, funding will be a big consideration so how, as a collective group, will we resolve this? With NEL ICB cuts, we will have to look locally at what we are doing and why we are doing it! • There is an agreement that we will work together on a new formula to reflect the inequality between inner and outer NEL funding. There is a principle agreement with inner London that they will not get any growth in allocated funding for the foreseeable future to allow outer London to catch up. **Action:** a follow up note will be issued for members to: 1. Review the attached the stakeholder JHWS consultation document with colleagues and collate any feedback on behalf of your organisations- sending back to myself or Jane. 2. Share the following link through channels & networks etc. so residents can feedback on a shorter version: https://oneboroughvoice.lbbd.gov.uk/healthy-and-well-2023-2028 **Action:** consider setting up some workshops to allow time for some frank conversations. The Board noted the update.
5.0	**Joint Forward Plan**
	Charlotte Pomery (CP) provided an update on the Joint Forward Plan. Highlights included: • The Joint Forward Plan (JFP) – is a five-year plan describing how we will, as a system, deliver our Integrated Care Partnership Strategy as well as core NHS services – and a supporting reference document providing further detail on the transformation programmes described in the main plan. • We need to submit a draft of the plan to NHSE by the end of March, before further work and engagement across the system during April and May so that we can publish in June 2023. • The plan will then be refreshed on an annual basis. • The Partnership Board is asked to provide comments on the plan so that these can be incorporated into the April-June process. Comments from the Board:

	• The Strategy lays out the challenges in NEL. We can use our collective force to lobby for inequalities that don't help us as at Place e.g. the difference in London weighting. • There is a need to have some meeting papers such as this one sent separately, aside of the grouped meeting pack, so that copies can be retained for individual retention. **Action:** DH to share key documents in a zipped folder in word/presentation form to allow sharing of some parts of the documents with colleagues. Board members noted the update.
7 0	**AOB**
	None noted
	Date of next meeting – 27 April 2023 **Council Chamber - Barking Town Hall, Town Hall Square, Barking, IG11 7LU**

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