Barking & Dagenham

Notice of Meeting of the

ASSEMBLY

**to be held on Wednesday, 15 May 2024
commencing at 7:00 pm in the
Council Chamber, Town Hall, Barking**

To all Members of the Council of the London Borough of Barking and Dagenham

Date of publication: 7 May 2024

Fiona Taylor
Chief Executive

Contact Officer: Alan Dawson
E-mail: alan.dawson@lbbd.gov.uk

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. Appointment of Chair and Deputy Chair

The Chief Executive shall invite nominations and conduct the vote for the positions of Chair and Deputy Chair of the Assembly.

2. Apologies for Absence

3. 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.

4. Minutes - To confirm as correct the minutes of the meeting held on 28 February 2024 (Pages 5 - 12)

5. Death of Former Councillor Jeff Wade (Page 13)

6. Leader's Statement

The Leader will present his statement.

7. Appointments to the Political Structure and Other Bodies 2024/25 (Pages 15 - 21)

8. Appointment of Church Representative (Church of England) Co-optee to the Overview and Scrutiny Committee (Pages 23 - 24)

9. OFSTED Inspection of Children's Services Improvement Plan and the Children's Care and Support Self-Evaluation 2023/24 (Pages 25 - 46)

10. Health Scrutiny Committee Annual Report 2022/23 (Pages 47 - 57)

11. Annual Report of the Director of Public Health 2022/23 (Pages 59 - 153)

12. Members' Allowances Scheme 2024/25 (Pages 155 - 166)

13. Appointment of Statutory Scrutiny Officer (Pages 167 - 168)

14. Motions

15. Questions With Notice

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

17. 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.***

18. Any confidential or exempt items which the Chair decides are urgent

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Barking & Dagenham

Our Vision for Barking and Dagenham

ONE BOROUGH; ONE COMMUNITY; NO-ONE LEFT BEHIND

Our Priorities

- Residents are supported during the current Cost-of-Living Crisis;
- Residents are safe, protected, and supported at their most vulnerable;
- Residents live healthier, happier, independent lives for longer;
- Residents prosper from good education, skills development, and secure employment;
- Residents benefit from inclusive growth and regeneration;
- Residents live in, and play their part in creating, safer, cleaner, and greener neighbourhoods;
- Residents live in good housing and avoid becoming homeless.

To support the delivery of these priorities, the Council will:

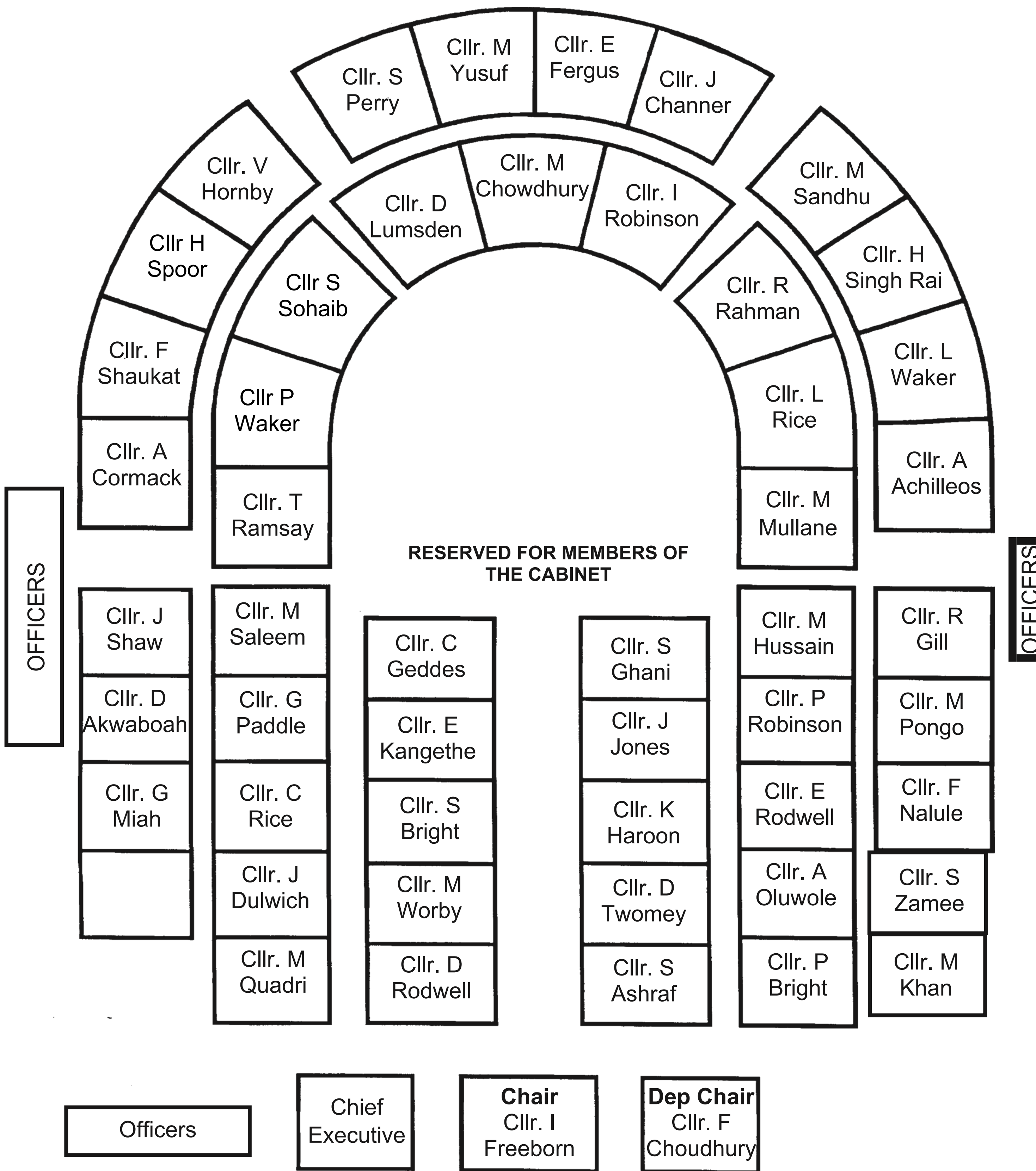
- Work in partnership;
- Engage and facilitate co-production;
- Be evidence-led and data driven;
- Focus on prevention and early intervention;
- Provide value for money;
- Be strengths-based;
- Strengthen risk management and compliance;
- Adopt a “Health in all policies” approach.

Barking & Dagenham

The Council has also established the following three objectives that will underpin its approach to equality, diversity, equity and inclusion:

- Addressing structural inequality: activity aimed at addressing inequalities related to the wider determinants of health and wellbeing, including unemployment, debt, and safety;
- Providing leadership in the community: activity related to community leadership, including faith, cohesion and integration; building awareness within the community throughout programme of equalities events;
- Fair and transparent services: activity aimed at addressing workforce issues related to leadership, recruitment, retention, and staff experience; organisational policies and processes including use of Equality Impact Assessments, commissioning practices and approach to social value.

BARKING TOWN HALL
COUNCIL CHAMBER



SEATING PLAN FOR THE ASSEMBLY

May'24

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MINUTES OF ASSEMBLY

Wednesday, 28 February 2024
(7:00 - 8:34 pm)

PRESENT

Cllr Irma Freeborn (Chair)
Cllr Tony Ramsay (Deputy Chair)

Cllr Andrew Achilleos
Cllr Dorothy Akwaboah
Cllr Saima Ashraf
Cllr Princess Bright
Cllr Sade Bright
Cllr Josie Channer
Cllr Muhib Chowdhury
Cllr Alison Cormack
Cllr John Dulwich
Cllr Cameron Geddes
Cllr Syed Ghani
Cllr Rocky Gill
Cllr Kashif Haroon
Cllr Victoria Hornby
Cllr Manzoor Hussain
Cllr Jane Jones
Cllr Elizabeth Kangethe
Cllr Mohammed Khan
Cllr Donna Lumsden
Cllr Giasuddin Miah
Cllr Margaret Mullane
Cllr Fatuma Nalule
Cllr Adegboyega Oluwole
Cllr Glenda Paddle
Cllr Simon Perry
Cllr Michel Pongo
Cllr Moin Quadri
Cllr Regina Rahman
Cllr Hardial Singh Rai
Cllr Chris Rice
Cllr Lynda Rice
Cllr Ingrid Robinson
Cllr Muhammad Saleem
Cllr Muazzam Sandhu
Cllr Faraaz Shaukat
Cllr Summya Sohaib
Cllr Harriet Spoor
Cllr Dominic Twomey
Cllr Phil Waker
Cllr Maureen Worby
Cllr Sabbir Zamee

APOLOGIES FOR ABSENCE

Cllr Faruk Choudhury
Cllr Edna Fergus
Cllr Paul Robinson
Cllr Darren Rodwell
Cllr Emily Rodwell
Cllr Jack Shaw
Cllr Lee Waker
Cllr Mukhtar Yusuf

60. Declaration of Members' Interests

There were no declarations of interest.

61. Minutes (31 January 2024)

The minutes of the meeting held on 31 January 2024 were confirmed as correct.

62. Leader's Statement

There was no Leader’s Statement.

63. Appointments

There were no appointments.

64. Budget Framework 2024/25 and Medium Term Financial Strategy 2024/25 - 2027/28

The Cabinet Member for Finance, Performance and Core Services presented the Council's proposed budget framework for 2024/25 which incorporated the following:

- Proposed General Fund revenue budget for 2024/25;
- Proposed level of Council Tax for 2024/25;
- Medium Term Financial Strategy (MTFS) 2024/25 to 2026/27;
- Draft Capital Budget for 2024/25 and revised Capital Programme 2024/25 to 2026/27;
- Strategy for the Flexible Use of Capital Receipts 2024/25;
- Chief Financial Officer's Statutory Finance Report (Section 25 Statement)

The proposed General Fund net budget for 2024/25 was £221.745m, which incorporated a drawdown from reserves of £8.809m to balance the 2024/25 budget after the inclusion of £15.595m of savings and £54.129m of growth from the 2023/24 revised budget. In order to achieve that budget, it would be necessary for the Council to increase its element of the Council Tax by 4.99%, made up of 2.99% for general spending and 2% that would be ringfenced as an adult social care precept. The Greater London Authority element of the Council Tax would increase by 8.6%.

The Cabinet Member outlined the steps taken by the Council to achieve a balanced budget for 2024/25 in the context of high inflation, the cost-of-living crisis, increasing pressures and demand for social care services and the continued uncertainty around local government finances. The Government's delay in introducing Fair Funding reforms meant that Barking and Dagenham continued to be significantly disadvantaged due to its population increase and high levels of deprivation which were not being properly funded by the Government.

The Cabinet Member also highlighted a number of other important aspects within the report, which included:

- The key principles that underpinned the Council's Medium Term Financial Strategy, as set out under paragraph 4.14 of the report;
- The key financial risks for both the local government sector as a whole and those specific to Barking and Dagenham, as detailed in section 18 of the report;
- The key implications of the Local Government Finance Settlement for 2024/25, as set out under paragraph 7.7 of the report, and the continued failure of the Government to provide local authorities with any confidence to plan for the future;
- The service budgets for 2024/25, which included details of the growth, inflation and savings to be achieved in each area, as set out under paragraph 12.1 of the report;
- The Council's reserves position for 2024/25, which meant that the main budget reserve would remain above the £12m minimum level previously set even after the drawdown to achieve a balanced budget for 2023/24; and
- The outcome of the budget consultation exercise recently undertaken which reflected the local community's acknowledgement of the need for the Council to

increase Council Tax by the maximum amount allowed in order to deliver its aspirations and the priorities that were most important to residents.

In response to questions, the Cabinet Member advised that pressures on the budget were coming from across the borough impacting on all services; however, pressures were fundamentally coming from Government with a third of funding for the Council lost and the fair funding deal not yet being finalised. Demand for Council services had increased considerably, creating a huge funding gap of £4bn over next two years to keep services where they were now across the country. Councils were struggling to find resources to cover the gaps and were being encouraged by Government to spend reserves, when most Councils, if not all, had already looked into the use of reserves to balance budgets.

The Cabinet Member advised that the cost of placements for those in social care were skyrocketing in both childrens and adults services, with particular concern regarding private providers.

The Cabinet Member further advised that whilst the Council had undertaken borrowing from the Public Works Loan Board, which were secure and locked in at low rates, the Council also had tangible assets in place to back up any debt.

With regard to savings, the Cabinet Member advised that savings proposals were monitored and went through a rigours process to ensure they were achievable before approved. Directors were held accountable by the Cabinet, who robustly challenged savings proposals that were put forward for approval.
The Cabinet Member took the opportunity to remind residents that there were discretionary funds in place from the Council for those who were struggling to pay their council tax.

In accordance with paragraph 10.3.2 of Part 2, Chapter 3 of the Council Constitution, the budget was put to a recorded vote and was **agreed** as follows:

For: Councillors Achilleos, Akwaboah, Ashraf, P Bright, S Bright, Channer, Chowdhury, Cormack, Dulwich, Freeborn, Geddes, Ghani, Haroon, Hornby, Hussain, Jones, Kangethe, Khan, Lumsden, Miah, Mullane, Nalule, Oluwole, Paddle, Perry, Pongo, Quadri, Rahman, Rai, Ramsay, C Rice, I Robinson, P Robinson, Saleem, Sandhu, Shaukat, Sohaib, Spoor, Twomey, P Waker, Worby and Zamee (42)

Against: Councillor L Rice (1)

Abstain: None (0)

(Note: Councillor Gill left the chamber at 19:38 and therefore was not present to vote)

The Assembly **resolved** to:

(i) Agree that the basic amount of Council Tax (Band D equivalent) shall increase by 2.99%, and by a further 2% for the Adult Social Care precept, bringing the total increase to 4.99%;

(ii) Agree that the Council Tax to be set for 2024/25 shall be £1,531.35 for a Band D property, comprising £1,310.70 for core Council Tax and £220.65 for the Adult Social Care precept, an increase of £43.61 and £29.17 per year respectively;

(iii) Note that the Council shall levy an additional £471.40 on the Band D amount above on behalf of the Greater London Authority which represented an increase of 8.6%;

(iv) Note the amount of 54,916.54 as the Council Tax Base for Barking and Dagenham for 2024/25, an increase of 1,589.69 on the previous year, in accordance with Regulation 3 of the Local Authorities (Calculation of Council Tax Base) Regulations 1992 made under the Local Government Finance Act 1992 (as amended);

(v) Agree, in setting the Council's General Fund revenue budget, to set the Council Tax requirement at £84.096m for 2024/25;

(vi) Consider and have due regard to budget consultation feedback with residents and businesses as set out in Section 20 to the report and note that no changes were recommended as a result;

(vii) Agree the Statutory Budget Determination for 2024/25 as set out at Appendix D to the report;

(viii) Approve the proposed General Fund Revenue Budget for 2024/25 as set out in Appendix A to the report, subject to any changes required from the final Local Government Finance Settlement;

(ix) Delegate authority to the Strategic Director, Resources, in consultation with the Cabinet Member for Finance, Growth and Core Services, to make further changes to the 2024/25 budget proposals up to a maximum amount of £1.0m;

(x) Agree the new savings and growth proposals as set out in Appendix B to the report;

(xi) Agree that the current budget gap of £8.809m shall be funded from use of reserves for 2024/25 and to note that additional permanent savings proposals shall need to be identified;

(xii) Approve the latest General Fund Medium Term Financial Strategy 2024/25 to 2026/27 as set out in section 4 and Appendix A to the report;

(xiii) Note that the proposals maintain a General Fund balance of £12m in line with the Council's approved Reserves Policy (July 2023);

(xiv) Note the projected reserve balances at 31 March 2025 following the planned use of £8.809m to achieve a balanced budget, as set out in Section 19 of the report;

(xv) Approve the Council's provisional Capital Programme, including Investment and Acquisition Strategy (IAS) schemes, for 2024/25 to 2026/27 as detailed in section 8 and Appendix G to the report;

(xvi) Agree to set a Capital Budget for 2024/25 at £209.462m, as detailed in Appendix G to the report;

(xvii) Approve the Strategy for the Flexible Use of Capital Receipts 2024/25 at Appendix I to the report, in line with the regulatory requirements to facilitate the delivery of efficiency savings including capitalisation of redundancy costs;

(xviii) Note the Chief Financial Officer's Statutory Finance Report (Section 25 Statement) as set out in Appendix H to the report and, in particular, their determination of "the robustness of the estimates made for the purposes of the calculations, and the adequacy of the proposed financial reserves"; and

(xix) Note the changes to the report since its endorsement by the Cabinet on 19 February, as set out in paragraph 19.13 of the report.

65. Treasury Management Strategy Statement 2024/25 and Capital Strategy 2024/25 to 2026/27

The Cabinet Member for Finance, Growth and Core Services introduced the Treasury Management Strategy Statement (TMSS) 2024/25 report which set out the Council's borrowing, investment and funding plans for the year ahead.

The Cabinet Member highlighted the main points within the report, several of which had been considered as part of the Budget Framework 2024/25 discussion and had been recommended by the Cabinet it its meeting on 19 February 2024.

The Assembly **resolved** to approve the Treasury Management Strategy Statement for 2024/25 and, in doing so, to:

(i) Note the current treasury position for 2024/25 and prospects for interest rates, as referred to in sections 4 and 8 of the report;

(ii) Approve the Annual Investment Strategy 2024/25 outlining the investments that the Council may use for the prudent management of its investment balances, as set out in Appendix 1 to the report;

(iii) Approve the Council's Borrowing Strategy 2024/25 to 2026/27, as set out in Appendix 2 to the report;

(iv) Approve the Capital Prudential and Treasury Indicators 2024/25 to 2026/27, as set out in Appendix 3 to the report;

(v) Approve the Operational Boundary Limit of £1.9bn and the Authorised Borrowing Limit of £2.0bn for 2024/25, representing the statutory limit determined by the Council pursuant to section 3(1) of the Local Government Act 2003, as referred to in Appendix 3 to the report;

(vi) Approve the Capital Strategy, including the Capital Programme for 2024/25 to 2026/27, as set out in Appendix 4 to the report;

(vii) Approve the revised Minimum Revenue Provision Policy Statement for 2024/25, the Council's policy on repayment of debt, as set out in Appendix 5 to the report;

(viii) Note that changes made to the Prudential Code and Treasury Management code, published in December 2021, have been fully implemented for the 2024/25 TMSS;

(ix) Approve the Liability Benchmark data in section 11, including the impact of schemes agreed in 2022 but also the impact of pipeline schemes on the amount of borrowing required by the Council;

(x) Delegate authority to the Strategic Director, Resources, in consultation with the Cabinet Member for Finance, Growth and Core Services, to

proportionally amend the counterparty lending limits agreed within the Treasury Management Strategy Statement to consider the increase in short-term cash held from borrowing;

(xi) Note the economic, development and operational risks for the IAS schemes as outlined in section 8 and within the IAS and Borrowing reports;

(xii) Note the Council's total borrowing is £1.260bn, split into £296m for the HRA, £689m of long-term borrowing and £275m of short-term borrowing;

(xiii) Approve the CFR projections of £2.022bn for 2024/25, £2.11bn for 2025/26 and £2.02bn for 2026/27; and

(xiv) Note that the Investment and Acquisitions Strategy shall be updated and presented for approval in April 2024.

66. Overview and Scrutiny Committee Annual Report 2022/23

The Chair of the Overview and Scrutiny Committee (OSC) presented an Annual Report highlighting the work of the Overview and Scrutiny Committee during the 2022/23 municipal year.

The Chair opened her presentation with a brief overview about the structure and function of the Committee explaining the purpose of scrutiny and its importance to the operation of the Council by helping to improve services for the benefit of the local community. OSC had a wide remit and was able to look into internal Council services, as well as those of our external partners such as the Police, BDSIP and Be First, holding decision makers to account, including the Cabinet, whilst reviewing policy and in so doing, making recommendations for improvement.

The year had again begun by meeting with Cabinet Members, Directors and officers to learn more about their thoughts around key issues, which also helped to guide the Committee in developing a meaningful work programme. The Chair recognised the support given by Cabinet Members who were committed to the scrutiny process and had always attended OSC meetings wherever possible, listening to the Committee's feedback and responding to any questions.

OSC covered a wide range of items during 2022/23, of which the Chair highlighted a few of the achievements including suggestions to improve job prospects for post-18 SEND individuals, alongside highlighting the importance of graduate opportunities with the introduction of the Film Studios, UCL PEARL and the City of London wholesale markets. Recommendations to improve BDTP services and the Customer Contact Centre following extremely high demand during the pandemic were made by the Committee.

The Committee also engaged with the Metropolitan Police and shared their concerns regarding issues such as women's safety as part of the Community Safety Partnership Plan 2023-26.

Additionally, the Committee recognised the importance of strengthening the Council's relationship with faith groups in the Borough, and so pushed for better cross-group working between faith groups to facilitate positive relationships.

In conclusion the Chair thanked Masuma Ahmed, Claudia Wakefield and Alex Powell for their support to her and the Committee and also thanked Leanna McPherson, Lois Taylor and Ayesha Malik for their continued support.

The Assembly **resolved** to note the report.

67. Reactivation of Uphill and Waters Education Foundation

The Cabinet Member for Educational Attainment & School Improvement presented the report on the reactivation of Uphill and Waters Education Foundation.

The Council was seeking to re-activate a dormant trust fund that could be used to support young people's education and entry into employment in the borough. The Uphill and Waters Education Foundation had been inactive for many years. Reactivation of the Foundation according to the terms laid out in its constitution will enable it to work with the Council to continue to provide resources for young people.

The Foundation would also allow the Council to build on the work that had begun through use of the Colin Pond Trust over the past three years, which had already had a demonstrable impact on retaining our schools' top performing GCSE students at in-borough institutions. Approximately £90,000 was available, which would be invested in order to sustain the fund over many years.

The Assembly **resolved** to:

(i) Support the proposal to reactive the Uphill and Waters Educational Foundation to provide additional resources to disadvantaged young people in the Borough;

(ii) Appoint Councillors Kangethe and Jones and Jane Hargreaves, Commissioning Director, Education, to serve as Council-appointed Trustees to the Foundation;

(iii) Note that the London Borough of Redbridge shall be asked to appoint a Redbridge Councillor as a Trustee to the Foundation; and

(iv) Delegate authority to the Commissioning Director, Education, to appoint a member of the local clergy as the ex-officio Trustee to the Foundation.

68. Pay Policy Statement 2024/25

The Cabinet Member for Finance, Growth and Core Services presented a report of the Pay Policy Statement 2024/25.

Under the terms of the Localism Act 2011 the Council must agree, before the start of the new financial year, a pay policy statement relating to the remuneration of its chief officers and the remuneration of its other employees. The Act also set out the matters which must be covered in the statement.

The Council's draft Pay Policy Statement for 2024/25 was attached Appendix A and set out the expected position at 1 April 2024.

The Assembly **resolved** to approve the Pay Policy Statement for the London Borough of Barking and Dagenham for 2024/25 as set out at Appendix A to the report, for publication on the Council's website with effect from April 2024.

69. Motions

There were no motions.

70. Questions With Notice

There were no questions with notice.

ASSEMBLY

15 May 2024

Title: Death of Former Councillor Jeff Wade	
Report of the Chief Executive	
Open Report	**For Information**
Wards Affected: None	**Key Decision:** No
Report Author: Alan Dawson, Head of Governance & Electoral Services	**Contact Details:** Tel: 020 8227 2348 E-mail: alan.dawson@lbbd.gov.uk
Accountable Director: Deirdre Collins, Head of Legal and Monitoring Officer	
Accountable Executive Team Director: Fiona Taylor, Chief Executive	
Summary The Assembly is asked to note with deep regret that former Councillor Jeff Wade sadly passed away on Tuesday 5 March 2024 aged 79. Mr Wade was first elected as a Labour Party councillor in May 2010, representing Chadwell Heath ward, and was re-elected in May 2014 before deciding to step down from the Council at the May 2018 elections. As a councillor, Mr Wade served on a number of committees and was also the Deputy Chair of the Living and Working Select Committee during his tenure. Mr Wade's funeral took place on Thursday 21 March at Chadwell Heath Cemetery. The Borough flag at the Town Hall was flown at half-mast on learning of his passing and the day of the funeral.	
Recommendation(s) The Assembly is asked to mark the passing of former Councillor Jeff Wade with a minute's silence in his memory.	

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ASSEMBLY

15 May 2024

Title: Appointments to the Political Structure and Other Bodies 2024/25	
Report of the Chief Executive	
Open Report	**For Decision**
Wards Affected: None	**Key Decision:** No
Report Author: Alan Dawson, Head of Governance & Electoral Services	**Contact Details:** E-mail: alan.dawson@lbbd.gov.uk
Accountable Director: Deirdre Collins, Head of Legal and Monitoring Officer	
Accountable Executive Team Director: Fiona Taylor, Chief Executive	

Summary

The Assembly is responsible for appointments to the political structure and various other internal and external bodies, except those reserved to the Leader and/or Cabinet Members.

Appendix 1 to this report shows the proposed appointments for the 2024/25 municipal year relating to Council committees and other internal and external bodies which are the responsibility of the Assembly.

The appointment of the Mayor for 2024/25 will be dealt with at the meeting of the Ceremonial Council on Friday 17 May.

Recommendation(s)

The Assembly is recommended to:

(i) Approve the appointments to various Council committees and other internal and external bodies, as set out in Appendix 1 to the report; and

(ii) Delegate authority to the Chief Executive, in consultation with the Leader of the Council, to approve the appointment of councillors to fill any vacant positions prior to the next meeting of the Assembly on 24 July 2024.

Reason(s)

To meet the Council's statutory and constitutional requirements and to ensure relevant positions are appointed to.

1. Introduction and Background

1.1 Part 2, Chapter 4 of the Constitution sets out the Assembly's responsibilities in respect of appointments to the political structure and various other internal and external bodies.

1.2 Section 15 of the Local Government and Housing Act 1989 imposes a duty on local authorities at their annual meeting, or as soon as possible after it, to review the allocation of seats on committees of the Council between political groups. Political groups on the Council are formed in accordance with the Local Government (Committees and Political Groups) Regulations 1990 when two or more councillors notify the Chief Executive, as Proper Officer, of their wish to be treated as a Group.

1.3 At present, the Council consists of 50 Labour councillors and one independent councillor. The formation of the Labour Group was noted at the 2022 Annual Assembly meeting, following the 2022 Local Elections.

1.4 The following principles apply to the allocation of seats:

a) That not all the seats on the body to which appointments are being made are allocated to the same political group;
b) That the majority of seats on each committee are allocated to a particular group if the number of persons belonging to that group is a majority of the authority's membership;
c) That, subject to (a) and (b), when allocating seats to a political group, the total number of their seats across all the ordinary committees of the Council, must reflect their proportion of the authority's membership; and
d) Subject to (a) to (c), that the number of seats on each committee is as far as possible in proportion to the group's membership of the authority.

1.5 The Cabinet and the Health and Wellbeing Board are not required to be proportional, as they are 'Executive bodies', and so are outside of the political balance calculation.

1.6 Sub-committees, with the exception of the Licensing Sub-Committee, are also governed by the political balance rules, but it is not necessary to add up all the sub-committee seats and then allocate them in proportion. As far as this is practicable, the allocation of seats on each sub-committee should reflect the proportional representation of the political groups on the Council.

1.7 The Local Government and Housing Act 1989 requires that, once the Assembly has determined the allocation of committee places between the political groups, it must then appoint the nominees of the political groups to the committees.

1.8 Any non-aligned (independent) members are to be appointed to available seats on committees by the Council.

2. Proposal and Issues

2.1 The nomination process for the various positions to which appointments are required for the municipal year 2024/25 is dealt with through party groups which, for Barking and Dagenham, is just the Labour Group.

2.2 Attached at Appendix 1 is the schedule of nominations from the Labour Group for the 2024/25 municipal year in respect of appointments which the Assembly has responsibility for appointing to. These appointments relate to main Council committees and other internal and external body meetings.

2.3 Any changes / additions to the information contained in the appendix will be reported at the meeting.

2.4 The Labour Group agreed not to fill all seats on Council committees to which the Assembly makes appointments to allow the independent councillor, Lynda Rice, to take up at least one position on a Council committee, in line with best practice. Councillor Lynda Rice has been allocated a seat on the Licensing and Regulatory Committee.

2.5 In normal circumstances, the filling of any remaining vacancies on committees etc. that are the responsibility of the Assembly would require the approval of the Assembly. However, as the next meeting is not until 24 July 2024 it is proposed that the Chief Executive be authorised, in consultation with the Leader, to approve the filling of vacant positions to enable individuals to participate as a formal Member in relevant meetings as soon as possible.

3. Options Appraisal

3.1 Any delay in reappointing Members to the various meetings and other bodies puts the normal decision-making process and business of the Council at risk.

4. Consultation

4.1 Consultation has taken place with Members and officers as appropriate.

5. Financial Implications

Implications completed by: Kenny Leshi, Finance Business Partner

5.1 There are no financial implications associated with this report. This concerns the annual appointment of elected Members to Boards and Committees. Where an appointment carries an allowance the financial impact of this is set out in another report to this meeting.

6. Legal Implications

Implications completed by: Dr Paul Feild, Principal Governance Lawyer

6.1 The Assembly is a meeting of full Council for the purposes of Section 8 and Schedule 2 of the Local Government Act 1972. This meeting of the Assembly is the annual meeting where the Council decides on the overall political structure and makes the necessary appointments.

6.2 Part 2 (the Articles) of the Council's Constitution sets out the membership requirements and terms of reference for the various Council committees. The appointments in this report meet statutory and constitutional requirements and

ensure the Council is able to proceed with the business reserved to each committee.

6.3 It is further proposed that the Chief Executive, in consultation with the Leader of the Council, be authorised to approve the appointment of councillors to fill any vacant positions that may not be filled at this Assembly meeting. This is permissible pursuant to section 101(1) of the Local Government Act 1972, so as to enable a full complement of councillors to take a full part in the Council's business straight away.

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

List of appendices:
- **Appendix 1** – Schedule of nominations for 2024/25

Main Council Committees to be appointed to – May 2024
(Appointments are for one year unless otherwise stated)

Committee (and typical meeting arrangements)	**Appointments Required (shown in bold)**	**Nominations**
Assembly Bi-monthly	**Chair** **Deputy Chair**	Cllr Freeborn Cllr F Choudhury
Audit and Standards Committee Quarterly	**Chair** **Deputy Chair** **Plus 6 additional members**	Cllr P Bright Cllr Khan Cllrs Akwaboah, Channer, Gill, Oluwole, Yusuf, Zamee
Health Scrutiny Committee Bi-monthly	**Chair** **Deputy Chair** **Plus 4 additional members**	Cllr P Robinson Cllr Pongo Cllrs M Chowdhury, Freeborn, Lumsden, Nalule
JNC Appointments, Structures and Salaries Panel As and when required, typically daytime.	**6 non-Cabinet members (to form a pool)**	Cllrs Lumsden, Oluwole, Saleem, Shaukat, P Waker, Yusuf
Licensing & Regulatory Committee Quarterly (Members also called to sit on Sub-Committee's as and when required)	**Chair** **Deputy Chair** **Plus 8 additional members**	Cllr Oluwole Cllr Zamee Cllrs Cormack, Hornby, Mullane, Rai, L Rice, Sandhu, Sohaib, Spoor
Overview & Scrutiny Committee Monthly	**Chair** **Deputy Chair** **Plus 8 additional members**	Cllr Paddle Cllr Akwaboah Cllrs Achilleos, Hussain, Lumsden, Rahman, P Robinson, Sandu, P Waker, Yusuf

Committee (and typical meeting arrangements)	**Appointments Required** **(shown in bold)**	**Nominations**
Pensions Committee Quarterly	**Chair** **Deputy Chair** **Plus 5 additional Members** (two-year appointment to May 2026)	Cllr Hussain Cllr Gill Cllrs Lumsden, Miah, Ramsay, Sohaib, Yusuf
Personnel Board As and when required on a Thursday from 10am at Barking Town Hall (and *at least* half a day's duration)	**Chair** **Deputy Chair** **Plus 7 additional members** **(to form a pool)**	Cllr E Rodwell Cllr Nalule Cllr F Choudhury, Dulwich, Hornby, Perry, Rahman, Sandhu, P Waker.
Planning Committee Monthly	**Chair** **Deputy Chair** **Plus 6 additional members** (Cabinet Members for Regeneration & Economic Development and Finance, Growth & Core Services appointed as ex-officio voting members)	Cllr Saleem Cllr Shaw Cllrs F Choudhury, Cormack, Fergus, Miah, Sohaib, Zamee (Cllrs Geddes, Twomey)

Other Internal / Outside Bodies to be appointed to – May 2024
(Appointments are for one year unless otherwise stated)

Body / Committee	Appointment required (shown in bold)	Nominations
East London Waste Authority	**1 Councillor** (Cabinet Member for Public Realm & Climate Change automatically appointed	Cllr Akwaboah (Cllr Haroon)
Employee Joint Consultative Committee	**5 Councillors** (Cabinet Member for Finance, Growth & Core Services automatically appointed	Cllrs Ghani, Hornby, Lumsden, Saleem, Yusuf (Cllr Twomey)
London Road Safety Council	**2 Councillors** (two-year appointments to 2026)	Cllrs Oluwole, Cllr Sandhu
Member Development Group	**Up to 12 Councillors** (Cabinet Member for Employment, Skills & Aspiration automatically a Member)	Cllrs P Bright, M Chowdhury, Hornby, Khan, Lumsden, Nalule, Oluwole, Rahman, Rai, I Robinson, Saleem, Zamee (Cllr S Bright)
OFSTED Report Panel	**Up to 9 Councillors** (Cabinet Member for Educational Attainment & School Improvement automatically a Member)	Cllrs Akwaboah, Fergus, Lumsden, Oluwole, Paddle, Rahman, I Robinson, Sandhu, P Waker (Cllr Kangethe)

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ASSEMBLY

15 May 2024

Title: Appointment of Church Representative (Church of England) Co-optee to the Overview and Scrutiny Committee	
Report of the Chief Executive	
Open Report	**For Decision**
Wards Affected: None	**Key Decision:** No
Report Author: Alan Dawson, Head of Governance & Electoral Services	**Contact Details:** Email: alan.dawson@lbbd.gov.uk
Accountable Director: Deidre Collins, Head of Legal and Monitoring Officer	
Accountable Executive Team Director: Fiona Taylor, Chief Executive	

Summary

The Church Representative (Church of England) co-optee position on the Overview and Scrutiny Committee is currently vacant.

As stated in Part 2, Chapter 8 of the Council's Constitution and in accordance with the Education Act 1996 and the Local Government Act 2000, the Overview and Scrutiny Committee should include the above listed co-optee to scrutinise education matters, appointed by the Assembly. Statutory co-optees have voting rights in respect of education matters only.

Nominations to fill the vacancy were sought by Governance Services. The exercise resulted in one application, from the Reverend Mark Adams, current Vicar at St. Margaret's Church, Barking. Due to their being only one applicant, an election process was not necessary.

Recommendation(s)

The Assembly is recommended to agree the appointment of Reverend Mark Adams, Church Representative (Church of England), as a co-optee on the Overview and Scrutiny Committee.

Reason(s)

To ensure that the Council's Scrutiny function is in accordance with the Council's Constitution and legislation.

1. Financial Implications

Implications completed by: Kenny Leshi, Finance Business Partner

1.1 This report concerns the appointment of two nominees to co-optee positions on the Overview and Scrutiny Committee. There are no financial implications.

2. Legal Implications

Implications completed by: Dr Paul Feild, Principal Governance Lawyer

2.1 The appointment of Co-opted Members to Committees of the Council is an Assembly function. Part 2, Chapter 4 paragraph 2.1 (viii) of the Council's Constitution provides the Assembly with the power to agree and/or amend the overall political structure of meetings, the terms of reference of Committees, their composition and to make appointments to them.

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

List of appendices: None

ASSEMBLY

15 May 2024

Title: OFSTED Inspection of Children's Services Improvement Plan and the Children's Care and Support Self-Evaluation 2023/24	
Report of the Cabinet Member for Children's Social Care and Disabilities	
Open Report	**For Information**
Wards Affected: All	**Key Decision:** No
Report Authors: April Bald; Operational Director for Children's Care and Support and Vikki Rix; Head of Performance and Intelligence for Care and Support	Contact Details: Email: April.Bald@lbbd.gov.uk; Vikki.Rix@lbbd.gov.uk
Accountable Director: April Bald; Operational Director for Children's Care and Support	
Accountable Executive Team Director: Elaine Allegretti; Strategic Director for Children and Adults	

Summary

In July, the Council was subject to a Standard Inspection under the OFSTED Inspection of Local Authority Children's Service (ILACS) framework. The OFSTED inspection report was published on 4 September 2023.

In response to the eight recommendations made, the Council was required to develop and publish an improvement plan by 11 December 2023. The children's care and support improvement plan covering the eight area of recommendations was published to Ofsted on time and is attached in Appendix A.

This report sets out key high-level areas of progress made against the improvement plan as described in detail in the attached latest children's care and support self-evaluation 2023/24.

The self-evaluation is shared with OFSTED as part of the ILACS annual engagement meeting process. Our annual engagement meeting with OFSTED took place on the 17 April 2024, where the self-evaluation and progress on improving the quality and impact of social work practice and progress against the improvement plan was discussed in detail. The meeting was positive.

Recommendation(s)

The Assembly is asked to:

(i) Note the OFSTED Improvement Plan published on 11 December 2023;

(ii) Note the progress made and areas requiring further improvement throughout the duration of this improvement plan; and

(iii) Note the latest version of the children's care and support self-evaluation 2023/24.

Reasons

The OFSTED Improvement Plan is a key plank of the Council's plans to continue improvement to children's social care.

The children's care and support self-evaluation is an annual report and part of the OFSTED ILACS statutory requirement.

1. Introduction and Background

1.1 Between 10 July 2023 and the 21 July 2023, the Council was subject to a Standard Inspection under the OFSTED Inspection of Local Authority Children's Service (ILACS) framework. The final 'OFSTED Letter' formally setting-out OFSTED's findings was published on 4 September 2023.

1.2 In response to the eight recommendations made by OFSTED for improving children's social care in the borough, a detailed improvement plan has been produced and published to OFSTED on the 11 December 2023. This report provides Assembly with a copy of the improvement plan and a high-level update on progress to date. The lifetime of this improvement plan is up to 2025.

1.3 The latest children's care and support assessment of the quality and impact of social work practice is also attached covering this financial year up to end of January 2023/24.

1.4 It is important to note that the challenging financial landscape the Council has faced and continues to face, and how these impact on the delivery of the plan and improvement especially where transformation and growth is required.

2. Summary of Findings

2.1 The judgement from the OFSTED inspection is that services for children in Barking and Dagenham 'requires improvement to be good', as was the case at the last inspection.

Judgement	Grade
The impact of leaders on social work practice with children and families	Requires improvement to be good
The experiences and progress of children who need help and protection	Requires improvement to be good
The experiences and progress of children in care	Requires improvement to be good
The experiences and progress of care leavers	Good
Overall effectiveness	Requires improvement to be good

2.2 Although services for children requires improvement to be good, OFSTED inspectors reported that there have been improvements since the previous inspection in 2019. It was also well received that care leavers a new judgement in the ILACS framework was rated as good in Barking and Dagenham.

2.3 A previous scrutiny report detailed the findings and areas of strengths and weaknesses in the inspection letter. This report focuses on the improvement plan against the eight recommendations required for improving services to be good.

3. The Eight Key Ofsted Recommendations – Progress Update

3.1 OFSTED identified eight key recommendations where they felt improvement was most strongly required. These are:

- Timeliness of strategy meetings.
- Assessment and decision-making for children experiencing neglect.
- Timeliness of pre-proceedings pathways.
- Consistency of response to 16- and 17-year-olds who present as homeless.
- Oversight of children's placements in unregistered children's homes.
- Application of threshold in early help.
- Life-story work and permanency planning.

3.2 The improvement plan is set out in Appendix A. The remaining section of this report focuses on progress made to date and future iterations of this update will be made during the life span of the improvement plan.

Recommendation	Progress Update
Timeliness of strategy meetings.	A weekly performance dashboard has been produced and automated for the service to track timeliness of strategy discussions, including police attendance. Data is showing an improvement in timeliness with the average number of days to complete strategy discussions reducing to 3.17 days and over 70% are now being held in timescale. This is an ongoing priority area for further improvement. The strategy meeting scheduling system is in place and making a difference to co-ordination and timeliness – police are using the slot-based approach including CAIT. Practice workshops have been held across the service to ensure all practitioners are following standards. Multiagency workshops will be taking place in April /May 2024. Audits/dip sampling is taking place and quality of strategy meetings are improving with good multi agency attendance and participation with improved management follow up on decisions being made.
The capacity, quality, consistency and impact of supervision and management oversight.	Capacity has increased with 1.5 FTE Head of Service in Family Support and Safeguarding (FS&S). The wider review of children's care and support operational management capacity and structure is outstanding and has been delayed due to the financial situation of the Council. The development of the CARES Academy (driving learning, development, overall practice improvement and staff retention) is in train and a project manager has been recruited. The online platform will be ready by end of

	March and branding discussions have started with the overall aim of launching April 2024. Delivering comprehensive skills-based supervision training across the service is ongoing. The principle social worker is auditing quality of supervision records, testing impact of the training and whilst some inconsistency, there is evidence of more reflective supervisions. Heads of service undertake weekly dip sampling of practice in their area whilst includes an overview of supervision and management oversight. Dip samples are now routinely highlighting good and regular management oversight as a theme. Monthly case file audit has also indicated evidence of improved supervision driving plans and stronger management oversight. A supervision scheduling pilot is currently underway in Family Support and Safeguarding to evaluate how supervision timelines can be improved using a booking system. Demand is being managed with the number of children open to social care at 2355 compared to 2425 at end of Q2 2023/24 and 2386 at end of year 2022/23. Supervision timeliness at 8 weeks is at 87% and 4 weekly is at 67% – 4 weekly supervision is our practice standard and requires further improvement but going in the right direction. Average caseloads are manageable across the service although around 1:20 in assessment and intervention. However, 39 out of 157 (25%) of case holding social workers still hold more children than their respective target, a 1% decrease from the previous month (41, 26%). Those social workers are in Assessment and Intervention and FS&S. High caseloads impact on supervision timeliness and quality.
Assessment and decision-making for children experiencing neglect.	A new LBDD Safeguarding children's partnership (BDSCP) Neglect Strategy has been developed through the Neglect Improvement Programme Task and Finish Group (NIPTFG), with multi agency input. The Strategy will be launched across the workforce in March 2024 at an event where we will engage staff in the finalisation of the related action plan, ensuring we are understanding the needs of practitioners, as well as children, young people, and their families. The strategy contains key outcomes and measures which will be monitored quarterly by the NIPTFG and reported to the BDSCP Executive by exception. The NIPTFG was established by the BDSCP in October 2023. The NIPTFG has an independent Chair, representation from across partners, agencies and services and meets monthly. The NIPTIF has established five thematic subgroups. • 0-5 Babies and Children Subgroup • 5+ Children and Young People Subgroup • Social Care Subgroup • Poverty, Housing and Environment Subgroup • Information, Advice and Guidance Subgroup These subgroups meet monthly and are driving forward the improvement activity in their thematic area. The NIPTFG agrees all improvement proposals developed by the subgroups. Funding to appoint a practice lead has not been identified, in the context of significant financial pressures. The use of the Graded Care Profile 2 (GCP2), a tool that supports practitioners in assessing neglect and formulating meaningful plans with families, is being embedded in several ways: • The NIPTFG have identified the use of tools as a key issue, and reviews data on use. The improvement work includes developing resources for

	practitioners and training and establishing Neglect Champions, building on the DA Champions model. • The BDSCP has agreed to allocate resources to improve the Neglect learning and development offer in 2024/25 - the aim will be to improve skills and knowledge in recognising and responding robustly to neglect. • A joint Adults and Childrens Children Safeguarding Partnership Boards are hosting a Neglect Practice Week May 2025 - the outcomes of these will further inform the work of the NIPTFG and the action plan of our new Neglect Strategy. DARAC training has been rolled out, with 200 training spaces provided. This tool supports practitioners in identifying and assessing risk of domestic abuse. Train the Trainer training has been scheduled for March 2024. The DA Learning and Development Lead will continue to provide DARAC training through our BDSCP Learning and Development Offer. Other attendees will become the Champions for DARAC, rolling out workshops and sessions to support practitioners. Key practitioners in Support 2 Safety, our front door multi-disciplinary domestic abuse triage team have been trained to DARAC and incorporated the tool into their approach. We have also formally launched Domestic Abuse Champions corporately. We have an Implementation Lead in place to embed the Safe and Together approach to working with families where domestic abuse is an issue. The lead provided through Respect is delivering core and partnership training on Safe and Together. Attendance and engagement have been strong for this. The lead is establishing Action Learning Sets to support. They are collocating with the Specialist Intervention Service providing DA expertise within the SIS enabling effective challenge and embedding of the Safe and Together Approach in our practice. The Domestic Abuse pages of the social care intranet provide full and detailed information to practitioners - including a detailed Practitioners Guidance, and At a Glance Guide, MARAC Protocol and Referral Forms, available support services and referral forms and pathways. The pages also promote our DA Champions. We are finalising similar content for neglect. Funding has been sought for a Hidden harm worker to be based in the Specialist intervention service supporting practice with children and young people whose parents have substance misuse problems. Public health colleagues have funded and delivered perinatal mental health training for practitioners, enhancing their understanding of the impact of poor mental health on parenting. Poor parental mental health is a key feature in our longstanding child protection cases and those in pre proceedings. The Child Protection Panel is in place ensuring senior management and partnership review and oversight of 11 month+ Child protection plans, repeat CP plans and de-plans at 3 months with a strong focus on lived experience of the child. At end of January, 18 children out of 268 children on CP plans had been on the plan for 2 years plus (7%). Repeat CP plan performance is at 20% (47 children) above target and higher than benchmarks. A recent audit focusing on repeat and long duration plans with a lens on neglect highlighted that most children had been known to social care on and off over many years. All but one of the cohorts audited had been exposed to domestic abuse, and for most substance misuse issues was prevalent. A small minority had their CP plan ended prematurely due to over-optimism, and over a quarter ended as they were placed in alternative care. There was overall evidence of good Child protection planning, supervision, and direct work with children. There was an absence of focus on the perpetrator (hence the importance of us embedding the Safe & together approach to domestic abuse which puts the focus back on the perpetrator and safety planning for the mother and children). The audit also evidenced the early help offer was

	not effective for this cohort of families highlighting the necessity of the work with the Partnership on effective early help responses to neglect and domestic abuse. A Child in need (CIN) partnership review meeting chaired by Head of Service meets monthly to ensure better oversight of 9 month plus CIN plans tackling any drift and ensuring progress is made. The majority of children in need are visited 6 weekly and have plans reviewed 3 monthly. Children on CiN plans for more than a year but less than 2 years has increased to 75 13% compared to 11% at end of year (60 children) while those open for 2 years plus has remained at 2.5% 14 children. This cohort tend to be made up of vulnerable adolescents who require longer term intensive intervention. Audit and dip sample work indicate the positive impact of the Specialist intervention service e.g. family group conferences and family support work and improved quality of CIN plans. 20% of new Looked after children have entered care on Police Protection – up 1%. (29 children – 1 sibling group of 5, 1 sibling of 3, 2 sibling groups of 2 and 17 individuals) – above our target of 13%. This proportion is higher than all benchmarks and is under regular review. Heads of Service have oversight of all police protections and submit a need-to-know notification to the Director which outlines a review of the quality of practice and whether the police protection could have been prevented. A summary of these notifications highlights overall improved response to children who have been taken into police protection, with robust MASH enquiries and decision making, strategy meetings being held in a timely way with good partnership attendance and good decision making with consideration of child protection medicals and legal proceedings. Of the cohort most were returned home within 2 weeks of the police protection. Children are being seen quickly and wider family members being considered for children who cannot be placed back with their parent/s. A few children need not have come into care via a police protection had there been earlier more decisive assessments e.g. GCP2 and decisions made about their care. In these instances, a specific incident triggered the police protection in the context of longer-term chronic neglect e.g. mother found under the influence of alcohol and home being found in chronic conditions. Similarly, a homeless 16/17-year-old need not have triggered a Police protection as a child of this age can request to come into care. Larger families in the borough impact on the percentage of children.
Timeliness of pre-proceedings pathways.	The number of children in pre-proceedings has increased by one family and one child as at end of January 2024 - 20 children (9 families) compared to 19 children (10 families) this time last year. However, the number of children in pre-proceedings for over 16 weeks is lower – 7 children (3 families) at end of January 2024 compared to 11 children (6 families) one year ago. Timeliness is therefore improving. Good progress is taking place with improving pre-proceeding pathways with an ongoing review of all pre-proceeding children at maximum of 12 weeks regardless of whether assessments have been completed or are still in progress. TCLPM (Legal planning meetings) are now considering whether children can be safely stepped out of pre-proceedings post 12 weeks with assessments continuing under the child protection plan if significant harm to the child has been reduced. Some children have stepped across to a CP plan as a result. At 12 weeks, if further assessments are required, Social Worker and Solicitor are now identifying relevant experts prior to returning to TCLPM to avoid delay. Decisions are audited by TCLPM and recorded on file. Regular dip samples are undertaken, and a monthly report is sent to Director for Children's outlining progress for all Pre-Proceedings cases over 16 weeks but also covers general Pre-Proceedings update. These updates reflect

	some positive impact of the increased tracking and management oversight with more decisive decision making. Assessments commissioned by external independent assessors e.g. clinical psychologists, or independent social workers continue to contribute to the delay in pre-proceedings. We have proposed setting up and inhouse expert assessment team however the financial context of the borough has delayed any progress on this as it would require some growth monies. We therefore remain dependent on a limited pool of external experts.
Consistency of response to 16- and 17-year-olds who present as homeless.	The training and practice standards have been refreshed following the Inspection with a new training module which now includes case studies and role playing to ensure staff clearly understand the processes and the placement options for young people who present as homeless. The 16/17 Homeless Protocol is being reviewed. The first draft will be available for review on 11 March 2024. The inhouse children's rights advisor for looked after children now sees all homeless 16/17-year old's offering them independent advocacy asset out in National Guidance. The joint homeless assessment form has been revised so that the social worker and the children's rights officer both clearly record the options discussed with the young person about accommodation provision under section 20 or Section 17. Following the three-way meeting between housing, social worker and the young person, an options letter and leaflet is provided to the young person which clearly states what was discussed during the meeting highlighting the possible outcomes, accommodation options and the role of the independent advisor. All 16 plus presenting as homeless are now being notified to the Operations Director in the form of a Need-to-Know notification. This includes quality assurance by the Head of service. Overall, we are seeing an improvement in responses to homeless 16 /17-year-olds who present as homeless. Their needs are being assessed and there is evidence that they have seen the children's rights officer and had the options available to them explained. There is also good evidence of efforts to re-unify them with family, when safe to do so, through intervention by the restorative intervention team. There is evidence of swift management decision making and intervention when the social worker has not followed due process. Regular audits are undertaken, and outcomes shared at the Vulnerable 16-15 persons Housing meeting chaired by the Director of Operations. Audit findings indicate the improvement work is impacting positively although social workers and managers need to pay attention to the quality of their recording.
Oversight of children's placements in unregistered children's homes.	Director Need to know notifications are now completed for Director authorisation of any placement of a child aged under 16 children in an unregulated setting. The protocol on timely notifications to Ofsted on all under 16 placed in unregistered homes has been revised and in place since July 2023. For those placements, notifications are sent to Ofsted by the Placement Finding Manager as soon as the child moves into placement. Since July there has been 100% compliance with this notification process. A list of children and details on their unregulated placement is included on the agenda for the monthly Provider Risk, Quality & Concerns meetings. This list includes the date of the placement, the date the notification was sent to Ofsted, a summary of pre-placement checks (or if it is a framework provider) and a summary of the findings from a visit by the Provider Quality Team (in person or virtual visit depending on placement location). These papers are

	distributed to a wide range of people, including the Commissioning and Operational directors. Children who are under 16 in 16+ provisions or children over 16 in a 16+ but on a DOLS provision are discussed at the monthly Residential oversight meeting (ROM). This meeting quality assures the child's care package including progress being made to find a registered placement or step the child back to a foster/ family placement. Expectations on frequency of visiting to under 16's in unregulated settings has been set and Practice guidance has been issued to all staff and will be monitored via performance data on visits to children in care. Dip sample activity indicates increased visiting by social workers to these children, although distance of the placement does prove a challenge. These children are also being seen in placement by their IRO and one child has a Family support worker funded by the Local authority visiting 3 times a week. There is also evidence of frequent management oversight and supervision for these children.
Application of threshold in early help.	Roadshows in October 2023 and monthly drop-in sessions have taken place to further embed the continuum of needs threshold across children's care and support workforce and partners. Weekly dip sampling of decision making in MASH is undertaken by the MASH Head of service. This work includes review of the work undertaken by early help with consideration of their decision making to step up to MASH. Overall, decision making in MASH is good and informed by robust MASH enquiries where partners have contributed information enabling the MASH managers to make an evidence-based risk assessment and decision. History is routinely taken into consideration and analysis is child centred. There is evidence of MASH managers routinely evidencing the rationale for decisions rather than merely ratifying the social work recommendation. Around 70% of referrals into MASH now have a detailed MASH enquiry, which contributes to improved decision making. Targeted Early Help Advisory service and Locality service manager use the current step-up and step-down protocol in collaboration with MASH and regularly review of threshold application. Audit shows increased confidence in application of threshold. Audit of the decision making by the Support 2 Safety (S2S) domestic abuse team in MASH shows consistently strong decision making and application of the Continuum of Need threshold. Domestic abuse referrals were previously likely to be subject to repeat referrals. The expertise within the S2S team has strengthened the quality of decisions with the needs of perpetrators being routinely considered, safety planning included and a marked increase in referrals to MARAC. The MASH multi agency monthly audits continue, and the vast majority now have a 'good' finding with some outstanding areas of practice. Quality of referrals are seeing some improvements. Dip samples highlight more timely early help planning and interventions with families. However, lack of parental consent can hamper progress and lead to re -referral back into social care. Many repeat referrals are in relation to vulnerable adolescents and children with special education needs and the early help offer not being readily available or impactful for this cohort. The Early Help improvement work includes a focus on this cohort. The January monthly case file audit highlighted improved focus on the lived experience of the child in the Early help work and some outstanding early help assessments with strong partnership involvement and purposeful direct

	work. Where work was less strong was where families who had long term involvement with social care services due to neglect and had been stepped down, audit indicated the early help offer was less effective for these families.
Life-story work and permanence planning.	A great deal of improvement work has focused on timely permanence planning. A detailed weekly permanence tracker provides single oversight on the prevalence of permanence plans for all looked after children. This tracker supports managers in ensuring more timely permanence planning meetings. Current data shows that 94% of looked after children have had a permanence planning meeting and 99.5% have had a PPM by second LAC review. This is excellent progress. Permanence practice guidance has been issued and training rolled out to staff. The most recent dip sample showed improving practice with better understanding of parallel planning and consideration of the permanence options available for the child with family group conferences being routinely held. There is further work to do to support more coordinated early planning for adoption, although the adoption scorecard is still impacted by delayed court proceedings for these children. The Principal Social Worker is currently planning regular bitesize workshops on the ethos and planning needed for ensuring early permanence and this will include the sharing of best practice and exemplars. Efforts are underway to purchase a Life Story App which will be available to all looked after children and become a repository for photos, certificates, and other memorabilia that a parent and child will collect and keep as they grow. This app will support the child understanding their story, family connections and childhood experiences. Our inhouse therapy team continue to support quality life story work and are developing a new training offer for staff in the corporate parenting and children with disabilities service to support improved life story work. Dip sample activity by the Head of Service is evidencing increased prevalence of photos and direct work with young people focusing on 'their story 'and identity. We have recently been successful in winning a bid from the DfE of £650 k to implement a Lifelong links offer. This will contribute to strengthened life story work and connecting young people with wider family and important people in their lives which in turn will strengthen their understanding of their history and improve their sense of belonging.

4. Children's Care and Support Self-Evaluation

4.1 The self-evaluation of social work practice in Barking and Dagenham demonstrates an improving picture across many areas of social care performance and quality assurance activity highlighting improvements in management oversight, quality of supervision, improved threshold application at the front door, improved permanence planning, better outcomes for children in care and care leavers.

5. Consultation

5.1 The OFSTED Improvement Plan was developed in conjunction with key stakeholders across the Council, including the Lead Member for Children's Services. This included partners outside of Children's Care and Support who will

play a significant role in delivering the improved outcomes for our children and young people.

5.2 Findings from the inspection and the associated improvement plan has been presented to the Local Safeguarding Children Partnership. This Improvement Plan will also be formally presented to the local Health and Wellbeing Board and NEL ICB.

6 Financial Implications

Implications completed by: Antony Envoldsen-Harris, Finance Business Partner

6.1 There are no financial implications.

7. Legal Implications

Implications completed by: Dr Paul Feild, Principal Governance Lawyer

7.1 This report is for noting only. It sets out a comprehensive description of the required improvement plan focused on the necessary steps to raise the standards to establish arrangements which deliver the outcomes which the inspectors report identifies to be achieved across the board. The plan has been delivered and published on 11 December 2023 before the final date for doing so.

8 Other Implications

8.1 **Risk Management –** there is significant risk in failing to deliver an adequate Children's Service. There are considerable risks to the children and young people who we have a duty to safeguard, as well as the risks to the Council of failing to adequately discharge statutory duties. As part of our governance and programme management arrangements, risks are being identified and will be managed through this process.

Public Background Papers Used in the Preparation of this Report.

- London Borough of Barking and Dagenham: Inspection of Children's Social Care Services (OFSTED Letter) September 2023 https://reports.ofsted.gov.uk/provider/44/80486

List of Appendices

- **Appendix A:** Children's Care and Support Improvement Plan

APPENDIX A

Barking & Dagenham CARES

Children's Care and Support OFSTED Improvement Plan

Our plan for improving Children's Social Care Services in Barking and Dagenham in response to OFSTED ILACS Inspection findings and recommendations

Ofsted Inspection July 2023

Introduction

The Ofsted inspection of Barking and Dagenham's Children's Social Care Services took place between 10 to 21 July 2023. The final OFSTED report formally setting out their findings was published on 4 September 2023.

The inspection judged services in Barking and Dagenham to be 'requires improvement to be good', with a grading of good for care leavers. The Improvement Plan for Children's Care and Support Services has been developed in response to the Ofsted report findings, covering the eight specific recommendations set out below, but also addressing all areas for improvement highlighted in our letter from OFSTED. This high-level plan sets out the key actions we will take over the next 12 months to address those recommendations and areas for improvement and to ensure outcomes improve for vulnerable children, young people and families in Barking and Dagenham.

Ultimately, we aim to deliver consistently good services for children, young people and their families and our ambition is be good by the time of our next inspection.

The Children's Improvement Board, chaired by the DCS and multi-agency in its composition, will oversee the delivery, monitoring and evaluation of this plan. The Children's Improvement Board will be responsible for ensuring all recommendations are responded to and acted upon. The Board will report into the existing corporate governance mechanisms responsible for all Council improvement activity. It will meet monthly to provide oversight and challenge, and progress will be formally monitored at all levels of the organisation. The remainder of this document sets the high-level plan for responding to those recommendations and how we will organise ourselves to deliver upon our ambitious plans.

What needs to improve? (Area 1) Timeliness of strategy meetings.

Action		Accountable Lead	By When	Expected Outcomes (what difference it will make)	Measures that matter
1.1	Set up multiagency practice workshops covering the purpose of strategy meetings, role of information sharing and decision making, embedding practice standards with a strong focus on improving chairing, recording, decision making, quality and timeliness.	Director of Operations	December 2023	Improved strategy meeting timeliness and multi-agency input in decision making. Increased timeliness of police attendance at strategy meetings. Strategy meetings that are purposeful, timely and in accordance with best practice. Actions agreed in strategy meetings are regularly reviewed to ensure actions are being followed through enabling improved timeliness of intervention. Children suffering sexual abuse getting the right specialist health response, sexual abuse medicals and well-being support.	Number and % of strategy meetings completed in a timely way. Increase in audits/practice evaluations on strategy meetings rated good or outstanding. Increase in number of children being referred to the NEL CSA Hub and Havens and accessing Barnardo's support as victims of CSA.
1.2	Team managers at point of Section 47 sign off quality assure all actions agreed at the strategy meeting ensuring they have progressed.	Team Managers	Ongoing		
1.3	Heads of Service (HoS) in MASH and Assessment to undertake monthly dip samples of strategy meetings, tracking quality of meetings, decision making, progress of actions and partnership attendance.	Head of MASH Head of Assessment	Monthly		
1.4	Implement a Business Support strategy meeting scheduling system with administrative support to improve co-ordination , quality of recording and tracking - this will include police attendance and other relevant partners.	Head of Service Development and Transformation	September 2023		
1.5	Develop data and performance reports to track timeliness of strategy meetings and report weekly/monthly.	Head of Performance and Intelligence	October 2023		
1.6	Child Sexual Abuse (CSA) Social Care Liaison Officer to provide regular consultation prior to CSA strategy meetings ensuring children are referred to the correct CSA service. Ensuring social workers are knowledgeable about sexual abuse pathways.	Director of Operations	Ongoing		

What needs to improve? (Area 2) The capacity, quality, consistency and impact of supervision and management oversight.

Action		Accountable Lead	By When	Expected Outcomes (what difference it will make)	Measures that matter
1.1	Review the children's care and support operational management capacity and structure with a view to implementing a fit for purpose management structure to manage the demand and deliver best practice.	DCS Chief Executive S115 Officer	March 2024	The children's care and support operational service has an increase in resources and a management structure that is proportionate to the demand. The management : social work ratio is equitable across the services and sufficient to meet the level of service demands ensuring good management oversight in line with practice standards. The frequency of supervision and management oversight is consistent across all teams and held in line with practice standards. Actions from supervision are reviewed in a timely way and progress made. If not, managers take immediate action to address and complete actions to reduce delay and risk. Developments and the lived experience of the child are embedded in supervision. Plans are progressing due to robust supervision and clear management direction. Line managers offer reflection and curiosity in supervision and align decisions to those made in other forums e.g. TCLPM and CPCC. All new managers joining the service have access to supervision training, the supervision policy and practice guidance enabling them to provide supervision in line with agreed practice standards. Audit shows consistently good supervisions across the management group.	Number and percentage of supervision completed every 4 weeks and 8 weekly by service and team. Number and % of management oversight on children 4 weekly by service and team. Audits report an increase in supervision being rated good or outstanding. Average caseloads by service and team in line with targets set. Equitable manager to staff ratio reflected in staffing structures. Number and percentage of children on plans by duration and repeat plans/episodes.
1.2	Develop the CARES Academy bringing together recruitment and retention activities and learning and development opportunities - driving the CARES values , practice priorities , principles and standards . The CARES Academy will champion strengths based and trauma informed practice approaches, and staff development with a focus on neglect and quality supervision.	Director of Operations	April 2024		
1.3	Deliver comprehensive skills based supervision training programme for all frontline managers, increasing their understanding of what good supervision looks like, and they partake in live action learning sets learning from critical feedback.	Head of Safeguarding and QA PSW	March 2024		
1.4	Pilot new booking system for supervision to drive improvements in frequency and timeliness.	Head of Service Development and Transformation	December 2023		
1.5	Further embed supervision policy and practice standards and undertake weekly dip sample activity to assess impact.	PSW	November 2023		
1.6	Heads of Service to undertake weekly dip sampling activity alongside team managers focusing on supervisions within their service and act upon areas for improvement and learning. Report to monthly performance meeting.	All Head of Service (Childrens Care and Support)	Weekly		
1.7	Produce a Panels Pack setting out the various panels/oversight meetings including terms of reference for each. Embed an understanding of how those panels interface and link to supervision i.e. supervisions should always consider decisions made on a case in another forum.	Head of Service Development and Transformation	February 2024		

What needs to improve? (Area 3) Assessment and decision-making for children experiencing neglect.

Action		Accountable Lead	By When	Expected Outcomes (what difference it will make)	Measures that matter
1.1	Develop, launch and embed the multiagency partnership neglect strategy to ensure measurable interventions from universal through to statutory services, utilising London safeguarding procedures and DfE best practice guidance on neglect.	Children's Safeguarding Partnership	March 2024	Improved assessment and decision making for children experiencing neglect. A reduction in repeat children in need and repeat children on child protection plans particularly where neglect and DA are a feature. Assessments progress quicker supported by measurable and evidence based interventions for children experiencing long term neglect demonstrating impact. Children enter care in a planned way with less trauma rather than on police protection. A knowledgeable workforce with increased skills and access to a suite of practice resources supporting quality direct work and interventions with children and families. A whole systems approach to neglect is in place where it is identified early, and families can access the right resources at the right time from universal services through to statutory.	Number and percentage of children open to social care with a completed Graded Care Profile 2 on file by service and team. Number and percentage of children on repeat CiN plans, including 9 months plus duration. Number and percentage of children on subsequent CP plan with category of neglect and DA (reduction), including 12 months plus duration. Monthly/quarterly audit of DA and neglect children on plans rated good or outstanding. Number and percentage of children entering care on police protection. Number and percentage of EPO and short notice hearings. Number and percentage of children entering care on police protection still in care 3 months and 6 months later.
1.2	Set up a multi-agency neglect task and finish group, independently chaired to ensure pace of change.	Children's Safeguarding Partnership	March 2024		
1.3	Appoint a neglect practice lead to embed use of GCP2 tool and run practice workshops increasing assessment skills and knowledge of interventions and resources across children's social care.	Director of Operations	January 2024		
1.4	Appoint a Domestic Abuse practice lead to embed use of DARAC domestic abuse risk assessment tool and run practice workshops increasing assessment skills and knowledge of interventions and resources across children's social care. Deliver on embedding the Safe and Together approach in responding to DA.	Director of Operations	December 2023		
1.5	Further embed the Support 2 Safety Pilot team in MASH . Include evaluation to measure impact on better early identification of risks associated with DA , appropriate threshold application , robust safety planning including increased engagement with perpetrators.	Head of MASH	April 2024		
1.6	Develop the LBBD social care intranet site to capture neglect and domestic abuse practice guidance, practice tools, relevant research and referral pathways to resources.	Head of Service Development and Transformation	March 2024		
1.7	Refresh the Child Protection Panel, ensuring senior management and partnership review and oversight of 11+ CP plans, repeat CP plans and de-plans at 3 months with a strong focus on lived experience of the child.	Head of Safeguarding and QA	September 2023		

What needs to improve? (Area 3) Assessment and decision-making for children experiencing neglect (continued)

Action		Accountable Lead	By When	Expected Outcomes (what difference it will make)	Measures that matter
1.8	Family support workers in the Specialist intervention team to adopt an evidence based practice approach with outcomes framework to better evidence neglect and impact of interventions.	Head of Specialist Intervention Service	February 2024	Improved assessment and decision making for children experiencing neglect. A reduction in repeat children in need and repeat children on child protection plans particularly where neglect and DA are a feature. Assessments progress quicker supported by measurable and evidence based interventions for children experiencing long term neglect demonstrating impact. Children enter care in a planned way with less trauma rather than on police protection. A knowledgeable workforce with increased skills and access to a suite of practice resources supporting quality direct work and interventions with children and families. A whole systems approach to neglect is in place where it is identified early, and families can access the right resources at the right time from universal services through to statutory.	Number and percentage of children open to social care with a completed Graded Care Profile 2 on file by service and team. Number and percentage of children on repeat CiN plans, including 9 months plus duration. Number and percentage of children on subsequent CP plan with category of neglect and DA (reduction), including 12 months plus duration. Monthly/quarterly audit of DA and neglect children on plans rated good or outstanding. Number and percentage of children entering care on police protection. Number and percentage of EPO and short notice hearings. Number and percentage of children entering care on police protection still in care 3 months and 6 months later.
1.9	Produce a quarterly report focusing on police protections - the quality of response and whether PPs could have been avoided to drive learning and practice improvement.	Head of Safeguarding and QA	Quarterly		
1.10	HoS complete a case file audit and director need to know notification for all children entering care on Police Protection to further improve quality of response post Police Protection and to support senior leadership oversight and practice development .	Head of Safeguarding and QA	Ongoing		
1.11	Recruit a Hidden Harm practitioner in the Specialist Intervention Service to strengthen assessments on impact of substance misuse on children.	Head of Specialist Intervention Service	March 2024		
1.12	Restructure the pre-birth team to ensure pre-birth work is consistently good across services -and include peri-natal training for staff to better understand impact of parental mental health and neglect on parenting capacity.	Director of Operations	March 2024		
1.13	Hold a CIN partnership review meeting chaired by HoS to ensure better oversight of 9 month plus children in need plans tackling any drift and ensuring progress is made.	Head of Family Support and Safeguarding	Monthly		

What needs to improve? (Area 4) Timeliness of pre-proceedings pathways.

	Action	Accountable Lead	By When	Expected Outcomes (what difference it will make)	Measures that matter
1.1	Threshold of Care Legal Planning Meetings (TCLPM) to review all pre-proceeding children at maximum of 12 weeks regardless of whether assessments have been completed or are still in progress. The social worker to produce an update outlining the child's current lived experience and impact of work under PLO.	Head of Corporate Parenting and Permanence	October 2023	No pre-proceedings longer than 16 week maximum. Improved and more effective child protection planning, and assessments undertaken in a timely way to reduce unnecessary pre-proceedings. External expert assessments no longer contributing to delay in pre proceedings. The launch of an in-house expert court assessment practice model bringing about improved quality of expert assessments.	Number and % of children for whom PLO pre-proceedings were completed within 16 weeks (monthly). Number and percentage of pre-proceedings out of timescale (monthly). Pre-proceedings by duration and outcome. Dip sample and audit activity evidences good and outstanding practice in pre-proceedings cases.
1.2	TCLPM to consider whether children can be safely stepped out of pre-proceedings post 12 weeks with assessments continuing under the CP plan, if significant harm to the child has been reduced.	Head of Corporate Parenting and Permanence	October 2023		
1.3	At 12 weeks, if further assessments are required, Social Worker and Solicitor to identify relevant experts prior to returning to TCLPM to avoid delay. Audit decisions to ensure delay or need for further assessments are well understood.	Court Progression Manager	October 2023		
1.4	HoS oversight on all pre-proceedings. Where intervention has no impact on the safety of the child, social worker to return to TCLPM no later than 6-8 weeks (prior to the 12 weeks).	All Heads of Service	October 2023		
1.5	Ensure expert assessments are considered as part of supervision, CP planning in core groups and midway reviews to identify effective interventions and/or evidencing harm at an earlier stage to avoid drift and to better inform legal planning.	Head of Family Support and Safeguarding Head of Safeguarding and QA	November 2023		
1.6	Monthly dip sample activity focussing on quality of work being undertaken within pre proceedings, threshold to remaining in pre proceedings , addressing any elements of drift and delay.	Court Progression Manager	Monthly		
1.7	Hold weekly pre-proceedings tracking meetings, involving SW, team managers, solicitor, CPM and Principal Solicitor and agreed actions to be added to the file.	Court Progression Manager	October 2023		
1.8	Establish an in house court expert assessment team, based in the Specialist Intervention Service to support timelier and improved quality expert assessments utilising in-house specialisms e.g. FSW, Therapist, FGC service. (financial investment permitting)	Head of Specialist Intervention Service	April 2024		

What needs to improve? (Area 5) Consistency of response to 16- and 17-year-olds who present as homeless.

Action		Accountable Lead	By When	Expected Outcomes (what difference it will make)	Measures that matter
1.1	Review pathways to ensure young people access to advocates and independent advice on entitlements re Section 20 and Sec 17 accommodation is well-understood and the referral pathway is clear and fit for purpose.	Head of Assessment	November 2023	Improved compliance with the national 16/17 year old Homeless Guidance, ensuring all children who present as homeless are assessed jointly with housing colleagues and the assessment is holistic. Young people will have a clearer and fuller understanding of their rights and access to an advocate for independent advice. Files will evidence the child has been well informed of their options and where safe to do so, efforts have been made to support their reunification with their family.	Increase in audits on joint assessments rated good or outstanding. Number and percentage of 16-17 homeless and joint assessments undertaken and recorded on Liquid Logic. Children's rights advocacy service reports increase in young people being referred for independent advice and advocacy. Reduction in older adolescents coming into care.
1.2	Refresh the 16/17 Homeless Protocol and Guidance and associated leaflets for young people.	Head of Assessment	December 2023		
1.3	Refresh and launch a new training module so that all staff are trained (include refresher sessions).	Head of Assessment	December 2023		
1.4	Review joint homeless assessment templates on Liquidlogic, ensuring alignment with the assessment of the child's wider needs alongside housing.	Head of Assessment	November 2023		
1.5	Report monthly data and performance to the 16-25 vulnerable homeless strategic group.	Head of Performance and Intelligence	November 2023		
1.6	Develop an edge of care team to promote and support adolescents remaining with family when it is safe to do so.	Director of Operations Head of Specialist Intervention Service	April 2024		
1.7	Undertake monthly audit of all young people who have presented as homeless or are at risk of becoming homeless to ensure that practice for 16/17-year-old homeless takes account of children’s needs and is in line with LBBD protocol and National Guidance.	Head of Specialist Intervention Service	Monthly		
1.8	HoS to complete a Director Need to know notification of any 16 plus presenting as homeless or where this is an investigation.	All Heads of Service	Ongoing		

What needs to improve? (Area 6) Oversight of children's placements in unregistered children's homes.

Action		Accountable Lead	By When	Expected Outcomes (what difference it will make)	Measures that matter
1.1	Director Need to know notification to be completed for Director authorisation of any placement of an under 16 child in an unregistered setting.	Director of Operations	July 2023	Evidence on files of Director oversight and decision making for children being placed in unregulated settings and immediate notifications to Ofsted. Case files evidence the following: extensive efforts to avoid such placements, Ofsted notifications, children home documentation on case files, frequent visits to child in line with protocol. Regular permanence planning meetings with discussions on 'step down ' and alternative placement options.	Number of children in unregistered provision. Timeliness of visits to children placed in unregulated provision (weekly). Dip sampling and audit shows senior management oversight and decision clearly recorded on the child's record.
1.2	Refresh protocol on timely notifications to Ofsted on all under 16 placed in unregistered homes.	Director of Commissioning	July 2023		
1.3	Develop and implement a protocol with practice standards for social workers and IROs on increased visiting and oversight of children in unregistered placements.	Head of Safeguarding and QA	December 2023		
1.4	Monthly review of all unregistered placements at the provider quality assurance meeting with commissioners and social care HoS, including support to provider to progress registration. Report to DCS and CIB on quality assurance visit outcomes.	Director of Commissioning	Monthly		
1.5	Residential oversight meeting to review children in unregistered; to include dip sampling files to ensure timely PPM, robust care planning and child being seen regularly.	Head of Corporate Parenting and Permanence	Monthly		

What needs to improve? (Area 7) Application of threshold in early help

Action		Accountable Lead	By When	Expected Outcomes (what difference it will make)	Measures that matter
1.1	Further embed the continuum of needs thresholds to ensure understanding and application across children's care and support workforce and wider partnerships via roadshows , monthly MASH drop in sessions and service specific presentations.	Head of MASH Head of Early Help	April 2024	Children will not move back and forth between MASH and Early help. Instead, children and families will receive the right help at the right time by the right service. Decisions in MASH will always reference the Continuum of Need evidencing the reason for the course of action and threshold decisions.	Number and percentage of step up and step down children between Early Help and CCS. Number and percentage of multiple contacts within 6 months. Number and percentage of re-referrals (social care). Number and percentage of Early Help repeat referrals. Dip sample audit reports show a decrease in threshold being inconsistently applied (thematic – qualitative). Increase in audits rated good or outstanding on threshold application.
1.2	Review step up and step down process and interface between EH and statutory social care to ensure current transition points support timely and accurate threshold decision making, and allegations of harm are appropriately investigated before step down.	Head of MASH Head of Early Help	November 2023		
1.3	All MASH staff including partners to be trained on the new DARAC (Domestic Abuse Risk Assessment Tool) and child sexual abuse response pathway.	Head of MASH Head of Early Help	January 2024		
1.4	Undertake weekly threshold dip sample audits focussing on management oversight, threshold decision making and partners involvement in MASH enquiries with specific focus on cases moving between Early Help and MASH and decision making on anonymous referrals . Report to Director of Operations and Children's Improvement Board.	Head of MASH Head of Early Help	Weekly		
1.5	Conduct multi agency audits of MASH decision making. Quarterly report to MASH Partnership Board.	Head of Safeguarding and QA	Monthly		

What needs to improve? (Area 8) Life-story work and permanence planning.

Action		Accountable Lead	By When	Expected Outcomes (what difference it will make)	Measures that matter
1.1	Principal Social Worker (PSW) to deliver the improvement plan borne out of the Direct work audit which includes focus on quality direct work starting at the front door	PSW	March 2024	All children and young people in care are able to access life story work to support and promote their understanding of their identity, family history and emotional and mental health wellbeing. Robust and regular permanence plans are produced for children which result in them experiencing good permanence outcomes in good time.	Number and percentage of children in care for 6 months or longer with life story work recorded in case notes. Practice evaluations demonstrate an increase in access and good quality life story work. Permanence tracker reports no children without a PPM and permanence plan by second review. PPMs are held with the right frequency. Audit evidences increased good and outstanding quality of permanence planning and outcomes. Improved adoption scorecard. Increase in early permanence adoption placements. Improved timeliness of children being matched to long term foster carers by Fostering Panel.
1.2	Provide regular consultations to practitioners managing complex life story work to improve confidence in dealing with traumatic issues, tools to use in the sessions, reviewing progress and offering ongoing support as work progresses.	Team Manager Consultant Clinical Social Worker and Play Therapist	September 2023 (ongoing)		
1.3	Provide specialist training to Social Workers and Leaving Care Advisers in life story work.	Head of Corporate Parenting and Permanence	September 2023 (ongoing)		
1.4	New Town Culture (NTC) to bring additionality to Direct work and Life story work - with new tools , resources and group work opportunities - this includes NTC practitioners evidencing work on case files.	Senior Curator Culture Programmes	March 2024		
1.5	Creative Social Work course at Goldsmiths University offered to SWs, particularly those that would benefit from improving their creativity in undertaking life story work.	PSW	Ongoing		
1.6	Explore implementation of Caring Life App which is specifically for Life story Work aimed at improving consistency and quality of life story work.	Head of Corporate Parenting and Permanence	December 2023		
1.7	Develop and roll out specific training and tools aimed at working with adolescents.	PSW Head of Adolescent and Youth Justice	December 2023		
1.8	Complete regular audits to identify evidence of good life story work and action any gaps.	Head of Safeguarding and QA	Quarterly		

What needs to improve? (Area 8) Life-story work and permanence planning (continued).

Action		Accountable Lead	By When	Expected Outcomes (what difference it will make)	Measures that matter
1.9	HoS to carry out regular dip sampling/auditing on the quality of permanence planning meetings.	Head of Corporate Parenting and Permanence	Ongoing	All children and young people in care are able to access life story work to support and promote their understanding of their identity, family history and emotional and mental health wellbeing. Robust and regular permanence plans are produced for children which result in them experiencing good permanence outcomes in good time.	Number and percentage of children in care for 6 months or longer with life story work recorded in case notes. Practice evaluations demonstrate an increase in access and good quality life story work. Permanence tracker reports no children without a PPM and permanence plan by second review. PPMs are held with the right frequency. Audit evidences increased good and outstanding quality of permanence planning and outcomes. Improved adoption scorecard. Increase in early permanence adoption placements. Improved timeliness of children being matched to long term foster carers by Fostering Panel.
1.10	Review Permanence Taskforce, composition and terms of reference to strengthen strategic oversight of permanence, including the role of IROs.	Director of Operations	November 2023		
1.11	Provide permanence tracker training to all HoS and service managers to ensure robust operational overview of permanence and support to HoS to run service specific permanence planning oversight meetings, which feed into the taskforce.	Head of Performance and Intelligence All HoS	November 2023		
1.12	Develop a suite of good quality PPMs accessible for all social care practitioners demonstrating what permanence means across all services and what a stable lived experience for the child looks like.	PSW	February 2024		
1.13	Implement model of PPM slots with BSO support to drive improvements in timeliness and frequency of PPM meetings for all children in care.	Head of Service Development and Transformation	July 2023		
1.14	Monthly permanence overview report to be produced from the permanence tracker and permanence performance dashboard to highlight progress and areas in need of improvement.	Head of Performance and Intelligence	Monthly		
1.15	Social care training programme to include regular permanence planning practice workshops to address issues with understanding of permanence planning, permanence timeliness and quality of PPMs.	PSW	December 2023		
1.16	Audit of permanence plans including focus on IRO and manager's scrutiny of permanence.	Head of Safeguarding and QA	Quarterly		

ASSEMBLY

15 May 2024

Title: Health Scrutiny Committee Annual Report 2022/23	
Report of the Chair of Overview and Scrutiny Committee	
Open Report	**For Information**
Wards Affected: None	**Key Decision:** No
Report Author: Leanna McPherson, Principal Governance Officer and Statutory Scrutiny Officer	**Contact Details:** Tel: 020 8227 2852 E-mail: leanna.mcpherson@lbbd.gov.uk

Summary

The four principles of good public scrutiny as described by the Centre for Governance and Scrutiny are:

1. Provide a constructive “critical friend” challenge;
2. Amplify the voice and concerns of the public;
3. Be led by independent people who take responsibility for their role; and
4. Drive improvement in public services.

This report outlines the work of the Health Scrutiny Committee, which can be found at Appendix A.

Recommendation(s)

The Assembly is recommended to note the Health Scrutiny Committee Annual Report 2022/23, as set out at Appendix A to the report.

Reason(s)

It is good practice for the Assembly to be made aware of the work of the Scrutiny Committees during the last municipal year.

1. Introduction and Background

1.1 Following a review of the Council’s governance arrangements in 2018 (Minute 56 refers), the Overview and Scrutiny Committee has been successfully operating for four years.

1.2 The Committee has looked at various issues throughout the municipal year, which are referred to in Appendix A.

1.3 There have been no referrals, call-ins or petitions to the Committee over the past year.

2. Financial Implications

Implications completed by: Sandra Pillinger, Finance Manager

2.1 This report outlines the work of the Scrutiny Committee and has no direct financial implications.

3. Legal Implications

Implications completed by: Dr Paul Feild, Principal Governance Lawyer

3.1 As the content of the report explains there is a legal requirement for councils which establish executive governance (this includes Leader and Cabinet, our model) to establish scrutiny and overview committees under the Local Government Act 2000. The precise arrangements are a matter for local determination and an amendment to the Act to require the appointment of a statutory scrutiny officer has given that role a specific duty to promote the scrutiny and overview function and provide support for the committee(s) and members. The Council's arrangements are to operate an Overview and Scrutiny Committee and a Health Scrutiny Committee. The division of responsibility is that the Overview and Scrutiny Committee is the lead Scrutiny Committee except for heath matters.

3.2 The Overview and Scrutiny Committee is a committee established under Section 21 of the Local Government Act 2000, as amended by the Localism Act 2011. Its functions are set out by law and also determined locally. It is responsible for addressing any Call-in/Councillor Call For Action that is received, except where the subject primarily relates to health matters in which case it will be dealt with by the Health Scrutiny Committee.

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

List of appendices:

- **Appendix A:** Health Scrutiny Committee Annual Report 2022/23

Health Scrutiny Committee (HSC) Annual Report 2022/23

Chair's Foreword

"Although the Covid-19 pandemic has passed, it has had a profound long-lasting impact on health care services nationally. We are now in the mists of a cost-of-living crisis that has further impacted our residents and health care services as evident throughout this report. The Committee would like to express our gratitude and thanks to all of our healthcare staff, partners and key colleagues for their dedication and ongoing support to our scrutiny processes and residents of the Borough during these difficult times.

The Committee undertook extensive scrutiny to our health services that matter most to our residents. We have addressed a broad range of topics from updates from healthcare centres within the Borough such as the *Tulasi Medical Centre Update*, to more wider matters such as the *Health Inequalities Funding*.

Councillor Lumsden, Councillor Chowdhury and I have also represented the Borough at the wider forum of the Outer North-East London Joint Health Overview and Scrutiny Committee (ONEL JHOSC) this municipal year. ONEL JHOSC has the responsibility for local joint health scrutiny arrangements amongst the three of our neighbouring London Boroughs which includes Havering, Redbridge, and Waltham Forest. Through this, we have looked to echo the voices and concerns of our residents to ensure our key priorities are achieved.

I look forward to continuing to work with colleagues over the coming year, with a view to reaching our vision of continuously improving health services and amenities for our residents."

Cllr P Robinson
Chair, Health Scrutiny Committee

Membership

During the 2022/23 municipal year, the Health Scrutiny Committee consisted of seven Councillors:

- Cllr Paul Robinson (Chair)
- Cllr Michel Pongo (Deputy Chair)
- Cllr Muhib Chowdhury
- Cllr Irma Freeborn
- Cllr Manzoor Hussain
- Cllr Chris Rice
- Cllr Maureen Worby (Invited to attend as Cabinet Member for Adult Social Care and Health Integration)

Support was received from Masuma Ahmed, Principal Governance Officer and Claudia Wakefield, Senior Governance Officer.

Proposed Diagnostic Centre at Barking Community Hospital

Members received a presentation on the proposed diagnostic centre at Barking Community Hospital (BCH). As part of a national NHS England-funded programme to improve access to diagnostics to support early diagnosis of disease, the £15 million CDC project would include CT, MRI, X-rays, ultrasounds, physiological measurements and blood tests. This would enable residents to benefit from a 'one stop shop' for diagnostics before secondary care referrals. Amongst the three CDCs which would open in the next few years, BCH CDC was proposed to open between October – December 2023.

Details surrounding the funding and organisation of the centre were outlined, alongside the strong apprenticeship model it carried as a representative of the local community. This would create 100 additional permanent jobs across the CDC as a means of starting a progressive career, with the support of an extra £250,000 from Health Education England in 2020 to improve its training academies. Although the CDC aimed to best serve the needs of the community, it was stated that mental health diagnostics were not included in the first stage of the CDC and would be introduced at a later stage. Engagement with the local community as service users was highlighted.

Enhanced Access Update

The Committee received an update on enhanced access. It was outlined that all Primary Care Networks (PCNs) in England were required to offer patients a new 'enhanced access' model of care form 1 October 2022, replacing the current Extended Hours and Extended Access services provided for non-urgent out-of-hours care. GP practices would be open between 6:30-8pm from Mondays to Fridays, and between 9am-5pm on Saturdays. Services would include GP, nurse, and therapy through face-to-face, telephone and remote appointments. Resident feedback and patient surveys would further develop the model, which would run from three local sites. Additional funding was secured to keep the current GP Access Hub service running until 31 March 2023.

Service users could choose their preferred appointment type with the 'enhanced access' model for routine patients, enabling approximately 72,000 additional appointments annually through six PCNs. GP practices aimed to accommodate 70 percent of appointments face-to-face, and the remaining 30 percent via E-Consult or 111 services, which would contribute to a reduction in patient visits to Accident & Emergency services. NHS NEL was also in discussion with Council colleagues on cost-effective, accessible sites such as Family and Children's Hubs to expand services across the Borough. GP practices would ensure that the availability of new staff and services would be best suited to patient's needs, alongside making services accessible for patients with learning disabilities. The Director of Public Health noted that the new 'enhanced access' model would create positive outcomes for residents who were unable to access current GP services due to work commitments.

Tulasi Medical Centre Update

Members received an update on the Tulasi Medical Centre (TMC) and the Faircross Health Centre (FMC), following their inadequate Care Quality Commission (CQC) ratings. TMC was rated inadequate and had its registration suspended based on the CQC's inspection of their practice as a safe, effective, caring, responsive to people's needs and well-led service. An action plan was necessary to address the highlighted issues such as medicine management, safeguarding and infection and disease control, where an NHS

NEL team would monitor weekly progress over a period of six months. Similarly, FMC was rated inadequate by the CQC, and received support from NHS NEL on its action plan, but remained registered with the CQC following the inspection.

A CQC reinspection was due to take place at the end of the six-month remedial period with a new team to perform thorough checks on the services. The change in GP practices over time was recognised, and associated with this was the increasing pressures on workload, workforce and funding which required improvement, and were looked into by the NHS NEL quality roundtable. Challenges during Covid-19 for TMC, and GPs in general, were noted as they provided multiple services due to high demand. To support this, there were monthly GP education and training events in Barking and Dagenham which explored common themes and issues. TMC also had additional resources to assist with remedial work, alongside resources and funding from the GP Federation and NHS NEL to further support them. Regular updates were provided to CQC and NHSE by TMC to track progress.

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

The Committee received an update on the Integrated Care System (ICS) approach to managing winter pressures in 2022/23, and the recent winter summit held by Barking and Dagenham Partnership, to consider actions locally to keep people safe and well at home. The ICS received additional funding over winter, directed to providers such as Barking, Havering and Redbridge University Hospitals Trust (BHRUT), North East London NHS Foundation Trust (NEFLT) and the local authority, to invest in workforce capacity.

The funding would support care provider partnerships, training and skills development recruitment, social work in A&E and aimed to increase capacity in emergency response services. Other collaborative measures between Primary Care, community care and voluntary services include proactive care; the NEL ICB commissioned an enhanced health care home scheme to support residents in care homes with complex needs. Collaboration was essential for health management, where people received guidance on keeping well at home; and urgent care services, which enabled rapid community responses for people with long-term health conditions. Moreover, ICB Internal Discharge Hubs would support hospital discharge with ongoing care assessments which was strengthened during Covid-19. Discussions on the Winter Summit focused on children and young people's health through improving flu immunisation rates and addressing respiratory viruses for young children. It was highlighted that the cost-of-living also required collaboration, especially for clinically vulnerable people, to reduce A&E visits whilst educating them available support, medically or via warm spaces networks or organisations such as the Cost-of-Living Alliance. The Council's Cosy Homes Scheme was recognised to support residents facing the Cost-of-Living crisis to stay warm, save energy and lower their energy bills through subsidised energy-saving improvements.

Place-Based Partnership Update

Members received 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.

Although the Health Scrutiny Committee would continue to have a key role in governance and decision-making, it was important that the Committee's work programme aligned with some of the decisions that were to be taken across the ICS. Going forward, the Committee would scrutinise decisions of all partners across place, including Health partners, system leaders such as the NHS, the Voluntary and Community sector, the Council and provider collaboratives. It was recognised that ensuring all key decisions were brought to the Committee to be able to deliver its statutory duties and service changes, would be a challenge for officers. Further, the terms of reference for the Committee would be amended to account for its wider role, as well as having a wider attendance to accommodate for additional key partners. A collaborative approach to address health inequalities within the Borough was highlighted, encouraging ongoing and open dialogue for effective decision-making to improve the quality and allocation of resources across services.

New Moorfields Hospital Eye Hub at Stratford, London

Members received a report on the proposal to provide additional eye care at a new site in Stratford from Spring 2023.This would facilitate 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 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.

Details of patient accessibility were discussed, where transport for eligible patients would be available to and from the Stratford site which benefitted from better facilities, whilst the majority of patients continued to receive care at Barking. Alongside the Barking CDC, such facilities would enable diagnostic services for patients separate from hospital sites, effectively creating a 'one stop' model for services in a good location with parking and public transport links. A mixed pathway would be prioritised across various sites for patients with medical retina and glaucoma, depending on the frequency of treatment and intervention. The Trust was also explored its emergency care model of delivery; a pilot model at the City Road site enabled it to triage patients who were referred to A&E. Patient feedback suggested that this model should be available at the Stratford site in the future. Issues surrounding patient appointment attendance was also mentioned; the Trust aimed to reduce 'Did Not Attends' from 30 percent during the peak of Covid-19, to 10 percent by improving patient portal and communication.

Health Inequalities Funding

The Committee received 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. The Council offered access to social prescribers providing expert advice on debt and health for adults who struggled with debt such as Council Tax or those who struggled with mental health problems, as shown on social care records. The Council aspired to upscale this facility with help from the NHS. It was detailed that the debt workstream focused on residents who were falling into debt prior to escalation, so referrals into Talking Therapies or IAPT would not be made as medical diagnosis or clinical assessment were not a part of the programme. The Council emphasised having a shared understanding on health inequalities across the

system to better support planning delivery and worked closely with its Data Insight Hub to put this into effect.

The NEL ICB stated that there was an opportunity to look at how residents could be better signposted to NHS services and confirmed the recurrent debt workstream funding which supported long-term planning. Self-referral into IAPT services was also available for concerned residents. Inequality Clinical Leads for each Primary Care Network also had access to resources to identify different conditions and provide a tailored approach to these areas. In consideration of children and young people, there was a workstream to identify interventions to target low-level mental health issues, alongside self-referrals to the Barking and Dagenham CAMHS service. Ensuring that school counsellors and GP services were young people-friendly was also mentioned, whilst promoting services across public spaces was key to encourage an open dialogue.

NHS North East London – Severe Weather System Response Presentation

Members received an update on the NHS North East London Severe Weather System Response. From a NEL ICB perspective, the main risk related to the Summer 2022 heatwave was around fire incidents. This winter, there had not been a cold weather alert but the presented risks were linked to Covid-19 and infection.

Elderly residents were recognised as a vulnerable group with increased likelihood of impacts from severe weather than younger patients, but as part of the Severe Weather Plan objectives, it was clear that the system for identifying vulnerable groups needed to be improved. To gain a better understanding of how crises impacted vulnerable groups at a local level, a data sharing agreement between local partners was suggested to support vulnerable patients effectively across the system. It was important to define the term 'vulnerability' to effectively provide support to patients in extreme weather cases which impacted treatment pathways and appointment attendance. The ICD at NELFT detailed the Government's 'Must Do Must Supply' energy list which included the NHS, which identified priority sites which would receive energy supply during crises. A local infrastructure forum looked to coordinate improvement actions required around estates, ultimately to re-provide services or potentially bring in capital to improve services. Specific sites would be prioritised through the Estates team and NELFT would look at options to ensure that services could continue running despite severe weather conditions. Moreover, uptake of the flu vaccine had been very low compared to the Covid-19 vaccine, despite its communications and publicity campaigns across North East London. The Director of Public Health stated the potential impact of flu could result in excess pneumonia deaths due to lack of vaccination.

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

The Director of Public Health (DPH) presented his 2022 Annual Report, which was a statutory requirement of the DPH, mapping out the key issues facing Barking and Dagenham and considering potential solutions based on evidence and epidemiology.

The presentation detailed the context of the report, and provided links between the report itself, the Health and Wellbeing Strategy and the Integrated Care Strategy. A focus on contributing factors to widening health inequalities was highlighted; these included individuals' reluctancy to come forward for early identification of disease, implications surrounding the Covid-19 pandemic and the cost-of-living crisis within the Borough.

Potential solutions were suggested, such as through the development of the Place-based arrangements and the Integrated Care System.

Shaping the Refresh for the Joint Local Health and Wellbeing Strategy 2023-28

The Committee received a report to provide comment on the direction of travel for refreshing the Joint Local Health and Wellbeing Strategy (JLHWBS), in the context of the newly established Place-based Partnership and Integrated Care System. The current Barking and Dagenham Health and Wellbeing Strategy (HWBS) would end in March 2023, replaced with the Joint Local Health and Wellbeing Strategy (JLHWBS), to include the new Integrated Care System (ICS) and the Council's relationships through the new place-based arrangements. The refreshed Strategy would set out a renewed vision for improving residents' health and wellbeing whilst reducing inequalities at every stage of residents' lives by 2028. It was noted that the NHS NEL ICS would need to be considered when preparing the new Strategy. A Joint Forward Plan would be developed to deliver the ICS, in alignment with a Local Delivery Plan.

The importance of ensuring that all documents tied in together and reflected Barking and Dagenham priorities, as well as those of the other boroughs within outer North East London, was highlighted. This would allow for the Committee to challenge and identify any potential gaps which would help to create an effective local Strategy. The priority of mental health related issues, such as anxiety and depression, were most prevalent in Barking and Dagenham highlighted necessary improvements to be made, including CAMHS' waiting lists. Whilst many issues affected other Boroughs, it was important to understand that the needs and unique representation of the Borough were reflected. The involvement of Partnership Board, as well as NELFT AND NEL ICB into Barking and Dagenham Health Scrutiny Committee was useful for Members to look at items of interest and examine changes to services.

North East London Integrated Care Strategy Development

Members received a short update on the North East London Integrated Care Strategy Development, which was originally presented to the ONEL JHOSC at its meeting on 10 January 2023. The update focused on key points such as the next steps around the development of smarter metrics to measure success against the Strategy's objectives, and engagement work which was undertaken by the Voluntary Sector as part of the Strategy development. Opportunities for the Committee to provide feedback on the Strategy were raised to be shared with NEL ICB.

The Cabinet Member for Adult Social Care and Health Integration shared details about a programme called 'the Big Conversation' in North East London, which was useful for community consultation and the development of the Strategy. These conversations would be influenced on a place-level, conducted within each borough and the best practise would be reflected into the engagement process. As community feedback was received, the Strategy which was an interim document, would continue to change. This would ensure that the Strategy and community conversations would be as effective as possible.

NELFT CQC Inspection Update: March 2023

Members received an update on the NELFT Care Quality Commission (CQC) Inspection as of March 2023. The CQC Well-Led inspection of NELFT between April to June 2022

was completed with a new rating of ‘Good’, with positive feedback received regarding NELFT safeguarding policies and the Well-Led Improvement Plan would be monitored for progress.

The response backlog for complaint response times through Datex, an electronic system for NELFT’s incident reporting and complaints monitoring, was discussed. NELFT’s acknowledgement rate of complaints within a three-day period was now at 90%. The Lead Inspector praised NELFT in 2022 for its cultural and behavioural changes alongside senior leadership improvements, which helped to address its previous challenges in its 2019 inspection. NELFT aspired to become an ‘Outstanding’ trust by engaging with its CQC action plan through its new place-based arrangements, though they faced challenges such as significant population growth and the continued impact of Covid-19. Staff recruitment and retention programmes were also discussed. NELFT staff surveys suggested the work environment was based on inclusivity, agile working and flexibility. Despite a national workforce shortage, NELFT recruited over 240 internally educated nurses. Further, 18-week breaches in Adult’s Autism, Paediatric Autism and Paediatric Speech and Language pathways were problematic due to suspended physical assessments during the pandemic. Waiting lists depended on the service, and some services focused on providing assessment and initial treatment, as opposed to longer-term treatment. Group provision had been introduced above one-to-one service, and other interventions included utilizing Assistant Psychologists to provide lower intensity programmes whilst patients waited for treatment.

Early Pregnancy Assessment Unit (EPAU)

The Committee received a presentation on the Early Pregnancy Assessment Unit (EPAU), which focused on the accessibility of the service, miscarriage care and support, the Trust’s efforts to decrease the risk of repeat miscarriages and patient feedback.

Effectively managing miscarrying patients included facilities such as a quiet room for patients and their families who received bad news. A bespoke quiet room was not currently available due to changes during the pandemic. Furthermore, the decreased miscarriage rate in 2022/23 in comparison to the pandemic was directly linked to lower birth rates recently. Support in the Early Pregnancy Unit was acknowledged through mental health first aid for both staff and patients, alongside training on communication skills to deal with sensitive situations effectively. BHRUT was linked with SANDS (a bereavement charity); bereavement midwives further provided close support with links to Adults and Perinatal mental health services, making direct and inpatient referrals easily accessible if required during early stages of pregnancy. NELFT perinatal infant mental health services (PIMS) and the Tulip services were available as a maternal mental health specific pathway. The Committee also suggested that support for fathers, partners and vulnerable populations such as teenagers who experienced miscarriage and pregnancy loss was essential. Women were encouraged to visit GPs, antenatal services and Early Pregnancy Units through self-referral to receive support early on. Genetic testing for women who experienced recurrent miscarriages to investigate potential underlying causes under the Fetal Medicine Unit. Safeguarding was highly important, and the importance of looking after staff health and wellbeing due to the emotional burden and psychological challenges they may face.

Proposed Governance for Place-Based Partnerships

Members received 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 to come into place from 1 April 2023.

Discussions focused on streamlining processes to reduce the number of meetings with the same agenda items. Therefore, 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, to speed up decision-making and reduce health inequalities in a more efficient manner. Between now and July 2023, all partners would need to consider how this approach would operate in consideration of factors such as administration. Moreover, refinements of the Health and Wellbeing Board were to be considered; for example, Primary Care Networks (PCNs) and the GP Federation were not currently on the HWB or the ICB Sub-Committee. Once the Committee agreed, it was hoped that the new arrangements would bring issues closer to local politicians and residents in order to have more involvement in decision-making over services and resource allocation according to the needs of local people.

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

Members received a presentation on the Joint Local Health and Wellbeing Strategy 2023-28 refresh framework for delivery and consultation. This set out the health and wellbeing needs of residents and the proposed actions to be undertaken over the following three to five years to improve health outcomes.

The Council was engaging on the Strategy with professionals, partners and the wider community through social media, digital media through the website and the Council's newsletter. The outcomes of the recently undertaken consultation on the Council's Bets Chance in Life Strategy for prenatal conception care through to age 25 were considered in the Health and Wellbeing Strategy. Moreover, the Council's engagement with 'harder to reach' patient groups, including the homeless, asylum seekers and emerging communities, such as the growing Romanian community, was recognised through its existing networks, partners and Healthwatch. Challenges due to complex medical language, speech and language barriers or learning disabilities were highlighted in relation to delivering medical and mental health care. However, the Council was investing in more interpretation services for patients, alongside introducing community advocates by co-locating community hubs within faith community spaces to improve health inequalities overall. NELFT's contract with the Language Shop which provided interpreting services across London boroughs for both sign and spoken languages, both in-person and over the phone. Engagement through annual school health surveys and the LGBTQ+ community was also mentioned, where the Borough had well-established partners. The needs of the Lithuanian community needed to be better considered, and further work would be done to improve their access to services.

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

The Committee agreed to undertake a scrutiny review in 2022/23 on the Voluntary and Community Sector (VCS) to consider how it may contribute to reducing health inequalities within communities and identify opportunities to ensure that the VCS and residents have a

meaningful role in shaping future strategy/ service delivery. This review has recently concluded and I will be updating all members on this in due course.

Contact

For further information on the Health Scrutiny Committee, or the Council's scrutiny arrangements in general, please contact:

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ASSEMBLY

15 May 2024

Title: Annual Report of the Director of Public Health 2022/23	
Open Report	**For Information**
Wards Affected: None	**Key Decision:** No
Report Authors: Jane Leaman, Consultant in Public Health Matthew Cole, Director of Public Health	**Contact Details:** matthew.cole@lbbd.gov.uk
Accountable Director: Matthew Cole, Director of Public Health	
Accountable Executive Team Director: Elaine Allegretti, Strategic Director, Children and Adults	

Summary:

Directors of Public Health (DPH) have a statutory requirement to write an annual report on the health of their population.

This cover paper gives an overview of the Director of Public Health's Annual Report 2022/23 which informs local people about the health of their community, as well as providing necessary information for decision-makers in local health services and authorities on health gaps and priorities that need to be addressed. The DPH's Annual Report 2022/23 is attached at Appendix A.

Recommendation(s)

The Assembly is recommended to note the Director of Public Health's Annual Report 2022/23, as set out at Appendix A to the report.

Reason(s)

The report provides independent public health advice to the Place- based Partnership on the key priorities to deliver improved health and wellbeing in the borough, as identified in the Joint Local Health and Wellbeing Strategy, informed by the Joint Strategic Needs Assessment. The report also supports to the Borough Manifesto vision "One Borough; One Community; No-one left behind" and contributes to the delivery of all Corporate Plan priorities, particularly:

- *Residents are safe, protected, supported at their most vulnerable.*
- *Residents live healthier, happier, independent lives for longer*.

and supports the following principles within it:

- Work in partnership.
- Engage and facilitate co-production.
- Be evidence-led and data driven.
- Focus on prevention and early intervention.
- Provide value for money.

- Be strengths-based.
- Adopt a “Health in all Policies” approach.

1. Introduction and Background

1.1 To support a local government-led approach to better public health, every local authority with public health responsibilities must, jointly with the Secretary of State (SoS) for Health and Social Care, appoint a specialist Director of Public Health (DPH). The DPH is a statutory chief officer of their authority, accountable for the delivery of public health responsibilities, and the principal adviser on all health matters to elected members and officers, with a front-line leadership role spanning all 3 domains– health improvement, health protection and healthcare public health. The DPH also has a vital system leadership role, working closely with place-based organisations in efforts to secure better public health.

1.2 As part of this role of the Director of Public Health has a statutory requirement to publish an annual report which informs local people about the health of their community, as well as providing necessary information for decision-makers in local health services and authorities on health gaps and priorities that need to be addressed.

2. Proposal and Issues

2.1 The first chapter reflects on the DPH’s professional advice given over the last 10 years following Public Health’s transfer from the NHS to local authorities in 2013. Themes have been repeated from the evidence base in our pursuit of finding better ways to tackle the deep seated and entrenched inequalities in Barking and Dagenham

2.2 Ensuring good health and wellbeing and preventing the need for expensive health and social care is crucial in this financial climate, with funding pressures for all our system partners. The report advises we must therefore prioritise; focusing on impacts over the next five years on those interventions which will improve healthy life expectancy and address health inequalities and address the immediate demands of expensive health and social care services, as well as contributing to meeting the wider priorities of the council for example improving opportunities for employment, training and education.

2.3 In response to this, chapter 2 looks at how we can use the opportunities of the integrated care system at place to improve the health of our residents. Particularly how to transition the shared outcomes in our Joint Local Health & Wellbeing Strategy (JLHWS) 2023-28 into drivers for commissioning a whole systems approach. The key message is that we should exploit the opportunities we have in the Place-based Partnership to improve healthy life expectancy by:

- Agreeing shared outcomes and priorities.
- Aligning strategic plans, develop agreed delivery plans and outcomes of the locality model.
- Invest together on programmes to deliver our priorities and reprioritise our spending of the Public Health Grant.

2.4 Chapter 3 describes why we should focus on increasing healthy life expectancy and addressing those contributing factors which in the short term, impact on overall health, ability to live independently in later life, and on the increasing demand on our health and care system. It determines that is our approach is well structured, actions identified can provide results within the five years of the JLHWS.

To increase the number of years of our residents spend in good health, we should target our collective resources into:

- Enhancing our early diagnosis programmes, that target key groups of residents, supported by assessable and culturally appropriate chronic disease management programmes.
- Reducing high levels of smoking and obesity.
- Reducing mortality rates associated with cardiovascular disease and cancer.
- Addressing the variation in health and social care outcomes experienced within and between our communities in each of these areas.

2.5 Chapter 4 sets how and what we need to do to address the key contributing factors to health life expectancy i.e., addressing long term conditions, key behavioural risk factors and the wider determinants of health (developing the building block for good health).

To improve healthy life expectancy the evidence suggests:

- Taking a place-based approach to address early identification and early treatment for people with long term conditions:
  - to ensure all residents with a health condition are identified and are supported to manage their condition.
  - that addresses social, economic, and physical environment that causes our residents to make decisions that damage their health and lead to long term conditions, such as those driving obesity through unhealthy diets and lack of physical activity.
- Providing a targeted support programme to residents to address obesity and smoking.
- Addressing wider determinants of health for example to insulate and remove damp and mould in homes; support people with long term conditions or disabilities, including young people with special educational needs and disabilities to gain and stay in employment, and mitigate the health harms of the cost-of-living crisis.
- Improving mental health and wellbeing as an underpinning factor.

To address underpinning health inequalities, we need to:

- Develop a shared understanding of health inequalities, its drivers and local priorities (including across our population groups and geographic areas) to direct decision making and action.
- To align the NHS's mandated duty to address health inequalities with the overall place-based programme.
- Work with NHS North East London on their Healthy Equity Academy and their evolving Health Equity Fellowship (including extending beyond the NHS to create analogous community sector fellowships).

- Continue and expand cross-sector action on the ongoing health legacy of COVID-19 and impacts of the cost-of-living crisis that are increasing health inequalities for residents.
- Ensure a 'health in all policies approach' in which all systems partners are engaged to understand and address the role of health inequalities in driving community priorities (e.g., employment).

2.6 A large part of the report is focusing on actions which relate to adults and actions that can affect short term change, but action across the life course is important - today's children will be tomorrow's adults, and the things that happen to them in childhood can shape the trajectory of their health through to older age. Therefore, we need to maintain a focus for children to improve the health outcomes for our general population across the life course.

2.7 To do this chapter 5 provides data and evidence on the importance of strengthening our approach to giving children the best start in life, via universal support/prevention activities, early identification of emerging issues, and provision of timely help to support families, by maximising the opportunities of the 0-19 programme so it better links to the needs of the children and young people and the drivers of demands in Health and Social Care.

2.8 The Public Health advice is for the 0-19 programme to focus on the high impact areas of the Healthy Child Programme.

- Address the causes of Adverse Childhood Experiences including Domestic Abuse and parental mental ill-health.
- Support for our vulnerable children to thrive in their home and school environment - focusing on:
  - school readiness (0–5-year-olds)
  - a better offer for those with social, emotional, and mental health needs (5–19-year-olds);
  - opportunities to identify and address neglect.

2.9 Protecting residents from communicable diseases remains one of the DPH's core statutory responsibilities, with the public health system working together to manage and prevent serious notifiable diseases and outbreaks. The most important function is the containment of notifiable infectious diseases.

2.10 Chapter 6 describes how COVID-19 has changed the way health protection issues are addressed –for example we recognise the importance of all communities having access to vaccinations and we now seek to understand and address why people are hesitant to take up opportunities to protect their health. Furthermore, as was identified in the Public Health England report[1], people who have poorer health e.g. living with one or more long term condition, had less resilience and were more likely to become seriously unwell compared to others.

2.11 This chapter focuses on the importance of vaccination and immunisations including improving the uptake of the MMR vaccination due to the rise in measles cases in England.

[1] Beyond the Data: Understanding the Impact of COVID-19 on BAME Communities (publishing.service.gov.uk)

2.12 To support this action the public health advice is for:

- Our Place Based Partnership to prioritise childhood immunisation to improve and reduce the differences of uptake within our communities.
- Enough investment to improve the uptake of vaccinations- specially MMR, reduce the inequity of uptake and to introduce the chickenpox vaccination if directed, following recommendations of the Joint Committee of Vaccinations and Immunisations.
- Communications strategies that are simple and hard-hitting, with continuous messaging on the importance and benefits of vaccination.

3 Consultation

3.1 The draft Annual Report was presented to the Barking and Dagenham Integrated Care Partnership Executive Group and LBBD Executive Management Team prior to being considered and endorsed at the 'Committees in Common' meeting of the Health and Wellbeing Board and Integrated Care Board (ICB) Sub-Committee at its meeting on 16 January 2024.

4. Financial Implications

Implications by: Amar Barot, Head of Finance for People Services

4.1 There are no finance implications arising from this report. Any financial implications from initiatives in the report above will be or have been evaluated through the Council's governance procedures.

5. Legal Implications

Implications by: Dr Paul Feild, Principal Standards and Governance Lawyer

5.1 Under the National Health Service Act 2006 (as amended by Health and Social Care Act 2012) section 73B (5), the Director of Public Health for a local authority must prepare an annual report on the health of the people in the area of the local authority which by section 73B (6) the local authority is required to publish.

5.2 There are no additional legal considerations arising directly as a result of recommendations in this report.

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

List of Appendices:

- **Appendix A:** LBBD Director of Public Health's Annual Report 2022/23

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APPENDIX A

Annual Director of Public Health Report 2022/23

Living Longer; Living Healthier

– a focus on prevention and early diagnosis

Barking & Dagenham

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Foreword

Welcome to the Director of Public Health's Annual Report for 2022/23. The last year has been challenging for many residents due to cost-of-living pressures and these have impacted on health and wellbeing in many ways. Our health and social care system remains firmly in the eye of the inflationary storm and severe funding and demand pressures mean that NHS and council finances are under pressure like never before. Simply put we can no longer afford to meet the rising needs of our population by spending more money on the kinds of services we currently provide.

Against this backdrop as Director of Public Health, it is my responsibility to describe and advocate how we can improve health through a lens that's wider than traditional health and care. This is challenging at a time when we need resources to keep pace with need and, dare I say it, a levelling up of resourcing!

Over the next 12 months we will be rethinking how we deliver public services to address the scale of the financial savings to be made while the borough's population continues to increase. Our Integrated Care System arrangements have now been established with our Health & Wellbeing Board and Integrated Care Board Sub Committee forming a groundbreaking Committees in Common. This arrangement will provide the leadership and oversight to ensure the collective efforts of all our partners are focused on delivering the shared outcomes in our Joint Local Health & Wellbeing Strategy 2023-28 and closing the gap for those with the poorest outcomes.

Central to realising the opportunities of 'Place Leadership' is the need to change the engagement relationship between our residents and the council as well as between patients and the NHS to determine the way we provide services where the best outcomes can be delivered at the right cost. The partners recognise that whatever the solutions, it is increasingly clear that the future depends on a much closer working relationship with residents and communities focused on the neighbourhoods in which they live.

As we know services on their own will not improve our agreed public health outcomes or manage health and social care demand without a radical upgrade in prevention that addresses the wider social determinants of health. Real world evidence tells us that approximately 20 per cent of a person's health is dependent on the healthcare services they receive. The other 80 per cent is accounted for by what is known as the social determinants of health.

The World Health Organisation states that "the social conditions in which people are born, live, and work are the single most important determinant of good health or ill health, of a long and productive life, or a short and poor quality one. Social determinants of health include

experience during the early years, education, working conditions, income, housing, communities and environment, and discrimination and exclusion".

We now need to apply a laser-like focus to improving population health, be clear where our inequalities in outcomes within and between communities are, for example by providing opportunities for children suffering from neglect or actions to improve access to mental and physical health services for those with mental health conditions. There is much still to do, but the guiding principles should be for tangible actions that inspire residents in terms of what we can achieve and to gather enough meaningful actions so we can see that the sum of these actions leads to real change. Without this we risk piecemeal and inconsistent activities that are not enough to make a real difference.

My report gives a professional perspective that informs this approach based on sound evidence and objective explanation, taken mostly from our 2022 Joint Strategic Needs Assessment. 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.'

In Chapter 1, I reflect on my professional advice given over the last 10 years following Public Health's transfer from the NHS to local authorities in 2013. Themes have been repeated from the evidence base in our pursuit of finding better ways to tackle our deep seated and entrenched inequalities. Providing comments on how Best Value may be achieved has been at the centre of my reports. This has led me to provide focused advice on realising the ambitions of new models of care and meet the transformation targets of the council and NHS that require us to work beyond traditional organisational boundaries. Underpinned by the need for local determination around resources and ensure that we are cleverly using data to effectively manage demand and prioritising human relationships in the way we connect with residents.

Chapter 2 examines the next steps in using the opportunities of the integrated care system at place to improve the health of our residents. Particularly how we transition the shared outcomes in our Joint Local Health & Wellbeing Strategy 2023-28 into drivers for commissioning a whole systems approach. This will help to widen the reach and impact of our combined partnership resources by overcoming the challenge of individual partners focussing on their own organisational priorities dominated by measuring inputs and outputs. A better understanding both of what matters to people, and what works will reinforce our shared efforts to meet national outcomes and regulation requirements.

Part of this ask is to streamline the complexity of the integrated care system that by design has developed 'systems within systems' to focus on various aspects of performance, transformation, and access, drawing on skills and services from across the partnership. The challenge is to ensure that activities of separate groups form part of a coherent, mutually reinforcing approach, rather than becoming a disjointed set of initiatives.

Chapter 3 examines our understanding of the data to support the prioritisation of long-term conditions based on prevalence and the variation in outcomes between our communities which is critical to our ability not only to improve healthy life expectancy but also for population health management.

Focusing on the long-term conditions that are driving our health and social care demand is essential to how we effectively manage the local system. Early intervention and diagnosis are critical to deal with issues before they impact negatively on a person's health and wellbeing and the wellbeing of the community. The answer to improving healthy life expectancy is not solely a medical one its one that integrates our primary care and secondary care disease management programmes with council and voluntary and community sector services.

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In following reports, I have focused on the need for continuous improvement in addressing the borough's widening health inequalities and the need to have ways of working that target residents through their networks and where they are to further our efforts in closing the gap. Chapter 4 examines how we can do this. Better use of data and community insight will enable us to focus down on where the variations in outcomes exist and identify those variations that that have an uneven impact on healthy life expectancy, thus targeting our resources proportionate to need.

Setting a small number of strategic inequality outcome measures linked to the shared outcomes in our Joint Local Health & Wellbeing Strategy 2023-28 would be helpful in bringing clarity on what variation we are targeting. This can then be built into a coherent narrative through strategies, plans and communications. Key to this is the enhanced ability to systematically measure performance against variation as well as gaining a deeper understanding of the risk and protective factors for vulnerable groups across the life course. This will provide a more powerful mechanism for embedding an integrated approach to tackling health inequalities.

Chapter 5 takes forward the commitment in last year's report to undertake an in-depth review of our 0-5 (health visiting) and 5-19 (school nursing) services. The review was timely as the Department for Health released revised Healthy Child Programme Guidance on 27th June 2023, which aligns outcomes with the Family Hubs programme.

The review recommended that consideration is given to reviewing investment levels, service change (including the impact of reduced services elsewhere) and innovation to improve the outcomes of children's public health services. This is to ensure that our service offer is reflective of the changing demographic profile of the borough and delivery of the Healthy Child programme, including the universal mandated elements.

In the closing chapter, I discuss the significant efforts into promoting the importance of vaccination, mainly amongst groups with the lowest uptake, greatest vulnerability, and lowest vaccine confidence. Childhood immunisation uptake continues to remain a concern due to performance remaining below national uptake target levels. Poliovirus detection in London and decreases in MMR vaccination uptake pose a particular concern for child health.

As for the challenge of winter, we know that vaccine hesitancy remains a big 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.

Later this year we will publish the refreshed Barking and Dagenham Joint Strategic Needs Assessment. This will provide an overview of the local data and insights that will both support the understanding of the key local population health needs that I highlight in this report and inform a partnership approach to reduce health inequalities and improve healthy life expectancy.

I hope you enjoy reading this report as well as finding it of interest and value.

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

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Chapter 1: Back to the Future

10 YEARS

It has been 10 years since public health responsibilities moved into local authorities, and therefore I feel this is an opportune moment to look back and learn from what has happened.

Interestingly, over this time, the landscape of commissioning and providing social care, health care and public health, has considerably changed through government policy. However, several issues remain as significant today, such as the importance of place; strong relationships with residents; a vibrant voluntary sector; and integrated services to deliver health outcomes. But most importantly, poor health and profound health inequalities persist, with a very worrying trend in infant mortality getting worse in most deprived communities[1] partly by the cost of living crisis.

Changes in outcomes take years to happen (the Health Foundation report highlights it can take up to 10 years to see changes in health inequalities) and be seen in the data, but data published this year from Census 2021 improves our understanding of relevant factors. The Census provides the most accurate data on changes over time of key determinants of health and health inequalities (population and households, housing, employment, health, education and transport).

Key findings and comparison for the borough, versus other areas of England and Wales between 2011 and 2021 include:

- *Rapid population growth* – 3rd highest increase in ten years (17.7%)
- *Young population* – Highest proportion (26.1%) of residents' under-16 years old
- *Deprivation* – Highest proportion of households (62.4%) deprived for education, employment, health or housing
- *Household structure* – 4th highest average household size (2.96%), highest lone parent households (12.8%) and 2nd highest multi-family households (8.6%)
- *Employment* – 3rd highest proportion of adults who had never worked (42%) and highest proportion who work offshore, in no fixed place or outside the UK (22.4%)
- *Disability within household* – Highest proportion of households in London with a disabled resident (29.8%)
- *Change in diversity* – Highest increase in residents born outside the UK (10.4%) and greatest increase in ethnic diversity (including highest proportion of Black African and 4th highest proportion of Asian Bangladeshi residents, 16.0% and 10.2%)
- Compared to the 2011 Census, a lower proportion of residents considered themselves to be in either *bad health or very bad health* – mirrored in London and nationally
- After accounting for age, Barking and Dagenham is higher than both London and England in terms of residents with *fair, bad and very bad health* in 2021

The Office for Health Improvement and Disparities Health Inequalities Dashboard also highlights:

- *Healthy life expectancy and life expectancy* has reduced in males and for females (although not significantly)
- Under 75 year old mortality rates for *cardiovascular disease* has gone up, but under 75 year old mortality rates for cancer has reduced (although neither are big changes)
- Suicides have increased (though not majorly)

Firstly, it should be recognised that many of these changes and characteristics (e.g. diversity, youth etc) bring benefits to our communities. Yet the pace of population change often brings big challenges for services and communities, e.g. an analysis of London house prices and life expectancies between 2002 and 2019 suggested areas with low house prices and rapid inflow of people have seen growing inequality in life expectancy[2]. A recent NHS North East London profile of the demography of north east London highlighted that Barking and Dagenham is expecting the greatest population growth in north east London of 37% (83,000) respectively by 2041. The largest growth will be seen in Barking Riverside where major development is planned to provide 10,000 new homes to house an additional 55,000 people – this is equivalent to growth of 520% of the current ward population.

This sets the context of my look back at the themes of my annual reports of the last decade.

Making the Healthier Choices, the Easier Choice for All

In 2013 I set out my challenge to make healthier choices the easier choice for all, which required supporting people to stay healthier; joined up and high-quality care; protecting people's health and providing care and support of children.

Now, 10 years on, the focus of this report has not changed. There remains a high burden of ill health (high mortality, coronary heart disease, cancer and respiratory disease); the need to continue to develop primary and social care to provide better care outside the hospital. If these services are going to be unsustainable, they need to effectively manage the demand pressures of the rapidly changing population. Keeping pace with changing needs and numbers must be at the forefront of partnership planning. As well as the knowledge that many healthy choices have become even harder, for example the diet meeting the Eatwell guidance is less affordable.

Obesity remains one of the biggest public health problems, still needing a system wide approach to tackle. Alongside other health improvement areas such as reducing smoking and improving mental health and wellbeing, the newly formed place-based partnership provides the best chance for this to now happen, alongside the commitment of the council to develop a 'Health in All Polices approach within its Corporate Plan. This recognises the role of green spaces, active travel and transport, access to training opportunities and good quality jobs and healthy homes has on health. The transfer of Public Health responsibilities in 2013 allowed the council to take a population focus as democratic stewards of local population well-being; shaping services to meet needs including environment; influencing wider social factors of health; and tackling health inequalities by taking strategic action across several functions e.g. housing, economic and environmental regeneration.

My call for a focus on good mental health 'as everybody's business' also remains a key building block for good health and enables people to participate in society, not least because good mental health is positive to the economy – people are less likely to be in employment or take more days off sick.

The need for better interventions to improve early years outcomes in the first five years - through the healthy child (0-5) programme was back in 2013 supported by the Family Nurse Partnerships and Troubled Families Programme, but we now have the opportunity through the re- procurement of 0-19 healthy child programme, the development of the family hubs and early start programmes.

The high numbers of early deaths identified in 2013, are still based on a high level of residents with long term conditions (LTCs) which need planned and proactive management, including optimum case finding to reduce need for hospital admissions and primary and social care support.

In 2014, The NHS Five Year Forward view was published which marked a radical upgrade in prevention, promoting crucial partnership between NHS and council, and the Transforming Primary Care in London programme set the context for better coordinated, accessible, and proactive care - focusing on health and well-being, which remains, alongside the integration of health and social care. At this time, we were working across a three-council footprint Barking Havering and Redbridge, which has now moved to be more localised with the formation of borough-based Place based Partnership, enabling our elected members and residents to have a stronger voice in decision making for their communities.

Growing the Borough to Improve Health

Throughout the years I continued to bring a focus back to the role of Place to grow the borough to improve health – demonstrating the opportunities of its regeneration plans, for example through the aspirations of the Barking Riverside 'healthy new town' proposal, recognising the broader role the council has in improving the public's health:

Growth and regeneration provide an opportunity to develop and use community assets, strengthen partnerships between communities and service providers.

Focusing on What Matters and Reframing Health Challenges

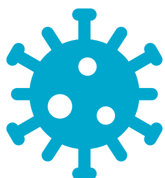
Reports 2015/16 and 2016/17 continued to focus on:

- Diagnosing illness early and managing it well including increasing breast, cervical, and bowel cancer screening uptake and identifying cardiovascular disease risk factors via the NHS Health Check, supported by a drive to reduce variation of quality of primary care by reshaping models of care pathways.
- Prevention to help residents to maintain their independence and reduce the risk of needing care or support, or delay the need for increased care and support, emphasised in the Prevention and Care Act 2014.
- Continued widening of health inequalities and together with the increase in long term conditions; action driven by the acknowledgement that we can no longer afford the services as they are by *not doing more but doing things differently or even stop doing something.*
- The need for a proper and robust framework around spending choices of the Public Health Grant to ensure effective use of the grant against agreed health outcomes with: *Better quality data on activities cost and outcomes to assess performance is required.*
- Importance of evolved power to commission and deliver against locally shared health and care outcomes, the delivery of integrated health and social care pathways, and the concept of place-based working in localities through the new model of care proposed through Accountable Care Organisations.

All of which at the time were captured in the new Sustainability and Transformation Plan.

The council's 2020 ambition to address the funding gap it faced was started, through which I identified the need for programme of change to tackle health inequalities through reducing smoking, improving blood pressure and cholesterol control and a focus on secondary prevention (detection of undiagnosed LTCs i.e. reducing numbers not included on GP monitoring lists, increase drug and lifestyle management and improving and reducing variations in cancer screening uptake, which developed different strategies to meet the different health needs of our population). It also needed to focus on requirements for a 'best start in life' including a reduction in newborn and infant mortality, providing good quality antenatal care, delivery and postnatal care including increasing vaccine and breastfeeding uptake, increasing well-being education, improving the goals of young people.

In **2015/16** I also first reported that pandemic influenza was the biggest communicable disease threat to the health of the population, but not even I could have foreseen the level, depth, spread and impact across the globe that the COVID-19 pandemic would have. Both directly on how death rates were unequal across communities and the indirect impact of the public health measures that we introduced at the time. And the ongoing negative impact on mental health, especially of children and the experiences of long COVID throughout the population. The pandemic has also changed the way we work on health protection issues today. I return to this in this report.



Creating Health

In **2018/19** I introduced the importance of improving healthy life expectancy - with the desire for residents to live longer in good health. I acknowledged that interventions that seek to change behaviour – won't work without understanding the specific needs of the population and addressing wider social and environmental constraints on choice – system wide working is paramount. The focus of my report today, builds on this by emphasising if we address factors which impact on healthy life expectancy in the short term; for example, managing LTCs this would have a direct link to reducing demand on health and social care services.

Equalities Challenges

The **2020/21** report focused on equalities challenges and learning from COVID, which recognised the impact of COVID-19 and impact of housing, and the indirect impact on employment with out of work benefits increased, increase of support levels.

And the key messages remain. We need to: better understand the different needs of our communities; continue to develop the role of council and partners in reducing health inequalities; create more opportunity for resident engagement and involvement particularly with underserved, vulnerable and marginalised groups; focus on best start in life, including reducing family poverty and access to mental health services, education and training for young people, increase diagnosis and early intervention; address social determinants of health to remove barriers to health and develop the use of social prescribing.

People, Partnerships and Place

In 2021/22 I reported on the development of the Place-based Partnership, the publication of the best start in life strategic framework, with a particular focus on supporting parents to improve development and school readiness, and the actions needed to address inequalities using the Marmot principles within the population intervention triangle which remains the model of place-based working.

2023

So, to 2023 - this report takes the issues laid out over the last 10 years further, with a particular focus on improving healthy life expectancy, looking at how:

- The Partnership through the development of placed based working (localities)
  - creates a better shared understanding of health, social and wellbeing outcomes, based on data and evidence of need to develop community civic and services-based interventions (the population intervention triangle (see Figure 3)
  - can lead the coordination of more accessible and engaged services using the POTS framework (see Figure 4)
  - can take a systematic approach to target specific health and wellbeing outcomes causing the greatest problems to individuals' communities and care system
  - creates opportunities for joint commissioning first and a step towards pooling budgets
- An in-depth review of services for 0-5- and 5–19-year-olds can help us re-procure the 0-19 healthy child programme services to meet the agreed Joint Local Health and Wellbeing Strategy 2023-28 shared outcomes and developing healthy building blocks for the future.
- We need to develop the current lifestyles services to meet the differing needs of the population and produce population health outcomes, based on what good looks like.
- We can meet the level of investment needed to protect the population from communicable disease threats and meeting the new health protection responsibilities of the council, learning from COVID-19.

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Chapter 2: Exploiting Opportunities to Improve Health

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Key facts

Residents are around three times more likely to suffer an avoidable death than people living in the 10 least deprived areas of England[3].

Adults in Barking and Dagenham are more likely to have a long-term health condition than their counterparts in other areas, with the borough having the highest prevalence of four of the 'Top 10' health conditions (heart disease, chronic obstructive pulmonary disease, lung cancer and stroke).

Many residents suffer unrecognised and therefore unmanaged long-term conditions, with around 38,000 estimated undiagnosed cases of the six most common long-term conditions. Approximately 1 in 3 people have at least 1 long term condition and 1 in 6 people have 2 or more long term conditions.[4]

In 2022/23 there were 790 school reception children in Barking and Dagenham measured as overweight or obese (24%) which was the highest in London.

This report is focusing what we can do in the short term (during the next 5 years) to improve the health of the population, to increase the number of years our residents spend in good health and able to live independently for longer.

The recently published annual report of the Chief Medical Officer highlights the importance of improving the quality of life of older people by tackling conditions – both medical and environmental - which impact on their ability to live independently and in good health. Even though he was particularly highlighting issues in areas where there is often a higher population of older people than in Barking and Dagenham – the issues remain important to our residents as:

- Black ethnicities develop a long-term health condition over five years earlier than their White neighbours (see Table 3),
- have high demand for support services.
- high levels of unhealthy behaviours and
- are more impacted by the cost-of-living crisis which puts them at higher risk of poor health.

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Therefore, the report's recommendations are useful to take into our current planning discussions:

a) **Services to prevent or treat disease and provide infrastructure** need to be planned, including support services e.g. housing.

b) **Develop the environmental infrastructure** which can delay or prevent the chances of early ageing (primary prevention), for example making it easy and attractive for people to exercise throughout their lives; reducing smoking, air pollution and exposure to environments that promote obesity.

c) **Delaying disease to the greatest possible extent**, to delay the period of disability in older age - the longer people live with risk factors such as hypertension or high cholesterol, the earlier the start of their disabilities will be. Screening programmes help to delay or stop the onset of serious disease and therefore prevent ill health in later life. It is essential that we prioritise secondary prevention and screening services and do more to extend these services to groups with reduced access and historically low uptake.

d) The medical profession needs to **respond to the rise of multiple long term conditions.** NHS organisations also need to minimise the probability that the same person must attend multiple clinics for a predictable cluster of diseases.

I therefore advise **we need to consider** introducing shared outcomes aligned to reducing the gap in both female and male healthy life expectancy, focused on:

1. Preventing and managing long term conditions, ensuring early diagnosis and pathways are clear to support early intervention.
2. Reducing obesity and smoking through targeting services to those who need is greatest as well as developing wider system working (see Figure 4).
3. Improving the number of children achieving a good level of development by five.

To set this in context this chapter provides an overview of the key health needs of our residents; particularly focusing on improving our healthy life expectancy outcomes and the need for us to tackle the large health differences experienced by our residents; the need to level up of resources across the NHS North East London (NHS NEL) footprint based on the significant unmet need there is within our population recently reported and acknowledged by NHS NEL, including the opportunities we have to address these through our current agreed strategic direction; leadership to deliver outcomes through joint delivery plans, our place-based working and how we decide to invest our collective resources.

Strategic Plans and Agreed Outcomes

The recently published Joint Local Health and Well Being Strategy, which aligns with the councils Corporate Plan and NHS North East London Joint Forward Plan provide us foci for our direction of travel including the desire to address the differences in health experienced by different communities – what our data shows is that some residents die earlier than we would expect against the national average and too many of our residents live longer in poorer health than others. This is unacceptable and despite many commitments across partner organisations this situation has not changed over the last 10 years.

It is however difficult to assume a cause-and-effect relationship between what has been done and these outcomes as we have seen the 3rd highest increase in London in ten years (17.7%), and the highest raise (26.1%) in our residents under-16 years old the young population, bringing families with more complex needs and ethnic diversity as Barking and Dagenham is seen as a more affordable borough to its counterparts in inner London with excellent transport links into central London.

But we must not be disheartened and remain committed to addressing these differences and meet the vision of our Joint Local Health and Wellbeing Strategy for our residents to have improved physical and mental health and wellbeing, with a reduction in the gap in health inequalities between Barking and Dagenham residents and people living elsewhere.

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Outcomes

The vision of the Joint Local Health & Wellbeing Strategy 2023-28 (JLHWS) has been translated into shared outcomes for overall improvement in life expectancy and healthy life expectancy (I return to this later in this chapter).

The following long-term outcomes have been agreed:

Best Start in Life

We want babies, children, and young people in the borough to:

- Get the best start, be healthy, be happy and achieve
- Thrive in inclusive schools, settings and communities
- Be safe and secure, free from neglect, harm, and exploitation
- Grow up to be successful young adults

Living Well

We want to ensure residents live well and realise their potential, and when they need help, they can access the right support, at the right time in a way that works for them.

Ageing Well

We want residents to live healthily for longer and:

- Be able to manage their health, including health behaviours, recognising and acting on symptoms and managing any long-term conditions.
- Have increased opportunities to have an early diagnosis of health conditions and be provided with appropriate care to manage a condition before it becomes more serious.
- Their health and wellbeing are improved to support better opportunities (educational, employment, social) and independent living for as long as possible.
- Achievements of these outcomes will take time and shorter actions are needed. I return to this later in this chapter.

Our Priorities Over the Next Five Years

Ensuring good health and wellbeing and preventing the need for expensive health and social care is crucial in this financial climate, with funding pressures for all our system partners. We must therefore prioritise; focusing on impacts over the next five years on those interventions which will improve healthy life expectancy and address health inequalities which will also help us meet the wider priorities of the council for example good quality employment doesn't only enable good health, good health also is important to maintain economic activity.

As a report from ONS[5] identified; the number of people economically inactive because of long-term sickness has risen to over 2.5 million people, an increase of over 400,000 since the start of COVID-19. And for those economically inactive because of long-term sickness, nearly two-fifths (38%) reported having five or more health conditions (up from 34% in 2019), suggesting that many have interlinked and complex health issues.

A recent report[6] revealed that nearly 460,000 people in the UK are unemployed due to the consequences of health-harming products, resulting in a loss of £31.1bn from the economy. The analysis shows that 289,000 people are not working due to poor health caused by smoking, while 99,000 are unemployed because of illness caused by alcohol, and 70,000 are unemployed because of weight-related health conditions.

The following priorities have been agreed within the JLHWS; but we need to focus our attention on actions which will make the biggest difference in healthy life expectancy over the next five years, and therefore are suggesting we focus on the top three, but recognising there will be elements of the last three reflected in delivery plans.

The Joint Strategic Needs Assessment 2023 has been complemented by other important sources (such as the 2021 Census) to create a set of key priorities agreed by the Place-Based Partnership and set out in the Joint Local Health and Wellbeing Strategy 2023-28.

These are:

- Improving outcomes for people with long term conditions in children and adults.
- Addressing unhealthy weight and smoking in children and adults.
- Providing the best start in life for our babies, children, and young people.
- Preventing and addressing domestic abuse.
- Preventing exposure to and the consequences of adverse childhood experiences.
- Addressing wider determinants of health- for example unemployment, poor housing, low level of training, education and skills development.

Measuring Impact

It will be important that the Place-based Partnership decides on the measures it wants to reach against its agreed outcomes, based on realistic timescales (see Figure 2). For example, the Health Foundation reports that it can take up to 10 years to see a difference in health inequalities[7] and a review of the impact of the comprehensive programme to reduce health inequalities in England implemented by the UK government between 1997 and 2010. Health inequalities Strategy[8] suggested improvements in inequalities in life expectancy between more and least deprived areas could be seen within three years, which is likely to have been related to the targeted action (although this cannot be proved with the analysis[9].)

This would be underpinned by the actions we are taking to address health inequalities and work is currently underway to identify and agree using targets to better support health inequalities reduction, and we will use the key recommendations from the Health Foundation to do this, which include:

- Focus on improving the health of the most disadvantaged groups and geographic areas (e.g. the 20% most deprived areas***, children and minority ethnic groups).
- Taking a long-term viewpoint, as it takes around 10 years to achieve measurable reductions in health inequalities.
- Focus on ambitious, but achievable targets using both a range of long-term health indicators (e.g. infant mortality rates, life expectancy, healthy life expectancy, prevalence of overweight and obesity in adults and children, prevalence of anxiety and depression in adults, and suicide rates) and interim indicators of social and behavioural determinants of health (e.g. household relative poverty rates, employment rates, relative child poverty rates, educational attainment rates, physical activity, diet).

We also need to consider the existing Borough Manifesto targets:

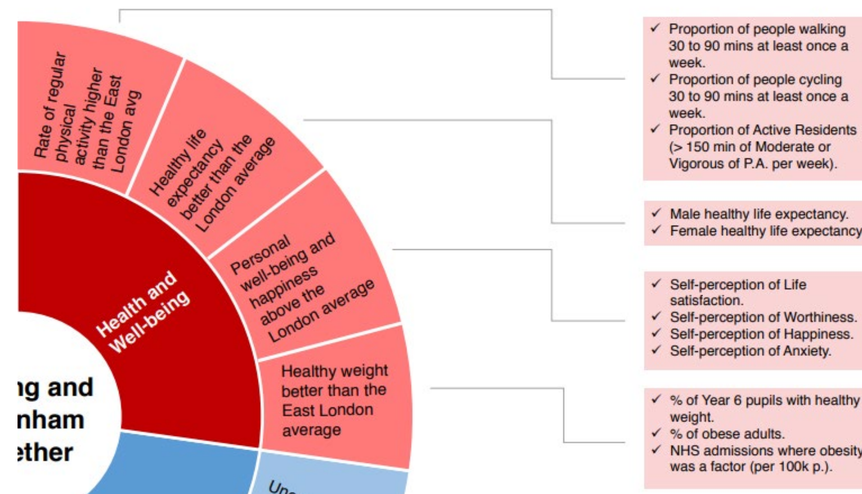

Figure 1: Barking and Dagenhams' Borough Manifesto health and wellbeing targets

*** all but 3 of our wards are in 20% most deprived by Index of Multiple Deprivation nationally, which means there is a need for hyper-localised approaches to target the communities most in need

Delivery Plans

Actions to deliver our agreed priorities have different development times (see Figure 2) which would need to be considered in any overall delivery plan, particularly if we want to see impacts over the next 5 years. A logic model can be a useful tool to provide an overview of the different interventions which will have incremental impacts to achieve our agreed outcomes.

This figure shows which actions will have impact in the short term, benefiting high service demands. But we should not forget the importance of the longer-term benefits of interventions within A and B, which must run alongside any actions benefiting the short term. They also coexist and often people need support to deal with many social determinants of health for example impacts of the cost-of-living crisis before they can consider health behaviour choices.

Substantial impact in 3-5 years; manage hypertension; CHD; diabetes; cancer

Substantial impact in 8-10 years; tobacco; alcohol harm; obesity management

Substantial impact in 12-15 years; work and skills; reduce poverty; housing

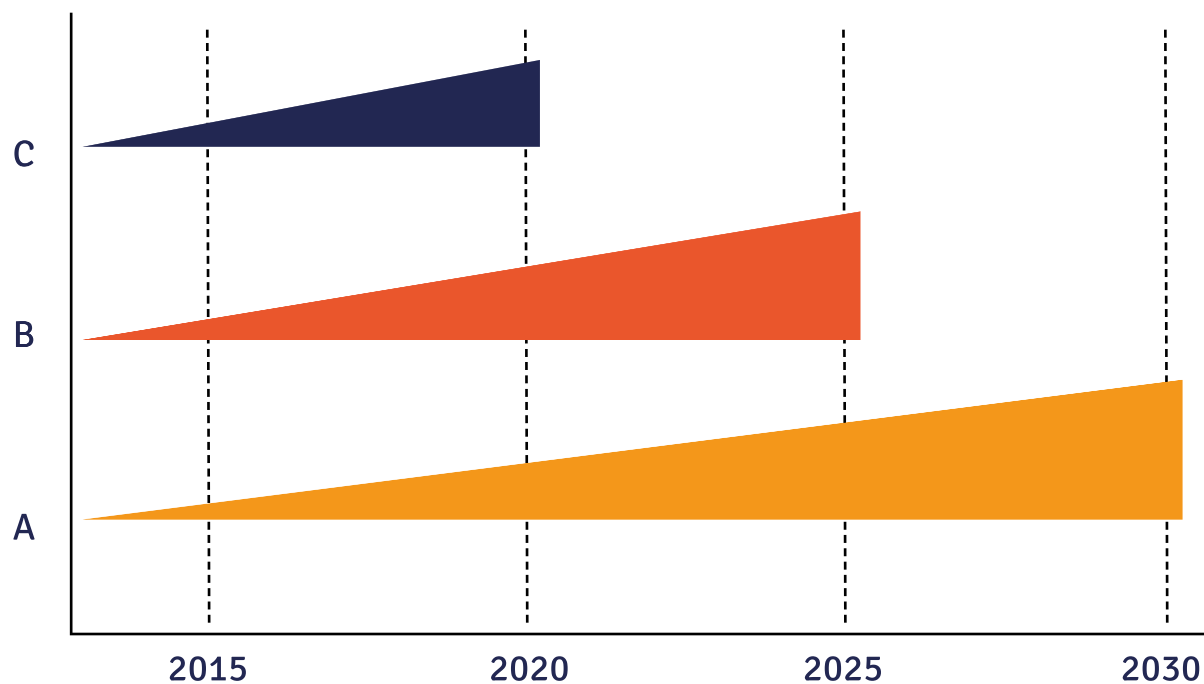

Figure 2: Time needed to deliver outcomes from different intervention types[10]

Place Based Working

Effective delivery will only happen if **place-based action** is framed within the Population Intervention Triangle - which requires robust governance with clear leadership and evidence - based delivery plans setting out responsibilities across all partner organisations, that have been coproduced with residents.

Working in localities is a key delivery model for this way of working.

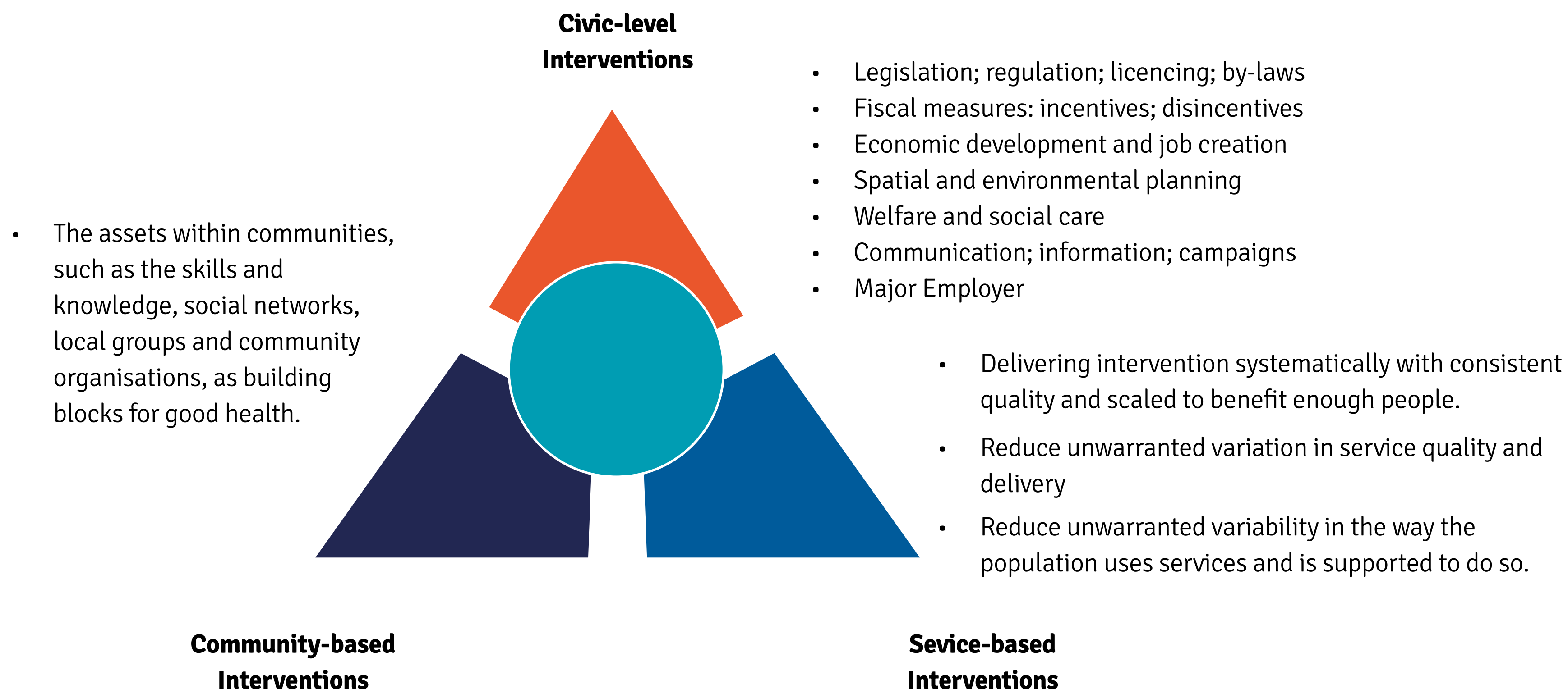

Figure 3: The Population Intervention Triangle

Developing Place-Based Working – The Role of Localities

At the forefront of action is a genuine commitment to the value of relationships and coproduction with residents in designing or discovering changes to meet the needs of our communities

Joint Local Health & Wellbeing Strategy 2023-28

Three of the key principles underpin delivery – coproduction with communities, Integrated Care and taking place based action are central to the development of an effective model to deliver services and develop healthy places which address health inequalities and improve healthy life expectancy.

My reports in 2016/17 and 2018/19 describe an evolving locality model in Barking and Dagenham, which enables a place-based response to improve the health and wellbeing of our residents and reduce service demands.

Key to this is how we make natural delivery connections to our housing and other wider determinant based services. The following principles reported in previous reports, remain relevant today:

- There needs to be a degree of flex in how we define a population footprint, as this will be more helpful to teams and services that don't naturally come together around the same footprints.
- The starting point to establish place-based systems of care is to define the population served and what the barriers to, and boundaries of, collective working are. The scope should not just be focused on the NHS and social care but also on the wide range of other council services and other partners that contribute to health, such as the Metropolitan Police, London Fire Brigade, schools, and the voluntary community sector. This provides the opportunity to focus on the wider health and social care needs of the population that they serve.

- Within the locality model there will need to be a neighbourhood level. This is primarily to address inequalities by delivering a range of interventions aimed at improving the health of individuals within the small geographical areas (such as deprived estates). These interventions are many and varied and involve input from several organisations and services.
- Central to this is the place-based care model, which encourages providers of services to work together to improve the health and care of their population around a shared vision and shared objectives, using pooled budgets to deliver services that work together.
- We can build upon our Integrated Care Model that works in our existing localities, which includes co-located health and social care teams. We need to build on this existing good practice with a clear focus on population-level outcomes and shared decision-making processes to assess how best to get there.

Since my last report, the Fuller report was published- this recognises the essential role primary care (including community pharmacy, dentistry, optometry, and audiology) must play working in partnership to prevent ill health, tackle health inequalities and manage long-term conditions.

This vision is key to an integrated locality model which aims to deliver prevention and early intervention tailored to the needs of the local community; providing choice about how they access care; proactive personalised care supported by multidisciplinary teams and action to help people stay well for longer.

This approach and a recognition of the broader role of primary care, provides an excellent opportunity to tie this workforce into the wider localities model we are currently leading (described below), particularly when looking at our approach to preventing, and managing long term conditions.

This reorientation of the workforce will also enable us to support our most vulnerable residents and those with complex needs to stay at home and access care in the community which will, over time, contribute significantly to efforts to reduce growth in hospital demand.

Improving urgent care and providing more personalised care to those who need it the most will be central to improving the access issues that have beset the NHS for some time now. Beyond that – and just as importantly – it will create the backdrop and headroom for local systems and teams to work together with communities to tackle the wider determinants of health[11]

Locality Working

The development of locality working at Place is an iterative process comprised of several stages. The experience of those who are further ahead suggests it is important that places invest in the process of developing locality ways of working, approaching engagement in this as a meaningful way of furthering integrated working arrangements, and recognising that there is the likelihood of further iteration and evolution of the model over time.

This is where the shared outcomes outlined in our Joint Local Health & Wellbeing Strategy 2023-28 are a powerful mechanism for making integrated services a reality. From there, our partners set out how the priorities will be delivered, and the measurables used to monitor progress. A locality focused delivery plan may map out how organisations and services will collectively deliver the priorities.

Shared outcomes support integration at place level and are key in connecting our partners plans and strategies into coherent and focused delivery plans for meeting those outcomes. For me, the key benefit will be to address current complexity of service planning that by design has developed 'systems within systems' to focus on various aspects of performance, transformation, and access across the life course, drawing on skills and services from across the partnership. The challenge to new 'ways of working' going forward is to ensure that the services we deliver forms part of a coherent, mutually reinforcing approach, rather than becoming a disjointed set of initiatives. And puts residents in the heart of decision making to improve accessibility and acceptability of services and programmes to improve health.

This approach also provides the opportunity to deliver an evidenced base approach to tackle health inequalities. As discussed earlier this chapter, achieving a reduction in population health inequalities requires a long-term, place-based approach across three types of interventions (i.e. the Population Intervention Triangle): Civic-level interventions (e.g. licensing, economic development); Community-based interventions (e.g. using and building assets within communities); and Services-based interventions (e.g. quality and scale, reducing variation).

But more specifically to address factors which are driving our poor healthy life expectancy and related health inequalities I advise that the Barking and Dagenham Place-based Partnership use the Population Outcomes through Services (POTS) (Figure 4) evidence-based framework to determine which interventions to develop and apply the following criteria needs to ensure these interventions are effective:

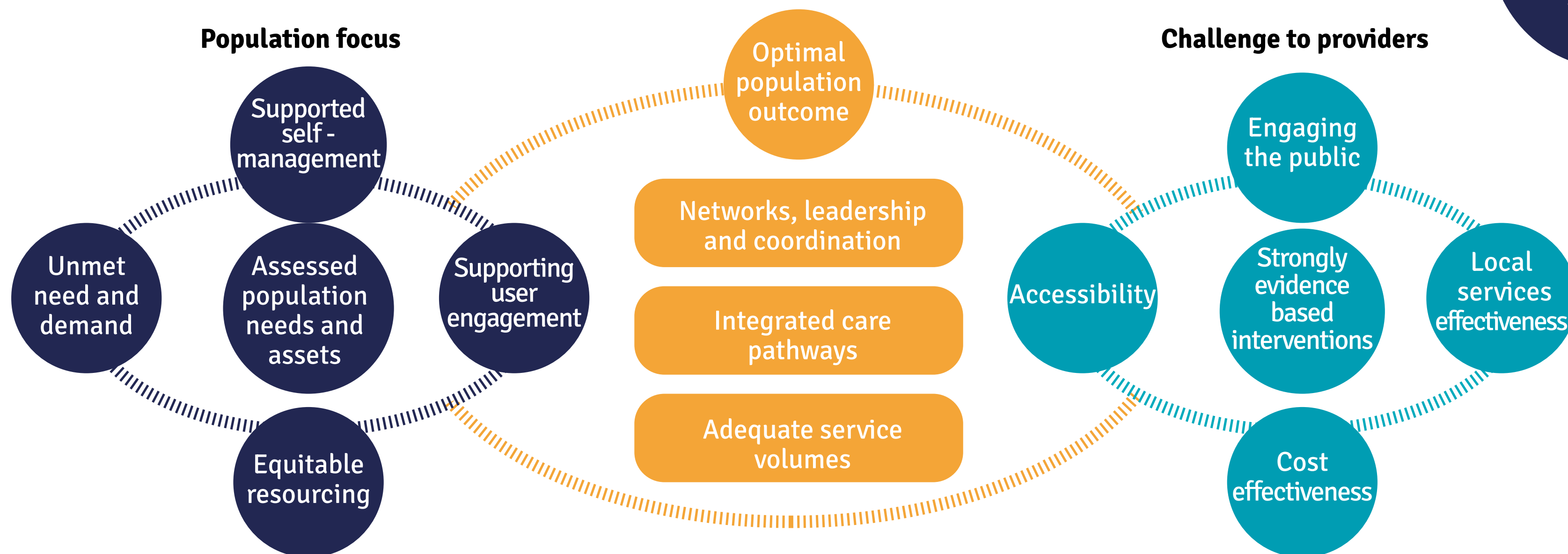

Figure 4: The population outcomes through services (POTS) framework[12]

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Localities network case study

In the first year of the health inequalities programme, invested in community sector infrastructure to improve health at a population level through creating networks of civil society organisations working with residents to re-define local problems and solutions related to health inequalities and the cost-of-living crisis, alongside statutory sector partners building on the lessons of the BD CAN partnership during the pandemic.

Community Locality Leads were established and have operated over the last year borough-wide across six areas, roughly the same geographies as the Primary Care Networks, across the borough's three localities. The Leads are voluntary sector organisations that provide local connections in communities; triage support for residents; build a connected network of community partners and working with residents to design prototypes to meet cost-of-living and health inequality challenges as identified by residents.

Through their triage process, Community Locality Leads have held around 2,600 conversations with residents, which informs their approaches, as does the mapping of 'connecting places' such as civil society organisations, social spaces and natural points of connection, with an estimated 500+ such places in each locality. Community-led design has ranged from collaboration with statutory sector partners to bring health services into the community and improve access for marginalised groups, such as pop-up clinics for those who are homeless, to small-scale community groups like choirs.

To date, the approach has enabled shared learning between the voluntary sector, NHS and council partners and a shift in statutory partners' understanding of the value of the voluntary sector and the relationships they hold with residents.

Following this 'proof of concept', is currently being reviewed which will complete in early 2024 with the revised approach planned for Summer 2024 onwards.

Investing to Improve Health

Although there is a strong and steadily growing evidence base that prevention is a cost-effective way to reduce demand on the NHS and social care services, our existing prevention programmes and services are yet to provide these benefits, as achieved in other parts of London and the country. We will miss a trick if we don't capitalise on this opportunity to jointly plan, invest, and deliver integrated prevention programmes that go beyond care to address our agreed outcomes and priorities.

It is also important to acknowledge that reducing demand and prevention are not the same thing. A key long-term outcome of prevention would be a reduction in the use of high-cost downstream services, such as emergency departments, adult social care and care homes and prevention programmes are part of the solution.

The Place based Partnership has made a strategic commitment to improve the health of the residents of Barking and Dagenham. Therefore, core funding and activities must be jointly considered to deliver agreed plans against our priorities. The funding provided by the Public Health Grant (PHG) can add value to this mainstream activity and funding. Over time formal joint funding arrangements could be considered, learning from our experience with the existing Better Care Fund which is a joint budget between the NHS and the council with a focus on prevention.

Firstly however, I need to consider whether the PHG is being invested in the right services/interventions which impact on our shared public health outcomes as detailed in our Joint Local Health and Wellbeing Strategy 2023-28. As well as the required balance of the PHG allocation to deliver both population health management as well the shared public health outcomes.

The allocation has remained mostly unchanged since 2016 and now is an opportunity for this to be reviewed in line with the borough's changing demography and need. This section provides an overview of how the grant was spent in 2022/23 and changes to responsibilities and accountability for delivery of value for money and outcomes for public health programmes and services linked to assurance statements.

The Health and Care Act 2012 transferred public health responsibilities to local authorities by way of a ring-fenced PHG received from national government to:

- Significantly improve the health and wellbeing of local populations.
- Carry out health protection functions delegated from the Secretary of State.
- Reduce health inequalities across the life course, including within hard-to-reach groups.
- Ensure the provision of population healthcare advice.

Local authorities are mandated, through the grant to fund a range of public health activities including sexual health services, sexually transmitted infections testing and treatment and contraception; NHS Health Check programme; health protection; public health advice to commissioners; the National Child Measurement Programme and mandated children's 0-5 services and health visiting.

It is planned that from 2023 end of year returns, categories for reporting local authority public health spend will be split into prescribed and non-prescribed functions[14], as shown in Figure 5 overleaf.

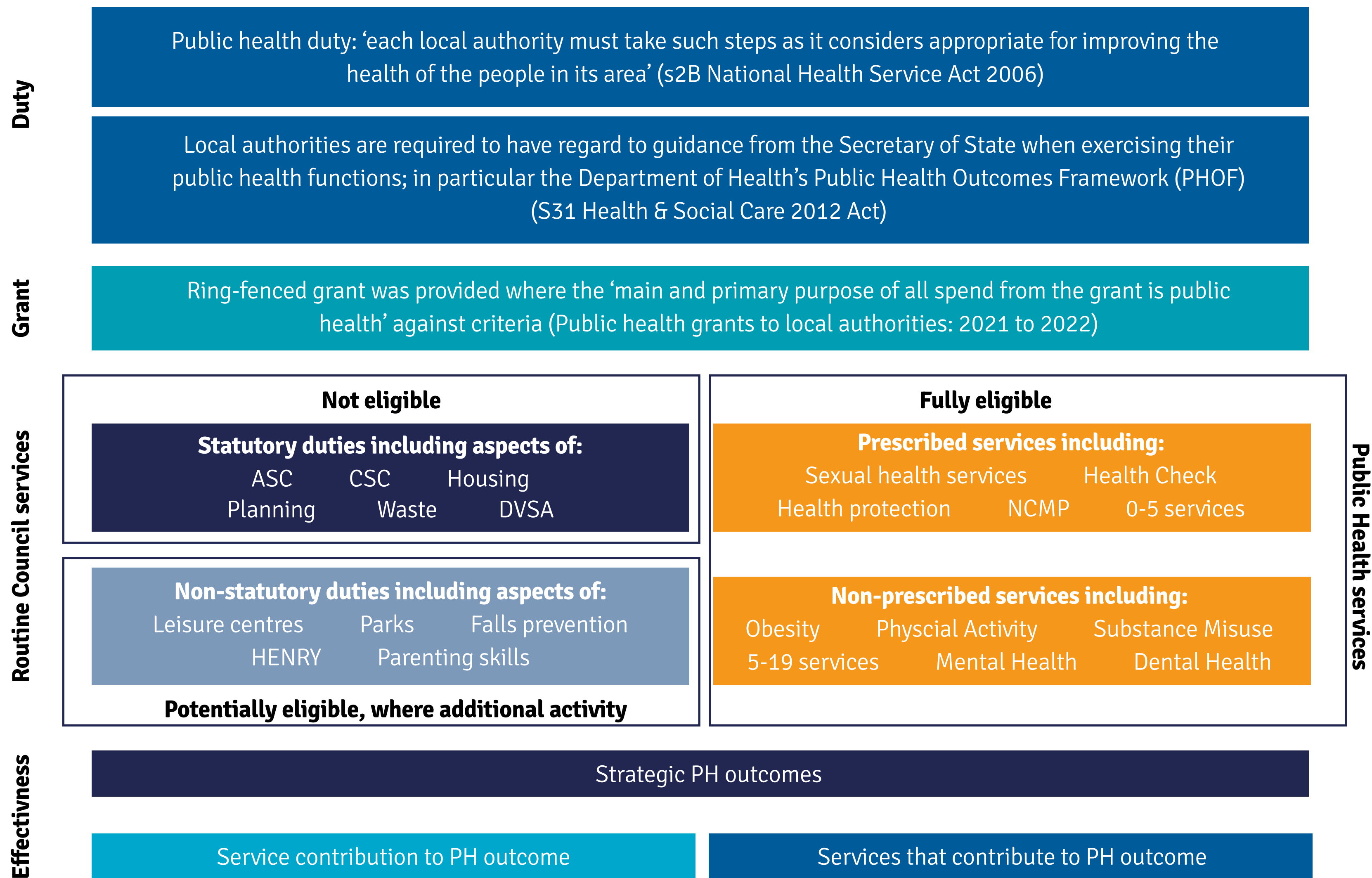


Figure 5: The public health duty for local authorities

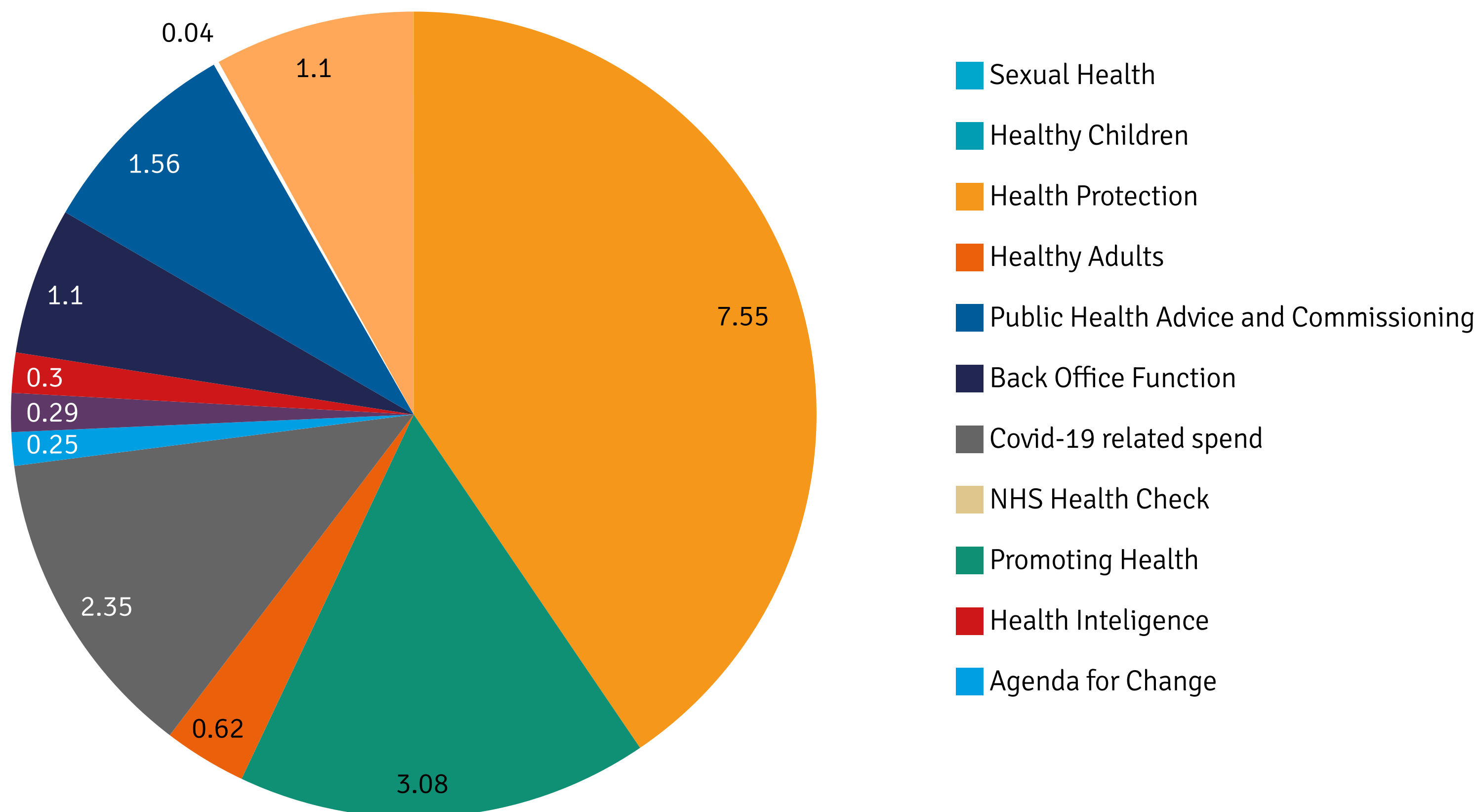


Figure 6: Breakdown of spend for the Barking and Dagenham Public Health Grant in 2022/23

For financial year 2022/23, the council received a PHG allocation of £17,787,080.

The grant allocation is mainly as below, going forward, the allocations will be reviewed to see if they are still the right thing to commission from next year, to meet our priorities.

The PHG spend is monitored by a public health programmes board chaired by the Director of Public Health.

Figure 7 below gives an overview of the grant allocation compared to other north east London borough neighbours that are similar in socioeconomic profile. This reflects that the PHG received does not meet the needs in the borough as the allocation per head is 3rd lowest of the boroughs, despite having one of the highest needs.

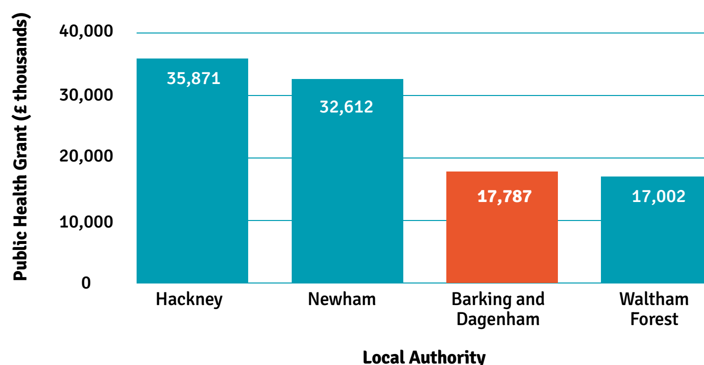
Benchmarking of Cost Drivers

Public Health grant allocations for 2022-23

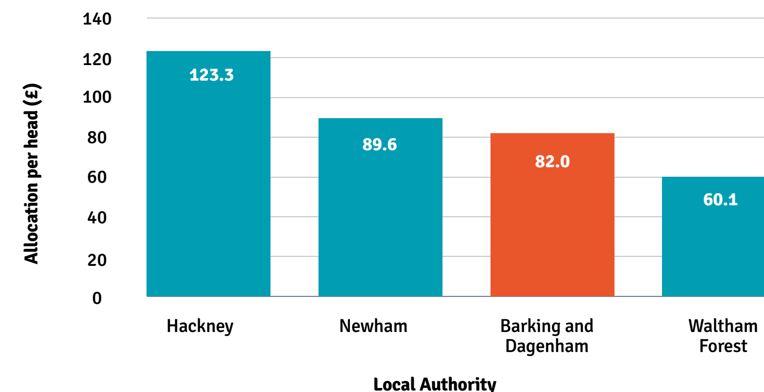
Local Authority	Public Health Grant (£ thousands)	Allocation per head (£)	2022 projected population
Hackney	35,871	123.3	290,891
Newham	32,612	89.6	364,021
Barking & Dagenham	**17,787**	**82.0**	**216,826**
Waltham Forest	17,002	60.1	283,108

Barking and Dagenham is compared to NEL neighbours who are also CIPFA nearest neighbours (matched on socioeconomic profile). CIPFA does not take into account ethnicity, but NEL boroughs will have similar ethnic profiles.

Public Health Grant 2022-23



Public Health Grant 2022-23 Allocation per head 2022-23



Source: Public Health local authority allocations 2022 -23

Figure 7: Public health grant allocations for similar north east London boroughs 2022-23

This is demonstrated when we look at performance across key public health outcomes (see Table 1); we are among the worst nationally for healthy life expectancy, obesity, school readiness, and some sexual health and immunisations outcomes. Whilst this is associated with our local deprivation; when we compare ourselves to Newham, a local neighbour with similar socioeconomic need and public health allocation per head, we are worse in relation to healthy life expectancy, obesity and school readiness outcomes.

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Key Outcome Indicators

Category	Outcome Indicators (indicative sample, not all represented)	National performance	**LBBD performance**	Newham performance	Period	LBBD National Benchmarking Summary
Overarching	Life Expectancy M F	M 79.4 F 83.1	**M 77.0 F 81.7**	M 79.0 F 83.1	2018-20	worst/lowest to 25th percentile
	Healthy Life expectancy at birth M F	M 63.1 F 63.9	**M 58.1 F 60.1**	M 59.5 F 64.6	2018-20	worst/lowest to 25th percentile
	Cumulative percentage of people who received a healthcheck age 40-74	27.4%	**46.5%**	100% (data quality issue)	2018/19-22/23	75th percentile to best/highest
Child Health	Low birth weight of term babies	2.8%	**3.8%**	5.0%	2021	worst/lowest to 25th percentile, no significant change
	Hospital admissions caused by unintentional and deliberate injuries in children age 0-14 crude rate/1000	84.3	**52.3**	58.2	2021/22	75th percentile to best/highest
	% of school children achieving a good level of development at reception	81.1%	**62.5%**	68.7%	2021/22	worst/lowest to 25th percentile
Sexual Health	New STI diagnoses (excluding chlamydia aged under 25) per 100,000’	496	**599**	990	2022	worst/lowest to 25th percentile
	Under 18 Conception Rate/1000	13.1	**12.5**	9.9	2021	25th percentile to 75th percentile
Substance Misuse	Admissions episodes for alcohol (persons) (per 100,000)	494	**354**	352	2021/22	75th percentile to best/highest
	Deaths from Drug misuse (per 100,000)	5.0	**3.0**	2.6	2018 - 20	75th percentile to best/highest

Health Protection	Population vaccination coverage : MMR (5 yrs old)	1 dose 93.4% 2 doses 85.7%	**1 dose 86.4% 2 doses 67.8%**	1 dose 84.9% 2 doses 69.9%	2021/22	worst/lowest to 25th percentile, worsening
	Cancer Screening coverage: bowel cancer	70.3%	**57.4%**	55.4%	2022	worst/lowest to 25th percentile, improving
Tobacco	% smoking prevalence in adults (18+) - current smokers (APS)	13.0%	**11.3%**	13.9%	2021	25th percentile to 75th percentile
Obesity/ Physical Activity	% overweight/obese at reception	22.3%	**27.5%**	22.7%	2021/22	worst/lowest to 25th percentile, no significant change
	% overweight/obese at yr6	37.8%	**49.1%**	46.3%	2021/22	worst/lowest to 25th percentile, worsening
	% overweight/obese at adult	63.8%	**70.5%**	47.3%	2021/22	worst/lowest to 25th percentile
	% physically active adults	67.3%	**58.4%**	63.9%	2021/22	worst/lowest to 25th percentile
Mental Health	Self reported wellbeing: % with a low satisfaction score	5.0%	**2.8%**	low count	2021/22	75th percentile to best/highest
	Emergency hospital admissions for intentional self harm (per 100,000)	163.9	**69.6**	52.1	2021/22	75th percentile to best/highest

Table 1: Public health outcomes for Barking and Dagenham compared with national averages and Newham

The Future Direction of the Public Health Grant

We are proposing to transform public health programmes from 2024/25; partially through the development of partnership plans to delivery our priorities, but also through changes to the PHG allocation and services commissioned and delivered against public health outcomes, which recognises the commitment of all partners to meet the priorities set out in the Joint Local Health & Wellbeing Strategy 2023-28.

Therefore, the PHG needs to be directed towards those factors which the evidence suggests will improve health life expectancy (which I describe in chapter 3) i.e. addressing long term conditions and risk factors for poor health – smoking and obesity, focusing on the underpinning health inequalities within in these contributory factors. To address these issues, there are several building blocks for health which are needed, including best start for life, in particular school readiness, health literacy, community cohesion, unemployment and improving mental health and wellbeing that need to be addressed (see Figure 8).

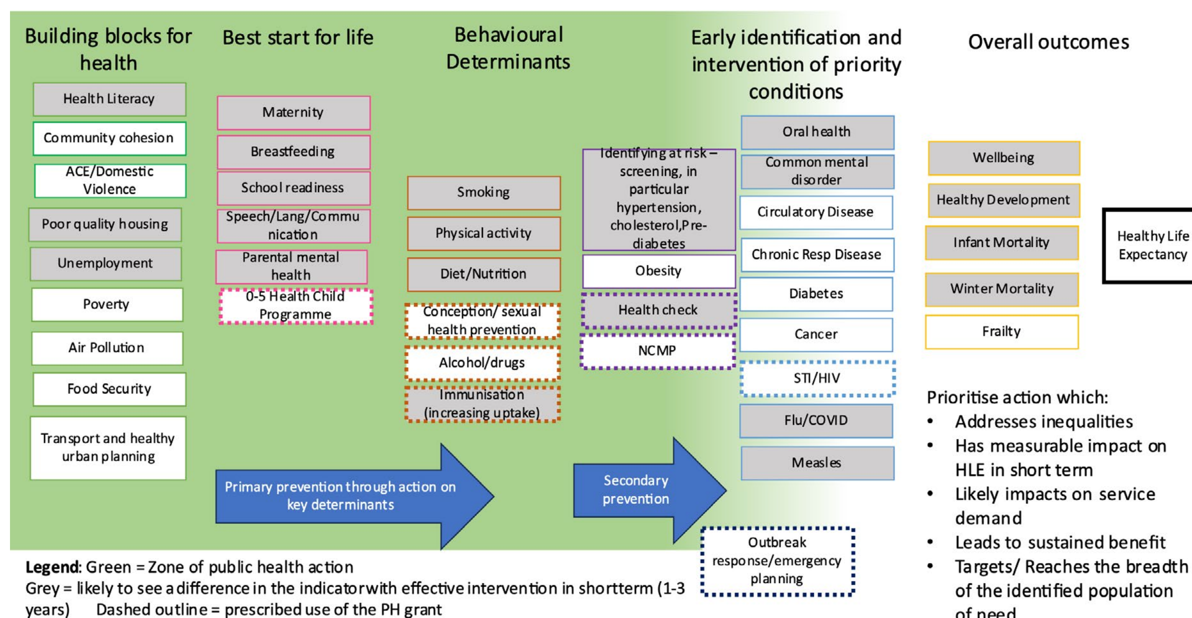

Figure 8: Action to improve/reduce inequality in healthy life expectancy in Barking and Dagenham over 5 years

Public Health Advice

We need to exploit the opportunities we have in the Place based Partnership to improve healthy life expectancy by:

- Agreeing shared outcomes and priorities.
- Aligning strategic plans, develop agreed delivery plans and outcomes of the locality model.
- Invest together on programmes to deliver our priorities and reprioritise our spending of the Public Health Grant.

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Chapter 3: Why is healthy life expectancy key to improving health and managing health and social care demand?

Measuring Impact

Although increasing life expectancy, particularly the inequalities we see in Barking and Dagenham is important (see JSNA, 2022), I suggest in this report that we focus on increasing healthy life expectancy and addressing those contributing factors which in the short term, impact on overall health, ability to live independently in later life, and on the increasing demand on our health and care system. If an approach is well structured, actions identified can provide results within the five years of the Joint Local Health & Wellbeing Strategy 2023-28 (JLHWS).

Healthy Life Expectancy

Healthy life expectancy (HLE) describes the average number of years a baby born today would expect to live in good health. It is based on data combining risk of death and people's self-reported good health. Analysis of why we have lower healthy life expectancy can also help us develop a plan to reduce the impact on the rising demands on social care and health services. It is often measured through 'Disability Adjusted Life Years'. This is a measure of the number of healthy years of life lost from disease and ill-health.

Nationally there has been little change in HLE between 2014-16 and 2017-19 because improvements in health in older people have been balanced by worsening health in the younger population. The cost-of-living crisis has put additional strain on the wider determinants of health. It is therefore important to focus on efforts to improve HLE across the life-course, as our JLHWS identifies starting well, living well and ageing well, even if the impacts on children and young people take years to realise.

Our Borough Manifesto in 2017 set out targets to achieve a better healthy life expectancy than the London Average by 2037 (14th out of all London Boroughs). However, recent, and ongoing challenges mean we have seen little improvement in recent years – and this is true both of London and nationally.

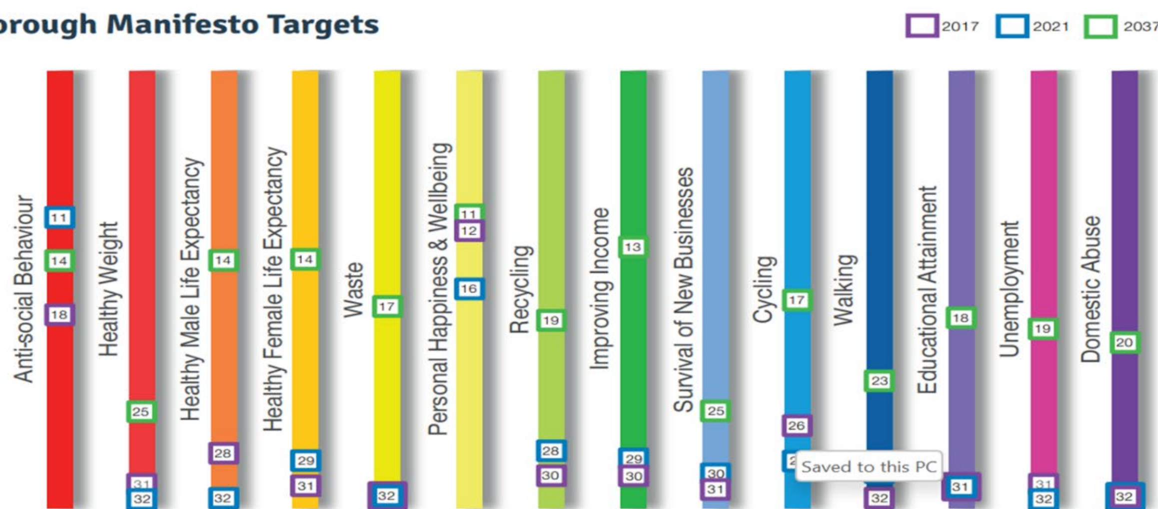


Figure 9: The Borough Manifesto targets for 2017-2037

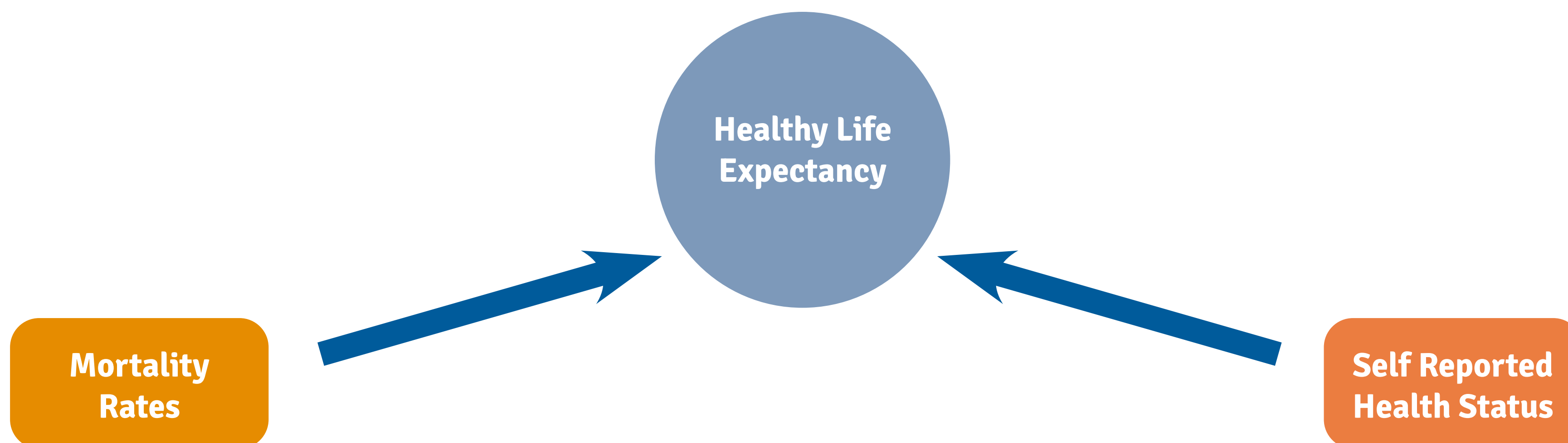


Figure 10: The relationship of self-reported health status, mortality rates and healthy life expectancy[12]

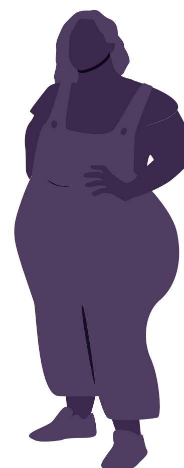
Male healthy life expectancy is 58.1 years in Barking and Dagenham, which is lower than the England average of 63.1 years (in 2018-20) and has been significantly lower most years during the last decade.

Female healthy life expectancy is 60.1 years, this is also significantly lower than the England average of 63.9 years for England (in 2018-20), and again has been for most years during the last decade, although improvements have been seen since 2012-2014 when healthy life expectancy for women in Barking and Dagenham was only 53.6 years.

Self-reported Health

National analysis[14] shows an increase in self-reported good health has a greater impact on healthy life expectancy compared to a decrease in mortality rates, although it should be noted that factors linked with poorer mortality and self-reported health status are complex, overlapping, and likely to interact with one another.

In addition to the strength of association between the health condition and self-reported poor health, the prevalence of the condition will also be important in determining its overall influence on population-level healthy life expectancy.



For example, a 2% improvement in mortality rates would improve healthy life expectancy by 0.1 years, compared to a 2% increase in self-reported good health that would improve healthy life expectancy by 1.3 years.

What Are the Main Contributors to Self-Reported Ill Health?

Research shows that the most consistent and strongest links with self-reported poor health are **chronic health conditions and multiple long term conditions**. In almost all studies, having a chronic condition significantly increased the chances of self-reported poor health. There was also strong evidence that a cumulative effect of having multiple chronic conditions increased the odds of self-reporting poor health further.

National data and wider research suggest the following are linked with worse self-reported good health.[16],[17], Data below shows that our residents are affected by all contributors.

Ill health:

- Having a long-term condition: 29.1% of GP registered patients have one or more long-term condition in Barking and Dagenham[18] (there are more registered patients than those living in the borough, as some patients do not always re-register when they move).
- Having multiple long term conditions (has a cumulative effect): 13.4 % of GP registered patients have 2 or more long term conditions[19].
- Muscular Skeletal Conditions are one of the top three conditions which impact on numbers of healthy years lost.[20]

Risk factors for ill health:

- Smoking: 13.7% of residents smoke (similar to England 12.7%)[21].
- Obesity/overweight: 70.5% of adult residents are obese or overweight. (worse than London 55.9%, England 63.8%).
- Being physically inactive: 35% of residents (worse than London 22.9%, England 22.3%).

Wider determinants:

- Having low income (23.9% of children live in relative low-income families, (England 19.9%).
- Low educational attainment (Average Attainment 8 score age 15-16 is 49.9, similar to England 48.7; 22.7% have no qualifications (higher than London, 16.2%)[22].
- Living in deprived areas. (62.4%[23] of households are subject to 1 or more forms of deprivation, the highest level of deprivation experienced by any London borough).
- Psychological distress: Time lived in country of residence, financial stability and regularity of contact with family and friends are all protective factors for this in urban settings[24].
- Reduced access to health care. Average journey times to hospital for Barking and Dagenham residents are public transport 33 minutes; cycle 25 minutes; car 17 minutes; walking 56 minutes.[25]
- Food insecurity: 26.7% of Barking and Dagenham pupils are eligible for free school meals[26].

Demographics[27]:

- Being older (above 35 years). Currently 53.4% of the population is under 35, but as they age the likelihood of good self-reported health will reduce.
- Ethnic minority status (55.2% of residents are non-white).
- Being single (57.3% of adult residents are single or separated/widowed).

As the research identifies long term conditions, are one of the most important contributors to healthy life expectancy; demands on health social care services, and with concerted effort at place, impacts can be seen in the next 5 years.

Long Term Conditions

Long term conditions (LTCs) – also called chronic conditions – are health conditions for which there is no cure and require management through medication or other treatment. Therefore, identifying someone with a condition and getting them onto treatment programmes is vitally important.

> As long-term conditions increase, what was once considered a health issue is now a societal one and needs a societal response requiring a focus on wider determinants of health.

Around 15 million people have a long-term health condition in England, including over half (58%) of us by the age of 60[28]. This impacts all aspects of life for individuals and communities, e.g.:

- **Employment** – e.g. over 1 in 3 working age people have a long term condition, with 2.5 million people not working nor looking for work as a consequence[29].
- **Demand for health services** – e.g. 50% of GP appointments, 64% of outpatient appointments and over 70% of inpatient bed days are for people with long-term conditions[30]
- **Cost of health and social care – e.g.** £7 in every £10 of health and social care funding is spent on treatment and care of long-term conditions[31]
- **Impacts on friends, families and communities** – e.g., almost 1 in 10 (9%) of the population provide care for someone[32] with a cost to their own health, social and economic wellbeing (e.g. caring results in a £6-9k drop in annual income for a carer[33])
- **Social participation and wellbeing –** e.g. 1 in 6 people with a LTC find it difficult to find or stay in work, 1 in 2 say it reduces their ability to maintain social relationships[34]
- **Susceptibility to illness and worse outcomes –** e.g.: 90% of COVID-19 deaths were in people with LTCs
- **Informal caring** – 52% of carers have a long-term health condition, with 87% reporting health has impacted their caring responsibilities[35]

Modelling by the Health Foundation suggests that there will be 2.5 million more people in England with a major illness by 2040; 1 in 5 adults compared to 1 in 6 currently. Although mostly driven by an ageing population (i.e. 80% of the increase will be in people aged 70 years and over), ill health is increasing across all ages. The 37% increase in people with major conditions is nine times the rate at which the working age population (20-69 year olds) is expected to grow, creating additional pressures on how to care for and fund a growing population with high health needs.

Increasing multiple long term conditions

Historically, focus on long term conditions has taken a single condition focus (e.g. strategies, funding, etc.); however, that is not the reality. Increasingly people are suffering from 'multi-morbidity, which is the presence of two or more health conditions[36]. Multiple long term conditions is associated with[37]:

- Reduced quality of life and life expectancy.
- Mental health difficulties, such as anxiety and depression.
- Higher treatment needs and use of services (including unplanned or emergency care).

Inequalities in Long Term Conditions

There are inequalities across all aspects of long term conditions: risk factors for developing a condition, likelihood of having a condition, risk of multiple conditions and management of that condition. These inequalities can be seen across gender, ethnicity, socioeconomics, etc.[38]

Residents and communities in Barking and Dagenham have a higher level of LTCs than their counterparts in other areas, ranking us worst in London for four of the 'top 10' health conditions; heart disease, chronic obstructive pulmonary disease, lung cancer and stroke[39], with almost 1 in 8 (13%) having two or more conditions[40]. Musculoskeletal conditions and mental health disorders caused the third and fourth greatest number of years of healthy life lost to disability, after cancer and cardiovascular disease (JSNA, 2022).

As health conditions amendable to secondary prevention, it is alarming to know that, by comparing the number of people we expect to have the six common LTCs versus those in treatment (based on being on a GP disease register) our findings suggest around 38,000 cases are unidentified and therefore unmanaged[41].

There appears to be inequalities by geography, genders (higher in males apart from chronic kidney disease (CKD)), age (highest in 35-54, except for coronary heart disease (CHD) and ethnicity (highest in White ethnicity, except for hypertension and diabetes).

Long term conditions are a major driver of health and social care needs in Barking and Dagenham

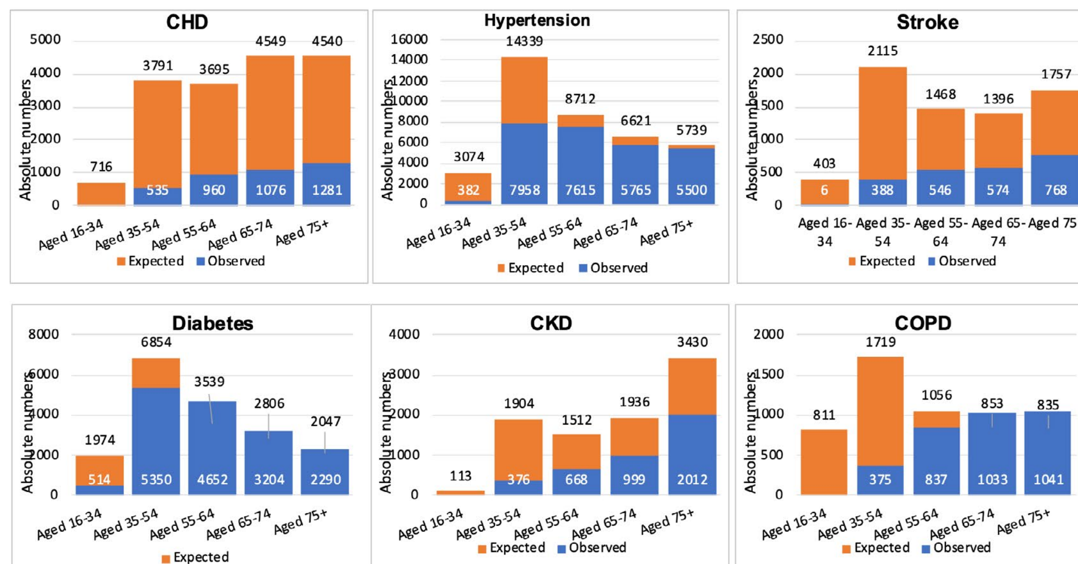


Figure 11: Estimated number of undiagnosed long-term conditions in the borough, by type and age

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In respect to multiple long-term conditions, Barking, Havering and Redbridge University Hospitals NHS Trust have also analysed LTCs across their three boroughs, including undertaking projections for the next 2, 5 and 10 years[42]. Analysis of 2022 found the highest number of avoidable deaths are in Barking and Dagenham; 37% and 54% higher than in Havering and Redbridge respectively. It also analysed use of acute services by people with LTCs, which was lower in Barking and Dagenham – which might be expected, having a younger population– and were driven (in order) by asthma, depression, diabetes, high blood pressure and cancer.

Table 2: Projections for key LTCs in Barking and Dagenham for 2, 5 and 10 years[43]

	18-64 years				65+ years				All ages			
	2023	2 years	5 years	10 years	2023	2 yeas	5 years	10 years	2023	2 years	5 years	10 years
Obesity	45,216	46,695	49,190	54,673	7,793	8,231	9,095	11,063	53,009	54,926	58,285	65,736
Hypertension	17,847	18,431	19,415	21,580	12,211	12,897	12,252	17,334	30,058	31,328	31,667	38,914
Depression	16,651	17,196	18,114	20,134	2,378	2,512	2,775	3,376	19,029	19,708	20,889	23,510
Diabetes	45,216	46,695	49,190	54,673	7,793	8,231	9,095	11,063	53,009	54,926	58,285	65,736
Asthma	7,035	7,265	7,653	8,506	1,877	1,982	2,191	2,665	8,912	9,247	9,844	11,171
CKD	1,594	1,646	1,734	1,927	4,064	4,292	4,743	5,769	5,658	5,938	6,477	7,696
% increase on 2023		**3**	**9**	**21**		**6**	**17**	**42**		**5**	**14**	**36**

Public Health Advice

To address long term conditions, we need to focus our efforts on:

- Reducing smoking and obesity by 2028 as they are primary risk factors associated with heart and lung diseases, cancers and diabetes.
- Identifying markers of early disease through improving identification of hypertension, high cholesterol and HbA1c blood levels, and identifying cancers early through the NHS screening programmes.
- Identify and tackle the health inequalities that exist within these risk factors.

What Are the Main Contributors to Mortality Rates?

However, although as explained earlier, focusing action on mortality rates will not impact as much on healthy life expectancy, as self-reported ill health, it is still important to recognise that deaths from cancer and cardiovascular disease make the largest contribution to years of life lost and therefore have the biggest impact on life expectancy; and tobacco is the risk factor making the largest contribution to years of life lost for both sexes followed by high body mass index (BMI), high cholesterol and high blood pressure. A recent analysis has shown that residents are around three times more likely to suffer an avoidable death than people living in the 10 least deprived areas of England[44].

Infant mortality is another key avoidable outcome impacting on healthy life expectancy, driven by perinatal maternal health and support received. Overall approaches to addressing health inequalities will impact on the health of women giving birth; as part of an overall approach to giving children the best start in life as highlighted in Chapter 5.

What Are the Health Inequalities Related to Healthy Life Expectancy?

Not only do we need to improve overall healthy life expectancy for females and males we also need to address the differences in healthy life expectancy experienced by our residents.

Last year's Annual Report highlighted the extent of health inequalities our residents and communities suffer.

Health inequalities exist for different groups, so addressing these should underpin everything we do – we need to continually understand the needs of our communities when addressing health outcomes and the wider determinants of health.

The healthy life expectancy experienced by our residents is 58.1/60.1 years (males / females) compared to 63.8/65.0 and 63.1/63.9 years for London and England respectively, which means they will develop a life-limiting condition impacting their ability to undertake normal activities (e.g. work, see friends and family, etc.) five years earlier than their counterparts in other areas of London and England.

And healthy life expectancy is also not felt the same within the borough, with inequalities within communities that vary by outcome and risk factor. There is currently a 6.4 year difference in healthy life expectancy between the least and most deprived males and a 5.8 year difference between the least and most deprived females within the borough,[45] and residents of Black ethnicities develop a long term health condition over five years earlier than their White neighbours (Table 3), while life expectancy and deaths from certain diseases (e.g. morbidity in cancer, dementia and Alzheimer's) are highest in White residents.

Table 3: Age of the first health condition by ethnicity[46]

Ethnicity	1st condition (age)	2nd condition (age)	3rd condition (age)
BAME	54.1	60.3	63.6
Asian / Asian British	52.6	57.5	60.7
Black/African/ Caribbean/Black British	49.8	55.0	57.8
Mixed/Multiple ethnic groups	55.4	62.2	65.6
White	55.4	62.1	66.2

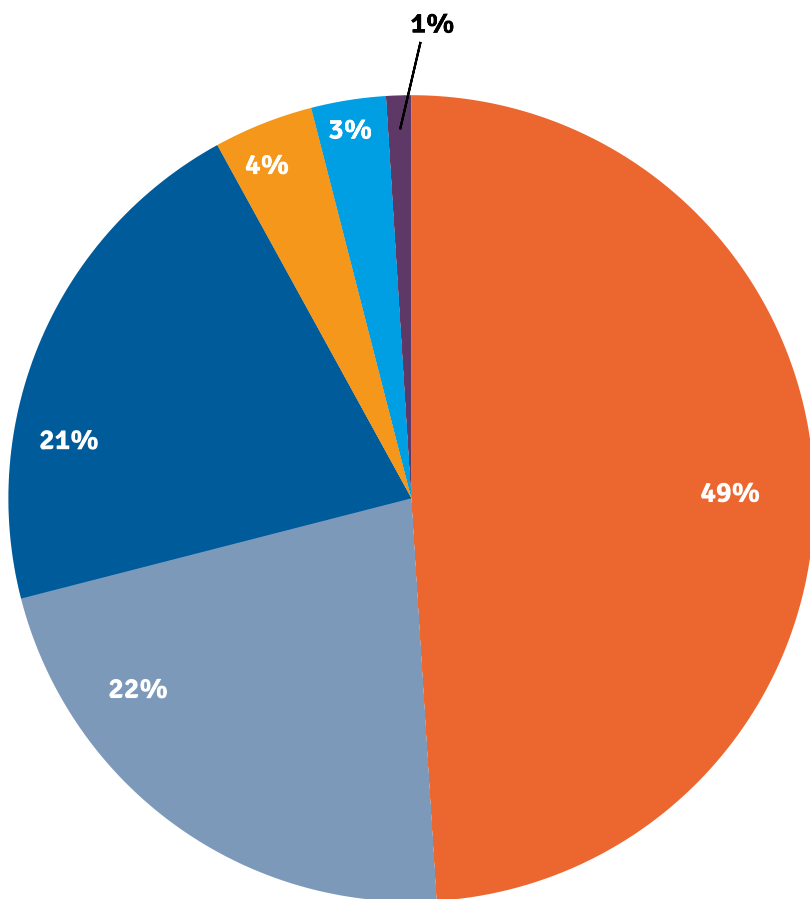

Figure 12: The percentage of residents with 1 known long term condition, by major ethnic group

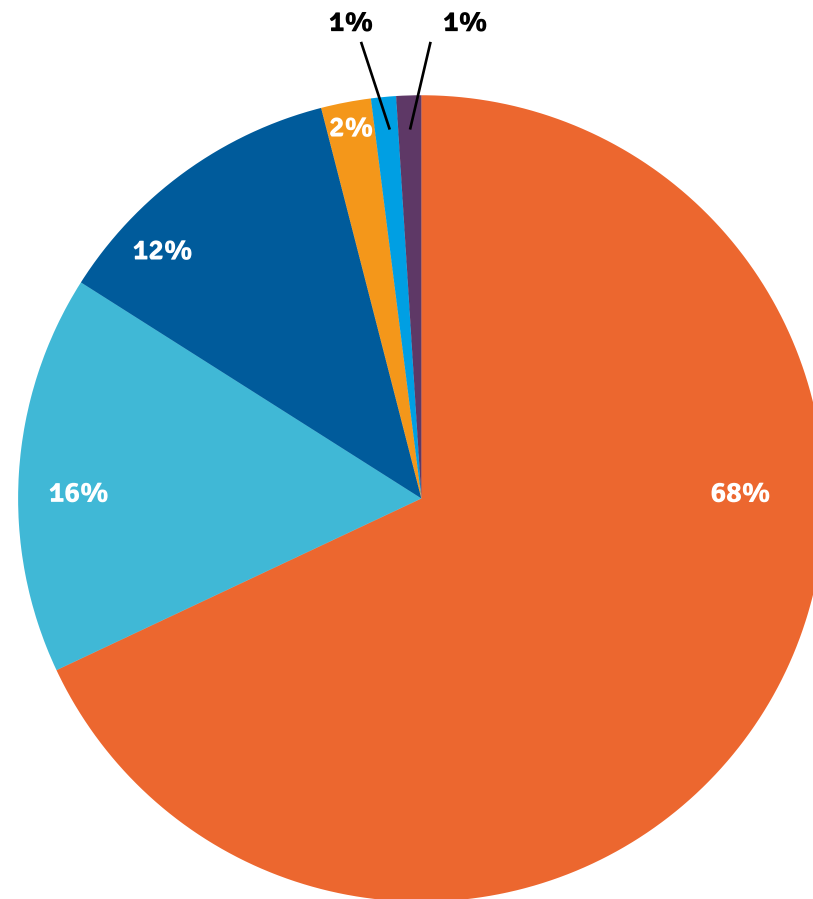

Figure 13: The percentage of residents with 4 known long term conditions, by major ethnic group

White
Asian or Asian British
Black or Black British
Other Ethnic Group
Mixed
Not Known

These inequalities are made worse by the cost-of-living crisis, reflecting the importance of addressing wider determinants of health alongside health behaviour and access to health services.

The key health risks associated with this are:

- Estimates suggest that some 10% of excess winter deaths are directly attributable to fuel poverty and 21.5% of excess winter deaths are attributable to the coldest 25% of homes.[47] Of note in 2021 15.3% of the population were in fuel poverty, worse than the London and England averages of 11.9% and 13.1% respectively. The number of deaths in the winter period was 78.9% higher when compared to non-winter period in 2020-2021; the third highest in the country.
- An increase of 1% in the percentage of households living in relative poverty is associated with a 6-month decrease in male healthy life expectancy[48].
- National analysis indicates prevalence of moderate to severe depressive symptoms was higher among adults who were economically inactive because of long-term sickness (59%), unpaid carers for 35 or more hours a week (37%), disabled adults (35%), adults in the most deprived areas of England (25%), young adults aged 16 to 29 years (28%) and women (19%).[49]
- Rates of mental health problems increased nationally during the pandemic and have still not recovered to pre-pandemic rates[50]. Estimated local prevalence of mental health problems in those age 16+ prior to the pandemic 2017 was 22.4%, higher than the England average (16.9%) and this is likely to have been exacerbated by recent events.
- Rates of economic inactivity and unemployment from 2021/22 in Barking and Dagenham were higher than London and England average locally, with 67.6% in employment compared to 75.2% and 75.4% respectively.[51] As a report from ONS[52] identified; the number of people economically inactive because of long term sickness has risen to over 2.5 million people, an increase of over 400,000 since the start of COVID-19. And for those economically inactive because of long term sickness, nearly two-fifths (38%) reported having five or more health conditions (up from 34% in 2019), suggesting that many have interlinked and complex health issues.

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Last year's report also referred to the risk to health and health inequalities of the 'Cost of Living Crisis', with our residents who are amongst the most vulnerable due to underlying issues (e.g., food insecurity, fuel poverty, child poverty, economic inactivity, etc.). As stated, it takes time for impacts to be seen in outcomes and data, but we can see the impact through increasing need for services.

All services and support provided by the council, NHS and community report increasing need and demand for services. For example, data from Citizens Advice highlight issues for residents include:

- **High energy costs** – By end March 2023, energy debt was the most common type of debt that the local Citizens Advice helped residents with, whereas it used to be rent or council tax arrears.
- **Need for crisis support** – Residents requiring crisis support (e.g. food banks) doubled in Q4 2022/23 compared to the previous year (13.54 people per 10,000 compared to 6.17 in Q4 of 2021/22)
- **Disproportionate impact on vulnerable people** – More than 60% of the people Citizens Advice have helped with crisis support nationally have been disabled or had a long term health condition.

Our Resident's Survey has also recorded the lived experience of residents suffering, e.g. the July-August 2023 Survey highlighted:

- **Inability to cope** – Almost 1 in 3 (31.2%) of residents reported that their living costs had increased and they were no longer able to cope; twice the proportion of the previous year's Survey.
- **Debt** –Just under 2 in 3 residents (59%) had to borrow from families and friends to pay bills, whilst many residents have also had to borrow from legal and illegal money lenders.
- **Inability to live healthily** – Over 1 in 2 residents (52%; versus 15.6% nationally) have smaller or skip meals due to cost and over 1 in 5 (21%; versus 10.9%) have been hungry but not eaten as could not afford or access food.

Public Health Advice

To increase the number of years residents spend in good health, we should focus our collective resources into:

- Enhancing our early diagnosis programmes, that target key cohorts of residents, supported by assessable and culturally appropriate chronic disease management programmes.
- Reducing the high levels of smoking and obesity.
- Reducing mortality rates associated with cardiovascular disease and cancer.
- Addressing the variation in health and social care outcomes experienced within and between our communities in each of these areas.

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Chapter 4: Action To Increase Healthy Life Expectancy and Address Health Inequalities

To improve healthy life expectancy, we need to create foundations for self-reported good health and tackle the more direct causes of mortality; with a focus on the local challenges.

This chapter sets how and what we need to do to address the key contributing factors to healthy life expectancy, identified in chapter 3:

- Long term conditions
- Key behavioural risk factors
- Wider determinants of health – developing the building block for good health

How to Address the Problem of Long-Term Conditions

The figures on long term conditions in the previous chapter are worrying and show England & Wales have amongst the worst population health in Europe, particularly so in Barking and Dagenham. However, we can do something about it.

The Government has published the case for change and strategic framework for the National Major Condition Strategy. It focuses on prevention, earlier diagnoses and treatment for six groups of major health conditions responsible for 60% of death and illness in England: cancers; cardiovascular disease, musculoskeletal disorders, mental ill health, dementia and chronic respiratory disease. It also identifies five areas for action to have the greatest impact over the next five years (Figure 14), which need to shape our Place based Partnership response.

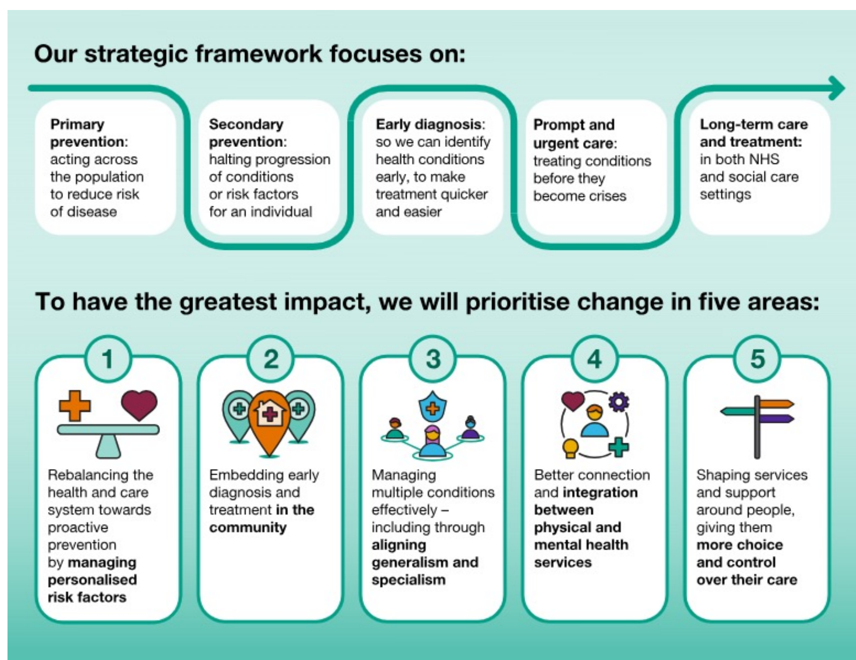


Figure 14: National Major Conditions Strategy strategic framework

The National Institute for Health and Care Research has also published an evidence review on multi-morbidity which found:

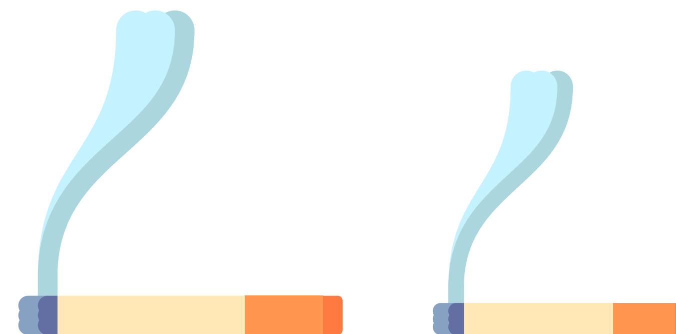
- Complexity and difficulty in accessing and navigating services, with a strong desire for greater service integration and coordination.
- Tendency for services to focus on symptoms and conditions and fail to see the things that matter to people. There is a need for more person-centred, holistic care.
- People felt that their mental health needs and emotional wellbeing were frequently ignored, which often resulted in a worsening of symptoms. Mental health services should be offered at the outset.

Addressing Long Term Conditions in Barking and Dagenham

The key contributor to our poor female and male healthy life expectancy is the prevalence of long-term conditions within our borough. This is recognised and prioritised by the Barking and Dagenham Local Joint Health and Wellbeing Strategy 2023-28.

At north east London level, addressing long term conditions (LTCs) is central to NHS North East London's (NHS NELs) Health and Care Partnership approach. LTCs are one of the four priorities in NHS NELs interim Integrated Care Strategy, which also includes Tackling health inequalities, Prevention, Personalised Care and Co-production with local people as cross-cutting themes. NHS NELs Joint Forward Plan places LTCs as a strategic priority and calls for greater focus on prevention and addressing unmet need (specifically on child obesity, mental health, tobacco and premature cardiovascular disease deaths).

To address the early identification of risk factors and early diagnosis of cardiovascular related conditions is the NHS Health Check. Our offer of an NHS Health Check is provided through General Practice and engagement activities at borough events. A nine-month pilot for the eligible 30–39-year-olds was carried out in 2022/23 by Together First, with positive health outcomes. Plans to reinstate the programme in our community pharmacies is currently in place, as a pilot.



However more needs to be done to find many more residents who we estimate are likely to have one or more long term condition but have not yet been diagnosed (see our analysis in the ‘Inequalities in Long Term Conditions’ section). We need to agree a single, multi-agency active case finding plan to identify these residents and enhance our efforts and programmes for LTC early diagnosis, by:

- Continuing to work with primary care to support our general practices to improve early diagnosis of key LTCs.
- Agreeing prioritisation of long-term conditions where data and evidence increase scale and pace of action to deliver the greatest health benefits (e.g. hypertension).
- Encouraging our general practices to identify patients aged 14 and over with learning disabilities, to maintain a learning disabilities ‘health check’ register and offer them an annual health check, (as recommended by NICE, 2016).
- Delivering Phase 2 pilot of 30–39-Year-Old targeted NHS Health Check service, offering more opportunities on reducing differences between people and communities from different backgrounds.
- Continuing to provide health checks through engagement activities at borough events and outreach.

Case Study: Targeted Case Finding by Together First

Taking the Public Health team’s estimate of the number of residents in the borough with undiagnosed long-term conditions as a starting point, the GP Federation Together First CIC set up a case finding project to find and treat residents across five disease areas. General Practice went through Clinical Effectiveness Group searches to identify patients who were not on disease registers but appeared to have symptoms of one or more of the following conditions: coronary heart disease, chronic kidney disease, hypertension, chronic obstructive pulmonary disease and asthma.

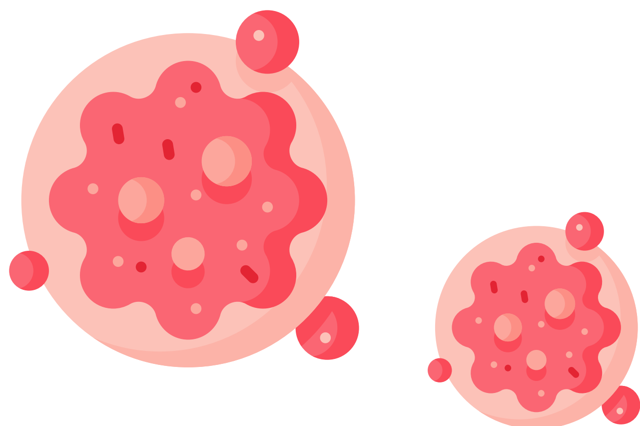
Patients were then invited in for a check-up and tests undertaken to confirm diagnosis. The pilot of this case finding work over spring 2023 uncovered 718 diagnoses of hypertension and 215 new cases of chronic kidney disease. Evaluation was undertaken by Together First and recommends exploring a mobile unit and having blood pressure monitoring in community venues, along with working with partners to identify other approaches to attract residents for checks.

Identifying Cancer Early

Cancer although not classified as a long-term condition does have significant impact on mortality rates in Barking and Dagenham, and therefore identifying cancer early to improve treatment outcomes is important.

The North East London Cancer Alliance works to improve and transform cancer patient pathways from prevention through to treatment and survival. The ambitions of the NHS Long Term Plan are to diagnose 75% of cancers at stage 1 or 2 and increase the number of people surviving cancer for more than a year by 55,000 by 2028.

Cancer Screening is the process of identifying healthy people who may have an increased chance of a disease or condition, to reduce associated problems or complications (UK National Screening Committee, 2023). Improving uptake is a regional priority for NHS England - London.



Cancer Screening Programmes performance in Barking and Dagenham:

Our bowel cervical and breast cancer, screening uptake rates are all significantly worse than England averages.[53]

Bowel cancer screening: the current uptake in Barking and Dagenham is lower than the expected uptake in London of >60%.

Breast cancer screening: The uptake in the outer north east London boroughs increased significantly from 48.5% in Q1 22/23 to 68.5% in Q2 22/23 (highest in London), because the service started sending second timed appointments for all women that did not attend their appointment.

Cervical cancer screening: There has been no increase in coverage.

We are working with NHS North East London to improve the uptake of screening and improvement in coverage across the borough, aligned to public information so our residents know what they can do to reduce the risk of developing cancer.

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We need to do the following to improve uptake:

1. Cervical Screening

- Work with general practices to support and promote the universal MSM human papillomavirus (HPV) vaccination programme for eligible adolescents and gay, bisexual, and other men who have sex with men (GBMSM) aged under 25 years.
- Support Vaccination UK to deliver the HPV vaccines to Year 8 students in January 2024 in all schools in the borough.
- Work with comms/engagement channels to support and promote the HPV vaccination programme.
- Support practices to promote the HPV screening tests in areas with low uptake.

2. Breast Screening

- Support NHS InHealth and partners to promote the mobile Breast Screening Units every 3 years in Barking and Dagenham.
- Support NHS InHealth's ongoing engagement activities and promotional work at borough events/outreaches and strengthen Breast Cancer Nurse Specialist's links in with Primary Care Networks.
- Build a strong partnership between public health, general practices and community organisations to raise awareness of breast screening.
- Support the current project to improve uptake for women with severe mental illness funded by NEL Cancer Network.
- Help practices promote breast screening at the InHealth Group fixed clinic for residents in areas with low uptake.

3. Bowel screening

- Have health promotional materials and information available in languages most suitable for the borough.
- Work with the Bowel Cancer Borough Lead, to continue to investigate barriers faced by men that prevent them from participating in screening and use this information to develop solutions.
- Support the annual NHS Bowel Cancer Screening Campaign in London in delivering the community outreach, to increase awareness of the home testing kit and increase uptake across ethnic minority groups.
- Support practices to increase uptake across all ages and target key areas of low uptake.

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How To Address the Behavioural Risk Factors of Low Healthy Life Expectancy

As I have regularly highlighted, a long-term system wide place-based approach is required to achieve population level health outcomes. Action is required across three types of interventions (i.e. the Population Intervention Triangle): Civic-level interventions (e.g. licensing, economic development); Community-based interventions (e.g. using and building assets within communities); and Services-based interventions (e.g. quality and scale, reducing variation).

Service based interventions to support the reduction of weight, smoking cessation and to promote physical activity have the potential to generate population-level change but this is often not achieved for several reasons, mostly:

- Differences in service quality and delivery (effectiveness; efficiency and accessibility).
- Variability in the way the population uses those services (based on knowledge, skills and health-seeking behaviours and resources) - and therefore variable needs for support to use those services appropriately.

Therefore, high-quality services can reduce unwarranted variation in outcomes, but they will not reduce inequalities at a population level unless they also identify and (with partners) give **graduated and targeted support to the populations in greatest need**, who are not using those services to best effect. The level of health inequalities experienced in Barking and Dagenham means that alongside providing high quality services, direct action is needed to address the needs of underserved populations.

We recently reviewed our weight management, smoking cessation and exercise on referral services against these principles and the main findings were:

- The need to develop strong place-based leadership.
- A need for a system wide approach to the issue, for example tackling smoking cannot ignore the legislative requirements of enforcement and addressing obesity must tackle the obesogenic environment we live in.
- More robust outcome commissioning and contract monitoring.
- Better targeted services to meet underserved populations and
- A stronger focus on delivering evidence-based practice.

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The review also looked at **social prescribing** as a key part of Universal Personalised Care through which local agencies can refer people to a link worker for holistic support to address their health and wellbeing needs. Our findings identified that we need to take a more strategic look at how the service could play an important part in promoting healthy behaviours and providing support to personalisation and anticipatory care in social care, to help manage demands. An internal council review of evidence-based opportunities to improve anticipatory care suggested a range of actions across the themes of maximising resourcing and efficacy; and realising a focus on social care within Place and integrated care.

As muscular skeletal conditions are one of our key causes to loss of years due to disability, we need to consider the anticipatory care offer to reduce frailty, falls and loss of independence to manage demand on our services.

What is anticipatory care and personalisation aiming to achieve?

Anticipatory Care aims for patients who are at high risk of unwarranted health outcomes to live well and independently for longer, through structured proactive care.

Personalisation aims for every person who receives support, whether provided by statutory services or funded by themselves, will have choice and control over the shape of that support in all care settings.

Since the review on our services, we have received the following direction on smoking cessation.

Stopping the start: a new plan to create a smokefree generation

In October 2023, the Government set out a new ambition to create a smokefree generation in the ‘command’ paper, to raise the age of access to tobacco one year every year, to prevent smoking before it starts.

The command paper sets out policy proposals for additional funding: to local Specialist Smoking Services to support smokers to quit, for awareness raising campaigns, for a national Swap to Vapes Scheme to stop smoking, and financial incentives for pregnant smokers to quit. Enforcement: there will be additional funding proposed for Trading Standards, Border Force, HMRC; on spot fines to be introduced and online age verification.

This will provide an additional 58k ring-fenced funding for Stop Smoking Services (28% increase) from 2024/25 to 2018-29 and an opportunity to participate in a ‘Swap to Stop’ pilot (which we have submitted an expression of interest for).

How To Create Building Blocks to Improve Healthy Life Expectancy

Creating Healthy Places

For us to be healthy, the building blocks of good health need to be in place in our communities – things like decent homes, good school and sound business practices. When these building blocks of health are weak or missing, our health can suffer: for example, when businesses promote unhealthy products like alcohol and junk food.

We need to balance our supporting to individuals to change their behaviour with creating healthy places for everyone[54]

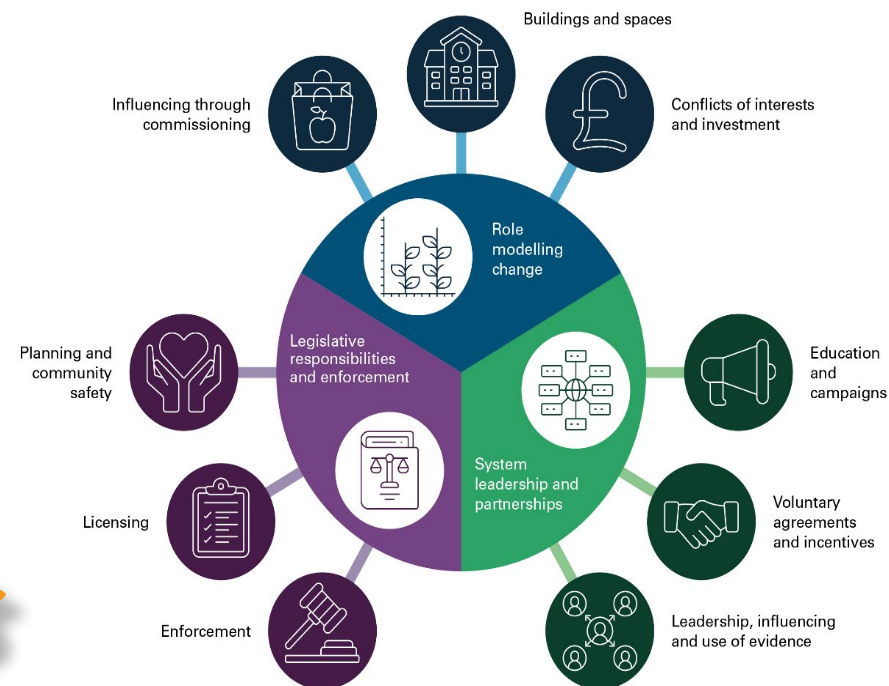


Figure 15: Tackling tobacco, alcohol and unhealthy food: A framework for local authorities[55]

The council is in a unique position to create healthy places, using opportunities combining statutory responsibilities, broad priorities, and local relationships – including with communities, businesses and with our place-based partnership. Due to the complexity of public health challenges, there is also a need for involvement and collaboration between council directorates and teams by taking a health in all polices approach. This means embedding a health lens across council services and decision making.

In London, 68% of residents live in areas (measured at levels called lower super output areas which translate to approximately 1000-3000 residents) which are in the worst performing 20% of environments in the region for access to health promoting and health demoting factors[56];

including: access to retail services (fast food outlets, gambling outlets, pubs/bars/nightclubs, off licences, tobacconists), access to health services (GP surgeries, Emergency Department hospitals, pharmacies, dentists and leisure centres), the physical environment (access to green spaces, and three air pollutants: nitrogen dioxide (NO_2) , airborne particulate matter (PM_{10}), sulphur dioxide (SO_2) levels). This means that people's homes are clustered in the unhealthiest environments. We plan to map this in the 2024 JSNA.

There are clear opportunities to use development and council management to create healthier environments. For some determinants there are clear links to improvements in healthy life expectancy that may be achieved in the next 5 years; and opportunities to build on existing strengths.

Example: Housing and Health

A recent study identified that challenging housing circumstances negatively affect health through faster biological ageing. However, biological ageing is reversible, highlighting the significant potential for housing policy changes to improve health[57]. We have also highlighted the links between fuel poverty and healthy life expectancy.[58] More immediate effects can be seen through damp and mould worsening respiratory disease[59] and overcrowding enabling easier spread of infectious disease.

Local authorities have levers through planning, licensing and enforcement to regulate housing quality and there are emerging areas where we can focus and develop work to mitigate against the health risks associated with poor housing:

- Work is currently underway to ensure damp and mould issues are resolved quickly and to support education for landlords alongside enforcement in the housing sector.
- The Healthy New Towns principles have been embedded into Barking Riverside regeneration plans.
- A homelessness Health Needs Assessment is underway to understand how best to support this vulnerable population in partnership with health pop up clinics with our NHS partners.

Other key opportunities include:

- Targeted work to help residents with long term conditions and disabilities gain and stay in employment, building on our existing local pilots.
- Work to support residents most vulnerable to the cost-of-living crisis.
- Using our connections with communities to establish connection, trust and belonging; aligned with the work of the BD Collective. For example, we are currently funding a health and faith initiative, co-producing health promotion projects with faith communities.
- Creating healthy streets that encourage walking and cycling, and safe streets around school zones.
- Reducing and mitigating the impacts of air pollution through a combination approach of transport, planning, industrial and behavioural interventions.[60]
- Supporting local health partners to develop as anchor institutions.[61]

Mental Health and Wellbeing

Good mental health is a key prerequisite across all factors impacting on healthy life expectancy, as well as people who have poor mental health are more likely to have higher health risk behaviour and suffer a long term condition, often due to the same pathways that influence both[62]

Our mental health incorporates mental illness, psychological distress and mental wellbeing (the positive aspects of mental health).

There are considerable inequalities in life expectancy for those with serious mental illness. Barking and Dagenham residents with severe mental illness are over three times as likely to die prematurely than those without.

However, the burden of psychological distress and common mental disorders (anxiety and depression) will cause a greater impact on healthy life expectancy overall. Additionally, as recognised by the Major Conditions strategy, mental and physical illness are inextricably interlinked[63]: Residents with physical health problems, especially long-term conditions, are at increased risk of poor mental health, particularly depression and anxiety. Around 30% of residents with any long-term physical health condition also have a mental health problem. Poor mental health, in turn, exacerbates some long-term conditions, such as chronic pain, as well as being linked to unhealthy behaviours such as disordered eating, alcohol consumption and smoking.

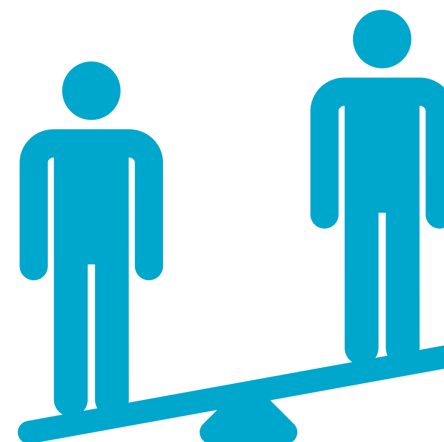
The determinants of mental health are in many ways the same as for physical health, but a greater importance is placed on the relationships around us in families and communities; our position in society and exposure to stressors such as abuse, discrimination, or financial hardship: many of our residents will be vulnerable to these stressors.

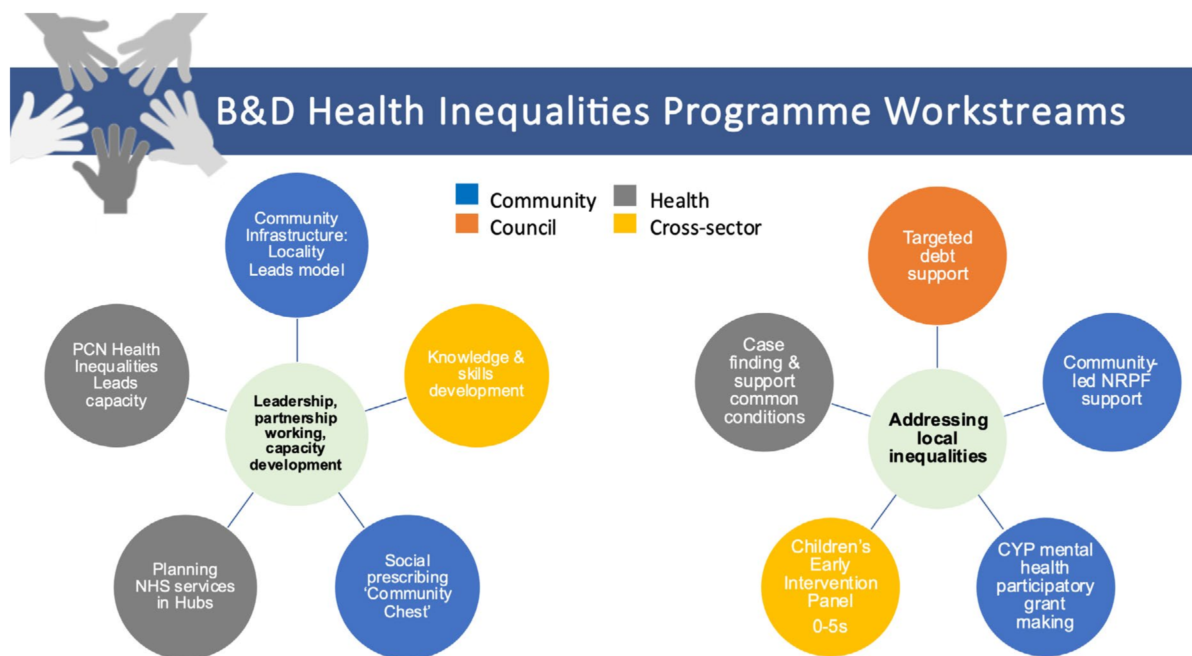
Prevention needs to start young: Half of all mental health problems have been established by the age of 14, rising to 75% by age 24.[64]

Addressing mental health therefore, needs to feature across work on long term conditions, inequalities and the best start in life, as well as building healthy places.

Addressing Health inequalities

The flipside of great need is the exciting potential to make improvements, and our health inequalities programme is making steps to develop an evidence-based 'whole place' approach. Yet there are few 'quick fixes' in health inequalities, so there is the need to coproduce, identify and invest in 'what works' to make tangible improvements in the medium and long terms. But targeting our action to address inequalities in cardiovascular disease, respiratory disease and diabetes, smoking and obesity will provide short term gains.





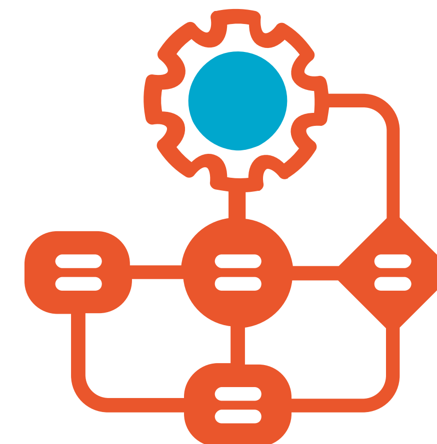


Figure 16: Summary of the Health Inequalities Programme 2022-23

The programme is in its first year of delivery several agreed milestones have been achieved:

Improved place working & action on health inequalities:

- Establishment of Community Locality Leads and Primary Care Network Health Inequalities Leads providing strategic and practical leadership for and between community and primary care sectors.
- 80% of professionals involved in the Place-based Children's Early Intervention Panel reported good, very good or excellent shared understanding of workforce behaviours across the partnership that lead to positive outcomes.
- 95% of Adult Social Care staff who attended Trauma Informed Practice training and completed the post course evaluation felt confident or very confident to apply the practice.
- 97% of frontline workers in statutory and voluntary sector working with residents with No Recourse to Public Funds (NRPF) said the local NRPF guidance significantly enhanced their awareness of local services and 96% agreed it significantly improved understanding of the needs of residents with NRPF.

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Services-led health improvement & inequalities reduction:

- 933 residents have been identified and assessed for undiagnosed / unmanaged health conditions.
- 213 residents with unidentified low level mental health issues were proactively contacted and a total of 80 holistic support interventions were delivered.
- All professionals who presented a family of concern to the Children Young People Early Intervention Panel for 0-5s said it left them more confident in the next steps with a family and many said they got families on their caseload access to appropriate services in a time effective way.

Community-led health improvement & reduction:

- Community mental health interventions by local community groups achieved improvements of their mental wellbeing (a one-point increase in their score on the Short Warwick-Edinburgh Mental Wellbeing Scale).
- 15 community organisations received funding through the Community Chest for Social Prescribing, 10 of which were global majority led and nine of which had never received external funding before.

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Case Study: Understanding the Needs of Residents with Special Educational Needs and Disabilities

One approach to addressing inequalities across a population is to focus on those with the worst outcomes, not just to act equitably but by improving support for the most underserved you can improve access to support for all.

For example, people with learning disabilities die 22-26 years younger than the general population, with 49% of deaths rated as 'avoidable' (over twice the 22% in the general population)[65]. Significant inequalities can also be seen within the population of people with learning disabilities, with an average of death of 34 years for people with learning disabilities of non-White ethnicities compared to 62 for their White counterparts[66].

Consequently, the Barking and Dagenham Public Health Team recently led a cross-sector educational and health needs assessment for residents with Special Educational Needs and Disabilities (SEND), which will include those with learning disabilities.

Currently, proportions of pupils in Barking and Dagenham accessing SEND support (12%) are like London but lower than England averages; but proportions of pupils with Education Health and Care (EHC) Plans are lower than London averages. Over the past 5 years (2018-2023) proportions of pupils with SEND support or EHC Plans have been increasing locally, regionally and nationally.

Assuming trends to date are maintained; the following projections can be made:

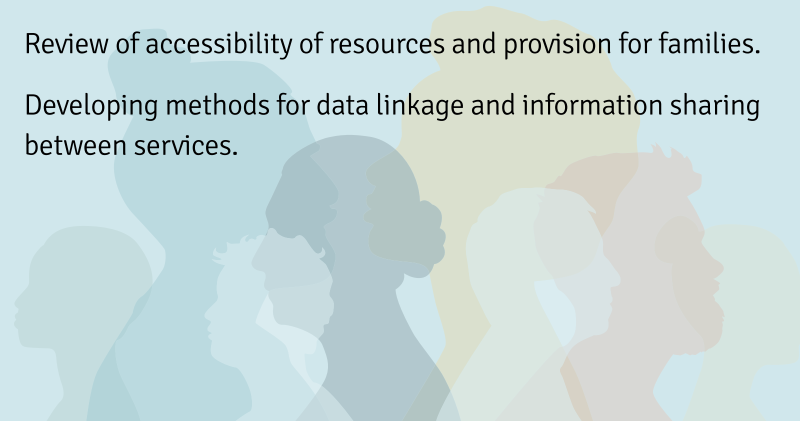
- The total number of pupils in primary, secondary and special schools combined on an EHC Plan is projected to rise threefold between 2018 and 2035 – this is faster than the rate of increase in the school population based on GLA projections.
- The total number of pupils on Special Education Need support is predicted to rise by 27% between 2018 and 2035, which is more aligned with increases in school population sizes.

There are several risk factors in the borough that could drive increases in SEND needs, including increasing ethnic variation and deprivation.

The existing challenges to delivering support that families need: shortages linked with difficult recruitment and retention of specialist staff; delays in obtaining EHC Plans and in effective multidisciplinary communication; and lack of clarity on the local offer.

The current and new challenges will require both additional provision and new ways of working to address this, including:

- Improving the accessibility of the local offer for families.
- Improving EHC Plan processes.
- Development of integrated care pathways.
- Early intervention to prevent escalation of problems; in particular for Speech, Language and Communication needs.
- Work to enhance recruitment and retention of specialist staff; and upskill wider health and education staff to support families.
- Review of accessibility of resources and provision for families.
- Developing methods for data linkage and information sharing between services.



Public Health Advice

To improve healthy life expectancy the evidence suggests the following action:

- Take a place-based approach to address early identification and early treatment for people with long term conditions:
    - to ensure all residents with a health condition are identified and are supported to manage their condition.
    - that addresses social, economic, and physical environment that causes our residents to make decisions that damage their health and lead to long term conditions, such as those driving obesity through unhealthy diets and lack of physical activity.
- Provide a targeted support programme to residents to address obesity and smoking.
- Address wider determinants of health for example to insulate and remove damp and mould in homes; support people with long term conditions or disabilities, including young people with special educational needs and disabilities to gain and stay in employment, and mitigate the health harms of the cost of living crisis.
- Improve mental health and wellbeing as an underpinning factor.

To address underpinning health inequalities, we need to:

- Develop a shared understanding of health inequalities, its drivers and local priorities (including across our population groups and geographic areas) to direct decision making and action.
- To align the NHS's mandated duty to address health inequalities with the overall place-based programme.
- Work with NHS North East London on their Healthy Equity Academy and their evolving Health Equity Fellowship (including extending beyond the NHS to create analogous community sector fellowships).
- Continue and expand cross-sector action on the ongoing health legacy of COVID-19 and impacts of the cost of living crisis that are increasing health inequalities for residents.
- Ensure a 'health in all policies approach' in which all systems partners are engaged to understand and address the role of health inequalities in driving community priorities (e.g., employment).

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Chapter 5:
Best Start in Life - The Building Blocks for a Healthy Life

KEY FACTS

Approximately 57,150 children are under 16 in the borough (the highest proportion in England and Wales) and we have the highest proportion of children aged 0-5 in the UK (8.8%).

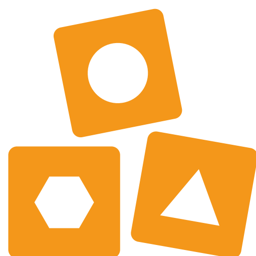
In 2021/22, only 6 in every 10 of Barking and Dagenham's children achieved a Good Level of Development (GLD) by the end of Reception year (for those children on free school meals, it was only 5 in 10).

Children who score badly on school readiness at the age of 5 are far less likely to succeed in secondary school – and far more likely to experience poor health and low pay as adults (Save the Children, 2018).

In 2022/23 just under half of our Year 6 children were overweight or obese (the 3rd highest rate in England and the highest in London).

Individuals who have adverse childhood experiences (ACEs) during childhood or adolescence tend to have more physical and mental health problems as adults and more likely to have an earlier death (Hughes et al., 2017).

The National Child Mortality Database (NCMD) recently reported the death rate in England for white infants has stayed steady at about three per 1,000 live births since 2020, but for Black and Black British babies it has risen from just under six to almost nine per 1,000. Death rates also doubled in more deprived areas compared to non-deprived, and the mortality for Asian and Asian British babies rose by.



A large part of this report has been focusing on actions which relate to adults and actions that can affect short term change, but action across the life course is important - today's children will be tomorrow's adults, and the things that happen to them in childhood can shape the trajectory of their health across childhood, into adulthood and throughout adulthood into older age. We need to maintain a focus for children to improve the health outcomes for our general population across the life course. It is significant to note that the JSNA, 2022 shows Barking and Dagenham has a very young population which has increased significantly over the past decade (17.7% total population increase since 2011 census – second highest increase in London).

> "Building an effective framework to prevent ill-health in childhood will secure the future wellbeing of an entire generation of adults able to enjoy healthy, productive, and long lives"
>
> (The Academy of Medical Royal Colleges, 2023)

The council's Corporate Plan, Joint Local Health and Wellbeing Strategy and Best Chance Strategy (for babies, children and young people) all have the best start in life as a key priority, alongside reducing inequalities and giving our children and young people opportunities to achieve.

Risk Factors for Ill Health

In 2022/23 around 45 in 100 year 6 children were overweight or obese (45.4%) – this was the 3rd highest rate in England and just under a quarter of our Year R children were overweight or obese (24.0%). Both are the highest in London. The evidence suggests that children who are overweight or obese are likely to stay obese into adulthood and to develop long term conditions like diabetes and cardiovascular diseases musculoskeletal disorders, especially osteoarthritis; and certain types of cancer (endometrial, breast and colon) (World Health Organisation, 2020).

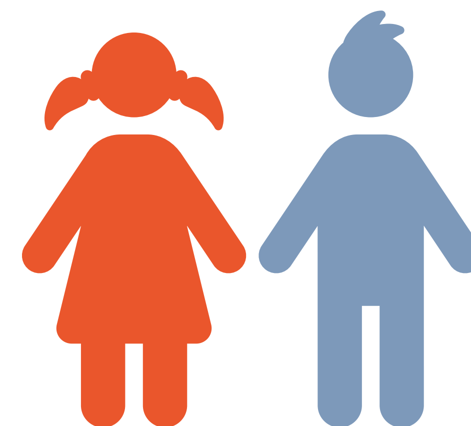
Investing in Early Years

But how we treat young children also shapes their lives. If we get the early years right, we pave the way for a lifetime of achievement. The first 1001 days from conception to age 2 is widely recognised as a key period in the life course of a developing child, providing a unique opportunity for professional involvement because it is the time when parents are often the most receptive to behaviour change interventions and where the evidence suggests it is most effective.

Every **£1** invested in quality early care and education **saves** taxpayers up to **£13** in future costs

Figure 17: An example of the return on investment in school readiness[67]

"The highest rate of return in early childhood development comes from investing as early as possible, from birth through age five, in disadvantaged families. Starting at age three or four is too little too late, as it fails to recognize that skills beget skills in a complementary and dynamic way. Efforts should focus on the first years for the greatest efficiency and effectiveness. The best investment is in quality early childhood development from birth to five for disadvantaged children and their families."— James J. Heckman, 2012



Preparing Children for School

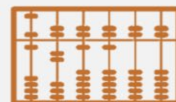
Ensuring children can get the best from education is vital; too many of our children are not starting school with the range of skills they need to succeed. Educational attainment is one of the main markers for wellbeing through the life course and so it is important that no child is left behind at the beginning of their school life. School readiness is a strong indicator of how prepared a child is to succeed in school cognitively, socially and emotionally, and it links to educational attainment, which impacts on life chances – having been shown to impact on health, future earnings, involvement in crime, and even death (Public Health England, 2015).

Children who score badly on school readiness at the age of 5 are far less likely to succeed in secondary school – and far more likely to experience poor health and low pay as adults (Save the Children, 2018).

School readiness is a key area for inequality – with more children from deprived backgrounds not being school ready, and a lack of school readiness contributing to further inequalities across the life course. There is a pronounced social gradient in early language development, with more young children from disadvantaged backgrounds having poor language skills (Public Health England, 2015). Nationally, children from the poorest homes are a year behind in their language and literacy skills by the age of 5 (Save the Children, 2018). In 2021/22, only 62.5% of our children achieved a good level of development (GLD) by the end of Reception year.

For children eligible for free school meals, only 51.8% had reached their key development milestones by this time[69]. Children who have a special educational need or disability (SEND) are also less likely to achieve a GLD by the end of reception year (The British Association for Early Childhood Education, 2022). The gap in language and communication among children in reception classes continue and widen throughout the school years. Over half of the inequality in learning outcomes at age 11 can be traced back to the pre-school years.

Children who don't achieve a good level of development aged 5 years struggle with:



which impacts on outcomes in childhood and later life:

Figure 18: A summary of the importance of school readiness[68]

Adverse Childhood Experiences

The experiences we have early in our lives, particularly in our early childhoods, have a huge impact on how we grow and develop, our physical and mental health, and our thoughts, feelings and behaviours.

Barking and Dagenham have some of the highest rates of child poverty in London, high levels of domestic abuse, high demand for social care, and high rates of homelessness amongst families with children – so the exposure of our children to potential adverse childhood experiences (ACEs) is significant. The cost of living crisis in the UK is worsening physical and mental health outcomes for children and young people and worsening health inequalities (Academy of Medical Royal Colleges, 2023).

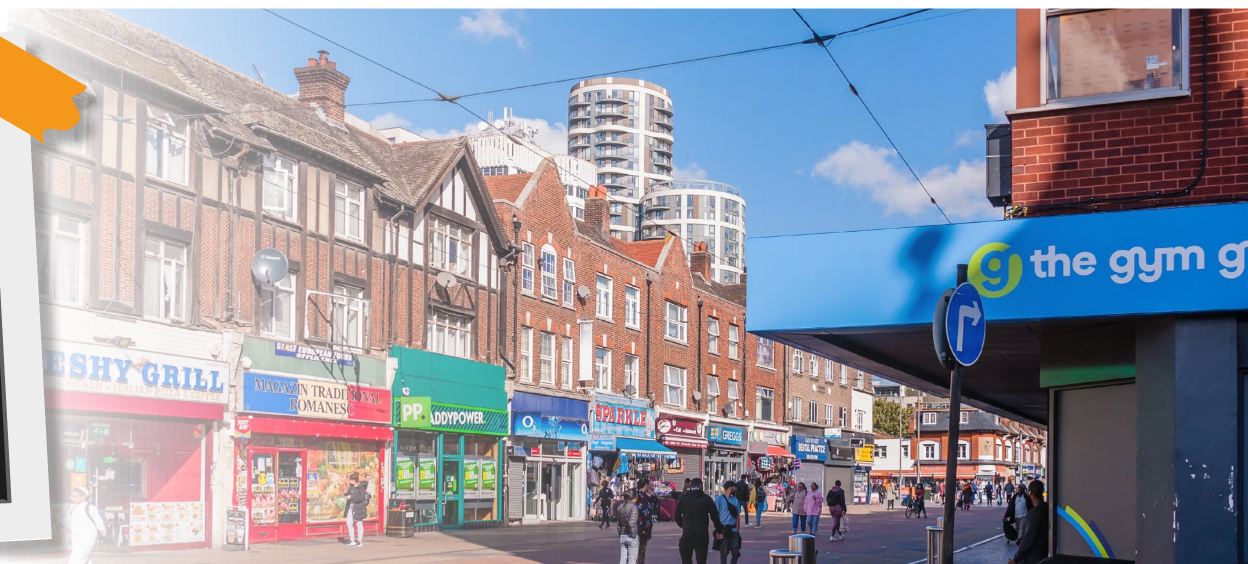
Individuals who have ACEs during childhood or adolescence tend to have more physical and mental health problems as adults and more likely to have an earlier death (Hughes et al., 2017).

One study suggested that 12% of binge drinking, 14% of poor diet, 23% of smoking, 52% of violence perpetration, 59% of heroin and crack cocaine use and 38% of unintended teenage pregnancy prevalence nationally could be attributed to ACE experience below the age of 18 (The Institute of Health Equity, 2015).

Domestic Abuse

There is increased potential for domestic abuse to escalate or start within a relationship during pregnancy. Early identification and intervention can reduce escalation and impacts on the parent-child relationship. A recent service impact review of the Barking and Dagenham Domestic Abuse service offer highlighted the wide range of services that are available to support people (mainly women) who are victims of domestic abuse, and the recent Commission commended the council on the leadership and wide-ranging support that is offered. However, there needs to be a greater focus on prevention and system wide approach through the new Place-based Partnership. There also needs to be clarity about what the overall outcome and impact measures are, to monitor progress of the work.

> "In short, failure to ensure that children are ready to learn not only robs them of their potential and squanders a vital national asset: it also reinforces inequality and obstructs social mobility".
> Save the Children, 2018



Mental Health

Poor parental mental health can have a large impact on the parent-child relationship and child development. Start for Life is currently funding a perinatal mental health support service for parents with low-moderate mental health distress, delivered by our partner MIND. This service is very popular, and outcomes are looking promising. We suggest that it would be sensible to consider the continuation of this service beyond the Start for Life grant period.

Opportunities to Address Issues Through the 0-19 Healthy Child Programme

Although not providing immediate impact, an area of focus to ensure our children and young people are healthy, is the 0-19 Healthy Child Programme.

What is the 0-19 Healthy Child Programme?

The 0-19 Healthy Child Programme (HCP) service is a statutory service funded under the council's Public Health Grant, providing public health input for every child in the borough in the form of the Health Visiting (0-5 years), which includes the 5 mandated health assessment visits and School Nursing services and includes the mandated National Child Measurement Programme (NCMP) (5-19 years)[70]. The current provider of the integrated 0-19 Healthy Child Programme service is North East London Foundation Trust (NELFT).

The Department for Health released the latest 0-19 Healthy Child Programme Guidance in June 2023, updating the evidence base and aligning outcomes with the new Family Hubs programme. Barking and Dagenham made a successful bid for Start for Life and Family Hubs funding and has prioritised Family Hubs as the delivery model to achieve many of the outcomes in the Best Chance Strategy.

Key Opportunities

The evidence is clear, that a focus on key 'high impact areas' for 0-5 and 5-19 will maximise the outcomes achieved by this service. They are central to both delivery models, contributing to achievement of the Early Years aims (focusing on preconceptual care and continuity of care, reducing vulnerability and inequalities, improving resilience and promoting health literacy, and ensuring children are ready to learn at 2 and ready for school at 5) and the aims for school aged children and young people (reduce inequalities and risk, ensure readiness for school at 5 and for life from 11 to 24, support autonomy and independence, increase life chances and opportunity).

> The Healthy Child Programme is the heart of public health services for children and families. It brings together the evidence on delivering good health, wellbeing and resilience for every child.'
> (ADPH, 2019)

The 6 early years (0-5 years) high impact areas:

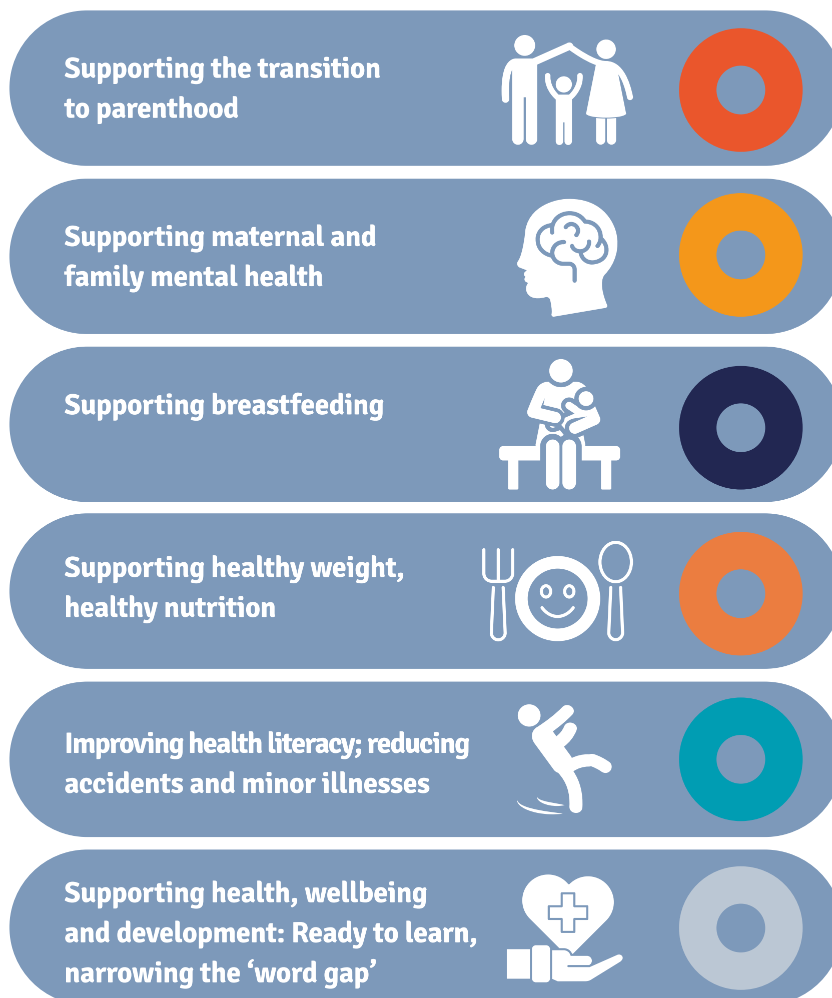


Figure 19: The high impact areas for early years

The 6 school age years (5-19) high impact areas:

Figure 20: The high impact areas for school age years

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The 0-5 HCP Service provides a series of mandated visits to all children under 5 in the borough (see Figure 21) and is in a strong position to identify families who may need additional support, and either provide this themselves or connect them with services to prevent ACEs escalating and impacting on that child. They also provide an opportunity to identify signs of neglect and offer the support required.

Our data indicates a need for a stronger **universal offer** to support parents for the first 1001 days to ensure that more of our children are 'school ready' by the time they start school. Redesigning our current service will allow for us to align provision to needs and use the most up to date evidence and recommendations to improve our outcomes.

The 5-19 HCP service can work with the rest of the system, providing public health leadership, to help with prevention, earlier identification, and addressing of ACES, therefore reducing risk and impact of ACES, improving health and saving money. It can also support building resilience, raising awareness of behaviour norms and environments which contribute to ACEs, and developing trauma informed practice within communities and settings.

These **universal reviews** (in Figures 21 and 22) provide opportunity to support personalised or tailored interventions in response to individual or family need, using health visitors' and school nurses' specialist public health skills and clinical judgement to work with the child and family or young person to determine and address needs. They also work collaboratively with partners to deliver evidence-based interventions, protect children and keep them safe (PHE, 2021).

Figure 21: Universal health and wellbeing reviews and suggested contacts as part of overall support 0 to 5 years

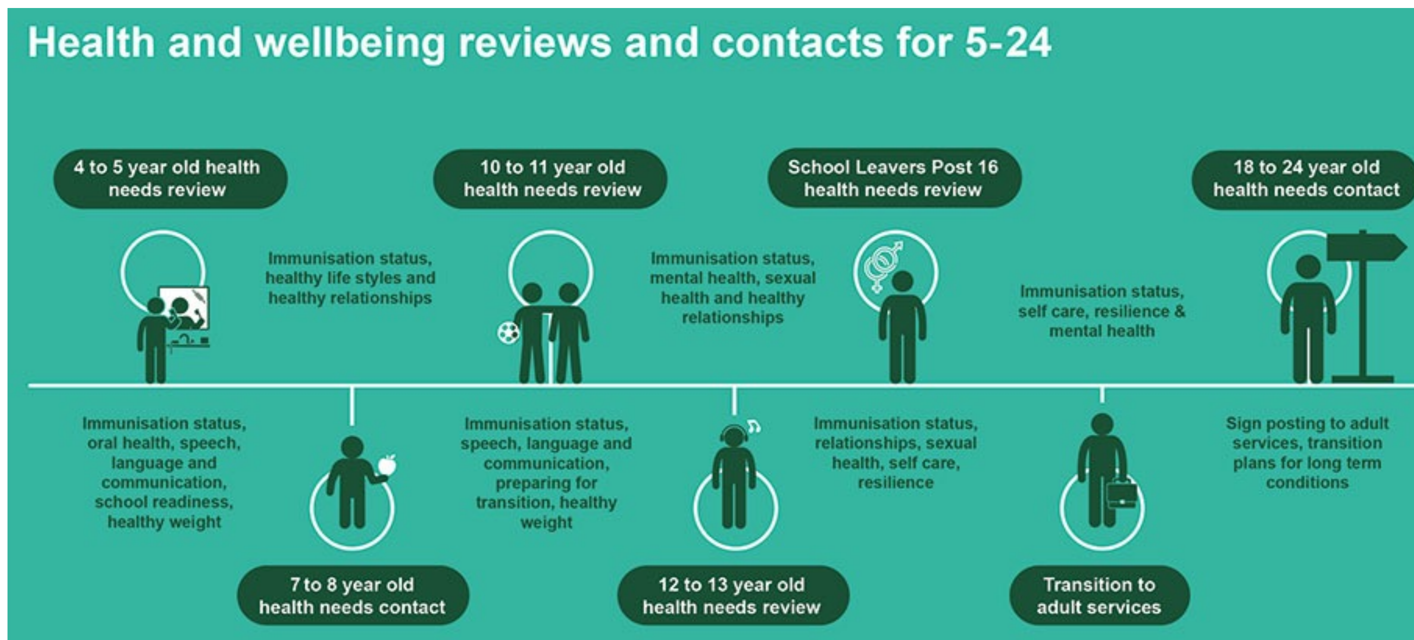

Figure 22: Universal health and wellbeing reviews and contacts as part of overall support 5 to 19, or 24

Prevention of ACEs

A redesigned 0-19 Healthy Child Programme would contribute to the following evidence-based approaches for preventing ACEs:

- Ensuring a strong start for children and paving the way for them to reach their full potential.
- Teaching skills to help parents and youth handle stress, manage emotions, and tackle everyday challenges.
- Connecting youth to caring adults and activities.
- Intervening to lessen immediate and long-term harms (Centres for Disease Control and Prevention, 2019).

Mental Well Being of Children and Young People

There remains significant need in the borough (and nationally) around mental wellbeing for children and young people. There is a clear role for School Nurses, as public health leaders, to advise schools and work with the wider system to support maximising the mental wellbeing of our children and young people. We suggest that the system needs to have increased focus on providing a better offer for those with social, emotional, and mental health needs, including timely access to CAMHS.

Our plans for the 0-19 Healthy Child Programme Service

Our 0-19 service is currently under review as it faces significant pressures of demand and the contract coming to an end provides a great opportunity to review the service, our needs and priorities, the evidence-base, the guidance, and the opportunities for change.

The following key challenges are impacting on our 0-19 HCP provision and will need considering in devising the new service contract:

- Increased population and **increased numbers of children under 19**.
- **Increased complexity of need** - including increase in special educational needs and disability (SEND), high domestic abuse, increases in safeguarding input required.
- **Lack of universal support for parents** - Children's Centres previously had a role in providing universal support but these are no longer funded across the borough, leaving a gap in this provision which is needed by many of our families.
- **Short term funding packages ending** - The Start for Life and Family Hubs programme (including the Early Help consortia) is currently providing universal support within the borough in parenting, infant feeding, perinatal mental health, 'home start', and home learning environment but this ends March 2025.
- **Workforce challenges** – national shortages and competition for staff with inner north east London boroughs makes recruitment challenging – a well skill-mixed 0-19 workforce would reduce these challenges by using staff to their maximum potential.
- **A siloed system** – There is a lot of silo working between services and families are struggling with 'falling through the cracks'. The family hubs programme is an opportunity for integrated working across the system to ensure that families find 'no wrong door' and only tell their story once to get the outcomes that they need. There is a clear opportunity for better links between the maternity system and the Health Visiting service.
- **High child poverty** (46% of households) Families who were already deprived are facing more challenges with life post-COVID and the cost of living crisis.
- **Poor school readiness and attainment** – COVID-19 has disrupted development for our youngest children: personal, social, and emotional development delayed in 44% of pupils nationally in 2022 - disadvantaged children and those with SEND are worst affected.
- **COVID-19:** Children born during the pandemic missed out on these crucial face to face contacts. Especially those due the 2-2.5yr review – delays were not picked up. No visits to spot early signs of risk or neglect. Increase in children not meeting a good level of development at 2-year checks;
- **Increase in cost of delivery** – meaning the current contract is underfunded even before considering the population increases;
- **Provider market** - Lack of alternative provider in the market and value on contract not attractive to other providers;
- Lack of funding for **specialist school nursing for Additional Resourced Provision** (ARPs) settings (which isn't funded by the NHS North East London) which is putting a strain on the school nursing service – the new service will have additional clarity on responsibilities and work is needed at a system level to ensure there is provision for ARPs;
- **High and increasing Obesity rates.**
- **Poor oral health** – there is a lack of oral health promotion provision in the borough, poor diets, and nationally there is insufficient NHS dentists to meet demand.

Public Health Advice

We need to strengthen our approach to giving children the best start in life, via universal support/prevention activities, early identification of emerging issues, and provision of timely help to support families. This can be achieved by maximising the opportunities of the 0-19 programme so it better links to the needs of the children and young people and the drivers of demands in Health and Social Care.

Therefore, the 0-19 programme needs to focus on the high impact areas of the Healthy Child Programme, to support our vulnerable children to thrive in their home and school environment.

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Chapter 6:
Keeping our Residents Safe from Infectious Disease

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Protecting residents from communicable diseases remains one of my core statutory responsibilities, with the public health system working together to manage and prevent serious notifiable diseases and outbreaks. The most important function is the containment of notifiable infectious diseases.

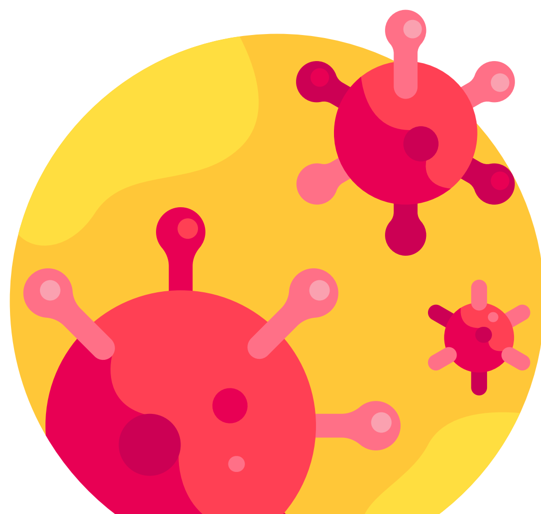
COVID-19 has changed the way we work on health protection issues today–for example we recognise the importance of all communities having access to vaccinations and we now seek to understand and address why people are hesitant to take up opportunities to protect their health. Furthermore, as was identified in the Public Health England report[71], people who have poorer health e.g. living with one or more long term condition, had less resilience and were more likely to become seriously unwell compared to others.

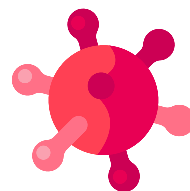
The latest analysis of national surveillance data on antibiotic resistant infection reported by UK Health Security Agency (UKSHA) at its recent conference also identified the stark inequalities in antibiotic resistance, with people in the lowest socio-economic group more likely to have a resistant infection compared to the highest group. UKSHA have also found that people from Asian or Asian British communities are unequally impacted by antibiotic resistance.

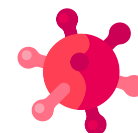
Vaccination & Immunisation

After clean water, vaccination is the most effective public health intervention in the world for saving lives and promoting good health, (UKHSA, 2014). The World Health Organisation (2023) states that vaccines reduce risks of getting a disease by working with your body's natural defences to build protection. This means that many hospitalisations and deaths could be prevented by immunisation in the short term. Immunisation doesn't just protect the individual, it also helps to protect families and the community, especially those who cannot be immunised for medical reasons. It is important to have high coverage rates in Barking and Dagenham to maintain herd immunity, which means a large part of the population of an area is immune to a specific disease.

Work in the borough continues to improve the immunisation uptake rates especially for those eligible, and from the vulnerable and underserved communities.







The following vaccines are offered in Barking and Dagenham and childhood immunisations are generally delivered in GP practices/ health centres, while Vaccination UK delivers the school-age immunisations in schools:

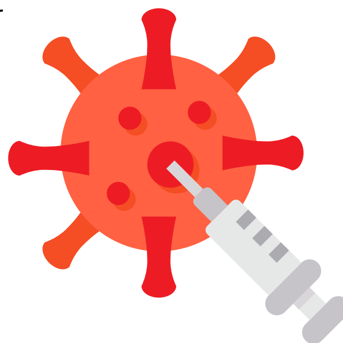
1. COVID-19 and Flu Vaccinations

These are offered to residents that are eligible at different seasons of the year. The offer is made via GP, community clinics, walk-in clinics, and community events. The seasonal booster uptake (2022/23) for older people was 65%, and frontline social care worker was 18%. Efforts to improve overall uptake are being made making more sites accessible, engagement activities, targeted messaging and communications, and a vaccination incentive programme within the care sector workforce.

2. School Aged Immunisations

School Age Immunisation Services providers are commissioned by NHS England - London (NHSE) to deliver the school-based immunisation programmes. Home schooled children and children not in mainstream schools for other reasons are also included. Vaccination UK are leading this programme and offering the following vaccinations in 2023/24: MMR, flu, HPV, two boosters to year 9s (DTP- Tetanus, diphtheria and polio, and Meningitis ACWY).

The public health team is supporting Vaccination UK and ensuring joint working and efforts with the schools, tailored communications, offering community clinics to also cater for homeschooling children, targeted clinics in areas with low vaccination uptake, and using the community organisations as levers to promote the programme.



3. Shingles Vaccination

Despite the seriousness of Shingles infection and the effectiveness of the vaccination to significantly reduce the chance of developing shingles, uptake rates of the vaccine are falling in London and across England. All eligible patients are offered the shingles vaccination by their GP as the practices are working to improve uptake all year-round following changes to the programme, from September 2023.

4. Polio

Following detections of polio virus in sewage samples in London in 2022, children aged 1-9 in London were offered an additional booster (or catch-up if not up to date) of the polio vaccine to ensure they were fully protected.

5. Measles Mumps and Rubella (MMR)

Measles is one of the world's most contagious diseases, spread by close or direct contact with an infected person via coughing or sneezing. One person infected by measles can infect nine out of 10 of their unvaccinated close contacts. Measles cases have been rising in London. There is no cure and vaccination is the only protection against becoming seriously unwell. Measles is one of the statutory notifiable infectious diseases.

The polio vaccination is offered in the MMR catch up programme and in April 2023, there were around 9,500 children aged 4-11 missing MMR or Polio in Barking and Dagenham. This equates to approximately, as reported by Together First: MMR Dose1 - 79%, and MMR Dose 2 - 67%. The World Health Organisation (WHO) recommends that an immunisation rate of 95% or more provides "herd immunity.

Vaccination UK started to deliver MMR catch-up campaign Phase 2 in August 2023 to the 4–11-year-old population, to ensure children are up to date with their childhood vaccinations, especially polio and MMR.

6. Chickenpox

The Joint Committee on Vaccination and Immunisation (JCVI) recommended in November 2023 that a universal varicella (chickenpox) vaccination programme should be introduced as part of the routine childhood schedule[72]. This should be a 2-dose programme offering vaccination at 12 and 18 months of age using the combined MMRV (measles, mumps, rubella and varicella) vaccine. It also recommended a catch-up programme should also be initiated following implementation of a programme to prevent a gap in immunity.

Why are Measles Vaccinations a Current Priority?

Background

Measles cases are rising in England this year. There were 128 cases between 1st January – 30th June 2023, of which the majority were in London, this is not expected to be higher. The vaccination rate is lower than the 95% target set by the WHO in areas of London, including Barking and Dagenham, in which 54% of 1–11-year-olds have received the full MMR vaccination dose as of September 2023[73].

Current Uptake of MMR in Barking and Dagenham

In 2021-22, only 67.8% of 5-year-old children in Barking and Dagenham had received 2 doses of the MMR vaccination. Of the 149 Local Authorities that submitted child vaccination data to NHS Digital that year, 143 had a higher second dose vaccination rate than Barking and Dagenham.

Analysis of our data shows a severe decline of our children receiving a first dose of the MMR vaccine at age 24 months, between 2013-14 and 2021-22, from 88.1% to 75.5%. This decline has occurred more rapidly in the borough than in London or England over the same period, highlighting the need for additional resource where available.

The decline in the first dose vaccination rate of children aged 5 years old has also declined between 2013-14 to 2021-22. However, the largest decline is seen in the percentage of 5-year-old children who have received a second dose of the MMR vaccine by the same age.

Inequalities in Uptake

NICE (2022) identifies the following population groups that are known to have low vaccine uptake or be at risk of low uptake:

- Some minority ethnic family backgrounds
- Gypsy, Roma and Traveller communities
- People with physical or learning disabilities
- Some religious communities (e.g., Orthodox Jewish)
- New migrants and asylum seekers
- Looked-after children and young people
- Children of young or lone parents
- Children from large families
- People who live in an area of high deprivation
- Babies or children who are hospitalised or have a chronic illness, and their siblings
- People not registered with a GP
- People from non-English-speaking families
- People who are homeless*

Many of these demographical characteristics can be seen within our population, so improving uptake needs more tailored approaches.

There are also several specific issues relating to our residents that we also need to consider:

- The transient population who moves around frequently and register at multiple practices without notification.
- Low vaccine acceptance in certain ethnic minorities.
- Despite being invited for vaccinations multiple times, parents/carers are still not bringing their child(ren) in to get vaccinated.
- Different immunisation schedule for Eastern Europeans clashes with the UK immunisation programme.
- Language barriers.
- Fear of link of MMR to autism causing the vaccine hesitancy.
- Cultural differences (due to diverse make-up of our population).

The following analysis provides some indication of this:

Deprivation

Primary Care Networks (PCN) in areas with higher levels of deprivation have lower rates of unvaccinated children than the areas with low levels of deprivation. There are also large variations in levels of vaccination uptake by GP Practice, even within the same PCN.

The most recent data received from Together First in August 2023 from our General Practices showed:

Ethnicity

When grouped into the 5 major ethnic groups, shows there are significant differences across ethnic lines in the proportion of children who have received a full MMR dose (when looking at all children aged 1-11) see Figure 23.

Children whose ethnicity is listed as Other (i.e. ethnicity not disclosed) had the highest proportion yet to complete the full MMR vaccination course.

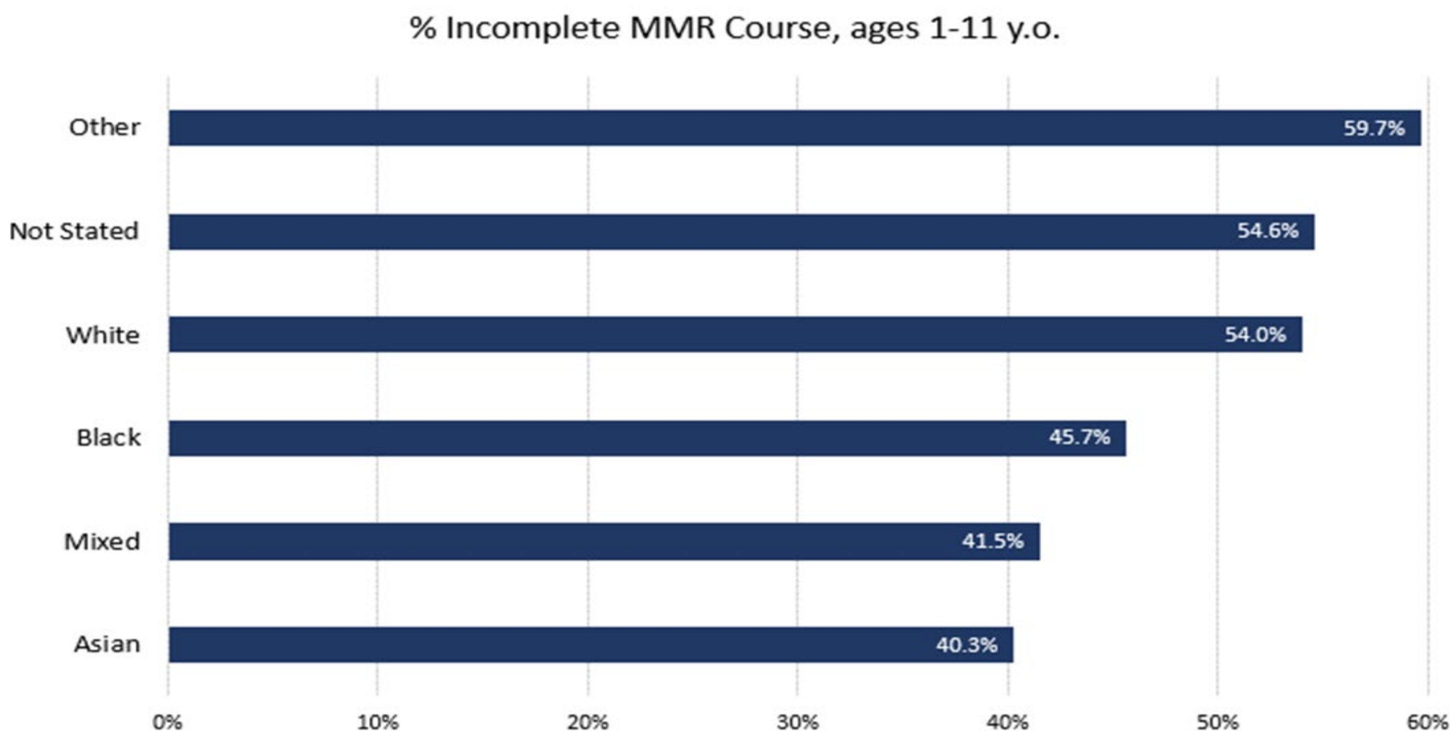


Figure 23: Percentage of 1-11 year olds that haven't had a full MMR dose, by major ethnic group

When excluding the group that we do not have ethnicity information for (the Not Stated group), the next highest group is the White ethnic group, with 54.0% of White children aged 1-11 having not received a full MMR vaccination course.

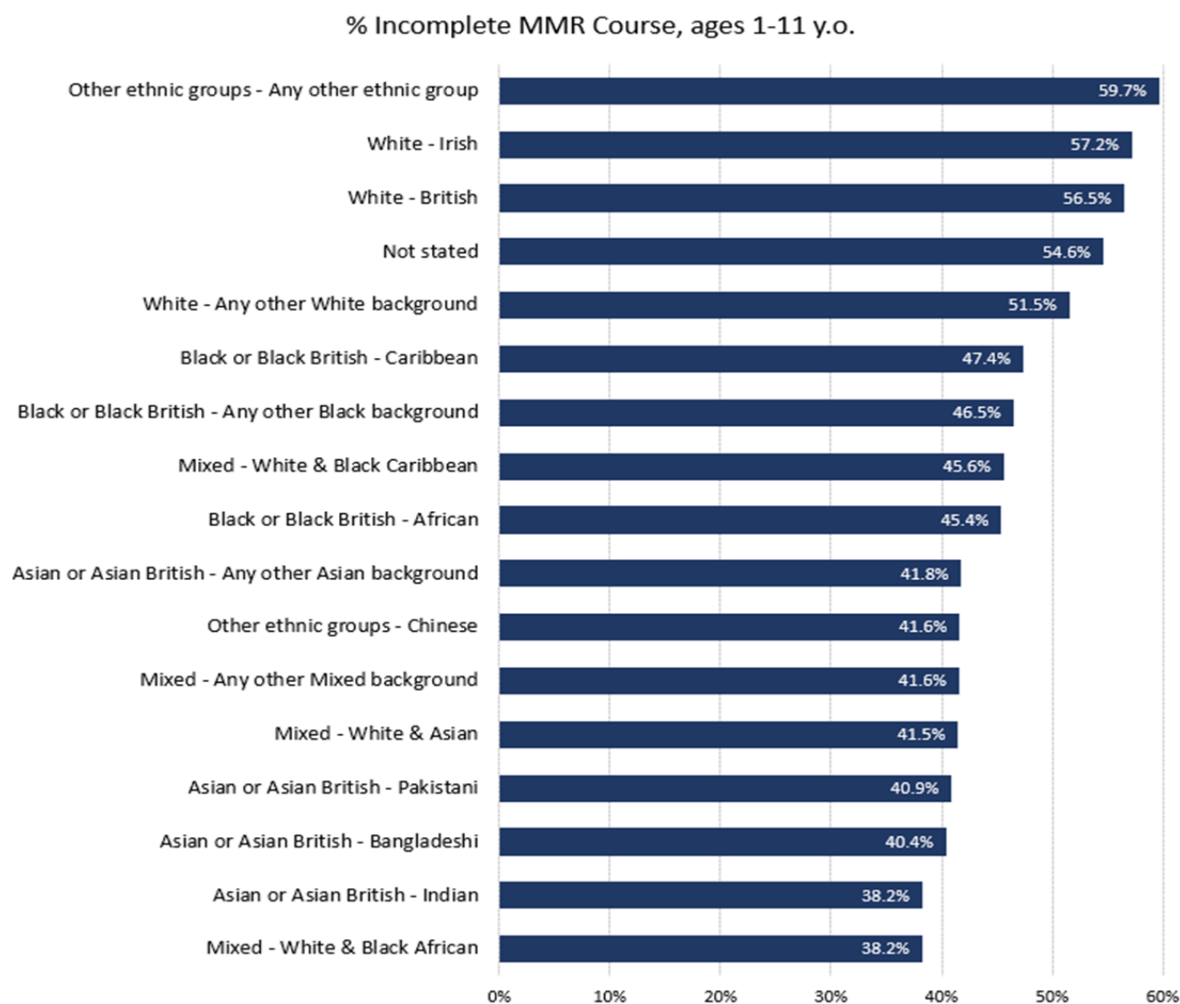


Figure 24: Percentage of 1- 11 year olds that haven't had a full dose of MMR, by specific ethnic group

This is reinforced in Figure 24 which shows that, after excluding the Not Stated group, 3 of the 4 ethnic subgroups with the highest proportion of incomplete full MMR courses were White. Those being the White – Irish (57.2%), White British (56.5%) and White – Any other background (51.5%) subgroups. Three of the next four highest groups are the 3 groups that combine to form the Black ethnic group: the Black or Black British – Caribbean (47.4%), the Black or Black British – Any other Black background (46.5%) and the Black or Black British – African (45.5%) subgroups. The gap between the highest and lowest groups in the borough is also quite high, at 21.5%, which is the difference between the Other ethnic group and the Mixed – White and Black African group.

There are also differences in incomplete vaccinations within ethnic groups at different ages. In particular, the 7 and 8-year-old age groups appear to be much less likely to have received a full course of vaccination than younger children of the same ethnicity in the White, Black, Asian and Not Stated groups as shown in Figure 25 below.

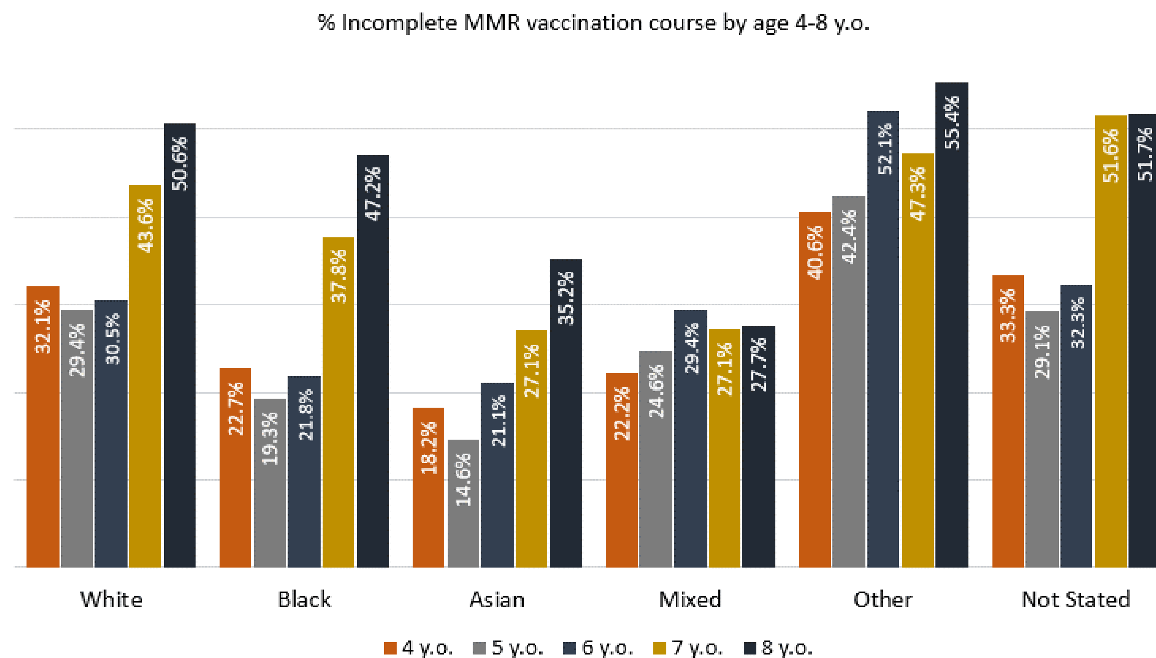


Figure 25: Percentage of 4–8-year-olds that haven't had a full dose of MMR, by major ethnic group

Action to Improve MMR Uptake in the Borough

Our plans are led through a partnership between the NHS, the council, and Vaccination UK, and have adopted the following UKHSA Risk Assessment recommendations[74] within our plans:

1. Assess population susceptibility to measles in all birth cohorts.
2. Improve MMR coverage to achieve 95% with 2 doses by time children are 5 years.
3. Urgent need for catch-up action for:
    - Children under-5 nationally
    - Children, teenagers and young people in London

Our plans also recognise the barriers identified by The Royal Society of Public Health[75] as accessibility and convenience of vaccination services and factors include timing of appointment and availability of appointments.

Plans are underpinned by Public Health England and NHS England (2020)[76] which recommended six areas of focus proven to optimise uptake of immunisations:

1. Strong leadership

2. Proactive promotion

3. Maintain accurate information

4. Effective call/recall

5. Maximise access and continuity

6. Trained and knowledgeable workforce

There were also lessons learnt from the COVID vaccine (NHSE, 2023):

- Lack of trust in government institution.
- Lack of trust in information.
- Belief that cost outweighs benefits, i.e., needing to inconvenience oneself. e.g., taking time off work to recover from the vaccine and its side-effects can lead to a reluctance to uptake.

And the following are recommended to overcome some of these challenges:

- Text messaging (information made available in relevant languages and proactively working to improve trust and relationships with patients).
- Community engagement.

The **MMR Action Group** commenced in August 2023 to improve vaccination MMR coverage with a target of 90%.

The following actions are taking place, adopted from NICE guidance, for areas with low vaccine uptake:

- Consider introducing targeted interventions to overcome identified local barriers and address identified inequalities in vaccine uptake between different population groups.
- Involve people in the local community when identifying barriers.
- Tailor service opening hours and locations for vaccinations to meet local needs.
- Provide a range of accessible options for booking appointments, consider using sites outside healthcare settings such as community and family hubs, or faith centres.
- The use of targeted messaging and community engagement. This will help to proactively improve trust and relationships with patients.

Examples of Specific Action

Together First has:

- Conducted Practice meetings with 27 out of 33 GP practices to better understand poor uptake and provide extra support where needed to help increase uptake rates.
- Set up a dedicated inbound booking line for parents/carers of registered patients and this has been extended to include outbound calls.
- Agreed with PCN East One about running a pilot to offer a ‘full delivery’ service option, where the team provide call handlers with a targeted list of parents/carers to contact and book in for MMR immunisations into the Enhanced clinics offered at the weekends to help working parents/carers.

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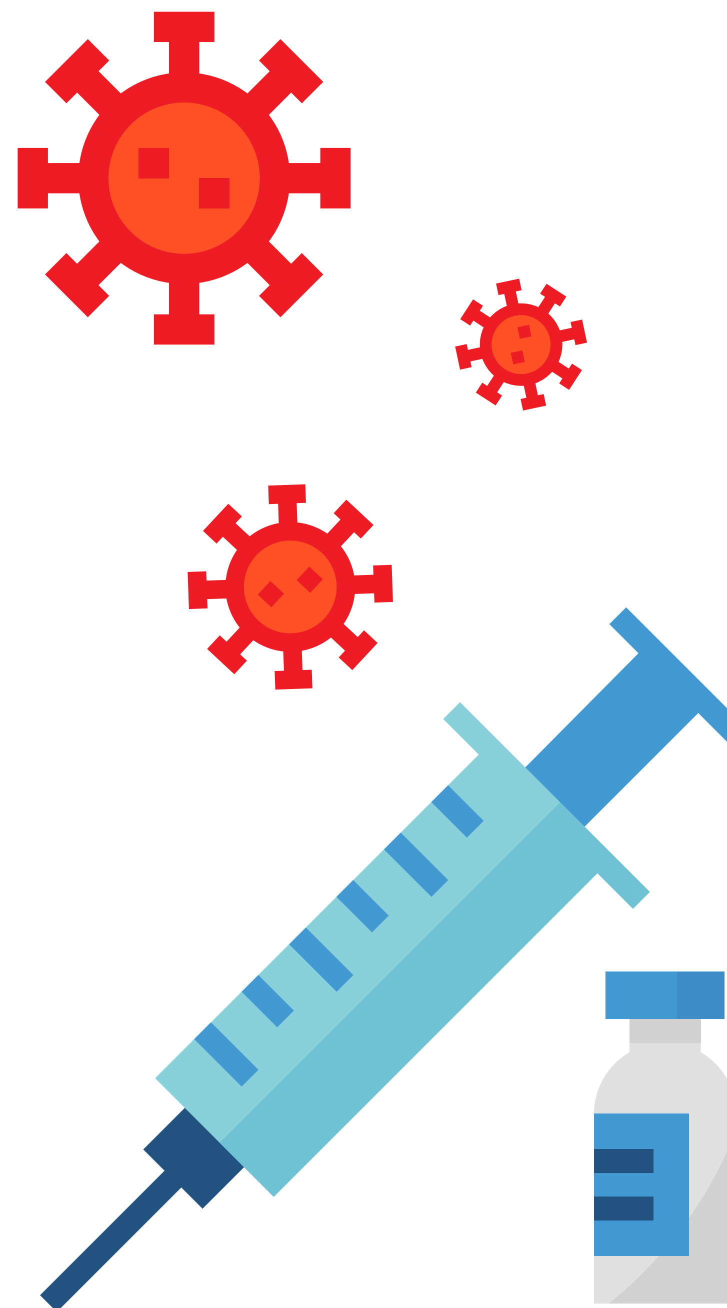
Vaccination UK has delivered community clinics across all areas - 50 clinics being held in August 2023, mostly in libraries. Outreach clinics are also in the community hubs are being planned along with increasing extended hours at the GP practices.

Taking all this into consideration, a programme of action has been developed across Barking and Dagenham place partners to address the above lessons/challenges, with eight targeted workstreams:

1. **Phase 2 MMR Campaign led by Vaccination UK:** (catch-up school programme for over 5-year-olds) focuses on under-vaccinated children who are least protected and at the highest risk of becoming seriously unwell with polio as well as other preventable disease such as measles. Vaccinations will be given at the selected schools with the highest numbers of unvaccinated children. All primary schools will be supporting in facilitating a school-centric awareness programme for these children and helping to raise awareness of the importance of routine childhood vaccinations. Three levels of approach: 1) Schools: targeting the top 20 schools in the area that have the most children without MMR 2) GPs: targeting the top 20 GP's that have the most children short of MMR/polio scheduled Immunisation. 3) Community clinics to catch up during school breaks or after school sessions.

2. **Family and community hubs:** outreach work (including pop up clinics) at our family and community hubs to address vaccination hesitancy, promote benefits and to administer MMR vaccinations. Joint working with Vaccination UK in the delivery of community pop-up clinics in the wards that have the lowest vaccination rates.

3. **Targeted communications and messaging:** an integrated campaign using a two-pronged approach of targeted and broad-brush borough awareness raising activity to encourage vaccine uptake in the lead up and at the start of the new school year.



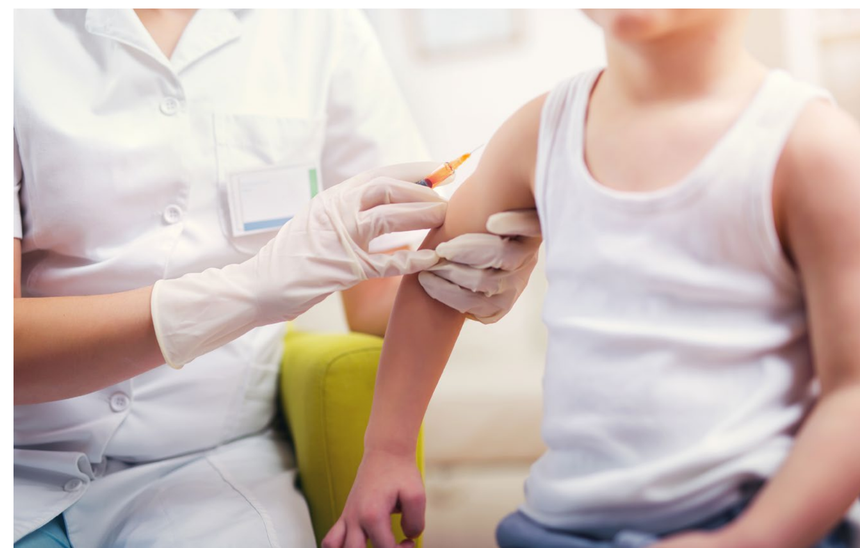
4. **Early years:** establish how to triangulate health visiting, GPs, and early years providers to improve take up, supported by GP Fed with additional enhanced clinics, for 0–5-year-olds. Training professionals and staff working in services in contact with families and young children, to ensure they have conversations to address vaccine hesitancy and to signpost families to the community clinics. These staff have a trusted relationship with the families, and this would encourage them to make every contact count.

5. **Engagement work with Eastern European communities:** (through our voluntary, community and faith partners) to provide additional support to practices and extra time for families who are vaccine hesitant to discuss their concerns with a health professional, through an interpreter where needed. An Eastern European organisation will work with public health for six months with the proposed activities for the MMR awareness outreach: venue/org mapping and ongoing engagement; leafleting; Barking food bank drop-ins; digital engagement; content resharing; online live events with a medical professional.

6. **Engagement work with faith groups:** links have been made with Black and African organisations/churches to engage with their community and address vaccine hesitancy. These will be levers and channels to promote the communications messaging and promote community clinics in the borough.

7. **Outreach work with refugee and asylum seekers:** dedicated health and wellbeing events for residents from migrant communities, delivered by local and community-based providers who specialise in providing holistic support for asylum seekers, refugees, and immigrants. Public health will promote MMR in the four hostels in the borough and include this cohort in the community pop-up events.

8. **Co-production:** partnership working with all key stakeholders, health, council and voluntary sector in the design and development of the plans. Effective data sharing arrangements with health and Vaccination UK, to ensure the effective continuity of the service delivery to the families.



Public Health Advice

We need:

- Our Place Based Partnership to prioritise childhood immunisation to improve and reduce the differences of uptake within our communities.
- To sustain investment to improve the uptake of vaccinations especially MMR, reduce the inequity of uptake and to introduce the chickenpox vaccination if directed, following recommendations of the Joint Committee of Vaccinations and Immunisations.
- Communications strategies that are simple and hard-hitting, with continuous messaging on the importance and benefits of vaccination.

Acknowledgements

I'd like to thank the following members of my team for their contributions to this report:

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Barking & Dagenham

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ASSEMBLY

15 May 2024

Title: Members' Allowances Scheme 2024/25	
Report of the Chief Executive	
Open Report	**For Decision**
Wards Affected: None	**Key Decision:** No
Report Authors: Alan Dawson, Head of Governance & Electoral Services	**Contact Details:** Email: alan.dawson@lbbd.gov.uk
Accountable Director: Deirdre Collins, Head of Legal and Monitoring Officer	
Accountable Executive Team Director: Fiona Taylor, Chief Executive	

Summary:

This report sets out proposals in relation to Members' allowances for the 2024/25 municipal year covering both the Basic Allowance payable to all councillors and Special Responsibility Allowances (SRAs) for those councillors appointed to specific positions.

At last year's Annual Assembly meeting (Minute 13, 17 May 2023 refers), it was agreed that in line with the recommendations of the 2022 London Councils Independent Remuneration Panel (LCIRP) report, the Council would apply the rates for allowances agreed as part of the Local Government Services Pay Agreement for the preceding year (ie. applying the rate increase for 2023/24 to 2024/25 allowances). The increase would apply to Members' Basic Allowances and SRAs going forward, as a way of ensuring that councillors' remuneration kept in line with that received by staff, albeit a year in arrears.

The allowances agreed as part of the Local Government Services Pay Agreement for 2023/24 were increased by 3.88%. There are no other proposed changes to Members' Basic Allowance or SRAs for 2024/25.

At last year's Annual Assembly meeting, it was further agreed that the Dependants' Carers' Allowance be increased in line with the effective date of any uplift to the London Living Wage (LLW). The LLW was increased from £11.95 to £13.15 per hour with effect from 24 October 2023.

Appendix A to the report reflects the 3.88% increase to the Basic Allowance and SRAs and the Dependants' Carers' Allowance increase, and represents the proposed LBBD Members' Allowances Scheme for 2024/25.

Recommendation(s)

The Assembly is recommended to adopt the Members' Allowances Scheme 2024/25 at Appendix A to the report, to be effective from 16 May 2024.

Reason(s) To accord with the Local Authorities (Members' Allowances) (England) Regulations 2003.

1. Introduction and Background

1.1 The Local Authorities (Members Allowances) (England) Regulations 2003 require local authorities to make an annual scheme of allowances.

1.2 In setting its annual scheme, the Council must have regard to any recommendations of an independent remuneration panel (IRP). The exceptions to this requirement are where allowances are to be increased in accordance with an approved index or where no increase is proposed, subject to a review every four years.

1.3 In June 2014, the Council disbanded its own IRP due to a number of the Panel Members stepping down and the decision was taken that, from that point, the Council would have regard to the London Councils Independent Remuneration Panel (LCIRP) recommendations when considering its annual allowances. The LCIRP was established by London Councils in 2001 to exercise the function on behalf of London Boroughs and produces a report every four years, the latest being its 2022 report.

1.4 By Minute 9 of its meeting on 25 May 2022, the Assembly approved the first set of changes to the LBBD Members' Allowances Scheme since 2018. Those changes included an increase to the Basic Allowance in line with the London Councils Independent Remuneration Panel (LCIRP) recommendations in its 2022 report which, to all intents and purposes, represented an increase to the Basic Allowance equivalent to the local government staff pay awards since 2018. With regard to SRAs and particularly the roles of Leader, Deputy Leader, Cabinet Member and Chair of Overview and Scrutiny Committee, consideration was given to the levels recommended in the 2022 LCIRP report and officers also conducted a benchmarking exercise against other London Boroughs' schemes to provide a comparison (based on allowance levels in 2021/22). Stemming from that, although it was agreed not to increase SRAs to the LCIRP recommended levels due to the ongoing pressures on the Council's finances, the Assembly did agree specific increases to some of those posts referred to above as well as an 'inflationary' increase to all SRAs, again equivalent to the local government staff pay awards since 2018.

1.5 By Minute 13 of its meeting on 17 May 2023, the Assembly agreed that, also in line with a recommendation of the 2022 London Councils Independent Remuneration Panel (LCIRP) report, the Council would, going forward, apply the rates for allowances agreed as part of the Local Government Services Pay Agreement for the preceding year (ie. applying the rate increase for 2023/24 to 2024/25 allowances) to Members' Basic Allowances and SRAs, as a way of ensuring that councillors' remuneration kept in line with that received by staff received by staff, albeit a year in arrears.

1.6 It was further agreed at that meeting that the Dependants' Carers' Allowance be increased in line with the effective date of any uplift to the London Living Wage (LLW). The LLW was increased from £11.95 to £13.15 per hour with effect from 24 October 2023.

1.7 The Members' Allowances Scheme forms part of the Council Constitution (Part 6).

2. Proposal and Issues

2.1 Basic and Special Responsibility Allowances

2.1.1 As referred to in paragraph 1.5 above, it has been agreed that the Council shall increase the Members' Basic and Special Responsibility Allowances in line with the increase to the rates for allowances agreed as part of the Local Government Services Pay Agreement for the preceding year.

2.1.2 Under the Local Government Services Pay Agreement for 2023/24, the rates for allowances were increased by 3.88%.

2.1.3 There are no other proposed changes to the Basic Allowance or SRAs, or shall be eligible to receive them, for 2024/25.

2.1.4 The table below shows the cumulative cost of the Basic and SRAs for 2023/24 and 2024/25.

	2023/24 Allowances	**2024/25 Allowances (increased by 3.88%)**
Basic Allowance (x51)	£653,157	£678,504
Leader SRA (x1)	£53,833	£55,922
Deputy Leader SRA (x2)	£63,960	£66,442
Cabinet Member SRA (x7)	£154,210	£160,195
Deputy Cabinet Member SRA (x1)	£7,995	£8,305
Chair O&S SRA (x1)	£13,858	£14,396
Deputy Chair O&S SRA (x1)	£6,929	£7,198
Chair Planning SRA (x1)	£10,660	£11,074
Deputy Chair Planning SRA (x1)	£5,330	£5,537
Other Chair's SRA (x7)	£40,579	£42,154
Other Deputy Chair's SRA (x7)	£20,286	£21,070
Opposition Leader SRA (x0)	0	0
Mayor's Purse (x1)	£13,913	£14,453
Total costs (excl. on-costs)	**£1,044,710**	**£1,085,250**

2.1.5 The net effect equates to an additional cost of £40,540 per annum (excluding on-costs).

2.2 **Other Allowances**

2.3.1 The Members' Allowances Scheme also includes allowances in relation to co-opted (and other) members, travelling, subsistence and dependants' carers' allowances.

2.3.2 It is proposed that those allowances remain unchanged for 2024/25 with the exception of the dependants' carers' allowance, which may be claimed towards the cost of care for children or other dependants within the household who have a recognised need for care when councillors are undertaking 'approved duties'.

2.3.3 The Council's Pay Policy Statement reflects that the Council is committed to pay its staff, including apprentices, no less than the "London Living Wage", which was set at £13.15 per hour with effect from 24 October 2023. Although the dependants' carers' allowance is not linked to the Council's Pay Policy, the Assembly has agreed that it is appropriate for that allowance to be increased annually from the effective date of the new London Living Wage. The increase to the dependants' carers' allowance has a minimal impact on the overall Members' Allowances budget and can be contained within the annual budget.

2.4 The proposed Members' Allowances Scheme for 2024/25 is set out at **Appendix A**.

3. Options Appraisal

3.1 The two most apparent options would be (i) freezing allowances for 2024/25, and (ii) applying an alternative increase to the Basic Allowance and/or SRAs.

3.2 The Assembly agreed last year to increase the Members' Basic and Special Responsibility Allowances in line with the increase to the rates for allowances agreed as part of the Local Government Services Pay Agreement. This was considered an appropriate balance between the cost-of-living pressures affecting all while being mindful of the impact on the Council's finances of an increase to the Members' Allowances budget.

4. Consultation

4.1 The proposals in this report have been discussed with relevant Cabinet Members and officers.

5. Financial Implications

Implications completed by: Kenny Leshi, Finance Business Partner

5.1 The Members' Allowances budget for 2023/24 is currently £1,041,315. The cumulative impact of the proposals in this report would amount to an additional £76,493 in payments to Members. Together with the increased rate of National Insurance contributions the budget requirement is expected to increase to £1,117,808. This increase will be funded from the pay and prices inflation provision included in the budget as part of the MTFS.

5.2 It should be noted that the pay award for Local Government staff was based on a flat rate of 3%. It has been agreed to use this percentage for members allowances

for simplicity and fairness – however in practice this will result in slightly different increases (some higher, some lower) than staff on equivalent salaries.

6. Legal Implications

Implications completed by: Dr Paul Feild, Principal Governance Lawyer

6.1 The legal basis for the payments is section 18 of the Local Government and Housing Act 1989 and regulations made by the Secretary of State being the Local Authorities (Members Allowances) (England) Regulations 2003 require local authorities to make an annual scheme of allowances.

6.2 Agreeing the scheme is specifically not a Cabinet function by virtue of paragraph 2(5) of the Local Authorities (Functions and Responsibilities) Regulations 2000 as amended, and so it must be approved by the Assembly.

Public Background Papers Used in the Preparation of the Report:

- London Councils Independent Panel Report “The Remuneration of Councillors in London 2022” (https://www.londoncouncils.gov.uk/who-we-are/about-us/financial-information/leadership-and-expenses/remuneration-councillors-london)
- “Members’ Allowances Scheme 2022/23” report to Assembly 25 May 2022 (Minute 9) https://modgov.lbbd.gov.uk/Internet/ieListDocuments.aspx?CId=179&MId=11188&Ver=4
- “Members’ Allowances Scheme 2023/24” report to Assembly 17 May 2023 (Minute 13) https://modgov.lbbd.gov.uk/Internet/ieListDocuments.aspx?CId=179&MId=12602&Ver=4

List of appendices:

- **Appendix A** – Proposed Members’ Allowances Scheme 2024/25

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APPENDIX A

Members' Allowances Scheme 2024/25

The Council of the London Borough of Barking and Dagenham, pursuant to the Local Authorities (Members' Allowances) (England) Regulations 2003 (“the Regulations”), hereby makes the following scheme.

1. Introduction

1.1 The Members’ Allowances Scheme (“the Scheme”) is approved each year by the Assembly at its annual meeting. The Assembly shall have regard to any recommendations made by an independent remuneration panel before making or amending the Scheme, except where allowances are to be increased in accordance with an approved index or where no increase is proposed, subject to a review every four years.

2. Types of Allowances

2.1 The allowances payable are:

a) Basic Allowance;

b) Special Responsibility Allowance;

c) Co-opted Members' Allowance;

d) Travelling and Subsistence Allowance;

e) Dependants' Carers' Allowance;

f) Other allowances as described in the Scheme.

3. Effective Date

3.1 This Scheme has effect from 16 May 2024.

4. Definitions

4.1 "Approved duties" means attendance by a Councillor or Co-opted Member at any:

a) formally convened meeting of any committee or body to which the individual has been appointed or nominated by the Authority, including any sub-committees or working parties thereof;

b) conference, training session and presentation organised by or on behalf of the Authority which the individual is required to attend;

c) meeting with a Strategic or other Director where the Councillor’s attendance has been requested in writing or by e-mail or where the Councillor is a member of the Cabinet.

4.2 “Co-opted Member” means any co-opted, added or independent Member of a Committee or other body to which this scheme relates regardless of whether or not the Co-opted Member receives a Co-opted Members’ Allowance.

5. Basic Allowance

5.1 A Basic Allowance shall be paid to each Councillor in accordance with Appendix 1 to this Scheme.

5.2 The Basic Allowance shall be annually adjusted in accordance with the average local government staff pay award for the preceding year.

6. Special Responsibility Allowances

6.1 Special Responsibility Allowances shall be paid in accordance with Appendix 1 to this Scheme.

6.2 Special Responsibility Allowances shall be annually adjusted in accordance with the average local government staff pay award for the preceding year.

6.3 Where a Councillor would otherwise be entitled under the Scheme to more than one Special Responsibility Allowance, the entitlement shall only be to the highest allowance.

6.4 In the event of a person receiving a Special Responsibility Allowance being absent or substantially unable to act for a period of at least three months, the Council may resolve to reduce the level of Special Responsibility Allowance payable to that person and instead resolve to pay the allowance, or part of it, to any person appointed as a deputy or vice-chair for such period as it determines.

7. Travelling and Subsistence Allowances

7.1 Travelling and subsistence allowances in respect of Approved Duties undertaken by Councillors and Co-opted Members are payable in accordance with Appendix 1 to this Scheme.

7.2 The provisions relating to eligibility to Travelling and Subsistence Allowances apply only to Approved Duties undertaken outside the Borough. Councillors and Co-opted Members are not permitted to claim Travelling and Subsistence Allowances for any activities undertaken within the Borough.

8. Dependants' Carers' Allowance

8.1 The Dependants' Carers' allowance in respect of Approved Duties undertaken by Councillors and Co-opted Members shall be annually adjusted in line with the minimum London Living Wage.

8.2 The allowance may be claimed towards the cost of care for children or other dependants within the household who have a recognised need for care.

8.3 The allowance will not be payable to a member of the immediate family or household.

8.4 The maximum period of the entitlement will be the duration of the approved duty and reasonable travelling time.

9. Co-opted Members

9.1 Co-opted Members shall be paid in accordance with Appendix 1 to this Scheme.

10. School Appeal Panel Members

10.1 School Appeal Panel (Admissions and Exclusions) members shall be entitled to an allowance as set out in Appendix 1 to this Scheme but shall not be eligible to receive travelling, subsistence or Dependants' Carers' allowances.

11. National Insurance and Income Tax

11.1 Payment of allowances shall be subject to such deductions as may be statutorily required in respect of national insurance and income tax.

12. Local Government Pension Scheme (LGPS)

12.1 In accordance with the Local Government Pension Scheme (Transitional Provisions, Savings and Amendment) Regulations 2014, Councillors are not eligible to be members of the LGPS.

13. Renunciation

13.1 A Councillor and/or Co-opted Member may, by notice in writing to the Chief Executive, elect to forgo all or any part of his/her entitlement to an allowance under this Scheme.

14. Payments and Claims

14.1 Payment of Basic and Special Responsibility Allowances shall be made in instalments of one-twelfth of the amounts specified on a monthly basis, unless other arrangements are agreed.

14.2 Where an individual takes office part way through a year, a proportionate part of any applicable allowance is payable, unless the allowance is a Special Responsibility Allowance for serving on a committee which is appointed for a period of less than a year.

14.3 The Council may determine that an allowance or a rate of allowance will not come into effect until a date other than the effective date of this Scheme. In such circumstances, the alternative date that the allowance shall be payable from shall be specified in Appendix 1 to this Scheme.

14.4 Claims for travelling, subsistence and dependants' carers' allowance should be completed monthly and no later than three months from the date that the expenditure was incurred.

15. Councillors who are Members of another Authority

15.1 Any Councillor who is also a Member of another Authority shall only receive allowances from one Authority in respect of the same duties.

15.2 In such instances, the Councillor shall be required to nominate the Authority from whom he/she wishes to receive the allowance(s) and advise the Chief Executive accordingly.

16. Record of Allowances Paid

16.1 A record of the payments made by the Authority to each Councillor and Co-opted Member shall be maintained and published in accordance with the Regulations.

17. Publication of Scheme

17.1 As soon as practicable after the making or amendment of this Scheme, arrangements shall be made for its publication within the Authority's area in accordance with the Regulations.

Appendix 1

London Borough of Barking and Dagenham
Schedule of Allowances for 2024/25

Type	**Allowance** (per annum unless otherwise stated)
BASIC ALLOWANCE (for all Councillors)	£13,304
SPECIAL RESPONSIBILITY ALLOWANCES	
Leader of the Council	£55,922
Deputy Leader(s) of the Council	£33,221
Other Cabinet Members	£22,885
Deputy Cabinet Members	£8,305
Chair, Overview and Scrutiny Committee	£14,396
Deputy Chair, Overview and Scrutiny Committee	£7,198
Chair, Planning Committee	£11,074
Deputy Chair, Planning Committee	£5,537
Chair, Assembly Chair, Audit and Standards Committee Chair, Health Scrutiny Committee Chair, Licensing and Regulatory Committee Chair, Pensions Committee Chair, Personnel Board Chair, Policy Task Group	£6,022
Deputy Chair, Assembly Deputy Chair, Audit and Standards Committee Deputy Chair, Health Scrutiny Committee Deputy Chair, Licensing and Regulatory Committee Deputy Chair, Pensions Committee Deputy Chair, Personnel Board Deputy Chair, Policy Task Group	£3,010
Leader(s) of the Minority Groups	£412 per seat (with a minimum of £1,337 per Leader)

Type	**Allowance** (per annum unless otherwise stated)
Mayor's Allowance (payable under section 3(5) of Part I of the Local Government Act 1972)	£14,453
CO-OPTED MEMBERS' AND OTHER ALLOWANCES	
Independent Member (to Audit and Standards Committee for audit functions)	£500 per meeting
Independent Persons (to Audit and Standards Committee for standards functions)	£500
School Appeal Panel Members (Admissions and Exclusions)	£20 per session (up to four hours)
TRAVELLING ALLOWANCES	
Mileage Rates	• Car: 45p per mile • Motorcycle: 24p per mile • Bicycle: 20p per mile
SUBSISTENCE ALLOWANCES	
Meal Allowances	• Breakfast (away between 7.00am and 11.00am) - £4.92 • Lunch (away between 12.00 noon and 2.00pm) - £6.77 • Tea (away between 3.00pm and 6.00pm) - £2.67 • Evening (away between 7.00pm and 11pm) - £8.35
Overnight (continuous period of 24 hours involving absence overnight)	• Normal - £79.82 • Greater London, AMA Annual Conference or other approved Association conferences - £91.04
DEPENDANTS' CARERS' ALLOWANCE	£13.15 per hour effective from 24 October 2023 (equivalent to minimum London Living Wage)

ASSEMBLY

15 May 2024

Title: Appointment of Statutory Scrutiny Officer	
Report of the Chief Executive	
Open Report	**For Decision**
Wards Affected: None	**Key Decision:** No
Report Author: Alan Dawson, Head of Governance & Electoral Services	**Contact Details:** Email: alan.dawson@lbbd.gov.uk
Accountable Director: Deidre Collins, Head of Legal and Monitoring Officer	
Accountable Executive Team Director: Fiona Taylor, Chief Executive	

Summary:

The Council must designate one of its officers to discharge the functions of statutory Scrutiny Officer, as required under section 9FB of the Local Government Act 2000 (amended by the Localism Act 2011). The statutory Scrutiny Officer cannot be the Council's Head of Paid Service (Chief Executive), the Monitoring Officer (Head of Legal) or the Chief Financial Officer (Strategic Director, Resources). The statutory scrutiny officer's role is to:

- promote the role of the Council's overview and scrutiny committee(s);
- provide support to the Council's overview and scrutiny committee(s) and its Members; and
- provide guidance to all Members and officers of the Council in relation to overview and scrutiny functions.

LBBD has typically designated its Director of Strategy as statutory Scrutiny Officer, as was the case when Alex Powell, interim Director of Strategy, was designated as statutory Scrutiny Officer by the Assembly on 27 July 2022 (Minute 19 refers). At the Assembly meeting on 27 September 2023 (Minute 34 refers), Members were advised of Mr Powell's imminent departure from the Council and the recruitment drive being undertaken for a permanent replacement. In the circumstances, the Assembly designated Leanna McPherson, Principal Governance Officer with responsibility for the governance and support to the Council's Overview and Scrutiny Committee and Health Scrutiny Committee, as the Council's interim statutory Scrutiny Officer. It was also noted that a further report would be presented to the Assembly after the new Director of Strategy had been appointed.

Sal Asghar was appointed as the Council's new Director of Strategy and commenced his duties in January 2024. It is now proposed that Mr Asghar assume the responsibilities of statutory Scrutiny Officer.

Recommendation(s) The Assembly is recommended to designate Sal Asghar, Director of Strategy, as the Council's statutory Scrutiny Officer with effect from 16 May 2024.
Reason(s) To accord with the requirements of section 9FB of the Local Government Act 2000 (as amended).

1. Financial Implications

Implications completed by: Kenny Leshi, Finance Business Partner

1.1 There are no financial implications associated with the proposal in this report.

2. Legal Implications

Implications completed by: Dr Paul Feild, Principal Governance Lawyer

2.1 As set out in the summary of this report the Council is obliged by law under section 9FB of the Local Government Act 2000 (amended by the Localism Act 2011) to appoint a Scrutiny Officer who will be tasked with promoting the role of the Council's overview and scrutiny committee(s) and supporting them in their business. In addition, the statutory Scrutiny Officer shall provide guidance to all Members and officers of the Council to in relation to overview and scrutiny functions, which can be found in the Constitution at Part 2 Chapter 8.

2.2 The Local Government Association gives further guidance on the role in that the statutory Scrutiny Officer activities could include as providing, or managing, administrative work, undertaking research, analysing data and preparation of reports.

2.3 The statutory Scrutiny Officer cannot be either the Council's Head of the Paid Service, the Monitoring Officer or the Chief Finance Officer (s151 LGA 1972 officer). They do not need the word 'scrutiny' in their job title and similarly, someone with the job title 'Scrutiny Officer' will not necessarily be the Council's Statutory Scrutiny Officer.

Public Background Papers Used in the Preparation of the Report:

- Section 9FB, Local Government Act 2000 (as amended) https://www.legislation.gov.uk/ukpga/2000/22/section/9FB

List of appendices: None