North East London Integrated Care Board

Barking & Dagenham

Notice of Meeting

HEALTH & WELLBEING BOARD AND ICB SUB-COMMITTEE (COMMITTEES IN COMMON)

Tuesday, 12 September 2023 - 5:00 pm
Council Chamber, Town Hall, Barking IG11 7LU

Date of publication: 4 September 2023

Fiona Taylor
Chief Executive, LBBD
Zina Etheridge
Chief Executive,
North East London ICB

LBBD Contact Officer: Alan Dawson
alan.dawson@lbbd.gov.uk
ICB Contact Officer: Anne-Marie Keliris
Annemarie.keliris@nhs.net

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).

Membership

Name	Title	HWBB	ICB
Cllr Maureen Worby (Chair)	Cabinet Member for Adult Social Care and Health Integration, LBBD	✓	✓
Elaine Allegretti	Strategic Director, Children and Adults, LBBD	✓	✓
Pooja Barot	Director, Care Provider Voice		✓
Matthew Cole	Director of Public Health, LBBD	✓	✓
Selina Douglas	Executive Director of Partnerships (NELFT)		✓
Cllr Syed Ghani	Cabinet Member for Enforcement and Community Safety, LBBD	✓	
Kathryn Halford	Chief Nurse, BHRUT	✓	
Dr Ramneek Hara	Clinical Care Director, NHS North East London	✓	✓
Ann Hepworth	Director of Strategy and Partnerships, BHRUT	✓	✓
Louise Jackson	Chief Inspector, Metropolitan Police	✓	
Cllr Jane Jones	Cabinet Member for Children's Social Care and Disabilities, LBBD	✓	
Cllr Elizabeth Kangethe	Cabinet Member for Educational Attainment and School Improvement, LBBD	✓	
Manisha Modhvadia	Chair, Healthwatch		✓
Sharon Morrow	Director of Partnership Impact and Delivery Barking and Dagenham, NHS North East London	✓	✓
Elspeth Paisley	Health Lead, BD Collective	✓	✓
Charlotte Pomery	Executive Director, NHS North East London	✓	
Dr Kanika Rai	Place based Partnership Primary Care, Development Clinical Lead		✓
Dr Shanika Sharma	Primary Care Network Director – West One		✓
Nathan Singleton	Chief Executive, Healthwatch - Lifeline Projects Ltd	✓	
Fiona Taylor	Chief Executive (Place Partnership Lead), LBBD	✓	✓
Sunil Thakker	Director of Finance or nominated rep, NHS North East London		✓
Chetan Vyas	Director of Quality or nominated rep, NHS North East London		✓
Melody Williams	Integrated Care Director, NELFT	✓	

Non-voting members

Craig Nikolic	Chief Operating Officer, Together First CIC, B&D GP Federation	✓	
Dr Uzma Haque	Primary Care Network Director, North	✓	
Dr Deeksha Kashyap	Primary Care Network Director, North West	✓	
Dr Jason John	Primary Care Network Director, New West	✓	
Dr Afzal Ahmed	Primary Care Network Director, East	✓	
Dr Natalya Bila	Primary Care Network Director, East One	✓	
Dalveer Johal	NEL Local Dental Committee Representative	✓	
Shilpa Shah	NEL Local Pharmaceutical Committee Representative	✓	

Standing Invited Guests

Cllr Paul Robinson	Chair, Health Scrutiny Committee, LBBD	✓	
Narinder Dail	Borough Commander, London Fire Brigade	✓	
Anju Ahluwalia	Independent Chair Local Safeguarding Adults Board, LBBD	✓	
Vacant	London Ambulance Service	✓	
Vacant	NHS England, London Region	✓	

AGENDA

1. **Apologies for Absence**

2. **Declaration of Members' Interests**

   In accordance with the Council's Constitution and the ICB Sub-Committee's Terms of Reference, Members of the Committees in Common are asked to declare any interest they may have in any matter which is to be considered at this meeting.

3. **Minutes - To confirm as correct the minutes of the meeting on 26 June 2023 (Pages 3 - 8)**

4. **Appointment of Deputy Chair**

   The Chair will call for nominations for the position of Deputy Chair. The Deputy Chair should be a member of both the Health and Wellbeing Board and the ICB Sub-Committee, in order to carry out the Chair's full responsibilities.

5. **HWB Membership (Pages 9 - 10)**

6. **Carers Charter and Action Plan Update 2022/23 (Pages 11 - 28)**

7. **Barking and Dagenham Place Based Partnership 2023/2024 Winter Planning (Pages 29 - 110)**

8. **Urgent Action - Extension to 0-19 Integrated Healthy Child Programme Service Contract (Pages 111 - 126)**

9. **Questions from the public**

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

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

Private Business

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

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

This page is intentionally left blank

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.

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.

MINUTES OF
HEALTH & WELLBEING BOARD and
ICB SUB-COMMITTEE
(COMMITTEES IN COMMON)

Monday, 26 June 2023
(5:00 - 6:45 pm)

Present: Cllr Maureen Worby (Chair), Elaine Allegretti, Pooja Barot, Matthew Cole, Selina Douglas, Cllr Syed Ghani, Dr Ramneek Hara, Ann Hepworth, Cllr Jane Jones, Cllr Elizabeth Kangethe, Manisha Modhvadia, Sharon Morrow, Elspeth Paisley, Charlotte Pomery, Dr Shanika Sharma, Sunil Thakker, Melody Williams, Dr Uzma Haque and Craig Nikolic

Invited Guests, Officers and Others Present: Anju Ahluwalia, Narinder Dail, Jane Leaman, Fiona Russell, Mike Brannan, Louise Hider-Davies, Annemarie Keliris, Debbie Harris, Yusuf Olow and Christine Brand

Apologies: Kathryn Halford, Dr Kanika Rai, Nathan Singleton, Fiona Taylor, Chetan Vyas, Dr Afzal Ahmed, Dr Natalya Bila, Dalveer Johal, Dr Jason John, Dr Deeksha Kashyap and Shilpa Shah

1. Declaration of Members' Interests

There were no declarations of interest.

2. Minutes of the Health and Wellbeing Board held on 14 March 2023

The minutes of the Health and Wellbeing Board held on 14 March 2023 were confirmed as correct.

3. Minutes of the Barking and Dagenham Place based Partnership Board held on 25 May 2023

The minutes of the Barking and Dagenham Place-based Partnership Board held on 25 May 2023 were confirmed as correct.

4. Action log

There was one residual action regarding capital programmes in relation the Barking and Dagenham Partnership Board estates programme and governance. It was envisaged that the matter would be addressed in a future finance paper. However, there was a paper that provided an update on the local infrastructure forum.

The ICB Sub-Committee noted the update.

5. Governance update and ICB sub-committee terms of reference

The Chief Participation and Place Officer (CPPO), NHS North East London, presented a report on governance arrangements relating to the new Health & Wellbeing Board (HWB) and Barking & Dagenham Integrated Care Board (ICB)

Sub-Committee 'Committees in Common' approach.

The CPPO thanked all those who had contributed to the establishment of the Committees in Common, commenting that bringing together the governance structures would enable decisions to be taken more efficiently and provide more time for the Adults and Children delivery groups to engage with communities and deliver services.

The report included revised Terms of Reference for the ICB Sub-Committee to reflect the new approach as well as the functions that the NEL ICB had delegated to the ICB Sub-Committee. The CPPO added that the new Committees in Common approach was a learning process and that it may be necessary to amend the terms of reference in future.

In response to a question from a member of the public regarding the membership of the HWB / ICB and the subject of domestic abuse, the Chair confirmed that a local senior Police officer was included in the HWB's membership, although one was not present at this meeting. With regard to a representative of the Council's Housing service being included in the membership, the Chair explained that whilst it would not be appropriate to extend the membership of the HWB / ICB to cover all potential interested parties, relevant officers would be invited to meetings to discuss specific issues.

The Health and Wellbeing Board and ICB Sub-Committee endorsed the proposed governance arrangements, including the new Terms of Reference of the ICB Sub-Committee.

The ICB Sub-Committee agreed to recommend approval of its new Terms of Reference of the ICB Board.

6. Progressing Our Ambition for Adults and Communities in Barking and Dagenham

The Director of Care and Community Health (DCCH), LBBD, invited the Committees in Common to discuss the delivery of the ambition to improve services for adults and communities in Barking and Dagenham. The intention of the discussion was to provide guidance to officers on the expectations that would enable the Council and NHS partners to develop relevant approaches.

The Council's Corporate Plan would follow the outcome of the Fuller Review which reviewed primary care integration in relation to general practice, community pharmacy, dentistry and optometry. The ICP strategy would follow the outcome of the Hewitt Review which related the review of integrated care systems and recommendations were made in relation to simplifying targets and focusing on prevention.

It was noted that the Care Quality Commission (CQC) would commence inspections in October 2023 and would have strong emphasis on adult care as well as the effect of the integrated care system.

Prevention and information guidance was the overall theme and over the next year development of the strategy would be undertaken which would involve:

- Co-production – with residents, staff and service users to ascertain what works and what does not, and which groups are most at need;
- Data analysis – rigorous analysis would be undertaken to ascertain which cohorts are at most risk and develop models to better support the most vulnerable; and
- Mapping – pathways and service provision would be mapped with a view to streamlining patient journeys in order to avoid unnecessary appointments and patients being 'bounced around'.

The Health and Wellbeing Board and ICB Sub-Committee noted the update.

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

Further to Minute 50 of the Health and Wellbeing Board on 14 March 2023, the Interim Consultant in Public Health (ICPH), LBBD, introduced the proposed Barking and Dagenham Joint Local Health and Wellbeing Strategy for 2023 - 2028.

The refreshed strategy set out a renewed vision for improving the health and wellbeing of local residents and reducing health inequalities at every stage of residents' lives by 2028. The refreshed Health and Wellbeing Strategy aligned with the recently published NHS NEL Integrated Care Strategy and the Joint Forward Plan that had been submitted to NHS England, as well as linking to the Council's Corporate Plan. The refreshed strategy set out a number of specific priorities including:

- Improving outcomes for those with long-term conditions (children and adults);
- Addressing obesity and smoking (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, such as poor housing, unemployment and low levels of training, education and skills development.

Development was still ongoing in delivering the priorities and how to measure outcomes. The IPHC advised that almost 30% of Barking and Dagenham adults were classified as obese and the Borough had the highest level of child obesity in London. In response to questions regarding tackling child obesity in the Borough, it was explained that the Borough had been selected for a pilot scheme that would involve a 'Tier 3' commissioning service being introduced, whereby a multi-disciplinary team provide targeted support to the individual and their family which would not require travel to the Royal London Hospital. The Director of Public Health (DPH), LBBD, commented that up until now, this area had a fragmented commissioning path as the Council commissioned Tier 1 and 2 services, such as weight management, whilst NHS bodies commissioned Tiers 4 and 5 which involved medical intervention, without a Tier 3 service being in place which had meant that children went from Tier 2 to Tier 4.

Members commended the Health and Wellbeing Strategy 2023 - 2028 and the Chair encouraged all stakeholders to disseminate the document and the

accompanying presentation.

The Health and Wellbeing Board approved the Joint Health and Wellbeing Strategy 2023-28 as set out at Appendix A to the report.

8. Better Care Fund 2023-2025

The Head of Adults' Commissioning (HAC), LBBD, introduced a report on the Better Care Fund (BCF) submission for 2023-25.

The HAC confirmed that for 2023/24, Barking and Dagenham had been allocated £33.69m by the Government, of which £18.4m was allocated to the ICB for out-of-hospital and community health services, reablement, independent / voluntary sector, Care Act implementation and Carers' Break funding. The remaining funding was allocated to the Council, to support Improved Better Care Fund (iBCF) projects, Disabled Facilities Grant and the new Discharge Fund. The provisional allocation for 2024/25 was £35.43m.

The HAC advised on changes to Better Care Fund arrangements, including the new Discharge Fund and a two-year planning process. There were also two further national conditions set by Government, covering how services the area commissions will support people to (1) receive the right care in the right place at the right time, and (2) remain independent for longer and, where possible, support them to remain in their own home.

It was noted that two key documents would need to be submitted to NHS England for approval, namely the Joint BCF Plan 2023-25 for Barking and Dagenham, Havering and Redbridge, which had been jointly developed by the three Boroughs and NHS NEL, and the BCF Planning Template 2023-25, which set out targets and a breakdown of how the funding would be allocated. All funding had been fully committed and would be reviewed as local plans were developed.

The HAC also highlighted that the discharge component of funding would be used to implement phase 2 of the reablement pilot. The Borough did not, at present, have a reablement service and it was intended that the lessons learned from the pilot would be used to establish one. Additionally, capacity would be increased for complex discharges, including mental health and homeless step-down beds, whilst provision would also be made for:

- homecare and crisis intervention; and
- nursing and supported living placements; and
- workforce initiatives to support market challenges.

In response to questioning regarding the rising number of people being admitted to rehabilitation homes or care homes following hospital discharge, the DIC noted that acuity, complexity of need and additional 1-2-1 support were the main reasons for the increase. This was connected to long term conditions.

The Health and Wellbeing Board and ICB Sub-Committee agreed:

(i) The Better Care Fund submission to NHS England, as set out at Appendices 1 and 2 to the report; and

(ii) To enter into a variation to effect the changes to the Section 75 Agreement governing the BCF, to reflect the BCF 2023-25 submission.

9. Health Inequalities Programme Plan 2023/24

The Consultant in Public Health (CHP), LBBD, presented a report on the Health Inequalities Programme Plan for 2023/24.

It was noted that NHS NEL would receive £6.6m funding annually for health inequalities for three year period 2023/24, 2024/25 and 2025/26, while the sum of £777,000 had been allocated to the Council for each of those three years. Up to an additional £400,000 would be contributed from the Council's Public Health Grant in 2023/24, should the need arise.

The aim of the funding was to tackle health inequalities in deprived areas including carers, people with learning disabilities, autism or are homeless. Among the services provided would be social prescribing, targeted debt advice, community leads, PCN health inequality leads, grants for children and adolescent mental health. The next step, subject to approval, would be to establish a B&D Health Inequalities Working Group followed by the establishment of a workstream pipeline.

The Health and Wellbeing Board and ICB Sub-Committee approved the Barking and Dagenham Health Inequalities Programme Plan for 2023/24, as set out at Appendix 1 to the report.

10. Improving Urgent and Emergency Care (UEC) across Barking and Dagenham, Havering and Redbridge

The Chief Participation and Place Officer (CPPO), NHS NEL, presented a report on the development of several improvement programmes aimed at resolving some of the significant pressures being felt across Barking and Dagenham, Havering and Redbridge in the Urgent and Emergency Care (UEC) service.

The CPPO referred to the unprecedented demand arising from the current high temperatures, which were causing air pollution and created a 'pollen bomb' which was adding to the pressures within UEC.

The Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) had been placed under the Single Oversight Framework level 4 (SOF4) as the result of a combination of non-elective performance challenges and financial sustainability issues. A Care Quality Commission (CQC) inspection took place in November 2022 at BHRUT, focused on urgent and emergency services. This was a follow-up to a visit in November 2021 where issues were identified within the UEC pathway. At the same time, all four urgent treatment centres provided by the Partnership of East London Cooperatives (PELC) were inspected along with both emergency departments and medical care provided by BHRUT.

The CQC was critical of BHRUT over quality of care and waiting times. The CQC also found that all four Urgent Treatment Centres (UTCs) delivered by PELC were inadequate and enforcement actions were issued. Inspection findings covered areas such as access to care and treatment in a timely way, a need to improve governance and accountability, a need for clearer vision and strategy and

leadership capacity and skills.

BHRUT have drawn up a plan of action to address the CQC's concerns. PWC was commissioned to provide an external perspective on the requirements necessary to improve the resilience of the system. Their report would be brought to the Committees in Common for consideration. The CPPO emphasised that the plan would address the entire system and not just emergency care services.

NEL ICB had been designated as an ICS in Tier 1 for urgent emergency care by NHS England. The CPPO explained that this was because of NEL ICB was an outlier in terms of its performance and that the designation would result in NHS England providing additional support. Keeping residents well at home in order to minimise avoidable admissions was a priority, as was ensuring that patients were not discharged until they were well enough and a care plan had been agreed.

The Executive Director of Partnerships (EDP) at North East London Foundation Trust (NELFT) noted that when people were in crisis, they often turn up at A&E and, as part of the mental health planning process, additional beds were being prioritised. It was acknowledged, however, that this would not address systemic issues as, overall, there was still a shortage.

There was a considerable debate on the issues and the role of all stakeholders in reducing demand for UEC, and how to communicate to the local community what services were available. The Chief Operating Officer for the B&D GP Federation asked that the Federation be involved in the process due to the integral role that GPs have in urgent care provision and the similar pressures on demand that they are experiencing. The Executive Director of Partnerships, NELFT, also referred to the challenges within the mental health service and the important role that the voluntary sector could play through the provision of community-based services. The DPH, LBBD, added that the issue was not necessarily the UEC service itself, but rather what was being done to prevent admissions to hospital and diagnose disease earlier.

The Chair suggested that further discussions take place over the Summer on the preferred model of access and the most appropriate way to communicate with residents on how to access the appropriate service.

The Health and Wellbeing Board and ICB Sub-Committee noted the report and UEC Improvement Plan, as set out at Appendix 1 to the report.

11. Questions from the Public

There were no additional questions from the public.

12. Yusuf Olow, Senior Governance Officer

The Chair advised that Yusuf Olow, LBBD Senior Governance Officer, would be leaving the Council in July. The Chair expressed the HWB's thanks for Yusuf's support and wished him well in his new role.

HEALTH AND WELLBEING BOARD AND ICB SUB-COMMITTEE

12 September 2023

Title: HWB Membership	
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: Alison Stuart, Chief Legal Officer and Monitoring Officer	
Accountable Executive Team Director: Fiona Taylor, Chief Executive	

Summary

The membership of the Health and Wellbeing Board (HWB) is partly prescribed by statute and partly by local choice. Part 2, Chapter 7 of the Council Constitution sets out the HWB membership which currently includes two representatives of the Barking and Havering and Redbridge University Hospitals NHS Trust (BHRUT), who are Ann Hepworth, Director of Strategy and Partnerships, and Kathryn Halford, Chief Nurse.

In view of the patient flows from Barking and Dagenham to Newham University Hospital (NUH), it has been proposed that one of the BHRUT places is reallocated to NUH. Kathryn Halford has offered to step down from the HWB to facilitate that arrangement and Simon Ashton, NUH Chief Executive Officer, has been nominated to take up the seat.

An approach has also been received from Andrea St. Croix, Cambridge House's Independent NHS Complaints Advocate for Barking and Dagenham, to be involved in the HWB/ICB Sub-Committee. A contract for advocacy services was awarded to Cambridge House effective from 1 July 2023 and the Independent NHS Complaints Advocate's role is to help individuals make a complaint about the NHS, covering most NHS-funded treatment and includes NHS hospitals, GP's, Ambulance Services, District Nurses, Mental Health Services, Dentists, Pharmacists or Opticians. In view of the contribution that the local Independent NHS Complaints Advocate could provide and following consultation with the Director of Public Health, it is proposed that the Advocate be given 'Standing Invited Guest' status on the HWB, which is a non-voting role.

The membership arrangements in the Council Constitution confirm that the HWB has the power to amend its membership, subject to a 75% majority of HWB members present voting in favour and the amendments being reported to the Council's Assembly.

Recommendation(s)

The HWB is recommended to:

(i) Approve the reallocation of one of the two BHRUT seats on the Board to NUH and note that Simon Ashton, Chief Executive Officer at NUH, has been nominated to take up the seat;

(ii) Agree that the Independent NHS Complaints Advocate for Barking and Dagenham be given 'Standing Invited Guest' status on the HWB; and

(iii) Note that the appropriate amendments to Part 2, Chapter 7 of the Council Constitution shall be reported to the next meeting of the Assembly.

The ICB Sub-Committee is recommended to note the report.

Reason(s)

To accord with the requirements of the Council Constitution.

1. Financial Implications

Implications completed by Katherine Heffernan, Head of Service Finance

1.1 There are no financial implications associated with this report.

2. Legal Implications

Implications completed by Dr Paul Feild, Senior Governance Lawyer

2.1 The Health and Wellbeing Board (HWB) was established by the Health and Social Care Act 2012 and its membership and terms or reference are set out in Part 2, Chapter 7 of the Council Constitution (https://modgov.lbbd.gov.uk/Internet/documents/s161831/Pt%202%20Ch%207%20-%20HWBB%20May23.pdf). The said legislation sets out the core membership of this committee; this is coupled with the power for the HWB to make appointments as it thinks appropriate and for the Council's Assembly to make additional appointments in consultation with the HWB.

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

List of appendices: None

HEALTH AND WELLBEING BOARD AND ICB SUB-COMMITTEE

12 September 2023

Title:	Carers Charter and Action Plan Update 2022/23
Report of the Strategic Director, Children and Adults	
Open Report	**For Decision**
Wards Affected: All	**Key Decision:** No
Report Author: Arabjan Iqbal, Commissioning Manager, Adults' Care and Support	**Contact Details:** E-mail: Arabjan.Iqbal@lbbd.gov.uk
Sponsor: Elaine Allegretti, Strategic Director, Children and Adults	

Summary:

Carers provide valuable care and support to vulnerable residents in the borough with health and care needs. Carers are increasingly supporting individuals with greater and more complex needs alongside fulfilling other daily responsibilities. By delivering on the Carers Charter the Council and its Partners better support carers in their caring role. This provides a focus on prevention and early intervention as well as specialist support facilitating longer-term cost avoidance within health and social care through prevention, resilience, financial independence and reducing health inequalities.

This report presents the first annual update on the delivery and ongoing development of the Action Plan linked to the Carers Charter 2022-2025. The Carers Charter (**Appendix 1**) is delivered through objectives detailed in the Action Plan (**Appendix 2**). The Action Plan acts as a framework for the delivery and development of services, working practices, identification and support of unpaid or informal carers in the borough, through a partnership approach. The key deliverables outlined in the Action Plan will be refreshed annually.

Recommendation(s)

The Health and Wellbeing Board and ICS Sub-Committee are recommended to:

(i) Note the update of the delivery of the Carers Charter Action Plan, as detailed in Appendix 2 to the report; and

(ii) Endorse the sharing of relevant data by partners to support the delivery of the Action Plan.

Reason(s)

The delivery of the Carers Charter supports the Council in meeting the priorities outlined in the Corporate Plan, by ensuring that residents are safe, protected, and supported at their most vulnerable and enabling residents to live healthier, happier, independent lives for longer. The Carers Charter facilitates the empowerment of carers through partnership

working to take care of themselves and their loved ones and become more resilient. Through accessing timely support and developing a carer friendly community, carers can be identified early and provided with the support they need to thrive alongside their caring role.

1. Introduction and Background

1.1 Carers also known as informal or unpaid carers provide a valuable support in maintaining the health and independence of vulnerable residents in the Borough, alongside providing a valuable contribution to health and social care. The Care Act 2014 brought carers to the forefront of service delivery in health and social care, by putting them on an equal footing to the cared for. The Health and Care Act 2022 introduced Integrated Care Systems aimed at integrating care across different organisations and settings, to improve population health and health inequalities focusing on places and the local population to deliver positive outcomes.

1.2 The Joint Health and Wellbeing Strategy aims are aligned with the Carers Charter and Action Plan. Through early diagnosis and intervention both the cared for and the carer can be supported through timely diagnosis and intervention. Carers and the cared for can both have health and wellbeing support needs, which when addressed early on can decrease or slow down the need for further support from health and social care.

1.3 The NHS Long Term Plan launched in January 2019 echoes the commitment to carers including better recognition and support of carers, especially from vulnerable communities, and improve outcomes. Carers need to be supported through emergencies and should not have to manage on their own. They should have access to out of hours options, contingency planning and specific support for young carers. In the Long-Term Plan there is also an increased focus on social prescribing in primary care and a co-ordinated, proactive approach to the delivery of the service to enable a more differentiated support offer, as such carers should benefit from this offer.

1.4 Becoming a carer can often happen overnight and have far reaching multifaceted impacts on the lives of the carer, especially when a person does not identify themselves as a carer or equally are not given the information to come to that conclusion, thereby, they are unable to access the right support. Building resilience and improving health and wellbeing outcomes using trauma-informed intervention models will enable carers to practice self-care as well as enable carers of all ages to participate in opportunities such as employment, education, and training.

Carers Charter

1.5 The Carers Charter was endorsed at the Health and Wellbeing Board (12/01/22) Minute 40 and covers four key areas:

- Working together for Carers
- Carers wellbeing and employment
- Supporting young carers
- Carers in the wider community

1.6 Alongside the Carers Charter an Action Plan was presented to the Health and Wellbeing Board outlining the delivery of the Carers Charter and the key partners involved. This report provides an update to the Board and the Integrated Care System Sub-Committee on the work done in the first year of the delivery of the Carers Charter Action Plan. Progress on this work has been supported by the valuable partnership working of the Carers Strategy Group and wider partners to deliver positive outcomes for carers and support carers in their caring role.

1.7 The delivery of the action plan is staggered and as this report discusses progress in the first year, the data will reflect the progress made on individual work streams. There is still some work that is at the development stage or has recently been initiated. These areas will be reported in next year's update report.

1.8 The Survey for Adult Carers in England (SACE) is a biennial survey run by Councils with Adult Social Services Responsibilities and is sent to carers that have had support from social care within the last 12 months. The last SACE was carried out in 2021-22 and along with detailing information of the carers that responded such as median age of carers, it showed that 52% have a long term health condition. 87% of respondents further reported that their health has been affected by their caring role.

1.9 Since the pandemic, residents are presenting with increasingly greater and complex needs which is naturally increasing the ask of carers locally to support their cared for. Taking account of the increase needs of the cared for the partnership through the delivery of the Carers Charter Action Plan are working towards supporting carers in their caring role, increasing resilience through information and advice, thereby empowering carers to advocate for themselves and the cared for. The partnership is also working collaboratively to support carers become financially more stable through the cost-of-living crisis, reduce opportunity losses for carers through education and employment and support working towards increasing positive outcomes including in health for carers and the cared for.

Census data

1.10 On 19 January 2023 the Office for National Statistics (ONS) released data on unpaid care from the 2021 Census. Key highlights for Barking and Dagenham include:

- Approximately 1 in 14 (7%) of people over the age of 5 provide unpaid care.
- Lower proportion of residents provided unpaid care compared to the previous census (2011) – this is mirrored in London and on a national level.
- Eastbrook and Rush Green (8%) had the highest proportion of residents providing unpaid care with Abbey (4%) with the lowest proportion of residents providing unpaid care.
- Residents providing 50 or more hours of unpaid care a week had the lowest employment rates and the highest rates of economic inactivity.
- The highest proportion of residents who considered themselves to be in bad or very bad health, were those providing 50 hours or more unpaid care a week.

Table1: Number of people and hours of care provided in Barking and Dagenham

Unpaid care (5 categories)	Percentage of population	Number
Provides 9 hours or less unpaid care a week	1.8	3533
Provides 10 to 19 hours unpaid care a week	1.0	1983
Provides 20 to 34 hours unpaid care a week	0.9	1827
Provides 35 to 49 hours unpaid care a week	1.1	2162
Provides 50 or more hours unpaid care a week	2.3	4719
Total		**14,224**

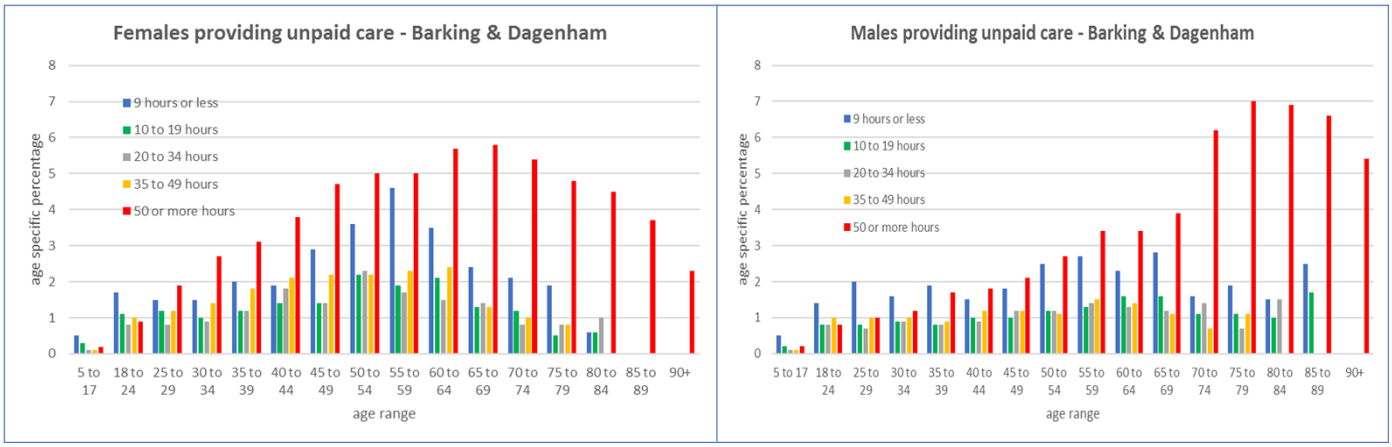
Unpaid Care Provision and Age

1.11 Within the census from age 25 years and over, a higher proportion of Barking and Dagenham females who provided unpaid care were providing 50 or more hours of unpaid care per week, shown in Chart 1.

1.12 This was the same for Barking and Dagenham males from age 40 years and over.

1.13 From the age of 70 the data shows that males started to provide more unpaid care than females.

Chart 1: Unpaid Care Provision and Age



2. Carers Charter Delivery Update

2.1 Feedback and data collated through the Carers Strategy Group alongside collaborative projects with wider partners on the different objectives in the Action Plan will be discussed within the body of this report for the period of 2022-2023. There is a phased implementation as projects were developed and mobilised so some data records are not for a complete 12 month period whilst others are in the process of being implemented or developed.

'Hidden Carers' Identification and Referral Training

2.2 Carers often become carers overnight with little information or support for them in their new role or to help them to identify themselves as informal carers. Carers often see the role that they carry out as something that they would just do. Timely

access to information and advice as well as access to the appropriate support is important so that carers can successfully maintain their caring role and thrive.

2.3 A key element in supporting carers is for professionals to identify carers, enabling them to have a conversation about their caring role and the information, advice and support opportunities available to them. It is known that there are 14,224 residents in Barking and Dagenham providing unpaid care, the number of carers known to services is 4,500. From this data there are just under 10,000 carers that are 'hidden carers' or carers that are not known to services. This is a pattern that is reflected nationally where a large proportion of carers are not known to services. Hidden carers can continue their caring role with no support and often present to services much later and are frequently at, or approaching, crisis.

2.4 The Council in partnership with Carers of Barking and Dagenham and the Integrated Care Board (ICB) have developed a training offer to identify hidden carers and refer them to Carers of Barking and Dagenham. This is being funded by the Ageing Well programme. This training is open to frontline staff within the Council, Health and the Community and Voluntary Sector. The training will be rolled out over several months and named individuals from our partners will support the publicising of this free training offer, including the ICB, BHR CEPN, BHRUT and the Community and Voluntary sector. At the time of writing this report 12 workshops have been advertised in the first tranche from August to December 2023, with 2024 dates to follow. Following the recent launch, there are 19 people registered on the training sessions.

Carers Hospital Discharge Pathway and Access to Support

2.5 An objective of the action plan was to look at developing a discharge pathway so that carers can be identified at the earliest opportunity within hospitals and provided with information and advice.

2.6 To support this a Task and Finish Group led by LBBD Commissioning and included representatives from specialist areas within BHRUT, including Therapies, Patient Advocacy and Customer Experience, (PACE), Red2Green Team, Integrated Discharge Hub (IDH) as well as Adult's and Children's Care and Support, ICB, North East London Foundation Trust, (NELFT), Social Care, Healthwatch, Carers of Barking and Dagenham, Redbridge Carers Support Service, Havering Carers Hub as well as Carers Leads for Havering and Redbridge Councils was created to support this objective.

2.7 An internal audit of discharge information carried out by the Red2Green team in BHRUT found that very little information was available on carers and the support available within the discharge information.

2.8 Two workstreams were run by the group to help improve carer identification through discharge information.

i. A section for carers in the upcoming BHRUT Hospital Discharge Leaflet including details of what a carer is, including Adult carers and Young Carers, outlining support available and where further information could be found. Carers Assessment are also discussed within this and where these can be accessed. To support digital inclusion, it also includes QR codes so that

individuals can access the relevant information about the local social care offer and the local carers commissioned services across Barking and Dagenham, Havering and Redbridge. The timing of this work has meant that this information will be included in the BHRUT Discharge Booklet which is currently being developed and will include all relevant information for patients at discharge. This leaflet aims to streamline the process for frontline staff, by including all relevant carer information through a standardised process across Barking and Dagenham, Havering and Redbridge.

ii. A short co-produced questionnaire was developed to understand the carers experience at hospital discharge and what can be done to support them when returning home. The responses will also inform potential future improvements for others, for example being included in the discharge process, having the medications explained to them, having an explanation of adaptations and all that this entails.

2.9 This piece of work was presented at the Discharge Improvement Working Group (DWIG) on the 9 August 2023 and was positively received. At the time of writing this report, the questionnaire was expected to be circulated and open for six weeks between 31 July and 8 September after which the results will be collated by the PACE teams with findings and recommendations brought forward to the Task and Finish Group in late September.

2.10 During the development of this work the Carers and Hospital Discharge Toolkit (London) was launched and informed the development of our local response as part of the Hospital Discharge Leaflet.

Carers in the development of the care plan

2.11 The development of the care plans led by social work colleagues involves carers in the decisions made in the care provision for the cared for. Alongside input from the cared for and the social work practitioner, the carer as an expert by experience informs and guides the development of the care plan, ensuring needs are met whilst expectations are managed. The inclusion of the carer as a practice is seen across social care and links in with the carers charter ‘I am recognised as an expert and equal partner of care with my views and opinions valued and respected’.

Targeted outreach for uptake of vaccinations for carers

2.12 Following the launch of the Carers Charter, work was done with Public Health to support uptake of the COVID booster and flu vaccinations. This built upon the relationships developed during the height of the pandemic and the initial tranches of vaccination. Through the Carers Strategy Group Carers were supported to access boosters and flu vaccinations. There were 924 carers vaccinated in the Seasonal Flu Vaccination Programme in 2022-23 which has surpassed the minimum target of 875. The data for COVID booster vaccinations does not currently capture carers.

Carers assessments

2.13 The number of carers assessments completed in 2022/23 was 246 which is slightly lower than the previous year 2021/22 at 312. Although there has been consistent work done by social care practitioners and partners to promote the uptake of carers assessment this hasn't been reflected in the uptake of the offer. This may be because people that are recently approaching social care have greater and more complex needs that there has been a higher need for residential care and as such carers are declining assessments. In addition to this there are also carers who decline carers assessments in general. Moving forward, a Task and Finish Group with members of the Carers Strategy Group, including social care practitioners, will be set up to monitor the number of carers assessments following the Hidden Carers training roll out, as well as quarterly reviews to look at the number of carers assessments completed.

Number of Carers Registered with GP Practices in the Borough

2.14 GP practice data in Barking and Dagenham shows that in 2021/22 there were 367 new carers identified and recorded at the GP practices in Barking and Dagenham. During 2022/23 following the launch of the Carers Charter, this number increased to 579 new carers identified and recorded at GP practices in Barking and Dagenham. This a reflection of the positive work that the partnership as a whole is doing to support the identification of carers including the GP Practices, the Clinical Lead for Carers within the ICB, ICB colleagues and the satellite services delivered at GP practices by Carers of Barking and Dagenham. In total there are 4193 carers identified by GP practices in Barking and Dagenham out of a population of 247,046 people registered with a GP Practice in the Borough.

GP TV Information Advert

2.15 As part of the delivery of the Carers Charter through the Carers Strategy Group, an information advert was developed to be broadcast on the GP waiting room TV screens to increase awareness of carers, and signpost carers to additional help and support. This work was led by ICB colleagues with representation from Clinical Lead for Carers, Commissioning representatives for Barking and Dagenham, Havering and Redbridge, NELFT, Carers of Barking and Dagenham, Havering Carers Hub and the Redbridge Carers Centre. Following development, this piece of work was rolled out across all three Boroughs and is continuously promoted.

EHCP Project

2.16 In March 2023 Healthwatch began working on the Education, Health and Care Plan (EHCP) project which asks carers of children with special needs or disability about the EHCP process, the effectiveness of the plans, what is working well and what isn't working well. The project will continue in 2023 and culminate in a report completed in Autumn 2023. Recommendations will then be taken forward following the report. During 2022-23 Healthwatch engaged with 80 self -identifying carers on general health and care issues.

Social Prescribing

2.17 The Social Prescribing Team in Community Solutions have been working closely with the Primary Care Networks to support the positive outcomes for local residents, including carers. The service has recently implemented a new social prescribing system - Joy. There will be a new template rolled out on both EMIS and JOY across NEL and this will enable us to identify the number of carers referred for support and the type of support offered.

Department for Work and Pensions

2.18 Through strengthened partnership working representatives from the Department of Work and Pensions (DWP) are active contributors to the Carers Strategy Group and support carers' wellbeing and employment, as part of the Carers Charter. The DWP committed to maximising carers' income and identifying hidden carers. They have put in place the mechanisms below to support the objectives of the Carers Charter:

- Work Coaches are upskilled with all new changes within the Carers agenda by communication shared with offices by a named officer who is part of the East London Partnership Team.
- Work Coaches are upskilled to make sure they ask probing questions to ensure they are able to identify hidden carers. This is so that the work coach can advise on benefits that they could be entitled to for example Carers Allowance if DLA and PIP in payment at Middle or Higher rate.
- Work Coaches are also advised to put easements on customer claims who have caring responsibilities so that they can put things in place for when they start work.

2.19 Within Barking and Dagenham, the Community Hubs at Barking Learning Centre and Dagenham Library are growing and now have established a good working network of providers, this is allowing easy access to all customers into services from one place. Including advice and support with money matters, housing issues, grants from the Council and job search support via Jobcentre Plus (JCP) and the Job Shop.

2.20 The Disability Employment Advisors (DEA) team will be running Changing Mindset Workshops that will build customer confidence and motivate them towards engagement in work or training. Currently this workshop has been offered to all customers attending the JCP office. However, after the summer leave period this team will begin to provide sessions for those who fall under the Carers remit, to support the Carers Charter.

2.21 The Front of House (FOH) team who are the first point of contact for customers attending Barking & Dagenham Jobcentre are fully aware of the benefits that customers may be entitled to and always discuss the customers' personal circumstance before advising them on what benefits they should claim.

Homes and Money Hub

2.22 The cost-of-living crisis has added additional pressure to carers who are known to be not as financially resilient as other groups. The Homes and Money Hub (HAM

Hub) has also committed to support maximising carers' income and identifying hidden carers to promote carers' wellbeing and employment. The Ham Hub team has agreed to support carers below the referral thresholds for support so that targeted intervention can be put in place earlier for this group and support carers in their caring role. As part of the targeted work in supporting carers during the cost-of-living crisis, and building resilience within the community, the team has delivered the following:

- Added carers to the new online form to enable carers to be identified and monitored and given the targeted support early, below the referral threshold.
- Identified 82 carers they are working with/have worked with since December 2022.
- Engaged with and closed 32 (39%) carer cases and for these carers and have:
    - Maximised income by £41,805.95 (this is based on one-month increased income only plus back payments as this is income that has been received)
    - Reduced Council Tax arrears for carers by £6,820.36
    - Reduced rent arrears for carers by £2,395.73
- Only 8% (7) have not engaged.
- There are currently 43 (52%) ongoing cases.
- Received training from the Carer's Hub as part of their targeted outreach work to help staff identify carers.

Carers of Barking and Dagenham

2.23 Carers of Barking and Dagenham actively contribute to the delivery of all sections of the Action Plan, working to promote the identification of hidden carers, advise professionals in supporting carers and accessing additional information advice and support. For 2022-2023, 406 new adult carers and 82 new young carers have been identified. Carers Peer Support Groups and Wellbeing events are also held for carers.

2.24 Another key objective in the action plan supported by Carers of Barking and Dagenham is to maximise income for carers through signposting and income/employment support. 154 carers have been supported in engaging with welfare benefits and there has been a 15% increase in uptake of Carers Allowance. Income to the borough through benefits and income maximisation support for carers amounts to £561,706.

2.25 With regard to employment support, 35 carers have attended carers training and 7280 volunteer hours were completed by carers, which equates to 4 full time staff. 7 carers have moved into employment. 996 signposting referrals were made to other organisations.

Supporting Young Carers

2.26 An objective from the Carer's Action Plan looks at enabling young carers to be able to access and attend support groups where they can meet with peers. Carers of Barking and Dagenham have supported 351 young carers to access services in 2022-23. For the final quarter there were a total of 833 young carers on the database.

2.27 The Action Plan also looks at increasing awareness and referral pathways for young carers, which has been achieved through various partners referring into services such as a disability service, early help services, youth services and social care.

2.28 In terms of enabling young carers to access mental health support, this objective is still being reviewed as the Local Authority does not hold information for Child and Adolescent Mental Health Services (CAMHS). Positively, young carers are also being signposted to Young Minds for support.

2.29 Carers of Barking and Dagenham raise awareness of young carers through ad-hoc focused sessions as required in schools and delivering assemblies, during 2022/23 there were 4 assemblies delivered at schools. Nine schools have made referrals for young carers over the period, however this does not reflect where a young person may not consent to a referral or may have been signposted to the service.

2.30 To support young carers to continue in education, training and employment, the delivery of homework clubs has continued allowing young carers a space to complete the homework away from caring responsibilities. They continue to offer support in relation to careers and offering the opportunity for young carers to access career guidance and employability via signposting to college, universities, Prince's Trust and apprenticeships.

Drug and Alcohol Services – Carers Support Group

2.31 As part of the Carers Charter Action an action was to set up a Carers Group for those supporting people with substance misuse issues. The provider Change, Grow, Live (CGL) have led this group which has supported family members who initially came to seek support for their loved ones and has also had a positive impact on them.

2.32 For the period of 2022/2023, there have been up to 15 face to face sessions held at the service based at St Lukes. There has also been 1 online session specifically requested by partners in Childrens Social Care to support access to the group. The group also supports carers whose loved ones are not in treatment.

2.33 Following implementation of the group, the members have reported the following:

- Although most members that attend the groups have come mainly to seek support for their loved one's addiction, attending the sessions has however impacted positively on them.
- It provides them with a better clarity and understanding of loved ones struggles with addiction and to an extent reassure members that they are not to blame for their loved one's addiction.
- Some of the topics covered at the meetings include:
    - Understanding addiction
    - Blame, shame, and fear
    - Enabling, and Manipulation
    - Communication, Resentment, and anxiety
    - Keeping safe and caring for yourself
    - Support in the community.

2.34 Moving forward the team will be working to increase awareness and discuss the group in more detail with partner agencies both statutory and non-statutory, particularly at the All-MASH Partners Team meeting.

3. Consultation

3.1 The report has been presented at the Barking and Dagenham Adults Delivery Group on 9 August 2023 and at the PRMG BAU meeting on 10 August 2023. The Cabinet Member for Adult Social Care and Health Integration was consulted on the report on 15 August and the report was presented at the Adults Improvement Board on 16 August. The report was received positively at each stage.

4. Summary

4.1 The Carers Charter continues to get positive feedback from external boroughs and partners. Through the strong partnership working and commitment from all the stakeholders we have jointly made a significant amount of progress in the delivery of the action plan and thereby supporting carers locally. Some of the work has meant that we have been able to implement standardised practice across Barking and Dagenham, Havering and Redbridge.

4.2 To support carers during the cost-of-living crisis, during 2022-23 cumulative work in delivering the Carers Charter Action Plan has resulted in £612,728.04 additional income directly to carers of which £9,216.09 is attributed to a reduction in Council Tax and rent arrears.

4.3 The Carers Strategy Group enables a strong focus and concerted effort in the delivery of the Action Plan. There is still a lot yet to do and the partners will be building on the foundations of this year. Data recording and accessing data can often be challenging and this is something that we will be focusing on moving forward with partners as well as working towards a wider Carer friendly community in the borough. Health inequalities and supporting carers with this will also be an area of focus moving forward.

Public Background Papers Used in the Preparation of the Report:

- Carers Charter 2022-25 and Action Plan 10a HWBB Report Carers Charter and Action Plan Final.pdf (lbbd.gov.uk)

List of Appendices:

- **Appendix 1** - The Carers Charter 2022-25
- **Appendix 2** - Carers Charter Action Plan

This page is intentionally left blank

Carers Charter 2022-25

This Carers Charter has been developed with unpaid carers in Barking and Dagenham who provide valuable support to loved ones. The charter outlines the commitment to carers across the borough including our partners and how we will help them in their caring role.

Working together for carers

1. I have help at an early stage.
2. I want friendly professionals who understand my role as a carer and listen to me.
3. I am recognised as an expert and equal partner of care with my views and opinions valued and respected.
4. I want to access a range of support, including breaks from my caring responsibilities, to help me live my life and continue to carry on with my caring role.

Carers wellbeing and employment

1. I have access to information and advice to help me look after my own mental and physical health.
2. I can access an effective response from health and social care to address changes in my loved ones needs, for instance increase in care package so that I can return to work quickly.
3. I am supported to maximise my income including accessing benefits.
4. I am supported with my caring responsibilities so that I can continue to work or study.

Supporting young carers

1. I can attend carers support groups and activities with young carers that understand what I am going through.
2. I can access help to support me with my mental health and wellbeing.
3. I am able to focus on my future and my studies without impacting on my caring role, including university, training, apprenticeships and employment options.
4. My school or college understands my caring role and I feel supported.

Carers in the wider community

1. I recognise I may need help both in my caring role and in maintaining my own health and well-being.
2. I can access a carers needs assessment when I need it.
3. I want to be able to find out information about what services are available in the community.
4. Information is shared with me and other professionals to raise awareness and signposted appropriately.

MC8995 AUG22

This page is intentionally left blank

Carers Charter Action Plan				APPENDIX 2	
Carers Charter Area					
Working together for Carers	**Objective**	**Action**	**Owner**	**Reporting time**	**Measure**
•I have help at an early stage. •I want friendly professionals who understand my role as a carer and listen to me.	Promote identification of hidden carers.	Training to identify carers/hidden carers and understand their contribution to health and social care for all frontline staff within the partnership.	All	Jul-23	Training developed and delivery dates in place.
	Support carers who support substance misuse clients.	substance misuse carers group to be set up.	CGL	Apr-23	Carers group in place.
	Develop a referral pathway at hospital discharge to the Carers Centre.	Referral pathway developed and promoted to staff at BHRUT to refer carers to Carers of Barking and Dagenham.	BHRUT	Mar-23	Referral pathway developed
	Promote identification of hidden carers by GPs.	Training and pop up reminder on GP system to promote recording of carers by GPs. Promote identification and recording of carers by GPs through GP intranet and PTI and links to signposting.	NEL ICB	Quaterly	Number of additional patients recorded as carers.
•I am recognised as an expert and equal partner of care with my views and opinions valued and respected.	Involve Carers in cared for health and wellbeing planning.	Involve carers in the assessment and development of support plans for the cared for.	LBBD Social Care NELFT	Quarterly	Case studies of carers supported
	Develop Carers Champions	Identify champions in the workforce to drive the delivery of the carers charter and bring carers to the forefront of service delivery.	All	Annually	Number of carers champions and successful initiatives
. •I want to access a range of support, including breaks from my caring responsibilities, to help me live the life; and continue to carry on with my caring role.	Support carers in a culturally competent approach to deliver person centred outcomes.	Increase awareness of support requirements for carers of different cultural and racial backgrounds by meaningfully considering race and identity of carers through training and shared learning.	All	Quarterly	Number of training and shared learning sessions that reflect culturally competent practice. Survey of carers experience of service (annual)
	Carers access support and breaks through direct payments.	Development of Carers Market for carers to use direct payments.	LBBD Commissioning Carers of Barking and Dagenham LBBD Social Care	Annually	Number of carers accessing support and breaks through direct payments.

Carers wellbeing and employment	Objective	Action	Owner	Reporting time	Measure
•I have access to information and advice to help me look after my own mental and physical health.	Maximise income for carers	Training to identify hidden carers Maximise income through employment, training and benefits.	LBBD Community Solutions/Inclusive Growth DWP Job Centre Plus Carers of Barking and Dagenham	Quarterly	% of staff completed training (target 60% per annum) - upskill work coaches, re identifying carers -accessing employment, including initiatives like, Plan for jobs, Jets, Work and Health Program, Sector-based work Academy programmes (SWAPS) DEA Direct support, DWP Apprenticeships, volunteering opportunities and employment programmes run by DWP. -increased engagement with Homes and Money Hub, including support with income maximisation, budgeting arrears reduction debt management, access grants etc. - wellbeing courses with a view to employment (confidence/motivation) -training -additional benefits -% increase of Carers Allowance from baseline. -number of carers supported by HAM Hub
	Increase screening and referrals for carers (prevention/early intervention)	Link worker to work with GPs and promote social prescribing carer referral.	LBBD Community Solutions/ NEL ICB	Quarterly	2% increase in carers accessing social prescribing
•I can access an effective response from health and social care to address changes in my loved ones needs, for instance increase in care package so that I can return to work quickly.	Increase awareness of working carers and impact of timely intervention for social care and health staff.	Work with health and social care partners to raise awareness.	Carers of Barking and Dagenham	Six monthly	Case studies of carers supported
•I am supported to maximise my income including accessing benefits.	Increase employment/training opportunities.	Work with Carers to access employment/training and utilise experience gained as a carer.	LBBD Community Solutions/ Job Centre Plus/ Inclusive Growth	Quarterly	% increase in number of carers accessing employment/training and volunteering. % carers engaging with JobShop and Adult College
	Increase uptake of NHS health checks and screening for eligible carers.	Promote uptake of health checks to carers	NEL CCG/ LBBD Public Health	Quarterly	No. of healthchecks accessed by carers.

•I am supported with my caring responsibilities so that I can continue to work or study.	Increase uptake of COVID and Flu vaccinations amongst carers	Continue to promote vaccinations to carers amongst partner organisations.	LBBD Public Health	Annually	% of identified carers vaccinated for COVID % of identified carers vaccinated for Flu
	Support older carers of adult children with disabilities to access advance care planning for cared for.	Plans for adult children with disabilities to be put in place to be implemented after parent passes away.	End of Life Care Service LBBD Social Care	Annually	Number of advance care plans in place
Supporting Young Carers	**Objective**	**Action**	**Owner**	**Reporting time**	**Measure**
•I can attend carers support groups and activities with young carers that understand want I am going through.	Young carers are able to attend activities and meet with peers who understand their situation, and they receive a break from their caring responsibilities.	Activities and regular groups take place to support young carers.	Carers of Barking and Dagenham	Quarterly	Number and type of online and face to face activities.
•Increase awareness and support for young carers.	Increase awareness and referral pathways for young carers	Safeguarding Board Partners are aware of the young carers services	Carers of Barking and Dagenham Disability Services WDP Sector Drugs and Alcohol Services Education Safeguarding	Quarterly	Partners are referring into services.
•I can access help to support me with my mental health and wellbeing.	Increase access to mental health and wellbeing support services.	Work with health partners to increase awareness of young carers and access support. Signpost young carers to mental health support	Carers of Barking and Dagenham, Education and all NHS partners	Quarterly	% increase from baseline young people accessing mental health support.
	Promote awareness of young carers	Work with Carers of Barking and Dagenham and Young Carers to promote carers in the young people's space.	Carers of Barking and Dagenham	Quarterly	Number of assemblies with schools.
•I am able to focus on my future and my studies without impacting on my caring role, including university training and employment options.	Support young people to continue in education, training and employment	Develop partnerships with schools to increase awareness of young carers and how schools/colleges can build on this work.	LBBD Education, Carers of Barking and Dagenham LBBD Community Solutions	Quarterly	Number of new initiatives delivered/ developed. - % increase in NEET young carers accessing advice services for training and employment.
•My school understands my caring role and I feel supported.	Schools where possible are able to work with and help young carers to meet their potential	Increase awareness of support requirements for carers in schools	Carers of Barking and Dagenham LBBD Social Care LBBD Education/ Designated Safeguarding Leads	Six monthly	Number of referrals from schools.
Carers in the wider community	**Objective**	**Action**	**Owner**	**Reporting time**	**Measure**
•Recognise I may need help both in my caring role and in maintaining my own health and well-being.	Identify carers and provide onward referral to Carers of Barking and Dagenham.	Increase awareness of support requirements for carers including providing culturally competent support by meaningfully considering race and identity of all age carers.	All	Quarterly	Breakdown and number of referrals received from partners by Carers of Barking and Dagenham -Case studies of carers supported

•I can access a carers needs assessment when I need.	Increase uptake of carers needs assessments.	All actively promote the carers needs assessment and referral to the Intake Team.	All LBBD Social Care LBBD Performance and Intelligence Team Carers of Barking and Dagenham LBBD Community Solutions Healthwatch	Quarterly	% increase in Carers Assessments from baseline.
•I want to be able to find out information about what services are available in the community.	Develop a carer friendly community.	Work with the all partners and local businesses and employers to develop a carer friendly community.	All Local businesses/ LBBD Community Solutions	Six monthly	Report initiatives and processes developed including service user feedback. - increase in number of flexible employment roles available for carers
	Identify and support carers at incidents or in contact with Police.	Increase awareness of all age carers and appropriately refer to carers support service.	Metropolitan Police	Quarterly	No of referrals received by Carers of Barking and Dagenham.
•Information is shared with me and other professionals to raise awareness and signposted appropriately.	Promote services to carers and partners including signposting and referral pathway.	Promote services through GP intranet, partner websites, faith forums, community and voluntary sector organisations.	All, BD Collective End of Life Care Service Healthwatch Carers of Barking and Dagenham Community Solutions Community Hubs	Quarterly	Monitor referral source to Carers of Barking and Dagenham Strong culture on feedback form referrals and areas where improvements can be made/best practice No of information and training sessions delivered. No of forums attended.

COMMITTEES IN COMMON

12 September 2023

Title:	**Barking and Dagenham Place Based Partnership 2023/2024 Winter Planning**
Open Report	**For Information**
Wards Affected: ALL	**Key Decision: No**
Report Author: Kelvin Hankins, Deputy Director Age Well, NHS NEL	**Contact Details:** kelvin.hankins@nhs.net
Lead Officer: Sharon Morrow, Director of Partnership, Impact and Delivery Barking and Dagenham	

Summary

This brief paper outlines the national requirements in respect of winter planning and plans underway to prepare for winter across the Barking and Dagenham partnership. Winter planning is underpinned by the partnership Barking and Dagenham, Havering and Redbridge (BHR) Places Urgent and Emergency Care (UEC) Improvement Plan, which was developed to respond to ongoing demand pressures for urgent and emergency care services.

The Place winter plan focuses on three core areas of prevention, hospital avoidance and discharge support. Priorities and key actions have been developed through a partnership workshop and will be developed further through the Adults and Children's Delivery Groups.

A winter resilience campaign is planned to help residents better understand how to access services and support people to stay well over winter. The plan is supported by some additional funding through the

The winter plan will be a live document led across the system and will be adapted and refined in line with the changing position over the coming months, ensuring it is responsive and dynamic.

Recommendations

The Committees in Common are asked to:

- Discuss the draft winter plan and emerging priorities
- Approve the demand and capacity investment plan
- Consider how the partnership can support the winter resilience campaign for residents

Reasons for report

Demand for health and social care services is expected to increase over the winter months due to a range of pressures including a rise in respiratory illnesses, flu and COVID. The cost of living crisis and rising energy prices could have a significant impact on cold and poverty related illness, particularly for vulnerable residents and those on low incomes. Workforce challenges are evident across the system, with further industrial action expected in the NHS.

With effective, system wide planning and collaboration we are well placed to ensure effective services and support for our residents.

1. Introduction and Background

1.1 This paper is to update the Committees in Common on winter planning preparation for 2023/24 and the emerging priorities for the place partnership.

1.2 The Committees received a report at the June meeting on Improving Urgent and Emergency Care (UEC) across Barking and Dagenham, Havering and Redbridge. This noted the unprecedented and ongoing demand in urgent and emergency care since the Covid-19 pandemic and updated on the development of a partnership BHR Places UEC Improvement Plan that draws together all the actions planned and underway to improve our system locally.

1.3 On 27 July 2023, NHS England published guidance on Delivering Operational Resilience across the NHS this Winter, linked to the National Urgent and Emergency Care Recovery plan and in recognition of the challenges in the winter of 2022/23. The guidance confirms the national approach to 2023/24 winter planning and key steps across all systems to meet the winter challenges, along with the Primary Care Recovery Plan, Elective Recovery Plan, and broader strategic and operational plans and priorities for the NHS.

1.4 There are four focus areas for the winter operating plan:

- Continue to deliver on the UEC Recovery Plan by ensuring high impact interventions are in place
- Complete operational and surge planning
- ICBs should ensure effective working across all parts of the system (all partners and the voluntary care sector)
- Support our workforce to deliver over winter – encompassing a systematic focus on the NHS people promise and NHS Long Term Workforce Plan

1.5 The two key measures identified as related to the winter plan are:

- 76% of patients admitted, transferred or discharged within 4 hours by March 2024 with further improvement in 2024/25
- Ambulance response time for category 2 incidents to 30 minutes average over 2023/24 with further improvements in 2024/25.

In addition, the plan focuses on the delivery of the High Impact Interventions (HII) as part of the winter plan, designated inputs and actions through system partnership.

2.0 NEL system roles and responsibilities

2.1 The national guidance set out that Integrated Care Boards (ICBs) will lead on the development of a winter operating plan, supported and developed in partnerships through placed based plans, health and social care partners and collaboratives.

2.2 Acute and Specialist trusts will lead on the following High Intensity Interventions (HII) through the Acute Provider Collaborative:

1.	Same day emergency care	Reducing variation in SDEC provision by operating a variety of SDEC services for at least 12 hours per day, 7 days per week
2.	Frailty	Reducing variation in acute frailty service provision. Improving recognition of cases that could benefit from specific frailty services and ensuring referrals to avoid admission
3.	Inpatient flow and length of stay (acute)	Reducing variation in inpatient care and length of stay for key pathways/conditions/cohorts by implementing in-hospital efficiencies and bringing forward discharge processes for pathway 0 patients
4.	Community bed productivity and flow	Reducing variation in inpatient care and length of stay, including mental health, by implementing in-hospital efficiencies and bringing forward discharge processes.

2.3 The ICB will lead on the following High Impact Interventions (HII).

5.	Care transfer hubs	Implementing a standard operating procedure and minimum standards for care transfer hubs to reduce variation and maximise access to community rehabilitation and prevent re-admission to a hospital bed
6.	Intermediate care demand and capacity	Supporting the operationalisation of ongoing demand and capacity planning, including through improved use of data to improve access to and quality of intermediate care including community rehab.
7.	Virtual wards	Standardising and improving care across all virtual ward services to improve the level of care to prevent admission to hospital, and improve discharge
8.	Urgent community response	Increasing volume and consistency of referrals to improve patient care, ease pressure on ambulance services, and avoid admission
9.	Single point of access	Driving standardisation of urgent integrated care coordination which will facilitate whole system management of patients into the right care setting, with the right clinician or team, at the right time.
10.	Acute respiratory infection hubs	Support consistent roll out of services, prioritising acute respiratory infection, to provide same day urgent assessment with the benefit of releasing capacity in ED and general practice to support system pressures

The ICB actions will be led via the Place Based Partnerships to be amalgamated into the NEL Plan.

2.4 There are defined responsibilities and roles for partners in developing collaboratively the winter operating plan. These include

- Primary Care
- Children and young people
- Community trust and Integrated care providers (HII 4-6)

- Ambulance trusts
- Mental health providers (HII 3,4 and 9)
- Local authorities / Social Care

2.5 The BHR Places Urgent and Emergency Care Improvement Board is co-ordinating the Barking and Dagenham, Havering and Redbridge system contribution to the ICB winter operational plan.

3.0 Aims and Objectives

3.1 The objective is to ensure that residents are able to access the care and support they need to keep them well this winter. This means:

- Helping people stay well, independent and healthy, preventing them needing acute levels of care as far as possible;
- Ensuring that we are planning for and delivering the capacity we need for those who do need it;
- Ensuring that people can access the right care at the right time, and which prevents them from becoming more unwell whilst they are waiting;
- When a resident has been admitted to hospital, ensuring that we have the right plans and support in place that they can move to a less acute setting and regain their independence as quickly as possible.

4.0 Draft winter plan

4.1 Winter planning is at the development stage across the system and places and the acute provider collaborative are in the process of mapping their collective activities and engaging on new plans for winter.

4.2 The Barking and Dagenham Adults Delivery Group held a workshop on 9th August 2023 to discuss opportunities to strengthen the partnership response to winter resilience. The workshop focused on the areas of Right Care First Time, prevention, proactive care and discharge support. Some key themes that came out of the discussion included:

- Improving the communication channels between providers – strengthening and improving access to a directory of services that enabled practitioners to refer to the full range of out of hospital services
- Education and better communication with our residents so they know how to access local community services and care for themselves and their families
- Early preparation and taking a more proactive approach to planning – engage with resident well ahead of winter sot that they feel that they have a stake in what is being offered
- Development of a robust response for people presenting with mental health conditions in the community

- Optimising current services and pathways e.g. integrated case management, voluntary sector support post discharge

- Improving the discharge process – better understand the reasons for delays for B&D residents and support early discharge planning

4.3 Priority areas for some specific partnership work are outlined in Attachment 1 alongside a first draft of initiatives that have been identified to support winter resilience. It is anticipated that the schemes and governance for the local plan will be developed further through the Adults Delivery Group and Children's Best Chance Group and Health Protection Board. System wide initiatives will be overseen by the BHR Places Urgent and Emergency Care Improvement Board.

4.4 The ICB winter resilience campaign aims to help people better understand how to access services, working with borough partnerships to pilot new approaches and deliver targeted outreach to help vulnerable groups stay well over winter. An overview of the campaign is provided in Attachment 1.

5.0 Community capacity

5.1 There has been additional investment committed this year in primary care, community, local authority and voluntary sector services to enhance capacity which will support resilience over winter:

- Demand and capacity funding has been allocated to enhance capacity in community, voluntary and social care services over winter (Attachment 1)

- Adult Social Care funding of £2391K has been pooled in the Better Care Fund budget. This is supporting
    - Phase 2 of our reablement pilot to support discharge to the community and prevent re-admission
    - Capacity and support for complex discharges, including Mental Health and homeless step down beds
    - Unfunded homecare and crisis intervention packages
    - Unfunded residential, nursing and supported living placements
    - Workforce initiatives to support market challenges

- NHS NEL is investing in primary care to extend standard primary care provision, provide easier access to primary care clinical support prior to A&E and support better planned care. This service will provide urgent primary care services between 6.30 pm to 8pm Monday to Friday and 10am to 8pm weekends and Bank holidays. This maintains the activity provided through the GP hubs and provides additional access sites.

- LBBD are proposing to fund a 12-month programme of monthly health and wellbeing pop up support at community hubs partnered with the local GP/PCN

- NHS NEL are progressing a business case to fund a pharmacy minor ailment scheme service.

- The partnership is supporting a number of schemes to support a reduction in health inequalities

6. Finance

6.1 Nationally, funding has been identified to support the winter resilience plans:

- 1 billion of dedicated funding to support capacity in urgent and emergency services, building on the £500 million used last winter.
- £250 million worth of capital investment to deliver additional capacity.
- £200 million for ambulance services to increase the number of ambulance hours on the road.
- Together with DHSC, an additional £1.6 billion of discharge funding over 2023/24 and 2024/25, building on the £500 million Adult Social Care Discharge Fund.

6.2 Across North East London ICS:

- Discharge funding has been allocated via Councils and the ICB to Better Care Funds in line with guidance. The Barking and Dagenham share of the allocation is outlined in Appendix 1.
- North East London has been allocated approximately £6m investment split across capital and revenue to deliver additional capacity
- It is not yet clear how the £200 million for ambulance services to increase the number of ambulance hours on the road will be distributed
- The capital incentive scheme depends on achievement of targets as noted elsewhere

6.3 Currently no further Winter Funding has been announced however the intention is to develop a list of potential schemes which the partnership has agreed in advance with a clear understanding of impact. Any new Winter Schemes will need to be linked to showing a reduction in hospital attendances, hospital admissions or reduction in length of stay.

7. Risks and mitigations

7.1 The system is already under significant pressure with high levels of demand touching all partners. A number of residents are living with increasing acuity and complexity of conditions which require highly specialised responses for both long term and urgent presentations. There is a need to ensure a dual focus on community and urgent care provision and to retain a focus on system working at all levels.

7.2 The cost-of-living crisis is hitting residents hard and there is a risk that this could further increase heath inequalities across the borough and impact on health outcomes. The partnership has invested in a number of schemes to reduce health inequalities.

7.3 Ongoing industrial action over the winter months will impact on elective care and waiting lists which may increase the demand and

List of Appendices:

Appendix 1 - Barking and Dagenham Place Based Partnership 2023/2024 Winter Plan (Draft v 1)

Appendix 2 – Barking Havering and Redbridge Urgent and Emergency Care Improvement Plan

APPENDIX 1

North East London Health & Care Partnership

NHS North East London

Barking and Dagenham Place Based Partnership 2023/2024 Winter Plan (Draft v 1)

Barking and Dagenham Place Winter Plan

Key Principles for the development the Barking and Dagenham Winter Plan

Plan ahead and start early

Agree our priorities

- What can we do now?
- How do we make every contact count?
- How can we strengthen our communication, engagement and marketing over winter?

Develop a pipeline of new projects that could be brought in at short notice

Priority Groups

There are a number of programmes that are in place e.g. flu/COVID vaccinations, carers action plan. It is proposed that the partnership focuses on three that may need target additional support this winter.

- Children (0-4) and families
- People with respiratory disease (adults and children)
- People with multi-morbidities accessing integrated case management

Plans will ensure a focus in reducing health inequalities in these groups.

How the plan has been developed:

On the 9th August the Place Partnership came together to develop the priorities, areas of concern and key actions for the winter plan. The workshop included representation from Adults and Children Services, Local Authority, NELFT, BHRUT, Barts Health, Voluntary Sector and Primary Care. The workshop was focussed on three core goals:

1. Engaging in proactive population health management to keep people well in the community. (Prevention)
2. Strengthening the provision and access of alternative pathways to reduce UEC footfall and attendance (Hospital Avoidance)
3. Optimising flow through Acute and Mental Health trust sites. (Discharge)

Children and Young People workstream

The key areas of focus for Children and Young People was for us to better understand the increase in children attending Emergency Care and what we need to focus on and have in place during winter to ensure appropriate community support is in place.

Barking and Dagenham Place Priorities	System Priorities
Prevention	
Better use of public health intelligence to prepare for community infections	Commission Pharmacy First Scheme
Optimise uptake of the MMR and flu vaccines	Explore commissioning of respiratory hubs
Proactive care for children and young people with asthma	Minor ailments scheme
Parent information pack to ensure consistent messaging	
Training for community pharmacists	
Asthma and allergy friendly school co-ordinator	
Development of integrated care pilot for children and young people	
Hospital Avoidance	
	Virtual ward: Hospital at home service (longer term)
	Increase access to paediatric expertise through further roll out of NHS111 Paediatric Clinical Advisory Service
Discharge	
	Better support for discharge through clear pathways and escalations including for people who live out of area

Adults workstream

The adults workstream have focussed on the impact of the cost of living crisis on physical and mental health wellbeing, maximising the update of flu and COVID vaccinations ensuring we have a “every contact counts” approach, targeting attendance and admission avoidance schemes to particular resident groups and ensure that we maximise the effectiveness and outcomes of existing pathways such as proactive care. Ensuring that we consider and support the needs of carers during winter as a key partner in our system.

Barking and Dagenham Place Priorities	System Priorities
Prevention	
Optimise uptake of flu, COVID and pneumococcal vaccinations	Respiratory hubs
Informal carers identification and support	Minor ailments scheme
Pre-winter checks for people with respiratory disease/cardiac disease - health and care	
Review access to integrated care management service and relaunch service	
Promote falls prevention services	
Develop community catheter service	
Support for people with financial pressures through Cost of Living Alliance and debt and health proactive outreach	
Hospital Avoidance	
Community urgent care 2 hour response	High intensity users
Anticipatory care for end of life	Virtual wards - frailty, catheter
Enhanced heath to care homes	Ensure access to 24/7 liaison mental health teams
Unscheduled Primary Care Hubs, supporting primary care with same day appointments	Ensure direct access to urgent mental health support through NHS 111 ‘option 2’

Discharge

The Barking and Dagenham system is unique in that it does not have an acute hospital within its footprint with residents, depending on where they live in the borough, will mainly access Queens Hospital in Romford or Newham University Hospital in Newham. Due to this arrangement the understanding of why Barking and Dagenham residents are not swiftly discharged from hospital is not well understood. To ensure that the system is as responsive as possible we are planning to undertake a deep dive of reasons for delays and the impact of these on our residents during September and October, the outcome will inform a improvement plan. The deep dive will also support us to deliver against national priorties on:

1. Intermediate Care and Reablement
2. Home First Discharge Principles
3. Discharge to Assess

Barking and Dagenham Place Priorities	System Priorities
Deep dive of the reasons for discharge delays in B&D (physical and mental health)	Agree plan for early discharge planning
Implement BD Collective/Care City discharge support pilot	Christmas plan to avoid late discharge of complex patients
Reablement pilot	Provide a befriending/take home and settle service
Commission extra care beds	
Strengthen discharge to assess pathway (residential and home)	

2023/24 Funding

New additional funding has not been announced to support winter however there are existing funding sources available to support the system. These include the Adult Social Care Discharge Funding, which for Barking and Dagenham is £2.3m, which is used to support adult social care discharge pathways during the year. The other source is non-recurrent Demand and Capacity Funding, which is comprised of three pots, £1.1m for BHR Places where services are delivered across the three boroughs, £1.4m for BHRUT and £600k for Barking and Dagenham place. The demand and capacity funding planned schemes, for out of hospital, is detailed below:

BHR Schemes

Schemes	Provider	Period covered	Cost	Objective
Additional rehab beds for winter	NELFT	1/11/23-31/3/24	£240,392	4 additional IPR beds
Intensive Rehab Service expansion	NELFT	28/11/23-31/3/24	£340,645	To increase capacity to meet demand and reduce waiting list
Key safe stock - held by BHRUT	BHRUT	14/11/23-31/3/24	£1,000	30 key safes to support discharge
Home first transport		01/7/23-31/3/24	£156,000	Support discharge for patients on the Home First pathway
Key safe fitting/ furniture moves	Age UK	14/11/23-31/3/24	£11,000	Equipment and furniture moves to support discharge and reduce LOS
Extension of ED social workers	LBH	1/1/24-31/3/24	£47,931	2 SWs in frailty units/ ED
Red cross - discharge support	Red Cross	28/11/22-31/3/23	£52,203	Support 60 users per month for discharge from CTT in ED or community
TOTAL			**£849,171**	
Allocation			£1,188,811	
Unallocated			**£339,640**	

Barking and Dagenham Place Schemes

Description of the scheme	Key partners	Benefits expected from the scheme	Time period	Allocated Funding
2x Social Workers in the community / hospital; 1 x social worker for MH support	BHRUT, NELFT, providers	Faster social work assessments, Faster POC starts, Faster ED discharge, Social Workers in Acute setting / Hospital	November 2022 - 31 March 2023	£76,182
Occupational Therapy Capacity (2 OTAs)	BHRUT.	Reduce OT waiting lists in the community and support quicker discharge where a community OT assessment	November 2022 - 31 March 2023	£50,788
Equipment and care technology	BHRUT, Med equip, vol sec organisation	Quicker discharges were equipment is required same or next day.	November 2022 - 31 March 2023	£203,152
Discharge flats (extra care) -	BHRUT, Housing	2 flats to be ring-fenced to support discharge with short term accommodation and care , where inpatient rehab or D2A is not required.	November 2022 - 31 March 2023	£42,323
Housing Support with voluntary sector organisation	BHRUT, LBBD Housing	Quicker discharge where there maybe housing issues delaying the return to the community.	November 2022 - 31 March 2023	£16,929
Unfunded Winter pressures: residential, nursing and homecare. Additional packages/placements in this area required to mitigate pressures.	BHRUT, NELFT, providers	Reduce admissions by providing enhanced capacity in supported living, residential, nursing, crisis intervention and homecare	November 2022 - 31 March 2023	£211,617
				£600,991

NHS
North East London

‘Finding the right NHS help’ campaign

Author: Jackie McMillan, Head of Communications & Engagement

Date: August 2023

Campaign objectives

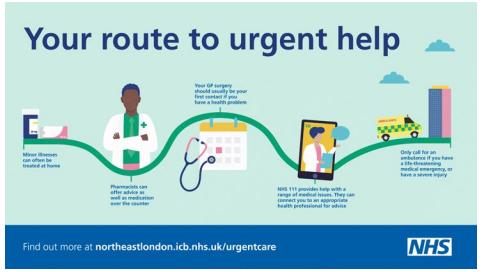
The reasons why people attend A&E unnecessarily are complex and cannot be solved through communications alone. What our campaign aims to do is to:

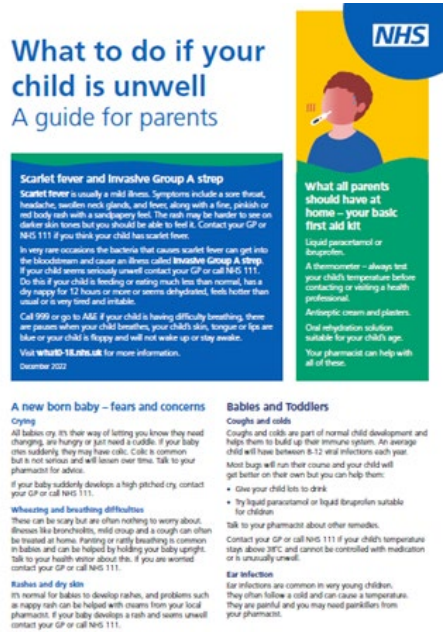
1. Help people understand how and when to access primary and urgent care.

2. Address the common reasons why people might attend A&E for non-urgent reasons and signpost to the right support.

3. Work with our borough partnerships to pilot new approaches and deliver targeted outreach to help vulnerable groups stay well over winter.

4. Target those more likely to attend A&E with low acuity issues (18-40s, parents of young children and people with lower income) focussing on these key themes:
    - How to access GP services, covering:
        - Types of appointments
        - Booking appointments out of hours
        - The range of health professionals you can be seen by
        - How and why you should register with a GP practice
    - Support from your local pharmacy and self-care
    - Children's health
    - NHS 111
    - Mental health crisis support services





Campaign strategy for 2023/24

Halo campaign

Finding the right NHS help "always on" content

PURPOSE: Building awareness, understanding and confidence in primary care in NEL.
Broken down into key themed strands: GP access, pharmacy, urgent help, staggered over 12 months

WHO: Digital campaign targeting all key audiences – 18-40, low economic groups, geography upweight in BHR, targeting those in close proximity to A&E and particular wards

HOW: Paid search advertising, paid social advertising, organic social, press, partner channels

Targeted interventions

Parents of young children

WHO:
Parents with children under 5 across north east London.

HOW:
Digital advertising targeting parents with child health content. Parent leaflets at key touch points / children's services etc.

Vulnerable groups

WHO:
Over 65s, social care recipients, unpaid carers, other vulnerable groups.

HOW:
Joint partnership Winter Wellness information pack targeting vulnerable demographics. Trialling a mail drop in Havering and B&D to test effectiveness. Booklet will include information on accessing NHS services, vaccinations, warm hubs, cost of living support etc.

Hyper local geo-targeted activity

WHO:
Targeting GP practices / postcodes / individuals which are driving the most unnecessary attendances.

HOW:
Winter Wellness events in B&D and Havering, comms at practice level. Push notifications, local out of home advertising, budget and data depending.

Responding to local need

Pressure Points

Boost halo messages in response to pressure in the system i.e. strikes, A&E closures, OPEL pressures

This could be via targeted direct text messaging, boosted social media advertising.

Halo campaign strands

The overarching campaign will start in September / October and run for 12 months, focusing on the following themes:

GPs and GP access

- Registrations
- The range of professionals you can be seen by
- Different ways to access your GP including online consultation forms
- The NHS app
- Convenient OOH appointments
- Fuller Review transformation

Pharmacy

- Support with minor ailments
- Emergency medicine
- Many pharmacies are open until late and at weekends. You do not need an appointment.
- CPCS
- Fuller Review expansion of prescriptions

Minor conditions and child health

- Minor condition focussed content directing people to pharmacy
- Parent focussed content directing people to pharmacy
- Long term condition management via GP

Urgent help

- Out of hours urgent GP appointments.
- NHS 111
- A&E for emergencies only
- Hierarchy of help – ‘route’ to help from self-care to A&E
- Mental health crisis support

Things we're doing differently this year

1. "Always on" approach. Activity planned over 12 months, upweighted in winter.

2. More data means we can target our audiences better. Bespoke marketing aimed at vulnerable groups and parents of young children.

3. Hyper local partnership activity in B&D and Havering where there is greatest pressure. Joint winter wellness events and marketing planned.

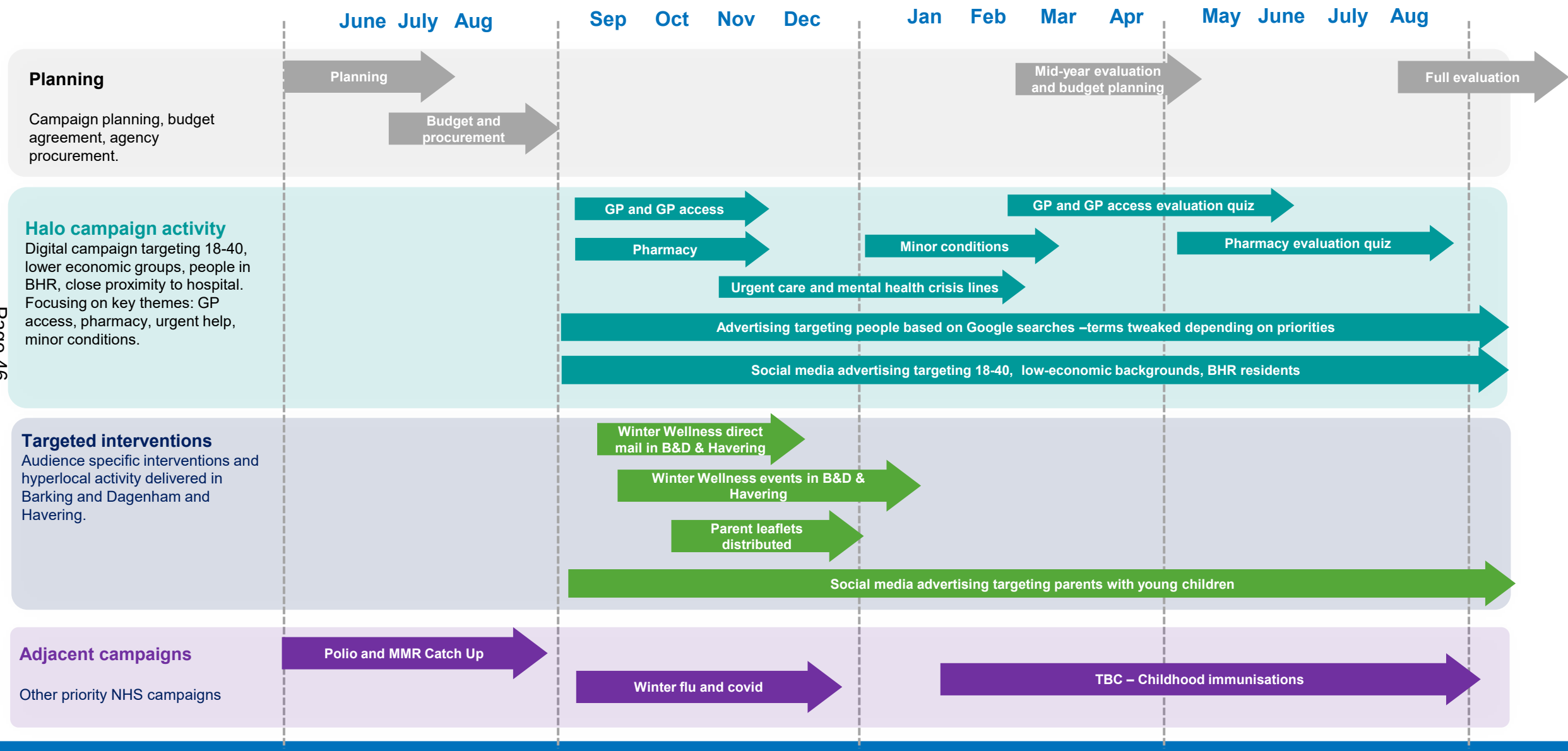
4. Ongoing content development with local clinicians, providers, faith groups, case studies and communities.

5. Extensive communications toolkit updated and shared weekly with over 700 stakeholders in north east London.

6. Improved methods of evaluation to show the impact of our digital and offline activity.

7. Budget agreed sooner so campaign will begin ahead of winter in Sept/October instead of December.

Indicative Timeline



Appendix: Last year's campaign summary for 2022/23

Phase 1 – Winter (December to March)

5.21 million
Impressions
(views of our adverts)

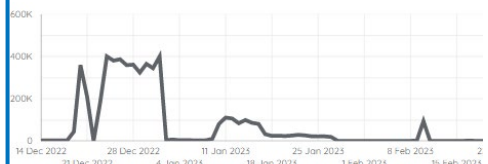
50,000+
Clicks

224,000
Interactions

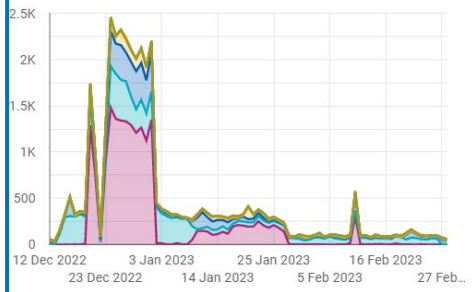
£0.78
Cost per click

£0.17
Cost per interaction

Adverts/impressions



Website page views



34,000
visitors to website

45,000
page views

25-44
most visitors from this age group

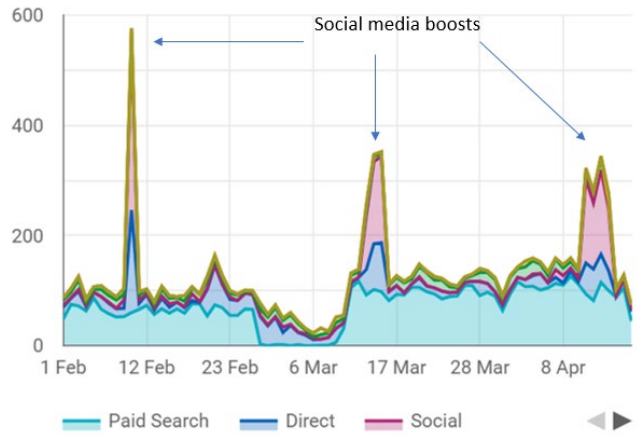
1min +
average read time

Phase 2 – Strikes (March onwards)

We carried the campaign on past March into April and May with 'always on' google search routing and paid for social media boosts around strike days.

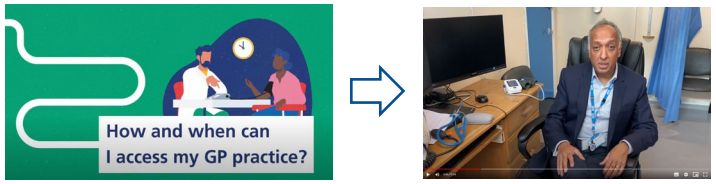
This drove a significant increase in traffic to our Urgent Care campaign pages on strike days (see below).

Around **2,750** visits to our campaign pages during those three periods of strike action. It proved very cost-effective – we had a consistently good cost per click rate on all strike days



Appendix: Last year's campaign summary for 2022/23

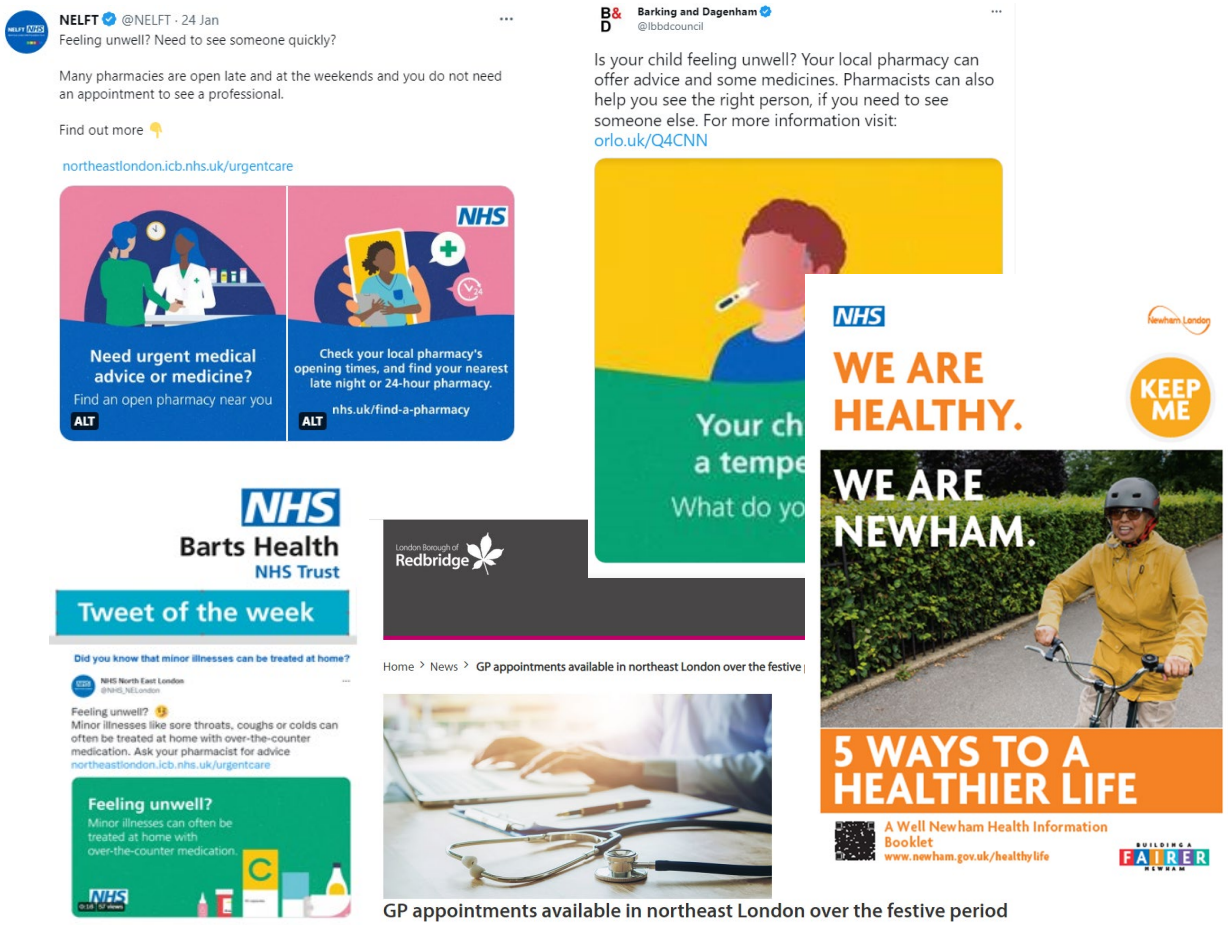
Content



- 100+ different assets (posters, screens, animations, social media ads) in different formats
- 5 x English language primary care videos
- 8 x community language videos
- Posters, leaflets including on child health
- Easy reads in 11 x community languages
- 5 x webpages updated with digital content
- Strikes video
- Monthly GP appointments infographic
- Press notices
- 7 x GP columns
- Toolkit for all partners

You can watch a 2 minute show reel of the materials we developed for the campaign here (copy into Chrome):
https://youtu.be/e_ApSbtIYUM

Working in partnership



GP appointments available in northeast London over the festive period

Outcome and Next Steps

There is further work to be undertaken on the detail behind the priorities and the expected impact of those priorities. The xxxxxxx Board is asked to:

1. Note the contents of this report and the progress made in the development of the Winter Plan.
2. Confirm that they are supportive of the priorities identified.

The next stages for development of the Winter Plan include:

1. For the Children and Adults Workstreams to develop a high level delivery plan against the priorities identified
2. Development of key performance and outcome measures to track progress against the Winter Plan.
3. Develop a prioritised list of schemes which can support during Winter if further funding is made available.

This page is intentionally left blank

APPENDIX 2

NHS
North East London

UEC Improvement Strategy and Plan: BHR Places

Version 7.0

June 2023

Overview of Barking and Dagenham, Havering, Redbridge Places

- **Within BHR there are significant areas of deprivation** - based on the 2021 census, out of all London local authorities, Barking and Dagenham has the highest number of households experiencing a dimension of deprivation (the four dimensions of deprivation are employment, education, housing and health and disability). The cost of living crisis is having a disproportionate impact on those from lower income households across north east London.

- **There is a growing population** – in total across BHR over the last five years alone the population has grown by 1.3% (19,618 people). Redbridge is the 11th largest borough in London with the 8th largest increase in population across all boroughs. Havering's children's population grew by 20% between the 2011 and 2021 census (highest in London, second highest in England) and is projected to grow by 15,000 by 2032. B&D's house building programme will result in at least another 50,000 residents over the next 20 years

- **Age demographics** – there is a high proportion of residents aged over 65 – in Havering this is expected to increase by 13% by 2032.
    - **Barking & Dagenham has a relatively young population** compared to the rest of London with 17.7% of residents aged 9 or under

- **Primary care – average GPs per 100k of the population is below the north east London (48.2 per 100k) and England (76 per 100k) averages in each of the three Places**
    - Redbridge 37
    - Havering 39
    - Barking and Dagenham 39

Overview of Barking and Dagenham, Havering, Redbridge Places (cont.)

- **BHRUT is one of the busiest A&Es in the country** - based on ED attendances (all types) in November 2022 – BHRUT was the 12th busiest in the country and the 4th busiest in London
- **Avoidable admissions** at Queens appear 3 times higher than other sites. There are practice outliers in B&D and Havering from which avoidable admissions are particularly high
- **The winter of 2022/2023** was exceptionally busy with high demand on ED and primary areas of need driven largely by frailty (older people) and respiratory (all ages)
- **Responses to people with mental health needs** can be variable, resulting in long waits in ED for appropriate assessment and support

System Overview

There is widespread recognition that the system has a role to play in bringing partners together, supporting collaboration and ensuring action as required. This improvement strategy sets out how we will work together as a system to ensure UEC services are resilient and delivering well for our local populations. This includes reporting from the Place Partnerships and Collaboratives on the work that supports the plan and ensuring a focus on addressing need and reducing demand as well as on responding to those requiring an urgent response.

We know that individual organisations are undertaking a range of actions, all of which are contributing to improvements, and it is through this Plan that we bring together all these actions to ensure we are co-ordinated, cohesive and having maximum impact. Acting in a system way we aim to understand their interdependencies, reduce duplication and fragmentation and to respond to the needs we have in our system. As noted above, this marks a change from previous approaches to urgent and emergency care locally.

The various elements that we are bringing together here include:

- Work at place (Borough) level to tackle drivers of ED attendance and admissions and ensure an effective response, whether prevention, diversion to alternative community provision or admission with timely discharge
- Work to sustain and increase primary care capacity and capability
- Work with LAS to increase appropriate conveyance avoidance in turn reducing ambulance delays and admission
- Responses to the findings of the CQC from their inspections of UTCs and BHRUT front doors improving experience and outcomes
- Support to and assurance of, PELC's improvement plan including an independent governance review of PELC
- System work on reducing long waits for those in mental health crisis in our emergency department
- Work to improve patient flow through each of the hospital sites
- Mobilisation and growth in capacity of Virtual Wards for both frailty and respiratory
- Communications assets and engagement with local people

System Overview: governance

We have increasingly robust system governance designed to enable us to work together to improve the urgent and emergency care pathway including a North East London UEC System Board chaired by the NHS NEL Chief Medical Officer which holds to account the BHR Places UEC Improvement Board for delivery against this Improvement Plan. There is a single programme approach, with a senior programme lead for north east London working to deliver a single, co-ordinated plan.

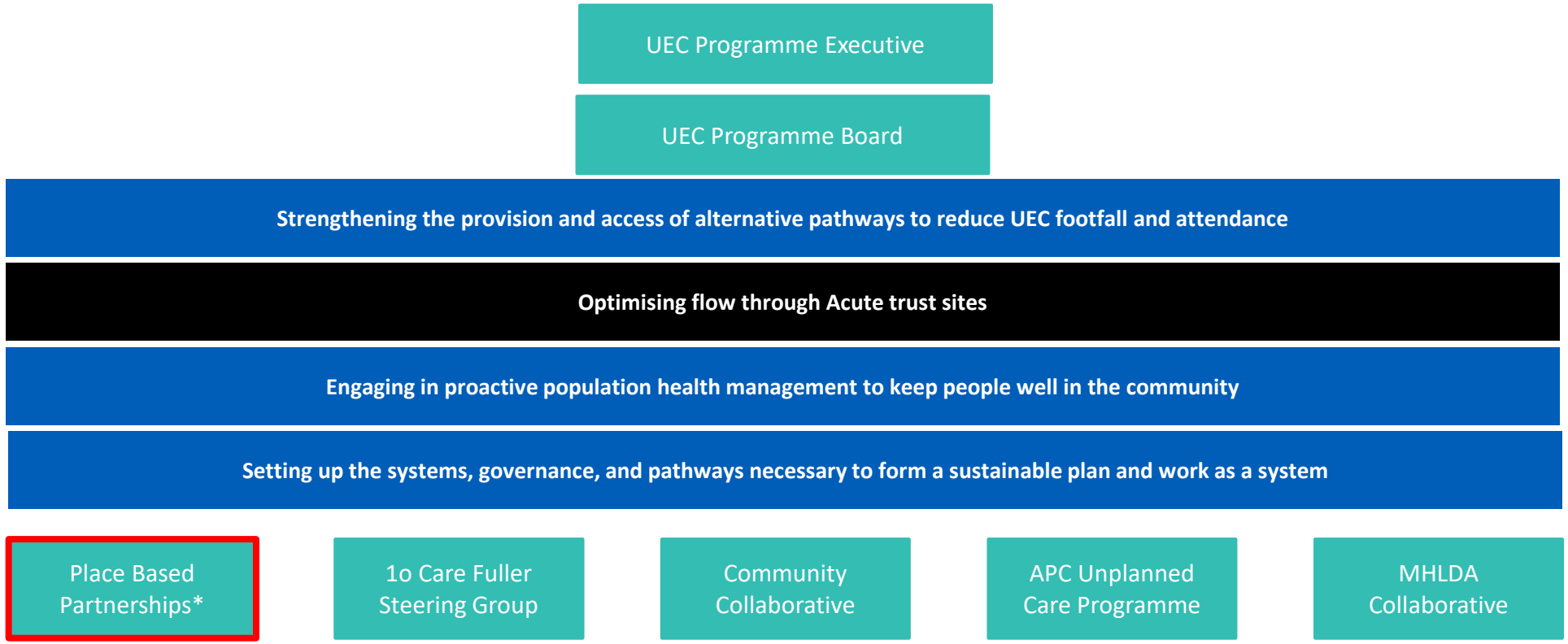
The BHR UEC Places Improvement Board (the Board) is a system level and strategic Board which oversees the Improvement Plan. The Board is clinically chaired and led, enabled by system leaders with responsibility for a range of deliverables. Reporting to the Board are a number of sub-groups which deliver on the wide range of workstream activity required. There are groups in place (as set out below) but others may be deemed necessary by the Improvement Board:

- Discharge Improvement Working Group
- PELC CQC Assurance Group
- BHRUT UEC Improvement Programme
- NELFT UEC Programme
- Place Partnership work including dedicated work on implementing integrated neighbourhood teams and delivering virtual wards
- NEL Primary Care development of same day capacity to deliver continuity of care

Whilst this is complex, it is important that the interdependencies are held at an appropriate level, here across the BHRUT footprint and for the BHR Places with contributions from across north east London and from individual Place Partnerships.

Proposed north east London UEC programme governance

- We want to align and connect all of the improvement work that is already underway and led by our Place Based Partnerships, individual providers and Provider Collaboratives
- All reporting of our improvement work to the UEC Programme Board is aligned to our five strategic system goals. Delivery of individual improvement projects is overseen by Place Based Partnerships, Provider Collaboratives and NEL programmes
- No additional meetings aligned to the strategic system goals will be introduced without agreement of the UEC Programme Board



* includes BHR improvement plan

System Overview: Demand

We recognise significant pressures on urgent and emergency care services across north east London, with the greatest pressure on services for residents in Barking & Dagenham, Havering and Redbridge using Queen's and King George Hospitals. We are beginning to better understand the nature of our demand which we can see is driven largely by three cohorts: older people with frailty, people of all ages with respiratory issues and people with mental health needs in crisis.

It is important that we recognise the context of need in which this demand sits. For frailty, the demographics of the local population, the levels of deprivation compounded by the cost of living crisis and the capacity in primary care can be seen as contributory factors to high demand from frail older people. For respiratory, we see high levels of air pollution, again linked to deprivation and housing development, with significant levels of smoking in parts of the population, poor asthma management and the reality of variable primary care capacity. And for mental health, again deprivation is an important context as are the wider pressures on mental health access and responses in the community.

During winter 2022/2023, demand on crisis and ED services was exceptionally high affecting performance but equally demonstrating the importance of working at a system level to keep people well at home and to avoid hospital attendances and admissions wherever possible. A cluster of factors, including population level concerns about Strep A for very young children, a resurgence in flu and Covid and variable access to same day primary care across the locality led to significant use of emergency provision. However, it is noteworthy that we are seeing exceptionally high levels of demand during the summer months too, with the hot weather, air pollution and pollen count leading to unprecedented demand on the front door of ED – all again underlining the need for a system approach which builds effectiveness of approach and efficiency of delivery together.

System Overview: Data

We recognise significant pressures on urgent and emergency care services across north east London, with the greatest pressure on services for residents in Barking & Dagenham, Havering and Redbridge using Queen's and King George Hospitals.

Some supporting data is provided in the next slides and has been used to identify areas requiring specific focus as then followed up in the Improvement Plan. We will use this data to track progress as we initiate the range of improvements, additions and changes set out in the Improvement Plan. Where intended impacts are not seen in our data we will review and reflect on next steps including further changes and improvements.

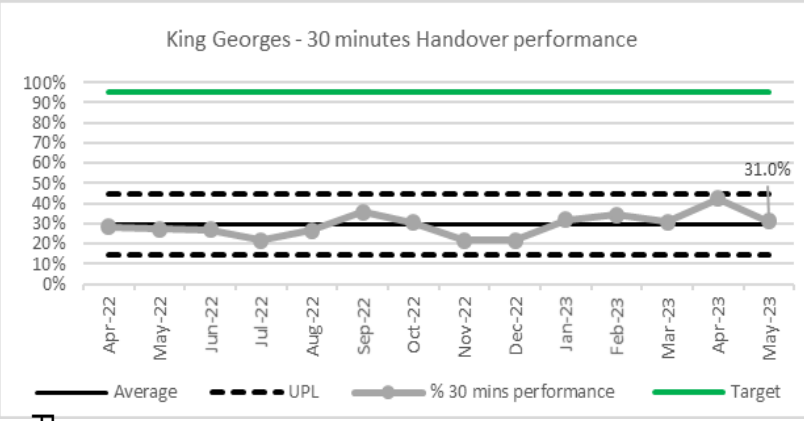
We see these pressures reflected in:

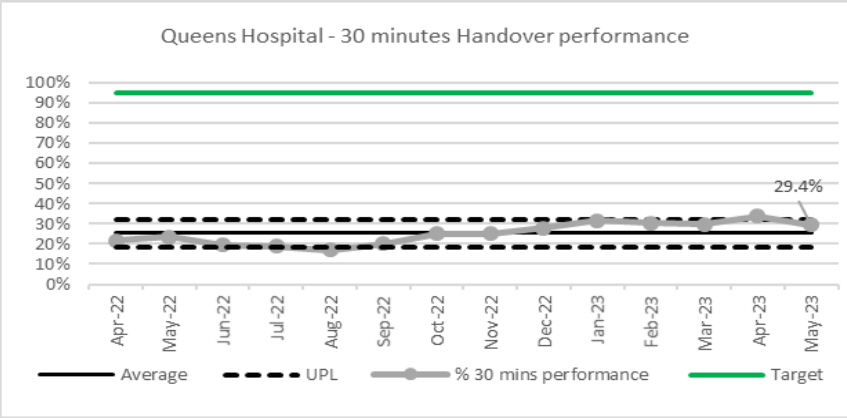
- Ambulance handover times against targets
- UTC – 15 min stream and 4 hour wait
- ED waits – 4 hour wait
- Bed occupancy
- 14 and 21 day Length of Stay
- Patients not meeting criteria to reside
- Activity levels in our GP Access Hubs, in Queen's and KGH's EDs and in the four UTCs across this area
- Elective waits

Ambulance Handovers

Data source – Ambulance monthly published data

30 minute handovers



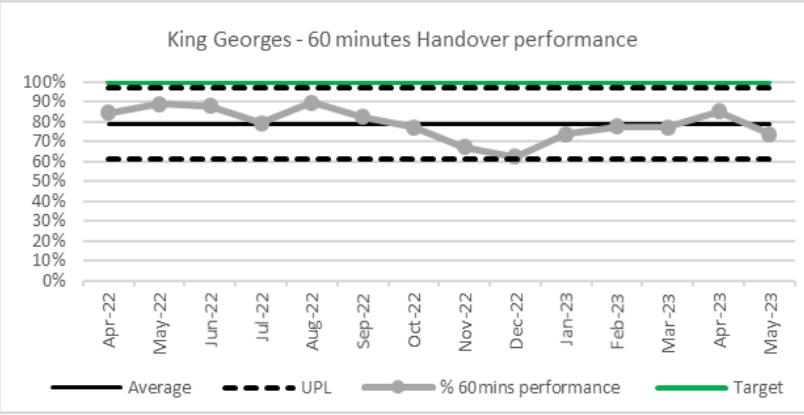


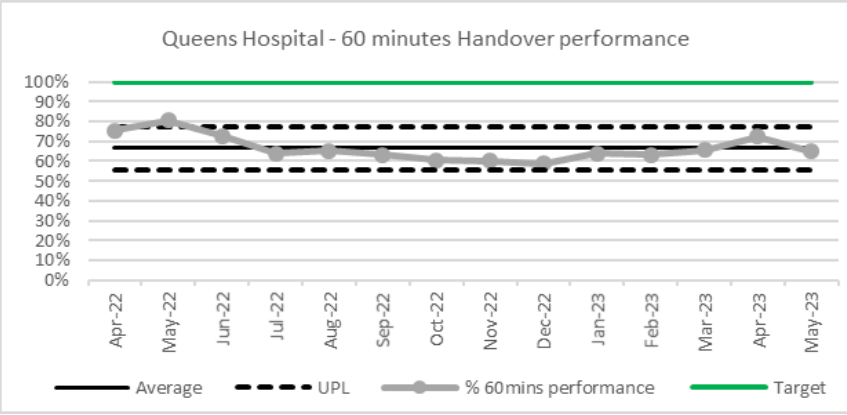
The charts on the left shows the 30 minute handover performance.

On an average,

- 29% of the handovers were within 30 minutes each month at KGH site in 2022-23.
- 25% of the handovers were within 30 minutes in Queen's hospital site.

60 minute handovers





The charts on the left shows the 60 minute handover performance

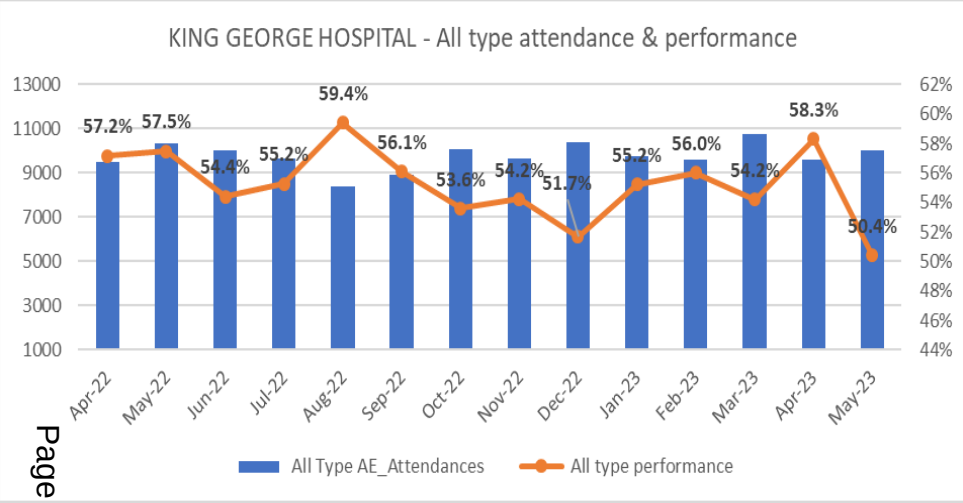
On an average

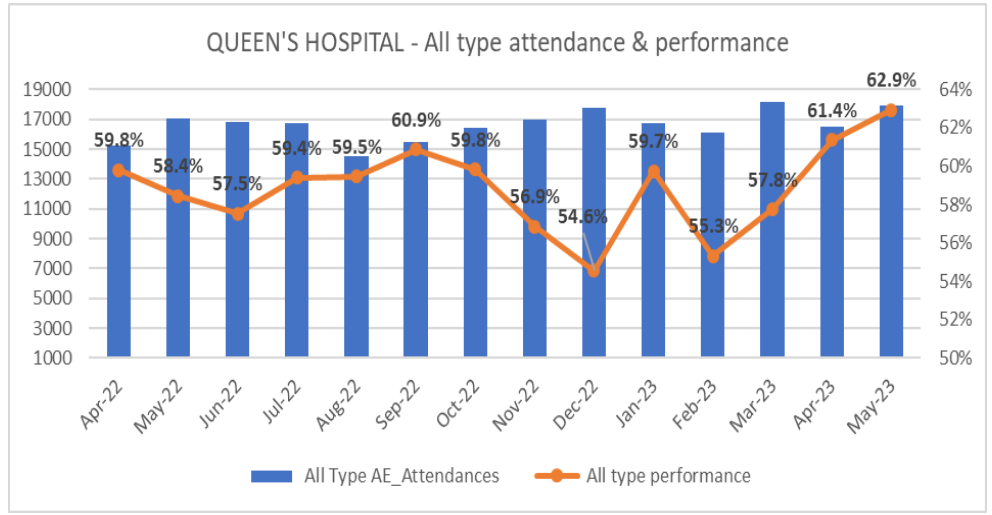
- 79% of the handovers were within 60 minutes at KGH site in 2022-23.
- 66% of the handovers were within 60 minutes in Queens.

A&E attendances & 4 hour performance – All Types and Type 1

Data source – Ambulance monthly published data

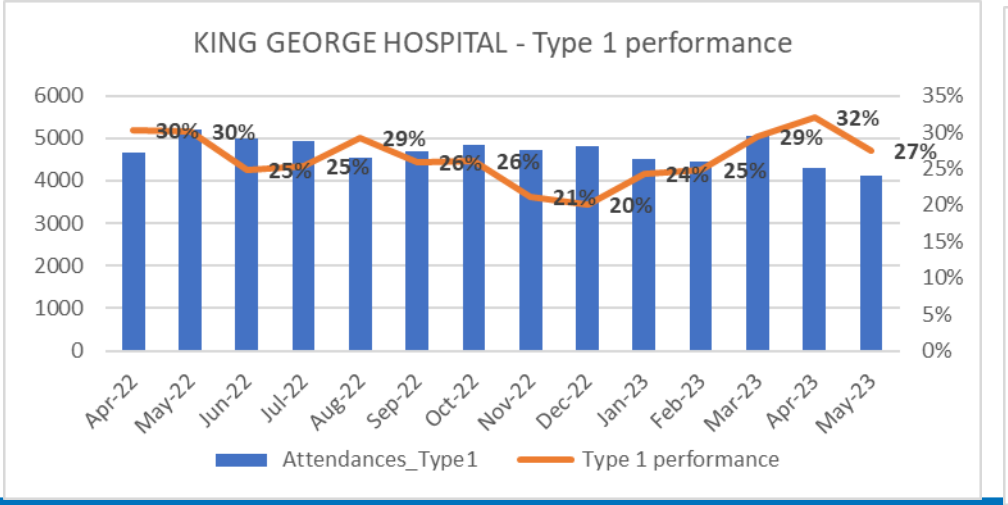
All Type attendances

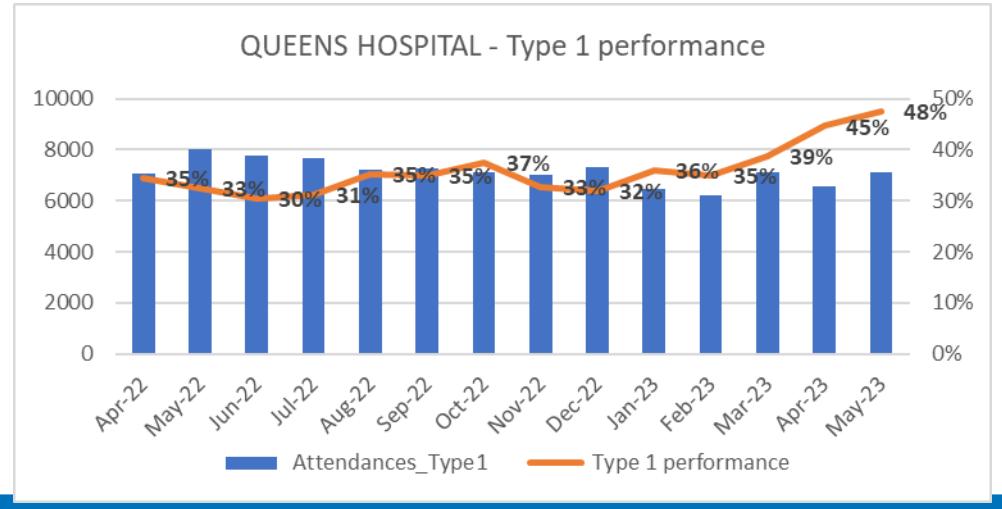




The charts on the left shows the trend of all type attendances and 4 hour performance at BHRUT sites.

Type 1 attendances

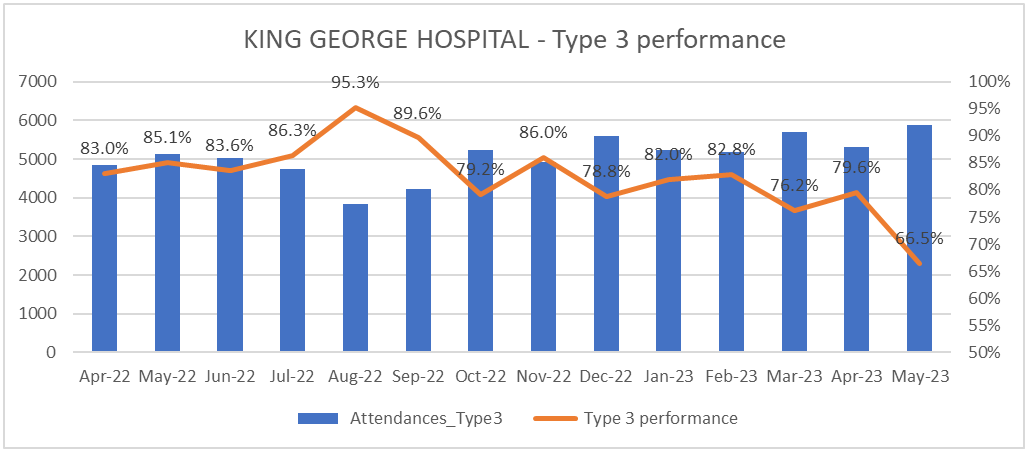


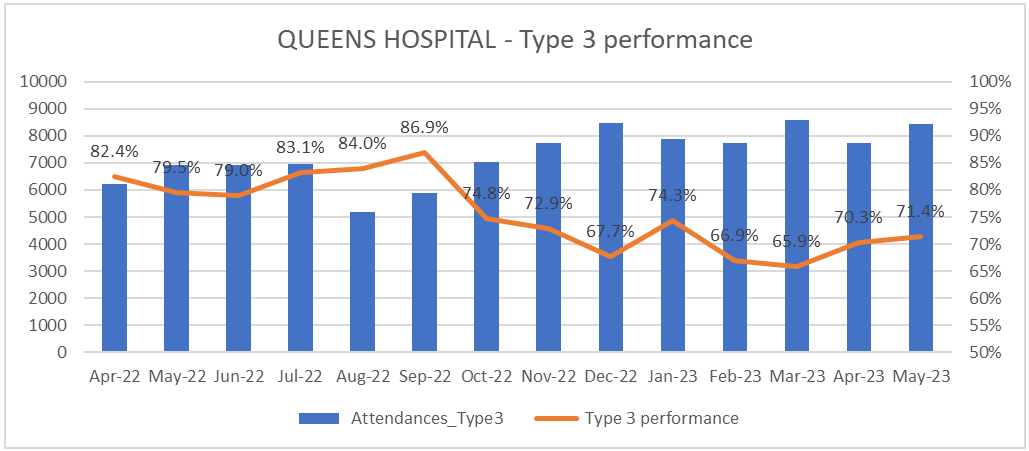


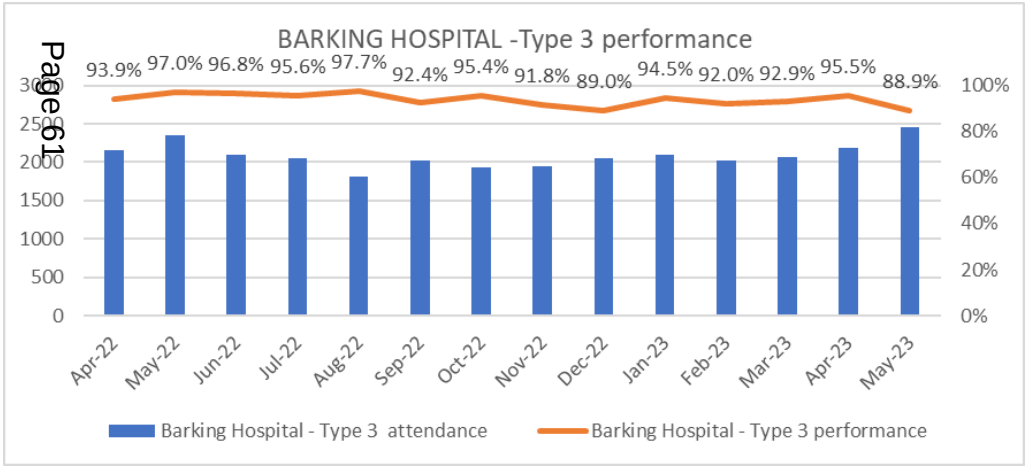
The charts on the left shows the trend of Type 1 attendances and 4 hour performance at BHRUT sites.

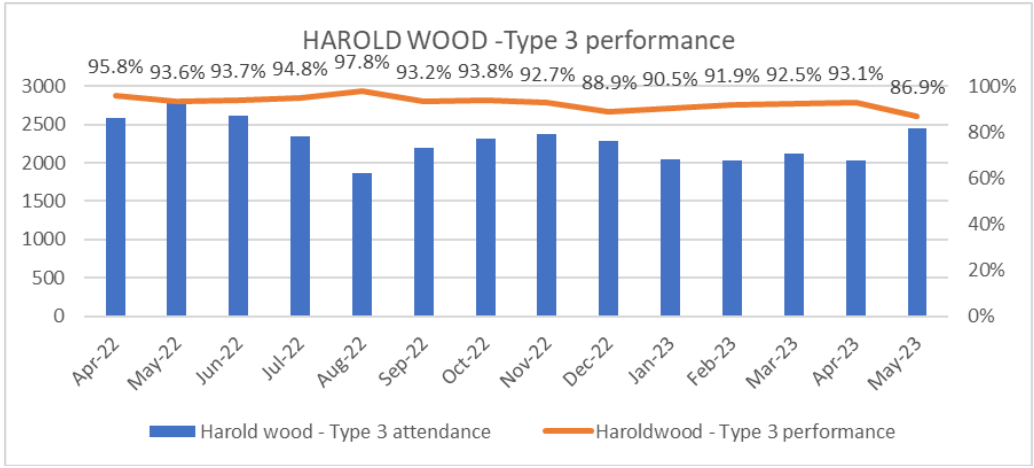
A&E attendances & 4 hour Performance – Type 3/UTC attendances

Data source – Ambulance monthly published data







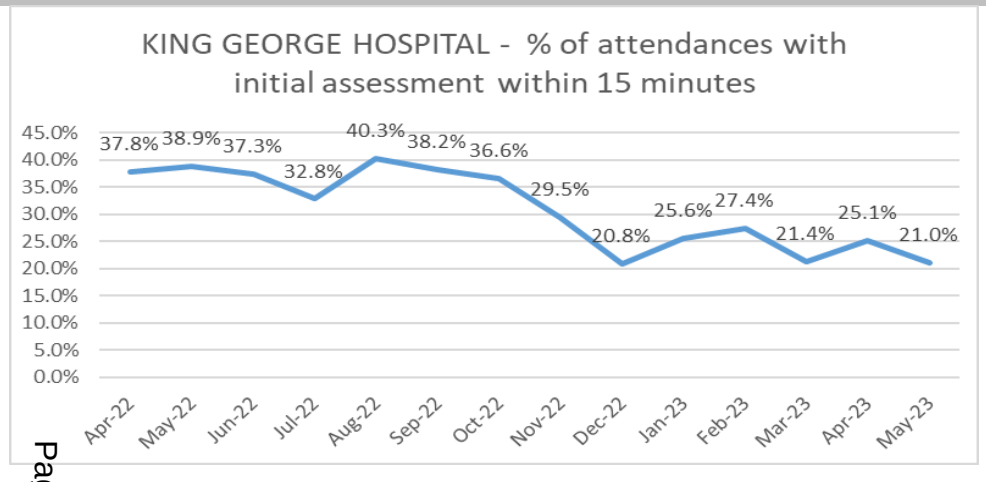


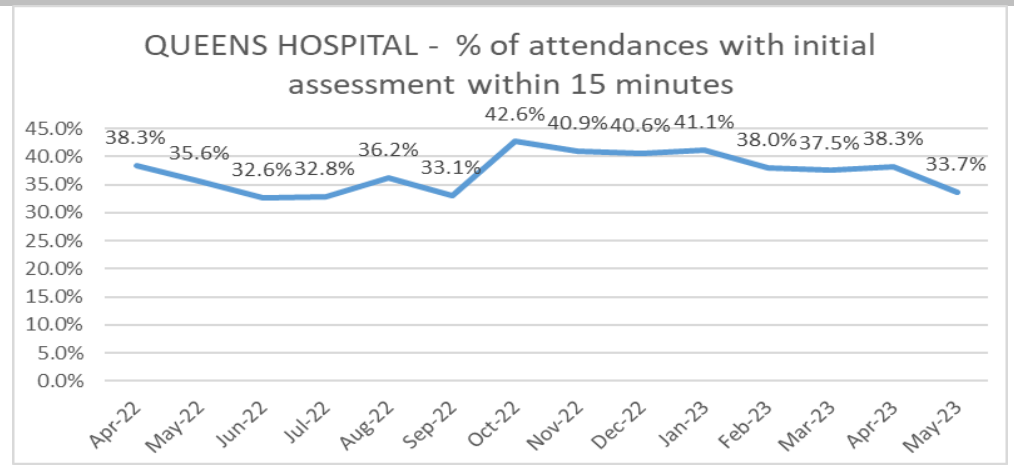
The charts on the left shows the trend of Type 3/ UTC attendances and their 4 hour performance.

ED and UTC streaming– 15 minutes

ED- Time to Initial assessment within 15 minutes

Data source – ECDS data

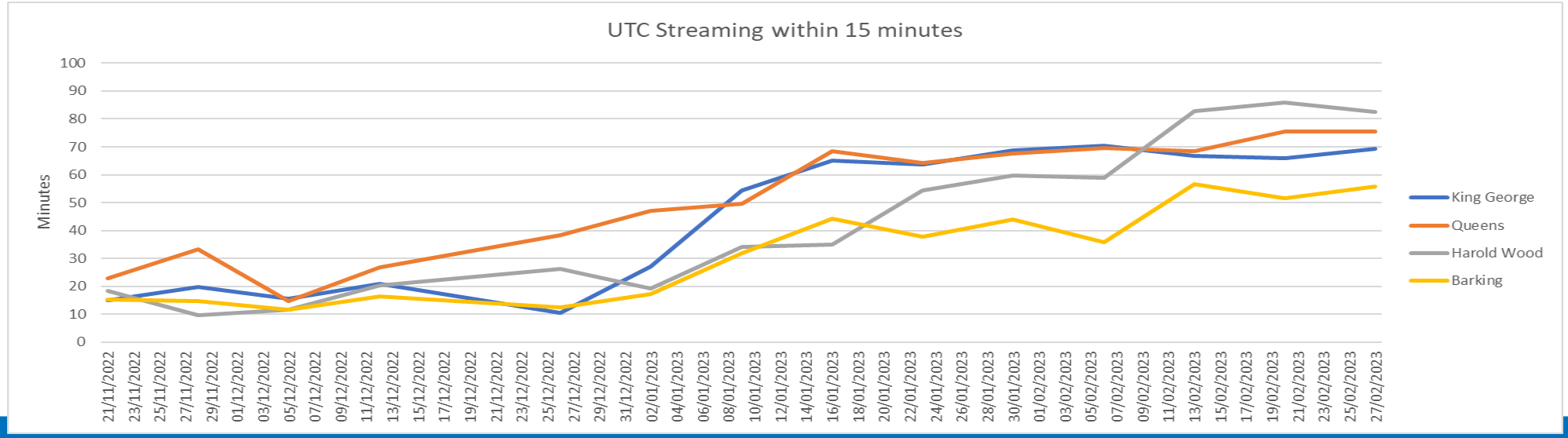




The charts on the left shows the time to initial assessment in ED within 15 minutes of arrival. This data is to be treated with caution due to data quality issues.

UTC Streaming- Time to Initial assessment within 15 minutes

Data source – PELC data



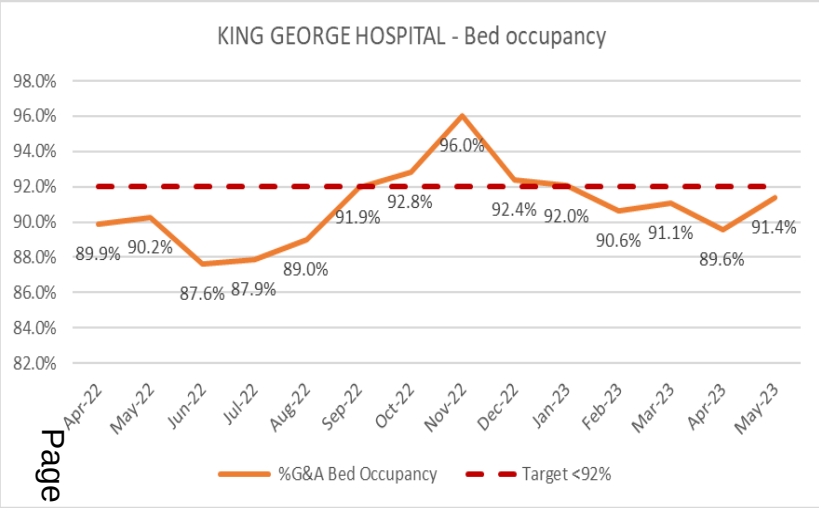
The charts on the left shows the time to initial assessment in UTC within 15 minutes of arrival.

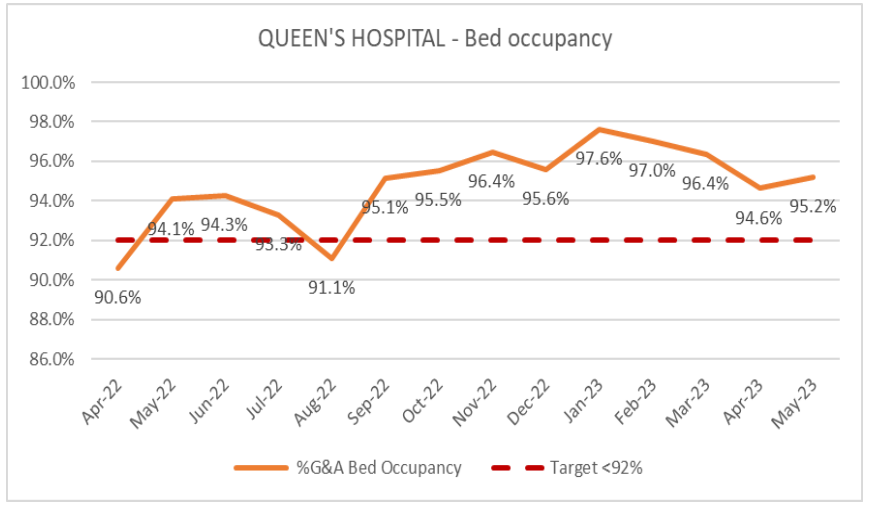
Data shows improvement in UTC streaming.

Bed Occupancy and Long stay patients occupying beds

Data source – UEC Daily Sitrep

Bed Occupancy

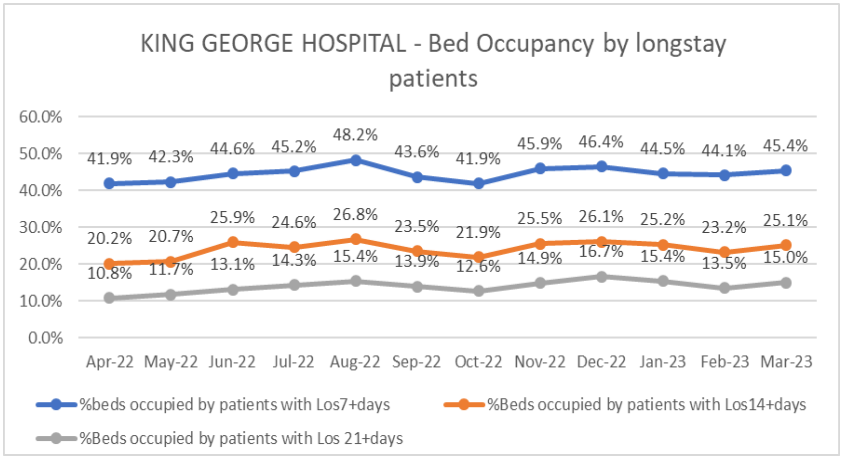


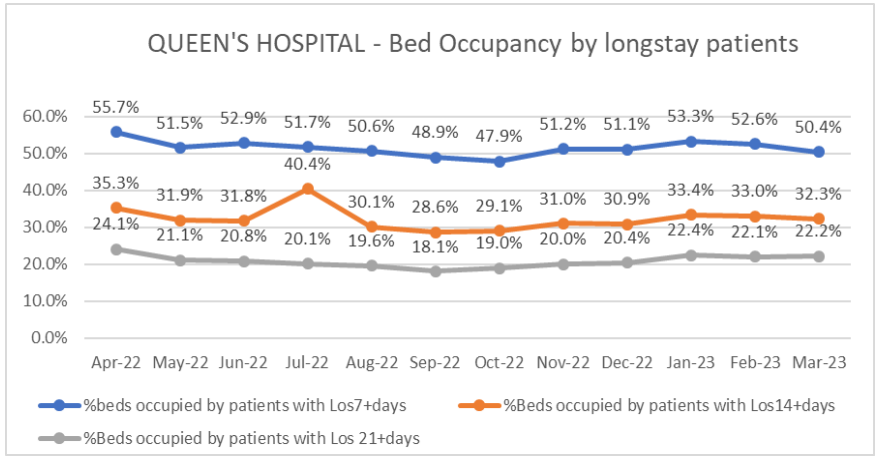


The charts on the left shows the G&A bed occupancy at BHRUT sites.

Significant Bed pressure in Queens.

Long Stay patients – LoS over 7 days, LoS over 14 days, Los over 21 days



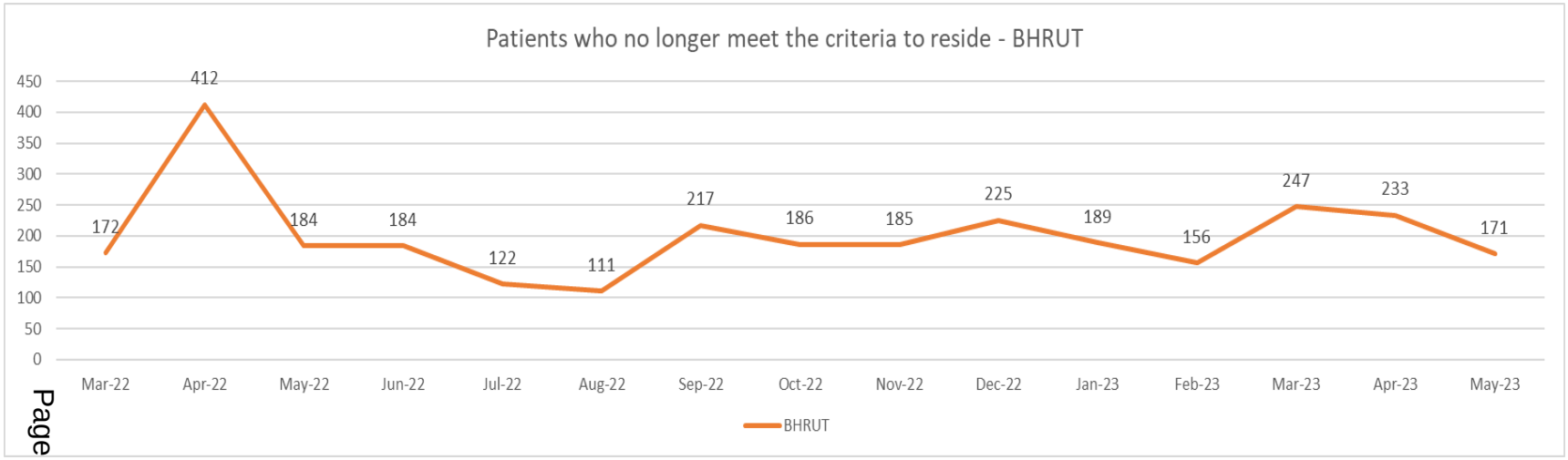


The charts on the left shows % of beds occupied by patients with length of stay over 7 days, 14+days and 21+ days.

Patients no longer meeting criteria to reside (CTR) and reasons for delays

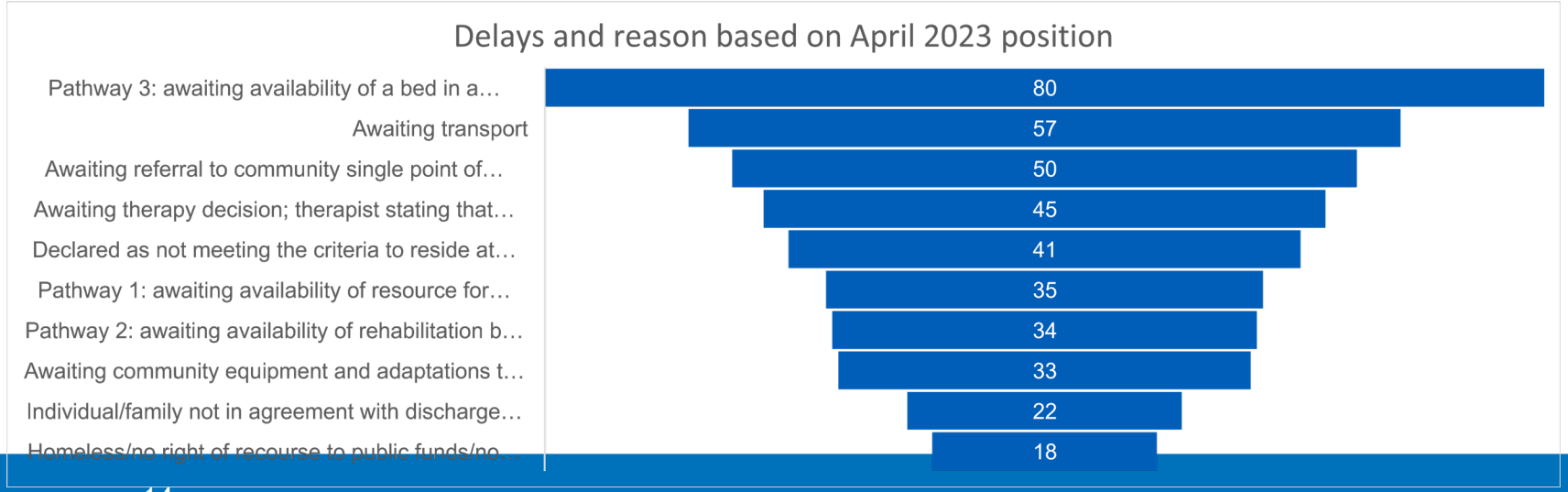
Data source – weekly discharge sitrep

Patients no longer meeting the criteria to reside(CTR)



The chart on the left shows the number of patients at the end of each month at BHRUT who no longer meet the criteria to reside but still continue to occupy the beds.

Reasons for delays with Los 7+ days

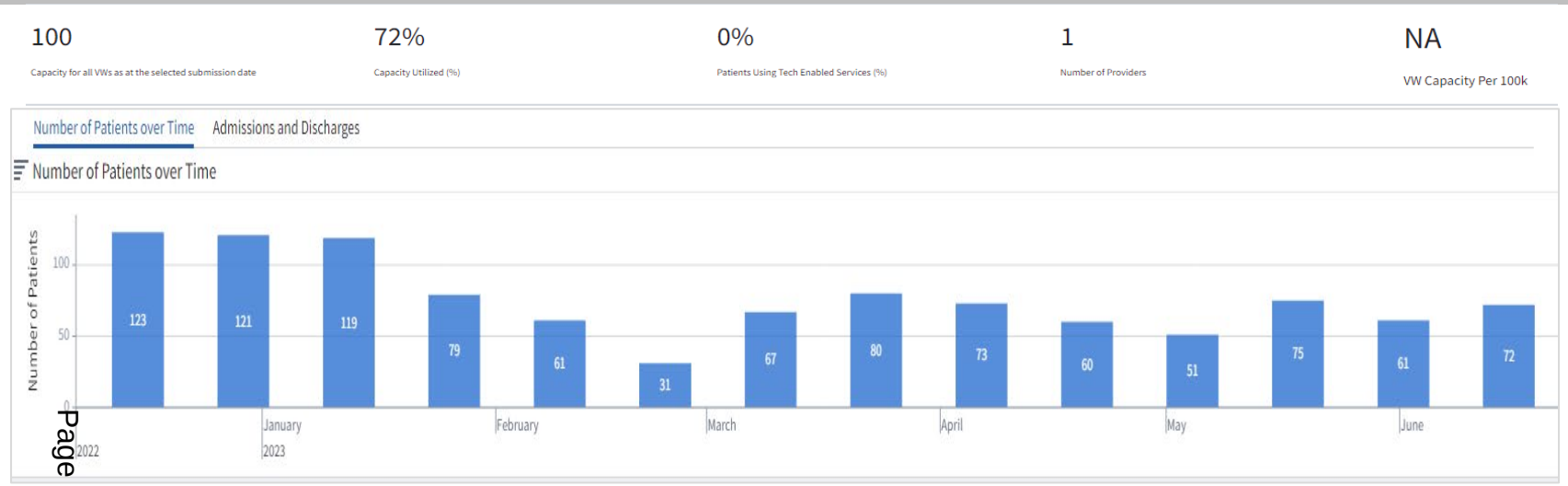


The chart on the left shows the reasons for delay in April for those staying over 7+ days

Virtual wards (VW) and Urgent Community Response (UCR- 2 hour standard)

Virtual wards

Data source – Virtual ward dashboard in NHS Foundry

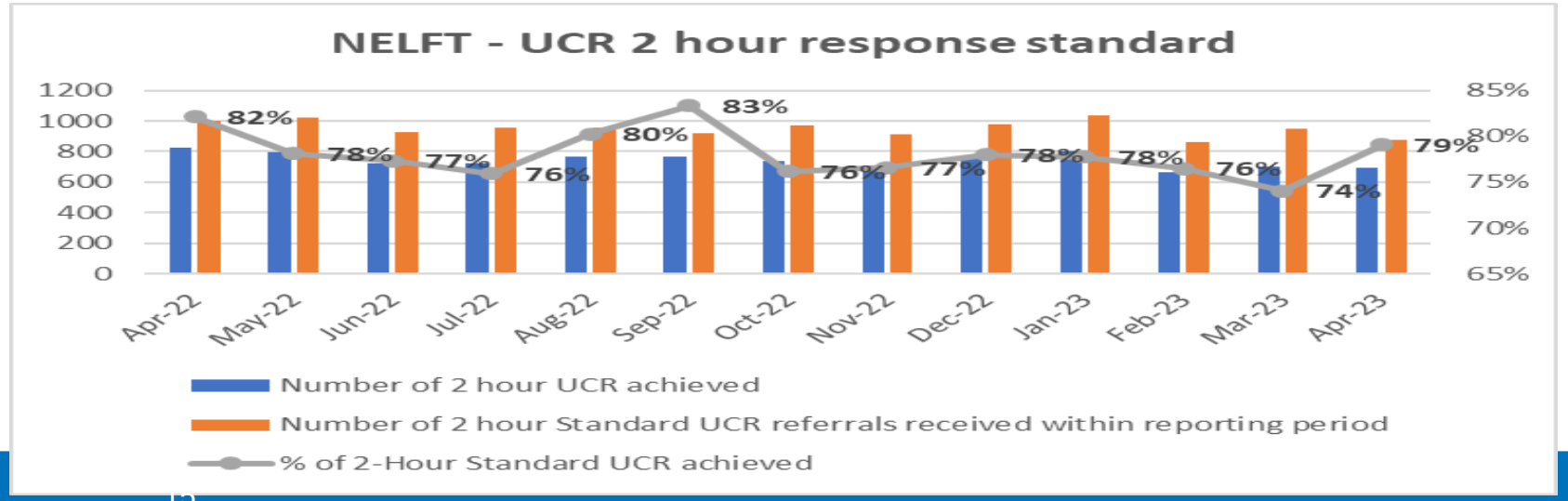


The numbers on the left shows the total VW beds by NELFT and the capacity.

There were 100 beds in the virtual ward and the virtual ward capacity based on 16th June submission was reported as 72%.

Urgent Community response (UCR)- 2 hour standard

Data source – UCR Data published data



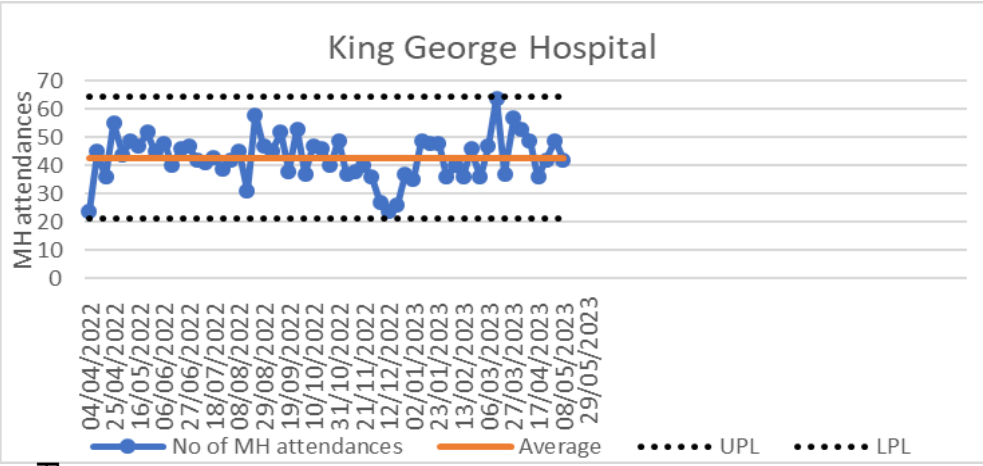
On an average 957 referrals in scope of two hour standard were received by NELFT in 22-23.

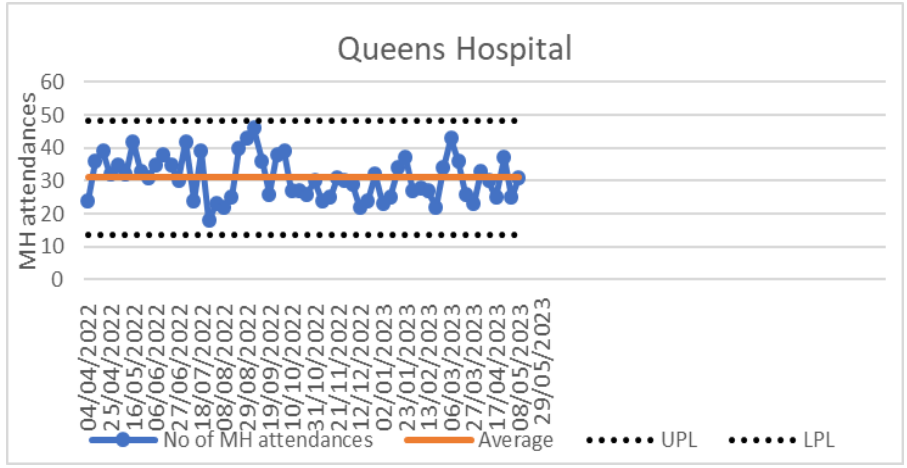
NELFT has been achieving the 70% standard rather has been exceeding consistently.

Mental Health attendances in ED

Data source – ECDS

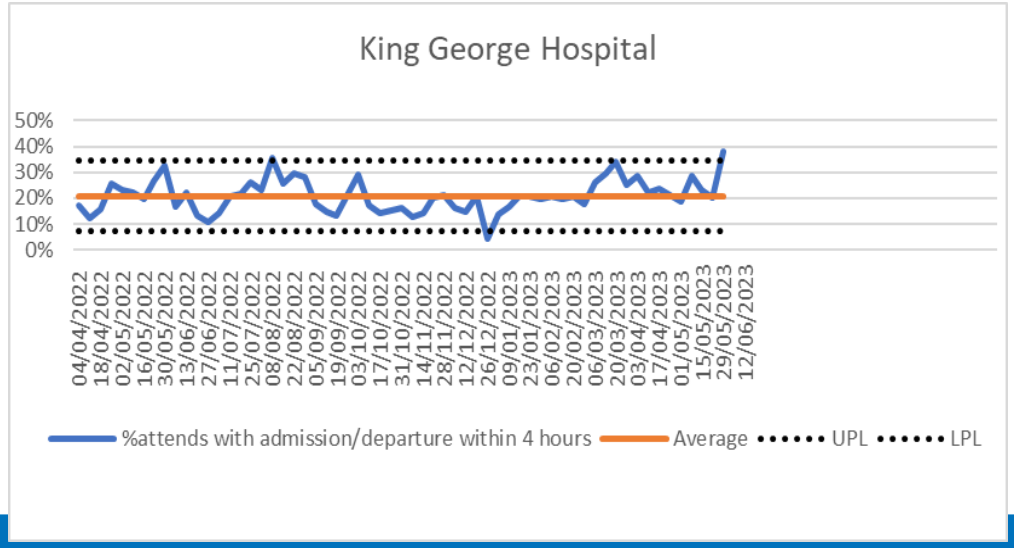
Mental health attendances in ED

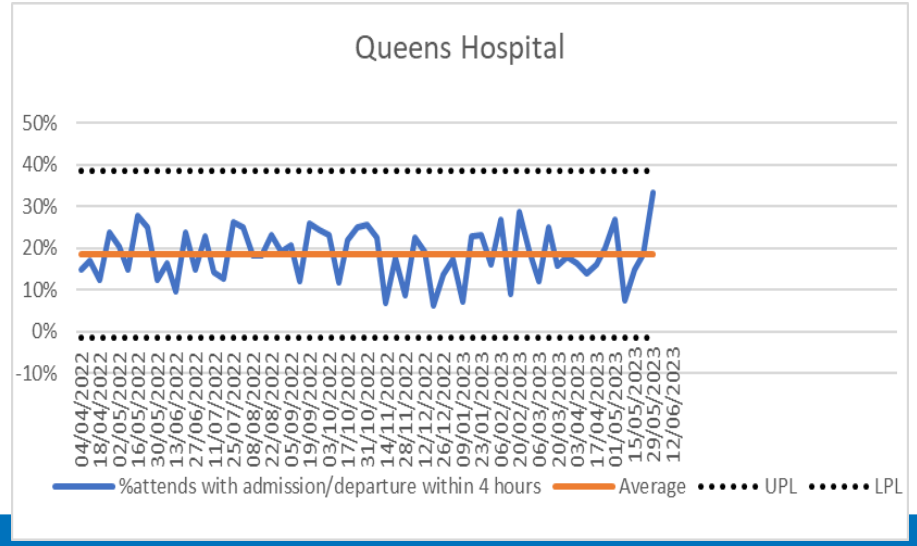




The charts on the left shows the number of attendances related to Mental Health.

Mental Health attendances – 4 hour waits





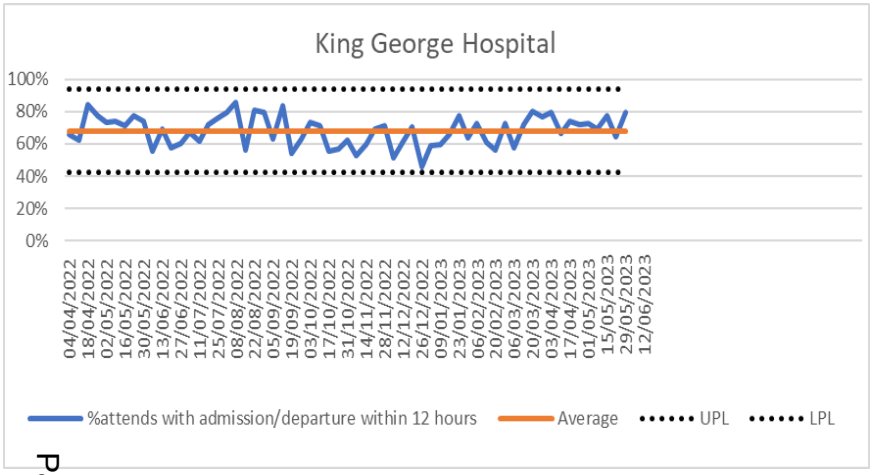
The charts on the left shows the % of attendances that waited less than 4 hours from arrival to departure.

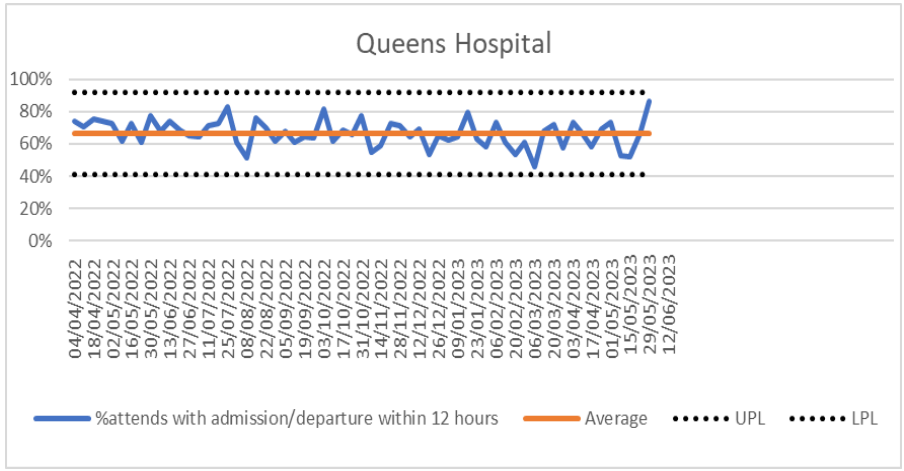
Improvement reported in both King Georges and Queens Site.

Mental Health attendances 12 hour waits and referrals to Crisis teams

Mental Health – 12 hour waits

Data source – ECDS



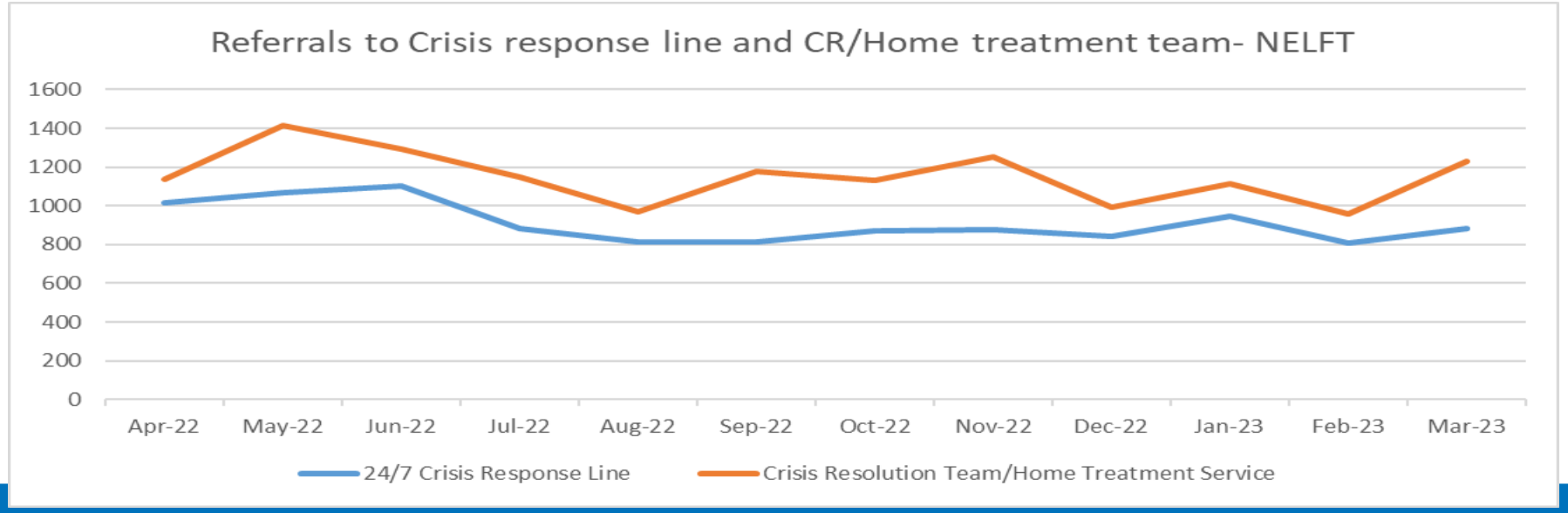


The charts on the left shows the % of attendances that waited less than 12 hours from arrival to departure from A&E.

Improvement reported in both King Georges and Queens Site.

Mental Health – Referrals to 24/7 Crisis team and Crisis resolution/Home treatment team

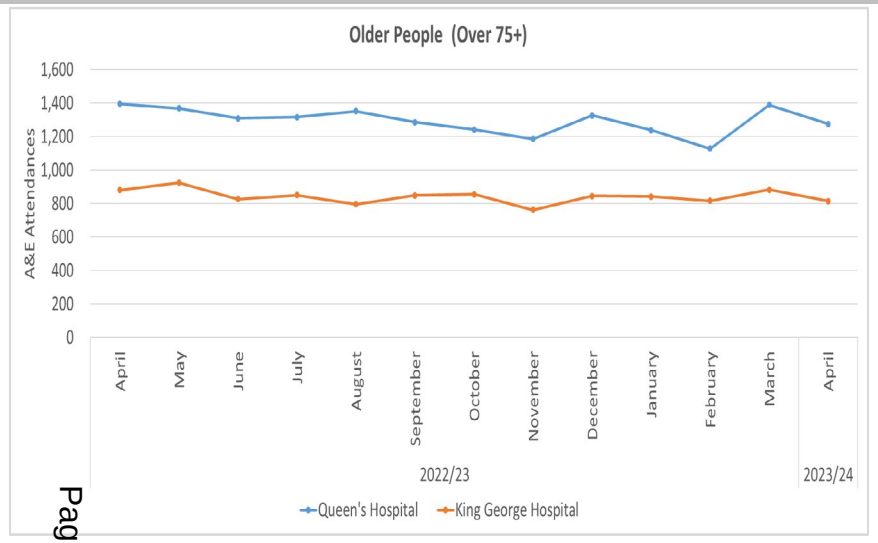
Data source – UEC MH Dashboard Tableau Server (England.NHS.UK)

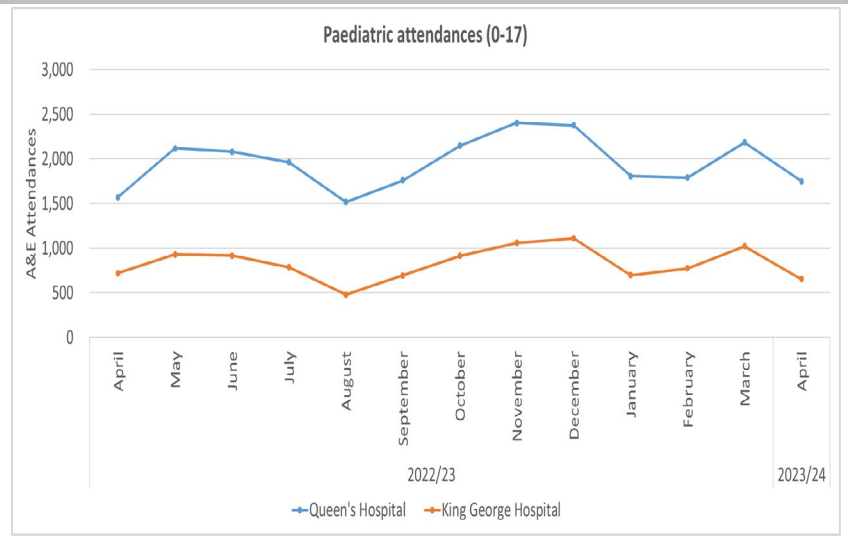


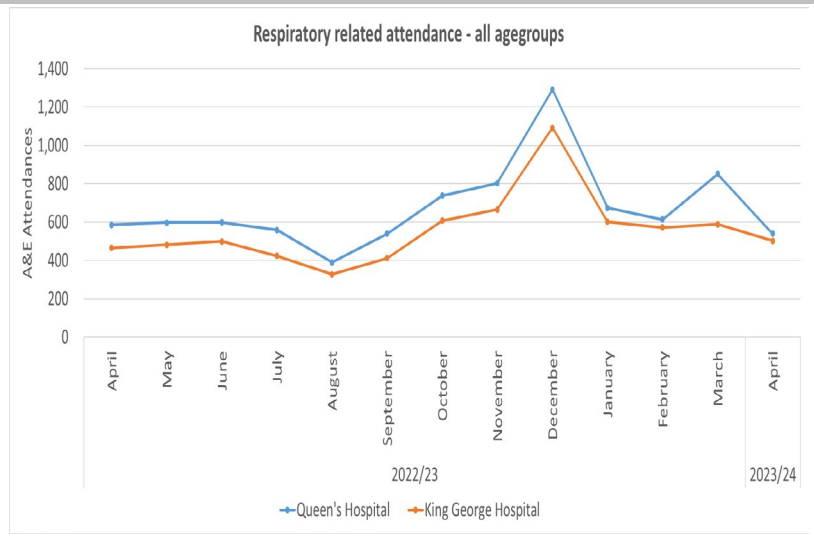
The charts on the left referrals to NELFT Services 24/7 Crisis team and Crisis resolution/ home treatment team.

Attendances – 75+ age group , Children (0-17)and people with respiratory conditions (all ages)

Data source – ECDS







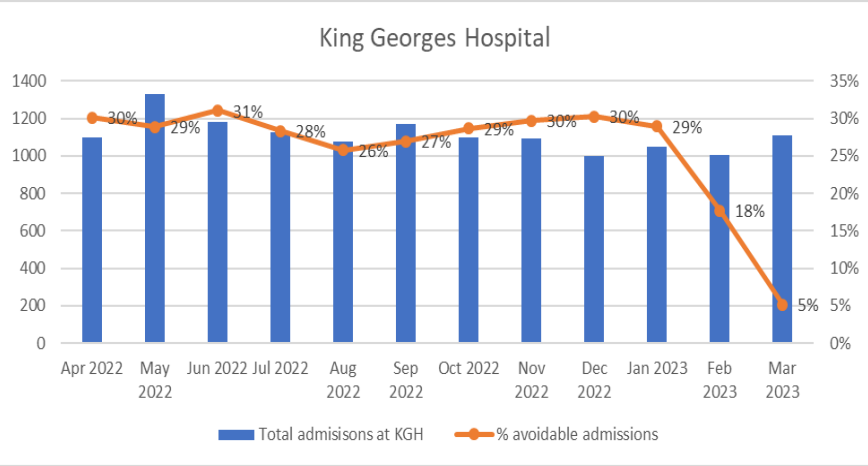
The charts on the above shows the A&E attendances for Over 75 age group, Children(0-17 age group) and those with respiratory related conditions.

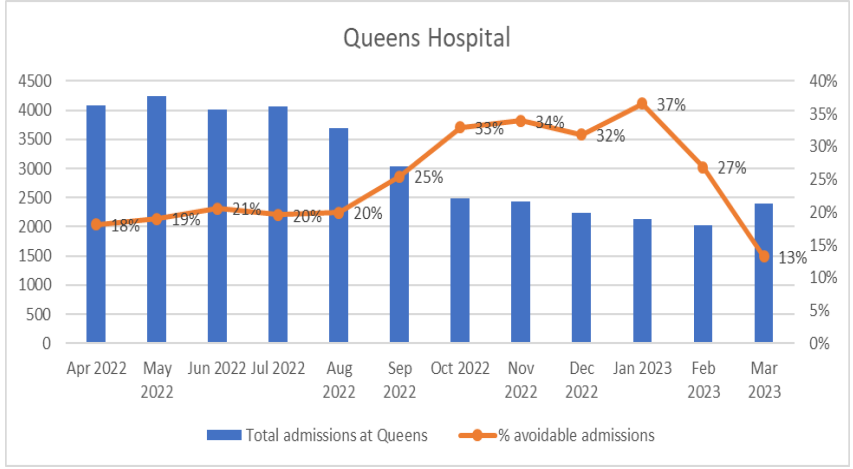
Older people (75+)- Data for 2022-23 shows that on an average there were over 2139 attendances per month across BHRUT sites.
Children (0-17) – Data for 2022-23 shows that on an average there were over 2600 attendances per month.
Respiratory related attendances- Data for 2022-23 shows that on an average there were circa 1248 attendances per month.

Avoidable admissions

Data source – SUS Data

Avoidable admissions as a % of total admissions





The charts on the left shows the avoidable admissions as a % of total admissions.

Reduction in avoidable admissions at both King Georges and KGH sites and this could be attributed to the various initiatives and transformation schemes.

The below table provide information on what has been considered as avoidable admission

Four indicators of avoidable admissions

In people of all ages:	In children and young people (0-18)
Emergency admissions for conditions not usually requiring hospital treatment (NHSOF: 2.3.i) Acute conditions such as ear/nose/throat infections, kidney/urinary tract infections and angina, among others, - *? Potential for management in primary care or outside of hospital*	Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s (NHSOF: 2.3.ii) Indicator measures how many young people (0-18) who have asthma, diabetes or epilepsy are admitted to hospital in an emergency. conditions are included in national indicator as they account for around 94% of admissions for children with LTC's conditions.
Unplanned hospitalisations for chronic ambulatory care sensitive conditions (NHSOF: 3a) Includes admissions for specific long-term conditions, which should not normally require hospitalisation, e.g. diabetes, epilepsy and high blood pressure. - *Assertion that optimum management can be achieved in the community (NHSOF)*	Emergency admissions for children with lower respiratory tract infections (NHSOF: 3.2) Indicator measures the number of emergency admissions to hospital of children (0-18 years) with selected types of lower respiratory tract infections (bronchiolitis, bronchopneumonia and pneumonia). ? Potential for avoidance of admission by some management in primary care or outside of hospital

* An ***Avoidable admission*** is one where there was scope for earlier, or different, action to prevent an individual's health deteriorating to the extent where hospital care is required.
It is NOT identifying any admission to be inappropriate. It is intended to identify only those where, if optimal primary and community care system were in place and proactive self-care supported, the exacerbation or infection may not have occurred.

Same day Urgent access

Data source

Published data is at ICB level does not provide break down at Place/Sub-system level, this is work in progress and important to the approach being adopted.

Electives- PTL size

Data source – National waiting list MDS data

PTL Size - 1st week of the Month

Year								2022					2023
Month	May	June	July	August	September	October	November	December	January	February	March	April	May
Provider Grouped	1	5	3	7	4	2	6	4	1	5	5	2	7
⊞ BHRUT	4,866	4,915	4,901	4,814	4,780	4,433	4,023	3,651	3,562	3,438	3,449	3,446	3,284

The chart on the left shows the trend of PTL size at the first week of the month in BHRUT.

Based on the data available there are 3284 patients on the list.

System Overview: Resident insight

Whilst quantitative data and analysis on performance is fundamental, to our Plan and areas of focus, we are also driven to improve by the experience of local people who need access to urgent and emergency care. Our overarching purpose as an ICS is to work with and for the people of north east London to improve their health and wellbeing and their insights are therefore critical to our improvement approach.

We have commissioned our 8 HealthWatches across north east London to work with local people to gain their insights into a range of areas, most relevantly here primary care access and urgent and emergency care. The HealthWatches have also been commissioned by the LAS to focus on their activity and its interaction with other parts of the urgent and emergency care system. This rich set of insights provides a backdrop to the work that we are doing to improve their experience and outcomes and sits in an accessible Community Insights System which we can use to test improvements and feedback. We also know from wider engagement through Place Partnerships, Scrutiny Committees, Health and Wellbeing Boards and JHOSCs for example that access is the single most frequently highlighted issue, often to same day primary care.

Working with local people is a clear part of our approach as many of the solutions to the challenges we face can be co-designed and co-produced, based on a shared understanding of the issues. We are currently engaging in the Big Conversation across north east London which continues to generate insights into what will work best from a resident perspective and where they see their priorities lying.

UEC improvement plan: Making a difference – outcomes

The Improvement Plan pulls together a number of contributing plans in order to demonstrate how we as a system are working strategically and operationally to improve our performance against key critical metrics, set out on the next slide. These metrics show how we as a system will achieve the following overarching outcomes, which have already been agreed across north east London:

1. Helping people stay well, independent and healthy, preventing them needing acute levels of care as far as possible;
2. Ensuring that we are planning for and delivering the capacity we need for those who do need it;
3. Ensuring that people can access the right care at the right time, and which prevents them from becoming more unwell whilst they are waiting;
4. When a resident has been admitted to hospital, ensuring that we have the right plans and support in place that they can move to a less acute setting and regain their independence as quickly as possible.

The contributing actions are fully meshed into a detailed project level action Plan, sitting behind this more strategic Improvement Plan. The more detailed plans include the UEC Improvement Plan for BHRUT, which incorporates the responses to the CQC findings and recommendations; PELC CQC Action Plan; NELFT's UEC Action Plan focusing on 4 workstreams.; (further contributing plans to be identified e.g. Primary Care, Mental Health, other Collaborative Plans). Together these Plans form the Improvement Plan.
The Improvement Plan sets out how we as a system will work to deliver improvements through a number of workstreams, each of which will in effect operate across three phases: issues to be addressed by winter; medium term issues which require a system response; longer term issues. Action on all three need to happen in parallel to avoid a single focus on the immediate and crisis actions, rather than the longer term and more preventative actions.

UEC improvement plan: Making a difference

The Improvement Plan sets out how we as a system will work to deliver improvements across urgent and emergency care measured through the following metrics, some of which are still in development and all of which are being monitored at regional and national level as well:

- People able to access same day urgent care through primary care (including pharmacy)
- Reduction in percentage of people with avoidable admissions
    - Emergency admissions for conditions not usually requiring hospital treatment (NHSOF: 2.3.i); Unplanned hospitalisations for chronic ambulatory care sensitive conditions (NHSOF: 3a); Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s (NHSOF: 2.3.ii); Emergency admissions for children with lower respiratory tract infections (NHSOF: 3.2)
- Patients being seen more quickly in emergency departments: with the ambition to improve to 76% of patients being admitted, transferred or discharged within four hours by March 2024, with further improvement in 2024/25 and monitoring of time spent in A&E, including 12 hour waits from time of arrival
- Ambulances getting to patients quicker: with improved ambulance response times for Category 2 incidents to 30 minutes on average over 2023/24, with further improvement in 2024/25 towards pre-pandemic levels.
- Ambulance handovers 85% within 30 minutes
- Discharge of those patients who do not meet the criteria to reside
- Improvement in experience of local people in staying well and accessing urgent and emergency care

BHR Places UEC Improvement Plan: Workstreams

From analysing the data, reflecting on the insights of local people and responding to the recent Care Quality Commission (CQC) inspections carried out in this area of activity, we have identified six workstreams which we believe will have the most impact and in a timely way on the local resident experience, the activity and performance and the high level outcomes we have agreed for this Plan. They span a range of actions across a range of partners and sectors, are often interdependent and require active work to deliver maximum impact. Each is being considered from an immediate, medium and long term perspective. They are:

- Keeping People well at home – to address need in the local population and seek to prevent the exacerbation of conditions
- Reducing avoidable admissions – to increase same day access and to care for people in the right place and where possible at home
- Improving in-hospital flow and discharge – to reduce length of stay and get people active and independent as early as possible
- Supporting mental health needs – to ensure the needs of people with mental ill-health receive parity of esteem
- Ensuring focus on children and young people – to reflect the local demography and respond sustainably to need
- Communicating and engaging – to engage with local populations to change behaviour and embed understanding

Three infrastructure workstreams are being led across north east London and support this work:

- Building effective data and digital resources
- Growing a sustainable workforce
- Supporting 999 and 111

As set out in the Introduction, the plan is structured to identify the workstreams which will have most impact on the performance of our system and the experience of our residents with the workstreams broken down into clusters of actions which need to be taken in the immediate, medium and longer term. The Plan is structured with more focus on the actions for the immediate horizon, to affect the performance and delivery of urgent and emergency care over winter, with the medium and long term issues set out at a high level and being worked up in more detail.

Workstream 1: Keeping People well at home – to address need in the local population and seek to prevent the exacerbation of conditions

Outcome 1: Our residents will be supported to stay well at home and in their communities during winter and for the longer term, increasing healthy life years.

A key area of focus is keeping people well at home. We know that good, joined up community services (delivered by a range of partners across health, social care and the voluntary and community sector) can support people to stay well for longer, receiving care closer to home and staying living well with a range of conditions and importantly we know that wherever possible people want to be at home, whether that for them is living independently in the community or in a care setting such as residential care. Community health services, including therapy services, help keep people well at home and in community settings close to home, and support people to live independently. When community services are delivered in combination with personalised care, they can reduce pressures on hospitals and emergency services by supporting people at home and in the community, as well as provide them with greater choice and control, leading to improved experience and outcomes.

Falls are the number one single reason why older people are taken to the emergency department, and around 30% of people 65 and over will fall at some point.

Care outside hospital is of particular importance for older people living with frailty, who are much more likely than younger people to be admitted to hospital, and likely to have a longer stay when they are admitted. Through better joint working and sharing of information between services we can help improve care for people who fall or are living with frailty.

Continued focus on mental health crisis prevention and a joined-up community response will ensure people are accessing the best service for their needs in a timely way, reducing avoidable admissions to hospital. Making use of new technology and better collaboration, including between ambulance services and community care, enables care that would often currently be delivered in a hospital to be delivered closer to people's homes.

For us, this workstream is fundamental to addressing need and reducing demand on our UEC system. It focuses on those cohorts most likely to attend ED or to be admitted in a crisis. This helps enable a more efficient system with better hospital flow and outcomes for local people.

Workstream 1: Keeping People well at home – to address need in the local population and seek to prevent the exacerbation of conditions

Outcome 1: Our residents will be supported to stay well at home and in their communities during winter and for the longer term, increasing healthy life years.

Objectives include:

- Improve quality of life and ageing well
- Increase support for carers and community support
- reduce the demand for unplanned care
- Increase take up of vaccinations and other health protection measures
- Support the sustainability of community-based care including care providers
- Build community resilience
- Improve support for MH crisis in the community

Contributes to Metrics:

- Preferred place of death for EOL
- Avoidable admissions
- Reduction on ambulance conveyances/ ED attendances/ admissions – including breakdown from care homes
- Vaccination rates
- Reduction in attendance and admissions for falls

Workstream 1: Keeping People well at home – to address need in the local population and seek to prevent the exacerbation of conditions

Deliver consistent enhanced health offer into care homes

Rationale: High number of care homes for older people across BHR including residential and nursing provision with variation in in blue light conveyancing, primary care and nursing cover and ability to keep people well in their home

Aims:

- To reduce level of blue light conveyancing by reducing risk of people becoming unwell and requiring urgent assistance
- To target those care homes with highest rates of blue light conveyances through skills development and quality improvement
- To support care homes to deliver a reablement approach to keep older people as active and well as possible

Milestones:

- Data analysis and engagement with care homes with high ED usage completed by end July 2023
- Programme of work in each targeted Care home in place by end August 2023, to include work with residents and families tested by data analysis every month

Target:

- All care homes to achieve best in class (residential, nursing, residential with dementia, nursing with dementia) by end September 2023

Facilitate easy access to vaccinations and screening

Rationale: Frailty and respiratory are the key drivers for ED attendance and admission and are those conditions for which vaccinations offer greatest benefit

Aims:

- To protect people from infection and to identify need early
- To target cohorts most at risk of ED attendance or admission

Milestones:

- Resourcing plan for flu and covid top up vaccinations in place by x

Target:

- Xx % of all older people and vulnerable cohorts to be vaccinated by October 2023

Workstream 1: Keeping People well at home – to address need in the local population and seek to prevent the exacerbation of conditions

Mobilise falls service for all of BHR

Rationale: falls is highest risk factor for ED attendances and admissions for frail older people, with use of falls service reducing risk

Aims:

- To reduce pressure on EDs by reducing falls in key cohorts through preventative action
- To expand falls services so that it is accessible to all older people across and has capacity to respond in a timely and proactive way to individuals requiring a service

Milestones:

- Model agreed and being implemented by end July 2023
- KPIs and capacity agreed by end July 2023
- Recruitment underway and complete by end September 2023

Target:

- Xx% of older people at risk of falls to be seen by a falls service

Ensure network of social prescribers, community connectors and local area co-ordinators work well together

Rationale: social isolation has a significant impact on physical health and increases attendance at ED

Aims:

- To provide early intervention and prevention, to reduce social isolation and to reduce impact on clinical and care services
- To reduce fragmentation and create a coherent network of early intervention

Milestones:

- Community of practice established in each Place by end September 2023
- Clear referral and introduction pathways in place by end October 2023

Target:

- Xxx% of vulnerable people able to access early intervention in the community without direct referral to clinical or care services

Workstream 1: Keeping People well at home – to address need in the local population and seek to prevent the exacerbation of conditions

Roll out Minor Ailments Service across north east London

Rationale: the cost of living crisis is driving people to attend primary care when their needs could be met elsewhere with the right support, this is particularly acute in our most deprived Places including B&D and Havering

Aims:

- To respond to the acute shock of the cost of living crisis and reduce unnecessary demand on primary care by targeting those households least able to afford over the counter solutions for common ailments
- To support primary care to keep people well by focusing activity on pharmacies and building awareness of wider community pharmacy offer

Milestones:

- Funding agreed by end July 2023 with plan for implementation
- Rollout during August – September 2023

Target:

- Coverage and promotion across north east London

Develop community catheter service

Rationale: alongside falls, catheter issues are a key driver of ambulance conveyances and admissions for frail elders

Aims:

- to reduce conveyancing and pressure on ED attendance
- To build skills in community provision

Milestones:

- to reduce conveyancing and pressure on ED attendance
- To build skills in community provision

Target:

- x

Workstream 1: Keeping People well at home – to address need in the local population and seek to prevent the exacerbation of conditions

Medium term

- **Develop and respond to NEL Wide Demand and capacity Plan across social care services to build market resilience, develop skills and grow relationships with the social care sector**
  - To ensure the robustness of the social care market across north east London, with a particular focus on Outer boroughs
- **Develop and respond to Demand and capacity Plan across community services to ensure consistent community services offer**
  - To ensure all residents have access to a consistent core community services offer
- **Review availability of Community equipment needed for winter**
  - To ensure people have timely access to community equipment whether living at home or in hospital
- **Support people waiting for elective interventions** (planned care)

Longer term

- **Implement Continuity of Care workstream in each Place – Fuller**
  - To reduce pressure for people with long term conditions and keep people well at home
- **Grow capability in primary care**
  - To build the right capacity to meet needs
- **To ensure joined up provision across primary care**
  - To join up capacity and resources across GPs, nursing, pharmacy, ARRS, etc.
- **Supporting people waiting for elective interventions**

Workstream 2: Reducing avoidable admissions – to increase same day access and to care for people in the right place and where possible at home

Outcome 2: Our residents will be supported in crisis to avoid attendance at ED and to prevent an attendance becoming an admittance to hospital or long-term bed-based care.

Objectives include:

- Reduce demand at the front door of ED and waiting times
- Reduce the growth in demand for institutional care in the longer term
- Increase quality of life and wellbeing during crisis
- Increase support carers and community support

Analysis has been undertaken to understand what is the variation in avoidable admissions across NEL and if there are opportunities to reduce this variation with the aim of *Keeping people well at* home. Analysis was done to understand this variation and to explore what may be driving these and looks at heterogeneity in social demographic factors and underlying health status and also proximity to an acute site. We also look at trends in admission rates by place using nationally published data from the NHS outcomes framework.

Our analysis shows there is considerable variation in the volume of avoidable admissions by site with this type of admission being nearly three times as common at Queen's Hospital than it is at the Royal London. This variation in volume plays out when we create age-standardised rates by GP practice and further when we view rates by GP practice in funnel plots to differentiate what may be random variation from what is non-random. In this analysis, we see noticeable clustering of these rates by place with, in particular, Tower Hamlets showing many practices as having low outlying rates. In contrast Barking & Dagenham and Havering in particular have a higher number of practices where rates are high outliers.

The analysis of proximity to an acute hospital site shows that this is not a factor in accounting for high rates, there is instead a weak inverse relationship between travel time and avoidable admission rates. There has been significant progress in building SDEC capability at KGH which is now operational and also focused collaborative work across BHRUT and PELC to improve the front door experience and flow which we believe are already having a positive impact for residents and the workforce.

Workstream 2: Reducing avoidable admissions – to increase same day access and to care for people in the right place and where possible at home

Safeguard and sustain primary care capacity currently delivered through the five GP Access Hubs (over 100,000 appointments per year)

Rationale: access demands met in primary care are better co-ordinated with wider care plans, ensure EDs focus on those in crisis and who are most unwell and improve resident experience as well as being more cost effective overall

Aims:

- to reduce risk of further pressure on UTCs and EDs over the winter months
- To build sustainable capacity through Primary Care Networks to prepare for Fuller

Milestones:

- Model agreed by end June 2023
- Contracting and sub-contracting in place by September 2023

Target:

- To ensure x % additional primary care capacity from September 2023 as compared with March 2023

Improve primary care capability

Rationale: responding to more complex presentations in primary care will reduce demand at the front door of ED, build continuity of care and ensure a more robust response to long term conditions, which have been under-resourced in primary care in outer NEL

- **Aims:**
- To strengthen primary care capability in outer NEL
- To make outer NEL a more attractive place to work improving recruitment and retention

Milestones:

- To strengthen primary care capability in outer NEL
- To make outer NEL a more attractive place to work improving recruitment and retention

Target:

- Continuity of care targets
- Complexity of cases

Workstream 2: Reducing avoidable admissions – to increase same day access and to care for people in the right place and where possible at home

Deliver a targeted improvement offer to primary care

Rationale: a small number of practices are associated with higher rates of avoidable admissions and targeted improvement work with those practices will improve rates of avoidable admissions

Aims:

- To reduce rate of avoidable admissions to QH and KGH
- To build sustainable capacity through Primary Care Networks to prepare for Fuller

Milestones:

- Improvement offer in place Summer 2023 2023
- Changes implemented in response to improvement offer by September 2023

Target:

- To bring avoidable admissions for QH and KGH in line with the rest of north east London

Increase the number of patients, requiring IV, who are safely managed in the community

Rationale: increasing IV antibiotics administration in the community will improve patient experience and reduce demand for hospital based services

- **Aims:**
- To strengthen primary care capability in outer NEL
- To make outer NEL a more attractive place to work improving recruitment and retention

Milestones:

- To agree community model and plan by end August 2023
- To implement new model by Autumn 2023

Target:

- To bring avoidable admissions for QH and KGH in line with the rest of north east London
- To reduce demand on the front door

Workstream 2: Reducing avoidable admissions – to increase same day access and to care for people in the right place and where possible at home

Extend REACH equitably across BHR

Rationale: supporting people to stay at home reduces demand at the front door and improves their outcomes and experience

Aims:

- To respond to people in their own homes and reduce activity at the front door of ED

Milestones:

- Fully staffed model in place from end July 2023
- Evaluation of model after 6 months of full operation

Target:

- Contributes to 76% target by depressing demand at the front door

Review Urgent Treatment Centre model

Rationale: to understand the efficacy of our current model and to build capacity and capability for the future

Aims:

- To build sustainability for the future as demand changes over time

Milestones:

- Lead appointed June 2023
- Intensive review work underway to complete review with proposals by end July 2023
- Agreement on next steps by September 2023 with any quick wins in place by start November 2023

Target:

- UTC performance to reach 98% target consistently throughout review and remodelling period

Workstream 3: Improving in-hospital flow and discharge – to reduce length of stay and get people active and independent as early as possible

Deliver PELC CQC and wider improvement actions, including plan to meet 98% 4 hour target

Rationale: As the front door to BHRUT, PELC is a vital partner and contributor to overall performance and experience across the hospital footprint

Aims:

- To ensure demand and capacity in UTC over winter are understood and acted on
- To increase community confidence in use of UTC

Milestones:

- Respond to all CQC recommendations and findings as part of a quality improvement approach within agreed timeframes
- Ensure demand and capacity in UTC over winter are understood and acted on
- Increase community confidence in use of UTC

Target:

- Performance to shift to 98% 4 hour waits by xx date to contribute to overall 76% target for the sites

Collaborative working on front door model between PELC/ BHRUT

Rationale: To improve flow and patient experience

Aims:

- To streamline activity and flow at the front door of ED improving resident experience and outcomes

Milestones:

- As above
- SDEC fully operational at KGH site by mid July 2023, building to full capacity by end August 2023
- Paediatrics pathway road testing from mid-June 2023, roll out from mid July if successful

Target:

- 76% 4 hour waits by xxx date

Workstream 2: Reducing avoidable admissions – to increase same day access and to care for people in the right place and where possible at home

Better understand demand and connect capacity across the system

Rationale: better use of alternative care pathways and visibility on their capacity will reduce demand at the front door

Aims:

- To integrate the models of community capacity better into wider system working on UEC

Milestones/Areas of activity

- Work proactively with people on the elective waiting lists (Planned Care lead)
- Monitor utilisation of UCR cars and PRU, maintaining delivery on 2 hour target, reviewing utilisation of new capacity
- Review HALO provision and update service specification
- Monitor impact of reducing conveyance and increased use of ACPs
- Extend and evaluate pilot of social workers in acute frailty units to increase early identification of people's need
- Deliver consistent speciality advice to GPs, confirming and promoting contacts and pathways
- Monitor people using ED frequently

Respond to high intensity users of ED

Rationale: better co-ordination and support of high intensity users will reduce levels of activity and reduce demand at the front door

Aims:

- To develop and implement a service to proactively manage the cohort of patients frequently attending the Emergency Department.

Milestones/Areas of activity

- Agree model by end July 2023
- Agree funding by end August 2023
- Monitor people using ED frequently

Targets:

- Number of reduced emergency admissions to hospital and reduction in A&E attendances

Workstream 2: Reducing avoidable admissions – to increase same day access and to care for people in the right place and where possible at home

Medium term

- Review and deliver Better Care Fund schemes with evaluation and impact
    - To ensure we are using funding appropriately to reduce admissions and support people to be discharged well
- Respond to review of UTCs in full
- Develop community led models of virtual ward to sit alongside acute led models
    - To ensure join up of urgent and emergency provision, community beds and care capacity to avoid admissions and to enable discharge
- Deliver Long Term Conditions LES
    - To build Fuller capacity for continuity of care across primary care

Longer term

- Implement Fuller incorporating same day urgent access model across primary care, UTCs etc.
    - To have a coherent and consistent model in place

Workstream 3: Improving in-hospital flow and discharge – to reduce length of stay and get people active and independent as early as possible

Outcome 4: When a resident has been admitted to hospital, ensuring that we have the right plans and support in place that they can move to a less acute setting and regain their independence as quickly as possible.

We know from local from people who use urgent and emergency care, and the national UEC recovery plan how important it is to have a smooth experience in hospital, and not to experience too many unnecessary delays, especially where it is not clear why.

The national plans sets out how the NHS will use existing capacity as effectively as possible by standardising processes so that patients get the right care at the right time, including when moving between organisations. There will be a focus on reducing variation in care when patients arrive at A&E, ensuring greater consistency in direct referrals to specialist care, and access to same day emergency care (SDEC) so people avoid unnecessary overnight stays. There will also be a more standardised approach to the first 72 hours in hospital so that people are assessed, get any required scans, and start their treatment as soon as possible.

Locally, we are focusing on work across our UTC and BHRUT, with a focus on improving flow, responding better to need and reducing waits. We are building SDEC capacity and capability now with immediate benefits for local people and the system overall. We are focusing on pathways to ensure those who are most ill are seen as soon as possible freeing up other frontline staff to respond to incoming demand.

We are also continuing to build and make effective use of our system control centre (SCC) using data to respond to emerging challenges and bring together experts from across the system to make better, real-time decisions. They will help us to ensure the highest quality of care possible for the population in every area by balancing the clinical risk within and across acute, community, mental health, primary care, and social care services. For us locally, we are focusing on the following actions over the winter, in the medium term and over the longer term too.

Workstream 3: Improving in-hospital flow and discharge – to reduce length of stay and get people active and independent as early as possible

Outcome 4: When a resident has been admitted to hospital, ensuring that we have the right plans and support in place that they can move to a less acute setting and regain their independence as quickly as possible.

We have worked to improve our discharge processes both through the hospital sites using initiatives such as Operation Snowball and through the Integrated Discharge Hub with partners across the system. As well as a north east London focus on discharge we have a BHR Discharge Working Group which responds both strategically and operationally to issues as they arise. With partners across north east London we have embarked on a Care Market Review to understand better the capacity we have across need cohorts in social care, to identify gaps and to build the appropriate capacity in light of demand for the future. This is a large scale piece of work, hosted by a partner local authority, with full support across north east London, including Continuing Health Care, which we believe will assist not only to effect timely discharge but to keep people well at home too.

Objectives include:

- Improve quality of life and ageing well
- Improve speed and quality of discharge
- reduce admissions to long term care
- Improve hospital bed utilisation

Contributes to Metrics:

- Reducing number of patients in beds not meeting criteria to reside
- Reduce 14 and 21 day LOS in beds

Workstream 3: Improving in-hospital flow and discharge – to reduce length of stay and get people active and independent as early as possible

BHRUT deliver CQC actions and operating plan targets for ambulance turnaround times

Rationale: Ambulance handover times are consistently longer than the rest of London due to the level of pressure being experienced in ED with consequences for ambulance call responsiveness and access to emergency care in BHRUT

Aims:

- To achieve parity with London on ambulance handovers
- To improve the experience for residents of blue light conveyancing

Milestones:

- Improved access to CADO within the department and processes to enable earlier patient handover (releasing crews) by September 2023
- Enable earlier clinical review including working with LAS to improve crew pin off by September 2023

Target:

- Contributes to 30 minute handover targets

Implement virtual wards for both frailty and ARI (recognition that this will have impact across workstreams)

Rationale: supporting people in the community with frailty and respiratory (the key drivers of need and demand into Queen's and KGH) will reduce length of stay, improve reablement potential and free up hospital capacity sooner

Aims:

- Increase capacity for patients to be managed safely in the community and avoid admission as well as being discharged sooner
- To co-ordinate activity across secondary, primary, community and social care

Milestones:

- Frailty virtual ward to open in July, increasing capacity to 45 over first year – focus on referrals from KGH and QH before community step- up referrals possible
- Respiratory virtual ward to open in September, 15 beds in first year – focus on referrals from KGH and QH before community step-up referrals possible
- Paediatrics virtual ward to open by October 2023

Target:

- 100% capacity

Workstream 3: Improving in-hospital flow and discharge – to reduce length of stay and get people active and independent as early as possible

Deliver PELC CQC and wider improvement actions, including plan to meet 98% 4 hour target

Rationale: As the front door to BHRUT, PELC is a vital partner and contributor to overall performance and experience across the hospital footprint

Aims:

- To ensure demand and capacity in UTC over winter are understood and acted on
- To increase community confidence in use of UTC

Milestones:

- Respond to all CQC recommendations and findings as part of a quality improvement approach within agreed timeframes
- Revised Paediatrics pathway road testing from mid-June 2023, roll out from mid July if successful
- Streaming move – pilot in place from mid-July 2023
- Minor/moderate injuries pathway – new model in place by mid-September 2023

Target:

- Performance to shift to 98% 4 hour waits by March 2024 to contribute to overall 76% target for the sites

Establish and grow SDEC capacity at KGH and QH

Rationale: To improve flow and patient experience

Aims:

- To streamline activity and flow at the front door of ED improving resident experience and outcomes

Milestones:

- SDEC fully operational 24/7 at KGH site by mid July 2023, building to full capacity by end August 2023
- Expanded capacity on QH site operational 24/7

Target:

- Contributes to 76% 4 hour waits

Workstream 3: Improving in-hospital flow and discharge – to reduce length of stay and get people active and independent as early as possible

Implement Welfare Checks pilot in Redbridge

Rationale: post-discharge readmissions are distressing and disorienting for older people and families and may be avoided by ensuring earlier identification of deterioration in the community

Aims:

- To reduce risk of readmission

Milestones

- Engagement with PCNs by end June 2023
- Training in place for co-ordinators by end July 2023
- Start of pilot July 2023 – pilot completes end October 2023 with evaluation and possibility to extend/expand

Targets:

- Reduction in rate of readmissions for over 75s in Redbridge

Increase reablement capacity across the BHR Places

Rationale: enabling people to regain their pre-hospital admission mobility and independence reduces dependence on care services and improves quality of life and wellbeing

Aims:

- To increase reablement activity and effectiveness

Milestones:

- Funding secured through BCF submissions for BHR Places end June 2023
- Recruitment of additional workforce and induction to processes

Target:

- Reduction in rate of readmissions and in care services over time

Workstream 3: Improving in-hospital flow and discharge – to reduce length of stay and get people active and independent as early as possible

Improve discharge lounge

Rationale: enabling discharges to take place earlier in the day both improves the experience for patients and their carers and makes best use of capacity in the hospital

Aims:

- To enable discharge earlier in the day from wards and to improve hospital flow

Milestones:

- New expanded criteria for discharge lounges in place from September 2023
- Improved environment in discharge lounges by September 2023

Targets:

- Increase in number of early day discharges and overall flow

Review and increase Intensive Rehabilitation Support in the community

Rationale: ensuring appropriate capacity to maximise discharge from hospital and support rehab in the community enabling people to regain their pre-hospital admission mobility and independence reduces dependence on care services and improves quality of life and wellbeing

Aims:

- To increase individuals' mobility, activity and independence

Milestones:

- Capacity and funding requirements agreed by end July 2023
- Plan for meeting capacity and funding requirements in place to enable implementation from Autumn 2023
- Improved pathway processes in place by Autumn 2023 to improve take up and usage

Target:

- Reduction in rate of readmissions and in care services over time

Workstream 3: Improving in-hospital flow and discharge – to reduce length of stay and get people active and independent as early as possible

Review Integrated Discharge Hub operations, including Trusted Assessor models

Rationale: Improved co-ordination of discharges will assist hospital flow and improve the patient experience

Aims:

- **T**o build equity across north east London and to reduce the numbers of people with no criteria to reside continuing to stay in hospital
- To ensure models and pathways meet the needs of all patients including those with a complex history of homelessness

Milestones:

- Review of model and new specification completed by end August 2023
- Change champions identified by end August 2023
- Improved processes in place by Autumn 2023

Targets:

- Contributes to reduction in numbers of people with no criteria to reside and improve patient experience

Develop and implement discharge to assess home for more patients

Rationale: supporting people to regain independence and to stay at home reduces reliance on long term care and improves wellbeing and quality of life

Aims:

- To increase individuals' mobility, activity and independence

Milestones:

- Review current pathways by July 2023
- Review best practice models and financials by end August 2023
- Agree improvement priorities and implement by Autumn 2023

Target:

- Reduction in long term care placements

Workstream 3: Improving in-hospital flow and discharge – to reduce length of stay and get people active and independent as early as possible

Medium term

- **Develop and respond to Demand and Capacity Plan for care across north east London**
  - To ensure we have an overview of need and gaps in care provision to plan better for the future
  - To ensure we have the right provision, in the right area, at the right capacity
  - To include reablement, intermediate care as well as care homes
- **Evaluate impact of Operation Snowball**
  - To ensure it is effective, sustainable and promotes patient wellbeing
- **Reconfigure ED and UTC spaces given relocation of renal unit and Rom Valley Gardens development to St George's 2024**
  - To improve UEC hospital flow

Longer term

- **Build community Stroke and Neuro rehab, implementing business case**
  - To enhance community rehab for people with complex needs to enable timely discharge and support in the community

Workstream 4: Supporting mental health needs – to ensure the needs of people with mental ill-health receive parity of esteem

Outcome 3: Ensuring that people can access the right care at the right time, and which prevents them from becoming more unwell whilst they are waiting

It is critically important to us that our urgent and emergency pathways and responses work well for people who are experiencing poor mental health and are entering a period of crisis as well as for those with a physical health need. We know that people attending ED in mental health crisis may also have physical health issues which may also need a response but it is critical that we reduce the incidences of people with mental health needs in ED waiting for mental health support and a mental health bed.

Our local plans reflect the range of work underway in the area to reduce ED attendances, to support people to stay well, to move people to appropriate provision at the earliest opportunity and to ensure that where delays do occur, people continue to be supported by people who can best respond to their needs.

We are ensuring a focus across each of our workstreams in effect for people with mental health needs, with specific targets to reduce lengths of stay in EDs for people with mental health needs. For us locally, we are focusing on the following actions over the winter, in the medium term and over the longer term too.

Outcome metrics:

- Length of stay for people with mental health needs in ED
- Numbers of people with no criteria to reside in MH beds

Workstream 4: Supporting mental health needs – to ensure the needs of people with mental ill-health receive parity of esteem

Improve crisis support and diversion, including building capacity and focusing existing work on diversion working across acute and secondary care with LAS, Met Police, Primary care and local authorities

Rationale: People with mental health needs nearing crisis need specialist support in a timely and effective way, ideally in a community setting

Aims:

- To reduce numbers of people attending ED in acute mental health need/crisis
- To enhance partnership working in this space
- To increase use by LAS of alternative care provision for MH

Milestones:

- Mental health partnership forums operational in each Place Partnership
- Information about alternative community options for local people and agencies
- Introduction of Crisis cafes across the BHR Places

Target:

- Reduction in numbers attending mental health in crisis

Improve processes at the front door to support people already in ED to receive timely care and support

Rationale: people with mental health needs in crisis need to be treated in a timely way to avoid further escalation of crisis and impact on other people using acute services

Aims:

- To ensure people with mental health needs get the right care at the right time
- To reduce impact for wider workforce of supporting people in mental health crisis without the specialist skills
- To improve quality and timeliness of data and escalation routes to support real time progress updates for all clinicians and ensure effective joint working

Milestones:

- New pathway in place
- Additional support

Target:

- Reduction of waiting times in ED for people in mental health crisis needing specialist support

Workstream 4: Supporting mental health needs – to ensure the needs of people with mental ill-health receive parity of esteem

Increase bed capacity through ensuring access to Winter Surge Beds, delivering of new 12 bed ward and a renewed focus on discharge

Rationale: wherever possible we want to support people who need an in-patient stay to be local, connected to their family, friends and community

Aims:

- To ensure we have additional capacity and are improving flows, supporting people to receive the right care in the right place at the right time
- To ensure we have an appropriate balance of in-patient and community based offers

Milestones:

- Opening of additional capacity by September 2023
- Discharge flow improvements from October 2023

Target:

- Reduced length of waits
- Reduced occupancy on wards to improve flow

Increase clinical Decision Unit capacity

Rationale: focal point for clinical decision making can support the pathway to work effectively

Aims:

- **to** improve flow from A&E into MH setting, and reduce length of stay in ED for people in mental health crisis

Milestones:

- Currently 20 beds at Goodmayes Hospital, with consideration being given to further expansion by end August 2023

Targets:

- Maintain reduction in length of stay on CDU (Average LOS from Aug-Jan was 45 days, average LOS for Feb was 8 days).

Workstream 4: Supporting mental health needs – to ensure the needs of people with mental ill-health receive parity of esteem

Improve flow in our MH UEC pathway

Rationale: flow through mental health interventions is important to enable patient recovery and support better outcomes, whilst making best use of resources

Aims:

- To develop partnership working by carrying out an audit across partners for 30 people who waited over 12hrs in each A&E in North East London
- To share back some of the findings of the Psychiatric Liaison Service review which has just got underway
- To provide some high-level teaching on theory of flow management
- To facilitate some site-specific theory-of-change work, and begin planning some tests of change for the next quarter

Milestones:

- Whole system UEC event focused on mental health mid-July 2023
- Key recommendations to be used across the partnership from September 2023

Targets:

- Reduction in waits in ED to meet 76% target

Workstream 4: Supporting mental health needs – to ensure the needs of people with mental ill-health receive parity of esteem

Medium term

- **Evaluate approach to crisis support and diversion, including with partners**
  - To reduce numbers of people attending ED in acute mental health need/crisis
  - To enhance partnership working in this space
- **Evaluate UTC MH streaming pilot and enhanced staffing to support in ED**
  - To support people already in ED to receive timely care and support
- **Embed CDU and reduce ED ALOS**
  - To support real time progress updates for all clinicians and ensure effective joint working

Longer term

- **Respond to findings of MH Demand and Capacity Plan across NEL for BHR, ensuring implementation to meet known gaps and capacity challenges**
  - To ensure equity and build capacity locally to reduce urgent and emergency pressures for individuals in crisis

Workstream 5: Ensuring focus on children and young people – to reflect the local demography and respond sustainably to need

Outcome 3: Ensuring that people can access the right care at the right time, and which prevents them from becoming more unwell whilst they are waiting

Babies, children and young people and their families need and use urgent and emergency care, and yet may not receive the focus required to ensure we as a system can meet their needs. As babies and children's health can deteriorate rapidly it is important that parents, carers and a wide range of practitioners and clinicians have confidence in our systems for early identification and follow through, with excellent support for parents and the broad front line workforce working with children and young people.

Children and young people's urgent and emergency care services have also faced unprecedented levels of demand, with CYP attendances peaking at 40% above pre-pandemic levels in December 2022, and as high as 60% above pre-pandemic levels for children aged 2-10. This has been particularly true for the BHRUT footprint, where demand over winter 2022/2023 and over early summer 2023 have been unprecedented.

The national plan set out specific interventions to improve urgent and emergency care for children and young people. It highlighted the need to ensure that services reflect the needs of different groups of people, including all age groups. It is crucial that implementation plans meet the specific needs of children and young people, parents/carers, and families. The most common conditions and symptoms experienced by children and young people presenting at ED are: • Fever • Respiratory: bronchiolitis; croup; asthma • Gastroenteritis • Abdominal pain

Many of these attendances could be managed effectively in primary care or community settings. Meta-analytic evidence suggests key reasons for parents attending emergency departments non-urgently include: parental worry, perceived advantages of paediatric ED, convenience and access, anticipated difficulty in accessing primary care, and the need for reassurance. Scaling up initiatives that provide additional support to children and families, improve flow, manage demand, and divert low-acuity CYP presentations to more appropriate care settings will be crucial to support children, their parents/carers, reduce pressure on ED, and increase capacity and operational resilience in urgent and emergency care. This is a core area of focus going forward to ensure sufficient capacity for paediatric responses and to improve the experience of babies, children, young people and their families.

Workstream 5: Ensuring focus on children and young people – to reflect the local demography and respond sustainably to need

Through our BCYP Programme across north east London, we have identified the following actions for urgent and emergency care. We have agreed a way of working to ensure focus on the specific needs of babies, children and young people. We recognise this as a key area of focus for this Improvement Plan – and whilst we have agreed to integrate responses for children and young people as appropriate (for example the changes to the paediatric pathways at the front door) we know that there needs to be a distinct focus for babies, children and young people in the same way as for people with mental health needs. Our main areas of focus are:

- Expand support and paediatric advice through NHS.UK, NHS111, and NHS111 online to support decision making and management of minor illness including information for Pharmacists and use of the 'What to do if your child is unwell' information for parents and carers

- Increase access to paediatric expertise through further roll out of NHS111 Paediatric Clinical Assessment Service

- Embed Family Support Workers across selected A&E sites to provide support to children with non-urgent issues, as well as outreach and additional support in community settings – consider the development of a BHR Social Care Liaison Officer (SCLO) role

- Ensure direct access to urgent mental health support through NHS 111 'option 2', to be universally available by April 2024

Workstream 5: Ensuring focus on children and young people – to reflect the local demography and respond sustainably to need

- Expand access to care in the community, including roll out of paediatric acute respiratory infections (ARI) hubs for children ahead of next winter
- Improve acute pathways through consistent adoption of paediatric Same Day Emergency Care
- EOL pathways for CYP – Haven House and Richard House: we will build on the excellent step down from BHRUT in place
- Implement locally the national roll-out of a standardised paediatric early warning system (PEWS) in inpatient settings in 2023/24 to improve identification and management of deterioration in children
- Develop streamlined pathways for mental health patients who need to remain in acute settings until their care can be transferred, with particular reference to better working with children and young people's mental health services 10. Better support for discharge through clear pathways and escalations including OOA
- Ensure access to 24/7 liaison mental health teams (or other age-appropriate equivalent for children and young people) that are resourced to be able to meet urgent and emergency mental health needs in both A&E and on the wards
- Provide consistent and repeated early parent education – to be developed at Place

This is an area for immediate development given the young populations across north east London and the need to build capability and capacity appropriately through work with Place.

Workstream 6: Communicating and engaging – to engage with local populations to change behaviour and embed understanding

Contributes to all outcomes but particularly Outcome 3: Ensuring that people can access the right care at the rig
from becoming more unwell whilst they are waiting

Working with local people and communities is critical to improving our urgent and emergency care response. We have a number of opportunities for local voice to be heard through the Healthwatch Community Insights System, through regular PPG meetings, through dedicated co-design work in specific areas, through population level communications and engagement plans and through feedback on specific services.

We are developing our mechanisms for people to contribute to this Plan and the many actions which will be in place to deliver against our top level outcomes. Whilst this is a north east London approach we are engaging locally and through the BHR Places Improvement Board and through our Place Partnerships with local people to support behaviour change.

We have evaluated our winter communications campaign and have been able to understand where we have had most impact on resident behaviours. While the focus will remain on helping people access the right NHS help at the right time, it can also support comms around wider drivers of ill health and NHS attendance in line with advice from partners and this wider Improvement Plan. It will also sit alongside other campaigns like immunisations to make every contact count and build the resilience of local communities to respond to needs arising within their communities.

The next slides set out our approach in more detail but we are keen to explore information and advice, ensure Healthwatch insights and information are used as core data in decision making, continue to implement all year round system resilience campaign, ensuring it reaches out to communities through other communication

Workstream 6: Communicating and engaging – to engage with local populations to change behaviour and embed understanding

Deliver a holistic communications and engagement campaign with outreach to communities we most need to target and engage

Rationale: the behaviours of our local populations drive need and demand and working alongside residents will help to shape those behaviours.

Aims:

- To build on the work at a place level to support holistic outreach through local hubs, events and community champions, working with our partners and sharing assets and collateral
- To operate in the digital and non-digital space
- To ensure accessible communication and engagement including community languages and disability friendly communications
- To increase the voices of local people in our messaging and materials and devote time to sourcing and curating them and work closely with Healthwatch and utilise the community insight system to develop content.

Milestones:

- Funding in place by end June 2023
- Campaign messages and approach agreed by end July 2023
- Move to develop hyper localisation of messaging and targeting based on new data sources, by end September 2023
- Commission other forms of digital marketing outside of social media and website adverts in place by end September

Targets:

- Fully operational campaign visible and active throughout the year

Workstream 6: Communicating and engaging – to engage with local populations to change behaviour and embed understanding

We will call our campaign **'Finding the right support'** and deliver messages in separate strands (sometimes overlapping) and will actively engage with local populations as it is developed. Our core strands are as set out below:

GPs and GP access

- The importance of registration.
- Helping people understand the different roles in GP practices and what receptionists do.
- Different ways to access your GP including online consultation forms.
- The NHS app.
- Convenient OOH appointments.
- Fuller Review transformation
- Pump prime before winter

Pharmacy

- Pharmacists are experts in medicines who can help you with NHS prescriptions as well as support for minor health concerns.
- Pharmacists can also help get you emergency medicine.
- Many pharmacies are open until late and at weekends. You do not need an appointment.
- Fuller Review expansion of prescriptions
- Pump prime before winter

Minor conditions and child health

- Minor condition focused content directing people to pharmacy
- Parent focused content directing people to pharmacy
- Long term condition management via GP
- Deploy during winter and other peaks

Mental health

- Available support including talking therapies
- Pump prime before winter
- Crisis lines and urgent support
- Deploy during winter and other peaks
- Support ELFT/NELFT campaigns

Urgent help

- Out of hours urgent GP appointments.
- NHS 111
- A&E for emergencies only
- Hierarchy of help – 'route' to help from self-care to A&E
- Deploy during winter and other peaks
- New OOH GP provision across NEL yet to be agreed

NEL wide enabler: Building effective data and digital resources

Improving our data and digital functionality across operational and strategic functions will enable us to operate more efficiently across our system and to understand better the impact of our actions on our intended outcomes both in real time and over time.

A London UEC IUC Digital transformation Programme has been developed for 2023/24. The vision for this programme is for a UEC IUC service that utilises digital technology, to streamline the patient journey and clinical interactions as much as possible. Key aspect of the programme include call before you convey, digital front door triage, direct booking and digital transfers of care. Much of this work is already underway, in particular direct booking from 111 into primary care, UTC's and ED's and work will continue to improve efficiency and functionality.

A UEC system dashboard has been developed across NEL, reporting on key metrics including 111, ambulance and ED performance. Work continues to develop the dashboard, to ensure key data is reported so that the system has clear oversight on activity.

Access to the Universal Care Plan is now available to all key stakeholders across north east London, including ED's ,UTC's and Primary Care. A Universal Care Plan dashboard is being rolled out to all stakeholders. In addition shared care models need to be agreed at pace to ensure we can move forward in more integrated ways. This will involve working with Information Governance to ensure we are building resilience and a focus on integration throughout our work.

Digital systems used within the unplanned care pathway have also been reviewed or are being reviewed, including UTC's and Urgent Care Response/Community referral processes. The aim of the reviews is to standardise digital processes where possible, using the IT systems used.

Discussions underway around the digital interface between UEC and Urgent Care Response services, across NEL ahead of winter.

All ICB's have been mandated to have procured and implemented a System Control Centre (SCC) by 1st November 2023. The SCC will improve situation awareness, holistic and real time management of capacity and co-ordinated action across north east London and mutual aid. Next steps for NEL include agreeing resource, procure a tech solution, recruitment and training.

There is an established UEC Digital Enabler Group within north east London to support with the delivery of key digital objectives relating to unplanned care.

NEL wide enabler: Growing a sustainable workforce

We are working with system partners to co-design a NEL-wide People and Workforce Strategy to implement a 'one workforce' model across health and social care providers, to ensure that we have the right capacity at the right time which is critical to the successful delivery of this ambitious Plan. From engagement with providers across the system, we have identified the following high level strategic priorities set out below:

Parity	Portability	Planning	Partnership	Purpose	Population	Productivity
• How we can achieve better equity in pay and benefits between health and social care . • We would also seek to promote seamless joint working and retention by ensuring comparable attractiveness of the offer for health and social care roles. • Address current disparities in high cost allowance between inner and outer London boroughs	• How we can use digital systems interoperability and solutions such as e-passports, remote supervision and digital up-skilling and other interventions to support 'one workforce' • To develop and enable effective joint teams and seamless working and deployment across health and social care employers.	• How we will strengthen our capability for pro-active, joined up, system-wide operational and strategic workforce planning • Develop a 'one workforce' perspective across both health and social care at system, place and neighbourhood levels.	• To address inequities in the system and ensure access to employment opportunities for young people, older people and under-representative groups in NEL. • Understand recognition of generational differences in perceptions of work and employee motivation, informing the design of health and social care careers and roles that would be attractive to our future workforce	• How we will strengthen collaboration between schools and higher education institutions and health and social care providers, to develop and train a continuous supply pipeline of talent to be channelled into innovative flexible careers • Delivery through apprenticeships, and redesigned roles, skills and entry requirements.	• How we will strengthen collaboration between schools and higher education institutions and health and social care providers, to develop and train a continuous supply pipeline of talent • To be channelled into innovative flexible careers through apprenticeships, and redesigned roles, skills and entry requirements.	• How we will put in place interventions to support, develop and ensure the health and mental well-being and resilience of all our system health and social care workforce, • Including primary care, the voluntary and independent care sectors, so as to enable and retain a productive, motivated and sustainable 'one workforce'.

NEL wide Enabler: Enhancing 999 and 111 services

London Ambulance Service provides both 999 and 111 services across the NEL footprint, both elements of which are challenged in terms of achieving contractual and national expectations in terms of performance. The following is a list of areas being developed across London Region, the NEL System footprint, and some BHRUT specific initiatives:

- 999
    - Evaluation of Pilot in NWL of 45 minute rapid release/handover of patients from LAS to EDs – likely pilot for 2 weeks in NEL within the next 2-3 months
    - Roll-out of Cat 2 Response pilot (completed in NCL) across London
    - Extension of the REACH model to include BHRUT
    - Dedicated evaluation of LAS and ED behaviours during patient handover/ambulance offload at both BHRUT EDs to identify areas for improvement
    - Enhancing the senior clinician cadre withing the LAS Emergency Operations Centre (The 'NEL Cell' trial was successful during recent periods of Industrial Action)
    - PAN NEL review of the LAS 'STEPS' to be more collaborative
- 111
    - National review of 111 service model expected in Q2 23/24
    - Remodelling of current 111 service in NEL & SEL including:
        - Review and update of Dx Codes
        - Recruitment of more senior clinicians for the CAS
    - Consideration of moving 111 from UEC to Primary Care to ensure linked in with both Fuller and Primary Care Recovery Plan

Improvement Plan: Conclusion

As set out throughout the presentation, this is a Plan under development. It is ambitious in its aims and in its system wide approach which recognises the contributions of Place, Providers, Collaboratives and Programme in improving outcomes in outer north east London. We are asking the Board today to comment on the Plan and on the next steps in its development which are summarised below:

- Finalise the metrics, data and reporting requirements throughout the governance
- Work through the governance arrangements, including the groups reporting into the BHR Places UEC Improvement Board, the role of Place Partnerships, Collaboratives and the oversight through the UEC System Board
- Work with colleagues across Providers, Primary Care, Planned Care and other relevant areas to provide detail on the north east London wide work which will support the delivery of this Plan with a clear focus on data and information governance as an enabling priority
- Develop a risks and issues log which will provide an at a glance picture of progress
- Agree the logic model, with clarity on input, activities, outputs and outcomes including a clear summary on the core outputs and outcomes to ensure focus and understanding
- Work with local people to co-design solutions for the challenges identified

HEALTH AND WELLBEING BOARD AND ICB SUB-COMMITTEE

12 September 2023

Title: Urgent Action - Extension to 0-19 Integrated Healthy Child Programme Service Contract	
Report of the LBBD 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: Alison Stuart, Chief Legal Officer and Monitoring Officer	
Accountable Executive Team Director: Fiona Taylor, Chief Executive	

Summary

The 0-19 Healthy Child Programme 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 and School Nursing services and National Child Measurement Programme (NCMP). A five-year contract was entered into with the North East London Foundation Trust (NELFT) to provide the service, which commenced on 1 September 2018.

The Department for Health released the latest 0-19 Healthy Child Programme Guidance in June 2023, which aligns outcomes with the Family Hubs. There is also a review of the Public Health Grant currently being undertaken, which will present findings to the Lead Member later this year.

As the attached report explains (Appendix 1), the Director of Public Health was of the view that given the scale and complexity of the procurement and to allow sufficient time to fully consider the implications of the new guidance and the available budget, it would be beneficial to pause the commissioning of a new long-term contract and extend the existing contract with NELFT up to the end of 2024. The value of the contract extension is estimated at £8.3m for the 16-month period.

As the contract extension needed to be in place for 1 September 2023 and the next meeting of the Board was not until 12 September, the Council's Chief Executive agreed that it was in the Council's best interests to approve the extension of the 0-19 Healthy Child Programme service contract under the Urgent Action provisions of Part 2, Chapter 17, paragraph 15 of the Council Constitution. In accordance with the Urgent Action procedure, the Chairs of the Council's Health and Wellbeing Board and Health Scrutiny Committee were advised of the proposal prior to the decision being taken and the matter is being reported to this meeting for information.

Recommendation(s)

The HWB and ICB Sub-Committee are asked to note the action taken by the Council's Chief Executive, in accordance with the Urgent Action procedure under Part 2, Chapter 16, paragraph 4 of the Council Constitution, in relation to:

(i) Agreeing to waive tendering requirements and approve the variation of the contract for the provision of the integrated 0-19 Healthy Child Programme with NELFT for a period of 16 months from 1 September 2023 to 31 December 2024, in accordance with the strategy set out in the report; and

(ii) Delegating authority to the Director of Public Health, in consultation with the Cabinet Member for Adult Social Care and Health Integration, to enter into the extended contract and all other necessary or ancillary agreements with NELFT to fully implement and effect the proposals.

Reason(s)

To accord with the requirements of the urgency procedures contained within the Council Constitution.

Public Background Papers Used in the Preparation of the Report:

- Chief Executive's signed letter of 25 August 2023 "Urgent Action under Part 2, Chapter 16, paragraph 4 of the Constitution – Extension to 0-19 Integrated Healthy Child Programme Service Contract" (https://modgov.lbbd.gov.uk/Internet/ecCatDisplay.aspx?sch=doc&cat=14766)

List of appendices:

- **Appendix 1** - Report entitled "Extension to 0-19 Integrated Healthy Child Programme Service Contract"

APPENDIX 1

Title: Extension to 0-19 Integrated Healthy Child Programme Service Contract	
Report of the Cabinet Member for Adult Social Care and Health Integration	
Open Report	**For Decision**
Wards Affected: None	**Key Decision:** No
Report Authors: Rebecca Nunn – Consultant in Public Health, Babies, Children and Young People Clare Brutton – Head of Commissioning for Disabilities	**Contact Details:** E-mail: Rebecca.nunn@lbbd.gov.uk Clare.brutton@lbbd.gov.uk
Accountable Director: Matthew Cole, Director of Public Health,	
Accountable Strategic Director: Elaine Allegretti, Strategic Director, Adults and Children	

Summary:

The 0-19 Healthy Child Programme 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 and School Nursing services and National Child Measurement Programme (NCMP).

The current provider of the integrated 0-19 Healthy Child Programme (HCP) service is North East London Foundation Trust (NELFT). The contract commenced on 1 September 2018 when approval was successfully sought to procure an integrated 0 - 19 HCP service for a contract term of up to five years; the contract expires on 31 August 2023.

The 0 - 5 element of the integrated HCP is led by the health visiting services through the five mandated health assessment visits. The 5 - 19 elements are led by school-based public health nursing services, which includes the mandated National Child Measurement Programme (NCMP).

The Department for Health released the latest 0-19 Healthy Child Programme Guidance in June 2023, which aligns outcomes with the Family Hubs. If the Council commenced with the commissioning process prior to release of the guidance, there would be significant deeds of variations at mobilisation phase to ensure the new contract was in line with the guidance. It may have also been possible that if any changes were substantial that such changes would not have been compliant with the Public Contracts Regulations 2015.

Given the scale and complexity of the procurement, the Director of Public Health agreed that pausing the commissioning process whilst awaiting the new guidance would be sensible.

There is currently a review of the Public Health Grant being undertaken, which will present findings to the lead Member for Health in September/October 2023. This review and subsequent decision-making process will determine the budget for the redesigned service. Due to significant population increases, more families with significant complex needs, and a change in the guidance, there is the need for increasing this financial envelope to be carefully considered. It is therefore prudent to ensure enough time in the procurement timeline for this review to conclude and the outcomes to determine the new service model budget and therefore the scope of the service.

The variation to the contract will allow for more appropriate timescales to plan and deliver a robust engagement and consultation process with service users and professionals, including benchmarking to collaboratively re-design the new specification, procure and mobilise a new service that aligns with local need/strategies to be sustainably fit for purpose and ensure value for money.

The variation to the contract to extend will ensure the current provider, NELFT, will continue to provide early intervention and preventative community, universal, targeted and specialist service delivery to improve the health and wellbeing of families, babies, children and young people beyond 31 August 2023, until a new service starts on 1 January 2025.

At this stage, it is not possible to confirm the detailed configuration or price of the new services, as the competitive procurement and negotiation process itself will feed into the overall design of the service which includes provider costing of the final model.

The extension will also provide the opportunity to develop new and effective partnerships with local voluntary community sector organisations, faith groups and others to advocate and deliver change to support innovative improvements in services for babies, children and young people health and wellbeing in all settings.

Recommendation(s)

The Health and Wellbeing Board is recommended to:

(i) Agree to waive tendering requirements and approve the variation of the contract for the provision of the integrated 0-19 Healthy Child Programme with NELFT for a period of 16 months from 1 September 2023 to 31 December 2024, in accordance with the strategy set out in the report; and

(ii) Delegate authority to the Director of Public Health, in consultation with the Cabinet Member for Adult Social Care and Health Integration, to enter into the extended contract and all other necessary or ancillary agreements with NELFT to fully implement and effect the proposals.

Reason(s)

To enable the Council to continue to provide the statutory 0 -19 Healthy Child Programme service and accord with the Council's Contract Rules.

1. Introduction and Background

1.1 Office for Health Improvement and Disparities (OHID - formally Public Health England) supports local authorities and the NHS in securing the greatest gains in health and wellbeing and reductions in health inequalities through evidence-based interventions. In October 2014, PHE published 'From Evidence into Action: Opportunities to protect and improve the nation's health'. This is linked to the NHS Long Term Plan, the Prevention Green Paper and the NHS Five Year Forward View.

1.2 The statutory Healthy Child Programme offers every family in LBBD an evidence-based programme of interventions, including screening tests, immunisations, developmental reviews, and information and guidance to support parenting and healthy choices. It also outlines all services that children and families need to receive if they are to achieve their optimum health and wellbeing.

1.3 The Healthy Child Programme remains universal in reach, continuing to set out a range of public health interventions to build healthy communities for families and children, reducing inequalities and vulnerabilities. It continues to include a schedule of interventions, which range from universal services for all, through to intensive support.

1.4 The Healthy Child Programme is personalised in response. All services and interventions need to be personalised to respond to families' needs across time. For many families this will be met by the universal offer. More targeted, intensive or specialised support and evidence-based interventions should be provided early to reduce the need for future demand on services.

1.5 The recent updates to the 0 - 19 Commissioning Guidance (Modernisation of the National Healthy Child Programme Best Start in Life and Beyond Improving public health outcomes for children young people and families), the development of the Barking & Dagenham Best Chance Strategy, and the recently developed Family Hub and Start for Life programme delivery plan further highlight the need for the thorough development of a new specification that aligns with service demands and recently updated and new national policy drivers and local strategies.

1.6 The NEL Integrated Care System is facing some significant challenges

- Highest birthrate in the UK; 120,000 in the last 5 years with a population growth prediction of 270,000 in the next 20 years
- The most diverse ICS in the country with 53% of the population identifying as Black, Asian or from a global majority compared to 11% across England overall
- 30% of the ICS population were born outside of the UK

1.7 Barking and Dagenham has many challenges of its own, with the increased social care and health demands faced by the borough including:

- The highest proportion of children (0–17) in the UK: almost three in ten residents (29.9%) are under 18.
- The highest proportion of under 5s in the UK: 8.8%.

- Child poverty is amongst the highest in London boroughs and the country: 46% of children live in households on the poverty line and waiting lists for housing are some of the largest in the country.
- Barking and Dagenham has the highest deprivation score in London
- Highest levels of Year 6 overweight and obesity in England.
- Covid 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.
- High demand for children's social care: In the last four years, there has been a significant increase in the number of CIN from 1,187 to 1,802 in 2021 – a growth rate far in excess of the population.
- Highest Domestic Abuse MERLINS, prosecutions and refuge referrals in London – it is estimated that 75.43 per 1000 of our 0-4 yr. olds live in households where a parent is suffering domestic abuse.
- One third of five-year-olds have experienced dental decay.

1.8 These significant population changes, along with the evident systematic inequalities that some communities experience, requires a tender and procurement process that is culturally competent, innovative and co-developed with stakeholders, to appropriately meet the needs of the existing and future generations of families in LBBD and to avoid a 'one size fits all' specification/ service.

1.9 The Best Chance Strategy has 4 shared Strategic Outcomes set out in their vision - Working collaboratively to give babies, children, young people and their families the best chance in life so that every baby, child, young person and their family gets the best start, is heathy, happy and achieves, thrives in inclusive schools and settings, in inclusive communities, are safe and secure, free from neglect, harm and exploitation, and grow up to be successful young adults. The 0-19 HCP service is a major contributor to all of these strategic outcomes, as it is provision for every child in the borough. The 0-19 HCP service also has potential to impact on all of the 6 priority areas for this strategy:

- Giving every child the best start in life (the first 1001 days);
- Reducing prevalence of harm caused by domestic abuse;
- Acting together against child poverty;
- Improving quality, access and support for those with SEND;
- Reducing obesity and improving best start health outcomes;
- A better offer for those with social, emotional and mental health needs.

1.10 Delivery of this vision in LBBD is reliant upon a wide range of partners working together and embracing change in order to:

- Ensure high quality services for children, young people and families from actions to improve women's health before, during and after pregnancy (Maternity Transformation Programmme/ Maternity and Neonatal 3-year Delivery Plan);
- Give every child the best start in life (infant feeding, childhood obesity, speech, language and communication, immunisations, attachment, perinatal mental health);
- Support school readiness and improve resilience for school aged children;
- Support young people to transition into adult services.

1.11 The HCP provides a framework to support collaborative work and a more integrated delivery of services, with aims to:

- Help parents, carers or guardians develop and sustain a strong bond with their children;
- Support parents, carers and guardians in keeping children healthy and safe and reaching their full potential;
- Protect children from serious disease, through screening and immunisation;
- Reduce childhood obesity by promoting healthy eating and physical activity;
- Promote oral health to reduce dental caries.
- Support resilience and positive maternal and family mental health
- Support the development of healthy relationships and good sexual and reproductive health.
- Identify health and wellbeing issues early, so support and early interventions can be provided in a timely manner.
- Make sure children are supported in all childcare, early years and education settings and especially supported to be 'ready to learn at 2' and 'ready for school at 5'

1.12 Effective design and implementation of the HCP service aims to improve a range of public health outcomes by: increasing breastfeeding rates, supporting transition to parenthood, advice and signposting parents to healthy weaning support services, ensuring all high impact area reviews by all parents, babies, children and young people to identify, assess and deliver intervention to improve overall emotional health and wellbeing for all.

1.13 A service needs review has commenced to support the complete re-design of the 0 - 19 HCP for LBBD to align with the health and developmental checks and assessment needs of the babies, children, young people and families. Stakeholder engagement and marketing workshops are being developed for roll out across the borough to engage with parents, carers, guardians and staff to agree priorities for the core service elements, collating and reviewing data.

1.14 The service re-design stage will be taken forward through a number of project workstreams looking at key development areas such as integrated structure, access and pathways, innovation, and desired outcomes and performance.

1.15 The stakeholder engagement and benchmarking activities will feed into the co-design and co-development of the final specification. The five areas of focus for this procurement process are:

- **Model and Design** - To improve services to align with best practice: with a balanced model, which meets strategic ambitions for child health – improving long term outcomes and reducing short term system pressures i.e. reduction in high cost social care interventions, reduction in A&E attendance for minor childhood illnesses
- **Partnership & Communication** - To develop and deliver services in partnership with parents, and to build effective partnerships with professionals across the system
- **Joined up offer** - For functional outcomes for children and young people to be at the heart of services linked to Place Based ambitions

- **Outcomes Focused** - To align delivery across the NHS, Voluntary sector and LA working collaboratively to provide a clear and holistic local approach to children's clinical services
- **Service provider developments** - To take forward specific service developments relevant to individual providers: NHS and LA

1.16 All points above link directly to the Council's four priorities: 1) Participation and Engagement 2) Inclusive Growth 3) Prevention, Independence and Resilience and 4) Well Run Organisation.

2. Proposed Procurement Strategy

2.1 Outline specification of the works, goods or services being procured:

2.1.1 The core service requirements of the statutory 0 - 19 Healthy Child Programme are to provide a single coherent 'offer' for families and deliver safe, effective family, child and young person-centred care. This will strongly link into the Family Hubs programme in the borough, as a way to improve integrated working across the system and deliver on the Best Chance Strategy.

2.1.2 The re-designed specification, that will be developed during the 16-month period will, require a lead provider to partner with and subcontract specific service elements to local/voluntary sector organisations.

2.1.3 This integrated service delivery approach will provide prevention interventions through a progressive universal approach, delivering targeted interventions, to those most in need and with the delivery of full population coverage of LBBD which should include:

- Antenatal and Newborn Support - Providing information and support to expectant parents during pregnancy. Conducting health assessments for newborns and providing support for early parenting, safe sleep, etc. Services delivered across LBBD at locations and times that increase accessibility for all.
- Developmental Reviews and Assessments – The delivery of developmental reviews and assessments at key stages of a child's development; 6-8 weeks, 1 year, 2-2.5 years, and 4-5 years in line with national targets.
- Monitoring the child's physical, emotional, and cognitive development.
- Identifying any potential developmental concerns or delays.
- Screenings to detect and manage health conditions early, such as hearing and vision screening, speech and language delays, dental health checks, and screening for developmental delays for appropriate referral.
- School Readiness – supporting parents to get their children school ready – including early development of speech, language and communication skills; potty training; social and emotional development.
- Immunisations and Vaccinations – Promoting vaccine awareness to parents/carers and parents/ carers-to-be. Where appropriate, administering/ referring babies for scheduled immunisations and vaccinations to protect children against common infectious diseases. Providing information and education about immunisations and their benefits.
- Health Promotion - Delivering health promotion and education sessions to parents, children, and young people i.e. infant/ breast feeding/ weaning, nutrition, physical activity, and mental well-being. Transition to parenthood and

other transition points during the early years (e.g. potty training, boundary setting, etc); oral health; Healthy weight, nutrition, movement/ exercise; Health literacy and education, accident prevention.

- Emotional Health and Well-being - Providing support and guidance on managing behavioral and emotional issues. Referrals to CAMHS, therapeutic services which can include support for parents, children, and young people.
- School Nursing Services - Delivering health services in schools, including health assessments for Education Health and Care Plans, Looked After Children etc. - support for children with specific health needs.
- Working closely with schools to promote a healthy environment and support overall well-being including sexual health, healthy relationships, substance misuse.
- Provision of the National Child Measurement Programme.
- Safeguarding and Child Protection - Identifying and addressing child protection concerns.
- Collaborating with other agencies to safeguard and promote the welfare of children and young people.
- Attending safeguarding meetings when child known to the school nursing individual/ team.

2.2 **Estimated Contract Value, including the value of any uplift or extension period**

2.2.1 To sustain the service for an additional 16-months, the total contract value will be £8,316,934. This is an uplift of 9.3% when compared to the original contract value for 1 September 2018 until 31 August 2023 of £28,525,000.

2.2.2 The LBBD Public Health budget allocation for 0-19 HCP was increased at the start of 2022/23 financial year so now reflected in this annual budget for the 16-month extension period. The allocation has increased in line with Agenda for Change; no uplift has been awarded outside the statutory mandated guidance.

2.3 **Duration of the contract, including any options for extension**

2.3.1 Extension of contract for 16 months covering 1 September 2023 to 31 December 2024, with no option to extend.

2.4 **Is the contract subject to (a) the Public Contracts Regulations 2015 or (b) Concession Contracts Regulations 2016? If Yes to (a) and contract is for services, are the services for social, health, education or other services subject to the Light Touch Regime?**

2.4.1 Yes, the service being procured falls within the description of services covered by the Light Touch Regime under the Public Contracts Regulations 2015.

2.5 **Recommended procurement procedure and reasons for the recommendation**

2.5.1 Modification of existing contract to allow for the variation until December 2024 when a new contract will be in place. This will be procured now that the new guidance has been released.

The proposed procurement timetable is as follows:

Activities/ Tasks	Date/ Deadline
Stakeholder consultation and engagement	July 2023 – October 2023
Issue PIN for Expression of Interest	September 2023
Market Engagement Event	November 2023
Specification document – Development and Sign off	October 2023 – January 2024
Issue Invitation to Tender	February 2024
Return of tenders	April 2024
Tender Evaluation	May 2024
Negotiation process/ Clarification (if required)	June 2024
Final Tender and Evaluation process	July 2024
Prepare contract award report for approval	August 2024
Provisional contract award	August 2024
Standstill period	Early September 2024
Final award	Late September 2024
Service Mobilisation inc. potential TUPE transfers	1 October – 31 December 2024
Contract commencement	1st January 2025

2.6 **The contract delivery methodology and documentation to be adopted**

2.6.1 For the contract variation, a Deed of Variation will be issued to vary the termination date of the contract.

2.6.2 **0 – 19 Healthy Child Programme – Health Visiting and School Nursing inc. the mandated National Child Measurement Programme**

Core elements of the service delivered are:

The HCP provides a framework to support collaborative work and a more integrated delivery of services, with aims to:

- Help parents, carers or guardians develop and sustain a strong bond with their children
- Support parents, carers and guardians in keeping children healthy and safe and reaching their full potential.
- Protect children from serious disease, through screening and immunisation.
- Reduce childhood obesity by promoting healthy eating and physical activity.
- Promote oral health to reduce dental caries.
- Support resilience and positive maternal and family mental health
- Support the development of healthy relationships and good sexual and reproductive health.

- Identify health and wellbeing issues early, so support and early interventions can be provided in a timely manner.
- Make sure children are supported in all childcare, early years and education settings and especially supported to be ‘ready to learn at 2’ and ‘ready for school at 5’.

The service will continue to provide the universal HCP assessments:

- Antenatal check – at around 28 weeks pregnant
- New baby check – at 10 – 14 days
- 6 – 8 week – maternal mood review
- 9 – 12 month development review
- 2 – 2 ½ years development review
- The National Child Measurement Programme (NCMP)
- Looked After Children Reviews
- Undertake vision and hearing screening and provide referral for health conditions

Which will help:

- To build community and family capacity so that families are better able to help themselves;
- To support parents, promoting good parenting skills;
- To improve early years’ outcomes through delivering targeted perinatal mental health, secure attachment nutrition and exercise, language, communication and school readiness;
- To provide effective information and advice to support self-help and other resources that promote physical, social, emotional and mental health and wellbeing in children, young people and families, both in the community and universal service delivery settings;
- To improve school attendance and engagement with learning from early childhood onwards – by working in partnership with families, communities, schools, early years providers and other services to ensure children are ready for school, have excellent attendance and engage with learning;
- To provide a leadership role for health policies and programmes in schools, promote a healthy school environment and provide direct care to students, leading the provision of health services in schools in schools including advice and guidance un areas such as sexual health, drugs and alcohol;
- To increase emotional wellbeing and resilience amongst children and young people – by raising awareness of mental health and its links to physical wellbeing, specifically targeting those at risk and providing early intervention and onward referral where appropriate;
- To help improve lifestyles and provide support to families, children and young people on areas such as healthy weight and oral health;
- To help young people prepare for adulthood.

2.6.3 The re- designed service specification will require the potential bidders to demonstrate a transparent plan to partner with local voluntary community sector organisations (VCSO) to deliver service elements within the specification along a pathway that is accessible and seamless for all families, babies, children and young people.

2.6.4 Services are to be provided to Barking & Dagenham residents only; the service specification will highlight respective service eligibility criteria.

2.6.5 Service performance will be monitored through a series of Key Performance Indicators (KPIs) as detailed in the service specification that includes quantitative and qualitative data, service user feedback and activity on outstanding action plans reviewed at quarterly meetings. Several KPIs are set nationally by the Department of Health and Social Care (DHSC) and these are in line with the Public Health Outcomes Framework, others will be set locally to reflect local priorities and population need/ needs assessment and robustly overseen as part of ongoing contract monitoring.

2.7 Outcomes, savings and efficiencies expected as a consequence of awarding the proposed contract

2.7.1 There are no anticipated cost savings to be made in the contract variation for the extension as it is a continuation of the current service which is now integrated - prior to 2018, LBBD HCP service was two separate services.

2.8 Criteria against which the tenderers are to be selected and contract is to be awarded

2.8.1 Not applicable.

2.9 How the procurement will address and implement the Council's Social Value policy

2.9.1 The Social Value for the 16-month extension (1st September 2023 – 31st December 2024) is currently undetermined. However, we will explore with the provider what social value can be obtained during this period (for example, participation in employment fayres, opportunities for local people, etc). Social Value will be expected in the bidder responses for the new HCP specification.

2.9.2 The re-designed service will likely be a lead provider arrangement with service elements sub-contracted and delivered via local VCSOs and community organisations, contributing directly to the Council's goals and priorities for Social Value and for supporting the local Community and Voluntary sector.

2.9.3 The procurement and tender process for the new specification will require potential providers to develop their Social Value proposals illustrating how they will deliver social value throughout the life of the contract, aligning with the goals and priorities of LBBD; 'Investment in Local People, Investment in Local Economy and Environmental Sustainability'.

2.9.4 The Social Value weighting in the assessment of tenders will be 10% - potential providers will demonstrate (the what and the how) in submission of their delivery plan and responses to the method statement questions, what actions that will be taken to deliver the HCP service beyond the core elements of the specification, to identify local opportunities for apprenticeships, training, work experience and recruitment for LBBD residents including young people.

2.9.5 All providers are expected to adhere to the highest possible ethical standards in employment and demonstrate their absolute commitment to preventing slavery and human trafficking within their own activities and through their supply chain.

2.10 **London Living Wage (LLW)**

2.10.1 It is understood that all posts employed under this contract will be above the LLW. As the new contract will be using a more diverse skill mix and there is the potential that not all posts will be on NHS pay scales, we will ensure that the LLW requirement is in the new specification and contract.

2.11 **How the Procurement will impact/support the Net Zero Carbon Target and Sustainability**

2.11.1 Relevant officers will collaborate on the development of the new service specification, which will include requirements in the new specification to support the Net Zero Carbon Target.

2.11.2 The current provider, NELFT, will have an action plan around this as they are required to. We will request this as part of the contract extension.

3. Options Appraisal

3.1 **Option 1: Do Nothing -** This is not a viable option, the Council is required to deliver on its statutory duties for children, young people and families through the 0 - 19 HCP service. In addition, the NCMP is an element of the school nursing programme that is also a mandated public health programme for the local authority. If the Council chose to do nothing there would be a detrimental impact on the health, social and emotional wellbeing of children, young people and families in the borough as well as the development and academic outcomes for each child. There is also the reputational and financial risk to the Council by the potential failure to perform its statutory duty to deliver public health services for 0 - 19 years.

3.2 **Option 2: Extend current contract and undertake a competitive procurement process -** This is the preferred option. Given the recent guidance updates and assessment of local need required, a 16-month extension is required which includes the lead in time for the mobilisation for the new provider.
This contract variation will ensure a thorough and robust engagement, consultation and benchmarking process to review any gaps in service provision alongside the rapidly changing needs of the community.

4. Consultation

4.1 Consultation has commenced as the current service undergoes an initial service review – should the 16-month extension be approved the project plan will include several consultations to gather data and feedback from all relevant stakeholders which will include the current provider, potential providers, neighbouring boroughs as part of the bench marking, families/ parents and young people as well as partner organisations and multi-disciplinary teams across the Council.

4.2 The proposals in this report were considered and endorsed by the following:

- PRMG BAU at its meeting on 3 August 2023;
- Children's Portfolio at its meeting on 8 August 2023;
- Health Portfolio at its meeting on 15 August 2023;
- Sub Procurement Board at its meeting on 7 August 2023;
- Procurement Board at its meeting on 21 August 2023.

5. Corporate Procurement

Implications completed by: Adebimpe Winjobi, Head of Public Health Programme

5.1 This report is seeking approval to waive the requirement to tender and approve the variation of the contract for the provision of the integrated 0-19 Healthy Child Programme with NELFT for a period of 16-months from 1 September 2023 to 31 December 2024, in accordance with the Council's Contract Rules.

5.2 The contract variation for this contract is based is Reg 72(c) of PCR 2015 and can justify the use as the need arises from circumstances which a 'diligent contracting authority could not have foreseen- in this case a delay to the procurement of a new service due to the delay in receiving new Healthy Child Programme guidance and ongoing review of the public health grant. In line with PCR regulation, the overall nature of the contract is not altered and the increase in price is less than or equal to 50% of the contract value.

6. Financial Implications

Implications completed by: Katherine Heffernan, Head of Service Finance

6.1 This report seeks approval to waive the requirement to tender for the contract for the statutory Healthy Child Programme and instead to extend the existing contract for an additional sixteen-month period beyond the end of the contract from September 2023 to December 2024.

6.2 The cost of the proposed contract variation will be £8,316,934 for sixteen months (an annual cost of £6,237,000). This is 9.3% higher than the average cost of the existing contract (£28,525m over the whole life which averages to £5.705m per year.) Given the current level of inflation (CPI was 8.7% in May) and the growth in the 0-19 population this is not an unreasonable increase.

6.3 The absence of a full tender process means that it is harder to be sure that the contract represents value for money. However, the report sets out the reasons why it is more effective to defer the procurement of the new contract so that the new service specification can be updated in the light of the new guidance and the development of the Family Hubs.

6.4 The report further sets out further detail the timetable and process for procurement of the new contract for January 2025. It will be important to ensure that these are adhered to and that all care is taken to ensure that the next contract does demonstrably achieve value for money and where possible savings and efficiencies are made.

6.5 The cost of the service will be fully met from the ringfenced Public Health grant with no demand on other Council budgets. There is sufficient funding available within

the grant for the whole period of the contract (an indicative allocation of the grant for 2024/25 has already been published.)

7. Legal Implications

Implications completed by: Kayleigh Eaton, Principal Contracts and Procurement Solicitor, Law & Governance

7.1 This report is seeking to vary the contract for the 0-19 Healthy Child Programme contract in order to extend by an additional 16 months. The term of the current contract ends on 31 August 2023 and this report is seeking a contract variation to 31 December 2024.

7.2 This report notes that the need for the modification to the contract term has arisen due to guidance being issued only in June 2023, the purpose of which is to improve outcomes for the new service. This report notes that had the procurement process started prior to the guidance being issued that the new contract would not have been compliant with the guidance and would have required substantial changes. The nature of these changes could have been incompatible with the Public Contracts Regulations 2015. The need for this guidance being issued so close to the contract end date was not foreseen in the original procurement.

7.3 Regulation 72 (c) of the Public Contracts Regulations 2015 states that modifications to existing contracts are permitted where the need for modification has been bought about by circumstances which a diligent contracting authority could not have foreseen, the modification does not alter the overall nature of the contract and the increase in price does not exceed more than 50% of the original contract value.

7.4 As noted above the need for this contract variation could not have been foreseen and the services during the additional 12 months will not differ from those originally procured so it will not alter the overall nature of the contract. The price increase is approximately 22%, which does not exceed the 50% threshold.

7.5 The Council will be required to publish a notice of this modification in accordance with Regulation 72 (3).

7.6 The variation should be recorded in writing and signed by all parties.

8. Other Implications

8.1 **Risk and Risk Management -** The HCP service is statutory, so not maintaining the service would result in significant reputational and financial harm to the Council. There would be significant risk of harm to the general health and wellbeing of the Barking and Dagenham families due to the lack of assessments, screening and referrals – resulting in missed opportunities for early intervention and prevention.

With a reduction in access to services, the existing health inequalities would be further exacerbated, in particular for families that have higher health needs/ complexities.

There would be additional pressure on A&E and primary care services without the delivery of the HCP service, which aims to increase the health literacy of families,

children and young people as well as partner agencies to reduce avoidable harm/ injury.

8.2 **TUPE, other staffing and trade union implications** – The extension of the 0 - 19 Healthy Child Programme contract has no additional implications.

8.3 **Corporate Policy and Equality Impact –** Consideration of these issues was given at the time of the original contract award.

8.4 **Health Issues -** This strategy proposal is in line with the outcomes and priorities of the joint Health and Wellbeing Strategy and will further enhance the quality and access of services, as well as experience of receiving and delivering the care. The 0 - 19 Healthy Child Programme Service contract will have a positive impact on our local community.

The 0 -19 Healthy Child contract in Barking and Dagenham has a significant impact on health needs of families, children and young people within the local community.

8.5 **Business Continuity / Disaster Recovery -** The extension of the 0 - 19 Healthy Child contract in Barking and Dagenham, will support and mitigate the impacts of continuity of supply to the Council through its own Business Continuity Plans or the supply chains.

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

List of appendices: None