TOWER HAMLETS

Meeting of the

HEALTH SCRUTINY PANEL

Tuesday, 11 September 2012 at 6.30 p.m.

A G E N D A

VENUE
Room C1, First Floor, Town Hall, Mulberry Place, 5 Clove Crescent, London, E14 2BG

Members:	**Deputies (if any):**
Chair: Councillor Rachael Saunders **Vice-Chair: Councillor Denise Jones**	
Councillor Lesley Pavitt **Councillor Dr. Emma Jones** **Councillor Mohammed Abdul Mukit MBE** **Councillor Gulam Robbani** **1 Vacancy**	Councillor Peter Golds, (Designated Deputy representing Councillor Dr. Emma Jones) Councillor Zenith Rahman, (Designated Deputy representing Councillors Rachael Saunders, Denise Jones, Lesley Pavitt and Mohammed Abdul Mukit, MBE) Councillor Motin Uz-Zaman, (Designated Deputy representing Councillors Rachael Saunders, Denise Jones, Lesley Pavitt and Mohammed Abdul Mukit, MBE) Councillor Abdal Ullah, (Designated Deputy representing Councillors Rachael Saunders, Denise Jones, Lesley Pavitt and Mohammed Abdul Mukit, MBE)
[Note: The quorum for this body is 3 Members].	

Co-opted Members:
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If you require any further information relating to this meeting, would like to request a large print, Braille or audio version of this document, or would like to discuss access arrangements or any other special requirements, please contact: Alan Ingram, Democratic Services,
Tel: 020 7364 0842, E-mail: alan.ingram@towerhamlets.gov.uk

LONDON BOROUGH OF TOWER HAMLETS

HEALTH SCRUTINY PANEL

Tuesday, 11 September 2012

6.30 p.m.

1. APOLOGIES FOR ABSENCE

To receive any apologies for absence.

2. DECLARATIONS OF DISCLOSABLE PECUNIARY INTERESTS

To note any declarations of interest made by Members, including those restricting Members from voting on the questions detailed in Section 106 of the Local Government Finance Act, 1992. See attached note from the Monitoring Officer.

		PAGE NUMBER	WARD(S) AFFECTED
3.	**UNRESTRICTED MINUTES**	**5 - 12**	
	To confirm as a correct record of the proceedings the unrestricted minutes of the ordinary meeting of Health Scrutiny Panel held on 26th June 2012.		
4.	**REPORTS FOR CONSIDERATION**		
4.1	**Tower Hamlets Health and Wellbeing Strategy**	**13 - 52**	**All Wards**
4.2	**Community Health Services - Verbal Update**		**All Wards**
4.3	**East London Foundation Trust Quality Accounts**	**53 - 110**	**All Wards**
4.4	**Health Scrutiny Panel Work Programme**	**111 - 114**	**All Wards**

5. ANY OTHER BUSINESS WHICH THE CHAIR CONSIDERS TO BE URGENT

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DECLARATIONS OF INTERESTS - NOTE FROM THE MONITORING OFFICER

This note is for guidance only. For further details please consult the Members' Code of Conduct at Part 5.1 of the Council's Constitution.

Please note that the question of whether a Member has an interest in any matter, and whether or not that interest is a Disclosable Pecuniary Interest, is for that Member to decide. Advice is available from officers as listed below but they cannot make the decision for the Member. If in doubt as to the nature of an interest it is advisable to seek advice **prior** to attending a meeting.

Interests and Disclosable Pecuniary Interests (DPIs)

You have an interest in any business of the authority where that business relates to or is likely to affect any of the persons, bodies or matters listed in section 4.1 (a) of the Code of Conduct; and might reasonably be regarded as affecting the well-being or financial position of yourself, a member of your family or a person with whom you have a close association, to a greater extent than the majority of other council tax payers, ratepayers or inhabitants of the ward affected.

You must notify the Monitoring Officer in writing of any such interest, for inclusion in the Register of Members' Interests which is available for public inspection and on the Council's Website.

Once you have recorded an interest in the Register, you are not then required to declare that interest at each meeting where the business is discussed, unless the interest is a Disclosable Pecuniary Interest (DPI).

A DPI is defined in Regulations as a pecuniary interest of any of the descriptions listed at **Appendix A** overleaf. Please note that a Member's DPIs include his/her own relevant interests and also those of his/her spouse or civil partner; or a person with whom the Member is living as husband and wife; or a person with whom the Member is living as if they were civil partners; if the Member is aware that that other person has the interest.

Effect of a Disclosable Pecuniary Interest on participation at meetings

Where you have a DPI in any business of the Council you must, unless you have obtained a dispensation from the authority's Monitoring Officer following consideration by the Dispensations Sub-Committee of the Standards Advisory Committee:-

- not seek to improperly influence a decision about that business; and
- not exercise executive functions in relation to that business.

If you are present at a meeting where that business is discussed, you must:-

- Disclose to the meeting the existence and nature of the interest at the start of the meeting or when the interest becomes apparent, if later; and
- Leave the room (including any public viewing area) for the duration of consideration and decision on the item and not seek to influence the debate or decision

When declaring a DPI, Members should specify the nature of the interest and the agenda item to which the interest relates. This procedure is designed to assist the public's understanding of the meeting and to enable a full record to be made in the minutes of the meeting.

Where you have a DPI in any business of the authority which is not included in the Member's register of interests and you attend a meeting of the authority at which the business is considered, in addition to disclosing the interest to that meeting, you must also within 28 days notify the Monitoring Officer of the interest for inclusion in the Register.

Further advice

For further advice please contact:-

Isabella Freeman, Assistant Chief Executive (Legal Services), 020 7364 4801; or
John Williams, Service Head, Democratic Services, 020 7364 4204

APPENDIX A: Definition of a Disclosable Pecuniary Interest

(Relevant Authorities (Disclosable Pecuniary Interests) Regulations 2012, Reg 2 and Schedule)

Subject	Prescribed description
Employment, office, trade, profession or vacation	Any employment, office, trade, profession or vocation carried on for profit or gain.
Sponsorship	Any payment or provision of any other financial benefit (other than from the relevant authority) made or provided within the relevant period in respect of any expenses incurred by the Member in carrying out duties as a member, or towards the election expenses of the Member. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.
Contracts	Any contract which is made between the relevant person (or a body in which the relevant person has a beneficial interest) and the relevant authority— (a) under which goods or services are to be provided or works are to be executed; and (b) which has not been fully discharged.
Land	Any beneficial interest in land which is within the area of the relevant authority.
Licences	Any licence (alone or jointly with others) to occupy land in the area of the relevant authority for a month or longer.
Corporate tenancies	Any tenancy where (to the Member's knowledge)— (a) the landlord is the relevant authority; and (b) the tenant is a body in which the relevant person has a beneficial interest.
Securities	Any beneficial interest in securities of a body where— (a) that body (to the Member's knowledge) has a place of business or land in the area of the relevant authority; and (b) either— (i) the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body; or (ii) if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which the relevant person has a beneficial interest exceeds one hundredth of the total issued share capital of that class.

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LONDON BOROUGH OF TOWER HAMLETS

MINUTES OF THE HEALTH SCRUTINY PANEL

HELD AT TIME NOT SPECIFIED ON TUESDAY, 26 JUNE 2012

COUNCIL CHAMBER, 1ST FLOOR TOWN HALL, MULBERRY PLACE, 5 CLOVE CRESCENT, LONDON, E14 2BG

Members Present:

Councillor Lesley Pavitt
Councillor Rachael Saunders
Councillor Denise Jones
Councillor Dr. Emma Jones

Co-opted Members Present:

Dr Amjad Rahi	–	(Chair of THINk/ Local Healthwatch)
David Burbridge	–	(THINk Steering Group Member)

Officers Present:

John Wardell	–	Chief Operating Officer, Tower Hamlets Clinical Commissioning Group
Sam Everington	–	Chair Tower Hamlets **Clinical Commissioning Group** (**CCG**)
Steve Gilvin	–	Director of Primary Care Commissioning, NHS North East London and the City
Afazul Hoque	–	(Senior Strategy Policy & Performance Officer, One Tower Hamlets, Chief Executive's)
Louise Russell	-	Service Head, Corporate Strategy and Equality

Isobel Cattermole	Corporate Director: Children, Schools and Families
Sarah Barr	Senior Strategy Policy and Performance Officer
Robert Driver	Senior Strategy Policy and Performance Officer

1. ELECTION OF VICE-CHAIR

The Overview & Scrutiny Committee appointed Councillor Rachael Saunders as the Chair of the Health Scrutiny Panel for the Municipal Year 2012/2013 at their 19 June 2012 meeting.

However, it is necessary to elect a Vice-Chair of the Health Scrutiny Panel for the Municipal Year 2012/2013. Councillor Lesley Pavitt nominated Councillor Denise Jones to serve as Vice-Chair, this was seconded by Councillor Emma Jones.

RESOLVED

That Councillor Denise Jones be elected Vice-Chair of the Health Scrutiny Panel for the remainder of the Municipal Year 2012/13.

2. APOLOGIES FOR ABSENCE

An apology was received from Cllr Mukit

3. DECLARATIONS OF INTEREST

There were no declarations of interest.

4. UNRESTRICTED MINUTES

RESOLVED that the unrestricted minutes of 24 April 2012 be agreed as a correct record of the proceedings.

5. REPORTS FOR CONSIDERATION

5.1 Health Scrutiny Panel Terms of Reference, Quorum, Membership and Dates of Meetings

The Chair presented the Terms of Reference report. The committee was informed that the report sets out the Terms of Reference, Quorum, Membership and Dates of meetings of the Health Scrutiny Panel for the municipal year 2012/2013.

The Chair asked officers to look into the list of Health Scrutiny Panel co-optees in the last five years, in order to review the background of organisations who are generally co-opted to the panel, as various people have expressed an interest.

David Burbridge named Anna Livingston, a local GP, as a possible future co-optee. The Chair noted that Dr Livingston has attended several Health Scrutiny Panel meetings. However she is moving into another role and has nominated other GPs from the local medical committee to attend instead. The Chair stated that whilst no more formal co-optees will be appointed, anyone interested in the issues discusses at Health Scrutiny Panel is welcome to attend and participate in the meetings.

The pharmaceutical committee and opticians were also suggested as possible future co-optees.

Action: Robert Driver

RESOLVED

That the report be noted.

5.2 Verbal update from Tower Hamlets Clinical Commissioning Group

John Wardell, CCG Chief Operating Officer, presented the report. The Panel was informed that the Clinical Commissioning Group (CCG) arrangement has been in operation since April 2011. There is a multidisciplinary board in place, consisting of GPs, practice managers, nurses, representatives from the Local Authority and Think. The CCG is currently undergoing authorisation and will be in phase three of the possible four, co-ordinated by the National Commissioning Board. Also, in the process of compiling the names of the individuals who will be contacted in the 360° assessment that the national commissioning board will run as part of its authorisation process and the chair of Health Scrutiny Panel will be invited to take part in this.

In terms of the commissioning support offer, the full management operating cost for clinical commission group is £25 per head. The panel should be mindful that not all the functions that were the responsibility of the PCT will be taken on, and other functions will move to other departments. Initial work has been to focus on setting up internal governance and managerial arrangement costs. Tower Hamlet's approach is to look into buying all of its commissioning support through one organisation. There is an agreement in principle about what that would include, however they are still awaiting further national guidance about the role of the CCG around safeguarding, Estates and IT support.

Mr Wardell continued that they are keen to work with Public Health and agree a memorandum of understanding, as they want to preserve Public Health relations with the local authority to ensure there is robust public health advice around commissioning and to continue working with a partnership approach. There is also a desire to find new ways of working with councillors.

In response to questions from the committee, the following information was provided.

- With regards to the relationship with commissioning support organisation, a member inquired whether there is an understanding of how that will vary locally. The Chief Operating Officer stated that each Clinical Commissioning Group (CCG) have taken a different approach, but essentially have gone through a similar process. However, there will be a core offer in relation to service, but the difference will be about the contracts being commissioned.
- The main changes in the new organisation will be a reduction in management cost, and a lot of time has been spent reducing duplication. However, still awaiting the final guidance about the role of the CCG in safeguarding, Estates and GP IT functions. Internal communication will be managed by the organisation but broader or national communications will be commissioned. There is a statutory responsibility to manage the finance and therefore a chief finance officer will be appointed. Dr Sam Everington, Chair of Tower Hamlets CCG, said that in a bid to influence commissioning, every practice has

a commissioning lead, and that commission lead will attend a locality meeting once a month and give feedback. There are also other ways to gather clinician input i.e. setting up an intranet service through which any GP or Nurse can send in messages and a number of forums that meet at lunch time and in evenings in order to tap into different groups. With regards to the possibility of buying services from the council, the Chief Operating Officer replied that it is not clear as to the long term plan after the national Commissioning Support Service (CSS) has expired. As a CCG we have to constantly ensure that we are getting value for money for commission support.

- The Chair, Tower Hamlets CCG replied that the Health and Wellbeing Board is a key area for official communication with councillors, but there are also lots of informal communication channels.
- In response to a question on how effective the Health Scrutiny Panel and Health and Wellbeing Board will be, the Chair, Tower Hamlets CCG replied that, the Health and Wellbeing Board is a statutory body and has excellent opportunities in the delivery of health matters. Mr Wardell continued that any forum that scrutinises work is useful, and any feed back from the various channels will be positive and will come to the panel as requested. As the CCG moves forward it is likely that challenges will be faced so any forum that assist in arriving at a solution will be welcomed
- In response to a question on what will happen if a company takes over the running of a GP practice, the Chair, Tower Hamlets CCG replied that the procurement process has been redesigned to ensure that it ties in with local services. The Chief Operating Officer also responded that whatever procurement process is adopted locally, there will be a requirement for that provider to engage with the model of service already in place and adhere to the constitution that the CCG has sign to, in relation to that process.

UPDATE ON TOWER HAMLETS OLYMPIC GAMES PLANNING

Steve Gilvin, Director of Primary Care Commissioning, NHS North East London the City, presented the verbal update report to the committee. He stated that the team manages the contracts to GPs and pharmacies across Dagenham, the City and Hackney, Havering, Newham, Redbridge, Tower Hamlets and Waltham Forest. The focus of the planning process is to provide business as usual during the Olympics and Paralympics Games. Sufficient preparation has been done for the games and there are contingencies in place in the eventuality that anything goes wrong.

The key risks are related to keeping business as usual given the expected disruption, for example staff getting to location, patients getting to services and the delivery of mediation. Each of the acute trust will have their own processes in place to deal with these eventualities.

There is an expectation of a 5% increase in visitors to the capital based on lessons from previous games, as a lot of new visitors will displace other visitors during this time. The sign posting for patients to access healthcare will

be to go to a pharmacist first, walk in centre next and then hospitals as a last resort .A small proportion are expected to access GP surgeries. 'Blue light' access to the Olympic Route Network has been secured for ambulances. Drugs deliveries to pharmacist will probably decrease to possible one delivery a day. A lot of work has been done with local pharmacists to ensure that they are aware of regulations that affect athletes and members of athletes' families and associated staff if they should attend a pharmacy. In terms of general practices for GPs and pharmacies, guidelines have been issued, and assurance processes has been completed to ask each contractor to provide a statement that they have gone through the check list.

In response to questions from the committee, the following information was provided.

- A member enquired about reports of patients with long term conditions having difficulties in getting their medication and whether this will be exacerbated during the games. The Director of Primary Care Commissioning clarified that this issue is partly around the quota system put in place by suppliers to combat exploitation by some pharmacies. This has caused some delays in the production of some drugs, but the Olympics should not affect this further. The ABPI which is the pharmacy umbrella group has been contacted to ask for the rules to be relaxed so that drugs can be stocked up during the games. There is the contingency of possibly couriering drugs to patients. However, there is confidence that supplies during the games will be able to cope, but there is also the possibility of asking patients to come earlier to obtain prescriptions.
- For each of the pharmacies that may have difficulties in receiving their delivery of supplies, there is the option of delivering to a neighbouring pharmacist so that they can collect themselves. There is also the option of night time deliveries.
- The director of Primary Care Commissioning informed the committee that the department will be migrating to the National Commissioning Board in the future and he will be happy to return to the panel to update members.

RESOLVED

That the verbal update be noted

5.3 Verbal update on merger of the Adults, Health and Wellbeing Directorate and the Children, Schools and Families Directorate

Isobel Cattermole, Corporate Director, Children, Schools and Families provided the update to the committee. The integration board was set up at the beginning of the year, consisting of key people and officers from both directorates across the council. As a result of meetings and discussions with

management across both directorates, a list of benefits from the integration has been identified:

- strengthening family focus and transition pathway for children with disabilities and mental illness.
- promoting independence and early intervention across the whole life course, and this sets the theme for the new children and young peoples plan. This also aligns with the Health and Wellbeing Board, Public Health and other department priorities.
- maximising efficiency and reducing duplication in the back office
- enriching professional skills of work force
- building on safeguarding and safeguarding adults

The integration is being managed in two phases; phase one will deliver the directorate's new management team, at which point educational social care and well being will come in, and this is the agreed name of the new directorate. This phase is nearing completion.

The Corporate Director, Children, Schools and Families is proposing a new DMT structure with a possible reduction of one service head, which is yet to be approved. Adult social care and children social care will be kept distinct under two service heads, this will happen after the Olympic period, preferably September onwards. The second phase approach will enable the team to plan the tier of integration SMT. A risk assessment has been carried out, as this will be the biggest directorate in the council with a large staff and budget, a constant review of risk is necessary. A paper will be brought to cabinet detailing all the issues covered, as well as the risk in managing the process.

There is plan to have a lead member for Adults and Children services; currently there is a safeguarding board for children and adult and it propose that both of these remain, however there is a desire to have one safeguarding board in the future.

In response to questions from the committee, the following information was provided.

- With regards to the matter of having one Executive Director, the Corporate Director, Children, Schools and Families replied that this is considered proportionate, but this is a high risk area because of the vulnerability of the client groups. However, it is measured that both directorates are very well resourced and managed. Moreover, the corporate risk is being shared by the corporate management team. Both directorates have worked closely with partners and the risk is shared across a partnership.
- Public health will move and be part of the Council, but it has not been decided on where it will be housed. There is a view that it is in line with this directorate, but there are parts of public health that could sit

elsewhere. It may be that some of its services may sit in different parts of the council.

- There are two Service Heads from Adult, Health and Wellbeing which will remain, and four in Children Schools and Families but due to the move of some services to Communities Localities and Culture, it will be reduced to 3 and so the proposal is to have 5 Service Heads in total.
- Cllr Pavitt congratulated CSF for informally receiving an outstanding/good grade in their recent Ofsted inspection. This was echoed by other members.

RESOLVED

That the report and comments be noted.

5.4 Developing a Local Healthwatch in Tower Hamlets

Afazul Hoque, Senior Strategy, Policy and Performance Officer, presented the report to the Panel. He informed the Panel that Local Healthwatch organisations are being set up to give people greater influence over their local health and social care services. Local authorities are to be placed under a statutory duty to commission effective and efficient local Healthwatch organisations by April 2013.

In response to comments and questions from the Panel, the following information was provided.

- A member raised concerns that the new organisation may not be able to fulfil all its functions with current staffing levels, especially on the delivery on advocacy which is a highly skilled and time intensive exercise. Mr Hoque confirmed that these concerns were recognised and stated that advocacy will be commissioned separately; a sub group is undertaking analysis of this.
- A member stated that there may be inherent tensions in the way the organisation is set up, if they are encouraging people to raise issues about health service providers whilst at the same time providing information about those organisations. There needs to be a demarcation of the functions so to avoid potential conflict of interest. Mr Hoque replied that talks with colleagues are underway to ensure that the right balance is achieved, so that the various functions can be carried out without this conflict.
- A member commented that the Healthwatch should have a map of how GPs are organised.
- A member commented that the local Healthwatch has the power to ‘enter and view’ services and therefore would like to see the local Healthwatch be the eyes and ears of the Health Scrutiny Panel, and would like to receive reports on such visits so that the committee’s comments can be followed up.
- A member commented that the local Healthwatch should aim to be located in a visible and accessible area.

RESOLVED

That the report and comments be noted.

5.5 Verbal update on the Health Scrutiny Panel's work programme

The Chair gave an update of the committee's work programme. Three broad areas were identified: overview and scrutiny of Barts Heath, accountability, and maximising the opportunities from the transition of public health to the local authority.

The Chair highlighted that Dr Everington is keen to do more work on public health and schools, and therefore proposed a challenge session on this subject this year.

A member urged the committee to consider a mapping exercise to list PCT services that were being provided in Tower Hamlets before they are disbanded as they are currently very reluctant to provide this information. The Chair agreed with this proposal but stated that the PCT may genuinely not know this information. The Chair proposed a follow up question be asked for the organisation to provide the information.

RESOLVED

That the update work programme be noted

6. ANY OTHER BUSINESS WHICH THE CHAIR CONSIDERS TO BE URGENT

The Chair reported back for information, that the August 2011 cabinet decision setup the shadow. It was also said that the Chair of Health Scrutiny Panel should attend. However at the last Health and Wellbeing Board meeting she was asked to leave and was told that the mayor no longer wants to stand by his previous decision. Overview and Scrutiny has agreed to write a letter to the Mayor setting out the chain of events and asking for a meeting between herself Cllr Ann Jackson and the Mayor to have a conversation about how Health and Wellbeing Board and Health Scrutiny Panel can work together more effectively. The letter will be circulated to the committee.

The meeting ended at 8.45 p.m.

Chair,
Health Scrutiny Panel

Committee:	Date:	Classification:	Report No.	Agenda Item No. 4.1
Health Scrutiny Panel	11 September 2012	Unrestricted		
Report of: Assistant Chief Executive, Legal Services London Borough of Tower Hamlets **Originating Officer:** Louise Russell		**Title:** Tower Hamlets Health and Wellbeing Strategy **Wards:** All		

1. SUMMARY

1.1 The Health and Social Care Act 2012 proposes to introduce the requirement for Health and Wellbeing Boards to prepare joint Health and Wellbeing Strategies (HWS) for their local areas, providing an overarching framework for improving health and social care outcomes in their local areas. The shadow Health and Wellbeing Board in Tower Hamlets has initiated the development of a new Health and Wellbeing Strategy. This draft Outline Strategy for Tower Hamlets is the result of a review of evidence about local need and local views, consultation with stakeholders and residents. The Outline Strategy is undergoing widespread consultation to ensure that it reflects the right priorities for our local area.

2. RECOMMENDATIONS

2.1 The Health Scrutiny Panel is asked to review and comment on the draft strategy.

3. COMMENTS OF THE CHIEF FINANCIAL OFFICER

3.1 This report presents the draft Health and Wellbeing Strategy as required by the Health and Social Care Act. This Outline Strategy is undergoing widespread consultation to ensure that it reflects the right priorities for Tower Hamlets.

3.2 There are no specific financial implications emanating from this report, and any additional costs that arise from implementing the strategy must be contained within directorate revenue budgets. If the Council agrees further action in response to this report's recommendations then officers will be obliged to seek the appropriate financial approval before further financial commitments are made.

4. CONCURRENT REPORT OF THE ASSISTANT CHIEF EXECUTIVE (LEGAL)

4.1 Section 193 of the Health and Social Care Act 2012 ("the 2012 Act") proposes to introduce a new section 116A into the Local Government and Public Involvement in Health Act 2007 ("the 2007 Act"). At this stage the new provision has not yet been given a commencement date, but it is intended to place an obligation on responsible local authorities (of which the Council is one), together with their partner clinical commissioning groups, to prepare a joint health and wellbeing strategy. This is a strategy for meeting the needs included in a joint strategic needs assessment prepared under section 116 of the 2007 Act. The strategy is to address how the needs may be met by the exercise of the functions of the authority, the NHS Commissioning Board or a clinical commissioning group ("CCG"). The strategy may also include a statement as to how the authority and the CCG think arrangements for the provision of health-related services in Tower Hamlets could be more closely integrated with arrangements for the provision of health and social care services.

4.2 Section 194 of the 2012 Act requires the Council to establish a Health and Wellbeing Board ("**HWB**") for its area. A commencement date has not yet been specified in respect of this provision, but it is expected to take effect from 1 April 2013. Once the HWB is established, section 196 of the 2012 Act intends to confer on the HWB the function of the Council and its partner CCG of preparing a joint health and wellbeing strategy.

4.3 Section 116A of the 2007 Act is intended to contain the following requirements in relation to the preparation of a joint health and wellbeing strategy –

- Consideration needs to be given to the extent to which needs could be met more effectively by the Council making arrangements with one or more NHS bodies under section 75 of the National Health Service Act 2006.
- Regard must be had to the mandate published by the Secretary of State under section 13A of the National Health Service Act 2006 and any guidance issued by the Secretary of State.
- There is an obligation to involve the Local Healthwatch organisation and local people.

4.4 It is reasonable to commence preparation of the strategy, but it must be recognised that the legislative framework is not yet in place and nor are key bodies and guidance. As a consequence, the strategy may well require significant revision as matters progress.

4.5 In participating in preparation of the strategy, the Council must have due regard to the need to eliminate unlawful conduct under the Equality Act 2010, the need to advance equality of opportunity and the need to

foster good relations between persons who share a protected characteristic and those who don't. Some form of equality analysis will be required and officers will have to decide how extensive this should be.

5. ONE TOWER HAMLETS CONSIDERATIONS

5.1 Health and wellbeing outcomes are important to all sections of our diverse community and we are aware that some groups experience particularly poor health outcomes. A key principle for the strategy is to understand and act upon the diverse needs of different groups, identifying and addressing areas of particular disadvantage or particular need. To this end, we are also seeking to engage with as wide a range of local community organisations as possible to inform the strategy and are working with the Tower Hamlets Involvement Network (THINK) to help achieve this.

6. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

6.1 There are no specific SAGE implications arising from the recommendations in the cover report. We are working with the Great Place to Live Community Plan Delivery Group to ensure we consider and address the environmental determinants of health.

7. RISK MANAGEMENT IMPLICATIONS

7.1 There are no specific risk management implications arising from the recommendations in the cover report.

8. CRIME AND DISORDER REDUCTION IMPLICATIONS

8.1 There are no specific Crime and Disorder Reduction implications arising from the recommendations in the cover report. We are working with the Community Safety Partnership to consider how we take a joint approach to areas such as drug abuse and substance misuse and domestic violence.

9. EFFICIENCY STATEMENT

9.1 There are no specific efficiency implications arising from the recommendations in the cover report. The final strategy will consider at a high level the most efficient use of resources to deliver health outcomes.

10. APPENDICES

Appendix 1: Tower Hamlets Health and Wellbeing Strategy: An outline

Local Government Act, 1972 Section 100D (As amended)
List of "Background Papers" used in the preparation of this report

Brief description of "background papers"	Name and telephone number of holder and address where open to inspection.
None	**n/a**

Tower Hamlets Health and Wellbeing Board

Tower Hamlets Health and Wellbeing Strategy: An outline

Draft for consultation – August 2012

Contents

Introduction

This Priorities Paper has been developed as a key stage in the development of a new Health and Wellbeing Strategy for Tower Hamlets. The Health and Social Care Act introduced the requirement for Health and Wellbeing Boards to prepare joint Health and Wellbeing Strategies (HWS) for their local areas. The joint Health and Wellbeing Strategy should provide an over-arching framework to ensuring a strategic response to the health and social care needs of the local population.

Tower Hamlets has had a partnership wide Health and Wellbeing Strategy since 2006. Significant progress has been made in delivering the key priorities of the strategy. There is a strong foundation on which to develop the new Health and Wellbeing Strategy.

The expectations for the new strategy are high – taking account of the health and social care needs of the entire population, it will provide a framework for the commissioning of health and social care in the local area and the means by which the statutory Health and Wellbeing Board seeks to hold health commissioners and providers to account and ensure improvements in key priority areas identified. In addition it will provide a means for working with a range of local agencies to embed consideration of the health impact within wider policy decisions. The Strategy will also act as a bridge to all those living in the borough, identifying how we can all take more responsibility for our health and how we can community groups and local people to contribute to achieving identified needs.

The shadow Health and Wellbeing Board has initiated the development of a new Health and Wellbeing Strategy, building on the strengths and successes of the existing strategy, but more wide-reaching and ambitious in its scope. A sub-group of the Board, with representation from within the local authority, public health and other parts of the NHS, has been set up to steer this process.

Through review of the key evidence in our local JSNA, review of our existing intelligence from users, carers and ‘less heard’ groups plus engagement activity with key groups and a publically available online survey, we have identified a set of draft key principles and priorities for the Health and Wellbeing Strategy. The Health and Wellbeing Board is committed to seeking widespread feedback on these priority areas before we finalise the strategy. Consequently, we have prepared this Priorities Paper for consultation with local stakeholders, voluntary and community groups and residents. This feedback will be used to inform the final development of the strategy which will also incorporate a set of key outcome measures and a Delivery Plan which will identify the key priorities for the Health and Wellbeing Board and local partners to meet identified needs and respond to feedback.

Tower Hamlets Context

Tower Hamlets: The Place

Tower Hamlets is unique; unparalleled in its history of diversity and growth.

In recent times Tower Hamlets has experienced the largest growth in the country and has been the focal point of regeneration in London. Significant development activities include the 2012 Olympic and Paralympic Games, continued development within the Thames Gateway and the expansion of Canary Wharf. This presents immense opportunities for the borough. There has also been significant residential development, with the borough experiencing the country's highest housing growth over the last few years.

The richness of Tower Hamlets is also evident in its physical and cultural assets. Tower Hamlets boasts extensive waterways, Victoria and Mile End Park, an assortment of museums and markets, and the Tower of London from which it derives its name. All of these contribute to the borough's unmatched sense of place and identity.

Deprivation is widespread in Tower Hamlets and the majority (72%) of areas in Tower Hamlets are amongst the 20% most deprived areas in the country. A significantly higher percentage of residents live in social housing (54%) compared to the rest of London (37%) and, despite the substantial housing growth, high levels of overcrowding persist. The borough also has less green space than the national average with 1.1 hectares per 1000 people compared to 2.4 nationally.

Tower Hamlets: The People

Diversity has always been a key strength of the borough. Tower Hamlets has historically been home to a mix of communities. It now has the fastest growing population in London, estimated to be 254,100 and projected to increase to 339,280 by 2026. This growing population is ethnically diverse, with nearly half of the borough's population comprising of Black and minority ethnic groups, with the largest of these (30%) being the Bangladeshi community.

Religion continues to play a prominent role in the lives of many of the borough's population, with 80% of residents claiming a religious belief and Tower Hamlets being home to the largest Muslim population in the country. The borough also has a relatively young population with 40.9% of people aged 20-34, compared to 20.3% across England. High population churn sees 29% of the borough's population move in to, out of, or around, the borough per year.

44% of households and 53% of children in the borough are in poverty – the highest rate in the country. At the same time the average earnings of those who work in the borough, but don't necessarily live in it, is £64,000 a year. Unemployment remains an issue with 13% of the working age population unemployed, compared to 9% across London.

3.7% of the borough's population provide more than 20 hours of unpaid care per week and 50% of them provide more than 50 hours of unpaid care.

While there have been improvements, life expectancy remains lower than the rest of the country: male life expectancy is 76.0 years compared to 78.3 nationally and female life expectancy is 80.9 years, compared to 82.3 nationally. Life expectancy varies by 12.0 years in males and 5.4 years in females between the most affluent and most deprived areas.

Tower Hamlets: The Partnership

Tower Hamlets has a long-standing and successful local strategic partnership, the Tower Hamlets Partnership, which brings together the Council, key public sector partners including health and the police, representatives from the business, voluntary and community sectors and local people. Since 2001 the Partnership has developed a joint Community Plan – the most recent was refreshed in 2010/11 with a vision taking us up to 2020 "to improve the quality of life of everyone living in Tower Hamlets". One of its four key priorities is to work towards a Healthy Community. The Health and Wellbeing Strategy is fundamental to taking forward this priority.

Tower Hamlets: Health Needs

Tower Hamlets, like all authorities, undertakes a Joint Strategic Needs Assessment (JSNA) to understand the health and social care needs of the local population. This wealth of evidence and analysis has been used to inform a range of local strategies and programmes, and is the basis from which our Health and Wellbeing strategy stems. Some of the key evidence from the JSNA is summarised below.

Being Born in Tower Hamlets

4,565 children were born in Tower Hamlets in 2010. While infant mortality is not significantly different to the rest of London, a higher percentage of babies are born with low birth weight (9%) when compared to London as a whole (7.5%). Given the correlation between high deprivation and low birth weight, this is not surprising. However, there are other behavioural risk factors that impact the health of a new born baby such as substance misuse, problem drinking, poor diet and smoking on the part of the mother. 3.3% of expectant mothers smoke during pregnancy, however this increases to 16% amongst white mothers. There has been a steady reduction in the teenage pregnancy rate since 1998 and it is now on par with the London average.

Growing up in Tower Hamlets

There are around 18,700 infants aged under-5 in Tower Hamlets. There are also around 28,700 children and adolescents aged 5-14 and 14,600 aged 16-19. Overall, around 60% of under-20s are Bangladeshi.

53% of children in Tower Hamlets live in poverty. By the age of 5, only 46% of infants in Tower Hamlets have achieved a good level of cognitive development compared to 56% nationally. However, when looking at educational attainment, our pupils are performing at or above the national average at Key Stages 1, 2 and 4.

12.7% of children in Reception year are obese – the 6th highest rate in the country – and by Year 6 (10-11 year olds) this increases to 25.6% and is the fourth highest rate in the country. However, it is encouraging that 88.9% of mothers initiate breast feeding at birth (compared to 73.7% across England) and 73.5% are still breast feeding at 6-8 weeks (compared to 45.2% across England). In addition, immunisation uptake in under-5s is amongst the highest in the country with 93.7% of children received the second dose of the MMR vaccine.

Being an adult in Tower Hamlets

There are around 125,500 people aged 20-39, 45,000 aged 40-59 and 21,400 over 60 living in Tower Hamlets.

Tower Hamlets has amongst the highest premature death rates from the major killers in London. The levels of long term illness/disability are also 34% higher than the national average. The borough has the 4th highest cancer premature mortality rate in London, the second highest cardiovascular disease (heart disease) premature mortality rate and the fifth highest mortality rate for chronic obstructive pulmonary disease (chronic bronchitis or emphysema). Rates of HIV, TB and sexually transmitted infections are amongst the highest in London.

When looking at some of the factors that lead to or contribute to the major killers, 27% of people in the borough smoke, compared to 21% nationally. However, in recent years our smoking cessation programme has delivered the best performance in London. Of the 50% of the adult population who are drinkers, 43% have alcohol consumption patterns that are either hazardous or harmful to their health; around twice the national average. Although levels of physical activity are around the national average, fewer people in Tower Hamlets consume the recommended level of fruit and vegetables (12%) compared to the rest of the country (30%). In addition, the rate of problem drug users (2.3%) is almost double that of the London rate (1.2%).

Growing old in Tower Hamlets

There are around 15,500 people who are 65 or over living in Tower Hamlets. 4,200 of these are 80 or over. 65% are white and 22% Bangladeshi and because women live longer a higher proportion are female (60%).

80% of them have at least one chronic condition of which 35% have at least 3 ‘comorbid’ conditions. There are indications of significant under-diagnosis of dementia and the second highest stroke mortality rate in London. In addition, most people in Tower Hamlets do not die in their place of choice – 64% die in hospitals although national surveys suggest that most people would like to die at home.

In line with the general deprivation in the borough, 50% of older people live below the poverty line and a higher proportion live alone (47%) when compared nationally (33%). In addition, only 10% of older people consume the recommended level of fruit and vegetable and only 20% meet recommended physical activity levels.

Challenges Ahead

The next few years will be challenging for Tower Hamlets. The improved outcomes for local people over the past decade have, in part, been as a result of action to effectively invest public sector resources. We are now experiencing challenging financial times, with the public sector having far less money to spend on services than before. This is happening alongside growing demand on services including a rapidly growing and ageing population.

Tower Hamlets is changing and changing rapidly. The 2011 Census confirmed that the population growth in Tower Hamlets was the highest in the country – a 29.6% increase on the 2001 Census result from 196,000 to 254,000, more than double the rate of population increase (14%) across London as a whole and more than four times the increase in the population of England and Wales. Population turnover and churn remains high with 28.9% of the borough's population either moving into the borough, out of the borough, or to a new address within the borough. The latest population projections from the Greater London Authority[16], suggest that the Tower Hamlets population will grow from 254,000 in 2011, to 326,000 in 2026; a rise of 72,000 and a percentage increase of 28 per cent. London's population is expected to grow by 11% in the same period.

The new national policy context is also important for Tower Hamlets. Policy developments, which include changes to social housing provision, the welfare reform programme changes to education funding and reform of the health service, pose challenges and opportunities for the borough.

The reform of the welfare system, including changes to benefits, tax credits and support for families, will in particular have a considerable impact on many residents in the borough. The combined effect for many residents will be a drop in household income both immediately and over time. Given the already high levels of poverty and deprivation in the borough, these changes will make it even harder for many households to get by; potentially affecting educational attainment, crime, health and wellbeing in the borough.

In addition, there are significant changes to the health service, both locally and nationally.The introduction of the Health and Social Care Act (2012) has seen a radical change in the way in which health services are commissioned and delivered. The changes will see the abolition of Primary Care Trusts (PCTs) and Strategic Health Authorities (SHA) and the introduction of 'clinical commissioning groups' (CCGs) whose role it will be to commission hospital and community health care services for their local populations. The CCGs will be clinically led with their

membership consisting of mainly healthcare clinicians and all local GPs. A CCG Board and Accountable Officer will take over the statutory responsibility from the current PCT. The CCGs will be supported and held to account by a new national body called the NHS Commissioning Board (NHS CB) which will also commission primary care services and some specialist services itself such as cancer screening.

The new CCGs will require support to commission effectively and new organisations providing commissioning support services (CSS) are currently being developed to provide commissioning expertise to the newly formed CCGs. Clinical leadership will also be provided through Clinical Senates that are expected to bring together clinical leaders across broad areas of the country to give clinical leadership and expert advice for commissioning.

Responsibility for public health will transfer from the abolished PCTs to local authorities from April 2013. Currently the Tower Hamlets Public Health team and the local authority are drawing up transition plans to shape what the new structures will look like in the future.

In terms of ensuring health scrutiny by patients and users of health services, local involvement networks known as THINk in Tower Hamlets, are being replaced by local HealthWatch organisations, who can visit health and social care services and report on concerns about services. HealthWatch will also be represented on the local Health and Wellbeing board.

Our strategy is developed against the backdrop of these new opportunities and challenges, seeking to ensure that we continue our journey of improvement in these changed and changing circumstances.

Tower Hamlets: The Potential

Despite the very real health needs and challenges within the borough, Tower Hamlets has some key assets which we can build on and draw on to improve local health and wellbeing outcomes.

Social capital and the capacity and skills embedded within our local community are key to this. We have a long and proud history of self-help and a thriving voluntary and community sector with strong community leadership and engagement. Our diversity is also a key strength, and the fact that despite this diversity, there is a strong sense of community cohesion with the vast majority of local people feeling that people from different communities get on well within Tower Hamlets. As a result, innovative solutions to some of the worst social problems have arisen from within local communities, interest and faith groups, often working closely with statutory providers. The Borough has also relatively recently established a directly elected Mayor, ensuring direct representation of, and accountability to, the local community. The Mayor chairs the Health and Wellbeing Board which will oversee delivery of this strategy.

In addition, the people of Tower Hamlets have a strong sense of neighbourhood identity to which local providers have responded, establishing local networks for the delivery of services, giving people a closer relationship to services and ensuring support is better targeted to those who need it.

Regeneration and development in the borough also provides considerable potential – it brings in new money, new ideas and new communities. The borough's housing stock is expected to increase by 46,000 between 2011 and 2026. This represents a projected increase of over 3,000 homes per year. In addition, it is forecast that Tower Hamlets will experience a 44.6% increase in the number of jobs between 2010 and 2031. This is over three times the projected growth for London as a whole. With Canary Wharf and the City fringe, Tower Hamlets is home to one of the most desirable office locations in London. A further increase in office stock between 2012 and 2020 of 26% is predicted, more than double the projected growth in the City of London (9.6%) and five times that of Westminster (5.2%).

Although it also brings challenges which need to be managed, the fact that the borough's physical environment changes much quicker than elsewhere provides opportunities to make changes which can improve the health and wellbeing of local people. Our challenge is to realise this potential.

Vision and Principles

The evidence in Tower Hamlets demonstrates that we still have a major task ahead of us to maximise health outcomes and reduce the health inequalities associated with poverty and deprivation in Tower Hamlets, particularly given the challenges ahead. Local engagement and feedback also tells us how important choice and control are in supporting independence and enabling people to play a full role in taking responsibility for their own health.

There is a strong interplay between being active and being independent:

"And I can understand, when you've got somebody doing it for you, you let them do it. And then you stop being able to do it yourself. So I think sometimes too much is done for people. They don't have the incentive to do it themselves. I know it is a hard road, if you have to do everything for yourself, but it should be. But that's just the way I feel. I suppose other people don't feel the same way"[1]

Consequently, the vision for this Health and Wellbeing strategy is:

To improve health and wellbeing through all stages of life to:

- **Reduce health inequalities**
- **Promote choice, control and independence**

Within the context of this broad vision, the Board and those engaged to date have also identified some key principles which should inform the new strategy. These are:

- **Focussing on prevention, early identification and early intervention** – intervening as early as possible within the life-course to maximise life chances.

Focussing on prevention, early identification and early intervention is all about making sure people get the right support at the right time.

- **Integrating care** - ensuring a patient centred approach to health and social care, with particular emphasis on improving this for older people and those with more than one health problem

In our recent survey to residents, one question asked what people thought stopped them from staying healthy. One resident responded:

"The constant focus of health care professionals on one long term condition to the detriment of any other injury/condition."[2]

By integrating care and working better in partnership our aim is to reduce the number of people that have this type of experience. Carers, service user and patients have

[1] BLT, 2012, Discovery Interview
[2] LBTH, 2012, Residents Health and Wellbeing Survey

all, through a variety of forums, raised frustration with the lack of joined up working between health and social care staff.

- **Looking across the life course** – a focus on health inequalities demonstrates the importance of considering what actions individuals and health and social care professionals need to take at each stage of the life course, from pregnancy and birth through youth, adulthood to old age, to maximise life chances and health outcomes. In planning how to achieve our priority outcomes, we will take a life course approach to identifying necessary action at each stage.

- **Family centred approach –** ensuring that we also consider patients and individuals as part of a family and consider how we can support the health and wellbeing of families jointly, including the key role of parents and other carers, particularly recognising the high level of informal care delivered within the family in Tower Hamlets

"I have had a hospital appointment and my son has had one as well...the trouble is the doctors only see you as a patient and don't take into account that you still have your caring role. I'm not an individual I always have to take my son into account." (White Female, Discovery Interview)[3]

- **Ensuring 'health in all policies' –** there is a wealth of evidence, most compellingly and recently compiled and presented within the Marmot review of health inequalities, identifying the considerable impact on health of wider social, economic and environmental impact on health, in particular housing, educational attainment, employment and the physical environment. The Tower Hamlets Partnership already has a strong focus on these areas through its Community Plan and these areas are also among the key priorities for the borough's directly elected Mayor. The Strategy will consider how the HWB Board should work with the relevant Community Plan delivery groups to ensure the health impact of all policies is considered.

When asked about what helps people to stay healthy residents responded with answers ranging from: family and friends, fresh air, healthy food, exercise to housing, education, and employment, illustrating that a focus on health and wellbeing really should be embedded into all of our policies. Restricting the availability of fast food in the Borough was also raised by people.

- **Understanding and addressing diversity –** Tower Hamlets is a diverse borough and health issues affect different equality groups in different ways. Our analysis has sought to understand the differential health issues for different groups and we have consulted with a range of organisations representing those more disadvantaged groups. In turning our priorities into

[3] THINk, 2011, A report on the barriers to self-management for people in Tower Hamlets with a long-term condition(s) p 16)

actions, we will ensure that particular areas of disadvantage or need are addressed.

- **Building on community potential and capacity –** whilst Tower Hamlets has significant health issues to address, it also has significant advantages in the strength and vibrancy of the voluntary and community sectors and the capacity, skills, knowledge of local communities. There is considerable potential for the strategy to build on this, supporting citizens and communities to become the co-producers of health and well-being rather than the recipients of services and promoting community networks, relationships and friendships that can provide caring, mutual help and empowerment. Existing work around mentors and health champions can be further developed and linked with the wider Partnership's work on promoting community champions, neighbourhood forums and neighbourhood agreements.

The residents that responded to our survey thought that that having a strong sense of community and peer support are all important for good health and wellbeing.

"Currently, I am a health champion offering a service to my community so I hope that this is helping." [4]

Our consultation survey asks you several questions about this part of the document, we would like to know if you agree with the vision and principles that we've outlined. In the survey you can answer questions like:

- Do you agree with the vision?

- Do you agree with the principles?

[4] LBTH, 2012, Residents Health and Wellbeing Survey

Framework and Priorities

Within the context of this vision and principles, a broad framework for the Strategy has been developed, identifying:

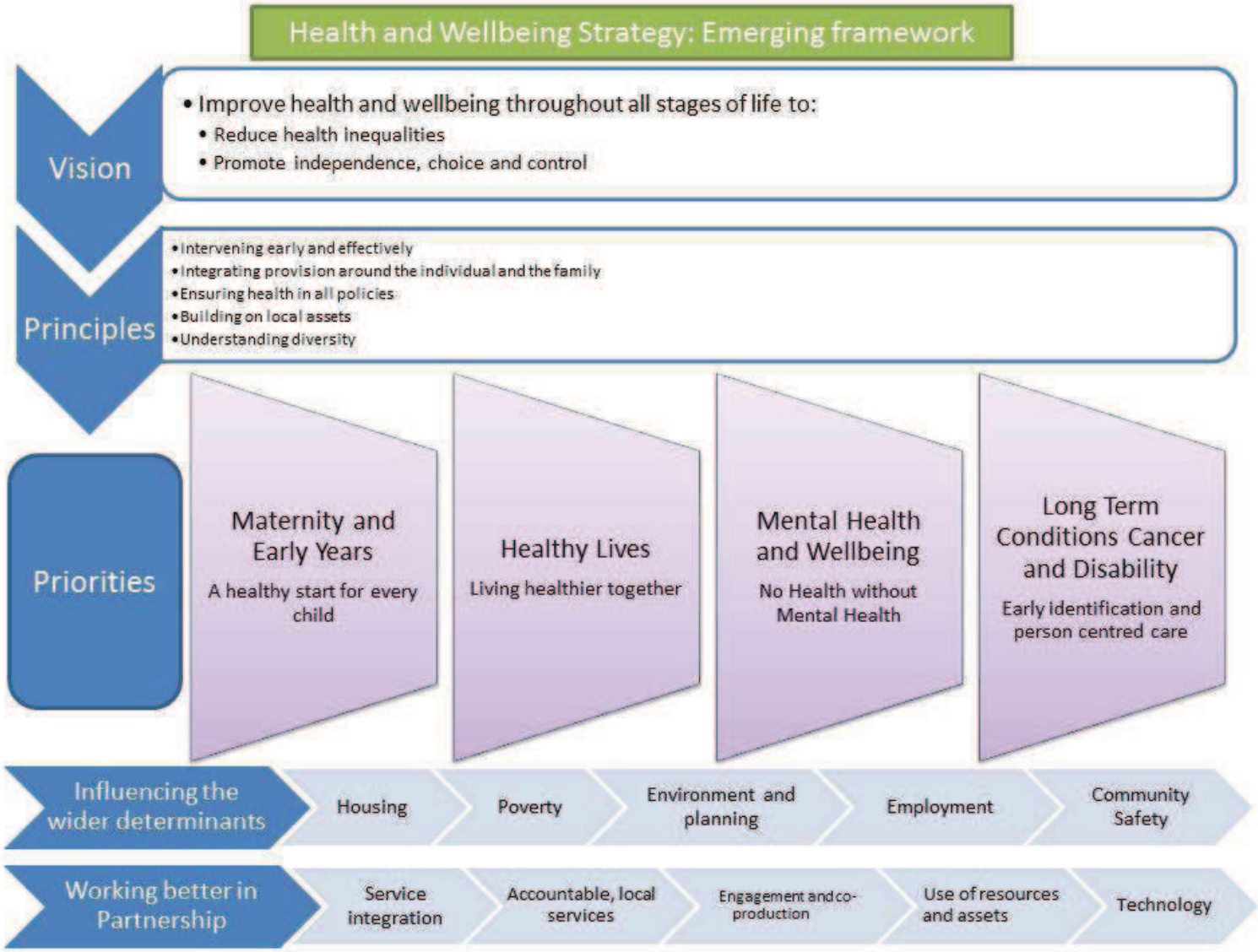
- some key priority areas for the Board to work on;
- broader social and environmental issues which the Board will want to work with partners to influence; and
- Partnership and accountability issues ensuring we maximise our effectiveness to deliver.

The framework for the strategy is set out diagrammatically overleaf.

Our consultation survey asks you several questions about the priorities, we'd like to know if you think we've got the priorities right. In the survey you can answer questions like:

- Do you agree with the priorities?
- If we were to have a 5th priority what do you think it should be?
- Why should this be a priority for Health and Wellbeing in Tower Hamlets?

Framework


Health and Wellbeing Strategy: Emerging framework
Vision
• Improve health and wellbeing throughout all stages of life to:
• Reduce health inequalities
• Promote independence, choice and control
Principles
• Intervening early and effectively
• Integrating provision around the individual and the family
• Ensuring health in all policies
• Building on local assets
• Understanding diversity
Priorities
Maternity and Early Years
A healthy start for every child
Healthy Lives
Living healthier together
Mental Health and Wellbeing
No Health without Mental Health
Long Term Conditions Cancer and Disability
Early identification and person centred care
Influencing the wider determinants
Housing
Poverty
Environment and planning
Employment
Community Safety
Working better in Partnership
Service integration
Accountable, local services
Engagement and co-production
Use of resources and assets
Technology

Priorities

Priority 1: Maternity and Early Years

A healthy start for every child

Maternal health, before, during and after pregnancy, and the first few years of a child's life are a critical period for a child's longer term health and well-being. The Marmot Strategic Review of Health Inequalities in England highlighted that social and biological influences on development start at or before conception and accumulate during pregnancy to influence the health of the child at birth. They present evidence that the accumulation of social, economic, psychological and environmental influences during the early years 'cast a long shadow' over the subsequent social development, behaviour and health and wellbeing of the individual.

Given the level of health inequalities within the borough, a focus on maternity and early years within this strategy, is consequently vital to ensure that we improve the health and wellbeing outcomes in the future. We have made real progress in some key areas:

- Teenage pregnancy and births to teenage parents are decreasing and now lower than average for London and England
- 95% of pregnant women in Tower Hamlets had booked for antenatal care by 12 weeks and 6 days (2011/12)
- Over 95% of infants have received the full range of childhood immunisations for that age
- Obesity in 4-5 year olds has declined year on year since 2006, though still high compared to London and England

Some key areas where the evidence indicates that our levels of need are high and we particularly need to focus are as follows:

- Smoking during pregnancy – our rates are lower than the London and England averages but there are certain groups where rates are higher and rates could increase as the population demographic changes
- High levels of diabetes in pregnancy
- Increasing levels of overweight and obesity among pregnant women, increasing risks to mother and child
- High levels of Vitamin D deficiency in pregnant women, linked to insufficient exposure to sunlight and poor diet

- Women at increased risk of domestic violence during pregnancy
- High proportion of low birth weight babies (which may contribute to increase risk for diabetes and cardiovascular disease in later life)
- Despite relatively high overall breastfeeding rates, exclusive breastfeeding rates are still low (i.e. a large proportion of mothers also bottle feed their babies)
- Evidence of poor weaning practices by some parents (likely to be contributing to high levels of obesity and dental decay in 4-5 year olds)
- Despite improvements over the last few years, patient surveys show there is still further improvements needed in patient experience of maternity services
- Female genital mutilation in some communities presents risks in childbirth
- School readiness assessed at the Early Years Foundation Stage, despite recent improvement, is still significantly below the national average

In addition, there are a range of wider factors which impact on early years development,

There are already a number of programmes and strategies to address these issues and as a result our community health services and children's centres have achieved the WHO/UNICEF Baby Friendly Accreditation demonstrating that they have policies and practices in place to support mothers in breastfeeding. Work is also in hand to review and refocus activity where appropriate. The Children and Families Plan also identifies early years as a key focus and its priorities include ensuring all children are healthy.

Key work strands for the HWB strategy include:

- Refresh of Health Improvement Strategy for Maternity Services, including enabling and empowering local women to have greater involvement in shaping these. Consideration of needs relating to women before during and after birth in refresh of Healthy Weight, Healthy Lives strategy and Tobacco Control strategy
- Implementing the nationwide 'A Call for Action' improvement programme for health visiting which aims to increase the number of practising health visitors in Tower Hamlets and improve the service model.
- Increasing resilience in families and their children by health proactively working in partnership with other services such as the Local Authority early years' service, education, housing and employment
- Intensive parenting support for pregnant women with complex needs including teenage parents (e.g. through the Family Nurse Partnership)

- More education directed at women of child bearing age on childcare and nutrition including folic acid, reducing overweight and obesity, vitamin D requirements.

From our engagement we have also heard that people would still like to see further improvements in maternity services, this was particularly voiced by the Community and Voluntary sector but has also been raised as part of our wider engagement activity:

Maternity services are better, but, still need improving:

- Staff attitudes especially post natal
- Widening access to the Barkantine Birth Centre (Bangladeshi/Somali)
- Community based post natal care – Health Visitors / Community midwives
- Lack of interpretation services[5]

Outcome objectives

The proposed outcome objectives for maternity and early years are:

- Healthier mothers pre and post conception and birth, with lower smoking and diabetes rates
- Improved experiences of maternity care
- Reduction in low birth weight babies
- Healthier and better nourished infants
- Reduction in obesity and dental decay in 4-5 year olds

Our consultation survey asks you several questions about the "Maternity and Early Years" priority. We'd like to know in a bit more detail about your thoughts on this. In the survey you can answer questions like:

- How strongly do you agree that it should be a priority?
- How important are the outcomes to you.
- If you think we've missed an outcome you can tell us.
- What do you think we should do to achieve these outcomes?
- What do you think you/your organisation can do to help achieving these outcomes?
- How can the HWB Board support you to do this?

[5] CVS, 2012, Health and Wellbeing Forum

Priority 2: Healthy Lives

Living healthier together

Living a healthy life prevents illness and enhances wellbeing. We know that people who do not smoke, take adequate physical activity, eat a healthy diet and drink alcohol in moderation have a risk of dying early that is around four times less than those who do not adopt these behaviours. We also know that they have better mental health.

Local authorities, health services and others can do much to support and promote healthy lives. This involves taking a comprehensive approach to promoting healthy weight, increasing physical activity, stopping smoking or oral tobacco use and tackling problem drug and alcohol use. This involves working towards an environment that supports healthy lives, for example increasing green spaces, increasing availability of affordable healthy food, reducing availability of illicit or counterfeit tobacco, alcohol or drugs, as well as ensuring that people are informed and empowered to lead healthy lives throughout life. It also involves working alongside local communities, and the individuals, families and institutions, within them, to develop locally led approaches to support and promote healthy lives.

Although there have been improvements in recent years, we know that there are higher levels of lifestyle risk factors in Tower Hamlets compared to elsewhere. Comparison of national and local intelligence tells us that within the Tower Hamlets population there are higher levels of tobacco use, unhealthy diet, physical inactivity, problem drinking in those who drink alcohol, risky sexual behaviour and drug use.

Some of the key evidence shows that in the Tower Hamlets population:

- 13% of children aged 4-5 are obese (7th highest in the country) and 1 in 4 children aged 10-11 are obese, amongst the highest in the country
- 39% have experience of tooth decay (compared to 31% nationally)
- 40% of under 16s are estimated to have a vitamin D deficiency
- There are 42 fast food outlets per secondary school (the second highest in London)
- 27% local people smoke (compared to 21% nationally)
- 88% of local people do not consume the recommended 5 fruit and veg a day (compared to 70% nationally)
- 68% do not meet recommended levels of physical activity (compared to 66% nationally) with significantly lower levels in more deprived parts of the borough and in older people
- 8th highest levels of sexually transmitted infections

- 43% of drinkers have hazardous or harmful patterns of consumption (21% nationally)
- Amongst the highest rates of known drug use in London

There have been a number of programmes and strategies put in place to address these issues including the Healthy Borough Programme, Healthy Weight Healthy Lives, Tobacco Control, Substance Misuse, Sexual Health strategies as well as the LinkAge Plus programme aimed at older people. Key successes include

- Levels of childhood obesity are stabilising; and
- In 2011/12, 3600 smokers in Tower Hamlets were helped to quit through local cessation services, the best performance in London

We asked residents what they thought helped them to stay healthy. Healthy food, exercise and environment were the top 3 responses. However, residents have also told us that time, money and knowledge can be barriers to living a healthy lifestyle. Respondents acknowledged the facilities that exist in the Borough like the outdoor gyms and the leisure centres and recognised attempts to make these affordable. There is a sense though that more needs to be done to encourage people to "Get Active" given some of the barriers. For older people isolation and not knowing anyone can prevent people from being active.

When we asked about the main health concern for local people is obesity came out top. We asked about what local people could do to improve their health and wellbeing examples:

"The council to enable and empower local communities to take action in ways that work for them rather than being told what to do and developing enabling environments so that people can be more active, grow their own veg, learn riding bicycles as Bangladeshi women etc., - all really good examples already happening, need more support and use as best practice example to be replicated" [6]

From feedback collected by THINk patients have also said that they would like more support from their GP on weight loss and exercise programmes and more signposting to local programmes and services

In reviewing the evidence, there are some key areas where it is proposed the HWB strategy should develop further activity. These include:

An environment that supports healthy lives

- Improving the food environment – retail, fast food, workplace, NHS
- Promote active travel

[6] LBTH, 2012, Staff Health and Wellbeing Survey

- Work with local communities building on existing assets to develop locally led initiatives to promote healthy lives

Early years, children and adolescence

- Reduce smoking in pregnancy
- Promote active play
- Further embed healthy lives and health promotion into education and school reflecting the clear link between nutrition and attainment
- Further develop targeted childhood weight management programmes for obese children

Adulthood

- More focussed activity to address the accumulation of risk factors (diet, activity, smoking, alcohol/drug use) in 20-40 year age group
- Increased participation in sports and recreation
- Further promote healthy lives in the workplace
- Further embed healthy lives into clinical and social care pathways, increasing the role of hospitals and acute care
- Further develop targeted adult weight management programmes
- Improve knowledge and access to sexual health services, particularly among groups with specific needs including gay men and African communities
- Promotion of responsible drinking and awareness of harms of drug use
- Screening for alcohol/drug misuse in health and other settings
- Promotion of healthy lives with older people

Outcome objectives

The proposed outcome objectives for healthy lives are:

- Reduced levels of obesity and overweight
- Reduced prevalence of smoking
- Higher rates of physical activity
- Reduced prevalence of sexually transmitted infections
- Reduced levels of harmful or hazardous drinking

- Reduced rates of drug use

Our consultation survey asks you several questions about the “Healthy Lives” priority. We’d like to know in a bit more detail about your thoughts on this. In the survey you can answer questions like:

- How strongly do you agree that it should be a priority?
- How important are the outcomes to you.
- If you think we’ve missed an outcome you can tell us.
- What do you think we should do to achieve these outcomes?
- What do you think you/your organisation can do to help achieving these outcomes?
- How can the HWB Board support you to do this?

Priority 3: Mental Health and Wellbeing

No health without mental health

Good mental health and wellbeing is fundamental to quality of life: it impacts on physical health and life expectancy, on family life and relationships, on educational achievement and employment and on social interaction and participation. At least one in four people will experience a mental health problem at some point in their life and one in six adults has a mental health problem at any one time. In addition, the incidence of mental health problems can increase in times of economic and employment uncertainty.

With a high prevalence of risk factors for poor mental health, including deprivation, inequality, low levels of employment and less access to green space, in Tower Hamlets, actual numbers of people mental health conditions are likely to be higher than the national prevalence rates.

There are some key areas where the evidence indicates that our levels of need are high and where we particularly need to focus as follows:

- Higher hospital admission rates for mental illness;
- Insufficient accurate intelligence on unexpressed need and expressed but unmet need
- Poor mental health is associated with other health risk factors including obesity, smoking, drinking and problem drug use
- Link between long term conditions and reduced mental health and a consequent need for improved integration of physical and mental health pathways and from primary/secondary and wider social care.
- There is potential for a greater focus on mental wellbeing as well as mental ill health
- Dementia is thought to be significantly under-recorded in the Borough. Significant numbers of people with dementia never receive a diagnosis. The numbers of people with dementia are projected to increase significantly in the coming years, in line with an ageing population.

In discussions with community groups, residents and staff, mental health and emotional health are seen as a priority. The Carers Forum, The Tower Hamlets Housing Forum, The Tower Hamlets Inter Faith Forum, The Older People's Partnership Board, The Great Place to Live Community Plan Delivery Group and the Community Voluntary Sector Health and Wellbeing Forum all raised Mental Health as a priority.

Our engagement highlights different areas of focus for different parts of the lifecourse/circumstances:

Carers: Impact of caring roles on people's mental and emotional health

Young People: transitions from young people's services to adult services, emotional health and wellbeing and its impact on educational attainment, relationships with parents, substance misuse and bullying.

Being and Adult: GP patients have reported to THINk that they want to feel like they are being treated as a whole person and that their emotional and mental wellbeing is being looked after as well as their physical wellbeing.

Older People: ranging from the impact of social isolation on mental wellbeing to dementia.

There are already a number of programmes and strategies to address these issues overseen by the Mental Health Partnership Board which involves key statutory bodies plus the third sector, service users and carers. The Mayor has made a high profile commitment to ending mental health discrimination, signing the 'Time to Change' pledge committing the Council to tackling the discrimination and stigma associated with mental illness.

The Partnership Board is overseeing the development of an over-arching Mental Health strategy within the context of the Health and Wellbeing Strategy and reporting to the Health and Wellbeing Board. Some of the key areas to be addressed are:

- Developing services oriented towards prevention and wellbeing, building community and individual capacity and resilience;
- Effective mental health promotion initiatives
- Opportunities for older people to enhance and strengthen positive mental health and wellbeing
- Early detection and treatment of mental illness
- Collaborative commissioning and greater focus on co-production of commissioning including the involvement of service users and carers as well as front line health workers
- Personalisation of budgets building more choice and control for service users
- Integration of services to make a reality of the 'No Health without mental health' aspiration
- Take forward work to address stigma and discrimination through further activity to promote and embed the Time for Change campaign, including working with non-health related organisations, for example places of worship and community organisations

Outcome objectives

The proposed outcome objectives for mental health and wellbeing are based on the recent Department of Health National Framework to improve mental health and wellbeing and will be revised further to reflect local issues as we develop our Mental Health Strategy, in particular to ensure an appropriate reflection of the needs of older people and children:

- More people will have good mental health
- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- More people will have a positive experience of care and support
- Fewer people will experience stigma and discrimination

Our consultation survey asks you several questions about the "Mental Health and Wellbeing" priority. We'd like to know in a bit more detail about your thoughts on this. In the survey you can answer questions like:

- How strongly do you agree that it should be a priority?
- How important are the outcomes to you.
- If you think we've missed an outcome you can tell us.
- What do you think we should do to achieve these outcomes?
- What do you think you/your organisation can do to help achieving these outcomes?
- How can the HWB Board support you to do this?

Priority 4: Long Term Conditions, Cancer and Disability

Early identification and person centred care

Long term health conditions, cancer and disability, which are often linked, have a significant impact on quality of life; reducing the ability of those experiencing them to participate in employment, social and family life, reducing life expectancy and effecting mental wellbeing. Tower Hamlets has some of the highest premature death rates from three of the most life threatening conditions; cancer, cardiovascular (heart) disease, and lung disease. Furthermore at least 50% of the Tower Hamlets population aged over 65 have two or more long term conditions.

People with long term conditions, cancer and disabilities often report that there is a need for health and social care services to be more joined up and integrated in their approach to delivering care and support. They also identify the need for health and social care professionals to take a holistic and person centred approach to supporting them, especially in cases where individuals are living with more than one long term condition.

There are also poor survival rates, particularly from cancer and a real need to further increase screening, public awareness and early diagnosis to improve survival. Prevalence of diabetes is also high and increasing, linked to high levels of obesity in the population. Early identification of risk and encouragement to healthier lifestyles are key to addressing diabetes.

Typically for an inner city area with high levels of deprivation, there are also high levels of infectious diseases with high and increasing levels of tuberculosis (TB), HIV and other sexually transmitted infections.

There are also a significant number of people who are living with disability, and significant numbers of people report mobility difficulties. Poor mobility appears to be related to social deprivation, with higher proportions of the Tower Hamlets population reporting mobility difficulties living in social housing or poor quality housing, unemployed, with poor levels of education, literacy or English language. Poor mobility is also strongly correlated to poorer self-reported mental wellbeing.

There is also a higher than average number of people in Tower Hamlets who have a learning disability. Analysis of GP data reveals that if you have a learning disability you are more likely to be affected by other health conditions such as diabetes, asthma, or epilepsy. Similarly there is a 10 times higher recorded prevalence of serious mental illness in the population with learning disabilities compared to the general population.

Not surprisingly, given higher levels of long term conditions and disabilities, Tower Hamlets has a high level of carers – an estimated 9,000 people locally providing 20 or more hours of unpaid care per week. Carers' needs have been recognised in a

strategy which seeks to ensure that carers receive the support they require to continue to fulfil this vital role.

Members of the Carers Forum highlighted a particular concern that GPs and other health services often do not always recognise the role and needs of carers. One carer, highlighting his own experience, felt that for himself and others in similar situations, there should be more proactive work by health care services to reach out more to carers.[7]

Through the Transformation of Adult Social Care Programme, Adults Health and Wellbeing in the Council is focusing on promoting choice and control for the people who use adult social care services. This programme has grown in momentum, as changes have been delivered to enable people to have more choice and control over the support and care they receive such as the introduction of personal budget. The use of Personal Budgets increases the amount of choice and control that people have over their own support, and allows much more creativity in how their needs are met.

The Partnership has already made strides in tackling long term conditions and reducing premature mortality. The Tower Hamlets Cancer Strategy 2011-2015 set out a clear vision and set of actions for reducing premature mortality and addressing the inequality between Tower Hamlets and England in terms of survival rates.

The Primary Care Investment Programme (PCIP) which focused on improving primary care provision for vascular and respiratory conditions, as well as immunisations and vaccinations has demonstrated some significant improvements in health outcomes for the residents of Tower Hamlets. These include

- the highest childhood immunisation rate in London with 95% of the population immunised (compared with just 80% in 2009)
- a *5.4% reduction in emergency hospital admission for those with COPD over the period April 2011 to December 2011 ,*
- more people being diagnosed with COPD and managed in a primary and community care setting
- an increase from 92.53% (April 2010) to 96.40% (March 2012) of patients screened for key diabetes indicators such as Hba1c, BP and cholesterol resulting in better managed care and identification of those at risk.

In addition, care package programmes have been introduced to drive improvement in the management and treatment of long term conditions through a standardised approach which places the patient at the centre of care. Where these have been introduced, for example in relation to diabetes and for those at high risk of heart disease, they are already showing improvement.

[7] Tower Hamlets Equalities Steering Group Minutes, May 2012.

The roll out of the Community Virtual Ward (CVW) across Tower Hamlets supports this patient centred approach by caring for vulnerable people at high risk of hospitalisation such as the elderly or those with long term conditions. The CVW identifies those most likely to be at risk and co-ordinates their care so they can live independently.

Users of health and social care services have raised a number of ways in which their experience as patients could be improved:

- People with Long Term Conditions have told us that they want to be more involved in their care and that services need to work better together.

- We've had some feedback to suggest that people find the social care and health systems confusing, particularly related to the number of staff and departments involved, as illustrated by the following quote: "*For normal, ordinary people, you don't really sort of understand who to ask for what and I don't always get the difference. So I think it would be quite helpful to have one particular person that you can contact*"[8]

- A focus on care in the community rather than acute settings: *"Home environment is always better than hospital environment, when you are in a hospital it makes you feel more ill being around others who are ill; it makes you a bit miserable. In your home environment you get to be with your own family, and it is just much more comfortable than being in a hospital. One person said that a lot of people get anxious when they go to hospitals; always start thinking of the worst. With the idea of the Virtual Ward it would eliminate the anxiety of going into the hospital*" [9]

Existing work will be sustained and stepped up with an ongoing focus for the Health and Wellbeing Strategy on prevention, early identification and effective treatment for these long term and life threatening conditions.

Some of the key areas for the strategy going forward are:

- Improvements in integrated and person centred health, housing and social care for those with complex needs or experiencing more than one long term condition

- Timely advanced care planning and appropriate end of life care and place of death

- Improve rates for cardiac rehab and reduce emergency admissions and re-admission to hospital

- Earlier diagnosis of lung disease and cancer through greater public awareness and screening uptake

[8] BLT Discovery Interview, June 2012.
[9] Older People's Reference Group, May 2011

- Awareness raising and increased uptake of HIV testing
- Increase identification, diagnosis of learning disability and ensure robust and integrated care and support, including a focus on improved housing options and support for young people
- Address gaps in services for adults with autism including a new diagnostic service and a Multi Disciplinary Teams care pathway
- Improve engagement and understanding of carers by primary care services including improved recognition of specific needs of carers, increased use of carers' registers, and greater provision of health checks

Outcome objectives

The proposed outcome objectives for long term conditions, cancer and disability are:

- Reduced prevalence of the major 'killers' and increased life expectancy
- More people with long term conditions diagnosed earlier and surviving for longer
- Improved patient experience and co-ordination of health, housing and social care for those with single or multiple long term conditions
- More people with learning disabilities receiving high quality care and support
- More carers having good physical and mental health and feel fully supported

Our consultation survey asks you several questions about the "Long Term Conditions, Cancer and Disability" priority. We'd like to know in a bit more detail about your thoughts on this. In the survey you can answer questions like:

- How strongly do you agree that it should be a priority?
- How important are the outcomes to you.
- If you think we've missed an outcome you can tell us.
- What do you think we should do to achieve these outcomes?
- What do you think you/your organisation can do to help achieving these outcomes?
- How can the HWB Board support you to do this?

Influencing wider social and environmental factors

There is considerable evidence that wider social and environmental factors, including housing, employment, education and the local environment, have significant impact on health outcomes.

Our residents have also told us that things that affect their health and wellbeing are broader than those traditionally "health related". Over 50% of respondents to our survey when asked about what stops them from staying healthy included a reference to wider social and environmental factors.

Tower Hamlets has a strong Community Plan, overseen by the Tower Hamlets Partnership, and with shared targets and delivery arrangements, which is seeking to address a range of these issues. The Health and Wellbeing Board is committed to working with the other Community Plan Delivery Groups to develop joint areas of work to ensure the health impacts of these areas are addressed. Work is underway to agree joint priorities with the relevant CPDGs – some of the key areas where we will look to work together are.

Housing

- Overcrowding, poor quality housing, fuel poverty and the impacts on physical and mental health
- Access to green/open space and ensuring this is factored in to new development including small scale local projects such as community gardens/allotments
- Role of housing providers and estate based community projects/neighbourhood forums in building capacity and awareness around health and wellbeing
- Engaging housing officers as key frontline workers identifying issues/promoting key messages
- Mental health and support needs of housing tenants
- Adaptations to enable people to live independently in their own homes

One resident when asked, "What do you think stops you from staying healthy?" responded "Worrying about money, housing and benefits being cut".

For people with long term conditions the accessibility of their home can impact on the health and wellbeing of the individual and their family. This quote illustrates some of the issues:

"I have a shower attached to the wall but I have to climb over the bath and have fallen a few times. The shower broke and I had to have a bath which was a nightmare. I've been in the house 35 years ... They told me they won't give me a

walk in shower because they will have to change it again when I leave because the house will go to a family. I can't blame them really"[10]

Employment

- Low levels of employment and high rates of sickness/disability claimants
- Health benefits of employment, especially in relation to mental health, and the role of GPs in supporting people back into work through use of the new 'fit note'
- Role of Board members as key employers – e.g. entry level schemes, employment of those with disabilities and mental health problems, Time for Change and the role in tackling mental health stigma

Unemployment can have a negative effect on Health and Wellbeing but poor quality employment can have a negative effect too. A few respondents to the Health and Wellbeing survey referenced "stress" impacting on their health and wellbeing, this included references to stress at work and work pressure.

Poverty

- High levels of child poverty
- Poverty significantly associated with worklessness – but also high levels of in work poverty in Tower Hamlets. Include consideration of how to promote London Living Wage among providers and commissioned services
- Welfare reform and the potential to worsen poverty and reduce safety nets for those dependent on benefits including disabled claimants. There is a need to better understand the impact and prepare providers to respond.
- Access to affordable sports and leisure

Environment and Planning

- Impact of land use planning on access to open space and promotion of physical activity, outdoor play, walking/cycling – further expansion of schemes such as the Green Grid and car free zones
- Significant opportunities to develop commitments in Local Development Framework and Core Strategy and use strategic planning process to address the above
- Health impact assessments for new developments/re-developments
- Using planning powers to manage the number and location of fast food outlets

[10] THINk, 2011, Patient Quotes specifically regarding Tower Hamlets Local Authority taken from the Long-Term Conditions Project

Environmental issues were raised by residents as having a negative impact on their health and wellbeing. These included busy roads, pollution and noise.

Community Safety

- Safety from injury and harm – role of frontline health workers in identifying and notifying risks
- Understanding high level of accidental and non-accidental injuries
- Links with Violence Against Women and Girls strategy – particularly at high risk months such as pregnancy and childbirth and the role of health workers to identify/support
- Hate crime associated with disability/mental health
- Road safety, prevention of accidents and perceived safety for walking/cycling
- Perceptions of safety and freedom from anti-social behaviour emerges as a key issue from consultation

Perceptions of safety in the Borough affect people's decisions and life choices. When people at the THINk AGM were asked about what needed to change to improve health and wellbeing of people growing older in Tower Hamlets, safety was a key concern: *"Older people live in fear and all of these factors affect their health."*

Safety is a similar concern for adult social care users with a learning disability in relation to independence:

"Fears were discussed around discrimination, people pointing and making remarks directed at them"[11]

Respondents to the Health and Wellbeing survey also raised concerns about safe play spaces for children:

"Anti-social behaviour - young people hanging out in the children's play areas - is sometimes off putting when I want to take my son there."[12]

Our consultation survey asks you several questions about other factors that affect your health. In the survey you can answer questions like:

- Have we got the list of other things that affect your health right?
- Which factors have the biggest impact on your health?

[11] LBTH, 2012, Modernising LD Day Opportunities in LBTH: BME Communities – March 2012
[12] LBTH, 2012, Residents Health and Wellbeing Survey

How we will deliver: accountability and working in partners

Once the key priorities and outcome objectives have been finalised, the Health and Wellbeing Board will work with partners and local communities to identify key actions needed to deliver the objectives. We have already, through review of current structures and engagement feedback, identified that there are a number of key **enablers** which will support the achievement of health and wellbeing aims.

These are grouped around the theme of **'Accountability and Working in partnership'** and include:

- **Integrating services** – including taking forward work around the integration of health and social care and the interfaces between social, primary and acute care. This needs to be supported through organisational development activity which ensures that collaboration and integration permeates all levels throughout organisations. As well as formal integration of services, there are real opportunities to maximise the value of every contact with health and social care services, ensuring, for example, that all frontline health workers, from GPs to home carers, regularly provide advice about healthy diet and activity.

- **Accountability for the quality of local services –** the Board needs to be sure that there are robust mechanisms in place to ensure health and social care outcomes are achieved and that health and social care services are accountable for the quality of service they provide to local people. This is particularly pertinent at a time when the provider and commissioning framework is changing fast. Commissioners, including the local authority and the Clinical Commissioning Group, need to have robust performance frameworks in place which ensure that service quality and responsiveness to patients is monitored and, where necessary, improved. The Health and Wellbeing Board will do this by implementing a robust performance framework that reflects the key outcomes outlined in this strategy and monitor progress regularly. The leadership of the Mayor and involvement of Cabinet members in the new Board will also strengthen democratic oversight and scrutiny of health provision in the borough.

  In this context, accountability to service users is also key. From April 2013, the borough will have a new statutory body, Healthwatch, in place to give people greater influence over their local health and social care services. Healthwatch will be represented on the Board and ensure patient views are shared and heard. But the Board will also want to develop a relationship directly with local residents, reporting to them on progress with the key outcomes in this Strategy, and where necessary holding services to account for poor quality service issues identified by local people.

- **Engagement and co-production** - A key principle of the strategy is to build on local community capacity and skills to enable communities to play a key role in the delivery of the strategy. By building on and linking existing assets within local communities such as schools, GP practices, faith and community groups, neighbourhood forums, housing and tenants associations and grass roots networks we will build health and wellbeing community engagement groups. These groups will be supported by our partners to identify, design and develop their own solutions to local health and wellbeing needs. Community leaders or 'HealthWatchers' will ensure the community voice is heard in strategic planning and that the community is able to identify and implement their own mechanisms to enable the system to work more effectively and efficiently.

- **Making effective use of resources and assets** - Since 2010, public services have seen reductions in funding and a requirement to deliver significant efficiency savings. The state of the economy and the Government's commitment to reduce the public sector deficit, means that there is no indication that the funding position will improve and every likelihood it will worsen. This is at a time when demands on health and social care are growing due in the most part to an ageing population. Locally, we will continue to make the case about the need for adequate resources to meet local health and care needs. At the same time, we will also continue to manage services as efficiently as possible to ensure that as much as possible of increasingly squeezed resources delivers real benefits for local people. In particular, the Board will need to work with commissioners and providers to consider how best shared resources can be allocated to priorities to deliver shared outcomes.

  At the same time, we need to think about the most effective use of physical assets within the health and social care sector, how we manage these most efficiently and ensure that in doing so we are providing modern local venues.

- **Using technology to improve outcomes** There are 3 ways that we think technology can help improve health and wellbeing services, the questions we will ask ourselves are:

  How can technology improve the lives of individuals?

  There is a growing body of evidence that supports the use of technology in health and social care settings and the impact this has on utilisation of health services. Health and social care providers face a considerable challenge to provide comprehensive care and support to an increasing number of people with complex care needs. Assistive Technology can be seen as a solution to this challenge, enabling people to live as independently as possible,

preventing or reducing the escalation of support needs through providing a service package and choice of technology tailored to meet their individual needs.

How can technology drive forward partnerships?

A consistent theme of user feedback is frustration at having to continually supply the same information to different parts of the health and social care system. We need to think about how we can develop a common record system across health and social care so that from a user perspective, time is not wasted in collecting the same data more than once and from a service provider perspective, resources are not wasted in duplicating activities (e.g. repeating investigations as the findings are not communicated).

In addition, we need to plan in a much more integrated way across the health and social care system - underpinning this is a need to share intelligence across the system and we need to think about how we can establish data sharing agreements that allow this information to be shared more freely between key partners.

How can technology support people taking greater responsibility for their own health?

Increasingly, local people, particularly but not exclusively younger generations, are using new technology to access information and support them organising and living their lives. Smartphone applications (apps), social media sites, Twitter and electronic messaging all provide opportunities to provide information to support healthy living and healthy choices in a host of new ways.

Tower Hamlets residents are increasingly using the internet as a method of communication; 15% of residents contacted the Council online over the last year, and 25 per cent say they would prefer to use this method in the future[13].

Tower Hamlets had a higher level of online returns to the 2011 Census than any other local area in the country at just under 30%.

In the survey you can tell us if you think we've identified the right things we need to do to make sure we're working better together, both across statutory organisations (the Council, NHS, and GPs), the voluntary and community sector and residents.

[13] Annual Residents Survey, 2011-12

Conclusion

This paper provides an outline of the key priorities identified for the Tower Hamlets joint Health and Wellbeing Strategy. It is a consultation draft and we are seeking your views to ensure that the final strategy fully reflects the range of issues important to Tower Hamlets.

The consultation is also important in identifying to the Board which are the key most important priorities where it can begin to have real impact, maximising the benefit of working in partnership across traditional organisational and sector boundaries, and engaging closely with the potential and capacity within the local community.

We are seeking formal responses to this consultation by **31st August 2012** – however engagement with stakeholders and the local community is an on-going process and we welcome views, through our website or to any of the officers named below over the coming weeks as we finalise the strategy. We are aiming to seek views on the final strategy early in 2013.

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Committee: Health Scrutiny Panel	**Date:** 11 September 2012	**Classification:** Unrestricted	**Report No.**	**Agenda Item No.** 4.3
Report of: East London Foundation Trust **Originating Officer:** Simon Tulloch, Head of Quality, Innovation and Patient Experience		**Title:** East London Foundation Trust Quality Accounts for 2012 **Wards:** All		

1. SUMMARY

1.1 Appendix 1 contains the Quality Accounts for East London Foundation Trust for 2012. The Quality Accounts are a report about the quality of services provided by East London NHS Foundation Trust. Quality Accounts are published annually by each NHS healthcare provider and made available to the public.

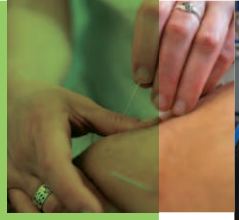
1.2 Appendix 2 contains a report providing feedback from the Quality Account process, including any lessons learnt and how the feedback has been used to improve service delivery.

2. RECOMMENDATIONS

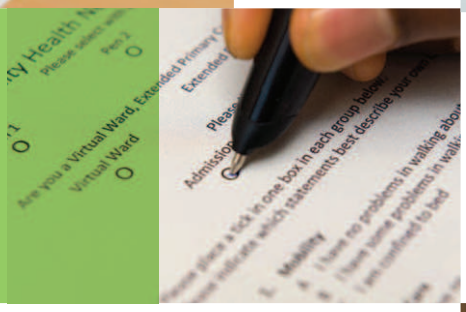
2.1 The Health Scrutiny Panel is asked to consider and comment on the information in the Quality Accounts and feedback report.

Local Government Act, 1972 Section 100D (As amended)
List of "Background Papers" used in the preparation of this report

Brief description of “background papers”	Name and telephone number of holder and address where open to inspection.
None	**n/a**







East London NHS Foundation Trust Quality Accounts 2011/12

East London NHS Foundation Trust

Presented to Parliament pursuant to Schedule 7, paragraph 25(4) of the National Health Service Act 2006

East London NHS Foundation Trust Annual Report and Accounts 2011-12

Contents

Executive Summary

The Quality Account Report forms part of our Annual Report for the same period. The Report reflects on the work undertaken across the Trust over the previous year and forward to the year ahead.

In 2010/11 the development of new priorities and measures of quality and satisfaction represented a fundamental shift in the Trust strategy and a move away from performance measures. The feedback we received from our stakeholders was a crucial factor in the shift. As such, the Trust will maintain the focus on these three key areas to ensure continuity and consistency.

- Improving service user and carer satisfaction
- Improving staff satisfaction
- Maintaining financial viability

As a result of adopting a consistent focus on the priority areas the Trust has achieved all ten of the quality indicators set in last year's Quality Accounts Report. Furthermore, the Trust has realised all the goals set by our commissioners and the Care Quality Commission (CQC).

We are committed throughout the organisation to ensure that quality continues to run throughout all that we do and that the people who use our services, or come in contact with them, have a positive experience.

Part 1
Statements on Quality

1.1
Statement on Quality from Dr Robert Dolan, Chief Executive

Our Quality Account Report this year reflects the activity that has taken place across the Trust to develop and strengthen the quality of our services. This year we have focussed on a number of specific areas to build on our expertise and experience to improve the quality of the care and treatment we provide.

Our quality indicators were developed in partnership with our key stakeholders, such as service users, carers and representative groups across the three boroughs and concern three domains: patient safety, clinical effectiveness and patient experience. We have been able to focus our time and resources on these priorities to achieve the ten targets we set ourselves. It is our intention to focus on these same priorities in the coming 12 months.

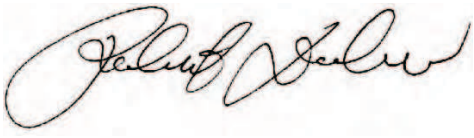
Additionally, the Trust has exceeded the goals agreed as part of the Commissioning for Quality and Innovation payment framework. (CQUIN) agreed between the Trust and East London and the City Alliance for the provision of NHS services.

The Trust's Improving Access to Psychological Therapies (IAPT) service in Newham is leading the way in the adoption of IAPTus, an integrated IT system which records the service user pathway and includes outcome measurement, clinical records and service reports. The Newham IAPT is now a well established service providing effective and accessible talking therapies as recommended by the National Institute of Clinical Effectiveness.

In Community Health Newham, we have further developed the Extended Primary Care/Virtual Ward model to better address the multiple needs of vulnerable people to avoid preventable hospital admission. The teams now include Older Adult Community Psychiatric Nursing staff and all disciplines are working in an innovative and cohesive way. Those who have used the service are positive about its impact on their health and rehabilitation and the indications are that the Virtual Ward is resulting in people being discharged from hospital to home earlier.

The Trust is using technology to find out the real-time experiences and perceptions of service users. DigiPen technology is in use to collect PROMs (Patient Reported Outcome Measures) and PREMs (Patient Reported Experience Measures) and we have also implemented the use of 'touch screens' in community settings for people to tell us about their experience so that we can act quickly to make changes if needed.

The information contained in our Quality Accounts is accurate to the best of my knowledge. Whilst we have achieved a great deal in the past year, it is important that we continue to listen to service users and staff and build on these improvements to be confident that our services provide optimum support to meet service user needs.



1.2 Statement on Quality from Dr Kevin Cleary, Medical Director

It has been a challenging and exciting year to be working as part of a team that is focussed on improving the quality of healthcare we provide to our patients and service users. The inclusion of community services in Newham in the Trust's portfolio of healthcare provision has provided an opportunity to look at how we deliver services and the different approaches that are taken to quality in community services. We have definitely gained a wider perspective on what patients value from healthcare providers and how we can tailor our services to meet the needs of our customers.

Our biggest challenge in healthcare quality is how to change the culture of the organisation and its workforce so that the patient is at the centre of everything we do. We started the year with a survey of staff's attitudes to patient safety using a standardised tool. The results were positive and greatly heartening; staff were definitely aware of the importance of patient safety and viewed the organisation as one that was attempting to learn from previous incidents. In addition our staff wanted to report incidents and did not feel inhibited in their reporting. This has provided us with a great base on which to develop a positive safety culture within the organisation. On the national stage it is often reported that senior clinicians are difficult to engage in patient safety work but our experience has been that senior staff have very actively engaged in our programme of learning lessons.

We have taken part in a number of national audits reviewing aspects of the care that we provide which offers us a chance to compare the effectiveness and safety of our services with other similar providers around England. We have also worked with the relevant confidential inquiries to assist with their critically important work on improving patient outcomes. The benchmarking part of these processes is important but is not what we value most. What is of the greatest value is the scrutiny of external agencies and the application of validated standards to our work. Measurement is the basis of improvement: you cannot improve something unless you can measure it. The coherent use of externally validated standards is an important lever in our management of quality improvement.

What our patients and service users think of our services is crucial but has proved to be difficult at times to assess accurately. The national surveys are important but often have low return rates. Over the year we have moved to involving service users in the collection of information from other service users and also introduced new technology to ensure that we can capture real-time data from our patients about what they think. We use this information to drive change in how we deliver their care.

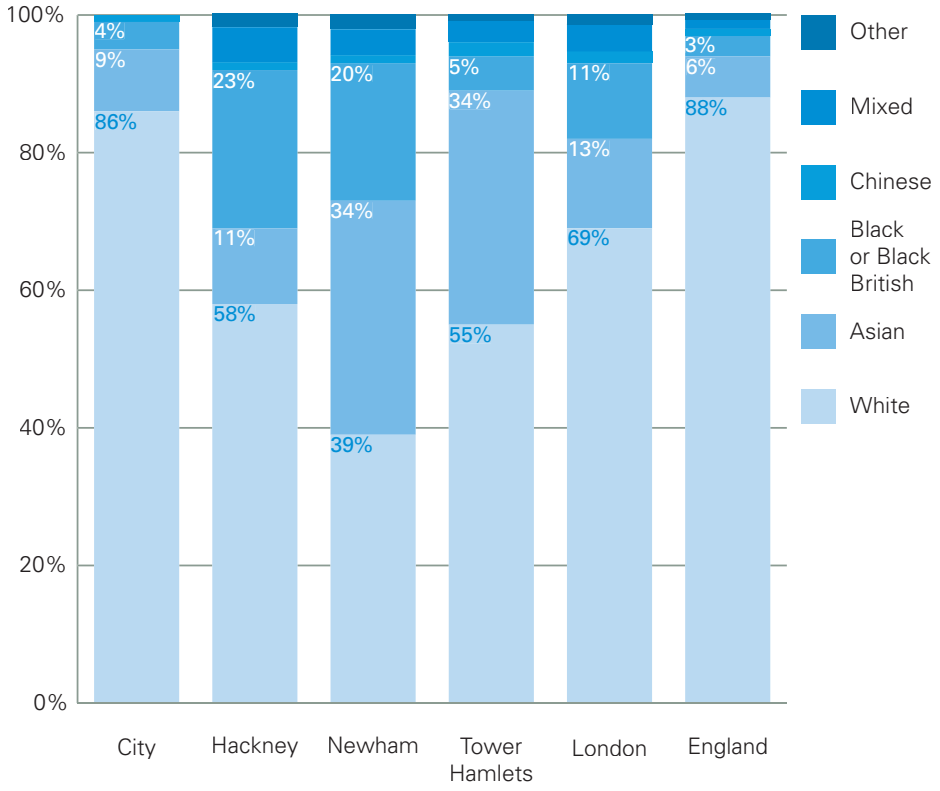
Looking forward we want to continue our improvement work. The key to success will be increasing the capacity for bottom up initiatives from our staff to drive the quality improvement work rather than relying on central initiatives. It is the staff delivering services and our patients and service users who have the best insights into service quality and we will be harnessing this over the next year to ensure continual improvement in our care.

Part 2
Priorities for Improvement

2.1 The Population of East London and the City

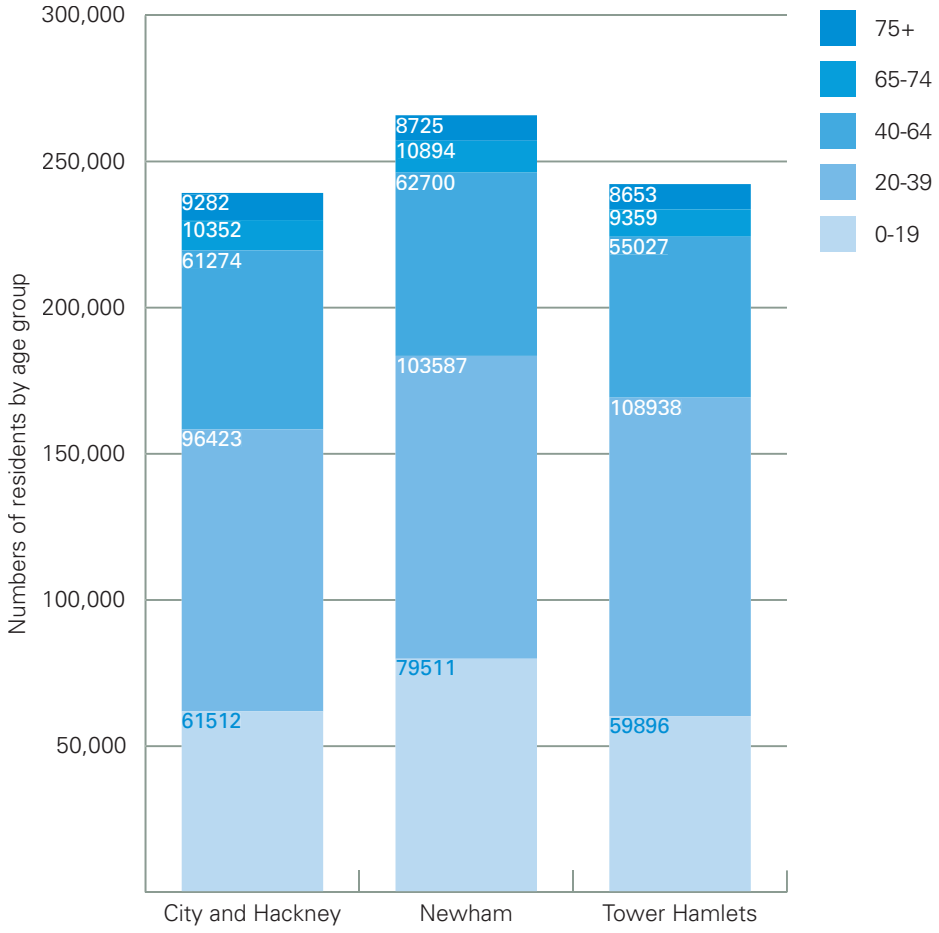
East London NHS Foundation Trust (ELFT) serves four boroughs: Hackney, The City of London, Newham and Tower Hamlets. These areas are culturally diverse with significant levels of mental and physical health need. East London is exclusively inner city urban, with high levels of immigration, socio-economic deprivation and health inequalities. The area is also densely populated and has a relatively young population. Ethnicity data indicate that the East London area has the largest black and minority ethnic (BME) population (49%) in the UK. The BME population nationwide is eight per cent.

Figure 1. ELFT population by ethnicity



The figure below shows that the area has a very young population, with a high proportion of adults aged 20-39 years. The proportion of older people is therefore much smaller than the national average.

Figure 2. ELFT population by age group



London's population is estimated to grow by 810,000 from 7.3 million in 2003 to 8.1 million by 2016. The population served by the Trust is expected to increase overall by 25% (178,000 people), with 31% in Newham (80,900), 35% in Tower Hamlets (78,200), and 8% in City & Hackney (18,900).

There are a number of implications for ELFT services. Many of the severe mental illnesses such as schizophrenia and bipolar disorder first present in early adulthood. There will therefore be a disproportionately higher number of new diagnoses of these conditions, which will require significant service input to establish treatment. The large working age population offers a substantial opportunity to improve mental health through the workplace and similarly to prevent poor mental health triggered by workplace factors, such as stress.

However, amongst the working age population, levels of economic inactivity vary markedly across the East London area, with particularly high levels in Tower Hamlets. Consequently, there is a high proportion of children born into poverty. The area has some of the highest child poverty levels in the country.

In spite of this, the Trust has demonstrated that it is performing well compared to other Trusts in terms of inpatient efficiency, for example low length of stay, lower readmission rates and lower delayed transfers of care. Compared to the level of morbidity, we have one of the lowest levels of investments for one of the most deprived areas of the country.

2.2 Review of Services

1,500,000

The Trust's forensic services are provided to a population of 1.5 million in north east London.

East London NHS Foundation Trust (ELFT) provides a wide range of community and inpatient mental health services to the City of London, Hackney, Newham and Tower Hamlets. Forensic services are also provided to Barking and Dagenham, Havering, Redbridge and Waltham Forest, as well as Community Health Services in Newham. In the year ahead, the Trust will also provide psychological therapies to people in Richmond (South West London) in partnership with the mental health charity Mind.

During 2011/12 the Trust provided and/or sub-contracted one NHS service. The Trust has reviewed all the data available to them on the quality of care in this service.

The income generated by the NHS services reviewed in 2011/12 represents 100 per cent of the total income generated from the provision of NHS services by the Trust for this period.

Mental Health Service Provision

Trust service provision includes community and inpatient services for children, young people, adults of working age and older adults who live in the City of London, Hackney, Newham and Tower Hamlets. The Trust has a large and well established Child & Adolescent Mental Health Service (CAMHS), provides a range of psychological therapies services and was one of two national demonstrator sites for Improving Access to Psychological Therapies (IAPT).

The Trust provides forensic services to the four local boroughs as well as the North East London boroughs of Barking and Dagenham, Havering, Redbridge and Waltham Forest and other specialist mental health services to North London, Hertfordshire and Essex. The specialist Chronic Fatigue Syndrome/ME adult outpatient service also serves North London and the South of England.

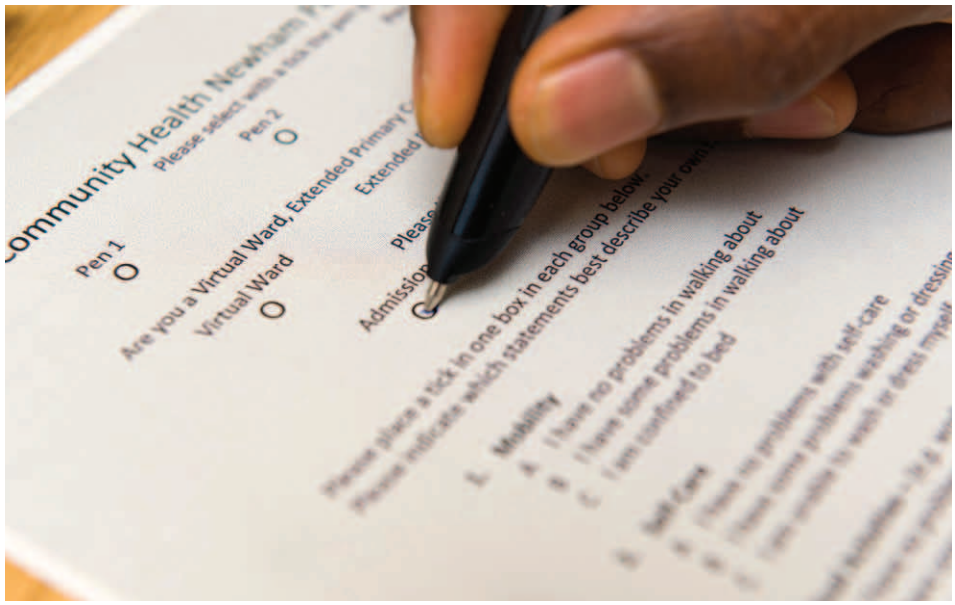
The Trust's local services are provided to a population of 710,000 in East London and the Trust's forensic services are provided to a population of 1.5 million in North East London. The areas served by the Trust are the most culturally diverse and deprived areas in England and therefore present significant challenges for the provision of mental health services.

As of June 2012, the Trust will also provide Primary Mental Health services in Richmond. These services will be part of the Improving Access to Psychological Therapies (IAPT) model, currently used in Newham. As a result, 33 new staff will be providing psychological services across multiple sites in the Richmond area.

Community Health Newham Services

Community Health Newham has been a fully integrated part of the Trust for over a year (since 1 February 2011). The Community Health Newham (CHN) Directorate is responsible for improving the health and well-being of the people of Newham through healthcare services in community settings. CHN has a key role in delivering personalised services that promote and enhance peoples' independence and well-being.

As a result of this integration, the Trust now employs an additional 900 staff and provides community health services from 33 sites, including an inpatient facility of 78 beds at the East Ham Care Centre for continuing care, respite care and intermediate care service users. Some of these sites are also used by mental health services.



2.3 Participation in Clinical Audits

During 2011/12, **three** national clinical audits and **one** national confidential enquiry covered NHS services that East London NHS Foundation Trust provides.

During that period the Trust participated in **100%** of national clinical audits and **100%** of national confidential enquiries that it was eligible to participate in.

The national clinical audits and national confidential enquiries that East London NHS Foundation Trust participated in during 2011/12 are below:

Description of National Audit	Submitted to
National Sentinel Stroke Audit	Royal College of Physicians Stroke Audit Team Clinical Standards Department Clinical Effectiveness and Evaluation Unit Royal College of Physicians of London *Valid for two years; next audit due in April-June 2012*
National Audit of Intermediate Care	NHS Benchmarking, 3000 Aviator Way Manchester Business Park Manchester M22 5TG
National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness	Centre for Suicide Prevention Psychiatry Research Group School of Community-Based Medicine University of Manchester 2nd Floor, Jean McFarlane Building Oxford Road Manchester M13 9PL
National Audit of Schizophrenia	Royal College of Psychiatrists 4th Floor, Standon House 21 Mansell Street London, E1 8AA

The Royal College of Psychiatrists College Centre for Quality Improvement (CCQI) also undertakes a range of external and peer review programmes. The Trust participates in a wide range of improvement projects as outlined below:

CCQI Programme	Participation by ELNFT	% of cases submitted
Service accreditation programme		
ECT Clinics	2 ECT clinics	100
Working Age adult wards	14 wards	100
Psychiatric intensive care units	4 PICU's	100
Older people mental health wards	4 wards	100
Memory services	3 services	100
Psychiatric liaison teams	2 teams	66
Service quality improvement networks		
Inpatient child and adolescent units	1 unit	100
Child and adolescent community MH teams	1 team	33
Therapeutic communities	1 community	100
Forensic mental health services	1 service	100
Perinatal mental health inpatient units	1 units	100
National Audit of psychological therapies (NAPT)	**2 teams**	**100**
Multisource feedback for psychiatrists (ACP 360)	**23 enrolments**	**69 in total**
POMH TOPIC	**Number of patients**	
Monitoring of patient prescribed lithium	97	100
Medicines reconciliation	64	100
Use of antipsychotics in people with learning disability	0	
Use of antipsychotic medication in CAMHS	53	100

The Trust also undertook a range of local audits:

Audit Priority	Lead Committee	Directorate
CPA & Risk Assessment Audit	Quality Committee / CPA Group	All
Discharge Audit for inpatient services	Quality Committee / PCT	Adult inpatient Units
Record Keeping Audit	Quality Committee / Health Records Development Group	All
Medicines Policy – Prescribing & Administration Audits	Quality Committee / Medicines Committee	All
Infection Control Audit	Quality Committee / Infection Control Committee	All
Trust-wide Case Note Audit (CQC standards)	Quality Committee / Service Delivery Board	Adult inpatient units
Safeguarding Children Audit	Safeguarding Committee	All
Section 58 Consent to treatment / Section 132 Patient Rights / Section 17 Leave of Absence	Quality Committee / Mental Health Act Committee	Adult Inpatient Units
Monitoring of patients prescribed lithium (POM UK	Quality Committee / Medicines Committee	Adult inpatient & community
Prescribing antipsychotic medicines for people with dementia (POM UK)	Quality Committee / Medicines Committee	MHCOP Teams
Prescribing antipsychotics for children and adolescents (POM UK)	Quality Committee / Medicines Committee	CAMHS / Adult Teams

The Trust develops specific action plans for each audit that are managed through the Quality Committee, for example, as a result of the CPA & Risk Assessment Audit the Quality Committee & CPA Group initiated additional training, revised the documentation and closely monitored the implementation of these processes.

2.4 Research

100

Each year since 2007 there have been over 100 publications resulting from our involvement in research.

Being a centre of excellence for research is one of the key strategic objectives of East London NHS Foundation Trust. To achieve this objective, the Trust collaborates closely with academic partners, such as Queen Mary University of London and City University and concentrates on research that improves the delivery of health care in East London. Research in the Trust is linked to the specific local context, reflects national priorities, and plays a leading role internationally.

The aim of the research is to provide evidence that contributes to the worldwide evidence base, and directly or indirectly, leads to improvements in healthcare. To achieve this, research has to be of high quality and receive recognition on an international level.

The work of the research groups has influenced public and professional debates on policy and clinical issues in mental health care on local, national and international levels. The impact of our research on policy and practice can sometimes be rather indirect and difficult to distinguish from the effects of other contributions to the same debates. In other areas, however, it is possible to identify some direct impact of our research on health services and policy. Some examples include:

- A finding that black and minority ethnic patients detained for involuntary psychiatric treatment experience more coercion than similar white patients. However, when looking within a given geographic area, such as East London, the differences between ethnic groups disappear. East London was the geographic area with the highest level of perceived coercion across all ethnic groups. Therefore, attempts should be made to reduce perceived coercion in all groups in the Trust rather than specific ethnic groups. As a result of these findings the Trust is considering how changes can be made.
- Based on findings that patients registered more anger, irritation and depression as a consequence of locked doors than staff or visitors thought they experience, all attempts should be made to avoid locked doors on the wards in our Trust.
- Wards with good leadership, teamwork, structure, attitudes towards patients and low burnout had significantly lower rates of containment events (coerced medication, manual restraint, etc.). Interventions to reduce rates of containment towards may need to address staff issues at every level, from leadership to staff attitudes.
- Female patients benefit from acute treatment in day hospitals as compared to conventional inpatient wards, whilst there is no difference for men. Acute day hospitals such as the one in Newham may be part of a gender specific service provision.
- All available population-based indices for the funding of mental health care suggest that East London has the highest need in the whole country. Since the need reflected by population-based indices is not matched by actual funding, this evidence needs to be pointed out to Commissioners and the public.
- The DIALOG intervention (computer-mediated structuring of patient-clinician communication) was found to be effective in a trial in six European countries. Out of all areas in which it was tried, the effect was greatest in East London. Based on the research evidence, the intervention will be implemented and further developed in East London.
- Cognitive behavioural therapy (CBT) and graded exercise therapy (GET) (both in addition to specialist medical care) were more effective in the treatment of Chronic Fatigue Syndrome than specialist medical care alone or with adaptive pacing therapy. Therefore the Trust's practice of providing CBT and GET is shown to be an effective treatment, although it might be criticised by some patient groups.

The number of participants from the East London NHS Foundation Trust recruited in 2011/2012 to take part in research included on the National Institute of Health Research (NIHR) Portfolio was 709 (includes recruitment reported through 27 February 2012). This represents a 68% increase over the previous year.

In every calendar year since 2007 there have been over 100 publications resulting from our involvement in research, helping to improve patient outcomes and experience across the NHS.

Further information regarding the research undertaken across the Trust, including a list of ongoing and previous research is available: http://www.eastlondon.nhs.uk/rande/

2.5 Goals Agreed with Commissioners 2011/2012

Use of the CQUIN Payment Framework

A proportion of East London NHS Foundation Trust's income in 2011/12 was conditional on achieving quality improvement and innovation goals agreed between ELFT and East London and the City Alliance for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. In 2011/12 this constituted 1%, in 2012/13 2.5% of the Trusts' total income will be conditional on successful achievement of the CQUINs.

Further details of the agreed goals for 2011/12 and for the following 12 month period are available electronically on the website: http://www.eastlondon.nhs.uk/ or on request from the Trust Secretary (see Contact Us section at the back of this report).

The table below summarise the Trust's final position on delivery of 2011/12 Mental Health CQUIN targets.

2011/12 Mental Health CQUIN Indicators	2011/12 Target	Trust Performance (31 March 2012)	Status
Improve the physical health and medicines reconciliation of patients with mental health problems			
CQUIN 1a – 90% of all hospital and community based patients to have a complete set of mental and physical health high mortality ICD10 codes	90%	97.5%	Complete
CQUIN 1b – The Trust must demonstrate medicine reconciliation within care plans within 72 hours of admission to inpatient care	90%	96.6%	Complete
CQUIN 1c – Notification of discharge for all hospital based patients to be undertaken within one week of discharge from inpatient care	90%	97.5%	Complete
Improve the responsiveness to the personal needs of patients in CMHTs.			
CQUIN 2 – Implementation of real-time data collection methods in community settings, analysis of one quarters' worth of data and development of action plan	Yes/No	Yes	Complete
To enable safe, effective and supportive care for SMI patients discharged to Primary Care			
CQUIN 3 – Work with GPs across the four Boroughs to agree a protocol that streamlines all patients on the SMI register that require assessment and/or treatment within 24 hours of the GP referring/contacting the appropriate provider service	Yes/No	Yes	Complete
Recovery and patient focused care planning			
CQUIN 4 – The Trust will introduce a care planning process that imbeds developing a care plan written in the first person, first tense – with community patients on CPA and/ or in Clusters 11 to 14.	30%	51.6%	Complete

2011/12 CQUIN targets for Forensic Services, Child and Adolescent Mental Health Services, Newham Talking Therapies and Community Health Newham have been met.

2.6 What Others Say about the Provider

Statements from the Care Quality Commission (CQC)

East London NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is without any conditions. The Care Quality Commission has not taken enforcement action against ELFT during 2011/12.

There were no relevant special reviews or investigations by the CQC during the reporting period. Below are quotes from the reviews of services undertaken in 2011/12.

Inspections are ongoing across Trust services and will be reported next year.

CQC Compliance Report – Tower Hamlets

"We found that Adult Mental Health Services – Tower Hamlets Directorate was meeting all the essential standards of quality and safety we reviewed."

"The provider recognises the diversity of the community it serves and supports patients whose first language is not English to be involved in decisions about their care, treatment and support."

CQC Compliance Report – Forensic Learning Disability Services

"We found that Woodbury Ward was meeting all the essential standards of quality and safety we reviewed but, to maintain this, we have suggested that some improvements are made [to the recording of episodes of seclusion]."

"Care plans were detailed and person centred. Discharge and discharge planning of patients was happening. Patients' health was regularly monitored and patients' risk was managed appropriately. Overall, we found that Woodbury Ward was meeting this essential standard (care and welfare of people who use services)."

CQC Compliance Report – Safeguarding and Looked after Children's Services

(Part of a wider review involving Local Authority Services)

"Health and social care leadership has been rated as adequate. Both agencies have ambition and are working to a shared vision and agreed priorities through the Children's Trust in which health plays a full part."

Trust response

The CQC reports were disseminated across the Trust and discussed at the Service Delivery Board, Quality Committee and Assurance Committee. The Trust submitted action plans in response to the improvement actions requested by CQC.

Further information

http://www.eastlondon.nhs.uk/about_us/care_quality_commission.asp

2.7 Data Quality

The Trust's Information Governance (IG) framework, including Data Quality (or 'Information Quality Assurance') policy and responsibilities/management arrangements are embedded in the Trust's Information Governance and Information Management and Technology Security Policy.

Information Quality Assurance:

- The Trust established and maintains policies and procedures for information quality assurance and the effective management of records
- The Trust undertakes or commissions annual assessments and audits of its information quality and records management arrangements
- Data standards are set through clear and consistent definition of data items, in accordance with national standards
- The Trust promotes information quality and effective records management through policies, procedures/user manuals and training.

The Trust's Commissioners, Trust Board and Information Governance Steering Group receive regular reports on data quality/completion rates against agreed targets. The IG Steering group receives and reviews performance on data quality benchmarked across London and nationally – including the use of the national data quality dashboard.

To support action and improvement plans, Directorate Management Teams receive a range of cumulative and snapshot data quality reports from the Trust's Information Management team – these show missing or invalid data at ward, team and down to individual patient level. Data validity and accreditation checks are undertaken annually (often more frequently) in line with the IG Toolkit national requirements and an annual audit of clinical coding is undertaken in line with the IG Toolkit national requirements.

East London NHS Foundation Trust submits records during 2011/12 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics that are included in the latest published data. The percentage of records in the published data taken from local RiO data as of 29 February 2012:

- which included the patient's valid NHS number was: 97.2% for admitted patient care, and 99.5% for outpatient care
- which included the patient's valid General Medical Practice Code was: 91.8% for admitted patient care, and 95.4% for outpatient care.

The Trust has implemented the following actions to improve the data quality:

- Deployment of RiO clinical across mental health services
- Monthly performance management meetings

2.7.1 Information Governance Toolkit Attainment Levels

East London NHS Foundation Trust Information Governance Assessment Report score overall score for 2011/12 was 81%.

2.7.2 Clinical Coding Error Rate

East London NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2011/12 by the Audit Commission.

2.8 Trust Priorities for 2012/13

In 2010/11 the development of new priorities and measures of quality and satisfaction represented a fundamental shift in the Trust strategy and a move away from the existing wide range of 'output' focused performance measures. The feedback we have received from our key stakeholder groups, such as the LINks, Commissioners and the Trust Members Council was a crucial factor in the shift. As such, the Trust will maintain the focus on these three key areas to ensure continuity and consistency:

- Improving service user and carer satisfaction
- Improving staff satisfaction
- Maintaining financial viability

In spite of significant challenges, the Trust has directed considerable resources to improve these key priorities; we intend to build on this momentum. The challenge for the year ahead is to keep all areas of quality (patient safety, clinical effectiveness and patient experience) central to the care and treatment we provide.

2.9 Quality Indicators for 2012/13

The Trust monitors quality in a number of ways, including through designated Board committees, robust performance management processes, internal scrutiny, self-assessment and feedback from service users and carers.

A revised set of indicators will enable the Trust to better monitor the quality of service delivery within the annual plan and through the in-year monitoring process.

They are grouped into the categories of:

- Patient safety
- Clinical effectiveness
- Patient experience

The quality indicators will provide a renewed emphasis on service user focussed measures for quality. This work will allow the Trust to measure real aspects of recovery and experience and improve performance.

Much of the work the Trust undertakes to improve the quality of the services we deliver is in partnership with external organisations and stakeholder groups. We hope to continue this positive experience in the future.

In addition to the 10 quality indicators set out overleaf, a range of initiatives will be undertaken over the next 12 months in the following areas:

Improving service user and carer satisfaction

- Complete review of capacity of inpatient acute and female PICU
- Focus on personalisation agenda and care planning in community services
- Increase number of health visitors in Community Health Newham
- Increasing the amount of service user and carer involvement in the staff training programme
- Better use of quality indicators and patient experience feedback
- Implementation of NICE guidance 'Service user experience in adult mental health'
- Implementation of recovery model
- Establishment of a Social Inclusion Board

Improving staff satisfaction

- Continue with the Organisational Development programme
- Improve staff engagement and communication
- Better use of staff satisfaction indicators

Maintaining financial viability

The Trust is required to meet the operating framework assumption as part of its compliance obligation which for 2012/13 equates to 4% Cash Releasing Efficiency Savings (CRES). As in previous years, the Trust adopts an approach of delivering CRES plans that have the least impact on service users.

- Be on track to meet all financial targets, including a savings programme of £11.2m
- Achieve financial risk rating of 4
- Deliver Cash Releasing Efficiency Savings (CRES) of £9.6m
- Deliver CQUIN targets and contract requirements
- Continue to seek new business.

The Trust has developed a range of reporting mechanisms, including the monthly Quality & Performance meeting that includes all directorates. Ultimately, we hope to see improvements in our Service User and Staff satisfaction surveys.

The Quality Indicator priorities 2012/13

1

All Adult & Older Adult Community Teams to increase the % of caseload receiving face to face contact per month

Rationale
Regular and frequent face-to-face contact with patients is essential to gain a full understanding of each patients needs. This is essential to ensure that an appropriate care plan is in place.

Process
Care co-ordinators will enter data on to the RiO data system. Teams will be measured against data from the previous year and progress will be tracked on a quarterly basis.

Category
Patient experience; Clinical effectiveness

2

Percentage of young people in contact with Community CAMHS Teams who have shown improvement as measured by CORC outcome measures

Rationale
Changes in the CORC outcome scales enable us to understand whether we are offering the appropriate interventions to each of the young people in our care.

Process
CAMHS clinicians will collect and input data into the CORC database. Teams will be measured against data from the previous year and progress will be tracked on a quarterly basis.

Category
Clinical effectiveness; Patient experience

3

Amount of time care co-ordinators working in Adult and Older Adult services are in contact with patients as a proportion of their working week

Rationale
Increased levels of contact are associated with higher levels of satisfaction.

Process
Care co-ordinators will enter appointments data into their electronic diary. Teams will be measured against data from the previous year and progress will be tracked on a quarterly basis.

Category
Patient experience

4

An increase in the % of patients with enhanced CPA with a crisis plan and risk assessment up to date

Rationale
Crisis plans and risk assessments are core to ensuring that patient and staff know what to do when a patient is experiencing a crisis, and what risks they may face either to themselves or others.

Process
Care co-ordinators will enter data onto the RiO data system. Teams will be measured against target data from the previous year (90%) and progress will be tracked on a quarterly basis.

Category
Patient experience; Patient safety

5

Reduce the total number of medicine errors of three high risk medications (Insulin, Lithium and Clozapine)

Rationale
Medicine errors are potentially dangerous events that can have a detrimental effect on the health and well being of our patients. Reducing errors whilst encouraging reporting of all errors is key to protecting patients.

Process
Clinicians will enter the DATIX data collection system. Levels will be measured against data from the previous year and progress will be tracked on a quarterly basis.

Category
Patient safety; Clinical effectiveness

6

Increase the % of patients who have had their medicines reconciled within 72 hours of admission

Rationale
Medicine reconciliation ensures continuity of medication which may have been prescribed by other medical staff whilst a patient is in the hospital environment.

Process
Pharmacists will upload information onto RiO data system. Teams will be measured against target data from the previous year (90%) and progress will be tracked on a quarterly basis.

Category
Patient safety; Clinical effectiveness

7

Consolidation of real-time satisfaction measures for service users across services.

Rationale
Real-time data collection methods have been implemented across inpatient and community settings. Data are currently collected using questions developed centrally or from national guidance. To fully embed the principle of local ownership it is crucial for questions to be developed locally (individual teams) and fed back regularly.

Process
Regular feedback via local team meetings and quarterly Trust-wide inpatient and community care forum meetings.

Category
Patient experience

8

Percentage of all patients with diabetes with a physical health care plan that specifies targets for glycaemic control.

Rationale
Diabetic patients for this measure include all patients on the DSN caseload plus all inpatients with a diagnosis of diabetes who have been on the ward for 4 weeks.

Process
Clinicians will enter data onto the RiO data system. Aim to establish a baseline measurement and track progress on a quarterly basis.

Category
Patient experience; Clinical effectiveness; Patient safety

9

Increase the proportion of staff who report having well structured appraisals in the last 12 months.

Rationale
Staff supervision and appraisal can affect employee well-being and morale, as such, those seeking to create healthier workplaces should acknowledge the important role supervision and appraisal have.

Process
Data collected via the annual staff survey undertaken by Quality Health

Category
Patient experience; Clinical effectiveness

10

Each Clinical team to develop one quality initiative to improve patient satisfaction

Rationale
Clinical Teams and the service users within each of the teams are best placed to know what improvements will have the biggest impact on them. This will allow each team to decide a priority and for the Trust to dedicate resources to supporting the team and its users to develop and implement this.

Process
Written reports produced by each team tracked on a quarterly basis.

Category
Patient experience; Clinical effectiveness; Patient safety

2.10 Special Focus across the Trust

2.10.1 Improving Access to Psychological Therapies (IAPT)

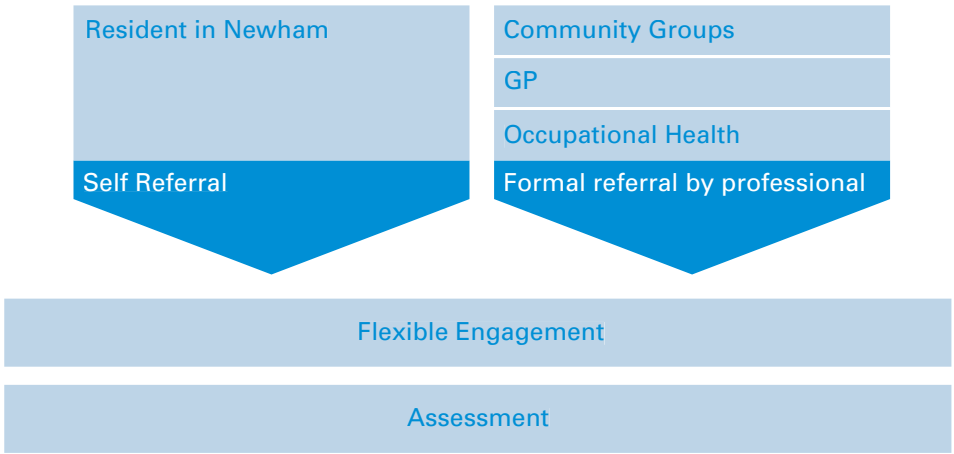
The Trust became one of the two national IAPT demonstration sites in 2006 that spearheaded the national IAPT rollout. The Trust provided a comprehensive Cognitive Behaviour Therapy (CBT) service to people presenting with common mental health problems across the borough.

The service was delivered by CBT trained therapists and provided either in the individual's practice or in a local treatment centre. Local employers also access the service to help people stay in employment. The programme is complemented by increasing access to Employment Coaches provided by Mental Health Matters (MHM). The service treats over 3,000 people per year and has developed a range of culturally sensitive interventions.

The Trust developed robust referral management processes and as a result of this experience has developed a flexible innovative approach in response to local needs. This service model is now widely used in IAPT services nationally.

The referral management service was developed following extensive research into best practice and has been continuously updated in consultation with local GPs. Our success is reflected in the 90% of patients who access and are referred to appropriate services within one working day (see model below).

Pathways into Service



Trust clinicians also lead in the development of the IAPTus, the IT system currently used across all IAPT services. This single integrated IT system captures the service user pathway from start to finish and includes outcome measurement and clinical records whilst ensuring development and automatic production of service reports. The Trust is also piloting the system's rollout to the primary care enhanced mental health team for GPs in a local borough.

Key Achievements

- Delivered NICE recommended talking therapies for common mental health problems overcoming the gap between policy and practice
- Empowered and informed service user choice
- Developed and implemented robust information structures to support service users, clinicians and service managers
- Delivered an accessible, popular and effective talking therapy service
- Provided an integrated service that:
  - educated patients to be their own therapists,
  - improved their well being,
  - reduced the risk of recurrence and-promoted social inclusion.

1,000

The Virtual Wards have cared for over 1,000 patients in the first year

2.10.2 Virtual Ward

The new Extended Primary Care Team (EPCT)/Virtual Wards (VW) service commenced on the 1 February 2011. Importantly, these teams now include Older Adult Community Psychiatric Nursing staff. This means that the multiple needs of vulnerable people are being better addressed in an integrated and comprehensive way through multi-disciplinary working. Work continues on developing this new service and in engaging with key partners to ensure successful sustainability of this innovative service. Results to date are very promising with some excellent outcomes reported and good quality 'patient experience' accounts from those who have received Virtual Ward services. Across the borough the Virtual Wards have cared for over 1,000 patients in the first year.

The teams are now using Digi pen technology to collect PROMs (Patient Reported Outcome Measures) and PREMs (Patient Reported Experience Measures). Early results are encouraging and support the database of good patient stories. The positive results are collated monthly and shared regularly with commissioners and GP groups.

Feedback from geriatricians also suggests that the Virtual Ward service is facilitating earlier discharge and is beginning to work in an integrated way with the day hospital.

Of note, and relevance to the future development of Virtual Wards and EPCTs in Newham, a major national trial of Telehealth and Telecare was undertaken over the past three years (in Newham, Kent and Cornwall). The national evaluation of our experience was published at the end of 2011 and is now informing both national and international practice.

In short, there were very positive outcomes from the Randomised Control Trial of over 6,000 Telehealth/care participants, in terms of very significantly decreased mortality, avoided hospital admissions and resultant secondary care costs. CHN is now developing a recasting of its VW and EPCT structures and resources, in order to build in the mainstream use of Telehealth, informed by a risk tool indicating community residents risk of hospital admissions. That way, a well targeted approach to monitoring and care can be delivered. This is also a key contributor to the current emphasis on self-care and personalisation within our services.

Stakeholder Engagement

The Directorate has benefited from the high profile involvement with local GP Commissioning engagement from the CEO and the Acting Director of Performance and Business Development.

This has come at a crucial time during transformation for the Extended Primary Care Teams and Virtual Ward Service. The Directorate has been active in setting up new Patient Related Outcome and Patient Experience monitoring programmes as part of the Patient/Public involvement agenda and capturing patients' clinical improvement outcomes and experiences.

2.10.3 Forensic Services

The East London Forensic Mental Health Service is an established one with a track record of providing safe, effective care alongside good patient experience. The service received a very favourable report through the Royal College of Psychiatrist Quality Network Peer Review.

In respect of safety, there are a low number of matters recorded as serious untoward incidents with no cases of clinical negligence. The hospitals have an excellent track record with no escapes in the last five years. Regarding clinical effectiveness the service is discharging double the number of patients compared to five years ago and there is a consistent average length of stay in medium security of below two years. For patient experience, a recent audit found that inpatients across the service had more

than twenty-five hours of meaningful activity available to them in a week. Inpatients of the forensic service consistently report high levels of patient satisfaction.

Thus, the challenge for the forensic service is to maintain and raise further an already high quality service in a time of financial constraint. This is also in a situation where there is a focus on targets and compliance, with the need to be able to demonstrate quality through audit and external review particularly by the CQC.

Important quality issues for the year ahead

The Forensic Service is now being commissioned within the new National Commissioning framework and the London Region subgroup. The service is required to comply with tighter timescales for assessment for admission and a twelve-week programme of inpatient assessment. This means marshalling resources to achieve the timescales required and recording that to demonstrate compliance or to identify difficulty and then rectify it. This is a challenge because it involves imposing external regulatory requirements upon clinicians who have differing ways of working. The service has, however, developed a revised assessment and care pathway procedure, which dovetails with commissioning requirements. It is thus comparatively well placed to meet the challenge, but this situation will need to be carefully monitored.

More generally, there are a wide range of CQUIN targets and other targets that the service needs to achieve. The challenge for the service is to maintain a focus on these whilst providing good quality clinical care more generally. Excessive focus on targets can lead to neglect of quality in other areas, whilst the service appreciates that quality targets do need to be met. The challenge is to keep all areas of quality (patient safety, clinical effectiveness and patient experience) in mind and under review to continue to drive up quality, as has been consistently occurring.

2.10.4 Mental Health Care of Older People (MHCOP)

The Mental Health Care of Older People (MHCOP) Directorate is mid-way through a three-year review and service redesign. This has involved a substantial expansion of community services and a redesign of ward provision. The service is now better able to offer extended levels of support to older people with mental health needs and those with dementia, to enable these individuals to live more independently at home and to reduce the need for hospital care. The increased capacity also means that in the boroughs of Newham and Tower Hamlets MHCOP have established specialist liaison services that focus on the needs of older people with dementia who have been admitted to either the Barts and The London NHS Trust group of hospitals or Newham University Hospital.

The redesigned service has seen a significant reduction in the number of admissions into MHCOP beds. Consequently, the directorate has been able to reduce its need for ward based services and has established a new centrally located dementia assessment ward. The ward environment was designed in collaboration with the Dementia Design Unit at Kingston University and delivers specialist inpatient care within a structured clinical pathway. The older adult wards all meet 'Accreditation for Inpatient Mental Health Services' (AIMS) standards, with some rated as excellent, and it is anticipated that the new ward will also achieve an excellent AIMS rating.

As a result of the service redesign, referrals to all local memory clinics have increased by more than fifty percent and it was particularly gratifying that dementia services in Newham were recently cited by Paul Burstow, Minister of State for Care Services as a beacon of good practice and a model that should be embedded across the NHS.

Future work for the directorate involves learning from the service redesign with the aim of reviewing existing bed and community requirements for older people with mental illness.

2.10.5 Real-Time Service User Data Collection

The government's Health White Paper proposed an information revolution, centred on the patients themselves. In particular, the government is keen to "encourage more widespread use of patient experience surveys and real-time feedback."

The Trust is aware that it is essential to systematically collect and utilise feedback from service users that truly represents their actual experiences and perceptions. In partnership with service users and

carer groups, the Trust developed a set of standards that services should strive towards and a set of questions to assess whether they were achieving them based on service user and carer perceptions. This process became known as the Service User-Led Standards Audit (SULSA).

What makes the SULSA particularly service user focused is that the process of data collection is facilitated by trained service user auditors, who ask current service users a set of questions that provide quantitative and qualitative data about their experience.

The results are collated, analysed and made available to ELFT staff, service users on the wards and at service user and carer forums, and to commissioners who have adopted the SULSA as a valid assessment of service quality.

In the summer of 2011, the Trust implemented the use of electronic data collection devices, specifically 'touch screens' in community settings and the use of Digital pens for all service user feedback data from inpatient wards.

This process has had a significant positive impact. For example, the service users joining the auditing team have developed new skills and report feeling more empowered. Similarly, current service users in wards see former service users in a new and influential position. This is inspiring and provides hope. Furthermore, the number of services users who now provide feedback on their experience has increased over 50% in the last 12 months because of this process.

Crucially, the findings from the service user feedback lead to ongoing changes to improve the quality of care and treatment the Trusts provides.

Part 3
Review of Quality Performance 2011/2012

3.1 Priorities for 2011/12

In the 2010/11 Quality Account Report we acknowledged that in spite of meeting the vast majority of the Key Performance Indicators set by our commissioners, there had still been serious incidents in the previous 12 months. We outlined that the Trust was moving away from performance related indicators towards improving the quality of the care and treatment we provide in three domains: patient safety, clinical effectiveness and patient experience.

The quality indicators set out below were developed in partnership with our key stakeholders, such as service users, carers and representative groups across the four boroughs and cover those three main domains. By focusing our time and resources on these priorities, the Trust has been able to achieve each of the targets. This is why we have chosen to maintain this focus for 2012/13.

Below are the details for each of the ten priorities set out for 2011/12.

3.2 The Quality Indicator Priorities 2011/12

Priority	Category	Target	Status
1. All community, Adult & Older Adult and NSF Teams to report the % of caseload receiving face to face contact per month	Patient experience; Clinical effectiveness	80%	88.6%
2. % of young people in contact with inpatient & Community CAMHS Teams who have shown improvement as measured by CORC outcome measures	Clinical effectiveness	80%	85.7%
3. % of patients on enhanced CPA with a written copy of the care plan in date	Patient experience	90%	98.5%
4. % of enhanced CPA patients with a crisis plan and risk assessment in date	Patient experience; Patient safety	90%	98.5%
5. Reduce the number of medicine errors reported as a % of all incidents	Patient safety; Clinical effectiveness	<3%	2.85%
6. % of patients who have had their medicines reconciled within 72hours	Patient safety; Clinical effectiveness	90%	96.6%
7. Development of a real time satisfaction measures for service user and staff	Patient experience	Yes/No	Yes (CMHT's and CHN settings)
8. Achievement of four Service Areas implementing Productive Community Service principles	Patient experience; Clinical effectiveness; Patient safety	Yes/No	Yes
9. Identify the number of end-of-life patients cared for in the four virtual wards and the caseload of community matrons and other case managers and to demonstrate a minimum of weekly MDT meetings about these patients to which the patient's GP has been invited and sent the meeting notes evidencing adherence to Gold Standard Framework (GSF), Liverpool Care Pathway (LCP) and Advanced Care Planning (ACP) as appropriate.	Patient experience; Clinical effectiveness	Yes/No	Yes
10. Each Clinical team to develop one quality initiative to improve patient satisfaction	Patient experience; Clinical effectiveness; Patient safety	Yes/No	Yes

Monitor Assurance

As a Foundation Trust, we are also required to deliver against the following Monitor requirements. Two are statutory, one is locally defined.

Monitor targets	Target 2011/12	Actual 2011/12
1. CPA inpatient discharges followed up within 7 days (face to face and telephone)	95%	96.4%
2. Patients occupying beds with delayed transfer of care – Adult & Older Adult	7.5%	1.2%
3. It was recorded that a Baseline physical health examination was conducted at admission.	95%	99%

3.3 Good Quality Care across the Trust

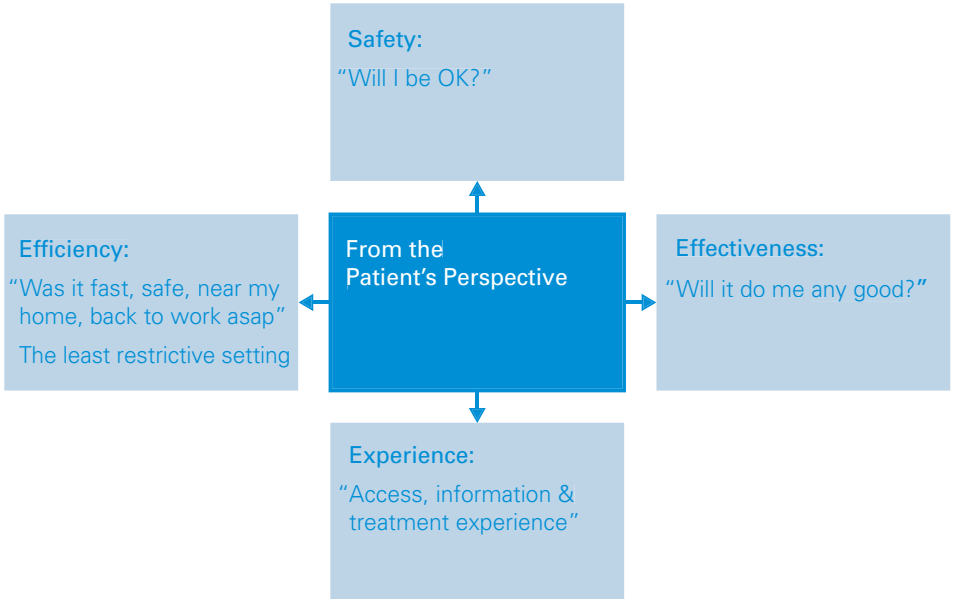
The Trust participates in a range of additional activities that are designed to improve the quality of the care and treatment we provide. The following section provides information on a range of areas that influence good quality care.

The information is derived from a range of sources, both from internal process and external review. The aim of this section is to provide a sample of the work the Trust engages in to improve the quality of the services we provide.

In addition to fulfilling all the priorities set out over the previous year, the Trust has met all Care Quality Commission (CQC) and all commissioner targets

3.3.1 A definition of quality

It is essential that the Trust works with a definition of quality. This should include the patient's viewpoint. The diagram below, developed by Professor Bruce Keogh (Medical Director of the NHS), incorporates the key elements of the priorities for the Trust.



3.3.2 First Person Care Plans

To ensure patients are involved in developing their care plan, the Trust has introduced a 'First Person Care Plan' that contains goals and steps towards recovery as defined by the patient.

This may involve a member of staff assisting patients to develop a care plan written from their perspective (first person). This care plan is subsequently shared with the care coordinator, consultant and anybody else the patient wishes to, to ensure all care and treatment is co-ordinated.

The Trust was aiming to implement this process with 30% of patients in clusters 11-14 (i.e. with 'specific diagnoses') by end of the year. In fact, **over 53%** of these patients now have a care plan developed by them and setting out their goals and aspirations towards recovery.

3.3.3 PEAT Scores (Patient Environment Action Team)

PEAT is an annual assessment of inpatient healthcare sites that have more than 10 beds.

It is a benchmarking tool to ensure improvements are made in the non-clinical aspects of patient care including environment, food, privacy and dignity.

The assessment results help to highlight areas for improvement and share best practice across healthcare organisations in England.

The results of PEAT inspections carried out in the year, and ratings achieved, are summarised in the table below:

Site Name	Environment Score	Food Score	Privacy and Dignity Score
Homerton East Wing	4	3	4
The Lodge	4	4	4
Newham Centre for Mental Health	4	5	5
John Howard Centre	4	4	4
Tower Hamlets Centre for Mental Health	4	4	4
Recovery Unit, Wolfston House	4	4	4

PEAT Score Ratings Key (maximum 5): Excellent – 5, Good – 4, Acceptable – 3; Poor – 2, Unacceptable – 1, N/A – 0

3.3.4 Length of Stay and Readmission Rates

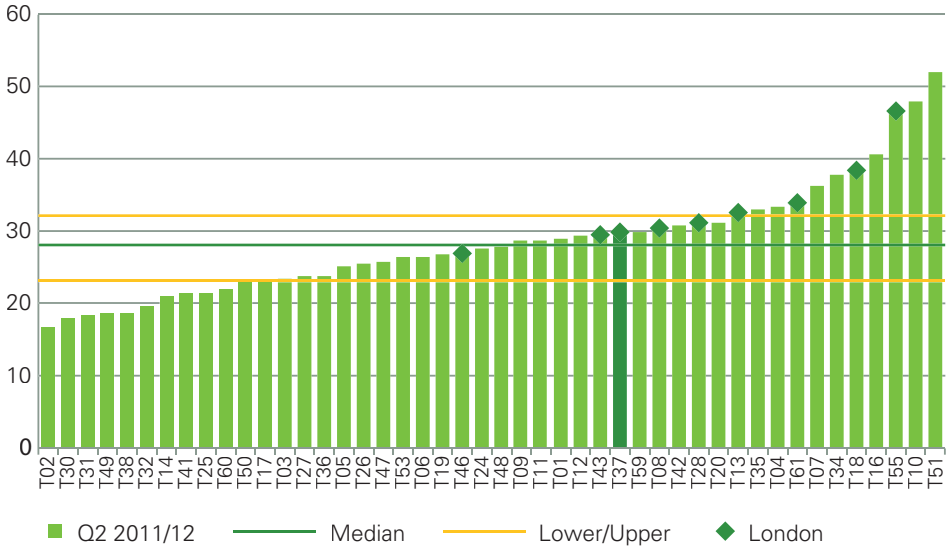
The autumn 2011 report from the Audit Commission's 'Trust Practice Mental Health Benchmarking Club' compared Trust performance against the majority of mental health trusts nationally (n=50).

The report stated that in adult services the data shows that ELFT deals with significant demand for services effectively.

ELFT admissions per 100,000 weighted head of population (Q2 2011/12 data) compared to the Audit Commission Benchmarking Club for other Mental Health Trusts nationally.

Available beds for weighted population numbers are relatively low given the high level of mental health needs in East London [T37 = ELFT].

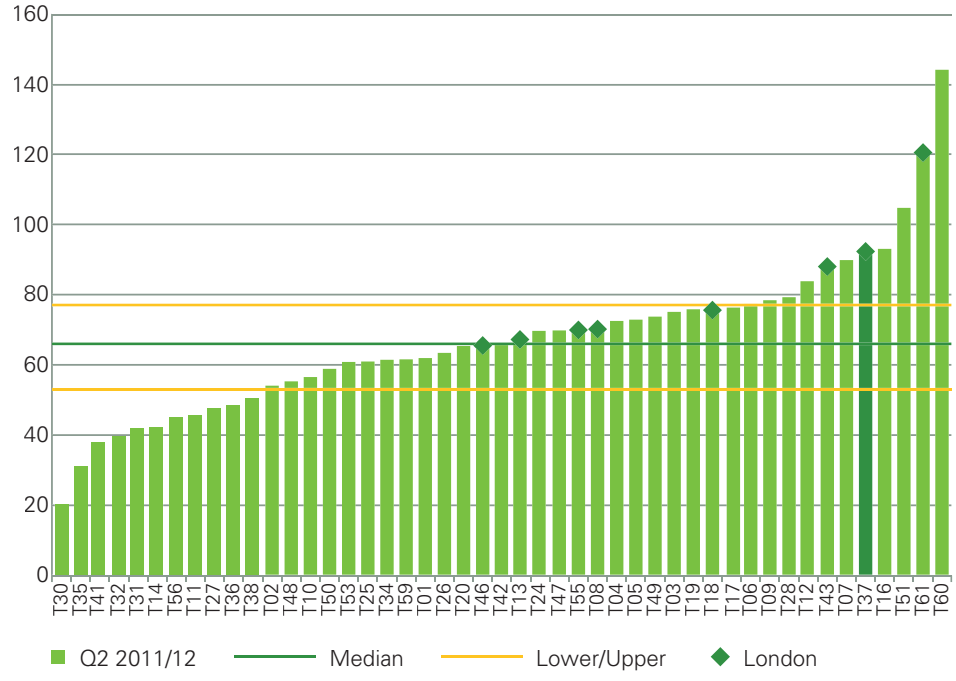
Adult acute – Available beds per 100,000 weighted head of population



Source: Audit Commission Autumn 2011

The Audit Commission stated that ELFT services nevertheless deal with admission rates that are above the London average whilst maintaining low levels of readmission rates and average lengths of stay.

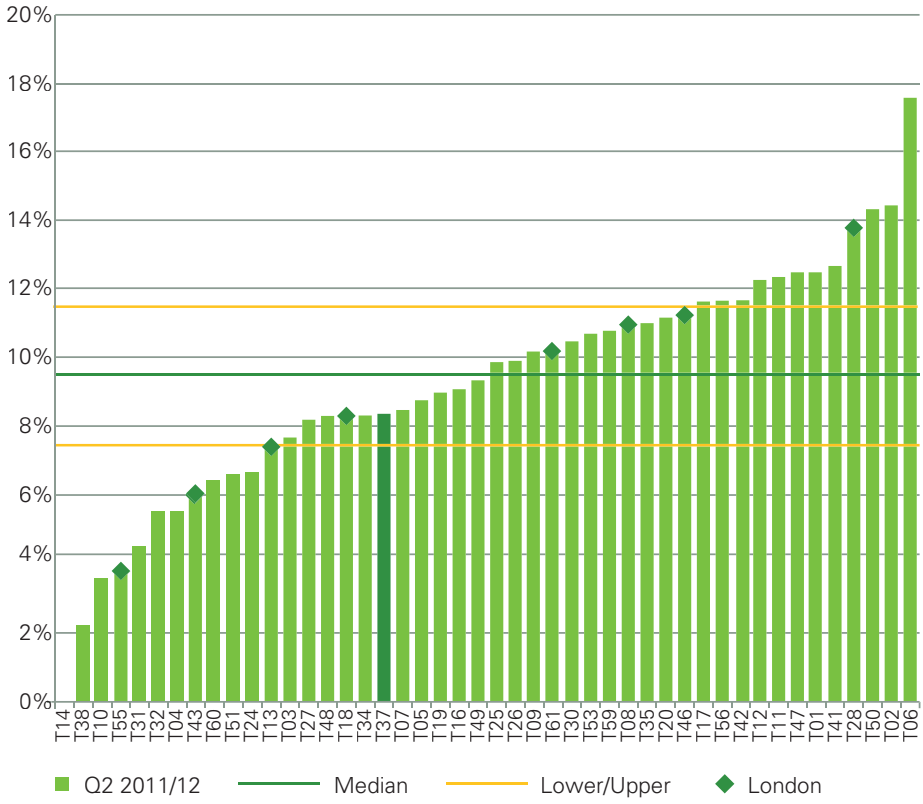
Adult acute – Admissions per 100,000 weighed head of population



Source: Audit Commission Autumn 2011

ELFT readmission rates (Q2 2011/12 data) compared to the Audit Commission Benchmarking Club.

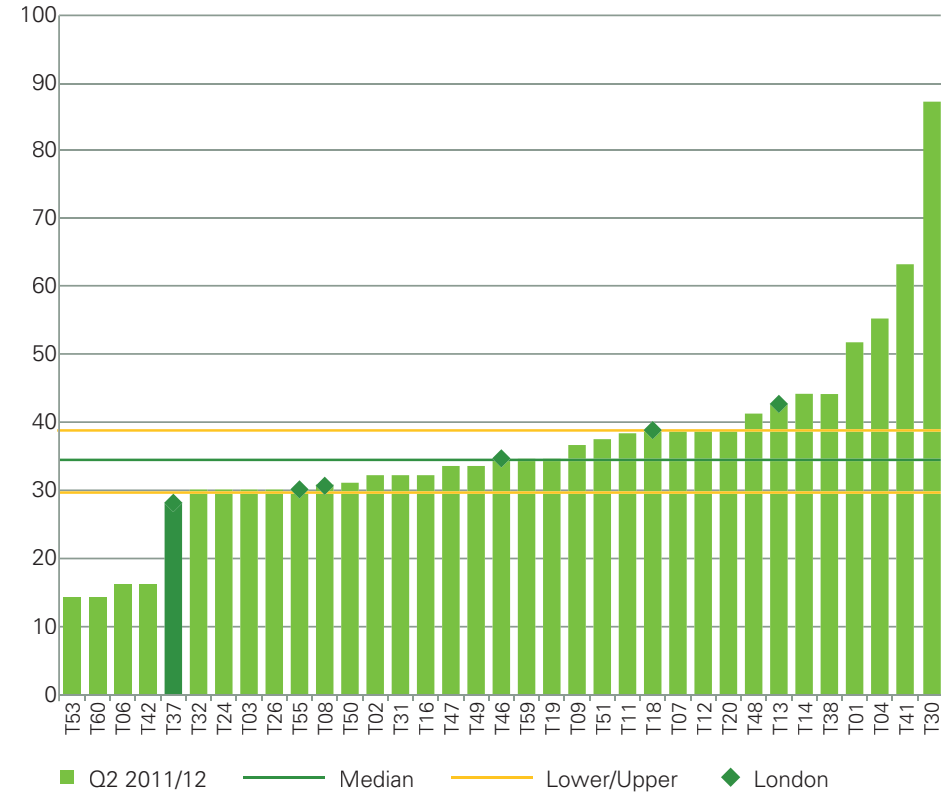
Adult acute – Readmission rate as a percentage of discharges



Source: Audit Commission Autumn 2011

Average ELNFT length of stay (Q3 2010/11 data) compared to the Audit Commission Benchmarking Club for other London Mental Health Trusts.

Adult acute – Mean average length of stay (including outliers, excluding leave)



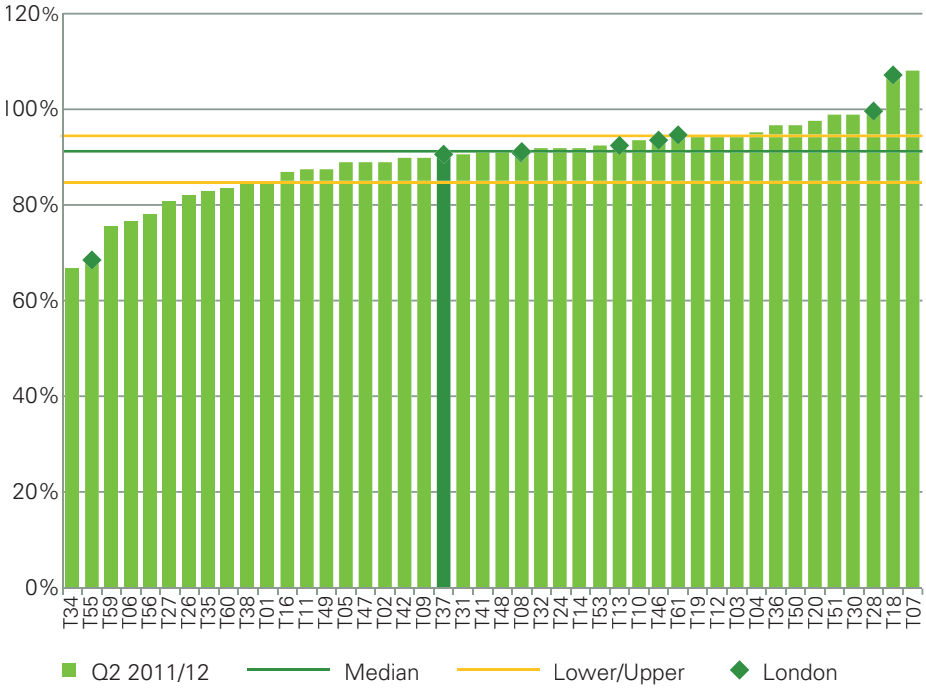
Source: Audit Commission Autumn 2011

Bed occupancy has improved significantly over the last 12 months. As a result of this we managed to reach our goal of 85% bed occupancy.

85%

We reached our goal of 85% bed occupancy

Adult acute – Occupancy rate (excluding leave)



Source: Audit Commission Autumn 2011

3.3.5 Care Programme Approach (CPA)

The CPA is the framework through which the care and treatment is delivered for a large proportion of the Trust's service users. The table below shows that for the vast majority of service users on CPA their care plans are kept up to date.

However, the proportion of service users on CPA who are seen every month is below the level we would hope to achieve increasing contact time is one of the Trust's priorities for the year ahead.

Indicator	Target	Actual performance
CPA patients – care plans in date (documents 12 months old)	95%	98.5%
CPA patients – care plans in date (documents 6 months old)	95%	96.4%
% CPA patients seen in month – face to face only	90%	88.6%

3.3.6 Safeguarding Adults and Children

The Trust works with around 16,000 adult mental health service users at any one time. Many of these are parents, pregnant women, grandparents, step-parents or in contact with children in some way. Over 25% of our service users will be subject to the Care Programme Approach.

Child and Adolescent Mental Health Services (CAMHS) received 4,370 referrals during the year. CAMHS had 43,539 total contacts with approximately 4,082 children and young people on CAMHS caseloads.

The following information is provided to demonstrate that good performance in training compliance in health and safety areas can have an impact with leading to a reduction in staff safety incidents and therefore can lead to a reduction in potential for personal injury claims. This is vital in the process of improving in the areas of patient safety, clinical effectiveness and patient experience the cornerstones of the Trust's priorities.

CPA Audit Tool – Safeguarding Children Standards: Four of the standards in the CPA audit tool relate to safeguarding children. These are to ensure children are identified at the outset. Once it is known that the service user has children, the Safeguarding Children Audit Tools apply.

'Safeguarding Children Level 1' training compliance: The Trust continues to ensure that all staff attends relevant mandatory training courses. The target set by the CQC for all levels is 80%.

Safeguarding Children Level 1

Total	Number of staff	Number of staff attended	% compliance
2010/11	2,562	2,306	90.0%
2011/12	3,592	3,404	94.8%

The Trust is about to embark on a major training programme around safeguarding adults to ensure that all our staff have the appropriate training to manage this agenda.

Safeguarding Adults' training compliance

Total	Number of staff	Number of staff attended	% compliance
2010/11	2,562	1,018	80.6%
2011/12	3,592	2,913	81.1%

3.3.7 Health and Safety

The Trust has a comprehensive work plan to address the actions required at both corporate and local level to ensure compliance with Health & Safety legislation and Security Management Service directions. This covers all aspects of training and regulatory compliance.

Incident data

Total	Fire	Moving and handling	Falls (non-clinical)	***RIDDOR reportable	Smoking in an un-authorised area	Total
2010/11	106*	8	66	24	123	**303**
2011/12	146**	14	96	16	157	**413**

*32 actual fires **42 actual fires
*** RIDDORs are excluded from any total, as they are not incidents in their own right and so likely to be counted twice

The increase in incidents reported since the last financial year can be explained by:

- The integration of Newham Provider Services in February 2011
- Improved reporting practices supported by improvements in the Datix incident reporting system implemented during April 2011
- Ongoing work corporately and locally to promote incident reporting, support people involved in incidents and develop systems to enable learning from incidents.

'Health and Safety' training compliance

Total	Number of staff	Number of staff attended	% compliance
2010/11	2,562	1,331	**52.0%**
2011/12	3,592	2,969	**82.7%**

'Manual Handling' training compliance

Total	Number of staff	Number of staff attended	% compliance
2010/11	2,562	2,237	**87.3%**
2011/12	2,901	2,684	**92.5%**

'Fire Safety (including fire marshal)' training compliance

Total	Number of staff	Number of staff attended	% compliance
2010/11	2,562	2,401	**93.7%**
2011/12	3,592	2,665	**74.2%**

3.3.8 Medicines Management

Medicines management is a high risk area of activity; we therefore pay specific attention to medication errors of all types and have recently introduced an e-learning package for all staff who administer medication.

Incident data

	Prescribing error	Dispensing error	Administration error	Chart not signed	Medication availablity	Other	Total
Total	24	20	120	6	11	79	260

Medicines incidents continued to be reported via the Trust DATIX system and discussed at Medicines Safety Groups. Measures are then taken to minimise risk and repetition of incidents.

Training compliance

All clinical staff receive medicines safety training. This increases awareness of how to minimise risks around the prescribing, dispensing and administration of medicines.

Medicines Safety

	Number of staff	Number of staff attended	% compliance
Total	1,421	1,058	74.45%

The Trust has also developed an e-learning programme for nurses for the safe administration of medicines. Nurses are given protected time to complete the training.

Safe administration of medicines (e-learning)

	Nurses completing e-learning package
Total	533

Medicines Reconciliation

The Trust's target is that over 90% of patients' medicines are to be reconciled by pharmacy staff within 72 hours. This is a directive from the NPSA, NICE and also a CQUIN target for the Trust. Reconciliation of medicines on admission ensures that medicines are prescribed accurately in the early stages of admission. It involves checking that the medicines prescribed on admission are the same as those that were being taken before admission and involves contacting the patient's GP.

Directorate	Total	Missing	Complete
City & Hackney	266	22	91.7%
MHCOP	69	6	91.3%
Newham	222	11	95.0%
Tower Hamlets	181	4	97.8%
Trust Total	738	43	94.2%

3.3.9 Drug savings

The Trust has reduced expenditure on medicines by 15% in 2011/12. This has been achieved through several initiatives, including:

- Reduced waste
- Managed entry of new drugs
- Centralised procurement
- Use of generic medicines.

3.3.10 Service User-Lead Standards Audit

Below is a summary of findings from the Service User-Led Standards Audit for Quarter 4 (January to March 2012). The audit collects information across ten service user developed standards by asking two questions per standard.

The data are presented as 'mean scores' for each directorate against the standards listed below.

Standard 1
Service users can access ward staff at all times and feel treated with dignity and understanding.

Standard 2
Service users are provided with information and guidance on how to complain and feel able to raise concerns without fear.

Standard 3
The religious, spiritual and cultural needs of every service user are respected and accounted for.

Standard 4
Service users are provided with information (written) and guidance (verbal) about medications, including potential side effects.

Standard 5
Service users are involved in important decisions about care planning and discharge.

Standard 6
Service users have regular access to therapeutic groups and activities that enhance their wellbeing.

Standard 7
Service users receive regular, quality 1:1 time with their allocated nurse

Standard 8
Service users are informed of their rights in regard to Mental Health Act 1983 and accessing clinical notes.

Standard 9
Service users are provided with information and advice on practical matters, such as housing and benefits.

Standard 10
On admission, service users receive a Welcome Pack containing useful information.

Survey scale used by Service Users

1	2	3	4	5	N/A
No Never Not at all Strongly Disagree Very Poor	Rarely Slightly Disagree Poor	Sometimes Moderately Neither Fair	Often Very Agree Good	Yes Always Extremely Strongly agree Excellent	Don't know Not applicable

Standard	1	2	3	4	5	6	7	8	9	10	Mean
City & Hackney	4.5	2.8	3.4	2.8	2.9	4.1	3.1	2.8	1.9	3.1	**3.1**
Newham	3.8	3.7	3.1	3.8	3.0	4.1	3.4	2.9	3.1	3.4	**3.4**
Tower Hamlets	4.2	3.5	3.3	3.6	3.3	4.1	2.9	3.3	3.2	3.4	**3.5**
MHCOP	4.6	4.1	4.1	4.4	4.4	4.5	4.6	4.8	4.6	N/A	**4.5**
Forensic	4.5	4.0	3.8	4.0	3.8	3.7	3.3	4.2	4.0	3.5	**3.9**
Wolfston House	4.5	3.4	4.0	4.1	3.9	4.0	3.2	4.2	3.9	4.1	**3.9**
Trust Total	**4.4**	**3.6**	**3.6**	**3.8**	**3.6**	**4.1**	**3.4**	**3.7**	**3.5**	**3.5**	**3.7**

3.3.11 CQC – Community patient survey (2011)

We use national surveys to find out about the experience of service users when receiving care and treatment from the Trust. At the start of 2011, a questionnaire was sent to 850 service users. Responses were received from 215 service users at East London NHS Foundation Trust.

The ELFT scores are compared against scores from other trusts nationally. This takes into account the number of respondents from each trust as well as the scores for all other trusts, and makes it possible to identify which scores we can confidently say are 'better' or 'worse' than the majority of other trusts.

Based on patients responses to the survey, this trust scored	How this score compares with other trusts	How these data compare with last year
8.4/10 Health and Social Care Workers	About the Same	Increase
7.3/10 Medications	About the Same	Increase
7.2/10 Talking Therapies	About the Same	Increase
8.3/10 Care Coordinator	About the Same	Same
6.4/10 Care Plan	About the Same	Increase
7.5/10 Care review	About the Same	Increase
6.9/10 Crisis Care	About the Same	Increase
5.7/10 Day to Day Living	About the Same	Decrease
6.3/10 Overall	About the Same	Decrease

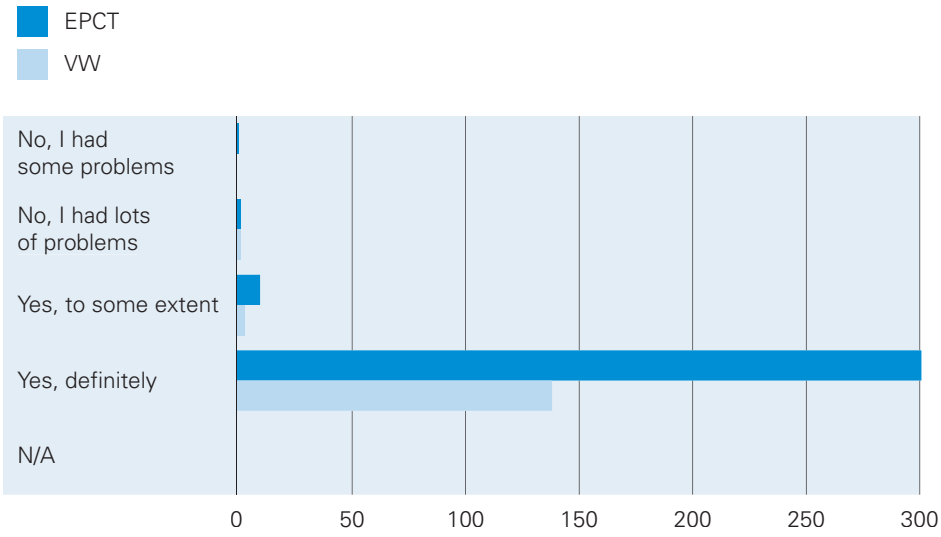
ELFT user ratings have increased in six of the nine domains. The greatest positive change relates to perceptions of Talking Therapies (from 6.5 to 7.2). This is significant, as the Trust has focused on this area over the last 12 months.

3.3.12 Community Health Newham (CHN) – Patient Reported Outcomes

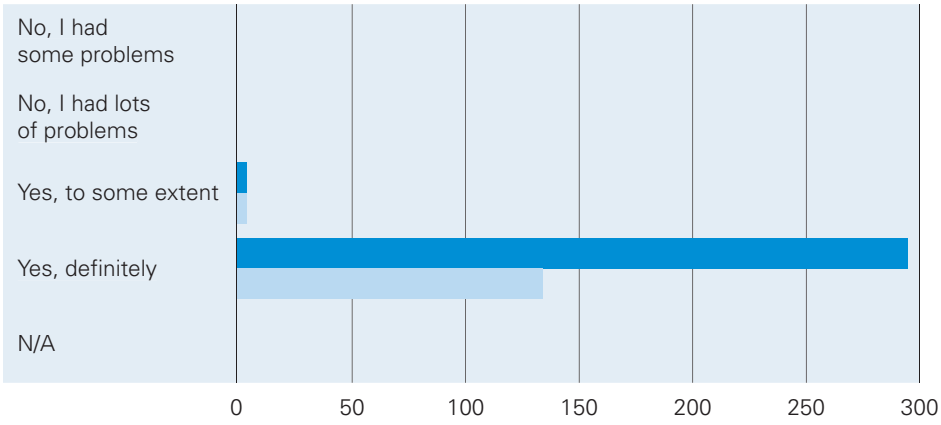
Real-time data collection methods have been implemented in a range of CHN services. Presented below are responses to five standardised questions from the Extended Primary Care Team (EPCT) and the Virtual Ward (VW).

In the first eight months of engaging in this process, 820 people have completed this process and provided these teams with valuable, and often very positive, feedback data.

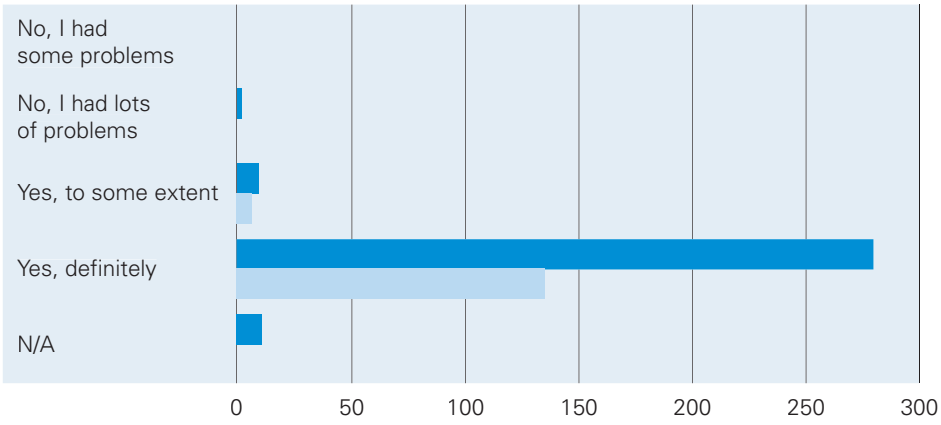
Did you have trust and confidence in the professional that saw you today



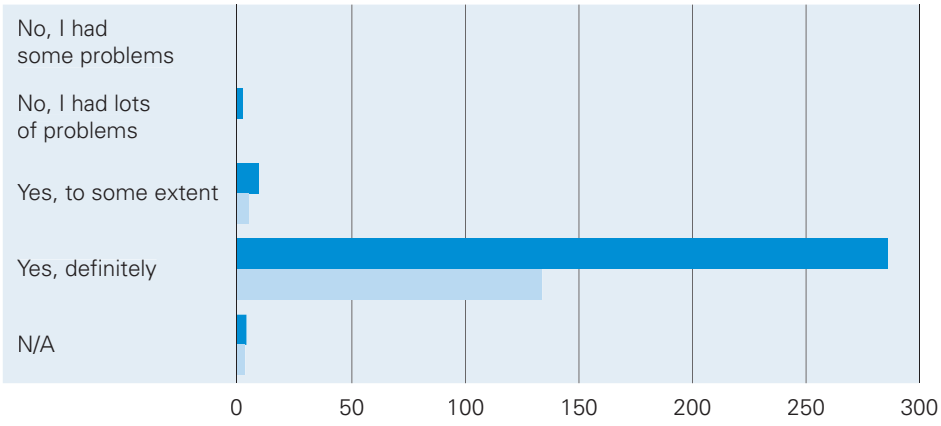
Did this person treat you with respect and dignity?



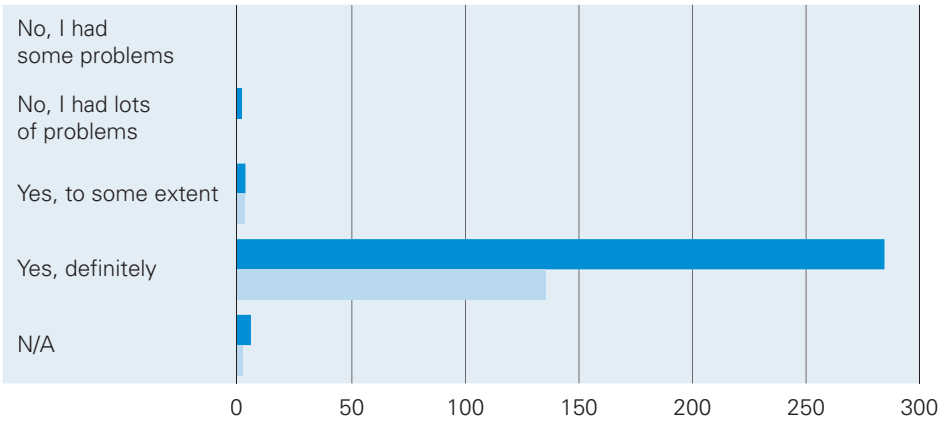
Did this person give you information you could understand about your/your child's care, treatment or condition?



When you had important questions to ask this person, did you get answers that you could understand?



Were you involved as much as you wanted to be in discussions about your/your child's care and treatment today?

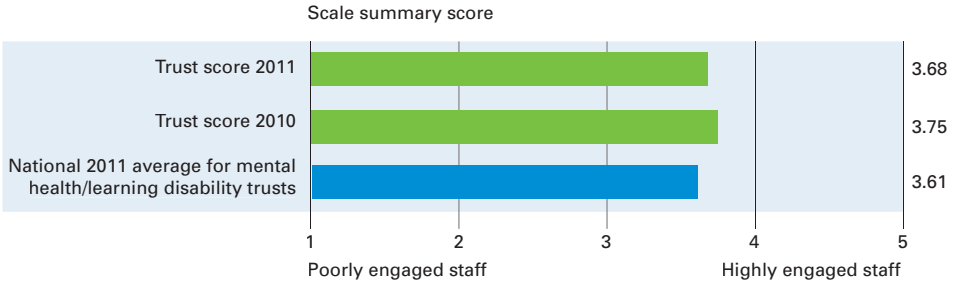


3.3.13 NHS Staff Survey 2011

Overall Indicator of Staff Engagement for East London NHS Foundation Trust

The figure below shows how East London NHS Foundation Trust compares with other mental health/learning disability trusts on an overall indicator of staff engagement. Scores range from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their trust) and 5 indicating that staff are highly engaged. The Trust's score of 3.68 was **above (better than) average** when compared with trusts of a similar type.

Overall staff engagement (the higher the better)



This overall indicator of staff engagement has been calculated using the results that make up Key Findings 31, 34 and 35. These Key Findings relate to the following aspects of staff engagement: staff members' perceived ability to contribute to improvements at work (Key Finding 31); their willingness to recommend the Trust as a place to work or receive treatment (Key Finding 34); and the extent to which they feel motivated and engaged with their work (Key Finding 35).

The table below shows how East London NHS Foundation Trust compares with other mental health/learning disability trusts on each of the key findings of staff engagement, and whether there has been a change since the 2010 survey.

	Change since 2010 survey	Ranking, compared with all mental health trusts
Overall staff engagement	No change	✔ Above (better than) average
KF31. Staff ability to contribute towards improvements at work *(the extent to which staff are able to make suggestions to improve the work of their team, have frequent opportunities to show intiative in their role, and are able to make improvements at work.)*	No change	✔ Highest (best) 20%
KF34. Staff recommendation of the trust as a place to work or receive treatment *(the extent to which staff think care of the patients/service users is the Trust's top priority, would recommend their Trust to others as a place to work, and would be happy with the standard or care provided by the Trust if a friend or relative needed treatment.)*	No change	✔ Above (better than) average
KF35. Staff motivation at work *(the extent to which they look forward to going to work, and are enthusiastic about and absorbed in their jobs.)*	No change	Average

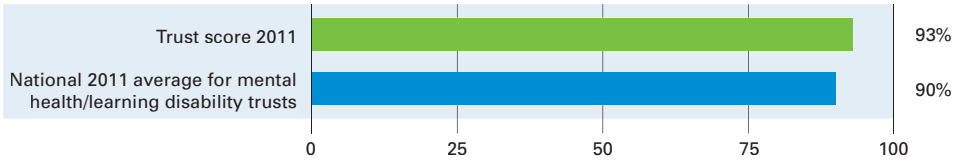
Summary of 2011 Key Findings for East London NHS Foundation Trust

Top and Bottom Ranking Scores

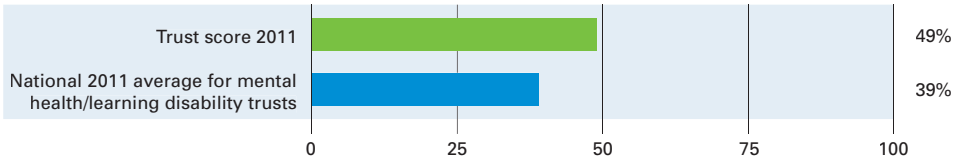
This page highlights the four Key Findings for which East London NHS Foundation Trust compares most favourably with other mental health/learning disability trusts in England.

Top four ranking scores

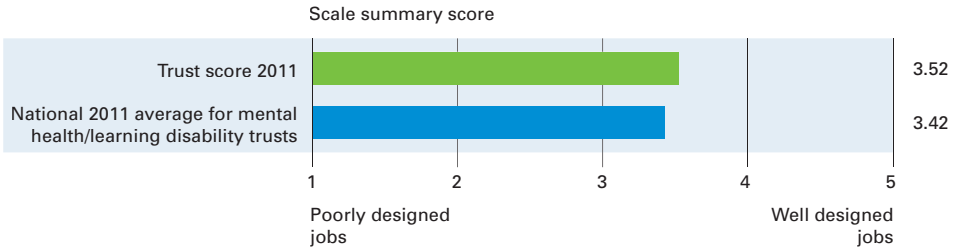
✔ KF2. Percentage of staff agreeing that their role makes a difference to patients



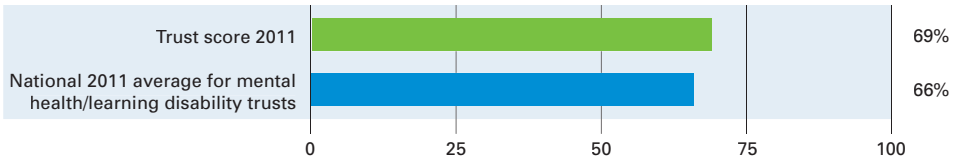
✔ KF13. Percentage of staff having well structured appraisals in last 12 months



✔ KF4. Quality of job design (clear job content, feedback and staff involvement)



✔ KF31. Percentage of staff able to contribute towards improvements at work



93%

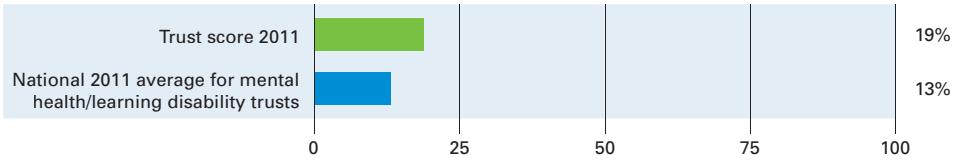
The percentage of staff who agree that their role makes a difference to patients

For each of the 38 Key Findings, the mental health/learning disability trusts in England were placed in order from 1 (the top ranking score) to 59 (the bottom ranking score). East London NHS Foundation Trust's four highest ranking scores are presented here, i.e. those for which the Trust's Key Finding score is ranked closest to 1.

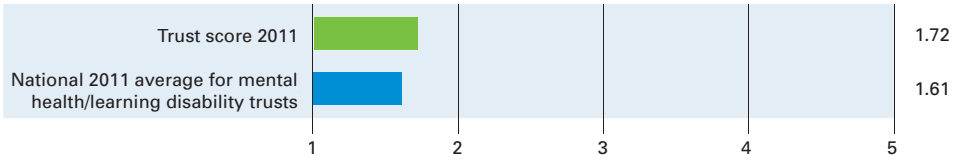
The page overleaf highlights the four Key Findings for which East London NHS Foundation Trust compares least favourably with other mental health/learning disability trusts in England. It is suggested that these areas might be seen as a starting point for local action to improve as an employer.

Bottom four ranking scores

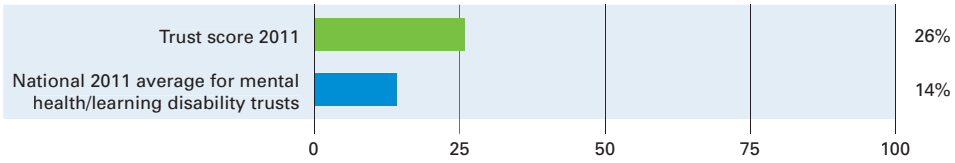
KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months



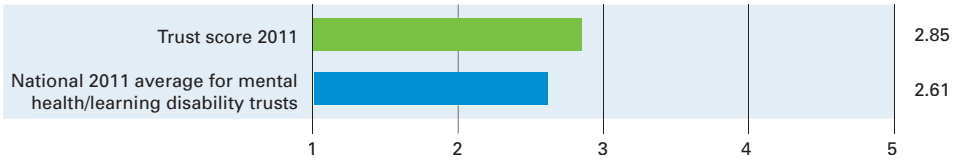
KF28. Impact of health and well-being on ability to perform work or daily activities



KF38. Percentage of staff experiencing discrimination at work in last 12 months



KF33. Staff intention to leave jobs



For each of the 38 Key Findings, the mental health/learning disability trusts in England were placed in order from 1 (the top ranking score) to 59 (the bottom ranking score). East London NHS Foundation Trust's four lowest ranking scores are presented here, i.e. those for which the Trust's Key Finding score is ranked closest to 59.

Trust Response...
In response to the 2011 Staff Survey results, the Human Resource (HR) Department has, together with the Service Directors, analysed key areas for improvement and devised a set of locally targeted action plans.

The overall engagement strategy will encompass key initiatives on improving job satisfaction, reducing staff attrition where possible, improving staff perception of equality of opportunities and reducing bullying and harassment incidents within the Trust.

These initiatives will be delivered through 'Staff Engagement Road Shows', effective training on appraisals, reducing stress workshops, equality & diversity, harassment and bullying awareness sessions, enhanced reward and recognition schemes and Senior Management involvement at grass root level.

The overall objective is to enhance staff morale and staff engagement through continuous improvement.

3.3.14 Carers Update

Trust-wide Carers Committee

Over the course of the last year the Trust has broadened the membership of the Trust-wide Carers Committee and this now includes members from the Local Authority, Voluntary Sector Groups, as well as staff from specialised areas and a greater number of carers. The aim of this broadened membership is to look at how all agencies can work together better to achieve greater partnership working around carers' issues. More work will take place in this area over the course of the coming year.

Trust-wide Carers Event

Carers and staff jointly planned a Trust-wide event that was held in September 2011. It brought together carers, staff and service users. More than 80 people attended the event that looked at carers' plans, carers' issues, and offered workshops and information for carers. This event provided a platform for local carers leads showcasing the work regarding their carers plans, as well as an opportunity for carers to link directly with the Trust Chief Executive and other senior members of staff.

Triangle of Care

Last year the Trust initiated the use of the Triangle of Care across mental health services. The Triangle of Care is a guide to best practice in acute mental health care provision that encourages a therapeutic alliance between service user, staff member and carer. The initial stage of this guide involves undertaking a baseline assessment to establish current practices around involving carers. City and Hackney, Newham and Tower Hamlets have now all completed this initial assessment process. Working groups have also been established in the localities to further build on the required elements for better collaboration and partnership with carers in the service users and carers' journey through an acute episode.

Carer Involvement in Delivering Training

ELFT carers have become more involved in delivering training to Trust staff members over the course of the last year. This includes delivering CPA and risk management training, as well as Approved Mental Health Professional (AMHP) training.

3.3.15 Patient Advice and Liaison Service (PALS)

The Trust Patient Advice and Liaison Service (PALS) provides information, advice and support to those who come into contact with the Trust.

PALS is a confidential service. It provides information and advice, helps people to deal with worries and concerns before they become serious enough for people to want to make a complaint.

- During the year 2011/12, PALS dealt with 380 enquiries. These were largely initiated by telephone that accounted for 250 enquiries (67%)
- Between 1 February 2011-31 March 2012 for the new Community Health Newham Directorate, PALS received 26 enquiries. These were largely initiated by telephone, 18 enquiries (69%) and email enquiries, 7 (27%)
- In some cases, some of the contacts were passed on to us by either another PALS service or referred by other health professionals.

PALS is based at the Trust Headquarters and has a Freephone number, tel: 0800 783 4839. (Voicemail service available out of office hours). PALS can also be contacted by e-mail: PALS@eastlondon.nhs.uk

3.3.16 Complaints

This is the first full annual complaint report since the integration of Community Health Newham in February 2011.

The information below is a summary of all formal complaints (461) received between 1 April 2011 and 31 March 2012. This is 155 more than the previous year, which represents a 51% increase. Community Health Newham complaints accounted for 74% of this increase (111 complaints).

74% (year to date figures) of complainants received a full written response either within the Trust's target timescale of 25 working days or an extended timescale agreed with the complainant. Many complainants took up the offer of a meeting with staff to ensure their concerns were clearly understood and to discuss how these might best be resolved.

No complaints were investigated by the Health Service Ombudsman during this period. Accessibility to the complaints procedure remains a priority. The Trust

has a Freephone number that is advertised on posters displayed in all service areas and a freepost address. The Trust also has a complaints leaflet which provides information on the complaints procedure, as well as details of organisations which can provide independent advice and support to service users, their relatives and carers who wish to complain. There are also laminated cards by phone boxes on the wards.

The top complaint subject for this year was staff attitude. 27% of complainants raised issues about staff attitude. Other top subjects this year were poor communication, access to services, medication and discharge and transfer arrangements.

Some examples of lessons learnt...

A complaint regarding how a service user's medication was being managed identified the need for the Trust to produce a Trust-wide operational policy and procedure on the management of Clozapine.

It also recommended the need to work with GPs to establish clear systems for the monitoring of patients prescribed antipsychotic medication. It was also agreed that the Trust should review what training is available to non-Trust staff caring for its service users in residential homes to ensure that they were aware of the need to monitor and assess side effects.

There were several complaints about occasions when phlebotomy services had had to curtail their advertised opening times at short notice. Investigations of these complaints identified that clients were not always made aware of the reasons for these changes and not told about alternative services they could access in the borough.

Managers have since done work with reception staff to improve their communication with clients, ensuring that they are given good explanations for any changes in opening times and also provide information about alternative services.

3.4 An Explanation of Which Stakeholders Have Been Involved

The priorities for 2012/13 are a continuation of the priorities developed in 2011/12. The proposed priority areas were reviewed and appraised by the Trust Governors and Service User groups over a series of meetings. These discussions form part of an ongoing dialogue about the quality of our services and are intended to make the Quality Accounts process as practicable as possible, whilst allowing for the realities of good practice.

3.5 Statement from Lead Commissioning PCT – North East London and the City PCT

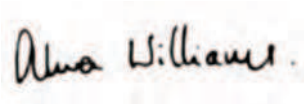
Statement from NHS North East London and the City's Chief Executive for East London Foundation Trust's Quality Account

NHS North East london and the City welcomes the opportunity to provide this statement on East london NHS Foundation Trust's Quality Account. We confirm that we have reviewed the information contained within the Account and checked this against data sources where this is available to us as part of existing contract/performance monitoring discussions and is accurate in relation to the services provided.

We have reviewed the content of the Account and confirm that this complies with the prescribed information, form and content as set out by the Department of Health. We believe that the Account represents a fair, representative and balanced overview of the quality of care at East London NHS Foundation Trust. We have discussed the development of this Quality Account with East London NHS Foundation Trust over the year and have been able to contribute our views on consultation and content.

This Account has been reviewed within NHS North East London and the City by colleagues in commissioning, quality and clinical governance, Clinical Commissioning Groups (CeGs), as well as specialists in infection control and safeguarding.

Overall we welcome the vision described within the Quality Account, agree on the priority areas and will continue to work with East London NHS Foundation Trust to continually improve the quality of services provided to patients



Alwen Williams
Chief Executive Officer
NHS North East London and the City

3.6 Statements from East London and City Local Involvement Networks

We are very pleased that the Trust recognises that its greatest challenge is to change the culture of the organisation and its workforce so that the patient is at the centre of everything that they do. We agree with the continued focus on both service user and patient satisfaction, and welcome the identification of clearer quality indicators to measure improvements. The change of Quality Account priorities last year has led to a direct improvement in service user experience and introducing clearer quality indicators should see these improvements continue.

Research
We would like to see a connection between the findings of the research, the setting of objectives and service changes/ improvements. For example:

- black and minority ethnic patients detained for involuntary psychiatric treatment experience more coercion
- female patients benefit from acute treatment in day hospitals
- patients register more anger, irritation and depression as a consequence of locked doors (at the Mile End Mental Health Unit, all doors are locked).

Improving service user satisfaction
We recognise that the Trust has developed mechanisms to enable the findings from service user feedback to lead to ongoing changes to improve the quality of care and treatment. With a move away from the secondary care setting and with less of a hospital focus how is user satisfaction in primary care going to be measured more effectively?

There are significant service user concerns regarding the (discharge to) move to more GP based services and given choice in relation to being (discharged to) referred to primary care. The principle of patient choice must be respected here.

Integrated care
We would like to see greater focus on integrated care across service providers. We know that people who have been diagnosed with a long-term physical condition often need mental health support, and people with a mental health condition often feel their physical health is ignored. If the service is to be patient centred there may need to be further input into joined-up services or better relationships between primary, secondary and social care as well as the voluntary and community sector and carers. How do we ensure that patients are able to navigate the health and social care system in order to support greater self-management? Can we promote more joined-up information and service guidance?

There is no mention of the contribution of voluntary organisations and how ELFT can improve relationships, especially when they are involved in CPAs. Would the term co-production be appropriate here?

Carers
It is important that service user satisfaction also includes the experience of carers. We would like to see the Trust promoting the uptake of personal budgets for carers and direct payments where that is there wish.

Serious incidents
There have been a significant number of serious incidents over the last two years and it would reassure service users if there was information regarding the actions taken and how those actions will lead to a reduction in the number of such incidents and an improvement in the quality of services.

More information on complaints (and the response to them) would be particularly useful. The top complaint is staff attitude – is this similar to other trusts?

Equalities
Given the diverse communities that the Trust serves we would like to have seen some analysis and/or identification of the specific quality issues that this might raise. If research has identified particular equalities issues, we would need to see that and to ask:

- What action is being taken to address those issues?
- What issues do language barriers raise on inpatient wards and how are they tackled?
- Have the mental health issues of the LGBT community been addressed?
- What is being done to measure whether there has been a reduction of anti-psychotic and other 'tranquilising' medication for older, and particularly older inpatient, service users?

Improving staff satisfaction

- More text to say what the Trust are going to do/action plans to tackle the issues highlighted in Red, (bottom Four Ranking Scores), page 42.
- National Staff Survey 2011 – ELFT are average compared to other mental health trusts, but the percentage of staff experiencing harassment, bullying or abuse from other members of staff

remains high 18% (median = 13%) and this has been an area of concern highlighted in previous years. 26% report experiencing discrimination at work in the last 12 months (median = 14%). 30% report that they will probably look for work in another Trust in the next 12 months (median = 22%). There has been little overall change in results since 2010.

Maintaining financial viability
There needs to be an acknowledgment of the high and growing demand for services predicted in the current economic climate, and the corresponding financial 'efficiencies'drive that is being initiated by the Trust and commissioners.

We think service users and the community need to be involved at the earliest possible stage of the decision-making process regarding all strategic planning and any future cuts, not when decisions have already been made. It is important to ask users where efficiencies can be made with the least impact on user outcomes.

There is concern about the impact of payment by results for mental health on service users.

There is recognition of the difficulty of working across three boroughs and the City, and that the different CCGs will have different aims and objectives.

3.7 An Explanation of any Changes Made

As a result of the feedback received from our various stakeholder groups substantial changes have been made, specifically in relation to including more service user feedback data, data that allows comparison to other Trusts and the perennial issue of trying to make the report more 'user-friendly'.

We always appreciate the careful consideration of the report and the detailed feedback provided.

3.8 Feedback

If you would like to provide feedback on the report or make suggestions for the content of future reports, please contact the Trust Secretary, Mr Mason Fitzgerald on tel: 0207 655 4000.

3.9 2011/12 Statement of Directors' Responsibilities in Respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the Quality Report.

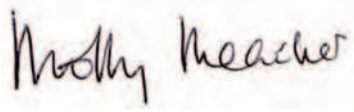
In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period; April '11 – April '12
  - Papers relating to Quality reported to the Board over the period; April '11- April '12
  - Feedback from the commissioners dated; 25 May '12
  - Feedback from governors dated; 19 January, 22 March & 10 May '12
  - Feedback from LINks dated; 28 May '12
  - The Trusts complaints which constitute part of the 'Integrated Governance Report reported Quarterly to the Trust Board; 26 January '12
  - The [latest] national patient survey; 23 January '12
  - The [latest] national staff survey; 2 March '11
  - The Head of Internal Audit's annual opinion over the Trust's control environment dated; 23 April '12
  - Care Quality Commission quality and risk profiles dated; April '12
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual)).

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

30.05.2012



Molly Meacher
Chairman

30.05.2012

Dr Robert Dolan
Chief Executive

3.10 Glossary

Term	Definition
Admission	The point at which a person begins an episode of care, e.g. arriving at an inpatient ward.
Assessment	Assessment happens when a person first comes into contact with health services. Information is collected in order to identify the person's needs and plan treatment.
Black and minority ethnic (BME)	People with a cultural heritage distinct from the majority population.
Care Co-ordinator	A care co-ordinator is the person responsible for making sure that a patient gets the care that they need. Once a patient has been assessed as needing care under the Care Programme Approach they will be told who their care co-ordinator is. The care co-ordinator is likely to be community mental health nurse, social worker or occupational therapist.
Care pathway	A pre-determined plan of care for patients with a specific condition.
Care plan	A care plan is a written plan that describes the care and support staff will give a service user. Service users should be fully involved in developing and agreeing the care plan, sign it and keep a copy. (see Care Programme Approach).
Care Programme Approach (CPA)	The Care Programme Approach is a standardised way of planning a person's care. It is a multidisciplinary (see definition) approach that includes the service user, and, where appropriate, their carer, to develop an appropriate package of care that is acceptable to health professionals, social services and the service user. The care plan and care co-ordinator are important parts of this. (see Care Plan and Care Co-ordinator).
Care Quality Commission (CQC)	The Care Quality Commission is the independent regulator of health and social care in England. They regulate care provided by the NHS, local authorities, private companies and voluntary organisations.
Case Note Audit	An audit of patient case notes conducted across the Trust based on the specific audit criteria outlined by CQC.
Child and Adolescent Mental Health Services (CAMHS)	CAMHS is a term used to refer to mental health services for children and adolescents. CAMHS are usually multidisciplinary teams including psychiatrists, psychologists, nurses, social workers and others.
CAMHS Outcome Research Consortium (CORC)	CORC aims to foster the effective and routine use of outcome measures in work with children and young people (and their families and carers) who experience mental health and emotional wellbeing difficulties.
Community care	Community Care aims to provide health and social care services in the community to enable people to live as independently as possible in their own homes or in other accommodation in the community.
Community Health Newham (CHN)	Community Health Newham provides a wide range of adult and children's community health services within the Newham area, including continuing care and respite, district nursing and physiotherapy.
Community Mental Health Team (CMHT)	A multidisciplinary team offering specialist assessment, treatment and care to people in their own homes and the community.
Continuing care	The criteria for assessing long term care eligibility.
DATIX	Datix is patient safety software for healthcare risk management, incident reporting software and adverse event reporting.
Discharge	The point at which a person formally leaves services. On discharge from hospital the multidisciplinary team and the service user will develop a care plan. (see Care plan).

Term	Definition
East London NHS Foundation Trust (ELNFT)	East London NHS Foundation Trust provides a wide range of community and inpatient mental health services to the City of London, Hackney, Newham and Tower Hamlets. Forensic Psychiatric Services are also provided to Barking & Dagenham, Havering, Redbridge and Waltham Forest. Community Health Services are provided in Newham.
General Practitioner (GP)	A family doctor who works from a local surgery to provide medical advice and treatment to patients registered on their list.
Mental health services	A range of specialist clinical and therapeutic interventions across mental health and social care provision, integrated across organisational boundaries.
Multidisciplinary	Multidisciplinary denotes an approach to care that involves more than one discipline. Typically this will mean that doctors, nurses, psychologists and occupational therapists are involved.
Named Nurse	This is a ward nurse who will have a special responsibility for a patient while they are in hospital.
National Institute of Health Research (NIHR)	The goal of the NIHR is to create a health research system in which the NHS supports outstanding individuals, working in world class facilities, conducting leading edge research focused on the needs of patients and the public.
National Institute for health and Clinical Excellence (NICE)	NICE is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health.
(NCI / NCISH)	The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCI / NCISH) is a research project that examines all incidences of suicide and homicide by people in contact with mental health services in the UK.
Patient Advice and Liaison Service (PALS)	The Patient Advice and Liaison Service offers patients information, advice, and a solution of problems or access to the complaints procedure.
Prescribing Observatory for Mental Health (POMH-UK)	POMH-UK is an independent review process which helps specialist mental health services improve prescribing practice.
Primary care	Collective term for all services which are people's first point of contact with the NHS. GPs, and other health-care professionals, such as opticians, dentists, and pharmacists provide primary care, as they are often the first point of contact for patients.
Primary Care Trust (PCT)	Statutory NHS bodies with responsibility for delivering healthcare and health improvements to their local areas. They commission or directly provide a range of community health services as part of their functions.
Quality Accounts	Quality Accounts aim to enhance accountability to the public and engage the leaders of an organisation in their quality improvement agenda.
RiO	The electronic patient record system which holds information about referrals, appointments and clinical information.
Service user	This is someone who uses health services. Other common terms are patient, service survivor and client. Different people prefer different terms.
Serious Mental Illness (SMI)	Serious mental illness includes diagnoses which typically involve psychosis (losing touch with reality or experiencing delusions) or high levels of care, and which may require hospital treatment.

Contact Us

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Your opinions are valuable to us. If you have any views about this report please contact Simon Tulloch, Head of Quality, Innovation and Patient Experience at the address above or by email simon.tulloch@eastlondon.nhs.uk You can also call 020 7655 4236/ 07930 619 493

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DIVERSITY CHAMPION

East London NHS
NHS Foundation Trust

From: Simon Tulloch – Head of Quality, Innovation and Patient Experience

To: Tower Hamlets OSC

Date: 10th August 2012

Subject: Feedback from the Quality Account process

1.0 Purpose of the Report

1.1 The purpose of this report is to provide feedback from the Quality Account process, including any lessons learnt and how the feedback has been used to improve service delivery.

2.0 Executive Summary

2.1 The Quality Account Report forms part of the Annual Report for the same period. The report reflects on the work undertaken across the Trust over the previous year and forward to the year ahead.

2.2 As part of the process to develop the report, ELFT consults with key stakeholders on a range of issues, including the priorities identified for the year ahead and the progress made against previous year's priorities.

2.3 Feedback also includes how information is presented in the report.

2.4 Presented below is a summary of the changes implemented and lessons learnt as result of the feedback the Trust received from our stakeholders.

3.0 Summary of changes

3.1 We always appreciate the careful consideration of the report and the detailed feedback provided. As a result of the feedback received from our various stakeholder groups substantial changes have occurred. These will be presented under eight main headings :

3.2 Improving Service User satisfaction

- The Trust is continuously striving to improve levels of service user satisfaction, this is evidenced by the increased use 'real-time' of feedback mechanisms throughout the Trust

- The Trust has reconfigured the internal reporting structure to include a specific 'Patient Experience Committee' which feeds directly into the Trustwide Quality Committee

- As part of the Annual Plan, the Trust is implementing an increase in flexible hour's delivery, one of the main areas of concerns that stakeholders raised.

3.3 **Research**

- The Trust is implementing a pilot project using' DIALOG' software (as developed at Queen Mary University) across the Trust. The evidence indicates that the use of 'DIALOG' increases levels of communication between Service Users and clinicians and increases levels of satisfaction with services

- Recent research from City University has focused on reducing the use of seclusion in inpatient wards by using sensory rooms. The Trust is implementing this process across a range of settings.

3.4 **Integrated Care**

- The Trust works with a wide range of partners in primary, secondary and social care, as well as voluntary and community sector providers. To ensure greater collaboration and co-ordination the Trust has dedicated staff (People Participation Leads) who work across sectors

- The Trust currently works with a wide variety of 3rd sector organisations, such as Look Ahead in the Tower Hamlets Crisis House and Mind for the delivery of IAPT services. The Trust is keen to continue and expand these relationships.

3.5 **Carers**

- The Trust has acknowledged that carers have not received the level of involvement and participation that they would have wished. As a result, a new carers strategy has been produced and will be presented to the Trust Board in October. Consequently, an action plan will be developed and implemented. Carers groups are directly involved in this process

- The Trust has recently appointed an Associate Director to lead in this area who's responsibilities will include the implementation of personal budgets for carers and direct payments.

3.6 **Serious Incidents**

- The Trust has a policy of providing feedback to all parties directly involved in serious incidents

- All interested parties, including commissioners, are invited to 'learning events' whereby the Trust develops procedures to learn from previous incidents and improve service delivery. This has led to a change in the way the Trust reviews incidents

- All learning and action plans are made available on the Trust website.

3.7 **Equalities**

- The Trust has recently undertaken a full 'Equalities Analysis' and made this available on the Trust website

- The Trust has also implemented a process of employing bi-lingual staff and staff who are representative of the community we serve to improve the issues around language and cultural barriers

- The Trust participates in the national Prescribing Observatory Audit (POMH-UK). This process includes the analysis of specific medication, such as the use of anti-psychotics and other 'tranquilising' medication with older people

- The Trust has implemented an improved data collection system to ensure that data is collected on a wide range of equality issue, not just ethnicity, as was previously the case.

3.8 **Staff satisfaction**

- A task force led by the Director of Operations has been established to look at creative ways to improve staff satisfaction. An action plan will be developed from this process which will be made available on the Trust website and implemented throughout the year ahead

- The Trust has held a number of focus groups with staff to feedback the findings from the staff survey and develop learning initiatives.

3.9 **Maintaining Financial Viability**

- The Trust received feedback from stakeholders concerning the financial efficiencies being made across the services. The Trust discusses all changes at governors meetings prior to any changes being made.

4.0 Conclusion

4.1 As a result of the feedback received from our various stakeholder groups substantial changes have occurred both in relation to the Quality Accounts Report and across service provision

4.2 We hope the information provided above indicates our intention to continually improve the quality of the services we provide.

Committee:	Date:	Classification:	Report No.	Agenda Item No. 4.4
Health Scrutiny Panel	11 September 2012	Unrestricted		

Report of:	Title:
Assistant Chief Executive (Legal Services) **Originating Officer:** Robert Driver, Strategy Policy and Performance Officer, One tower Hamlets Service, Chief Executive's Directorate	Health Scrutiny Panel Work Programme **Wards:** All

1. SUMMARY

1.1 This report outlines the Health Scrutiny Panel (HSP) work programme for 2012-13 and into 2013-14.

1.2 The report sets out the work programme for 2012-13 and indicates some work programme items for 2013-14. The work programme will be refreshed at the beginning of the 2013-14 municipal year.

1.3 The report indicates the topic, key stakeholders, methodology and timetable for each piece of work.

2. RECOMMENDATIONS

2.1 Health Scrutiny Panel is asked to comment on and agree the Health Scrutiny Work Programme.

3. COMMENTS OF THE CHIEF FINANCIAL OFFICER

3.1 This report sets out the work programme for the Health Scrutiny Panel (HSP) for municipal year 2012/2013 and into 2013-2014.

3.2 There are no specific financial implications emanating from this report, and any costs that arise from the work programme of the Health Scrutiny Panel must be contained within directorate revenue budgets. If the Council agrees further action in response to this report's recommendations then officers will be obliged to seek the appropriate financial approval before further financial commitments are made.

4. CONCURRENT REPORT OF THE ASSISTANT CHIEF EXECUTIVE (LEGAL)

4.1 The Health Scrutiny Panel is a standing sub-committee of the Overview and Scrutiny Committee. Rule 8 of the Overview and Scrutiny Procedure Rules, contained in the Council's Constitution, provides that

the Overview and Scrutiny Committee will be responsible for agreeing its work programme each year and it is reasonable for Health Scrutiny Panel to do the same.

5. ONE TOWER HAMLETS CONSIDERATIONS

5.1 Tackling inequalities and reducing poverty is central to the work of the Overview and Scrutiny Committee and Health Scrutiny Panel and this is reflected in work around access to health services and health promotion and prevention. Equal opportunities and diversity implications will be considered during each of the scrutiny reviews.

6. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

6.1 There are no specific SAGE implications arising from the recommendations in the cover report.

7. RISK MANAGEMENT IMPLICATIONS

7.1 There are no specific risk management implications arising from the recommendations in the cover report.

8. CRIME AND DISORDER REDUCTION IMPLICATIONS

8.1 There are no specific Crime and Disorder Reduction implications arising from the recommendations in the cover report.

9. EFFICIENCY STATEMENT

9.1 There are no specific efficiency implications arising from the recommendations in the cover report.

10. APPENDICES

10.1 Appendix 1: Health Scrutiny Panel Work Programme 2012-14

Local Government Act, 1972 Section 100D (As amended)
List of "Background Papers" used in the preparation of this report

Brief description of "background papers"	Name and telephone number of holder and address where open to inspection.
None	**n/a**

Health Scrutiny Panel Work Programme 2012-14			
Topic	Stakeholders	Methodology	Date
Workstream 1: Scrutiny of Barts Health NHS Trust			
Overview of governance and finances of Barts Health	Barts Health senior management team	Scrutiny of Trust Strategy at HSP	November 2012
Community Health Services and Integrated Care	NHS North East London and the City, Barts Health Community Health Services, Tower Hamlets Clinical Commissioning Group (CCG)	Community Health Services presentation at HSP Challenge session on CHS and integrated care	September 2012 Late 2013
Patient Engagement and Quality Accounts	Barts Health Engagement team, Barts Health Quality Improvement team	Agenda item at HSP	September 2012 and ongoing
Workstream 2: Accountability			
Development of Healthwatch	One Tower Hamlets Team, organisation commissioned to run Healthwatch	Agenda item at HSP	October 2013 and ongoing
Patient Involvement Structures	All providers, THINk/Healthwatch, Adults Health and Wellbeing directorate	All providers to present their patient involvement strategies HSP event/workshop	November 2012 January 2013
Workstream 3: Public Health and health promotion across the life course			
Development of Health and Wellbeing Strategy	Corporate Strategy and Equality Team, Adults Health and Wellbeing directorate	Regular updates to HSP	September 2012 and ongoing
Legacy of the Healthy Borough	Public health, all council directorates	Discussion on children and	January 2013

Programme	Health and Wellbeing Board	schools elements of Healthy Borough Programme at HSP meeting. Other elements of programme to be considered at future meetings and workshops.	Throughout 2013-14
Transition of Public Health to local authority	Public Health, Health and Wellbeing Board, Council directorates	Regular updates to HSP	To be confirmed
Understanding community assets: Strengthening our approach to health promotion	Adults Health and Wellbeing, Corporate Strategy and Equality Team, THINk/Healthwatch, Public Health	Scrutiny Review – beginning with engagement in wards by members to map 'community assets' in different areas.	September 2012 onwards