TOWER HAMLETS

Meeting of the

HEALTH SCRUTINY PANEL

Tuesday, 13 November 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 Dr. Emma Jones **Councillor M. A. Mukit MBE** **Councillor Lesley Pavitt** **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:
Dr Amjad Rahi
Mr David Burbridge

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, 13 November 2012

6.30 p.m.

1. APOLOGIES FOR ABSENCE

To receive any apologies for absence.

2. DECLARATIONS OF INTEREST

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 Chief Executive.

		PAGE NUMBER	WARD(S) AFFECTED
3.	**UNRESTRICTED MINUTES** To confirm as a correct record of the proceedings the unrestricted minutes of the ordinary meeting of Health Scrutiny Panel held on 11 September 2012.	**3 - 10**	
4.	**REPORTS FOR CONSIDERATION**		
4.1	**Health Priorities for Children Living in Tower Hamlets**	**11 - 60**	**All Wards**
4.2	**Update on Healthy Community Project**	**61 - 62**	**All Wards**

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

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DECLARATIONS OF INTERESTS - NOTE FROM THE CHIEF EXECUTIVE

This note is guidance only. Members should consult the Council's Code of Conduct for further details. Note: Only Members can decide if they have an interest therefore they must make their own decision. If in doubt as to the nature of an interest it is advisable to seek advice **prior** to attending at a meeting.

Declaration of interests for Members

Where Members have a personal interest in any business of the authority as described in paragraph 4 of the Council's Code of Conduct (contained in part 5 of the Council's Constitution) then s/he must disclose this personal interest as in accordance with paragraph 5 of the Code. Members must disclose the existence and nature of the interest at the start of the meeting and certainly no later than the commencement of the item or where the interest becomes apparent.

You have a **personal interest** in any business of your authority where it relates to or is likely to affect:

(a) An interest that you must **register**

(b) An interest that is not on the register, but where the well-being or financial position of you, members of your family, or people with whom you have a close association, is likely to be affected by the business of your authority more than it would affect the majority of inhabitants of the ward affected by the decision.

Where a personal interest is declared a Member may stay and take part in the debate and decision on that item.

What constitutes a prejudicial interest? - Please refer to paragraph 6 of the adopted Code of Conduct.

Your personal interest will also be a prejudicial interest in a matter if (a), (b) and either (c) or (d) below apply:-

(a) A member of the public, who knows the relevant facts, would reasonably think that your personal interests are so significant that it is likely to prejudice your judgment of the public interests; AND
(b) The matter does not fall within one of the exempt categories of decision listed in paragraph 6.2 of the Code; AND EITHER
(c) The matter affects your financial position or the financial interest of a body with which you are associated; or
(d) The matter relates to the determination of a licensing or regulatory application

The key points to remember if you have a prejudicial interest in a matter being discussed at a meeting:-

i. You must declare that you have a prejudicial interest, and the nature of that interest, as soon as that interest becomes apparent to you; and

ii. You must leave the room for the duration of consideration and decision on the item and not seek to influence the debate or decision unless (iv) below applies; and

iii. You must not seek to improperly influence a decision in which you have a prejudicial interest.

iv. If Members of the public are allowed to speak or make representations at the meeting, give evidence or answer questions about the matter, by statutory right or otherwise (e.g. planning or licensing committees), you can declare your prejudicial interest but make representations. However, you must immediately leave the room once you have finished your representations and answered questions (if any). You cannot remain in the meeting or in the public gallery during the debate or decision on the matter.

LONDON BOROUGH OF TOWER HAMLETS

MINUTES OF THE HEALTH SCRUTINY PANEL

HELD AT 6.30 P.M. ON TUESDAY, 11 SEPTEMBER 2012

ROOM C1, FIRST FLOOR, TOWN HALL, MULBERRY PLACE, 5 CLOVE CRESCENT, LONDON, E14 2BG

Members Present:

Councillor Rachael Saunders (Chair)

Councillor Lesley Pavitt
Councillor Dr. Emma Jones
Councillor Mohammed Abdul Mukit MBE

Other Councillors Present:
Councillor Ann Jackson - Chair, Overview & Scrutiny Committee

Co-opted Members Present:
David Burbridge

Guests Present:

Dianne Barham	–	(THINk Director)
Simon Tulloch	–	(Head of Quality, Innovation & Patient Experience, East London Trust Foundation)
Dr Nancy Fontaine	–	(Barts NHS Trust)
Janet Lewis	–	(Operations Director - Ambulatory Care, Barts NHS Trust)

Officers Present:

Robert Driver	–	(Strategy, Policy and Performance Officer, One Tower Hamlets, Chief Executives)
Sarah Barr	–	(Senior Strategy Policy and Performance Officer, One Tower Hamlets, Chief Executive's)
Deborah Cohen	–	(Service Head, Commissioning and Strategy, Adults Health and Wellbeing)
Louise Russell	–	(Service Head Corporate Strategy and Equalities, Chief Executive's)
Alan Ingram	–	(Democratic Services)

COUNCILLOR RACHAEL SAUNDERS (CHAIR) IN THE CHAIR

1. APOLOGIES FOR ABSENCE

Apologies for absence were submitted from Councillor Denise Jones (Vice-Chair) and Dr Amjad Rahi (Co-opted Member).

2. DECLARATIONS OF DISCLOSABLE PECUNIARY INTERESTS

No declarations of Disclosable Pecuniary Interest were made.

3. UNRESTRICTED MINUTES

RESOLVED that the unrestricted minutes of the meeting of the Panel held on 26 June 2012 be agreed as a correct record of the proceedings.

4. REPORTS FOR CONSIDERATION

4.1 Tower Hamlets Health and Wellbeing Strategy

Ms Louise Russell, Service Head Corporate Strategy and Equality, introduced the report setting out the draft Outline Health and Wellbeing Strategy for Tower Hamlets, as required by the Health and Social Care Act 2012 and initiated by the Borough Shadow Health and Wellbeing Board (SHWB).

The draft Outline Strategy was the result of a review of evidence about local need and local views, consultation with stakeholders and residents. Ms Russell indicated that the document would be submitted to the SHWB in the following week and placed emphasis on giving local people a voice. Other comments regarding long-term health conditions and cancer had also been taken on board, with issues around disability being pushed up throughout the Strategy and the Equality Analysis further feeding in.

The next steps would see proposed specific actions feeding into the delivery stage and workshops involving the community were being arranged around the various themes of the document, which would then be put forward to the SHWB in December 2012.

In response to questions from the Panel, the following information was provided:

- Holding GP commissioning agencies to account was mainly the role of provider boards, rather than the SHWB, which focused on key strategies.
- The SHWB had already identified the prevalence of diabetes in the Borough as a priority for action, in the Healthy Lives and long-term conditions theme, and a delivery plan would be developed specific to Tower Hamlets' needs.
- The needs of women in some sectors of the BME community who could be isolated and without access to local facilities or the internet were being addressed as part of the CCG consultation and public engagement strategy. Creative use of new technology, including

community TV channels and interactive packages were being considered in this respect.

Ms Russell undertook to provide details of the numbers of Health Visitors in the Borough in response to queries from Councillor Lesley Pavitt (to be made available to all Panel Members).

Members also commented that:

- The role of carers was crucial to the welfare of individuals and their importance needed to be recognised.
- People should be enabled to take responsibility for their own health care and choices for the management of health conditions, with expert patient involvement. This should be considered in conjunction with the draft Strategy's key enabler relating to engagement and co-production.
- Engagement with the community needed to be undertaken at a grassroots level, so that a true assessment of local need could be made.

Action by: Louise Russell

RESOLVED

That the comments of the Panel be reported to the SHWB as part of the consultation process on the draft Strategy.

4.2 Community Health Services - Verbal Update

Ms Janet Lewis, Operations Director – Ambulatory Care, Barts NHS Trust, made a verbal and slide show presentation updating progress on creating the new organisation, Barts Health.

Ms Lewis outlined the Barts vision aimed at changing lives of service users in:

- Offering acute, specialist and community services that were tailored to meet the needs of local communities.
- Being recognised locally, nationally and internationally for outstanding clinical services, research and education.

She set out the organisational values to be adopted in achieving the over-arching aims in being caring and compassionate; actively listening and responding; improving and innovating for patient safety; achieving ambitious results and valuing all staff and their contributions to patient care.

Ms Lewis explained the work of the Ambulatory Care Clinical Academic Group (CAG), which was one of eight CAGs in Barts Health and which was looking at how to support people living at home with chronic diseases. It was hoped that the CAGs would steer the way to excellent local health services for East London. Work was also underway on integrating community health services, involving GPs, local authority, mental health and acute partners. The intention was that the Acute Trust would work more along the lines of community services, integrate adult community nursing into networks and maintain local

services for Tower Hamlets patients alongside the tertiary services in the Royal London and Barts hospitals (e.g. stroke).

Aspirations for service improvements had been expressed by staff and work was in progress on the use of new technology to ensure all staff could access systems from any site. Staff and patients were being engaged in the creation of the Barts vision and values and it would be ensured that each CAG and service group was led by a clinical director who worked in the service and would be involved in setting the strategic direction.

Barts Health was also committed to a range of patient engagement measures in setting up patients' panels and patients sitting on the CAG boards. Mile End beds would be managed under the care of the elderly team to ensure patients transferred seamlessly within the service. Work was being undertaken with the clinical teams to ensure better communication of care plans and IT systems would be structured to ensure that sharing of information was possible. The number of services that could be delivered out of hospital would be maximised across the CAGs.

Ms Lewis concluded by setting out priorities for community health services, which included:

- Continued resolution of IT issues and greater use of technology, particularly mobile devices.
- Reduction in the number of pressure sores in the community.
- Working more closely with primary care, particularly around adult community nursing.
- Improving the healthy child pathway, ensuring better services for children from age 0 to 19.
- Working with GP commissioners to develop priorities for the coming years.

Following questions put by Panel members, the following information was provided:

- The stroke service currently provided was the 4th best in the country in getting people home after acute treatment. Good tertiary services enabled early discharge so that patients could return to their own homes.
- There was not a high degree of acute kidney disease in the Borough but the Trust performed on a regional basis in this connection, which meant that local residents would benefit.
- The Trust was trying to empower clinicians to work on research as part of their overall service delivery and attempts were being made to move to a culture which encouraged that. All patients would be offered the opportunity to become involved in the research function.
- Diabetes treatment was a priority for the CCG and a group of clinicians had been in discussion with Diabetes UK to take this forward.
- It was accepted that the organisation had not previously listened to patients as much as it should and it was acknowledged that staff needed to improve on that.

- Numbers of staff had been aligned in different services, rather than being lost but staffing levels had to be managed and quality maintained while responding to Government imposition of financial constraints.
- Recruitment for a patient representative on the CAG was currently in progress and there was strong commitment to patient engagement.
- There was a high level of advocacy and interpretation provision in Tower Hamlets and no cutbacks were anticipated.

The Chair thanked Ms Lewis for her presentation.

RESOLVED

That the verbal report be noted

4.3 East London Foundation Trust Quality Accounts

Mr Simon Tulloch, Head of Quality, Innovation and Patient Experience at the East London Foundation Trust, made a detailed presentation on the report relating to Quality Accounts for the Trust for 2012, as circulated with the meeting agenda.

In response to queries from Panel members, Mr Tulloch replied that:

- He would provide the Panel with details of diabetes patients who had been on ward for four weeks, with reasons as to why there had been admissions for such a period.
- He would also provide the Panel with details of prescriptions of antipsychotic drugs for patients with dementia, as provided to the Royal College of Psychiatrists.
- Information on service satisfaction obtained from patients on-ward, even if acutely ill, was still accurate and there was a strong correlation of early-collected information with how people still felt at the time of discharge.
- Patient engagement methods included dedicated advocates – People Participation Leads – who attended monthly stakeholder groups. In addition, attempts were made to involve local people as Trust members.

The Chair thanked Mr Tulloch for his presentation.

Also with regard to Quality Accounts, Dr Nancy Fontaine, Director of Nursing at Whipps Cross Hospital, stated that she had spent two years in improving the position regarding care at that hospital and would be shortly moving to Barts Health. Patients had been involved in designing Barts Health from its inception and there was an agreement for the need to provide a safe and caring environment. Values and behaviour requirements had been designed by staff and patients together and were embedded by holding joint events with stakeholders, which would allow Barts Health to be held to account. Barts would build upon the Whipps Cross model for women's services and there

had been work over 18 months with faith leaders in mosques, Somali and Muslim women's groups and the Chinese community to achieve real engagement. This had resulted in women being attracted back to the Whipps Cross maternity unit.

Dr Fontaine commented that similar improvements had been achieved for stroke patients and their carers. An orthopaedic multi-lingual patient group had been established, made up from people with hip replacements, etc, who were given access to details of all serious incidents concerning care. The Trust Board were presented monthly with an instance of where patient care was perceived to have failed to reach required standards and clinicians had to report back on how this had been addressed and procedures changed accordingly.

In response to queries raised by panel members, Dr Fontaine stated that:

- There was recognition of where services had been failing and the advocacy system at Newham was being tailored towards use at Barts Health. A project plan with milestones for achievements was under preparation and she undertook to make this available for panel members after the September Trust Board meeting.
- There was an annual in-patient survey asking how long people had waited for operations, etc and it was also proposed to work with GPs on the Patient Experience.

The Chair made the point that Councillors should be invited to attend visits to mosques and other organisations to help provide local feedback. She then thanked Dr Fontaine for her attendance.

RESOLVED

That the report be noted.

4.4 Health Scrutiny Panel Work Programme

Mr Robert Driver, Strategy Policy & Performance Officer, introduced the report outlining the Health Scrutiny Panel work programme for 2012-13 and into 2013-14.

The Chair commented that, following the earlier discussions in the meeting, it was clear that there was a need to address issues around diabetes in the Borough.

Referring to Workstream 1 of the work programme, Mr Driver explained that this had been devised through a number of inputs, including information from working groups. It would be desirable to undertake scrutiny of arrangements for Barts Health, both pre and post-merger. In addition, it was necessary to drill down on other issues raised earlier in the meeting.

He added that a key issue in Workstream 2 would be the development of Healthwatch. The patient involvement theme would include a Patient Experience strategy report, to be submitted to the next meeting. It was also intended that the Legacy of the Healthy Borough Programme would be the basis of a report to the next meeting.

During further discussion of the work programme, Panel members expressed the view that it would be necessary to address the overview and scrutiny role at Barts Health, involving the JOSC where overlapping issues were concerned, and also to monitor the Patient Engagement experience at Barts. Mr R. Burbridge pointed out that there was an upcoming public health conference aimed at bringing together stakeholders on the matter of diabetes. The Chair stated that the Panel should be represented at the conference.

Mr Driver referred to the proposed work programme item concerning the understanding of public assets and tabled an information paper setting out a suggested way forward, together with an I&DEA document in this connection. Ms Sarah Barr, Senior Strategy & Performance Officer, added that this would sit well with the Healthy Borough project and the report asked Panel members to think about assets and participate in a community-led asset mapping exercise. She added that Mr Driver would email Members on progressing this matter.

Action by: Robert Driver

RESOLVED

That the work programme be endorsed as set out in the report provided, subject to the additional comments made.

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

(a) Shadow Health & Wellbeing Board – 20 September 2012-09-20

The Chair stated that she would be unable to attend the above meeting but would pass the agenda papers to Councillor Ann Jackson.

(b) Adults Health & Wellbeing Commissioning Plan

The Chair referred to the two reports in connection with the above that had been considered by Cabinet on 5 September and asked that Ms Deborah Cohen, Service Head Commissioning & Strategy, circulate a catch-up paper to Panel members. Ms Cohen added that she would be happy to hold a members' seminar on the subject.

Action by: Deborah Cohen

The meeting ended at 9.15 p.m.

Chair, Councillor Rachael Saunders
Health Scrutiny Panel

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Committee: Health Scrutiny Panel	**Date:** 13 November 2012	**Classification:** Unrestricted	**Report No.**	**Agenda Item No.** 1
Report of: Assistant Chief Executive **Originating Officer:** Robert Driver, Strategy, Policy and Performance Officer		**Title:** Health Priorities for Children living in Tower Hamlets **Wards:** All		

1. SUMMARY

1.1 This agenda item will provide the Health Scrutiny Panel with updates from Tower Hamlets Clinical Commissioning Group, Barts Health NHS Trust, Public Health and the Children and Families Partnership on their respective health priorities for children living in Tower Hamlets and how the different organisations work together to achieve their health objectives for this group.

1.2 This report contains two key documents which provide a background to the Partnership approach taken towards improving health outcomes for children living in Tower Hamlets.

1.3 Appendix 1 contains the Children and Families Plan 2012-15. The Children and Families Plan 2012-15 has been developed by the Children and Families Partnership to provide a framework for partnership working to continue to improve outcomes for children and families in Tower Hamlets. This was agreed by Cabinet in October 2012.

1.4 Appendix 2 contains a report from Public Health highlighting health priorities and objectives for children living in Tower Hamlets.

2. RECOMMENDATIONS

2.1 The Health Scrutiny Panel is asked to consider and comment on the information contained in the Children and Families Plan 2012-15.

2.2 The Health Scrutiny Panel is asked to consider and comment on how the Tower Hamlets Clinical Commissioning Group, Barts Health NHS Trust, Public Health and the Children and Families Partnership work together to achieve their respective health objectives for children living in Tower Hamlets.

3. COMMENTS OF THE CHIEF FINANCIAL OFFICER

3.1 This report describes the health priorities for Children in Tower Hamlets from the following groups: Tower Hamlets Clinical Commissioning Group; Barts Health NHS Trust; and the Public Health and the Children and Families Partnership.

3.2 There are no specific financial implications emanating from this report. However, 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 which exercises health scrutiny functions provided for in section 244 of the National Health Service Act 2006 and the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002. Primarily these functions cover the review and scrutiny of matters relating to the planning, provision and operation of health services in Tower Hamlets. The Children and Families Plan deals with health outcomes and, to this extent, it is appropriate for the Panel to consider and comment on the Plan.

5. ONE TOWER HAMLETS CONSIDERATIONS

5.1 The Children and Families Plan 2012-15 is targeted at meeting the need of our most vulnerable children and families. The focus is on addressing gaps in support for groups such as young carers, teenage parents and their children, children in need or with a child protection plan, underachieving children at school and young people being bullied. The plan, with a focus on vulnerable groups, therefore addresses issues of inequality and promotes community cohesion in the borough.

6. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

6.1 There are no Sustainable Action for a Greener Environment implications.

7. RISK MANAGEMENT IMPLICATIONS

7.1 There are no Risk Management implications

8. CRIME AND DISORDER REDUCTION IMPLICATIONS

8.1 There are no Crime and Disorder Reduction implications

9. EFFICIENCY STATEMENT

9.1 The Children and Families Plan 2012-15 and the Public Health report support this theme and include the provision for more effective and joined up services in their plans, that allow the Council to work efficiently and effectively together with its health partners in delivering value for money services.

10. APPENDICES

Appendix 1 - Children and Families Plan 2012-15

Appendix 2 – Public Health Briefing on Health Priorities

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**

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APPENDIX 1

Mayor Lutfur Rahman

I am delighted to welcome the new Children and Families Plan and endorse the partnerships approach to improving outcomes for children, young people and their families in the borough.

Children, Schools and Family services in Tower Hamlets are a huge success story. The continued progression in GCSE results over the last ten years is testament to this, as is the recognition for excellence we have received from Ofsted for services to our most vulnerable children and families.

It is now imperative on us to build on our successes and ensure that services to children and young people continue to meet their needs and strive for excellence.

The Plan continues to put children, young people and families at the heart of future policy. By empowering our young residents and valuing them as citizens, we can develop a framework that will ensure our young people and families have a future marked by safety, security, health and achievement.

Cllr Oliur Rahman

We are currently facing a period of austerity that will be extremely tough for public services. We need to find new and creative methods of delivery to ensure that as a partnership will still continue to deliver children's services of the highest quality.

That means looking at how to make the best use of the resources that we have, and it means close collaborative work with our partner agencies and the voluntary sector.

Our work needs to be more targeted and focused on the most vulnerable young people in the borough, this Plan sets out a blueprint for early intervention to tackle the key issues across the life course, from maternal mental health to children in care, substance misuse amongst young people and the underachievement of some pupil groups.

We have a huge pool of talented staff working towards improving outcomes for children and young people in the borough. As a partnership, we will continue to meet the high standards that young people and their families expect and deserve.

Children and Families Plan 2012-15

Introduction

The Children and Families Plan 2012-15 has been developed by the Children and Families Partnership to provide us with a framework for how we will work together to continue to improve outcomes for children and families in Tower Hamlets. The plan has also been scrutinised and developed in conjunction with agencies represented on the borough's Local Safeguarding Children Board (LSCB).

The Children and Families Partnership and the LSCB comprise a range of local organisations and other representatives, including:

- Barts HealthNHS Trust (Acute Division and Community Health Services Division)
- East London NHS Foundation Trust (Child and Adolescent Mental Health Services and adult mental health)
- GPs
- London Borough of Tower Hamlets (Children, Schools and Families Directorate; Adults Health and Wellbeing Directorate; domestic violence and drug and alcohol teams in Communities,Localities and Culture Directorate; Housing Options Service and Strategy, Innovation and Sustainability team in Development and Renewal Directorate)
- London Probation
- Metropolitan Police
- NHS East London and the City (Public Health and Commissioning Support Service)
- Parents representatives
- Registered Housing Providers
- Schools
- Third sector
- Tower Hamlets College.

Context

There are an estimated 65,769 children and young people aged 0 to 19 in Tower Hamlets in 2012, representing 26.1% of the total population.[1] The young population in the borough is projected to rise over the course of this plan, with the number of children between 0 and 19 years of age expected to grow by 7% in the next five years to 2015, with further growth projected by 2025.

[1] GLA population projections – 2011 round

In 2012, 89% of the school population were classified as belonging to an ethnic group other than White British compared to 26% in England overall. Furthermore, English is an additional language for74% of pupils and English and Bengali are the most commonly recorded spoken community languages in the area. Of those children and young people under 19 years, 55% come from a Bangladeshi background.

The latest child poverty rates for 2009 show that 29,680 children in Tower Hamlets were living in poverty which represents 53 per cent of all children.[2]Our high levels of child poverty are also evident in the high proportion of children entitled to Free School Meals (FSM) in 2011 at 57 per cent.

Children and young people with additional needs include:

- 1,582 children and young people registered with the Council as having a disability (February 2012)
- 1,392 children and young people with a statement of special educational needs, and 6,909 registered as School Action or School Action Plus (of the total 39,596 children on the School Census for Autumn 2011)
- 296 Looked After Children (LAC), 274 children with child protection plans and 1,155 child in need cases (31 March 2012).

There are 98 schools in the borough. Of these, there are 70 primary schools (including one academy), 15 secondary schools (including one academy), the pupil referral unit and six special and short stay schools. Early years' service provision is delivered predominantly through the private and voluntary sector in over 53 settings and there are six local authority maintained nurseries. In each of the borough's four paired Local Area Partnerships there are three main Children's Centres, which act as hubs for their local community.

Achievements and challenges for the Partnership

This plan follows on from the completion of two previous Children and Young People's Plans (CYPPs), the first from 2006-2009, and the second from 2009-2012. These previous planswere organised around the Every Child Matters priorities for children to be safe, healthy, enjoy and achieve, make a positive contribution and achieve economic wellbeing.

During the course of theCYPP 2009-2012, we achieved some impressive outcomes for children and young people in the borough. Young people's

[2] HMRC Child Poverty Statistics 2009. Child poverty data is based on the proportion of children living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income. This data is released each September, for data for two years previously

educational attainment continued to improve, particularly at GCSE where we saw a 20 percentage point improvement in attainment during the life of the plan. There was a sustained reduction in the proportion of young people not in education, employment or training (NEET). Young people were encouraged to stay in education through the introduction of the Tower Hamlets Mayor's Education Award, the first of its kind nationally following the end of the Education Maintenance Allowance in England in 2011.In addition, health outcomes improved, with increasing immunisation rates and a reducing under 18 conception rate.

Despite our successes, we know there is more to do and our new plan aims to both build on where we have been successful in the past and address the areas where we need to do better. We know more needs to be done to decrease the prevalence of childhood obesity in reception (5 year olds) and year 6 (10 year olds). We need to improve outcomes in the early years through improvements in attainment at the Early Years Foundation Stage (EYFS)[3]. We also need to see success at GCSE translated into improving outcomes at post 16, where currently results still lag behind the national average.[4]

Another key priority during the course of the last CYPP was to reduce child poverty in the borough. Although we do not have data to show us how child poverty rates changed between 2009 and 2012, as it is not available nationally, data from 2006 shows continued improvement in tackling child poverty, with a reduction from 60.3% to 53% of children living in poverty in 2009.[5] This is the best improvement rate in London, and also compares favourably to the national rate of improvement. Tackling child poverty continues to be a key priority for our new plan. We expect this to be more challenging given the national economic outlook and as a result of welfare reform which is likely to result in reductions in incomes for many families in the borough.

Methodology for developing the new plan

In developing a brand new plan from 2012, we wanted to ensure that it helped the Partnership to work as efficiently as possible in the context of decreasing funding for all agencies and a challenging economic climate for children and

[3]The EYFS is a statutory framework that sets the standards for the learning, development and care of children from birth to five

[4] For detailed information on our achievements and challenges for 2009-12, see the Children and Young People's Plan 2009-12: End of Plan Review, at www.childrenandfamiliestrust.co.uk

[5]Child poverty data is based on the proportion of children living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income. This data is released each September, for data for two years previously

families. Our initial needs analysis for the plan focused on the needs of vulnerable children, identified using the Tower Hamlets Family Wellbeing Model. A list of the vulnerable groups we considered is in appendix 2.

The needs and services available for these groups were analysed using a PESTLE analysis. This tool provided a framework for considering the various factors (**P**olitical, **E**conomic, **S**ocial, **T**echnological, **L**egal and **E**nvironmental) impacting on the needs and available service provision for each group. The analysis for each group was completed using Joint Strategic Needs Assessment (JSNA) fact sheets, national research, emerging government policy and local research and information. The analysis was considered by a range of stakeholders from across the Partnership.

The tool helped us to respond to a changing national policy context, including:

- *Education reform,* with the increase in academies and the introduction of free schools and changes to careers, advice and guidance provision
- *Special Educational Needs reform*, including the personalisation agenda and changes to assessment frameworks
- *Welfare reform*, with the significant changes to how welfare benefits are calculated and how they are paid to families living on low incomes
- *Health reform*with responsibility for Public Health moving from the NHS to local authorities, new statutory Health and Wellbeing Boards and the introduction of GP clinical commissioning groups
- The increasing national focus on early intervention and early help, following reviews by Frank Field, Graham Allen, Eileen Munro and Professor Marmot.

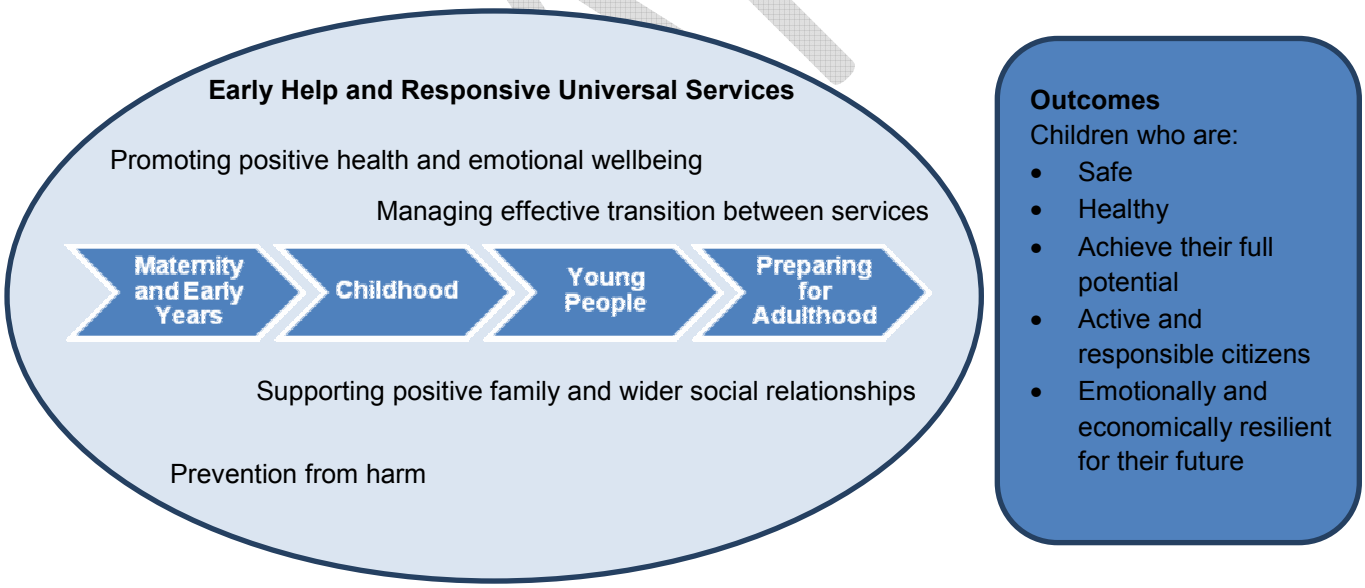
Using this analysis, the Partnership confirmed its vision for children and young people, and identified five themes which the evidence suggested was relevant to all vulnerable groups. Further to this, we agreed to take a life course approach for our plan, in response to the evidence that the aspirations and outcomes for children and families are different at different stages in a child's life.

Our vision

Our vision is for all children and young people to be safe and healthy, achieve their full potential and be active and responsible citizens and emotionally and economically resilient for their future.

Our plan uses a life course approach to achieve this, helping us to work effectively with families at key stages in their child's development. For each life stage, we have identified the following themes to guide how we work as a Partnership:

- **Early help and responsive universal services**:Working effectively together to identify needs early, at all ages, and put coordinated action plans in place to improve outcomes is an overarching principle of the new plan.
- **Prevention from harm**: Safeguarding all children across all partner agencies remains a top priority.
- **Supporting positive family and wider social relationships**: Improving pathways into parental engagement in order to support all parents/carers to achieve positive parenting becomes a key priority.
- **Promoting positive health and wellbeing**: Keeping children healthy and responding effectively to health needs remains a priority, with a focus on emotional wellbeing and mental health.
- **Managing effective transition between services**: We will focus on working in a coordinated way across services to support children and young people as they begin in a new school or enter further education or employment, and when they move from a specialist service into a targeted or universal service, or from children's services into adult services.



The following sections set out the detail of the challenges for each life stage, the outcomes we're aiming for and how we plan to work together to achieve them.

For further information see our website www.childrenandfamiliestrust.co.uk

1. Maternity and Early Years (pre-birth to 5 year olds)

4,565 children were born to Tower Hamlets residents in 2010. The birth rate in Tower Hamlets is 66.2 live births per 1,000 females aged 15 to 44. The birth rate in Tower Hamlets is lower than the average in London (72.1), but about the same as England (65.5). In the 5 years between 2009/10 and 2014/15 the rate is projected to increase by 5.3% (235 additional births); in the subsequent 5 years between 2014/15 to 2019/20 the rate is projected to increase by 2.2% (100 additional births).In 2010/11, of the caseloadfor midwifery-led antenatal and postnatal care for vulnerable women and their families,56% had severe mental illness, and 17% suffered domestic abuse[6].Of the 3,798 births in 2009 with ethnicity recorded, 46.5% were born to Bangladeshi women, 21.7% to white women and 6.1% to Black African women. The average birth rate per 1,000 for Bangladeshi women aged 15 to 44 is 1.52 times the average for all women. Bangladeshi mothers also tend to be younger than non-Bangladeshi mothers[7].

There is a high prevalence of gestational diabetes (9%) in the borough[8] and a 2005/06 audit found that 81.7% of women with gestational diabetes were Bangladeshi[9] . Diabetes in pregnancy is associated with a number of poor foetal and maternal health outcomes and early detection and management, together with on-going lifestyle modification will offer benefits to both mother and baby before, during and after pregnancy. A high proportion of the babies born in the borough have a low birth weight which also increases the risk of type 2 diabetes, as well as cardiovascular disease in later life. However, despite a low birth rate levels of infant mortality in the borough are not significantly different to the rest of London and England.

The under-fives are the largest age group within Tower Hamlets' 0 to 19 population and the group is expected to grow at a greater rate than other age groups. The 0 to 5 year old population in Tower Hamlets makes up 9.6% of the total population in the borough and 36.8% of the 0 to 19 population. Greater London Authority (GLA) population projections show a population of 24,307 under -fives in 2012. The 0-5 population is projected to rise to 26,251 in 2015 (representing an increase of 7.4%). Of children aged 0-4, 23.7% are white and 55.6% Bangladeshi[10].

[6] Barts and The London Hospital Midwifery Gateway team, annual report 2010/11

[7] Mayhew dataset (Network Knowledge Management (NKM) population), is based on administrative databases which include a detailed analysis of the administrative data sets at March 2011

[8] Diabetes & Pregnancy, Pre-existing Diabetes at The Royal London Hospital (Pregnancy Outcomes for 2010). Nickey Tomkins. 2011

[9] Audit of Postnatal Diabetes, Royal London Hospital, Sooi-Mai Jones, 2008

[10] 2011 Round of demographic changes 2011

Vitamin D deficiency and insufficiency is a substantial issue for the population of Tower Hamlets. The estimated prevalence of vitamin D deficiency and insufficiency in pregnant women at booking is 74% and 11% respectively [11]and in children under 5 tested in primary care this was 35% and 52% respectively[12].

As is the case for all age groups, a high proportion of under-fives and their families live in poverty, with an estimated[13] 50% of this age group eligible for Free School Meals.

There were 9,277 children in nursery years 1 and 2, reception and primary year 1 in 2011. Of these, 186 had a statement of special educational needs (2%). In addition, there were 800 under-fives (9%) registered as School Action or School Action Plus.

At 1 February 2012, 368 children under-fives were registered with the Council as having a disability – this is 2% of all under-fives according to 2011 population estimates.

At 31 March 2012, there were 67 Looked After Childrenaged under five (23% of all LAC cases), 274 children with child protection plans (44% of all CP cases) and 350 child in need cases (30% of all CiN cases).

We have seen steady improvement in young children's achievement at the Early Years Foundation Stage, improving by 10 percentage points between 2009 and 2012. However, we have not succeeded in closing the gap with the national average and remain nine percentage points below the national figure.

The challenges of securing the best possible outcomes for babies and young children in Tower Hamlets need to be understood in the context of the challenges for parents and carers in the borough. High levels of overcrowding and inadequate housing provision can mean additional challenges for families in ensuring the best possible start in life for their children. Furthermore, the complex needs of many parents of young children is evident through rising referrals to antenatal and postnatal care for vulnerable women and their families, including for severe mental illness and domestic abuse.[14]

[11] Results of antenatal vitamin D screening at Barts and The London Royal London NHS Trust, April 2010

[12] Audit of all tests performed in routine clinical practice in primary care during 2009

[13] For the purposes of funding for early years places for disadvantaged two year olds, we are making the assumption that 50% would meet the FSM criteria, on the grounds that the benefit of 15 hours free childcare may be considered to be a greater incentive to claim than that of a free meal. 50% is also the average across all age groups

[14] Tower Hamlets JSNA, safeguarding factsheet 2012

Data on postnatal depression (PND) is limited, but the national incidence is estimated to be at least 13%[15]. Risk factors include past history of psychopathology, low social support, poor marital relationship, and potentially unplanned pregnancy, unemployment, antenatal parental stress or having two or more children. It has not been possible to obtain local data on this, but since many of the risk factors listed above apply to a significant number of women in Tower Hamlets, it can be assumed that the incidence of PND is at least 13% if not more, which would have been approximately 570 women in 2009 (based on 4358 births), and 580 women in 2010/11, assuming a projected number of births of 4,468[16].

Despite challenges, in many areas health outcomes are improving, including early access to maternity services, decreasing proportions of mothers smoking at the time their baby is born, increasing breastfeeding rates and increasing uptake and coverage of the childhood immunisation programme. These successes are not evident for all groups, however. The proportion of white women smoking when their child is born is higher than the England average, for example.

Although we are seeing an improving trend in the proportion of children who are obese in the reception year at school, obesity in childhood is still a major cause for concern. In 2011 just under 13% of 4-5 year olds were obese which was the sixth highest rate in London.

What outcomes do we want to see during maternity and in the early years?

This section sets out the outcomes [17]we want to impact on as a Partnership in the next three years.

Children are safe

- Reduction in emergency admissions caused by unintentional or deliberate injuries *
- Improvements in Common Assessment Framework (CAF) scores by time of CAF review
- Reduction in cases of domestic abuse *

[15]Mental Health in East London and the City. A Sector-Level Health Needs Assessment. 2011
[16]Tower Hamlets JSNA Core Dataset/ONS
[17] Those with an asterix (*) denote those in the Public Health Framework. See appendix 3 for overview of outcomes and indicators

Children are healthy

- Good and improving maternal health – including maternal nutrition*, good mental health, decreasing maternal obesity and decreasing numbers smoking at time of delivery*
- Low infant mortality rates*
- Reduced proportion of babies born with low birth weight* to vulnerable mothers, including teenage mothers and mothers who substance misuse
- Reduction in under 18 conceptions*
- Good and improving exclusive breastfeeding ratesand healthy weaning practices*
- Maintain good immunisation rates*
- Decreasing levels of obese and overweight children in reception year*, more opportunities for active play andmore healthy choices at home and in nurseries, schools, leisure centres and other public places
- Decreasing levels of tooth decay*in under-fives and all children are registered with a dentist
- Good coverage levels for antenatal and newborn screening
- Early detection and treatment of disability and illness
- All parents and children achieve positive physical and emotional development milestones*.

Children are achieving their full potential and are active and responsible citizens

- Good outcomes at the two year old development check* – which includes good development in:
    - communication
    - fine motor
    - gross motor
    - social skills and behaviour
    - problem solving
- Good and improving key stage 1[18]attainment*
- Good and improving EYFS attainment: for all children and for the bottom 20%.*

Children are emotionally and economically resilient for their future

- Decreasing numbers of children living in poverty*

[18] KS1 covers two years of schooling in maintained schools in England and Wales normally known as year 1 and year2, when pupils are aged between 5 and 7. Key stage 1 attainment is based on teacher assessment taking into account a child's performance in several tasks and tests

- Parents are supported into sustainable employment and are supported to balance work and family life
- Teenage parents are supported into education, employment or training and to develop good parenting skills
- Improving levels of speech and language development amongst the most vulnerable children in the borough.

How do we make sure we're on track to achieve these outcomes? What will we monitor, as a Partnership, during the course of the plan?

Listed below is the additional data we will look at throughout the life of the plan to ensure we are on track to achieve the outcomes above.

Monitoring whether children are safe

- Hospital emergency admissions caused by unintentional and deliberate injuries in age 0-4 years, per 10,000 resident population (Hospital Episode Statistics) and better data on cause of injuries
- Quarterly data on number of contacts and referrals for 0 to 5s to Children's Social Care
- Learning from LSCB serious case reviews,child death reviews and LSCB audits – local and national learning relevant to 0 to 5s
- Annual CAF outcomes report
- Annual sample report from SIP (considers number and type of referrals plus number of closed cases and reasons for closure)

Monitoring whether children are healthy

- Early maternityaccess at 12+6 weeks
- Quarterly rate of smoking at booking and time of delivery per 100 maternities
- Quarterly breastfeeding data – prevalence at initiation and 6-8 week check;prevalence of exclusive breastfeeding
- Annual National Child Measurement Programme school health data, proportion of children aged 4-5 classified as overweight or obese
- Quarterly Health Visitordata, including new birth visits, Body Mass Index (BMI) at 2 and 3 year reviews
- Annual FNP data related to breastfeeding, smoking in pregnancy, use of long-acting reversible contraception (LARCs)
- Quarterly childhood immunisations coverage data (0-5 years)
- Quarterly uptake of Healthy start vitamins
- Final report from the Vitamin D/Healthy Start parent champions outreach project

- Tooth decay in under-fives (data published every four years)
- Quarterly CAMHS referral data for under-fives
- Quarterly report on number of under-fives registered with a disability and disability category
- Annual report on Healthy Early Years accreditation, including outcomes related to communication skills, physical development, emotional wellbeing, healthy eating and oral health
- Quarterly coverage levels for antenatal and newborn screening
- Annual report on Healthy Early Years accreditation and healthy schools accreditation monitoring.

Monitoring whether children are achieving their full potential and are active and responsible citizens

- Annual EYFS results
- Annual key stage 1 results
- Quarterly update on Ofsted reports on childminders, Children's Centres and other early years settings
- Quarterly report on involvement of new parents/carers in Children's Centre parent forums and the Parent Council.

Monitoring whether children are emotionally and economically resilient for their future

- Quarterly NEET data for teenage parents
- Data on parents accessing training and employment advice in Children's Centres
- Data from the FNP
- Data on prevalence of PND.

Monitoring all outcomes

- Quarterly Children's Centre reach and volume data, and annual equalities analysis of this data
- Annual report on Children's Centre questionnaire
- Disadvantaged two year olds placements data
- Quarterly data on CAFs completed by all early years services
- Quarterly completion of evidence-based parenting programmes for new parents/carers.

Themes to drive our work to achieve these outcomes

This section sets out what we think we need to do as a Partnership to make a difference to the outcomes of children and their parents in the maternity and early years.

Promoting positive health and emotional wellbeing

- Promote healthy lifestyles for parents and carers, both pre and postnatal, including preconception uptake of folic acid and vitamin D
- Promote healthy lifestyles for babies and young children, including through the Healthy Start scheme, Healthy Early Years Accreditation, EYFS, FNP and provision of quality early learning places for two year olds.[19]
- Implementation of an effective Smoke Free Homes and cars programme in Tower Hamlets
- Ensure high quality antenatal and newborn screening immunisation programmes
- Promote the use of Children's Centres and universal childcare provision for children with a disability and/or learning difficulty and their families during the early years, in order to meet their needs within universal provision wherever possible
- Improve access to psychological therapies through the development of the Improving Access to Psychological Therapies (IAPT) project
- Continued alignment of the Healthy Early Years Accreditation Scheme with Healthy Lives in schools.
- Take-up rates of Genetic Counselling service for children with disabilities and their families.

Supporting positive family and wider social relationships

- Provide women-centred care and enable informed decision making throughout the antenatal period
- Build on and extend parenting programmes tailored for parents and carers with children under the age of 3, including through quality pre-natal provision
- Learn lessons from the provision from Family Nurse Partnership to benefit all new parents through high quality pre and postnatal provision, including through engaging fathers in pre and postnatal provision
- Expand the Family Nurse Partnership

[19] Healthy lifestyles includes promotion of breastfeeding, advice on weaning, healthy eating, oral health and active play

- Promote positive interaction and communication within the wider family, through group sessions, tailored advice and support to families from health and early years practitioners
- Support parents and carers to access sustainable employment, in particular supporting parents to prepare for moving onto Job Seekers Allowance (JSA) when their youngest child is five
- Support financial independence in families by embedding financial inclusion into services and raising awareness of changes to welfare benefits eligibility and sign posting families to appropriate money management or debt advice services.

Prevention from harm

- Raise understanding of child development theory and practiceamongst all children's practitioners
- Ensure effective engagement with adult services for parents with additional needs, including parents with disabilities, learning difficulties, or mental health needs and parents or carers who are victims of domestic violence
- Increase the take up of services by male perpetrators of domestic violence and parents who misuse drugs and alcohol
- Increase the quality and availability of services available to children affected by domestic violence
- Support families to ensure the home environment is safe for their child
- Engage with schools to ensure that the teaching of SRE is balanced and adequate.

Managing effective transition between services

- Develop links between early years provision, nurseries, Children's Centres and primary schools to help support families as their children start primary school
- Ensure a coordinated step-down from children social care to suitable services when tier three intervention ends; and from Family Nurse Partnership (FNP) to suitable services when FNP support ends at the child's second birthday.

Additional strategy, policy and research work to be undertaken during the course of the plan

These are pieces of work which will be commissioned by the Partnership during the course of the plan to enable us to better understand issues and to target support appropriately.

- Investigate the local prevalence of consanguinity and its impact on child health to inform an assessment of need for genetic counselling and wider awareness raising in affected communities
- Undertake qualitative research into intergenerational influences on partial breastfeeding
- Refresh thematernity health improvement strategy
- Complete theAccident and Emergencypilot data collection of causes of admissions for unintentional injuries and deliberate injuries to inform the development of the child injury prevention strategy
- Develop the EARLY (Evidence-based Assessment for Risk-reduced Little-ones' foundation Years) Health Visitors Assessment Toolkit (Burdett Trust funded project)
- Develop a Mental Health and Wellbeing strategy (across the life course)
- Establish the prevalence of postnatal depression in the borough.

2. Childhood (6 to 11 year olds)

There are 19,275 children aged six to eleven, which is 8% of the total population in the borough and 29% of the 0 to 19 population (the second largest age group within the 0 to 19 population). The six to elevenpopulation is projected to rise by 7.3% by 2015 to 20,789[20].There are high levels of poverty with 46.4% of primary age pupils eligible for Free School Meals in 2011, and take-up at 39.7%.

Of the 17,572 children in this age group registered on the 2011 Autumn School Census, 631 have a statement of Special Educational Needs (2%), and a further 3,696 (21%) are registered as School Action or School Action Plus.[21]

At 1 February 2012, there were 632 children aged 6 to 11 registered with the Council as having a disability, which is 3% of all 6 to 11 year olds.[22]

In 2010, 2011 of 5 to 15 year olds registered with a GP were identified as having asthma.[23] Asthma is one of three conditions (the others being epilepsy and diabetes) which account for 94% of emergency admissions for children (under 19's) with long-term conditions.[24] Asthma in Tower Hamlets is statistically significantly 'worse' than the total population prevalence.

At 31 March 2012, there were 51 Looked After Childrenaged 6 to 11 (17% of all LAC cases), 94 children with child protection plans (34% of all CP cases) and 343 child in need cases (30% of all CiN cases).[25]

We have seen improvements at key stage 1 in reading, writing and maths at Level 2 and Level 2b+ in 2011, although performance is still slightly below national averages.At key stage 2[26], our performance in English and maths combined is consistently rising. In 2011, 76% of children achieved level 4 compared to 74%. The achievement gap between those eligible for free school meals and their peers is 5% points compared to 20% nationally.

[20] GLA population projections – 2011 round. Borough-level population projections by single years of age

[21] Autumn 2011 School Census, LBTH

[22] Children with disability database, LBTH, February 2012

[23] East London Clinical Effectiveness Group data (2010)

[24]Tower Hamlets JSNA Asthma factsheet. http://www.towerhamlets.gov.uk/lgsl/701-750/732_jsna.aspx

[25] Children's Social Management Information Report, LBTH, March 2012

[26] KS2 covers four years of schooling in maintained schools in England and Wales normally known as year 3, year 4, year 5 and year 6, when pupils are aged between 7 and 11. KS2 attainment reflects teacher assessment of a child as well as national test results

Achievement for Looked After Children is also impressive, with 55% achieving level 4 in 2011 compared with 40% of Looked After Children nationally. The gap between the percentage of LAC attending school and their peers is closing. In the primary sector, children who have been looked after for a year or more are exceeding attendance rates of their peers and national targets. For those with special education needs, 12% of those with a statement achieved level 4 compared to 15% nationally, and 48% of those with special educational needs but without a statement achieved level 4 compared to 38% nationally.

For the academic year 2010/11, primary school attendance was 94.8% – a new record high for the borough, just above the London rate of 94.7% and just 0.2% below the national rate at 95%. No schools had attendance below 92% and there was a trend of gradual improvement over the course of the year.

Although prevalence of childhood obesity in Year 6 has plateaued for the last three years, with the current rate at 25.6% for 2011/12, it is the 2nd highest in London and more needs to be done so that the rate starts to decline for year 6, as it has for children at reception.

The last available School PE and Sport Survey (2009/10) showed that children in Tower Hamlets take part in less formal physical activity than the England average, and the proportion of primary school children walking to school (whilst high) has fallen year-on-year, with levels of cycling to primary school remaining significantly lower than the national average.[27]

Hospital admissions caused by unintentional and deliberate injuries in under 18s are significantly higher than the London average with a crude rate of 122.5 per 10,000 population aged 0-17 years. Children and young people from lower socio-economic groups are more likely to be affected by unintentional injuries. The social gradient is particularly steep in relation to deaths caused by household fires or sustained whilst walking and cycling.

What outcomes do we want to see during childhood?

This section sets out the outcomes[28] we want to impact on as a Partnership in the next three years.

Children are safe

- There are improvements in CAF scores by time of the CAF review

[27] Tower Hamlets JSNA Young People and Physical Activity factsheethttp://www.towerhamlets.gov.uk/lgsl/701-750/732_jsna.aspx

[28] Those with an asterix (*) denote those in the Public Health Framework. See appendix 3 for overview of outcomes and indicators

- Children are walking and cycling safely in the borough, with a decrease in the number of accidents sustained
- Reduction in emergency admissions caused by unintentional or deliberate injuries.*
- Children and young people are protected from harm and families are supported to provide a safe environment

Reducing harmful relationships among peer/gender groups.

Children are healthy

- Decreasing levels of obesity and overweight 10 and 11 year olds, more opportunities for active play, walking and cycling and more healthy food choices at home and in schools, leisure centres and local takeaways, cafes and shops *

- Looked After Children receive their annual healthassessment, are fully immunised and have had their appropriate screening checks eg. vision and dentist within the previous 12 months
- Looked After Children have good emotional wellbeing, indicated through positive results in their Strengths and Difficulties (SDQ) Questionnaire
- Children with disabilities and their families are supported following diagnosis
- Reduction in emergency admissions for children with asthma.

Children are achieving their full potential and are active and responsible citizens

- Good and improving key stage 2 attainment of level 4 English and maths, and good levels of progression between key stage 1 and 2 in English and in Maths
    - for all pupils
    - for pupils on Free School Meals
    - for pupils with Special Educational Needs
    - for Looked After Children
    - for all ethnic groups and genders, with a particular focus on groups who have tended not to demonstrate high levels of attainment in the past
- Children who are victims of racial or homophobic incidents and bullying are identified and supported, and incidents decrease.

Children are emotionally and economically resilient for their future

- Children are attending primary school, with good levels of overall attendance rate and low levels of persistent absence

- Children are engaged in primary school, with low levels of children being excluded
- Children have an awareness of good money management.

How do we make sure we're on track to achieve these outcomes? What will we monitor, as a Partnership, during the course of the plan?

Listed below is the additional data we will look at throughout the life of the plan to ensure we are on track to achieve the outcomes above.

Monitoring whether children are safe

- Hospital emergency admissions caused by unintentional and deliberate injuries in age 5-17 years, per 10,000 resident population (Hospital Episode Statistics) and data on causes of injury
- Quarterly social care data – number of contacts and referrals for 6-11s, information share from LSCB reviews and audits
- Annual CAF outcomes report
- Annual sample report from SIP (considers number and type of referrals plus number of closed cases and reasons for closure)
- Child Protection Plans lasting 2 years or more
- Percentage of children becoming the subject of Child Protection Plan for a second or subsequent timeAnnual report on racial and homophobic incidents and bullying.

Monitoring whether children are healthy

- Annual National Child Measurement Programme data – proportion of children aged 10-11 classified as overweight or obese
- Annual report on Healthy Schools accreditation
- Data from school travel plans on numbers of school children walking and cycling to school
- Quarterly CAMHS referral data – including information on 'no shows'
- Annual trend emergency hospital admissions data for children with asthma

Monitoring whether children are achieving their full potential and are active and responsible citizens

- Quarterly update on primary school Ofsted inspections, including update on any schools in special measures
- Annual report on number of primary schools below Department for Education (DfE) floor standard (i.e. schools with fewer than 60% pupils

achieving L4+ in combined English & Maths, and where levels of progress in English & Maths are below the national median)
- Annual attainment data forkey stage 2 attainment in English and Maths, and expected levels of progress in English and maths - for all pupils, FSM, SEN, LAC, by gender and by ethnic groups.

Monitoring whether children are emotionally and economically resilient for their future

- Quarterly data on numbers accessing the Youth Inclusion and Support Panel (YISP)
- Annual report on number of schools which have delivered financial education programmes for pupils and parents.

Themes to drive our work to achieve these outcomes

This section sets out what we think we need to do as a Partnership to make a difference to the outcomes of children and their parents.

Promoting positive health and emotional wellbeing

- Develop and promote opportunities for play and everyday physical activity for all children, including disabled children
- Ensure access to appropriate and high quality mental health support for children, both in and out of school
- Ensure every primary aged child has the opportunity and support to be involved in enrichment activities. This could include performing on stage; taking part in a sporting event; participating in a residential trip; singing in a choir; playing a musical instrument; having a position of responsibility; beginning to learn another language; or participating in public speaking
- Ensure support for young parents in the care of their children and in the management of asthma in the home; providing support as well as facilitating access to health advice and therapy through NHS Direct and enhanced primary care
- Reviewing processes and procedures to ensure that we are in line with the government's approach to special educational needs and disability.

Supporting positive family and wider social relationships

- Engage and support parents and carers as their children start primary school, and when they start planning for secondary school
- Identify and meet the needs of very young carers
- Ensure we have a clear offer of targeted support for children at tier two of the Family Wellbeing Model who are aged 6to 11, with appropriate

practitioners taking the lead practitioner role and working at a Team Around the Child, both to prevent escalation to tier 3 and at step down.

Prevention from harm

- Promote road and canal safety amongst primary school pupils
- Work with community and other universal services to stop the use of physical chastisement
- Enable children to develop positive, healthy peer/gender relationships, promoting a zero tolerance approach to violent and exploitative relationships
- Continue to promote greater awareness of eSafety including keeping ahead of technological developments.

Managing effective transition between services

- Develop better links between primary and secondary schools so that children and their families are supported with the move into secondary school
- Ensure a coordinated step-down from children's social care to targeted and universal support, when tier three intervention ends. Also explore the development of further targeted support for this age group.

3. Young People (12 to 16 year olds)

The 12 to 16 year old population in Tower Hamlets makes up 6% of the total population in the borough and 21% of the 0 to 19 population. In 2012 the GLA estimate that there are 14,071 young people aged between 12 years and 16 years old. The number of 12 to 16 year olds is set to rise to 14,897 by 2015 (representing an increase of 5.5%).[29]

The locally developed Mayhew dataset now estimatesthat 61.2% of young people aged between 12 and 16 years of age are from a Bangladeshi background.[30] There are high levels of poverty with 60% of secondary age pupils eligible for Free School Meals, the highest in the country.

Of the 12,803 young people in school years 8 to 12, 568 had a statement of Special Educational Needs (4.4%) and 2183 (17%) were School Action or School Action Plus.[31]

There are 394 young people aged between 12 and 16 registered with the Council as having a disability, which is 24.9% of all12-16 year olds.[32]

At 31March 2012, there were 142 Looked After children aged 12 to 16 (48% of all LAC cases), 58 children with child protection plans (21.2% of all CP cases) and 261 child in need cases (22.6% of all CiN cases).[33]

In 2011/12 there were 199 young offenders aged between 12 and 16 years, representing 67% of all young offenders in that year. Since April 2011 we have seen a significant rise in the number of young people being referred into Triage diversion for screening and intervention. The team has dealt with 106 young people and has managed to divert 81 young people from becoming first time entrants into the criminal justice system.

Reoffending rates between 2009 and 2011 increased by 1.3 percentage points in Tower Hamlets with similar increases also seen in London (1.6 percentage point increase). Data for 2011/12 should give a more rounded view of progress in this area, and will be available later this year.

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[29] GLA population projections – 2011 round. Borough-level population projections by single years of age

[30] Mayhew

[31] Autumn 2011 School Census, LBTH

[32] Children with disability database, LBTH, February 2012

[33] Children's social Management Information Report, LBTH, March 2012

119 young people aged 12 to 19 years of age were in treatment for alcohol and substance misuse in 2011/12. Of all substance misuse referrals, 30.7% were for young people aged 13 and 14 years. 59% of all referrals to Child and Adolescent Mental Health Services (CAMHS) were also for young people aged 12 to 18.

Mental health data is limited, but national evidence shows that one in ten children aged between 5 and 16 has a clinically diagnosable mental health problem.. About half of these have a conduct disorder, 3.7% an emotional disorder (anxiety, depression) and 1-2% have severe Attention Deficit Hyperactivity Disorder (ADHD). Half of those with lifetime mental illness (excluding dementia) first experience symptoms by the age of 14, and three-quarters before their mid-20s. The rate of disorders rise steeply in middle to late adolescence.

11-16 year olds with an emotional disorder are more likely to smoke, drink and use drugs. Nationally, around 60% of Looked After Children and 72% of those in residential care have some level of emotional and mental health problem. A high proportion experience poor health, educational and social outcomes after leaving care. Self-harming amongst young people is not uncommon (10-13% of 15-16 year olds have self-harmed) but of a fraction of cases are seen in hospital settings.

While local data is no longer available, previous data shows that rates of cigarette smoking are similar to the national average and may be increasing amongst girls.

We have seen continuous improvement at key stage 4[34]with 16 year olds last summer achieving the borough's best ever results at GCSE. 61.4% of pupils achieved 5 or more A*-C grade GCSEs, including English and maths which meant they performed better than their peers nationally and Tower Hamlets' results improved by almost 10 percentagepoints from summer 2010.

Furthermore, the percentage of low performing pupils (based on key stage 2 scores) making the expected level of progress at key stage 4 bucks the national trend. For English, it is 19.6 percentagepoints higher than the national performance in this area and for maths it is 25.9 percentagepoints higher.

[34] KS4 covers two years of school educationwhich incorporate GCSEs, and other exams, in maintained schools in England , Wales and Northern Ireland normally known as year 10 and 11, when a pupils are aged between 14 and 16

Pupils eligible for Free School Meals also performed comparatively well with 57.5% achieving 5 or more A*-C grade GCSEs, including English and maths compared to 34.6% of children nationally. The achievement gap between pupils eligible for free school meals and their peers is 9 percentage points in Tower Hamlets, compared to 27.4 percentage points nationally in 2011/12.

However, young people from a White British background have low levels of attainment compared to their peers nationally. 44% of young people from a White British background achieved 5 or more A*-C grade GCSE including English and Maths compared to 58% nationally.

Achievement of Looked After Children is significantly below that of their peers in the borough at GCSE, but is improving and is better than the national picture. In 2011/12 23.5% of Looked After Children achieved 5 or more A*-C grade GCSEs which compares to 18.5% in 2009/10 and 9.8% nationally.

For those with special educational needs, 17.3% of those with a statement achieved 5 or more A* - C GCSEs including English and Maths compared to 8.5% nationally, and 34.8% of those with special educational needs but without a statement achieved this level compared to 24.7% nationally.

Attendance figures for the 2010/11 academic year shows a new record high for attendanceat both primary and secondary; and a continuation of the downward trend in persistent absence at both primary and secondary. For the academic year 2010/11, secondary school attendance was 94.3%, above the London rate of 94% and the national rate of 93.5%. Secondary school persistent absence for the same period was 2.8% which is below the London rate of 3.5% and national rate of 4%.

We have also seen an impressive reduction in the under 18 conception rate in Tower Hamlets with a decrease of 21.9% from the 2009 rate. Tower Hamlets achieved the second highest reduction in London and ranked 5th in England and Wales at Unitary Authority level. The indicator is measured as a percentage change on the 1998 baseline. In 2010 there were 101 young people recorded in this cohort for Tower Hamlets, compared to 132 in 2009.

What outcomes do we want to see for young people?

This section sets out the outcomes[35] we want to impact on as a Partnership in the next three years.

Young people are safe

- Decreasing levels of serious youth violence*
- Reduction in the number of children and young people missing from home or care, and reducing risks of sexual exploitation
- Reduction in the number of young people sustaining road traffic injuries (reduction innumbers of children who are killed or seriously injured and slight casualties)*
- Reduction in the number of young people who self-harm, and an increase in access to support for those who do.

Young people are healthy

- Reduction in the under 18 conception rate*
- Decreasing levels of young people with sexually transmitted infections and betterdetection of Chlamydia in 15-24 year olds
- Reduction in young people entering alcohol and substance misuse treatment for a second or subsequent time*
- Reduction in take up of smoking amongst young people *
- Increased take up of human papilloma virus(HPV) vaccination in girls and of school leavers booster
- Good and improving immunisation rates*
- Looked After Children receive their annual healthassessment and have had their teeth checked by a dentist within the previous 12 months
- Looked After Children have good emotional wellbeing, indicated through positive results in their Strengths and Difficulties (SDQ) Questionnaire.
- All young people with mental health needs to have access to appropriate services

Young people are achieving their full potential and are active and responsible citizens

[35] Those with an asterix (*) denote those in the Public Health Framework. See appendix 3 for overview of outcomes and indicators

- Good and improving key stage 4 attainment (5 or more A*-C grade GCSEs including English and maths)
    - for all pupils
    - for pupils on Free School Meals
    - for all pupils with SEN
    - for Looked After Children
    - for underachieving groups eg. White British young people
- Increasing numbers of young peoplevolunteering
- Increased identification of young carers
- Decreasing numbers of young people entering youth justice for the first time*
- Increasing numbers of young people securing accredited outcomes through Positive Activities for Young People (PAYP) and increasing numbers of girls accessing youth services.

Young people are emotionally and economically resilient for their future

- Children are attending secondary school, with good levels of overall attendance ratesand low levels of persistent absence
- Children are engaged in secondary school, with low levels of children being excluded
- Young people have an awareness of good money management
- Young people have high aspirations for their future
- Increasing numbers of young people in casual employment who have an approved and acceptable working environment *
- Increasing numbers of young people are progressing into further education
- Increasing numbers of young people develop their work related skills
- Increasing uptake of parenting support services by parents of young people aged 16-24.

How do we make sure we're on track to achieve these outcomes? What will we monitor, as a Partnership, during the course of the plan?

Listed below is the additional data we will look at throughout the life of the plan to ensure we are on track to achieve the outcomes above.

Monitoring whether young people are safe

- Quarterly social care data – including numbers of LAC and disability data
- Annual secondary school data on racial and other discriminatory incidents

- Annual CAF outcomes report
- Annual sample report from SIP (considers number and type of referrals plus number of closed cases and reasons for closure)
- Annual report on racial and homophobic incidents and bullying.

Monitoring whether young people are healthy

- Annual sexual health data from the Tower HamletsYoung People Relationship and Sexual Health Questionnaire
- Health Protection Agency chlamydia screening rates
- Quarterly CAMHS referral data, including DNA and waiting times and drop-out figures (if available)
- Quarterly data on number of young people accessing education psychology services
- Annual alcohol and substance misuse commissioning report from the National Drug Treatment Management System
- Annual results from the school immunisation programme.

Monitoring whether young people are achieving their full potential and are active and responsible citizens

- Annual attainment data for key stage 4
- Quarterly Ofsted inspection results for secondary schools
- Number of secondary schools below DfE floor standard
- Numbers of schools in special measures
- Secondary annual attendance and exclusion data
- Quarterly youth offending management information report (Prevention and Diversion).
- Numbers of young people participating in Young Mayor's elections/Youth Parliament

Monitoring whether young people are emotionally and economically resilient for their future

- Quarterly PAYP data and data on numbers accessing the youth service
- Numbers of secondary schools providing financial education and access to financial capability projects
- Establish a comprehensive list of young carers in the borough

Themes to drive work to achieve outcomes

This section sets out what we think we need to do as a Partnership to make a difference to the outcomes of young people and their parents.

Promoting positive health and emotional wellbeing

- Ensure access and take up of appropriate and high quality mental health support for young people aged 12 to 16 (improved levels of DNA to CAMHS)
- Support young people with caring responsibilities to identify themselves as carers at an early stage, recognising the value of their contribution and enabling a whole family approach to assessment
- Support more young people to live healthier lives encouraging better diet and involvement in physical activity
- Providehigh quality Sex and Relationship Education (SRE), easy access to youth-centred sexual health services and early intervention to target young women at greatest risk of pregnancy
- Ensure enrichment activities are available for all secondary aged young people both in cross-borough activities and within their school. This could include performing on stage; taking part in a sporting event; participating in a residential trip; having a position of responsibility; visiting a FE College, university or employer; work experience; and taking part in voluntary work
- Improve access to psychological therapies through the development of the Improving Access to Psychological Therapies (IAPT) project.

Supporting positive family and wider social relationships

- Ensure that young people are able to make informed decisions about drug use, based on high quality drug education and prevention approaches and rapid access to treatment services if problems develop
- Ensure that young people have access to early targeted intervention and advice on employment, education and training (EET), including advice on money management and financial services
- Encourage stronger male role models for the most vulnerable young people.

Prevention from harm

- Intervene early to support young people to keep out of the youth justice system and reduce serious youth violence among young people

- Improve monitoring of children who go missing from home and care
- Promote healthy relationships between young peopleand increase awareness of possible exploitative relationships, enabling young people to stay safe and build resilience.

Managing effective transition between services

- Develop support to parents as their children progress through secondary school and start to prepare for their transition to further education or employment
- Ensure a coordinated step-down from children's social care and from the Youth Offending Team (YOT) to targeted and universal support.

Additional strategy, policy and research work to be undertaken during the course of the plan

These are pieces of work which will be commissioned by the Partnership during the course of the plan to enable us to better understand issues and to target support appropriately.

- Undertake more work to find out about the needs of young people with a parent in prison and the extent of the numbers of children and families affected
- Undertake research to identify the prevalence of child sexual exploitation locally. Trial Bedford University's toolkit for monitoring sexual exploitation
- Undertake research to identify why White working class boys are underachieving.

4. Preparing for Adulthood (17-24 year olds)

It is estimated that Tower Hamlets has 32,114 residents aged 17-24; this is equivalent to 12.7% of the borough's population and 35.8% of allunder 24sin the borough. Compared to London, Tower Hamlets has a higher proportion of 17-24 year olds but population projections suggest that this age group willonly grow by 1.7% by 2015. However, this group includes 8,115 young people aged 17 to 19, which is projected to rise by 6.3% within the next five years.[36]

The gender and ethnic breakdown of this group broadly reflects the wider under 24 population.In 2011, locally developed data estimated that 54 per cent of the young people in this age group were female and 46 per cent were male.[37]

2,465 of young people in the school census are in years 13 and14, and of these 107 had a statement (5.5%) while96 (5%) were School Action or School Action Plus.

We have seen some improvement in A-Level attainment, with an average point score per pupil of642.4 in 2011, but improvement has only been marginal and we have failed to close the gap between Tower Hamlets' attainment and the national average.

Overall, more 16-18 year olds in the borough are achieving three or more A Levels. Achievement of level 2 qualifications (GCSE or equivalent), and level 3 qualifications (A Level or equivalent) by the age of 19 also improved in 2011; 75.8 per cent of young people had achieved a level 2 qualification by the age of 19 and 47.4 per cent had achieved a level 3 qualification, although we are still performing below the national average.

According to the Tower Hamlets Destination Survey 2011, 91 per cent of the 2011 Year 11 cohort went onto full time education, although this includes more females than males. Of the 18 year olds surveyed, 24 per cent progressed to higher education, whilst 43.9%remained in another form of full time education.

Over the past four years the proportion of 16-18 year olds who are not in education, employment or training has decreased by 3.3 percentage points. After accounting for the recent extension to the NEET criteria to include 19

[36] GLA population projections – 2011 round. Borough-level population projections by single years of age

[37] Mayhew dataset (Network Knowledge Management (NKM) population), is based on administrative databases which include a detailed analysis of the administrative data sets at March 2011

year olds, NEET figures stand at 5 per cent (2011/12) in Tower Hamlets and still compare favourably tothe national average of 6.1 per cent. However, the proportion of young people aged 18-24 claiming Job Seekers Allowance has increased since 2008 and was 10.3 per cent in 2012[38], implying the progress made at ages 16-18 does not always translate to longer term progress at ages 18-24. The higher percentage of JSA claims is also indicative of the wider economic and employment situation nationally.

Children's social care services work with children and young people up to the age of 18 except where they are entitled to a leaving care service in which case they will continue to receive support until the age of 21 (or 25 if in higher education). Some young people with special educational needs will continue to be entitled to support until they are 25 if the proposals set out in the SEN Green Paper are put into effect.

In March 2012, 36 young peopleaged over 16 years were looked after, 1 child was subject to a child protection plan; and 201 were children in need. There were23 young people aged 17-19 yearsallocated to the children with disabilities team.[39] In 2011, 87 per cent of 19 year olds who had been looked after at the age of 16 were in education, employment or training.This is more than 20 percentage points above the London and national average.[40] However, indications are that the numbers are now reducing.

Chlamydia rates in the borough are lower than average for the 15-24 age group, though women aged 16-19 are considered at risk.

What outcomes do we want to see for young people who are preparing for adulthood?

This section sets out the outcomes[41] we want to impact on as a Partnership in the next three years.

Young people are safe

- Increased reporting of domestic violence incidents among young couples and siblings and victims accessing domestic violence services.*

[38] ONS Data, March 2012: http://www.neighbourhood.statistics.gov.uk/HTMLDocs/dvc6/jsamap.html
[39] Children's Social Care Management Information Report, March 2011
[40] DfE data release, March 2011: http://www.education.gov.uk/rsgateway/DB/SFR/s001026/index.shtml
[41] Those with an asterix (*) denote those in the Public Health Framework. See appendix 3 for overview of outcomes and indicators

- Increasing numbers of our most vulnerable young people, including young people leaving care, young offenders and young people with a disability, learning difficulty or mental health problem securing appropriate, safe housing.*

Young people are healthy

- Increasing numbers of under 24 years olds accessing sexual health services and decreasing levels of young people with sexually transmitted infections
- Increasing numbers of young people, especially young people leaving care, registering and accessing primary care services
- Good and improving levels of young people with mental health needs progressing to adult services.

Young people are achieving their full potential and are active and responsible citizens

- Good and improving attainment at key stage 5[42]
- Good and improving achievement of level 3 qualifications, especially for young people leaving the criminal justice system, care leavers, young carers, teenage parents and children with disabilities
- An improving proportion of students progressing to a sustained education destination within one year of 16-18 learning (based on 2012/13 baseline)
- Good levels of participation in the National Citizenship Programme (based on 2012/13 baseline).

Young peopleare emotionally and economically resilient for their future

- Increased uptake and completion of apprenticeships and work based learning opportunities, including by Looked After Children
- Increasing numbers of 16-24 years olds are in education, employment or training, with a particular focus on young people leaving care, teenage parents and young people who are known to the YOT and young people with a disability and/or learning difficulty *
- Increasing levels of young people accessing careers advice and job brokerage services
- Increasing uptake of parenting support services by parents of young people aged 16-24
- Increased uptake of parenting support services by teenage parents
- Increased number of care leavers in education training or employment

[42] KS5 is used to describe the two years of post-compulsory education for students aged 16-18, at school or at college

- Increasing numbers of students in sixth forms/college develop their work related skills.

How do we make sure we're on track to achieve these outcomes? What will we monitor, as a Partnership, during the course of the plan?

Listed below is the additional data we will look at throughout the life of the plan to ensure we are on track to achieve the outcomes above.

Monitoring whether young people who are safe

- Quarterly DV reporting data
- Quarterly Transition plans data for CWD andSEN
- Reports and recommendations from Serious Case Reviews
- Numbers of young people known to Adult and Children's Social Care
- Annual CAF outcomes report
- Annual sample report from SIP (considers number and type of referrals plus number of closed cases and reasons for closure).

Monitoring whether young people who are healthy

- Annual scores on the effectiveness of CAMHS
- Sexual health screening data
- Health Protection Agency Chlamydia screening rates.Number of young people accessing emergency dental services

Monitoring whether young people who are achieving their full potential and are active and responsible citizens

- Annual key stage 5 attainment data
- NEET data for CWD, LAC, SEN and young people leaving the criminal justice system
- Annual data on proportion of students who progressed to a sustained education destination within one year of 16-18 learning (reporting from 2013-14)
- Annual apprenticeships data by vulnerable groups
- DWP Work Experience Programme Data.

Monitoring whether young people are emotionally and economically resilient for their future

- Annual data on young people accessing supported accommodation
- Monthly JSA claimant data
- Termly uptake of Mayor's Education Allowance and 16-19 Bursary
- Careers and Skillsmatch data.

Monitoring all outcomes

- Monthly monitoring reports for Transitional Support Services and New Start.

Themes to drive our work to achieve these outcomes

This section sets out what we think we need to do as a Partnership to make a difference to the outcomes of young people aged 17 plus and their parents.

Prevention from harm

- Develop support for our most vulnerable young people and ensure they have access to safe, appropriate accommodation.

Promoting positive health and emotional wellbeing

- Promote healthy choices and healthy behaviour to ensure good sexual health
- Work with vulnerable groups to improve registrations with GPs
- Develop pathways to training and employment for young people who have disabilities or mental health needs, care leavers and young people leaving the youth justice system
- Deliver high quality apprenticeships which are responsive to economic needs
- Deliver financial literacy sessions and explore how financial literacy and welfare reform programmes can be tailored to vulnerable groups.

Supporting positive family and wider social relationships

- Tailor existing parenting programmes to parents/carers of children who are preparing for further and higher education or employment, and children with a disability as they prepare for adulthood
- Provide effective support to teenage parents
- Promote positive role models and tailored mentoring programmes.

Managing effective transition between services

- Ensure timely transition plans for young people leaving care, accessing substance misuse services and young people with disabilities or mental health needs who are progressing to adult services
- Provide effective support to meet the emotional needs of young people with a disability, learning difficulty and/or life threatening medical condition as they face the challenges of approaching adulthood.

Additional strategy, policy and research work to be undertaken during the course of the plan

These are pieces of work which will be commissioned by the Partnership during the course of the plan to enable us to better understand issues and to target support appropriately.

- Develop a better understanding of domestic violence amongst young people in intimate relationships and links with sexual exploitation
- Explore maltreatment of 18-24 year olds by family members
- Improve our understanding of forced marriages in the borough.

Appendix 1

Related documents

The Children and Families Plan is the overarching strategic plan for children and families in the borough, and therefore sets out the overarching framework for the Children and Families Partnership for 2012 to 2015. It sits alongside the borough's Health and Wellbeing Strategy which applies to the population as a whole.

The Children and Families Plan also supports the implementation of the Tower Hamlets Community Plan and its vision "to improve the quality of life of everyone living in Tower Hamlets". The Children and Families Plan is fundamental in taking forward the Community Plan priorities to make Tower Hamlets a prosperous, safe and supportive and a healthy community.

Other related strategies and policies for improving outcomes for children and families in the borough include:

- Family wellbeing model
- Maternity health improvement strategy
- Health and wellbeing strategy
- Violence against women and girls strategy
- Parental engagement and support policy
- Child poverty strategy
- Financial inclusion Strategy
- Employment strategy
- Homelessness strategy
- Public health outcomes framework
- Healthy weight strategy
- Sexual health strategy
- Mental health strategy
- Breastfeeding policy

Appendix 2

CAF headings	Vulnerable groups
Parent factors	Neglected or abused children: children in need, children with protection plans or looked after children
	Children whose parents/ carers have difficulties providing positive parenting, or who may need additional support in parenting
	Teenage parents and their children
	Young carers or those whose progress is being affected by problems of family members such as substance abuse, physical or learning disabilities, or mental health concerns
	Children from families where there are domestic violence concerns
	Children with a parent in prison
Family and environmental factors	Children/young people at risk of substance abuse or children misusing substances
	Children/young people with poor lifestyles in terms of exercise and/or diet
	Children/young people in the criminal justice system, or at risk of entering the criminal justice system
	Children whose progress is being affected by extreme poverty, family worklessness and/or housing problems or homelessness
	Children experiencing bereavement, loss, separation or other family disruption
	Asylum seekers, refugees, travellers
Development of the baby, child or young person	Very young babies/children (aged 0 to 5)
	Children/young people with physical disabilities and serious medical conditions
	Children/young people with mental health needs
	Underachieving children at school or at risk of underachieving (KS 1 – KS4)– this covers absence, exclusions, children struggling with transition, children with SEN, looked after children and children on free school meals. It also considers attainment by ethnicity, and overall performance of pupils at key stage exams
	Underachieving or at risk of underachieving post 16, including young people NEET or at risk of becoming NEET
	Those bullying or bullied
	Young runaways
	LGBT children/young people

Appendix 3 Public health outcomes framework, overview of outcomes and indicators

Vision

To improve and protect the nation's health and wellbeing, and improve the health of the poorest fastest.

Outcome measures

Outcome 1: Increased healthy life expectancy, ie taking account of the health quality as well as the length of life.

Outcome 2: Reduced differences in life expectancy and healthy life expectancy between communities (through greater improvements in more disadvantaged communities).

1 Improving the wider determinants of health

Objective

Improvements against wider factors that affect health and wellbeing and health inequalities

Indicators

- Children in poverty
- *School readiness (Placeholder)*
- Pupil absence
- First time entrants to the youth justice system
- 16-18 year olds not in education, employment or training
- People with mental illness or disability in settled accommodation
- *People in prison who have a mental illness or significant mental illness (Placeholder)*
- Employment for those with a long-term health condition including those with a learning difficulty/ disability or mental illness
- Sickness absence rate
- Killed or seriously injured casualties on England's roads
- *Domestic abuse (Placeholder)*
- *Violent crime (including sexual violence) (Placeholder)*
- Re-offending
- *The percentage of the population affected by noise (Placeholder)*
- Statutory homelessness
- Utilisation of green space for exercise/health reasons
- Fuel poverty
- *Social connectedness (Placeholder)*
- *Older people's perception of community safety (Placeholder)*

2 Health Improvement

Objective

People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities

Indicators

- Low birth weight of term babies
- Breastfeeding
- Smoking status at time of delivery
- Under 18 conceptions
- *Child development at 2-2.5 years (Placeholder)*
- Excess weight in 4-5 and 10-11 year olds
- Hospital admissions caused by unintentional and deliberate injuries in under 18s
- *Emotional wellbeing of looked-after children (Placeholder)*
- *Smoking prevalence – 15 year olds (Placeholder)*
- Hospital admissions as a result of self-harm
- *Diet (Placeholder)*
- Excess weight in adults
- Proportion of physically active and inactive adults
- Smoking prevalence – adult (over 18s)
- Successful completion of drug treatment
- People entering prison with substance dependence issues who are previously not known to community treatment
- Recorded diabetes
- Alcohol-related admissions to hospital
- *Cancer diagnosed at stage 1 and 2 (Placeholder)*
- Cancer screening coverage
- Access to non-cancer screening programmes
- Take up of the NHS Health Check Programme – by those eligible
- Self-reported wellbeing
- Falls and injuries in the over 65s

3 Health protection

Objective

The population's health is protected from major incidents and other threats, while reducing health inequalities

Indicators

- Air pollution
- Chlamydia diagnoses (15-24 year olds)
- Population vaccination coverage
- People presenting with HIV at a late stage of infection
- Treatment completion for tuberculosis
- Public sector organisations with board-approved sustainable development management plans
- *Comprehensive, agreed inter-agency plans for responding to public health incidents (Placeholder)*

4 Healthcare public health and preventing premature mortality

Objective

Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities

Indicators

- Infant mortality
- Tooth decay in children aged five
- Mortality from causes considered preventable
- Mortality from all cardiovascular diseases (including heart disease and stroke)
- Mortality from cancer
- Mortality from liver disease
- Mortality from respiratory diseases
- *Mortality from communicable diseases (Placeholder)*
- *Excess under 75 mortality in adults with serious mental illness (Placeholder)*
- Suicide
- *Emergency readmissions within 30 days of discharge from hospital (Placeholder)*
- Preventable sight loss
- *Health-related quality of life for older people (Placeholder)*
- Hip fractures in over 65s
- Excess winter deaths
- *Dementia and its impacts (Placeholder)*

APPENDIX 2

Early Years, Childhood and Adolescent Health in Tower Hamlets

Tower Hamlets Public Health

October 2012

Introduction

Whilst a person's health depends to a limited extent on 'fixed factors' such as age, gender and ethnicity, it is now widely accepted that the strongest determinants of health are social, economic and environmental. This is evident from what is known about health inequalities and the reasons for them. Differences in people's health are explained to a large extent by differences in the social, economic and environmental circumstances of their lives that impact from before birth and throughout life.[1]While many of the factors that impact upon the health and well-being of pregnant women, children and families are evident nationally, there are a number of demographic and socioeconomic factors that particularlyaffect the current and future health experiences of these groups in Tower Hamlets.

Determinants and indicators of health and well-being

53% of children in Tower Hamlets are living in poverty, the highest in the country, and this deprivation is reflected in a number of other socio-economic and health indicators as set out below:

- Over one half of children in Tower Hamlets live in benefit dependent families*;
- 33% of families live on an annual income of less than £20,000, compared to 22% nationally;
- 29.3% of families live in overcrowded housing;
- 57% of pupils are entitled to free school meals*;
- Despite recent improvement, school readiness assessed at Early Years Foundation stage is still significantly below the national average (50% in Tower Hamlets versus 59% achieving at least 78 points across the EYFS in 2011/12);
- 9% of babies weight less than 2.5kg at birth, compared to 7.5% in London and 7.2% in England (2007/09);
- 39.1% of 5 year olds have experience of dental decay, compared to 32.7% in London and 30.9% in England (2007/08);
- Children from lower socio-economic groups are more likely to be affected by unintentional injuries, and hospital admissions caused by unintentional and deliberate injuries in under 18s are higher in Tower Hamlets than London (a crude rate of 122.5 per 10,000 population aged 0-17 years);
- The best available estimate suggests that the prevalence of mental disorders among children in Tower Hamlets aged 15 years and under is 9.1%;

[1] Sir Michael Marmot (2012) Strategic Review of Health Inequalities Post 2010 (Fair Society, Health Lives)

* Highest in the country

- 13.3% of 4-5 year olds are obese, 7th highest in the country (2011/12)
- 25.7% of 10-11 year olds are obese, 4thhighest in the country (2011/12)
- Children in Tower Hamlets take part in less formal physical activity than the England average; the proportion of primary school children walking to school (whilst high) has fallen year-on-year, with levels of cycling to school remaining significantly lower than the national average.

However on some health indicators Tower Hamlets performs as well or better than London and/or England, for example:

- Maternity access by 12 weeks 6 days gestation. 93.7% versus 81.2% for London and 86.9% for England; Q1 20112/13;
- Infant mortality (4.4 deaths per 1,000 live births < I year) not significantly different to London (4.4) and England (4.7);
- Breastfeeding at 6-8 weeks: Q1 2012/13 66.02%Tower Hamlets[2](28.8% exclusive), 68.4% London, 46.9% England;
- Uptake and coverage of the childhood immunisation programme, 2011/12: 94.8% Tower Hamlets, 86.7% London, 92.2% National;
- Smoking in pregnancy Q3 2011/12: 3.1% compared to London (6.1%) and England (13.4%);
- Breastfeeding initiation: Q1 2012/13 88.6% Tower Hamlets (49.62% exclusive), 87.2% London, 74% England.

There is also growing evidence of significant improvement in Tower Hamlets, despite continued poverty and deprivation. The most marked of these being that educational attainment at Key stages 1, 2 and 4 is now at or above the national average. Other areas of significant improvement, or where the gap between Tower Hamlets and London and/or England has narrowed or closed, include:

- Child mortality for all causes in under 15's;
- Teenage pregnancy, 45% reduction since 1998,compared with a national decrease of 24% and a London decrease of 27.4%;
- Child immunisation, 12-21 % improvement across the different vaccinations since 2007/08, achieving herd immunity (95%) on most vaccinations and best performing PCT in London;
- Dental decay in 4-5 year olds, although still higher than London and England, the gap has been reduced by 4.6% (London) and 2.5% (England) since 2003/04;
- Obesity in 4-5 year olds, 2% decrease since 2007/08;
- Childhood obesity as measured at age 4-5 has fallen year on year since the National Child Measurement Programme (NCMP) began 5 years ago; childhood obesity as measured at age 10-11 has plateaued for the last 2 years, compared to 1.0% year on year rises in the first years of the NCMP.

Partnership working to improve health outcomes

[2] Unusual quarter as has been consistently above both London and England. Improvement in Q2 2012/13, 71.7% but London and National comparators not yet available.

There is a strong history of partnership working in Tower Hamlets focussed on improving socio-economic and health outcomes for children and families. This is brought together by the Children and Families Partnership Board and the Local Safeguarding Children's Board. Some of the key partnership strategies and public health interventions are listed below.

1. Joint Strategic Needs Assessments

The Joint Strategic Needs Assessment (JSNA) is a process through which Public Health (NHS Tower Hamlets) works together withcouncil services (both the Adults Health and Wellbeing, and Children, Schools and Families directorates)to assess the needs of the Tower Hamlets population and determine priorities for commissioning services.

Existing JSNA factsheets (can be accessed via http://www.towerhamlets.gov.uk/lgsl/701-750/732_jsna.aspx)

- North East locality maternity and child health profile
- South East locality maternity and child health profile
- North West locality maternity and child health profile
- South West locality maternity and child health profile
- Infant Mortality
- Smoking and pregnancy
- Safeguarding Children
- Physical Activity in Young People
- Physical Health of Young Offenders
- Oral health in children
- Teenage pregnancy
- Tobacco use and young people
- Alcohol and Substance Misuse Young People
- Child and adolescent mental illness, mental health and emotional wellbeing
- Health of Looked After Children

JSNA factsheets in progress

- Maternal health
- Maternal and early years nutrition
- Obesity – all ages
- Intentional injuries
- Unintentional injuries
- Gestational and pre-existing diabetes in pregnancy
- Vitamin D

New JSNA factsheets to be completed

- Maternal obesity
- Children of vulnerable/young (or teenage) parents
- Children with disabilities and long term conditions
- Young carers
- Sexual violence

2. Key strategies and partnerships

- Children and Families Plan
- Teenage pregnancy Strategy
- Health Improvement Strategy for Maternity Services
- Immunisation Action Plan
- Healthy Weight, Healthy Lives Strategy and Tower Hamlets Healthy Borough programme
- Tobacco Control Strategy
- Substance misuse Strategy
- Mental health and wellbeing Strategy (in development)
- Child Death Overview Panel

3. Public Health commissioned interventions

- Family Nurse Partnership (supported, but not commissioned, by Public Health)
- Improving early access to maternity services
- Expanded antenatal parenting classes
- Smoking and pregnancy service
- Doula project (lay support in pregnancy)
- Haemoglobinopathy counselling service
- Baby Friendly Initiative (promoting breastfeeding)
- Healthy Start vitamins distribution
- Healthy Start community champions
- Weaning pilot project
- Oral health promotion , including:
  - Brushing for Life (children's centres)
  - Fluoride varnishing scheme
  - Happy Smiles (primary schools)
  - Oral health promotion training for health and childcare workers
- Healthy Weight, Healthy Lives and Healthy Borough projects, including:
  - Healthy Breakfast clubs (funding ended July 2012)
  - Promoting active play, healthy eating and cooking skills
  - Bike It (delivered by Sustrans)
  - Healthy Early Years accreditation scheme
  - Active play, healthy eating (Toyhouse libraries)
  - Cook4Life (including weaning pilot)
  - Breastfeeding welcome venues
  - Healthy Families (parenting skills)
  - Child weight management and early intervention service
  - Participatory training for parents
  - Community led projects including 'Can Do' grants
- Healthy Lives Team, responsible for:
  - Healthy Schools and Advanced Healthy Schools programme
  - Sex and relationships education
  - Healthy eating and physical activity
  - Drugs and alcohol education
  - Pupil led projects
- Peer led programmes, including::
  - ASSIST (smoking prevention)
  - Alcohol awareness
  - Sex education

Priorities for future action

Life course stage	**Priority**

Being born	- Good and improving maternal health – including maternal nutrition, good mental health, decreasing maternal obesity and decreasing numbers smoking at time of delivery
	- Reduce infant mortality rates;
	- Reduced proportion of babies born with low birth weight to vulnerable mothers, including teenage mothers and mothers who substance misuse;
	- Further improving exclusive breastfeeding rates and healthy weaning practices;
	- Support community engagement to encourage women to disclose female genital mutilation, development of referral pathways, training for health professionals;
	- Expand parent education and support into the postnatal period (e.g. practical sessions related to bathing and nappy changing; coping with change);
	- Provide guidance and support women with complex social factors through:
	  - continuation of the Doula Service,
	  - continuation of the development of antenatal care through centering,
	  - supporting the continuation and expansion of the Family Nurse Partnership.
	- Establishing the prevalence of postnatal depression in the borough;
	- Development of a pathway for women, not eligible for the specialist perinatal mental health service, with mild depression/postnatal depression;
	- Promotion of mental health and well being in the early years with a particular focus on strengthening family resilience and parenting skills;
	- Further improving access to and uptake of Healthy Start vitamins;
	- Decreasing levels of tooth decay in under-fives, increasing uptake of fluoride varnishing programme and ensuring all children are registered with a dentist.
	- Reduction in under 18 conceptions;
	- Maintaining good immunisation rates;
	- Good coverage levels for antenatal and newborn screening;
	- Early detection and treatment of disability and illness ;
	- All parents and children achieve positive physical and emotional development milestones.

Growing up	- Decreasing levels of obese and overweight children, more opportunities for active play and more healthy choices at home and in nurseries, schools, leisure centres and other public places; - Develop methods of communicating with CYP so that they can understand mental health & wellbeing/their mental health condition and their choices.
Crosscutting	- Reduction in emergency admissions caused by unintentional or deliberate injuries by means of local injury surveillance and multi-agency strategy development; - Review of multi-agency action to prevent accidents within and outside the home; - Review of Violence against Women and Girls Strategy and hidden harm strategy with particular focus on reducing the impact of domestic violence on children; - Building on the work undertaken as part of the Healthy Borough programme,

	working with the Local Authority spatial planners to ensure that sufficient provision of both internal space /amenity and play space are included in all new developments; - Map and communicate to frontline services information on mental health services to describe target audience, thresholds, and outcomes anticipated and referral pathways; - Strengthening partnership working and review of commissioning across the local authority and NHS to minimise the impact of cuts to public sector funding on vulnerable children and families so that the substantial improvements in Tower Hamlets are sustained and not reversed.

Committee: Health Scrutiny Panel	**Date:** 13 November 2012	**Classification:** Unrestricted	**Report No.**	**Agenda Item No.** 2
Report of: Tower Hamlets Involvement Network (THINk) **Originating Officer:** Dianne Barham, THINk Director		**Title:** Update on Healthy Community Groups project **Wards:** All		

1. SUMMARY

1.1 To engage patients and the community in the Clinical Commissioning Group and the Health and Wellbeing Board THINk are developing community led health projects in the wards of Whitechapel, Stepney Green, Shadwell and St Katherine's and Wapping.

1.2 The aim of these projects are to set up a Healthy Community Group of at least 200 people who will be provided with information, training, support and resources in return for their providing information on their experience of services, ideas on improving services and taking part in healthy lifestyle activities.

2. RECOMMENDATIONS

2.1 The Health Scrutiny Panel is asked to consider and comment on the development of the Healthy Community Group projects.

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**

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