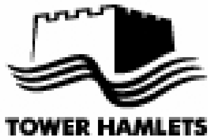

TOWER HAMLETS HEALTH AND WELLBEING BOARD

Tuesday, 10 March 2015 at 5.00 p.m. Committee Room MP701, 7th Floor, Town Hall, Mulberry Place, 5 Clove Crescent, London E14 2BG

This meeting is open to the public to attend.

Members:	**Representing**
Chair: Mayor Lutfur Rahman	(Mayor)
Vice-Chair: Councillor Abdul Asad	(Cabinet Member for Health and Adult Services)
Councillor Alibor Choudhury	(Cabinet Member for Resources)
Councillor Gulam Robbani	(Cabinet Member for Children's Services)
Councillor Mahbub Alam	(Executive Advisor on Adult Social Care)
Councillor Denise Jones	(Non - Executive Group Councillor)
Robert McCulloch-Graham	(Corporate Director, Education Social Care and Wellbeing)
Dr Somen Banerjee	(Interim Director of Public Health, LBTH)
Dr Amjad Rahi	(Healthwatch Tower Hamlets Representative)
Dr Sam Everington	(Chair, NHS Tower Hamlets Clinical Commissioning Group)
Jane Milligan	(Chief Officer, Tower Hamlets Clinical Commissioning Group)
Co-opted Members	
Steve Stride	(Chief Executive, Poplar HARCA)
Dr Navina Evans	(Deputy Chief Executive and Director of Operations)
Mahdi Alam	(Young Mayor)
James Ross	(Hospital Director at Newham Hospital)
Suzanne Firth	(Tower Hamlets Community Voluntary Sector)
1 Vacancy	

The quorum of the Board is a quarter of the membership including at least one Elected Member of the Council and one representative from the NHS Tower Hamlets Clinical Commissioning Group.

Questions
Before the formal business of the Board is considered, up to 15 minutes are available for public questions on any items of business on the agenda. Please send questions to the Officer below by **5pm the day before the meeting**.

Contact for further enquiries:
Elizabeth Dowuona, Democratic Services
1st Floor, Mulberry Place, Town Hall, 5 Clove Crescent, E14 2BG

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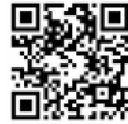

Role of the Tower Hamlets Health and Wellbeing Board.

- To encourage integrated working between persons who arrange for the provision of any health or social services in Tower Hamlets for the advancement of the health and wellbeing of the people in Tower Hamlets.
- To identify needs and priorities across Tower Hamlets and publish and refresh the Tower Hamlets Joint Strategic Needs Assessment (JSNA) so that future commissioning/policy decisions are based on evidence.
- To prepare the Joint Health and Wellbeing Strategy.
- To be involved in the development of any Clinical Commissioning Group (CCG) Commissioning Plan that applies to Tower Hamlets and to give its opinion to the CCG on any such proposed plan.
- To communicate and engage with local people on how they could achieve the best possible quality of life and be supported to exercise choice and control over their personal health and wellbeing. This will involve working with Local HealthWatch to make sure there’s a continuous dialogue with the public to ensure services are meeting need.
- To carry out new functions as requested by the Secretary of State and as advised in guidance issued from time to time.

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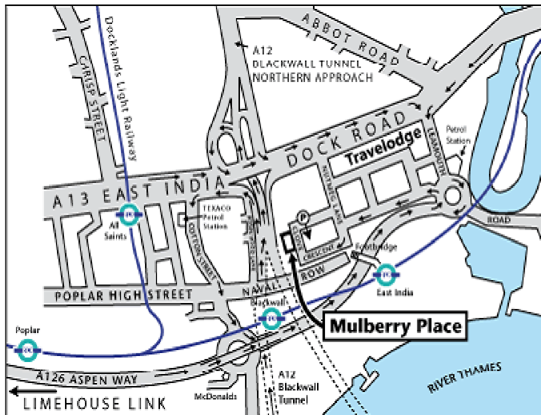

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PAGE NUMBER(S)

1. PUBLIC QUESTIONS

2. STANDING ITEMS OF BUSINESS

2 .1 Welcome

Chair to welcome those present to the meeting and request introductions.

2 .2 Apologies for Absence and Substitutions

To receive apologies for absence and to note substitutions.

2 .3 Minutes of the Meeting on 13 January 2015 — 1 - 12

To confirm as a correct record of the proceedings the notes of the ordinary meeting of the Tower Hamlets Health and Wellbeing Board held on 13 January 2015.

2 .4 Declarations of Disclosable Pecuniary Interests — 13 - 16

To note any declarations of interest made by members of the Board. (See attached note of Monitoring Officer).

2 .5 Forward Programme — 17 - 18

To consider and comment on the Forward Programme.

Lead for Item : Dr Somen Banerjee (Interim Director, Public Health)

ITEMS FOR CONSIDERATION

3. INTEGRATION : HEALTHWATCH PERSPECTIVE

3 .1 Evaluation: Tower Hamlets Coordinated Care Programme - Summary — 19 - 24

Lead Officer : Dianne Barham

The report provides a summary of the key findings of an evaluation of the new Co-ordinated Care Programme during 2014 commissioned by THCGG Healthwatch Tower Hamlets. Its main purpose was to understand the experiences of and feedback from both the providers and the users of the new service over a period of time so that the programme could be both improved and tailored to their needs.
RECOMMENDATIONS:

To note the report.

3 .2 Integrated Care Programme Update **25 - 28**

Lead officer: Jane Milligan

The report provides an update of activity in Integrated during February 2015.

RECOMMENDATIONS:

To note the report.

3 .3 Better Care Fund S75 Agreement **29 - 98**

Lead Officer : Robert McCulloch Graham

The report introduces the terms of the section 75 agreement, as well as proposing for specific approval the intended governance arrangements of the Tower Hamlets Better Care Fund.

RECOMMENDATIONS

1. Note that the terms of the Tower Hamlets Better Care Fund section 75 agreement between NHS Tower Hamlets Clinical Commissioning Group (the CCG) and the London Borough of Tower Hamlets (the Council) as attached at Appendix 2 to this report are consistent with the Better Care Fund Plan approved by HWB on 9 September 2014 and recommend approval of the agreement to the CCG and the Council;

2. Note the lead commissioning arrangements for managing the delivery of the Tower Hamlets Better Care Fund;

3. Delegate authority for overseeing delivery of the Better Care Fund plan to the Tower Hamlets Integrated Care Board and to note the arrangements for reporting of progress back to the Health and Wellbeing Board.

4. HEALTH AND WELLBEING STRATEGY - DELIVERY PLAN **99 - 104**

Lead Officer : Louise Russell

The report refreshes the Wellbeing Board’s strategy delivery plans.

RECOMMENDATIONS

1. Agree the refreshed delivery plans, including the proposed outcome measures and targets. These will be the measures used to track progress on the plan and on which performance will be reported to the Board. The measures are drawn from the social care, public health and NHS outcomes frameworks to reflect our strategic priorities.
2. Agree the delivery and performance monitoring

arrangements set out in section 3 below.

3. Agree that the Health and Wellbeing Strategy subgroup shall monitor and adapt the delivery plan targets on behalf of the Health and Wellbeing Board and provide 6 monthly updates

4 .1 Early Years **105 - 110**

Lead Officer : Somen Banerjee

4 .2 Healthy Lives **111 - 132**

Lead Officer : Somen Banerjee

4 .3 Long Term Conditions and Cancer **133 - 140**

Lead Officer : Jane Milligan

5. CCG COMMISSIONING UPDATE **141 - 144**

Lead Officer : Jane Milligan

The report provides a general update of the CCG's commissioning activity covering:

- Primary Care Co-commissioning
- Prime Minister's Challenge Fund
- WELC Integration Pioneer: Kings Fund Review
- Improving Mental Health Inpatient Services

RECOMMENDATIONS:

To note the report

6. LOCAL ACCOUNT 2013/14 **145 - 206**

Lead Officer : Robert McCulloch Graham

The report provides the basis to assessing and reporting on Adult Social Care performance, following the withdrawal of the Care Quality Commission's Annual Performance Assessment. The Local Account is a report for citizens and consumers about the performance of Adult Social Care, leading to greater involvement and challenge and is to be used as a tool for self-improvement.

This Local Account covers the period of 2013-2014 and also sets out priorities for 2013/14.

RECOMMENDATIONS:

(i) To note the content and format of Tower Hamlets Local Account for 2013/14 and approve it for publication.
(ii) To refer the proposal to CABINET for formal consideration.

7. LOCAL GOVERNMENT DECLARATION ON TOBACCO CONTROL — 207 - 216

Lead Officer : Somen Banerjee

The report outlines the implementation of a comprehensive tobacco control strategy working in partnership across health, social care, education and the voluntary sector to reduce tobacco use and subsequent harm.
The report presents the opportunity to enhance this work by inviting Tower Hamlets and its partners to sign up to the Local Government Declaration on Tobacco Control. NHS partners were also invited to sign the National NHS statement of support which is due to be launched at the Palace of Westminster on Feb 23rd 2015.

RECOMMENDATION:

4. To note the good progress that has been made in reducing the harm associated with tobacco use in Tower Hamlets.

5. To ask the Mayor, as the chair of the HWB to sign the Local Government Declaration on Tobacco Control.

6. Consider communication and publication opportunities where partners can demonstrate their commitment to the declaration.

8. PHARMACEUTICAL NEEDS ASSESSMENT — 217 - 220

Lead Officer : Somen Banerjee

The report provides the findings of the Pharmaceutical Needs Assessment to inform the NHS planning of local pharmacy services. Specifically, they are used by NHS England for informing decisions on; applications for new pharmacies, changes in premises for existing pharmacies, and changing services of existing pharmacies.

RECOMMENDATIONS:

1. Provide feedback and comments on the consultation document

2. Note that an amended version of the consultation document will be distributed electronically to Board members on the 23rd of March for final comments

9. ANY OTHER BUSINESS

To consider any other business the Chair considers urgent.

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LONDON BOROUGH OF TOWER HAMLETS
MINUTES OF THE TOWER HAMLETS HEALTH AND WELLBEING BOARD
ON TUESDAY, 13 JANUARY 2015
COMMITTEE ROOM MP702, 7TH FLOOR, TOWN HALL, MULBERRY PLACE, 5 CLOVE CRESCENT, LONDON E14 2BG

Members Present

Councillor Abdul Asad	Cabinet Member for Health and Adult Services(Vice-Chair in the Chair)
Councillor Mahbub Alam	Executive Advisor on Adult Social Care
Councillor Denise Jones	Non-Executive Group Councillor
Robert McCulloch-Graham	Corporate Director, Education Social Care and Wellbeing
Dr Somen Banerjee	Interim Director of Public Health, LBTH
Dr Amjad Rahi	Healthwatch Tower Hamlets Representative
Dr Sam Everington	Chair, Tower Hamlets Clinical Commissioning Group
Jane Milligan	Tower Hamlets Clinical Commissioning Group/LBTH
Tania Anastasiadis	Tower Hamlets Clinical Commissioning Group

Co-opted Members Present:

Sarah Castro for Steve Stride	Chief Executive, Poplar HARCA
John Wilkins	East London NHS Foundation Trust
James Ross	Hospital Director, Newham Hospital
Suzanne Firth	Tower Hamlets Community Voluntary Sector

Other Councillors Present:

None

Others Present:

Chris Lovitt	Associate Director of Public Health,LBTH
Dianne Barham	Director of Healthwatch Tower Hamlets
Sarah Williams	Independent Chair - Tower Hamlets Safeguarding Adults Board
Bozena Allen	Interim Head, ASC
Sandra Howard	Interim Service Manager, ASC

Officers in Attendance:

Louise Russell	Service Head Corporate Strategy and Equality, Law Probity & Governance
Leo Nicholas	(Strategy, Policy and Performance Officer, Education, Social Care and Wellbeing)
Elizabeth Dowuona	Committee Officer, Directorate Law, Probity and Governance)

1. STANDING ITEMS OF BUSINESS

1 .1 Welcome, Introductions and Apologies for Absence

Welcome

The Chair welcomed everyone to the first meeting of the Health and Wellbeing Board in 2015 and expressed his good wishes for the New Year to all.

The Chair reported that the meeting would be focusing on the Long Term Conditions and Cancer priority. The Board's meeting in March 2015 would largely focus on the refresh of the Strategy Delivery Plans in addition to some statutory duties such as signing off the Better Care Fund Section 75 Agreement and the Pharmaceutical Needs Assessment.

Apologies for Absence

An apology for absence was received from Cllr Alibor Choudhury (Cabinet Member, Resources) and for lateness from Dr Sam Everington (Chair, Tower Hamlets Commissioning Group) and Steve Stride (chief Executive, Poplar HARCA.

Membership

The Chair reported that John Wilkins, Deputy Chief Executive, East London and the Foundation Trust Co-opted Member had been replaced by Dr Navina Evans, Deputy Chief Executive, East London and the Foundation Trust.
The Chair on behalf of the Wellbeing Board thanked John Wilkins for his contribution and welcomed Dr Navina Evans onto the Board.

Order of the Agenda

The Board noted the Chair's decision to reorder the agenda making Item 2.3, Halve It Coalition the first substantive item on the agenda. The other items were considered in the order they appeared on the agenda.

Public Questions

The Board noted that no questions had been received from members of the public.

1 .2 Minutes of the Previous Meeting and Matters Arising

Resolved:

That the minutes of the meeting held on 9 December 2014 be approved as a correct record, subject to the inclusion of Councillor Denise Jones on the list of Members Present.

1 .3 Declarations of Disclosable Pecuniary Interests

There were no declarations of interest.

The Board noted the advice of the Legal Adviser to the Board, regarding the query raised at the last meeting on the declaration interests already declared in the Members Register of Interests.

It was agreed that the advice was reported to the next meeting of the Board.

1 .4 Forward Programme

Health and Wellbeing Strategy Monitoring 2013/14

It was noted that Officers were in the process of refreshing the delivery plans in the strategy to ensure they were up to date as agreed by the HWBB Sub-Group. Accordingly, the updated plans would be submitted to the Board in March 2015 as well as ideas for refreshing the HWBB Strategy for 2016 onwards.

The Board noted the Forward Plan.

ITEMS FOR CONSIDERATION

2. HEALTH AND WELLBEING STRATEGY

2 .1 Breast Cancer Screening Assurance

Dr Somen Banerjee, Interim Director, Public Health, introduced the report that detailed and highlighted a particular area of concern around breast cancer screening where there has been a decline of 6.5% in breast cancer screening coverage over one year.

Dr Banerjee provided some background to the breast cancer screening

programme and coverage. He also provided data released by Public Health England in November 2014 showing a sharp reduction in breast screening coverage in Tower Hamlets (67.8% to 61.5%) in the year following transfer of responsibility and budget for screening to NHS England (April 2013 to March 2014). The downward trend appeared to be continuing and showed a consistent decline in coverage rates since 2013/2014.

In summer 2013, NHS England acknowledged numerous concerns over the quality of service delivery at Central & East London Breast Screening Service (CELBSS).Following a management team meeting to discuss the service and find ways to address the areas of concern, a number of actions were put in place which yielded significant improvements in the quality of service provided.

Concerns identified by Tower Hamlets Public Health however included a lack of outreach service to increase screening uptake in Tower Hamlets. It was noted that in July 2013 the commissioner reported serious concerns in the performance of the breast screening provider, CELBSS. It was expected that the "slowing" of the breast screening service (as part of the package of measures to manage performance) would impact on screening coverage. However, the decline seen in breast screening coverage in Tower Hamlets in 2013/4 had not occurred in the neighbouring boroughs of Newham, Hackney or Waltham Forest also served by CELBSS.

During 2013/4, NHSE London continued to commission Community Links (a local voluntary sector organisation) to provide an outreach and "calling" service in Newham, to telephone women from GP practices and provide endorsement and support to attend screening appointments. There was evidence of the impact of this model on increasing the uptake of screening in Tower Hamlets, however no similar service was provided in Tower Hamlets despite the transfer of funds to enable this.
The team of 4 cancer screening facilitators in Tower Hamlets was decommissioned by NHS England in April 2014.

In discussion, Members expressed disappointment in the decline in breast cancer screening in Tower Hamlets. They considered that the integration of services across healthcare (breast screening, health checks, and referrals by GP services), social care (assessments and reviews of care needs) and public health was essential in efforts to reverse the decline of breast cancer screening.

RESOLVED -

1. That the significant decline in breast cancer screening in Tower Hamlets over the past year be noted;

2. That assurance be sought from NHS England (London) that it was taking the necessary measure to reverse the decline in uptake of

breast cancer screening in the local population e.g. by providing evidence-based outreach and primary care endorsement services such as those it funds in Newham.

3. That the monitoring of the progress on breast cancer screening uptake through 15/16 (via the Health and Wellbeing Board Executive Officers Group) be continued.

Action By: Dr Somen Banerjee (Interim Director of Public Health, LBTH)

2 .2 The National Cancer Patient Experience Survey 2014 - Tower Hamlets results

Dr Somen Banerjee, Interim Director, Public Health) introduced the report and outlined some of the work that had taken place in the last year. The report focused on patients' experience of care, highlighting the views of respondents treated for cancer by Bart's Health NHS Trust living in Tower hamlets, Waltham Forest, Newham and City and Hackney.

Following discussion, it was

RESOLVED -

1. That the findings of the survey and the areas where there had been improvement and where there continue to be gaps be noted;

2. That assurance be sought from service provider representatives and commissioner representatives that the issues of concern identified in the report were being addressed;

3. To report back to the Health & Wellbeing Board in the next municipal year.

Action By: Dr Somen Banerjee (Interim Director of Public Health, LBTH)
Elizabeth Dowuona (Committee Officer LBTH)

2 .3 Request for HWB to consider becoming a supporter of the Halve it Coalition

Chris Lovitt (Associate Director of Public Health, LBTH) presented the report,which highlighted the reduction in the late diagnosis of HIV as a national and local priority.

He described the Halve it Coalition as an organisation comprising 21 HIV charities, patient groups, clinician groups and observer members including the Local Government Association, Department of Health, Public Health England, NICE which had as its support of Leader of the Opposition, Prime Minister and Deputy Prime Minister

The Halve it Coalition patient groups and clinician groups sought the support of statutory and voluntary partners to continue to prioritise HIV as an important public health issue through action to implement the following stated aims:-

- Fully implement National Institute for Health and Care Excellence (NICE) public health guidance on HIV testing.
- Support the delivery of the Public Health Outcomes Framework (PHOF) by ensuring that local health organisations were equipped to realise the benefits of early detection of HIV.
- Offer incentives to test for HIV in a variety of healthcare settings, for example through the Quality and Outcomes Framework (QOF) and Commissioning for Quality and Innovation (CQUIN) frameworks.
- Ensure that people diagnosed with HIV had access to any retroviral therapies (ARTs) to prevent onward transmission in line with the joint recommendations of the Expert Advisory Group on AIDS (EAGA) and the British HIV Association (BHIVA).
- Ensure quality-assured (i.e. CE marked) self-testing kits for HIV when available, were integrated into local HIV testing strategies along with home sampling kits.

It was noted that the Halve it Coalition had been successful in achieving national support including through observer members such as the Local Government Association, Department of Health, Public Health England, NICE and had already achieved many of their stated aims at a national level and were now seeking local organisations to sign up as supporters.

It was also noted that Tower Hamlets Health and Well Being would be the first HWB to sign up and join Lewisham Council who signed up as a supporter on the 1st Dec 2014 as early local adopters.

In response to questions the following points were noted:

- The Tower Hamlets Health and Well Being Board, in agreeing to the invitation to be enlisted as a supporter of the Coalition meant a public endorsement to the Coalition’s aims and a show of leadership in the commitment to continue the campaign on early diagnosis, a reduction in HIV infections and associated health harms.

- That it was important that Tower Hamletswas involved in national recommendations and requirements to widen access to HIV testing, given that it was one of 64 Local Authorities with a high incidence of HIV.

- That reducing HIV late diagnosis was a Public Health Outcome Framework reflecting the importance of early diagnosis for both the

individual and the public sector.

- That there were no financial implications for the Council;

The Board noted expressions of support from Members present.

RESOLVED -

1. That the good progress that had been made in reducing the late diagnosis in Tower Hamlets of HIV through effective partnership work across the NHS, council and voluntary sector be noted.

2. To ask the Mayor, as Chair of the Health Well Being Board, to contact the Halve it Coalition and request that the Tower Hamlets Health and Well Being Board is listed as a supporter of the coalition's aims.

3. To note that there was no dissension on the part of partners of the Board on the request that Tower Hamlets Health and Well Being Board was listed as a supporter of the coalition's aims.

4. That the work across the partnership to increase the availability and uptake of HIV testing to ensure the realisation of health benefits of early diagnosis be continued.

   Action by : Chris Lovitt (Associate Director of Public Health, LBTH)

3. REGULATORY OVERSIGHT

3 .1 Winterbourne Review Report - Time for Change (2014)

Bozena Allen, Interim Head of ASC and Sandra Howard, Interim Service Manager, presented the report, which outlined the latest recommendations from the post-Winterbourne Review Report, an assessment of local implications, the next steps to develop an action plan for implementation; and a second annual update of progress of local actions agreed by the Board in 2013 following the first Government report in 2012. They outlined a phased approach and with some priorities on the proposed action plan.

The 'Winterbourne View - Time for Change' was published in late 2014 and made recommendations for a national commissioning framework, under which local commissioners should identify gaps in provision for people with challenging behaviour and Learning Disabilities.

It recommended a community-based alternative to inpatient care, through the creation of a mandatory commissioning framework requiring local authorities and NHS clinical commissioning groups to pool health, social care and housing budgets.

The report provided a summary of the eleven post-Winterbourne recommendations (set out in the report by a steering group of the NHS England set up to make recommendations for a national commissioning framework in which local commissioners would secure community based support for people with learning disabilities. It was noted that the Government was likely to publish their response in early 2015.
The Board noted that the implications for Tower Hamlets and its Partners was that the Health and Wellbeing Board could play a significant role in leading a local response to the Winterbourne Review of 2012 and 2014 by making in helping reshape local services to improve health outcomes for children and adults with learning disabilities and/or autism who have mental health conditions or behaviour that challenges.

The Board also noted that the proposed local response to these recommendations was to:

a) set up a local 'Post-Winterbourne Actions Project Team' with joint working between LBTH CCG, Tower Hamlets Council, and local partners;
b) to develop a local action plan and monitor its implementation.

The project team would be set up to agree a time specific plan for delivery of the other recommendations. This would be overseen by the Learning Disabilities Partnership Board and the Health and Well-being Board.

Members welcomed the proposed action plan which they regarded as a testament to the good work that had been done in Tower Hamlets.
The proposed action plan was noted as follows: To develop a Charter of Rights for people with Learning Disabilities;

1. Although good work was in progress with the local police to ensure that people with learning disabilities were better treated by the criminal justice system, there was an opportunity for the project team to discuss developing a local agreement;
2. Recommendation three was partially met where learning difficulties service users had the 'right to challenge' decisions through a complaint system;
3. There was work in progress where Bart's Health and Clinical Commissioning Group (CCG) were leading on considering the extension of a personal health budget, although further consideration was required from the proposed project team;
4. The proposed project team to work with the Housing Benefit service to protect a person's home tenancy when on hospital admission;
5. The proposed project team to consider developing a 'mandatory commissioning' plan for Learning Disabilities Service;
6. The proposed project team to consider the implications of community –based providers 'right to propose alternatives' to inpatient care;
7. The project team to consider whether the commissioning framework

should be accompanied by a closure programme of institutions (if that is applicable to this borough);

8. Proposed project team to consider workforce data from the NMDS-SC to help assess local workforce skills in this area;
9. The project team to consider fostering partnership working to establish a ‘Life in the Community’ Social Investment Fund;
10. The proposed project team to review what local data was collected and that was relevant for publication.

RESOLVED -

1. That the contents of the report be noted and that the proposal to set up a ‘Post-Winterbourne Actions Project Team’ to formulate an action plan for way forward be agreed. That all commissioners across all areas (including housing) work with Public Health to identify the gaps, and put in place a clear plan for delivery of commissioning priorities, which was time specific, and informed by service users;

2. That the second annual update of local actions since the Winterbourne Review, including proposals of future actions specified in the report, especially those marked out in paragraph 6.2 (e) be noted;

3. That the actions from Resolution (1) above be delegated to the Learning Disabilities Partnership Board to set up a commissioning specific work-stream which would put into place a plan of action based on the eleven recommendations.

4. To report back to the Health & Wellbeing Board at a future date.

Action By: Bozena Allen (Interim Head of Adult Services, Education Social Care and Wellbeing)
Elizabeth Dowuona (Committee Officer LBTH)

4. ANY OTHER BUSINESS

Primary Care Co-Commissioning

Special circumstances and Reasons for Urgency

The Board noted that the report had not been available for inspection within the timescales set out in the Authority’s Constitution, but agreed that there were special reasons for urgency and that the report should therefore be considered at the meeting in order to afford the Board the opportunity to consider the proposal in advance of its implementation in April 2015.

Jane Milligan, Chief Officer, Tower Hamlets Clinical Commissioning Group presented the report which provided a full and comprehensive

Update on primary care commissioning. The report outlined the invitation in May 2014 by NHS England for CCGs to express an interest in taking on an increased role in the commissioning of primary care services. Three models of co-commissioning were proposed, ranging from greater responsibility for CCGs in primary care decision making, the lowest level of involvement, through to delegated commissioning, the greatest level of involvement and responsibility;

It was noted that following engagement its membership and Governing Body, the Tower Hamlets CCG opted to apply for delegated commissioning arrangements. An application was submitted on 9th January 2015 in partnership with the CCGs across WEL (Tower Hamlets, Newham and Waltham Forest). Should the application be successful, implementation of delegated commissioning arrangements would take place from April 1st 2015.

Jane Milligan explained that the aim of the proposed co-commissioning was to establish a collaborative effort with WEL CCGs to improve commissioning for their local residents. The Board noted a summary of the benefits and risks of co-commissioning for the primary care services forCCGs across WEL (Tower Hamlets, Newham and Waltham Forest).

The proposed new arrangement would necessitate changes to the CCGs:

- Governance Structures
- Conflicts of Interest Policy and the separation in powers in the interests of accountability.
- Constitution

Members asked a number of questions on the decision making process, membership, voting powers and the remit of the new CCG Governing Bodies. In response, the following points were noted:

- Decisions would be made about primary care locally by the proposed CCG Committees by voting members made up of lay members and CCG officers and ratified by the CCG Governing Body;
-
- The proposed CCG Committees would be supported by the WEL Collaborative Forum whose role would be to make recommendations to the CCG Committees on the outcome of procurement processes and contract performance management decisions, including the monitoring of contracts;

- That the membership of the proposed CCG Committees included GP representatives and they would b fully engaged with the work of the Committees.

Members welcomed the proposals as a joint up working model and expressed their willingness to work with the CCG to ensure that the opportunities of bringing commissioning together and the making use of economies of scale through the sharing of resources would be realised.

RESOLVED

1. That the submitted application for delegated co-commissioning and its impact on future arrangements be noted;
2. That the contents of the co-commissioning application pending a decision from NHSE in February / March 2015 at which point further information would be provided on next steps be noted.
3. That officers report back to the Board in March 2015.

Action By: Jane Milligan (Chief Officer, Tower Hamlets Clinical CommissioningGroup)
Elizabeth Dowuona (Committee Officer LBTH)

5. Date of Next Meeting:

Noted that the next meeting of the Board was scheduled to be held on Tuesday, 10 March 2015 at 5.00 p.m. in Committee Room MP701, 7th Floor, Town Hall, Mulberry Place, 5 Clove Crescent, London E14 2BG

The meeting ended at 7.00pm

Vice Chair, Councillor Abdul Asad
Tower Hamlets Health and Wellbeing Board

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DECLARATIONS OF INTERESTS - NOTE FROM THE MONITORING OFFICER

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

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

Interests and Disclosable Pecuniary Interests (DPIs)

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

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

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

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

Effect of a Disclosable Pecuniary Interest on participation at meetings

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

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

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

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

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

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

Further advice

For further advice please contact:-

Meic Sullivan-Gould, Monitoring Officer, Telephone Number: 020 7364 4801

APPENDIX A: Definition of a Disclosable Pecuniary Interest

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

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

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Health and Wellbeing Board Forward Plan

Date: 10 March 2015

	Report Title	Lead Officer	Reason for submission	Time
Public Questions	Public Questions			
Standing Items	Apologies & Substitutions Minutes & Matters Arising Forward Plan	Chair		10 mins
	Healthwatch Perspective - Evaluation of THs coordinated care programme 2014 - Integrated Care Programme Update	Dianne Barham Jane Milligan		15 mins
Health and Wellbeing Strategy	HWBS Delivery Plan refresh - Early Years - Healthy Lives - Long Term Conditionsn and Cancer	Louise Russell - Esther Trenchard-Mabere - Somen Banerjee - Dorne Kanareck/Jane Milligan		30 mins
Board Oversight	BCF - Section 75 agreement	Robert McCulloch Graham		20 mins
	CCG Commissioning Update	Jane Milligan		10 mins
	Pharmaceutical Needs Assessment (PNA)	Somen Banerjee		10 mins
	The Local Account 2013/14	Robert McCulloch Graham		10 mins
	Local Governmnet on Tobacco Control	Somen Banerjee		10 mins
Any Other Information		All		5 mins

Date: June 2015
(Dates will be finilaised by Cabinet in April/May 2015 for the municipal year-2015/16)

	Report Title	Lead Officer	Reason for submission	Time
Public Questions	Public Questions			
Standing Items	Apologies & Substitutions Minutes & Matters Arising Forward Plan	Chair		10 mins
	Healthwatch Perspective	Dianne Barham		10 mins
Health and Wellbeing Strategy	HWBS Delivery Plan Update - Mental Health - Early Years - Health and Housing	Louise Russell		20 mins
Board Oversight	Liver Disease	Somen Banerjee		10 mins
	Homeless Health Charter	Somen Banerjee		10 mins
For Information Only				
Any Other Information		All		5 mins

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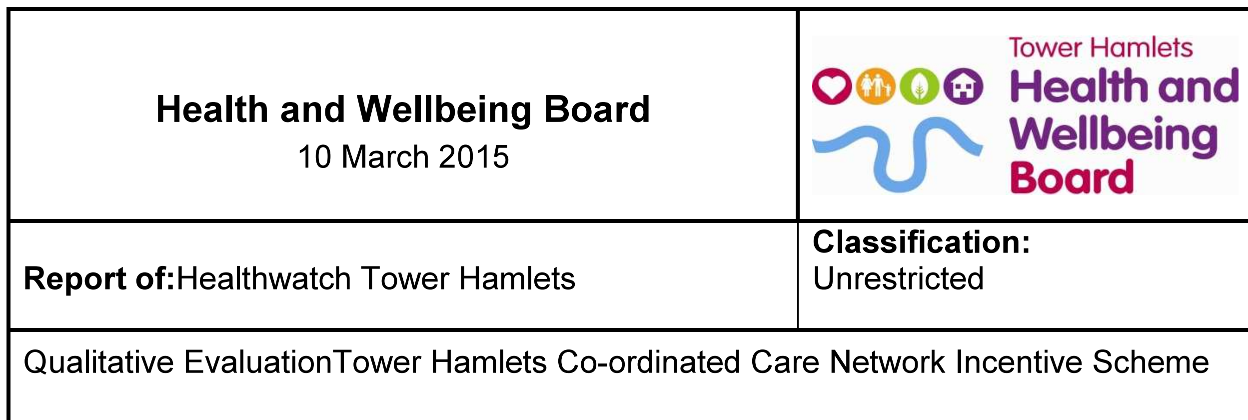


Health and Wellbeing Board 10 March 2015	Tower Hamlets Health and Wellbeing Board
Report of: Healthwatch Tower Hamlets	**Classification:** Unrestricted
Qualitative EvaluationTower Hamlets Co-ordinated Care Network Incentive Scheme	

Contact for information	Dianne Barham

Executive Summary

Healthwatch Tower Hamlets was commissioned by THCGG to carry out an evaluation the new Co-ordinated Care Programme during 2014. Its main purpose was to understand the experiences of and feedback from both the providers and the users of the new service over a period of time so that the programme could be both improved and tailored to their needs.

Thisreport provides a summary of the key findings.

Recommendations:

The Health and Wellbeing Board is recommended to:

1. Note the report.

healthwatch Tower Hamlets

Qualitative Evaluation
Tower Hamlets Co-ordinated Care NIS

The following summary of key findings should only be read in conjunction with the full report[1] so that the context is fully understood and that justice is done to the richness of the data collected. The detailed methodology is also outlined in the report.

Summary of provider findings

Research carried out between April and June 2014.

- Concerns about 'integrated care' focused not on whether it should be implemented but, instead, on how and in what way.

- Although providers tended to have a vision of 'integrated care', it was not a shared vision across providers and provider teams either conceptually or practically in terms of what it was and how it should be implemented.

- There were some examples cited of where 'integrated care' was seen to be working but not only were some services seen as being more 'separate' than others but there were additional organisational and governance protocols that hindered greater integration. This was seen to be compounded by differing levels of commitment particularly within the GP community and a perceived lack of understanding of the roles of different professionals with respect to the implementation of 'integrated care'. Some also considered that it remained based on a 'medical model'.

- There were general confusion at all professional levels between the Tower Hamlets 'Integrated Care Package' and the Co-ordinated Care NIS particularly in terms of understanding the distinctive features of each initiative and where they overlapped. This was important not so much for the patients' care which most felt would be the same but because of the protocols, pathways and governance involved. It was also felt that, with the new DES, this confusion would only get worse.

- There was equally a lack of clarity of the purpose of the NIS which again influenced how providers, especially GPs, approached its implementation. At one end of the spectrum were those who believed that the NIS was merely the next evolutionary phase following the Virtual Ward and that 'change' should be given time to settle. At the other end, was the argument that its real purpose and benefit would be in identifying patients that might have previously 'slipped through the net' as well as providing an opportunity

[1]**A copy of the report can be downloaded by clicking this link** Healthwatch Reports or at http://www.healthwatchtowerhamlets.co.uk/our-work/documents/.

to catch problems early. Some also felt that the NIS would act as a point of reference giving GPs a chance to reflect upon their patients.

- Many perceived the NIS to have been set-up in a rush with constant reiterations and poor communication. Further there was no uniform way in which it was being approached by surgeries.

- Concerns were raised about the level of resources available in terms of finance, staffing and training GPs but the most common concern focused on the staff shortages within Community Health Services. Many within these services predicted a greater workload within rapidly changing services which was being constantly transformed without any apparent and concurrent organisational development which in turn fed into the difficulties of implementing co-ordinated care.

- The majority of providers agreed that the NIS was capturing the appropriate cohort of patients but it was also argued that they were generally the patients they would be seeing anyway on a regular basis. Thus although the new package would offer an opportunity to interact with patients differently, they may well not spend any longer with them than previously.

- Although the NIS might pick up patients and crises early providing a faster service, there were also patients who might deteriorate fast and it would not necessarily be possible to avoid hospital admission.

- Many thought that it would be unlikely that there would be a great change in patient experience and if there were it would probably go unnoticed. Further some GPs argued that care would be no different for their patients since they already provided 'holistic' care. It was also argued that there was a potential danger the NIS would become another tick-box exercise.

- The majority believed that the appropriate professions were in the multi-disciplinary Teams and including social workers and a geriatrician was seen as a huge bonus. There was more debate about the role of the Care Navigators but the concept was applauded and seen as integral to the concept of the NIS.

- Some difficulties were reported in the development of the multi-disciplinary meetings across practices in terms of both how they were being conducted and attendance. Members of the CHS also reported they felt 'superfluous' at meetings emphasising the lack of integrated working and difficulties within their relationships with practice staff. They also pointed out that they held their own meetings every day to discuss patients.

- Most acknowledged that the Care Plan was a useful document but there was confusion as to whether it was a 'plan', a 'referral' or an 'assessment'. It was considered that all professionals should be involved in its compilation and it should not be the responsibility of one professional group. A number of professional groups argued that they would still need to do their own specialist care plan for their patients but the most common concern was

that it should be a 'live' document and would need to be constantly updated. There was also criticism of the length of the form and the nature of the questions particularly those about 'end of life' care and 'wellbeing' and a general feeling that the form was running the risk of becoming another 'tick box' activity. It was additionally queried whether the Care Plan was needed at all if there were regular multi-disciplinary meetings held and if the Orion system was working effectively.

- Although 'consent' was seen as being both appropriate and necessary, a number from all professional groups argued that there was a lack of clarity about how the information would be used and by whom and this led to a sense of uneasiness not least since many patients would sign 'anything' if asked to. Potentially, it was thought by some, that it could undermine the trust that existed between patients and GPs.

- The vast majority felt that the Single Point of Access was working well and effectively but for a minority there was a lack of clarity particularly about who was able to telephone the service, whether it was patients as well as providers.

- The majority considered that Orion would be a huge bonus if it worked. There was nonetheless a level of scepticism as to whether it would meet all expectations.

- The Mental Capacity Assessment raised no particular issues or concerns and the new training was generally welcomed.

- Finally, most felt it was too early for an evaluation of the NIS but there was greater concern as to how the CCG would evaluate it and whether or not there would be outcome measurements. There was a general consensus that hospital admissions could not or should not be the only indicator and that 'better health' should be the key issue as seen from the perspective of patients.

Summary of patient findings

Research carried out between September and November 2014.

- There was evidence that the patients interviewed, who were suffering from a range of co-morbidities, felt a loss of control of their lives, exacerbated by their medical condition and by a element of fatalism, particularly with regard to the provision of their care. There was a belief among the older respondents that old age was not respected and, across the cohort, was a level of general anxiety and depression which cut across those living alone and those living with families.

- Interviewees focussed particularly on their day-to-day needs, not simply in terms of health but more frequently in terms of concerns such as the fear of a loss of a 'partner/carer', the need to keep their homes clean, malfunctioning of home gadgets, burglaries and so on.

- There was a call for greater 'support' but the nature and level of support was rarely clarified. Partly this was because the deterioration of the medical condition could not be predicted but it was also hard for respondents to think beyond their immediate concerns which were more pressing. What appeared to be critical was the need for support to enable patients to articulate and communicate what they needed and at what point.

- GPs were generally perceived to be only able to deal with purely 'health' and medical issues. Many respondents were reluctant to ask the GP for support or help, some even for 'health' issues.

- Other sources of support were discussed such as a specific individual who might provide a co-ordinating role or simply be a 'befriender'. A free telephone service was suggested as was a directory of key telephone numbers listing all the centres of care, including social care.

- The support of families was seen as pivotal and there was a stark contrast with those interviewees who did not have a family around them in terms of support needed rather than in terms of the nature of the problems raised by illness.

- Specific individuals (such as a District Nurse, a GP, a social worker, the local librarian), often played a critical role in patients' lives and the removal of this support, through job changes for example, could have negative consequences for the individuals concerned.

- Many respondents believed that socialising benefitted them and their health and the lack of social contact was difficult for those on their own as well as for those living with families. Accessing social provision could also be beset with difficulties for this group and there was a call for more volunteers to help visit the elderly and infirm.

- Anxieties about their own health fed into perceptions about provision which again was more acute for those living on their own. However, expectations and perceptions of medical provision also appeared to be dependent on previous experiences either of others or their own but the extent to which negative experiences was treated with equanimity was notable. Many, too, acknowledged they found complaining difficult.

- Many were unaware of services to which they were entitled but there was an overriding concern as to how to obtain care when it was needed. Others complained of poor administration but more importantly about how professionals who did not do what they had said they were going to do such as visit or make contact. Almost all commented upon the long waits for provision and appointments. Other issues mentioned were discharge difficulties, poor transport and language issues.

- GPs tended to be perceived as the gateway to provision and often the most 'trusted' professional. They were, though, criticised for the difficulties in

obtaining appointments, their rushed nature and only being able to bring up one problem at each visit. Others called for GPs to carry out more home visits, sometimes to simply 'check' on patients

- An explanation of the Co-ordinated Care NIS was generally well received with particular support for the idea of a Care Co-Ordinator.

- The majority of patients had little recollection of either the Care Plan or the Consent Form. In terms of the latter there was confusion as to what precisely had been signed and there was a request for more information to be given. Experiences of the Care Plan varied widely and, in contrast, more patients could recall the recent letter they had received from their GP surgery regarding having a 'named' GP - a move that was favourably met.

- Few patients had noticed any change in their care over the two interviews during the evaluation.

- Patients tended to see care in 'silos' and, as a result, found it hard to envisage holistic provision.

- Sharing notes was seen to be a good idea. Most believed that GPs and hospitals shared notes but would be surprised if this were the case for other branches of provision.

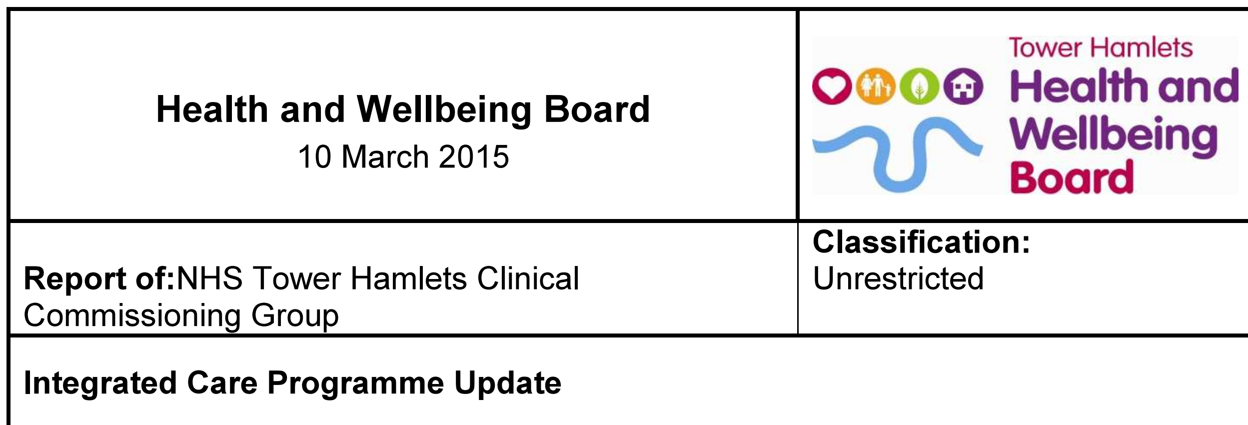
- Whether or not respondents felt 'involved in' their care or 'listened to' by health professionals appeared to depend partly on their understanding of the terms and partly on the extent to which they were focused on their daily existence and able to think beyond their immediate concerns. In addition, patients would argue they were 'involved in' their care and 'listened to' but their experiences contradicted this. There were, though, also those who did not feel 'involved' or 'listened to' as well as those who did not want 'involvement' in their care.

- Respondents varied as to whether they were more concerned about co-ordination of their care or administrative co-ordination. Whereas some believed that it was essential the GP should 'know' them others felt as long as a GP had their notes it did not matter.

- The cohort sampled in this study was not homogenous. Three broad sub-groups were detected based on the evidence. The sub-groups, which were fluid and not static, were determined on the basis of perceived service and support needs in particular as well as on expectations of service provision. It was notable that the difference in service and support needs between those living on their own and those living with families appeared to be one of emphasis rather than a requirement for different services.

Research carried out by Kate Melvin

Agenda Item 3.2



Health and Wellbeing Board 10 March 2015	Tower Hamlets Health and Wellbeing Board
Report of: NHS Tower Hamlets Clinical Commissioning Group	**Classification:** Unrestricted
Integrated Care Programme Update	

Contact for information	Julie Dublin, Transformation Manager, Integrated Care NHS Tower Hamlets CCG

Executive Summary

The Integrated Care Programme is a key component of the Waltham Forest and East London (WEL) Care Collaborative and an established Programme in Newham, Tower Hamlets and Waltham Forest and is one of 14 national pioneer sites.

It currently focuses on patients who have been identified as between very high risk and medium risk according to risk stratification and is based upon the Integrated Care Case for Change which was approved by the Governing Bodies of Newham, Tower Hamlets in Jan 2013. The Integrated Care work is a key component of the Better Care Fund plans.

Objectives

The Programme has three high level objectives:

1. Shaping the local health economy around the patient

2. Changing behaviours across the system

3. Developing the provider landscape

Key partners include acute, primary care (GPs), mental health and the local authority.

Integrated Care is underpinned by four principles':

- Care co-ordination
- Rapid Respond
- Discharge Support
- RAID and mental health liaison
- Self-Care and Self-Management

Recommendations:

The Health and Wellbeing Board is recommended to:

1. To note the report.

1. DETAILS OF REPORT

The following is an update of activity in Integrated during February 2015.

1.1 Care Co-ordination

Expand identification and enrolment of the eligible population from to cover 6% of the population during 2015/16. Enrolment involves people consenting to share information with the four statutory providers and join the integrated care programme.

People are able to select which provider organisation they are prepared to share with.

Lists are shared with providers to flag onto their local systems.

1.2 Care Planning

A workshop in February brought together a selection of patients with a range of health professionals working across WELC who are involved in developing care plans and the care planning process. The workshop was intended to

- use the emerging findings from the audit currently being undertaken and other evidence base (national and international) to stocktake where we are as a pioneer site with care planning and the development of care plans e.g., who develops them, how are they developed, who is using them, where, what for and what do they look like?
- use the various patient and professional groups to determine "what is the problem that a care plan is trying to address"?
- develop and agree a common set of principles to inform and drive forward the local approaches to developing care plans and care planning processes within in each borough

A Task and Finish Group is being establish to take forward the recommendations from the workshop to agree a standardised care planning approach and the resulting IT requirements. Terms of reference, membership and timeframes for this group are still to be agreed.

1.3 Discharge Support

A task and finish group is established to map the discharge process from hospital into the community and interface between the community, social care and mental health.

1.4 Information Technology

The ability to share relevant information is a key enabler for delivering integrated care. The Tower Hamlets Integrated Care Record is being deployed to deliver a shared system.

The portal has the ability to extract information from multiple provider systems and present a single view of the patient records. Interfaces are currently in place with

- Primary Care
- Acute
- GP OOH

Work is underway to interface with Mental Health and the Local Authority systems. This work is aiming to complete by March 2015. Only patients who have consented to share will be viewed in the portal and access is limited to those organisations that have been selected.

1.5 Self Care and self-management

Patient Activation Measure

Tower Hamlets CCG is a national pilot site for the implementation of the Patient Activation Measure (PAM) in England. The CCG has secured 60,000 licenses for the tool through NHSE, with view to using these in the next two years. A Learning Set has been established to support pilot sites and discuss approach to the national evaluation..

Self ManagementWorkstream
A workstream is established to oversee the delivery of the following initiatives:

- CCG self management pilots
- PAM pilot
- HENCEL funded Self-Management UK pilot
- Social prescribing pilot
- Any Innovation Bursary projects that have a self-management component
- Links with primary are innovations projects commissioned by the Excellence in General Practice programme.

This workstream will report to the Integrated Care Board for strategic oversight. The delivery of the workstream will be undertaken by a Working Group with the following membership:

- Clinical Lead (to be identified)
- Transformation Manager for Integrated Care
- Transformation Manager for Long Term Conditions (LTC)
- Presentation from LBTH Public Health

- Representation from CCG Mental Health
- Representation from TH Primary Care Networks

This approach will enable alignment of work undertaken within the Long Term Conditions and Integrated Care programmes around self-management and reduce duplication of effort.

NEXT STEPS

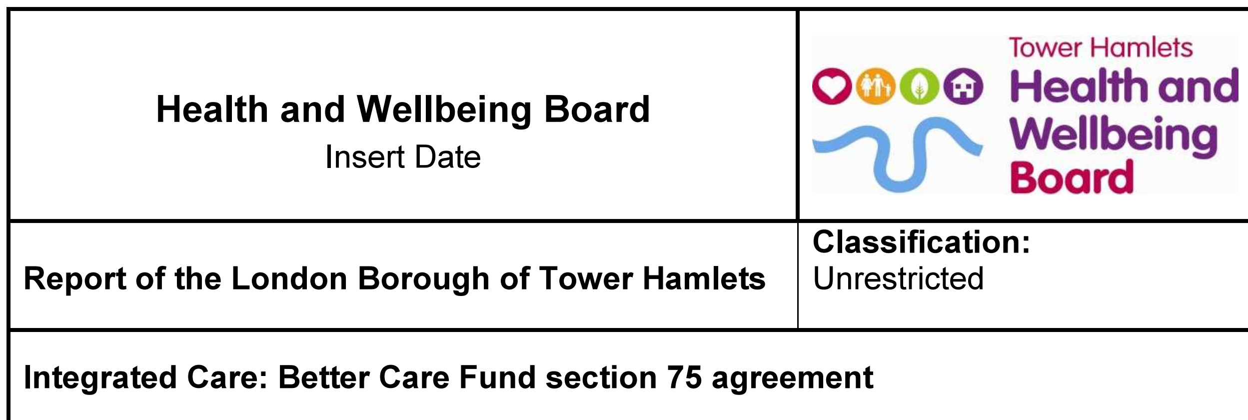
- Launch IC NIS 1st April . Develop resources and provide guidelines for practices
- Focussed discussion at WELC Ops group to agree content of single plan
- Workshop co-design the evaluation and provide PAM training to the pilots.
- Organise social prescribing workshop mid-March
- Negotiate with Orion developers to procure additional functions and agree new working arrangements

2. FINANCE COMMENTS

2.1. Funding for delivering this programme is incorporated in the Better Care Fund.

Appendices

- None.



Health and Wellbeing Board Insert Date	Tower Hamlets Health and Wellbeing Board
Report of the London Borough of Tower Hamlets	**Classification:** Unrestricted
Integrated Care: Better Care Fund section 75 agreement	

Lead Officer	Robert McCulloch-Graham; Corporate Director: Education, Social Care and Wellbeing
Contact Officers	Dorne Kanareck; Interim Service Head: Commissioning and Health Josh Potter; Deputy Director of Commissioning and Transformation, NHS Tower Hamlets CCG
Executive Key Decision?	Yes

Executive Summary

The Tower Hamlets Better Care Fund plan was submitted to the Department of Health in April 2014, a revised version was submitted in September 2014 and approval of the plan was confirmed by NHS England on 07 January 2015 (see Appendix 1).The plan has effect from 01 April 2015. The planned expenditure covered by the Better Care Fund plan is £21.577 million in 2015/16.

In order to provide a governance framework for the commissioning and delivery of the Better Care Fund and the management of the budget and expenditure, an agreement made under section 75 of the National Health Services Act 2006 is required. This agreement includes the following core components:

- Commissioning arrangements, including confirmation of which agency will act as Lead Commissioner for each element of the fund;
- Governance arrangements, including arrangements for reporting progress in delivering the plan to the Health and Wellbeing Board;
- Arrangements for management of the pooled funds;
- Arrangements for managing risk across the partners to the agreement;
- Information about each of the individual schemes which together make up the Better Care programme; and
- A standard range of terms and conditions covering issues such as dispute resolution and information sharing. A detailed table of contents is included on pages i to ii of the section 75 agreement, which is attached to this report as Appendix 2.

The report introduces the terms of the section 75 agreement, as well as proposing for specific approval the intended governance arrangements.

Recommendations:

The Health and Wellbeing Board is recommended to:

1. Note that the terms of the Tower Hamlets Better Care Fund section 75 agreement between NHS Tower Hamlets Clinical Commissioning Group (the CCG) and the London Borough of Tower Hamlets (the Council) as attached at Appendix 2 to this reportare consistent with the Better Care Fund Plan approved by HWB on 9 September 2014 and recommend approval of the agreement to the CCG and the Council;

2. Note the lead commissioning arrangements for managing the delivery of the Tower Hamlets Better Care Fund;

3. Delegate authority for overseeing delivery of the Better Care Fund plan to the Tower Hamlets Integrated Care Board and to note the arrangements for reporting of progress back to the Health and Wellbeing Board.

1. REASONS FOR THE DECISIONS

1.1 The standard conditions applied by NHS England to the funding provided under the Better Care Fund require that a section 75 pooled budget arrangement is in place for 01 April 2015. The approval letter at Appendix 1 to this report confirms that requirement.

2. ALTERNATIVE OPTIONS

2.1 The requirement to have a section 75 pooled budget arrangement in place in order for the Better Care Funds to be released by NHS England mean that there is no alternative option to having such an agreement in place other than to agree not to draw down the Better Care Funds. These funds amount to c£20.5 million in 2015/16 and their loss to the borough would have a significantly deleterious impact on health and social care services locally.

2.2 The Board could resolve to retain direct oversight of plan delivery as an alternative to devolving this responsibility to the Tower Hamlets Integrated Care Board (the ICB). Given, however, that the ICB is a sub-group of the Health and Wellbeing Board, and that individual members of the ICB have sufficient executive authority to resolve the significant majority of issues that may arise during plan delivery, it is recommended that this is unnecessary. The Board may however wish to propose that the ICB provide more frequent progress reports than currently proposed.

3. DETAILS OF REPORT

3.1 The Tower Hamlets Better Care Fund plan was submitted to the Department of Health in April 2014, with an updated version being submitted in September 2014 and approval of the plan was confirmed by NHS England on 07 January 2015 (see Appendix 1). The plan has effect from 01 April 2015. The planned expenditure covered by the Better Care Fund plan is £21.577 million in 2015/16. The final version of the plan, as approved by NHS England is included at Schedule 6 in Appendix 2 to this report.

3.2 It is a requirement for the release of the funding that the Council and CCG have agreed a pooled budget arrangement for managing this funding. This agreement is to be made pursuant to section 75 of the National Health Services Act 2006 (s75). NHS England commissioned Bevan Brittan LLP to develop a template s75 agreement for this purpose, which has been used as the basis from which the Tower Hamlets agreement has been developed.

3.3 A detailed table of contents for the s75 agreement can be found at pages i to ii of Appendix 2, but its core content can be summarised as including the following:

- Commissioning arrangements, including confirmation of which agency will act as Lead Commissioner for each element of the Fund;

- Governance arrangements, including arrangements for reporting progress in delivering the plan to the Health and Wellbeing Board;
- Arrangements for management of the pooled funds;
- Arrangements for managing risk across the partners to the agreement;
- Information about each of the individual schemes which together make up the Better Care programme; and
- A standard range of terms and conditions covering issues such as dispute resolution and information sharing.

Commissioning arrangements

3.4 **The Section 75 agreement gives the CCG the overall role of Lead Commissioner for the Better Care Fund, with the Council retaining Lead Commissioning responsibility for specific schemes**.

3.5 The individual schemes within the Better Care Fund plan are set out below along with the Lead Commissioner for each of the schemes identified:

Scheme	Sub-scheme	Lead Commissioner
Integrated Community Health Team	Integrated Community Health Team Reablement and Rehabilitation Joint Working Pilot Seven day working by the Social Work Team at Royal London Hospital Integrated Health and Social Care Continuing Health Care Assessment	CCG
Mental Health Support and Liaison	RAID Recovery College	CCG
Independent Living	Independent Living	CCG
Integrated Care Incentive Scheme	Integrated Care Incentive Scheme	CCG
Protection of adult social care services	Personalisation Carers Information, advice and support	Council

	Quality Safeguarding Assessment and eligibility Veterans Law reform	
Carers	Carers assessments Carers services	Council
Capital funding	Disabled Facilities Grants Social Care Capital Grant	Council

3.7 In addition to the BCF schemes set out at 3.6 above, the CCG has also decided to include the following schemes, each of which supports the delivery of the BCF plan, within the scope of the section 75 agreement:

Scheme	Lead Commissioner
Social Prescribing	CCG
Additional Community Geriatrician	CCG
Personalisation and Integrated Personal Commissioning	CCG

3.8 Irrespective of which agency has the Lead Commissioning role for individual schemes, it will be necessary to put in place management arrangements which ensure that the overall Lead Commissioner has the authority necessary to direct the actions of commissioners from the partner agency in respect of those services for which the partner agency is responsible for commissioning. It is recommended that these management arrangements be resolved within the wider work that is currently ongoing between the Council and the CCG to establish new joint commissioning arrangements in order to ensure that the arrangements put in place are consistent with this wider work. As an interim measure, and until such time as the wider arrangements are agreed, the ICB will determine suitable working arrangements.

Governance arrangements

3.9 The Health and Wellbeing Board is the body to which the Lead Commissioner is ultimately accountable for delivery of the Better Care Fund plan**. It is recommended that the Health and Wellbeing Board devolve responsibility for overseeing delivery of the Better Care Fund plan to the Integrated Care Board, which is a sub-group of the Board. It is further recommended that the Integrated Care Board provide an annual report**

on performance against the plan, to include any recommendations for change. The ICB will report more frequently to the HWBB by exception as required and in particular where actual performance is varying significantly from planned. In this case any exception reporting will include plans for recovering performance and any associated recommendations.

3.10 If the recommendation to devolve oversight to the ICB is agreed, the Terms of Reference for the ICB will be amended to reflect the additional requirements relating to overseeing plan delivery. Each partner to the agreement will nominate a Senior Responsible Officer to assist the Board Chair in agenda setting.

3.11 The Lead Commissioner will be required to report on performance against the plan on a monthly basis and each of these monthly reports will be provided to the ICB in order that it can properly fulfil its oversight role.

Risk share

3.12 Risk in the context of the BCF relates to

- any unanticipated overspends in the fund budget. Given the nature of the services and contractual arrangements included within the scope of the plan the likelihood of this risk materialising is considered to be low; and
- the risk associated with meeting the targets set out in the plan. The primary impact of this second risk is that the amount of reward that is made available to the Health and Wellbeing Board for allocation to local priorities is reduced proportionate to the level of under-performance. Any amount held back by the CCG to reflect under delivery can only be used to mitigate pressures on the health system directly arising from the under performance in plan delivery (which will manifest itself as a failure to achieve the target reduction in hospital admissions).

4. COMMENTS OF THE CHIEF FINANCE OFFICER

4.1. The Better Care Fund is worth £3.8 billion nationally. Tower Hamlets overall share of this has been confirmed as £20.550m for 2015/16.

4.2. The Councils share of the BCF in 2015/16 is £9.092m with the CCG allocated £11.458m, an additional contribution by the CCG of £1.027m results in a total pooled fund of £21.577m. The S.75 agreement between the CCG and the Council identifies the host partner for individual schemes within the overall BCF.

4.3. For the Council’s share of the BCF of £9.092m the Council is identified as the host partner, this allows the council to comply with VAT regulations and to carry forward surplus balances in the event of any underspends.

4.4. The risk share arrangement in regards to potential overspends within the BCF states that individual scheme overspends are to be absorbed by the partner

managing the scheme. However there is also avenue within the agreement for the ICB to authorise virements from elsewhere in the fund by agreement, if there is sufficient underspend in other areas of the pooled budget.

5. LEGALCOMMENTS

Better Care Fund Plan

5.1 The Care Act 2014 places a duty on the Council to exercise its function by ensuring the integration of care and support provision with health provision, promote the well-being of adults in its area with needs for care and support and contribute to the prevention or delay of the development by adults in its area of needs for care and support. The 2014 Act alsoamended the National Health Service Act 2006 to provide the legislative basis for the Better Care Fund. It allows for the NHS Mandate to include specific requirements relating to the establishment and use of an integration fund.

5.2 The Government is providing funding to local authorities under the Better Care Fund to integrate local services. The funding is to be made available via two statutory mechanisms –

- In 2014/2015, NHS England made payments under section 256 of the National Health Service (NHS) Act 2006. Such payments could be made to support social services functions, education for the benefit of disabled persons, the provision of housing and health-related functions.
- In 2015/2016, a pooled budget will be made available upon the Council entering into an agreement with a relevant NHS body under section 75 of the NHS Act 2006. Such agreements may be entered into where arrangements are proposed which are likely to lead to improvement in the way that prescribed NHS functions and prescribed health-related functions of the Council are exercised.

5.3 In order to receive the Better Care funding, the Government requires the Council to set out its plans for the application of those monies. The Government published guidance related to the Better Care Fund programme which indicated that plans should be agreed by the Council's Health and Wellbeing Board ("**HWB**"). This is consistent with the general policy, reflected in the Health and Social Care Act 2012, of giving HWBs responsibility for joint health and wellbeing strategies and the joint strategic needs assessment.

5.4 The joint plan was agreed by the CCG and the Local Authority and approved through the HWB on 24 March 2014, as endorsement of the plan falls within the Terms of Reference for HWB. That commitment and sign off by the Council was a key decision for the Mayor to take, and the plan was therefore approved by Cabinet on 2 April 2014. The Council's proposal complied with the Better Care Fund Planning Guidance issued by NHS England in December 2013. However, on 18 August 2014, a revised Better Care Fund Planning Guidance and technical guidance documents were issued by NHS England, so a more detailedplan was approvedby HWB on 9 September 2014, and approved by Individual Mayoral Decision on 18 September 2014.

Contracting

5.5 Pursuant to section 75 of the National Health Service Act 2006, the NHS Bodies and Local Authorities Partnerships Arrangements Regulations 2000, the s75 Agreement provides for the establishment of funds made up of contributions from the Council and NHS CCG out of which payments may be made towards expenditure incurred in the exercise of their functions; for the exercise by NHS CCG of the Council's functions and for the exercise by the Council of the NHS CCG's functions in writing. In addition, the s75 Agreement covers specific objectives in relation (including but not limited) to:

5.5.1 agreed aims and outcomes of the partnership including the Council and NHS CCG's respective legal and regulatory responsibilities, and the client groups for whom the services will be delivered under the arrangement

5.5.2 operational arrangements for managing the partnership including performance and governance structures encompassing the resolution of disputes, conditions for renewal and termination of the partnership, provision and mechanisms for annual review, the treatment of VAT, legal issues, complaints and risk sharing

5.5.3 the respective financial contributions and other resources provided in support of the partnership including arrangements for financial monitoring, reporting and management of pooled, delegated and aligned budgets

5.5.4 linking in with existing governance arrangements including the role and function of the Integrated Care Board

5.5.5 achieving best value from Service Providers and principles in connection with the management of staff; and

5.5.6 flexibilities for the Council and NHS CCG in being permitted to add relevant service provisions and deciding future budgets for existing services within the remit of the s75 Agreement.

5.12 The s75 Agreement is consistent with the Better Care Fund Plan approved by HWB on 9 September 2014 and entering into it formalises the arrangements agreed by the Council and NHS CCG in accordance with the statutory, regulatory and guidance frameworks.

Recommendations

5.6 Although it is an executive function of the Council and CCG to finalise the terms of the section 75 agreement and to make arrangements to sign it on behalf of the respective bodies, HWB should note that the terms of the agreement are consistent with the approved Better Care Fund Plan. The first 2 recommendations made in this report therefore fall within the HWB's functions.

5.7 In respect of the third recommendation, the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013

modifys101 of the Local Government Act 1972 to permit HWB to arrange to discharge any of its functionsby a sub-committee of the HWB, unless the Council otherwise directs.

5.8 In respect of its functions under section 196(2) of the 2012 Act (arranging for the Health and Wellbeing Board to exercise any functions that are exercisable by the Council), the HWB may arrange for the discharge of any of those functions by a sub-committee of the Board or an officer of the authorityunless the Council otherwise directs. Further, unless the Board otherwise directs, the sub-committee may then arrange for the discharge of any of those functions by an officer of the authority.

5.9 Oversight of delivery of the Better Care Fund plan falls within the HWB's functions and therefore the recommendation to delegate authority for this function to the Tower Hamlets Integrated Care Board is also within HWB's powers.

Welfare Principle and Equalities Duties

5.10 The Care Act 2014 (coming into effect on 1 April 2015) creates a general duty on the Council to promote an individual's well-being when exercising a function under that Act. Well-being is defined as including physical and mental health and emotional well-being and in exercising a function under the Act, the Council must have regard to the importance of preventing or delaying the development of needs for care and support or needs for support and the importance of reducing needs of either kind that already exist. The well-being principle should therefore inform the delivery of universal services which are provided to all people in the local population, including services provided through the Better Care Fund.

5.11 The Equality Act 2010 requires the council in the exercise of its functions to have due regard to the need to avoid discrimination and other unlawful conduct under the Act, the need to promote equality of opportunity and the need to foster good relations between people who share a protected characteristic (including age, disability, maternity and pregnancy) and those who do not.

6. ONE TOWER HAMLETS CONSIDERATIONS

6.1. The target cohorts to which services will be delivered via the Better Care Fund plan are those identified as being at Very High, High and Moderate risk of admission to hospital. This cohort includes many of the most vulnerable residents of the borough, including older people, those with complex long term conditions, with mental health difficulties and with a range of other health and social care needs. The activities which form the basis of the plan are designed to improve the wellbeing and quality of life of the individuals within the target cohort, and to reduce their risk of experiencing unplanned hospital admissions. Successful delivery of the plan will therefore positively contribute

to the wider work of the One Tower Hamlets partnership to address equalities issues relating to older people and people with disabilities.

7. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

7.1 There are no identifiable environmental impacts arising from the delivery of the Better Care Fund plan.

8. RISK MANAGEMENT IMPLICATIONS

8.1. Detailed risk management and risk sharing arrangements have been developed within the section 75 agreement and can be found at section 12 and schedule 3 of the agreement. These arrangements include explicit agreement about the proportion of the financial risk accruing to each party to the agreement.

9. CRIME AND DISORDER REDUCTION IMPLICATIONS

9.1 The Better Care Fund plan does not have any identifiable impact on Crime and Disorder reduction.

10. EFFICIENCY STATEMENT

10.1 The management and delivery arrangements for the Better Care Fund plan set out in the attached s75 are intended to ensure the efficient delivery of the plan. In particular the governance, joint commissioning and pooled fund management arrangements are intended to ensure that any duplication of effort across the two partners is removed wherever practicable and minimised where necessary.

Appendices and Background Documents

Appendices

Appendix 1: Letter from NHS England, dated 07 January 2015, confirming approval of the Tower Hamlets Better Care Fund plan;

Appendix 2: Final DraftFramework Partnership Agreement Relating to the Commissioning of Health and Social Care Services to deliver the Tower Hamlets Better Care Fund Plan

Background Documents

NONE

Bevan Brittan

Dated 2015

LONDON BOROUGH OF TOWER HAMLETS

and

NHS TOWER HAMLETS CLINICAL COMMISSIONING GROUP

FRAMEWORK PARTNERSHIPAGREEMENT RELATING TO THE COMMISSIONING OF HEALTH AND SOCIAL CARE SERVICESTO DELIVER THE TOWER HAMLETS BETTER CARE FUND PLAN

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THIS AGREEMENTis made on the day of 2015

PARTIES

(1) **LONDON BOROUGH OFTOWER HAMLETS**of the Town Hall, Mulberry Place, 5 Clove Crescent, London E14 2BG (the **"Council"**)

(2) **NHS TOWER HAMLETSCLINICAL COMMISSIONING GROUP**of2nd Floor Alderney Building, Mile End Hospital, Bancroft Road, London, E1 4DG (the "**CCG"**)

BACKGROUND

(A) The Council has responsibility for commissioning and/or providing social care services on behalf of the population of the borough ofTower Hamlets.

(B) The CCG has the responsibility for commissioning health services pursuant to the 2006 Act in the borough of Tower Hamlets.

(C) The Better Care Fund has been established by the Government to provide funds to local areas to support the integration of health and social care and to seek to achieve the National Conditions and Local Objectives. It is a requirement of the Better Care Fund that the CCG and the Council establish a pooled fund for this purpose.The Partners wish to extend the use of Pooled Fund to include funding streams from outside of the Better Care Fund.

(D) Section 75 of the 2006 Act gives powers to local authorities and clinical commissioning groups to establish and maintain pooled funds out of which payment may be made towards expenditure incurred in the exercise of prescribed local authority functions and prescribed NHS functions.

(E) The purpose of this Agreement is to set out the terms on which the Partners have agreed to collaborate and to establish a framework through which the Partners can secure the future position of health and social care services through lead or joint commissioning arrangements. It is also the means through which the Partners will pool funds and align budgets as agreed between the Partners.

(F) The aims and benefits of the Partners in entering in to this Agreement are to:

a) improve the quality and efficiency of the Services;

b) meet the National Conditions and Local Objectives;

c) make more effective use of resources through the establishment and maintenance of a pooled fund for revenue expenditure on the Services; and

d) support the achievement of the vision for integrated care in the borough for a health and social care Services system that:

i. coordinates care around the patient and delivers care in the most appropriate setting;

ii. empowers patients, users and their carers;

iii. provides more responsive, coordinated and proactive care, including data sharing information between providers to enhance the quality of care; and

iv. ensures consistency and efficiency of care.

(G) The Partners have jointly carried out consultations on the proposals for this Agreement with all those persons likely to be affected by the arrangements. Additional consultations will be undertaken

as necessary, and in line with each Partners obligations regarding consultation with affected parties, in respect of any future proposals to vary the plan or individual schemes.

(H) The Partners are entering into this Agreement in exercise of the powers referred to in Section 75 of the 2006 Act and/or Section 13Z(2) and 14Z(3) of the 2006 Act as applicable, to the extent that exercise of these powers is required for this Agreement.

1 DEFINED TERMS AND INTERPRETATION

1.1 In this Agreement, save where the context requires otherwise, the following words, terms and expressions shall have the following meanings:

1998 Act means the Data Protection Act 1998.

2000 Actmeans the Freedom of Information Act 2000.

2004 Regulationsmeans the Environmental Information Regulations 2004.

2006 Actmeans the National Health Service Act 2006.

Affected Partnermeans, in the context of Clause 24, the Partner whose obligations under the Agreement have been affected by the occurrence of a Force Majeure Event

Agreementmeans this agreement including its Schedules and Appendices.

Approved Expendituremeans any additional expenditure approved by the Partners in relation to an Individual Service above any Contract Price and Performance Payments.

Authorised Officersmeans an officer of each Partner appointed to be that Partner's representative for the purpose of this Agreement.

Better Care Fundmeans the Better Care Fund as described in NHS England Publications Gateway Ref. No.00314 and NHS England Publications Gateway Ref. No.00535 as relevant to the Partners.

Better Care Fund Planmeans the plan attached at Schedule 6 setting out the Partners plan for the use of the Better Care Fund.

CCG Statutory Duties means the Duties of the CCG pursuant to Sections 14P to 14Z2 of the 2006 Act

Change in Law means the coming into effect or repeal (without re-enactment or consolidation) in England of any Law, or any amendment or variation to any Law, or any judgment of a relevant court of law which changes binding precedent in England after the date of this Agreement

Commencement Datemeans 00:01 hrs on 01 April 2015.

Confidential Informationmeans information, data and/or material of any nature which any Partner may receive or obtain in connection with the operation of this Agreement and the Services and:

(a) which comprises Personal Data or Sensitive Personal Data or which relates to any patient or his treatment or medical history;

(b) the release of which is likely to prejudice the commercial interests of a Partner or the interests of a Service User respectively; or

(c) which is a trade secret.

Contract Pricemeans any sum payable to a Provider under a Service Contract as consideration for the provision of Services and which, for the avoidance of doubt, does not include any Default Liability or Performance Payment.

Default Liabilitymeans any sum which is agreed or determined by Law or in accordance with the terms of a Services Contract to be payable by any Partner(s) to aProvider as a consequence of (i) breach of the Partner's obligation(s) in whole or in part under a relevant Services Contract or (ii) any act or omission of a third party for which the Partneris, under the terms of a relevant Services Contract, liable to a Provider.

Financial Contributionsmeans the financial contributions made by each Partner to a Pooled Fund in any Financial Year.

Financial Contributions Proposal means a proposal made by each Partner to a Pooled Fund or Non-Pooled Fund in respect of each Partner's financial contribution for each Individual Scheme subsequent to the first Financial Year's Financial Contributions.

Financial Yearmeans each financial year running from 1 April in any year to 31 March in the following calendar year.

Force Majeure Event means one or more of the following:

(a) war, civil war (whether declared or undeclared), riot or armed conflict;

(b) acts of terrorism;

(c) acts of God;

(d) fire or flood;

(e) industrial action;

(f) prevention from or hindrance in obtaining raw materials, energy or other supplies;

(g) any form of contamination or virus outbreak; and

(h) any other event,

in each case where such event is beyond the reasonable control of the Partner claiming relief.

Functions means the NHS Functions and the Health Related Functions

Health Related Functionsmeans those of the health related functions of the Council, specified in Regulation 6 of the Regulations as relevant to the commissioning of the Services and which may be further described in the relevant Scheme Specification.

Host Partner means for each Pooled Fund the Partner that will host the Pooled Fund [and for each Aligned Fund the Partner that will host the Aligned Fund]

Health and Wellbeing Boardmeans the Health and Wellbeing Board established by the Council pursuant to Section 194 of the Health and Social Care Act 2012.

Indirect Lossesmeans loss of profits, loss of use, loss of production, increased operating costs, loss of business, loss of business opportunity, loss of reputation or goodwill or any other consequential or indirect loss of any nature, whether arising in tort or on any other basis.

Individual Schememeans one of the schemes which is agreed by the Partners to be included within this Agreement using the powers under Section 75 as documented in a Scheme Specification.

Integrated Commissioning means arrangements by which both Partners commission Services in relation to an individual Scheme on behalf of each other inexercise of both the NHS Functions and Council Functions through integrated structures.

Joint (Aligned) Commissioning means a mechanism by which the Partners jointly commission a Service. For the avoidance of doubt, a joint (aligned) commissioning arrangement does not involve the delegation of any functions pursuant to Section 75.

Lawmeans:

(d) any statute or proclamation or any delegated or subordinate legislation;

(e) any enforceable community right within the meaning of Section 2(1) European Communities Act 1972;

(f) any guidance, direction or determination with which the Partner(s) or relevant third party (as applicable) are bound to comply to the extent that the same are published and publicly available or the existence or contents of them have been notified to the Partner(s) or relevant third party (as applicable); and

(g) any judgment of a relevant court of law which is a binding precedent in England.

Lead Commissioning Arrangementsmeans the arrangements by which one Partner commissions Services in relation to an Individual Scheme on behalf of the other Partner in exercise of both the NHS Functions and the Council Functions.

Lead Commissioner means the Partner responsible for commissioning an Individual Service under a Scheme Specification.

London Living Wage means the hourly rate of pay set by the Mayor of London for residents working in London (as amended from time to time).

Lossesmeans all damage, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional services), proceedings, demands and charges whether arising under statute, contract or at common law but excluding Indirect Losses and "Loss" shall be interpreted accordingly.

Monthmeans a calendar month.

National Conditions mean the national conditions as set out in theNHS England Planning Guidance as are amended or replaced from time to time.

NHS Functionsmeans those of the NHS functions listed in Regulation 5 of the Regulations as are exercisable by the CCG as are relevant to the commissioning of the Services and which may be further described in each Service Schedule

Non Pooled Fund means the budget detailing the financial contributions of the Partners which are not included in a Pooled Fund in respect of a particular Service as set out in the relevant Scheme Specification

Non-Recurrent Payments means funding provided by a Partner to a Pooled Fund in addition to the Financial Contributions pursuant to arrangements agreed in accordance with Clause 10.5.

Overspendmeans any expenditure from a Pooled Fund in a Financial Year which exceeds the Financial Contributions for that Financial Year.

Partnermeans each of the CCG and the Council, and references to "**Partners**" shall be construed accordingly.

Partnership Board means the partnership board responsible for review of performance and oversight of this Agreement as set out in Schedule 2 (for the avoidance of doubt,in Tower Hamlets this is the Integrated Care Board).

Permitted Budget means in relation to a Service where the Council is the Provider, the budget that the Partners have set in relation to the particular Service.

Permitted Expenditurehas the meaning given in Clause 7.3.

Personal Data means Personal Data as defined by the 1998 Act.

Pooled Fundmeans any pooled fund established and maintained by the Partners as a pooled fund in accordance with the Regulations

Pooled Fund Managermeans such officer of the Host Partner which includes a Section 113 Officer for the relevant Pooled Fund established under an Individual Scheme as is nominated by the Host Partner from time to time to manage the Pooled Fund in accordance with Clause 8.

Providermeans a provider of any Services commissioned under the arrangements set out in this Agreement.

Public Health Englandmeans the SOSH trading as Public Health England.

Quartermeans each of the following periods in a Financial Year:

1 April to 30 June

1 July to 30 September

1 October to 31 December

1 January to 31 March

and"**Quarterly**" shall be interpreted accordingly.

Regulationsmeans the means the NHS Bodies and Local Authorities Partnership ArrangementsRegulations 2000 No 617 (as amended).

Performance Payment Arrangement*means any arrangement agreed with a Provider and one of more Partners in relation to the cost of providing Services on such terms as agreed in writing by all Partners.*

Performance Paymentsmeans any sum over and above the relevant Contract Price which is payable to the Provider in accordance with a Performance Payment Arrangement.

Scheme Specification means a specification setting out the arrangements for an Individual Scheme agreed by the Partners to be commissioned under this Agreement.

Sensitive Personal Datameans Sensitive Personal Data as defined in the 1998 Act.

Servicesmeans such health and social care services as agreed from time to time by the Partners as commissioned under the arrangements set out in this Agreement and more specifically defined in each Scheme Specification.

Services Contractmeans an agreementfor the provision of Services entered into with a Provider by one or more of the Partners in accordance with the relevant Individual Scheme.

Service Usersmeans those individual for whom the Partners have a responsibility to commission the Services.

Standing Orders and Standing Financial Instructions (or equivalent) means the Partners' internal constitutional and corporate governance rules detailing the Partners' respective powers and delegations amongst other things.

SOSHmeans the Secretary of State for Health.

Third Party Costsmeans all such third party costs (including but not limited to legal, accounting and auditing costs) in respect of each Individual Scheme as a Partner reasonably and properly incurs in the proper performance of its obligations under this Agreement and as agreed by the Partnership Board.

Working Daymeans 8.00am to 6.00pm on any day except Saturday, Sunday, Christmas Day, Good Friday or a day which is a bank holiday (in England) under the Banking & Financial Dealings Act 1971.

1.2 In this Agreement, all references to any statute or statutory provision shall be deemed to include references to any statute or statutory provision which amends, extends, consolidates or replaces the same and shall include any orders, regulations, codes of practice, instruments or other subordinate legislation made thereunder and any conditions attaching thereto. Where relevant, references to English statutes and statutory provisions shall be construed as references also to equivalent statutes, statutory provisions and rules of law in other jurisdictions.

1.3 Any headings to Clauses, together with the front cover and the index are for convenience only and shall not affect the meaning of this Agreement. Unless the contrary is stated, references to Clauses and Schedules shall mean the clauses and schedules of this Agreement.

1.4 Any reference to the Partners shall include their respective statutory successors, employees and agents.

1.5 In the event of a conflict, the conditions set out in the Clauses to this Agreement shall take priority over the Schedules.

1.6 Where a term of this Agreement provides for a list of items following the word "including" or "includes", then such list is not to be interpreted as being an exhaustive list.

1.7 In this Agreement, words importing any particular gender include all other genders, and the term "person" includes any individual, partnership, firm, trust, body corporate, government, governmental body, trust, agency, unincorporated body of persons or association and a reference to a person includes a reference to that person's successors and permitted assigns.

1.8 In this Agreement, words importing the singular only shall include the plural and vice versa.

1.9 In this Agreement, "staff" and "employees" shall have the same meaning and shall include reference to any full or part time employee or officer, director, manager and agent.

1.10 Subject to the contrary being stated expressly or implied from the context in these terms and conditions, all communication between the Partners shall be in writing.

1.11 Unless expressly stated otherwise, all monetary amounts are expressed in pounds sterling but in the event that pounds sterling is replaced as legal tender in the United Kingdom by a different currency then all monetary amounts shall be converted into such other currency at the rate prevailing on the date such other currency first became legal tender in the United Kingdom.

1.12 All references to the Agreement include (subject to all relevant approvals) a reference to the Agreement as amended, supplemented, substituted, novated or assigned from time to time.

2 TERM

2.1 This Agreement shall come into force on the Commencement Date.

2.2 This Agreement shall continue until it is terminated in accordance with Clause 22.

2.3 The duration of the arrangements for each Individual Scheme shall be as set out in the relevant Scheme Specification.

3 GENERAL PRINCIPLES

3.1 Nothing in this Agreement shall affect:

3.1.1 the liabilities of the Partners to each other or to any third parties for the exercise of their respective functions and obligations (including the Functions); or

3.1.2 any power or duty to recover charges for the provision of any services (including the Services) in the exercise of any local authority function.

3.2 The Partners agree to:

3.2.1 treat each other with respect and an equality of esteem;

3.2.2 be open with information about the performance and financial status of each; and

3.2.3 provide early information and notice about relevant problems.

3.3 For the avoidance of doubt, the aims and outcomes relating to an Individual Scheme may be set out in the relevant Scheme specification.

4 PARTNERSHIP FLEXIBILITIES

4.1 This Agreement sets out the mechanism through which the Partners will work together to establish one or more of the following:

4.1.1 Lead Commissioning Arrangements; and

4.1.2 the establishment of one or more Pooled Fund.

in relation to Individual Schemes (the "**Flexibilities**")

4.2 The Council delegates to the CCG and the CCG agrees to exercise, on the Council's behalf, the Health Related Functions to the extent necessary for the purpose of performing its obligations under this Agreement in conjunction with the NHS Functions.

4.3 The CCG delegates to the Council and the Council agrees to exercise on the CCG's behalf the NHS Functions to the extent necessary for the purpose of performing its obligations under this Agreement in conjunction with the Health Related Functions.

4.4 Where the powers of a Partner to delegate any of its statutory powers or functions are restricted, such limitations will automatically be deemed to apply to the relevant Scheme Specification and the Partners shall agree arrangements designed to achieve the greatest degree of delegation to the other Partner necessary for the purposes of this Agreement which is consistent with the statutory constraints.

5 FUNCTIONS

5.1 The purpose of this Agreement is to establish a framework through which the Partners can secure the provision of health and social care services in accordance with the terms of this Agreement.

5.2 This Agreement shall include such functions as shall be agreed from time to time by the Partners.

5.3 On the Commencement Date of this Agreementthe following Individual Schemes will be included in the scope of this Agreement:

5.3.1 Individual Schemesfunded from the Better Care Fund:

Scheme	Sub-scheme	Lead Commissioner
Integrated Community Health Team	Integrated Community Health Team Reablement and Rehabilitation Joint Working Pilot Seven day working by the Social Work Team at Royal London Hospital Integrated Health and Social Care Continuing Health Care Assessment	CCG
Mental Health Support and Liaison	RAID Recovery College	CCG
Independent Living	Independent Living	CCG
Integrated Care Incentive Scheme	Integrated Care Incentive Scheme	CCG
Protection of adult social care services(pursuant to Care Act 2014 responsibilities)	Personalisation Carers Information, advice and support Quality Safeguarding Assessment and eligibility Veterans Law reform	Council
Carers	Carers assessments Carers services	Council
Capital funding	Disabled Facilities Grants Social Care Capital Grant	Council

5.3.2 Individual Schemes funded by Tower Hamlets CCG that support the delivery of the Better Care Fund Plan:

Scheme	Lead Commissioner
Social Prescribing	CCG
Additional Community Geriatrician	CCG
Personalisation and Integrated Personal Commissioning	CCG

5.4 Where the Partners add a new Individual Scheme to this Agreement a Scheme Specification for each Individual Scheme shall be in the form set out in Schedule 1 andshall be completed and agreed between the Partners. The initial Scheme Specification is set out in Schedule 1 part 2 (which may be varied from time to time by the Partners in accordance with the terms of this Agreement).

5.5 The Partners shall not enter into a Scheme Specification in respect of an Individual Scheme unless they are satisfied that the Individual Scheme in question will improve health and well-being in accordance with this Agreement.

5.6 The introduction of any Individual Scheme will be subject to:

5.6.1 a business case (on the respective template of the Partner wishing to propose the same or as otherwise agreed between the Partners); and

5.6.2 approval by thePartnership Board.

6 COMMISSIONING ARRANGEMENTS

Integrated Commissioning

6.1 Where there are IntegratedCommissioning arrangements in respect of an Individual Scheme, both Partners shall work in cooperation and shall endeavour to ensure that the NHS Functions and Health Related Functions are commissioned with all due skill, care and attention.

6.2 Both Partners shall be responsible for compliance with and making payments of all sums due to a Provider pursuant to the terms of each Service Contract.

6.3 Both Partners shall work in cooperation and endeavour to ensure that the relevant Services as set out in each Scheme Specification are commissioned within each Partner's Financial Contribution in respect of that particular Service in each Financial Year.

6.4 The Partners shall comply with the arrangements in respect of the Joint (Aligned) Commissioning as set out in the relevant Scheme Specification.

6.5 Each Partner shall keep the other Partners and the Partnership Board regularly informed of the effectiveness of the arrangements including the Better Care Fund and any Overspend or Underspend in a Pooled Fund or Non Pooled Fund.

6.6 The Partnership Board will report back to the Health and Wellbeing Board as required by its Terms of Reference.

Appointment of a Lead Commissioner

6.7 Where there are Lead Commissioning Arrangements in respect of an Individual Scheme the Lead Commissioner shall:

6.7.1 exercise the NHS Functions in conjunction with the Health Related Functions as identified in the relevant Scheme Specification;

6.7.2 endeavour to ensure that the NHS Functions and the Health Related Functions are funded within the parameters of the Financial Contributions of each Partner in relation to each particular Service in each Financial Year.

6.7.3 commission Services for individuals who meet the eligibility criteria set out in the relevant Scheme Specification;

6.7.4 contract with Provider(s) for the provision of the Services on terms agreed with the other Partners;

6.7.5 comply with all relevant legal duties (including any Change in Law) and guidance (as amended from time to time) of both Partners in relation to the Services being commissioned;

6.7.6 where Services are commissioned using the NHS Standard Form Contract, perform the obligations of the "Commissioner" and "Co-ordinating Commissioner" with all due skill, care and attention and where Services are commissioned using any other form of contract to perform its obligations with all due skill and attention;

6.7.7 undertake performance management and contract monitoring of all Service Contracts and ensure that effective and timely action to remediate any non-performance is taken;

6.7.8 make payment of all sums due to a Provider pursuant to the terms of any Services Contract.

6.7.9 keep the other Partner and the Partnership Board regularly informed of the effectiveness of the arrangements including the Better Care Fund and any Overspend or Underspend in a Pooled Fund or Non Pooled Fund.

Responsibilities of the other Partner

6.8 The other Partner, insofar as they are a provider of services under Individual Schemes, shall undertake to provide all necessary performance and financial data necessary to enabling the Lead Commissioner to fulfil the responsibilities at 6.7.

7 ESTABLISHMENT OF A POOLED FUND

7.1 In exercise of their respective powers under Section 75 of the 2006 Act, the Partners have agreed to establish and maintain such pooled funds for revenue expenditure as set out in the Scheme Specifications.

7.2 Each Pooled Fund shall be managed and maintained in accordance with the terms of this Agreement.

7.3 It is agreed that the monies held in a Pooled Fund may only be expended on the following:

7.3.1 the Contract Price*;*

7.3.2 where the Council is to be the Provider, the Permitted Budget;

7.3.3 Performance Payments;

7.3.4 Third Party Costs;

7.3.5 Approved Expenditure;

7.3.6 any other explicit allowances stipulated in this Agreement; and

7.3.7 subject to Clause 7.4, Permitted Expenditure

7.4 The Partners may only depart from the definition of Permitted Expenditure to include or exclude other revenue expenditure with the express written agreement of each Partner and the Partnership Board.

7.5 For the avoidance of doubt, monies held in the Pooled Fund may not be expended on Default Liabilities unless this is agreed by all Partners.

7.6 Pursuant to this Agreement, the Partners agree to appoint a Host Partner for each of the Pooled Funds set out in the Scheme Specifications. The Host Partner shall be the Partner responsible for:

7.6.1 holding all monies contributed to the Pooled Fund on behalf of itself and the other Partners;

7.6.2 providing the financial administrative systems for the Pooled Fund; and

7.6.3 appointing the Pooled Fund Manager;

7.6.4 ensuring that the Pooled Fund Manager complies with its obligations under this Agreement.

7.7 At the Commencement Date of this Agreement there shall be four (4) Pooled Funds:

POOLED FUND	LEAD COMMISSIONER	HOST PARTNER
CCG Better Care Fund Core Individual schemes: ➢ Mental Health Support and Liaison ➢ Integrated Care NIS ➢ Integrated Care Community Health Team ➢ Enablers (CCG)	CCG	CCG
LBTH Better Care Fund Core ➢ Mental Health Recovery College ➢ Community Geriatrician ➢ Additional Community Health Teams Investment ➢ 7 day hospital discharge / avoidance and step down ➢ Independent	CCG	Council

Living ➢ Enablers (LBTH) Specific schemes within core fund for which LBTH is Lead Commissioner: ➢ Protection of adult social care services (pursuant to Care Act 2014 responsibilities) ➢ Carers	 LBTH LBTH	
Strategy and Development Fund	CCG	Council
Better Care Fund Capital	Council	Council

8 POOLED FUND MANAGEMENT

8.1 When introducing a Pooled Fund in respect of an Individual Scheme, the Partners shall agree:

8.1.1 which of the Partners shall act as Host Partner for the purposes of Regulations 7(4) and 7(5) and shall provide the financial administrative systems for the Pooled Fund;

8.1.2 which officer of the Host Partner shall act as the Pooled Fund Manager for the purposes of Regulation 7(4) of the Regulations.

8.2 The Pooled Fund Manager in respect of each Individual Service where there is a Pooled Fund shall have the following duties and responsibilities:

8.2.1 the day to day operation and management of the Pooled Fund;

8.2.2 ensuring that all expenditure from the Pooled Fund is in accordance with the provisions of this Agreement and the relevant Scheme Specification;

8.2.3 maintaining an overview of all joint financial issues affecting the Partners in relation to the Services and the Pooled Fund;

8.2.4 ensuring that full and proper records for accounting purposes are kept in respect of the Pooled Fund and liaising with Internal and External Auditors as necessary;

8.2.5 reporting to the Partnership Board as required by the Partnership Board and the relevant Scheme Specification;

8.2.6 ensuring action is taken to manage any projected under or overspends relating to the Pooled Fund in accordance with this Agreement;

8.2.7 preparing and submitting to the Partnership Board Quarterly reports (or more frequent reports if required by the Partnership Board) and an annual return about the income and expenditure from the Pooled Fund together with such other information as may be required by the Partners and the Partnership Board to monitor the effectiveness of the Pooled Fund and to enable the Partners to complete their own financial accounts and returns. The Partners agree to provide all necessary information to the Pooled Fund Manager in time for the reporting requirements to be met.

8.2.8 preparing and submitting reports to the Health and Wellbeing Board as required by it.

8.3 In carrying out their responsibilities as provided under Clause 8.2 the Pooled Fund Manager shall have regard to the recommendations of the Partnership Board and shall be accountable to the Partners.

8.4 The Partnership Board may agree to the viring of funds between Pooled Funds subject always to the Law and the Partners' Standing Orders and Standing Financial Instructions.

8.5 The Partnership Board may agree to the secondment of employees between Partners for the purposes of managing Pooled Funds or management and delivery of Individual Schemes subject always to the Law, Partners' Standing Orders and Standing Financial Instructions, and the Partners' Human Resource and Managing Organisational Change policies and procedures.

9 NON POOLED FUNDS

9.1 Any Financial Contributions agreed to be held within a Non Pooled Fund will be notionally held in a fund established for the purpose of commissioning that Service as set out in the relevant Scheme Specification. For the avoidance of doubt, a Non Pooled Fund does not constitute a pooled fund for the purposes of Regulation 7 of the Regulations.

9.2 When introducing a Non Pooled Fund in respect of an Individual Scheme, the Partners shall agree:

9.2.1 which Partner if any shall host the Non-Pooled Fund; and

9.2.2 how and when Financial Contributions shall be made to the Non-Pooled Fund.

9.3 The Host Partner will be responsible for establishing the financial and administrative support necessary to enable the effective and efficient management of the Non-Pooled Fund, meeting all required accounting and auditing obligations.

9.4 Both Partners shall ensure that Services commissioned using a Non Pooled Fund are commissioned solely in accordance with the relevant Scheme Specification.

9.5 Where there are Joint (Aligned) Commissioning arrangements, both Partners shall work in cooperation and shall endeavour to ensure that:

9.5.1 the NHS Functions funded from a Non-Pooled Fund are carried out within the CCG Financial Contribution to the Non- Pooled Fund for the relevant Service in each Financial Year; and

9.5.2 the Health Related Functions funded from a Non-Pooled Fund are carried out within the Council's Financial Contribution to the Non-Pooled Fund for the relevant Service in each Financial Year.

10 FINANCIALCONTRIBUTIONS

10.1 The Financial Contribution of the CCG and the Council to any Pooled Fundor Non-Pooled Fund for the first Financial Year of operation of each Individual Scheme shall be as set out in the relevant Scheme Specification.

10.2 Each Partner shall submit a Financial Contributions Proposal to the Partnership Board not less than 60 Working Days prior to the end of each Financial Yearbased on a review of the performance of each Individual Scheme from their respective commencement dates.

10.3 The Partnership Board shall submit any Financial Contributions Proposal made by the Partners pursuant to Clause 10.2 to the Health and Wellbeing Board which shall determine the Financial Contribution of each Partner to any Pooled Fund or Non-Pooled Fund for subsequent Financial Year(s) of operation of each Individual Scheme.

10.4 Financial Contributions will be paid as set out in the each Scheme Specification.

10.5 With the exception of Clause 13, no provision of this Agreement shall preclude the Partners from making additional contributions of Non-Recurrent Payments to the Pooled Fund from time to time by mutual agreement. Any such additional contributions of Non-Recurrent Payments shall be explicitly recorded in Partnership Board minutes and recorded in the budget statement as a separate item.

11 NON FINANCIAL CONTRIBUTIONS

11.1 The Scheme Specification shall set out non-financial contributions of each Partner including staff (including the Pooled Fund Manager), premises, IT support and other non-financial resources necessary to perform its obligations pursuant to this Agreement (including, but not limited to, management of Service Contracts and the Pooled Fund).

12 RISK SHARE ARRANGMENTS, OVERSPENDS AND UNDERSPENDS

Risk share arrangements

12.1 The Partners have agreed risk share arrangements as set out in Schedule 3, which provide for financial risks arising within the commissioning of Services from the pooled funds and the financial risk to the pool arising from the payment for performance element of the Better Care Fund.

Overspends in Pooled Fund

12.2 Subject to Clause 12.3, the Host Partner for the relevant Pooled Fund shall manage expenditure from a Pooled Fund within the Financial Contributions and shall ensure that the expenditure is limited to Permitted Expenditure.

12.3 The Host Partner shall not be in breach of its obligations under this Agreement if an Overspend occurs PROVIDED THAT the only expenditure from a Pooled Fund has been in accordance with Permitted Expenditure and it has informed the Partnership Board in accordance with Clause 12.4.

12.4 Where the Pooled Fund Manager identifies an actual or projected Overspend and notifies the Partnership Boardin accordance with Clause 8.9 the provisions of Clause 12.5, 12.6 and Schedule 3 shall apply.

12.5 Subject to Clause 12.6, for twelve (12) months from the Commencement Date of this Agreement the Partners agree that any Overspends occurring in respect of Individual Schemes however such Overspends arise, shall be the responsibility of the Scheme Provider to manage. For the absence of doubt this includes schemes for which the Council is the Service Provider.

12.6 The Partnership Board may agree, in circumstances where an Overspend arises and for which there is a causal relationship to the operation of other Better Care Fund Schemes, to contribute to the mitigation of said Overspend by authorising the virement of funds from elsewhere within the Pooled Fund subject always to there being sufficient capacity within the Pooled Fund to avoid the creation of a consequential Overspend elsewhere.

Overspends in Non Pooled Funds

12.7 Where in Joint (Aligned) Commissioning Arrangements either Partner forecasts an Overspend in relation to a Partner's Financial Contribution to a Non-Pooled Fund or Aligned Fund that Partner shall as soon as reasonably practicable inform the other Partner and the Partnership Board.

12.8 Where there is a Lead Commissioning Arrangement the Lead Commissioner is responsible for the management of the Non-Pooled Fund and Aligned Fund and shall discharge this responsibility in a manner consistent with the responsibilities assigned to the Host Partner by clauses 12.2 to 12.6. The Lead Commissioner shall as soon as reasonably practicable inform the other Partner and the Partnership Board.

Underspend

12.9 In the event that expenditure from any Pooled Fund or Non Pooled Fund in any Financial Year is less than the aggregate value of the Financial Contributions made for that Financial Year the Partners shall agree how the surplus monies shall be spent, carried forward and/or returned to the Partners. Such arrangements shall be subject to the Law and the Standing Orders and Standing Financial Instructions (or equivalent) of the Partners and the terms of the Performance Payment Arrangement.

13 CAPITAL EXPENDITURE

13.1 With the exception of Pooled Funds covered by clause 13.2, neither Pooled Funds nor Non Pooled Funds shall normally be applied towards any one-off expenditure on goods and/or services, which will provide continuing benefit and would historically have been funded from the capital budgets of one of the Partners. If a need for capital expenditure is identified this must be agreed by the Partners.

13.2 The elements of the Pooled Funds which relate to Disabled Facilities Grants and to the Social Care Capital Grant shall be treated as capital funds and all expenditure against these funds shall be subject to the Law and the Standing Orders and Standing Financial Instructions (or equivalent) of the Partners.

13.3 Any arrangements for the sharing of capital expenditure shall be made separately and in accordance with Section 256 (or Section 76) of the NHS Act 2006 and directions thereunder.

14 VAT

The Partners shall agree the treatment of the Pooled Fund for VAT purposes in accordance with any relevant guidance from HM Customs and Excise.

15 AUDIT AND RIGHT OF ACCESS

15.1 All Partners shall promote a culture of probity and sound financial discipline and control. The Host Partner shall arrange for the audit of the accounts of the relevant Pooled Fund and shall require the Audit Commission to make arrangements to certify an annual return of those accounts underSections 20 and 21 (whichever is applicable to the relevant Host Partner of the relevant Pooled Fund) of the Local Audit and Accountability Act 2014..

15.2 All internal and external auditors and all other persons authorised by the Partners will be given the right of access by them to any document, information or explanation they require from any employee, member of the Partner in order to carry out their duties. This right is not limited to financial information or accounting records and applies equally to premises or equipment used in connection with this Agreement. Access may be at any time without notice, provided there is good cause for access without notice.

16 LIABILITIES AND INSURANCE AND INDEMNITY

16.1 Subject to Clause 16.2, and 16.3, if a Partner ("**First Partner**") incurs a Loss arising out of or in connection with this Agreement or the Services Contract as a consequence of any act or omission of another Partner ("**Other Partner**") which constitutes negligence, fraud or a breach of contract in relation to this Agreement or the Services Contract then the Other Partner shall be liable to the First Partner for that Loss and shall indemnify the First Partner accordingly.

16.2 Clause 16.1 shall only apply to the extent that the acts or omissions of the Other Partner contributed to the relevant Loss. Furthermore, it shall not apply if such act or omission occurred as a consequence of the Other Partner acting in accordance with the instructions or requests of the First Partner or the Partnership Board.

16.3 If any third party makes a claim or intimates an intention to make a claim against either Partner, which may reasonably be considered as likely to give rise to liability under this Clause 16. the Partner that may claim against the other indemnifying Partner will:

16.3.1 as soon as reasonably practicable give written notice of that matter to the Other Partner specifying in reasonable detail the nature of the relevant claim;

16.3.2 not make any admission of liability, agreement or compromise in relation to the relevant claim without the prior written consent of the Other Partner (such consent not to be unreasonably conditioned, withheld or delayed);

16.3.3 give the Other Partner and its professional advisers reasonable access to its premises and personnel and to any relevant assets, accounts, documents and records within its power or control so as to enable the indemnifying Partner and its professional advisers to examine such premises, assets, accounts, documents and records and to take copies at their own expense for the purpose of assessing the merits of, and if necessary defending, the relevant claim.

16.4 Subject to Clause 16.2 and 16.3, if any third party makes a claim against either Partner which gives rise to liability under this Clause 16. andsuch claim arises from unrecoverable non-performance by a Service Provider which for the avoidance of doubt includes but is not limited to:

16.4.1 a breach of the Provider's obligations under the Services Contract;

16.4.2 a termination event (as defined under the Services Contract) which entitles a third party to terminate the Provider's Services Contract

and all reasonable steps have been taken by the relevant Partner to recover such liabilities, the liability shall be met from the Pooled Funds.

16.5 For the purposes of Clause 16.4, where such action creates an Overspend such expenditure shall be deemed to be Permitted Expenditure under Clause 12.3.

16.6 Each Partner shall ensure that they maintain policies of insurance (or equivalent arrangements through schemes operated by the National Health Service Litigation Authority) in respect of all potential liabilities arising from this Agreement.

16.7 Each Partner shall at all times take all reasonable steps to minimise and mitigate any loss for which one party is entitled to bring a claim against the other pursuant to this Agreement.

17 STANDARDS OF CONDUCT AND SERVICE

17.1 The Partners will at all times comply with Law and ensure good corporate governance in respect of each Partner (including the Partners respective Standing Orders and Standing Financial Instructions).

17.2 The Council is subject to the duty of Best Value under the Local Government Act 1999. This Agreement and the operation of the Pooled Fund is therefore subject to the Council's obligations for Best Value and the other Partners will co-operate with all reasonable requests from the Council which the Council considers necessary in order to fulfil its Best Value obligations.

17.3 The CCG is subject to the CCG Statutory Duties and these incorporate a duty of clinical governance, which is a framework through which they are accountable for continuously improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. This Agreement and the operation of the Pooled Funds are therefore subject toensuring compliance with the CCG Statutory Duties and clinical governance obligations.

17.4 The Partners acknowledge their respective duties under equality legislation to eliminate unlawful discrimination, harassment and victimisation, and to advance quality of opportunity and foster good relations between different groups and their respective policies. The Partners will maintain and

develop these policies as applied to the Services, with the aim of developing a joint strategy for all elements of the Services.

17.5 The Partners acknowledge their respective commitments to the London Living Wage in this Agreement. Where applicable, the Partners shall use their reasonable endeavours to procure that Service Providers commissioned in respect of any Individual Schemes for which the Partners are responsible, accept and agree to the London Living Wage in their Services Contracts.

18 CONFLICTS OF INTEREST

The Partners shall comply with the agreed policy for identifying and managing conflicts of interest as set out in schedule 7.

19 GOVERNANCE

19.1 Overall strategic oversight of partnership working between the partners is vested in the Health and Well Being Board, which for these purposes shall make recommendations to the Partners as to any action it considers necessary.

19.2 The Partners have established a Partnership Board to oversee:

19.2.1 Delivery of commissioned Integrated Care Services provided by the Tower Hamlets Integrated Provider Partnership; and

19.2.2 Development of Integrated Care strategy, including the Better Care Fund.

19.3 The Partnership Board is based on a joint working group structure. Each member of the Partnership Board shall be an officer of one of the Partners and will have individual delegated responsibility from the Partner employing them to make decisions which enable the Partnership Board to carry out its objects, roles, duties and functions as set out in this Clause 19 and Schedule 2.

19.4 The terms of reference of the Partnership Board shall be as set out in Schedule 2

19.5 Each Partner has secured internal reporting arrangements to ensure the standards of accountability and probity required by each Partner's own statutory duties and organisation are complied with.

19.6 The Health and Wellbeing Boardshall be responsible for the overall approval of the Individual Scheme, ensuring compliance with the Better Care Fund Plan and the strategic direction of the Better Care Fund.

19.7 Each Services Schedule shall confirm the governance arrangements in respect of the Individual Scheme and how that Individual Scheme is reported to the Partnership Board and Health and Wellbeing Board.

19.8 Each Services Schedule shall confirm the governance arrangements in respect of the Individual Service and how that Individual Services is reported to the Partnership Board and Health and Wellbeing Board.

20 REVIEW

20.1 Save where the Partnership Board agree alternative arrangements (including alternative frequencies) the Partners shall undertake an annual review ("**Annual Review**") of the operation of this Agreement, any Pooled Fund and the provision of the Services within 3 Months of the end of each Financial Year.

20.2 Subject to any variations to this process required by the Partnership Board, Annual Reviews shall be conducted in good faith and, where applicable, in accordance with the governance arrangements set out in Schedule 2.

20.3 The Partners shall within 20 Working Days of the Annual Review prepare a joint annual report documenting the matters referred to in this Clause 20. A copy of this report shall be provided to the Partnership Board, and subsequently to the Health and Wellbeing Board. Each Partner has secured internal reporting arrangements to ensure the standards of accountability and probity required by each Partner's own statutory duties and organisation are complied with.

20.4 In the event that the Partners fail to meet the requirements of the Better Care Fund Plan and NHS England the Partners shall provide full co-operation with NHS England to agree a recovery plan. The Lead Commissioner will act as the lead Partner in any such engagement with NHS England.

21 COMPLAINTS

The Partners' own complaints procedures shall apply to this Agreement. The Partners agree to assist one another in the management of complaints arising from this Agreement or the provision of the Services and shall keep records of all complaints and provide the same for review by the Partnership Board every Quarter of this Agreement (or as otherwise agreed between the Partners).

22 TERMINATION & DEFAULT

22.1 This Agreement may be terminated by any Partner giving not less than 3Months' notice in writing to terminate this Agreement provided that such termination shall not take effect prior to the termination or expiry of all Individual Schemes.

22.2 Each Individual Scheme may be terminated in accordance with the terms set out in the relevant Scheme Specification provided that the Partners ensure that the Better Care Fund requirements continue to be met.

22.3 If any Partner ("Relevant Partner") fails to meet any of its obligations under this Agreement, the other Partnermay by notice require the Relevant Partner to take such reasonable action within a reasonable timescale as the other Partner may specify to rectify such failure. Should the Relevant Partner fail to rectify such failure within such reasonable timescale, the matter shall be referred for resolution in accordance with Clause 23.

22.4 Termination of this Agreement (whether by effluxion of time or otherwise) shall be without prejudice to the Partners' rights in respect of any antecedent breach and the provisions of Clauses 15 (Audit and Right of Access) 16 (Liabilities and Insurance and Indemnity) 22 (Termination & Default) 25 (Confidentiality) 26 (Freedom of Information and Environmental Protection Regulations) and 28 (Information Sharing).

22.5 In the event of termination of this Agreement, the Partners agree to cooperate to ensure an orderly wind down of their joint activities and to use their best endeavours to minimise disruption to the health and social care which is provided to the Service Users.

22.6 Upon termination of this Agreement for any reason whatsoever the following shall apply:

22.6.1 the Partners agree that they will work together and co-operate to ensure that the winding down and disaggregation of the integrated and joint activities to the separate responsibilities of the Partners is carried out smoothly and with as little disruption as possible to service users, employees, the Partners and third parties, so as to minimise costs and liabilities of each Partner in doing so;

22.6.2 where either Partner has entered into a Service Contract which continues after the termination of this Agreement, both Partners shall continue to contribute to the Contract Price in accordance with the agreed contribution for that Service prior to termination and will enter into all appropriate legal documentation required in respect of this;

22.6.3 the Lead Commissioner shall make reasonable endeavours to amend or terminate a Service Contract (which shall for the avoidance of doubt not include any act or omission that would place the Lead Commissioner in breach of the Service Contract) where the other Partner requests the same in writing Provided that the Lead Commissioner shall not

be required to make any payments to the Provider for such amendment or termination unless the Partners shall have agreed in advance who shall be responsible for any such payment.

22.6.4 where a Service Contract held by a Lead Commissioner relates all or partially to services which relate to the other Partner's Functions then provided that the Service Contract allows the other Partner may request that the Lead Commissioner assigns the Service Contract in whole or part upon the same terms mutatis mutandis as the original contract.

22.6.5 the Partnership Board shall continue to operate for the purposes of functions associated with this Agreement for the remainder of any contracts and commitments relating to this Agreement; and

22.6.6 Termination of this Agreement shall have no effect on the liability of any rights or remedies of either Partner already accrued, prior to the date upon which such termination takes effect.

22.7 In the event of termination in relation to an Individual Scheme the provisions of Clause 22.6 shall apply mutatis mutandis in relation to the Individual Scheme (as though references as to this Agreement were to that Individual Scheme).

23 DISPUTE RESOLUTION

23.1 In the event of a dispute between the Partners arising out of this Agreement, either Partner may serve written notice of the dispute on the other Partner, setting out full details of the dispute.

23.2 The Authorised Officers shall meet in good faith as soon as possible and in any event within seven (7) days of notice of the dispute being served pursuant to Clause 23.1, at a meeting convened for the purpose of resolving the dispute.

23.3 If the dispute remains after the meeting detailed in Clause 23.2 has taken place, the Council'sDirector of Adult Social Servicesand the CCG's Chief Officer or their nominees shall meet in good faith as soon as possible after the relevant meeting and in any event with fourteen (14) days of the date of the meeting, for the purpose of resolving the dispute.

23.4 If the dispute remains after the meeting detailed in Clause 23.3 has taken place, then the Partners will jointly refer the matter to either (whichever is the sooner):

23.4.1 the next scheduled meeting of the Health and Wellbeing Board for settlement; or

23.4.2 the Partnership Board if the Chair of the Health and Wellbeing Board has agreed to devolve responsibility for settling the dispute to the Partnership Board.

23.5 If the dispute remains after the meeting detailed in Clause 23.4 has taken place, then the Partners will attempt to settle such dispute by mediation in accordance with the CEDR Model Mediation Procedure or any other model mediation procedure as agreed by the Partners. To initiate a mediation, either Partner may give notice in writing (a **"Mediation Notice"**) to the other requesting mediation of the dispute and shall send a copy thereof to CEDR or an equivalent mediation organisation as agreed by the Partners asking them to nominate a mediator. The mediation shall commence within twenty (20) Working Days of the Mediation Notice being served. Neither Partner will terminate such mediation until each of them has made its opening presentation and the mediator has met each of them separately for at least one (1) hour. Thereafter, paragraph 14 of the Model Mediation Procedure will apply (or the equivalent paragraph of any other model mediation procedure agreed by the Partners). The Partners will co-operate with any person appointed as mediator, providing him with such information and other assistance as he shall require and will pay his costs as he shall determine or in the absence of such determination such costs will be shared equally.

23.6 Nothing in the procedure set out in this Clause 23 shall in any way affect either Partner's right to terminate this Agreement in accordance with any of its terms or take immediate legal action.

24 FORCE MAJEURE

24.1 Neither Partner shall be entitled to bring a claim for a breach of obligations under this Agreement by the other Partner or incur any liability to the other Partner for any losses or damages incurred by that Partner to the extent that a Force Majeure Event occurs and it is prevented from carrying out its obligations by that Force Majeure Event.

24.2 On the occurrence of a Force Majeure Event, the Affected Partner shall notify the other Partner as soon as practicable. Such notification shall include details of the Force Majeure Event, including evidence of its effect on the obligations of the Affected Partner and any action proposed to mitigate its effect.

24.3 As soon as practicable, following notification as detailed in Clause 24.2, the Partners shall consult with each other in good faith and use all best endeavours to agree appropriate terms to mitigate the effects of the Force Majeure Event and, subject to Clause 24.4, facilitate the continued performance of the Agreement.

24.4 If the Force Majeure Event continues for a period of more than sixty (60) days, either Partner shall have the right to terminate the Agreement by giving fourteen (14) days written notice of termination to the other Partner. For the avoidance of doubt, no compensation shall be payable by either Partner as a direct consequence of this Agreement being terminated in accordance with this Clause.

25 CONFIDENTIALITY

25.1 In respect of any Confidential Information a Partner receives from another Partner (the "**Discloser**") and subject always to the remainder of this Clause 25, each Partner (the "**Recipient**") undertakes to keep secret and strictly confidential and shall not disclose any such Confidential Information to any third party, without the Discloser's prior written consent provided that:

25.1.1 the Recipient shall not be prevented from using any general knowledge, experience or skills which were in its possession prior to the Commencement Date; and

25.1.2 the provisions of this Clause 25 shall not apply to any Confidential Information which:

(a) is in or enters the public domain other than by breach of the Agreement or other act or omission of the Recipient; or

(b) is obtained by a third party who is lawfully authorised to disclose such information.

25.2 Nothing in this Clause 25 shall prevent the Recipient from disclosing Confidential Information where it is required to do so in fulfilment of statutory obligations or by judicial, administrative, governmental or regulatory process in connection with any action, suit, proceedings or claim or otherwise by applicable Law.

25.3 Each Partner:

25.3.1 may only disclose Confidential Information to its employees and professional advisors to the extent strictly necessary for such employees to carry out their duties under the Agreement; and

25.3.2 will ensure that, where Confidential Information is disclosed in accordance with Clause 25.3.1, the recipient(s) of that information is made subject to a duty of confidentiality equivalent to that contained in this Clause 25;

25.3.3 shall not use Confidential Information other than strictly for the performance of its obligations under this Agreement.

26 FREEDOM OF INFORMATION AND ENVIRONMENTAL PROTECTION REGULATIONS

26.1 The Partners agree that they will each cooperate with each other to enable any Partner receiving a request for information under the 2000 Act or the 2004 Act to respond to a request promptly and within the statutory timescales. This cooperation shall include but not be limited to finding, retrieving and supplying information held, directing requests to other Partners as appropriate and responding to any requests by the Partner receiving a request for comments or other assistance.

26.2 Any and all agreements between the Partners as to confidentiality shall be subject to their duties under the 2000 Act and 2004 Act. No Partner shall be in breach of Clause 26 if it makes disclosures of information in accordance with the 2000 Act and/or 2004 Act.

27 OMBUDSMEN AND PROHIBITED ACTS

27.1 The Partners will co-operate with any investigation undertaken by the Health Service Commissioner for England or the Local Government Commissioner for England (or both of them) in connection with this Agreement.

27.2 Neither Partner shall do any of the following:

a) offer, give, or agree to give the other Partner (or any of its officers, employees or agents) any gift or consideration of any kind as an inducement or reward for doing or not doing or for having done or not having done any act in relation to the obtaining of performance of this Agreement or any other contract with the other Partner, or for showing or not showing favour or disfavour to any person in relation to this Agreement or any other contract with the other Partner; and

b) in connection with this Agreement, pay or agree to pay any commission, other than a payment, particulars of which (including the terms and conditions of the agreement for its payment) have been disclosed in writing to the other Partner,

(together "**Prohibited Acts**" for the purposes of Clauses 27.2 to 27.6).

27.3 If either Partner or its employees or agents (or anyone acting on its or their behalf) commits any Prohibited Act or commits any offence under the Bribery Act 2010 with or without the knowledge of the other Partner in relation to this Agreement, the non-defaulting Partner shall be entitled:

a) to exercise its right to terminate under clause 22 and to recover from the defaulting Partner the amount of any loss resulting from the termination; and

b) to recover from the defaulting Partner the amount or value of any gift, consideration or commission concerned; and

c) to recover from the defaulting Partner any loss or expense sustained in consequence of the carrying out of the Prohibited Act or the commission of the offence.

27.4 Each Partner must provide the other Partner upon written request with all reasonable assistance to enable that Partner to perform any activity required for the purposes of complying with the Bribery Act 2010. Should either Partner request such assistance the Partner requesting assistance must pay the reasonable expenses of the other Partner arising as a result of such request.

27.5 The Partners must have in place an anti-bribery policy for the purposes of preventing any of their staff from committing a prohibited act under the Bribery Act 2010. If either Partner requests the other Partner's policies to be disclosed then the Partners shall endeavour to do so within a reasonable timescale and in any event within 20 Working Days.

27.6 Should the Partners become aware of or suspect any breach of Clauses 27.2 to 27.6, it will notify the other Partner immediately. Following such notification, the Partner must respond promptly and fully to any enquiries of the other Partner, co-operate with any investigation undertaken by the Partner and allow the Partner to audit any books, records and other relevant documentation.

28 INFORMATION SHARING

The Partners will follow the Information Governance Protocol set out in schedule 8, and in so doing will ensure that the operation this Agreement complies comply with Law, in particular the 1998 Act**.**

29 NOTICES AND PUBLICITY

29.1 Any notice to be given under this Agreement shall either be delivered personally or sent by first class post or electronic mail. The address for service of each Partner shall be as set out in Clause 29.3 or such other address as each Partner may previously have notified to the other Partner in writing. A notice shall be deemed to have been served if:

29.1.1 personally delivered, at the time of delivery;

29.1.2 posted, at the expiration of forty eight (48) hours after the envelope containing the same was delivered into the custody of the postal authorities; and

29.1.3 if sent by electronic mail, at the time of transmission and a telephone call must be made to the recipient warning the recipient that an electronic mail message has been sent to him (as evidenced by a contemporaneous note of the Partner sending the notice) and a hard copy of such notice is also sent by first class recorded delivery post (airmail if overseas) within one (1) Working Day as that on which the electronic mail is sent.

29.2 In proving such service, it shall be sufficient to prove that personal delivery was made, or that the envelope containing such notice was properly addressed and delivered into the custody of the postal authority as prepaid first class or airmail letter (as appropriate), or that the electronic mail was properly addressed and no message was received informing the sender that it had not been received by the recipient (as the case may be).

29.3 The address for service of notices as referred to in Clause 29.1 shall be as follows unless otherwise notified to the other Partner in writing:

29.3.1 if to the Council, addressed to the:Service Head: Commissioning and Health, Education, Social Care and Wellbeing, London Borough of Tower Hamlets, 5th Floor, Mulberry Place, 5 Clove Crescent, London, E14 2BG;

Tel: 020 7364 3131
E.Mail: dorne.kanareck@towerhamlets.gov.uk

and

29.3.2 if to the CCG, addressed to: Deputy Director of Commissioning and Transformation, NHS Tower Hamlets Clinical Commissioning Group, 2nd Floor Alderney Building, Mile End Hospital, Bancroft Road, London, E1 4DG;

Tel: 020 3688 2518
E.Mail: josh.potter@towerhamletsccg.nhs.uk

29.4 Without prejudice to Clause 26, except with the written consent of the other Partner, (such consent not to be unreasonably withheld or delayed), the Partners must not make any press announcements in relation to this Agreement in any way.

29.5 The Partners must take all reasonable steps to ensure the observance of the provisions of Clause 29.4 by their staff, servants, agents, consultants and sub-contractors.

30 VARIATION

No variations to this Agreement will be valid unless they are recorded in writing and signed for and on behalf of each of the Partners subject to the Law and the Partners' Standing Orders and Standing Financial Instructions.

31 CHANGE IN LAW

31.1 The Partners shall ascertain, observe, perform and comply with all relevant Laws, and shall do and execute or cause to be done and executed all acts required to be done under or by virtue of any Laws.

31.2 On the occurrence of any Change in Law, the Partners shallagree in good faithany amendment required to this Agreement as a result of the Change in Law subject to the Partners using all reasonable endeavours to mitigate the adverse effects of such Change in Law and taking all reasonable steps to minimise any increase in costs arising from such Change in Law.

31.3 In the event of failure by the Partners to agree the relevant amendments to the Agreement (as appropriate), the Clause 23 (Dispute Resolution) shall apply.

32 WAIVER

No failure or delay by any Partner to exercise any right, power or remedy will operate as a waiver of it nor will any partial exercise preclude any further exercise of the same or of some other right to remedy.

33 SEVERANCE

If any provision of this Agreement, not being of a fundamental nature, shall be held to be illegal or unenforceable, the enforceability of the remainder of this Agreement shall not thereby be affected.

34 ASSIGNMENT AND SUB CONTRACTING

The Partners shall not sub contract, assign or transfer the whole or any part of this Agreement, without the prior written consent of the other Partners, which shall not be unreasonably withheld or delayed. This shall not apply to any assignment to a statutory successor of all or part of a Partner's statutory functions.

35 EXCLUSION OF PARTNERSHIP AND AGENCY

35.1 Nothing in this Agreement shall create or be deemed to create a partnership under the Partnership Act 1890 or the Limited Partnership Act 1907, a joint venture or the relationship of employer and employee between the Partners or render either Partner directly liable to any third party for the debts, liabilities or obligations of the other.

35.2 Except as expressly provided otherwise in this Agreement or where the context or any statutory provision otherwise necessarily requires, neither Partner will have authority to, or hold itself out as having authority to:

35.2.1 act as an agent of the other;

35.2.2 make any representations or give any warranties to third parties on behalf of or in respect of the other; or

35.2.3 bind the other in any way.

36 THIRD PARTY RIGHTS

Unless the right of enforcement is expressly provided, no third party shall have the right to pursue any right under this Contract pursuant to the Contracts (Rights of Third Parties) Act 1999 or otherwise.

37 ENTIRE AGREEMENT

37.1 The terms herein contained together with the contents of the Schedules constitute the complete agreement between the Partners with respect to the subject matter hereof and supersede all previous communications representations understandings and agreement and any representation promise or condition not incorporated herein shall not be binding on any Partner.

37.2 No agreement or understanding varying or extending or pursuant to any of the terms or provisions hereof shall be binding upon any Partner unless in writing and signed by a duly authorised officer or representative of the parties.

38 COUNTERPARTS

This Agreement may be executed in one or more counterparts. Any single counterpart or a set of counterparts executed, in either case, by all Partners shall constitute a full original of this Agreement for all purposes.

39 GOVERNING LAW AND JURISDICTION

39.1 This Agreement and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the laws of England and Wales.

39.2 Subject to Clause 23 (Dispute Resolution), the Partners irrevocably agree that the courts of England and Wales shall have exclusive jurisdiction to hear and settle any action, suit, proceedings, dispute or claim, which may arises out of, or in connection with, this Agreement, its subject matter or formation (including non-contractual disputes or claims).

IN WITNESS WHEREOF this Agreement has been executed AS A DEED by the Partners on the date of this Agreement

THE CORPORATE SEAL of)
THE LONDON BOROUGH OF)
TOWER HAMLETS)
was hereunto affixed in the presence of:)

Signed for on behalf of NHS TOWER HAMLETS CLINICAL COMMISSIONING GROUP

____

Authorised Signatory

SCHEDULE 1– SCHEME SPECIFICATION

Part 1– Template Services Schedule

TEMPLATE SERVICE SCHEDULE

Unless the context otherwise requires, the defined terms used in this Scheme Specification shall have the meanings set out in the Agreement.

40 OVERVIEW OF SERVICES

40.1 Context and background information

Local Context

Tower Hamlets has a resident population of 242,000 people with an unusually young age profile. Only 7.1% (15,000-18,000) of the population is over 65 with LAPS 1 and 5 having the oldest residents in the area and LAP 8 having a young working population due the presence of Canary Wharf. The population is expected to increase by over 23,000 people up to 2015, an increase of about 10%. The largest growth is expected in LAPs 6 and 8 (over 7,000 people in each, a 28% and 17% increase respectively). The age profile of residents is not anticipated to change dramatically over this time. 50% of the population is classified as white and 33% Bangladeshi although this distribution varies substantially across different age groups. 59% of the 0-20 age range is Bangladeshi, this proportion decreases to 25% of the 20-64 age range (adult) population and just 22% of the 65 years and over population. In contrast, just 21% of the 0-20 age range population is white, rising to 60% of the 20-64 age range population and 65% of 65 years and over population.

Headline health indicators indicate significant health inequalities between Tower Hamlets and the rest of the country. Both male and female life expectancy is shorter than national averages (male life expectancy is 75.3 years and female life expectancy is 80.4). Tower Hamlets has the highest or second highest mortality in London for the three major killers: cardiovascular disease, cancer and chronic respiratory disease (COPD). There are an increasing number of complex patients with co-morbidities, particularly in the 65 years and over age group, and the distribution of these patients varies across the borough. The highest percentages of patients with multiple co morbidities are based in LAPs 1, 6 and 7. Within this there are variances in prevalence of long term conditions across different ethnicities, age groups and genders in Tower Hamlets. Hypertension, depression and asthma are the most common conditions affecting the white population, whereas asthma, diabetes and hypertension are most commonly seen in the Bangladeshi population.

Around 1,140 Tower Hamlets residents will die per year of which around 870 are potentially predictable deaths. The majority of these people will be aged over 65. Tower Hamlets has a higher hospital death rate compared to national (68%) and a significantly lower home death rate (17%) despite people`s preference to die at home. Our aim is that care should focus on reversing/ stabilising or effectively managing deterioration in functional or health status with palliative care as an integral component in line with our shift of focus on palliative care to a wider Last Years of Life perspective.

Integrated Care

The Tower Hamlets integrated care programme is part of the Integration Pioneer WELC integrated care programme. The programme requires that a holistic approach is taken to the management and care of patients. The component services within the programme will be delivered by a range of staff types and grades across a number of providers in a wide number of locations including patients' own homes.

The target population for Integrated Care over the next 3-5 years is the same for all providers and is identified as patients who have very high risk, high risk or moderate risk of a hospital admission in the next 12 months and have consented to participate in the programme. Across the borough this makes up the top 20% of the population who is at risk of admission.

Over the year 2014-15, the target population for the Integrated Care programme in Tower Hamlets will be the top 4% of the population who is at risk of admission boroughwide.

40.2 Pooled Funds:

At the Commencement Date of this Agreement there shall be four (4) Pooled Funds:

POOLED FUND	LEAD COMMISSIONER	HOST PARTNER
CCG Better Care Fund Core Individual schemes: ➢ Mental Health Support and Liaison ➢ Integrated Care NIS ➢ Integrated Care Community Health Team ➢ Enablers (CCG) ➢	CCG	CCG
LBTH Better Care Fund Core ➢ Mental Health Recovery College ➢ Community Geriatrician ➢ Additional Community Health Teams Investment ➢ 7 day hospital discharge / avoidance and step down ➢ Independent Living ➢ Enablers (LBTH) Specific schemes within core fund for which LBTH is Lead Commissioner: ➢ Protection of adult social care services (pursuant to Care Act 2014 responsibilities)	CCG LBTH LBTH	Council

➢ Carers		
Strategy and Development Fund	CCG	Council
Better Care Fund Capital	Council	Council

40.3 Strategic Objectives

The strategic objectives for each individual scheme are as follows:

40.3.1 **Integrated Community Health Teams**

The Locality based Community Health Teams will provide an integrated team approach to the care of patients in the community and incorporate the function of the following services:

- Community virtual ward and case managers
- Community rehabilitation and support team (CReST) including the falls team
- Last years of life centre (facilitators and coordinators, service development and MCNS service)
- Adult community nursing (including IV therapy, community liaison, last years of life facilitators, district nursing, continence service and out of hour nursing)

40.3.2 **Reablement and Rehabilitation Joint Working Pilot**

The service being proposed by two organisations is a joint working process that involves goal planning, interventions and a protocol between the Reablement Service (LBTH) and the Community Health Team therapies (BLT) for the three following user groups :

- Users who present with a physical dysfunction without a diagnostic cause or identified impairment
- User with a cognitive impairment (non-progressive) but who present with potential to improve function
- Users who would benefit from physiotherapy intervention alongside social care / restorative Occupational Therapy input

40.3.3 **Social work team 7 day working at Royal London Hospital**
The scheme will extend the current hospital discharge team from working Mon – Fri, to a 7 day service. It will have social work staff available to assess and discharge patients on acute wards who are deemed medically fit for discharge at weekends and public holidays. This will free up acute beds within the Royal London Hospital, who otherwise would have to wait until Monday to be assessed and discharged.

40.3.4 **Integrated Health and Social Care Continuing Health Care Assessment**

This scheme proposes a trial project which introduces joint and coordinated multidisciplinary assessments and care planning which would include CHC checklists, LHNA, DSTs as well Integrated Support Plans (Joint Funded). It would be piloting the concept of joint assessments between community health and social care teams ensuring person centre planning with carers and families from the outset. There is some work to be done about identifying the exact cohort.

40.3.5 **Mental Health Liaison (RAID)**

The Royal London Hospital Liaison Psychiatry Service is being commissioned to provide a single multi-disciplinary mental health and drug and alcohol assessment service to provide expert advice, support and training to Royal London Hospital clinicians. The Service will be fully integrated into the Royal London Hospital and associated Barts Health sites in Tower Hamlets, and will maintain a very high profile within the hospital.

40.3.6 **Re-commissioning of Care Homes and Extra Care Sheltered Housing for people with Dementia**

Tower Hamlets Council and CCG are jointly undertaking a review of care homes commissioned for people with dementia in order to improve the quality of the care provided, reduce admission to hospital, and ensure provision is sufficient to sustain future demographic growth.

40.3.7 **Recovery College**

The Recovery College model complements health and social care specialist assessment and treatment by helping people with mental health problems and/or other long term conditions to understand their problems and learn how to manage these better in pursuit of their aspirations.

By supporting the principle of recovery and progression through course based education and peer support, the Recovery College acts as a bridge to resources already available in the local area (e.g. courses run by local colleges)

40.3.8 **Independent Living**

The strategic objective of the scheme is to develop to better enable vulnerable residents of Tower Hamlets to live independently in their own homes. This will be done primarily by refocusing the Telecare, Community Equipment Service and Assistive Technology services.

The scheme will also consider and evaluate the inclusion of other functions in an integrated service provision model that would provide a single point of contact for service users to access a wide range of services to support their independent living.

40.3.9 **Integrated Care Incentive Scheme**

The introduction of the Integrated Care Network Incentive Scheme aims to incentivise an integrated care approach for patients in the top risk levels in Tower Hamlets.

The Tower Hamlets integrated care programme is part of the Integration Pioneer WELC integrated care programme. The programme requires that a holistic approach is taken to the management and care of patients. The component services within the programme will be delivered by a range of staff types and grades across a number of providers in a wide number of locations including patients' own homes.

41 AIMS AND OUTCOMES

41.1 Integrated Community Health Teams

- Provide integrated nursing and therapy care services across the locality ranging from a 2 hour response service to avoid admission to complex case management and promoting self-care
- Systematically identify adults in Tower Hamlets who are most vulnerable/at risk of hospitalisation and provide support and care to these patients which is coordinated and multidisciplinary in approach
- Reduce non-essential use of A&E and unplanned admissions
- Reduce readmission rates within 30 days of discharge from any acute setting
- Assess and support people with Long term conditions in the community, promoting self-management and enabling patients to regain or maintain functional independence and restore confidence within a set timeframe
- Involve patients/service users and carers in planning and providing care;
- Facilitate carer assessment (either by completing the assessment or by referring to other agencies to carry out carer assessment);
- Ensure continuing health care assessment and reviews are completed in line with defined timescales
- Seek to improve health outcomes for the population through strong clinical leadership and governance and ensure productivity, innovation and efficiency are core service deliverables

41.2 Reablement and Rehabilitation Joint Working Pilot

- Better identify the most suitable rehabilitative pathway for service users post discharge from the acute hospital setting
- Reduce ‘hand-offs’ and changes of key team/worker for the person
- Deliver greater efficiencies for services by getting it right’ first time and reducing duplications of effort
- Reduce intervention periods for service users going through health and social care pathways

41.3 Social work team 7 day working at Royal London Hospital

- Demonstrate how a change in working practise in the hospital social work service can deliver better outcomes to patients being discharged from the Royal London hospital.
- Identify potential efficiency savings
- Facilitate and work with any additional Consultants in supporting patients in a timely fashion, who are medically fit for discharge.
- Help reduce any bottle necks occurring over weekends on acute wards, thereby improving patient flow through AAU and A&E.
- Increase availability of beds at weekends by 10%

41.4 Integrated Health and Social Care Continuing Health Care Assessment

- Enhanced quality, choice and control for clients, carers and families.
- Decreased length of stay in hospital wards.
- Greater number of integrated partnerships working across health and social care resulting in a reduction in (re)admissions to hospital, delays in long term care provision and placements in care homes.

41.5 Mental Health Liaison (RAID)

- Improve health outcomes for patients with a mental health or drug or alcohol problem who have been admitted to wards at the Royal London Hospital
- Reduce length of stay for patients with a mental health or drug or alcohol problem who are admitted to wards at the Royal London Hospital
- Reduce readmissions for patients with a mental health or drug or alcohol problem who have been discharged.

41.6 Re-commission Care Homes and Extra Care Sheltered Housing for people with Dementia across LA and NHS

- Deliver an evidence-based framework to explicitly set out our expectations for the care offer to people with dementia living in care homes and ECSH.
- Lever improvements to drive up quality of care provided in Care Homes and Extra Care Sheltered Housing

41.7 Recovery College

- Increased use of scheduled care and decreased use of episodic care
- Decrease or better managed symptoms of mental ill health (anxiety, depression, psychosis)
- Improved mental health well-being
- Reduced social isolation
- Increased Trust roles available for volunteering
- Increased uptake of mainstream adult learning opportunities
- Increased uptake of employment support opportunities
- Increased ability to cope with everyday domestic situations and skills acquired to develop strategies and build resilience
- Increased knowledge of local health care systems and navigation of these (Primary and Secondary care)
- Increased knowledge of local community facilities and the confidence to access them
- Increased uptake of personalisation budgets and choice

41.8 Independent Living Service

- Provision of equipment and a highly responsive service that helps promote safety, peace of mind, security and wellbeing by enabling service users to live more independently in their own homes.
- Provision of equipment and a service that facilitates discharge from hospital.
- Provision of a service that helps support and reassures carers.
- Reduction of preventable hospital admissions
- Provision of an accessible and reliable out of hours referral service.
- Provision of accurate and timely information to Duty Social Workers.

41.9 Integrated Care Incentive Scheme

- Fewer avoidable emergency admissions to hospital [Non elective admissions]
- Shorter admissions and safer discharges with lower readmission rates [Non elective bed days, Non elective readmission within 28 and 90 days, Delayed transfer, Discharge from hospital to residential home]
- Improvement in people dying in the place of their choice
- Impacts on other service utilisation- prescribing costs, planned secondary care, continuing care
- Impact on disease specific care package payment metric performance- we will report metrics for the care packages without frail or complex for payment purposes AND the overall population performance to allow comparison with previous years.
- For those within the integrated care programme who make contact with urgent or emergency care providers/ LAS who have an anticipatory care plan (ACP) the % of people where the ACP is accessed
- People getting the right joined up care at the right time in the right place [SEAs on deaths, audits of unplanned admissions (mandatory for AUA DES target group only)]
- Proportion of local authority spend on nursing and residential care in over 65 yrs
- Quality reviews of care planning outputs

42 THE ARRANGEMENTS

		Sub-scheme	**Lead Commissioner**
1	Integrated Community Health Team	Integrated Community Health Team Reablement and Rehabilitation Joint Working Pilot Seven day working by the Social Work Team at Royal London Hospital Integrated Health and Social Care Continuing Health Care Assessment	CCG
2	Mental Health Support and Liaison	RAID Recovery College	CCG
3	Independent Living	Independent Living	CCG
4	Integrated Care Incentive Scheme	Integrated Care Incentive Scheme	CCG

5	Protection of adult social care services (pursuant to Care Act 2014 responsibilities)	Personalisation Carers Information, advice and support Quality Safeguarding Assessment and eligibility Veterans Law reform	Council
6	Carers	Carers assessments Carers services	Council
7	Capital funding	Disabled Facilities Grants Social Care Capital Grant	Council

	Scheme	**Lead Commissioner**
8	Social Prescribing	CCG
9	Additional Community Geriatrician	CCG
10	Personalisation and Integrated Personal Commissioning	CCG

Pooled Funds:

Pooled Fund	Lead Commissioner	Pooled Fund Manager
Better Care Fund Core (schemes 1,2,3,4) Specific schemes within core fund for which LBTH is Lead Commissioner: ➢ Protection of adult social care services (pursuant to Care Act 2014 responsibilities) (Scheme 5) ➢ Carers (Scheme 6)	CCG LBTH LBTH	CCG CCG CCG
Strategy and Development Fund (Schemes 8,9,10)	CCG	LBTH

Better Care Fund Capital (Scheme 7)	LBTH	LBTH

43 FUNCTIONS

Set out the Council's Functions and the CCG's Functions which are the subject of the Individual Scheme including where appropriate the delegation of such functions for the commissioning of the relevant service.

Consider whether there are any exclusions from the standard functions included (see definition of NHS Functions and Council Health Related Functions)

44 SERVICES

Scheme	*Services*	*Beneficiaries**	*Contracts in place*
Integrated Community Health Teams	Community virtual ward and case managers Community rehabilitation and support team (CReST) including the falls team Last years of life centre (facilitators and coordinators, service development and MCNS service) Adult community nursing (including IV therapy, community liaison, last years of life facilitators, district nursing, continence service and out of hour nursing).	*See**	*Community Health Services Contract with Barts Health*
Reablement and Rehabilitation Joint Working Pilot	- Barts Community Health Team - Tower Hamlets Reablement Service	Users who present with a physical dysfunction without a diagnostic cause or identified impairment Users with a cognitive impairment (non-progressive) but who present with potential to improve function Users who would benefit from physiotherapy intervention alongside social care / restorative Occupational Therapy input	*Community Health Services Contract with Barts Health* *Service Level Agreement in development for Tower Hamlets Reablement Service*
Social Work Team 7 day working Royal	- *Social Work Team*	*Patients at the Royal London Hospital who are deemed medically fit at the weekend but require social services support*	*Service Level Agreement in development for Social Work Team*

London Hospital		*before they can be discharged*	*7 day working*
Integrated Health and Social Care Continuing Health Care Assessment		Exact Cohort TBC	
Mental Health Liaision (RAID)	- *Royal London Hospital Liaison Psychiatry Service*	People with a diagnosed mental health condition who present at / are admitted to Barts Health sites. Barts Health Clinical Staff	*Mental Health Contract with East London Foundation Trust*
Recovery College		Stage 1: (Pilot) Mental health service users who have used ELFT (Tower Hamlet) services in the previous 12 months, including those who have been discharged. Stage 2: (Roll Out) Supporters (carers, family, friends) of people using mental health services in Tower Hamlets. ELFT, local authority and voluntary sector staff working within mental health services. Complex co-morbidity – mental health issue and other long term physical condition Groups at risk of emergency hospital admission where effective self-care within a professional/peer supported environment (i.e. recovery college) may reduce preventable admissions.	
Independent Living	- Telecare, Assistive Technology and Community Equipment services	People living with a disability, the elderly or those with a long term illness, who require equipment to help them cope with daily living tasks such as dressing, washing, bathing, or preparing meals.	*Service Level Agreement in development for Social Work Team 7 day working*
Integrated Care Incentive Scheme	- *Integrated Care Incentive Scheme*	All patients who are in the top 4% risk of admission (borough level risk) who are eligible for Level 1 All patients in the four mandatory groups: palliative, heart failure, dementia and nursing home- irrespective of QAdmissions risk. These patients will be eligible for	*Network Improved Service Contract with Primary Care Networks*

		both Level 1 and Level2 All discretionary patients under the previous CC NIS who were identified in the CEG August 2013 baseline search and who were consented into the CC NIS by 31/3/14, irrespective of Q Admissions risk. These patients will be eligible for both Level 1 and Level2 [No further discretionary patients can enter the programme currently]	

***Beneficiaries of services**

All beneficiaries of these services will be residents within Tower Hamlets and graded as being at very high risk of hospital admission, using the Q-admissions rating scale.

Overall inclusion criteria are:

- Patient has a risk score sufficient to qualify them as at least medium risk of admission
- Patient is likely to have at least one long term condition
- Patient has consented to inclusion in the integrated care programme
- Patient is a Tower Hamlet resident (temporary or permanent);
- Over the age of 18 years

45 COMMISSIONING, CONTRACTING, ACCESS

Commissioning Arrangements

45.1 Commissioning arrangements for each of the schemes are consistent with those set out in the main body of the agreement at, but not limited to, Clause 4: Partnership Flexibilities and Clause 6: Commissioning, Contracting and Access.

45.2 Service Level Agreements will be developed for each of Council's directly provided services that are included in the Individual Schemes.

46 FINANCIAL CONTRIBUTIONS

Contributor	2015/16(£000s)
LBTH	1629
CCG Mandated	18738
CCG Additional Contribution	183
CCG Strategic Development	852
Total	21402

Deployment of contributions:

Scheme	2015/16 (£000s)
Raid	2106.42
Mental health recovery college	110

Integrated care incentive scheme	1020.746
Integrated community health team	7336.449
7 day working at social work team royal london hopsital	866
7 day hospital discharge	1200
Reablement and rehabilitation	2350
Independent living	1212.187
ENABLERS (see section 7)	198
DFG and CAPITAL	1629
Performance pool	1091.343
Care act implementation	733
Support for carers	697
Strategic development	852
Total	21402.145

47 FINANCIAL GOVERNANCE ARRANGEMENTS

Management of the Pooled Fund	
Are any amendments required to the Agreement in relation to the management of Pooled Fund	**No**
Have the levels of contributions been agreed? *How will changes to the levels of contributions be implemented?*	**Yes. See S75 for rules on changes**
Have eligibility criteria been established?	**Yes, see scheme descriptors**
What are the rules about access to the pooled budget?	**See S75**
Does the pooled fund manager require training?	**No**
Have the pooled fund managers delegated powers been determined?	**Yes, in line with current SFIs**
Is there a protocol for disputes?	**Yes, see S75**
Audit Arrangements	
What Audit arrangements are needed?	**The current audit arrangements will apply**
Has an internal auditor been appointed?	
Who will liaise with/manage the auditors?	
Whose external audit regime will apply?	
Financial Management	
Which financial systems will be used?	**Existing financial systems in each partner org**
What monitoring arrangements are in place?	**Monthly budget reports** **Monthly provider**

	performance reports
Who will produce monitoring reports?	**Lead commissioner of that scheme**
Has the scale of contributions to the pool been agreed?	**Yes**
What is the frequency of monitoring reports?	**Monthly**
What are the rules for managing overspends?	**See S75**
Do budget managers have delegated powers to overspend?	**No, see S75**
Will delegated powers allow underspends recurring or non-recurring, to be transferred between budgets?	**See S75**
How will overspends and underspends be treated at year end?	**See S75**
Will there be a facility to carry forward funds?	**See S75**
How will pay and non pay inflation be financed?	**Annual review of budgets in accordance with S75 agreement**
Will a contingency reserve be maintained, and if so by whom?	**Performance pool. See S75**
How will efficiency savings be managed?	**See S75**
How will revenue and capital investment be managed?	**See S75**
Who is responsible for means testing?	**LBTH**
Who will own capital assets?	**NA**
How will capital investments be financed?	**NA**
What management costs can legitimately be charged to pool?	**None, the pool does not currently include management costs**
What re the arrangement for overheads?	**None, the pool does not currently include commissioning overheads**
What will happen to the existing capital programme?	**NA**
What will happen on transfer where if resources exceed current liability (i.e. commitments exceed budget) immediate overspend secure?	**See S75**

48 VAT

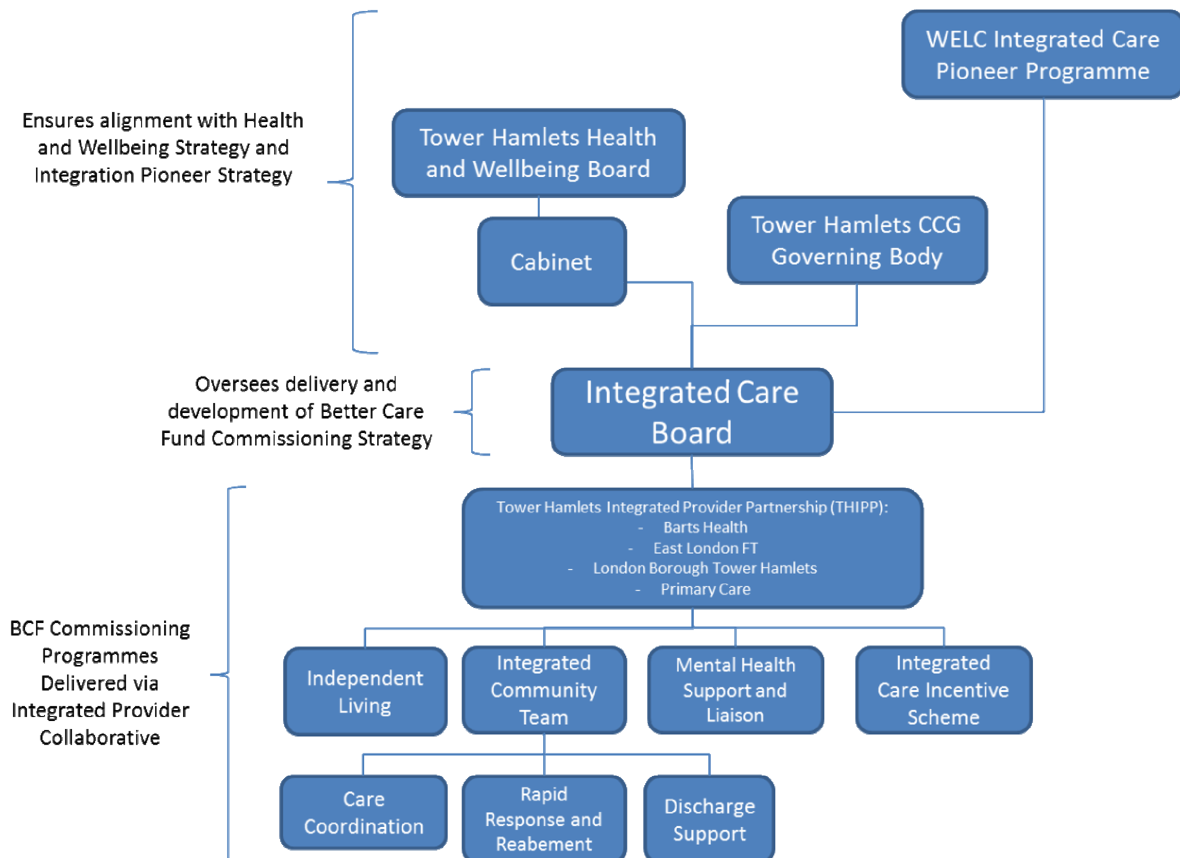
VAT arrangements will be in accordance with normal arrangements for the Lead Commissioner

49 GOVERNANCE ARRANGEMENTS FOR THE PARTNERSHIP

49.1 Integrated Care in Tower Hamlets is overseen and driven by a joint Integrated Care Board (ICB). The ICB includes representatives from:
- CCG and LA commissioners
- Provider colleagues from social care acute, community, mental health and primary care
- Voluntary sector
- Chaired by a provider non Executive director

49.2 The ICB is a formal sub-committee of the Health and Wellbeing Board, as well as being a Tower Hamlets CCG programme board. The Chair of the Integrated Care Board sits on the Health and Wellbeing Board, and Integration is a key strategic priority under the Tower Hamlets Health and Wellbeing Strategy.

49.3 The Integrated Care Board oversees:
- Delivery of commissioned Integrated Care services, provided by the Tower Hamlets Integrated Provider Partnership
- Development of Integrated Care strategy, including the Better Care Fund



50 NON FINANCIAL RESOURCES

Council contribution

	Details	Charging arrangements	Comments
Premises	NA	NA	NA
Assets and equipment	NA	NA	NA
Contracts	NA	NA	NA
Central support services	NA	NA	NA

CCG Contribution

	Details	Charging arrangements	Comments
Premises	NA	NA	NA
Assets and equipment	NA	NA	NA
Contracts	NA	NA	NA
Central support services	NA	NA	NA

51 STAFF

To be inserted

52 ASSURANCE AND MONITORING

See Better Care Fund application excel submission

Outcome	Metric	Source	Timeliness
BCF Metrics	See Part 2	See Part 2	Monthly
Emergency admissions for target group	Emergency admissions for target group	Integrated Care Dashboard	Monthly
Readmissions for target group	Readmissions for target group	Integrated Care Dashboard	Monthly
Average length of stay	Average length of stay	Integrated Care Dashboard	Monthly
Total bed days	Total bed days	Integrated Care Dashboard	Monthly
Bed days per 1000 eligible population	Bed days per 1000 eligible population	Integrated Care Dashboard	Monthly
Non-elective admission rate per 1000 eligible population	Non-elective admission rate per 1000 eligible population	Integrated Care Dashboard	Monthly
Number of attendances at A&E	Number of attendances at A&E	Integrated Care Dashboard	Monthly
Proportion of patients readmitted to acute hospital within 30 days of discharge	Proportion of patients readmitted to acute hospital within 30 days of discharge	Integrated Care Dashboard	Monthly
Proportion of patients readmitted to acute hospital within 91 days	Proportion of patients readmitted to acute hospital within 91 days	Integrated Care Dashboard	Monthly

of discharge	of discharge		
Average acute cost per patient	Average acute cost per patient	Integrated Care Dashboard	Monthly
Avoidable emergency admissions	Avoidable emergency admissions	Integrated Care Dashboard	Monthly

53 LEAD OFFICERS

Partner	Name of Lead Officer	Address	Telephone Number	Email Address
Council	Dorne Kanerack	Education, Social Care and Wellbeing, London Borough of Tower Hamlets, 5th Floor, Mulberry Place, 5 Clove Crescent, London, E14 2BG	020 7364 0497	dorne.kanareck@towerhamlets.gov.uk
CCG	Josh Potter	NHS Tower Hamlets Clinical Commissioning Group, 2nd Floor Alderney Building, Mile End Hospital, Bancroft Road, London, E1 4DG	020 3688 2518	josh.potter@towerhamletsccg.nhs.uk

54 REGULATORY REQUIREMENTS

See individual service specifications

55 INFORMATION SHARING AND COMMUNICATION

See section 7c in Part One BCF application

SCHEDULE 2– GOVERNANCE

1 Partnership Board

1.1 The Tower Hamlets Integrated Care Board will act as the Partnership Board defined by this agreement and its Terms of Reference will be amended to encompass the governance arrangements set out in the remainder of this Schedule and elsewhere in this agreement including, but not limited to, Clauses 5,6 and 19.

1.2 The membership of the Partnership Board will be as follows:

Name	Role	ICB function
Alastair Camp	Non-Executive Director, Barts Health	Chair
John Wardell	WELC PMO	CCG Accountable Officer
GP Representative		
Isabel Hodkinson Liliana Risi Victoria Tzortiou-Brown	GP Board lead: IT/Informatics; Last Years of Life Clinical lead:Cancer; Last Years of Life GP Board lead: Integrated Care	Clinical Lead Clinical Lead Clinical Lead
Local Authority Representatives		
Bozena Allen Dorne Karnacek Paul Iggulden Judith Shankleman	Interim Service Head Adult Social Care Service Head: Commission & Health Education, Social Care and Wellbeing (London Borough Tower Hamlets) *London Borough Tower Hamlets -Public Health Department* Associate Director Senior Strategist	Local Authority Social Care Local Authority Public Health Public Health
CCG Representatives		
Josh Potter Julie Dublin Richard Fradgley DanijelaLevarda	Deputy Director of Commissioning and Transformation Transformation Manager for ICB Deputy Director of Mental Health and Joint Commissioning Programme Manager (WELC Integrated Care Programme)	Commissioning Commissioning Mental Health Commissioning WELC PMO
NEL CSU Representative		
David Bush	Senior Commissioning Support Manager	CSU Representative
Barts Health Representative		
Steve Ryan Dr SheraChok Sven Bunn Abigail Jago Fiona Wheeler	Medical Director Director of Primary Care Associate Director of Strategy – Foundation Trust Programme Lead Programme Manager (Integrated Care) – Barts Health Fiona Wheeler	Barts Barts Barts Barts Barts
East London NHS Foundation Trust		
Navina Evans Anna Burnside	Director of Operations Dr Anna Burnside, Consultant Psychiatrist and Clinical Lead Department of Psychological Medicine	East London Foundation Trust East London Foundation Trust
GP Care Group		

Dr Phillip Bennett-Richards	GP Care Group	GP
Tower Hamlets Integrated Provider Partnership		
Dr Phillip Bennett-Richards Abigail Jago Fiona Wheeler Sven Bunn Navina Evans Bozena Allen	GP Care Group Programme Manager (Integrated Care) – Barts Health Fiona Wheeler Associate Director of Strategy – Foundation Trust Programme Lead Director of Operations Interim Service Head Adult Social Care	GP Barts Barts Barts East London Foundation Trust Local Authority Social Care
Navina Evans	Director of Operations	East London Foundation Trust
TH Community Voluntary Sector Representatives		
Zoe Portlock Myra Garrett	Director of Services, Bromley By Bow Centre	Community Voluntary Sector Community Voluntary Sector

2 Role of Partnership Board

3 The Partnership Board shall:

3.1.1 Provide strategic direction on the Individual Schemes

3.1.2 receive the financial and activity information;

3.1.3 review the operation of this Agreement and performance manage the Individual Services;

3.1.4 agree such variations to this Agreement from time to time as it thinks fit;

3.1.5 review and agree annually a risk assessment and a Performance Payment protocol;

3.1.6 review and agree annually revised Schedules as necessary;

3.1.7 request such protocols and guidance as it may consider necessary in order to enable teach Pooled Fund Manager to approve expenditure from a Pooled Fund;

3.1.8 provide, at least annually, a report on progress in delivering the Better Care Fund plan to the Health and Wellbeing Board and to the CCG Board. The Partnership Board will report to the same two bodies more frequently by exception in respect of remedial action to address non-performance that it is beyond the delegated authorities of the Partnership Board to resolve.

4 Partnership Board Support

The Partnership Board will be supported by officers from the Partners from time to time.

5 Meetings

5.1 The Partnership Board will meet Quarterly at a time to be agreed within fourteen (14) days following receipt of each Quarterly report of the Pooled Fund Manager.

5.2 The quorum for meetings of the Partnership Board shall be a minimum of one representative (CCG Senior Management Team / LBTH ESCW Directorate Management Team seniority) from each of the Partner organisations.

5.3 Decisions of the Partnership Board shall be made unanimously. Where unanimity is not reached then the item in question will in the first instance be referred to the next meeting of the Partnership Board. If no unanimity is reached on the second occasion it is discussed then the matter shall be dealt with in accordance with the dispute resolution procedure set out in the Agreement at Clause 23.

5.4 Where a Partner is not present and has not given prior written notification of its intended position on a matter to be discussed, then those present may not make or record commitments on behalf of that Partner in any way.

5.5 Minutes of all decisions shall be kept and copied to the Authorised Officers within seven (7) days of every meeting.

6 Delegated Authority

6.1 The Partnership Board is authorised within the limited of delegated authority for its members (which is received through their respective organisation's own financial scheme of delegation) to:

6.1.1 authorise commitments which exceed or are reasonably likely to lead to exceeding the contributions of the Partners to the aggregate contributions of the Partners to any Pooled Fund; and

6.1.2 authorise a Lead Commissioner to enter into any contract for services necessary for the provision of Services under an Individual Scheme

7 Information and Reports

Each Pooled Fund Manager shall supply to the Partnership Board on a Quarterly basis the financial and activity information as required under the Agreement.

8 Post-termination

The Partnership Board shall continue to operate in accordance with this Schedule following any termination of this Agreement but shall endeavour to ensure that the benefits of any contracts are received by the Partners in the same proportions as their respective contributions at that time.

SCHEDULE 3– RISK SHARE AND OVERSPENDS

1. To the extent that the pay for performance element of the Better Care fund is not available to the Pooled fund as a result of a failure to fully meet the target for reducing unplanned emergency activity the partners have agreed that the CCG will utilise the withheld Performance Funding as a risk pool to mitigate the direct impact of additional costs incurred in the health system as a result of this failure.

2 The CCG also agrees to give proper consideration to any submission by the Council to the effect that the failure to meet the target for reducing unplanned emergency activity has had a direct and demonstrable impact on the Council's social care budgets by, for example, leading to an increase in permanent admissions to residential care. Where the CCG is satisfied that such an impact is demonstrated the CCG undertakes to give consideration to allocating a suitable proportion of the risk pool to mitigate this impact.

3. The Partners agree that Overspends shall be apportioned in accordance with this Schedule 3.

Pooled Fund Management

4. The Pooled Fund Manager for each scheme within the Better Care Fund Plan will be responsible for quarterly reporting of income and expenditure for each scheme. Clause 8.2.7 of this Agreement defines this responsibility. The income and expenditure reports for each scheme will be incorporated into the Quarterly Performance Report submitted to the Partnership Board.

Overspend

5. Where potential or actual Overspends are reported in respect of any individual scheme the Board shall give consideration to the following options for remediating, subject always to Clause 12.5 of this Agreement:

    - agreeing an action plan to reduce expenditure in the relevant scheme or schemes;
    - identifying Underspends that can be vired from any other Fund maintained under this agreement or outside of this agreement;
    - agreeing additional investment by the respective Partners (in so far as the delegated authorities to Board representatives allow for this);
    - if no suitable investment or reduction in expenditure can be identified, agreeing a plan of action, which may include decommissioning all or any part of the Individual Service to which the Fund relates.

6. The Partnership Board shall act reasonably having taken into consideration all relevant factors including, where appropriate the Better Care Fund Plan and any agreed outcomes and any other budgetary constraints in agreeing appropriate action in relation to Overspends.

7. The Partners agree to co-operate fully in order to establish an agreed position in relation to any Overspends for which it is not possible or reasonable to identify mitigating action.

8. Overspends which occur in relation to any Performance Payments shall be subject to alternative provisions in the relevant Performance Payment Arrangement, and be apportioned between the Partners pro rata to the value of their respective Financial Contributions (excluding Non-Recurrent Payments)for the Financial Year in respect of which the Overspend occurs.

9. Where there is an overspend in a Non Pooled Fund at the end of the Financial Year or at termination of the Agreement such overspend shall be met by the Partner whose financial contributions to the relevant Non Pooled Fund were intended to meet the expenditure to which the overspend relates save to the extent that such overspend is not the fault of the other Partner.

10. Subject to any continuing obligations under any Service Contract entered into by either Partner, either Partner may give notice to terminate a Service or Individual Scheme where the Scheme Specification provides and where the Service does not form part of the Better Care Fund Plan.

SCHEDULE 4– JOINT WORKING OBLIGATIONS

Part 1– LEAD COMMISSIONER OBLIGATIONS

Terminology used in this Schedule shall have the meaning attributed to it in the NHS Standard Form Contract save where this Agreement or the context requires otherwise.

9 The Lead Commissioner shall notify the other Partners if it receives or serves:

9.1 a Change in Control Notice;

9.2 a Notice of an Event of Force Majeure;

9.3 a Contract Query;

9.4 Exception Reports

and provide copies of the same.

10 The Lead Commissioner shall provide the other Partners with copies of any and all:

10.1 CQUIN Performance Reports;

10.2 Monthly Activity Reports;

10.3 Review Records; and

10.4 Remedial Action Plans;

10.5 Joint Investigation Reports;

10.6 Service Quality Performance Report;

11 The Lead Commissioner shall consult with the other Partners before attending:

11.1 an Activity Management Meeting;

11.2 Contract Management Meeting;

11.3 Review Meeting;

and, to the extent the Service Contract permits, raise issues reasonably requested by a Partner at those meetings.

12 The Lead Commissioner shall not:

12.1 permanently or temporarily withhold or retain monies pursuant to the Withholding and Retaining of Payment Provisions;

12.2 vary any Provider Plans (excluding Remedial Action Plans);

12.3 agree (or vary) the terms of a Joint Investigation or a Joint Action Plan;

12.4 give any approvals under the Service Contract;

12.5 agree to or propose any variation to the Service Contract (including any Schedule or Appendices);

12.6 suspend all or part of the Services;

12.7 serve any notice to terminate the Service Contract (in whole or in part);

12.8 serve any notice;

12.9 agree (or vary) the terms of a Succession Plan;

without the prior approval of the other Partners acting through the Partnership Board. Such approval not to be unreasonably withheld or delayed.

13 The Lead Commissioner shall advise the other Partners of any matter which has been referred for dispute and agree what (if any) matters will require the prior approval of one or more of the other Partners as part of that process.

14 The Lead Commissioner shall notify the other Partners of the outcome of any Dispute that is agreed or determined by Dispute Resolution

15 The Lead Commissioner shall share copies of any reports submitted by the Service Provider to the Lead Commissioner pursuant to the Service Contract (including audit reports)

Part 2– OBLIGATIONS OF THE OTHER PARTNER

Terminology used in this Schedule shall have the meaning attributed to it in the NHS Standard Form Contract save where this Agreement or the context requires otherwise.

16 Each Partner shall (at its own cost) provide such cooperation, assistance and support to the Lead Commissioner (including the provision of data and other information) as is reasonably necessary to enable the Lead Commissioner to:

16.1 resolve disputes pursuant to a Service Contract;

16.2 comply with its obligations pursuant to a Service Contract and this Agreement;

16.3 ensure continuity and a smooth transfer of any Services that have been suspended, expired or terminated pursuant to the terms of the relevant Service Contract;

17 No Partner shall unreasonably withhold or delay consent requested by the Lead Commissioner.

18 Each Partner (other than the Lead Commissioner) shall:

18.1 comply with the requirements imposed on the Lead Commissioner pursuant to the relevant Service Contract in relation to any information disclosed to the other Partners;

18.2 notify the Lead Commissioner of any matters that might prevent the Lead Commissioner from giving any of the warranties set out in a Services Contract or which might cause the Lead Commissioner to be in breach of warranty.

SCHEDULE 5– PERFORMANCE ARRANGMENTS

1. The Partners have agreed that the achievement of the benefits it is intended be realised through the successful delivery of the Better Care Fund plan will be measured using three key methods:

   - Monthly activity and progress reporting by Providers to the Partnership Board;
   - Quarterly reporting of the Integrated Care Dashboard, which includes all metrics relevant to Better Care Fund plan delivery, to the Partnership Board; and
   - Use of a Patient Experience Metric being developed for 2015/16 as part of the WELC Integrated Care Pioneer Programme. Quarterly reporting against this metric will be incorporated into the Integrated Care Dashboard for reporting to the Partnership Board.

2. The Partnership Board will use the monthly activity and progress reports for each scheme submitted by Providers as a means of providing early warning of potential non-performance in respect of individual schemes. The Board will be proactive in discussing and implementing remedial actions designed to deal with identified non-performance. A lead Partner or Provider will be identified as being responsible for implementing the necessary remedial actions.

3. Progress in implementing any remedial actions will continue to be reported, by the Lead Partner or Provider, to subsequent meetings of the Partnership Board until such time as the Board is satisfied that the non-performance has been properly addressed and rectified.

4. In circumstances where authority to implement the necessary remedial actions is beyond the delegated powers of the Board or individual Partner or Provider representatives the following escalation procedures shall apply:

4.1 Where the Board as a whole does not have sufficient delegated authority the Chair of the Board will be responsible for escalating to the next meeting of the Health and Wellbeing Board for resolution. In circumstances where this is not practicable, for example because of time constraints, the Authorised Officers for each Partner will seek the necessary authority from their respective organisations.

4.2 Where the issue relates to the delegated authority of an individual Partner or Provider representative, said representative will be responsible for escalating the agreed remedial actions for approval within their own organisation.

5. The Lead Commissioner shall be responsible for presenting the Integrated Care Dashboard, with an accompanying narrative providing an overview of performance against the plan, to the Partnership Board on a quarterly basis. The Board shall use this report to take a more considered and strategic view of progress against the plan as a whole and to consider whether any adjustments across and between individual schemes, additional investment or disinvestment, or other interventions are necessary to maintain the desired level of progress in delivering against the plan.

6. The quarterly report prepared by the Lead Commissioner shall also include the income and expenditure report required by Clause 8.2.7 of this Agreement.

7. Where the wider quarterly review undertaken by the Board identifies potential or actual non-performance against the plan, the process for implementing remedial actions shall be as set out in Clauses 2 to 4 of this Schedule above.

8. The Lead Commissioner shall be responsible for the preparation of the Annual Performance Report to meet the requirements set out in Clause 20 of this Agreement and for presenting it to the Health and Wellbeing Board within the prescribed timescale.

9. As and when directed by the Partnership Board as per Schedule 2, Clause 3.1.8, the Lead Commissioner shall be responsible for preparing exception reports to the Health and Wellbeing Board.

10. The Partners acknowledge that as the WELC Integrated Care Pioneer Programme develops it is likely that the metrics and performance reporting arrangements underpinning the wider Programme

will continue to be refined and developed. The Partners therefore agree to keep the performance arrangements set out in this Schedule and elsewhere in this Agreement under review and to develop them as necessary to maintain continuity with the performance arrangements for the wider Programme.

SCHEDULE 6– BETTER CARE FUND PLAN

1. The Tower Hamlets Better Care Fund plan, as approved by NHS England on 07 January 2015, can be viewed via the following link: *(Link to be inserted)*

2. The approved plan has the following appendices:

- Appendix A: Integration Function
- Appendix B: WEL 5 Year Strategic Plan "Transforming Services Together"
- Appendix C: Integrated Care Data Analysis (Impact measures)
- Appendix D: NHS & Monitor PILS
- Appendix E: EOI from WELC in co-commissioning primary care
- Appendix F: Specification for Integrated Care Incentive Scheme
- Appendix G: Methodology and rationale for patient experience indicator
- Appendix H: WELC Integrated Care Pioneer Programme
- Appendix I: Summary of the Tower Hamlets Integrated Provider Partnership arrangements.
- Appendix J: Metrics and Key Performance Indicators used in performance managing the RAID service.

3. Each of these appendices can also be viewed via the link at 1. above.

SCHEDULE 7– POLICY FOR THE MANAGEMENT OF CONFLICTS OF INTEREST

1. The Council and the CCG jointly recognise that each operates in a complex practice, policy and political environment and that from time to time this complexity could give rise to situations where the wider interests of one Partner may create an actual or perceived conflict of interest in respect of delivery of the Better Care Fund plan.

2. Both Partners also recognise that the complexity of the environment in which each operates means that it is incumbent on each Partner to ensure that in planning any investment or disinvestment decisions and/or policy or practice changes any potential impact on Better Care Fund plan delivery is considered and appropriate mitigation sought during the planning of change. In so doing, the Partners wish to reduce the likelihood of conflicts of interest arising inadvertently.

3. The Partners undertake to use best endeavours to minimise the risk of any such conflicts arising, and to minimise the adverse impact should such conflicts (actual or perceived) arise. At all times when addressing any actual or perceived conflicts the Partners will have due regard to the terms of this agreement, and the partnership approach underpinning it, and in particular to the General Principles set out in Clause 3.2 of the Agreement.

4. The Authorised Officers will, in the first instance, seek to resolve any actual or perceived conflict of interest that arises during the term of this Agreement through discussion. While this can be managed informally, a record of the actual or perceived conflict, and of the agreed means of resolving, should be kept by the Authorised Officers and reported to the next available Partnership Board meeting for noting.

5. In circumstances the Authorised Officers are unable to resolve the conflict of interest through informal discussion the Dispute Resolution procedure set out at Clause 23 of the Agreement shall be followed.

6. The Council recognises that its role as both Commissioner and Provider of services means that it is necessary to put additional safeguards in place to ensure transparency of decision making and to assure the CCG that the best interests of the Partnership are the primary consideration with regards to Better Care Fund plan delivery. In order to provide this assurance the Council will:

6.1 Ensure that at all times it is represented on the Partnership Board by at least one senior officer whose job functions are primarily Commissioning based, and who has no line management responsibility (or line management accountability to senior officers) for the delivery of Provider functions;

6.2 Ensure at all times that Commissioning intentions or decisions agreed by the Partners, or made under delegated authority by the Pooled Fund Manager, are not communicated to Provider functions within the Council in advance of their formal communication to the relevant Provider or Providers by the Partnership.

SCHEDULE 8 – INFORMATION GOVERNANCE PROTOCOL

1. Information Governance, including assurance of compliance with relevant Laws and the requirements of the Caldicott Guardians for each Partner, is a key component of the WELC Integrated Care Pioneer Programme. Arrangements for ensuring that individually identifiable data is managed securely and in full compliance with all relevant legislative requirements have been or are being put in place via this programme in order to ensure that the sharing of information necessary for delivering properly integrated arrangements can be facilitated. Details of the Information Governance protocols in place to support the Integrated Care Pioneer Programme can be obtained from the WELC Programme Office, currently hosted by NHS Tower Hamlets CCG.

2. The Partners to this Agreement have resolved, therefore, that the Information Governance arrangements to support the delivery of the Better Care Fund plan will be those established for the WELC Integrated Care Pioneer Programme. In particular, NHS numbers will be used as the common identifier for individual recipients of services, and the Council reconfirms its commitment to ensuring that all individual records held pursuant to discharge of its Community Care responsibilities include the individual's NHS number. For the purposes of Better Care Fund plan delivery this commitment extends to individuals aged eighteen (18) and over whose services are being provided under the Children and Families Act 2014 and related legislation and regulation.

3. Each Partner remains at all times responsible, through their own Information Governance arrangements, for assuring themselves that all data sharing and other agreements put in place to facilitate the sharing or transfer of individually identifiable data are compliant with the legislation relevant to that partner and to any internal protocols in place pursuant to ensuring that compliance.

NHS England

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To:
Leo Nicholas – Tower Hamlets Health and Wellbeing Board
Jane Milligan – Tower Hamlets CCG

7 January 2015

Copy to:
Karen Sugars – Tower Hamlets Local Authority

Dear colleague,

Thank you for submitting further evidence to move your Better Care Fund plan to a fully approved status. We know that the BCF is an ambitious programme and preparing the plans at pace has proved an immensely challenging task. However, your plan is now part of an ongoing process to transform local services and improve the lives of people in your community.

It is clear that your team and partners have worked very hard over the last year, making valuable changes to your plan in order to improve people's care.

NHS England is now able to formally approve plans following the publication of the 2015/16 Mandate. I am delighted to let you know that, following the subsequent Nationally Consistent Assurance Review (NCAR) process, your plan has been classified as **'Approved'**. Essentially, your plan is clear and ambitious and we support your ambitions. This puts you in a strong position for delivering the change outlined above.

Your BCF funding will be made available to you subject to the following standard conditions which apply to all BCF plans:

- The Fund being used in accordance with your final approved plan and through a section 75 pooled fund agreement;
- The full value of the element of the Fund linked to non-elective admissions reduction target will be paid over to CCGs at the start of the financial year. However, CCGs may only release the full value of this funding into the pool if the admissions reduction target is met as detailed in the BCF Technical Guidance[1]. If the target is not met, the CCG(s) may only release into the pool a part of that funding proportionate to the partial achievement of the target. Any part of this funding that is not released into the pool due to the target not being met must be dealt with in accordance with NHS England requirements. Full details are set out in the BCF Technical Guidance

The conditions are being imposed through NHS England's powers under sections

223G and 223GA of the NHS Act 2006 (as amended by the Care Act 2014). These allow NHS England to make payment of the BCF allocation subject to conditions. If the conditions are not complied with, NHS England is able to withhold or recover funding, or direct the CCG that it be spent in a particular way.

We are confident that there are no areas of high risk in your plan and as such you should progress with your plans for implementation.

Any ongoing support and oversight with your BCF plan will be led by your NHS England Regional/Area Team along with your Local Government Regional peer rather than the BCF Taskforce from this point onwards.

Non-elective (general and acute) admissions reductions ambition

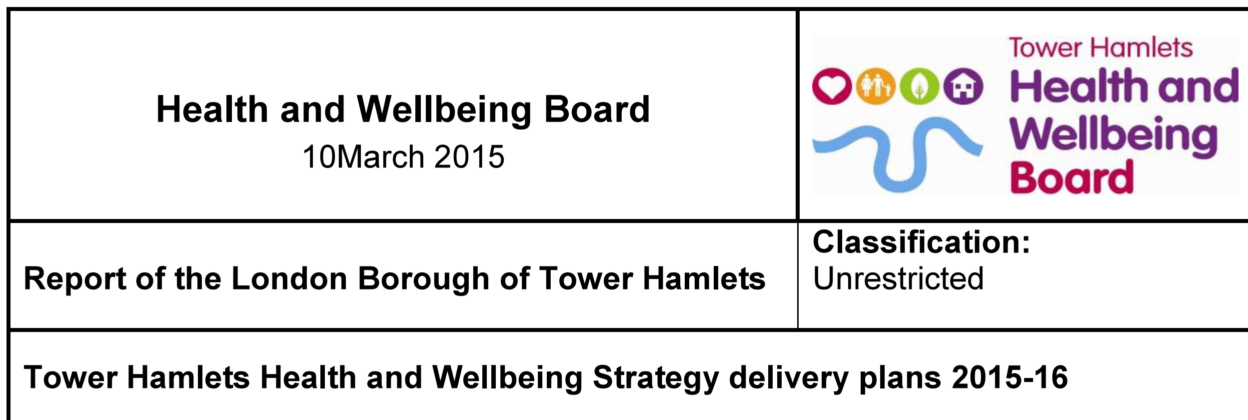
We recognise that some areas may want to revisit their ambitions for the level of reduction of non-elective admissions, in light of their experience of actual performance over the winter, and as they become more confident of the 2014/15 outturn, and firm-up their plans to inform the 2015/16 contracting round. Any such review should include appropriate involvement from local authorities and be approved by HWBs. NHS England will assess the extent to which any proposed change has been locally agreed in line with BCF requirements, as well as the risk to delivery of the ambition, as part of its assurance of CCGs' operational plans.

Once again, thank you for your work and we look forward to the next stage.

Yours sincerely,

Dame Barbara Hakin
National Director: Commissioning Operations
NHS England

[1] http://www.england.nhs.uk/wp-content/uploads/2014/08/bcf-technical-guidance-v2.pdf



Health and Wellbeing Board 10March 2015	
Report of the London Borough of Tower Hamlets	**Classification:** Unrestricted
Tower Hamlets Health and Wellbeing Strategy delivery plans 2015-16	

Lead Officer	Louise Russell
Contact Officers	Louise Russell
Executive Key Decision?	No

Executive Summary

The Health and Wellbeing Strategy's current delivery plans have been a key driver for achieving the Board's joint aims and many of the proposed actions have now been completed. The strategy is due to be refreshedduring2015-16 with a view to a new strategy commencing from April 2016. In the meantime, we are revising the current, delivery plans to ensure delivery against the current strategy's objectives continues in 2015-16.

Formal approval of the refreshed 2015-16 delivery plans is now sought from the Health and Wellbeing Board. Once approval has been given, the 2015/16 delivery plans will be published.

Recommendations:

The Health and Wellbeing Board is recommended to:

1. Agree the delivery plans, proposed outcome measures and targets. These will be the measures used to track progress on the plan and on which performance will be reported to the Board. The measures are drawn from the social care, public health and NHS outcomes frameworks to reflect our strategic priorities.
2. Agree the delivery and performance monitoring arrangements set out in section 3 below.
3. Agree that the Health and Wellbeing Strategy subgroup shall monitor and adapt the delivery plan targets on behalf of the Health and Wellbeing Board and provide 6 monthly updates

1. REASONS FOR THE DECISIONS

1.1 All Health and Wellbeing Boards have a statutory duty under the Health and Social Care Act 2012 to publish and deliver local health and wellbeing strategies.

2. ALTERNATIVE OPTIONS

2.1 All Health and Wellbeing Boards are required to publish a health and wellbeing strategy. An alternative strategy delivery plan can be developed.

3. DETAILS OF REPORT

3.1 Introduction

3.1.1 The activities associated with the Healthy Lives, Maternity and Early years and Long Term Conditions and Cancer priorities in the Strategy's delivery plans are mostly completed.

3.1.2 The current strategy is due to be refreshed for April 2016. In the meantime there is a need for a new set of actions, for the above priorities, to ensure we deliver against the objectives outlined in the Health and Wellbeing Strategy.

3.1.3 The Mental Healthy Strategy's delivery plans have been developed and considered by the Board more recently and consequently have not been refreshed at this time.

3.2 Key decisions for the Board

3.2.1 The Board is asked to

- Agree the refreshed delivery plans, including the proposed outcome measures and targets. These will be the measures used to track progress on the plan and on which performance will be reported to the Board. The measures are drawn from the social care, public health and NHS outcomes frameworks to reflect our strategic priorities.
- Agree the delivery and performance monitoring arrangements set out in section 3 below.
- Agree that the Health and Wellbeing Strategy subgroup shall monitor and adapt the delivery plan targets on behalf of the Health and Wellbeing Board and provide 6 monthly updates

3.3 Delivery and Performance Monitoring

3.3.1 The following arrangements for the delivery and monitoring of the Health and Wellbeing Strategy have previously been agreed as follows:

- There will be arrangements for overseeing delivery of the Delivery Plans , as follows
    - Healthy Lives – group chaired by Somen Banerjee;
    - Maternity and Early years – MEY Group of Children and Families Board;
    - Long Term Conditions and Cancer – Integrated Care Board, and additional leads in Council and CCG for relevant issues; and
    - Mental Health – Mental Health Partnership Board

- The Council's Corporate Strategy and Equality team, on behalf of the Strategy sub-group, will liaise with agreed leads to oversee the monitoring of progress of the strategy compiling six monthly reports to the Board on progress with key outcome measures and an annual report on progress against the delivery plans;
- Delivery of cross-cutting activity in the Strategy in relation to wider determinants or enablers will be overseen by the Strategy sub-group which will meet bi-monthly to progress this work, liaising with other Boards and Community Plan Delivery Groups as required. To date, the sub-group has focused on the relationship between health and housing as a key wider determinant, and also reviewed progress around the strategy enablers.
- Healthwatch will also make regular dashboard reports to each quarterly Board meeting identifying key issues from patient and resident experiences of health and social care services, as well as a more in-depth examination of a key issue related to the HWB agenda; and
- Based on the regular review of performance and patient experience data, the Board may identify areas for improvement and request 'spotlight' sessions on specific issues of concern or local significance. These sessions will seek to understand improvement plans in place and identify areas where partnership working might help to resolve blockages.

4. COMMENTS OF THE CHIEF FINANCE OFFICER

4.1. There are no financial implications of this report as it sets the framework within which the Board would consider prioritisation of available resources.

5. LEGAL COMMENTS

5.1. Section 193 of the Health and Social Care Act 2012 inserts a new s116A into the Local Government and Public Involvement in Health Act 2007, which places a duty on the Health and Wellbeing Board ('HWB') to prepare a joint strategic health and wellbeing strategy in respect of the needs identified in the Joint Strategic Needs Assessment. The duty to prepare this plan falls on local authorities and the Clinical Commissioning Group, but must be discharged by the HWB.

5.2. In preparing this strategy, the HWB must have regard to whether these needscould better be met under s75 of the National Health Service Act 2006. Further, the Board must have regard to the Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies published on 26 March 2013, and can only depart from this with good reason.

5.3. The recommendations to agree the delivery plans, proposed outcome measures and targets, and to agree the delivery and performance monitoring arrangements, fall within the HWB's terms of reference, in particular:

- To have oversight of assurance systems in operation
- To identify needs and priorities across Tower Hamlets and publish and refresh the Tower Hamlets Joint Strategic Needs Assessment (JSNA) so that future commissioning/policy decisions are based on evidence.
- To have oversight of the quality, safety, and performance mechanisms

5.4. The HWB is authorised under the Council's Constitution to establish supporting sub groups to deliver the work of the HWB as required.The recommendation that the Health and Wellbeing Strategy subgroup should monitor and adapt the delivery plan targets on behalf of the HWB and provide 6 monthly updates is therefore permissible under the Constitution.

5.5. This strategy must be prepared in accordance with the public sector equalities duty to eliminate unlawful conduct under the Equalities Act 2010, the need to advance equality of opportunity and the need to foster good relations between persons who share a protected characteristic and those who do not.

6. ONE TOWER HAMLETS CONSIDERATIONS

6.1 An equalities assurance exercise has been undertaken as part of the strategy development the strategy was informed by a detailed assessment of equalities impacts on health.

7. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

7.1 There is a wealth of evidence, most recently compiled and presented within the Marmot review of health inequalities, identifying the considerable impact on health of wider social, economic and environmental impact on health, in particular housing, educational attainment, employment and the physical

environment. These are addressed as wider determinants of health within the Health and Wellbeing Strategy.

7.2 One specific initiative is the 'Green Grid' which seeks to sustain and create across the borough a network of high quality well-connected open spaces to promote bio-diversity and healthy, active lifestyles. In addition, the Tower Hamlets Partnership encourages walking and cycling through a range of projects and programmes delivering training in schools to encourage students to cycle by equipping them with the necessary confidence, skills and safety training and free adult cycle confidence training for anyone who lives, works or studies in the borough. Schemes are also in place to promote cycling amongst disabled people and traditionally harder to reach groups such as BME women.

7.3 Other initiatives already in place include a Healthy Walking Programme, the borough-wide expansion of the Barclays Cycle Hire Scheme, and meeting the targets set through the Community Partnership's Air Quality Action Plan.

8. RISK MANAGEMENT IMPLICATIONS

8.1. The Tower Hamlets Health and Wellbeing Strategy is, by its nature, extremely broad. Its success depends on a range of enablers which are considered within the Strategy.

8.2. Delivery planning and performance management arrangements have been put in place to ensure delivery of the strategy and they are outlined in this report. The Health and Wellbeing Strategy Sub-Group, which is formed of representatives from partners on the Board, including Healthwatch and voluntary sector representatives, will be key to driving the strategy centrally, as will the groups and leads driving and reporting on each of the four priority areas. The Health and Wellbeing Board will need to play a pivotal role in ensuring that outcomes are met and that challenges are raised where necessary.

8.3. Due to the breadth of the strategy and its four delivery plans, there is a risk that the Board could be overburdened with data and reporting. Therefore, it is suggested that the Board instead agrees the suggested monitoring arrangements set out in paragraph 3.3.1 of the report.

9. CRIME AND DISORDER REDUCTION IMPLICATIONS

9.1 Health issues, in particular in relation to mental health, alcohol and drugs misuse have a significant impact on crime and disorder. The Health and Wellbeing Strategy identifies key opportunities where it could work with partners and the Crime and Disorder Partnership, including around substance misuse, domestic abuse and the health needs of sex workers.

10. EFFICIENCY STATEMENT

10.1 The Health and Wellbeing Strategy identifies effective use of shared resources as a key enabler, seeking to increase efficiency through effective partnership working, collaboration over use of resources and assets and integrating health and social care.

Appendices and Background Documents

Appendices

- Maternity and Early Years Delivery Plan
- Healthy Lives Delivery Plan
- Long Term Conditions and Cancer Delivery Plan

Background Documents

If your report is a decision making report, please list any background documents not already in the public domain including officer contact information.

Appendix 1 Action Plan Template – Early Years

Outcome Objective **More children having a healthy start** **More 0-5 year olds** • **Supported by parents and carers with good physical and mental health before, during and after pregnancy** • **With secure emotional attachment and good cognitive development** • **Being breastfed and establishing healthy eating habits** • **With strong foundations for excellent oral health** • **Developing physically and socially through play** • **Living in environments free from the health harms of alcohol, tobacco and drugs** • **Fully immunised**			
Proposed outcome measures			
Measure	**Outcome 2013/14**	**Target 2014/15**	**Target 2015/16**
Infant mortality	5.3 per 1,000 live births		Track indicator
Low birth weight of term babies	5%		4.8%
Percentage of children achieving good level of development at end of reception	55.0%		57.0%
Percentage of children with free school meal status achieving good level of development at end of reception	50.7%		52.0%
Breast feeding – breastfeeding initiation	Tbc (data missing from PHOF report)		tbc

Breast feeding – prevalence at 6-8 weeks after birth	Tbc (data missing from PHOF report)		tbc
Tooth decay in children aged 5 (mean number teeth decayed)	1.78		1.70
Excess weight 4-5 year olds	23.7%		23.5%
Smoking status at time of delivery	3.2%		Maintain (but develop indicator based on ethnicity breakdown)
Population vaccine coverage – DTP/IPV/Hib	96.4%		Maintain
Population vaccine coverage – MMR for two doses (5 yr old)	93.0%		95.0%
1. More 0-5s with good health and foundations for future health (Cross Cutting)			
Action/strategy/programme to deliver	**Lead**	**Milestones**	**Timescale**
Develop and implement new model for Health Visiting and Family Nurse Partnership in Tower Hamlets	Esther Trenchard-Mabere	Set out new model of delivery of Health Visiting following stakeholder engagement Decide on options for delivery going forward (procurement or in house options) – further steps will depend on this decision Health Visiting contract (Barts Health) novated to the Council	By April 2015 By May 2015 October 2015

Review progress on current maternity, early years and childhood action plan (Children and Families Partnership)	Esther Trenchard-Mabere	Milestones to be confirmed	
2. More 0-5 year olds with secure emotional attachment and good cognitive development			
Action/strategy/programme to deliver	**Lead**	**Milestones**	**Timescale**
Mobilisation of new parent and infant wellbeing programme	Esther Trenchard-Mabere	Contract mobilised Contractual monitoring	By April 2015 Quarterly
Continue work to develop an integrated 2 year review	Esther Trenchard-Mabere	Set out specification in new HV service Implementation	By June 2015 July 2015 to March 2016
Strengthen role of HVs in emotional attachment and development in new service	Esther Trenchard-Mabere	Set out specification in new HV service Implementation	By June 2015 July 2015 to March 2016
3. More 0-5 year olds being breastfed, establishing healthy eating habits and developing strong foundations for excellent oral health and developing physically and socially through play			
Action/strategy/programme to deliver	**Lead**	**Milestones**	**Timescale**
Mobilisation of new baby feeding (breast feeding) initiative contract	Esther Trenchard-Mabere	Contractual monitoring	Quarterly
Follow up recommendations from research on partial breast feeding	Esther Trenchard-Mabere	Report completed Implement recommendations	By July 2015 July 2015 to March 2016

Implement healthy weaning and healthy eating plan for under 5s (UCLP research)	Esther Trenchard-Mabere	Timescales to be confirmed	
Strengthen breast feeding and healthy weaning role of health visitors	Esther Trenchard-Mabere	Set out specification in new HV service Implementation	By June 2015 July 2015 to March 2016
Continue to build on community led activity on healthy eating and play	Esther Trenchard-Mabere	Contractual monitoring Evaluation of current programme completed	Quarterly By December 2015
Integrate oral health into existing parenting programmes	Esther Trenchard-Mabere/ Desmond Wright	Oral health input integrated into all existing parenting programmes	By September 2015
Review mechanisms for increasing uptake of fluoride varnish programme	Esther Trenchard-Mabere/ Desmond Wright	Report on strategies to increase uptake of fluoride varnish programme Implement strategy Evidence of increased uptake	By April 2015 By May 2015 By March 2016
3. More 0-5 year olds living in environments free from the health harms of alcohol, tobacco and drugs			
Proposed outcome measures			
Action/strategy/programme to deliver	**Lead**	**Milestones**	**Timescale**
Review and improve outcomes from smoking in pregnancy service	Esther Trenchard-Mabere/ Chris Lovitt	Contractual monitoring Evaluation of current programme completed	Quarterly By December 2015

As part of substance misuse procurement, implement programme for specialist midwife support for substance misuse	Andy Bamber	Reprocure services for drug and alcohol abuse (pending Cabinet approval) Complete procurement process	By July 2015 By April 2016
4. More 0-5s who are fully immunised			
Action/strategy/programme to deliver	**Lead**	**Milestones**	**Timescale**
Continue to work with Public Health England to maintain and improve uptake of childhood immunisation	Esther Trenchard-Mabere	Review monitoring reports Liaise with Public Health England through Health Protection Forum t	Monthly Quarterly

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Appendix 1 Action Plan Template – Healthy Lives Priority

Overview

The action plan below covers the actions for the Healthy Lives Priority of the Health and Wellbeing Strategy for 2015/16.

Approach:

Tackling health inequalities requires a whole system approach recognising the importance of wider determinants of health (eg income, employment, education), healthy environments, (eg housing, physical environment), strong communities and integrated services promoting prevention and early intervention. This approach also recognises that health behaviours impacting on health such as diet, physical activity, smoking are strongly influenced by the environments the people live in. This approach requires us to put health and wellbeing at the heart of everything we do across the partnership.

Framework:

The action plan is structured around aspirations for change that contribute to an overarching aim to improve health and wellbeing and reduce health inequalities in the borough.

It sets out actions around the following sections

1. ***More people living healthy fulfilling lives (cross cutting actions around developing new HWBS Strategy in 16/17)***
2. ***Healthy People (supporting mental wellbeing, physical health, healthy habits and protecting from health harms)***
    a. ***More 0-5 have a health start (see Early Years Priority)***
    b. ***Healthy families, children and adolescents***
    c. ***Healthy adults***
3. ***Healthy place***
    a. ***Healthy environments***
    b. ***Healthy communities***
    c. ***High quality integrated services supporting prevention and early intervention***

Outcome Objective (Cross Cutting) More people living healthy, fulfilling lives through a whole system approach to improving health and reducing health inequalities in Tower Hamlets			
Proposed outcome measures			
Measure	**Outcome 2013/14**		**2015/16**
Healthy life expectancy – males	52.5		Track indicator
Healthy life expectancy – females	57.2		Track indicator
Self-reported happiness – (happy or very happy)	71.7%		Track indicator
Action/strategy/programme to deliver	**Lead**	**Milestones**	**Timescale**
Develop and implement a residents Health and Wellbeing Survey	Somen Banerjee/ Louise Russell	• Provider for survey identified • Survey content and delivery agreed • Survey implemented • Results analysed	By July 2015 By September 2015 By January 2015 By March 2016
Develop and implement a programme of community based participatory research to engage with residents on priorities around healthy lives	Somen Banerjee	• Network of researchers from community identified and trained and research questions agreed	By July 2015 July to November 2015

		• Data gathered • Summary report of findings written	By January 2015
Develop and implement a programme of stakeholder engagement events around aspirations for healthy lives	Somen Banerjee	• Healthy environments • Health communities • Healthy children • Healthy adults	By July 2015 By September 2015 By November 2015 By January 2015

Priority: Healthy Lives

Outcome Objective

More children who are healthy and have the foundations for lifelong health

More children:

- **With good emotional health and foundations for lifelong mental wellbeing**
- **Who are eating healthily at home, in school and outside school**
- **Who are enjoying regular physical activity**
- **With excellent oral health**
- **Growing up in environments free from the health harms of alcohol, tobacco and drugs**
- **With life skills for fulfilling social and emotional relationships**

Proposed outcome measures

Measure	Outcome 2013/14	Target 2014/15	Target 2015/16
Excess weight in 10-11 year olds	42.3%		41.8%
Smoking prevalence age 15 – regular smokers	Tbc		Track indicator (synthetic data so target cannot be set)
Under 18 conceptions	24.3/1,000		24.0/1,000

Under 18 conceptions in those aged under 16	5.4/1,000		5.2/1,000
Chlamydia detection rate (15-24)	1451/100,000		1600/100,000
More children with good health and foundations for future health (Cross Cutting)			
Action/strategy/programme to deliver	**Lead**	**Milestones**	**Timescale**
Mobilising School Health (nursing) Contract	Esther Trenchard-Mabere	Transition to new provider completed Contractual monitoring	By May 2015 Quarterly
Develop new specification for Healthy Lives Team	Esther Trenchard- Mabere/ Chris Lovitt	Specifications for services contract through public health grant integrated Inhouse monitoring	By April 2015 Quarterly
Continue to implement and develop Healthy Schools Programme	Esther Trenchard-Mabere/ Kate Smith	Ongoing programme of monitoring and support to schools delivered	Ongoing
Continue to develop School Health Forum (bringing together stakeholders around school health issues)	Esther Trenchard-Mabere	Quarterly meetings continued	Quarterly
Support implementation of Healthy Youth Service	Chris Lovitt/ Andy Bamber	Review of existing provision and set out proposal for developing health offer of youth services completed Implement recommendations	By June 2015 June 2015 to March 2016
More children with good emotional health and foundations for lifelong mental wellbeing			

Proposed outcome measures			
Action/strategy/programme to deliver	**Lead**	**Milestones**	**Timescale**
Mobilising school health contract – emotional	Esther Trenchard-Mabere	As above (see Mobilising school health contract)	
Implement 'Young Minds Empowerment' project (training school nurses to support emotional wellbeing)	Esther Trenchard-Mabere	Contractual monitoring	Quarterly
Commissioning mindfulness training for teachers	Esther Trenchard-Mabere	Tender for provider of training completed Contractual monitoring	By May 2015 Quarterly
More children who are eating healthily at home, in school and outside school More children who are enjoying regular physical activity			
Action/strategy/programme to deliver	**Lead**	**Milestones**	**Timescale**
Implementing Healthy Schools Programme – health eating and physical activity components	Esther Trenchard-Mabere/ Kate Smith	Ongoing monitoring	Quarterly
Mobilisation of new child and family weight management programme	Esther Trenchard-Mabere	Contractual monitoring	Quarterly
Expansion of the Cook and Eat programme	Esther Trenchard-Mabere	Contractual monitoring	Quarterly
Take forward action research project on promoting healthy weight in Bangladeshi boys	Esther Trenchard-Mabere	Research completed Review and implement recommendations	By July 2015 August 2015 to March 16
Strengthen community based	Esther Trenchard-Mabere	Contractual monitoring	Quarterly

physical activity programme (Bike It, Active Play)			
Monitoring uptake of free school meals	Esther Trenchard-Mabere	Uptake review Impact reviewed	Quarterly By March 16
More children with excellent oral health			
Action/strategy/programme to deliver	**Lead**	**Milestones**	**Timescale**
Identify training needs of primary care dental teams in providing preventive care and deliver training	Esther Trenchard-Mabere/ Desmond Wright	Report on training needs of primary care dental teams completed Training programme developed	By September 2015 By November 2015
Complete work on dental paediatric care pathway and implement recommendations	Esther Trenchard-Mabere/ Desmond Wright	Paediatric Pathway Developed Commence implementation of pathway	By December 2015 March 2016
More children growing up in environments free from the health harms of alcohol, tobacco and drugs, violence			
Action/strategy/programme to deliver	**Lead**	**Milestones**	**Timescale**
Implement Healthy Schools – alcohol, tobacco and drugs components	Esther Trenchard-Mabere/ Kate Smith	As above	Ongoing
Continue to develop peer education programme to reduce uptake of smoking in children	Esther Trenchard-Mabere	Monitoring of inhouseprovison Evaluation of programme	Quarterly By December 2015
Continue enforcement of under age sales of tobacco and alcohol	Chris Lovitt/ Dave Tolley	Quarterly monitoring of progress through Tobacco Control Alliance meetings	Quarterly
Expand scope of young people	Chris Lovitt	Training of providers	By June 2015

substance misuse services to include tobacco cessation		Monitoring of quit referrals	Quarterly
Conduct audit of referrals to specialist substance misuse services	Chris Lovitt	Audit completed Recommendations implemented	By September 2015 October 2015-March 2015
More children with life skills for fulfilling social and emotional relationships			
Action/strategy/programme to deliver	**Lead**	**Milestones**	**Timescale**
Implement Healthy Schools – Sex and Relationship Education	Esther Trenchard-Mabere/ Chris Lovitt	Monitoring of in house provision	Quarterly
Continue to implement Aspire programme	Chris Lovitt	Monitoring of in house provision	Quarterly

Priority: Healthy Lives			
Outcome Objective **More adults who are healthy and have the foundations for lifelong health** • **With good mental wellbeing** • **Introducing or continuing healthy habits and reducing harmful health behaviours eg tobacco, alcohol and drug misuse, risky sex and poor oral hygiene** • **Aware of their risk of physical and mental health conditions and taking action to reduce risk** • **Aware of symptoms and signs of physical and mental health conditions and seeking help as early as possible** • **Supported to choose where they are cared for in their last years of life and their place of death**			
Proposed outcome measures– *relating to above objective*			
Measure	**Outcome 2013/14**	**Target 2014/15**	**Target 2015/16**
Mortality rate from causes considered preventable	241.7/100,000		Track indicator
Excess weight in adults	47.2%		Track indicator (synthetic data so cannot use for targets)
Physical activity in adults – active adults	53.4%		Track indicator (synthetic data so cannot use for targets)
Smoking prevalence	19.3%		19%
Smoking prevalence – routine and manual	21.6%		21%
Alcohol related admissions –	924/100,000		910/100,000

male			
Successful completion of drug treatment – opiate users	4.2%		tbc
Successful completion of drug treatment – non-opiate users	35.3%		tbc
Uptake of LARC in primary care (20% increase)	555 women		660 women
Cumulative % eligible population aged 45-74 offered health check	17.2%		17.5%
Cumulative % eligible population aged 45-74 offered health check who received a health check	70.5%		72%
Uptake of HIV testing in primary care	5276 screens		6331 screens
People presenting with HIV at a late stage of infection	29.9%		28.0%
Cancer screening coverage – Breast cancer	61.5%		Tbc (agree targets with PHE)
Cancer screening coverage – Cervical cancer	69.0%		Tbc (agree targets with PHE)
Cancer diagnosed at an early stage (experimental data)	35.7%		Tbc (agree targets with PHE)
Action/strategy/programme to deliver	**Lead**	**Milestones**	**Timescale**
More adults with good emotional health and foundations for lifelong mental wellbeing (need to align with mental health strategy)			

Commission and deliver a community led programme to raise awareness, address stigma, encourage early identification and access support around mental health issues.	Abigail Knight	• Specification & procurement process complete with contract(s) in place • Project delivery phase • Evaluation report	By May 2015 June 2015 – April 2016 May 2016
Evaluation of provision of physical health services for people with Severe Mental Illness	Abigail Knight	• Initial assessment of current provision of services including service user perspectives • Next steps to be agreed and recommendations implemented	May 2015 June 2015 – March 2016
More adults living healthier lives; embedding positive health habits – healthy eating, regular physical activity, good sexual health			
Action/strategy/programme to deliver	**Lead**	**Milestones**	**Timescale**
Continue to implement and conduct an evaluation of the health trainers programme	Esther Trenchard-Mabere	• Contractual monitoring conducted • Evaluation completed	Quarterly By December 2015
Implement redesigned adult weight management programme	Abigail Knight	• Tender process completed • Programme implemented and monitored	March 2015 Quarterly monitoing

Continue promotion of positive health habits in older people through Linkage Plus	Abigail Knight	• Health promotion activities in Linkage Plus contract monitored • Health promotion activity in contract evaluated	Quarterly By March 2016
Continue to promote contraceptive choice and positive sexual relationships	Chris Lovitt	• Ongoing monitoring of sexual health contracts around prevention, primary care, community health and acute (see section below on STIs)	
Continue to deliver an oral health promotion programme for older people (Still Smiling Project)	Esther Trenchard-Mabere/ Desmond Wright	• Develop work plan • Implement and monitor	May 2015 Quarterly monitoring
More adults free from harmful health behaviours – tobacco, alcohol, drug misuse and risky sex			
Action/strategy/programme to deliver	**Lead**	**Milestones**	**Timescale**
Continue to provide universal and targeted tobacco cessation with focus on high prevalence groups	Chris Lovitt	• Implementation of primary care enhanced service monitored • Implementation of pharmacy enhanced service monitored • Implementation of targeted services (specialist, BME services) monitored • Review of tobacco programme	Quarterly Quarterly Quarterly By July 2015

Improved treatment pathway for drugs and alcohol abuse through re-commissioning of services	Andy Bamber	• Reprocure services for drug and alcohol abuse (pending Cabinet approval) • Complete procurement process	By July 2015 By April 2016
Refresh drugs and alcohol strategy	Andy Bamber	• Implement process for refresh of strategy (including review of existing strategy, stakeholder engagement and consultation, taking through council process for strategies)	By March 2016
Improve role of acute health trusts in promoting smoking cessation and sensible drinking through a 'healthy lives CQUIN'	Chris Lovitt	• Implement 'Healthy Lives CQUIN' with Barts Health (covering alcohol and tobacco) • Review options for CQUIN 16/17	Quarterly monitoring By January 2016
Increase screening for STIs, HIV uptake of contraception, and continue to develop integrated sexual health pathway	Chris Lovitt	• Implementation of high risk prevention programmes monitored • Implementation of primary care sexual health network enhanced service monitored • Implementation of pharmacy enhanced service monitored	Quarterly monitoring Quarterly monitoring Quarterly monitoring

		• Implementation of community sexual health service contract monitored • Provision of acute GUM services monitored • Sexual health programme evaluated	Quarterly monitoring Quarterly monitoring By January 2016
More adults • ***Aware of their risk of physical and mental health conditions and taking action to reduce risk*** • ***Aware of symptoms and signs of physical and mental health conditions and seeking help as early as possible***			
Action/strategy/programme to deliver	**Lead**	**Milestones**	**Timescale**
Continue to deliver the NHS Health Checks programme with particular focus on monitoring equity and responding to inequalities in access	Abigail Knight	• Implementation of primary care enhanced service to deliver health checks monitored • Health checks programme evaluated	Quarterly By December 2015
Develop a diabetes risk programme identifying and supporting people identified as high risk	Abigail Knight	• Specification developed for piloting projects to identify and support people at high risk of diabetes • Implementation of programme • Evaluation of diabetes risk programme (interim)	By July 2015 July 2015 – March 2016 December 2015
Monitor coverage of main screening programmes (cancer	Abigail Knight	• Quarterly uptake and coverage reports	Quarterly monitoring

and diabetic eye screening) and work with Public Health England in improving uptake		received and discussed with Public Health England	
Scope work to introduce early identification of COPD through smoking cessation services	Chris Lovitt/Abigail Knight	• Review case for developing smoking cessation services as setting for early identification COPD	By December 2015
Continue to implement programmesto increase public awareness and understanding of long term conditions (encouraging early awareness and diagnosis)	Abigail Knight	• Contractual monitoring of community led public awareness of cancer contract • Contractual monitoring of health literacy through ESOL programmes • Evaluate health literacy through ESOL programmes	Quarterly monitoring By December 2015
Reduce undiagnosed hepatitis B and C through awareness and case finding	Chris Lovitt	• Develop a specification for a social marketing campaign to promote public awareness of hepatitis B and C and promote testing and identify provider(s) to deliver • Implement campaign	By July 2015 August 2015 to March 2016
Continue to monitor uptake of flu immunisation in vulnerable groups and over 65s working with PHE to improve uptake	Chris Lovitt/Abigail Knight	• Receive evaluation report of 14/15 campaign from PHE on lessons learn from this	By May 2015

		year's campaign • Monitor uptake through seasonal flu immunisation period • Work with Public Health England to ensure effective uptake	August 2015 to March 2016

Outcome Objective

A healthier place

More people:

- **Leading healthier lives supported by sufficient income, good lifelong education, good housing, decent employment and freedom from the fear of crime**
- **Living in environments that are safe, health enhancing, sustainable and provide opportunities for physical activity and healthy eating**
- **Supported by community and family networks to be resilient and lead healthier lives**
- **Free from mental and physical abuse or neglect (put this across life course)**
- **With access to the range of high quality services they need to support healthier lives**

More people living in environments that are safe, health enhancing, sustainable and provide opportunities for physical activity and healthy eating

Proposed outcome measures– *relating to above objective*

Measure	**Outcome 2013/14**	**Target 2014/15**	**Target 2015/16**
Fraction of mortality attributable to particulate air pollution	7.4%		Track indicator
Utilisation of outdoor space for exercise/health reasons	4.4%		Tbc (review data reliability)
Physical activity in adults – active adults	53.4%		54%
Excess weight in adults	47.2%		Track indicator (synthetic data – not suitable for targets)
Comprehensive, agreed interagency plans for responding to health protection	Yes		Yes

incidents and emergencies (PHOF indicator)			
Treatment completion for TB	90.7%		Maintain (exceeding national goal of 85%)
Domestic abuse	18.6%		Tbc – for further discussion
Social isolation: % of adult social care users who have as much social contact as they would like	38.9%		40%
Action/strategy/programme to deliver	**Lead**	**Milestones**	**Timescale**
To continue work around Local Plan to ensure development maximises potential for health gain		• Revised options for Local Plan have been systematically reviewed for health impacts	By December 2015
To enhance partnership work on the food environment in the borough - increasing access to affordable and healthy food	Esther Trenchard-Mabere	• Contractual targets for Food 4 Health and Buywell achieved • Food growing programme (Gardens for Life) commissioned • A5 restrictions (hot food takeaways) in new Local Plan maintained • Feasibility study to improve healthiness of fast food outlets commissioned	Quarterly targets By July 2015 By December 2015 By July 2015
To enhance partnership work to improve the urban environment to support increased physical activity,	Owen Whalley	• Green Grid Strategy implementation continued (ensuring easy access to green	Quarterly oversight by Green Grid Steering Group – quarterly oversight

including activity travel	Jamie Blake	route to everyday destinations) • Continued implementation of safer cycles scheme • Continue to offer free cycling to all adults in the borough and all school children • Introduce 'Play Streets'	Ongoing Ongoing
To implement local initiatives to mitigate the impact air pollution as a significant hazard to the health of residents – in particular children	Andy Bamber	• Continue to implement air quality management strategy • 'No Idling Zone' implemented • Safe routes to school incorporating air quality developed	Ongoing Ongoing Ongoing
To reduce people killed/seriously injured on the road	Jamie Blake	• Introduction of 20 mph zone across Tower Hamlets implemented	
To continue to develop and implement plans around Healthy High Streets	Andy Scott	• Officer group to scope plans for implementation established	By July 2015
To develop and implement plans to increase smoke free homes in the borough	Chris Lovitt	• Develop plan to increase smoke free homes • Implement plans	By September 2015 September 2015 to March 2015

Continue to implement plans to reduce availability of illegal tobacco and alcohol	Chris Lovitt	• Monitor inhouse delivery through Tobacco Control Alliance	Quarterly
To work with partners across NHS/PHE/emergency services/council to ensure health protection actions are in place around TB, pandemic responsiveness, immunisation and other health protection issues	Chris Lovitt	• Monitoring and collaborative working through health protection forum	Quarterly
More people supported by community and family networks to be resilient and lead healthier lives			
Action/strategy/programme to deliver	**Lead**	**Milestones**	**Timescale**
To continue to implement the WELL London programme (coproduce initiatives to improve wellbeing, cohesion and resilience within local communities)	Esther Trenchard-Mabere	• Old Bethnal Green programme fully implemented • Further sites as part of WELL London implementation Phase 3 bid for	By July 2015 By December 2015
To develop and implement a community led pilot programme to identify and tackle isolation and loneliness in the borough	Abigail Knight	• Produce specification to develop a network of local people in three neighbourhoods who are actively engaged in understanding and taking action to tackle loneliness locally. • Implement programme • Interim evaluation report to inform future	By May 2015 June – March 2016 By December 2015

		development of programme	
More people with access to the range of high quality services they need to support healthier lives (this refers to services in general but also prevention being embedded into services)			
Action/strategy/programme to deliver	**Lead**	**Milestones**	**Timescale**
To continue to work with local NHS partners to deliver new and expanded primary care premises funded in part by monies secured through the planning process (section 106 and Community Infrastructure Levy)	Owen Whalley	• Capital estates group (LBTH, CCG, NHSE, NHSPS, HUDU) meeting 6 weekly to maintain programme for monitoring and expanding primary care estate • Once estate capacity needs identified to ensure timely submission of project initiation document to the Planning Contributions Overview Panel for approval	Ongoing Ongoing
To implement the Health Outreach Worker programme to help residents to support their own health, make the best use of local services and provide insights on how services could be improved	Esther Trenchard-Mabere	• Recruit and train 12 health outreach workers to be based in Ideas stores • Monitor, train and support workers in their new roles • Evaluation of programme (interim)	By June 2015 June 2015-March 2016 By January 2016

Implement Making Every Contact Count Programme embedding healthy lives into health and social care services	Team 3 AD (tbc)	• Incorporate MECC training into corporate training progamme of council • Hold partnership stakeholder event including NHS, Council, Housing and Voluntary Sector exploring common approach across health and social care economy	By June 2016 By November 2016

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Appendix 1 Action Plan Template – Long Term Conditions, Cancer and Integrated Care

Outcome Objective

The council and NHS share a vision of an integrated care system in which care is coordinated around the person and is delivered in the most appropriate setting.

The vision is based around three high level objectives.

- **More patients, users and their carers empowered**
- **More patients receiving responsive, coordinated and proactive care including sharing data between providers across the NHS, Council and other provider organisations**
- **More patients receiving quality of care that is consistent and cost effective**

Since the previous action plan, the key strategic and policy developments have been:

- **The Care Act**
- **The Better Care Fund, a significant lever for driving integrated care**
- **Transforming Services Together Programme which is a five year strategic plan commissioned by Newham, Tower Hamlets and Waltham Forest with 14 workstreams (nine clinical, five enabler)**

The action plan sets out high level, high impact priorities for the health and care economy in 15/16

Proposed outcome measures			
Measure	**Outcome 2013/14**	**Target 2014/15**	**Target 2015/16**
Under 75 mortality rate from all CVD considered preventable	**71.2**		**For tracking**
Under 75 mortality rate from all cancer considered preventable	**108.6**		**For tracking**
Under 75 mortality rate from all respiratory disease considered preventable	**33.0**		**For tracking**

Under 75 mortality rate from all liver disease considered preventable	26.7		For tracking
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	667.2	609.5	577.9
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	80.4	84.4	88.9
Delayed transfers of care from hospital per 100,000 population	837.2	581.3	560.0
Non Elective Admissions - Month on Month Rate per 1000 (of the risk bands 1 & 2)	65.7	NA	60.1
Patient/service user experience	Tbc – DH in development indicator on experience of integration		
Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s	66.9 (provisional data)		tbc
An integrated care system in which care is coordinated around the person and is delivered in the most appropriate setting			
Action/strategy/programme to deliver	**Lead**	**Milestones**	**Timescale**
Implementation of Better Care Funding schemes • Integrated Community Health Team • Mental Health Support and Liaison	Jane Milligan/ Robert McCulloch-Graham	• Go live of Section of BCF and mobilisation of service developments • Q1 Review • Q2 Review • Commissioning intentions	By April 2015 By July 2015 By September 2015

• Independent Living • Integrated Care Incentive Scheme		submitted to providers re new Community Health Services Contract • Q3 Review	By September/October 2015 By January 2015
More patients, users and their carers empowered			
Action/strategy/programme to deliver	**Lead**	**Milestones**	**Timescale**
Incorporate resident views into monitoring and development of health and social care services through Healthwatch		• Review specification of Health Watch • Contractual monitoring of Health Watch against plan • Input of Healthwatch to key bodies including Health and Wellbeing Board, Clinical Commissioning Governing Body and relevant subgroups	By April 2015 Quarterly monitoring Ongoing
Ensure prevention, information and advice requirements of Care Act are in place	Somen Banerjee	• Online universal information and advice in place on council website • E-Marketplace launched • Ongoing updating, monitoring and promotion of information and advice • Making Every Contact Count training available through Council Corporate Training programme	By April 2015 By April 2015 April 2015 to March 2016 By May 2015

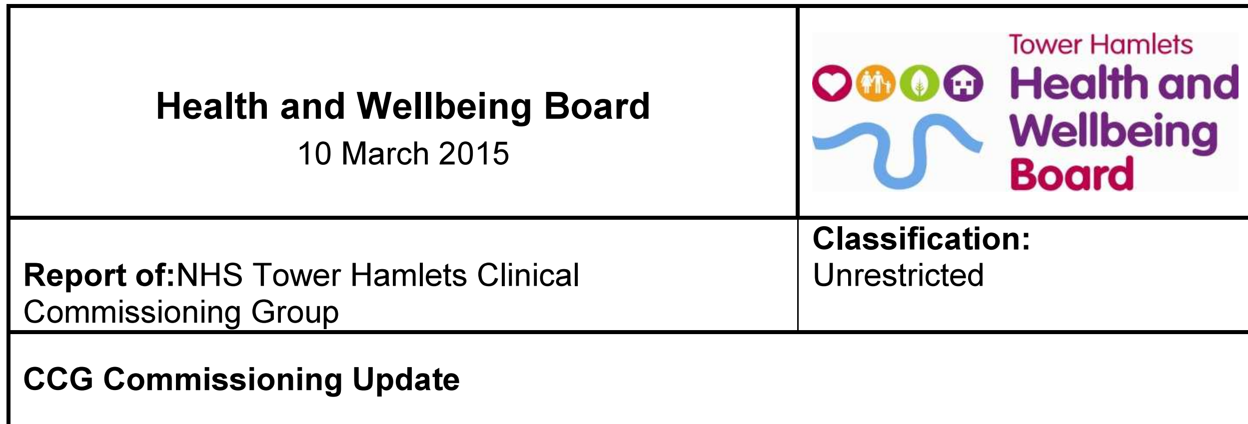
Ensure assessment, eligibility and care planning requirements for adults set out in Care Act are in place	Service Head Adult Social Care (starting March 15)	• Ongoing monitoring of actions implemented prior to April 15	April 2015 to March 2016
Ensure assessment, eligibility and care planning requirements for adults set out in Care Act are in place	Service Head Adult Social Care (starting March 15)	• Ongoing monitoring of actions implemented prior to April 15 • Refresh of carers strategy to ensure Care Act requirements are met	April 2015 to March 2016 By July 2016
Piloting of personal health budgets and integrated personal commissioning	John Wardell/Dorne Kanareck	• Set up programme structure including recruitment of clinical leadership • Develop personal budget offer for pilot groups • Begin to offer personal budgets to pilot groups • Review of process and implications of pilot for commissioning intentions: • Begin discussions with providers on impact of programme • Contract negotiations with Provider • Set up sustainable arrangements	By April 2015 By July 2015 By July 2015 By October 2015 By December 2015 By January 2016 January 2016-April 2016
More patients receiving safe, responsive, coordinated and proactive care including sharing data between providers			

across the NHS, Council and other provider organisations			
Action/strategy/programme to deliver	**Lead**	**Milestones**	**Timescale**
Assessment and further implementation of Transforming Services Together enabler workstreams • Population health informatics • Workforce • Organisational development/clinical leadership • Estates • Long, term financial management	Jane Milligan/ Robert McCulloch-Graham	• Plans for enabler workstreams for 15/16 produced • Review proposed changes and implementation for local and collaborative work	By July 2015 July 2015 to March 2016
Implementation of Better Care Funding schemes • Integrated Community Health Team • Mental Health Support and Liaison • Independent Living • Integrated Care Incentive Scheme	Jane Miligan/ Robert McCulloch-Graham	• Go live of Section of BCF and mobilisation of service developments • Q1 Review • Q2 Review • Commissioning intentions submitted to providers re new Community Health Services Contract • Q3 Review	By April 2015 By July 2015 By September 2015 By September/October 2015 By January 2015
Ensure quality and safety requirements of Care Act are in place – adult safeguarding, information sharing		• Ongoing monitoring of actions implemented prior to April 15	April 2015 to March 2016

Develop and implement Virtual Ward for Children		• Identify patient cohort: • Establish baseline quantitative and qualitative data: • Recruit clinical staff required to deliver the project: • Implement MDT meetings: • Agree commissioning intentions for 2016/17 (based on mid-year project findings): • Incorporate commissioning intentions into contract negotiations with providers (if required): • Implement 2016/17 commissioning model (if required): • Complete evaluation:	By Apr 2015 By Apr 2015 By May 2015 June 2015 – June 2016 By October 2015 January – March 2016 By April 2016 By June 2016
More patients receiving quality of care that is consistent and cost effective			
Action/strategy/programme to deliver	**Lead**	**Milestones**	**Timescale**
Assessment and further implementation of Transforming Services Together Clinical Strategy for workstreams	Jane Milligan	• Clinical strategy published • Review proposed changes and	By July 2015 July 2015 to March 2016

• Diagnostic services • Maternity and newborn care • Children and young people • Surgery • Pathway redesign (long term conditions, including cancer) • Primary care • Integrated Care • Mental Health • Urgent and emergency care coordination		implementation for local and collaborative work	
Review of Long Term Conditions packages		• Review current care packages • Develop new specifications base on review	By December 2015
Review childrens outpatient pathway review		• Undertake audit/review of outpatient data • Based on data analysis, identify top 3-5 pathways for re-design • Re-design pathways, to include widespread engagement with primary/secondary clinicians and patients • Finalise new pathways • Incorporate any pathway changes into contract	By April 2015 By April 2015 By August 2015 By September 2015 January 2016-March 2016

		negotiations with providers (if required) • Implement new pathways:	From April 2016



Health and Wellbeing Board 10 March 2015	Tower Hamlets Health and Wellbeing Board
Report of: NHS Tower Hamlets Clinical Commissioning Group	**Classification:** Unrestricted
CCG Commissioning Update	

Contact for information	Josh Potter: Deputy Director of Commissioning and Transformation, Tower Hamlets CCG

Executive Summary

This paper comprises of a general update of the CCG's commissioning activity covering:

- Primary Care Co-commissioning
- Prime Minister's Challenge Fund
- WELC Integration Pioneer: Kings Fund Review
- Improving Mental Health Inpatient Services

Recommendations:

The Health and Wellbeing Board is recommended to:

1. Note the report

1. DETAILS OF REPORT

1.1 Primary Care Co-Commissioning

Tower Hamlets CCG is one of 64 CCGs across the country that have been approved by NHS England to take on greater 'delegated' commissioning responsibility for GP services from April this year. This follows plans set out by NHS England Chief Executive Simon Stevens, early last year, to give patients, communities and clinicians more scope in deciding how local services are developed.

The latest move follows the plan set out in the Next steps towards primary care co-commissioning document developed by the joint CCG and NHS England primary care co-commissioning programme oversight group in partnership with NHS Clinical Commissioners, and is another step towards delivering the wider strategic agenda set out in the Five Year Forward View.

1.2 Prime Minister's Challenge Fund

The Tower Hamlets GP Care Group put in a bid for the Prime Minister's Challenge Fund, to improve primary care access of Tower Hamlets residents to face to face primary care services from 8am to 8pm 7 days a week, for provision of routine and urgent care. The fund will also be used to improve working in partnership with community pharmacies to offer an enhanced Minor Ailments Service with increased formulary and upskilling of pharmacists as independent prescribers as well as working closely with voluntary groups in the borough to complement enhanced primary care provision to address the cycle of demand.

The GP Care Group is awaiting the outcome of the bid, and we should know this by early March 2015.

1.3 WELC Integrated Care Programme: Kings Fund Review

A recent review by the King's Fund celebrated the scale and ambition of the WELC Integrated Care Programme, recognising the significant progress made over the recent years. The King's Fund Review took place in December and January, and involved stakeholder interviews along with a literature review. The King's Fund noted a clear vision for integrated care across WELC and the successful implementation of a number of new services and interventions to support integration. The emerging challenges highlighted the demanding plan for capitated budgets and the requirement to change behaviours and cultures throughout local organisations to facilitate integrated working.

1.4 Improving mental health inpatient services for older people in City and Hackney and Tower Hamlets

Tower Hamlets and City and Hackney Clinical Commissioning Groups in partnership with East London NHS Foundation Trust (ELFT) are conducting a 13 week consultation on proposed changes to inpatient services for older people with mental

health problems aged 65 and over, who live in City and Hackney and Tower Hamlets. The proposal outlines the merge of two inpatient wards onto one site at Mile End Hospital. This consultation focuses on inpatient services for older people whohave conditions that have apsychological cause such as depression, schizophrenia, mood disorders or anxiety. The consultation will end on 16 March 2015.

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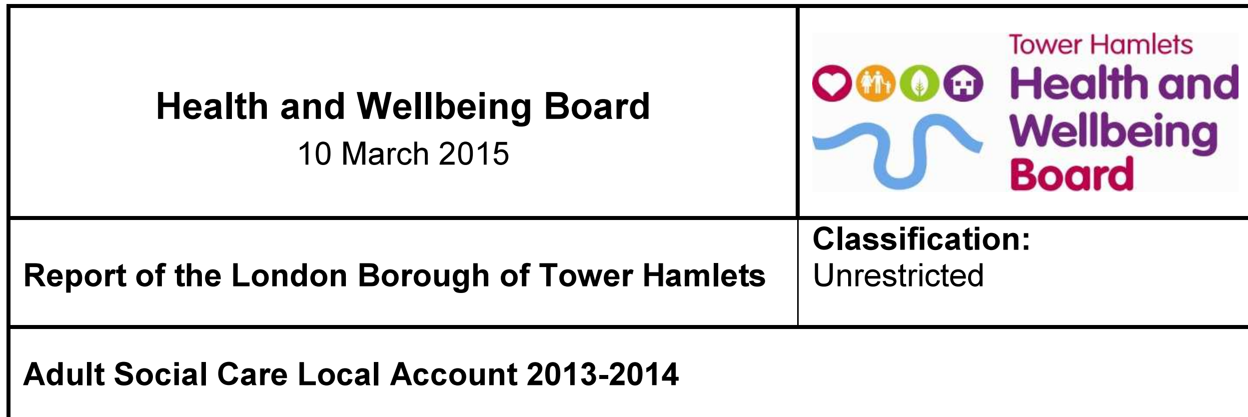

Health and Wellbeing Board 10 March 2015	Tower Hamlets Health and Wellbeing Board
Report of the London Borough of Tower Hamlets	**Classification:** Unrestricted
Adult Social Care Local Account 2013-2014	

Lead Officer	Robert McCulloch-Graham
Contact Officers	Jack Kerr - ESCW SPP
Executive Key Decision?	Yes/No

Executive Summary

Local accounts provide the basis to assessing and reporting on Adult Social Care performance, following the withdrawal of the Care Quality Commission's Annual Performance Assessment. The Local Account is a report for citizens and consumers about the performance of Adult Social Care, leading to greater involvement and challenge and is to be used as a tool for self-improvement.

This Local Account covers the period of 2013-2014 and also sets out priorities for 2013/14.

Recommendations:

The Health and Wellbeing Board is recommended to:

1. Note the content and format of Tower Hamlets Local Account for 2013/14 and approve it for publication
   This proposal will require formal consideration by the CABINET

1. REASONS FOR THE DECISIONS

1.1 The Local Account is being put before HWB for sign off and information purposes.

2. ALTERNATIVE OPTIONS

2.1 N/A

3. DETAILS OF REPORT

3.1 The role of Care Quality Commission (CQC) in relation to local authorities and social care changed in 2011. The requirement for local authorities to produce an Annual Performance Assessment within a format prescribed by CQC has been abolished. A sector led approach to improvement has replaced the external regime.

3.2 In 2011 the Government also introduced the publication of a single data set for local government. Following consultation a new outcomes framework for adult social care (ASCOF) was also introduced along with complimentary frameworks covering public health and the NHS.

3.3 Part of the focus for these changes was to strengthen local accountability to residents, users and carers. To enable this, councils need to find meaningful way of reporting back to citizens and consumers about performance. Across the sector it has been suggested that one means of achieving this is to provide a local account, a self-assessment accessible to local people to comment on.

3.4 The Association of Directors of Adult Social Services (ADASS) has recommended that all councils with social care responsibilities produce a 'local account' as a means of reporting back to people on the quality of services and performance in adult social care. Local Accounts were described in the Department of Health's 'Transparency in outcomes: a framework for adult social care' consultation paper (November 2010, section 4) as a way of being more open and transparent about the care and support that is provided locally by the Council.

3.5 There is no prescription about the content or format of Local Accounts, as local circumstances and needs are likely to vary. ESCW has previously produced three Local Accounts for 2010-11, 2011-12 and 2012-13. Although this is not a statutory requirement, it is a document which is viewed as a key means of communicating with a variety of key stakeholders. The information within the Local Account acknowledges the invaluable contribution made by our health and care partner organisations.

3.6 The purpose of the Local Account is to make the people of Tower Hamlets aware of the work undertaken by the Department during 2013-14, in relation to both social care and safeguarding. It uses a combination of performance information, survey results and case studies to demonstrate how Tower Hamlets Council has enhanced the quality of life for people using care and support services.

3.7 The Local Account will help to publicise the range and scale of services we provide. The Local Account will be published as a council wide document and made available to the public through the Tower Hamlets Council website.

Tower Hamlet's Local Account

3.8 The intention locally is to use the Local Account as a live document;part of a wider set of mechanisms for obtaining customer views and feedback and informing residents, users and carers about our progress in delivering outcomes and our priorities for the future.

3.9 Without replicating the extensive narrative contained within the Local Account, key messages include:

3.9.1 We continue to respond to one of the greatest challenges we have ever had to face – significant cuts in funding provided by Central Government to Local Government. These cuts are leading to difficult decisions across the public sector, and will continue to do so for the next few years. In addition to this, many of the borough's residents are facing their own challenges, because of changes being made to welfare benefits

3.9.2 The introduction of the 2014 Care Act. The Act brings together more than 40 separate pieces of legislation and puts people's needs, goals and aspirations at the centre of care and support, supporting people to make their own decision, realise their potential and pursue life opportunities. Significantly the Bill sets out new rights for carers, emphasises the need to prevent and reduce care and support needs, and introduces a national eligibility threshold for care and support. Additionally It introduces a cap on the costs that people will have to pay for care and sets out a universal deferred payment scheme so that people will not have to sell their home in their lifetime to pay for residential care. The Care Act will be implemented in two phases in April 2015 and April 2016. In preparation for these changes we have set up a Care and Health Reform Programme. Much of the information in this Local Account and our plans for the future relate to the Care Act.

3.9.3 The number of people in England who have health problems requiring both health and social care is increasing. For example, in the next 20 years, the percentage of people over 85 will double. This means there are likely to be more people with 'complex health needs' - more than one health problem - who require a combination of health and social care services. But these services often don't work together very well. For example, people are sent to hospital, or they stay in hospital too long, when it would have been better for them to get care at home. Sometimes people get the same service twice - from the NHS and social care organisations - or an important part of their care is missing. Consequently the government has announced that the Health and Social Care system will be fully integrated by 2018. Work to make this a reality in Tower Hamlets has been a key priority for us in the previous year. Tower Hamlets Health and Wellbeing Board has oversees these developments through the Integrated Care Board. The strategy for Integration in Tower Hamlets is part of a shared 5 year plan, 'Transforming Services Together', across Tower Hamlets, Newham and Waltham Forest. Tower Hamlets, working alongside Waltham Forest and Newham became part of the "WELC Integrated Care Pioneer". The WELC Pioneer Programme drives the

delivery of the Integrated Care Programme within the 5 year 'Transforming Services Together' plan. In 2013/14 the introduction of the Better Care Fund provided us with a great opportunity to drive our Integration agenda forward. This work has been spearheaded by Tower Hamlets Health and Wellbeing Board who have agreed how this money will best be spent.

3.9.4 Looking at the ASCOF results (attached in the appendix of the Local Account) the key issue that stands out was our performance against ASCOF measure 2A part 2, namely the number of council-supported permanent admissions of older people aged 65 and over to residential and nursing care per 100,000 of the population (the lower the number the better here as the idea is to help keep people in the community for as long possible) Our level of performance in this area was 644.2, above the national average of 650.6 but below both the inner London average of 545.2 and the London average of 454. However there are a number of facts behind this figure that show our performance in this area is not as bad as it may initially look when compared with other London boroughs. Namely,

- Over the last four years we have continued to make significant improvements in this area. In 2010/11, 785 per 100,000 of the population were supported in this way. In 2013/14 this figure was 644 per 100,000 of the population. Our improvement in this area over that period is the third best nationally.
- ASCOF 2A is a two part measure and it should be noted the two figures directly impact each other. ASCOF 2A part 1 measures the number of council-supported permanent admissions of younger adults aged 18 to 65 to residential and nursing care per 100,000 of the population. In Tower Hamlets we do a very good job at keeping people as independent as possible for as long in possible in their own community. The number of council-supported permanent admissions of adults aged 18-64 to residential and nursing care is 9.2 per 100,000 of the population. This a significant improvement on lasts years figure of 22.2 per 100,000 of the population and is above the national average of 14.4 per 100,000 of the population, the London average of 10.2 per 100,000 of the population, and the inner London average of 11.6 per 100,000 of the population. As a consequence of supporting people in the community for longer our residents generally tend to access residential and nursing care at an older age than other boroughs at a point where they are too frail to be supported in the community.

3.9.5 In last year's Local Account we acknowledged that Tower Hamlets had some work to do to improve its delayed transfers of care from hospital which are attributable to adult social care. As a result we have invested money from our Winter Resilience budget to fund four 'Step Down' beds to assist in discharging medically fit patients from the Royal London Hospital. There are 2 beds that are residential for people with dementia and 2 beds in Extra Care Sheltered Housing. We have worked hard to improve this, in 2013/14 the average number of delayed transfers of care which are attributable to social care per 100,000 adult (18+) population was 1.5. This

is below both London average of 2.3 and the national average of 3.1. It can be said that our new step down beds have helped to contribute to this.

4. COMMENTS OF THE CHIEF FINANCE OFFICER

4.1. The cost of producing the Local Account will be met through existing budgets, there are no other direct financial implications arising from the publication of the local account.

4.2. The Local Account includes a section on the financial position of the relevant divisions of the ESCW directorate. This includes financial outturn and performance data for 2013/2014 which is consistent with publications and reports that are already within the public domain. In particular, the Council's annual accounts and reports submitted to Cabinet and full Council.

5. LEGALCOMMENTS

5.1. The report informs members about the publication of a Tower Hamlets Local Account. The local account is intended to be a source of information, developed locally, which may include quality and outcome priorities and how these have been progressed; a description of partnership working; and data relating to quality and performance. Local information and local outcome measures should be contained in a local account, supplementary to national outcomes measures so as to promote quality, transparency and accountability in adult social care.

5.2. The delivery by the Council of its statutory functions in respect of adult social care in a way that is high quality, transparent and accountable is consistent with good administration. There is thus adequate power to support development of a local account inherent within the statutory functions which will be the subject of the local account narrative. Were it necessary, an additional source of power may be found in the general power of competence in section 1 of the Localism Act 2011. The general power enables the Council to do anything that individuals generally may do, subject to such restrictions and limitations as are imposed by other statutes.

5.3. The local account is a report and summary that ranges across the Council's adult social care functions. To the extent that the local account sets out priorities or actions, these are a reflection of the content of a number of Council plans and strategies. The delivery of these may give rise to legal issues that will need to be addressed. The Council will continue to have act within its statutory functions, including by complying with its many duties in respect of adult social care and its best value duty under section 3 of the Local Government Act 1999.

5.4. In developing the local account, the Council will need to have due regard to the need to eliminate discrimination, harassment, victimisation and any other conduct prohibited under the Equality Act 2010, the need to advance equality of opportunity and the need to foster good relations between persons who share a protected characteristic and those who don't

6. ONE TOWER HAMLETS CONSIDERATIONS

6.1. The report informs Cabinet that the Local Account is a requirement under Transparency in Outcomes: A framework for adult social care (ASCOF). The Local Account development process seeks to identify areas of inequality for local people. The report highlights areas where further work will be carried out in the coming year to better understand and address potential issues.

6.2 The report addresses provision of care and support for vulnerable people, particularly safeguarding, in conjunction with partners. The report is therefore very relevant to the aims of One Tower Hamlets and has a direct impact on the following Strategic Objectives:

7. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

7.1 NA

8. RISK MANAGEMENT IMPLICATIONS

8.1. NA

9. CRIME AND DISORDER REDUCTION IMPLICATIONS

9.1 NA

10. EFFICIENCY STATEMENT

10.1 NA

Appendices and Background Documents

Appendices

- Appendix 1 - Tower Hamlets Adult Social Care Local Account 2013/14

London Borough Of Tower Hamlets

Local Account 2013-14

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Foreword from Mayor Rahman

As Mayor I am committed to delivering to you a healthy and supportive community. As you read through this fourth Local Account for adult social care services, you'll learn about some of the great work that takes place in our borough and our plans for the future for Tower Hamlets.

I have introduced a host of pledges to ensure that our adult social care is helping people to lead fulfilling, healthy and independent lives. We remain only one of two boroughs to still provide free homecare for the elderly, a pledge that I have committed to during my next four years as Mayor. I have also promised to tackle loneliness and isolation and access to lunch clubs; to build more GPs surgeries and to step up the fight against diabetes and heart disease. These are just some of the ways that we are working to helping people have control over their health in adult life.

But while we are making changes for the better, there are also big challenges ahead in adult social care. Our 2012-13 Local Account highlighted the challenge of meeting an increased demand for care with fewer resources. Unfortunately, those challenges will continue. There is no avoiding the financial pressures each Local Authority is facing, especially at a time when people are living longer and relying on support services to help them live independently. We know we will have to think innovatively, but we refuse to compromise on the quality of the care and support services provided in Tower Hamlets.

We need to make sure the money we spend supports the right people in the borough at the right time, and that we continuously look for ways to improve. One way we will achieve this will be to take full advantage of the opportunities offered to us. For example, through the Better Care Fund we will have access to a £3.8 billion nationally pooled budget to create more integrated health and social care services and ultimately better outcomes for older and disabled people. We will also take full advantage of the opportunities brought to us by the Care Act, without compromising on what's important to us. Through all of this, our key concern will be to protect our identity as a borough – by my pledge to, for example, continue to be only one of two boroughs in the UK that provides free homecare.

Our success depends heavily on our ability to work with our many partners including the NHS, the voluntary sector, service users and carers. We look forward to working even more closely with all our partners in the coming year to improve the health and wellbeing outcomes of our most vulnerable residents.

Healthwatch Tower Hamlets

Go, feel what I have felt;
Go, bear what I have borne;
Go, hear what I have heard;
The sobs of sad despair.

Members of Healthwatch Tower Hamlets are too familiar with the sentiments expressed in this anonymous poem. It is, therefore very encouraging to go through this Adult Social Care Annual Account (2013-2014) and find that the commissioners and providers of these services are not only caring, but also listen to the community, have empathy and treat the users with dignity and respect.

It is in the backdrop, that Healthwatch Tower Hamlets as the consumer champion welcomes the production of this Annual Local Account by Tower Hamlets Council. Adult Social care deals mainly with the needs of people with physical disability, learning difficulty, mental health needs, and other vulnerable individuals. This report provides local residents the opportunity to learn what and how social care is provided in the Borough. It also provides the community with an opportunity to hold the Council to account for the services they directly provide or commission through various agencies.

In spite of constraints on the budget, the Council has dealt with an increasing number of people contacting them for help, advice and support resulting in a needs assessment and review of their care.

Healthwatch play an important and independent role in ensuring people have a positive experience of adult social care. Healthwatch gives local people ways of getting involved and influencing service, design, review and development of health and social care services. They are independent of the Local Authority and the NHS and can comment on all health and social care including local hospitals, GPs, care homes, and pharmacies.
Visit
www.healthwatchtowerhamlets.co.uk
or phone
020 8223 8922
to find out more or get

This report clearly shows that Adult Social Care services in Tower Hamlets have worked hard to capture the views of service users and have engaged Healthwatch directly over the past year. Service user involvement and feedback are vital and both Healthwatch and the Council must continue to support peer researchers and independent feedback mechanisms.

Having identified that there are a large number of unpaid carers, the Council has put special emphasis on supporting them. It is important that their voices are regularly heard in any quality improvement and commissioning programmes.

Throughout the Local Account there is information about how to get involved and where to get further information and advice. With so many changes on the horizon it is satisfying that meaningful information is available in this document, making it easy for the residents to contact the right people for help and support.

We at Healthwatch Tower Hamlets are extremely grateful to all involved policy decisions and to those responsible for designing and delivery of Adult Social Care in Tower Hamlets

Introduction

Welcome to Tower Hamlets Council's Adult Social Care Local Account. This is our fourth annual local account and is an important part of the Council's commitment to being open and transparent.

Our vision for Tower Hamlets adult social care is one of high quality, which uses prevention and earlier intervention to help people retain the highest possible levels of independence for as long as they can. At the same time we want to ensure that we support vulnerable people to remain safe at home, giving them choice and control over support to meet their unique personal needs. We aim to build self-reliance, protect people's dignity and enhance their quality of life. We were pleased that this year, 66 per cent of adult social care users in Tower Hamlets said they were extremely or very satisfied with their care and support services. These satisfaction levels are higher than both the London and England average[1]. This report will inform you about the work we have done over the past year to achieve such record results and will preview some of the things we have planned to improve the way we do things to continue to meet the needs of our residents.

Like all Councils, we are facing both financial and social challenges and we are changing the way we do things. The population in need of care and support is growing in Tower Hamlets, levels of need are increasing and many related costs are rising. The Council is in a very challenging financial position and there is an increasing focus on delivering financial savings and efficiencies alongside maintaining good outcomes for those receiving our support. Through changing the way we do business, we have managed to reduce our overall budget over the past two years but we expect to have to make further substantial savings over the next few years.

What is the Local Account?

The Local Account is produced annually by Tower Hamlets Council to show how local adult social care services are doing. The Local Account is for everybody. It is one important way to let local people know what we have done in the past year, how much it cost, what challenges we face to improve support and what our plans and priorities are for the future. The Local Account is not supposed to be a complicated technical report, but an open and frank conversation with the residents of Tower Hamlets about the Council's performance. We have tried hard to avoid using words, phrases or abbreviations that only people who work in the Council understand. We really want this to be a common sense report about how we think we are doing with our social care services in Tower Hamlets.

[1] London: 60 per cent are extremely/very satisfied. England: 65 per cent are extremely/very satisfied. Tower Hamlets result, 66 per cent, is the highest result we achieved since we began sending out the survey four years ago.

Of course there is a lot more information available. If you'd like to know more, please visit http://www.towerhamlets.gov.uk/lgnl/health_and_social_care.aspx or email qualityandperformance@towerhamlets.gov.uk .

All councils have a legal duty to publish various statistics and to compare themselves with national averages and groups of other similar Councils. There is flexibility in the way we report our performance, but there is an expectation that the Council will engage local residents and improve accountability through targets and priority setting. The Local Account provides us with an opportunity to do this.

Structure of the Local Account

The Local Account is split into three sections.

1. The first section will provide a broad introduction to the services provided by Adult Social Care to our residents.

2. This will be followed by a review of the key developments nationally and the opportunities and challenges this poses for the Council.

3. The final section is built around the four outcome domains of the Department of Health's 'Adult Social Care Outcomes Framework' (ASCOF). The framework helps the Council to understand how we are performing in the following areas

    i. Enhancing quality of life for people with care and support needs
    ii. Delaying and reducing the need for care and support
    iii. Ensuring that people have a positive experience of care and support
    iv. Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm

Throughout the Local Account you will find 'resident action points' highlighted in blue text boxes. Resident action points provide an overview of the work we have done to respond to the points residents asked us to focus on in last year's Local Account.

We have also included a number of appendixes, which includes:
- Glossary
- Performance Data and a detailed breakdown of our ASCOF results compared to the previous year.

Section 1 Tower Hamlets Adult Social Care - What we do and how we do it

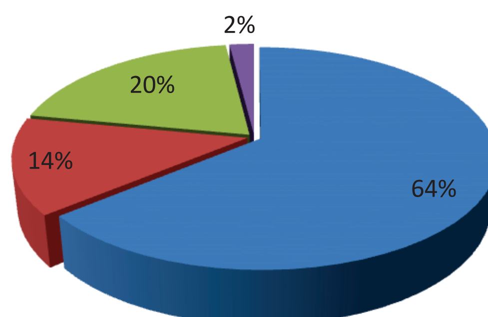
Adult Social Care is part of the Education, Social Care and Wellbeing directorate of the Council. Adult social care covers a range of support available to vulnerable people, aged 18 and over, who need some care and support to live as safely as possible. This section gives you an overview of who we support, how we support them and how we spent our budget in 2013/14.

Who do we support?

Adult social care supports adults who have significant needs as a result of physical disabilities, sight or hearing problems, learning disabilities, mental illnesses, frail people including those with dementia, people needing drug or alcohol recovery services and other vulnerable adults. We also provide support to the family, friends or neighbours who help care for these people if this is having a significant impact on their own wellbeing. Additionally we work closely with colleagues in children's services to support young people as they move into adulthood and are in need of support to do so.

4,660 people received long-term support with their needs[2] in 2013/14. The table below provides more detail on who received support:

- People with a Physical Disability, Frailty, or Sensory Impairment
- People with a Learning Disability
- People with Mental Health Needs

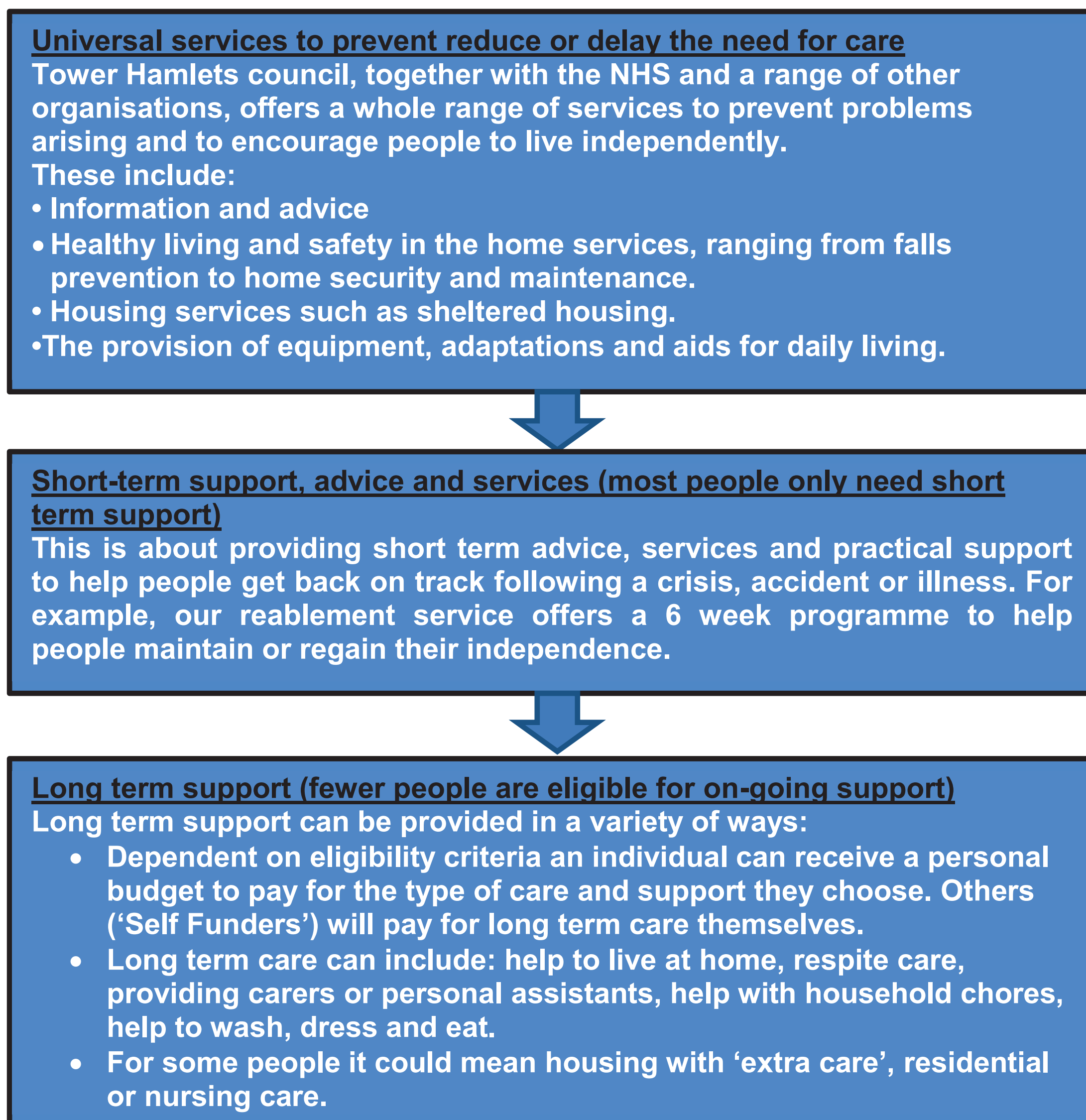


How are people supported?

We support people in a number of ways. We provide information and advice related to social care which everyone can access. We fund a range of services and activities designed to keep people as well as possible for as long

[2] 2013/14 Referrals Assessments and Packages of Care (RAP) Return (2000 people were aged 18-14, 2660 were aged 65+)

as possible. People who need a higher level of support are offered the support that is right for them. This could range from residential care to personal budgets, which are an amount of money to spend on support. The diagram below provides an outline of the different care and support we provide.



Around 95 per cent of the care and support funded by the Council is provided by other organisations on our behalf. We work hard to ensure that there is a diverse range of good quality provision for people in Tower Hamlets who need support. You will find more information on how we quality assure support services and work with others on page 40 and throughout this Local Account.

The Adult Social Care Service also has a duty to ensure that people who are not able to decide for themselves, in care homes and hospital, receive care and treatment that is in their best interests. We also take the lead in ensuring the safety of vulnerable adults in the borough who may be subject to abuse or poor quality care. More information on what has happened in this area over the last year can be found in the Safeguarding adults section that begins on page 44 of this report.

How we spent our money in 2013/14

In 2013/14 the Adult Social Care net budget was approximately £99 million, a slight decrease of 2 per cent on the previous year. This decrease is a result of the reduction in central government funding. The reality for all local authorities is that we are operating in an environment of restricted resource. More information on what this means and the challenges we face are set out in the next section.

The net budget for Adult Social Care represents 36 per cent of the Councils total budget, the largest allocation of money within the council. This reaffirms the council's commitment to prioritise adult social care, marking an increase on the percentage allocated in previous years.[3]

The table below sets out how we spent our budget in 2013/14:

	Net 2013/14	**% of Budget**
Residential Care and Nursing Care; *including non-permanent care such as respite*	£30 million	30%
Assessment; *staff costs for carrying out community care assessments, support plans and reviews*	£18m	18%
Home Care; *care services provided to people in their own homes*	£18m	18%
Supported Accommodation; *housing that enables people to live independently but with support*	£2m	2%
Direct Payments; *money which is passed directly to people so they can purchase and manage services to meet their eligible needs*	£7m	7%
Day Care; *support access during the day*	£9m	9%
Voluntary Organisations; *contributions to preventative services*	£5m	5%
Management, Commissioning & Operational costs	£1m	1%
Reablement; *intensive short term support which encourages people to be independent as possible*	£3m	3%
Occupational Therapy, Equipment & Client aids to daily living	£2m	2%
Transport	£2m	3%
Extra Care Housing Accommodation *with varying on-site support*	£2m	2%
Total Adult Spend	**£99m**	

[3] 2012/13= 32% 2011/12= 33%, 2010/11= 30%, 2009/10= 28% of council budget

The way in which the adult social care budget was used in 2013/14 is consistent with the way our money was spent in 2012/13.

As the table above demonstrates, residential and nursing care represents the single biggest area of spend for adult social care. A significant proportion of the budget, £50m was used to support people to live independently in the community. There is a heavy emphasis here on prevention, to keep people as well as possible for as long as possible without the need for emergency hospital admissions. This includes services such as Home Care, Day Care, Supported accommodation, Reablement, Direct Payments, Occupational Therapy, Transport, Extra Care Sheltered Housing accommodation, and the services provided by Voluntary Organisations.

Section 2: Opportunities and Challenges facing Tower Hamlets Adult Social Care

Adult social care is operating in a time of rapid change. We face a number of opportunities and challenges, and anticipate more to come. Demand for adult social care is rising; however our financial resources are reducing as a result of Government spending cuts. We therefore need to look at providing support in new and more innovative ways. The 2014 Care Act provides us with a great opportunity to do this. So too does the Better Care Fund which will contribute to make sure NHS and social care services are better integrated. This section describes these opportunities and challenges in more detail and starts to set out our future plans.

Increased demand on Adult Social Care

One of the main challenges we face in Tower Hamlets is that demand for adult social care is rising, and this is likely to continue in future.

Demand for support rose last year. In 2013/14, 6,855 people contacted Tower Hamlets Council's adult social care services for help or advice, a 15 per cent increase on the previous year[4]. There was a 25 per cent increase in service users receiving an assessment compared to 2012/13[5]

Evidence suggests that there will be a gradual increase in demand for adult social care services across all client groups in future, and that without using our resources better, this trend will continue at least until 2021, resulting in increased pressures on budgets in the next few years. The reasons behind this increase are many. They include:

- More people living in Tower Hamlets as a result of general population growth
- People living for longer, including those with longer-term conditions
- More people with serious health conditions surviving into adulthood.

One of the main ways we can predict who might need support in future is by looking at how the Borough continues to change. Nationally, in the most recent Census (2011) the percentage of the population aged 65 and over was the highest seen in any Census at 16 per cent. With regards to Tower Hamlets the 2011 Census revealed the number of people aged over 65 fell from 18,362 in the 2001 Census to 15,500 in 2011. However, there was an increase of 7.7 per cent in those aged over 80.

It is expected that by 2021 the number of the working age adults with a learning disability will increase by 16.4per cent (against a 2012/13 baseline).

[4] 2013/14 Referrals Assessments and Packages of Care (RAP) Return R1

[5] RAP A1 (Number of existing clients that had a review completed by primary client type and age group.)

This will place an additional demand of £350,000 each year[6] on an already stretched budget.

We also expect demand for adult social care services from working-age adults with mental health issues to increase in future if recent trends continue. Demand for mental health services are likely to increase the required budget by £325,000 per annum

Projected demand for ASC Services[7]	2012/13	2014/15	2016/17	2018/19	2020/21
Adults with learning disabilities	598	624	652	691	727
Mental health - Psychotic disorder/2 or more psychiatric disorders	682	715	740	771	800
Older people	2710	2728	2815	2919	3045
Physical disability	672	706	741	781	823

We also expect more carers to approach us to get support in their caring role. We know from the 2011 Census that there are around 19,000 carers in Tower Hamlets, but a relatively small proportion of these are in contact with us. The Care Act means we will have new legal obligations towards carers from April 2015, and we expect an increase in demand for support from carers as a result of this. More details on what the Care Act means for carers can be found on page 15.

With all of this information in mind, it is vital that we focus on delaying and reducing the need for care and support for both service users and carers. As such, 'wellbeing' will be at the forefront of the Council's approach to delaying and reducing the need for care and support.

Finance pressures and public sector austerity

Dealing with an increase demand against a backdrop of prolonged real term reduction in public spending is another major challenge for adult social care. The government's 2013 Spending Review and subsequent statements from the Office for Budget Responsibility have seen extensive and ongoing reductions in central government funding. The Council has already made good progress in achieving savings, however further savings are needed to be made across the Council over the coming years, projected to be around £28m in 2015/16, £42m in 2016/17, and £40m in 2017/18.

[6] Future expenditure is expected to increase from £26,670,000 in 2012/13 to £32,423,000 in 2020/21
[7] Tower Hamlets Demand Modelling Summary Paper

Resident Action Point

We know that residents fear a reduction in the current levels of funding will result in a reduction in the care and support they receive. Last year we said that in the face of this financial challenge we will continue to prioritise the packages of care and support they receive.

Adult social care sits within the Education, Social Care and Wellbeing Directorate in the Council. It is by far the largest Directorate within the Council. There will inevitably be an effect on the way we support people as a result of these reductions. However, in the last year Members and Officers within the Council have worked incredibly hard to mitigate the impact on the services that the community rely on and that provide such essential support. We have listened to what Tower Hamlets residents say is important to them and taken this on board when making decisions. In the context of making these difficult decisions, we carried out a programme of public consultation on budget saving proposals over September and October 2014. Overall, over 380 people attended meeting to discuss specific proposals, over 280 people gave feedback in writing or over the phone, and 180 people gave feedback via the Tower Hamlets website. Overall, the expectation is that the budget reductions should be deliverable without any significant impact on those who need support and their carers. This is because we are looking at how we can deliver services more efficiently as well as how we can provide support to people differently in an effective and dynamic way. The rest of this Local Account sets out how we intend to do this, whilst continuing our commitment to providing the quality and valued services we do now.

Welfare Reform

Changes to benefits remains one of our biggest challenges in terms of the economic wellbeing of residents as well as the financial impact on the council and housing providers. We know that money is a big issue for many people in Tower Hamlets. We know that welfare reform and changes to benefits are already having an impact on many adult social care users and carers. We need to work with other organisations to understand and demonstrate their impact on local people, as well as supporting residents through them. The government's changes to benefits have disproportionately affected local residents with over 700 households subject to the benefit cap and a further 2300 losing income because of the under-occupancy penalty. Local research estimates that by 2015 the cumulative impact of all welfare reforms will mean that on average households claiming benefits will be £1670 per year, or £32 per week, worse off. These impacts will affect over 40,000 households; over half will be households where someone is in work.

Next on the horizon is the introduction of Universal Credit and the transition from Disability Living Allowance to Personal Independence Payments. Improving digital and financial inclusion are issues particularly relevant to these changes, as benefit claims become digital by default and monthly payments are made directly to residents.

We know that for those who are fit to work employment at living wage levels provides a means to mitigate the impact of welfare reform. We are thereof working across the Council to develop employment services that look at all the things affecting people and their ability to work. A range of organisations will work together to create a holistic response to residents in need of some

extra help, not just in terms of employment services, but housing and welfare advice, health and wellbeing, family support, English and maths skills, financial and digital inclusion and childcare. This "partnership approach" will be essential as we move towards the next phase of welfare reform: the national roll-out of Universal Credit.

Resident Action Point

We know that welfare reform and changes to benefits is impacting on many adult social care users and carers. Last year we promised that we would ensure we help residents prepare for the impacts of Welfare Reform.

Our role has been to help people to understand the changes and to support them to get the benefits they are entitled to. Three of the keys ways we are doing this as a Council is by working on "financial inclusion", "digital inclusion" and employment support:

- Financial inclusion provides free support and advice for people struggling with debt, benefits, welfare and legal issues. The aim is to give people the financial know-how and to help people get the skills, wellbeing, confidence and opportunities to improve their lives. This includes teaching people how to manage their money so they can budget it to pay their bills themselves.
- Digital inclusion is mainly focused on getting people to use the internet. The introduction of the Universal Credit is part of the changes being made to people's benefits and will mean all applications are made online. Our digital inclusion work provides residents in the borough with the computer skills to do this.
- Lastly we have just begun work on an integrated employment support service. This is aimed at developing a set of support looking at benefits, employment, housing, skills, money and debt and health and family support. It will enable residents to address multiple barriers to work and sustainable housing, and improve their wellbeing.

In the 2013-14 Service User Survey, 20 per cent of respondents said they had less money as a result of these changes. Whilst we are pleased that the amount of social care users saying they do not know enough about welfare reform has reduced from 34 per cent last year to 15 per cent this year, we will continue to work to both raise awareness and support people through these changes, especially with the introduction of Universal Credit and the transfer of Disability Living Allowance to Personal Impendence Payments in 2015.

Care Act

The Care Act became law in 2014, and brought with it a series of opportunities and challenges for adult social care. Ahead of these changes being put into place, we have been busy preparing for their introduction. We have set up a "Care and Health Reform Programme" to shape the way we work in Tower Hamlets. Much of the information in this Local Account and our plans for the future relate to the Care Act.

The Care Act will lead to significant changes in how adult social care operates and how we support people. These changes will mostly come into effect from April 2015 with some additional changes to the social care system being introduced in April 2016.

The list below sets out the top things we think you need to know about the Care Act. More detailed information can be found here:
https://www.gov.uk/government/publications/care-act-2014-part-1-factsheets

From April 2015:

1. **Councils must follow new national eligibility criteria to decide whether or not someone should get support from them.**
   The criteria have been updated, with a view to ensuring that all local authorities take a similar approach to deciding what levels of need are met. This is being set nationally. What the government are saying is that all councils must ensure a person's needs are met if they have a 'significant impact' on their wellbeing. We are looking at how we will put these criteria into place and have been getting input from staff and residents on this issue. We will provide a more detailed update in the next Local Account.

2. **You have a legal right to know how much it will cost the Council to meet your care needs if you qualify for Council support so that you can choose to take this budget together with your own resources and arrange your own support.**
   We call this amount of money a "personal budget". People have been receiving personal budgets for a number of years, and our plans are to continue to offer them. More information on our work around personal budgets can be found on page 21. It's important that we are clear with you how much the Council has a duty to spend, which must be the most cost effective option, so that this can feed into some important changes in 2016, but also that we offer you the opportunity to 'top-up' the support with more expensive options if you wish.

3. **If you qualify for Council support and you have difficulty speaking up for yourself, the Council must offer support to you in this area.**
   This type of support is called "advocacy". We currently fund a number of organisations to provide advocacy, and we will increase the availability of this support from April

4. **If you are funding your own care, the Council must arrange your services if you want them to.**
   People who fund their own care are often called "self-funders". Traditionally the Council has not been in contact with many self-funders; however the Care Act means that this is likely to change as self-funders can get advice and input from the Council if they choose.

5. **You can defer the payment of any care home fees so that your home does not need to be sold in your lifetime to cover the costs of your care.**
   We already offer these "deferred payments" in Tower Hamlets. The Care Act puts this offer on a legal footing. We can now also offer these deferred payments to people in Extra Care Sheltered Housing.

6. **If you care for a friend or family member who has care and support needs, you have a legal right to an assessment of your own needs as a carer, and to get support services if you qualify (see point 1 above).**

This important change means that carers are recognised in the law in the same way as those they care for. We already support carers in a number of ways and carry out "carer assessments" to see what kind of support carers need to carry on in their caring role. The Care Act means that our approach to carers will need to be closely aligned with our approach to service users. Another important change is that you do not need to live in the same borough as the person you care for. The support you might receive is based on where your cared for person lives.

7. **The Council has a duty to provide services that help prevent or delay the development of care and support needs, or reduce care and support needs.**
   As you will see from this Local Account, we already provide a range of support to prevent, reduce or delay the need for support and to help people be as independent of services as possible. The Care Act makes this activity a legal duty, and so provides us with an opportunity to strengthen our approach.

8. **The Council must ensure that if you move to another borough, that your support isn't interrupted**
   If you are planning to move from Tower Hamlets and are currently receiving support, you will need to tell us so that we can work effectively with your new Council so that they plan to meet your needs too.

More changes will come in from April 2016. These include the introduction of a 'cap' on care costs, which means that there will be a limit on what a person has to pay towards the cost of care in their lifetime. The Government will also provide new financial help to those with "modest wealth".

More details of funding reform can be found at the link below:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366086/Factsheet_6_-_Funding_reform.pdf

We will also provide more information on our website in the coming months.

Health and Wellbeing Board

The Health and Wellbeing Board is a statutory committee of the council and a forum where the council and key partners from the health and care system work together to improve the health and wellbeing of our local population and to reduce health inequalities. The Board works to ensure there is a shared and comprehensive understanding of local health and wellbeing needs, and a clear strategy to meet them. In today's age of austerity, the partnership also plays a vital role in ensuring that public money for health and wellbeing is spent in the best possible way, offering value for money and delivering health services that best meet local need.

Key to delivering the Health and Wellbeing Boards vision '*Towards a Healthier Tower Hamlets*' is the Health and Wellbeing Strategy. The Health and Wellbeing Strategy, agreed by the Board at its first full meeting in February 2014, drives the collective actions of the NHS and local government, both commissioners and providers, and engages communities in the improvement

of their own health and wellbeing. The members of the Board have drawn up action plans in four priority areas:

- **Maternity and Early Years**

A key aim of the Health and Wellbeing Strategy is to ensure every child in Tower Hamlets gets a healthy start in life. A key outcome of this work will be to reduce infant mortality and promote good infant health (such as decreasing the amount of children with tooth decay). As children grow up, the Strategy will work towards helping all children be physically, emotionally, behaviourally and cognitively ready for school.

Key achievements

- More babies are breast feeding in Tower Hamlets at 6-8 weeks (69.0%) compared to the England average (47.2%)
- More women are receiving healthy start vitamins in Tower Hamlets (7144; over the target of 5992)
- More children are receiving their immunisations in Tower Hamlets, (93.4% received two doses of MMR at 5 years, compared to 87.7% on average in England).

- **Healthy Lives**

The Health and Wellbeing Strategy focuses on illness prevention and promoting wellbeing for all residents of Tower Hamlets. A key focus of this is tackling obesity through promoting exercise and working towards restrictions on hot food takeaways near schools and leisure centres. Also, a sexual health promotion plan (including sex and relationship education in schools) will be developed and access to sexual health services and contraception choices promoted among all frontline services.

Key achievements:

- More children are attending active play sessions in Tower Hamlets (70 per quarter; over the target of 46 per quarter)
- More schools ($\geq$12) are participating in “Bike it” a school based cycling promotion in Tower Hamlets
- In 2013/14 a total of 5,700 children (62% of the target population) were screened and 4,600 children (50%) had fluoride varnish applied to their teeth, compared to 59% and 49% respectively in 2012/13.
- 1851 people quit smoking in the last year (2013/14) using local stop smoking services
- 71 % of eligible adults who were offered an NHS health check attended, 5333 in total (higher than the England average of 49%).
- 3972 adults have participated in healthy lifestyles activities (physical activity, healthy eating sessions) as part of the Health Trainers Programme.

- **Mental Health**

The Tower Hamlets Mental Health Strategy, developed by the Health and Wellbeing Board, NHS Tower Hamlets Clinical Commissioning Group and Tower Hamlets Council, sets out our collective approach for improving the quality of life for people with mental health problems. The Strategy was informed by a mental health Joint Strategic Needs Assessment, and a series of stakeholder workshops to identify key priorities and evidence reviews to identify what works. This strategy will make mental health everybody's business. The Strategy includes the care and support we commission and provide for people with multiple health problems. We want to make sure that mental health becomes part of our everyday conversation and that health and social care staff have good mental health awareness. In particular, through our Joint Carers Plan, we will provide information and advice for carers for people with mental health problems, and ensure that carers are able to access appropriate care and support.

Key achievements in the past year include

- The school nursing service has been re-specified with a much greater emphasis on their role in supporting mental health and wellbeing.
- The reprocurement of tobacco cessation services specified the need for access for people with mental health conditions.
- Two additional dementia cafes have been commissioned, bringing the total to 4, operating once a month for people with dementia and their carers.
- GP training has been delivered on dementia, the Mental Capacity Act and learning disability.

- **Long Term Conditions and Cancer**

The Health and Wellbeing Strategy aims to reduced prevalence of the major 'killers' and increased life expectancy, a key aspect of this will be ensuring more people with long term conditions are diagnosed earlier and surviving for longer. There will also be a key focus on carers through ensuring they have good physical and mental health, and feel fully supported.

Key Achievements:

- Significant improvement in success identifying and measuring respiratory diseases, rising from amongst the lowest 20% in England for testing to the very highest rate in the country in 2012/13.
- Significant improvement in progress in monitoring and controlling blood pressure for people with diabetes and coronary heart disease (CHD), with amongst the best rates of testing in England (moving from the bottom national quartile of performance to the top national quartile in the course of three years for a range of outcomes, including prescribing for high blood pressure, the proportion of those with CHD suffering from high blood pressure)
- Tower Hamlets ranked as the best in England in the 2013/14 for blood pressure control in people with coronary heart disease and diabetes.
- "More people with early stage lung cancer had life-saving surgery at the Royal London Hospital, and there has been a reduction in the proportion of women in Tower Hamlets with late stage breast cancer.

- The Integrated Community Health Team went live in November 2013 and there has been an improvement in the coordination and consistency between reablement and rehabilitation; greater integration of social workers into the locality based clinics; and the development of robust community based Geriatric provision.
- A plan for autism services and improvement has been developed and implemented, with a diagnostic and Intervention Team in place. (See page 27 for more details)

A key focus for the Board has been on the integration of care between health and social care services in order to achieve better health outcomes for residents in Tower Hamlets. For more information on this please see page 33 of this Local Account.

Section 3: Tower Hamlets Adult Social Care – How our services are performing

This section describes our activity over the last year and our plans for the future in more detail. We have structured this section around the Department of Health Adult Social Care Outcomes Framework, as these are the outcomes we are seeking to achieve for people in Tower Hamlets.

1) Enhancing quality of life for people with care and support needs

This year we have focused on enhancing the quality of life for people with care and support needs through:

- Increasing the number of people receiving support through personal budgets and direct payments
- Supporting more carers in their caring role
- Providing an innovative support service to people with dementia
- Developing a new mental health service
- Improving the support we provide to adults with a learning disability
- Developing a new service for people with autism
- Supporting people with money and finances

More details on each of these is set out below.

Increasing the number of people receiving support through personal budgets and direct payments

Personalisation is about giving people more choice and control over their care and support. Personal budgets are a key part of this: They are an allocation of funding given to users after an assessment and used to meet their eligible care needs. Users can either take their personal budget as a direct payment, or while still choosing how their care needs are met and by whom, leave the Councils with the responsibility to commission support for them.

The Department of Health has set councils the challenging target of 70 per cent for the provision of personal budgets amongst its services users and carers. Whilst we have not yet met this target we have consistently improved our performance over the last couple of years: 55% of our service users and carers received a personal budget in 2013/14, an increase from 52.6% in 2012/13 and 38.3% in 2011/12. 1105 people out of 2820 receiving a personal budget in 2013/14 chose to receive it as a direct payment[8]

Going forward, our plans are:

- To continue to offer personal budgets to people who are eligible to receive them. We will encourage people to take these as direct payments as we know this can give people more choice and control over their support. However, people will always be able to ask the Council to manage their personal budget on their behalf.
- To extend our offer of personal budgets to carers.

[8] ASCOF 1C pt1 & pt2

- To help people understand that direct payments can be used in a flexible and creative way.

Supporting more carers in their caring role

We fully recognise the contribution carers make, and this year as with previous years, we have worked hard to support them. We are fully committed to ensuring all carers in Tower Hamlets receive the best possible care and support and have a range of support specifically targeted at carers themselves. The Carers Plan 2012-15 re-affirms our commitment to support all carers in the borough to have a life of their own, stay mentally and physically well and stay out of financial hardship due to caring. The Care Act will bring big changes for carers from April 2015 onwards, so another big task has been to prepare for these changes.

From April 2015 the Care Act will introduce a legal duty to assess carer's needs to support them in their caring role. As previously noted, Tower Hamlets has around 19,300 unpaid carers in the borough, around 4,800 of whom provide over 50 hours of unpaid care a week[9]**.** A much smaller number of carers are in contact with us. We carried out 1425 carer assessments in 2013/14, though we expect this number to rise significantly in future years as a result of the Care Act.

In 2013/14 1250 carers received support from adult social care, a slight increase from 1125 carers in receipt of adult social care services in 2012/13. Support to carers can take many forms and is often essential in helping them sustain their caring role and in enabling the cared for person to stay at home.

We funded the Tower Hamlets Carer Hub to provide a range of support to carers in partnership with other organisations. This ranges from specialist information and advice to one-off direct payments to services and activities to alleviate and manage stress and provide a break from caring.

In 2013/14 we worked hard to extend our reach to support carers from Black and Minority Ethnic (BME) and lesbian, gay, bisexual and transgender groups, as well as carers needing specialist support. Last year:

- 159 carers got support from the Somali Carers Support Service
- 155 carers who support a person with dementia got specific support with this.
- 150 carers went to a support group or retreat organised by the London Buddhist Centre
- 60 carers got support from a service targeting Bangladeshi women

Another success in this area over the last year has been health and wellbeing checks for carers. Research has shown that being an unpaid carer can adversely affect a carer's health. In line with our focus on prevention, Health and Wellbeing Checks for carers are designed to prevent any deterioration in a carer's physical and mental health, providing them with direct support to prevent them from reaching crisis point. Based on the evaluation of this project and continued feedback from carers it was found that carers feel better

[9] Census 2011 data

prepared to make decisions after a health and wellbeing check and value having some time to look at their own health and life as a carer. Following the health and wellbeing check, a letter is sent to the carer's G.P. outlining the key aspects of the check and identifies further help that can be used to access support. In 2013/14, 303 carers received a Carer Health and Wellbeing Check and 124 carers were reviewed by the service.

Going forward, our future plans for carers include:

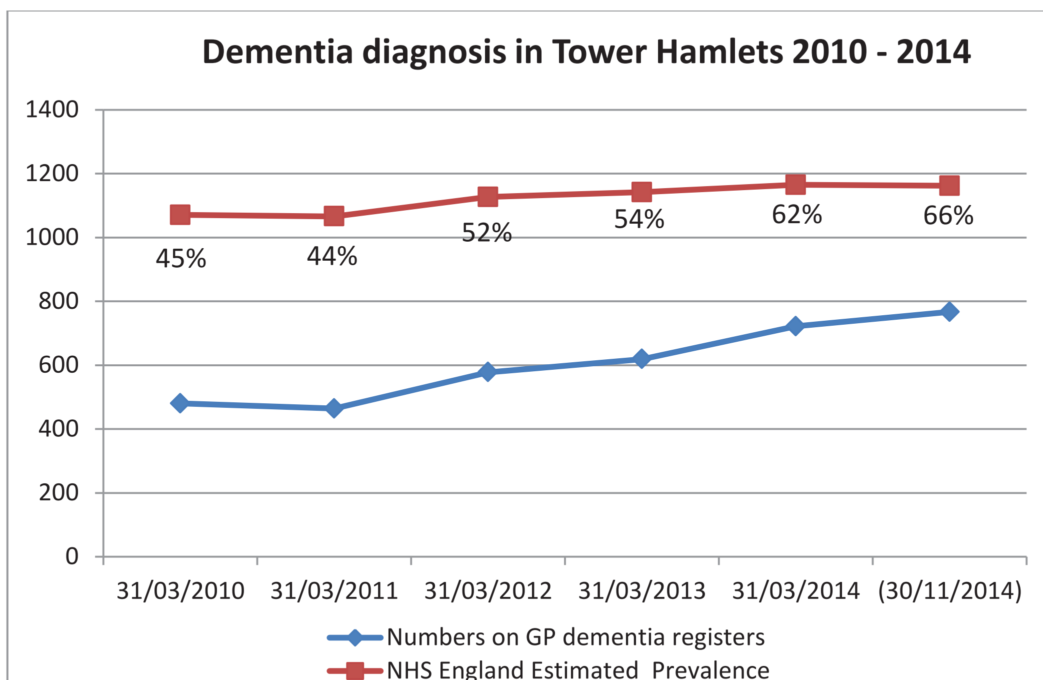
- Changing the way we offer and carry out carer assessments. From April 2015, carers will have the same legal rights as service users, and our approach will reflect this. Carers can expect to be offered an assessment if it appears they would benefit from this and their eligibility for services will be determined by new criteria.
- Helping carers to access a much wider range of support. From April 2015, carers who are eligible for support can receive this in the form of a personal budget. Like service users, carers can expect to have more choice and control over the support they receive as carers.
- Re-commissioning the carers short breaks services to ensure new services will be available from April 2015. Our aim, in line with what carers have told us, is to develop more flexible and innovative short breaks for carers.
- All these changes will be set out in a 2015-18 Carers Plan. This Plan will reaffirm our commitment to carers and set out how we will meet the requirements of the Care Act and how we will support carers in their caring role.

Providing an innovative support to people with dementia

This year as in previous years, the Council has been working together with the NHS and third sector organisations to provide excellent support to people with dementia. Since 2010, this “integrated dementia pathway” has been a national exemplar, improving the wellbeing of people with dementia and their carers. In 2013, the partnership of the Local Authority, NHS and third sector won the Local Government Chronicle Award for this work.

The Council supports people in a range of ways as part of this project. This includes supporting people from BME communities to access dementia services, supporting carers of people with dementia and running dementia cafés across the borough.

The development of this support over the past four years has resulted in a 20 per cent increase in the dementia diagnosis rate and we currently have the third highest diagnosis rate in London. The on the next page sets out the number of people diagnosed with dementia in comparison with expected prevalence levels, and shows that we are narrowing the gap:



Dementia Cafes and carer support have helped to keep people active, informed and in contact with people who have similar experiences. In line with our commitment to prevention, this support helps to delay people's condition deteriorating. A recent survey of dementia café users found that 100 per cent of service users experienced positive social engagement, 87.5 per cent said they had a better understanding of dementia and 80 per cent reported higher take up of other local support services.

The Tower Hamlets "dementia pathway" continues to be highlighted as an example of excellent practice. In 2014 we hosted visits from leading health and social care figures, and have been the subject of articles in the national press and a Department of Health documentary. Following a visit last summer, Professor Alistair Burns, National Clinical Director, commented: "It was really striking to see the passion for collaboration and the 'can-do' attitude in the room. A key part of the success of the developments in Tower Hamlets has been the adoption of a joint strategy that everyone has signed up for. The success is palpable and is serving the needs of people with dementia and their carers fantastically well."

The Council, in partnership with Tower Hamlets Clinical Commissioning Group, has also started to initiate a dementia support programme in care homes and Extra Care Sheltered Housing schemes. This programme involves an Occupational Therapist providing specialist dementia support for four months. The Occupational Therapist (in partnership with others) provides training to care home staff and supports them to put that learning into practice to improve care. As of December 2014, the Occupational Therapist had focused on three care homes. Examples of the work carried out so far include:

- Updating people's life histories and activity plans, with commitment to make the implementation of the plans 'everybody's business' in the home
- Supporting all homes to consider the Mental Capacity Act and Deprivation of Liberty Safeguards
- Supporting staff to set up a relatives and carers board for services in the community that they can access following the training

To date, the project has received positive feedback from staff. Here are some examples:

"A resident was shouting, and before last week I would have just said that it was their dementia, but I asked my colleague who was also on the training to come and talk to the resident and we managed to find out that it was a physical problem, that we soon got the GP to prescribe treatment for" – Care Worker

"It has been very useful and you have made me think in a different way, I used to think I was observant, but now I really think about the reason why people are saying/doing things and what I can do to support this" – Care Home Manager

Going forward, we look forward to continuing our success in supporting people with dementia and their carers through the "dementia pathway". In 2015 the specialist support provided to care homes and extra-care sheltered housing by the Occupational Therapist will start working with more homes. By the end of 2015 we aim to have worked with all the homes in Tower Hamlets.

Improving the support we provide to adults with Mental Health Needs

Tower Hamlets Health and Wellbeing Board is committed to improving outcomes for people with mental health problems. Mental health is one of the Boards four priorities in the Health and Wellbeing Strategy. In February 2014, the Health & Wellbeing Board approved the Tower Hamlets Mental Health Strategy. The Strategy is a five year plan for improving outcomes for people with, or at risk of, mental health problems in Tower Hamlets, and includes within its scope children and young people, adults of working age and older people. The Strategy sets out how Tower Hamlets partners will work together to promote mental health and wellbeing in our communities, prevent residents from developing more significant mental health problems, and ensure that when people do need them, mental health services are of the highest possible quality, proactively supporting people to recover. It demonstrates our ambition to deliver against the National Outcomes Framework for Mental Health contained in No Health Without Mental Health, Closing the Gap, and other national guidance.

90.5 per cent of adults receiving secondary mental health services in 2013/14 were supported to live independently in Tower Hamlets, an improvement on the previous year and better than the London and National averages.

Resident Action Point

Last year, when thinking about the kind of services residents would like us to prioritise they reported back that they value daycentres and community services which they would prioritise over other services.

Subsequently in 2013 we carried out a review of mental health day opportunity services. We gathered feedback from over 380 people about this and held 12 events to hear people's views. We have listened to people share personal stories, concerns and aspirations about the future. People told us what they value about day opportunity support: that they provide safe and supportive places for people to get support and keep in touch with others, that they help people stay well, support recovery and help people achieve their goals. People also told us what they wanted from a new support service: For example, highlighting the importance of people getting the right information at the right time.

Informed by this review planning has now begun to develop a new Mental Health Recovery and Wellbeing Service for 2015 in order to improve mental health social care services. A range of support, traditionally called 'day opportunities' have been helping people with mental health problems in the community for many years. We currently fund 11 organisations to provide this type of support.

There has been a long time aspiration and commitment to improve this support to help more people recover from mental health problems and – in line with our commitment to prevention - to stay well. We have been working together with people who use and provide services to make improvements and arrange a new Mental Health Recovery and Wellbeing Service for Tower Hamlets.

Going forward, we envisage the new Mental Health and Recovery service starting in late 2015. The new service will consist of:

- A new information, signposting and support team
- Longer term one-to-one support and recovery-focussed programmes of support. These will be focused on vocational skills, education, learning and employment. There will be more opportunities for people looking to gain employment or valuable experience through social enterprise initiatives.

Improving the support we provide to adults with a learning disability

The Community Learning Disability service (CLDS) provides care and support to adults with a learning disability in Tower Hamlets. In 2013 a programme of work was implemented to restructure the service to improve this support. The new CLDS structure went live in May 2014. Whilst it is still too early to evaluate the success of this restructure the new design of the service was created in partnership with service users and carers. Some of the main aims of the programme we hope to achieve are:

- To improve the experience of service users and carers
- To reduce waiting times for social care assessments and annual reviews

- Opening out the role of Bangladeshi Parent Advisers so that they can carry out carer assessments and support planning with *all* carers supporting someone with a learning disability
- Retaining the focus around mental health and challenging behaviour for people who have a learning disability or autism
- Ensuring that safeguarding cases are seen in adherence to Pan-London timelines and that service users are protected

In addition to this programme of work, we have worked hard over the last year to support more adults with a learning disability into employment. When service users in CLDS were asked what things were important to them, over 70 per cent said they wanted a job. Currently 6.2 per cent[10] of our service users with a learning disability are supported into employment. This equates to 42 people with a learning disability supported into employment. This falls slightly short of the national target and last year's figure (both 7.9 per cent) so we know we have more work to do.

One of the ways we are doing this is through extending our work placement schemes for adults with a learning disability within the Council and beyond. In 2013 we launched a new scheme, offering ten one-year work placements to adults with a learning disability alongside a Level 1 NVQ Business Administration qualification. A further twelve new recruits started in March 2014. The Council was able to extend the scheme this year with an additional ten placements being supported from September 2014 and a further ten from February 2015. The placements have been working in a range of departments and services.

The scheme has been hugely successful with five people gaining paid employment after year one. Feedback has focused on how rewarding and confidence building the project has been on an individual level. For example, one person said: "I was really excited to start work. I was a little nervous to start with but have really enjoyed my time so far and I am learning lots."

Going forward, our plans are to continue to improve the support provided through the Community Learning Disability Service and to continue to support adults with a learning disability into employment. We will be working to extend work placement opportunities in other organisations, such as the NHS.

Developing new support for people with Autism

The new Tower Hamlets Autism Service was officially launched in October 2014, though it has been operating for a number of years. We estimate that there are around 800 adults with Autism in the borough, and around 300 children and young people in local schools[11]. The Tower Hamlets Autism service has been set up to meet this need. It aims to provide:

- A timely diagnosis to those who may have Autism
- A clear pathway to any post-diagnosis support for adults with Autism
- Specialist support in the community for people with Autism

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[10] ASCOF 1E

[11] Analysis of SEN data indicates a further 296 children and young people (aged 3 to 18) with the condition in local schools.

- An effective transition for people who are moving from children to adult social care services
- Support to those with Autism to access employment and training opportunities

The service has already achieved a number of successes. For example, as of October 2014 the employment and training service has received 53 referrals. Two people diagnosed with Autism have been supported by this service into employment[12].

Going forward, we look forward to supporting more people with Autism in Tower Hamlets.

[12] Tower Hamlets Autism Diagnostic and Intervention service Quarterly monitoring report

2) Delaying and reducing the need for care and support

Delaying and reducing the need for care and support is a key focus of our work. It is a huge part of how we intend to address the issue of an anticipated increase in future demand for adult social care. Last year some of our key activity included:

- Working to reduce social isolation and loneliness
- Helping people return home from hospital
- Supporting more people through our short-term Reablement programme
- Offering Telecare to more people
- Developing Assistive Technology
- Supporting more people via equipment and adaptations
- Changing some of our day-time support for people with a learning disability
- Helping people to travel independently
- Supporting people to stay in the community

More details on each of these is set out below.

Working to reduce social isolation and loneliness

We know that social isolation and loneliness can be devastating for people and that it can impact on both their mental and physical wellbeing. Just over a quarter of adult social care users tell us that they do not have enough social contact with others[13], so we know it is an issue affecting a number of people we support.

We have learned more about the reasons behind social isolation and the impact of this over the last year: For example, Healthwatch Tower Hamlets carried out a piece of work in partnership with Tower Hamlets Friends and Neighbours to look at the experiences of housebound people. The report found that:

"A loss of social space was an issue for housebound people who felt disconnected from the world and a sense that that they were both isolated and in a community that did not care very much. Many were reliant on formal care for their social contact[14]"

[13] 2013/14 Service User Survey. 26% of respondents said they did not have enough social contact with others. This figure is slightly higher than the London and England average (25 and 22 per cent respectively

[14] Report on the Voices of Housebound Residents in Tower Hamlets" (June 2014) Tower Hamlets Friends and Neighbours

Resident Action Point

Last year we said that we would prioritise services that helped to prevent social isolation.

In the last year we funded a number of initiatives to try and tackle isolation, and we have started work with colleagues across the Council to tackle this issue on a wider scale. Here are just some of the ways we currently support people I this area

- We fund two borough-wide befriending services for older people who are socially isolated or at risk of becoming so, including those who are housebound. Support and companionship is provided through visits to the client's home, phone calls and escorting to appointments and/or other community services dependent on the user's wishes. Both services place a focus on involving the service user in all aspects of the service they receive. For example, one client (from Age UK) expressed an interest in developing IT skills in order to communicate with family overseas. They were matched with a befriender who was able to provide basic training during visits and assisted the client in setting up a Skype account enabling them to regularly contact their family and friends.
- We fund 41 Lunch Clubs around the borough, enabling older people to come together and socialise. Attendance at Lunch Clubs was over 23,000 in 2013/14.
- We fund a number of LinkAge Plus Centre's around the borough. Centre's offer a range of information and activities to anyone over the age of 50. For example, 315 people got involved in physical activities last year and 539 took part in computer/IT sessions. Through outreach work the centres also identify residents who may be socially isolated and not accessing any events or activities, and support them to start.

In addition to this, we are working with colleagues across the Council and in other organisations to tackle social isolation. Last year our Public Health service worked on a project seeking to engage the local community to help prevent and reduce loneliness in older people. This volunteer-led programme will look to develop local support networks and organise groups and events. Ideally the volunteers will be recruited directly from the neighbourhoods and will find out about social isolation and loneliness in their area. With support and training they will produce a detailed report of the findings. This, in turn, will help us decide what projects we should fund to address loneliness in the area. This project has only just begun and will be developed further in the coming year. We will give you an update in next year's local account

You can find recent research on loneliness and social isolation in the borough here:
www.towerhamlets.gov.uk/jsna

Going forward, our plans to tackle social isolation and loneliness include:

- Using the research gathered by public health on loneliness and social isolation to help us decide what types of support to fund going forward
- Working closely with colleagues across the Council and beyond to tackle social isolation and loneliness

Helping people return home from hospital

We know that helping people to return home from hospital can help them stay as well as possible for as long as possible. In Tower Hamlets, the rate of people experiencing delays in their discharge from hospital as a result of problems with social care services is almost half that of the national average[15]

We already ensure that social care staff are available at weekends for some departments in the Royal London Hospital, including Accident and Emergency. However, we are using the Better Care Fund to explore the possibility of extending this model across all of the wards in the hospital. This will enable more people to be discharged from hospital at weekends where they might previously have needed to wait until the following week, or indeed be discharged without valuable input from adult social care. Changing the way we work at the Royal London Hospital will help ensure people get the right care at the right time, which in turn will help to keep people's condition from deteriorating. It will also ensure that any carers are fully involved in the process of a person returning home.

In last year's Local Account we acknowledged that Tower Hamlets has some work to do to improve its delayed transfers of care from hospital which are attributable to adult social care. The average number of delayed transfers of care in 2012/13 which are attributable to social care per 100,000 adult (18+) population was 2.3 for Tower Hamlets. We have worked hard to improve this, in 2013/14 the average number of delayed transfers of care which are attributable to social care per 100,000 adult (18+) population was 1.5. This is below both London average of 2.3 and the national average of 3.1.

We realised that last year most delays were due to people delaying leaving hospital to wait for suitable placements for those who need residential care. As a result we have invested money from our Winter Resilience budget to fund four 'Step Down' beds to assist in discharging medically fit patients from the Royal London Hospital. There are 2 beds that are residential for people with dementia and 2 beds in Extra Care Sheltered Housing. This space is used as "step down" accommodation for people that are medically fit for discharge but unable to either return home or have not yet chosen a care home to move to. Step down beds are only used for a maximum of 6 weeks, in which time we are able to commission a care service for them. This allows us to improve a person's health and wellbeing whilst at the same time freeing up hospital beds for people who really need them.

Going forward we will therefore be looking at:

- All Royal London Hospital wards having access to social care staff at weekends
- The possibility of using residential and Extra Care Sheltered Housing on a temporary basis for people who are medically fit to be discharged from hospital but unable to return home.

[15] ASCOF 2C pt2

Supporting more people through our short-term Reablement programme

Our Reablement programme supports people to be as independent as possible. The team includes Social Workers, Occupational Therapists, Nurse Advisors, Independent planners and Reablement officers. They visit people at home for up to six weeks to promote rapid recovery after an episode of illness or other change in circumstances in order to help maximise a person's independence and wellbeing to live safely in their own home.

Last year, 963 people went through our Reablement programme[16]. People who have been through the programme consistently give positive feedback, particularly about feeling treated with respect and that their views are listened to[17]. In winter 2014 we extended our programme to offer a weekend Reablement service to enable people to leave hospital at this time.
There are around 150 people who receive both Reablement services from adult social care and Rehabilitation services from the NHS. We are using the Better Care Fund to work more closely with health services so that this group experiences better health and wellbeing.

Going forward, our plans for the Reablement programme include:

- Working closely with the NHS to improve the experience of people who need both Reablement and hospital Rehabilitation support. Possible options include having a single point-of-access for people and getting the teams to work in the same place.
- Raise awareness of Reablement for staff who work in the Royal London Hospital.

Offering Telecare to more people

Telecare is a good example of how we are utilising technology to help delay and reduce the need for care and support. Telecare is the name for equipment that provides 'alert' systems for people at home. People can use it to call for help or it can be set to call automatically when required. Examples include systems to alert carers if a person falls over, or out of bed, or needs changing, or is having a seizure. In an emergency or when assistance is required, Telecare clients can press their alarm to summon help. This triggers an alarm call which is received at the Telecare control centre. Telecare staff are then able to communicate with the caller to establish what the problem is and organise the most appropriate help.

Telecare is available to everyone. People have their own reasons for choosing Telecare but the great majority of our clients say that our service gives them and their relative's peace of mind, a feeling of greater security and reduced feelings of isolation. The service also helps to prevent people from having to go into extra care or residential care for as long as possible by supporting them to remain in their own homes.

As of May 2014, over 2,300 people had Telecare, but this figure increases all the time: An average of 65 Telecare or Assistive Technology equipment are installed each month.

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[16] Reablement Outcomes Report - TASC Customer Journey Compliant
[17] Reablement User Survey - approximate sample size of 130 users with approximate 25% response rate

This year the Telecare team has particularly focused on ensuring Telecare equipment is installed for people who are in hospital, to enable them to leave hospital without delay.

Going forward, a key priority for the team is to work closely with colleagues in NHS, to explore opportunities for working together.

Developing Assistive Technology

We are increasingly looking at technology to help people to stay as well as possible for as long as possible. Assistive Technology is an umbrella term that includes assistive, adaptive, and rehabilitative devices for people with disabilities. Assistive Technology promotes greater independence by enabling people to perform tasks that they were formerly unable to do, or had great difficulty doing, by utilising technology. Technology such as sensors that detect movement can help people to manage their conditions and to minimise risks to vulnerable people.

The team is relatively new, having been set up in 2012. Part of their work over the past year has therefore been to train and support staff in adult social care so that they have a better understanding of Assistive Technology and its benefit. The team has also worked to expand the range of electronic devices which can be prescribed.

Since the beginning of 2013, 476 requests for Assistive Technology have been made.

Going forward, some of our plans for Assistive Technology include:

- Working with GPs to see if technology can be further utilised to help people take their medication on time.
- Looking at Telehealth devices that can measure health information remotely.
- Looking to expand Assistive Technology to children with disabilities and their carers.

Supporting more people via equipment and adaptations

Equipment to help people manage their daily lives is another way we help people to stay well. Equipment can include minor adaptations such as bannister rails to simple items like raised toilet seats, to more specialist equipment like pressure-relieving mattresses. Equipment and minor adaptations help disabled people to maintain their independence as much as possible, and helps reduce hospital admission.

The demand for support increased last year: In 2013/14 18,800 items of equipment were delivered, marking a 49 per cent increase on the year before.

Over the last year we have continued to offer people more choice over their equipment. People receive a “prescription” for equipment that they can use at one of 26 accredited retailers in the borough. This is a free service to eligible

residents of Tower Hamlets, but people can choose to pay extra for a more bespoke item (for example, in a different finish). Over 14,600 simple aids were provided in this way over 2013/14. Residents who are not eligible for statutory support still have the opportunity to go to a local accredited retailer and buy their own simple items of equipment to help them or someone else.

More recently we have extended the opening of the service to seven days a week so that people who need equipment can get this without delay.

Working together with health services

As mentioned earlier in this Local Account we are trying to strengthen the way we work together with health and other organisations in almost every area, as can see throughout this Local Account.

The Health and Wellbeing Board is leading this integration of care. Over the past year Tower Hamlets Health and Wellbeing Board has been busy overseeing the delivery of the Councils Integrated Care agenda. The strategy for Integration in Tower Hamlets is part of a shared 5 year plan, 'Transforming Services Together', across Tower Hamlets, Newham and Waltham Forest. Each borough within the programme has its own Integrated Care Board reporting to the local Health and Wellbeing Board ensuring the inclusion of local factors within each borough's plans.

In October 2013 the Government announced fourteen pioneering initiatives which would showcase innovative ways to of deliver coordinated. These pioneering initiatives were designed to transform the way health and care is delivered to patients by bringing services closer together than ever before. Tower Hamlets, working alongside Waltham Forest and Newham became part of the "WELC Integrated Care Pioneer". The WELC Pioneer Programme drives the delivery of the Integrated Care Programme within the 5 year 'Transforming Services Together' plan.

Resident Action Point

In last year's Local Account we reported how there is a strong feeling from patients and users of social care that health professionals and social care staff need to work closer together to produce a streamlined approach to care.

A key development overseen by the Health and Wellbeing Board in 2013/14 was the introduction of the Better Care Fund (BCF). The £3.8bn Better Care Fund was announced by the Government in the June 2013 spending round, to ensure a transformation in integrated health and social care. The BCF is one of the most ambitious programmes ever across the NHS and Local Government. It creates a local single pooled budget to incentivise the NHS and local government to work more closely together around people, placing their wellbeing as the focus of health and care services. Using the resources made available through the BCF to enable our Integrated Care Programme our vision for health and care services in Tower Hamlets is of an integrated care system that coordinates care around the patient and delivers care in the most appropriate setting, empowering patients, users and carers. By putting patients/service users in control we aim to unlock greater health benefits for our residents so they can live longer and healthier lives.

The BCF programme of work has just started and we have already begun to explore how we can best utilise the resources made available to us. Tower Hamlets Health and Wellbeing Board have recently signed off on proposals as to how this money can be put to best use. One of the ways we are using the Better Care Fund is to look at how we can work more effectively with health colleagues when it comes to equipment, assistive technology and Telecare. The impact of these kinds of services on carers can often make the difference between being able to continue to provide care to their loved one, or developing needs for health and care support themselves. Carers provide a key service in preventing their loved ones from developing a health condition or slowing the development of a health condition and we have good evidence that carers are more able to continue in their caring roles through provision of Assistive Technology.

Another area of focus is the potential integration of health and social care teams. Community Health Teams are integrated teams comprising of nurses, physiotherapists, occupational therapists, and others. We are looking at these teams joining up with Social Work teams in adult social care. We are currently carrying out a detailed analysis of how these teams could be joined up in practice. The aim is to prevent residents who are at a high risk of health interventions (such as hospital admission) of requiring this. Instead support will be provided in the community, providing care and support closer to home.

Going forward,

- Our work will continue to be aimed at enabling people greater levels of self-management over their conditions to prevent things like hospital or residential care admission. One option being explored is having this type of support in health and social care housed under one "Independent Living Service". This would be more accessible to people and would place a greater emphasis on keeping people well.
- We will come to a decision on how Community Health Teams and Social Work Teams can best integrate. We anticipate improvements being made from 2015/16 onwards.

Changing some of our day-time support for people with a learning disability

We already fund a number of local projects which enable adults with a disability to socialise, learn new skills and improve their wellbeing.

Over the last year, work has been underway to redesign a Centre used by adults with a learning disability. This "Create" service will include a café as a social enterprise and will have a more accessible and dynamic space for training, workshops, IT and movement and arts and crafts.

Helping people to travel independently

Over the last two years we have worked to support adults with a learning disability to use public transport independently. This project initially focused on people with a learning disability who had transport provided by the Council to go college. A number of these people went on "travel training". This involves a staff member supporting individuals to travel independently. It could be through supporting them to use public transport or help to figure out a walking route. In total 50 of the 71 service users using transport did not need transport services and have now gone through or are completing travel training in order to maximise their independence. Most importantly, people with a learning disability are enjoying the independence the travel training has given them.

Going forward, our plans are to offer this training to everyone in day services who may benefit from this.

Supporting people to stay in the community

We know it is important for people to be as independent as they can. A lot of the support provided through adult social care enables people to stay in their communities and delays or reduces the need to move into a care home. It is to this end that we provided home care to 2545[18] adults in 2013/14. Home care typically involves a care worker visiting someone and helping with things like getting up and going to bed, keeping clean and tidy and eating and drinking properly. Sheltered and extra-care sheltered housing is another example of how we support people to stay in the community. Extra Care Sheltered Housing provides an alternative to a care home in specialist self-contained flats that promote independence and allow individuals to be in control of their lifestyle. There are now six Extra Care Sheltered Housing schemes in Tower Hamlets, providing 214 apartments for rent.

[18] RAP P2f

Resident Action Point

We know that people want to remain as active and independent as possible in their own communities. Last year we said that we would continue to make this a priority. As a result of all the preventative work demonstrated throughout this Local Account we have reduced the number of people placed in residential care over the last four years: In 2010/11, 785 per 100,000 of the population was supported in this way. In 2013/14 this figure was 644 per 100,000 of the population. Our rate of improvement over this period is the third best nationally.

Our 2013/14 result is above the London average of 650 but is lower than the London average of 454 which is largely a result of the variance of need within the local population. One possible explanation for this that in Tower Hamlets we do a very good job at keeping people as independent as possible for as long in possible in their own community. The number of council-supported permanent admissions of adults aged 18-64 to residential and nursing care is 9.2 per 100,000 of the population. This a significant improvement on lasts years figure of 22.2 per 100,000 of the population and is above the national average of 14.4 per 100,000 of the population, the London average of 10.2 per 100,000 of the population, and the inner London average of 11.6 per 100,000 of the population. As a consequence of supporting people in the community for longer our residents generally tend to access

3) Ensuring that people have a positive experience of care and support

We are committed to ensuring that people have a positive experience of adult social care. As stated in the introduction of this Local Account, we were pleased that this year 66 per cent of adult social care users said they were extremely or very satisfied with their care and support services. A further 24 per cent were quite satisfied[19]. These satisfaction levels are both higher than the London and England average[20], and the highest they have been since we started sending out a yearly 'Service User Survey' four years ago. Last year some of our key activity included:

- Developing information and advice related to adult social care
- Checking the quality of services
- Giving people a choice over the support they receive
- Monitoring people's perceptions of social care staff
- Looking at complaints and putting things right
- Looking at the impact of care and support

More details on each of these is set out below.

Developing information and advice related to adult social care

The importance of information on adult social care that is good quality, clear and easy to find continues to be one of main messages we hear from people who need support from adult social care. People often tell us that they want to know what support is out there and who can get it. People want simple ways of getting information and advice and, when they find it, it needs to be clear and jargon-free.

We have been working on a number of projects over the last few years to try and improve our information and advice. For example

- We set up the First Response team for people who might need support or want to make changes to their support. They can be contacted on 020 7364 5005.
- We fund a number of organisations to provide information and advice. We advise people to contact an organisation called Real if they are not sure where to start. Real can be contacted on 020 7001 2170.
- We have produced a number of publications to try and explain the often complicated world of social care.
- We have been developing an online "e-marketplace" to provide information on the social care services that are out there. This is due to be launched in the next year. We know that not everyone has internet access, so we will be making sure people have other ways of getting this information.

[19] 2013-14 Service User Survey in Tower Hamlets. Based on 1127 responses. A further 6 per cent of respondents answered "neither satisfied or dissatisfied". 4 per cent were dissatisfied.
[20] London: 60 per cent are extremely/very satisfied. England: 65 per cent are extremely/very satisfied.

In a recent survey, a quarter of adult social care service users said that information and advice on support, services or benefits is difficult to find[24]. This figure is slightly higher than both the England and London average (19 and 22 per cent respectively) so we know we still have work to do. The majority of service users say they are happy with the information once they have found it (67 per cent).

At the same time, the Care Act which came into law this year, means we now have a legal duty to provide information and advice on adult social care. We know that information and advice can be powerful aids to delaying and reducing the need for care and support, as it enables people to get the right help at an early stage and can stop problems from escalating.

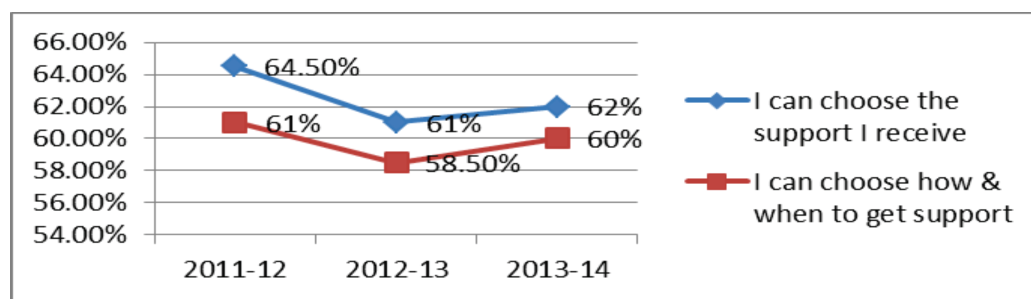
Going forward then and in response to both the Care Act and service user feedback, we are looking again at how we provide information and advice. We are drawing up an "Information Plan" that will set out the changes we plan to make. The plan will be in place by the end of the year, and will be developed in partnership with service users and carers.

Giving people choice over the support they receive

Resident Action Point

Last year residents told us that they would like more information on the services available to them. It is in response to this that we have been busy finalising the e-marketplace and developing the 'Quality Excellence Framework' that you can read about in more detail in the sections below.

This year as with previous years, we asked adult social care users in Tower Hamlets about how much choice they feel they have over their care and support. The graph below sets out the results:



We are pleased that the results have improved on last year, but will be doing more work to understand the reasons behind why 12 per cent of service users say they do not have choice over their care and support.

We are currently in the final stages of implementing our 'eMarketplace'. An eMarketplace is a website, similar to Amazon or eBay for social care, where people can find out about and purchase support services in the local area.

Organisations will be able to advertise their services on this site and eventually people will be able to purchase care through the site. In 2013/14 we got feedback from service users and carers on the eMarketplace, and have developed it with this feedback in mind.

Going forward, we will launch the eMarketplace to enable people to have more choice over their care and support.

Checking the quality of services

As previously noted, the vast majority of support in adult social care is provided by organisations who are funded by the Council. We thoroughly monitor the quality of the support we fund to ensure that people are having a positive experience. Monitoring also enables us to act quickly if things go wrong.

This year, we have continued to monitor the services we fund through our “Quality Excellence Framework”. This includes three-monthly reviews and visits to services from Council staff.

This year we have also started work to help people make decisions on the support that is right for them. People who buy their own care and support using direct payments or their own money often ask for information about how good an organisation is. The Council has lots of information about organisations that we have contracts with. However, there are a lot of organisations in our community doing great work that we don’t know much about. Sometimes they are too small to spend a long time getting a complicated quality mark so it is hard for them to show off how good they are.

Alongside five other east London boroughs (Barking and Dagenham, Havering, Newham, Redbridge, and Waltham Forest) we have therefore designed a quality assurance system for organisations or individuals who wish to offer services to individuals who manage their own care and support arrangements via a direct payment.

Look out for this quality mark which shows that an organisation meets all of our standards

It is also a way for small organisations to get onto our eMarketplace without filling in lots of complicated forms. People can use pictures or videos to show us they meet the standards. We want as many organisations to understand it then there is more choice and variety for you. We are also working with other East London boroughs to make sure we have information not just on organisations in the borough but also organisations on our doorstep.

It is very important to us to develop something useful to yourselves. As a good example, East London residents told us that they would be more likely to use personal assistants if we did the checks they suggested and kept a register.

Going forward, we are developing a code of conduct for Personal Assistants in partnership with the people who employ them. Next year will bring lots of choice and information about Personal Assistants who have been checked out using criteria that you have told us is important to you

Monitoring people's perceptions of social care staff

People who need support and carers continue to highlight the importance of staff who:

- Listen
- Care
- Have empathy
- Treat others with respect

This year as with previous years, the vast majority of service users have told us that they were treated with respect by staff assessing their need for social care. 81 per cent said this in the 2013-14 Service User Survey, whilst 3 per cent felt they were not treated with respect.

In another survey distributed to service users by staff who work for adult social care at the Council, 83 per cent of respondents said they felt their views were listened to and acted on where possible. Two per cent did not feel this way.

Service users, carers and representative organisations such as Healthwatch have told us that health and social care need to work better together, as do teams within social care. For the first time this year, we asked people in the annual Service User Survey about their experiences of this. The results show that 60 per cent of adult social care users feel that their care is co-ordinated well, whilst 14 per cent do not feel this way.

Going forward, our work around the Better Care Fund will continue to address this area which remains a key priority for us in the years ahead.

Looking at complaints and putting things right

We work hard to put things right if things go wrong. Over 2013/14, the Council received 57 formal complaints about adult social care. The number we received this year has decreased by three complaints compared to last year. We received an increased number of "locally resolved concerns" 119 this year compared to 63 last year[21]. These are concerns that people have raised that are dealt with there and then, and are not formerly raised as complaints. We monitor this information as it provides us with a valuable insight into how people are experiencing services. The table below breaks down the number of complaints we received last year.

[21] Please note this includes two additional months of data compared to last year

Since 2011 the biggest topic of complaint continues to be about “challenging decisions”. Often, these complaints involve people being unhappy with a

Topic	Complaints 2012/13	Complaints 2013/14	Total Locally Resolved Concerns (Jun 2012 - Mar 2013)	Total Locally Resolved Concerns (Apr 2013 - Mar 2014)
Access to services	4	0	0	0
Policy/procedure	1	0	2	0
Service delay/failure	18	14	23	57
Service quality	1	1	22	34
Staff conduct / competence	14	15	8	13
Challenge decision	22	24	5	5
Other	0	3	3	10
Total	60	57	63	119

decision to reduce or end the care and support they receive. A decision like this is made if someone is considered “ineligible” for care and support services

“Service delay/failure” remains the biggest issue raised through “locally resolved concerns” since 2012. This might involve – for example – someone being concerned that a care worker arrived late for a visit. Our commissioning staff are closely working with homecare agency to ensure that care workers keep an accurate log of arrival and leaving times.

Going forward, we will continue to monitor complaints. We will make sure that complaints are addressed on both an individual and department-wide level as appropriate, and that we learn from them.

Looking at the impact of care and support

One of the key positive things service users have told us over the last year is how care and support services are impacting on their lives. 2013-14 Service User Survey respondents say care and support improves their quality of life, helps them feel in control, helps them to feel safe and helps them be as independent as possible. Tower Hamlets has improved over time across each of these areas, and the results for this year are higher than both London and England averages. The following table provides more detail on this:

This year, 64 per cent of service users in the 2013/14 Service User Survey said respondents said they feel "as safe as they want", an increase of six percentage points on last year and one of the biggest single areas of improvement. This compares with an England average of 66 per cent and a London average of 63 per cent[23]. 70 per cent said they had enough control over their daily lives. These results are the highest we have had for three years.

Help to…	2011-12	2012-13	2013-14
Have a better quality of life – LBTH	n/a	91%	92.5%
Have a better quality of life – London	n/a	87%	88%
Have a better quality of life – England	n/a	89%	90%
To feel safe – LBTH	n/a	85%	86%
To feel safe – London	n/a	74%	77%
To feel safe – England	n/a	78%	79%
More control over daily life – LBTH	83%	87%	89%
More control over daily life – London	82%	83%	84%
More control over daily life – England	85%	85%	87%
To be as independent as possible – LBTH[22]	78%	78%	81%

Going forward, we look forward to continuing our success in these areas.

[22] This question has only been asked in Tower Hamlets so no benchmarking data is available
[23] 2013-14 Service User Survey

4) Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm

One of the core functions of adult social care is to safeguard vulnerable adults from abuse and avoidable harm. Last year as in previous years, we have worked hard on this issue. Some of our key activity included:

- Raising awareness of adult abuse
- Analysing who is raising concerns and experiencing abuse
- Analysing safeguarding information

More details on each of these is set out below

Raising awareness of adult abuse

Last year, we published an article on adult abuse and safeguarding in the local paper. Alongside this we continued our ongoing work to raise awareness about adult abuse and safeguarding.

The Council receives a comparatively high volume of safeguarding alerts (many of which were received from sources other social care and health staff). Whilst this might appear worrying, we have reason to believe it demonstrates that there is good awareness of safeguarding procedures in the local community.

We received 525 initial safeguarding contacts in 2013 -14, this is a slight drop on the previous year safeguarding contacts, but is above the London average of 493 referrals for the same period. Again, whilst this initially appears worrying, we think it demonstrates that the wider community understand that abuse is not acceptable.

Going forward, we intend to publish more articles emphasising that men can be abused too as there is a general concern that abuse against men may be hidden. We will also improve how we engage with the public to raise general awareness of safeguarding. Likewise, we will work with colleagues in the Council and beyond to ensure they know their responsibilities in relation to safeguarding. We will develop a training plan on this issue across partner agencies in Tower Hamlets with this in mind.

Analysing who is raising concerns and experiencing abuse

Each year we carry out detailed analysis of who is raising concerns about safeguarding and who experiences abuse. This enables us to see if there is a section of the community we need to work more closely with.

Here is a summary of what we have found out for Tower Hamlets:

- 60 per cent of alleged victims of abuse are female. This reflects the England average.
- White ethnic groups are slightly over-represented as subjects of referrals at 60.4% compared to being 45% of population (based on 2011 census). Asian ethnic groups are underrepresented when compared to population statistics – only 25.5% of referrals come from this group whilst they make up 41% of population locally.
- 89 per cent of safeguarding referrals are amongst individuals already 'known to the Local Authority', which usually means they are in receipt of services or are eligible for services under the Community Care Act.
- The highest proportion of safeguarding referrals are made in relation to people who have physical disabilities (53.8 per cent), this is line with the England average of 50.7
- In 2013-14, Tower Hamlets appeared to have a slightly lower proportion of referrals amongst Mental Health Clients (18.3 per cent) compared to an England average of 24.4 per cent.

Analysing safeguarding information

Each year we also carry out detailed analysis of safeguarding cases. As in the previous section, it enables us to see if there is specific action we need to take to prevent or tackle adult abuse.

Here is a summary of what we have found out for Tower Hamlets:

- The highest proportion of completed safeguarding referrals last year for Tower Hamlets identified 'neglect or act of omission' as the largest type of reported abuse, is consistent with the England average.
- In 2013-14 there was a higher proportion of 'financial abuse' (24.7 per cent) reported in this borough than the England average (18.3 per cent).
- The majority of safeguarding issues take place in the alleged victims own home. The figure is 63.2 per cent in Tower Hamlets, which is higher than the England average of 42 per cent.
- 54 per cent of individuals or organisations believed to be the source of risk are known to the alleged victim. 23 per cent are allegedly perpetrated by those providing social care and support.
- 36.4 per cent of safeguarding cases cannot be substantiated, as the alleged types of abuse are either unfounded or disproved. This is higher than the England average of 30.2 per cent and the London average of 34.5 per cent and work will be undertaken to understand this.
- 76 per cent of individuals were assessed as 'not lacking capacity' and thus able to make decisions in the safeguarding process. For those individuals identified as 'lacking capacity', 82 per cent were effectively provided with support or were represented by an advocate, family member or friend.

Going forward, we will:

- Look at further publicising the issue of financial abuse to ensure people are safe around this issue and possibly training for staff.

- Develop a better understanding as to why 36.4 per cent of completed referrals resulted in 'no further action required under safeguarding.
- Develop a better understanding of why our performance is lower than the London and England averages when it comes to the number of allegations concluded as either fully or partially substantiated.

Improving safeguarding

We have improved safeguarding practice in Tower Hamlets in a number of ways over the last year. Below are some examples:

- We have improved our performance around Deprivation of Liberty Safeguards. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. The safeguards should ensure that a care home, hospital or supported living arrangement only deprives someone of their liberty in a safe and correct way, and that this is only done when it is in the best interests of the person and there is no other way to look after them. The requests for authorisations to deprive somebody of their liberty if their wellbeing is at risk increased from 12 to 28, which is a significant improvement from the previous two years. On 19 March, the Supreme Court published its judgment in the case of P v Cheshire West and Chester Council and P and Q v Surrey County Council. This judgment clarified the test and definition for Deprivation of Liberty for adults who lack capacity to make decisions about whether to be accommodated in care. This means that a much greater number of service users and patients will now be subject to a deprivation of liberty and will come under the protection of the DOLS procedure.
- The Safeguarding Adults Board continues to do good work. Linked to this Board are sub-groups on Good Practice and Training, Quality Assurance and Performance and a Champions Group. These sub-groups have contributed to the work of the Board and supported improvements in safeguarding in the borough.

Going forward, our priority is to meet some of the wider national changes happening in safeguarding. This means:

- Reviewing our Safeguarding Adults Board to make sure it meets the requirements of the Care Act
- Including self-neglect and hoarding under safeguarding and deciding when action needs to be taken in relation to this
- Changing the way we work with victims of abuse to ensure they are at the centre of any investigation and the support they receive.
- Comply with the Supreme Court judgement and guidance in relation to Deprivation of Liberty and ensure our practice is under pinned by the revised Mental Capacity Act Code of Practice

In addition, we will continue to work to improve our performance and work closely with other organisations to prevent and tackle adult abuse.

Appendix 1 – Glossary

Advocacy	Support to help a person say what they want, secure their rights and represent their interests.
Assistive technology	Products or equipment that help people to carry out daily tasks and stay safe.
Audit	Inspecting work to see whether it is being carried out properly.
Benefit Cap	A limit on the amount of money someone can receive in benefits.
Better Care Fund	BCF is a nationally pooled £3.8 billion budget that shifts resources into social care and community services for the benefit of the NHS and local government
Block contracts	A contract to say an organisation will provide a large number (or "block") of services.
Carers	Support or "look after" a friend or family member who needs help.
Clinical Commissioning Group	Group of GPs who decide on a lot of local health services.
Commissioning	Funding other organisations to provide social care on our behalf.
Community Virtual Ward	Getting support from a range of health professionals without being admitted to hospital.
Direct payment	Money paid directly into someone's bank account.
Electronic Home Care Monitoring	A way to record when a Care Worker starts and ends their shift when caring for someone at home.
e-marketplace	An online catalogue, showing what support people could buy with a personal budget.
Equipment	Things like an alarm or a bath seat. Equipment helps people stay safe and carry out tasks like washing and cooking.
Extra-care sheltered housing	Housing (e.g. a block of flats) where residents each have their own flat but get support from social care staff with daily tasks.
Fair Access to Care Services Criteria	The main criteria we use to decide who can get social care.
Family Wellbeing Model	Looking at the needs of a whole family (e.g. parents and children) rather than just one family member.
Financial inclusion	Everyone being able to get the most from their money and avoiding charges or fees.
Financial inclusion strategy	A plan saying how we will help people get the most from their money and avoid fees and charges.
First Response service	The first point-of-contact for any adult social care queries or concerns.
Framework Agreement	A list of approved organisations we can fund to provide adult social care on our behalf.
Health and Wellbeing Board	The Board is there to drive forward plans to improve health and wellbeing in Tower Hamlets.
Health and Wellbeing Strategy	The plan lays out how the Council and other organisations will improve health and wellbeing.
HealthWatch	A group of local residents who give their views and

	try to improve health and social care. HealthWatch took over from "THINk" in 2013.
Housing-related support	Support to help someone to be independent, linked to where they live. Homeless hostels, women's refuges and sheltered housing are all examples.
Independence plans	A plan in the "Reablement" service, saying what changes a person would like to see as a result of getting support.
Joint Strategic Needs Assessment	Research into the current and future health and wellbeing of Tower Hamlets residents.
Link Age Plus	Centres offering information, advice, activities and support to older people.
Local Housing Allowance	A way of working out Housing Benefit for people who rent from a private landlord.
Long-term condition	A long-term health problem, such as asthma or diabetes.
NHS East London Foundation Trust	Part of the NHS, running things like mental health services.
NHS Barts Health Trust	Part of the NHS, running things like the Royal London Hospital.
Outcomes	The changes, benefits or other results that happen as a result of getting support from social care.
Personal budget	An amount of money from the Council to buy social care.
Personalisation	A person who needs social care having more choice and control over their lives and the support they get.
Procurement	The process of purchasing or buying something.
Provider	An organisation we fund or "commission" to provide adult social care on our behalf.
Public health	Public health looks at how to improve the overall health and wellbeing of a population, rather than individuals.
Reablement	A short-term programme of support designed to help people regain their confidence and independence.
Recovery	A way of dealing with mental health problems, aimed at improving a person's health and quality of life.
Respite	A temporary rest period. Respite care is normally a temporary break for carers of the ill or disabled.
Safeguarding	Protecting people who are vulnerable from harm or abuse.
Self-directed support	Support that a person chooses, organises and controls to meet their needs in a way that suits them.
Sensory impairment	A sight or hearing problem.
Social care assessment	An assessment is looks at what support a person needs. FACS Criteria is used to decide whether someone is eligible to get support from social care.
Supporting People	A government programme helping vulnerable people live independently and keep their social housing tenancies.
Support package review	A review to check if a person's need for support has changed, and to see the support they are getting is

	still right for them.
Support planning	Laying out the support a person will get and what changes they want to see as a result.
Transitions	Moving from children's social services to adult's social services.

Appendix 2 – Key 2013/14 Referrals Assessments and Packages of Care (RAP)

In Tower Hamlets last year:

- 4660 people received adult social care services, which is consistent with the level from the previous year
- 6855 people contacted Tower Hamlets Council's adult social care services for help or advice, a 15per cent increase on the previous year
- 2830 new service users had an assessment of their needs, a 25per cent increase on the previous year
- 2965 existing service users' received a review of their care needs, a 2per cent increase on the previous year
- 1250 Carers received care and support services, an 11per cent increase on the previous year
- 1425 Carers received a carers assessment, a 9per cent decrease on the previous year.

Appendix 3 – Adult Social Care Outcomes Framework (ASCOF) Measures

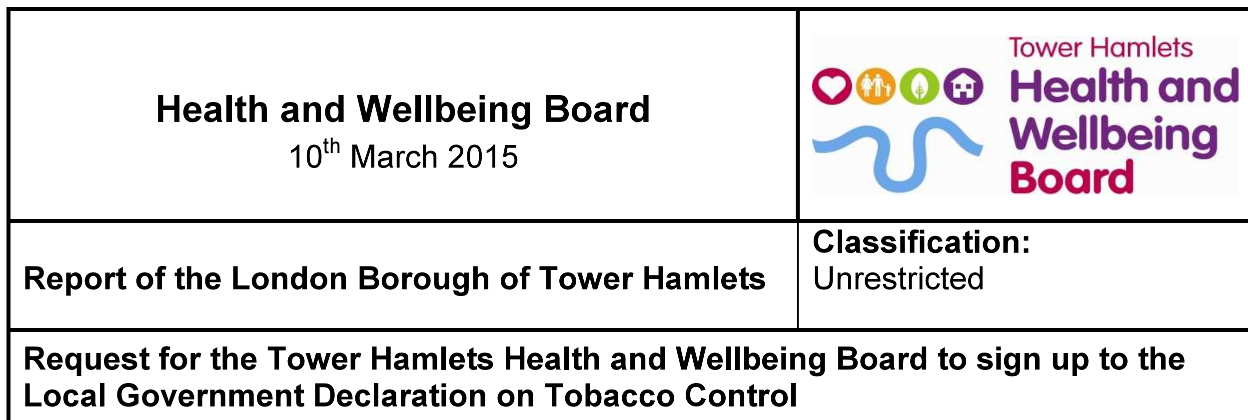
		2013-14 Outcome Measures				2012-13 Outcome Measures				
		Tower Hamlets	Inner London	London	England	Tower Hamlets	Inner London	London	England	
	Number of respondents who answered all eight questions	**1,030**	**6,665**	**14,775**	**65235**	815	5,335	12,685	60,410	***ASCS - questions 3a to 9a and 11***
1A	The sum of the scores for all respondents who answered all eight questions divided by the number of respondents who answered all eight questions	**18.5**	**18.4**	**18.5**	**19.0**	**18.0**	**18.1**	**18.3**	**18.8**	** Outcome is a weighted value*
1B	Proportion of respondents who felt they had control over their daily life	**69.9**	**71.8**	**72.4**	**76.8**	**68.8**	**70.8**	**70.9**	**76.1**	** Outcome is a weighted value*
1C(1)	Number of clients and carers receiving self-directed support in the year to 31 March as a percentage of clients receiving community-based services and carers receiving carer specific services *(aged 18 and over)*	**55.0**	**65.6**	**67.5**	**61.9**	**52.6**	**60.3**	**63.9**	**56.2**	
1C(2)	Number of users and carers receiving direct payments in the year to 31 March as a percentage of clients receiving community-based services and carers receiving carer specific services *(aged 18 and over)*	**21.6**	**23.9**	**22.6**	**19.1**	**23.4**	**21.3**	**19.5**	**16.8**	
1D	The sum of the scores for all respondents who answered all six questions divided by the number of respondents who answered all six questions	**..**	**..**	**..**	**..**	**7.3**	**7.5**	**7.7**	**8.1**	**Please note this information is reported biannually and as such data is not available for**

										2013/4
1E	Working age learning disabled clients known to CASSRs in paid employment as a percentage of working age learning disabled clients known to CASSRs in the year to 31 March *(aged 18 to 64)*	**6.2**	**6.7**	**8.8**	**6.7**	**7.9**	**7.3**	**9.1**	**7.0**	
1F	Working age adults who are receiving secondary mental health services and who are on the Care Programme Approach recorded as being employed as a percentage of working age adults who are receiving secondary mental health services and who were on the Care Programme Approach *(aged 18 to 69)*	**5.7**	**5.0**	**5.4**	**7.0**	**6.8**	**5.8**	**6.9**	**8.8**	
1G	Working-age learning disabled clients who are living in their own home or with their family as a percentage of working-age learning disabled clients *(aged 18 to 64)*	**63.7**	**70.9**	**68.6**	**74.9**	**60.5**	**69.5**	**68.1**	**73.5**	
1H	Adults who are receiving secondary mental health services on the Care Programme Approach recorded as living independently , with or without support as a percentage of adults who are receiving secondary mental health services and who are on the Care Programme Approach *(aged 18 to 69)*	**90.5**	**77.5**	**78.6**	**60.8**	**86.4**	**78.1**	**79.4**	**58.5**	
1I1	Number of respondents who answered 'I have as much social contact as I want with people I like' as a percentage of all respondents to ASCS question 8a	**38.9**	**40.1**	**40.7**	**44.5**	N/A	N/A	N/A	N/A	** 2013-14 Outcome is a weighted value, Previously combined from ASCS and CS; not comparable with latest performance*
1I2	Number of respondents who answered "I have as much social contact I want with people I like" as a percentage of all respondents to CS question 11	..	..	..	..	N/A	N/A	N/A	N/A	

2A(1)	Number of council-supported permanent admissions of younger adults to residential and nursing care divided by the size of the younger adult population in the area multiplied by 100,000 *(aged 18 to 64)*	**9.2**	**11.6**	**10.2**	**14.4**	**22.2**	**11.6**	**10.6**	**15.0**
2A(2)	Number of council-supported permanent admissions of older people to residential and nursing care divided by the size of the older people population in the area multiplied by 100,000 *(aged 65 and over)*	**644.2**	**545.2**	**454.0**	**650.6**	**654.7**	**564.3**	**478.2**	**697.2**
2B(1)	Proportion of older people *(aged 65 and over)* discharged from acute or community hospitals to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting), who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital.	**80.4**	**92.9**	**88.1**	**82.5**	**81.8**	**89.3**	**85.3**	**81.4**
2B(2)	Number of older people *(aged 65 and over)* discharged from acute or community hospitals from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with the clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting) as a percentage of the total number of people *(aged 65 and over)* discharged alive from hospitals in England between 1st October and 31st December. This includes all specialities and zero-length stays	**3.5**	**7.2**	**5.0**	**3.3**	**2.7**	**5.1**	**4.5**	**3.2**
2C(1)	Average number of delayed transfers of care on a particular day taken over the year divided by the size of the adult population in the area *(aged 18 and over)* multiplied by 100,000	**5.7**	**6.8**	**6.8**	**9.6**	**7.9**	**6.2**	**6.9**	**9.4**
2C(2)	Average number of delayed transfers of care on a particular day taken over the year that are attributable to social care or jointly to social care and the NHS divided by the size of the adult population in the area *(aged 18 and over)* multiplied by 100,000	**1.5**	**2.8**	**2.3**	**3.1**	**2.3**	**2.5**	**2.6**	**3.2**

3A	Total number of respondents to question 1 as a percentage of those respondents who answered 'I am extremely satisfied' or 'I am very satisfied' or 'I am very happy with the way staff help me, it's really good'	**65.8**	**60.0**	**60.3**	**64.8**	**61.1**	**59.5**	**59.3**	**64.1**	** Outcome is a weighted value*
3B	Respondents who answered 'I am extremely satisfied' or 'I am very satisfied' as a percentage of all respondents to the question excluding those who answered 'We haven't received any support or services from Social Services in the last 12 months'	..	..	..	..	**28.4**	**34.6**	**35.2**	**42.7**	Please note this information is reported biannually and as such data is not available for 2013/4
3C	Respondents who answered 'I always felt involved or consulted' or ' I usually felt involved or consulted' as a percentage of all respondents to question 15 excluding those who answered 'There have been no discussions that I am aware of, in the last 12 months'	..	..	..	..	**63.4**	**65.8**	**65.9**	**72.9**	Please note this information is reported biannually and as such data is not available for 2013/4
3D1	Number of respondents who answered "Very easy to find" and "Fairly easy to find" as a percentage of all respondents to question 12 (excluding those who answered "I've never tried to find information or advice")	**71.1**	**73.0**	**72.8**	**74.5**	**67.5**	**68.9**	**68.3**	**71.4**	** 2013-14 Outcome is a weighted value,* ***2012-13 is average of the two ASCS and CS outcomes ; not comparable with latest***
3D2	Number of respondents who answered "Very easy to find" or "Fairly easy to find" as a percentage of all respondents to question 13 (excluding those who answered "I have not tried to find information or advice in the last 12 months").	..	..	..	..					

										performa nce
4A	Respondents who answered 'I feel as safe as I want' as a percentage of all respondents to question 7a	**63.5**	**60.9**	**62.8**	**66.0**	**58.3**	**58.7**	**60.5**	**65.1**	** Outcome is a weighted value*
4B	Respondents who answered 'Yes' as a percentage of all respondents to question 7b	**86.5**	**75.0**	**76.8**	**79.1**	**84.9**	**74.6**	**73.9**	**78.1**	** Outcome is a weighted value*



Health and Wellbeing Board 10th March 2015	Tower Hamlets Health and Wellbeing Board
Report of the London Borough of Tower Hamlets	**Classification:** Unrestricted
Request for the Tower Hamlets Health and Wellbeing Board to sign up to the Local Government Declaration on Tobacco Control	

Lead Officer	Somen Banerjee
Contact Officers	Chris Lovitt
Executive Key Decision?	No

Executive Summary

The use of tobacco in the borough harms both the individual and the wider community. It is the main cause of premature death and poorer health in our local residents.

Since 2007 the Borough has implemented a comprehensive tobacco control strategy working in partnership across health, social care, education and the voluntary sector to reduce tobacco use and subsequent harm. This partnership work has led to some of the most successful outcomes of any London borough in terms of cessation and tobacco control. The Tower Hamlets Tobacco Control Alliance continues to support and implement this strategy.

The Tower Hamlets HWB and represented parties now have the opportunity to enhance this work by signing up to the Local Government Declaration on Tobacco Control. NHS partners were also invited to sign the National NHS statement of support which is due to be launched at the Palace of Westminster on Feb 23rd 2015.

Recommendations:

The Health and Wellbeing Board is recommended to:

1. To note the good progress that has been made in reducing the harm associated with tobacco use in Tower Hamlets.

2. To ask the Mayor, as the chair of the HWB to sign the Local Government Declaration on Tobacco Control.

3. Consider communication and publication opportunities where partners can demonstrate their commitment to the declaration.

1. REASONS FOR THE DECISIONS

1.1 The use of tobacco in the borough harms both the individual and the wider community. It is the main cause of premature death and poorer health in our local residents.

1.2 Tower Hamlets has amongst the highest rates of smoking in London and the highest use of smokeless tobacco.

1.3 This tobacco use costs the local community an estimated £71.1 million per year in terms of costs to the health service, loss of productivity, litter, anti-social behaviour and fire.

1.4 Tobacco continues to be both widely available and used in all sections of our local residents.

1.5 Most smokers start in their teens so targeting young people is a major priority for the tobacco industry as they replace smokers who have died or successfully stopped smoking. Young people from deprived areas are more likely to start smoking than their counterparts from more affluent areas.

2. ALTERNATIVE OPTIONS

2.1 To request each individual organisation who are members of the Health and Well Being Board to support the Declaration on Tobacco Control - however this is likely to take some considerable time and be duplicative.

2.2 Not to support the declaration.

3. DETAILS OF REPORT

BACKGROUND

What harm does tobacco cause?

3.1 Smoking is the principal cause of morbidity and mortality in the UK and is the major reason for the inequalities in death rates between rich and poor in the UK. This is particularly pertinent to Tower Hamlets which has high levels of deprivation and has a disproportionably high disease burden compared to England as a whole. It is one of the most important factors in health inequalities that persist in Tower Hamlets. Smoking is more common in deprived areas and is strongly associated with low educational attainment, unemployment, living in social housing, being illiterate in English and migration.

3.2 Preventing smoking in children and young people is an important public health measure to avoid the long term serious health consequences and prematuredeath. Exposure to environmental tobacco smoke, passive

smoking, is a cause of bronchitis, pneumonia, coughing and wheezing, asthma attacks, middle ear infection and cot death.

3.3 Children living in the poorest households have the highest levels of exposure to secondhand tobacco smoke. About 30% of children live with at least one adult smoker, rising to 57% among low income families.

3.4 Cheap illicit tobacco is widely available in spite of regulations and this makes it easier for children and young people to become addicted to tobacco as age restrictions are circumvented and cost is more affordable.

What has been done locally to address harms?

3.5 Smoking rates in Tower Hamlets have reduced over the past few years with the overall adult smoking prevalence now estimated at 19.3%. However the prevalence for routine and manual groups remains higher at 22% and is a major reason for the borough's high levels of premature morbidity, mortality and account for the borough's health inequalities. 50% of all smokers die prematurely.

3.6 The Tower Hamlets Tobacco Alliance was formed in 2007 and was responsible for producing a comprehensive tobacco strategy to reduce smoking prevalence with programmes to promote smokefree environments, reduce the availability of illicit tobacco and provide quality accessible support services for smoking/tobacco cessation

.

3.7 Smoking cessations services are being provided across the borough; these have been integrated into care pathways and enhanced services in primary and secondary and mental health care settings. Community Health Care professionals and Outreach workers are tailoring and delivering services to those with high rates of smoking, but low access to mainstream services.

3.8 Illicit tobacco, contraband and counterfeit cigarettes, and underage sales are enforced by LBTH Trading Standards. Trading Standards monitors compliance and raises awareness of the age of sale for tobacco during routine visits to retailers and are introducing a 'Responsible Trader' scheme and regularly employ young test purchasers.

3.9 As a result of local actions and national legislation smoking prevalence in Tower Hamlets have reduced over the past few years.Thepercentage of adult is 19.3%; however this increases to 22% amongst routine and manual residents and is a major reason for the borough's high levels of premature morbidity, mortality and health inequalities. 50% of all smokers die prematurely.

What is the Local Government declaration?

3.10 The Declaration has been endorsed by: Public Health England; Public Health Minister; Chief Medical Officer; Association of Directors of Public Health;

Faculty of Public Health; Chartered institute of Environmental Health, and; Trading Standards Institute.

3.11 The Declaration aims to ensure that there is clear local leadership on reducing smoking rates and that tobacco control is part of mainstream public health work. The Declaration includes a number of specific commitments for individual boroughs to sign up to:

- Reduce smoking prevalence and health inequalities
- Develop plans with partners and local communities
- Participate in local and regional networks
- Support government action at national level
- Protect tobacco control work from the commercial and vested interests of the tobacco industry
- Monitor the progress of our plans
- Join the Smokefree Action Coalition

What is Tower Hamlets already doing in relation to the declaration commitments?

3.12 *To reduce smoking prevalence and health inequalities*the borough commissions services to meet the needs of Tower Hamlets diverse population. Initiatives for the prevention of tobacco use are in place including a comprehensive programme of prevention (peer education, PHSE and national curriculum, cessation (school based services) and smokefree (enforcement and signage). We are also piloting a responsible trader scheme working with traders to help them understand why under age sales is significant alongside test purchasing on under age sales of tobacco.

3.13 *Develop plans with partners and local communities*: The Tower Hamlets tobacco control programme is delivered through partnership working with the CCG, Barts Health, ELFT, primary care and community groups, including joint commissioning of services.

3.14 *Participate in local and regional networks*:LBTH is an active member of the regional tobacco Network and is working with the Association of Directors of Public Health as the DPH sector led for tobacco to provide peer support across London in the delivery of tobacco strategies. We are also working in partnership with Waltham Forest and Newham on CQUINS for 2015/16 to improve the referral rates from secondary care into local stop smoking services.

3.15 *Support government action at national level:* LBTH has played an active part in the implementation of recent legislation e.g. standardised packing and smokefree cars. Letters of support have been sent to local MPs and the government from the Mayor of Tower Hamlets and the Tobacco Control Alliance.

3.16 *Protect tobacco control work from the commercial and vested interests of the tobacco industry*:LBTH is mindful of Article 5.3 on the Framework Convention

on Tobacco Control (FCTC) and follows recommendations from the NCSCT on reviewing prescribing practices.

3.17 Monitor the progress of our plans: The Tobacco Alliance is in the process of reviewing its works through the re submission of the CLeaR self-assessment and is developing an action plan to improve any potential gaps in service delivery.

3.18 Join the Smokefree Action Coalition: LBTH works actively with the SFAC, supporting their responses to consultations on latest Government policies, e.g. standardised packaging; smokefree cars.

What would we need to do differently if we signed up to the declaration?

3.19 Tower Hamlets already has a well-developed and fully funded programme of work that exceeds the requirements of the declaration. No additional work would need to be undertaken. However, by signing the declaration we would provide a communication opportunity to showcase the work that is already being undertaken by partners in Tower Hamlets.

4. COMMENTS OF THE CHIEF FINANCE OFFICER

4.1. There are no additional costs associated with signing up to the declaration on tobacco control, any communication costs to showcase work already being undertaken will be met from existing budgets.

5. LEGALCOMMENTS

5.1. The Health and Social Care Act 2012 conferred duties on the Council to improve public health, and transferred public health functions to local authorities from the former NHS primary care trusts. Under this Act, the Council must take such steps as it considers appropriate for improving the health of the people in their areas.

5.2. The Care Act 2014 places a duty on the Council to enable access to services and integrate with partners to prevent, reduce or delay needs for care and support. The accompanying Care and Support Statutory Guidance sets out how the Council should implement the Act in April 2015 and includes guidance on how preventive services should be provided.

5.3. The recommendations to note the good progress that has been made in reducing the harm associated with tobacco use in Tower Hamlets; ask the Mayor, as the chair of the HWB to sign the Local Government Declaration on Tobacco Control; and consider communication and publication opportunities where partners can demonstrate their commitment to the declaration, are consistent with the general policy, reflected in the Health and Social Care Act 2012, of giving HWBs responsibility for joint health and wellbeing strategies.

5.4. These recommendations are within the terms of reference of the HWB agreed by the Mayor in Cabinet on 4 December 2013, in particular:

i) To encourage integrated working between persons who arrange for the provision of any health or social services in Tower Hamlets for the advancement of the health and wellbeing of the people in Tower Hamlets.
ii) To consider and promote engagement from wider stakeholders.
iii) To communicate and engage with local people on how they could achieve the best possible quality of life and be supported to exercise choice and control over their personal health and wellbeing.
iv) To have oversight of the quality, safety, and performance mechanisms operated by member organisations of the Board, and the use of relevant public sector resources across a wide spectrum of services and interventions, with greater focus on integration across outcomes spanning health care, social care and public health. Areas of focus to be agreed from time to time by members of the Board as part of work planning for the Board.

6. ONE TOWER HAMLETS CONSIDERATIONS

6.1. Tobacco use is over represented in certain ethnic communities, in people with disabilities, LGBT people and in people from working class backgrounds. Tobacco use is a key factor in health inequalities and by implementing the declaration we will help to reduce inequalities.

7. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

7.1 Tobacco production is a resource intensive and environment degrading both during its production and its use through increased litter, anti-social behaviour and fires. Reducing the demand for tobacco products will have a positive impact on the environment.

8. RISK MANAGEMENT IMPLICATIONS

8.1. The tobacco industry has well-funded public affairs organisations that are likely to continue to seek a high level of scrutiny on tobacco control initatives. Signing the declaration may temporarily increase the amount of FOI and related activity. However in the medium term referring to the declaration will assist in responding to such enquires.

9. CRIME AND DISORDER REDUCTION IMPLICATIONS

9.1 The sale of illicit and counterfeit tobacco is a significant source of income for organised crime both locally and nationally, as well as being a major loss of revenue.

9.2 Under age sales of tobacco by retailers is likely to be an indicator of poor adherence to a range of legal and regulatory conditions.

9.3 By signing up to the declaration we commit to continuing the local work to address both illicit and underage sales which will have a positive impact on reducing the income of organised crime.

10. EFFICIENCY STATEMENT

10.1 There is no expenditure directly associated with signing up to the declaration. However, continuing to drive down the use of tobacco will result in large efficiencies gained through reducing the health and social care costs of smoking related diseases.

Appendices and Background Documents

Appendices

- Local Government Declaration

Background Documents

- NONE

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Local Government Declaration on Tobacco Control

We acknowledge that:

- Smoking is the single greatest cause of premature death and disease in our communities;
- Reducing smoking in our communities significantly increases household incomes and benefits the local economy;
- Reducing smoking amongst the most disadvantaged in our communities is the single most important means of reducing health inequalities;
- Smoking is an addiction largely taken up by children and young people, two thirds of smokers start before the age of 18;
- Smoking is an epidemic created and sustained by the tobacco industry, which promotes uptake of smoking to replace the 80,000 people its products kill in England every year; and
- The illicit trade in tobacco funds the activities of organised criminal gangs and gives children access to cheap tobacco.

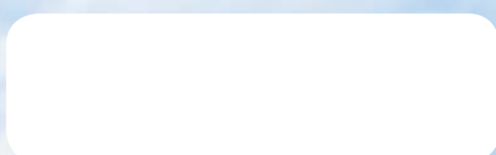
As local leaders in public health we welcome the:

- Opportunity for local government to lead local action to tackle smoking and secure the health, welfare, social, economic and environmental benefits that come from reducing smoking prevalence;
- Commitment by the government to live up to its obligations as a party to the World Health Organization's Framework Convention on Tobacco Control (FCTC) and in particular to protect the development of public health policy from the vested interests of the tobacco industry; and
- Endorsement of this declaration by the Department of Health, Public Health England and professional bodies.

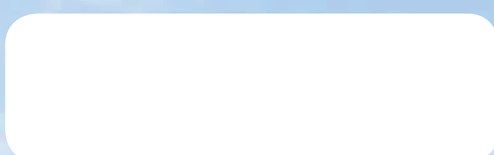
We commit our Council from this date ....to:

- Act at a local level to reduce smoking prevalence and health inequalities and to raise the profile of the harm caused by smoking to our communities;
- Develop plans with our partners and local communities to address the causes and impacts of tobacco use;
- Participate in local and regional networks for support;
- Support the government in taking action at national level to help local authorities reduce smoking prevalence and health inequalities in our communities;
- Protect our tobacco control work from the commercial and vested interests of the tobacco industry by not accepting any partnerships, payments, gifts and services, monetary or in kind or research funding offered by the tobacco industry to officials or employees;
- Monitor the progress of our plans against our commitments and publish the results; and
- Publicly declare our commitment to reducing smoking in our communities by joining the Smokefree Action Coalition, the alliance of organisations working to reduce the harm caused by tobacco.

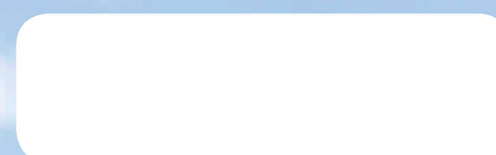
Signatories



Leader of Council



Chief Executive



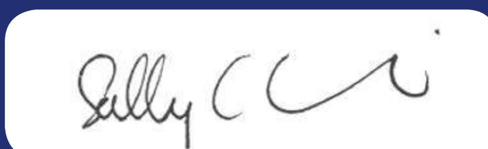
Director of Public Health

Endorsed by

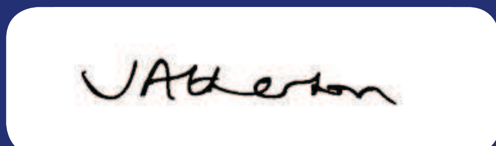
Jane Ellison, Public Health Minister, Department of Health

Duncan Selbie, Chief Executive, Public Health England

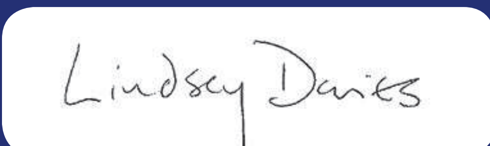
Professor Dame Sally Davies, Chief Medical Officer, Department of Health



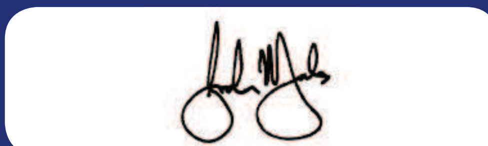
Dr Janet Atherton, President, Association of Directors of Public Health



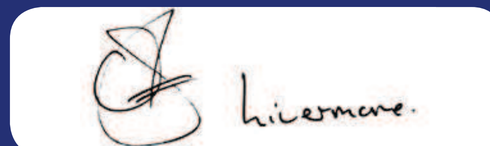
Dr Lindsey Davies, President, UK Faculty of Public Health



Graham Jukes, Chief Executive, Chartered Institute of Environmental Health



Leon Livermore, Chief Executive, Trading Standards Institute



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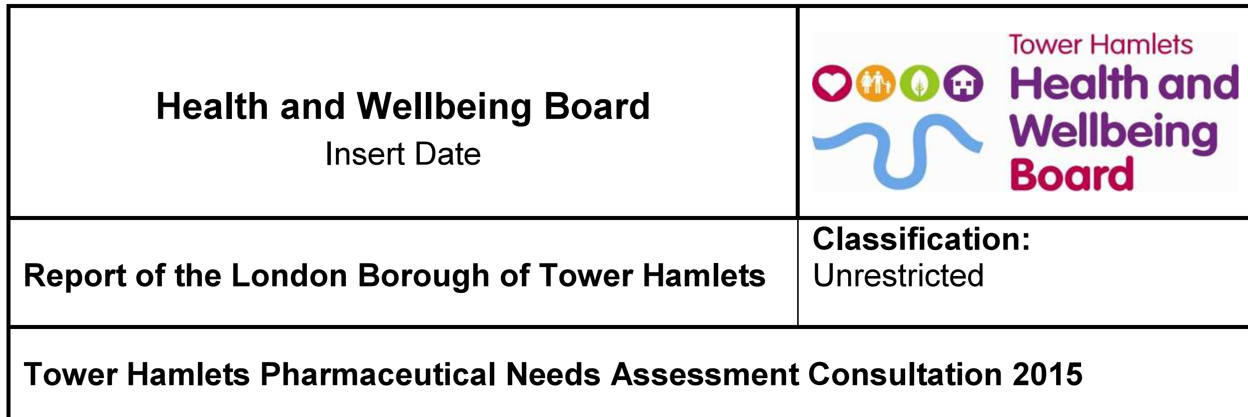

Health and Wellbeing Board Insert Date	
Report of the London Borough of Tower Hamlets	**Classification:** Unrestricted
Tower Hamlets Pharmaceutical Needs Assessment Consultation 2015	

Lead Officer	Somen Banerjee
Contact Officers	Somen Banerjee, Director of Public Health (interim)
Executive Key Decision?	No

Executive Summary

1. Under the Health and Social Care Act 2012, there is a statutory requirement to produce, on behalf of the Board, a Pharmaceutical Needs Assessment (PNA) by March 2015. The PNA examines health needs in the borough, what is currently provided, what people of think of services and how services could be improved in future.

2. The findings of the PNA inform NHS planning of local pharmacy services. Specifically, they are used by NHS England for informing decisions on; applications for new pharmacies, changes in premises for existing pharmacies, and changing services of existing pharmacies.

3. The PNA includes demographic and health data relevant to the need for pharmacy services, an outline of the current pharmacy provision and user views on services. The document was developed in consultation with a stakeholder group with representatives from the Council, Healthwatch, pharmacists, GPs, voluntary sector and NHS commissioners.

4. As discussed at the Health and Wellbeing Board in January, the PNA consultation document was published on 30th January and the consultation will conclude at the end of March. The documentation can be found on the Council website at: http://www.towerhamlets.gov.uk/lgsl/851-900/867_consultation/pharmaceutical_needs.aspx

5. The consultation report has also been distributed widely to the pharmacists in the borough, the Local Pharmaceutical Committee (LPC), Local Medical Committee (LMC), the NHS Tower Hamlets Clinical Commissioning Group,

NHS England, Public Health England and neighbouring borough.

6. The key findings are set out in the Executive Summary of the attached consultation document (p6-8). The overall conclusions were that overall there is sufficient capacity of community pharmacy provision to meet need and no significant gaps were identified. However, the report highlights that population growth will increase need for services that could be met to an extent through increasing staff within existing provision and automating services to increase through throughput. Feedback from users on services was generally positive although some issues were identified around range of services provided, staff training and information provision (these are set out in chapters 7 and 8).

7. The core requirements around content and consultation is set out in DH guidance at https://www.gov.uk/government/publications/pharmaceutical-needs-assessments-information-pack. The consultation document has been developed to meet these requirements and timelines.

Recommendations:

The Health and Wellbeing Board is recommended to:

1. Provide feedback and comments on the consultation document

2. Note that an amended version of the consultation document will be distributed electronically to Board members on the 23rd of March for final comments

1. REASONS FOR THE DECISIONS

1.1 Under the 2012 Social Care Act, there is a statutory requirement to publish a pharmaceutical needs assessment for the borough by the 1st April, 2015

2. ALTERNATIVE OPTIONS

2.1 None

3. DETAILS OF REPORT

3.1 The report is attached

4. COMMENTS OF THE CHIEF FINANCE OFFICER

4.1. There are no direct financial implications as a result of the recommendations in this report.

5. LEGALCOMMENTS

5.1. Section 206 of the Health and Social Care Act 2012 amended section 128A of the National Health Services Act 2006, to transfer the responsibility to the Health and Wellbeing Board for assessing pharmaceutical needs in the Council's area and publishing a Pharmaceutical Needs Assessment in respect of its findings.

5.2. The PNA must comply with the requirements of the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 ('the Regulations'). Regulation 5 requires that the HWB must publish its first PNA by 1 April 2015, thenrevise this every 3 years (Regulation 6).

5.3. Schedule One of the Regulations require the PNA to address existing provision and any gaps in service in respect of pharmaceutical services which are either necessary or could be provided for the purpose of securing improvements to services. An explanation of how the PNA was carried out and a map of service in the Borough are also required.

5.4. Regulation 8 requires the HWB to consult with a number of persons and organisations during the course of the assessment, prior to publishing the PNA, including the Local Pharmaceutical Committee, the Local Medical Committee, dispensing doctors and chemists, NHS Trusts, the Local Healthwatch and neighbouring HWBs. Those consulted must be given at least 60 days to respond to the draft PNA.

5.5. The PNA should have regard to the needs and likely future pharmaceutical needs of the area, taking into consideration the demographics, risks to the health or wellbeing of people in this area, local variations and availability of choice across the Borough (Regulation 9).

5.6. The draft PNA Consultation documents on the Council's website and method of consultation appear to be consistent with the requirements of the Regulations.

5.7. The Equality Act 2010 requires the council in the exercise of its functions to have due regard to the need to avoid discrimination and other unlawful conduct under the Act, the need to promote equality of opportunity and the need to foster good relations between people who share a protected characteristic (including age, disability, maternity and pregnancy) and those who do not. The draft PNA gives due regard to the different needs of individuals in the Council's area who share a protected characteristic.

6. ONE TOWER HAMLETS CONSIDERATIONS

6.1. The report considers health inequalities in the borough and assess the extent to which pharmacy provision meets needs to address these.

7. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

7.1 Limited relevance

8. RISK MANAGEMENT IMPLICATIONS

8.1. The risks to the council are minimal. The report is to support the NHS to make decisions about future provision (although these may well be made in discussion with the council)

9. CRIME AND DISORDER REDUCTION IMPLICATIONS

9.1 Limited relevance

10. EFFICIENCY STATEMENT

10.1 Limited relevance for council

Appendices and Background Documents

Appendices

- Appendices to full report