TOWER HAMLETS HEALTH AND WELLBEING BOARD

Tuesday, 9 December 2014 at 5.00 p.m. Committee Room 1, 1st 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	
Alastair Camp	(Non-Executive Director, Barts Health and Chair of the Integrated Care Board)
Steve Stride	(Chief Executive, Poplar HARCA)
John Wilkins	(Deputy Chief Executive, East London and the Foundation Trust)
Mahdi Alam	(Young Mayor)
James Ross	(Hospital Director at Newham Hospital)
Suzanne Firth	(Tower Hamlets Community Voluntary Sector)

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:
Zoe Folley, Democratic Services
1st Floor, Mulberry Place, Town Hall, 5 Clove Crescent, E14 2BG
Tel: 02073644877
E:mail: zoe.folley@towerhamlets.gov.uk
Web: http://www.towerhamlets.gov.uk/committee

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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.

Public Information

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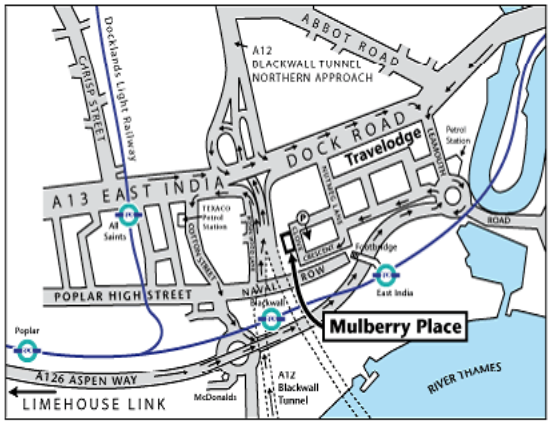

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PAGE NUMBER(S)

1. STANDING ITEMS OF BUSINESS

1 .1 Welcome, Introductions and Apologies for Absence

To receive apologies for absence and subsequently the Chair to welcome those present to the meeting and request introductions.

1 .2 Minutes of the Previous Meeting and Matters Arising **1 - 8**

To confirm as a correct record the minutes of the meeting of the Tower Hamlets Health and Wellbeing Board held on 9th September 2014.

1 .3 Declarations of Disclosable Pecuniary Interests **9 - 12**

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

1 .4 Forward Programme **13 - 14**

Recommendation:

To consider and comment on the Forward Programme.

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

1 .5 Healthwatch Update

Recommendation:

To receive a verbal update.

Lead for Item: Dianne Barham, Director of Healthwatch Tower Hamlets.

ITEMS FOR CONSIDERATION

2. HEALTH AND WELLBEING STRATEGY

2 .1 Health and Wellbeing Strategy Monitoring 2013/14 **15 - 78**

Recommendations:

1. Note the update on performance set out in part 3 of the report and detailed in Appendices 1- 5.

2. Comment on the usefulness of the information and format, as this is the first report of this type, which we can revise for future reports.

3. Indicate any areas of poor performance or delays where more information is requested.

4. Note that the next six monthly monitoring report will be considered

by the Health and Wellbeing Board in January 2015.

Lead for Item: Louise Russell, Service Head, Corporate Strategy & Equality, LBTH.

2 .2 Mental Health Strategy Update **79 - 88**

Recommendation:

Note the progress made in delivering the Tower Hamlets Health & Wellbeing Board Mental Health Strategy

Lead for Item: Richard Fradgley, Lead Commissioner for Mental Health.

2 .3 Transfer of Commissioning Responsibility for early years (0-5 years) Public Health Services from NHS England to the Local Authority **89 - 108**

Recommendation:

Endorse the proposed Stakeholder Engagement process and have an overview of the implementation of the new localised service specification where Public Health will report back periodically to the panel on progress.

Lead for Item: Esther Trenchard-Mabere, Associate Director of Public Health, LBTH

3. BOARD OVERSIGHT

3 .1 Healthwatch Annual Report Patient and User Voice Summary Report Aug 2013 - Sept 2014 **109 - 146**

Recommendations:

1. To note the report

2. Agree to work with Healthwatch to develop a more in-depth understanding of the four key issues outlined in the report.

Lead for Item: Dianne Barham, Director of Healthwatch Tower Hamlets.

3 .2 Tower Hamlets Clinical Commissioning Group Commissioning Intentions **147 - 154**

Recommendations:

1. To note the report

2. To consider how these commissioning intentions can support the delivery of the Health and Wellbeing Strategy.

Lead for Item: Jane Milligan, Chief Officer, Tower Hamlets Clinical Commissioning Group.

3 .3 Safeguarding Adult Board report 2013/14 **155 - 168**

Recommendation:

To consider and comment on the 2013/14 Safeguarding Adult Board annual report

Lead for Item: Brian Parrott Independent Chair of the Safeguarding Adult Board.

3 .4 Tower Hamlets Safeguarding Children Board Annual Report 2013-14 and Business Plan 2014-16 **169 - 238**

Recommendation:

To note the content of the Safeguarding Children Board's(LSCB) Annual Report and consider the LSCB's priorities and business plan for 2014-15 in relation to the work of the HWBB.

Lead for Item: Sarah Baker, Chair Tower Hamlets Safeguarding Children Board (LSCB)

4. OTHER REPORTS

4 .1 Pharmaceutical Needs Assessment-Progress Note and Permission to go to Consultation **239 - 244**

Recommendations:

1. Note the activities in progress in the report

2. Agree the information to be brought to the next meetings of the Board

3. Authorise the Director of Public Health to prepare the consultation draft of the pharmaceutical needs assessment and to commence the consultation.

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

4 .2 Community Plan Refresh Workshop

Recommendations: To receive a verbal update on the Community Plan Refresh

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

5. ANY OTHER BUSINESS

To consider any other business the Chair considers to be urgent.

Date of Next Meeting:
Tuesday, 13 January 2015 at 5.00 p.m. in Committee Room MP702, 7th Floor, Town Hall, Mulberry Place, 5 Clove Crescent, London E14 2BG

LONDON BOROUGH OF TOWER HAMLETS

MINUTES OF THE TOWER HAMLETS HEALTH AND WELLBEING BOARD

HELD AT 5.45 P.M. ON TUESDAY, 9 SEPTEMBER 2014

COMMITTEE ROOM 1, 1ST FLOOR, TOWN HALL, MULBERRY PLACE, TOWN HALL, 5 CLOVE CRESCENT, LONDON, E14 2BG

Members Present:

Councillor Abdul Asad (Vice-Chair)	(Cabinet Member for Health and Adult Services)
Councillor Alibor Choudhury	(Cabinet Member for Resources)
Councillor Mahbub Alam	(Executive Advisor on Adult Social Care)
Councillor Denise Jones	(Non-Executive Councillor)
Robert McCulloch-Graham	(Corporate Director, Education Social Care and Wellbeing, LBTH)
Dr Somen Banerjee	(Interim Director of Public Health, LBTH)
John Wardell (Substitute for Jane Milligan)	(Deputy Chief Officer, Tower Hamlets Clinical Commissioning Group)

Co-opted Members Present:

Alastair Camp	(Non-Executive Director Bart's Health and Chair of the Integrated Care Board)
Steve Stride	(Chief Executive, Poplar HARCA)
Mahdi Alam	(Young Mayor)

Other Councillors Present:

Councillor Danny Hassell
Councillor Andrew Wood

Others Present:

Sarah Baker	(Tower Hamlets Independent Local Safeguarding Children's Board Chair)
Roger Clifton	(Chief Executive Officer, East London Vision)
Neil Kennett-Brown	(Programme Director, Transformational Change NEL Commissioning Support Unit)
Dr. Anna Riddell	(Children's Services Clinical Director, Children's Clinical Academic Group)

Officers in Attendance:

Deborah Cohen	(Service Head, Commissioning and Health, Education, Social Care &

	Wellbeing, LBTH)
David Galpin	(Service Head, Legal Services, Law Probity & Governance, LBTH)
Shazia Hussain	(Service Head Culture, Learning and Leisure, Communities Localities & Culture, LBTH)
Jack Kerr	(Strategy Policy & Performance Officer, LBTH)
Zoe Folley	(Committee Officer, Directorate Law, Probity and Governance, LBTH)

Apologies:

Councillor Gulam Robbani, Dr Sam Everington, Jane Milligan, Sharon Hanooman, John Wilkins and James Ross

COUNCILLOR ABDUL ASAD (CHAIR)

Given the need to consider the Better Care Fund report at this meeting, the Chair decided to adjourn the meeting to obtain a quorum.

In the meantime, those present received an informal presentation from Roger Clifton (Chief Operating Officer of the East London Vision) on the Tower Hamlets Plan for Eye Care.

The meeting reconvened when the meeting was quorate and the formal meeting began.

Change in the order of business.

The Board agreed to change the order of business as follows: Item 2.4, 1.1-1.3, 3.1, 3.2 and 2.5. However for ease of reference, the minutes are set out in agenda order.

1. STANDING ITEMS OF BUSINESS

1.1 Welcome, Introductions and Apologies for Absence

Councillor Asad welcomed everyone to the meeting and invited everyone to introduce themselves.

1.2 Declarations of Disclosable Pecuniary Interests

No interests were declared.

1.3 Minutes of the Previous Meeting and Matters Arising

Resolved:

The minutes of the meeting held on 8th July 2014 be approved as a correct record.

Regarding the Presentation on the Expression of Interest for the co-commissioning of Primary Care Services in Tower Hamlets (item 2.4), John Wardell (Deputy Chief Officer, Tower Hamlets Clinical Commissioning Group) reported that it was expected to receive feedback on the application soon.

He also reported that no feedback had been received on the letter to the Secretary of State about GP services and the Minimum Practice Income Guarantee. However, it was understood that short term support would be made available for GP surgeries readjusting to the changes subject to compliance to a criteria. Mr Wardell stated that the CCG could carry out work to identify how many GP surgeries in TH could meet this criteria and were offering surgeries support to meet the criteria.

1.4 Forward Programme

Item deferred for consideration at the next meeting of the Board in November 2014.

1.5 Healthwatch Update

Item deferred for consideration at the next meeting of the Board in November 2014.

2. HEALTH AND WELLBEING STRATEGY

2.1 Health and Wellbeing Strategy 2013/14 Year End Monitoring Report

Report deferred for consideration at the next meeting of the Board in November 2014.

2.2 Tower Hamlets Plan for Eye Care

Discussed informally before meeting.

2.3 Integrated Care Update

Report deferred for consideration at the next meeting of the Board in November 2014.

2.4 Resubmission of the Better Care Fund Planning Template

Special reasons for urgency.

- The report was unavailable within the standard timescales set out in the Authority's Constitution because of continuing work to review the new NHS criteria for Better Care Fund applications and to finalise the Tower Hamlets Council and CCG submission.

- One of the terms of the Better Care Fund for 2015/16, is the requirement that HWBBs approve for submission to the Department of Health the updated template document which sets out the CCG and Council's joint plans for the application of those monies. The HWBB approved the Local Authority and CCGs BCF Planning Template on the 24th March 2014. However, following on from this the Department of Health and Local Government Association has asked all Local Authorities and CCGs to resubmit their Better Care Fund Planning Templates for 2015/16 with more narrative and detail on the proposed expenditure of the fund. Local Authorities and Clinical Commissioning Groups (CCGs) are now required to resubmit their jointly agreed Better Care Fund Planning Template for 2015-16 to the Local Government Association (LGA) and NHS England by 19th September 2014.

Deborah Cohen (Service Head, Commissioning and Strategy, Education, Social Care and Wellbeing, LBTH) invited the Board to consider the revised Better Care Fund (BCF) Planning template following consideration of the original BCF by the Board on 24th March 2014.

She explained the need for the resubmission of the template to reflect the reinstatement of the 'payment for performance' aspect for emergency admissions. As a result, greater narrative on the budget plans were required. The general thrust was the same as the original BCF plans signed off by the Board in March 2014.

Members were reminded of the aims of the BCF to deliver better integrated services, shared by the NHS and Local Authorities, in community settings for older and disabled people. Members were also advised of the key features of the BCF including the implementation plans.

It was anticipated that in future, a BCF model could be developed for Children's Services. A Member sought clarity about this.

It was noted that steps were being taken to ensure the BCF plans fitted into other health strategies – such as the CCG plans and the transforming lives agenda. John Wardell (Deputy Chief Officer, Tower Hamlets Clinical Commissioning Group) assured Members that the plans fully complied with the government requirements and highlighted the significant amount of

consultation with service users on the plan. He welcomed the true partnership approach to the BCF.

The Chair thanked the Council and the CCG staff for all their work in the BCF initiative and making it a success.

Subject to Mayoral approval

1. That the resubmitted version of the Better Care Fund Planning Template (Appendix 1) be agreed before final submission to NHS England on 19 September 2014

2. That it be noted that the resubmitted Better Care Fund Planning Template does not deviate from the original submission in April, but provides more detail on the agreed budget lines; risk mitigation and outcomes.

2.5 Liver Disease in Tower Hamlets - What are the issues, why does it need to be a priority and what are we doing?

Dr Somen Banerjee, (Interim Director of Public Health, LBTH) presented the report on Liver Disease in Tower Hamlets. He drew attention to the relatively high levels of liver disease in the Borough, based on a needs assessment, and the actions underway to address this. The aims for the future included: to increase awareness of liver disease, reduce incidence and improve early identification of hepatitis eg through immunisation and case finding, better linking of services, such as the drugs and alcohol services with liver disease treatment pathways. The priorities were fully set out in the paper.

In response to questions, the Board heard about the risk factors for liver disease such as diabetes and lifestyle factors. The Board felt that it was important to increase awareness of liver disease and the causes amongst younger people and teenagers given experience. It was suggested that the use of social marketing could help raise awareness amongst young people. The Board also noted the need to raise awareness in schools.

Members also noted the proposed timescale for these plans that reflected the service procurement timescale.

Resolved:

1. That the report and Board comments on the report be noted.

2. That an update be on progress be brought to the Board in 9 months.

3. REGULATORY OVERSIGHT

3.1 Transforming Services, Changing Lives

Neil Kennett-Brown (Programme Director, Transformational Change NEL Commissioning Support Unit) and Dr Anna Riddell (Children's Services Clinical Director Children's Clinical Academic Group Barts Health NHS Trust), presented the progress report on the Transforming Services, Changing Lives initiative.

The Board were reminded of the background to the programme, established by local health care providers to provide the best possible health services for local people. They also explained the drivers for change including: population growth and changes, the need to improve services to meet the challenges and to make better use of technology and resources.

They reminded Members of the continuing work to gain feedback on the plans including engagement with the patient group Health watch. Further consultation was planned. They also explained the key milestones. The interim Case for Change was published in July 2014. It was planned that the final plans would be published in the Autumn. The initiative covered a number of key areas including adolescent services, community services and urgent care. It did not at this stage outline any recommendations for change

With the permission of the Chair, the Board heard from Councillor Andrew Wood. Whilst noting the involvement of patients groups in the process, it was felt that the initiative had moved too quickly and that more effort should be made so that patients were on board.

A Board Member also stressed that the programme was about the benefits of collaboration across the North East London health economy and London as whole. It was not clear that this came across strongly in the public report.

The Chair of the Children's Safeguarding Board stressed the need for the Board to be fully involved in and consulted on the initiative.

It was also reported that LB Newham were considering setting up a joint HWB with other Authorities.

Resolved:

1. That the feedback from the Board be reported to the programme team based on their review of the Interim Case for Change. This will be used in the development of the final case for change, which is due to be published in October.
2. That the requirements and timings for future updates and presentations be agreed about the final Case for Change and any future work programmes.

3.2 Memorandum of Understanding

Deborah Cohen (Service Head, Commissioning and Strategy, Education, Social Care and Wellbeing, LBTH) presented the report on progress with the Memorandum of Understanding (MOU). The MOU was a non legally binding agreement between LBTH, the CCG and Barts Health to reduce equalities in respect of health and social care.

Most of the actions in the MOU had now been completed or superseded by the Better Care Fund. However, there was still a need to focus on the employment aspects in the MOU. These actions (points 5 and 6 in Appendix 1) would be taken forward by the Council's Development and Renewal Directorate.

It was noted that Bart's Health worked closely with the Council in creating local employment opportunities and skills as part of the initiative. (Appendix 3 of the report provided a breakdown of Bart's Health staff at 31st March 2014). Alistair Camp (Non-Executive Director, Barts Health and Chair of the Integrated Care Board) commented on the success of the placement scheme in terms of securing job offers for participants. It remained one of Bart's Health key ways of tackling unemployment.

Resolved:

That the Board note:

1. Progress made on the MOU, contained within the table within this report

2. The need for ongoing working between the Council and Barts Health on employment which exists in a number of different parts of the One Tower Hamlets Partnership but specifically lead by the One Tower Hamlets Prosperous Community theme which drives the work on employment and skills.

3. That the majority of the MOU's actions are being carried forward by existing work programmes connected to the HWBB such as the Better Care Fund, Public Health's Healthy Lives work programme and HWBB's subgroups.

4. The recommendations laid out in the table outlining the original MOU actions.

5. That the work on employment, enterprise and young people's careers be better carried out through the work of the Economic Task Force and that the decision to put in place a new MOU between the Council and Barts Health on skills development and local employment is facilitated by the Councils Economic Development Team.

3.3 Community Plan Refresh - Presentation

Report deferred for consideration at the next meeting of the Board in November 2014.

4. ANY OTHER BUSINESS

4.1 Deborah Cohen (Service Head, Commissioning and Strategy, Education, Social Care and Wellbeing, LBTH) - Last Meeting of the Board.

The Chair reported that this would be the last meeting of the Board that Deborah Cohen (Service Head, Commissioning and Strategy, Education, Social Care and Wellbeing, LBTH) would be attending as she would be leaving the Authority for a position with the NHS. The Board thanked Ms Cohen for all her work for the Board and Tower Hamlets and wished her well for the future.

4.2 Care Act Workshop 22nd September 3pm - 5pm, Jack Dash House, Council Chambers

Noted.

The meeting ended at 7.00 p.m.

Vice Chair,
Tower Hamlets Health and Wellbeing Board

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

	Report Title	Lead Officer	Reason for submission	Time(minutes)
Date: 9th December 2014				
Public Questions	Public Questions			15
Standing Items	Apologies & Substitutions Minutes & Matters Arising Forward Plan			5
Health and Wellbeing Strategy	Health and Wellbeing Strategy Monitoring 2013/14	Louise Russell		5
	Mental Health - Tower Hamlets CAMHS review	Richard Fradgely		20
	MEY - transition of the commissioning of Health Visits	Esther Trenchard-Mabere		25
Board Oversight	Healthwatch update - Annual Report	Dianne Barham		20
	CCG update - commissioning intentions	Jane Milligan		10
	Safeguarding - SAB annual report	Brian Parrott		10
	Safeguarding - LSCB annual report	Sarah Baker		10
For Information only	PNA	Somen Banerjee		
	Community Plan Refresh Workshop	Louise Russell		
Date: 13th January 2015				
	Report Title	**Lead Officer**	**Reason for submission**	**Time**
Public Questions	Public Questions			
Standing Items	Apologies & Substitutions Minutes & Matters Arising Forward Plan			
	Healthwatch Update	Dianne Barham		
Health and Wellbeing Strategy	LTC - Barts Health Cancer Services	Barts Health rep		
	Integrated Care Update - BCF section 75	Dorne Kanareck		
	Refresh of the HWBS delivery Plans	Louise Russell		
Board Oversight	Charter for Homeless Health	Somen Banerjee		
	Winterbourne View update	Bozena Allen		

For Information Only	EOG update	Somen Banerjee		
Date: March 2015				
	Report Title	**Lead Officer**	**Reason for submission**	**Time**
Public Questions	Public Questions			
Standing Items	Apologies & Substitutions Minutes & Matters Arising Forward Plan			
	Healthwatch Update	Dianne Barham		
Health and Wellbeing Strategy				
Board Oversight	The Local Account 2013/14	Robert McCulloch Graham		
For Information Only	EOG update	Somen Banerjee		

Health and Wellbeing Board 9 September 2014	Tower Hamlets Health and Wellbeing Board
Report of the London Borough of Tower Hamlets	**Classification:** [Unrestricted]
Health and Wellbeing Strategy 2013/14 Year End Monitoring Report	

Lead Officer	Louise Russell, Service Head Corporate Strategy and Equality
Contact Officers	Louise Fleming, Strategy, Policy and Performance Officer
Executive Key Decision?	No

Executive Summary

The Health and Wellbeing Board agreed that it would review progress against the Health and Wellbeing strategy delivery plans on a six monthly basis. This paper provides an update on delivery for the six month period ending 31st March 2014. Detailed performance information is set out in part 3 of the report.

Recommendations:

The Health and Wellbeing Board is recommended to:

1. Note the update on performance set out in part 3 of the report and detailed in Appendices 1- 5;

2. Comment on the usefulness of the information and format, as this is the first report of this type, which we can revise for future reports;

3. Indicate any areas of poor performance or delays where more information is requested.

4. Note that the next six monthly monitoring report will be considered by the Health and Wellbeing Board in January 2015.

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1. REASONS FOR THE DECISIONS

1.1 Good practice requires that regular reports be submitted to the Health and Wellbeing Board setting out the performance of the NHS and the Council, both commissioners and providers, against targets.

1.2 The regular reporting of the Health and Wellbeing Strategy monitoring should assist in ensuring that Members are able to scrutinise decisions of officers and health partners.

2. ALTERNATIVE OPTIONS

2.1 The Council reports performance against the actions in the Health and Wellbeing Strategy delivery plans and the outcome measures. Significant areas of success and underperformance, with corrective action taken, are reported in the body of the report and the appendices attached. No alternative options are proposed, and this report is produced to ensure that Members are kept informed about actions taken within the remit of the Strategy.

3. DETAILS OF REPORT

3.1 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.

3.2 Following the production of the strategy, agreed by the shadow Health & Wellbeing Board in June 2013, a delivery plan was developed to work towards the objectives of the strategy. This delivery plan also identified outcome measures that, in conjunction with the associated baseline data and targets, will enable progress against the aims of the strategy to be measured.

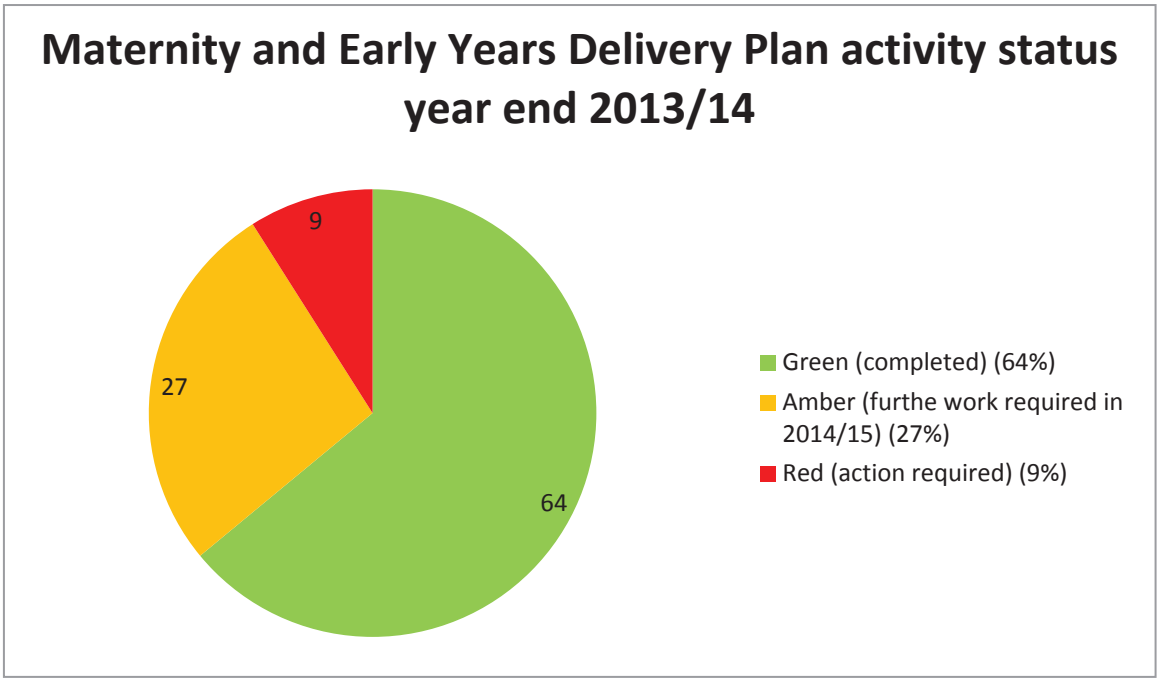
3.3 There are current delivery plans for all four priorities:

- Maternity and Early Years (although this is due for review)
- Healthy lives
- Mental Health (this was developed mid-year with the Strategy, therefore there is less monitoring information available at this year end point)
- Long term conditions and cancer

Maternity and Early Years

3.4 The delivery plan for Maternity & Early Years has been rationalised following a decision by the delivery groups for the Children and Families Plan to shorten and rationalise their draft plans and ensure they focused on areas that added value in relation to the wider partnership. Although the Maternity and Early Years delivery plan is being revised, it was agreed at the meeting of the Health and Wellbeing Strategy Sub-Group on 16th July that the activities in the current version of the delivery plan would be monitored. The delivery plan is attached at Appendix 1 and the key points are summarised below. It should be noted that the 13/14 outturn column has been amended to read 12/13 as this is the most recent data available from Public Health England.

3.5 There are 11 milestones in the current version of the delivery plan. Of those, 7 are rated Green (completed) (64%), 3 are rated Amber (completed in part but work still ongoing into 2014/15) (27%). One milestone is rated Red (action required) (9%).



3.6 The milestone rated **Red** (further action required) relates to the Child Injury Prevention action:

- **Review data on main causes of child injury presenting at A&E –** Data has not been made available from A&E. Officers will continue to try and obtain up to date figures to review.

3.7 A report on performance of Maternity and Early Years was presented to the Health and Wellbeing Board in July and the key points are set out below:

3.8 The proportion of children achieving a good level of school readiness at the end of reception is significantly lower in Tower Hamlets compared to England although when the comparison is between children in Tower Hamlets and England eligible for free school meals, our children do significantly better.

3.9 Other public health outcome indicators where Tower Hamlets is significantly worse than London and England are:

- Low birth weight of term babies – this may increase the risk of child obesity and diabetes and cardiovascular disease later in life
- Dental decay (5 year olds) – this has been highlighted as an area that requires more attention
- Excess weight in 10-11 year olds – this is one of the current priorities for action
- HPV vaccination (12-13 year olds) – this will be monitored to ensure that performance improves

3.10 The Maternity, Early Years and Childhood Commissioning and Delivery Group of the Children and Families Partnership Board is currently responsibly for taking forward the Maternity and Early Years priority of the Health and Wellbeing Strategy and is currently focussing on the following health priorities:

- Maternal and Infant Emotional Health and Wellbeing,
- Two Year Development Review
- Child Obesity

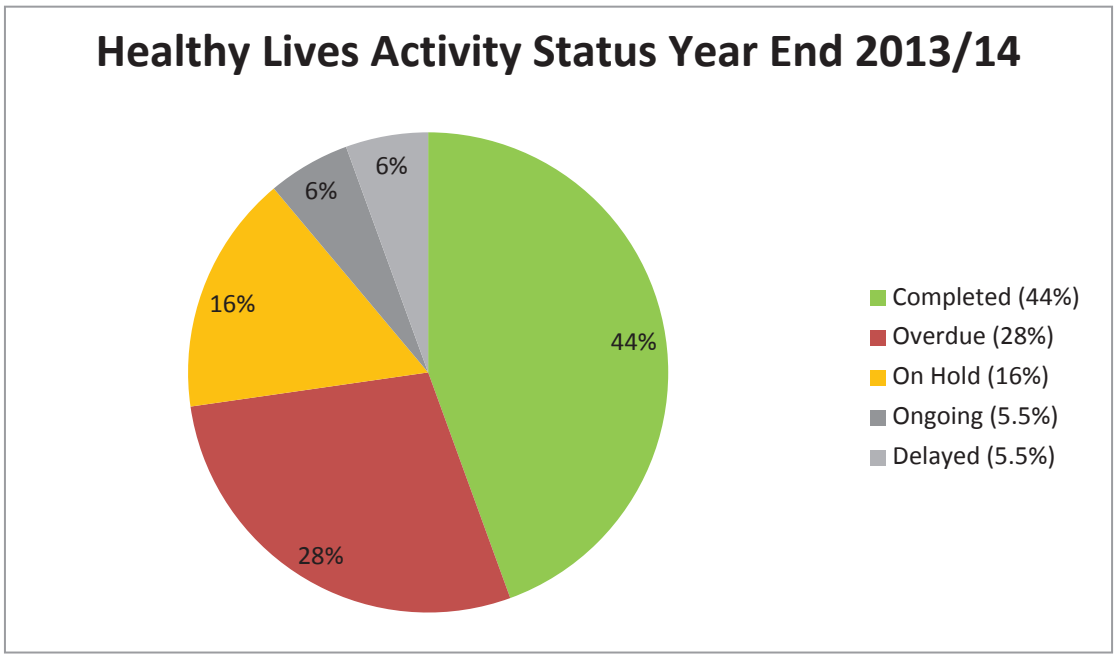
<u>Healthy lives</u>

3.11 All activities within the Healthy Lives delivery plan have been monitored and are included in Appendix 2. The following criteria are used to report on the status of activities at year end:

- Completed (Green)
- Overdue (Red) - where an activity has not completed in the 2013/14 financial year, or at the time of reporting. Where possible, managers have provided comments for all overdue activities to explain why the deadline was missed; what is being done to rectify the situation; and when the activity will be completed.

This section provides a monitoring update at year-end for the 2013/14 Plan.

3.12 There are 18 activities in the delivery plan. At year-end, just under half - 8 activities (44%) have been completed; and 5 (28%) are overdue, with most of these due to complete in 2014/15. 3 activities are On Hold (17%), 1 activity is Ongoing (5.5%) and 1 activity is delayed.



3.13 When the performance was monitored in Q2, there had been good progress and a number of activities/milestones were completed ahead of their deadline:

- A restriction on new hot food takeaways near schools and leisure centres which is now operating successfully;
- The development and implementation of a clear action plan for the borough in order to reduce the amount of illicit tobacco (counterfeit and contraband) available to young people, including regular meetings with trading standards and supporting pan-London /national campaigns and initiatives;
- Updating the Health & Wellbeing Board (via DAAT Board) on the Substance Misuse Action Plan;
- Considering the DAAT communications plan at the DAAT Board/HWB/CSP for agreement and to ensure that the proposal is championed;
- Integrating health impact into the Council licensing policy resulting in a pilot running in the Brick Lane area;
- Delivering a sexual health needs assessment and implementation plan for vulnerable groups.

3.14 In addition to the above, at year end:

- There has been good progress with reducing the use of smokeless tobacco through a programme of activity with Trading Standards.
- Cabinet agreement is currently being sought to extend the current Substance Misuse Strategy Action Plan.
- There is a consistent approach across the Partnership to the messages around harms caused by misuse of drugs and alcohol.

- An integrated approach to lifecourse treatment, recovery and reintegration in substance misuse has been championed.
- The Sexual Health workstream of the Healthy Lives Strategy has been implemented.

3.15 Of the 5 activities assessed as being **Overdue**, only 2 of these are less than 75% complete and are as follows:

- Outcome Objective 2: Reduce prevalence of tobacco use in Tower Hamlets
    - **Review and refresh approach to reducing tobacco uptake in adolescents and young people (63% complete)** – To be completed by the end of August as part of the Service Challenge.
- Outcome Objective 3 and 4: Reduced levels of harmful or hazardous drinking/reduced rates of drug use (PH framework)
    - **Embed screening and brief intervention around drugs and alcohol into front-line services (beyond A&E) (66% complete)** – This is to be carried over into 2014/15.

3.16 Three activities have been placed **'on hold'**, (shaded grey in the appendix). These relate to

- The **refresh of the Healthy Weight, Healthy Lives workstream** and related **engagement**.
- The **refresh and implement the Tobacco Control workstream of the Healthy Lives Strategy**.

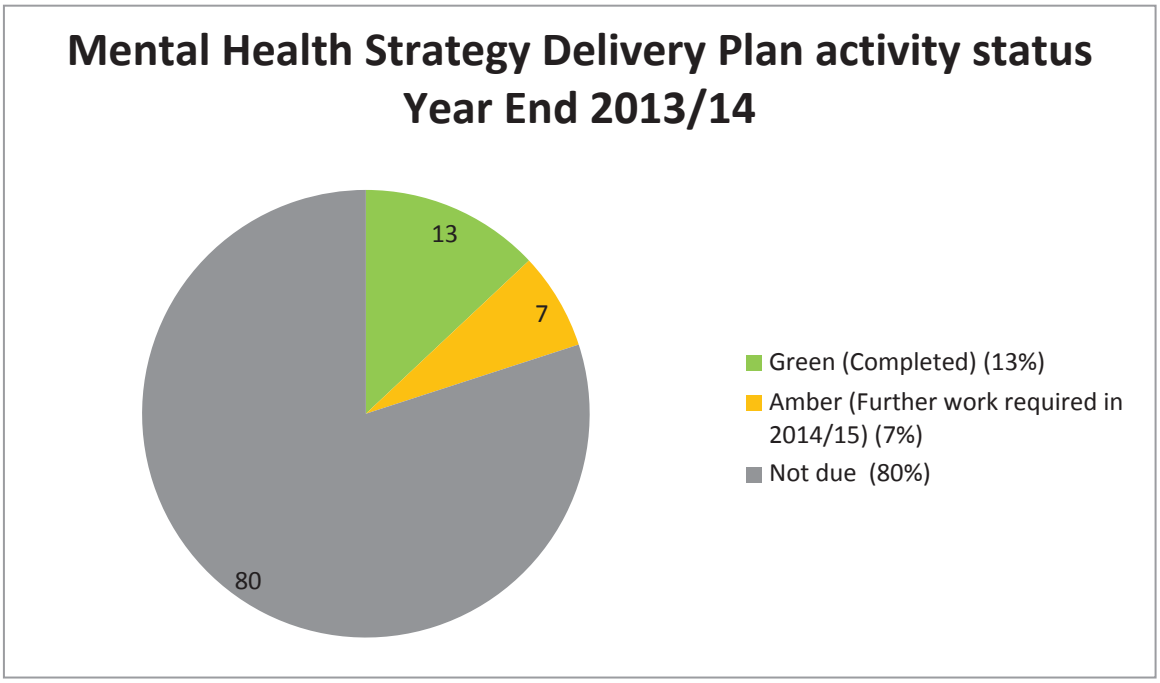
This is due to the workstreams needing to be integrated into the wider Healthy Lives Strategy, which is due to be launched in November 2014.

3.17 One activity is **ongoing**, relating to **the monitoring of the Local Development Framework and impact.** The Core Strategy and Managing Development document which contains a new policy approach to managing the overconcentration of A5 uses was approved by full Council in April 2014. There is ongoing delivery of TfL LIP and cycle schemes; and discussions to secure funding streams relation to access to open spaces.

Mental Health

3.18 The delivery plan for Mental Health has been developed as part of the wider Mental Health Strategy which was agreed by the Shadow Health and Wellbeing Board in February 2014. It was agreed that the Mental Health Strategy would be subject to separate, but linked, monitoring. The delivery plan is attached at Appendix 3.

3.19 There are 68 actions in the delivery plan. Of those, 54 (80%) are not reportable due to them not being due for completion yet. Of the 14 which are reportable, 9 are rated Green (complete) (13%) and 5 are rated as Amber (further work required in 2014/15) (7%).



3.20 Some good progress has been made as follows:

- A review of talking therapy pathways is underway.
- A review of rehabilitation pathways is underway.
- A review of demand, capacity and quality in residential, nursing and continuing care for people with dementia is underway, and will report in August
- Suppliers have been selected to develop a new information portal on mental health for the borough
- Work is about to commence to refresh the service model for Tier 2 and Tier 3 CAMHS
- 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.
- The Police and London Ambulance Service attended a concordat event and an action plan will be presented to the Health and Wellbeing Board in the Autumn to ensure to ensure there is a strategic overview of mental health crises in the Borough.
- GP training has been delivered on dementia, the Mental Capacity Act and learning disability.

3.21 Action rated as **Amber**, therefore requiring further work in 2014/15 include:

- Continuing to remodel rehabilitation and resettlement pathways.
- Continuing to develop primary care mental health services following additional capacity resources by the CCG.
- The development of a refreshed commissioning plan for people with a learning disability and mental health problems has been subsumed in the respecification of the Learning Disability Service.

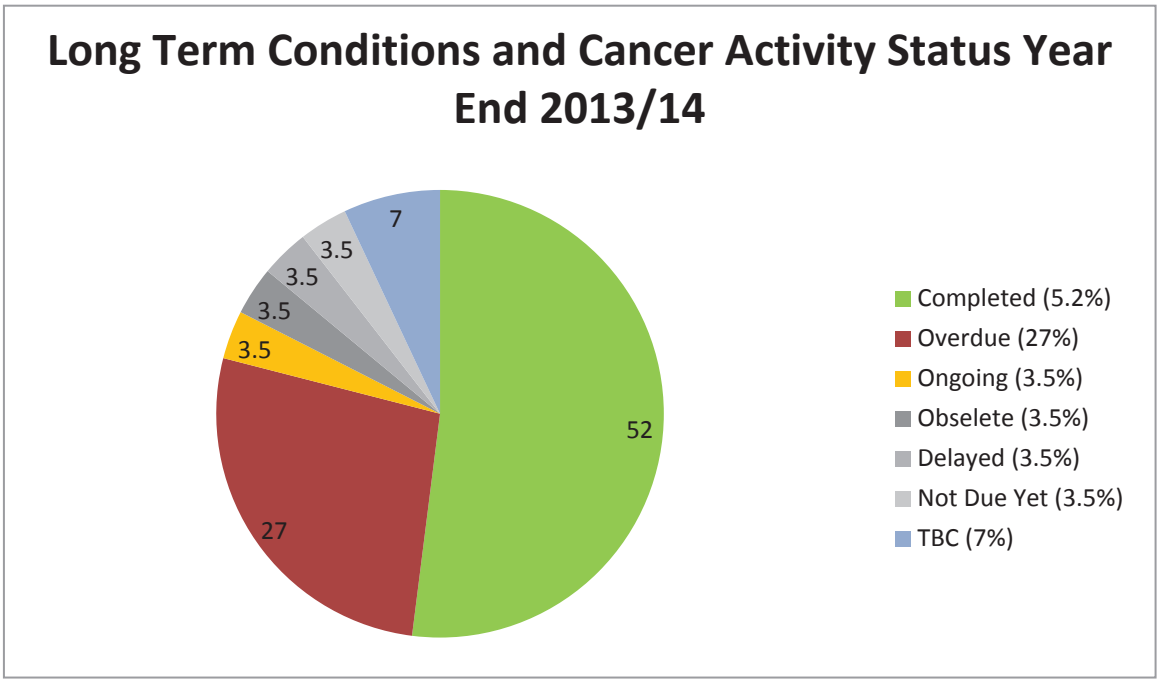
Long Term Conditions and Cancer

3.22 All activities within the Long Term Conditions and Cancer delivery plan have been monitored and are included in Appendix 4. The following criteria are used to report on the status of activities at year end:

- Completed (Green)
- Overdue (Red) - where an activity has not completed in the 2013/14 financial year, or at the time of reporting. Where possible, managers have provided comments for all overdue activities to explain why the deadline was missed; what is being done to rectify the situation; and when the activity will be completed.

This section provides a monitoring update at year-end for the 2013/14 Plan.

3.23 There are 29 activities in the delivery plan. At year-end, just over half - 15 activities (52%) have been completed; and 8 (27%) are overdue, with most of these due to complete in 2014/15. 1 activity is Delayed (3.5%), 1 activity is Not Due Yet, 1 activity is Ongoing and 1 activity is now obsolete. 2 activities are TBC (7%), as they are still to be set by the Health and Wellbeing Strategy Sub-Group and therefore no data is available.



3.24 When the performance was monitored in Q2 the following milestones were completed ahead of their deadline:

- Completing reviews of hypertension and COPD care packages;
- Review of whole system care pathways for childhood asthma and current provision and needs for adults' asthma; and
- Commissioning community organisations to engage directly with at least 2,800 local people in target groups to increase awareness cancer.

3.25 In addition to the above, at year end

- NHS Health Checks are being carried out to detect onset of cardiovascular diseases to appropriately refer onto care packages.
- Diabetes care planning is being reviewed on an ongoing basis as part of a continuous commissioning cycle.
- 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.
- "Small c campaign" performing well. 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.

3.26 Of the 9 activities assessed as being **Overdue**, 5 of these are less than 75% complete and are as follows:

- Outcome Objective 1: Reduced prevalence of the major 'killers' and increased life expectancy
    - **Early Identification through:**
      • increasing the uptake of breast, bowel and cervical screening using targeted outreach, primary care endorsement, improved practice systems
      • increasing public awareness of cancer and the need to report symptoms without delay through the small c campaign (73% complete) - The first part of this is an NHS England responsibility; Public Health has an assurance role. The small c campaign continuing, four contracts in place to deliver messages with local communities. These are all performing well to date. Evidence shows more people with early stage lung cancer had life-saving surgery at the Royal London Hospital, from 52 per

cent of early stage lung cancers in 2010 up to 68 per cent in 2012. The campaign also contributed to a reduction in the proportion of women in Tower Hamlets with late stage breast cancer, dropping from 13 per cent of all breast cancer cases to 9 per cent in 2012. Progress is being monitored on an ongoing basis by Public Health.

- Outcome Objective 2: Improved patient experience and co-ordination of health, housing and social care for those with single or multiple long term conditions
    - **Develop an integrated community health and social care contact point (Referral hub in health and First Response) (50% complete)** - Single point of access (SPA) started on 1st November for health related queries. Year two will look more at a move towards integrating health and social care SPA.
    - **Implement an integrated advanced care plan and record for patients that sit across health and social care (50% complete)** - An Integrated Care information sharing agreement is being developed. The Orion portal will provide a shared care record, but social care information is still outstanding.
    - **Engender a cultural shift that "normalises" death in the community and supports advanced care planning (20% complete)** – To be reviewed in 2014/15 by the CCG.
    - **Review current programmes that support preferred place of death and produce analysis of what works and what doesn't work (50% complete)** - There are significant issues with how this information is recorded and is variable across providers. Place of death is often recorded, but not if this was "preferred". Anticipatory Care Planning (under Integrated Care Programme) will mean in future this is recorded. Should be in place by April 2015.

3.27 One activity is **ongoing**, relating to **cancer waiting times, improvement against the 62 day wait standard.** Although not technically overdue, it is not producing the target outcomes and further work is needed in 2014/15.

3.28 One activity is **delayed**, relating to **Improving housing options for people with learning disabilities in Tower Hamlets.** This is due to the readjustment of two milestones following a review by the Learning Disabilities Partnership Board.

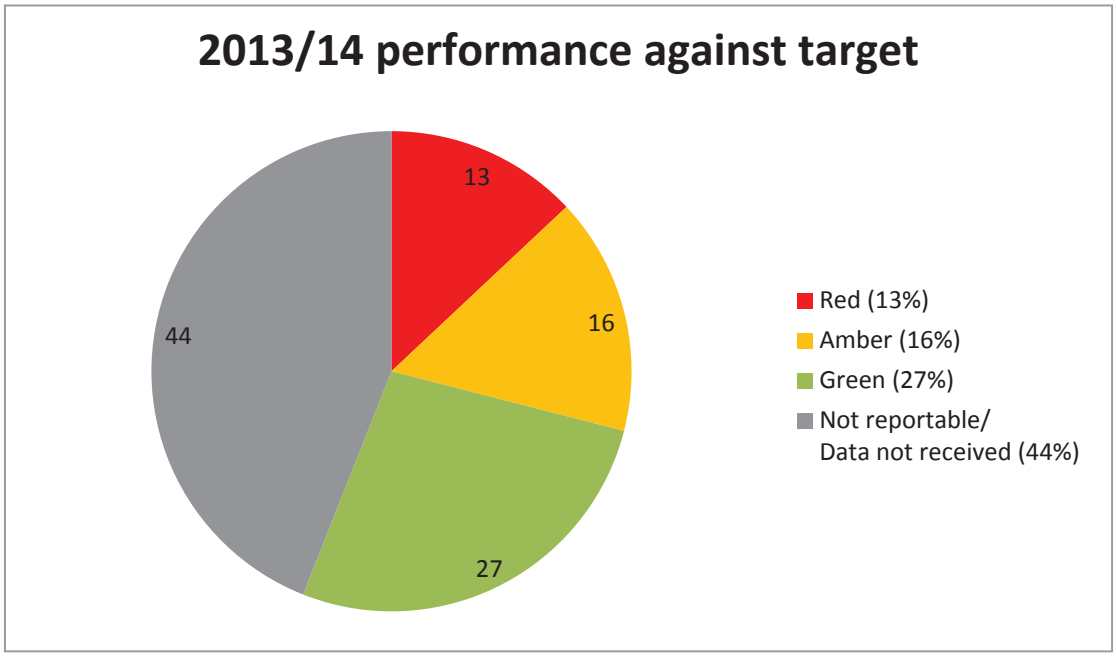
3.29 One activity is now **obsolete** (shaded grey in the appendix). The activities marked as obsolete relate to the establishment of a forum, jointly chaired with health and social care, to **develop an integrated approach to**

commissioning the older persons pathway. However, given developments with the Integrated Community Health Team and Integration Transformation Fund, these activities are now considered obsolete.

Measures

3.30 The outcome measures which are drawn from national outcome frameworks are used to monitor progress and report on an annual basis. The current position is attached at Appendix 4. Performance against target is measured as either 'Red', 'Amber' or 'Green' (RAG). Performance which has fallen more than 10% below the target is marked as Red. Performance which is less than 10% of the target is marked as Amber. Performance which has exceeded the target is marked as Green. As this is the first year of monitoring it is not possible to provide a direction of travel, however this will be provided in the next round of performance monitoring. London and national comparisons will be reported at a later date as information becomes available.

3.31 Of the 48 measures in the Health and Wellbeing Plan, only 27 are reportable due to either data being awaited from Public Health England; or some data not being available until later in 2014. 13 measures (27%) exceeded their target (Green); 8 (16%) were less than 10% below the target (Amber); and 6 were more than 10% below the target (13%) (Red).



A summary of the key points is as follows.

3.32 The Borough has performed well against the 2013/14 targets in respect of the **percentage of women who smoke during pregnancy** (3% against a target of 3.5%).

3.33 Tower Hamlets **rate for teenage pregnancy** is now lower than both London and England (24.3 per 1000 15-17 year olds, compared to 25.9/1000 and 27.7/1000 respectively).

3.34 The Public Health Outcomes Framework (PHOF) data relating to the **Proportion of babies born with low birth weight (<2.5kg)** indicated that the proportion is well below the target figure, so this target needs to be revised for 2014/15 (4.1% compared to a target of 9%).

3.35 The indicator relating to **Rate of deaths from causes considered preventable of persons under 75** is now **obsolete**. It should now read **Potential Years of Life Lost**. THCCG performance is 2848.2, with an operating plan target for 2018/19 of 2381.2.

3.36 There are three indicators which have been marked as Red. Although the most up to date data has been provided, it is data from 2012. It reads as if the 2013/14 targets have been missed, when there will not be a conclusive answer to this until 2015 at the earliest. They are as follows:

- **Rate of deaths from causes considered preventable of persons under 75** – 107.5 against a target of 81.4
- **Rate of deaths from all cardiovascular diseases (including heart disease and stroke) of persons under 75** – 150.2 against a target of 124
- **Rate of deaths from respiratory disease of persons under 75** – 40.6 against a target of 32.2.

4. COMMENTS OF THE CHIEF FINANCE OFFICER

4.1. This report provides an update on the progress against the Health and Wellbeing Strategy delivery plans for the six months to 31st March 2014, there are no direct financial implications as a result of this report.

5. LEGAL COMMENTS

5.1. This report provides an update on the progress against the Health and Wellbeing Strategy delivery plans for the six months to 31st March 2014. There are no immediate legal implications arising from this report. The recommendations for the HWB 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 and the joint strategic needs assessment, and fall within the functions of the HWB as set out in its Terms of Reference.

6. ONE TOWER HAMLETS CONSIDERATIONS

6.1. The Health and Wellbeing Strategy delivery plan and indicators are focussed on meeting the health needs of the diverse communities living in Tower Hamlets and supporting the delivery of One Tower Hamlets, in particular reducing health inequality in the Borough.

7. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

7.1 There are no specific environmental implications.

8. RISK MANAGEMENT IMPLICATIONS

8.1. In line with the Council's risk management strategy, the information contained within the delivery plans and outcome measures will assist the Health and Wellbeing Board and relevant service managers in delivering the ambitious targets set out in the Health and Wellbeing Strategy. Regular biannual monitoring reports will enable Members, officers and Health partners to keep progress under review.

9. CRIME AND DISORDER REDUCTION IMPLICATIONS

9.1 There are no specific crime and disorder implications.

Appendices and Background Documents

Appendices

Appendix 1 – Maternity and Early Years Delivery Plan Delivery Plan
Appendix 2 – Healthy Lives Delivery Plan
Appendix 3 – Mental Health Strategy Delivery Plan
Appendix 4 – Long Term Conditions and Cancer Delivery Plan
Appendix 5 – Health and Wellbeing Strategy Outcome Measures

Background Documents

- NONE

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Health and Wellbeing Strategy and Children & Families Plan: Maternity and Early Years Delivery Plan

Priority: Maternity and Early Years					
Outcome Objective 1: Good and improving maternal health – including good mental health, maternal nutrition, decreasing maternal obesity, diabetes and numbers smoking at time of delivery					
Proposed outcome measures					
Measure	**Baseline 2011/12**	**Target 2013/14**	**2014/15**	**2012/13 Outturn**	**Comments**
Proportion of women who smoke during pregnancy	3.9% (2011/12)	3.5%	3.5%[1]	3.0%	Risk that smoking rates in pregnancy rates could increase as a consequence of demographic changes.
Proportion of women who are obese during pregnancy (BMI > 30)	12.3% (July-November 2012)	12%	12%[2]		Data not currently available
Need to define new measure for maternal mental health					Work underway with UCL partners to develop quality outcome indicators for Health Visitors on maternal emotional health and wellbeing and maternal/infant attachment
Outcome Objective 2: Maintain reduction in under 18 conceptions and support teenage parents					
Proposed outcome measures					
Measure	**Baseline 2011/12**	**Target 2013/14**	**2014/15**	**2012/13 Outturn**	**Comments**

[1] Tower Hamlets' performance on this measure is currently one of the lowest in the country. Projected demographic changes suggest there will be an increase in the numbers of women who are more likely to smoke. Maintaining a reduced outturn is considered to be a sufficiently challenging target.
[2] As with other targets around obesity, this has been set in the context of a general upward trend

Teenage pregnancy rate	28.5 conceptions per 1,000 women aged 15-17 years (2011)	27.5 conceptions per 1,000 women aged 15-17 years	26.5 conceptions per 1,000 women aged 15-17 years	24.3 conception per 1,000 girls 15-17 years	The latest ONS conception statistics for 2012 show continual local progress in reducing teenage pregnancies since start of the national teenage pregnancy strategy. The under-18 conception rate has fallen by 58.0% since 1998, down from 57.8 conceptions per 1,000, compared with a national decrease of 40.6% and London decrease of 49.3%. Tower Hamlets rate is lower than England (27.7/1000) and London (25.9/1000). Family Nurse Partnership provides intensive support for first time teenage parents that will significantly improve life chances of the children.
Action/strategy/programme to deliver	**Lead (and key partners)**	**Milestones**	**Timescale**	**RAG**	**Comments**
***Maternal and infant mental health*:** develop partnerships across health, children's centres and community organisations to support maternal mental health and wellbeing and secure attachment with the baby during the first year of life	• **Public Health** (Kelley Webb-Martin/Vivienne Cencora, Esther Trenchard-Mabere) • **CCG** (Judith Littlejohns/Emma	Review and the ante and post natal depression pathway and identify gaps and opportunities	October	G	Multi-agency steering group convened and has met twice (October 2013, March 2014) Mapping complete, using framework from 1001 Critical Days (Cross Party Manifesto, Wave Trust and NSPCC)
		Convene wider multi-agency meeting/worksh	November	G	Multi-agency workshop held on 15th January 2014

	Radcliffe/Catherine Platt) • **Perinatal mental health service** (lead TBC) • **Compass** / Primary Care Mental Health service) Lucy Marks • **Children's Centres** (TBC) • **Parent and Carers Council** (Jill McGinley) • **Gateway Midwifery team, Barts Health** (TBC) • **Voluntary sector** (Alex Nelson/Pip Pinhorn) • **Family Nurse Partnership** (Anne Lynch) • **Health Visiting Service, Barts Health** (Rita	op to scope work across children's centres, voluntary sector and health			
		Develop proposal to strengthen 'Universal' elements of support for maternal and infant emotional health and wellbeing plus pilot support package for pregnant women and parents/carers of infants identified to be 'at risk'	December	A	Second multi-agency workshop held on 22nd July 2014 to consult on proposed model to strengthen 'Universal' elements of support for maternal and infant emotional health and wellbeing. Outline proposal has been agreed (training for community organisations/volunteers and health professionals plus supervision and support networks).
		Secure funding / commission pilot intervention	January	A	Some funding for 2014/15 has been identified from the public health grant. Ongoing funding (initially for 2015-17) still to be confirmed. Exploring opportunities to bid for external / match funding

	Wallace)	Agree and implement action plan for strengthening 'Universal' elements of support for maternal and infant emotional health and wellbeing		G	Action Plan agreed at steering group meeting 3rd June

Ensure that on-going partnership work is maintained and supported, including:

- Refresh of action plan for Maternity and Early Years Health Improvement Group
- Improve pre-conceptual advice for women with diabetes or a history of GDM
- Identify all pregnant women with BMI > 30 at booking and ensure appropriate advice and referral
- Identify smoking status of all women at booking and refer smokers for specialist support
- Improve data available on maternal health outcomes including mental health
- Enhance health education for young people and women of child bearing age including sex and relationships education, pre-conceptual care (including folic acid) and factors affecting maternal and newborn health, how to access antenatal care
- Improve uptake of Healthy Start Vitamins
- Review care pathway and raise awareness of female genital mutilation (FGM) and its impact on maternal health
- Ensure that all children and young people have access to high quality and appropriate SRE in schools and/or alternative settings
- Ensure vulnerable young mothers have access to support from the Family Nurse Partnership by improving timeliness of referral and links to other services

Priority: Maternity and Early Years					
Outcome Objective 3: Early detection and treatment of disability and illness and ensure that children achieve positive physical, cognitive and emotional development milestones					
Proposed outcome measures					
Measure	**Baseline 2011/12**	**Target 2013/14**	**2014/15**	**2012/13 Outturn**	**Comments**
Child development at 2-2.5 years (Indicator to be confirmed)	TBC	TBC	TBC		Not yet available
School readiness (Reception), 2012/13				45.9%	While the proportion of children achieving a good level of school readiness at the end of reception in Tower Hamlets is significantly worse than the national average (51.7%), this reflects the high levels of child poverty. When the comparison is with children entitled to free school meals Tower Hamlets children do significantly better than average (36.2%). Improving school readiness in Tower Hamlets remains a priority
School readiness, pupils entitled to free school meals (Reception) 2012/13				42.6%	
Outcome Objective 4: Maintain low infant mortality rates and promote good health in infancy and early years					
Proposed outcome measures					
Measure	**Baseline 2011/12**	**Target 2013/14**	**2014/15**	**2012/13 Outturn**	**Comments**

Rate of infant mortality (children who die before reaching their first birthday)	5.3/1000 live births (2009-11)	5.0/1000 live births (2010-12)	4.8/1000 live births (2011-13)	4.98 (2009/11 TBC)	Infant mortality in TH was previously lower than average for London and England. There has been a recent increase but small numbers mean that it is hard to interpret. This is being monitored to see if it is becoming a trend.
Proportion of babies born with low birth weight (<2.5kg)	9.2% (2011)	9%	8.8%	4.1% (2011) (term babies)	Note that Public Health Outcomes Framework (PHOF) data indicated that the proportion is well below the target figure, so we need to relook at this target for 2014/15. This data needs checking it looks wrong
Proportion of women who smoke during pregnancy	3.9%	3.5%	3.5%	3.0%	See earlier comment.
Proportion of mothers who breastfeed at birth	88.35%	88.5%	89%	86.8%	Barts Health maternity service recently reassessed for UNICEF BFI reaccreditation which has now been confirmed with areas for monitoring including ensuring recording of reason when infant formula provided and ensuring that midwives on night shifts are able to provide advice and support on breastfeeding
Proportion of mothers who are breastfeeding at 6-8	71.1%	71.5%	72%	71.1% (2011/12)	Community services (Health Visitors and Children's Centres)

weeks					successfully achieved BFI re-accreditation and the Breastfeeding Support Service was commended. Despite high total breastfeeding rates we have low exclusive breastfeeding rates and recent local research has highlighted the role of the extended family: grandmothers and mothers in law in influencing infant feeding practices. The recommendations are being discussed with services.
Proportion of babies who receive the MMR vaccination when they are two years old	93.9%	95%	95%	93.8%	Coverage of the child immunisation programme remains high, it is important to maintain a focus on this programme to ensure that coverage does not drop.
Action/strategy/programme to deliver	**Lead**	**Milestones**	**Timescale**	**RAG**	
***Two year development review*:** building on the 2/2.5 year healthy child development review (health visiting) develop and strengthen partnerships across health, children's centres, nurseries and community organisations to	**Learning and Achievement** (Monika Forty) **Health Visiting Service**, Barts Health (Rita Wallace) **Public Health** (Kelley Webb-	Review current referral pathways and partnerships supporting the 2/2.5 year healthy child development review	December	G	Workshop held December 2013

promote children's physical, social, emotional and cognitive development	Martin/Vivienne Cencora, Esther Trenchard-Mabere) **Voluntary sector** (Alex Nelson/Pip Pinhorn) **Children's Centres** (TBC)	Identify opportunities for wider join up to ensure that children at risk of impaired physical, social, emotional and cognitive development are identified and supported		G	Public health strategist now attending integrated 2 year review steering group (includes representatives from health, learning and achievement and children's centres. Next meeting 3rd June 2014

Ensure that on-going partnership work is maintained and supported, including:

- Full implementation of the Healthy Child (0-5) programme including neonatal examination, new baby review, 6-8 week check, 1 year check and 2 year check
- Maintain and improve quality of antenatal and newborn screening programmes to ensure early detection of preventable conditions
- Analysis of impact of consanguinity on prevalence of disability (and mortality) in affected communities and agree action as appropriate
- Review and strengthen the early years care pathway for child disability
- Deliver an effective Smoke Free Homes and cars programme in Tower Hamlets
- Undertake an intergenerational study on the factors influencing partial breastfeeding rates
- Develop and implement communications plan to raise awareness amongst health professionals, parents and the wider public of key risks identified by the Child Death Overview Panel, including: risks of co-sleeping and how to identify a seriously sick child and when to call emergency services
- Reduce A&E attendance and emergency admissions due to unintentional and deliberate injuries amongst 0--5 year olds
- Improving exclusive breastfeeding initiation and maintenance
- Promote uptake of Healthy Start Vitamins amongst eligible 0-4 year olds
- Maintain good immunisation coverage at 1 year (and at 5 years)
- Improve access to advice and support on healthy weaning practices through Children's Centres and other services

Priority: Maternity and Early Years					
Outcome Objective 5: Decreasing levels of obese and overweight children in reception year, provide more opportunities for active play and healthy eating.					
Proposed outcome measures					
Measure	**Baseline 2011/12**	**Target 2013/14**	**2014/15**	**2012/13 Outturn**	**Comments**
Proportion of children in Reception who are overweight[3]	10.8%	10.8%	10.8%	10.9%	Small, not significant, increase in proportion of overweight
Proportion of children in Reception who are obese[4]	13.1%	13.1%	13.1%	12.7%	Levels of obesity have been decreasing since 2006/07 although for the last 3 years this seems to have plateaued 2012/13 figure is same as for 2010/11 (with slight increase in 2011/12)
Proportion of children in Reception who are overweight or obese	23.9%			23.6%	National monitoring is now of the combined figure for overweight and obese
Outcome Objective 6: Reduce dental decay in 5 year olds					
Proposed outcome measures					
Measure	**Baseline 2011/12**	**Target 2013/14**	**2014/15**	**2012 Outturn**	

[3] Given the national trend of increasing proportion of overweight and obese children, the goal is to prevent any further increase as a first step to reducing levels of overweight and obese children locally.
[4] As above

Proportion of children under 5 with tooth decay	39.1% (2007/08)[5]	30.0% (2011/12)	28% (2013/14)	45.9%	Following improvements and a narrowing of the gap between Tower Hamlets and London and England from 2002-08, there has been a deterioration in Tower Hamlets. More needs to be done both to improve children's access to dental care and also preventive work including raising awareness of impact of dietary sugar and oral hygiene. This will be linked to work on health weaning.
Proportion of children accessing dental services	53.4%[6]	55%	56%	53.4% (2013)	A number of children access primary care dental services at the Dental Institute of Queen Mary University. The figures are not included in the national data. The proportion of children accessing dental services in Tower Hamlets is therefore thought to be much higher than the current figure of 53.4%.
Action/strategy/programme to deliver	**Lead**	**Milestones**	**Timescale**	**RAG**	**Comments**
Child obesity: create wider opportunities for children to engage in physical activity and healthy eating in	**Public Health** (Cathie Shaw, Esther Trenchard-	Review current opportunities and identify how to build in wider		G	Wider opportunities in new action plan includes: strengthening work on weaning, building stronger links with

[5] This indicator is based on a survey carried out every two years.
[6] This indicator has historically been very low. After increases in the outturn, there was a decrease – in Tower Hamlets, across London and nationally – in 2012. The targets in for this measure have been set using the convergence principles.

community, leisure, school, faith and home settings *(priority across both maternity and early years and children 5-12 years)*	Mabere) **Early Years Accreditation Scheme** (Selina) **Healthy Lives (Schools)** (Kate Smith) **Voluntary sector** (Alex Nelson / Pip Pinhorn) **Parents and Carers Council** (Jill McGinley)	opportunities for healthy eating and physical activity into existing services and everyday lives			parental engagement team and oral health team. Healthy eating and active play service for 0-5 years has been re-commissioned.
		Agree priorities and develop action plan	April 2103	G	New action plan has been developed and agreed by PRG and the MEYC C&D Group (see report submitted to H&WB Board June 2014 for full action plan)
Child injury prevention: develop new partnerships to tackle the main causes of child injury at home and in the community (priority across both maternity and early years and children 5-12 years)	**Public Health** (Simon Twite, Esther Trenchard-Mabere) **Transport and Highways** (Margaret Cooper) **Health Visiting Service, Barts Health** (Rita Wallace) **Children's Centres** (TBC) **Healthy Lives (Schools)** (Kate	Review data on main causes of child injury presenting at A&E		R	Data has not been available from A&E
		Agree priorities and develop action plan		A	Work has started mapping multi-agency action against NICE guidance to inform an action plan

	Smith) **Voluntary sector** (Alex Nelson / Pip Pinhorn) **Parents and Carers Council** (Jill McGinley)				
Ensure that on-going partnership work is maintained and supported, including: • Early identification of families at risk of obesity, including identification at booking for antenatal care and linking to wider services • Improve physical activity opportunities available for under-5s • Expand uptake and support maintenance of Early Years Accreditation Scheme • Deliver the following oral health promotion programmes: Brushing for Life, Smiling Start, Healthy Teeth in Schools (fluoride varnish), Happy Smiles (health promotion in schools programme) and 'train the trainers' • Develop an oral health promotion programme for children with SEN.					

Recommend:
Improve employment prospects for mothers by increasing access to volunteering opportunities, including links to Children's Centres, School and TH College – is picked up under 'Emotional and Economic Resilience'

Healthy Lives

Outcome Objective 1: Stop the increase in levels of obesity and overweight children					
Activity	**Lead Officer**	**Deadline**	**Status**	**% Comp**	**Comments**
Refresh Tower Hamlets 'Healthy Weight, Healthy Lives' strategy to become Tower Hamlets 'Healthy Food, Active Lives' workstream of Healthy Lives Strategy	Public Health (Esther Trenchard-Mabere)	31/03/2014	On Hold	50%	Review and RAG rating of Healthy Weight Healthy Lives action plan completed and draft framework outlining future priorities written but put on hold as it has now been agreed that this needs to be integrated into wider Healthy Lives strategy
Milestone	**Lead Officer**	**Deadline**	**Status**	**%**	**Comments**
Finalise plan	Public Health (Esther Trenchard-Mabere)	30/06/2013	On Hold		Healthy Lives Strategy supersedes (Launch November 2014)
Present to H&WB board for agreement	Public Health (Esther Trenchard-Mabere)	TBC	On Hold		Healthy Lives Strategy supersedes (Launch November 2014)
Identify Board level champion and leads across partner agencies and local authority directorates	Public Health (Esther Trenchard-Mabere)	TBC	On Hold		Healthy Lives Strategy supersedes (Launch November 2014)
Involve Healthwatch/Vol Sector in planning Stakeholder Conference	Public Health (Esther Trenchard-Mabere)	30/09/2013	On Hold		Healthy Lives Strategy supersedes (Launch November 2014)
Report to H&WB Board on implementation	Public Health (Esther Trenchard-Mabere)	31/03/2014	On Hold		Healthy Lives Strategy supersedes (Launch November 2014)
Review funding for 'Can Do' community led projects and seek partnership commitment to sustain the programme	Public Health (Esther Trenchard-Mabere)	30/04/2013	Completed	100%	Has been funded from public health grant although would still benefit from additional investment from partner agencies.
Activity	**Lead Officer**	**Deadline**	**Status**	**% Comp**	**Comments**
Build on and extend community engagement in the development and implementation of the new strategy	Public Health (Esther Trenchard-Mabere) Healthwatch (Diane Barham) VCS H&WB forum (TBC)	30/04/2013	On Hold		Healthy Lives Strategy supersedes (Launch November 2014)
Milestone	**Lead Officer**	**Deadline**	**Status**	**%**	**Comments**
Make links between strategy objectives and wider community development work	Public Health (Esther Trenchard-Mabere) Healthwatch (Diane Barham) VCS H&WB forum (TBC)	30/04/2013	On Hold		Healthy Lives Strategy supersedes (Launch November 2014)
Present to H&WB Board	Public Health (Esther Trenchard-Mabere) Healthwatch (Diane Barham) VCS H&WB forum (TBC)	30/04/2013	On Hold		On hold

Activity	Lead Officer	Deadline	Status	% Comp	Comments
Agree and implement evidence based health food standards across partner agencies as exemplars of good practice	Public Health (Esther Trenchard-Mabere) Barts Health (Michele Sandelson)	TBC	Delayed	75%	Standards drafted and discussions with GLL and CLC regarding the Poplar Baths programme and implementation of healthy vending machines and healthy options for the Community Café.
Milestone	**Lead Officer**	**Deadline**	**Status**	**%**	**Comments**
Finalise food policy with evidence based standards	Public Health (Esther Trenchard-Mabere) Barts Health (Michele Sandelson)	30/04/2013	Overdue	90%	A draft document has been written, which needs more work before being circulated for comment.
Agree implementation plans with partner agencies	Public Health (Esther Trenchard-Mabere) Barts Health (Michele Sandelson)	30/06/2013	Overdue	60%	The Poplar Baths programme is being used to test. Talks with partner agencies are ongoing.
Presentation to the H&WB Board	Public Health (Esther Trenchard-Mabere) Barts Health (Michele Sandelson)	TBC	Delayed	75%	This will be reported to the Health and Wellbeing Board when there is more progress on how this has been incorporated into the Poplar Baths programme. This will be reported to the H&WBB Officer Group in January 2015.
Activity	**Lead Officer**	**Deadline**	**Status**	**% Comp**	**Comments**
Monitor the implementation of the Local Development Framework and impact	Public Health (Tim Madelin) LBTH, D&R (Michael Bell)	On-going	Ongoing		The Core Strategy and subsequent Managing Development Document, which contains a new policy approach to manage the overconcentration of A5 uses, was approved by Full Council in Aprl 2013.
Milestone	**Lead Officer**	**Deadline**	**Status**	**%**	**Comments**
Cycling and walking infrastructure	Public Health (Tim Madelin) LBTH, D&R (Michael Bell)	On-going	Ongoing		Ongoing delivery of TfL LIP schemes and Cycle parking, including in new developments.
Access to open spaces through Green Grid	Public Health (Tim Madelin) LBTH, D&R (Michael Bell)	2020-2025	Ongoing		Green Grid is adopted Council strategy which is aimed to be delivered over a 20 year period. Discussions are underway to secure funding streams.
Local food growing and urban agriculture	Public Health (Tim Madelin) LBTH, D&R (Michael Bell)	On-going	Ongoing		Advertisement placed for recruitment of community Gardeners.
Restrictions on new hot food takeaways near schools and leisure centres	Public Health (Tim Madelin) LBTH, D&R (Michael Bell)		Completed	100%	Policy to limit over concentration of A5 uses is successfully applied in practice.

Agree process for strengthening community engagement into spatial planning	Public Health (Tim Madelin) LBTH, D&R (Michael Bell)	TBC			
Outcome Objective 2: Reduced prevalence of tobacco use in Tower Hamlets					
Activity	**Lead Officer**	**Deadline**	**Status**	**% Comp**	**Comments**
Refresh and implement the Tobacco Control workstream of the Healthy Lives Strategy	Public Health (Chris Lovitt)	TBC	On hold	75%	Healthy Lives Strategy supersedes (Launch November 2014)
Milestone	**Lead Officer**	**Deadline**	**Status**	**%**	**Comments**
Finalise plan	Public Health (Chris Lovitt)	03/02/2014	On Hold	75%	Healthy Lives Strategy supersedes (Launch November 2014)
Present to H&WB board for agreement	Public Health (Chris Lovitt)	01/03/2014	On Hold	75%	Healthy Lives Strategy supersedes (Launch November 2014)
Activity	**Lead Officer**	**Deadline**	**Status**	**% Comp**	**Comments**
Review and refresh approach to reducing tobacco uptake in adolescents and young people	Public Health (Chris Lovitt)	31/03/2014	Overdue	63%	To be completed by the end of August.
Milestone	**Lead Officer**	**Deadline**	**Status**	**%**	**Comments**
Incorporate into refreshed plan	Public Health (Chris Lovitt)	30/06/2013	Completed	100%	Completed
Evaluate outcomes for ASSIST programme	Public Health (Chris Lovitt)	28/02/2014	Overdue	60%	Awaiting data from the Youth Service. This is due to be completed by the end of August.
Review commissioning process and re-commission ASSIST if effective	Public Health (Chris Lovitt)	31/03/2014	Overdue	30%	To be completed by the end of August as part of the Service Challenge.
Activity	**Lead Officer**	**Deadline**	**Status**	**% Comp**	**Comments**
Develop a clear action plan for the borough in order to reduce the amount of illicit tobacco (counterfeit and contraband) available to young people	Public Health (Chris Lovitt) LBTH, CLC (Dave Tolley)	30/10/2013	Completed	100%	Completed
Milestone	**Lead Officer**	**Deadline**	**Status**	**%**	**Comments**
Incorporate into refreshed plan	Public Health (Chris Lovitt) LBTH, CLC (Dave Tolley)	30/06/2013	Completed	100%	completed
Meet quarterly with trading standards at LBTH to receive an update on KPIs re this area	Public Health (Chris Lovitt) LBTH, CLC (Dave Tolley)	Quarterly	Completed	100%	Completed
Support and pan London /national campaigns and initiatives	Public Health (Chris Lovitt) LBTH, CLC (Dave Tolley)	30/10/2013	Completed	100%	Tower Hamlets DPH is confirmed as the lead for London on Tobacco control

Activity	Lead Officer	Deadline	Status	% Comp	Comments
Embed healthy lives brief advice into all health and social care making every contact counts	Public Health (Paul Iggulden) CCG (Jane Milligan) Barts Health (Ian Basnett) Education, Social Care and Wellbeing (Anne	03/03/2014	Overdue	75%	In the process of identifying frontline provider teams in ESCW for training around brief interventions, setting targets for 2014/15 and incorporation of training into the corporate training directory. This is also linked to the Care Bill implementation (prevention workstream).
Milestone	**Lead Officer**	**Deadline**	**Status**	**%**	**Comments**
Develop joint action plan with Barts Health (working with public health director)	Public Health (Paul Iggulden) CCG (Jane Milligan) Barts Health (Ian Basnett) Education, Social Care and Wellbeing (Anne	30/06/2013	Overdue	60%	This has been developed for tobacco but there are further areas to develop for 2014/15.
Primary care – implement healthy lives locally enhanced services and revise spec for 14/15	Public Health (Paul Iggulden) CCG (Jane Milligan) Barts Health (Ian Basnett) Education, Social Care and Wellbeing (Anne	Ongoing	Completed	100%	Completed
Community pharmacy – develop healthy lives plan with community pharmacists	Public Health (Paul Iggulden) CCG (Jane Milligan) Barts Health (Ian Basnett) Education, Social Care and Wellbeing (Anne	30/09/2013	Completed	100%	2013/14 priorities completed (commissioning of enhanced public health services for 2014/15)
Social care - develop plan with social care leads in ESW and public health	Public Health (Paul Iggulden) CCG (Jane Milligan) Barts Health (Ian Basnett) Education, Social Care and Wellbeing (Anne	30/09/2013	Overdue	40%	This is linked to the Every Contact Counts action item above.

Activity	Lead Officer	Deadline	Status	% Comp	Comments
Reduce the use of smokeless tobacco	Public Health (Chris Lovitt) LBTH, CLC (Dave Tolley)	30/06/2013	Completed	100%	Trading standards programme of activity to reduce access and uptake.
Milestone	**Lead Officer**	**Deadline**	**Status**	**%**	**Comments**
Consult with stakeholders from the local community including small businesses	Public Health (Chris Lovitt) LBTH, CLC (Dave Tolley)	30/06/2013	Completed	100%	Consultation was undertaken 30/09/13 and has fed into action plan
Finalise plan	Public Health (Chris Lovitt) LBTH, CLC (Dave Tolley)	30/06/2013	Completed	100%	Completed
Outcome Objective 3: Reduced levels of harmful or hazardous drinking (PH framework) **Outcome Objective 4: Reduced rates of drug use (PH framework)**					
Activity	**Lead Officer**	**Deadline**	**Status**	**% Comp**	**Comments**
Co-ordination of Substance Misuse Strategy Action Plan	DAAT Coordinator (Mark Edmunds) Public Health (Chris Lovitt)	30/09/2013	Completed	100%	Agreement to extend the current plan is being sought via Cabinet with a full update on delivery.
Milestone	**Lead Officer**	**Deadline**	**Status**	**%**	**Comments**
Update action plan and review progress of action plan	DAAT Coordinator (Mark Edmunds) Public Health (Chris Lovitt)	31/07/2013	Completed	100%	
Agree priorities and review timescales for action plan delivery	DAAT Coordinator (Mark Edmunds) Public Health (Chris Lovitt)	30/09/2013	Completed	100%	
Update HWB (via DAAT Board) on substance misuse action plan	DAAT Coordinator (Mark Edmunds) Public Health (Chris Lovitt)	Annually or as appropriate	Completed	100%	Agreement to extend the current plan is being sought via Cabinet with a full update on delivery.

Activity	Lead Officer	Deadline	Status	% Comp	Comments
Ensure a consistent approach across the partnership to messaging around harms caused by misuse of drugs and alcohol	DAAT Coordinator (Mark Edmunds) Public Health (Chris Lovitt)	31/12/2013	Completed	100%	
Milestone	**Lead Officer**	**Deadline**	**Status**	**%**	**Comments**
Review at DAAT board the agencies that should be involved/included	DAAT Coordinator (Mark Edmunds) Public Health (Chris Lovitt)	30/04/2013	Completed	100%	Plan was reviewed at the DAAT Board.
Develop communication plans which aim to achieve widespread awareness across all agencies on the harms caused by misuse of drugs and alcohol	DAAT Coordinator (Mark Edmunds) Public Health (Chris Lovitt)	30/06/2013	Completed	100%	Messages programmed and sequenced for release for the whole year.
Take proposal to the DAAT Board/HWB/CSP for agreement and to ensure that the proposal is championed	DAAT Coordinator (Mark Edmunds) Public Health (Chris Lovitt)	30/09/13 - 31/12/13	Completed	100%	As above
Activity	**Lead Officer**	**Deadline**	**Status**	**% Comp**	**Comments**
Champion an integrated life-course approach to treatment, recovery & re-integration in substance misuse	DAAT Coordinator (Mark Edmunds) Public Health (Chris Lovitt)	31/08/2013	Completed	100%	
Milestone	**Lead Officer**	**Deadline**	**Status**	**%**	**Comments**
Review treatment pathways to ensure that they are recovery and re-integration orientated to meet the needs of all clients	DAAT Coordinator (Mark Edmunds) Public Health (Chris Lovitt)	31/08/2013	Completed	100%	A service review has been undertaken and a proposed new treatment system has been developed.
Identify (where relevant) appropriate changes to the treatment system to ensure that models and pathways are recovery & re-integration orientated	DAAT Coordinator (Mark Edmunds) Public Health (Chris Lovitt)	31/07/2013	Completed	100%	Reprocurement to commence in Q2 2014/15.
DAAT/CSP to sign off	DAAT Coordinator (Mark Edmunds) Public Health (Chris Lovitt)	31/08/2013	Completed	100%	Approved by DAAT Board. Cabinet report to be presented on 23/07/14.

Activity	Lead Officer	Deadline	Status	% Comp	Comments
Embed screening and brief intervention around drugs and alcohol into front-line services (beyond A&E)	DAAT Coordinator (Mark Edmunds) Public Health (Chris Lovitt)	30/06/2013	Overdue	66%	To be carried over into 2014/15.
Milestone	**Lead Officer**	**Deadline**	**Status**	**%**	**Comments**
Review the existing screening and brief intervention evidence nationally for drugs and alcohol and lessons from local implementation in Tower Hamlets	DAAT Coordinator (Mark Edmunds) Public Health (Chris Lovitt)	30/04/2013	Completed	100%	
Consider from the evidence, the frontline services within which to roll-out screening and brief interventions and ensure sign up	DAAT Coordinator (Mark Edmunds) Public Health (Chris Lovitt)	31/05/2013	Overdue	0%	No formal process initiated beyond primary care and the Royal London Hospital. Further work is required following changes to services.
Develop a package for training and implementation for front-line staff, including evaluation	DAAT Coordinator (Mark Edmunds) Public Health (Chris Lovitt)	30/06/2013	Completed	100%	

Activity	Lead Officer	Deadline	Status	% Comp	Comments
Develop and implement the Integrated Offender Management plan	Police (TBC with DAAT Board)	31/12/2013	Completed	100%	There is a strategy and action plan in place which address the co-ordinated approaches of offenders mental health and physical needs.
Milestone	**Lead Officer**	**Deadline**	**Status**	**%**	**Comments**
CSP/IOM/DAAT Board to review progress of IOM delivery and the development of a more co-ordinated approach to the substance misuse and health needs of offenders	Police (TBC with DAAT Board)	30/09/13 - 31/12/13	Completed	100%	
Deliver the TH IOM action to address the links between mental and physical health needs of offenders	Police (TBC with DAAT Board)	31/10/2013	Completed	100%	
Activity	**Lead Officer**	**Deadline**	**Status**	**% Comp**	**Comments**
Integrate health impact into the Council licensing policy	Public Health (Chris Lovitt) LBTH, CLC (Dave Tolley)	31/12/2013	Completed	100%	Completed
Milestone	**Lead Officer**	**Deadline**	**Status**	**%**	**Comments**
Update the health section of the Council's licensing policy to include issues such a minimum price, strength, promotions etc. – consultation paper to be drafted.	Public Health (Chris Lovitt) LBTH, CLC (Dave Tolley)	30/04/2013	Completed	100%	Completed
Consultation to be carried out with a view for adoption by December 2013	Public Health (Chris Lovitt) LBTH, CLC (Dave Tolley)	31/12/2013	Completed	100%	Completed
Outcome Objective 5: Reduced prevalence of Sexually transmitted infections and promote sexual health					
Activity	**Lead Officer**	**Deadline**	**Status**	**% Comp**	**Comments**
Implement Tower Hamlets Sexual Health workstream 2013-16 of the Healthy Lives Strategy	Public Health (Chris Lovitt)	30/09/2013	Completed	100%	Procurement of sexual health services underway with refocused emphasis on prevention of STIs and promotion of sexual health
Milestone	**Lead Officer**	**Deadline**	**Status**	**%**	**Comments**
Finalise plan	Public Health (Chris Lovitt)	30/06/2013	Completed	100%	Final draft produced and adopted by sexual health advisory board
Partnership sexual health adopted and key objectives widely communicated	Public Health (Chris Lovitt)	30/09/2013	Completed	100%	Draft adopted and awaiting healthy lives framework for key actions to be communicated
Sexual Health commissioning responsibilities transferred to LBTH	Public Health (Chris Lovitt)	30/04/2013	Completed	100%	Procurement of sexual health services underway with refocused emphasis on prevention of STIs and promotion of sexual health
Develop metrics and trajectory on uptake of asymptomatic screening in primary care	Public Health (Chris Lovitt)	30/06/2013	Completed	100%	Primary Care enhanced services specification reviewed and increased performance is being delivered
Develop metrics and trajectory on treatment for STIs, reinfection rates, partner notification and partner treatment rates	Public Health (Chris Lovitt)	30/06/2013	Completed	100%	PHE Laser report now reports on these metrics

Activity	Lead Officer	Deadline	Status	% Comp	Comments
Deliver a sexual health needs assessment for high risk, vulnerable groups including looked after children and adults with learning disabilities	Public Health (Chris Lovitt)	31/11/2013	Overdue	90%	This is largely completed. Further focus on protected characteristics to be considered pending national data release.
Milestone	**Lead Officer**	**Deadline**	**Status**	**%**	**Comments**
Needs assessment undertaken across care pathways	Public Health (Chris Lovitt)	01/02/2014	Overdue	80%	This remains outstanding for 2014/15. To be considered as part of recommissioning of services.
Implementation plan for vulnerable groups	Public Health (Chris Lovitt)	31/10/2013	Completed	100%	Sexual health service provider lead clinical is confirmed lead for vulnerable groups and is reviewing pathways
Activity	**Lead Officer**	**Deadline**	**Status**	**% Comp**	**Comments**
Develop a lifecourse sexual health promotion plan (including SRE in school) and promote access to sexual health services and contraception choices by all front line services	Public Health (Chris Lovitt) Health Lives Team (Kate Smith) Options Team (Liat Sarner)	31/10/2013	Overdue	80%	The workplan is in place but the delivery has been delayed. This will be covered in the Healthy Lives Strategy
Milestone	**Lead Officer**	**Deadline**	**Status**	**%**	**Comments**
Lifecourse Promotion and Access Plan developed and adopted	Public Health (Chris Lovitt) Health Lives Team (Kate Smith) Options Team (Liat Sarner)	31/05/2013	Completed	100%	
Monitoring of uptake of plan	Public Health (Chris Lovitt) Health Lives Team (Kate Smith) Options Team (Liat Sarner)	31/10/2013	Overdue	60%	Employee recruited in June 2014 to deliver SRE. The workplan is in development.

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Tower Hamlets Mental Health Strategy Delivery Plan 2014-16

Pillar	Commitment	Action	Lead officer	Timescale	Comments	RAG
BEING BORN AND GROWING UP IN TOWER HAMLETS						
Building resilience: mental health and wellbeing for all	As part of partnership work across health, local authority, voluntary and community sectors we will improve the availability and consistency of support during pregnancy and in the first year of life to promote parent/infant attachment, parent and infant communication and emotional regulation in order to promote lifelong resilience and mental health and wellbeing.	We will map current services available to support maternal and infant mental health in order to identify gaps, improve access for groups at higher risk, improve coordination across services and develop proposals to strengthen the universal tier of the service (including Maternity services, Health Visiting and services delivered from Children's Centres, primary care and by voluntary and community organisations) (CYP)	Esther Trenchard-Mabere, Public Health Consultant, LBTH	March 2014 complete mapping and prioritisation June 2014 proposal for training programme to support universal tier of service plus recommendations for strengthening targeted services	Mapping completed, two multi agency workshops held first to inform mapping process and second to inform proposals to strengthen the universal tier of the service. Currently developing service specifications with the intention to go out to procerurement September/October 2014 subject to agreement of funding.	G
Not Due Yet						
Building resilience: mental health and wellbeing for all	As part of our coordinated work to design new pathways of support for children and young people, we will work across the Partnership to develop an anti-stigma campaign specific to children and young people (CYP)	We will develop a public mental health and well-being programme which will include a portfolio of evidence based public mental health interventions, which will identify how we will deliver this, alongside other public mental health commitments over 2014/16	Paul Iggledun, Public Healh Consultant, LBTH	September 2014 for plan		
High Quality Treatment & Support	We will develop a model for taking a family orientated approach to mental health across the partnership to be integrated into practice, where people with a mental health problem are parents (CYP, AWA)		Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	December 2015		
Building resilience: mental health	In our review of the School Health Service, we will ensure that promotion of emotional health and well-being health is considered as a central component of future commissioned	We will ensure that the roles of school nurses in relation to emotional health and well-being are clearly articulated in	Esther Trenchard-Mabere, Public	December 2014		

Pillar	Commitment	Action	Lead officer	Timescale	Comments	RAG
and wellbeing for all	services. We wil in 2015 and beyond consider the role of health visitors in promoting emotional health and wellbeing (CYP).	specifications for the reprocurement of the School Health service.	Health Consultant, LBTH			
High Quality Treatment & Support	As part of our coordinated work to design new pathways of support for children and young people, we will ensure that they take account of the life events that impact on young people with mental health problems, including leaving education, leaving home, leaving family, emerging autonomy (CYP)	We will develop a refreshed service model for child and adolescent mental health services. A project board will be set up across all stakeholders to oversee this work including the development of a set of service specifications to deliver the refreshed service model.This will inclue consideration of the impact of potential changes to the CAMHS service model to services for adults of working age.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG and Karen Badgery, Service Manager Childrens Commissioning, LBTH	Project board in place by end March 2014; service model and specification s delivered by March 2015	Project plan in place; advisory group in place; work progressing	G
High Quality Treatment & Support	As part of our coordinated work to design new pathways of support for children and young people, we will ensure that they take account of the requirements of, and emergent good practice in relation to, the Children and Families Act 2014 (CYP)					
High Quality Treatment & Support	As part of our coordinated work to design new pathways of support for children and young people, we will consider how to most effectively provide support to children at risk, including looked after children, and in particular how to most effectively support children's social care staff with developing knowledge and skills around mental health (CYP)					
High Quality Treatment & Support	As part of our coordinated work to design new pathways of support for children and young people, we will develop a new model of Tier 2 mental health support to schools, childrens centres, colleges and youth services. This will incorporate specialist mental health support, mentoring programmes, and generic support provided via the Healthy Child and Nutrition Programme. We will review the evidence base which underpins interventions. This will also include consideration of formal and informal training needs of the school nursing service and the school workforce around mental health, and standards for school counseling. We will consider the possibilities of using social media and new technologies in developing our offer to schools (CYP)					
High Quality Treatment & Support	As part of our coordinated work to design new pathways of support for children and young people, we will consider Tier 2 and 3 CAMHS services, with the aim of ensuring that waiting times are as little as possible, that people who do not attend are robustly followed up, and that access to services by BME communities are in line with what we would expect (CYP)					

Pillar	Commitment	Action	Lead Officer	Timescale	Comments	RAG
BEING AN ADULT IN TOWER HAMLETS						
High Quality Treatment & Support	In the context of our Mental Health Accommodation Strategy, we will review our resettlement and rehabilitation team pathways in order to ensure they are working effectively, and in this context that specialist accommodation providers are appropriately supported by specialist services (AWA)	We will continue the work to remodel and recommission resettlement and rehabilitation team pathways.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	Review and commissioning plan complete by April 2014	Funding arrangements in place for 14/15 for Resettlement Team; further work planned to remodel services by end of year.	A
High Quality Treatment & Support	We will increase the capacity of the Primary Care Mental Health Service to support more clinically appropriate service users to access its support, including service users who require depot medication or who are in receipt of a commissioned social care service (AWA)	We will develop service and activity model for the primary care mental health service (including social care)	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	Refreshed service model design in place by June 2014	Work to develop primary care based mental health services currently underway; new capacity has been resourced by the CCG as part of 2014/15 plans	A
High Quality Treatment & Support	We will work with East London NHS Foundation Trust to further develop the interface between primary and secondary care, with a particular focus on provision of population based advice and support to practices, and the development of primary care consultation by consultant psychiatrists and other mental health professionals (AWA, OP)					
High Quality Treatment & Support	With East London NHS Foundation Trust, we will further develop opportunities for practice based clinics (AWA)					
High Quality Treatment & Support	We will in particular ensure that in the re-commissioning of tobacco cessation and obesity services, that access for people with a serious mental illness is addressed (AWA)	We will reprocure tobacco cessation and obesity services to explicitly include access for people with a serious mental illness.	Chirs Lovitt, Public Health Consultant LBTH, and Esther Trenchard Mabere, Public Health Consultant, LBTH	June 2014	The following was specified in the procurement exercise and in the contract as service specification:- • Those living with severe or enduring mental illness within the community • Those who may be smoking tobacco along with the use of illegal	G

Pillar	Commitment	Action	Lead Officer	Timescale	Comments	RAG
					substances such as cannabis Services have now been recomissioned and we are mobilising new contracts. The target groups for the Fit 4 Life Programme are adults aged 18+ who are motivated to change their diet, activity and weight and who have mental illnesses. We have also re-procured our health trainer programme and the specification for this service includes integration with the mental health trainers service.	
Living well with a mental health problem	We will commission, via non-recurrent funds, a provider or consortium of providers to develop a self-sustaining recovery college (AWA)	We will test the viability of this approach to commissioning a recovery college.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	June 2014	Contracted with East London FT to work with local providers to develop during 14/15	G
Not Due Yet						
Building resilience: mental health and wellbeing for all	We will refresh our review of day opportunity and support services, with a view to considering how the expertise and dynamism of voluntary sector services, and their closeness to the various communities of Tower Hamlets, can support our aspiration for more accessible targeted prevention services for all communities (AWA)	We will develop a refreshed model for the delivery of day opportunity and support services, with an accompanying procurement plan.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	Service model and procurement plan in place by September 2014		
Building resilience: mental health and	We will work with the Ideas Stores to capitalize on opportunities for improving access to self help support and	We will develop a public mental health and well-being programme which will	Paul Iggledun, Public Healh	June 2014 for plan;		

Pillar	Commitment	Action	Lead Officer	Timescale	Comments	RAG
wellbeing for all	bibliotherapy (AWA, OP)	include a portfolio of evidence based public mental health interventions, which will identify how we will deliver this, alongside other public mental health commitments over 2014/16	Consultant, LBTH	commitment commissioned by end March 2015		
Building resilience: mental health and wellbeing for all	We will review our existing investment into supporting service users via the Forensic Mental Health Practitioner and the Link Worker Scheme, to ensure it is optimally deployed (AWA)	Following the development of the Offender health JSNA factsheet; we will review the Forensic Mental Health Practitioner and the Link Worker Scheme	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG and Carrie Kilpatrick, Service Manager, Accommodation, LBTH	Review complete by March 2015		
Building resilience: mental health and wellbeing for all	We will work with probation and mental health service providers to ensure the successful delivery of support for offenders with mental health problems including personality disorder (AWA)	We will work with the Reducing Reoffending workstream of the Community Safety Partnership to ensure that mental health support is included within plans for Integrated Offender Management.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	March 2016		
Building resilience: mental health and wellbeing for all	We will implement the Hostels Strategy to ensure that appropriate support for people with mental health problems who are in hostels is built into the re-design of hostels (AWA, OP)	We will implement the Hostels Strategy.	Carrie Kilpatrick, Service Manager, Accommodation, LBTH	March 2016		
Building resilience: mental health and wellbeing for all	We will work with East London Foundation Trust to carry out a prospective audit of people who are admitted to hospital who were recorded as not previously known to mental health services in the borough. We will use this information to help plan how to better support early access to community services for this group of people in the future (AWA)	We will carry out a prospective audit of people who are admitted to hospital who were recorded as not previously known to mental health services in the borough.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG and Paul Iggledun, Public Healh Consultant, LBTH	Audit complete by June 2015		
Building resilience: mental health and wellbeing for all	We will develop a referral and diagnostic pathway for people with ASD who are not eligible for mental health services, with clear thresholds for where people may	We will review and evaluate the new commissioned service mid way through the contract (at 18 months)	Barbara Disney, Service Manager,	Referral pathway developed by		

Pillar	Commitment	Action	Lead Officer	Timescale	Comments	RAG
	require mental health services (AWA)		Strategic Commissioning, LBTH	March 2015		
High Quality Treatment & Support	We will evaluate the effectiveness in improving mental and physical health outcomes of our new liaison psychiatry team pilot at the Royal London Hospital (AWA, OP)	We will evaluate the effectiveness of our new liaison psychiatry team pilot at the Royal London Hospital	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	Evaluation complete by December 2016		
High Quality Treatment & Support	We will review talking therapies pathways across all providers of talking therapy services to inform future commissioning. We will in particular consider access to talking therapies for older people and people from BME communities (AWA, OP)	We will review talking therapies providers, and develop a commissioning plan for future talking therapies pathways.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	Review and commissioning plan complete by September 2014		
High Quality Treatment & Support	In light of our work on talking therapies pathways and anti-depressant prescribing, we will consider the case for developing a primary care depression service, including support for employment (AWA, OP)					
High Quality Treatment & Support	We will consider the configuration of adult community mental health services in light of work to develop CAMHS services and our review of older adults mental health services (AWA)	To be considered in the context of the CAMHS service design and older adults review.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	March 2016		
High Quality Treatment & Support	We will work across health and social care commissioners and providers to develop care packages for payment by results, and in particular will consider the contribution of social work and social care (AWA, OP)	We will ensure that all preparatory work for payment by results is in place during the 2014/15 shadow year and monitor its impact.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	March 2015		
High Quality Treatment & Support	We will review the recent national guidance for the commissioning of perinatal mental health services published by the Joint Commissioning Panel for Mental Health, and the implementation of NICE ante and postnatal guidance. This will inform our strategic thinking about how best to ensure suitable and effective services for this group (AWA)	We will review perinatal services.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	Review complete by March 2016		

Pillar	Commitment	Action	Lead Officer	Timescale	Comments	RAG
High Quality Treatment & Support	With the Drug and Alcohol Action Team we will review the design of support for people with a dual diagnosis including a serious mental illness and a substance misuse and/or alcohol problem (AWA)	We will review the dual diagnosis service model.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG and Rachael Sadegh, DAAT Coordinator, LBTH	Review complete by March 2016		
High Quality Treatment & Support	We will use the east London wide Home Treatment Team review and our local review of the Tower Hamlets Crisis House to inform our future commissioning of community crisis pathways (AWA)	Pending receipt of final evaluation, we will re-procure the Tower Hamlets crisis house.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	June 2016		
High Quality Treatment & Support	In the context of the pilot work detailed above, we will work across the Consortium with East London NHS Foundation Trust to consider the current crisis pathways, and identify any options for the future design of services that optimize safety, outcomes for service users, and value for money (AWA, OP)					
Living well with a mental health problem	We will work across the Partnership to self-assess our commissioning practice and service provision by statutory and voluntary sector partners, using the ImROC approach, as the starting point in the delivery of our ambitions to develop a recovery culture (AWA)	We will purchase the ImROC support pack to self-assess our recovery orientation across the partnership.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	March 2015		
Living well with a mental health problem	In our refresh of our review of voluntary sector day opportunity and support services, we will consider the appropriate range and balance of day opportunities services that should be provided in the borough (AWA)	We will develop a refreshed model for the delivery of day opportunity and support services, with an accompanying procurement plan.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	Service model and procurement plan in place by September 2014		
Living well with a mental health problem	In particular, we will explore how peer support may be delivered as part of the new primary care mental health service, and how applications for user led grants can be encouraged from hard to reach groups (AWA, OP)					
Living well with a mental health problem	We will work across the Consortium to consider opportunities for developing, and commissioning, the shared decision making approach in practice (AWA, OP)	As part of self-assessing our recovery orientation across the partnership, we will review the extent to which service	Richard Fradgley, Deputy Director	March 2016		

Pillar	Commitment	Action	Lead Officer	Timescale	Comments	RAG
		users feel they have control over care planning processes.	of Mental Health and Joint Commissioning, THCCG			
Living well with a mental health problem	We will develop capacity and capability for personal health budgets for people in receipt of continuing care funding, including mental health. We will look to pilot personal health budgets more generally in mental health, as more evidence accumulates nationally (AWA, OP)	We will pilot personal health budgets in mental health and ensure that revised service specifications promote and incentise the take up of direct payments for social care.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	March 2016		
Living well with a mental health problem	We will review the services we jointly provide and commission to support people into employment. We will ensure that we consider the evidence on what works in our refresh of our review of voluntary sector day opportunity and support services (AWA)	We will develop a refreshed model for the delivery of day opportunity and support services, with an accompanying procurement plan.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	Service model and procurement plan in place by September 2014		
Living well with a mental health problem	We will continue to implement our Commissioning Strategy for the Accommodation of Working Age Adults with a Mental Health Problem (AWA)	The existing accommodation strategy continues until 2016.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	Delivery of strategy by 2016		

Pillar	Commitment	Action	Lead Officer	Timescale	Comments	RAG
GROWING OLD IN TOWER HAMLETS						
Living well with a mental health problem	We will commission more dementia cafes to provide peer support for people with dementia and their carers (OP)	We will commission more dementia cafes.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	April 2014	2 additional dementia cafes have now been commissioned, bringing the total to 2 inclusive dementia cafes run in English and 2 Bangladeshi dementia cafes run in Sylheti, each running once a month for people with dementia and their	G

Pillar	Commitment	Action	Lead Officer	Timescale	Comments	RAG
					carers. The Alzheimer's Society won the tender to deliver these services, and the current contract will run until 31st March 2017	
Hight Quality Treatment & Support	We will ensure that older people have access to the Primary Care Mental Health Service (OP)	We will develop a refreshed service and activity model for the primary care mental health service	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	Refreshed service model design in place by June 2014	Work to develop primary care based mental health services currently underway; new capacity has been resourced by the CCG as part of 2014/15 plans	A
Not Due Yet						
Building resilience: mental health and wellbeing for all	We will continue to work specifically to raise awareness of dementia (OP)	We will develop a public mental health and well-being programme which will include a portfolio of evidence based public mental health interventions, which will identify how we will deliver this, alongside other public mental health commitments over 2014/16	Paul Iggledun, Public Healh Consultant, LBTH	June 2014 for plan; commitment commissioned by end December 2014		
Building resilience: mental health and wellbeing for all	We will work with providers of home care and day care to improve mental health and dementia awareness with their staff (OP)		Paul Iggledun, Public Healh Consultant, LBTH	June 2014 for plan; commitment commissioned by end December 2014		
Building resilience: mental health and wellbeing for all	We will consider the findings of the Campaign to End Loneliness report and project, as well as other initiatives such as those developed by Age UK. Having done so we will work to develop our plans to tackle loneliness, with a particular focus on older people (OP)		Paul Iggledun, Public Healh Consultant, LBTH	June 2014 for plan; commitment commissioned by end December 2014		
High Quality Treatment & Support	We will review current community pathways for older adults with a functional mental health problem, in the context of our developing plans for integrated care in the borough in the context of the development of our integrated care model (OP)	We will review the older adults CMHT.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning,	Review complete by June 2015		

Pillar	Commitment	Action	Lead Officer	Timescale	Comments	RAG
			THCCG			
High Quality Treatment & Support	We will work with the Clinical Effectiveness Group at Queen Mary University to audit coding of people with dementia in primary care, and prescribing of anti-psychotic medicine to people with dementia, to enable us to understand patterns of prescribing in more detail, to inform future commissioning (OP)	We will carry out an audit of anti-psychotic prescribing in care homes.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG and Bill Sandhu, Head of Medicines Management, NELCSU	Complete by December 2014		
Hight Quality Treatment & Support	We will review pathways for people with alcohol-related dementia, and will consider the review to inform future commissioning (OP)	We will review pathways for people with alcohol related dementia.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	Review complete by December 2014		
Hight Quality Treatment & Support	In the context of current occupancy across East London wards, we will review in-patient services for older adults with functional mental health problems (OP)	We will review the model for in-patient care of older adutls with a functional mental health problem.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	Review complete by June 2015		
Hight Quality Treatment & Support	We will commission specialist mental health input into the new community integrated care service to ensure that services can address the holistic needs of patients and service users in one place (OP)	We will develop a specification for mental health support in the community health service locality teams.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	Specification in place by June 2014		
Living well with a mental health problem	We will develop a range of respite options appropriate for people with dementia, for carers to choose from (OP)	We will develop a range of respite options appropriate for people with dementia.	Barbara Disney, Service Manager, Strategic Commissioning, LBTH	March 2015		
Living well with a mental health problem	We will review pathways into services, and service specifications for commissioned residential, nursing and continuing care for people with dementia to improve the quality of these services (OP)	We will develop a refreshed service model for residential, nursing and continuing care for people with dementia.	Richard Fradgley, Deputy Director of Mental Health	Service model developed by March 2015		

Pillar	Commitment	Action	Lead Officer	Timescale	Comments	RAG
			and Joint Commissioning, THCCG			

Pillar	Commitment	Action	Lead Officer	Timescale	Comments	RAG
GENERAL						
Foundations: Commissioning with commitment	We will invite the Police and London Ambulance Service to participate in the Tower Hamlets Mental Health Partnership Board, to ensure that there is a strategic overview of the management of mental health crises for Tower Hamlets residents (G)	We will review the Mental Health Partnership Board to ensure appropriate membership.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	June 2014	Complete; crisis concordat event held with Police & LAS present and Concordat action plan to be presented to HWBB Autumn 2014	G
Building Resilience: mental health and wellbeing for all	We will develop a rolling programme of training for GP's and other primary care staff on specific aspects of mental health (G)	We will develop a rolling programme of training for GP's and other primary care staff	Dr. Ashrafi Jabin, Clinical Lead for Mental Health, THCCG	In place by June 2014	Training delivered on dementia, mental capacity act, learning disability since Strategyapproved. GP survey on training needs due to be circulated w/c 4/8/14	G
High Quality Treatment and Support	We will develop the interface between primary and secondary care, with a particular focus on further developing the presence of secondary care clinicians in a primary care setting, as detailed elsewhere in this strategy (G)	We will develop a refreshed service and activity model for the primary care mental health service	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	Refreshed service model design in place by June 2014	Work to develop primary care based mental health services currently underway; new capacity has been resourced by the CCG as part of 2014/15 plans	A
High Quality Treatment and Support	We will review our crisis pathway against the Crisis Concordat when published to ensure that we are compliant (G)	We will review our crisis pathway against the crisis concordat when published.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	Review complete by June 2014	Complete; Concordat action plan to be presented to HWBB Autumn 2014	G
Building Resilience:	We will develop a refreshed commissioning plan for	We will develop a refreshed	Barbara Disney,	Plan in place by	This work has	A

Pillar	Commitment	Action	Lead Officer	Timescale	Comments	RAG
mental health and wellbeing for all	people with a learning disability and mental health problem (G)	commissioning plan.	Service Head, Stratrgic Commissioning, LBTH	June 2014	been subsumed into the re-specification of Learning Disability Services.	
Not Due Yet						
Foundations: Commissioning with commitment	To support effective working across the partnership with the wider range of stakeholders, we will hold an annual autumn Tower Hamlets Mental Health summit, to enable all stakeholders to come together to consider the Strategy action plans for the year ahead (G)	We will hold an annual mental health summit.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	First summit November 2014		
Foundations: Commissioning with commitment	We will develop an outcomes dashboard to track the delivery of this Strategy, which will be published on the CCG website (G)	We will develop an outcomes dashboard.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG and Paul Iggledun, Public Health Consultant, LBTH	Outcomes dashboard in place by December 2014		
Foundations: Commissioning with commitment	We will review our service user involvement structures against the NICE Quality Standard and work with service users, Healthwatch, and voluntary sector groups to identify and provide opportunities to support service users who wish to become more involved in planning mental health services in the future (G)	We will review current user involvement structures and develop a revised model.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	Review complete and revised model in place by June 2015		
Foundations: Commissioning with commitment	We will develop our capability in using data to drive our commissioning practice, in particular in tackling inequality of access by protected characteristic (G)	With the development of payment by results we will proactively use the Mental Health Minimum Dataset to monitor activity by protected characteristic to inform future commissioning, and publish specific reports on our website.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	2016		

Pillar	Commitment	Action	Lead Officer	Timescale	Comments	RAG
Foundations: Commissioning with commitment	We will identify and use opportunities for developing risk stratification models to help plan future mental health services (G)	We will monitor the literature on this emergent area.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	2016		
Foundations: Commissioning with commitment	As staff experience and satisfaction is so key to an organizations ability to provide compassionate care, we will work locally and across the Consortium to consider potential measures of staff experience into contractual arrangements with mental health service providers in the future (G	We will monitor the literature on this area.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	2016		
Building Resilience: mental health and wellbeing for all	We will, across the Council and the CCG, as the two main public sector commissioning bodies in the borough, use the Time to Change pledge to encourage our suppliers to provide a mental health friendly workplace for their employees (G)	We will review our contracting documents and processes to incorporate provisions regarding mental health friendly employment.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG and Paul Iggledun, Public Health Consultant, LBTH	March 2015		
Building Resilience: mental health and wellbeing for all	Using the Time to Change pledge, we will continue to use the leadership of the Health and Wellbeing Board to tackle stigma and discrimination by raising awareness and promoting positive perceptions of mental health across the Borough (G)	We will develop a public mental health and well-being programme which will include a portfolio of evidence based public mental health interventions, which will identify how we will deliver this, alongside other public mental health commitments over 2014/16	Paul Iggledun, Public Healh Consultant, LBTH	September 2014 for plan		
Building Resilience: mental health and wellbeing for all	We will develop our strategic partnership across the public and private sector to combat discrimination, encouraging local statutory organisations and local employers to sign the Time to Change pledge, and become mindful employers (G)		Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG and Paul Iggledun, Public Health Consultant, LBTH and Paul Iggledun, Public	September 2014 for plan		

Pillar	Commitment	Action	Lead Officer	Timescale	Comments	RAG
			Healh Consultant, LBTH			
Building Resilience: mental health and wellbeing for all	We will develop a local anti-stigma campaign. It will have a specific focus on BME communities, faith communities, and the LGBT community, where we have been told locally there is a need for focus (G)		Paul Iggledun, Public Healh Consultant, LBTH	June 2014 for plan; commitment commissioned by end December 2014		
Building Resilience: mental health and wellbeing for all	We will develop a new web resource that will provide easily accessible information on mental health services for children and young people, adults, and older people. The resource will act as a directory of mental health services for the borough, and an up to date repository of information about mental health related activities and events in the borough (G)	We will develop a new web resource.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	In place by December 2014		
Building Resilience: mental health and wellbeing for all	We will ensure that the web resource is publicized with community groups and services that support people who may not use the internet, so that people can be supported to access the information the web resource will hold. We will also ensure that providers publish relevant information in appropriate languages (G)					
Building Resilience: mental health and wellbeing for all	We will deliver our approach to raising mental health awareness through the commitments identified to tackle stigma and discrimination, as above (G)	We will develop a public mental health and well-being programme which will include a portfolio of evidence based public mental health interventions, which will identify how we will deliver this, alongside other public mental health commitments over 2014/16	Paul Iggledun, Public Healh Consultant, LBTH	June 2014 for plan; commitment commissioned by end December 2014		
Building Resilience: mental health and wellbeing for all	We will work with housing providers to improve mental health awareness with staff who work in and around housing (G)	We will develop a public mental health and well-being programme which will include a portfolio of evidence based public mental health interventions, which will identify how we will deliver this, alongside other public mental health commitments over 2014/16	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG and Carrie Kilpatrick, Service Manager, Accommodation, LBTH	In place by March 2015		
Building Resilience: mental health and	In our public mental health programme we will target health promotion interventions at all ages. We will seek		Paul Iggledun, Public Health	June 2014 for plan; commitment		

Pillar	Commitment	Action	Lead Officer	Timescale	Comments	RAG
wellbeing for all	to make them culturally relevant to our diverse population. We will ensure that commissioning focuses on improving the linkage between physical and mental health and contribute to the achievement of parity of esteem (G)		Consultant, LBTH	commissioned by end December 2014		
Building Resilience: mental health and wellbeing for all	We will, across the Council and the CCG, as the two main public sector commissioning bodies in the borough, use the Time to Change pledge to encourage our suppliers to adopt an Emotional First Aid programme for their employees (G)		Paul Iggledun, Public Healh Consultant, LBTH	June 2014 for plan; commitment commissioned by end December 2014		
Building Resilience: mental health and wellbeing for all	We will develop a specific plan for young carers of parents with a mental health problem as part of our work to develop family orientated care and support (G)	We will develop a specific plan for young carers of parents with a mental health problem.	Karen Badgery, Service Manager, Childrens Commissioning, LBTH	March 2015		
Building Resilience: mental health and wellbeing for all	We will use the contractual levers available to us to improve the experience of carers of people with mental health problems (G)	We will consider options for CQUIN and quality indicators for improving carer support.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	2016		
Building Resilience: mental health and wellbeing for all	With NHS England and public health within the Council, we will develop a JSNA factsheet specific to the mental health needs of offenders to help inform future commissioning arrangements (G)	We will develop a JSNA factsheet specific to the mental health needs of offenders	Paul Iggledun, Public Healh Consultant, LBTH	March 2015		
Building Resilience: mental health and wellbeing for all	We will develop as part of our responsibilities under the Public Sector Equalities Duty, a dashboard for access to services by race and other equality strand, to inform future commissioning (G)	We will monitor activity by protected characteristic to inform future commissioning, and publish specific reports on our website.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	2016		
Building Resilience: mental health and wellbeing for all	We will work with providers to improve recording of sexual orientation as part of equalities monitoring requirements to inform future commissioning (G)	We will monitor activity by protected characteristic to inform future commissioning, and publish specific reports on our website.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning,	2016		

Pillar	Commitment	Action	Lead Officer	Timescale	Comments	RAG
			THCCG			
High Quality Treatment and Support	We will develop a more complete understanding of prescribing activity for anti-psychotic and anti-depressant medicine in the borough. Led by our Commissioning Support Unit Medicines Optimisation Team, we will work across the Clinical Commissioning Group, East London NHS Foundation Trust and the Clinical Effectiveness Group at Queen Mary University to identify available meaningful information about prescribing practice, and triangulate this across primary care and secondary care to inform future commissioning and practice development, including the development of more robust care packages including shared care arrangements (G)	We will develop a methodology to understand prescribing activity and undertake a review.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG and Bill Sandhu, Head of Medicines Management, NELCSU	Complete by March 2015		
High Quality Treatment and Support	We will use the introduction of Payment by Results into mental health as an opportunity to develop clear clinically effective health and social care pathways, and to support service users to make choices about their care and support (G)	We will ensure that all preparatory work for payment by results is in place during the 2014/15 shadow year.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	March 2015		
Building Resilience: mental health and wellbeing for all	We will extend social prescribing to mental health (G)	We will consider the outcomes of the social prescribing pilot to establish the case for commissioning the pilot into mental health.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	2016		
High Quality Treatment and Support	We will ensure that waiting times for mental health services are minimized, and we will publish waiting times for key services as part of our partnership dashboard (G)	We will publish waiting times for key services as part of our partnership dashboard.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG			
High Quality Treatment and Support	In the review of the Healthy Lifestyles programmes, including healthy community and environment; maternity, early years and childhood; oral health, tobacco cessation; long term conditions, we will ensure that the specific barriers to access for people with a serious mental illness are addressed (G)	We will ensure that the specific barriers to access for people with a serious mental illness are addressed	Paul Iggledun, Public Health Consultant LBTH, and Esther Trenchard Mabere, Public	December 2014		

Pillar	Commitment	Action	Lead Officer	Timescale	Comments	RAG
			Health Consultant, LBTH			
High Quality Treatment and Support	In particular within the Clinical Commissioning Group, we will identify and secure opportunities for supporting people with mental health problems in each of our major workstreams, including: Maternity, Children and young people, Urgent care, Planned care, Integrated care, Long term conditions, Last years of life, Information and technology, Prescribing, Primary care development (G)	We will ensure that the specific barriers to access for people with a serious mental illness are addressed	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG			
Living well with a mental health problem	We will strengthen our approach to commissioning user-led grants to enable more service users to see their ideas for peer support realized in practice. We will also examine opportunities for service users to pool their personal budgets (health or social care) to form user led groups (G)	We will award 2 year grants for user led groups for 2014-16, and consider opportunities for pooled personal budgets	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	April 2014 for 2 year ULG contract award; June 2015 for personal budget consideration	Two year User Led Grants issued	G
Living well with a mental health problem	We will include in future specifications for relevant and appropriate services a requirement that an element of the service be delivered through peer support. This may include services delivered both by statutory and voluntary sector services (G)	We will consider opportunities for commissioning peer support as part of existing services.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	2016		

Long Term Conditions and Cancer

Outcome Objective 1: Reduced prevalence of the major 'killers' and increased life expectancy					
Cardiovascular					
Activity	**Lead Officer**	**Deadline**	**Status**	**% Comp**	**Comments**
NHS Health Checks to detect onset of cardiovascular disease to appropriately refer onto care packages	Public Health	30/03/2014	Completed	100%	
Milestone	**Lead Officer**	**Deadline**	**Status**	**%**	**Comments**
Quarterly reports to monitor the uptake of the NHS health check.	Public Health	30/06/13 30/09/13 31/12/13 31/03/14	Completed	100%	
To evaluate the current programme in relation who is accessing the NHS Health checks.	Public Health	30/01/2014	Completed	100%	
Identify developments and Implement changes required to ensure the checks are accessed on an equitable basis.	Public Health	31/03/2014	Completed	100%	There has been good representation from the Bangladeshi community. More work needed in respect of white working class (especially men) accessing health checks.
Activity	**Lead Officer**	**Deadline**	**Status**	**% Comp**	**Comments**
Finalise review of diagnostics provision including ECG survey and echo. Explore the feasibility of setting up a pilot provision with Barts Health for open access echo and 24hr ECG service at BLT.	TH CCG	31/07/2013	Completed	100%	CCG are reprocuring AECG and Echo. Aiming to have new provider in place by April-May 2014
Milestone	**Lead Officer**	**Deadline**	**Status**	**%**	**Comments**
Complete exploratory work	TH CCG	31/07/2013	Completed	100%	
Activity	**Lead Officer**	**Deadline**	**Status**	**% Comp**	**Comments**
Review of CVD care package	TH CCG	31/10/2013	Completed	100%	This care package is reviewed annually. Changes for 2014/15 have been implemented.
Milestone	**Lead Officer**	**Deadline**	**Status**	**%**	**Comments**
Review reports and recommendations included in commissioning intentions	TH CCG	31/10/2013	Completed	100%	Will be signed off at CCG committee in December
Diabetes					
Activity	**Lead Officer**	**Deadline**	**Status**	**% Comp**	**Comments**
Review diabetes care planning, including the use of high cost insulin	TH CCG	30/04/2014	Completed	100%	These are on-going actions as part of a continuous commissioning cycle.
Milestone	**Lead Officer**	**Deadline**	**Status**	**%**	**Comments**
Work with prescribing team in cross-sector prescribing initiative to reduce spend on high cost insulin use	TH CCG	30/04/2013	Completed	100%	This is now a permanent part of the prescribing process
Seek qualitative feedback from patients on their experience of their care planning consultation within the diabetes care package	TH CCG	30/09/2013	Completed	100%	Developing plans with a view to implement new requirement in 14/15, based on judgement that current requirements don't provide meaningful feedback

Review the diabetes care package to support individual general practices in tighter control of diabetes within their patient population in the first 10 years after diagnosis	TH CCG	31/10/2013	Completed	100%	These are on-going actions as part of a continuous commissioning cycle.
Introduce changes	TH CCG	30/04/2014	Completed	100	These are on-going actions as part of a continuous commissioning cycle.
Hypertension					
Activity	**Lead Officer**	**Deadline**	**Status**	**% Comp**	**Comments**
Review of hypertension care package	TH CCG	30/04/2014	Completed	100%	
Milestone	**Lead Officer**	**Deadline**	**Status**	**%**	**Comments**
Carry out review	TH CCG	30/09/2013	Completed	100%	
Changes built into commissioning intentions	TH CCG	31/10/2013	Completed	100%	No changes required. Subject to annual review
Changes to care package introduced	TH CCG	30/04/2014	Completed	100%	No changes required. Subject to annual review
Respiratory					
Activity	**Lead Officer**	**Deadline**	**Status**	**% Comp**	**Comments**
Review of COPD Care Package	TH CCG	31/03/2014	Completed	100%	
Milestone	**Lead Officer**	**Deadline**	**Status**	**%**	**Comments**
Results fed into commissioning intentions	TH CCG	31/03/2014	Completed	100%	Introducing smoking cessation metric
Activity	**Lead Officer**	**Deadline**	**Status**	**% Comp**	**Comments**
Review of whole system care pathways for Childhood Asthma	TH CCG	31/03/2014	Completed	100%	Scrutiny of the data shows this isn't an issue for Tower Hamlets
Milestone	**Lead Officer**	**Deadline**	**Status**	**%**	**Comments**
Findings will be used to inform the future work plans of the CCG and commissioning intentions for 2014/15 and beyond	TH CCG	31/03/2014	Completed	100%	above
Activity	**Lead Officer**	**Deadline**	**Status**	**% Comp**	**Comments**
Current provision and needs for Adults Asthma	TH CCG	31/10/2013	Completed	100%	Signed up to Asthma UK quality standards, to be in place by 2016
Milestone	**Lead Officer**	**Deadline**	**Status**	**%**	**Comments**
Examine JSNA data on asthma admissions, in particular differentiating between adult and children.	TH CCG	31/08/2013	Completed	100%	
Results fed into commissioning intentions	TH CCG	31/10/2013	Completed	100%	
Activity	**Lead Officer**	**Deadline**	**Status**	**% Comp**	**Comments**
Appoint a Home Oxygen Specialist to undertake cost benefit analysis of developing a HOSAR, with support from the CSU.	TH CCG	31/01/2014	Overdue	75%	Funding agreed in November. See commentary below.
Milestone	**Lead Officer**	**Deadline**	**Status**	**%**	**Comments**
Appointment of specialist	TH CCG	31/01/2014	Completed	100%	Home Oxygen specialist in post from April 2014.
Recommendations to be included in contract negotiations	TH CCG	31/01/2014	Overdue	50%	Awaiting recommendations to be ready by September 2014 to inform commissioning plans for 2014/15.

Cancer					
Activity	**Lead Officer**	**Deadline**	**Status**	**% Comp**	**Comments**
Early Identification through: • increasing the uptake of breast, bowel and cervical screening using targeted outreach, primary care endorsement, improved practice systems • increasing public awareness of cancer and the need to report symptoms without delay through the small c campaign	Public Health	31/03/2014	Overdue	73%	Please note: the first part of this is an NHS England responsibility, Public Health has an assurance role. The small c campaign continuing, four contracts in place to deliver messages with local communities. These are all performing well to date. Progress is being monitored on an ongoing basis by Public Health.
Milestone	**Lead Officer**	**Deadline**	**Status**	**%**	**Comments**
Link with Public Health England to • agree screening targets	Public Health	31/07/2013	Overdue	60%	Awaiting response from NHS E/PHW. This is to be followed up. An assurance meeting is planned for October 2014.
• agree assurance process	Public Health	31/07/2013	Overdue	60%	LGA guidance has been used as a tool for measuring performance. Initial assessment suggested underperformance. Issues to be raised by DPH with PHE and have been shared with London DsPHs. An assurance meeting is planned for October 2014.
Commissioned community organisations will engage directly with at least 2,800 local people in target groups to increase awareness cancer	Public Health	31/03/2014	Completed	100%	Small c campaign continuing, four contracts in place to deliver messages with local communities. These are all performing well to date.
Activity	**Lead Officer**	**Deadline**	**Status**	**% Comp**	**Comments**
Cancer waiting times, improvement against the 62 day wait standard	TH CCG	31/03/2014	Ongoing	66%	This is an ongoing activity. Despite this not being technically overdue, it is not producing the outcomes it should and further work is needed in 2014/15.
Milestone	**Lead Officer**	**Deadline**	**Status**	**%**	**Comments**
Set local priority for monitoring of 62 day wait	TH CCG	30/04/2013	Completed	100%	Local priority embedded into plans
Develop 'flag' when patients reach day 42	TH CCG	30/09/2013	Completed	100%	Monitored under Barts Health performance reviews.
Monthly review of performance	TH CCG	31/03/2014	Ongoing		
Making Every Contact Count					
Activity	**Lead Officer**	**Deadline**	**Status**	**% Comp**	**Comments**
To develop a public health approach in the health and social care consultations which take place as part of the long-term conditions care packages consultations to "make every contact count".	Public Health	31/03/2014	Completed	100%	Beginning to make progress on housing and health agenda, very preliminary to date. Undertaking an exploratory workshop with PH colleagues ahead of possible wider ESCW engagement.
Milestone	**Lead Officer**	**Deadline**	**Status**	**%**	**Comments**
To identify the how public health issues are currently integrated specific long-term conditions consultations	Public Health	31/10/2013	Completed	100%	This is incorporated into long term conditions care packages.
To develop initiatives and implement changes to start to improve content of the consultations with patients within the long-term care packages	Public Health	31/03/2014	Completed	100%	This is incorporated into long term conditions care packages.

Outcome Objective 2: Improved patient experience and co-ordination of health, housing and social care for those with single or multiple long term conditions					
Activity	**Lead Officer**	**Deadline**	**Status**	**% Comp**	**Comments**
Lead a cultural change programme for professionals and staff about self-care	Health and Wellbeing Board	TBC			
Milestone	**Lead Officer**	**Deadline**	**Status**	**%**	**Comments**
TBC	Health and Wellbeing Board	TBC			
Activity	**Lead Officer**	**Deadline**	**Status**	**% Comp**	**Comments**
Develop an integrated community health and social care contact point (Referral hub in health and First Response)	Integrated Care Board	30/06/2013	Overdue	50%	Single point of access started on 1st November for health related queries. Year two will look at move towards integrating health and social care SPA
Milestone	**Lead Officer**	**Deadline**	**Status**	**%**	**Comments**
Sign off of integrated care delivery plan	Integrated Care Board	30/06/2013	Completed	100%	Delivery plan signed off and monitored regularly at Integrated Care Board
Design group for integrated community health team commences	Integrated Care Board	30/06/2013	Completed	100%	Integrated Community Health Team (ICHT) went live 1st November
Activity	**Lead Officer**	**Deadline**	**Status**	**% Comp**	**Comments**
Improve coordination and consistency between re-ablement and rehabilitation.	Integrated Care Board	30/09/2013	Completed	100%	ICHT went live 1st November
Milestone	**Lead Officer**	**Deadline**	**Status**	**%**	**Comments**
Go live of new specification	Integrated Care Board	30/09/2013	Completed	100%	ICHT went live 1st November
Activity	**Lead Officer**	**Deadline**	**Status**	**% Comp**	**Comments**
Review evidence of self-care programmes	Public Health	31/01/2014	Completed	100%	
Milestone	**Lead Officer**	**Deadline**	**Status**	**%**	**Comments**
Complete literature review of evidence of cost effective self care programmes, aligned to patient groups targeted by integrated care	Public Health	30/09/2013	Completed	100%	
Make recommendations for the CCG Board to consider	Public Health	31/10/2013	Completed	100%	
Activity	**Lead Officer**	**Deadline**	**Status**	**% Comp**	**Comments**
Implement an integrated advanced care plan and record for patients that sit across health and social care	Integrated Care Board	30/09/2013	Overdue	50%	An Integrated Care information sharing agreement is being developed. The Orion portal will provide a shared care record, but social care information is still outstanding.
Milestone	**Lead Officer**	**Deadline**	**Status**	**%**	**Comments**
Roll out of ORION pilot	Integrated Care Board	30/09/2013	Completed	100%	
Finalise info sharing agreements	Integrated Care Board	30/09/2013	Overdue	10%	Primary care, Barts Health, ELFT, Social Care is outstanding.
Develop joint care assessment	Integrated Care Board	31/07/2013	Overdue	10%	

Activity	Lead Officer	Deadline	Status	% Comp	Comments
18 month pilot to integrate social workers in the Multi-Disciplinary team meetings for the community virtual ward and co-locate with community matrons	Integrated Care Board	31/07/2013	Completed	100%	ICHT went live 1st November
Milestone	**Lead Officer**	**Deadline**	**Status**	**%**	**Comments**
Recruitment and appointment process underway	Integrated Care Board	28/02/2013	Completed	100%	see above
Co-locate social workers into the locality based clinics	Integrated Care Board	31/07/2013	Completed	100%	see above
Activity	**Lead Officer**	**Deadline**	**Status**	**% Comp**	**Comments**
Develop and provide robust community-based Geriatric provision focus on admission avoidance, early discharge and effective community-based management of complex and/or vulnerable cases including last years of life	Integrated Care Board	31/05/2013	Completed	100%	ICHT went live 1st November
Milestone	**Lead Officer**	**Deadline**	**Status**	**%**	**Comments**
Recruitment and appointment locum cover	Integrated Care Board	30/04/2013	Completed	100%	ICHT went live 1st November
Establish working arrangement to co-locate in the locality based clinics	Integrated Care Board	31/05/2013	Completed	100%	ICHT went live 1st November
Activity	**Lead Officer**	**Deadline**	**Status**	**% Comp**	**Comments**
Develop and provide continence service in care homes	Integrated Care Board	30/04/2014	Overdue	0%	No proposals in place. Care homes being independent organisations will have their own arrangements in place. A review of H&WB Action Plan needs to consider the original rationale for this proposal as it did not exist in any CCG, LBTH or provider work stream.
Milestone	**Lead Officer**	**Deadline**	**Status**	**%**	**Comments**
Provision of continence equipment	Integrated Care Board	30/04/2014	Overdue	0%	
Activity	**Lead Officer**	**Deadline**	**Status**	**% Comp**	**Comments**
Establish jointly chaired forum with health and social care to develop an integrated approach to commissioning the older persons pathway that takes a whole system person centred approach	Integrated Care Board	30/09/2013	Obsolete		Action obsolete given developments with Integrated Community Health Team and Integration Transformation Fund.
Milestone	**Lead Officer**	**Deadline**	**Status**	**%**	**Comments**
Develop workplan for older persons pathway	Integrated Care Board	30/09/2013	Obsolete		
Activity	**Lead Officer**	**Deadline**	**Status**	**% Comp**	**Comments**
Formalise and make clearer the communication about patient prognosis to patients and between secondary and primary care	TH CCG	30/04/2015	Not due yet		
Milestone	**Lead Officer**	**Deadline**	**Status**	**%**	**Comments**
OD with BH	TH CCG	30/04/2015	Not due yet		`
Early adapter groups	TH CCG	30/04/2015	Not due yet		
Shared language re: prognosis	TH CCG	30/04/2015	Not due yet		

Activity	Lead Officer	Deadline	Status	% Comp	Comments
Engender a cultural shift that 'normalises' death in the community and supports advanced care planning	TH CCG	30/04/2014	Overdue	20%	To be reviewed in 2014/15.
Milestone	**Lead Officer**	**Deadline**	**Status**	**%**	**Comments**
Use engagement to test where advance care planning could be accessed e.g. when registering with GP / benefit advice etc	TH CCG	30/04/2014	Overdue	20%	
Collecting data and qualitative feedback to develop a baseline position to inform developments of advance care planning	TH CCG	30/04/2014	Overdue	20%	
Activity	**Lead Officer**	**Deadline**	**Status**	**% Comp**	**Comments**
Improve availability and access to information on healthy dying by embedding in single health and social care information resource system for professionals and residents	Health and Wellbeing Board	TBC			
Milestone	**Lead Officer**	**Deadline**	**Status**	**%**	**Comments**
Collate directory of support available	Health and Wellbeing Board	TBC			
Activity	**Lead Officer**	**Deadline**	**Status**	**% Comp**	**Comments**
Improve support given to those dying and their carers	TH CCG	30/04/2014	Overdue	75%	
Milestone	**Lead Officer**	**Deadline**	**Status**	**%**	**Comments**
Create a checklist of things to consider and where to get support for patients / carers.	TH CCG	30/04/2014	Completed	100%	
Checklist triggered when GP issues DS1500 to patients	TH CCG	30/04/2014	Overdue	50%	
Activity	**Lead Officer**	**Deadline**	**Status**	**% Comp**	**Comments**
Review current programmes that support preferred place of death and produce analysis of what works and what doesn't work	TH CCG	30/04/2014	Overdue	50%	There are significant issues with how this information is recorded and is variable across providers. Place of death is often recorded, but not if this was "preferred". Anticipatory Care Planning (under Integrated Care Programme) will mean in future this is recorded. Should be in place by April 2015.
Milestone	**Lead Officer**	**Deadline**	**Status**	**%**	**Comments**
Commission research/needs assessment with public health	TH CCG	30/04/2014	Overdue	50%	The Lead for this milestone is Public Health. A Needs assessment is underway to report between December 2014 and March 2015.
Outcome Objective 3: More people with learning disabilities receiving high quality care and support					
Activity	**Lead Officer**	**Deadline**	**Status**	**% Comp**	**Comments**
Implement the recommendations from the Learning Disability Self Assessment Framework	Learning Disability Partnership Board (Bozena Allen)and TH CCG	31/03/2014	Completed	100%	Implementation of the SAF recommendations are being taken to the Learning Disabilities Partnership Board; with identified areas of work delegated to releavnt LDPB subgroups.
Milestone	**Lead Officer**	**Deadline**	**Status**	**%**	**Comments**

Oversee implementation of the aims of Valuing People Now and other local objectives to improve the lives of people with learning disabilities in Tower Hamlets	Learning Disability Partnership Board (Bozena Allen) and TH CCG	31/03/2014	Completed	100%	Ongoing piece of work with progress against the aims embedded in the SAF returns.

Activity	Lead Officer	Deadline	Status	% Comp	Comments
Develop and implement plan for autism services and improvement	Autism Strategy Implementation Group (Barbara Disney)	31/03/2014	Completed	100%	The Austism Strategy Implementation Group will be meeting in September to review progress against the plan.
Milestone	**Lead Officer**	**Deadline**	**Status**	**%**	**Comments**
Autism plan developed and agreed	Autism Strategy Implementation Group (Barbara Disney)	31/03/2014	Completed	100%	The Autism Plan has been signed off.
Diagnostic and Intervention Team in place	Autism Strategy Implementation Group (Barbara Disney)	31/03/2014	Completed	100%	The contract has been awarded from 1st May 2014. Mobilisation is underway and referrals coming through. KPIs agreed and contract being signed.
Activity	**Lead Officer**	**Deadline**	**Status**	**% Comp**	**Comments**
Improve housing options for people with learning disabilities in Tower Hamlets	Learning Disability Partnership Board (Bozena Allen)	31/03/2016	Delayed	25%	Readjustment of two LDPB milestones following a review by the Partnership Board.
Milestone	**Lead Officer**	**Deadline**	**Status**	**%**	**Comments**
Commissioning plan for accommodation options agreed	Learning Disability Partnership Board (Bozena Allen)	30/06/2013	Completed	100%	Phase One of delivering this plan - Needs and Capacity Analysis; was complete in Spring 2013. The report formally confirms that this is high priority area for the borough, but clearly identified a number of pieces of priority work which need to be undertaken before a high quality strategic plan can be produced. It has been agreed that a Learning Disabilities Accommodation Sub-Group of the Partnership Board should be developed to lead this piece of and new timescales will be identified.
Existing learning disabilities accommodation remodelled where appropriate	Learning Disability Partnership Board (Bozena Allen)	30/04/2014	Delayed	0%	The LDPB has set a target for the 31/03/2017 for this piece of work.
Delivery of commissioning plan outcomes within identified timescales in the Commissioning Plan, with the exception of those that are reliant on decommissioning or procuring buildings	Learning Disability Partnership Board (Bozena Allen)	30/04/2014	Delayed	0%	The LDPB has set a target for 31/03/2016 for this piece of work.
New services as identified in the plan in place	Learning Disability Partnership Board (Bozena Allen)	31/03/2016	On target	0%	Ongoing piece of work and is on target for 31/03/2016.

Indicator	2013/14 Target	2013/14 Q2 Target	2013/14 Q4 Local Outturn	2013/14 Q4 London Outturn	Comments	RAG
Proportion of women who smoke during pregnancy	3.50%	3.50%	3.00%	5.00%	There is a risk that smoking rates in pregancy rates could increase as a consequence of demographic changes.	G
Proportion of women who are obese during pregnancy (BMI > 30)	12%	12%				
Teenage pregnancy rate	27.50%	27.50%	24.30%		The latest ONS conception statistics for 2012 show continual local progress in reducing teenage pregnancies since start of the national teenage pregnancy strategy. The under-18 conception rate has fallen by 58.0% since 1998, down from 57.8 conceptions per 1,000, compared with a national decrease of 40.6% and London decrease of 49.3%. Tower Hamlets rate is lower than England (27.7/1000) and London (25.9/1000). Family Nurse Partnership provides intensive support for first time teenage parents that will significantly improve life chances of the children.	G
Proportion of pregnant women who have an antenatal screening for HIV	Data Quality					
Proportion of pregnant women who have an antenatal screening for Downs Syndrome (Completion of lab request forms)	97%	97%			Data awaited from Public Health England	
Proportion of pregnant women who have antenatal screenings for sickle cell and thalassemia	Data Quality				Data awaited from Public Health England	
Proportion of new born babies given a blood spot screening	95%	95%			Data awaited from Public Health England	
Proportion of new born babies given a hearing screening	95%	95%			Data awaited from Public Health England	
Child development at 2-2.5 years	TBC	N/A			Data awaited from Public Health England	
Rate of infant mortality (children who die before reaching their first birthday)	5	5	5.3		Infant mortality in TH was previously lower than average for London and England. There has been a recent increase but small numbers mean that it is hard to interpret. This is being monitored to see if it is becoming a trend.	A
Proportion of babies born with low birth weight (<2.5kg)	9%	9%	4.1%		Note that Public Health Outcomes Framework (PHOF) data indicated that the proportion is well below the target figure, so we need to relook at this target for 2014/15.	G
Proportion of mothers who breastfeed at birth	88.50%	88.50%	86.80%		Barts Health maternity service recently reassessed for UNICEF BFI reaccreditation and had improved in a number of areas but the decision is still under review due to evidence that infant formula is sometimes given without valid medical grounds or evidence of informed maternal choice.	A
Proportion of mothers who are breastfeeding at 6-8 weeks	71.50%	71.50%	71.10%		Community services (Health Visitors and Children's Centres) successfully achieved BFI re-accreditation and the Breastfeeding Support Service was commended. Despite high total breastfeeding rates we have low exclusive breastfeeding rates and recent local research has highlighted the role of the extended family: grandmothers and mothers in law in influencing infant feeding practices. The recommendations are being discussed with services.	A
Proportion of babies who receive the BCG vaccination when they are a year old	95%	95%			Data awaited from Public Health England	
Proportion of babies who receive the DTap/IPV/Hib vaccination when they are a year old	95%	95%	96.8%		Coverage of the child immunisation programme remains high, it is important to maintain a focus on this programme to ensure that coverage does not drop.	G
Proportion of babies who receive the MMR vaccination when they are two years old	95%	95%	93.8%		See comment above.	A
Proportion of babies who receive the DTap/IPV/Hib vaccination when they are five years old	95%	95%			See comment above.	
Proportion of babies who receive two doses of the MMR vaccination when they are five years old	95%	95%	93.4%		See comment above.	A
Proportion of children in Reception who are overweight	10.80%	10.80%	10.90%		**There is now a combined figure for overweight and obese** Levels of obesity have been decreasing since 2006/07 although for the last 3 years this seems to have plateaued.	A
Proportion of children in Reception who are obese	13.10%	13.10%	12.70%		As above	G
Proportion of children under 5 with tooth decay	30.00%	30.00%	27.90%		Following improvements and a narrowing of the gap between Tower Hamlets and London and England from 2002-08, there has been a deterioration in Tower Hamlets. More needs to be done both to improve children's access to dental care and also preventive work including raising awareness of impact of dietary sugar and oral hygiene. This will be linked to work on health weaning.	G
Proportion of children accessing dental services	62.9%	62.9%			Figure will be updated in due course - data awaited	
Proportion of children in Year 6 who are obese	25.10%	25.10%	26.50%			A
Proportion of adults (18+) who smoke	21%	21%	19%			G
Rate of admissions to hospital that are alcohol- related per 100,000 population	2424.3	2424.3	2577		PHOF 2.18 has a figure of 634 which does not appear comparable.	A
Proportion of all in treatment, who successfully completed treatment and did not re-present within 6 months (opiates)	11%	11%	9%			R
Successful completions of treatment for children and young people	74.50%	74.50%				
Successful completion of alcohol treatment	55%	55%	33%			R
People arrested and identified as having substance misuse issues who are previously not known to the Drug Intervention Programme	20/month	120	57			G
Number of binge drinking callouts (Incidents where London Ambulance Service have attended someone suffering from an alcohol related illness)	1273	636.5	293			G
Numbers of screenings completed in primary care	25000	12500				
Rate of people aged 15-24 testing positive for chlamydia	1800	900	1479			G
Proportion of HIV infections diagnosed late	33%	33%	32%			G
Rate of deaths from causes considered preventable of persons under 75	107.4	107.4			This indicator is wrong. It should read "Potential Years of Life Lost". THCCG performance is 2848.2, with an operating plan target for 18/19 of 2381.2	
Rate of deaths from all cardiovascular diseases (including heart disease and stroke) of persons under 75	81.4	81.4	107.5		2012 data%	R
Rate of deaths from cancer of persons under 75	124	124	150.2		2012 data%	R

Rate of deaths from respiratory disease of persons under 75	32.2	32.2	40.6		2012 data%	R
Percentage of people who are eligible for cancer screening who are screened	TBC with Public Health England				Data awaited from Public Health England	
Proportion of people who are eligible, who take up the NHS Health Check Programme	+12%	+12%	15%		Estimate calculated by multiplying the % eligible who were invited by the % invited who took it up.	G
Proportion of people feeling supported to manage their condition	91%	91%	70%		This is 2010 data.	R
Proportion of people who use services and carers who find it easy to find information about services	75%	75%				
Overall satisfaction of people who use services with their care and support	66%	66%				
Overall satisfaction of people with learning disabilities who use services with their care and support	93%	93%			Data will not be available until later on in the year.	
Proportion of adults with learning disabilities in paid employment	9%	9%			As above	
Proportion of adults with learning disabilities who live in their own home or with their family	65%	65%			As above	
Quality of life as reported by carers	TBC	TBC			The last Carers' Survey took place in 2012 with the next survey due this Autumn.	
Proportion of carers who report that they have been included or consulted in discussions about the person they care for	30%	30%			As above	
Health-related quality of life for carers	45%	45%	75%		Covers July 11 to March 12. Period 12-13 supressed by the Health and Social Care Information Centre (HSIC) due to a low number of responses resulting in null result.	G

Health and Wellbeing Board 9th December 2014	Tower Hamlets Health and Wellbeing Board
Report of the London Borough of Tower Hamlets	**Classification:** [Unrestricted]
Mental Health Strategy Update	

Lead Officer	Robert McCulloch Graham
Contact Officers	Richard Fradgley
Executive Key Decision?	No

Executive Summary

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 well-being 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.

This paper provides an update on the delivery of the Strategy to the Board.

Recommendations:

The Health and Wellbeing Board is recommended to:

1. Note the progress made in delivering the Tower Hamlets Health & Wellbeing Board Mental Health Strategy

1. REASONS FOR THE DECISIONS

1.1 Tower Hamlets has amongst the highest prevalence of mental ill-health of any borough in England. People with mental health problems experience poorer life outcomes than the general population, including physical health, education, employment and family and relationships. Mental health is a significant priority in national health and social care policy, and is one of the four key priorities of the Tower Hamlets Health and Wellbeing Board.

1.2 The Tower Hamlets Mental Health Strategy, based on extensive engagement with service users, and health and social care professionals, details the Health and Wellbeing Board, CCG and Council commitments to improve outcomes for people with mental health problems in the borough over the next five years, with an action plan for the delivery of the strategy until 2016. The Strategy was approved by the Health & Wellbeing Board in February 2014.

1.3 This paper updates the Board on progress in delivering the Strategy.

2. ALTERNATIVE OPTIONS

2.1 There are no alternative options. In view of the high level of mental health need in Tower Hamlets, it is essential for the Health and Wellbeing Board to have a Mental Health Strategy in place and to be assured of progress in delivery.

3. DETAILS OF REPORT

3.1The Tower Hamlets Health and Well-Being Board, NHS Tower Hamlets Clinical Commissioning Group, and the London Borough of Tower Hamlets are 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, and the Board's commitments to mental health are detailed in the five year Mental Health Strategy, approved in February 2014.

3.2 The Strategy is an ambitious plan to improve outcomes for children and young people, adults of working age and older people who have, or are at risk of developing, a mental health problem.

Context – why mental health?

3.3 Tower Hamlets has a high prevalence of risk factors that can contribute to the development of mental health problems in individuals, for example child poverty, long term unemployment, older people living in poverty, overcrowded households, population density, homelessness, crime including hate crime against specific communities, carers working over 50 hours per week, harmful alcohol use.

3.4 Tower Hamlets has a very high prevalence of mental health problems. We have the fourth highest proportion of people with depression in London, the fourth highest incidence of first episode psychosis, and the highest incidence of psychosis in east London according to GP registers. In total there are approximately 30,000 adults

estimated to have symptoms of a common mental health problem in the borough, with around 15,900 people known to their GP to have depression, and 3,300 known to have a serious mental illness, with a prevalence of c. 1200 people with dementia. Local information on prevalence of mental health problems in children is not known, however we would anticipate between 3,400 and 15,000 children at any one time to be in touch with some part of the health, social care and education systems due to concerns about their mental health.

3.5 The impact of mental health problems on individuals, families and communities can be profound. For example:

- Mental illness has a profound impact on health, relationship, housing, educational and employment outcomes. In a recent study, the London School of Economics found that mental health accounts for more felt suffering than physical health problems, or income deprivation
- Mental illness has the same effect on life-expectancy as smoking, and more than obesity. People with a serious mental illness die on average 20 years earlier than the general population
- Amongst people in work, mental illness accounts for nearly half of all absenteeism. And amongst people out of work, almost half are on incapacity benefit on account of a mental health problem.

3.6 Improving mental health services currently has high national visibility. Since the Health & Wellbeing Board approved the Strategy in February 2014, there have been several key national policy decisions that provide further focus on improving mental health services including:

- The introduction of waiting time targets into mental health for the first time, in 2015/16 including a two week access target to Early Intervention in Psychosis services, and a six week referral to treatment target for talking therapies in primary care
- The introduction of choice at first outpatient appointment following GP referral into mental health services
- The introduction of Integrated Personal Commissioning pilots, bringing health and social care personal budgets together
- The requirement on local partnerships to develop a local action plan to deliver the Mental Health Crisis Concordat
- The publication of the Health Select Committee report on Child and Adolescent Mental Health Services and the development of a national task force to review commissioning of CAMHS across the NHS, local government and education
- The publication of the Health Select Committee report on the implementation of the Mental Capacity Act
- The publication of the Care Act Statutory Guidance on Implementation
- The publication of Monitor Tariff Implementation Guidance, which gives local commissioners more freedom to move towards outcomes based contracts.

Progress

3.7 The Strategy's vision is as detailed below:

"Our vision is to deliver substantially improved outcomes for people with mental health problems in Tower Hamlets through integrated mental health services that are safe and effective, with friendly staff that inspire confidence in the people and families using them, and which help people to take control of their own lives and recovery"

3.8 In summary, the Strategy aims tobuild resilience in our population, ensure high quality treatment and support, and support people to live well with a mental health problem. The foundations of the Strategy lie in the shared values that underpin a whole person approach and the principle that mental health is everybody's business. The overarching principle that governs the Strategy is that it takes a lifecourse approach, actively considering how the whole population can be supported to be mentally healthy from birth. We believe that in delivering the commitments that we will detail in this Strategy, we will measurably improve outcomes for people with mental health problems and their carers.

3.9 The strategy's objectives are laid out in the diagram below:

A life course approach to mental health and well-being			
Building resilience: mental health and wellbeing for all	**High Quality Treatment & Support**	**Living well with a mental health problem**	**Improved outcomes**
Fewer people will experience stigma and discrimination	People in general settings like schools and hospitals will have access to mental health support	People will feel that mental health services treat them with dignity and respect, and inspire hope and confidence	
People will have access to improved information on what services are available	People will have access to high quality mental health support in primary care, including GP practices and primary care psychology	People will have access to support from peers and service user led services	
Mental health awareness across our communities, schools and employers and in the health, social care and education workforce will improve	People will receive a diagnosis and appropriate support as early as possible	People will be able to make choices about their care, including through personal budgets	
People will have access to a range of preventative and health promotion services	People will have timely access to specialist mental health services	People will feel supported to develop relationships and connections to mainstream community support	
Families and carers will feel more supported	People will be able to access timely crisis resolution, close to home	People will have access to support to find employment, training or education	
People will experience smooth transitions between services	When they need to access multiple services, people will feel that they are joined up	People will have access to accommodation that meets their needs, in the borough	

3.10 Since approval of the Strategy, the CCG and the Council have made considerable progress with key deliverables for 2014-15, as detailed below:

2014-15 Strategy commitment	RAG rating	Update on progress
Public mental health programme: We will develop a public mental health and well-being programme which will include a portfolio of evidence based public mental health interventions, which will identify how we will deliver this, alongside other public mental health commitments over 2014/16	September 2014	A public mental health programme has been developed and is currently pending final approval within the Council. There has been a delay to the production of the final plan against the Strategy target of September 2014 Significant progress has been made by key HWBB agencies who signed the Time to Change Pledge in October 2013
Parent and infant mental health wellbeing: We will map current services available to support maternal and infant mental health in order to identify gaps, improve access for groups at higher risk, improve coordination across services and develop proposals to strengthen the universal tier of the service (including Maternity services, Health Visiting and services delivered from Children's Centres, primary care and by voluntary and community organisations)	March 2014	The mapping exercise is complete, and has informed the development of a business case to support a coordinated programme of training across providers
School nursing and mental health and wellbeing: We will ensure that the roles of school nurses in relation to emotional health and well-being are clearly articulated in specifications for the re-procurement of the School Health service	December 2014	The school nursing service has been re-specified and a procurement process has been undertaken and is pending contract award
Whole system child and adolescent mental health services: We will develop a refreshed service model for child	March 2015	The project to re-design services for children and young people with a mental health has begun; a project advisory group and project team has been formed, with support from North East London

and adolescent mental health services. A project board will be set up across all stakeholders to oversee this work including the development of a set of service specifications to deliver the refreshed service model. This will include consideration of the impact of potential changes to the CAMHS service model to services for adults of working age. We will develop a refreshed model for the delivery of day opportunity and support services, with an accompanying procurement plan		Commissioning Support Unit to develop an outcomes based approach. A series of co-production workshops with children and young people to help develop key outcomes to be delivered from a future whole system CAMHS service begins w/c 18/11/14. The project is on track for an outline business case to be completed by January 2015.
Improving accommodation with support for adults with a serious mental illness: We will continue the work to remodel and re-commission resettlement and rehabilitation team pathways	April 2014	Two new supported accommodation schemes for people with mental health problems have opened during 2014, enabling us to support more people to live locally rather than in out of borough residential care. As of October 2014, there were 88 people living in residential care compared with the baseline of 135 in 2009/10. The partnership is currently reviewing options for the form of the resettlement and rehabilitation teams for 2015/16.
Access to talking therapies: We will review talking therapies providers, and develop a commissioning plan for future talking therapies pathways	September 2014	This commitment is being considered as part of delivering a new model for primary care mental health services, as detailed below.
We will develop a refreshed service and activity model for the primary care mental health service (including social care)	June 2015	This work is well underway, with a project group comprising CCG, ELFT, LBTH and Compass participants and engagement with service users
We will re-procure tobacco cessation and obesity services to explicitly include access for people with a serious mental illness	June 2014	The Tobacco Cessation Service has been procured with a clear focus on supporting people with a serious mental illness to stop smoking; the obesity service is pending contract award
We will review the model for in-patient care of older adults with a functional mental health problem	June 2015	A business case has been completed proposing a single assessment ward for older people with mental health problems to support residents of City & Hackney and Tower Hamlets, to be based at Mile End Hospital. This has been considered by the CCG Governing Body and Health Scrutiny Committee at LBTH, and will proceed to public consultation in the near future.
We will develop a specification for mental health support in the community health service locality teams (within the Integrated Care Programme)	June 2014	There has been a delay to finalising the specification for this service, which we anticipate will be complete by end November 2014
We will review community mental health services for older adults in the context of our work to develop integrated care	June 2015	This is dependent on the outcome of the review of inpatient care for older adults with a functional mental health problem

We will commission more dementia cafes	April 2014	Fortnightly English and Sylhetti speaking dementia cafes have been commissioned, and a Somali café is currently being piloted
We will develop a new web resource summarising information on mental health services in the borough for service users and professionals	December 2014	A new web resource hosted on the Idea Store website called "In the Know" has been developed and will be launched in December 2014
We will develop a rolling programme of training for GP's and other primary care staff.	June 2014	A range of training has been coordinated for GP's including: Mental Capacity Act, dementia, safeguarding adults, personality disorder, psychosis, learning disability

3.11 More generally, Tower Hamlets mental health services have performed well in many areas during 2014-15 year to date, including:

- A highly effective crisis pathway for adults of working age, with primary care, Community Mental Health Teams, the Home Treatment Team, Crisis House, inpatient services and supported accommodation services working well together. This is highlighted by in-patient occupancy at the Tower Hamlets Centre for Mental Health consistently being in the region of 75%
- Highly effective accommodation pathway for adults of working age, delivering recovery orientated accommodation based support much closer to home and providing significant savings to the Council and the CCG
- Highly effective community dementia services, with the third highest diagnosis rate for dementia in London, excellent reported experience by carers, and national recognition of the service as a site of best practice
- Excellent service user and staff feedback on East London Foundation Trust services, with the Trust top six in the country on service user experience according to the National Patient Survey, and being recognised as a top ten employer in the NHS in the country by the Health Service Journal

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. The Care Act 2014 was enacted in May 2014 and comes mostly into effect in April 2015. From April 2015the duties under the Care Act replace the Council's duties under S.29 National Assistance Act 1948, S.2 of the Chronically Sick and Disabled Persons Act 1970 and S.47 NHS & Community Care Act 1990. The earlier pieces of legislation will be repealed.Relevant Guidance and regulations supporting the Act have been issued in October 2014. Section 1 of the Care Act places a general duty on the Council when exercising its functions, to promote an individual's well-being relating to their physical and mental health, emotional well-being and personal dignity.

5.2. The Care Act 2014 replaces the existing duties in respect of assessing and meeting an individual's eligible care needs. Section 8 provides that those eligible needs may be met in a number of ways, including care and support at home or in the community, and by providing the service itself, arranging another provider to provide the service, or direct payments.

5.3. Additionally, the Act places a duty on local authorities to assess the carers of persons with eligible needs, and provide them with services to support them in caring for the service user if the carer is assessed as having an eligible need.

5.4. Section 193 of the Health and Social Care Act 2012 ('the 2012 Act') 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 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 Health and Wellbeing Board.

5.5. Section 1 of the 2012 Act amends the National Health Service Act 2006 to specifically include mental health in the Secretary of State's duty to promote the health of the people of England.

5.6. In preparing this strategy, the Board must have regard to whether these needscould better be met under s75 of the NHS 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. The guidance sets out that mental health must be given equal priority to physical health.

5.7. This strategy must be prepared in accordance with the public sector equalities duty to eliminate unlawful conduct under the Equalities Act 2010. The duty is set out at Section 149 of the Equality Act 2010. It requires the Council, when exercising its functions, to have 'due regard' to the need to eliminate discrimination (both direct and indirect discrimination), harassment and victimization and other conduct prohibited under the Act, and to advance equality of opportunity and foster good relations between those who share a 'protected characteristic' and those who do not share that protected characteristic.

5.8. An Equalities Impact Assessment must be carried out to consider in detail what impact the proposals could have on the protected characteristics (age, disability, gender re-assignment, pregnancy, maternity, race, religion or belief, gender and sexual orientation) of the service users as well as carers and action that will be taken to mitigate the risk of disproportionate impacts upon protected characteristics.

6. ONE TOWER HAMLETS CONSIDERATIONS

6.1 The strategy details commitments to improve access to mental health services for people with protected characteristics, including:

- Developing our intelligence on access to mental health services by people with protected characteristics
- Improving access to child and adolescent mental health services for children and young people from the Bangladeshi community
- Improving access to talking therapies by people from BME communities and older people
- Improving access to services by people from LGBT communities.

7. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

7.1 No implications.

8. RISK MANAGEMENT IMPLICATIONS

8.1 The Strategy details commitments to improve mental health services including crisis pathways in line with the national Crisis Concordat, ensuring that the council's duties to provide support for people with mental health problems are delivered safely and effectively.

9. CRIME AND DISORDER REDUCTION IMPLICATIONS

9.1 The Strategy details commitments to improve mental health support for offenders.

10. EFFICIENCY STATEMENT

10.1 The Strategy details the partnerships commitments to ensuring that providers of mental health services are productive and efficient.

Appendices and Background Documents

Appendices

NONE

Background Documents

The Tower Hamlets Mental Health Strategy can be found here:
http://moderngov.towerhamlets.gov.uk/ieListDocuments.aspx?CId=632&MId=4951&Ver=4

The Tower Hamlets Mental Health JSNA and consultation documents can be found here: http://www.towerhamletsccg.nhs.uk/Get_Involved/mental-health-consultation.htm

Health and Wellbeing Board 9th December 2014	Tower Hamlets Health and Wellbeing Board
Report of the London Borough of Tower Hamlets **Public Health, ESCW**	**Classification:** [Unrestricted or Exempt]
Transfer of commissioning responsibility for early years (0-5 years) public health services from NHS England to the local authority	

Lead Officer	Somen Banerjee, Interim Director of Public Health
Contact Officers	Esther Trenchard-Mabere, Associate Director of Public Health
Executive Key Decision?	No

Executive Summary

The purpose of this report is to provide information about the forthcoming transfer of commissioning responsibilities for early years (0-5 years) public health services (the health visiting service and family nurse partnership) from NHS England to the local authority on 1st October 2015.

The report provides background information on what these services are, their importance in terms of the long term impact of early years on lifelong health and wellbeing, current commissioning arrangements and preparations underway to prepare for the transfer of commissioning responsibilities to the local authority.

The report highlights that this transfer provides an opportunity to review the health visiting service and develop a new localised specification to improve integration with other early years services and that a Stakeholder Engagement process should be undertaken to inform the development of this new specification.

Recommendations:

The Health and Wellbeing Board is recommended to:

1. Endorse the proposed Stakeholder Engagement process and have an overview of the implementation of the new localised service specification where Public Health will report back periodically to the panel on progress.

1. REASONS FOR THE DECISIONS

1.1 The HWBB is asked to have oversight of the transfer of commissioning responsibility for early years (0-5 years) public health services from NHS England to the local authority.

2. ALTERNATIVE OPTIONS

2.1 None

3. DETAILS OF REPORT

3.1 The transfer of public health commissioning responsibilities for 0-5 year olds from NHS England to local authorities on 1st October 2015 marks the final part of the overall transfer of public health responsibilities to the local authority. The services transferring are:
Health visiting services (HV services) – universal and targeted services;
Family Nurse Partnership (FNP) – intensive targeted service for vulnerable teenage mothers

3.2 The Marmot Review (2010) highlighted the importance of early years as a critical period for virtually every aspect of human development with lifelong effects on health and wellbeing. The HV and FNP services are central to ensuring that children and families have access to health promotion, preventive and early intervention services to support healthy physical, emotional, social and cognitive development.

3.3 In recognition of their potential impact on long term health and wellbeing and inequalities, the Coalition Government has prioritised these services for additional investment to enable expansion of the national workforce by an extra 4,200 health visitors by 2015 ('Call to Action') and roll out of the family nurse partnership (FNP). The implications for Tower Hamlets is an increase in the qualified health visiting workforce to at least 95 WTE (not including Clinical Lead posts and support staff) which will enable a significant strengthening of the service. Tower Hamlets already had a FNP and so there are no changes proposed for this service.

3.4 In order to ensure the expansion of the HV service and roll out of FNP, in April 2013 commissioning responsibility for these services was temporarily transferred to NHS England when the responsibility for the majority of local public health services transferred to the local authority.

3.5 Negotiations are still underway regarding the commissioning budget for these services to transfer to the local authority. The current estimated budget submitted by NHS England covers workforce but does not cover accommodation, IT and other running costs and so has not been signed off by

the local authority. There are a number of other London Boroughs who also have not signed off the budget.

BODY OF REPORT

3.6 The transfer of 0-5 public health commissioning to the local authority, along with the significant expansion of the health visiting workforce, provides an important opportunity to strengthen the public health role of health visitors in prevention and early detection and to improve integration with other local authority children's services, improving continuity for children and their families. It will also be important to maintain strong links with primary care, and other NHS and voluntary sector services.

3.7 The services will transfer to the local authority with standard NHS contracts that will run up to 31 March 2016 based on national service specifications. Local authorities have been advised that these contracts can be novated and extended up to 31 March 2017 and that timescales for re-procurement are for local decision.

3.8 Local authorities will have the freedom to 'localise' the national service specification to reflect local needs and priorities and ensure good integration with other local services.

3.9 Subject to parliamentary approval, the Department of Health is proposing to "mandate" the following aspects of the 0-5 Healthy Child Programme, in the same way as it has for the national child measurement programme, sexual health and health checks:

- Antenatal health promoting visits
- New baby review
- 6-8 week assessment
- 1 year assessment
- 2-2½ review

3.10 This is to ensure that these services are provided in the context of a national, standard format, to ensure universal coverage, and hence that the nation's health and wellbeing overall is improved and protected. This would mean there is less local flexibility and discretion regarding how these universal services are provided. Any mandated elements will be set out in regulations under section 6C of the NHS Act 2006 and will be fully funded.

3.11 The proposed 2015/16 commissioning budget submitted to the local authority by NHS England is £6,693,000 for the HV service and £540,000 for FNP, making a total budget of £7,233.000. This budget is adequate to cover the full projected workforce but does not include funding for accommodation, IT and other running costs and so has not been signed off by the local authority.

3.12 Following sign off, DH is planning to consult (for 4-6 weeks) with local government on budgets for health visiting and FNP with the intention of announcing part year effect budget for 2015/16 by 1st December 2014. However the delay in sign off of the budget by Tower Hamlets and 18 other

London Boroughs means that this timescale may no longer be feasible. This budget will be added to the ring fenced public health grant.

4. COMMENTS OF THE CHIEF FINANCE OFFICER

4.1 At present the proposed 2015/16 commissioning budgets totalling £7.233million cover workforce related costs however do not include overheads such as IT, accommodation and other resources. These are estimated to be in the region of £1million for Tower Hamlets, as a consequence the current proposals have not been agreed by Tower Hamlets and a number of other London Boroughs. A joint concern has been registered by the London Boroughs to Public Health England, with the expectation that negotiations will continue and that the full expected costs of the HV and FNP services will be included in the transfer.

4.2 Once agreed the funding will be added to the Public Health Grant received by the authority. It is expected that the funding for both the HV and FNP services will be recurrent each year.

4.3 It is also noted that funding for additional commissioning resources has not been identified as part of the transfer. Securing the maximum funding in respect to overheads and any other incidental costs will be imperative for the borough. Once transferred any pressures will need to be met from within the Public Health Grant allocation.

5. LEGALCOMMENTS

5.1. The Council assumed responsibility for the provision of various public health functions following the amendment of the National Health Service Act 2006. By regulations under that act the Secretary Of State may require local authorities to provide further services relating to Public Health from time to time. It would appear that there is an intention to do exactly this, although the exact wording of the new regulations is not clear.

5.2. The introduction of further regulations by the Secretary Of State will legally oblige the Council to provide these services. However, it is anticipated that (as with the existing transfer of services) the Council will have general duties to discharge obligations relating to public health but will have the discretion to determine how this is carried out.

5.3. However, best practice dictates that the Council should give due regard to professional and health service led opinion when determining the exact nature of the services.

5.4. Where the Council elects to purchase the relevant services from organisations outside of the Council the Council has a duty to achieve Best Value in accordance with the Local Government Act 1999. This means that the Council should subject any purchases to an appropriate level of competition.

5.5. It is anticipated that the law in respect of European tendering will have changed by the time the Council becomes responsible for these services. The most significant change will be that the distinction between Part A and Part B services will have disappeared. Currently, services of the nature covered in this report would be determined as Part B services which would have meant that the Council would not have had to advertise these services in Europe in any event. However, the new procurement regulations will introduce a "light touch" regime which may mean though that these services may have to be advertised either in Europe or in some other new manner.

5.6. Currently NHS England has a number of contracts with existing providers for these services. It is understood that NHS England are currently extending the existing arrangements such that the contracts will still be in place on the date of transfer. It is the intention that on the date of transfer the Council will take over the existing contracts in place of NHS England so that there is continuity of service provision following the transfer to the Council of the duty to provide these services.

5.7. However, as stated previously the Council is under an obligation to obtain best value and so the value of these contracts needs to be tested as soon as possible after the transfer. However, the Council after the transfer will be obliged to comply with the agreements throughout the remainder of the term. Therefore the Council should take a number of steps:

5.7.1 be part of the extension discussions as we will take over the contracts. Ideally we require an extension of a term just long enough to carry out a procurement for the same services. An extension of some sort is required to ensure that there is no break in service provision whilst the Council carries out the tender.

5.7.2 prepare to carry out a number of tender exercises as soon as possible. This means not only preparing for the volume of tenders but also ensuring the availability of resources.

5.7.3 consider the nature of the existing services and start to determine the reconfiguration of services that will still meet our statutory obligations created by the Secretary Of State but will also assist us in the achievement of best value.

5.8. Many of these services may well deal with persons who have protected characteristics for the purposes of the Equality Act 2010. Therefore, the Council must ensure that it eliminates any discrimination in the provision of the services between people who have a protected characteristic and people who do not and also to actively promote the equal treatment of people who have a protected characteristic when compared with people who do not in accordance with its obligations under section 149 of the Equality Act.

5.9. For the purposes of promotion as described under clause 6.8 the Council should ensure that its contractors are under a similar duty created by terms under the contracts

6. ONE TOWER HAMLETS CONSIDERATIONS

6.1. The health visiting service provides both universal and targeted services and plays an important role in improving life chances for all children and also reducing inequalities by identifying and supporting vulnerable families. The family nurse partnership is a targeted service supporting first time teenage parents. There is a strong evidence base showing that this programme improves short, medium and long term health, educational and social outcomes for both mother and child. It is estimated that the FNP programme produces a return on investment of at least £1.94 for every £1 spent as a result of savings in spend on social care, youth offending and benefits.

7. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

7.1 N/A

8. RISK MANAGEMENT IMPLICATIONS

8.1 The biggest risk to the local authority is begin allocated a commissioning budget that does not cover the full costs of the service and for this reason the local authority has not yet signed off the budget.

9. CRIME AND DISORDER REDUCTION IMPLICATIONS

9.1 There is evidence that the family nurse partnership programme will contribute to a long term reduction of crime and disorder.

10. EFFICIENCY STATEMENT

10.1 N/A

Appendices and Background Documents

Appendices

- Appendix 1 – Transfer of commissioning responsibility for early years (0-5 years) public health services from NHS England to the local authority (full report)
- Appendix 2 - Transfer of 0-5 children's public health commissioning to localauthorities - Finance fact sheet, Department of Health factsheet.

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Transfer of commissioning responsibility for early years (0-5 years) public health services from NHS England to the local authority

1. Background

1.1 The transfer of public health commissioning responsibilities for 0-5 year olds from NHS England to local authorities on 1st October 2015 marks the final part of the overall transfer of public health responsibilities to the local authority.

1.2 The Marmot Review (2010) highlighted the importance of early years as a critical period for virtually every aspect of human development with lifelong effects on health and wellbeing[1]. The 0-5 Healthy Child Programme (HCP) is central to ensuring that children and families have access to health promotion, preventive and early intervention services to support healthy physical, emotional, social and cognitive development.

1.3 The 0-5 HCP consists of:

- Health visiting services (HV services) - universal and targeted services;
- Family Nurse Partnership(FNP) – intensive targeted service for vulnerable teenage mothers
- Child Health Information Systems (CHIS)
- The 6-8 week GP check (also known as Child Health Surveillance).

1.4 Health visitors are qualified nurses with additional post graduate training to prepare them for a public health/preventative role focusing on improving child health and reducing inequalities.The HV visits the family in their home and undertakes a holistic assessment of the whole family's social, emotional and physical health and well-being at each visit that can identify a range of health and well-being issues including housing, relationships, emotional health, mental health, social inclusion, physical health or financial circumstances[2].

1.5 TheHV service plays a key role in helping to ensure that families have a positive start, working in partnership with GPs, maternity and other health services, Children's Centres, other early years services and wider services such as social care, housing and education. However, across the country and particularly in London, numbers of health visitors were in decline and in many areas there are not enough health visitors to offer all families the support they need[3]

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[1]Fair Society, Healthy Lives: A Strategic Review of Health Inequalities in England Post-2010, 11 February 2010

[2]The role of the Health Visitor in a multi- agency team, Institute of Health Visiting (2014)

1.6 This lack of capacity has meantthat sometimes health visitors have beenunable to fully perform the wider public health role that they have trained for, working with communities to improve health outcomes, and that opportunities for early intervention can be missed. For example, to provide a clinically effective intervention to a depressed mother struggling with a new baby; to identify during a developmental check a child with speech and language problems who would benefit from early help or to help families access other local services, like parenting or relationship support through their local Children's Centre[3].

1.7 In recognition of the importance of the HV service and the overall lack of capacity, the government made acommitment to expand the national workforce by an extra 4,200 health visitors by 2015.This has been translated into a 'Call to Action trajectory' for each local area. In Tower Hamlets the 'Call to Action trajectory' will take the workforce to 95 WTE qualified health visitors (not including clinical leads and support staff), subject to successful recruitment and retention.

1.8 The FNP provides more intensive, targeted support for vulnerable teenage first time mothers and their families by a family nurse who is usually a health visitor or midwife. The family nurse receives additional specialist training to deliver the programme.

1.9 The FNP is an evidence-based, licensed programme that is still in pilot phase in this country. Findings from a randomised controlled trial of the impact of the programme in the English context (compared to existing universal services) are due to be reported in 2014/15.It has been estimated that the FNP could provide savings five times greater than the cost of the programme in the form of reduced welfare and criminal justice expenditures; higher tax revenues and improved physical and mental health[4].

1.10 The DH also made a commitment to expand the FNP, with particular priority to areas with a high level of need. Not all areas have a FNP established. Tower Hamlets was in the first wave of FNPs and established a service in April 2007 with local funding that was expanded by two additional family nurses in 2009 as part of the DH funded randomised controlled trial 'Building Blocks'. Funding for the two additional nurses was picked up by NHS England in April 2013. The local funding for the core service was transferred from the PCT to NHS England in 1st April 2013.

1.11 In order to ensure the expansion of the HV service and roll out of FNP, in April 2013 commissioning responsibility for these services was temporarily transferred to NHS England when the responsibility for the majority of local public health services transferred to the local authority.

[3]The Health Visitor Implementation Plan 2011-15: A Call to Action (DH, February 2011)
[4]Department for Children, Schools and Families (2007) Cost–Benefit Analysis of Interventions with Parents. Research Report DCSF-RW008

2. Opportunities arising from the transfer of these responsibilities to the local authority

2.1 The transfer of 0-5 public health commissioning will enable join-up with the public health services for children and young people 5-19[5], notably School Health, that are already commissioned by the local authority, improving continuity for children and their families.

2.2 The transfer of commissioning responsibility to the local authority also provides important opportunities for closer integration with the wider early years workforce in Children's Centres, voluntary sector and children's social care and the development of a service that is more responsive to local priorities and needs. It will also be important to maintain and strengthen links with general practice, primary care and other NHS services.

2.3 In Tower Hamlets, due to the priority given to early years, we already commissioned a number of 0-5 public health services e.g. Baby Friendly Initiative, Breastfeeding Support service, Universal Healthy Start Vitamins, Healthy Eating and Active Play programme,Cook4Life courses, Brushing 4Life, Fluoride varnishing and Child and Family Weight Management (which includes an early intervention) . Responsibility for commissioning the HVservice and FNP will provide the opportunity to develop closer links across these services.

2.4 During September – November 2013 we conducted a consultation and engagement process, The Healthy Child Review, to get stakeholder input into the process of re-designing and re-commissioning child public health services 0-19. The findings of this review will be of value to inform the process of 'localising' the service specification for the health visiting service[6].

2.5 We are currently developing a new parent and infant emotional health and wellbeing programme to strengthen and join up services provided across the NHS, local authority and voluntary sector. This programme will provide a useful framework to support the development of a more community focused HV service.

3. Governance of transfer process

3.1 The transfer is primarily a local one: from NHS England Area Teams as the "sender" to the local authority as the "receiver". A national task and finish group co-chaired by Mark Rogers, Chief Executive, Birmingham City Council and Viv Bennett, Director of Nursing, Department of Health has been set up

[5] and up to age 25 for young people with Special Educational Needs and Disability (SEND)

[6] Healthy Child Review: Progress report and recommendations for commissioning and wider service and partnership development. Paper for the Children and Families Partnership Board meeting on Monday 27th January 2014

under the leadership of Jon Rouse at the Department of Health (DH) to support the process.

3.2 The national task and finish group includes representatives from the Local Government Association (LGA), the Society of Local Authority Chief Executives (SOLACE), Association of the Directors of Public Health (ADPH), Association of the Directors of Children's Services (ADCS), NHS England, Public Health England and the Department for Communities and Local Government. Each partner will keep their members up to date on the progress of the transfer via their networks.

3.3 Local authorities have been provided with a data collection detailing workforce and finance for 2014/15 and 2015/16 for sign off to enable the DH to set baseline funding allocations (see section 6 below). To date Tower Hamlets, along with a number of other London Boroughs, have not been able to sign off the workforce and finance data as the funding presented did not cover accommodation and other infrastructure requirements.

4. Commissioning responsibilities to be transferred

4.1 Commissioning responsibilities for the following services will transfer to local authorities on 1st October 2015:
The 0-5 Healthy Child Programme (universal/universal plus) which includes:

- Health visiting services (universal and targeted services);
- Family Nurse Partnership (targeted service for teenage mothers)

4.2 It is responsibility for commissioning, not service provision, which will transfer. It is not therefore a transfer of the health visiting workforce who sit in provider organisations.

4.3 The following commissioning responsibilities will remain with NHS England:

- Child Health Information Systems (CHIS) in order to improve systems nationally. This will be reassessed in 2020
- The 6-8 week GP check (also known as the Child Health Surveillance).

5. Proposed mandationof universal services

5.1 Subject to parliamentary approval, the Department of Health is proposing to "mandate"the following aspects of the 0-5 Healthy Child Programme, in the same way as it has for the national child measurement programme, sexual health and health checks:

- Antenatal health promoting visits
- New baby review
- 6-8 week assessment
- 1 year assessment

- 2-2½ review

5.2 This is to ensure that theseservices are provided in the context of a national, standard format, to ensure universal coverage, and hence that the nation's health and wellbeing overall is improved and protected.

5.3 This would mean there is less local flexibility and discretion regarding how these universal services are provided. Any mandated elements will be set out in regulations under section 6C of the NHS Act 2006 and will be fully funded.

5.4 Subject to Parliamentary approval, the aim is that regulations are in place by May 2015, with a 'sunset clause' at 18 months (ie March 2017). A review at 12 months, involving Public Health England, will inform future arrangements.

5.5 Mandation will ensure that the increase in HV services' capacity continues as the basis for national provision of evidence-based universal services - supporting the best start for all our children and enabling impact to be measured. Local authorities will be able to demonstrate progress on the relevant public health outcome indicators through early years profiles. Local authorities will have flexibility to ensure that these universal services support local community development, early intervention and complex care packages[7].

6. Process for agreeing funding allocations

6.1 Funding for the 0-5 Healthy Child Programme will sit within the overall 'ring-fenced' public health grant.

6.2 National guidance has stated that, as in the previous public health transfer, the baseline expenditure on 0-5 services by local authority will provide the basis for each local authority's individual allocations for 2015/16. This would be based on the cost of existing services (and contracts) to be transferred in each area. Over time funding allocations would be expected to move towards a needs-based funding formula, in the same way as anticipated for the wider public health grant[8].

6.3 In London concerns have been raised that health visiting staffing levels are significantly below the 'Call to Action' trajectories and, despite a major recruitment and retention drive, will remain so at the time of transfer,

[7]Transfer of 0-5 children's public health commissioning to local authorities. Factsheet: Commissioning the national Healthy Child Programme - mandation to ensure universal prevention, protection and health promotion services, DH

[8]Transfer of public health commissioning responsibilities for 0-5 year olds from NHS England to local authorities. Letter from Carolyn Downs, Chief Executive Local Government Association to Local Authority Chief Executives cc Directors of Children's Services, Public Health and Human Resources, July 2014

1st October 2015. If funding allocations are based on the cost of existing services this would not be sufficient for the local authority to continue to expand the service up to the 'Call to Action' trajectory.

6.4 At a meeting on 8th August 2014 between representatives from NHS England (London Area team), London Councils and LBTH Public Health it wasconfirmed that the funding allocation will be sufficient to cover the full 'Call to Action' trajectory and that the funding for the health visiting service will be based on the cost of the existing service (including 'on costs' estates, IT etc.) plus funding for additional posts up to the 'Call to Action' trajectory of 95 WTE funded at mid-point Grade 6 (NHS Agenda for Change pay scales). Funding for the FNP will be based on the cost of the existing service.

6.5 We were informed that a data return with a detailed analysis of workforce and finance would be submitted by NHS England to the local authority by the end of August 2014 for checking and sign off by 12th September. There was a delay in submission of the data return which did not reach us until 8th September 2014.

6.6 The data return submitted by NHS London on 8th September detailed the following current (2014/15) establishment for the health visiting service:

Management / Clinical Leadership	1.0 WTE (Grade 8C)
Qualified Health Visitors	58.38 WTE (5.2 WTE Grade 8A[9], 41.27 Grade 7, 11.91 Grade 6)
Registered Nurses	12.48 WTE (Grade 5)
Nursery Nurses	7.0 WTE (Grade 4)
Healthcare Assistants	21.77 WTE (Grade 3)
Other	1.5 WTE (Grade 5)

6.7 The current (2014/15) funding for this service was given as £4,582,000 which includes £4,524,000 for employee costs (including agency costs) and £58,000 for non-employee costs. However it was noted that the 2014/15 contract value does not cover overheads including accommodation, IT and other running costs.

6.8 The data return indicated that for 2015/16 the contract value would include additional growth funding of £2,111,000 (£1,961,000 employee costs and £150,000 non-employee costs) to fund 45.0 WTE additional Health Visitors (costed at mid-point Grade 6), making a total of £6,693,000.

6.9 The data return detailed the following current (2014/15) establishment for the FNP:

Management / supervision	1.5 WTE (Grade 8A)
Family Nurses	5.6 WTE (Grade 7)
Quality Support Officer	1.0 WTE (Grade 4)

[9]Note: the Grade 8A Clinical Leads do not count towards the 95 WTE target

6.10 The data return indicated that the current (2014/15) funding for FNP is £540,000 (including £450,000 employee costs and £90,000 non-employee costs). The same value was given for 2015/16.

6.12 It has also been noted that no funding has been identified to cover the additional commissioning resource that will be required to manage these contracts. NHS England have indicated that it would be difficult to identify resources for commissioning as it is currently managed by one post working across the 31 London Boroughs.

7. **Process of transfer**

7.1 At the meeting on 8th August we were informed that NHSEngland would send the local authority a data collection by the end of August which they would ask us to sign off by 12th September to confirm that we are confident that the workforce and funding are adequate. This needs to be agreed by our Section 151 Officer (Director of Finance/Resources).

7.2 Following sign off, DH intends to consult (for 4-6 weeks) with local government on budgets for health visiting and FNP. By 1st December the part year effect budget for 2015/16 should be announced.

7.3 At the meeting on 8th August we were informed that we should expect a 1.17% salary uplift for subsequent years.

7.4 The NHSEngland contracts for both services will run up to March 2016 and can be novated to the local authority. We will need to decide at what time we might want to start the process of re-procurement or to explore other options. The NHSE England (London Area Team) representative has advised that if we decide to start a re-procurement process prior to 1st October 2015 it would be advisable to agree an Integrated Governance Framework with NHS England.

7.4 In light of the late submission of the workforce and finance data collection, NHS England informed us that the deadline for sign off could be extended to 30th September 2014, although a request was made to meet the original deadline if possible.

7.5 After checking the data collection it was concluded that we could not sign it off as it did not include funding for accommodation, IT and other resources necessary for the running of the services. We estimate that these costs could be in excess of £1,000,000.

7.6 We informed Clive Grimshaw (Programme Manager, Early Years Commissioning Transfer, London Councils/NHS England) and on

24th September Joanne Murfitt, Head of Public Health, Health in the Justice System and Military Health, NHS England (London) wrote to Mark Ogden, Barts Health with a request for an urgent response by 26th September but no reply has been received to date.

7.7 At a regional briefing on 9th October we were informed that 25 London Boroughs had not signed off the workforce and finance data. NHSE reported that in 16 cases the issues to be resolved were relatively minor but for 9 cases (including Tower Hamlets) the issues were more serious and more difficult to resolve.

7.8 At a local authority chief executives meeting held on 24th October it was confirmed that 19 London Boroughs have not been able to sign off the workforce and finance data. Cheryl Coppell, Chief Executive for London Borough of Havering and Chair of the group is submitting a paper to NHSE stating that they will not accept the transfer unless additional funding is found for the 19 of London boroughs.

8. Local preparations to date

8.1 A meeting was held on 8th August 2014 between representatives from NHS England (London Area team), London Councils and LBTH Public Health to confirm the process for transfer of the commissioning responsibilities.

8.2 A memorandum of understanding (MOU) has been signed between NHS England and Tower Hamlets CCG which allows for joint performance management of the Tower Hamlets health visiting service by NHS England, Tower Hamlets CCG and LBTH Public Health. Maintaining links with the NHS, particularly primary care, is important.

8.3 Following an initial meeting on 21st July 2014 to agree terms of reference, process etc. the first joint quarterly performance meeting was held on 23rd October 2014. At this meeting it was confirmed that the service is meeting the coverage targets for the new birth visit but is below target for the other universal visits. The service manager confirmed that the full range of mandated services will be achievable once the full workforce has been recruited.

8.4 Concerns about difficulties in recruiting and retaining student health visitors have been raised and discussed a number of times at the Children and Families Partnership Board and support has been offered to Bart Health including confirming eligibility for health visitors on the Key Worker scheme that affords additional priority on the Council's Housing List.

8.5 After a difficult start the service is doing better in recruiting and retaining student health visitors. At the performance meeting on 23rd October it was

confirmed that there are currently 13 students in post, 8 students just due to start and an additional 12 students due to start in January 2015. However it is projected that we will not have fully achieved the target of 95 WTE by 1st October 2015.

8.4 Dame Elizabeth Fradd, Chair of the Health Visitor Taskforce, arranged a visit to Barts Health on 25th September 2014 to review progress on the 'Call to Action' including what is being done on recruitment and retention. Dame Elizabeth Fradd commended the service on the innovative work that they have developed and noted local concerns to feed back to the National Health Visiting taskforce.

8.5 LBTH Public Health was invited to present at the above event and also to the Health Visitors Forum on 6th October 2014 on the implications of the transfer of commissioning responsibility to the local authority and on the proposed local consultation process.

8.6 LBTH Public Health chairs the Strategic Advisory Board for the FNP and supports the service in developing partnerships (e.g. with Housing), needs assessment, planning and monitoring outcomes. Two family nurses and a client attended the Children and Families Partnership Board on 14th July 2014 to raise awareness of the service and the opportunities associated with the forthcoming transfer of commissioning responsibilities.

9. Issues for action and decision

9.1 Ensure that the budget transferring to the local authority is sufficient to cover the full costs of delivering these services, including accommodation and IT.

9.2 Review and localise the national service specification for health visiting.
The new national service specification provides a good starting point but it will be important to review and localise the service specification to ensure that the service is responsive to local needs and priorities, to optimise the benefits from the larger workforce and ensure closer integration with other local services.

The work of the Healthy Child Review and our new service specification for the School Health service will helpto inform this process but it is proposed that we run an additional stakeholder engagement process during early 2015. This would involve workshops with parents and carers, the service providers, Children's Centre staff, GPs and other primary care staff, Children's Social Care, other local authority and NHS commissioners and providers and community and voluntary sector organisations.

9.3 Decide the timescales and approach for any future re-procurement of these services

NHS England have confirmed that we can novate the NHS contracts that will be transferred to us and postpone any re-procurement or on the other hand start the process prior to 1st October so that new contacts would be issued during 2015/16. An options paper is being prepared to inform a decision about the timescales and approach for re-procurement. Broadly the options are as follows:

1. Rapid re-procurement commencing prior to 1st October 2015 to have new contracts in place by early 2016
2. Rapid decision to bring one or both services into local authority management
3. Postpone decision regarding re-procurement or bringing the services in house until the stakeholder engagement process to inform a new localised service specification has been completed (January - April 2015)

Some key considerations that will need to be taken into account include:

- The impact on staff recruitment and retention. In view of the difficulty in recruiting and retaining health visitors and the currently highly competitive recruitment situation across London, it is important to ensure that the service is seen as an attractive, innovative and secure place to work. It will be important to ensure that NHS terms and conditions are maintained to enable opportunities for career progression.
- Clinical governance arrangements for the services
- The synergies and fit with the proposed new model and organisational arrangements being developed for the Education, Social Care and Wellbeing Directorate of LBTH
- Adequate time to develop a new service model and specification to encourage innovative thinking and set the foundations for effective, holistic, child and family centred services that are responsive to local needs and priorities.
- Relationships with other services, including School Health as well as other local authority, NHS and voluntary sector early years and children's servicesto ensure integrated, efficient, accessible and responsive services.

Department of Health

Transfer of 0-5 children's public health commissioning to local authorities - Finance fact sheet

1. Responsibility for commissioning 0-5 children's public health services is transferring from NHS England to Local Government on 1 October 2015.
2. DH has been working in partnership with the LGA, SOLACE, ADPH, ADCS, NHS England and PHE through the 0-5 Public Health Commissioning Transfer Programme Board.
3. 0-5 children's public health services comprises commissioning the Healthy Child Programme including the health visiting service and Family Nurse Partnership (FNP) -targeted services for teenage mothers.
4. Local authorities will receive funding, as part of their public health grant, to commission services.

Determining local authority allocations

5. NHS England Area Teams, with the engagement of local authorities, have been completing returns to build an accurate and well understood picture of 0-5 finances and contracts in 2014/15 and forecasts for delivery for the whole of 2015/16.
6. For 2015/16 we will use 'lift and shift' principles as a basis for the transfer of commissioning responsibilities to local authorities to support contracts which are in place and a safe mid-year transfer. We set out below how this will change in 2016/17.

Baseline Agreement Exercise

7. Publication of the Baseline Agreement Exercise will mark the start of a four week engagement period before we make the final decisions about local authority allocations. Its purpose is to set out:
   - The proposed funding allocations for local authority commissioning of 0-5 public health services from 1 October 2015 until 31 March 2016.
   - The process through which we will reach agreement that the funding provided is sufficient to meet the costs of commissioned services that will be transferring in 2015-16.

Publication timeline

8. We had originally intended to publish the Baseline Agreement Exercise in late October, with a view to publishing final allocations alongside the Local Government Finance Settlement in December. We have now taken the decision to delay publication to allow us time to work through some of the issues which have been raised. We have agreed this approach with our partners.
9. We intend to publish the Baseline Agreement Exercise, which includes proposed allocations, ahead of the Local Government Finance Settlement in December. Although the allocations won't have been finalised at that point as originally planned, where there is already a high degree of agreement over the numbers – as there is in many parts of the country – or outstanding issues that can be resolved quickly, then this provides a good degree of certainty for local authorities on which to start financial planning.
10. We intend to publish final local authority allocations early in the New Year, having allowed time for local authorities and NHS England to comment, and for consideration of those comments.

Recognising some of the issues raised

11. The data collection exercise brought to light a number of issues, which the 0-5 Programme Board has worked to refine and address as far as possible ahead of publication. There were

three main concerns raised by a large number of local authorities; and following reflection on these, adjustments are being made to the figures which were submitted by Area teams and local authorities in September. The following explains the principles behind these:

a. **CQUIN** – The 0-5 Transfer Programme Board took the decision that where CQUIN (Commissioning for Quality and Innovation) is an integral part of how providers meet 0-5 costs, then it should be included as part of the transfer and where services remain with NHS England, it should be excluded. A number of adjustments to the proposed allocations have been made to ensure they are in line with this principle. Area teams will shortly be able to provide this information to local authorities.

b. **Inflation** – The guidance sent out with the returns proposed that 2014-15 prices should apply in 2015-16 unless there was a good reason to do otherwise. This assumption is consistent with how the Department is setting the Section 7A total for NHS England as a whole and a number of adjustments to the proposed allocations have been made in line with this principle. Where local areas were assuming a bigger saving by imposing a net tariff deflator, this saving has been added back into the numbers for the relevant local authorities.

c. **Commissioning Costs** – The Department will provide £2m extra funding to cover local authority commissioning costs for 2015-16. The baseline agreement exercise will set out more detail.

12. We recognise that in some areas there may still be a number of issues to work through and that this is requiring effort in advance of transfer by local authorities. We are looking for Area Teams and local authorities to continue dialogue, for NHS England to continue to share information on an open book basis, and for where possible agreement to be reached.

13. If areas need extra support, Public Health England Centre Directors and local PHE children's leads, through local networks, can assist in the process of facilitating agreements by gathering local intelligence and identifying and supporting resolutions.

14. Regional Oversight Groups are established for each local government region, chaired by their local chief executive lead for health and social care issues with representation from NHS England Area teams, Local Authorities and PHE. It is intended that these groups provide oversight and support where appropriate for local solutions and to escalate for support nationally if required to the three representatives for NHS England, LGA and PHE on the national transfer board.

Mandation

15. The Government has already set out its intention to mandate the 5 universal elements of the Healthy Child Programme. These are set out here: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/347047/Mandation_factsheet_final_22-8-14.pdf

16. We are clear that we need to avoid creating new burdens and we intend that any ask of local government will be no greater than the ask of the NHS at the point of transfer. We intend that this approach will be reflected in the mandation regulations.

Funding from 2016/17

17. From 2016/17 the allocations are expected to move towards a distribution based on population needs. The fair shares formula would be based on advice from the Advisory Committee on Resource Allocation (ACRA). The public health grant allocation formula would need to be revised from 2016-17 onwards to take account of the transfer of 0-5 responsibilities. This has been included in the ACRA work programme along with their work on sexual health and substance misuse. ACRA plan to run an engagement exercise on overall changes to the public health grant formula starting in the New Year.

Health and Wellbeing Board 9th December 2014	Tower Hamlets Health and Wellbeing Board
Report of: Healthwatch Tower Hamlets	**Classification:** Unrestricted
Patient and User Voice Summary Report Aug 2013 – Sept 2014	

Contact for information	Dianne Barham

Executive Summary

People in Tower Hamlets are generally satisfied with the health and social care services that they receive. Where people are not happy, it doesn't generally relate to the care itself, but is a frustration with the administrative processes that surround the care and/or because of the perceived attitudes of staff.

There seems to be a multitude of points in the care journey where the system fails patients and users including:

- accessing a GP appointment
- getting a referral from the GP to secondary care
- receiving the correct appointment information at the right time
- being able to change appointments without being sent back to the GP for re referral
- patient transport getting them to their appointment in time so they didn't have to go back to their GP for re referral
- being able to find the clinic or ward they were attending
- being seen promptly when they were at their appointment
- the right medical notes/information/tests being available to clinicians at their appointment
- actually getting into the operating theatre as operations are being cancelled or postponed at the last minute
- waiting hours in the discharge lounge for a prescription to be filled after being discharged
- arriving home again without the necessary links to the district nurse, reablement, home adaption's or social care and mental health support teams.

There is a perception in some areas of staff being too few, being unhelpful, uncaring and unwilling to signpost. Some patients feel that staff are equally frustrated with administration problems and are either taking this frustration out on patients or using it as an excuse for a poor patient service. There seems to be a particular issue with receptionists from across providers. The quality and availability of interpreters was also a frequently raised concern which seemed to exacerbate stress and/or medical conditions.

Clearly we need to see a radical improvement to the administration and appointments systems alongside training/re training of staff on providing a patient focused service. We would also like to see measures in place to monitor whether improvements are having an impact on patient experience outcomes.

More in depth work is required to understand the:

1. patient journey and the nature of the need for 'support' services within provision particularly for the elderly and the young.
2. 'expectations' and the determinants within that including demographic factors
3. 'quality care' among different cohorts of patients and the factors that contribute to 'good' care
4. experiences of those groups who appear underrepresented in our work to-date e.g. Eastern European groups and sub-groups, Somali's

Recommendations:

The Health and Wellbeing Board is recommended to:

1. note the report
2. agree to work with Healthwatch to develop a more in-depth understanding of the four key issues outlined above.

1. DETAILS OF REPORT

1.1. Healthwatch Tower Hamlets' Annual Report

Appendices

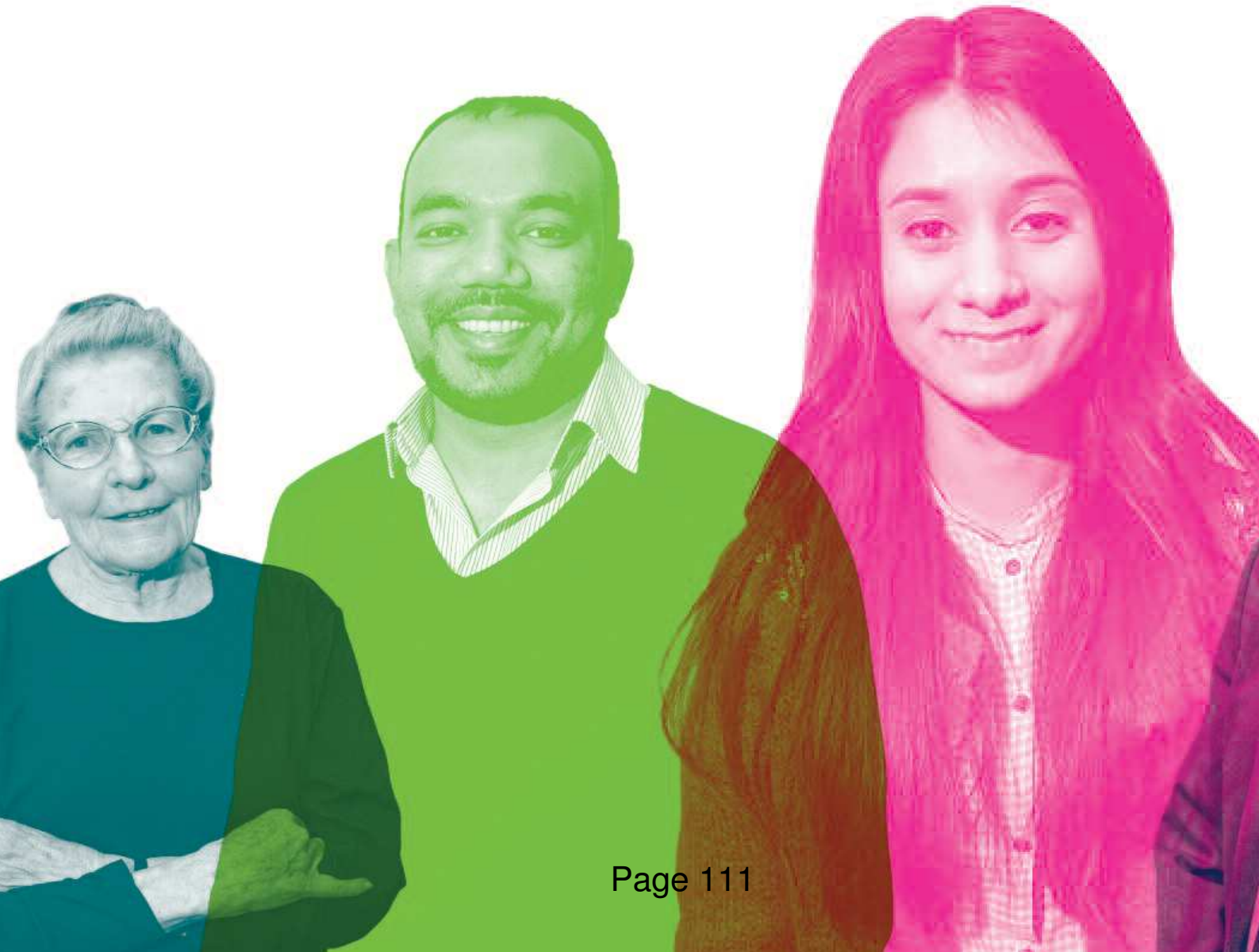
Appendices

- NONE

healthwatch Tower Hamlets

Patient and User Voice Summary Report

August 2013 - September 2014

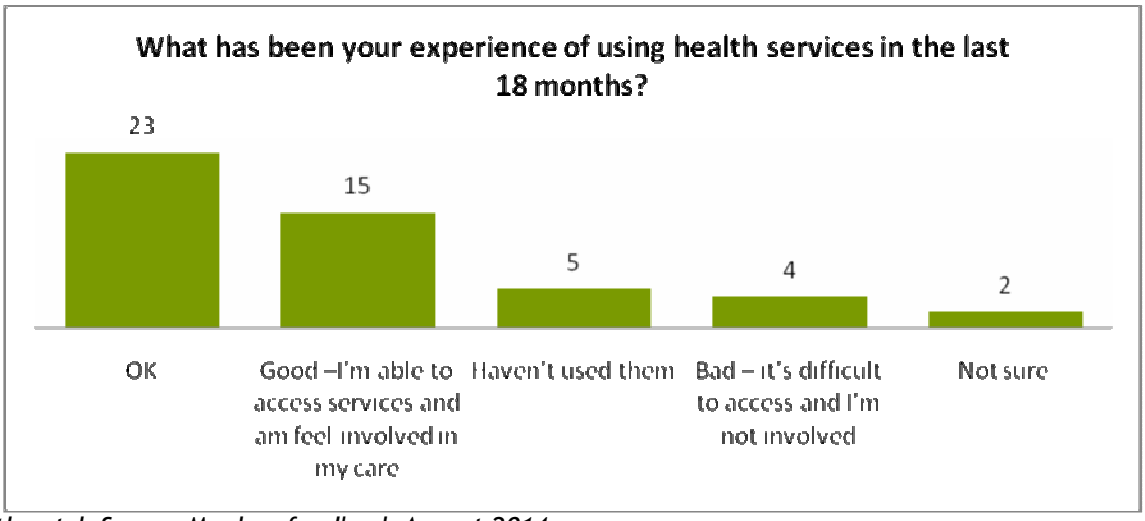


healthwatch Tower Hamlets

Contents

1. EXECUTIVE SUMMARY

1.1. People in Tower Hamlets are generally satisfied with the services that they receive



Healthwatch Survey Monkey feedback August 2014

1.2. Where people were not happy with their care, it generally did not relate to the care itself, but was a frustration with the administration and processes that surrounded the care and/or because of the perceived attitudes of staff.

1.3. There seemed to be a multitude of points in their care journey where the system failed patients and users including:

- accessing a GP appointment
- getting a referral from the GP to secondary care
- receiving the correct appointment information at the right time
- being able to change appointments without being sent back to the GP for re referral
- patient transport getting them to their appointment in time so they didn't have to go back to their GP for re referral
- being able to find the clinic or ward they were attending
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- the right medical notes/information/tests being available to clinicians at their appointment
- actually getting into the operating theatre as operations are being cancelled or postponed at the last minute
- waiting hours in the discharge lounge for a prescription to be filled after being discharged

- arriving home again without necessary links to the district nurse, reablement, home adaption's or social care and mental health support packages in place.

I have been waiting to have a gallstone operation for one year, when I finally got an appointment and booked my place for day surgery, I received a call to say that they needed to change my appointment due to it being double booked. Then when I got the confirmation appointment through the post, it was on a date that I did not agree with when the lady called to cancel. Finally when the surgery day arrived, I got there at 6.30am. At 7am the nurse told me that they cannot find me on the list and therefore I cannot have the surgery as they have too many patients. After two weeks, I got a letter home to say I missed my appointment (which I did not as I didn't receive a letter in the first place) and that they have discharged me to my GP. Now I am waiting again for another referral to be made so I can get my gallstones out and go for the process all over again. I find the process really bad, and I was angry and disappointed, frustrated about the whole thing. (Female, Bangladeshi - Barts Voices, Stifford Centre)

1.4. There is a perception in some areas of staff being too few, being unhelpful, uncaring and unwilling to signpost. Some patients feel that staff are equally frustrated with administration problems and are either taking this frustration out on patients or using it as an excuse for a poor patient service. There seems to be a particular issue with receptionists from across providers. The quality and availability of interpreters was also a frequently raised concern which seemed to exacerbate stress and/or medical conditions.

1.5. Patient experience also seems to be heavily influenced by expectations and there appeared to be a 'domino' effect in the sense that when one element of care went awry, such as transport services, waiting for appointments or perceived rudeness, then it appeared likely that the whole patient experience became negative. We need to get a better understanding of the process that dictates experiences and the extent to which 'expectations' are dependent on demographic or other factors.

1.6. These process issues not only lead to poor patient experience but patients feel they are wasting valuable NHS resources which they are being told are scarce.

1.7. There is an evident demand for more 'individualised' care particularly with reference to 'older people' and families with children. This also needs to be linked to better communication both directly to patients but also between primary and secondary care and between different departments.

1.8. Clearly we need to see a radical improvement to the administration and appointments systems alongside training/re training of staff on providing a patient focused service. We would also like to see measures in place to monitor whether improvements are having an impact on patient experience outcomes.

1.9. More in depth work is required to understand the:

- patient journey and the nature of the need for 'support' services within provision particularly for the elderly and the young.
- 'expectations' and the determinants within that including demographic factors
- 'quality care' among different cohorts of patients and the factors that contribute to 'good' care
- experiences of those groups who appear underrepresented in our work to-date e.g. Eastern European groups and sub-groups, Somali's

2. INTRODUCTION

2.1. A core function of Healthwatch Tower Hamlets is to obtain the views of local people about their need for and experience of local care services and make those views known to those involved in the commissioning, provision and scrutiny of care services.

2.2. This report summarises key themes that have emerged from the patient and user views gathered by Healthwatch Tower Hamlets during 2013-2014. These views were gathered through the following activities:

2.3. **Barts Health Patient Voices Project:** This project was designed to enable local community groups to collect patient feedback on behalf of Healthwatch. The feedback obtained focused upon the services of the Royal London Hospital, Mile End Hospital, the London Chest Hospital and Community Health Services all of which come within the remit of Barts Health. The Project took place between March and August 2014 and involved the following community groups. Full details are available in the Appendices.

- Limehouse Welfare Association (LWA)
- Tower Hamlets Friends and Neighbours (THFN)
- Collective of Bangladeshi School Governors (CBSG)
- Stepney Wisdom Group - Social Action for Health (SAFH)
- Globe Wisdom Group - Social Action for Health (SAFH)
- Stifford Centre
- Deaf Plus

- East London Vision (ELVIS)

2.4. **Enter and View visits** which have taken place on a regular basis over the past year. Healthwatch Tower Hamlets Board members are responsible for agreeing the Enter and View programme and take into consideration:
- Concerns raised by patients and the public
- Areas currently the subject of service redesign or re/de commissioning
- Joint Strategic Needs Assessment priorities and gaps
- Services from across the physical and mental health and social services.

(full details of each visit can be seen in the Appendices)

2.5. General Community Feedback
- General outreach at community events and gathering points
- Members' feedback via attendance at Advisory Group and other Healthwatch meetings
- Responses to online questionnaires
- People who phone or come into the office for information and signposting to services

(a full database of comments collected can be requested from Healthwatch)

Please note that there is a fuller version of this report that includes more detailed user feedback as well as enter and review reports and survey information. Please contact info@healthwatchtowerhamlets if you would like to be sent a copy.

3. KEY THEMES

3.1. All comments were collated and explored for key themes and patterns in preparation for this report. It is important to note that the methods of collection and methodology of each piece of work varied. Full details of each source and the methodologies used can be requested from Healthwatch and it would also be possible to browse through the entire comments database if requested.

3.2. There were, similar to last year, key themes that emerge from the range of comments across the sources. The data is organised by life-stage and subsequently by themes. Interestingly, almost all of the themes cut across life-stages. Certain issues relating to GPs, Dental Surgeries and services for those with complex needs as well as those with mental health issues have, where appropriate, been discussed separately within the section on Adults

4. UNDER 5s AND CHILDREN

4.1. It was clear that at one level there was great appreciation of the services that were received by families.

My son is two years old and had been having tonsillitis problems for over a year now. So then he was referred by our GP to the RLH to get his tonsils removed. As we arrived at the children's department for pre admission the receptionist was welcoming and helpful. The environment was very child friendly. We didn't wait long before we were seen by a doctor. After he explained the procedure of the surgery and reassured us that it would be ok and sent home after a few hours. The doctor gave us opportunity to ask questions that was very important for us. We asked is there a possibility anything going wrong. The doctor gave us some leaflets for us to read through. It feels good that we had met the doctor before surgery it is very reassuring and made us feel that our son would be in safe hands. I believe that the children service is at good standard and does not need improvements (Parent of Female, Bangladeshi – Barts Voices Project, SAfH)

4.2. However, in some cases, the actual care appeared to be questioned;

The appointment letter came very quickly and she was seen in the Clinic by an Ophthalmologist. Prior to seeing an Ophthalmologist she was seen by Nurses to have drops in her eyes in order for tests to be carried out. Considering they are working in a Children's Department I expected them to be more understanding and reassuring towards children. My daughter was afraid to have the drops in and they were rushing me to hold her down as there were other patients waiting. They did have to hold her down as the eye drops causes stinging she was struggling to get free. I just feel they could be more welcoming and reassuring towards my daughter so she wouldn't feel afraid, same goes for all children. The tests were done quickly although the waiting is a very long time. The Ophthalmologists are lovely; very welcoming and always spoke to my daughter regarding her care and problems. They do a brilliant job. The nurses could be more considerate and understanding towards my daughter. The waiting is far too long (Parent, Female, Bangladeshi – Barts Voices, Stifford Centre – Opthamology)

4.3. It appeared that a recurrent problem was the lack of information given to patients and poor communication.

The Consultant called us through and I sat and briefly explained the problem. The Consultant very quickly looked down my son's throat and concluded that he will need a tonsillectomy. I was given a leaflet to go home and read about tonsillectomies and the whole consultation lasted for no more than 5 minutes. I was very shocked that the consultant had reached a conclusion without doing any form of examination. Though it is only a tonsillectomy, it is still an operation that carries risks just like any other operation. It seemed strange that the consultant reached such a drastic conclusion without actually examining my son or carrying any other tests to see if there was an alternative that we could try first. So I would like to have seen a thorough investigation on my son before giving the option of an operation. Secondly I feel that the Consultant should have spent a few minutes explaining the procedure and the risks to me and even answer some of the frequently asked questions, rather than just giving me a leaflet to read at home. A tonsillectomy may seem like a trivial thing to a medic but for me and my child it is still a big deal (Parent of Male, Bangladeshi – Barts Voices Project, SAfH)

4.4. At times, there was also evidence of poor communication between primary and secondary care:

My son had been complaining of consistent migraines that I had gone and seen my GP about. My GP referred us to the hospital for a CT scan. When we went to the appointment the consultant refused to do a scan on the basis that the GP had failed to provide sufficient information. I had taken my son out of school and felt that the day was a waste of everyone's valuable time. We then had to go back to the GP who wrote another letter explaining in full why my child needed a scan. We then had to wait a fortnight or so for another (Parent of Male, Bangladeshi – Barts Voices Project – SAfH)

4.5. Often, too, a good number of the difficulties families encountered tended to be those that involved administration including the often long waiting times to be seen by a medical professional both in planned and in unplanned care. Further, when there was a hold-up, staff were seen, at times, to be particularly unhelpful:

I was quite disappointed with my appointment as this was the second time they did not have my child's files. We were waiting for over an hour where our appointment was at 9:15 and did not get seen until 10:30 because they could not locate the file. When they finally did see me, there was no apology or anything. If I was late for an appointment, they wouldn't have seen me. Prior to my appointment, the files etc. should have been located and ready for me to be seen on time. In general, the waiting room was tidy and clean. The receptionist could have been friendlier; but that's the usual with hospital receptionists – not approachable and communication skills are poor. (Parent, Bangladeshi – Barts Voices Project, Stifford Centre – ENT Department)

4.6. In addition, staff were also often considered to be unhelpful, particularly when directing patients appropriately:

I received my child's appointment through the post after my GP referred us to the ENT department. My son was suffering from tonsillitis that several doses of antibiotics had not cleared up. Once I got to the RLH I found that the ward was not sign posted and I didn't know which lift to take. So I went to one of the reception desks on the ground floor. I was directed to a lift and told to go to the 6th floor. In order to get to the correct lift I had a long walk with a child that didn't want to come to the hospital and was dragging his heels. When I got to the 6th floor the receptionist told me that I had come to the wrong place. I was then directed to the 7th floor. By then I had a child that was screaming and I found that all of this was very stressful and unnecessary had the place been well signposted (Parent of Male, Bangladeshi – Barts Voices Project, SAFH)

4.7. There were also criticisms of the environment in which families found themselves and the facilities available:

The clinic itself is quite small, not enough seats for so many people who were waiting with their children. There were two or three toys and a TV. The clinic was clean and tidy which I liked… If there aren't enough seats to provide for patients to sit down in the clinic surely something must be wrong; either too many people are booked in or they need a bigger clinic with more doctors (Parent of Female, Bangladeshi – Barts Voices, Stifford Centre – Opthamology)

5. YOUNG PEOPLE

5.1. Once people move into the next 'life stage', it appears one of the largest difficulties became waiting for appointments and the long waiting times. A number felt that this was due to inadequate staffing

The reason they gave me as to why I had to wait very long time that they were understaffed. I was not very happy with the service because I feel due to the shortage of staff there is often a lack of appointment slots available that delay my child's follow up appointments (Male, 16-18, Bangladeshi – Barts Voices Project, LWA, Orthopaedics, Royal London Hospital)

5.2. More pertinently, long waiting times, not simply for appointments and waiting to be seen but equally for prescriptions, gave the impression of a lack of care for patients

I found it extremely difficult to get an appointment – I had to wait one month. The doctor explained my current health state to me very well. Staff attitude overall was good but the nurses were a little rude which I recognised when they answered my questions. As a suggestion for an improvement I would say that there should be more appointments available so there would be more convenient dates and nurses need to be given more training on patients' care (Female, 19-21, White British – Enter and View A&E)

5.3. This could also be exacerbated by staff who were perceived as being rude and simply uncaring. One mother described how she had gone to A&E with her son who had cut his hand. Her GP's receptionist advised her to go to A&E but, on arrival, the triage nurse had been rude and dismissive assumingly because it was an unnecessary visit. Another young woman described her visit to A&E in the following terms:

Staff attitude overall was good, but the nurses were a little rude which I recognised when they answered my questions, when I asked a receptionist when will I be seen by the doctor he replied saying "I do not know, the doctor knows" in a very ignoring manner (Male, 19-21, Bangladeshi – Barts Voices Project, CBSG)

5.4. Perhaps a more important and underlying issue was that diagnoses appeared to have been slow for a number of patients who had less common conditions.

My 15 year old son suffers from a condition known as Overlap Multiple Syndrome. Initially the GP ignored his condition and as a result of poor care he had to go into accident and emergency on several occasions. Then when his health started to further deteriorate and worsen he went into A&E again and was hospitalised for a few months. He had to pass trauma and stress, and mentally suffered. GPs and doctors often initially said his health was nothing of a concern; they didn't really pay much attention to his symptoms I think doctors should be more prompt in getting to the root of the problems, taking full body checks rather than just prescribing medicines and dismissing the conditions, symptoms and patients concerns. I am overall unhappy with overall service my son received as his diagnosis was delayed. The catastrophic journey he passed is unforgettable and we strongly suggest the professional should

look into the issue earlier rather later to save patients life (Parent of 13-15 year old, Male, Bangladeshi – Barts Voices Project CBSG)

5.5. The issue of interpreters also arose:

I often accompany my son to his appointment as he is under 16 and usually I speak on his behalf regarding his eczema, however as I cannot speak fluent English I require an interpreter but there are usually no interpreters available and this means the quality of the service is poor and the lack of communication with the doctor could affect my son's condition in some ways (Parent of 13-15 year old, Male, Bangladeshi – Barts Voices Project, LWA – Dermatology)

5.6. But for some the care was good:

Access to information regarding treatment is excellent – I can contact my doctor or specialist via phone to ask any questions or discuss any concerns I have fairly easily (Female, 16-18, Bangladeshi – Barts Voice Project, LWA, Epilepsy Sufferer)

6. ADULTS

6.1. A striking feature of the comments collected with regard to the 'adult' life-stage was that there was a lack of consistency within a patient's journey often leading to unfulfilled expectations and dashed hopes. The following comment refers to a labour experience but it reflects the sense of dissatisfaction, evident in so many experiences and journeys, that appears to have been caused by the lack of consistency in what seems to each individual as 'good care'.

I gave birth at Royal London six months ago. I was very disappointed in the consistency of the care I had throughout my labour. It is worth noting that the rooms and facilities were great and many of the staff were professional and supportive especially the trainees. However, I was truly shocked by some of the staff whose care I was under. I had one midwife who was extremely rude and made my birthing experience become quite negative. She did not introduce herself or ask how I was feeling at any stage. She did not explain why I had to be connected to the monitor for so long (2.5 hours when it should be a half an hour) which prevented me from sleeping. She laughed at my birth plan and when I asked for toilet paper at 2am she said 'That's not my job'. My partner had to source it from another room and leave me during the labour. I asked for paracetemol as pain relief and it wasn't received until after two hours. There was no explanation for this, it was merely placed on the tray. I felt extremely nervous and vulnerable as a new mother once I was in the care of this person. Up until then I was treated very well and felt confident. I broke down in tears when the doctor came in in the morning and explained to them what had happened. She said that she was not surprised to hear that as I wasn't the first woman to complain about her. It really shocked me that someone known amongst their colleagues to be incapable of being a caring professional was working with women in labour. I refused to take a second round of induction gel because I did not trust the woman who made me feel so bad to put her hand inside my body. You might appreciate that this also

dragged out my whole labour and subsequently affected my decision making after as I had not slept the whole night in her care.

After the birth I had absolutely no help and was thankful to have my mum and partner there as I had had an emergency c section and was unable to leave the bed. Any time I rang the bell I waited for so long and nobody offered to help. The staff seemed to busy filling out paper work. One nurse even said that she then had to enter the notes into a computer system and was complaining about doubling the work. The advice I was given too with regards feeding my baby and dressing her etc was all conflicting. This advice was also only given when I asked for it having nearly given up on breastfeeding. Some medical professionals should clearly not be working. However, there were some fantastic staff and I had two student midwives who were absolutely lovely and made me feel a lot better than their more experienced colleagues. (Female, 26-30, White Other – Survey Monkey Feedback)

6.2. Further, when patient journeys did not run smoothly, it appeared that the problem was not simply that there was inefficiencies with appointments but that there was a far more systemic issue and the cases below did not appear to be isolated ones

In my experience waiting times have been a nightmare- when arriving early for appointment and still not seen on time especially when being penalised if you're five minutes late you would think they would give you the same courtesy in return. The waiting area is too 'intimate' for my liking and at times stuffy. I don't want to leave with more illnesses than what I first came in for! Accessing interpreting services can be difficult. When getting in touch with the advocacy service it can be a long wait before getting any confirmation. Reception staff to organise advocacy services and should be their doing. They should be more flexible with their time especially when there's a long wait for the next appointment. They need to look at quality of care across the board rather than people feeling like a statistic they need to do away with as soon as they get through the door. Receptionists should be more friendly and be trained to speak to patients in a nicer way as they are the first point of contact whether face to face or over the phone. I've found a lot of the receptionists to be quite cold and patronising especially when speaking with people who don't speak English fluently- talk about the lack of training in taking the non-judgemental approach! (Male, 33-40, Bangladeshi – Barts Voices Project, Stifford Centre – Diabetes Screening)

6.3. It was thus notable for patients when everything appeared to run smoothly as it had for these patients:

I have been registered with this practice for the past twenty-two years and generally very happy with the service and treatment I get here. This is my first visit after a two year absence. I am happy with the way the receptionist spoke to me over the phone and also very happy that I was offered an appointment within two days of making the call. In the past I was always happy with the way the dentist explained the treatments and costs and I hope that this will the same this time around. I find the environment friendly and welcoming and receptionists are also friendly. If I need interpreting support the frontline

staff always offer to help. (Female, Bangladeshi – Abbey Dental Practice, Enter and View visit)

All the care we received in A&E was good. The Doctors were efficient and informed us of what they were doing and if it didn't work what they would do next (Female, 51-59, Bangladeshi – Barts Voices Project, SAfH, Eye Clinic, RLH)

X *is my main Consultant. Over the years I have built a good rapport with him. I find that he is welcoming; he always greets me and calls me out by my name. He explains in simple terms what is happening to me and how my treatment is going. My Consultant contacts me directly by phone or email to inform me of test results and any changes in my medication. I feel that he trusts my judgement and is willing to try what I suggest. I have an open relationship with him and feel free to speak my mind* (Female, 41-45, Bangladeshi – Barts Voices Project, SAfH, Renal Department)

6.4. As with all other categories, the seeming lack of appointments and the long waiting times to be seen were an issue. Low numbers of staff were frequently seen as a key factor.

I visited the Bethnal Green chest hospital on the 14th of April due to my heart problem. I did not find booking this appointment very easy and had to wait over two weeks for it. I had to wait very long to be called by the doctor which was very disappointing and I had to go in to work a little late. I booked for interpreting services and was given an interpreter but not all the times are interpreters available (Female, Bangladeshi – Barts Voices Project, LWA)

6.5. From the present evidence, this seemed to be a particular issue with A&E:

My experience at the RLH (A&E) *was really outrageous. I went to the emergency department as I had an agonising pain in my fingers. I went in at 9pm and left the department by 3am in the morning. The waiting time was so long I was in pain frustrated then told by the receptionist that there were only two doctors available. I would suggest to have more doctors at night duties or have them on call if it is really busy to reduce waiting time* (Male, 31-35, Bangladeshi – Barts Voices Project – Stifford Centre

I was taken by ambulance to A&E at 11pm and was finally seen by a doctor at roughly 4am. When I asked why there was such a delay the receptionist said that there are many patients to be seen however there were hardly any – only me and another 2 people. There was also only one doctor on shift and I don't know whether this was because it was night but it is truly disappointing as people come to A&E for emergencies and it is not good if there are no medics and doctors to treat them and see to them (Male, 41-45, Bangladeshi – Barts Voices Project, LWA)

6.6. Delayed appointments were also perceived to have adverse effects on the patients' health:

But to have the tests sometime it was very difficult for me to get an appointment. Due to this many of my appointments were delayed. Also the

delay to my diagnosis had adverse effects on my health (Male, 46-50, Bangladeshi – Barts Voices Project CBSG)

6.7. Not surprisingly, frustration with GP surgeries in trying to obtain appointments was equally common and this seemed to be an issue with most surgeries:

Getting an appointment is difficult; recently they have changed the appointment system, now you have to call the surgery and the reception staff takes your details and then gets a nurse or a GP to call you back, it's a hassle as you have to wait around for a long time before someone calls you back...on the last occasion when the GP called back she decided that I did not have to be seen urgently, however I felt I needed to be seen sooner… the previous 'walk-in' system was also not very good as there was long queues that could go outside of the practice and by the time you got to the front of the queue all the appointments would be gone. I would prefer if they just had a traditional appointment system where you just call in and speak to reception staff and they offer you an appointment. Also it takes forever for the surgery to pick up the phone, on the last occasion it nearly took 25 minutes. Female, 22-25, Bangladeshi – Enter and View visit, Harford Health Centre)

It can be quite difficult to get an appointment here, usually 3-4 days. If it's an emergency, you can request for a telephone consultation and the doctor calls back you to assess if you should be seen and offers an appointment time and date. I called in today and requested an emergency appointment; the doctor called me back within 20 minutes and offered an appointment for today (Male, 31-35, Other – Enter and View visit, Wapping Health Centre)

6.8. Adapting to a new appointment system additionally seemed to cause problems for patients.

I don't like this new triage appointment system, even though I spoke to a nurse on the day I called in, I was offered the appointment two weeks later (which is today), also we had to wait the whole day for the nurse to call back, we would have preferred a time slot for calling back. We would like a normal appointment system where receptionists can offer appointments and also we would like to be seen within 2-3 days. .. My husband waited 1.5 weeks to get an appointment, when he turned up, they told him that there was no rooms available for doctors consultation, although there was a doctor there was no rooms available for him to see patients…how strange…they said he had to make another appointment, but reception staff refused to offer him a new appointment and said my husband had to call back…he was very upset as he had waited a 1.5 weeks to get this appointment and take time off work and through no fault of his own they decide to cancel the appointment , but on top of that they refused to offer a new appointment… after a bit of arguing with the receptionists about all this, the nurse came out and offered him this appointment (Female, 31-35, Bangladeshi – Enter and View visit – Harford Health Centre)

I don't like the new appointment system of calling back; sometimes you can wait for ages before you receive the phone call by the doctor. I prefer the old 'walk in' system; it was much faster in the sense of getting to see a doctor

sooner. (Female, 22-25, Bangladeshi – Enter and View visit – Harford Health Centre)

6.9. Some patients related the difficulties with appointments to potentially unnecessary A&E visits

Getting an appointment at this surgery is very difficult, it seems like they are not bothered or care about patient's wellbeing. I don't feel it's right that a doctor should decide whether you should be seen by talking to a patient on the phone, not everyone can explain things properly, then there is also language issues…also it takes a long time to get a call back i.e. 5-6 hours and when they finally call you, they offer you an appointment after two weeks…this is the reason why some patients end up going to hospital or A&E (Male, 31-35, Bangladeshi – Enter and View visit, Harford Health Centre)

6.10. It was also extremely frustrating for patients across the system not to be able to contact the relevant people.

I was referred to the physio department by my GP for my back. The timing of the appointment wasn't suitable, so I called the department. The receptionist stated that if I wanted to reschedule they don't have any appointments till a few months and they are fully booked. She informed me that I wasn't able to book two months in advance anyway. The receptionist also informed me to keep the appointment and phone closer to the time to re-arrange. Furthermore, she added that if I cancel the appointment I will be taken off their system!! Closer to the time of the appointment, I called the department but no one picked up. For that whole week, not one person picked the phone up. I sent an email to address my issues but haven't heard from anyone to hear of rescheduling of the appointment. It's been 6-7 months!!!! I now have to wait to be referred by the GP AGAIN and wait to hear from them Of course!!!!!!! There has to be an efficient and effective service. One should be able to re-arrange their appointment without having to be discharged!! (Female, 31-35, Bangladeshi – Barts Voices Project, Stifford Centre)

6.11. A further view was that text messages were just not appropriate for contacting patients and it was suggested that an appointment system that could be accessed on-line might work well.

I wasn't happy with the text message reminder sent. It has no detail as to where or what department the appointment is for. It also does not state the name of the patient. This is confusing for myself as to whom the appointment is for myself or my children. And also I am under treatment for several appointments so how would I know whether it's for example a physio or dermatology appointment. In order for the text message to be helpful it needs to include; patient's name and department for the appointment as well as times (Female, 31-35, Bangladeshi – Barts Voices Project, Stifford Centre)

6.12. Cancelling, particularly, at short notice could also be highly problematical for patients

I had an appointment before Christmas, and they cancelled this appointment on the day of the appointment, apparently the thing that needed to be placed in my teeth had not been delivered...this late notice was a problem for me as I had taken some time off work to attend the appointment, I feel they could

have told me this information the day before and I could have gone to work. Furthermore they did not make me another appointment, I had to chase them up to get this appointment...I feel if they cancel an appointment they should take the initiative to make another appointment for patients. Also staff should look at patient records the day before appointments to make sure everything is in place for the next day, if not, this will give them an opportunity to notify patients earlier about any cancellations... (Male, 31-35, Bangladeshi – Enter and View visit, Abbey Dental Practice)

After a long wait we were given an appointment in May but then we received a letter of cancellation and another giving us an appointment in June. My mum's condition has been unbearable for some time so the change in dates did not help (Female, 51-59, Bangladeshi – Barts Voices Project - Stifford Centre)

6.13. More generally, in direct contrast to patient experiences of obtaining appointments in much of provision, at dental surgeries it was a different picture. It was interesting to note that obtaining appointments appeared not merely just part of an overall experience but a very critical one:

I've been registered with Abby Dental Practice for seven years now and my experience so far has been positive. I was given a next day appointment as I was in pain and I am very happy about that. The receptionists are very friendly and also very professional over the phone. I think the environment is relaxing, welcoming and safe. I am usually happy with the explanation of the treatment and the service I receive from my dentist, however I last visited the dentist only eight weeks ago and now I am back with severe pain, I feel I should have had an X-ray during my last visit and this would have probably prevented me from coming here again and enduring the pain I am in now. Overall, I am happy with this practice and would happily recommend it to others (Female, 22-25, White/Black Caribbean – Enter and View visit, Abbey Dental Practice)

6.14. Co-ordination of information was an area of concern that arose for patients across provision particularly those with long-term conditions.

I visited a number of different health services throughout last year – 2013, including angiogram, x-ray, ECG, blood test, Accident & Emergency and also optical. I also visited the A&E more recently this year – June 2014. However as improvements to the service I would suggest a coordinated information system to be implemented as I found myself having to repeat myself many times to several doctors, which is exhausting and frustrating (Female, 51-59, Bangladeshi, Barts Voices Project, LWA)

6.15. Communication between departments and different service providers was also frequently seen to be poor.

I have had lower abdomen pains for some time now and after visiting the gynae department I found out that I have ovarian cysts. The cysts are regularly monitored to check they don't grow too big so I go for ultrasound scans on a regular basis. When the letter arrived for my January appointment I noticed something different. This time they wrote in the letter that I have to fast from mid-night and my appointment was late in the afternoon. So I found it

strange that they'd never asked me to fast before and why they had given me an afternoon appointment if they require me to fast. The letter also stated this was my final scan. When I arrived for my appointment I went to the reception desk. When I was called through by the sonographer she too was surprised that I had been asked to fast and said this was not necessary. This made me really angry that I had been put through such hardship the whole day on a clerical error. After having the scan, previously I have asked the sonographer for details of the scan and they have always told me that I need to speak with my GP to discuss the results. Also often I wasn't informed that my GP has my scan results but has not called me in to discuss them. Contrary to my previous appointments, this time the sonographer asked me why I had been discharged from the clinic as my cysts had actually started to grow. After informing my GP of this information he has now referred me back to the clinic again. There seems to be little communication between the Gynae Department and my GP. It seems to me that rather than communicating direct that I am the 'go-between' that is passing information in both direction (Female, 36-40, Bangladeshi – Barts Voices Project, SAfH)

6.16. It was also common to hear requests for continuity of care, especially when pregnant:

I always get to see a different midwife, I would prefer to see the same one, I feel I keep repeating myself, which is frustrating and also due to the changes of midwifes you don't get the opportunity to know someone better or feel comfortable around them (Female, 22-25, Bangladeshi – Enter and View visit – Harford Health Centre)

6.17. An integral part of the dissatisfaction reported appeared to be the attitude of staff towards patients particularly those who worked in reception areas.

I can only begin with my first impressions of the service I received at reception, which is in my opinion at the forefront of a duty of care. It was my first visit at the hospital, hence I was somewhat worried if I would find my way round. I stopped at the main reception on the ground floor. Assuming that I was at the right place I approached the lady sitting at the desk and informed her I was here for my dermatology appointment. Without a helpful smile or any sense of attention towards me, she vaguely gave some directions. I ended up in the wrong department. I went back to the main reception feeling flustered. The same lady was there and she had the same attitude. She questioned my knowledge of English and was very rude. Without looking up she told me to go back up. At that point I was not feeling calm at her lack of help and went to find the right department myself. The manners and people skills the receptionist lady displayed to me that day was appalling.. (Female, 26-30, Bangladeshi – Barts Voices Project, Stifford Centre)

The receptionist was very rude, and didn't seem to be interested in helping me. There were two at the reception; they spent 10-15 minutes chatting before they acknowledged me (Female, 31-35, Bangladeshi – Barts Voices Project, Stifford Centre, A&E)

6.18. But it was clearly not only reception staff that came in for criticism:

Also the night ward staff especially the nurses behave very rudely, and this needs to be addressed…The nurses need to be appropriately trained. (Male, 26-30, Bangladeshi – Barts Voices Project, CBSG)

Staff in 8B were very rude, did not come when I pressed the buzzer, would not let my husband come and translate for me nor did they give or offer a translator. When I was given IV Fluids, saline, when it ran out the staff were supposed to give me another but when my husband informed them the nurse replied 'don't tell me how to do my job', the staff on this ward were very unprofessional (Female, 26-30, Bangladeshi – Barts Voices Project, Stifford Centre)

I was admitted to the Royal London Hospital, during the night the ward was very short staffed and I had to wait a very long time and ask at least three times for medication. I feel that more staff are needed during the night to ensure a good level of care for all patients (Female, 41-45, White British – Barts Voices Project, Stifford Centre)

6.19. Those who had experienced the maternity services were often particularly dissatisfied with the way in which they had been treated.

For my first appointment when I became pregnant with my son, I was made to wait for 10 minutes to queue in order to sign in at reception. It was really hot and there was not enough seating for the amount of people that were there. In general, the space was very small and confined. Reception staff were less than helpful and had bad attitude. They were talking amongst themselves whilst being approached by patients. It's very rude not to be acknowledged whilst trying to ask for some help especially if that is the requirement of their job role. Reception staff need to be more helpful and willing to direct assist patients when needed. The air in the waiting area should be more regulated and the seat should be more comfortable and more seats made available to accommodate for everyone in the waiting area (Female, 22-25, Other - Barts Voices Project, Stifford Centre)

The experience I had during the birth of my first baby was awful. I never thought anyone could be treated in such a way especially when under such circumstances. The staff nurse I had to unfortunately deal with on my ward during my stay there did not have any customer/patient care skills and found her to be short and abrupt with me whenever I spoke with her to the point where I thought she had an issue with me. I spoke with one of the other new mothers on my ward and soon came to realise that this was just the nurses' nature. I don't understand why people who have no compassion and clearly cannot empathise with their patients/people they are dealing with on a day to day basis; they should not be working as front line staff if they do not have the right attributes for it. They should really look into this before hiring miserable staff! The waiting period when asking for something that was needed I found was quite lengthy and nurses would say they were busy as they had other patients to tend to and would take their sweet time before returning to see what the matter was in the first place. My birth plan was discarded and was not taken into consideration at all. I was a new mother

treated very unfairly! (Female, 26-30, Bangladeshi – Barts Voices Project, Stifford Centre)

The first nurse who started the process of inducing me was very unfriendly and showed little emotions towards me. She continued to do her work robotically with a lack of empathy towards me and my hip condition. The second nurse was wonderful. She connected with me and was very empathetic towards me. She continued to ask how I was and whether I needed anything. She also made suggestions as to how I can make myself more comfortable. She went and got me more pillows and would wet my lips with water as I was nil-by-mouth in case I needed a C-section. She asked after me and showed genuine concern for me and my well-being...When I was taken to the post natal ward I was faced yet again by cold, unsympathetic nurses who tried to push me into things without explanation such as giving me medication and just telling me to take them. I need to know what it is I'm taking and why it is that I'm taking it. I didn't appreciate being treated like cattle! They would also do crazy things like just come without warning and switch the lights off. So I'll be doing something like changing by baby and before I know it we were in darkness. It wouldn't hurt them to be a bit nicer to people (Female, 40-45, Bangladeshi – Barts Voices Project, SAfH, Maternity Ward)

The head nurse was ridiculous, attacking every new mother verbally. The other nurses were very polite and helpful. But they were very under staffed…they need more staff on duty to take care of vulnerable mothers. It is important that mother's needs are met at all times (Female, 26-30, Asian- Barts Voices Project – Stifford Centre, Maternity ward)

6.20. As well as experiencing more negative attitudes, patients also complained of feeling that they were being 'rushed' in and out of appointments and this appeared to be the case both in primary and secondary provision:

Some doctors are ok and give you time, but some always try to get rid of you… (Male, 31-35, Bangladeshi – Enter and View visit, Harford Health Centre)

I thought the doctors were rushing and so therefore didn't explain things to me well or check me thoroughly (Male, 26-30, Bangladeshi – Barts Voices Project, CBSG)

6.21. Perhaps more importantly, was the need to consult patients and to speak to and act towards them with appropriate respect. Thus, for example, using correct nomenclature or asking them whether they minded a student attending the observation before the student comes into the room. And as this young man explained:

For improvements I would suggest staff need to be trained regularly to have better and developed interpersonal skills and empathy so they can relate to the patients and not behave unprofessionally towards them (Male, 22-25, Bangladeshi, Barts Voices Project, CBSG)

My GP referred me to Mile End hospital for an x-ray. I visited the hospital in June this year. The staff I believe were not polite at all, they were too rude to me and their attitude was appalling. The radiographer told me to change into

the gown provided. When I had come back the radiographer behaved very rudely towards me. In a very aggressive manner he said "don't you understand what I had told you, you have to remove your vest as well". I replied correcting him that he had not told me to do so, but despite so I went to remove my vest. The radiographer was not very cooperative either. I strongly feel a number of improvements will need to be made to the service so people get better care. Also to treat all patients fairly and not rudely because they may not understand or speak fluent English – they need to be patient and at the same time polite (Male, Bangladeshi – Barts Voices Project, CBSG)

6.22. And this could be especially galling for those with special needs:

I have explained to the receptionist (at Bethnal Green Medical Mission Practice) *that I wish to register with the surgery. The receptionist was rather awkward towards me for some reason. I tried to make effort to communicate with receptionist but the receptionist was being difficult. I tried to have eye contact with her but she did not even acknowledge me. The receptionist was asking for my proof of address so I showed my bank statement with the address to the receptionist. The receptionist was rather rude as she was looking at my balance. I felt offended and I snatched the statement off from her. I decided that I had enough with the receptionist's attitude and walked out from the surgery. I asked the Deaf Plus advocacy to deal with it. The advocacy called the practice for me and explained the situation. The receptionist stereotyped me as deaf and DUMB service user. The advocacy has explained that DUMB term do not exist anymore in modern days* (Female, White Other – Barts Voices – Deaf Plus)

I got an appointment with my GP and was expected to have British Sign Language interpreter for the appointment. Unfortunately BSL interpreter failed to turn up and I was stressed about it as I knew that I cannot communicate with GP without BSL interpreter. So the appointment was postponed to another date which it was not helpful at all. I felt that it was not fair…Why should I suffer from this while hearing people easily see GP without any problems? (Female, White British – Barts Voices Project – Deaf Plus)

I am constantly frustrated when arriving at the Royal London to be told that I need to go "that way", when I am carrying a white stick (Barts Voices Project, ELVIS)

There seems to be no mechanism for one department or service that knows I have a sight problem to pass this on to another. This was both the case within different clinics within the hospital and then when I was discharged but needed to see a District Nurse for a while (Barts Voices Project, ELVIS)

I was very concerned when visiting the diabetes clinic at the Mile End hospital. They advised me what I should and shouldn't eat and then gave me a printed sheet of information, which of course I couldn't read. I therefore did my best, but it was guesswork (Barts Voices Project, ELVIS)

6.23. From the data, too, it seemed that clear communication between doctor and patient was an essential component of the patient journey.

The doctor was very consistent and thorough in checking me over. She was also very helpful and friendly. The staff were also very informative which I found a delight as I felt I was getting all the right information on my treatment which in turn made me less anxious and confused (Female, 51-59, Bangladeshi – Barts Voices Project, CBSG)

6.24. Certainly the lack of interpreting facilities was again an issue for many and often exacerbated stress and/or medical conditions.

My English isn't very good so sometimes I feel I need an interpreter to help me explain my problems well to the GP so that the doctor gets a better understanding of why I came however there are hardly any interpreters available when I call in and ask and they often say the next suitable appointment with where an interpreter will be available is in two weeks or so. This really annoys me because I feel there's no point coming after 2 weeks when I am suffering at the moment. The receptionist also says that if I feel worse I should go into A&E and this also disappoints me because GPs are supposed to be your first point of contact that you're supposed to be easily accessible to. (Male, 51-59, Bangladeshi – Barts Voices LWA)

I need to highlight this as I feel like it is dangerous practice, when I was taken in for a procedure 'Gastroscopy', they told me in visually and pointing to parts of mouth what they will do, although I can't speak English and I can understand very little, they did not inform my husband nor did they get an interpreter to explain the procedure, they made me sign and did not explain any risks. I'm extremely angry about this. I had another procedure done, I can't remember the name and the same thing, nobody explained what it was and risk involved. This is dangerous practice (Female, 26,30, Bangladeshi-Barts Voices Project, Stifford Centre)

When my daughter spoke to the staff in A&E, they didn't want to explain to her much, but my daughter wanted to know exactly what's going on, the nurse didn't want to explain, I think if your treating a patient who doesn't understand the language then it's vital for the person treating to explain to their next of kin what is going on (Female, 51-59, Bangladeshi – Barts Voices Project, Stifford Centre)

6.25. A substantial amount of spontaneous comments concentrated upon the environment of hospitals and in particular waiting areas. Some complained of the size and the lack of refreshments, seats and of space more generally. Others felt that since they were spending a good deal of time in there with all the endless waiting there could be a good many improvements:

The waiting area in the Renal Department is very small. Many people who are on dialysis are wheelchair bound so sometimes I feel there is no space for everyone in the waiting area. I particularly feel this is the case for people in wheelchairs. I would like to see more health information in the waiting are on how to look after your kidneys, what to eat and what not to. Maybe also some general information, magazines and even a TV to keep us entertained if

patients are expected to wait 45 minutes. (Female, 41-45, Bangladeshi – Barts Voices Project – SAfH)

Hot drinks and sandwiches in A&E would also make things easier for patients and those that accompany them (Female, 31-35, Bangladeshi – Barts Voices Project – Stifford Centre)

6.26. Poor signage additionally caused patients consternation

After visiting a friend who has recently given birth, I found making my way to her very difficult and confusing, the halls seem to go on and on, there doesn't seem to be any clear signs directing me to her floor let alone what room she was in, I could not find a member of staff nearby and all the information desks seemed to be empty. After calling her again, she had a nurse who was next to her that was very helpful and was able to give me directions and tell me which lift I needed to get and where from and only then did I finally find her after 30 minutes in the hospital (Female, 26-30, White British – Barts Voices Project, Stifford Centre)

When getting to the hospital I felt very confused I didn't understand any signs. In the old building there was talking signage that was very convenient to use to find where to go in my language. The new building had better facilities but it was like you had to go around the building department seemed very far away. I didn't understand the lifts were very confusing different department different lifts type outside buttons it's just too much changes. Even my daughter who is born in this country found it absolutely horrendous (Female, 51-59, Bangladeshi – Barts Voices Project, Stifford Centre)

However my greatest issues are the lifts, finding my around the hospital I just don't understand it. It makes me really frustrated and angry. I had to take a member of my family with me sometimes it is not convenient for them to come with me so I have to cancel my appointment. There is no support for translation or people to ask to guide or to support me at the hospital (Female 51-59, Bangladeshi – Barts Voices Project - Stifford Centre)

6.27. GPs and Dentists – Specific Issues

6.27.1. As has been noted, many of the issues detailed above cut across service provision including GP provision. However, there were one or two issues that appeared to be unique to GPs. In the first place, the fact that GPs were generalists and, for the most part, not specialist, seemed to have had implications for some patients:

However I think my GP practice (XX place) is not really fussed about my diabetes...sometimes I feel unwell and it could be diabetes related, but it's so difficult to get an appointment there...the receptionist don't seem to be bothered about the type of illness I have, for them everyone is the same. (Healthwatch signposting phone call)

6.27.2. Given this, it is interesting that there was evidence of patients needing services that were more 'holistic', furthering their generalist approach:

I think they should have one doctor for emergencies only, and also it would be nice to have someone to talk to about general concerns regarding health, like a councillor (Female, 51-59, White British – Enter and View visit, Wapping Health Centre)

6.27.3. A striking feature of the nature of the comments over the past year was, as has been noted in the Executive Summary, that patients tended not to concentrate on concerns or issues about their care per se. Instead they tended to concentrate on issues surrounding or linked to their care as detailed above. It was notable, therefore, that patients did tend to comment on the care they had received from dentists and, occasionally, GPs:

I've been coming here for around 9 years, they offer quick appointments and really look after you...even though I am on benefit, I feel they do not discriminate against me and provide me the best care and service. I have a great relationship with my dentist, she is very friendly and provides good treatment, she even goes the extra mile to keep me happy, for example she cleaned my teeth today, even though I am here for other reasons- which I am really happy about. The people in this dentist are like family, they are all very warm and friendly (Male, 22-25, Bangladeshi – Enter and View visit – Abbey Dental Practice)

This is my fifth visit to this dentist, today I am here for my six month check up, and I originally came here by family recommendation. The dentist is very good; they explain diagnosis and treatment properly and always answer any questions I have. They also explained the charges properly and I understand what I am entitled to. The staff are friendly and polite and I am very happy with the service I get here. Inside the dentist the surrounding and decoration looks nice and clean (Male, 22-25, Bangladeshi – Enter and View visit – Whitechapel Dental Practice)

6.27.4. Interestingly, in both dental and GP provision, confidentiality seemed to be an issue:

I also feel that there is lack of privacy as the waiting area is small and treatment doors tend to be left open i.e. you can hear conversations and treatments (Female, 41-45, White Other – Enter and View visit, Whitechapel Dental Practice)

I do have issues with some of the reception staff and also the lack of privacy at reception, People behind can hear clearly your discussions with reception staff (Female, 36-40, Bangladeshi – Enter and View visit – Harford Health Centre)

6.27.5. In addition, there appeared to be an issue for patients who wished to complain: *And also the complaints procedure with the NHS is really complicated, so I didn't bother putting in a complaint about the other practice* (Female, 31-35, White British – Enter and View visit – Wapping Health Centre)

6.27.6. Finally, Healthwatch additionally carried out an Enter and View visit to Health E1, a GP practice in Tower Hamlets,that caters for the 'homeless' and often

those with complex needs. In this instance, there was, on the whole, praise for the surgery:

I was referred to Health E1 through Dellow Centre. It is easy to get an appointment, I am usually seen on the same day .I think the service is really good and the staff are really good at dealing with problematic patients. I'm usually seen quite quickly, usually within the space of 15 -20 minutes and I am always treated with respect and dignity. Health E1 staff are very good in how they treat their patients. They have a non-judgmental attitude and treat everyone with respect, no matter what the issues is. Overall it is a good service and I have no suggestions to improving this service (Male, 36-40, White British - Enter and View visit, Health E1)

6.27.7. Long waiting times also did not appear to have the impact as they did on patients attending other surgeries:

The hostel I was staying in referred me to Health E1; I have been here 3 times in the last year. The walk in service is very good but it usually takes a long time before you are seen by a doctor; however the doctors are good, so far my experience has been good and I don't have any suggestions for improving the service (Male, 31-35, Bangladeshi – Enter and View visit - Health E1)

It's the only GP practice around here for homeless people, I come here every fortnight to see a GP, and they make regular appointments for me. (XXX) *is friendly and helpful,* (XXX) *is also very good, the doctors and nurses here treat you with dignity and give you respect. Sometimes you have to wait a long time if you use the walk in service, but I am very happy with the service I get here* (Enter and View visit – E1 Health Centre)

6.27.8. Even for those who had left the borough, it remained the place to go:

It's a very good service; you can be seen anytime… I have been coming here for the past 15 months and I was referred here by the Dellow Centre, one day I was not feeling well and asked the staff at the Dellow Centre if anyone could help and they told me about this place. When you come in the morning walk in sessions you tend to wait a long time, but I don't mind waiting as I always get to see a doctor. I have now moved out of this borough, I am now living in Newham in sheltered accommodation, but I like this place and still come here as I like the doctors because they are caring and friendly and also it's flexible as I can see a doctor anytime (Male, 26-30, African – Enter and View visit, E1 Health)

6.27.9. There was also a request for greater provision:

I have one suggestion; I think it would be beneficial to have more afternoon walk in sessions (Male, 26-30, African – Enter and View visit, E1 Health)

In terms of improving service I would suggest they have longer walk-in clinic opening times (Male, 36-40, Bangladeshi – Enter and View visit, Health E1)

It would be great if they can open on Saturdays, there is nothing for homeless people in the weekends (Enter and View visit – E1 Health)

6.28. Mental Health Provision – Specific issues

6.28.1. For a number of patients with mental health issues, the process of finding suitable support could be daunting:

Initially accessing Crisis House was difficult, I had to go to A&E, then hospital, then got discharged and then Home Treatment Team referred me to the Crisis House, I feel this place should be promoted more, its better coming here in the first instance then going through the whole process of being admitted to hospital. When I was admitted to hospital last year I was new to the borough, coming here has allowed me to learn about other services available in this community (Male, 41-45, White British – Enter and View visit – Crisis House)

6.28.2. However, once provided with appropriate support there was often only praise:

This place was great for me; it gave me the anchor to move back into the community and believe in myself and helped build my self esteem. It's also a safe place and socialising with other tenants helped me to be relaxed and get support from peers. Staff always take an interest in you and they also did not judge me based on my life history and what I had done. When I came here I felt people believed me and this made a real difference, I felt people trusted me and I could trust people back. Being active was a key part in my recovery, staff here got me involved with other community groups such as the Bromley by Bow Centre, I got involved with Bromley by Bow Centres time banking and gardening projects. Whilst I was staying here, every third day I would get to see my key worker to review my goals, setting little goals was very good as you felt like you achieved something; this helped to strategise and get back on my feet. Even after being discharged they provided me with on- going support for about two weeks and called me every day to see how I was doing and even after being technically discharged the staff supported me with getting access to see my daughter. Currently I am involved with Look Ahead as a 'peer mentor', I have been involved with the recruitment of staff members (interview panel) and also deliver training to Look Ahead staff on mental health and also delivered presentations to other Crisis Houses in other areas. This place has been like an 'Angel', it has been my saviour (Male, 41-45, White British – Enter and View visit – Crisis House)

6.28.3. Overwhelmingly, however, there appeared to be support for the benefits of social interaction for those with mental health issues:

I like it here you get to socialise with other Bangladeshi people, being here makes me feel happy and I feel that I am not on my own (less isolated), we go to the parks for walk and take part in yoga, also the new 'Fitness Group' is also very good as it helps to keep me healthy (Male, 31-35, Bangladeshi – Enter and View Visit, Pritchard's Row, Day Centre)

Before coming here I use to sit at home and feel angry, agitated and also lonely, since coming here (5 months now) I feel a lot happier mentally because I am able to socialise with other men from my community and also take part in activities. (XXX) *is very friendly, he encourages us to take part in activities, organises activities for us and also talks about what is happening around the world (news)* (Male, 51-59, Bangladeshi – Enter and View visit – Pritchard's Row Day Centre)

6.28.4. And there was a strong call for more sessions and particularly at times when service users might most need them. Cutbacks too were a concern.
There should be a 'drop in' at the weekend for when some of us are unwell and want to socialise with other people. It's somewhere to go and it is better than having to go to A&E. I would like to see more Drop Ins, the compulsory activities are too rigid; can do with more flexibility for when people are unwell. Sometimes feel that I am being forced and pressured to join a group activity when I do not want to. The place keeps people safe. It makes me feels better. Prevention is better that cure. Everyone welcomes you and there is a family feel to it; that is why I have been coming here for last 16 years. The staffs are doing an especially good job. This place provides a safe place for me when I feel frightened of the world (Female, 46-50, White British – Enter and View visit, Pritchard's Row Day Centre)

I like the Somali Group, we make food, eat together have group discussions…it's a nice place, I am very happy and I feel much better coming here. The staff are very caring and very helpful…we are very happy here. I like the new activities; I think this place is better than before… I would like this place to be open in the evenings and also weekends and it would be great if we can have the Somali group session available more days of the week (Male, 51-59, Somali – Enter and View visit, MIND in Tower Hamlets and Newham)

6.28.5. The classes offered and the benefits accrued also tended to be very much appreciated

I take part in a lot of activities here; I have been to trips and take part in exercise classes. I have also taken a course in basic computing and been a volunteer at the Tea Bar (Male, 31-35, Bangladeshi – Enter and View visit – Pritchard's Row Day Centre)

I like the service here, they always try to help you for example if I am feeling down they arrange a counsellor to see me. Before I use to come here Monday to Friday, now you have to sign up to an activity to attend. I like coming to the groups, I think the activities are good as it gives us options to do things, before we use to do nothing, now they are encouraging us to use our mind (Male, 41-45, Somali – Enter and View visit, MIND in Newham and Tower Hamlets)

6.28.6. But there was some concern that service users were not consulted adequately

I have also noticed that a lot of people want to socialise and they like the drop-ins and they don't want to participate in activities, I guess this could be the reason why some people are no longer attending…anyway I think the group activities should be based on what service users want to do, they should be involved in the decision making. In regards to the current activities people were told that they was going to implement the activities and that was that…it would have been useful to ask people what they wanted to do then come up with a activity timetable.. (Female, 22-25, White British – Enter and View visit – MIND in Newham and Tower Hamlets)

I think Mind is very helpful, and the staff are very helpful. I like the Music Therapy Group, it's very good as I find it therapeutic…the new programme is helpful, it would be better if they could ask users what should be

included...also I would like more drop-in sessions (Male, 31-35, African – Enter and View visit – MIND in Newham and Tower Hamlets)

6.28.7. However, the majority of comments about the staff were notably complimentary

(XXX) is my key worker, I get to see her at least twice a week, she is very helpful, she helps me with filling up forms, helps with my housing and benefits problems…I like the staff here, they talk to me and give me time (Male, 31-35, Bangladeshi – Enter and View visit, MIND in Tower Hamlets and Newham)

I have been coming here for over 20 years; I was referred by my psychiatrist. I have received excellent support and could not do without my link worker. The present staff are very engaging, they make time for me and everybody, they are the best team that I have come across and they have done more for me than my CPN or Social Worker. Here is the only stable place where I can feel safe, the staff and users make me feel that I belong and am part of a family. I need to go somewhere every day to make friends and socialise and staying home makes me ill. I do not know what I would do if I did not have this place to come to. I am lucky that I have a partner but most people live on their own. This place is heaven to me. Staff do not force you to do group activity if you feel unwell (Male, 31-35, Bangladeshi – Enter and View visit, Pritchard's Day Centre)

6.28.8. And it was noted when staff had made a particular effort

I feel pressured to join the group activity when I do not want to because I am unwell. It takes the staff a while before they understand what you are going through and then it is fine (Male,51-59, White British – Enter and View visit, Pritchard's Row Day Centre)

6.28.9. On the other hand, some felt that the support given by the staff was slightly double edged:

I am happy to participate in the group activities but sometimes staff pressure me to take part and I feel like I am in a Nursery. They talk to me like I am a child and I do not like that. It could be thier way of encouragement. I cannot explain. Before I started coming here, I did not want to go out of my home. The one to one support which I received has helped with my recovery. The users and staff are very welcoming (Female, 46-50, White British – Enter and View visit, Pritchard's Row Day Centre)

6.28.10. There appeared to be a further concern about the lack of staff:

I also feel that there is not enough staff to integrate with users and sometimes it can feel there is lack of staff presence…the staff that are here, they always try their best and always try to support you and I feel they represent us well in the service user forum (Female, 51-59, White British – Enter and Visit, Pritchard's Row Day Centre)

There needs to be more staff to talk to users, general staff engagement with service users is important as they can help service users feel better…just having someone to talk to is important, now you have to make an appointment

to talk to someone. I use to like the drop in service, if you feel unwell you can have the opportunity to go somewhere and socialise for a while. I would suggest that we have more drop-in sessions. I groups activities can be great, but they need to have more interaction as sometimes you don't know the people attending the groups. .... Currently the whole place is dead…some people live a long way and coming down for an hour is not enough, you want to come for at least half a day… also if you participate in activity in the morning and also want to participate in a activity in the afternoon, you are told to come back…this is not possible if you live far away or in the mean time where do you go? It seems unreasonable…I feel there needs to be a balance of both, socialising as well as activities, but they need to be practical about it. Before I use come here almost every day, now it 1 or 2 days, this is making me feel depressed as I am not socialising as much. The current programme does not meet my needs and also it seems they just appeared, there was no engagement with user, I feel staff have not listened to users in this regards and I also feel funders needs don't meet our needs. Evening drop-ins are great, however I feel there needs to be more staff on duty, as currently I feel it is not a safe environment (Male, 41-45, African – Enter and View visit, MIND in Newham and Tower Hamlets)

7. OLDER PEOPLE

7.1. Many of the issues raised by the younger age groups were of course areas of concerns for older people except that they tended to be exacerbated given their stage of life and possible co-morbidities. For these two respondents, for example, the effects of poor communication were unquestionably significant.

I went to Mile End Hospital for my appointment at 9am as my son dropped me off. When I got there I was told that I had come to the wrong hospital and my appointment was for RLH as it had been moved there. I was really angry as the letter did not specify which hospital to go to and I didn't know the eye clinic has been moved. In the future if certain services are being moved I would like to be notified as a pensioner who has been going to a certain service for a long time I assumed it will be at Mile End Hospital (Male, 76-80. Bangladeshi – Barts Voices Project, Stifford Centre)

Recently I received a letter to have my eyes tested, usually it is in Mile End Hospital, I went all the way to the hospital for my 9.30 appointment on a Friday, when I got there they said they cannot see me as it is has moved to London Hospital and I need to go there. They were very were very adamant they cannot see me, so I travelled all the way to London Hospital. When I got there, they saw me but said they could have seen me at Mile End too. In the future when changes are made to departments that patients have been going to for years, they should write to us and inform us that the diabetic eye clinic has moved to Whitechapel so people like me who are not able to read English that well will have taken a note beforehand (Male, 76-80. Bangladeshi – Barts Voices Project, Stifford Centre)

7.2. There was also evidence of a lack of support for the older age group so that when, for example, diagnosis was perceived to be slow, patients could be left feeling particularly distressed

Due to the pain in my chest I went to my local GP several times hoping to understand what is causing it. I was diagnosed with having gallstones. I was told that I will need to undergo an operation to remove the gallstone and I was referred to the hospital where I had my operation. I then started experiencing very strong abdominal pains and went to my GP again. I was told that the gallstone may have still remained and that is what is causing the pain. I was told that I may require further operation. I feel very distressed due to the doctors failing to find what was wrong with me and they were not very certain. Furthermore I I had gone through an endoscopy and various other tests which was also very stressful for me (Female, 71-75, Bangladeshi, Barts Voices Project, LWA)

7.3. In addition, a strong sentiment was expressed that more time should be allocated to older patients almost to counteract the feeling of uncertainty and vulnerability

I feel the doctor doesn't give enough time to patient because of time limit so as a suggestion of area of improvement I think the appointment slots need to be flexible enough to meet each patient's requirements. Appropriate times with patients will allow sooner diagnoses to be made. Also I have come across the fact that many GPs just simply prescribe medication but they don't explain the disease itself and to how to take the medicine, the side effects and I think it is crucial that the patient knows more about the medication he or she is taking. This should not be left with the pharmacists and the GPs can't be completely certain that the pharmacist will explain to the patient (Male, Bangladeshi – Barts Voices Project, CBSG)

7.4. Again, too, were the difficulties of obtaining appointments, particularly at the London Chest Hospital, as well as the seemingly endless waiting once at the appointment:

Arranging an appointment nowadays is very hard and it often takes two to three months of waiting for the next hospital appointment (Male, Bangladeshi – Barts Voices Project, CBSG)

Around three months ago I was told by the podiatrist at Wapping that I needed to have an assessment at Mile End Hospital and that they would send a letter confirming the appointments, however I never received any letters, so I tried on several occasion to call the foot clinic at Mile End and never managed to get through on the phone, after months of trying I finally managed to get through yesterday and they gave me an appointment for today. I would suggest that they pay a bit more attention to answering phone calls (Male, 80+, White British – Enter and View visit, Foot Health Clinic)

Having been seen by my GP I was referred to the Royal London hospital regarding my heart problem. It was difficult for me to get an appointment and the delayed appointment meant an adverse affect on health. The support I received was not bad but for follow up treatment I found myself having to

phone and ask them questions on my medication rather than the doctor calling me (Male, 60-65, Bangladeshi – Barts Voices Project, LWA)

7.5. And delayed appointments were of particular concern

We waited 3 months for the appointment but would have appreciated it sooner as the appointment was for a sensitive issue. My mum was referred by the dentist as the dentist thought it may be mouth cancer. My concern was that if that was the case than she should have been seen sooner rather than later (Female, 60-65. Bangladeshi – Barts Voices Project, SAfH – Dental Hospital)

7.6. Finding their way around the hospital was nigh impossible for some and added to the difficulties encountered:

It's a big hospital and I feel like if I don't take someone with me I can get lost in the big empty corridors. I think more helpers, clear signs and directions should help people who don't always have someone to take them to appointments (Female, 60-65, Bangladeshi – Barts Voices Project, SAfH – Heart Clinic, RLH)

7.7. Certainly the behaviour of the staff for this age group was particularly noticeable and seemed to be an issue across provision.

Some of the nurses are really nice and helpful – I found them to have passion and willingness to 'care' for patients. Whereas other nurses walk around and behave like they are superior to us – majority are the ones with a lead role!!! However, I'd like to say not all nurses are like that!! The nurses are less friendly with people language difficulties too – I found that quite disturbing…. Patients are unable to express their needs anyway and to have nurses who aren't caring or willing to care is hard on top of it. The level of care has gone down compared to a few years ago, and the negligence of nurses is high (Male, 66-70, Bangladeshi – Barts Voice Project – Stifford Centre)

My father-in-law had had several strokes before and when he had his final stroke we took him straight to A&E. All the care we received there was good. The doctors were efficient and informed us of what they were doing and if it didn't work what they would do next. When we went to the Intensive Care unit, the care there was very different. We felt that none of the nurses had time for us. We also found their attitudes to be very rude. We understand that nurses were very limited and are busy but there is absolutely no need to be rude to relatives who are already suffering and grieving. I called nurses several times and they told me to give them a few moments but they disappeared after that. They should have at least come over and listen to what our needs were before deciding to dismiss us as a low priority case. This attitude really got to me and unfortunately I took it all out on the doctors that came to see us during their rounds. But the doctors were very empathetic towards us and showed some emotions to the fact that we had been there with my father-in-law and had spent more than 24 hours. I think that nurses should be given training on manners and how to talk and treat people who are

already stressed with their loved ones. Their rudeness and harsh attitudes just add to the problem and further stress people out. If nurses are not committed to their jobs and don't want to be polite to patients they should be forced out as they aren't fulfilling their job roles (Male, 71-75, Bangladeshi – Barts Voices Project, SAfH)

7.8. And many seemed to feel rebuffed by the behaviour of reception staff:

I went to have my first ever breast screen in June 2014. The receptionist looked like she didn't want to be at work, there was no hello, all she said was 'take a seat'. The waiting area was dull, there was no water available. I waited for 40 mins after my appointment time and when I got called, all the nurse said was, 'Take off your upper clothing and come and stand here', no explanation of what was going and what she will do. I had to ask my daughter to ask what are they going to do, even then the nurse said, 'your mother needs to stand here and I will use the machine to screen her breast'. I would like for the waiting area to have water available and for the staff to explain what the procedure and steps are. The receptionist should want to be at work (Female, 60-65, Bangladeshi – Barts Voices Project, Stifford Centre)

7.9. Some, too, appeared to have experienced simple neglect. During the Barts Voices Project, THFN discovered the case of one woman in her seventies who reported that given her incontinence problems she had wet her bed but was left to 'lie in it for ages' and when the staff came to clean her, they scalded her with the hot water. The family have made a formal complaint but have had no reply. Other respondents reported the following

The level of care varies throughout the day – during visiting hours, nurses are on their feet running around trying to tend to every patient. BUT after hours, it's different. My children have often expressed their feelings of sadness and distraught to be witnessing these situations. Patients are left unattended, with their soiled nappies… these patients are calling for assistance, but nurses aren't around. The nurses are less friendly with people language difficulties too – I found that quite disturbing…. Patients are unable to express their needs anyway and to have nurses who aren't caring or willing to care is hard on top of it (Male, 66-70, Bangladeshi - Barts Voices Project – Stifford Centre - Cardio Department)

Once I was admitted into the hospital the care I received I feel was not good. The nurse didn't take good care of me because the saline syringe which was injected in me was kept for 8 days and the nurse forgot to remove it sooner and this led to an infection in my hand. (Male, 80+, Bangladeshi- Barts Voices Project, LWA)

7.10. Key, too, was the clear need for someone to talk to and the loneliness when staff seemed to only 'do their job'. One woman, in her eighties, complained, for example, to THFN that she felt 'sad' that nurses did not wish to speak to her apart from pleasantries. Another interviewee in that project commented as follows:

*I get a carer to do my shopping but she buys what she likes not what I wanted. Why they are called 'carers' I do not know. She comes whenever she fancies (*Voices of the Housebound, THFN)

7.11. That social and health care were almost inseparable for this age group was also made very clear by this project. The lack of cohesion between services was (and has been a well-researched area of need) a key issue. Many for example had a myriad of regular appointments to attend

I attend a diabetes clinic and go to my GP for my depression; I go to RLH and Barts for my back problems (Voices of the Housebound, THFN)
I have regular hospital visits for eyes, hearing, back pain management, mental health clinic, chiropody clinic, pacemaker clinic. I have problems getting to the services I need (Voices of the Housebound, THFN)

I go to hospital for my problems and the befriender takes me there otherwise I would have to cancel them all (Voices of the Housebound, THFN)

7.12. Further, the attitude of homecare staff tended to be a prominent feature of this. Patients interviewed by THFN complained that carers often only did 'what they had time for'. Hence for one patient with dementia, they would not always have time to make the breakfast if for example it had taken too long to put on the compression socks

The carers are not caring or understanding; their communication is very poor…they ignore me completely and seem more interested to leave as soon as they walk in. They are not compassionate and they look at it (caring) as a routine. If there were in-house carers from Tower Hamlets it would work better; agencies aren't giving a satisfactory service to vulnerable people (Voices of the Housebound, THFN)
I would like my carers to be more talkative (Voices of the Housebound, THFN)

I have had several carers in the last few months and they do this their own way and they shout if I tell them. There have been times when they shout and swear; it frightens me and I get anxious before they come. …They just come to do their work and then they sit and play games on their mobile phones; (there is) *no human contact* (Voices of the Housebound, THFN)

I would like them (social carers) *to treat me like a human being- explain what is going on and be helpful towards me…. Nothing is clear* (about) *what they are supposed to do* (Voices of the Housebound, THFN)

7.13. THFN also discovered that many elderly people were confused by the seemingly endless stream of people coming to their home. They described how patients could feel they had lost control of their lives which in turn had, in some cases, led to a mistrust of health and social care professionals:

Everyone comes in and out of my home and no-one asks me if it is all right. I feel have been tricked into given up my keys (Male, 66-70, White British – Barts Voices Project, THFN)

Now I have so many people coming in and out to see me, doctors, nurse, social workers, it is getting confusing – they all just tell me what to do (Female, 80+, White British – Barts Voices Project, THFN)

7.14. This also had to be counterbalanced by the loneliness that could be experienced by this group

It would be nice to have a social club for people who live in the area. I would like a social club for history and literature and other interesting topics not only for a cup of tea and cakes. We might be elderly but a lot of us have tales to tell and have room to learn more and it's better to keep our brain occupied (Voices of the Housebound, THFN)

It would be better to have someone…to help me help myself (Voices of the Housebound, THFN)

7.15. It was also clear that the lack of interpreting services was especially pertinent for this group since it could lead to greater complications

I suffer from bowel cancer. However the doctor doesn't always prescribe medication and advises me to buy them for example vitamins from the local pharmacy. Also I can't speak English very well so I need an interpreter however most of the time interpreter is not available and when I speak to receptionist on the phone they ask me to bring in a family member. This angers me because I cannot take my son or daughter as they as they are not free, and not having an interpreter makes it difficult to communicate and understand the doctors advice (Male, 60-65, Bangladeshi – Barts Voices Project, Stifford Centre)

On my last visit I was seen by an dentist of Indian origin, I could not communicate with her as I speak very little English...this was a problem...luckily for me the dental nurse could speak Hindi, so I communicated with the dentist via her...it would have been useful if I had seen a Bengali dentist, as I could explain myself.. It would be useful if these things could be taken into consideration when booking appointments, especially in the case of elderly non English speaking patients (Male, 60-65, Bangladeshi, Enter and View visit – Abbey Dental Practice)

7.16. This of course was perceived to be a particular issue for those with special needs and having appropriate interpreters was clearly critical.

The patient explained that she was struggling to communicate with nurses and doctors. All the appointments at hospital were never provided with BSL Interpreters and meant her friend had to interpret for her but was not appropriately qualified. She explained that she did not get results about her heart. She was discharged and was given prescription tablets. She was not

given an explanation why she was given those tablets. She did ask for BSL interpreter during her stay and the staff took no action on it (Female, 66-70, White British – Barts Voices Project – Deaf Plus)

I was having my cataract operation on 21st March. I was already being provided with British Sign Language Interpreter for the day. I was being prepared to have injections to put me to sleep and I needed assistance from BSL interpreter to explain the situation. But BSL interpreter was being squeamish and left me alone in the operating theatre. I was panicked and the nurse tried to reassure me that it is ok and I was being calm after reassurance. After the operation I woke up and found that the BSL interpreter was not in the same room with her which I was not happy with as I wanted to communicate with the nurse so she had to wait till I was taken back to the resting room. I found the BSL interpreter in the resting room. BSL interpreter explained that she could not cope with things happening in the operation room. I was very angry with her as I felt that she was not fit to be an interpreter (76-80, White British – Barts Voices Project – Deaf Plus)

7.17. The difficulties of getting appropriate equipment and aides often seemed to make a potentially bad situation worse

I urgently need installation of a level access shower. This was approved in 2011 but LBTH has dragged their feet and now in 2014 my grant has expired and they want me to start the process all over again and wait another three years. I need more time on my social care package due to no washing facility but my social worker takes no notice (Voices of the Housebound, THFN)
A walk-in shower would definitely change my life and a ground floor flat. I'm waiting to join a social group for outings (Voices of the Housebound, THFN)
An electric wheelchair for outdoors and stair lift for indoors: this would help me get around more independently (Voices of the Housebound, THFN)
I have a wheelchair and would like someone to wheel me around when I'm lonely and the weather is good. I have asked for this so many times but I have never got it (Voices of the Housebound, THFN)

It is stupid with continence pads, (you've) *got to order them three weeks prior to needing them and at this age you forget* (Voices of the Housebound, THFN)

7.18. It is further of note that transport provision appeared to remain a large problem

What I do have an issue with is the patient transport system. I know ERS medical have recently taken over so are still a relatively new service but their time keeping is absolutely preposterous. I live in Roman Road so it takes me some time to get to the hospital. If I have an appointment at 10am the transport will arrive ten minutes before my appointment so you can imagine how late I actually arrive. I'm not at all impressed that they tell me to be ready two hours before my appointment time and yet they arrive so late! The main concern for me which I would like to see improvements in would be the patient transport to run more efficiently. I mean, there have been times where I have sat in the discharge lounge for a long time amongst other patients waiting to be taken home and can clearly see a row of patient

transport vehicles parked outside for ages and not moving-I spend enough time in hospitals without having to spend any more time than necessary especially when my immune system is very bad so really I should not be exposed to sitting around so many patients with all the various viruses and illnesses (60-65, Bangladeshi – Barts Voices Project, Stifford Centre)

7.19. Indeed, for this group there appeared to be an overall feeling that, given the problems encountered, it led to a perception that they were simply being dismissed. Often, it appeared that no-one was taking the appropriate responsibility as a volunteer befriender noted below:

I am a female aged 65 and suffer from a disability, diabetes and get frequent lung infections. I also have movement restrictions. I regularly visit the Royal London Hospital and my local GP practise due to my health conditions. GP doesn't pay any home visits but advises me to go into walk in centres or A&E. The Doctor often insists I take my medication and to be discharged when I am in hospital- they often claim I have nothing to worry about and will be better in a few days. (Female, 60-65. Asian Other, Barts Voices Project, CBSG)

Years ago THFN could phone the council for social support for someone and they would send a social worker, but that doesn't happen now. And no one is willing to take responsibility – a social worker will say its responsibility of the occupational therapist, who will say it's the social worker, and on and on…. (Voices of the Housebound, THFN)

7.20. Conversely, it was also striking from the evidence that when elderly respondents were pleased with the service, it was the above factors that had made the critical difference, as the following patients made clear:

We got the ambulance here today; they were very quick and got to me within ten minutes of calling- very happy about that. I was at the St Stephens Health Centre when I had a serious heart pain whilst waiting to see a doctor, the doctors checked me straight away and advised I go to A&E and called the ambulance- the staff were great. We got here at 10.15 am and they did tests straight away, I am now waiting for the doctor to give me the results. It's very good here, they are attentive and the staff are all very good, so far I have been very happy (Male, 80+, White British – Enter and View visit, A&E)

We arrived here at 10.30am, got here by an ambulance; ambulance was very quick got to our home with 15 minutes of calling, which we think is great! When we arrived here we got seen by a nurse straight away and also had some tests done...we are just waiting for the test result at moment. They provide a marvellous service here, all the staff are caring and the whole process has been excellent so far (71-75, White British – Enter and View visit, A&E)

When we did get seen the medical staffs were fantastic, they explained everything to us in detail and made sure we were comfortable with everything. She was given a follow-up appointment the following day- fantastic!!! (Female, 60-65, Bangladeshi – Barts Voices Project, Dental Hospital)

8. RECOMMENDATIONS

8.1. General

8.1.1. Understand the nature of the need for 'support' services within provision particularly for the elderly and the young

8.1.2. Develop an understanding of the processes that might dictate experiences

8.1.3. Develop a greater understanding of 'expectations' and the determinants within that including demographic factors

8.1.4. Develop a greater understanding of 'quality care' among different cohorts of patients and the factors that contribute to 'good' care

8.1.5. Explore and understand the experiences of those groups who appear underrepresented in the work to-date e.g. Eastern European groups and sub-groups, Somali's

8.2. Under 5s and Children

8.2.1. Explore how time allocation for appointments could be improved

8.2.2. Provide clear directions for patients and families possibly in the form of leaflets and ensure their effective dissemination

8.2.3. Explore whether there are adequate more general support services for families where there are ill children or children with severe medical issues and whether there is adequate signposting to those services

8.3. Young People

8.3.1. Further understand the difficulties that are encountered in the transition from child to post-18

8.3.2. Understand the discrepancies in terms of expectations on the part of both the provider and service users

8.4. Adults

8.4.1. Further understand how the 'adult' population breaks down into subgroups in terms of experiences and perceptions of those experiences and in terms of different aspects of the patient journey

8.4.2. Explore how different aspects of the patient journey could be improved for the different subgroups

8.5. Older People

8.5.1. Ensure that the learning from the provider feedback on 'integrated care' and the Co-ordinated Care Package has been fed back into service provision

8.5.2. Ensure feedback is collected from Care Co-ordinators to enable further understanding of the key issues for patients

8.5.3. Improve the way in which home visits by health professionals can best be managed for this age group

8.5.4. Whether the CCG consider that further staff training across the healthcare system with reference to the treatment of older people would make a marked difference in terms of the perceived lack of time and support, poor communication etc

8.5.5. Understand the mechanisms through which the elderly are able to articulate their needs

8.5.6. Understand the nature of the key ingredients for 'holistic' and 'patient centred care' to be effective

8.5.7. To what extent lessons can be learnt from present work that is looking at the process and implementation of integrated care so that it is applicable across social and health care provision

Health and Wellbeing Board	
Report of: Tower Hamlets Clinical Commissioning Group	**Classification:** Unrestricted
Tower Hamlets CCG Commissioning Intentions	

Contact for information	Josh Potter; Deputy Director of Commissioning and Transformation (josh.potter@towerhamletsccg.nhs.uk)

Executive Summary

The purpose of the commissioning intentions is to make our providers aware of:

- Any significant changes we plan to make over the next year(s)
- What we believe the impact of these changes will be
- What issues we will want to address with them throughout the contracting round process

Commissioning Intentions for 2015/16 build on the two year operating plan submitted in 2014/15, which in turn responded to and and supports the Health and Wellbeing strategy.

More detailed business cases will be reviewed and scrutinised by the Transformation and Integration Committee of the CCG. Approval of these business cases allows the team to take forward their commissioning intentions, and make them a reality through the contract negotiation process.

Recommendations:

The Health and Wellbeing Board is recommended to:

1. Note the report
2. Consider how these commissioning intentions can support the delivery of the Health and Wellbeing Strategy

1. DETAILS OF REPORT

1.1 The purpose of the commissioning intentions is to make our providers aware of:

- Any significant changes we plan to make over the next year(s)
- What we believe the impact of these changes will be
- What issues we will want to address with them throughout the contracting round process

Commissioning Intentions for 2015/16 build on the two year operating plan submitted in 2014/15, which in turn responded to and supports the Health and Wellbeing strategy.

More detailed business cases will be reviewed and scrutinised by the Transformation and Integration Committee of the CCG. Approval of these business cases allows the team to take forward their commissioning intentions, and make them a reality through the contract negotiation process.

1.2 Commissioning Intentions for 2015/16 build on our current delivery of strategy such as:

- Development of key strategic programmes such as Integrated Care, Primary Care Development, Mental Health and so on
- Responding to new legislation and national guidance, for example the Better Care Fund, Personal Health Budgets, other Operating Plan guidance (due in December 2014)
- An ongoing financial challenge, approximately£10m in 2015/16
- Quality and performance issues as highlighted in the Outcomes framework, National priority areas, Service alerts, Provider data and Patient feedback

1.3 A summary of commissioning Intentions for Services Commissioned from Barts Health Acute Contract are:

Programme	Outline	Expected Impact Areas
Maternity	Review and strengthen the antenatal care pathway Review and strengthen preventativehealth advice, care and management in the community Build on the 2014/15 CQUIN, focusing on improvinginformation that is received by parents throughout the Barts Health NHS Trust maternity pathway	Reduction in A&E attendances and emergency admissions Change in case mix; reduction in Payment by Results (PBR) defined “intensive” cases to more “intermediate” and “standard” cases Improving patientexperience and satisfaction

	Work with the community and voluntary sector to enhance emotional, physical and practical support services for parents in the community	
Children and young people	Expand the scope and remit of "The Bridge Project" – a pilot virtual ward model for the management of children and young people with complex conditions Develop and implement whole system pathways for high volume/cost presentations within secondary care Consider, in collaboration with WELC CCGS, the Barts Health NHST Trust paediatric and adolescent diabetes proposal, calling for a single and central diabetes centre operating across the Trust	Reduction in A&E attendances, emergency admissions, readmissions and LOS, particularly for children and young people with complex conditions Improvingintegration of services across primary, community and secondary care Improving quality of care for children and young people with complex conditions Reduction in outpatient activity Improving patient experience and satisfaction Improving quality of care for children and young people with diabetes, including Trust compliance with the national best practice tariff criteria
Integrated care	Continue to implement and refine the 2014/15 programme, which involved: Redesign of community health teams to include rapid response, care coordination and a discharge support function Better identification and management of high risk patients in primary care Expand the integrated care approach to a wider cohort of patients, from the top 4% to the top 20%	Significant reduction in A&E attendances, emergency admissions, readmissions and other associated activity and cost Improving quality of care Improving patient experience and satisfaction Increasing numbers of patients in the last years of life having their needs and wishes identified, reviewed and met

	Introduce a programme of extensive community self-management support Embed the Five Priorities for the Care of Dying People	
Urgent Care	Incorporate paediatric streaming into the urgent care centre service specification, building on the findings from the 2014/15 pilot Explore greater integration between the urgent care centre, GP out of hours service and the 2 walk in centres in Tower Hamlets	Increasing numbers of patients redirected from the urgent care centre back into primary and community care services, particularly for children and young people Supporting Barts Health NHST Trust to meet the 4 hour A&E target Improving communication and patient flow between urgent care services
Long Term Conditions	<u>Liver</u> Unbundle liver function testing for patients being initiated on statins Improve identification and management of liver disease patients in primary care <u>DVT</u> Improve identification and management of DVT patients in primary care <u>Diabetes</u> Review impact of the 2014/15 diabetes inpatient care CQUIN on LOS; findings to be reflected in 2015/16 activity plans 2014/15 diabetes inpatient care CQUIN to be "mainstreamed" i.e. incorporated into core Barts Health contract	Reduction in liver function testing activity for patients being initiated on statins Reduction in outpatient activity Reduction in LOS for diabetes inpatient admissions Increasing quality of care for diabetes inpatients Improving patient experience and satisfaction Reduction in A&E attendances, emergency admissions and readmissions

	<u>Epilepsy</u> Establish a secondary care led epilepsy telephone service, building on the pilot in 2014/15 <u>Heart failure</u> Improve identification and management of heart failure patients in primary care	
Planned Care	<u>Provider productivity</u> Review and agree productivity measures <u>Gastroenterology Pathway Redesign</u> Further embedding calprotectin testing to the IBD pathway Introduce straight to test service model	Achieving upper quartile benchmark for all productivity measure Reduction in outpatient activity Improving quality of care Reduction in waiting times for MSK and Pain services Improving patient experience and satisfaction

1.4 A summary of commissioning Intentions for Services Commissioned from Barts Health Community Health Services Contract are:

Programme	Outline	Expected Impact Areas
CHS Reprocurement	The CCG is currently developing a new clinical model for community health services, predicated on a care coordination function and a preferred procurement route in order to facilitate the delivery of improved service integration and overall patient experience	Improving service integration, access, clinical outcomes and patient experience for community health services
Contract Management and Data	Continue to improve the quality of data recording and reporting in accordance with national Health and Social Care Information Centre guidance, implement the Community Information Data Set (CIDS) from 1 April 2015	Ensuring the availability of comprehensive, robust and timely data on service activity, quality etc.
Learning Disabilities	Review and strengthen the service model of the adult	Improving patient experience and satisfaction

	learning disabilities team, with a particular focus on the potential for further integration between health and social care	Improving patient experience and satisfaction
Long Term Conditions	<u>Diabetes</u> Review and strengthen patient education provision delivered by the diabetes CHS service, with a particular focus on closer working with the community and voluntary sector <u>Respiratory</u> Review and strengthen the service model of the community respiratory team (ARCARE), including home oxygen provision <u>CVD</u> Review the CVD nursing service	Increasing preventative and self-management support for diabetes patients in the community Increasing collaboration with the community and voluntary sector Improving outcomes for adults with respiratory diseases, in particular COPD and asthma Reduction in A&E attendances, emergency admissions and readmissions Optimising medication management Informing commissioning decisions for 2016/17
Wheelchair Services	In partnership with WELC CCGs, participate in a national pilot of tariff for wheelchair services	Improving patient experience and satisfaction

1.5 A summary of commissioning Intentions for Services Commissioned from East London Foundation Trust are:

Programme	Outline	Expected Impact Areas
Mental Health	Develop new primary care mental health services Ensure mental health is at the centre of our integrated care system Refresh the service model for children and young people's mental health Develop recovery & wellbeing orientated services Roll out choice of first outpatient appointment	Improving outcomes for mental health patients Improving integration of care Improving quality of care Improving patient experience and

	in mental health Ensure that waiting times for mental health services are minimised Pilot personal health budgets in mental health Develop the mental health payment system Develop and implement a local crisis concordat Ensure that the Care Act and Mental Capacity Act are implemented by mental health services Develop a refreshed service model for people with a learning disability	satisfaction

1.6 A summary of commissioning intentions for services commissioned in other areas:

Programme	Outline	Expected Impact Areas
Prescribing	Renewal of electronic British National Formulary (BNF) Continued implementation of Scriptswtich Reduce waste in primary care prescribing Review and strengthen stoma prescribing guidelines Continued focus on the prescribing of specials	Increasing productivity Increasing quality of care
Network Incentive Schemes	Rationalise primary care incentive schemes	Improve productivity and value for money

2. FINANCE COMMENTS

2.1. Commissioning Intentions are one of the main levers in the CCG achieving its planned surplus over the life of the operating plan. As of 25th November the balance of these programmes is outlined below in terms of financial impact:

Programme	Savings (£000s)	Investments (£000s)	Non Recurrent	NET (£000s)	NET inc NR Investments

			Investments (£000s)		(£000s)
Integrated Care	2388	280	250	2108	1858
Mental Health	0	2115	0	-2115	-2115
Planned Care	2965	420	0	2545	2545
LTCs	593	211	10	382	372
Maternity	0	25	75	-25	-100
Urgent Care	30	0	0	30	30
Children and Young People	0	30	0	-30	-30
Quality in General Practice	0	0	0	0	0
Prescribing	1300	0	0	1300	1300
CHS	0	0	0	0	0
Cancer	0	60	0	-60	-60
Other	0	80	0	-80	-80
Total	7276	3221	335	4055	3720

In the event that the CCG's programmes leave the organisation with a projected deficit against our planned surplus, the Transformation and Innovation Committee will hold an extraordinary session to prioritise investments. The final set of plans will then go to the CCG Governing Body for final approval. The majority of plans will then commence mobilisation from 1st April 2015.

Appendices

Appendices

None

Health and Wellbeing Board 9th December 2014	Tower Hamlets Health and Wellbeing Board
Report of the London Borough of Tower Hamlets	**Classification:** Unrestricted
2013/14 Safeguarding Adult Board report	

Lead Officer	Robert McCulloch-Graham, Corporate Director Education, Social Care and Wellbeing
Contact Officers	Leo Nicholas
Executive Key Decision?	No

Executive Summary

The Safeguarding Adult Board publishes an Annual Report, this report is for the period 1st April 2013 to 31st March 2014. The report outlines the achievements of the Safeguarding Adult Board and its key partners including the CCG, Bart's Healthcare, East London Foundation NHS Trust and the Council.

The agenda itemis to discuss with Brian Parrott, Independent Chair of the Safeguarding Adult Board, the 2013/14 Annual Report and Safeguarding Adult Board performance. The Independent Chair will introduce the subject in its national, London and Tower Hamlets contexts. It is important that attendees have an appreciation of the statutory basis, scope, opportunities and limitations of the Safeguarding Adults Board.

Mr Parrott last year presented the annual report for 2012/13 highlighting the key issues and the work plan for the current year. He reported at the time overall that there was consistently a good spirit of inter-agency working and commitment as highlighted by the work on the serious case review. He highlighted the role of the SAB and the expectations from partners. There is now a written protocol between HWBB and Safeguarding Adults Board which is a very positive development between the two partnerships.

The 2013/14 Annual Report identifies that the SAB has:

- strengthened its knowledge about what actually happens to people receiving a service through its revised information, quality assurance and performance review arrangements
- liaised constructively with others in relation to the Care Quality Commission's scrutiny of Bart'sHealth services
- helped organisations embrace properly their responsibilities under the Mental Capacity Act and Deprivation of Liberties Safeguards
- promoted guidance, as simplified as possible, to staff of all organisations and the public, about what 'safeguarding' means and what people should do in the event of

concerns, allegations or suspicions of abuse

- begun to prepare for the implementation of the Care Act in 2015 which will give safeguarding adults a much stronger statutory basis

Recommendations:

The Health and Wellbeing Board is recommended to:

1. Consider and comment on the 2013/14 Safeguarding Adult Board annual report

1. REASONS FOR THE DECISIONS

1.1 The Safeguarding Adult Board Annual Report 2013/14 has been agreed at the Safeguarding Adult Board and this is for an information item and an opportunity to address any questions to the Independent Chair of the Adult Safeguarding Board

2. ALTERNATIVE OPTIONS

2.1 The Safeguarding Adult Board Annual Report 2013/14 has been agreed, there is not a statutory reason as to why the HWBB should discuss it.

3. DETAILS OF REPORT

3.1 The Safeguarding Adult Board publishes an Annual Report which details the work of the Safeguarding Adult Board and its members, across a financial year. The report being presented to the Health and Wellbeing Board is the 2013/14 Annual Report and is for information only.

3.2 The report identifies the work that partner organisations have been undertaking, including the identification of key issues for Adult Safeguarding in 2013-2014, achievements in 2013/14 against SAB work plan 2012- 2013 and provides a work plan /business Plan for 2014/15.

3.3 The developing of the 2014/15 Annual Report will be starting in December so any comments or recommendations as to what the HWBB would like to be considered for the 2014/15 report are welcome.

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. The Council is required by section 1 of the Care Act 2014 to exercise its functions under Part 1 of the Act so as to promote the well-being of adults, which includes safeguarding adults who have care needs, who are at risk of abuse and neglect. Pursuant to section 42 of the Act, the Council has a positive obligation to enquire into actual and potential cases of abuse or neglect so as to enable decisions to be taken about what action should be taken in each adult's case.

5.2. The Care Act 2014 will place the Council's duties in respect of safeguarding adults with care needs who are at risk of abuse or neglect on a statutory basis from April 2015. The requirements in respect of establishing a Safeguarding Adults Board (SAB) are set out in Sections 43-45 and Schedule 2 of the 2014 Act.

5.3 The Care and Support Statutory Guidance released in October 2014 sets out further detail in respect of the requirement to publish the SAB Strategic Plan and Annual Reports, at paragraphs 14.123-14.132 of the Guidance. The Strategic Plan for each financial year will need to set out how it will meet its main objective and what the members will do to achieve these objectives. The Plan must be developed with local community involvement and the SAB must consult the Local Healthwatch organisation.

5.4 A SAB must also publish an Annual Report as soon as possible after the end of each financial year, detailing what the SAB has done during the year to achieve its main objective and implement its Strategic Plan, and what each member has done to implement the strategy as well as detailing the findings of any Safeguarding Adults Reviews or any ongoing reviews.

5.5 From April 2015 the SAB must comply with those requirements, unless they can demonstrate legally sound reasons for not doing so.

5.6 The HWB is asked to consider and comment on the 2013/14 Safeguarding AdultBoard annual report, which is consistent with one of its functions under the HWB terms of reference, to have oversight of the quality, safety and performance mechanisms operated by member organisations of the Board.

5.7 When planning for integration of health and social care functions, the Council and its committees including the HWB must have due regard to the need to eliminate unlawful conduct under the Equality Act 2010, the need to advance equality of opportunity and the need to foster good relations between persons who share a protected characteristic and those who don't.

6. ONE TOWER HAMLETS CONSIDERATIONS

6.1. In Tower Hamlets, a female is 60% more likely than a male to be involved in a safeguarding issue as the alleged victim. This reflects the England average as per previous AVA results, 2011-12 (58%) and 2012-13 (61%). During this year the Safeguarding team publicised a feature on safeguarding adults in the local paper. Further features will emphasise the point that men can be abused too as there is a general concern that abuse against men may be hidden.

6.2. The data also indicates that 61% of safeguarding referrals are amongst individuals from white ethnic backgrounds in Tower Hamlets. This is lower than the England average of 88% (AVA - 2012-13). There is a higher proportion of safeguarding referrals in Tower Hamlets for the Asian population, mainly Bangladeshi population (25%) while nationally this equates to 3% (AVA - 2012-13). The Bangladeshi population makes up almost one third (32%) of Tower Hamlets population – considerably larger than the proportion across London (3%) or England (under 1 per cent).

7. RISK MANAGEMENT IMPLICATIONS

7.1 The Safeguarding Adult Board will become a statutory body from 1st April 2015 and there will be a statutory requirement to publish future Annual Report's and to publish a strategic plan.

7.2 Mr Parrot's presentation gives an opportunity to discuss the 2013/14 Safeguarding Adult Board Annual Report with the Independent Chair of the Safeguarding Adult Board.

8. CRIME AND DISORDER REDUCTION IMPLICATIONS

8.1 The Safeguarding Adult Board Annual Report 2013/14 identifies the work undertaken by the Tower Hamlets Safeguarding Adult Board during 2013/14, and identifies an action plan for 2014/15.

Appendices and Background Documents

Appendices

- Appendices:
  Appendix 1: Protocol between HWBB LSC and SAB
  Appendix 2: Objectives and core essentials of the Tower Hamlets Safeguarding Adults Board

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APPENDIX 1

Protocol in support of the relationship between the Tower Hamlets Health and Wellbeing Board, the Tower Hamlets Local Safeguarding Children Board and the Tower Hamlets Local Safeguarding Adults Board

March 2014

1. Introduction

1.1 Health and Wellbeing Boards (HWBB) were established by the Health and Social Care Act 2012. They are intended to be a forum where key leaders from the health and care system work together to improve the health and Wellbeing of their local population and reduce health inequalities.

1.2 The Children Act 2004 requires each local authority to establish a Local Safeguarding Children Board (LSCB). It is the key statutory mechanism for agreeing how the relevant organisations in each local area will co-operate to safeguard and promote the welfare of children and to ensure that these agencies are effective. It operates under guidelines known as 'Working Together to Safeguard Children'[1]; the latest version came into effect from 15th April 2013.

1.3 Safeguarding Adult Boards (SABs) are not currently statutory bodies but will assume this status with the passage of the forthcoming Care Bill. Currently Boards operate within the framework promoted by 'No Secrets'[2] which was published by the Department of Health and the Home Office in March 2000 and by 'Safeguarding Adults' which was published by the then Association of Directors of Social Services in October 2005[3].In March 2013, NHS England published a document 'Safeguarding Vulnerable People in the Reformed NHS- Accountability and Assurance Framework'[4] which gave guidance on the relationships between the Safeguarding Boards and the HWBB (section 4.2).

1.4 Following discussions between the Independent Chair of Tower Hamlets Safeguarding Adults Board, the Independent Chair of the Local Safeguarding Children's Board and the Chair of the Health and Wellbeing Board, it was agreed that there should be a formal agreement outlining this relationship.

1.5 This Tower Hamlets Protocol sets out the distinct roles and responsibilities of the Boards, the interrelationships between them in terms of safeguarding, and wellbeing and the means to ensure effective co-ordination between the Boards.

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[1] http://www.education.gov.uk/aboutdfe/statutory/g00213160/working-together-to-safeguard-children

[2] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/194272/No_secrets__guidance_on_developing_and_implementing_multi-agency_policies_and_procedures_to_protect_vulnerable_adults_from_abuse.pdf

[3] http://www.adass.org.uk/images/stories/Publications/Guidance/safeguarding.pdf

[4] http://www.england.nhs.uk/wp-content/uploads/2013/03/safeguarding-vulnerable-people.pdf

1.6 This agreement will be discussed at the next meetings of both Safeguarding Boards and then circulated to the Health and Wellbeing Board for ratification.

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2. The purpose of and principles of the Health and Wellbeing Board

2.1 Each top tier and unitary authority must have its own Health and Wellbeing Board.The Tower Hamlets Health and Wellbeing Board has agreed terms of reference which outline its underlying principles, keyresponsibilities, its role, purpose and membership. This document is included at Appendix 1.

3. What are the functions of Health and Wellbeing Boards?

3.1 Health and Wellbeing boards have strategic influence over commissioning decisions across health, public health and social care through their Joint Strategic Needs Assessment (JSNA) and the development of their Health and Wellbeing strategy.

3.2 Boards are intended to strengthen legitimacy by involving democratically elected representatives and patient representatives in commissioning decisions alongside commissioners across health and social care. The boards also provide a forum for challenge, discussion, and the involvement of local people.

3.3 Boards will bring together Clinical Commissioning Groups and councils to develop a shared understanding of the health and wellbeing needs of the community. They will undertake the JSNA and develop a joint strategy for how these needs can be best addressed. This will include recommendations for joint commissioning and integrating services across health and care.

3.4 Through undertaking the JSNA, the Board will drive local commissioning of health care, social care and public health and create a more effective and responsive local health and care system. Other services that impact on health and wellbeing such as housing and education provision will also be addressed.

4. The Purpose of the Tower Hamlets Local Safeguarding Children Board (LSCB)

4.1 Section 14 of the Children Act 2004 sets out the objectives of LSCBs, which are:

(a) to coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area;and
(b) to ensure the effectiveness of what is done by each such person or body forthose purposes

4.2 Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out that thefunctions of the LSCB in relation to the above objectives under section 14 of the Children Act2004, are as follows:

- developing policies and procedures for safeguarding and promoting the welfare ofchildren in the area of the authority, including policies and procedures in relation to:

- the action to be taken where there are concerns about a child's safety or welfare,including thresholds for intervention;
- training of persons who work with children or in services affecting the safety andwelfare of children;
- recruitment and supervision of persons who work with children;
- investigation of allegations concerning persons who work with children;
- safety and welfare of children who are privately fostered
- co-operation with neighbouring children's services authorities and their Boardpartners;
- communicating to persons and bodies in the area of the authority the need to safeguardand promote the welfare of children, raising their awareness of how this can best be doneand encouraging them to do so;
- monitoring and evaluating the effectiveness of what is done by the authority and theirBoard partners individually and collectively to safeguard and promote the welfare of childrenand advising them on ways to improve;
- participating in the planning of services for children in the area of the authority; and
- undertaking reviews of serious cases and advising the authority and their Board partnerson lessons to be learned

4.3 The role of the LSCB is to scrutinise and challenge the work of agencies both individuallyand collectively. The LSCB is not operationally responsible for managers and staff in theconstituent agencies.

5. Tower Hamlets Safeguarding Adults Boards (SAB)

5.1 The focus of the work of Safeguarding Adults Boards is the prevention of harm to'vulnerable' adults. The forms of abuse which the Board aims to prevent and address are:

- physical abuse, sexual abuse, psychological abuse, financial or material abuse, neglect oracts of omission, discriminatory abuse.

5.2 The role of the SAB is to ensure effective safeguarding arrangements are in place in both the commissioning and provision of services to vulnerable adults by individual agencies andto ensure the effective interagency working in this respect.

5.3 The Board has identified agreed objectives and priorities for its work which include clearpolicy, procedural and practice arrangements, mechanisms to secure coordination ofactivities between agencies, the provision of training and workforce development in supportof safeguarding and quality assurance and performance management arrangements to testthe effectiveness of safeguarding and the impact of the Board.

5.4 Effective communication and engagement between the Boards. Safeguarding is everyone's business. As such, all key strategic plans, whether they be formulated by individual agencies or by partnership forums, should include safeguarding asa cross-cutting consideration to ensure that existing strategies and service delivery, as well asemerging plans for change and improvement, include effective safeguarding arrangements.

6. Interrelationships

6.1 The Health and Wellbeing Strategy is a key commissioning strategy for the delivery ofservices to children and adults across the Borough and so it is critical that, in compilingdelivering and evaluating the strategy, there is effective interchange between the Health andWellbeing Board and the two Safeguarding Boards.Specifically there need to be formal interfaces between the Health and Wellbeing Board and the Safeguarding Boards at key points including:

- The needs analyses that drive the formulation of the Health and Wellbeing Strategy and
- The Safeguarding Boards' annual business plans. This needs to be reciprocal in natureassuring that Safeguarding Boards' needs analyses are fed into the JSNA and that theoutcomes of the JSNA are fed back into safeguarding boards' planning;
- Ensuring each Board is regularly updated on progress made in the implementation of theHealth and Wellbeing Strategy and the individual Board plans in a context of mutual challenge;
- Annually reporting evaluations of performance on plans to provide the opportunity forreciprocal scrutiny and challenge and to enable Boards to feed any improvement anddevelopment needs into the planning process for future years' strategies and plans.

6.2 Whilst currently there is no statutory requirement to secure a formal relationship between theHealth and Wellbeing Board and the safeguarding boards there is draft guidance steeringinthis direction that may become a requirement.For example in Working Together 2013 page 51 states "The NHS Commissioning Board (now NHS England)will also lead and define improvement in safeguarding practice andoutcomes and should also ensure that there are effective mechanisms for LSCBs and Healthand Well-Being boards to raise concerns about the engagement and leadership of the localNHS."

6.3 The guidelines also stipulate that the LSCB annual report should be submitted to the Chairof the HWBB. It is probable that these requirements will be replicated for Adult SafeguardingBoards when they are made statutory in the next year or so. The Tower Hamlets Health and Wellbeing Board received both safeguarding annual reports in September 2013 and will continue to receive these on an annual basis.

6.4 The opportunities presented by a formal working relationship between the Tower Hamlets Healthand Wellbeing Board and the two safeguarding boards can be summarised as follows:

- Securing an integrated approach to the JSNA, ensuring comprehensive safeguarding data analysis in the JSNA
- Reflecting safeguarding issues raised by the LSCB and SAB business plans with the HWB Strategy and related priority setting
- Ensuring safeguarding is ''everyone's business'', reflected in the public health agenda

- Evaluating the impact of the HWB Strategy on safeguarding outcomes, and ofsafeguarding on wider determinants of health outcomes (such as domestic abuse)
- Cross Board scrutiny and challenge and ‘’holding to account’’ the Wellbeing Board for embedding safeguarding, and the Safeguarding Boards for overall performance andcontribution to the HWB Strategy.

7. Arrangements to secure co-ordination between the Boards

7.1 In order to realise these opportunities, it is proposed that the following arrangements would be put in place to ensure effective co-ordination and coherence in the work of the threeBoards.

i. Between April and July each year, the Safeguarding Boards will share their proposed business plans with the Health and Wellbeing Board for challenge.

ii. Between May and September each year, the Health and Wellbeing Board will present to the Safeguarding Boards the review of the Health and Wellbeing Strategy, an update on the JSNA with the proposed priorities and objectives to enable the safeguarding boards to scrutinise and challenge performance of the Health and Wellbeing Board.

iii. Between September and December each year, the Independent Chairs of the two Safeguarding Boards would present to the Health and Wellbeing Board their annual reports outlining performance against business plan objectives in the previous financial year. This would be supplemented by a position statement on the Boards’ performance in the current financial year. This would provide the opportunity for the Health and Wellbeing Board to challenge the performance of the Boards, to draw across data to be included in the JSNA and to reflect on key issues that may need to be incorporated in any refresh of the Health and Wellbeing Strategy.

8. Conclusion

8.1 The roles of the LSCB and LSAB in relation to the HWB would be one of equal partners underpinned by this protocol sharing influence and mutual challenge on safeguarding and health across the lifecourse. Each is accountable to each other and the LSCB has astatutory responsibility to challenge and hold agencies to account for the safety of Tower Hamlets’ children. A similar responsibility will be given in law to the LSAB. This protocol is designedto ensure these functions are discharged effectively in Tower Hamlets without duplicating functionsor creating additional structures.

Supporting Documents

- Tower Hamlets Health and Wellbeing Board Terms of Reference
- Tower Hamlets LSCB Terms of Reference
- Objectives and core essentials of the Tower Hamlets Safeguarding Adults Board

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APPENDIX 2

Objectives and core essentials of the Tower Hamlets Safeguarding Adults Board (SAB)

Extract below from Tower Hamlets Safeguarding Adults Board (SAB) – Programme for 2013-14. Agreed formally at SAB meeting 21 May 2013

The draft Care Bill (2013/4), currently in its final parliamentary stages, intends that SABs should operate on a statutory basis whereby:

- Local authorities are responsible for establishing and running Safeguarding Adults Boards.
- Boards must coordinate and ensure the effectiveness of what each of its members does.
- The local authority, Clinical Commissioning Group and chief officer of police must be core members (Boards have the power to determine other appropriate members).
- The Board must publish a strategic plan each financial year setting out how it will protect people at risk of harm and what each member is to do to implement the strategy.
- At the end of the financial year the Board must publish an annual report on its achievements, members' activity and findings from any Safeguarding Reviews during that period.
- It must consult its area's Health Watch and involve the community in preparing the strategy.

In practice Tower Hamlets SAB has been working to most of these principles in recent years**.** In 2013-14 the SAB agree formally to work to these expectations given that most of the elements are already in place.

The SAB additionally agreed on 26 March 2013 that:

The Board needs to be clear about its key role as one of ‘Governance’ – assurance about:

- quality of practice
- compliance with policies and procedures
- quality of commissioning
- performance and quality of outcomes for people who need safeguarding interventions

There need to be clear statements, understood by all Board members and communicated within agencies, and 'owned by all', of SAB Strategy and Priorities. The Board must ensure that there is common understanding of all the essential features of safeguarding adults.

The SAB's Independent Chair stated that the SAB should:

- Ensure all relevant agencies and individuals work together to common policies, procedures and expectations of quality of practice and management - in a positive partnership spirit.

- Take initiatives and respond to events specifically related to:
  - the communities of LBTH
  - learning from individual cases or events

- Be assured that practice and performance fits with policy intentions and statutory requirements on both individual agency and a multi agency basis – holding all agencies and the SAB itself to account

Brian Parrott
Independent Chair, Safeguarding Adults Board
London Borough of Tower Hamlets
February 2014

Health and Wellbeing Board 9th December 2014	Tower Hamlets Health and Wellbeing Board
Report of the London Borough of Tower Hamlets	**Classification:** Unrestricted
Tower Hamlets Safeguarding Children Board Annual Report 2013-14 and Business Plan 2014-16	

Lead Officer	Robert McCulloch-Graham Corporate Director for Education, Social Care & Wellbeing
Contact Officers	Monawara Bakht, Senior Strategy, Policy & Performance Officer
Executive Key Decision?	No

Executive Summary

In accordance with DfE Working Together to Safeguard Children 2013 Guidance, LSCBs are required to publish an annual report on the effectiveness of child safeguarding arrangements and promoting the welfare of children in their localities.

The annual report assesses its strengths and areas for improvement as well as providing a transparent account of its budget and how contributions are spent. The annual report outlines the work undertaken by the LSCB and its partners to safeguard children, the learning form serious/case reviews, multi-agency audits and sets out the priorities for the year ahead.

The guidance requires the LSCB Independent Chair to make a copy of this report available to Chair of the Health and Wellbeing Board.

The report was signed off by the LSCB and published on 15th August 2014.

Recommendations:

The Health and Wellbeing Board is recommended to:

1. To note the content of the Safeguarding Children Board's Annual Report and consider the LSCB's priorities and business plan for 2014-15 in relation to the work of the HWBB.

1. REASONS FOR THE DECISIONS

1.1 No Executive Decision required

2. ALTERNATIVE OPTIONS

2.1 No alternative options have been considered as the LSCB Annual Report and Business Plan is presented only for HWBBs information.

3. DETAILS OF REPORT

3.1 The Annual Report outlines what has been undertaken by the LSCB in order to deliver its statutory functions alongside key statutory partners to improve single and multi-agency safeguarding children arrangements. The report provides information on key achievements, data and learning to highlight local safeguarding children performance.

3.2 The Annual Report contains additional information on the governance, financial and accountability arrangements for all partners.

4. COMMENTS OF THE CHIEF FINANCE OFFICER

4.1. The LSCB operates a pooled budget with member agencies providing both cash and in kind contributions e.g. staff time, training, venue costs etc. The Authority funds the cost of an LSCB Business Manager and training support. The LSCB pooled budget covers the expenses for serious case reviews, independent review authors and the LSCB chair.

5. LEGALCOMMENTS

5.1. The Council has established the LSCB in accordance with its obligation under section 13 of the Children Act 2004. The LSCB carries out the following functions as prescribed in the Local Safeguarding Children Boards Regulations 2006:

a. developing policies and procedures for safeguarding and promoting the welfare of children in Tower Hamlets;

b. communicating to persons and bodies in Tower Hamlets the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done, and encouraging them to do so;

c. monitoring and evaluating the effectiveness of what is done by the authority and their Board partners individually and collectively to safeguard and promote the welfare of children, and advising them on ways to improve;

d. participating in the planning of services for children in the area of the authority; and

e. undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

5.2. The LSCB is required by section 14A of the Children Act 2004 to prepare and publish an annual report about safeguarding and promoting the welfare of children in Tower Hamlets.

5.3. The Council's functions in relation to children include an obligation under section 11 of the Children Act 2004 to make arrangements to ensure that its functions are discharged having regard to the need to safeguard and promote the welfare of children. Consideration of the annual report of the LSCB may assist the Council in the discharge of its functions.

6. ONE TOWER HAMLETS CONSIDERATIONS

6.1. The Annual Report supports One Tower Hamlets by developing our approach to ensuring all children are appropriately safeguarded at all times.

7. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

7.1 N/A

8. RISK MANAGEMENT IMPLICATIONS

8.1. The LSCB maintains a Risk and Issues Register, capturing risks as identified by a member agency or the LSCB Independent Chair. The risks, mitigation and remedial actions are monitored by the LSCB Chair and Board Members. Risks causing concern are escalated by the LSCB Chair to the Chief Executive or senior officer of the relevant agency. The Head of Paid Services is also kept informed of the LSCB risk register through monthly one-to-one meetings with the LSCB independent chair.

9. CRIME AND DISORDER REDUCTION IMPLICATIONS

9.1 N/A

10. EFFICIENCY STATEMENT

10.1 N/A

Appendices and Background Documents

Appendices

- Tower Hamlets Safeguarding Children Board (LSCB) Annual Report 2013-14 and Business Plan 2014-16

Background Documents

- NONE

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Tower Hamlets Safeguarding Children Board

ANNUAL REPORT 2013-2014

Date published: August 2014

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Annual Report Foreword

Sarah Baker
Independent Chair
Tower Hamlets Safeguarding Children Board

Welcome to the sixth Annual Report of the London Borough of Tower Hamlets Safeguarding Children Board (TH SCB). The Annual Report provides an opportunity for the LSCB partnership to present to the community of this Borough the work it has undertaken to safeguard children and young people.

The Annual Report reflects the changes in Working Together to Safeguard Children 2013 which became statutory guidance in April 2013 and requires all Local Safeguarding Children Boards (LSCBs) to:

- Publish an Annual Report which reports on the effectiveness of child safeguarding and promoting the welfare of children in the local area. The report provides a rigorous and transparent assessment of the performance and effectiveness of local services, identifying weaknesses and actions being taken to address them.
- Share learning from Serious Case reviews
- Share the report with the Chief Executive , leader of the Council, the local police and crime commissioner as well as the Chair of the Health and Wellbeing Board

I was appointed to the role of Independent Chair in February 2014 having held the post on an interim basis for the preceding year. I am delighted to be part of a vibrant and committed partnership.

The TH SCB partnership is committed to ensuring that services that are commissioned and provided by the partnership and all subcontracted services are done so in a way that ensures all children and young people are safe. For example, when Barts Health Trust alerted the Board of their plans to discontinue the local religious male circumcision clinic and encourage parents to access an existing independent provider, Board members sought assurance about the credibility of the provider and ongoing monitoring of the services clinical standards and practice.

The Annual Report provides an opportunity to evaluate the effectiveness of partnership services in safeguarding children – TH SCB partners are fully engaged with the work of the LSCB demonstrated through their attendance at LSCB meetings, learning events including the annual safeguarding conference. As TH SCB chair, to see first-hand how partners are working to safeguard children, I spend time visiting both commissioners and providers to gain a greater understanding about their services and the safeguarding issues they face and how these are being managed. A recent visit to the private, voluntary and independent early years providers' forum highlighted the need for greater clarity around information sharing and child protection duties. The network was sign-posted to the LSCB inter-agency training programme and HM Governments 'seven golden rules to information sharing'.

The LSCB maintains a Risk Register enabling partners to share risks regarding safeguarding which can impact across the partnership. This allows for joint debate, discussion and partnership working to search for joint solutions, challenge the status quo and think outside the box. The risk register is incorporated into wider board discussions.

As TH SCB chair and accountable to the Council's Head of Paid Services, I am held to account through monthly meetings at which we discuss the work of the sub committees, the risk register. The Head of Paid services attends the LSCB which allows for open dialogue with the LSCB partners , to explore how we can impact on improving safeguarding and the requirement to ensuring resources are focused to allow effective functioning of the LSCB within a climate of austerity.

I also meet the Corporate Director of Education, Social Care and Wellbeing monthly to gain a greater understanding of the issues facing Children's Social Care and how partners are working together to enable statutory safeguarding practice to be undertaken. This has facilitated a focus on how we can embed safeguarding as every body's business across the London Borough Tower Hamlets.

The business manager and I work closely together supporting the work of the LSCB subgroups and ensuring the business of TH SCB drives forward. Examples include meeting sub group chairs to challenge and support the work of subgroups, as well as ensuring subgroup chairs recognise and maximise opportunities for joint working to safeguard children.

As Chair of the LSCB I am a member of the Children and Families Partnership board and am able to exercise my right in that role to challenge how services are safeguarding children. Examples include how NHS England and health providers are meeting the requirements in "A Call to Action".

During the summer of 2013 Tower Hamlets Children's Social Care participated in an Ofsted Thematic inspection of child neglect. The findings were published in their report 'In the Child's Time: Professional Responses to Neglect' (March 2014). Board members have since reviewed the steps that had already been implemented addressing the recommendations of the inspection. For example, the revision of the Family Wellbeing Model clarified thresholds and early help, a series of learning events focused on neglect as did the LSCB annual safeguarding conference. There has been an audit of under-fives who are subject to a child protection plan for nine-months or longer and social care has revised their recording

systems to improve early identification and recognition of cumulative harm. The LSCB has agreed a local Neglect Strategy and a comprehensive programme to deliver the DfE Neglect Training.

In line with Chapter 4 of Working Together 2013 TH SCB published a Serious Case Review (SCR) following the death of a young man in custody. The review was undertaken in partnership with Medway LSCB. Page 39 describes the work of the LSCB and the learning and improvement that is being undertaken in respect of the SCR.

The LSCB has also commissioned a further SCR following the death of an infant. The SCR is due to complete in the autumn of 2014. We have also commissioned a thematic case review into a number of young men who have either been seriously harmed or seriously/fatally harmed others. The young people were known to a range of agencies and the key purpose of the thematic review is to help us understand how we can, as a partnership, reduce the likelihood of older children either coming to serious harm or harming others (see page 41).

The LSCB has reviewed the style of Board meetings to enhance the quality and debate and promote challenge across the partnership. Board meetings are themed to allow for in depth review of performance and risk, the examination of local and national research and evaluation of services provided locally.

I would like to thank all Board members for their commitment and support, especially the contribution made by those who have moved on from their respective posts during this year.

A warm welcome is extended to new members who have joined the Board and I look forward to working with them in the coming year.

Sarah Baker
Independent LSCB Chair

Foreword from the Lead Member for Education and Children's Services

As the Cabinet Member for Education and Children's Services, I am fully committed to improving the lives of all our children in Tower Hamlets especially the vulnerable. As a social worker, I have seen how pivotal the role of safeguarding is in ensuring that children can move forward and live happy, stable lives. To continue to make that a reality is my personal ambition in this role.

Tower Hamlets is excellent at supporting children and young people, and we do that despite the multiple challenges that we face as a borough. Despite having one of the highest levels of child poverty in the country, we have some of the best schools in the world.

We have some astonishing individuals within the council who have been nationally recognised for their work in turning around the lives of young people and their families.

However we must not be complacent. In the next year, there will be further hurdles and challenges to overcome. This past four years we have seen cuts to public service funding and provision for children and young people, and we have done well as a council not to cut any of our frontline services, and to reduce the impact of these cuts. But the fight against cuts to local government is not over. With the welfare cap beginning to take its toll, a housing crisis and queues increasing at the local food-banks, our ability to provide a stable life for some of our most disadvantaged children and their families will become ever more challenging. That is why it is more important now than ever for organisations across the spectrum to come together in partnership and to work together to secure the best outcome for all our children and young people.

I am sure the Mayor's manifesto commitments to be delivered across other council departments - to provide better mental health support in schools for our most vulnerable young people; careers service advisors; and increased support around gangs will be essential. There will also be a massive drive within the council as we move towards better integration of social care with the NHS reinforced by the Mayor's key commitment to ensure the creation of better support services through that transition.

I am happy to welcome this report, which outlines ways in which we can work in partnership so that children and their families will receive the right services early on and to ensure the wellbeing of the whole family.

To this end the Mayor and I are fully committed to supporting the work of the Local Children's Safeguarding Board.

Thank you

Cllr Gulam Robbani
Cabinet Member for Education and Children's Services

Living in Tower Hamlets (Local Background Information)

Population:

The current official estimate from the Office of National Statistics (ONS) is that Tower Hamlets has a population of 263,000 residents (ONS 2012 estimate). Over the next 10 years the population is expected to increase by an additional 20%, to reach more than 320,000 residents by 2023.

With an area covering just 20 square kilometres, Tower Hamlets is the sixth smallest London borough by physical area and is the second most densely populated borough in London.

More than two thirds of the borough's population belong to minority ethnic groups (i.e. not White British) of which more than half are described to be from Black and Minority Ethnic groups.

The borough's two largest single groups are the Bangladeshi (32 per cent) and White British (31 per cent) population. The Bangladeshi community makes up almost one third of the borough's overall population with the highest proportion of Muslim residents in England. Conversely, the borough has the lowest proportion of Christian residents in England.

Tower Hamlets remains a place of acute contrast. The average annual earnings of those working in the borough is £68,000 yet a third of residents live in poverty. High levels of overcrowding and inadequate housing stock can mean increased stress and risk factors faced by our families.

Children and Young People

In 2013, there were an estimated 63,639 children and young people aged 0 to 19 living in Tower Hamlets, representing almost 24% of the total population[4]. The young population in the borough is projected to rise in line with the general population growth.

In spring 2014, the school census records indicated that 89.7% of pupils belonged to an ethnic group other than White British compared to 27% in England. Furthermore, English is recorded as an additional language for 74% of pupils where English and Bengali are the most commonly recorded spoken community languages in the area. The single largest group (56%) of children and young people under 19 years come from a Bangladeshi background.

Health

Health inequality remains a key characteristic of the borough, with the average life expectancy below the London average for both men and women, and a high proportion of babies born in the borough have a low birth weight. We also have a higher percentage of mothers who initiate breastfeeding compared to the average across England at 86.8%.

Children in Tower Hamlets have worse than average levels of obesity: 12.8% of children aged 4-5 years and 26.0% of children aged 10-11 years are classified as obese in the borough.

In 2011-12, 45.9% of five year olds had one or more decayed, filled or missing teeth, making our children's dental health worse than the average for England.

However, our immunisation coverage rates for under-fives remain amongst the highest in England and continue to improve since the success of a 'care package' approach to childhood immunisation in 2009-10.

The relationship of the LSCB and health partners, both commissioning and providing, is critical if we are to have an impact on improving the lives of vulnerable children and young people.

Child Poverty

The latest available child poverty data is from August 2011 and shows that 46 per cent of children and young people in the borough live in poverty. This is the highest child poverty rate in the UK.

The majority (78 per cent) of these children live in families reliant on out-of-work benefits. We know that the risk of child poverty rises with family size: in Tower Hamlets, 57 per cent of children who live in larger families with four or more children are in poverty compared with 37 per cent of those families with just one child.

In Tower Hamlets, just over half (53 per cent) of all children in poverty live in couple families and the remaining 47 per cent live in lone parent households. Tower Hamlets is unusual in this respect as in all other local authority areas more children in poverty live in lone parent than couple families.

Welfare Reform

Since the Welfare Reform Act received Royal Assent in March 2012, a wide range of reforms have been introduced by the Government in an attempt to deliver a fairer and simpler benefit and tax credit system. Such fundamental changes to the benefits system have had a dramatic impact across the country, and over the last two years a range of Welfare Reform changes have hit residents in Tower Hamlets significantly. A key issue faced by the LSCB partnership is in developing support for our most vulnerable children and young people and ensuring that they have access to safe, appropriate accommodation. It is important that the LSCB reflects on how these changes impact on families when considering safeguarding children:

- **Benefit Cap** – figures from December 2013 indicate 780 families affected in Tower Hamlets of which half are single parent households. We know this includes 2430 children.
- **Local Housing Allowance Cap** – there has been a 48% increase in homeless as a result of changes to short-hold tenancies and we have seen a 150% increase in homelessness as a result of evictions from private sector tenancies.
- **'Bedroom' Tax –** by the end of December 2013, approximately 2800 households were affected by the 'bedroom tax'.

Impact of welfare reforms so far

Although likely to materialise more slowly, there are significant concerns that the financial and housing stress caused by these national changes will begin to impact on education, health and social welfare. Schools in particular are concerned about families hit by the benefit cap, with potential disruption to family life and schooling. School staff are reporting they are increasingly referring families to food-banks, struggling to find appropriate courses to refer parents who are under pressure to re-enter the work market, and have concerns about the impact on children's attendance and punctuality when they have been placed in housing outside the borough. TH SCB has been promoting this through our partnership and working closely with housing, children's social care and our benefits team to ensure staff understand the implications and are prepared to support children and families. For example, through our welfare reform champions' programme, frontline services are kept abreast of changes and how they can respond through welfare reform workshops.

What does this mean for the LSCB?

The LSCB has been responding to the impact of these community and demographic factors through a variety of ways. We have developed and published a local Threshold document as part of the LBTH Family Wellbeing Model. The aim is to ensure families are identified and assessed to receive the right services and that these services are proactive and responsive to avoid families requiring the intervention of higher tiered services.

The LSCB Board held a development session to ensure there is a consistent and coherent understanding of the issues of neglect in LBTH and from this developed a neglect strategy which facilitates a greater understanding and targeting of the commissioning and provision of services to those vulnerable children and young people. The LSCB is commissioning neglect training across the partnership to support all practitioners in their work to recognise and respond to issues of child neglect.

Through the Children and Families Partnership Board the LSCB has signed up to the Mental Health Strategy for LBTH recognising the significant impact of adult mental health on the lives of children and young people and the pressures children and young people face. There is a requirement for both commissioners and providers to meet these needs. The LSCB is also aware of the needs of Looked after Children placed outside the borough and their mental health needs as demonstrated in the Child F SCR published in August 2013.

Statutory and Legislative Context

Tower Hamlets Safeguarding Children Board was established in April 2006 in response to statutory requirements under the Children Act 2004.

In its seventh year, the LSCB partnership continues to provide ongoing opportunities to improve local leadership and commitment to drive the safeguarding children agenda, enhance collaborative inter-agency working relationship, increase wider engagement and influence from the professional and local community, develop effective ways in which children are safeguarded for their long-term outcomes and promote the sharing of good practice.

The core objectives of the LSCBs are:

- To co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area of the authority
- To ensure the effectiveness of what is done by each such person or body for that purpose.

The scope of LSCBs includes safeguarding and promoting the welfare of children in three broad areas of activity:

- Activity that affects all children and aims to identify and prevent maltreatment, or impairment of health or development, and ensure children are growing up in circumstances consistent with safe and effective care
- Proactive work that aims to target particular groups
- Responsive work to protect children who are suffering, or are likely to suffer significant harm.

In April 2013, the DfE published the revised Working Together to Safeguard Children (2013) and in anticipation; TH SCB undertook a gap analysis exercise to identify the areas it needed to develop. For example, the reporting line for the LSCB chair was amended and steps were taken to improve the parity in financial responsibility for the LSCB. We have also developed an outcome based learning and improvement framework, which focuses on three areas of learning: serious case review, audits and multi-agency training.

As a consequence of Working Together 2013, the London Child Protection Procedures were also updated. These have now been published and local agencies are informed about and sign-posted to the new procedures via the LSCB website. The supplementary procedures supporting the London Child Protection Procedures will be available in June 2014.

Governance and Accountability Arrangements

Independent LSCB Chair

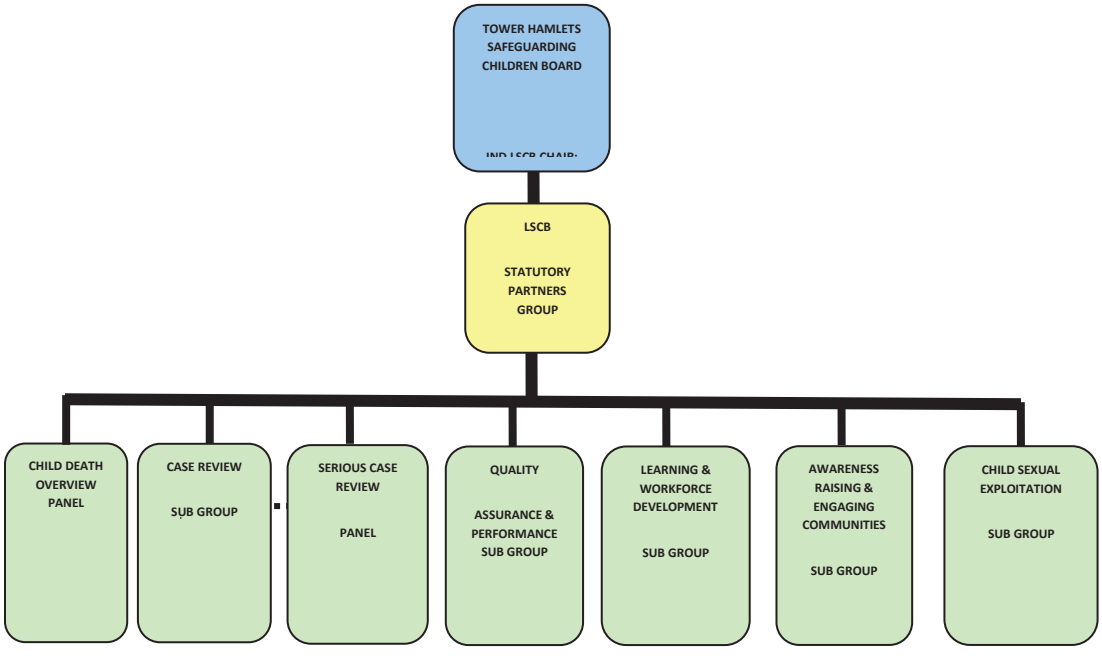
Sarah Baker was appointed the Independent Chair of Tower Hamlets Safeguarding Children Board in February 2014 but had acted in an interim capacity the preceding year.

In line with Working Together 2013, the chair reports directly to the Head of Paid Service and meets regularly with the Corporate Director of Education, Social Care and Wellbeing and the Interim Service Head for Children's Social care, who also acts as the Professional Advisor to the Board.

TH SCB is supported by a full-time business manager and the child death single point of contact administrator, the latter is funded by Barts Health NHS Trust. Additional support is also provided by the Council's wider Education, Social Care and Wellbeing's Strategy, Policy and Performance function. More so than ever in the past year the Chair has challenged Board and partners to ensure they directly contribute to the Board's effectiveness. This year has seen greater involvement of individual LSCB members especially when there has been a need to come together for task-specific activities, such as the development of the Neglect Strategy.

Attendance at LSCB Main Board meetings has been, as always, exceptionally good. Previously, it was reported that attendance at subgroup had been intermittent at times, but this is now greatly improved. The LSCB Business Plan and Risk Register are monitored by the Chair and business manager, reporting progress back to Board members. This has resulted in better leadership and cross-over of tasks amongst the groups.

The LSCB has six subgroups and the work of these groups is reflected within this report:



Subgroup chairs have made a concerted effort to ensure the membership of their groups means they have members who can act as influencers and make decisions. They have identified gaps and taken necessary steps to rectify this with partners. Each subgroup is now well represented by children's social care, acute, mental health and community health services, police, education and the voluntary sector.

TH SCB is keenly aware of the value of an additional independent voice at Board discussions and oversight of safeguarding arrangements. Previously, the LSCB decided to delay the recruitment of lay members, but following the publication of Working Together 2013 which said that all LSCBs should take reasonable steps to appoint two lay members from the local community, we have identified this is as **a priority action area** for us in 2014-15.

Financial Arrangements

The LSCB budget consists of contributions from a number of key partners and is managed by LBTH. Working Together 2013 placed increased emphasis on no one agency being overly burdened with the cost of running the LSCB and stated that the LSCB budget is a shared responsibility across the partnership.

Following this, an exercise was undertaken to review the actual costs of supporting LSCB work. For example, serious case reviews, learning events, communications and involving young people. As contributions have remained unchanged for several years and there is now a drive for more independent expertise and input, the LSCB Chair has requested an increase in funding from key partners. In the past year, the LSCB has concluded one serious case review and commenced another. The cost for these was substantially over and above the LSCB budget leading to the LBTH agreeing to cover its overspend.

LSCB Contributions

Agency	Contribution	Fixed
Met Police Service	5,000	Pan-London
London Probation Trust	2,000	Pan-London
East London Foundation NHS Trust	2,500	
CAFCASS	550	Nationally
Tower Hamlets Clinical Commissioning Group	15,000	
Barts Health NHS Trust	3,000	
LBTH Education, Social Care & Wellbeing	15,000	
Total Annual Contribution	**43,050**	

For a full breakdown of LSCB Income and Expenditure for 2013-14 – see **Appendix 4**

Relationship with other Strategic Boards

The LSCB has had a close working relationship with the Children and Families Partnership Board (formerly Trust) for some years. However, there has also been work to strengthen the LSCB's links with other existing strategic boards. There has been dialogue between the LSCB and other Boards to determine the remits and roles and to provide clarity around how they can work together to improve the safeguarding of children, their life-chances and future outcomes.

Health and Wellbeing Board

Health and Wellbeing Boards (HWBB) were established by the Health and Social Care Act 2012 and functioned in shadow form until this year. HWBBs are intended to be a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities.

The Tower Hamlets Health and Wellbeing Strategy is a key commissioning strategy for the delivery of services to children and adults across the borough and so it is critical that, in compiling, delivering and evaluating the strategy, there is effective interchange between the HWBB and both the Adult and Children's Safeguarding Boards. Specifically there needs to be formal interfaces between the Health and Wellbeing Board and the Safeguarding Boards at key points including:

- The needs analyses that drive the formulation of the Health and Wellbeing Strategy and
- The Safeguarding Boards' annual business plans. This needs to be reciprocal in nature assuring that Safeguarding Boards' needs analyses are fed into the Joint Strategic Needs Analysis (JSNA) and that the outcomes of the JSNA are fed back into safeguarding boards' planning;
- Ensuring each Board is regularly updated on progress made in the implementation of the Health and Wellbeing Strategy and the individual Board plans in a context of mutual challenge;
- Annually reporting evaluations of performance on plans to provide the opportunity for scrutiny and challenge and to enable Boards to feed any improvement and development needs into the planning process for future years' strategies and plans.

Following on from consultation between the Chairs of the HWBB, the LSCB and the Safeguarding Adults Board, a protocol has been agreed which sets out the expectations and interrelationships between health and safeguarding, making explicit the need for Boards to share plans and strategies and offer challenge to each other. The LSCB will therefore take its annual report to the HWBB and ensure that the Chair of the HWBB has sight of its Business Plan on an annual basis. The HWBB will bring its strategy to the LSCB on an annual basis. The Independent LSCB Chair is an identified stakeholder of the HWBB, receiving agendas and newsletters relating to the HWBB, in addition to attending the HWBB to present the annual report, and attending meetings to ensure synergy of work and challenge to the partnership to ensure safeguarding is prioritised.

Children and Families Partnership Board

The Children and Families Partnership Board (CFPB), unlike the LSCB and HWBB, is not statutory. However, in Tower Hamlets it is the recognised forum where multi agency partners convene to further a wider range of outcomes for children, young people and their families. The Independent LSCB Chair is a member of the CFPB, which meets every two months.

The role of the Independent Chair of the LSCB on the CFPB is crucial as it ensures that the policies, strategies and projects discussed at the CFPB can be aligned to safeguarding best practice and outcomes, providing challenge and opportunities for the LSCB and CFPB to work together. For example, the funding allocation for when health visiting transfers to the local authority will not include vacant posts. A recruitment drive for more health visitors is unlikely to meet the local targets. The Chair challenged the CFPB about the potential safeguarding gaps should positions remain unfilled by April 2015. These concerns were also registered with NHS England. As a result, alternative approaches have been implemented to increase health visitors in the borough through an employment-based vocation training programme.

Community Safety Partnership

The Tower Hamlets Community Safety Partnership (CSP) is a multi-agency strategic group set up following the Crime and Disorder Act 1998. The partnership approach is built on the premise that no single agency can deal with, or be responsible for dealing with, complex community safety issues and that these issues can be addressed more effectively and efficiently through working in partnership. The CSP is made up of both Statutory Agencies and Co-operating Bodies within the borough and supported by key local agencies from both the Public and Voluntary Sectors. Registered Social Landlords (RSLs) have a key role to play in addressing crime and disorder in their housing estates. Partners bring different skills and responsibilities to the CSP. Some agencies are responsible for crime prevention while others are responsible for intervention or enforcement. Some have a responsibility to support the victim and others have a responsibility to deal with the perpetrator. Ultimately the CSP has a duty to make Tower Hamlets a safer place for everyone.

The CSP is required by law to conduct and consult on an annual strategic assessment of crime, disorder, anti-social behaviour, substance misuse and re-offending within the borough and the findings are then used to produce the partnership's Community Safety Plan. The LSCB actively contributes to this wide reaching consultation process.

The CSP recognises that it has a responsibility to address all areas of crime, disorder, anti-social behaviour, substance misuse and re-offending as part of its core business. However, it also recognises that there are a few particular areas, which have a greater impact on the people of Tower Hamlets and their quality of life. For this reason, it has agreed that it will place an added focus on these areas and forms the 2013-16 priorities. These are:

- Gangs and Serious Youth Violence
- Anti-Social Behaviour (including Arson)
- Drugs and Alcohol
- Violence (with focus on Domestic Violence)
- Hate Crime and Cohesion
- Killed or Seriously Injured
- Property / Serious Acquisitive Crime
- Public Confidence

- Reducing Re-offending

In the last year, the work of the LSCB Children and Domestic Violence subgroup has been absorbed in to the Domestic Violence Forum (DV Forum) and Violence Against Women and Girls (VAWG) Strategy, both of which provide performance reports directly to the CSP. Arrangements have been made for a standing annual report covering outcomes for children living with domestic violence and safety planning (MARAC). Despite this significant change, the LSCB continues to maintain a link with the Domestic Violence and Hate Crime service area through Board membership and representation.

Safeguarding Adults Board

The Chairs of the Adult Safeguarding Board and LSCB have been meeting to discuss joint agendas and explore how the two boards can work more collaboratively with a focus on adult mental health, substance misuse, gang and knife crime and domestic abuse and the interface this has with safeguarding children. Both Chairs have worked particularly closely with the HWBB to develop a three-way joint protocol, setting expectations for reporting and planning.

TH SCB recognises there is scope for the children and adults safeguarding board to work better in particular to improve service provision from a holistic family perspective.

Work of the Tower Hamlets Safeguarding Children Board and Partners

2013-14 Priority Area Progress

Tower Hamlets Safeguarding Children Board set out six targeted priority areas in its overarching business plan. Whilst we have made good progress in many areas there are some areas where we have made less progress and these will remain a challenge and priority for us in 2014-15. Each of the priority areas and achievements are reviewed below:

PRIORITY 1 – GOVERNANCE AND ACCOUNTABILITY

LSCB has robust governance and accountability in place and in line with Working Together 2013 in order that its partners are confident and assured in respect of their roles in safeguarding children and families

An immediate task during 2013-14, was to review our governance strategy following the publication of Working Together 2013, so that specific requirements for the LSCB were reflected in our guidance. Within the year, the Head of Paid Service recruited Sarah Baker as permanent chair to TH SCB ensuring long-term improvement plans could be implemented. There are regular monthly meetings between the Chair and HoPS who also receives Board papers to maintain oversight of the Board's business.

TH SCB has strived hard to enhance its interface with frontline practitioners and seek assurance from those working directly with children and families. The Chair has undertaken a number of visits to front line services and network groups. This has allowed for a dialogue

to take place where the chair has been able to report back evidence of good practice but also areas of risks. For example, a visit to the local borough police brought to the chair's attention the need to improve appropriate adult services available to young people so as to ensure they are not held in a police station for longer than necessary. In turn, children's social care took steps to resolve this issue and young people now receive an appropriate adult within a reasonable timescale.

In addition to improving our communication, we have produced quarterly newsletters to inform front line practitioners and managers about the work of the LSCB, provide an update on current policy and local safeguarding development, spotlighting a partner agency and their role in safeguarding children or national campaigns such as Child Safety Week and alerting the workforce to upcoming learning events and opportunities. A challenge for the LSCB is to ensure our newsletter reaches as many staff members as possible through our board representatives. Dialogue with practitioners at the LSCB learning events suggests this is not always the case. Consecutive newsletters are also placed on the LSCB website as an alternative access route.

PRIORITY 2 – EARLY HELP AND ASSESSMENT

LSCB partners ensure there are effective processes for assessing the need for early help and confident there are a range of services in place to deliver a wide range of early help services to meet identified need

The LSCB was required to publish a local threshold document (Working Together 2013). This document is contained within the Family Wellbeing Model which has been through an extensive review and consultation process in 2013-14 and took centre stage at the LSCB safeguarding conference where over one hundred practitioners got the opportunity to explore the new areas of information and application to practice with children and families. The document contains information about early help services, the use of 'signs of safety' as a practice tool and an additional extended section setting out thresholds for intervention alongside information about the process of referral to and assessment by social care services. In response to the Ofsted Thematic Inspection of the impact of neglect on children under ten, the local authority was recommended to consider how to extend the information available about neglect and younger children within the FWBM. A new section was added to the document which draws attention to the possible range of neglect indicators.

Our threshold guidance will be further reviewed to take account of the single plan for children and young people with additional needs, as required by the Children and Families Act. The challenge for our partnership and **a priority action area** for the LSCB will be to ensure that local thresholds for intervention are widely and consistently understood by professionals so that children, young people and their families are able to access the right services at the right time to ensure a timely response to their needs.

Tower Hamlets was one of the first authorities to introduce a single assessment framework for the recording of social work assessment of children and their families. Following on from that social work staff were trained in the use of 'signs of safety' to provide a common

practice tool for undertaking social work assessment. SofS focuses on the existing strengths of the family, areas of concern and identifies what needs to change in order to address concerns. This year, a project group oversaw the wider implementation of this practice tool to help practitioners identify risks at an early stage by understanding family strengths and concerns. This means children have their needs assessed or protected within an appropriate timescale. We have rolled out the 'signs of safety' practice tool to community health practitioners and social care staff in joint training sessions throughout the year.

PRIORITY 3 – IMPROVING OUR PROCESSES

LSCB has an agreed process for reviewing unexpected child death and maximising learning across the partnership

TH SCB initiated one serious case review before the publication of Working Together 2013 and another after the guidance came into effect. We have used the most recent SCR to develop our own hybrid system approach based on our knowledge of what works well and using our experience of using the Social Care Institute for Excellence (SCIE) methodology.

Some valuable learning has been gained for the LSCB through a greater involvement of practitioners in SCRs and we can clearly see the difference they bring to a critical learning process. However, the LSCB recognises the challenge for all partners in balancing front line service delivery and learning opportunities. This is particularly pertinent when there is more than one process taking place. For example, during a serious case review, a domestic homicide review or health's internal serious incident reviews could be happening in parallel.

Our final approach to undertaking SCRs will be incorporated in to our wide evidence-based learning and improvement framework and this will be produced in 2014-15.

PRIORITY 4 – IMPROVING QUALITY ASSURANCE

LSCBs quality assurance framework improves scrutiny of its partners safeguarding performance

The LSCB reduced the number of performance indicators it was reporting, from 52 to 26 clustered indicators in recognition that it was 'data rich but intelligence poor'. The new approach strengthens the intelligence being provided to the Board which therefore increases its understanding of emerging local needs. The revised LSCB performance report consists of core safeguarding information from the key statutory partners to ensure greater scrutiny of practice across the partnership in a meaningful way. For example, the information provided enables exploration of the evidence of early help for risk groups such as missing children or young people who are sexually exploited and the correlation between them.

Following the introduction of the national safeguarding performance framework (SPF), Tower Hamlets Children's Social Care began reporting on a new set of information measures alongside local and former national measures.

We have been working with our partners to determine what is going to be useful information. This is still a continuing and evolving framework that captures the needs of our changing demographic across the borough.

LSCB Board members are required to identify how their participation in board meetings supports improvement in safeguarding outcomes for children and what actions they take between meetings to implement these.

A **priority action area** for 2014-15 will be finalising the full set of LSCB data, incorporating information and analysis from our partners and reporting our safeguarding performance and to Board members on a quarterly basis. This will contribute to informing future LSCB audits and quality assurance activity.

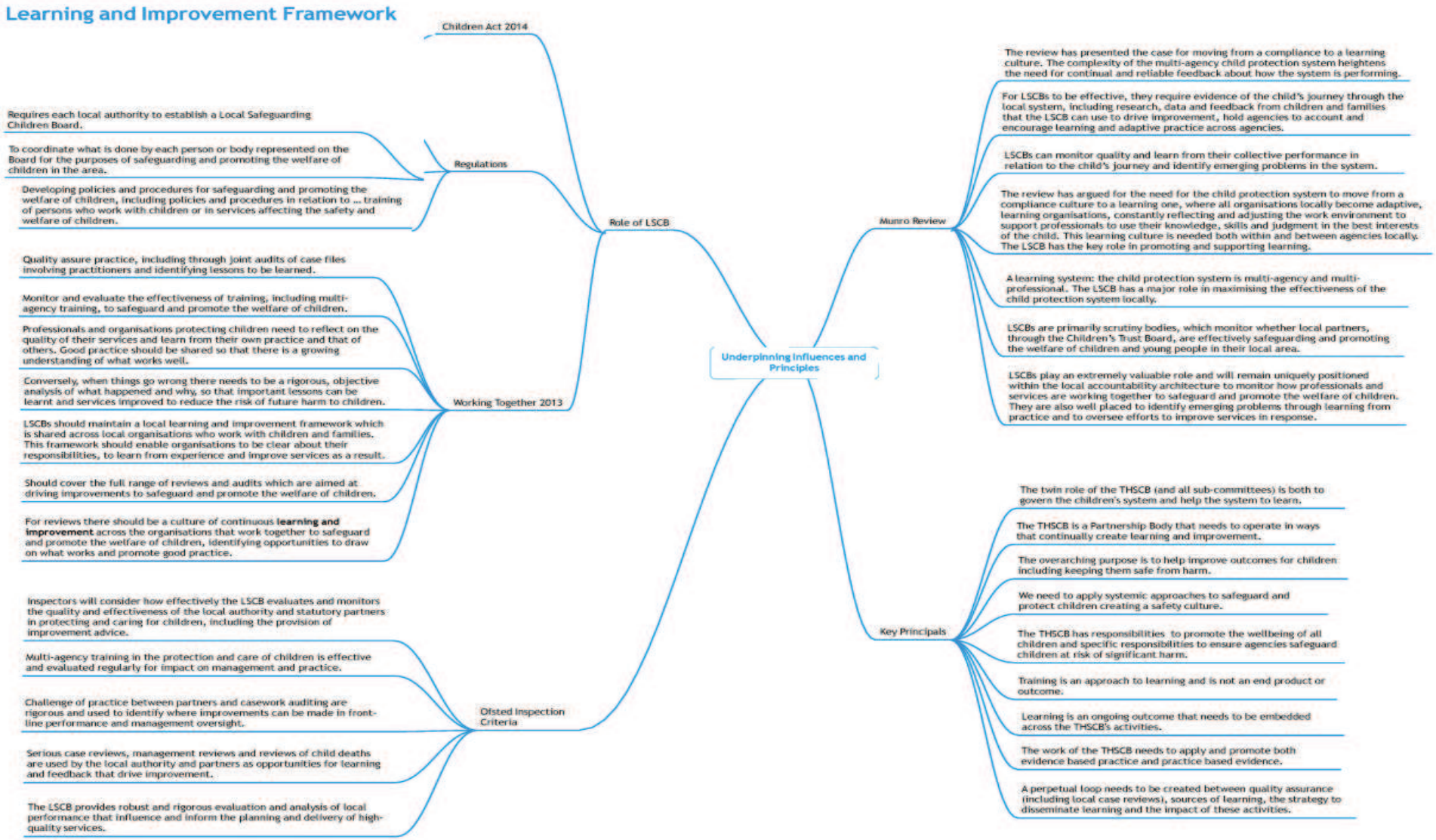
For the full LSCB Performance Dataset – **see Appendix 4**

PRIROTIY 5 – LEARNING AND IMPROVEMENT

LSCB ensures the children and families workforce are confident and competent to undertaken their safeguarding responsibilities

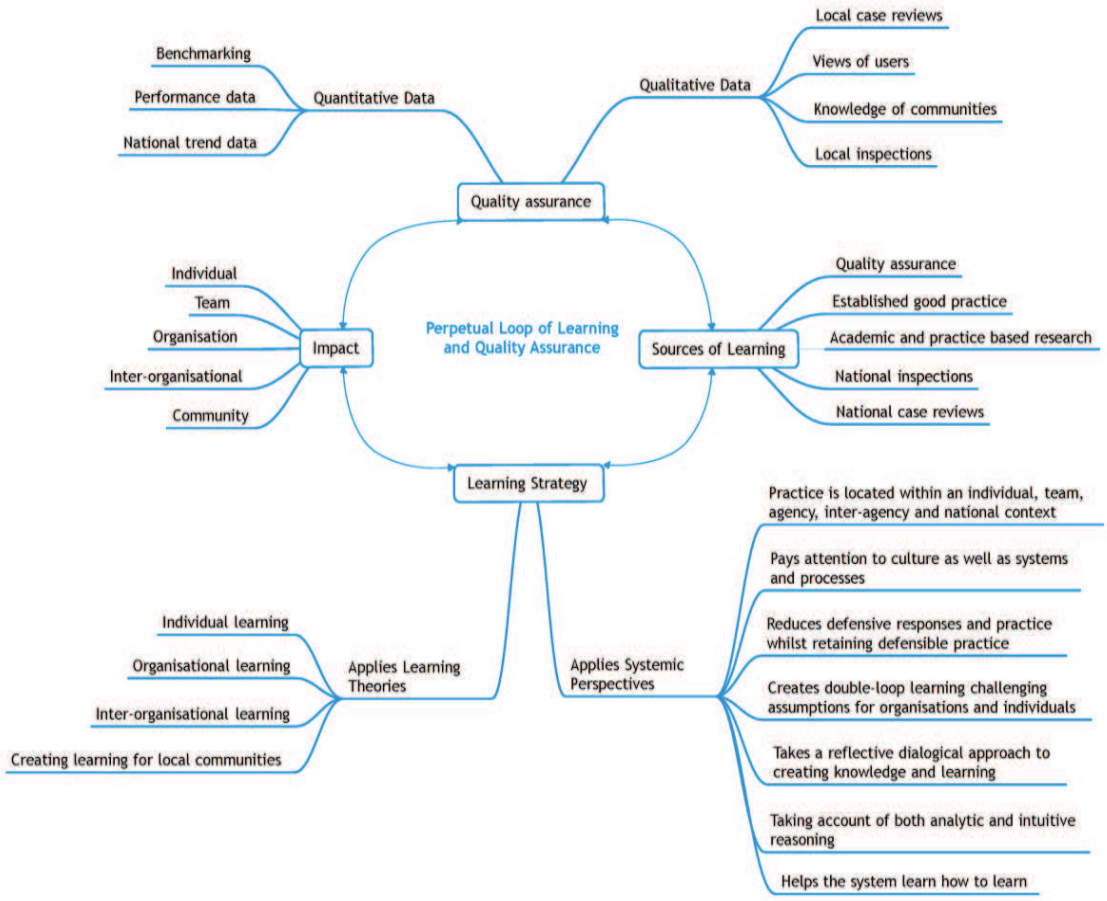
Working Together 2013 has placed more emphasis on LSCBs' learning and improving practice through audit and reviews. This means there have been more activities relying on independent oversight and this presents a challenge for us and other LSCBs in the context of financial pressures currently faced by all agencies.

The diagrams below provide an overview of the influences and principles underpinning our Learning and Improvement Framework



Learning and Improvement Framework

Our framework combines outcomes from serious case reviews, thematic and deep-dive case audits, performance and trends, evidencing our impact through quality assurance activities and disseminating learning through our training programme. The diagram below demonstrates our approach to continual learning and improvement



TH SCB has undertaken a number of safeguarding learning events across key areas of safeguarding. These include:

- **Multi-Agency Safeguarding Training**

  Courses are categorised at different levels depending on who they are intended for, and this will also depend on practitioners' levels of contact with and responsibility for children, young people and families. The groupings distinguish the workforce into three categories which are designed to correspond with the tiers of need set out in the Tower Hamlets Family Wellbeing Model.

- **Category A:** Training for all practitioners who work with children, young people and parents/ carers, delivering universal services. Practitioners in this group will include housing and hospital staff, youth workers, child minders, those working with children in residential and day care settings and those working in sport and leisure settings. Some training at this level is offered through an e-Learning platform and new staff are required to complete the modules as part of their induction or to refresh their knowledge.

- **Category B:** Training for all practitioners who need to address children and families' needs at Tier 2 (targeted) and 3 (specialist) of the Family Wellbeing Model.

Category C: Training for all operational and strategic managers who are responsible for services to children, young people and parents/carers operating at Tier 2 (targeted) and Tier 3 (specialist). This category links to single agency specialist training provision only.

A total of 79 out of 89 one and two day training courses covering 25 safeguarding subject areas were delivered between April 2013 - March 2014. We cancelled 10 training days and these were not rescheduled during this period.

See Appendix 5 for the full list of multi-agency training provided in 2013-14

It is important to understand factors that might affect the degree to which individuals from particular agencies might attend inter-agency training but the LSCB expects practitioners to attend and benefit from multi-agency training alongside their single agency provisions.

- **Learning Events**

As part of the business objective to close the gap between the LSCB and front line practitioners, Board members along with the Chair have facilitated a series of bi-monthly learning events. The main purpose of these sessions is to disseminate current safeguarding messages, changes in policy and explore and challenge multi-agency practice issues. Some of these events have been held in a debate-style format, for example, one focused on the findings from national serious case reviews where neglect was a feature and this was presented within the context of the LSCB's role. Participants were asked to debate the motion that tragedies such as Daniel Pelka, Hamza Khan or Keanu Williams could or could not happen in Tower Hamlets. This was a particularly popular workshop and a similar approach has been adopted for other events. Other discussions in these learning events have explored information sharing, escalation processes and barriers, as well as sign-posting individuals to further learning to address gaps in their safeguarding knowledge base.

- **Serious Case Review Dissemination Workshops**

The serious case review of a young person who died as a result of self-harm at a youth offending institute was concluded in the reporting year. A series of learning dissemination workshops were held and led by the report author, LSCB Chair and

Service Head for Children's Social Care. Sessions were first held with practitioners concluding with one for managers where issues raised by their staff members were incorporated in to the section dealing with 'taking forward learning'. At each workshop, the agency and LSCB action plans were shared with the audience, noting any impending changes to practice or policy.

- **LSCB Board Development Sessions**
  TH SCB has continued with its approach to ensure there is a development opportunity built into each business meeting. In addition, Board members participate in at least one annual development session focusing on reviewing the previous year, measuring our effectiveness and challenges which informs planning and priority setting for the following year. Board members have received intensive learning opportunities on various safeguarding topics such as an overview of working together 2013, undertaking a gap analysis and considering the implications for the LSCB and the Ofsted single agency inspection framework. The most recent development session explored the issue of child neglect in light of demographic changes, the impact of welfare reform and our knowledge gained from a recent Ofsted evaluation of neglect. These discussions led to the development of the multi-agency Neglect Strategy.

- **Multi-agency case audit staff focus groups**
  As part of the learning and improvement framework, multi-agency case audits undertaken by the LSCB have increased participation and input from the multi-agency professional network. Staff are now required to complete their agency audit and bring information together to a half-day case discussion when critical learning is explored. These events provide an opportunity to share and challenge agency perspectives on matters such as thresholds, pathways and rationale for decision-making, especially where there is a difference in view. The outcome of the focus groups contributes to the overall audit findings but importantly practitioners are involved in shaping the recommendations and improvement plans. Feedback has highlighted the tangible benefits to individual and wider workforce learning.

PRIORITY 6 – WORKING IN PARTNERSHIP

LSCB partners are compliant with Working Together 2013 and that assurance processes are in place to ensure robust safeguarding of children and families

Children's Social Care

Children Social Care has provided information regarding its safeguarding activity in a number of reports presented to the full Board. These statutory reports have included those on 'Missing Children' 'Private Fostering', 'Allegations against Adults Working with Children' and Corporate Parenting Report on 'Children Looked After'.

Child Sexual Exploitation:

Child Sexual Exploitation (CSE) has been a growing safeguarding concern for Tower Hamlets as well as a focus of Government attention. The Child Sexual Exploitation operational/ practitioner group chaired by Children's Social Care has provided a strong response to the issue of CSE. This multi-agency forum includes full representation from statutory and voluntary agencies. Over the year the group has provided support to those agencies working with young people subject to/ at risk of sexual exploitation, has identified the profile of both the young people concerned and of the alleged perpetrators, considered safety planning for individual cases, shared intelligence across the agencies to map out the 'hot spots' in Tower Hamlets and utilised all of that information to consider emerging wider safety issues. This group has provided a robust framework for securing the welfare of the young people concerned and has fed into LSCB CSE Steering Group.

The implementation of the LSCB Multi-Agency Sexual Exploitation (MASE) Group in February 2014, in response to the new statutory guidance, will build on the foundations of the operational/practitioners group, formalising that structure and ensuring the right representation from each agency at a more senior level and with clarity around expectations of who is attending and why. The MASE group will continue to coordinate safety plans, monitor the profile of victims and perpetrators and escalate young people in to the child protection process. Additionally it will be taking a more strategic role identifying unmet needs and trends, and areas of training need. There will be a strong reporting link between the MASE group and the LSCB CSE Subgroup.

Multi Agency Safeguarding Hub

For a number of years, the Integrated Pathways and Support Team (IPST) provided the "front door" into Children's Social Care Services whilst also sign posting children and their families to Early Help Services where appropriate. IPST brought together social work staff (including those with a specialist knowledge of working with children with disabilities), attendance and welfare officers, the youth offending team, health visiting, family support and domestic violence officers to provide a holistic approach to determining how best to support families. The transition to become a multi-agency safeguarding hub (MASH) in the autumn of 2013 marked a further evolution of this service with the co-location of the police public protection desk and regular input from the probation service as well as closer links into the MARAC and MAPPA processes. This development represents a significant step forward in the ability for the service to provide more effective and informed decision making at the first point of contact with a family utilising the information available from a variety of agencies.

MASH has been launched at the same time as a major review of the Tower Hamlets Family Wellbeing Model which sets out the thresholds for intervention across agencies in the borough as well as how to access early help services and the Social Inclusion Panel which considers the needs of children and young people on the threshold of social care intervention.

Court Work Project

Beginning in early 2013, the Court Work Project has been the local response to the Family Law Reform programme and to the requirements set out in the Children and Families Act for reducing the average length of time for care proceedings. There have been a number of strands to this project – improving social work practice through better planning for care proceedings and report writing; improving the knowledge and skills of social work staff involved in care proceedings; a robust approach to assessments and care planning to ensure that assessments are focussed, timely and proportionate to the circumstances of the child and family; a new approach to the use of Family Group Conferences and to the assessment of potential carers from amongst the extended family and improvements in the arrangements for the preparation of child permanence reports for children requiring a permanent alternative family.

In addition to the strands of the project identified above, the Project Group has worked with CAFCASS and engaged with the courts in order to ensure that there has been a common agenda for ensuring that proceedings are conducted in a timely fashion. The outcome of this project has been a significant reduction in the average length of care proceedings, down to around 30 weeks by early 2014. This means that, for those children where a risk of or actual significant harm has been identified, decisions about providing support to parents, identifying alternative carers from the extended family or decisions to place children permanently with foster carers or adopters have been made in time scales more appropriate to the needs of those children.

Eva Armsby Family Centre

Eva Armsby Family Centre was commended for its work during the last Ofsted inspection of services for vulnerable children in Tower Hamlets. Staff in the centre have also supported the improvements achieved through the court work project by providing timely, thorough and comprehensive "in house" assessments of parents when children are in care proceedings which have contributed to the reductions in the length of time taken for the completion of proceedings. They have also undertaken community based assessments where previously residential family assessments may have been undertaken – thereby providing a realistic and cost effective assessment of the child and their family.

Adoption

For those children who will not be able to return to the care of their parents or be looked after by extended family or friends, adoption is often the preferred means of providing a permanent alternative family, especially for younger children. Since the autumn of 2012, the adoption service has been working to increase the pool of adopters recruited locally, especially those from the Bangladeshi community, working with the local adoption consortium to make the best use of the existing pool of adopters and to reduce the time that children spend waiting for a permanent alternative home. In some cases, this has meant that children have been able to move to an adoptive placement at an early age or stage in care proceedings and use is now being made of the ability to use approved adopters as foster carers for children that are likely to be placed for adoption at a later stage. An improving pool of adopters and a focus on planning for the possibility of

permanence at an early stage has meant that more children are being placed more quickly, despite the concurrent increase in the number of special guardianship orders.

Recording Interventions

Social work staff can spend too much time recording what they have been doing and not enough time working with children and their families. However, recording what has been done and why is both important as a means of judging progress and in providing a record for the child in the future of the work that has been undertaken should it be required. The recording policy has been reviewed and re-issued in order to help social work staff be more focussed in what they record and why, to enable them to spend more time with families and to provide a better account of interventions, both to guide current practice and to assist children who may wish to review their records at a later stage.

Children's Social Cares - Strengthening Quality Assurance Activities:

Children's Social Care has continued to develop its Quality Assurance activities across the service areas. The monthly system of Quality Case File Audits, which managers carry out and the findings of which are reported to CSC Senior Management Team (CSCMT) is now fully embedded with very high ongoing compliance. Added to this there have been a number of independent service level audits conducted this year including an evaluation of outreach services; care pathways and an audit of completed PDRs which have been reported to CSCMT and utilised to inform practice. A study of the use of 'Step Down' commissioned by the LSCB has been completed and the findings will be taken forward by the LSCB Quality Assurance sub group. The system of monitoring management oversight has also become well embedded and is evidencing a high level of case management activity. The monthly management information data provided to CSCMT has been reviewed and extended to include for example compliance with statutory visit timescales.

The Independent Reviewing Officers (IROs) Practice Alert system referred to in last year's report is now embedded as part of the IRO QA role and utilised routinely where necessary. The vast majority of practice 'disputes' continue to be resolved informally and do not relate to significant practice issues. A midway care plan review process has been implemented which prioritises cases of babies placed for permanency and placement stability monitoring the timely implementation of care plans. The IRO annual report provides the overview of the work of the IRO service including the outcomes of the Quality Assurance activity. This report is presented to CSCMT.

It has not been possible to embed the Child Protection Conference Alert System in the same way due in part to technical recording system issues (FWI). As with the LAC review process the majority of practice issues are resolved informally both internally and with other agencies. A new quality checklist has however been introduced by the Child Protection chairs at the point of the scheduling of the initial child protection case conference. The purpose is to identify the preparation required for an effective initial conference including ensuring that the parents and children have the support they need to participate in the conference and receive conference information in a timely way. The compliance and outcome of the checklist will be analysed and reported to CSCMT.

Safeguarding work with Tower Hamlets Communities

Safeguarding with Tower Hamlets BAME and religious communities is promoted by the work of African Families Service (AFS) and the work with Muslim Families Service (MFS) both based within Children's Social Care. The work of both groups is supported and directed by cross agency steering groups. The AFS represents Tower Hamlets on the government's national working group on child abuse linked to faith or belief systems whilst the MFS represents Tower Hamlets on NSPCC's National Advisory Group on 'Safeguarding Muslim Children' and Metropolitan Police's working group on Abuse Linked to Religious Beliefs and Spirit Possession'.

The activities of both these Services aims to deliver the National Action Plan to tackle child abuse linked to faith or belief within the context of local need. The activities undertaken in the past year have been:

Community Partnership Working

Pastors and Community Leaders Forum

This is a forum held 7 times a year where Pastors and Community leaders come together to be informed about safeguarding issues which impact on the Black African community. The aim is to ensure that the religious and community leaders have an awareness of safeguarding issues and their responsibilities as community leaders, also that they are in a position to inform and support their congregations These are vibrant meetings where much discussion and debate takes place. Service users especially those who are isolated within their community also attend these meetings. The meetings are held within different churches and external speakers are invited to present. The average attendance for the pastors and community leaders' is 40-45, community and service users is 10-12. The service is currently involved with 75 different churches within Tower Hamlets.
Topics covered over the last year have included:

- Safeguarding Children with Disabilities
- Safeguarding - What We Need to Know
- Gangs, Violence and Anti-Social Behaviour
- Immigration Law Update
- Parenting Black African Children in the UK
- HIV and AIDS

Safeguarding workshops in Churches and Non-Government Organisations (NGOs)

These are delivered 4 times a year at individual churches and organisations to an audience of pastors, their congregations and community leaders and members at a time selected by the community. The areas covered include definition and categories of abuse, child protection legislation and expectations and the role of Children's Social Care. Two of these workshops are delivered in partnership with Somali organisations. As with the above forum the purpose of these workshops is to promote awareness of safeguarding issues and to ensure that parents have information about the legislation and expectations of parenting in the UK. The numbers attending these workshops range from 20 for the NGOs and 100 plus for the sessions in the churches.

Enhancing professionals knowledge and skills in working with Black African Children and Families

The AFS delivers three, two day sessions of the 'Safeguarding Black African Children and families' training to professionals per year. Over the last year 60 professionals across the LSCB agencies have received the training, Topics of female genital mutilation, spirituality, spirit possession, private fostering and trafficking are covered. This training is open to other LAs and there are regular external delegates attending from across the country.

Reflective Practice Group and Direct Work

A cross agency group of practitioners who have received specialist training provides a monthly forum for other professionals working with Black African families to discuss cases and receive advice. This is also open to other LA's and as with the 2 day training is used regularly particularly where cases are in the court arena.

The AFS works either alongside other professionals and services (primarily Children's Social Care and Education) bringing their specialist knowledge and skills or in their own right. Over the past year they have worked with 24 cases covering a wide range of issues including spirit possession, FGM, mental health, drug use, DV and drugs

European Links

The EU is seeking to promote cross European working and learning around harmful practices linked to belief systems and is making money available for project work. The AFS is part of a bid involving a number of European countries. There has already been sharing of learning through visits from Italian and Scandinavian organisations to Tower Hamlets and a reciprocal visit by AFS to Italy.

Working with Muslim Families Service

Continuing the Dialogue Seminars

These are delivered a minimum of twice a year in partnership with Tower Hamlets' Council of Mosques who are active members of the steering group. These were initially focused on enhancing the awareness of Imams /Islamic teachers of safeguarding issues and on ensuring professionals have the knowledge and skills necessary to work effectively Muslim families. Over the past 2 years however the focus of the seminars has changed to community groups and families themselves. The audiences now reflect this change of emphasis.

The three seminars delivered over the past year have been focussed on aspects of parenting and the impact of parental behaviour on children's behaviour– 'Children See Children Do' 'Impact of Emotional Abuse and Neglect' and 'What Makes Good Families'. There is always cross agency presentations and an Islamic perspective from locally based Muslim speakers. These seminars were attended by over 150 parents and representatives from community groups.

Safeguarding Children Training for Imams and Islamic Teachers

Safeguarding training sessions are delivered at individual Mosques and Madrassahs and to the Association of Islamic teachers. These individual sessions have become more important with the change in the focus of the seminars. The training covers general safeguarding information and safeguarding expectations of their role as well as key safeguarding messages such as forced marriage, sexual exploitation, private fostering. 12 of these sessions were delivered over the past year with audiences ranging from 15 to 72 in number.

Safer Parenting Sessions

Safe Parenting Sessions are delivered to parents within school settings. As well as covering general safeguarding information that parents need to be aware of, the sessions pick up on issues highlighted by parents themselves and continue the dialogue from the seminars. As with the Imams training the areas such as forced marriage, sexual exploitation and private fostering are covered. 13 of these sessions were delivered over the past year with audiences ranging from 5 to 50 parents.

Caring Dads Programme

The very first Bangladeshi Caring Dads 17-week programme was delivered this year.10 men completed the programme with positive outcomes. For those whose children were subject to child protection plans, the children were subsequently taken off plan and became either child in need or were closed. A second programme is currently in place.

Case Work

The Muslim Safeguarding Coordinator is a source of expert advice and is often consulted particularly for clarification on cultural and religious perspectives on areas such as spirit possession, forced marriage and domestic abuse.

The coordinator is also involved in cases primarily in relation to allegations of abuse against Arabic teachers based in a Mosque or Madrassah. Follow up work from these cases involves delivering the 'Safeguarding Children' to the Mosque or Madrassah involved in the allegation.

Learning and Achievement (Education)

Children with serious medical conditions

A new policy has been implemented in respect of the provision of education for children who cannot attend school due to health reasons (including mental health concerns). This ensures that educational outcomes are maximised and children suffering from long term or serious health conditions are not isolated in their homes but are able to attend school whenever possible and retain contact with peers when not.

Referrals for home tuition on medical grounds are monitored and since the policy on the provision of education for children who cannot attend school due to health reasons was implemented these have risen which suggests more pupils are now accessing this support.

Anti-bullying

The Anti-Bullying Advisor and members of the Behaviour Support Team provide schools with training and support to reduce bullying and undertake case work with families. We have contributed to the design of the local pupil attitude survey which enables pupils to comment on aspects of their lives and schooling anonymously. This includes information on their safety and wellbeing e.g. their experience of bullying and how well they feel their schools manage this issue. This is the first year of the new survey but comparisons with previous surveys suggest that the frequency with which pupils are experiencing bullying has dropped significantly.

Social Inclusion Panel (SIP)

This multi-agency panel (led within Learning and Achievement) monitors cases at the borderline of Tier 2/3. It reviews the Tier 2 Common Assessment action plans and provides support, advice and additional resources to address multi-agency concerns, to reduce risk and, where possible, prevent escalation to Tier 3. A baseline scoring across the full range of needs in the CAF and then use the scores at CAF review to determine how effective we are at helping families. In the most recent evaluation 60% of cases achieved improved outcomes by the review. During the first 9 months of 2013/14 SIP was able to close a third of cases because they had achieved successful outcomes at Tier 2. The remaining cases are still active or were closed for other reasons (e.g. left the borough).

Preventing Violent Extremism

The Social Inclusion Panel (SIP) has taken a lead role in overseeing Prevent plans for children at risk of violent extremism (Prevent is a Home Office funded programme targeting those at risk of Violent Extremism). Prevent cases are given Team Around the Child support and are monitored closely by SIP.

Children and young people with Special Educational Needs (SEN)

The Panels which make decisions for SEN pupils liaise with Children and Adult Social Care colleagues about every case where there seem to be potential Child Protection issues. These panels frequently reject poor quality generic advice and ask agencies to reflect on issues identified through the SEN assessment processes and to provide advice which focuses on the child's needs as identified through their own formal assessments. Caseworkers from all professional groups are expected to demonstrate how they have taken action to not only meet a child or young person's SEN but also to address any potential Child Protection issues identified.

Educational Psychology Service (EPS) case practice

Following the most recent serious case review the EPS held a training session for all its psychologists to consider how they could apply the learning from this review to their practice.

Governor Services

Newly appointed governors are reserved places on a central induction programme, which covers their statutory responsibilities, including safeguarding and child protection. Information on safeguarding workshops for whole governing bodies and Safer Recruitment training is sent to every governor three times a year. The service contributes to school improvement, the effectiveness of which in this respect is evaluated by LA school reviews and ultimately, Ofsted inspections.

The clerking service advises governing bodies that they are accountable for ensuring schools have effective policies and procedures that comply with statutory guidance, including for allegations against staff, the designation of a fully trained senior professional at the school and the accurate upkeep of the SCR. Governing bodies are also advised on policy in relation to DBS checks for governors.

Ofsted inspection support

Schools are given advice and guidance in meeting the OFSTED inspection requirements so that effective Child Protection procedures are explicit; staff are trained in following the procedures; the single central register is in place in all schools. Safer recruitment procedures are in place. OFSTED outcomes are monitored by the School Improvement Team and the School Improvement Officers monitor the outcomes of all OFSTED inspections. They also check that school follow proper procedures for safeguarding practices and staff recruitment at their visits to schools. No school has been criticised for any safeguarding issues, even where they may have been a cause for concern and requires improvement in other aspects of the inspection.

Youth Offending Services

There has been innovative joint work with Troubled Families and the Youth and Connexions service to provide youth outreach advisers to engage gang-involved young people and their peers,

Re-offending rates have fallen, as has the number of first time entrants (FTE) to the youth justice system as we divert more young people away from crime. Both successes have enhanced the welfare of the young offenders but also reduced the victimisation of other children and young people. We have sought external, independent investigation into our work with individuals who have committed grave crimes. The impact of this is aimed at challenging and improving our practice.

Future developments include extending our work with young women at risk from gang and sexual exploitation; work to achieve our government performance targets, reducing re-offending, custody (remands and sentences) and explore how to fund our early Intervention and Diversion team as part of the core service.

Public Health

Public Health carried out a Joint Strategic Needs Assessment (JSNA) analysis of Children with Disabilities which identified gaps in the data and made recommendations on strengthening the commissioning of integrated services, improving arrangements for transition between services, improving identification of cases and post diagnosis support and accommodation issues.

Public Health has challenged itself and others to improve safeguarding arrangements for children through:

- Public Health have secured additional funding for the Family Nurse Partnership (FNP) for two additional nurses previously on short term DH funding, making this evidence-based service available to 20 additional young, vulnerable first time mothers per year. User involvement in the Strategic Advisory Board has also been strengthened and links facilitated with Tower Hamlets Parents and Carers Council.

- Stakeholder consultation carried out as part of 'Healthy Child Review' identified the importance of strengthening 'tier 1' services to support children and young people's emotional health and wellbeing and opportunities for better coordination and data sharing between agencies. This is informing the new service specification that is being drawn up for School Health and will also feed in to the CCG review of child health services to be carried out in early 2014.

- Improving the health needs of remanded young offenders as a LAC through a needs analysis exercise.

- Feedback from public health has strengthened the focus on prevention and early years in the new Mental Health Strategy.

- Funding identified to make Healthy Start vitamins universally available for pregnant women and children up to 4 years to reduce the prevalence of Vitamin D deficiency, which is particularly relevant to our changing demographic groups in Tower Hamlets.

Public Health has identified the following priorities for 2014-15:

- To strengthen services to support maternal and infant mental health – in view of the evidence that the first year of life is a critical period for long term emotional health and wellbeing – carrying out a mapping of current services to identify gaps and opportunities for better join up and will be making the case to use public health grant funding to strengthen services to support maternal and infant mental health.

- To work with the CCG and other local authority commissioners to commission more joined up services for children and young people, drawing on findings from the 'Healthy Child Review' and forthcoming CCG review of children's health services.

- To develop a multi-agency strategy to reduce A&E attendances arising from intentional and unintentional injuries, which remain high in Tower Hamlets.

- To follow up on initial analysis of the prevalence of consanguinity in Tower Hamlets and implications for child disability and mortality.

Public Health has led on the implementation of recommendations from Child Death Overview Panel which included:

- Confirmation by CAMHS that policy on follow up of DNAs has been reviewed and strengthened
- School Health service strengthened procedures for identifying children with asthma so that action plan in case of acute attack is in place
- Issue of ensuring compliance with Housing Inspection Policy re: prevention of falls from windows and balconies raised with LBTH Housing
- Maternity service has updated protocols on the management of high risk women and guidelines on transfer to labour ward
- Have followed up with Maternity service to improve recording of consanguinity and ensure genetic counselling offered as appropriate
- Development of new protocol for primary care on follow up of children who DNA appointments for secondary care and CAMHS
- Development of communications plans with Children's Centres, Health Visitors and other frontline staff to raise public awareness of how to identify a child with acute life threatening illness and how to call for an ambulance
- Carried out JSNA analysis of prevalence of consanguinity, using available data from Maternity service and child health. This has identified evidence for higher prevalence of consanguinity in Tower Hamlets and possible association with developmental delay.

Tower Hamlets Clinical Commissioning Governance

As a commissioning agency the CCG continually reviews the safeguarding arrangements of the providers we commission. Included within this are regular quality reviews linked to a safeguarding quality and performance Dashboard. This Dashboard has been reviewed and currently seeks information of over a hundred metricises. Within the CCG safeguarding is at the heart of the commissioning decisions; the designated professions advise commissioners on safeguarding aspects of the services we commission. The CCG are reviewing children's services specifications ensuring safeguarding children is integral to this review. The CCG's 'Safeguarding and Commissioning Group' have intervened in issues when they have arisen or supported the providers in their response to issues, for instance (i) when an independent practice-site introduced a domestic violence drop in clinic in isolation to existing domestic violence pathways (ii) supporting Barts Health to prevent the Samaritans working from A&E while operating a none-disclosure policy this was raised with NHS England and the LSCB added to the LSCB risk register (iii) when a therapy service refused to see vulnerable children following an initial assessment because not specified within the contract.

THCCG considers all current safeguarding issues via its 'safeguarding and commissioning group' which meets monthly and feeds directly to the CCG governing body. Routine items at this meeting include; current risks, provider performance, quality issues, health provision for LAC. In addition the designated professionals are represented at both providers' integrated safeguarding children committees.

The function of the designated professionals being placed within CCGs is to challenge and advise with regard to safeguarding children. The CCG has, and continues to develop a safeguarding children mind-set in all that it does and will question itself, and also question the providers it commissions; for example at 'none obvious' safeguarding quality visits the CCG will consider safeguarding in light of the service area under review e.g. how the low staffing levels could lead to a safeguarding issue.

Tower Hamlets CCG has identified the following priorities for 2014-15:

1. Ensure its commissioning processes are robust enough to ensure future health demands of the increasing number of vulnerable children are met.
2. To secure the long-term expertise of a Designated Nurse for Looked After Children
3. Complete a review of the health provision for LAC

Barts Health NHS Trust

Barts Health has developed and supported a range of innovative practices to safeguard and promote the welfare of children and young people who use their services and to support the provision of early help and intervention.

The Barts Health 'health visiting toolkit' was developed to identify the most important issues facing local families. This process involved consulting a wide stakeholder group, using cycles of ranking and voting to identify and prioritise key issues. The high priority topics selected to be explored by the Toolkit project were:

- Infant stimulation and communications development
- Preventing childhood obesity
- Improving effectiveness of work with stressed and unsupported families

Stakeholders and partner organisations were involved through a steering group, workshops and meetings to discuss locally available support to parents in relation to the three identified issues above and to share ideas for improving services, identify barriers to effective practice and to suggest potential solutions. The project will be used to enhance the effectiveness of health visiting practice by:

- Developing a website to direct parents and staff to high quality, evidence-based resources which give information and ideas about play and communications, healthy eating, and physical activity and support available for families living in stressful situations. This website will showcase the unique contribution made by health visitors in supporting families with children aged 0-5
- Developing a leaflet outlining the health visiting service to parents and carers
- Delivering training in topics around which health visitors highlighted their need for new or updated knowledge and practical skills, including sleep, parent-infant attachment, perinatal mental health, weaning and forced feeding.

The specialist youth workers, employed by Tower Hamlets local authority are working with health staff in the emergency department at the Royal London Hospital with a specific role in an advising young people attending the department of the consequences of being in gangs, becoming involved in crime or taking drugs, and will put young people in touch with youth and sports centres as an alternative.

Barts Health staff have continued to provide representation at the multi-agency child sexual exploitation group to identify and support young people at risk of, or being, sexually exploited in Tower Hamlets.

Following the changes required by the Metropolitan Police in respect of sharing Merlin reports representatives from Barts Health and Tower Hamlets Children's Social Care met and devised a process that will ensure relevant Barts Health staff continue to get notifications of a Merlin being generated directly to the electronic record keeping system without the full detail in the report being shared.

Health staff will use this knowledge, along with what is currently known about the family; to assess what further action will need to be taken to ensure that the relevant support and intervention is offered to children, young people and their families.

Barts Health will prioritise the following safeguarding children activities and processes in 2014/15:

- Following the launch of the Tower Hamlets Multi-agency Safeguarding Hub (MASH) Barts Health will work with Children's Social Care colleagues to develop the role of the MASH health specialist to ensure that the role of health in MASH processes effectively contributes to the protection and safeguarding of those children identified to be most at risk.
- In response to the most recent CQC inspection of Barts Health services, support and care pathways for adolescents will be strengthened across the organisation.
- The Child Protection Information Sharing system (CP-IS) is a Department of Health/NHS England led project developed to enable details of children who are subject to child protection plan, or in care, to be shared by local authorities with health organisations via the NHS spine. Tower Hamlets local authority are an early implementer of this project and the Royal London Hospital, located in Tower Hamlets, will be part of this early work.
- Barts Health, in conjunction with Tower Hamlets local authority Children's Social Care will facilitate the implementation of CP-IS in urgent care settings at the Royal London Hospital. This will enable health professionals to be fully informed about any statutory involvement from children's social care which can inform the decision making process during assessment. Information pertaining to the health setting attendance will be shared with children's social care.

East London Foundation NHS Trust

ELFT safeguarding children practice is based on relevant national, local and professional guidance including *Working Together to Safeguard Children* 2013 and the Royal Colleges Inter-collegiate document (third edition March 2014) entitled *Safeguarding children and young people: roles and competences for health care staff.*

The Trust works across a number of LSCB areas and has continued to treat safeguarding children as a core activity to ensure it is embedded in the Trust's culture and ethos. The Safeguarding Children Team provides support, advice, training and consultation to staff across the organisation and facilitates inter-agency case working. A vacant post was filled this year which strengthened support for safeguarding children arrangements in Tower Hamlets.

We are developing our work around children and young people with caring responsibilities for adult mental health service users to address *CQUIN Goal 7: Improved Carers Assessments & Communication* with the aim of improving support for carers including young carers. Training on young carers has been run by Family Action, a code for identifying young carers was introduced and relationships are being developed with Young Carers Strategy Groups in Tower Hamlets.

We have revised our Training Needs Analysis (TNA) and strategy in the light of the UK Core Skills Training Framework Subject Guide produced by Skills for Health and the proposed revised inter-collegiate competence document. Certain clinical staff will now be required to attend multi-agency LSCB training for their Level 3 safeguarding refresher which should promote more effective partnership working.

As part of the range of mental health Electronic Patient Records Systems (EPRS) developments taking place we continue to review the most effective way to record information relating to safeguarding children (including use of codes, alerts and forms).
A Tower Hamlets adult mental health nurse has worked with inpatient staff regarding identification of adult patients who have children and has been developing resources and processes for children visiting their parents in hospital.

Adult mental health services have support for themselves and their service users from the CHAMP Team, Kids Time, Family Action Building Bridges Project and Carers Connect.

The ELFT Safeguarding Committee provides scrutiny and challenge regarding safeguarding children arrangements. This includes receiving assurance regarding practice in the form of audits agreed in the annual work plan and progress in implementing recommendations from serious case reviews. Safeguarding children activity is regularly monitored as part of our quality assurance framework and this is reported to the Trust Board in an Annual Report. Findings from case audits and reviews are shared with staff via management, and through training.

The Trust monitors reported incidents involving children and adults who have parenting responsibilities which includes those that become LSCB reviews. There have been no incidents in the Trust of child deaths caused by abuse or neglect involving adult service users since 2007.

Feedback and evaluations from training demonstrate an overall improvement in awareness, knowledge and reflection year on year. Staff are more confident and effective in their roles in identifying and acting on concerns or impact on children, including young carers and children visiting adults who are inpatients in mental health wards.

The clinical directorates monitor safeguarding children issues at management meetings and the Named Professional for Safeguarding Children attends the adult mental health directorate meetings on a quarterly basis.

The Named Professional for Safeguarding Children facilitates regular team learning and reflective sessions in Adult Mental Health and Specialist Addiction Services. The Trust's Supervision Policy includes a requirement for safeguarding children issues to be addressed in supervision.

The Trust is an active member of the LSCB and sub groups which helps it challenge itself and others regarding in-house and multi-agency safeguarding arrangements. At a strategic level the Trust also uses up to date statutory guidance, commissioning requirements and inspections to test out its infrastructure. In terms of individual cases, teams are encouraged and supported to discuss safeguarding children issues regularly and to escalate cases where necessary, for example, staff challenge Children's Social Care regarding decisions and timeliness of feedback.

The Safeguarding Children Team member for Tower Hamlets has a visible presence and effective relationships with managers in Children's Social Care and meets quarterly with CSC IPST/MASH and Hospital Team. Any case concerns from either the Trust or CSC are followed up to ensure effective child protection, child in need or team around the child processes are in place.
The Trust continues to respond to new initiatives regarding issues such as Child Sexual Exploitation, FGM and Domestic Abuse within the context of capacity.

East London Foundation NHS Trust will continue to priorities our work to:

- Strengthen supervision arrangements regarding safeguarding children
- Strengthen processes for carrying out the high volume of patient record checks that are required for MARAC, Child Protection Conferences, Child Deaths, Serious Case Reviews and other LSCB multi-agency quality assurance activity.
- Develop identification of young carers and signposting to services.

Additional priorities:

- Develop a combined Trust safeguarding strategy regarding children and adults.
- Formalise Trust safeguarding children audit programme.
- Consider use of Signs of Safety.

Met Police – Child Abuse Investigation Team (CAIT)

This year the Child Abuse Investigation Command has undergone a major restructure and has merged with the Sapphire (Rape) Command forming the new Sexual Offences, Exploitation and Child Abuse (SOECA) Command. Although at this stage CAIT retains its current remit, the future working of both Commands is under review. Senior leadership and support functions such as partnership, training, intelligence, quality assurance and pro-activity have been merged to provide a more efficient service to both Child Protection and Sapphire sides of the Command.

Performance and effectiveness is evaluated by the Command as a whole at a bi-monthly Management meeting. This meeting consists of Senior Leadership Team and Detective Inspectors from all CAIT teams representing LAs in the North East London Area.

Up-to-date performance figures are scrutinised and discussed, highlighting areas for improvement and any good practice taking place. Performance has shown that despite an overall increase of 16% for CAIT offences with no increase in staff, the Command has detected 86 more offenders than the same period last year.

Significant progress has been made within the CSE remit. This area of work is now co-ordinated by SOECA to ensure a consistent, effective response to Child Sexual Exploitation. The command has set up a dedicated CSE team, headed by a Detective Superintendent. The team consists of 2 Detective Inspectors with teams consisting of a SPOC for each Borough. These teams are able to liaise with Borough Police and CSC leads to provide a more in depth response, both reactive and proactive.

CAIT has challenged CSC partners across the East London Boroughs, including Tower Hamlets regarding their planning for children taken into Police Protection and their subsequent applications for an Emergency Protection Order (EPO). The risk by not challenging would have left the children with no legal basis to the protection afforded them. The option to return them to the family home, without any form of risk management would have placed the children at significant risk of harm.

This challenge resulted in CSC making successful applications to the court for an EPO; therefore ensuring children remained in a safe environment.

The role and remit of the Child Abuse Investigation Team was spotlighted in the September 2013 issue of the LSCB newsletter.

Voluntary Sector

The Voluntary Sector working with children, young people and their families in Tower Hamlets comprises of hundreds of organisations; 220 of which are members of the Voluntary Sector Children and Youth Forum (VSCYF), a network hosted by Volunteer Centre Tower Hamlets.

The LSCB and VSCYF continued to promote the national Safe Network Standards and the self-assessment audit tool as a useful resource for the voluntary sector. It sets the standards for this sector to operate safely and is section 11, Children Act compliant. The Voluntary Sector Children and Youth Forum Coordinator supported 16 organisations to complete an audit and has encouraged commissioners to consider making the audits a commissioning requirement.

The voluntary sector organisations that have completed Safe Network audits have reported that they have procedures in place that ensures they can take appropriate actions to keep children and young people safe. They have improved systems and communication and have therefore found that their members of staff and volunteers are much better informed and confident when it comes to safeguarding matters, are more aware in terms of safer recruitment, and vigilant in managing everyday behavioural issues with children and young people.

Two training courses were held for voluntary sector organisations which focused on writing policies and procedures and safeguarding tools. Workshops on e-safety and dealing with allegations were held as part of a rolling programme of themed workshops for the voluntary sector.

Information for parents on protecting their children and on resources for safeguarding deaf and disabled children was disseminated to the voluntary sector through the VSCYF e-bulletin. The VSCYF Coordinator also ensured providers were kept abreast of organisational changes due to developments in the Disclosure and Barring Service and Working Together 2013. Resources available to help children and young people stay safe using the internet were highlighted for Safer Internet Day.

The Voluntary Sector Children and Youth Forum has identified the following priority for 2014-15:

- Improved messages to children, young people and their families on how to deal with cyber bullying and other e-safety issues
- Support organisations in their understanding of child sexual exploitation and how to respond
- Support organisation to improve identifying early help and increase the use of the Family Wellbeing Model and the Common Assessment Framework.

The group ensured coherence between the various inspection processes, audit findings and serious case reviews by bringing together the findings and recommendations into a single umbrella plan.

The Quality Assurance & Performance Subgroup supports the scrutiny function of the LSCB and is responsible for analysing the data and providing narrative for the LSCB Performance Report. It also examines the impact of our safeguarding activities ensuring that the quality of multi-agency safeguarding practice is monitored and evaluated through thematic and deep-dive case audits. The subgroup leads on monitoring all action plans emerging from the various serious/case reviews, inspection processes, audits and has brought a coherence b bringing together the findings and recommendations into a single LSCB umbrella action plan. The purpose of this overarching umbrella action plan is to improve our oversight of progress made and highlight areas for improvement and intervention.

The work of our other subgroups also provides the LSCB with information about the quality and effectiveness of our safeguarding arrangements. This section provides the profile of our vulnerable children and young people groups, and our performance areas to demonstrate what we know and what we have done to improve their outcomes.

Profiles of Children Looked After, Children in Need and Children Subject to Child Protection Plans at 31 March 2014

	2013-14
Nos of children looked after	328
Nos of children living in private fostering arrangement	42
Nos of children subject to child protection plan	329
Nos of children subject to child protection plan for Sexual Abuse	8
Nos of children subject to child protection plan for Physical Abuse	39
Nos of children subject to child protection plan for Neglect	96
Nos of children subject to child protection plan for Emotional Abuse	180
Nos of children subject to child protection plan for Multiple Abuse	6
Nos of children in need	1398

Child Death Overview Panel

LSCBs are required to review all deaths of children resident in their area. The overall aim of the review process is to learn lessons in order to reduce the incidence of preventable child deaths in the future.

The Child Death Overview Panel (CDOP) is responsible for undertaking a review of all deaths of children, up to the age of 18 and excluding those babies who are stillborn. The review process involves collecting and analysing information about each child death to identify any case giving rise to the need for a review, any matters of concern affecting the safety and welfare of children in the area of the authority; and any wider public health or safety concerns arising from a particular death or pattern of deaths in that area.

The responsibility for determining the cause of death rests with the coroner or the doctor who signs the medical certificate and is therefore not the responsibility of the CDOP.

The panel decides which, if any, of the child deaths might have been prevented, and also whether there were any potentially modifiable factors where action might be taken locally, regionally or nationally to help prevent future deaths. By considering all local deaths, as well as looking at each child's individual circumstances, the panel considers any emerging themes and also whether there are changes that need to be made to local services or the environment, for example, road traffic safety. The aim of the CDOP is to reduce child deaths by understanding the reasons why children die.

During 2013-14 there were a total of 46 new child death notifications reported to the CDOP, 16 were children resident in Tower Hamlets and the remaining 30 were children resident in other areas. The reason we receive notification for the latter group is due to the fact that the Royal London Hospital is a major trauma centre where many children and adults are brought to for medical emergencies and treatment.

We have held five Panel meetings over the year to review child deaths and follow up on recommendations. In addition, rapid response meetings were held in response to four unexpected child deaths.

A total of 30 child deaths were reviewed during 2013-14, of which 8 deaths occurred in the reporting year, 14 were deaths that had occurred in 2012/13, 6 from 2011-12, 1 in 2010/11 and 1 in 2009/10.

Of the deaths reviewed only 1 had been subject to a serious case review and 2 were subject to a Serious Incident Review undertaken by Barts Health Trust.

Breakdown by age (30 reviewed cases)	
<1 year (including neonatal deaths)	19
1 < 5 years	2
5 <10 years	0
10 < 15 years	6
15 < 18 years	3

Breakdown by ethnicity (28 of the 30 cases)	
Bangladeshi	11
White British	4
Asian British	3
Asian Other	3
African	2
Mixed White/Other	2
Other	3

Breakdown of the causes of death (30 cases)	
Perinatal/neonatal	6
Acute medical or surgical	3
Chromosomal, genetic and congenital abnormalities	9
Life limiting condition	2
Chronic medical condition	3
Suicide or deliberate self-harm	3
Infection	3
Deliberately inflicted injury, abuse or neglect	1

In terms of the 30 child deaths reviewed, 5 were identified to have modifiable factors that is to say, where action can be taken locally, regionally or nationally to help prevent future deaths.

The CDOP has followed up actions to ensure implementation of recommendations from individual child death cases reviewed:

- Confirmation by CAMHS that policy on follow up of 'did not attend' (DNAs) has been reviewed and strengthened
- School Health Service strengthened procedures for identifying children with asthma so action plans in place in case of an acute attack
- Issue of ensuring compliance with Housing Inspection Policy re: prevention of falls from windows and balconies raised with LBTH Housing
- Maternity service has updated protocols on the management of high risk women and guidelines on transfer to labour ward
- Maternity service improved recording of consanguinity and ensure genetic counselling offered as appropriate
- Development of new protocol for primary care on follow up of children who DNA appointments for secondary care and CAMHS
- Development of communications plans with Children's Centres, Health Visitors and other frontline staff to raise public awareness of how to identify a child with acute life threatening illness (e.g. acute asthma attack) and when to call for an ambulance
- Carried out JSNA analysis of prevalence of consanguinity, using available data from Maternity service and child health. This has identified evidence for higher prevalence of consanguinity in Tower Hamlets and possible association with developmental delay.
- A Child Death information pack has been created to be distributed throughout Neonatal unit and Paediatric wards. The Child Death information pack will also be available on the hospital intranet for all staff to access
- Incorporated CDOP information to hospital staff Induction to explain the Child Death process, child death notification and data collection.
- From February 2014, the Designated Doctor for Child Deaths, has been working with the CCGs in Tower Hamlets, Newham and Waltham Forest and local palliative care providers to develop a strategy: with the aim of improving the quality, safety and experience of those in the last years of life across our three boroughs - regardless of age, ethnicity, diagnosis or care setting

Some recurrent themes and other impacting issues were identified through the child death reviews, these include:

- High rates of DNA / lack of follow up of DNAs indicating issues of possible neglect

- Increase in the number of infant deaths that requires further analysis

- A need to ensure that services are reminded of reporting procedures to ensure that all child deaths are reported promptly to the Single Point of Contact (SPOC)

- A need to improve engagement and information sharing with the Coroner

- A need to resolve the temporary management of the SPOC as recent changes to the post has presented challenges in making a suitable new appointment. The effective functioning of the CDOP is dependent on having a suitable person in post

- Problems with the child death database makes data analysis slow and cumbersome which in turn makes follow up of recommendations difficult. Public health will be exploring options for improving the technical infrastructure to support the work of the LSCB CDOP

Serious Case / Thematic Reviews

The Case Review Group has ensured the LSCB is meeting statutory requirements in relation to responding to serious incidents, submitting notifications to Ofsted, Department for Education and the newly formed National Serious Case Review Panel. Working Together 2013 provided new guidance around the approach to conducting SCRs and the subgroup considered a range of models before recommending taking a hybrid-systems approach to all new SCRs. This approach also applies to those cases that do not meet the threshold for a SCR where the subgroup believes a case or thematic review would elicit learning.

During 2013-14, TH SCB concluded a serious case review in to the death of Child F which had commenced the previous year. Child F was a looked after child who had died as a result of self-harm in a young offenders institution. The SCR was independently reviewed and findings have formed the basis of an action plan for Tower Hamlets Children's Social Care, Health Agency and the LSCB. The overview report and action plans were published on the LSCB website in August 2013. A series of learning dissemination workshops were held to inform practitioners and managers of the key messages and explore the implications for practice:

- Impact and legacy of sever abuse in early childhood
- Impact of long-term placement at a distance from the responsible local authority, including meeting needs arising from racial identity
- Difficulties in addressing educational problems
- Social Care practice and record keeping
- Quality assurance function for children looked after (independent reviewing service)
- Support strategies that can help 'difficult' adolescent
- Additional vulnerability of children in custody and secure settings
- Professional disagreement versus constructive challenge

The LSCB has responded to all the recommendations and have made improvements in the following area. This is not an exhaustive list of the recommendations.

- Improvements made to system to ensure that important documents and assessments are prominently marked in electronic social care records and that historical documents are transferred to current electronic files where necessary

- Formal information sharing arrangements between Tower Hamlets Looked After Children Services and the Youth Offending Service irrespective of where the young person is placed (or the offence occurs)

- The current arrangements for quality assurance and audit in the local authority to ensure that all of the areas of potential risk and vulnerability for looked after children are addressed

- Supervision notes and case management decisions relating to looked after children address relevant issues and are clearly documented on the electronic case record of every individual child

- Looked after and children in need services and the youth offending services work together in the most effective way in order to minimise risk to and vulnerability of young people in the youth justice system, including those in custody.

- Reviewed process for finding alternative placements for children to always include a proper assessment of need, vulnerability and risk and that there is proper consultation

- Improved arrangements to monitor the provision of education to looked after children paying particular attention to those attending alternative provisions and ensuring compliance with statutory guidance in relation to the education of looked after children who are in custody

In addition to Child F, another serious case review was initiated in December 2013 following the death of a baby as a result of neglect through maltreatment; this review will be concluded in autumn 2014. The report and findings will be published on the LSCB website and learning disseminated to the wider multi-agency workforce.

Over the past year, the case review group considered a number of cases that were deemed not to meet the threshold for a SCR but due to the serious nature of the incidents involved and the common features of their cases, a decision was taken in January 2014 to commission an independent thematic review on the basis that there would be significant practice/policy learning from a cohort of six young men who have either seriously harmed others or been seriously harmed. Some of the common features relate to early childhood neglect, head trauma, disrupted parental attachment and absent influence from fathers within the home, possible gang association, knife and drug related crimes, entry routes in to the care system and escalation to serious criminal acts. The LSCB has taken the decision to publish the findings of this thematic review as the learning is likely to be of significance to other LSCBs in the UK.

The new serious case review and the thematic review will be the two first reviews to be delivered within our learning and improvement framework.

However, the business of conducting these types of reviews continues to present a challenge for the LSCB and individual partner agency representatives. In order to fulfil the requirements of Working Together 2013, additional meetings were required to meet the demand and make decisions within timescales. This has meant the case review group was unable to cover other planned activities for 2013-14, such as considering learning from other LAs SCR.

Multi-Agency Thematic Case Audits

The LSCB has a quality assurance framework which includes multi-agency thematic and deep-dive case audits which the Quality Assurance and Performance Subgroup is responsible for delivering. The group has identified a two-year rolling programme of audits informed by case review, performance trends, national safeguarding developments and inspection findings. This year, the subgroup members have completed a thematic audit in to the Step-Down from tier 1 and tier 2 of the Family Wellbeing Model Framework. A further three thematic audits, which involved deep-dives in to casework and partnership working commenced during 2013-14 and the findings were being analysed at the time of writing the LSCB Annual Report. These audits explored child sexual abuse, neglect and child sexual exploitation and the following will be addressed next two years:

- Physical abuse
- Emotional harm
- Child Mental Health
- Substance misuse
- Missing children/runaways
- Children with Disabilities

Learning from last year's thematic audit on threshold to social care and the step-down audit has fed in to the revision of the Family Wellbeing Model.

The rationale for conducting the 'Step Down' audit developed out of concerns raised in the Ofsted Inspection (2012). The borough's inspection report noted that the *"council is aware that there is further work to do to support and develop the consistent use of 'step down' processes to support children, young people and their families as risk is reduced".* In response, Children's Social Care decided that '*the Family Wellbeing Model steering group would be tasked to establish some principles on 'step down arrangements'.* The LSCB audit was commissioned to evidence how well this had been understood and appropriately used to help children and families in need of non-statutory support. The findings suggest there is some confusion as expectations of social care had evolved in line with the FWBM, leading to a wide diversity of practice around 'Step Down' across the partnership. Whilst it is in within the body of the Family Well-Being Model, very few practitioners seemed to be aware of a written step-down policy. When further explored, there wide belief that 'step-down' was about closing a case, as opposed to preparing for a continuity of the case when Children's Social Care ceased to be involved.

The audit recommendations to the LSCB include:

- Consideration is given to developing a more formalised system for signing-off cases to ensure appropriate 'step-down' plans are in place without being overly bureaucratic. This includes a step-down checklist incorporated in to CSC's electronic recording system.

- Once system is in place, a visible launch of the concept of step-down is delivered to the LSCB partnership.

An action plan to implement the recommendations has been developed by the Quality Assurance & Performance Subgroup and CSC senior management team who will lead on this task in collaboration with the FWBM steering group.

Section 11 Audit

Section 11 is a reference to s.11 of the Children Act 2004, which places a duty on named statutory organisations to be mindful of the need to safeguard and promote the welfare of children. The audit measures the degree to which organisations comply with this duty, against a set of 8 standards covering governance and accountability arrangements, training, safe recruitment processes, effective multi-agency working, information sharing and how organisational development is informed by the views of children and young people.

TH SCB conducted its second bi-annual s.11 audit in Spring 2013 with partners and Tower Hamlets Schools. The exercise did not include the voluntary and community sector as they were encouraged to access the s11 compliant Safer Network self-assessment online tool. A challenge for the LSCB will be to bring commissioned services into the scope of future s11 audits.

The individual action plans generated by this exercise is being progressed and monitored by the Quality Assurance & Performance subgroup. In order to allow reasonable time for the tasks to be completed and produce results, the subgroup will conduct shorter deep-dive audits on specific s.11 standards which will be determined from intelligence gathered from other processes. For example, an audit sample of agencies safer recruitment processes cross-referenced with the Local Authority Designated Officer's (LADO) allegations against staff report.

Allegations against Staff

Tower Hamlets has a dedicated LADO who sits within CSC's child protection and reviewing service. The LADO provides an annual report for the academic year, 1st September – 31st August detailing the circumstances around the allegations against staff received, the follow-up undertaken and outcomes achieved in relation to statutory guidance and requirements.

The last report presented to the LSCB covered information from 2012-13, the year preceding period this annual report. It was noted that there was a significant increase in referrals (30%), of which 70% were completed within timescale below our target of 80%. This was mainly as a result of introducing a new reporting system. There has been an increase in support to the LADO role to monitor and prepare for its statutory reporting to the DfE and the LSCB. The Board noted that correlation between the increase in reporting by parents and of awareness raising activities.

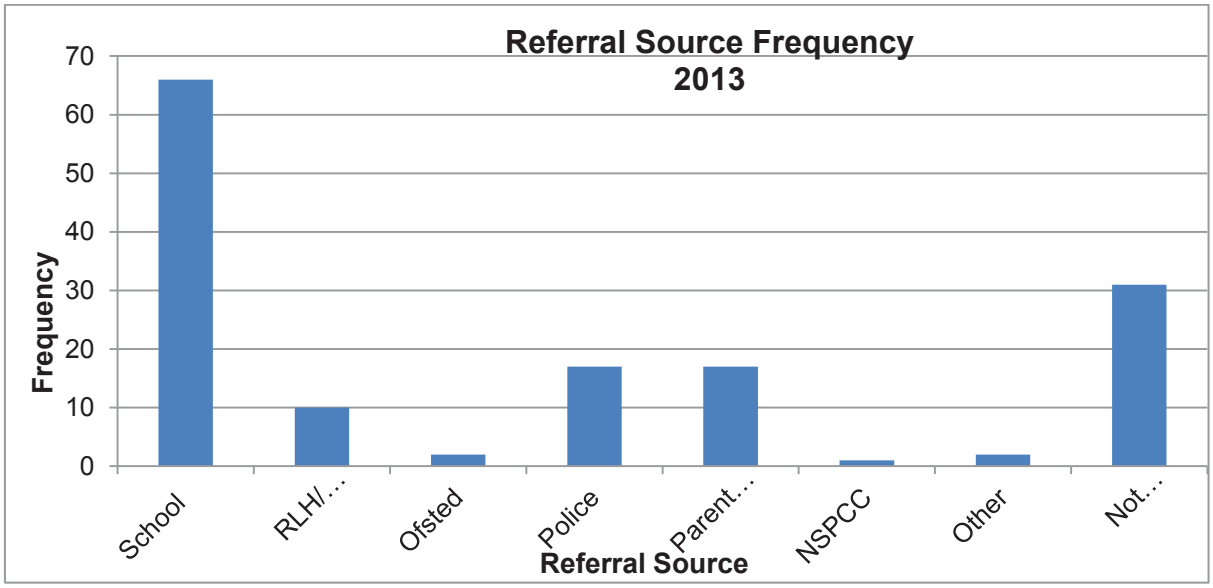
Total number of allegations per year:

Year	2009	2010	2011	2012	2013
Number of Referrals	**90**	**95**	**85**	**107**	**146**

Referral Source for 2013

Schools were the source of 66 of the total number of 146 referrals in 2012-13 representing 45%. They continue to be the source of the highest number of referrals though the percentage of the overall total has decreased from the average of 66% in the previous 4 years. This can be partly explained by more referrals being recorded as originating from parents as opposed to being reported through the school.

The Royal London Hospital/Health Professions were the sources of 10 (7%) of referrals, a development marking the integration and use of the LSCB procedures for reporting Allegations against Adults into their practice.

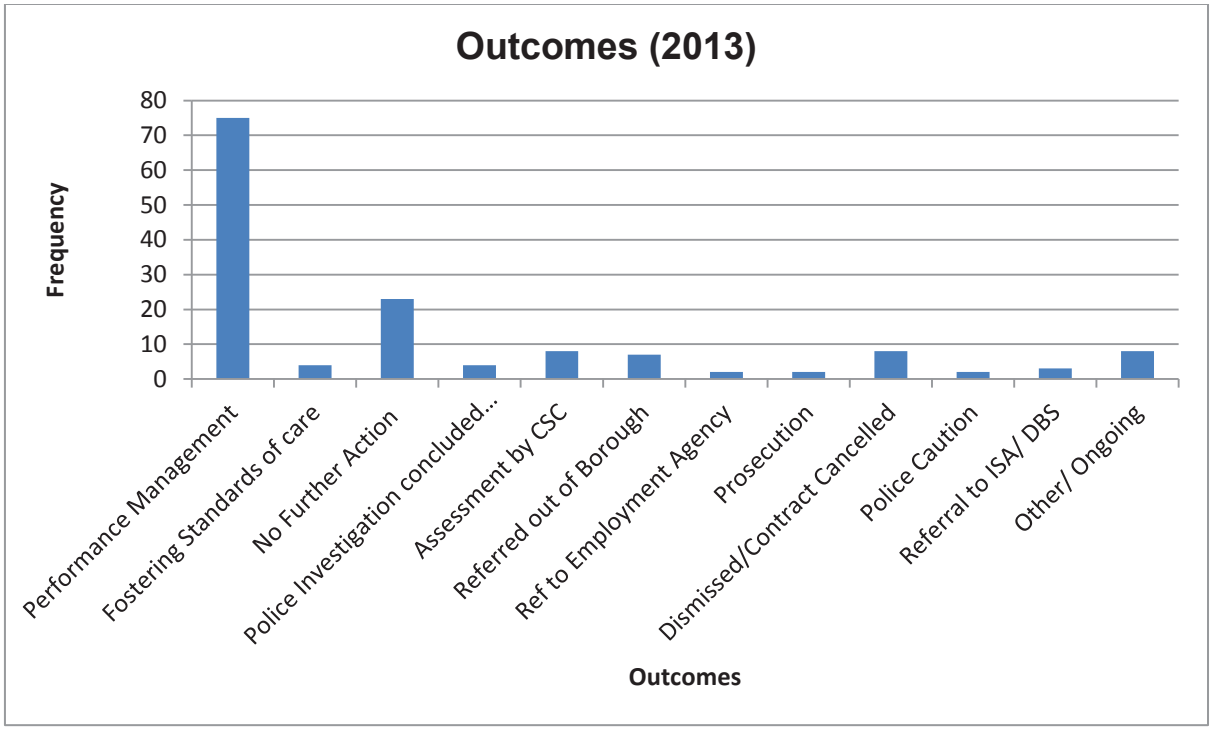


Outcomes of Investigations:

A total of 75 cases representing 51% of all allegations received ended with some form of Performance Management – an increase in number but a similar proportion when compared to 2011-12. Some 23 cases representing 16% of the total allegations received ended in No Further Action being taken.

In 8 cases (5%) the adult working with children was dismissed or had their contract cancelled.

In 3 cases (2%) the adult was referred to the Disclosure and Barring Service due to concerns about their suitability for employment working with children and vulnerable adults.



The LSCB Allegations against Staff Working with Children Procedures and the arrangements for the LADO role for managing the allegations of abuse against adults fulfilled the requirements of the DfE guidance for the period 2012-13.

Issues and Challenges

The LSCB has an accountability to safeguarding children and young people across the borough and in order to effectively achieve this an understanding of the safeguarding risks that each agency is managing is crucial to ensure safeguarding measures are being put in place and all available resources are mobilised to minimise the impact of the risks on children and young people.

The LSCB developed a risk register an essential part of the local quality assurance framework. The risks are identified by individual agencies and reported through to the Chair via the Safeguarding Risk Alert Form or through the standing agenda item at the board. Additional risks emerge through discussions at board meetings, in particular when scrutinising tabled reports. The Chair will capture and summarise new risk areas as a result of partnership debate. Agencies are expected to clarify mitigating actions and escalate when there is a direct need for the Chair's intervention, which in turn formulates the LSCBs remedial action. The LSCB risk register is monitored by the LSCB Chair, Business Manager and the LSCB Statutory Partner's Group, which has replaced the Executive Business Group.

During 2013-14, the following risks were identified:

Risk	Impact	Mitigation / Remedial Action
LSCB is becoming more at arm's length from CSC i.e. less social care led	low	Workshops on Working Together repositioned partnership relationships within context of statutory responsibilities. Accountability of LSCB Chair moved to HoPS but re-established CSC at agenda and forward planning meetings with Chair
CCG lead for safeguarding has one day per week designated to this role	low	Implications for safeguarding raised at monthly CCG/CSC safeguarding meetings so concerns can be proactively addressed LSCB Chair held 1:1 meetings with CCG representatives, including named GPs Designated Nurse provides agency updates at board meetings providing opportunity of on-going monitoring by the Chair
Staffing Cuts and potential impact on capacity to service delivery	Medium	Partners report on staff vacancies through LSCB performance framework Children are sign-posted to the appropriate services to ensure undue pressure is not place on any one agency Implementation of MASH should assist in appropriate sign-posting

Previous Ofsted judgement about LSCB's ambitious plans with low through-put	Medium	Chair introduced a number of measures to ensure focus on completing and reporting on tasks LSCB restructure and membership review to create capacity for LSCB business at subgroup level LSCB Board agenda reconfigured to increase debate time and development session to where the 'thinking' can be done
Changing Personnel – lack of leadership to drive LSCB and its work	Low	LSCB Chair appointed for 3 years Governance Strategy sets out direction of travel Regular meetings set up with subgroup chairs to monitor progress against LSCB business plan and subgroup work plans
LSCB Information & Communication is not robust enough to reach a wide audience	Low	LSCB Website refreshed LSCB Branding – new logo LSCB Quarterly Newsletter Frontline Service Visits by Chair introduced Frontline briefing sessions / learning events Annual Safeguarding Conference Dissemination of information from LSCB annual report to frontline staff and the public
Difficulty in collating data for LSCB performance report	Medium	Data Analysis Officer allocated to develop and collate performance information Subgroup chair will escalate nil returns to LSCB Chair who will write to relevant agencies to formally request the data
Implications of Samaritans Service within RLH due to their non-disclosure policy	Medium	BHT raised concerns with NHS England, whose position is the non-disclosure policy will need to be amended at some point ahead of amendments to Health and Social Care Act LSCB Chair wrote to Samaritan's CEO expressing concern resulting in withdrawal of service from A&E until further notice
Safeguarding Implications for Home Educated Children due to change in legislation removing LA monitoring responsibility	Medium	LSCB receives annual report of children missing from education services, which now includes home educated cohort LSCB ensure where children known to be home educated and families where there are existing or new concerns and refusing contact, these children to be escalated and reviewed by partnership to explore risks Working with schools to ensure they are accurately reporting children missing from education

Priorities for 2014-16

The LSCB Development Session in January 2014 reflected on the previous year's achievements, outstanding areas of work and undertook horizon scanning to inform the priorities for 2014 – 2016, in line with our 2 year business plan. These are:

PRIORITY 1 - Child Sexual Exploitation – continue to embed the local CSE protocol, refining our referral pathway and responding to intelligence emerging from the LSCB MASE group.

PRIORITY 2 - Harmful Practices – Participate in the MOPAC Harmful Practices Taskforce Pilot to raise awareness and address such practices as female genital mutilation, forced marriage, so called witchcraft killings and 'honour' crimes

PRIORITY 3 - Children Looked After – Needs of Children Looked After, including those eligible remanded to Youth Offenders Institutions

PRIORITY 4 - Neglect Strategy – Implement neglect and associated neglect training strategy; develop indicators to provide a wider picture of prevalence of neglect

PRIORITY 5 - SCR and Thematic Case Review – Implement learning from serious case review and thematic review and ensure this is wide reaching through a number of communication platform

PRIORITY 6 - Safeguarding children with disabilities – Incorporate children with disabilities in all LSCB activities, promote messages from research, local audit and CDOP trends to understand the wider risks and improve safeguarding for this vulnerable cohort

PRIORITY 7 – Recruitment of Lay Members – Involve the voice of the community through lay member representation to enhance the work of the LSCB partnership

PRIORITY 8 – Embed Family Wellbeing Model – Ensure local thresholds for intervention are widely and consistently understood and applied by professionals so that children and families are able to access the right type of services

PRIORITY 9 – LSCB Performance Dataset – A complete set inclusive the relevant key indicators will be finalised

Glossary and References

TH SCB	Tower Hamlets Safeguarding Children Board
LSCB	Local Safeguarding Children's Board
HWBB	Health and Wellbeing Board
CFPB	Children and Families Partnership Board
CSP	Community Safety Partnership
LBTH	London Borough of Tower Hamlets
DCS	Director of Children's Services
CSC	Children's Social Care
HoPS	Head of Paid Services
SCR	Serious Case Review
LAC	Looked After Children
CiN	Children in Need
CPP	Child Protection Plan
CSE	Child Sexual Exploitation
MASE	Multi-Agency Sexual Exploitation Group (safety planning)
FWBM	Family Wellbeing Model
LHA	Local Housing Allowance
JSNA	Joint Strategic Needs Analysis
AFS	African Families Service
MFS	Muslim Families Service
ELFT	East London Foundation NHS Trust
SofS	Signs of Safety
IPST	Integrated Pathways Support Team
MASH	Multi-Agency Safeguarding Hub

Appendix 1 – Tower Hamlets SCB Membership during 2013-14

NAME	JOB TITLE	EMAIL ADDRESS
Abzal Ali	Targeted Support Manager Youth & Community - LBTH	Abzali.ali@towerhamlets.gov.uk
Alex Nelson	Voluntary Sector Children & Youth Forum Coordinator	alex@vcth.org.uk
Andy Bamber	Service Head - Safer Communities	Andy.bamber@towerhamlets.gov.uk
Ann Roach	Service Manager, Child Protection & Reviewing , LBTH	Ann.roach@towerhamlets.gov.uk
Anne Canning	Service Head, Learning & Achievement, Education, Social Care & Wellbeing, LBTH	Anne.canning@towerhamlets.gov.uk
Claire Lillis	Secondary School Heads Rep (Ian Mikardo Secondary School)	head@ianmikardo.towerhamlets.sch.uk
Cllr Oliur Rahman	Lead Member for Children's Services	Oliur.rahman@towerhamlets.gov.uk
David Galpin	Legal Services – LBTH	David.galpin@towerhamlets.gov.uk
Emily Fieran-Reed	Service Manager, Domestic Violence & Hate Crime, Community Safety - LBTH	Emily.fieran-reed@towerhamlets.gov.uk
Emma Tukmachi (Dr)	GP Representative Tower Hamlets CCG	emmatukmachi@nhs.net
Esther Trenchard-Mabere	Associate Director of Public Health	Esther.trenchard-mabere@towerhamlets.gov.uk
Hannah Falvey (Dr)	CCG Representative	Hannah.falvey@bartshealth.nhs.uk
Helal Ahmed	Voluntary Sector Rep Poplar HARCA	Helal.ahmed@poplarharca.co.uk
Carole Austin (Jessica Juon)	Service Manager for Tower Hamlets, NSPCC	jjuan@nspcc.org.uk
Jan Pearson	Associate Director for Safeguarding Children, ELFT	jan.pearson@eastlondon.nhs.uk
Jackie Odunoye	Service Head, Housing & RSL Rep	Jackie.odunoye@towerhamlets.gov.uk
Jenny Green	Subgroup Chair – L&D Professional Development Manager – HR & Workforce - LBTH	Jenny.a.green@towerhamlets.gov.uk
Kate Gilbert	Interim Assistant - Chief Probation Officer, Probation Trust	kate.gilbert@london.probation.gsi.gov.uk
Khalida Khan	Service Manager Children with Disabilities Service, CSC	Khalida.khan@towerhamlets.gov.uk
Layla Richards	Service Manager Strategy, Policy & Performance - LBTH	layla.richards@towerhamlets.gov.uk

NAME	JOB TITLE	EMAIL ADDRESS
Linda Kim-Newby	Senior Service Manager CAFCASS	Linda.kim-newby@cafcass.gsi.gov.uk
Nick Steward	Director of Student Services Tower Hamlets College	Nick.steward@tower.ac.uk
Owen Hanmer (Dr)	Designated Doctor, Barts Health NHS Trust (Community Services)	owen.hanmer@nhs.net
Robert McCulloch-Graham	Corporate Director, Education, Social Care & Wellbeing – LBTH	Robert.mcCulloch-graham@towerhamlets.gov.uk
Robert Mills	Nurse Consultant for Safeguarding Children & Designated Nurse, Tower Hamlets CCG	rob.mills@towerhamletsccg.nhs.uk
Sally Shearer	Director for Nursing/Safeguarding Children, Barts Health NHS Trust	sally.shearer@bartshealth.nhs.uk
Sam Price (DCI) (Anthea Richards)	Met Police Service – Child Abuse Investigation Team	Sam.l.price@met.police.uk
Sara Haynes	Primary School Heads Rep (Arnhem Wharf)	head@arnhemwharf.towerhamlets.sch.uk
Sarah Baker	Independent LSCB Chair	Sarah.baker19@nhs.net
Sarah Wilson	Director of Specialist Services, ELFT	sarah.wilson@eastlondon.nhs.uk
Steve Liddicott	Service Manager – CSC, LBTH	steve.liddicott@towerhamlets.gov.uk
Stuart Johnson	Service Manager, Youth Offending Service - LBTH	Stuart.johnson@towerhamlets.gov.uk
Wendy Morgan (DCI)	Public Protection Unit, MPS Tower Hamlets	wendy.k.morgan@met.pnn.police.uk

Appendix 2 – LSCB Financial Statement

Partner Contributions for 2013-14

Police	5,000	Fixed Pan-London
Probation	2,000	Fixed Pan-London
ELFT	2,500	
CAFCASS	550	Fixed Nationally
CCG	15,000	
BHT	3,000	
Education, Social Care & Wellbeing	175,000	Covered shortfall
Public Health	0	
NHS England (London)	0	
Total Annual Contribution 2013/14	**206,050**	

LSCB – Fixed Annual Costs

	Actual 2013 /2014
LSCB Chair (30 days p/a)	15,000
LSCB Business Management	58,896
LSCB Administrator Support	0
Staffing Costs – QA & Safeguarding Manager	15,000
Staff Costs – Engaging Young People (Youth Service)	10,000
Staffing Costs – LSCB Training Coordinator & Support	35,000
Staffing Costs – CSC contribution to training	15,000
LSCB Training Contribution	7,000
HR & Workforce – Contribution for LSCB Training Programme	25,200
Total	**181,096**

LSCB - Recurring Variable Annual Costs

	Recurring Variable
Hospitality	500
Training/Conference (attendance)	1,200
Commensura Surcharges	600
Case Review Group:	
Case Review Group: Serious Case Review x 2 SCR Chair Costs x 2 Non-SCRs (thematic) x 1	 50,000 20,000 25,000
QA&P Subgroup:	
Audits – staff time	7,000
Safeguarding Conference Monthly Learning Events	6,000 1,000
Safeguarding Week Events	2,000
Engaging Young People	5,000
Campaigns/Publicity	1,500
Single Point of Contact (BHT cover costs)	34,530
MACE Admin Support	0
Awareness Raising	0
Total Costs	154,330

Appendix 3 – TH SCB Overarching Business Plan 2014-16

Introduction: The LSCB Work Plan is designed to outline the business of the Safeguarding Children Board over the year and the priorities have been identified to address gaps identified within the revised Working Together to Safeguard Children Guidance published in March 2013. The LSCB is committed to working closely with other themed partnerships to ensure governance and strategic co-ordination of common priorities and effective use of limited partnership resources. The LSCB Work Plan includes activities relating to statutory requirements set out in the Children Act 2004 and LSCB Regulations 2006. The LSCB Subgroups will be responsible for delivering and monitoring some of the activities contained in this document and will further develop detailed action plans to support this.

Overarching Priorities: **To ensure LSCB is able to deliver its core business in line with Working Together 2013**

Targeted Priorities: Governance and Accountability, Assessment & Early Help, Partnership Working, Voice of Children & Young People, Learning & Improvement, Workforce Development

Objective	Action	Outcome:	Evidence of Compliance	Lead	Target
LSCB Governance & Accountability The LSCB has robust Governance and accountability in place in line with WT 2013 in order that partners are confident and assured in respect of their roles in safeguarding children and families	Review a governance strategy to reflect WT13 • Recruitment & accountability of LSCB chair with Chief Executive • CEO to receive LSCB papers • Review financial contribution across LSCB partnership • Agree local MASH information sharing agreement to ensure effective identification, assessment and service provision	LSCB partners realises their potential to safeguarding all C&YP Confidence in the effectiveness of the LSCB by lead member for CS, Chief Executive, Partner Agencies Strengthen the assurance and accountability of the LSCB,HWB and CSP	LSCB partners sign up to LSCB COMPACT reviewed Inspection identifies LSCB compliance with statutory duties Each Agency to review their financial /in kind contribution to the LSCB	LSCB Chair & Business Manager	Jan 14 On-going Jan 14 Feb 14

Objective	Action	Outcome:	Evidence of Compliance	Lead	Target
	• Enhance interface between LSCB and frontline service areas to promote partnership work & seek assurance • Statutory partners to report annually on safeguarding performance Strengthen the accountability structure for the LSCB Chair with HoPS holding chair to account. Strengthen the political engagement and oversight of the LSCB	LSCB partner agencies resource contribution enable the LSCB to fulfil its functions LSCB has increased profile across strategic partners	LSCB Chair visits frontline services across partnership and meets with principle social worker LSCB chair reports back to LSCB Board on good practice areas and significant SG issues Audit of agency safeguarding annual reports LSCB chair and HoPS has monthly meetings. HoPS attends LSCB activities LSCB Chair, DCS and HoPS meet quarterly with lead member and elected Mayor Lead Member attends LSCB and associated activities		Aug 13 On-going 4 x per annum On-going

Objective	Action	Outcome:	Evidence of Compliance	Lead	Target
	Strengthen community accountability through appointment of at least two lay members, reflecting both public and business communities. Strengthen partnership working with strategic boards LSCB membership to reflect local services and local communities.	Enhanced understanding of local community issues and community engagement LSCB activities is informed by local services and service user needs reflecting community diversity	Successful appointment of Lay Members. Protocol agreed between LSCB & HWBB and CSP LSCB Chair member of and attends CFPB Annual review of membership		
Early Help LSCB partners to ensure there are effective processes for assessing for early help. LSCB partners to be confident there are a	To ensure Tower Hamlets FWBM/ Threshold document is embedded in front line practice. To review and influence Tower Hamlets commissioning and	Increase Nos of CAF reviewed and step-down reviews from CSC / YOT Gap analysis and evidence of service	LSCB ensures the FWBM is available through the LSCB and CFPB websites. Evaluation of FWBM and associated quality assurance activities are undertaken Monthly and Annual CAF data report on nos. of CAF Commissioners report on new and discontinued services	Chair of FWBM Steering Group Chair: Quality Assurance & Performance TIVCF/FWBM SG LA Commissioning	

Objective	Action	Outcome:	Evidence of Compliance	Lead	Target
range of services in place to deliver a wide range of early help to meet identified need	provision to enhance access to early help	change to meet identified need Improve quality of CAFs and reviews Effective CAF action plans are an integral part of early help	Annual audit of quality of scored CAFs and CAF review decisions Monitored through SIP minutes which records outcomes per child	Team Targeted Interventions for Vulnerable C&F Group Social Inclusion Panel (SIP)	
Serious Case Review & learning & improvement The LSCB has an agreed process for reviewing unexpected child death and seriously injured and maximising learning across the partnership	Review and design local methodology to undertake SCRs Develop and implement evidence based **learning & improvement framework** to support knowledge transfer and practice improvement, including: • Multi-agency learning & development offer • Annual conference • Supervision • National learning from SCRs and thematic reviews (inspection) • Identification of national and local good practice	LSCB has a greater understanding of the risk factors which can lead to serious injury and/or child death LSCB influences commissioners and providers to implement evidence based professional and service development.	Development of learning and improvement framework. Learning and development events to disseminate learning. Serious Case Review Action plans are: • Published • Completed within timescales. Audit assures embedding of best practice Compliance reporting to	Subgroup Chairs Learning & Development (training) Case Review Group	Aug 13 Nov 13

Objective	Action	Outcome:	Evidence of Compliance	Lead	Target
	• Thematic review of Child deaths **Develop a notification protocol in line with WT13**	LSCB Chair, DCS and HoPS informed of child death/incident and potential for SCR Individual staff and agencies are informed early of a potential SCR. National SCR Panel informed in line with DfE guidance	LSCB. Timely reporting across LSCB partnership	LSCB Business Manager	
Partnership Working: All partner agencies are compliant with WT2013 and that assurance processes are in place to ensure robust safeguarding of children and families	Review and develop LA Designated Officer reporting in line with WT2013	Safeguarding needs of C&YP are identified and acted upon across the safeguarding continuum (from universal to acute health provision)	Compliance reporting to LSCB within academic year	Service Manager – CPRS / LA LADO Officer	
Health Agencies: *NHS England (London)* *TH CCG* *BHT* *ELFT (CAMHS & Adult Mental*	Develop relationship with NHS England (London) and CCG to ensure effective commissioning arrangements are in place to safeguard children through health	Health partners (commissioners & providers) can work together to strengthen safeguarding arrangements	Annual Safeguarding Report to LSCB	Designated Professionals (Health)	

Objective	Action	Outcome:	Evidence of Compliance	Lead	Target
Health/Specialist Services)	services. Maintain and further develop joint working between the LSCB and health providers across primary and secondary care through review of health partner membership on LSCB Executive and Board.				
Children & Young People	Promote the work of the LSCB with children and young people across LBTH through working with: • Youth Council • You're Welcome Group • Young Mayor • Children in Care Council • Children with Disabilities • Young Carers • LGBT • Hidden Communities • Children as service users	C&YP report their voices have been heard by the LSCB C&YP report they are better able to access services to meet their needs and feel safer	Work plan developed by You're Welcome Group LSCB Workshop with focus on voice of C&YP Views of C&YP captured by LSCB partners including Police, Community Safety Partnership, Health, Children Social Care, Youth Service, Voluntary Sector	Head of Youth & Connexion Service / Young Mayor	
Voluntary & Independent Sector Faith & Community Sector	Enhance the relationship between the LSCB and Voluntary & Independent Sector, Faith & Community Sector to promote safeguarding.	LSCB has a deeper understanding of demographic specific safeguarding issues and influence service commissioning and development	Compliance with Safe Network National Standards Safeguarding events facilitated by LSCB Chair and Business Manager	Voluntary Sector Lead	

Objective	Action	Outcome:	Evidence of Compliance	Lead	Target
	LSCB Chair to meet with VCYPF Develop and deliver a programme of public and professional Safeguarding campaigns		LSCB Chair communicates with Academies, Free Schools & Independent School Robust S11 self-audit completed (Safer Network)	Subgroup Chair – Awareness Raising & EC LSCB Chair/ Business Manager	
Schools and Academies	Promote safeguarding as everybody's business across schools, academies and the College through workshops, learning and development events LSCB Chairs visit to Heads Teachers Forum	All schools have a designated professional who is up to date and confident to lead safeguarding within their establishment	Designated Professionals & Refresher Training evaluated and developed Escalation of safeguarding concerns	Safeguarding Trainer	
Quality Assurance Improve scrutiny of LSCB partners safeguarding performance To review and support services across LBTH to address the needs of vulnerable groups	Review, refine and implement s11 audit tool in response to organisation changes across LSCB partners` LSCB Agencies reporting safeguarding risks	S11 compliance is built into commissioning arrangements across the LSCB partnership (with attention to Any Qualified Provider [AQP] within Health)	Agency reporting to LSCB Provider contracts to be reviewed to ensure compliance Revised Threshold Guidance published	Subgroup Chairs Quality Assurance & Performance FWBM SG Chair	

Objective	Action	Outcome:	Evidence of Compliance	Lead	Target
including: Neglect/Child Sexual Exploitation /Domestic Abuse/Children Missing/ Children with Disability/ Young Carers	Review, publish & disseminate threshold document Launch local child sexual exploitation strategy in line with pan-London protocol Develop a local Neglect Strategy and practitioner toolkit Implement Quality Assurance Strategy through a programme of themed audits, deep dives and themed learning events to reflect identified Safeguarding issues Implement a partnership performance management framework identifying the effectiveness of early help and safeguarding services	Practitioners demonstrate increased knowledge and confidence in working with Vulnerable children. Services are developed to reflect outcomes of audit and reviews. Children and families report that services are more responsive to meeting their needs	Child Sexual Exploitation Protocol published MASE safety planning group set up LSCB receives reports from quality audit activity with identified learning an development and associated action plans LSCB Performance Reporting indicators revised	Child Sexual Exploitation Chair Quality Assurance & Performance Quality Assurance & Performance	
Learning and Development Ensure Children and Families Workforce are confident and	To review and deliver the LSCB Multi-Agency Training (MAT) programme (in line with	Workforce report increased confidence in managing	MAT programme incorporates training needs analysis findings	Subgroup Chair	March 14

Objective	Action	Outcome:	Evidence of Compliance	Lead	Target
competent to undertake their safeguarding responsibilities	London Competence Still Matters)	Safeguarding risks	LSCB partnership applying the learning and development strategy to everyday practice	Learning & Development	
To ensure partnership working and information sharing arrangements are effective	Adapt London Councils safeguarding boards training evaluation framework to develop a robust outcomes focussed model	Evidence of learning and development in impacting on improving safeguarding practice to improve outcomes for CYPF.	Reporting to the LSCB provides assurance of partnership engagement in learning and development activities.	L&D sub group	
	Ensure the LSCB partnership is signed up to and working within the agreed information sharing protocol (MASH)		LSCB learning events feedback forms capture staff confidence in information sharing		
	LSCB to capture single agency training data and ensure there are appropriate QA mechanisms in place	Staff report of effective information sharing			

Appendix 4 – TH SCB Performance Dataset

Children's Social Care Performance Indicators

Children in Need
Referral rate per 10,000 of the children & young people (C&YP) population
Percentage of referrals that were repeat referrals
Rate of assessments per 10,000 of the C&YP population
Assessments completed within 45 days or less from point of referral
Child Protection
Section 47 (child protection) enquiries rate per 10,000 C&YP population
Initial Child Protection Case Conferences – rate per 10,000 C&YP population
Initial Child Protection Case Conferences convened within 11-15 days from point Child Protection Strategy meeting held
Percentage of Child Protection Plans last two years of more at 31 March and for Child Protection Plans which ended during the year
Percentage of children becoming subject of a Child Protection Plan (CPP) for a second or subsequent time (within 2 years of the previous plans end date)
Percentage of cases where the lead social worker has seen the child in accordance with timescales specified in the CPP - TBC
Percentage of Child Protection Reviews carried out within statutory timescale
Percentage of children with CPP who are not allocated to a social worker
Percentage of LADO cases resolved in 30 days or less
Looked After Children
Percentage of Children Looked After (CLA) with three or more placements
CLA under16 years who are looked after for 2.5 years or more and in the same placement for 2 years
Percentage of CLA who went missing from care during the years as a percentage of all CLA during the year - TBC
CLA who participated in their review
Percentage of CLA with a named social worker
Looked After Children - Health
Percentage of CLA more than 12 months who had an annual Health and Dental Check
Percentage of CLA more than 12 months whose immunisations were up to date - TBC
Care Proceedings
Number of C&YP (per 10,000) aged 0-17 years who are the subject of an application to court in the past 6-months (including care & supervision orders) - TBC
Average length of care proceedings locally (weeks) - TBC
Leaving Care
Proportion of young people aged 19, 20, 21 who were looked after aged 16 who were not in employment, education or training
Proportion of young people aged 19, 20, 21 who were looked after aged 16 who were in suitable accommodation
Education
Percentage of CLA continuously for 12 months who achieved at least level 4 at Key Stage 2 in both English and Maths
Percentage of CLA who achieved 5 A*-C GCSEs (including English & Maths)

Met Police Performance Indicators
Police Protection Orders taken out - Tower Hamlets & across London (MPS average)
Domestic Violence Offences with a Child Victim or Witness – Tower Hamlets & London average
Domestic Violence Detections with Child Victim or Witness – Tower Hamlets & London average
Domestic Violence Detection Rate – Tower Hamlets & London average

Child & Adolescent Mental Health Service (ELFT CAMHS)
Number of referrals to CAMHS
Percentage of C&YP seen within target
Number of C&YP seen (caseload)
Percentage of C&YP seen by gender
Percentage of C&YP seen by age group – 0-4, 5-11 and 12-18 years
Percentage of C&YP showing an improvement

Barts Health NHS Trust
BHT Community Health Service – data to be finalised in early 2015
BHT Acute Service – data to be finalised in early 2015

Appendix 5 – Multi-Agency Training Programme 2013-14

Group A - Foundation	Course Detail x frequency per year	Training Lead
Introduction to CAF	e-learning modules	
Information Sharing	e-learning modules	
Integrated Working	e-learning modules	
Safeguarding Children	e-learning modules	
Working with Parent	e-learning modules	
Introduction & Overview of FWBM	e-learning modules	
Child Protection Refresher	1 day x 2 p/y	
Safeguarding Children - Foundation Level	1 day x 10 p/y	External Trainer
Safeguarding Children & Young People from being exploited on the internet	1 day	External Specialist Trainer
Prostitution Awareness (VAWG)	1 day x 2 p/y	LBTH VAWG Trainer
Sexual Violence Awareness	1 day	LBTH VAWG Trainer
Safeguarding in Schools – Basic Awareness	1 day	LBTH Safeguarding Trainer for Education Settings
LSCB Learning Event Workshops	1 day x 10 p/y	LSCB Members

Group B - Intermediate	Course Detail x frequency per year	Training Lead
CAMHS Foundation	5 day	East London Foundation Trust
Children's Rights	1 day	LBTH Children's Social Care
Domestic Abuse - Introduction	1 day x 7 p/y	LSCB Training Pool
Domestic Abuse - Advanced	1 day x 4 p/y	LSCB Training Pool
Impact of parental mental health problems and safeguarding children	1 day x 2 p/y	External Specialist Trainers
Life Story Work – An Integrated Approach	1 day	LBTH Children's Social Care
Managing Risks in Adolescence	1 day	External Specialist Trainers
Overcoming Dangerous Dynamics in Professional Practice	1 day	External Specialist Trainer
Safeguarding African Children & Families	2 day x 3 p/y	LBTH Children's Social Care
Safeguarding Children – Intermediate Level 2	1 day x 4 p/y	External Trainer
Safeguarding Children – Advanced Level 3	1 day	External Trainer
Safeguarding the Disabled Child	1 day	External Trainer
Solution Focused Interviewing – Skills for every day practice	1 day x 2 p/y	External Specialist Trainer
Working with Bangladeshi Children & Families	2 days x 4 p/y	LBTH Children's Social Care Trainers
Working with Resistant/Reluctant Parents & Carers	1 day x 3 p/y	LBTH Early Years' Service
Working with Young People at risk of sexual exploitation	1 day x 3 p/y	LSCB training pool
Working with Perpetrators of Violence	1 day	LBTH Specialist Trainer
Young People and Violence against Women and Girls	1 day x 2 p/y	

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Health and Wellbeing Board 9th December 2014	Tower Hamlets Health and Wellbeing Board
Report of the London Borough of Tower Hamlets	**Classification:** unrestricted
Pharmaceutical Needs Assessment-progress note and permission to go to consultation	

Lead Officer	Somen Banerjee , Director of Public Health
Contact Officers	
Executive Key Decision?	No

Executive Summary

There is a statutory requirement to produce, on behalf of the Board, a Pharmaceutical Needs Assessment (PNA) by March 2015. The PNA involves looking at the distribution of pharmacies across the Borough and the services they provide as well as assessing the population health needs for those services, before recommending any changes in service provision. Also factored in are public views on current services.

This report sets out the work in hand and proposes to bring the full Consultation report to the Board for discussion in January 2015 and the final recommendations in March 2015.

The timetable is tight due to the need for a 60 day consultation on the emerging proposals, and the consultation report needs to go out in the next few weeks.

Recommendations:

The Health and Wellbeing Board is invited to:

1. Note the activities in progress in the report
2. Agree the information to be brought to the next meetings of the Board
3. Authorise the Director of Public Health to prepare the consultation draft of the pharmaceutical needs assessment and to commence the consultation.

1. REASONS FOR THE DECISIONS

1.1 There is a statutory requirement to produce the Pharmaceutical Needs Assessment by March 2015, including a 60 day consultation period. The timetable set out is necessary to achieve this deadline.

2. ALTERNATIVE OPTIONS

2.1 The timetable in paragraph 4 of the report is the only one to deliver the PNA by the end of March2015

3. DETAILS OF REPORT

3.1 See Appendix

4. COMMENTS OF THE CHIEF FINANCE OFFICER

4.1 The costs of the consultation will be met from the Public Health grant allocation**.**

5. LEGALCOMMENTS

5.1 The NHS Act 2006, as amended by the Health and Social Care Act 2012, requires theHealth and Wellbeing Board ("HWB") to develop and publisha pharmaceutical needs assessment ("PNA") for Tower Hamlets. The NHS (Pharmaceutical Services and Local Pharmaceutical Services Regulations 2013) ("the 2013 Regulations")have been made under the Act, which set out a more detailed legislative framework for developing and updating PNAs.

5.2 Under the 2013 Regulations, a person who wishes to provide NHS pharmaceutical services must generally apply to NHS England to be included on a relevant list by proving they are able to meet a pharmaceutical need as set out in the relevant PNA. There are exceptions to this, such as applications for needs not foreseen in the PNA or to provide pharmaceutical services on a distance-selling (internet or mail order only) basis.

5.3 The Local Government and Public Involvement in Health Act 2007 requires the preparation of a Joint Strategic Needs Assessment ("JSNA") for Tower Hamlets. The aim of the JSNA is to improve the health and wellbeing of the local community and reduce inequalities for all ages. It involves a continuous

process of strategic assessment for the health and wellbeing needs of the local population. The JSNA is used to determine what actions local authorities, the NHS and other partners need to take to meet health and social care needs and to improve health outcomes and address health inequalities.

5.4 The 2013 Regulations require the HWB to do the following when developing the PNA:

- Assess needs for all pharmaceutical services in Tower Hamlets.
- Include as a minimum the information set out in Schedule 4 to the Regulations, including a map of relevant pharmaceutical sites in Tower Hamlets.
- Consult for a minimum period of 60 days with specified local health bodies, persons on the pharmaceutical lists and any dispensing doctors list for Tower Hamlets, the Local Healthwatch organisation and any neighbouring HWB. Consultees must be served with a draft of the proposed of the PNA for the purposes of consultation.
- Have regard to the following matters: the demography of Tower Hamlets; whether there is sufficient choice in Tower Hamlets for obtaining pharmaceutical services; any different needs of different localities in Tower Hamlets; the services provided in neighbouring boroughs and other NHS services in or out of Tower Hamlets which affect the need for pharmaceutical services in Tower Hamlets or whether further provision would secure better access or access to services of a specified type.

5.5 Any consultation carried out should comply with the following criteria: (1) it should be at a time when proposals are still at a formative stage; (2) the Council must give sufficient reasons for any proposal to permit intelligent consideration and response; (3) adequate time must be given for consideration and response; and (4) the product of consultation must be conscientiously taken into account. The duty to act fairly applies and this may require a greater deal of specificity when consulting people who are economically disadvantaged. It may require inviting and considering views about possible alternatives.

5.6 The preparation and consultation on the PNA should take account of the JSNA and other relevant strategies, such as children and young people's plan, the local housing plan and the crime and disorder reduction strategy in order to prevent duplication of work and multiple consultations with health groups, patients and the public. The development of the PNA is, however, a separate duty to that of developing the JSNA. The PNA cannot be subsumed as part of these other documents but can be annexed to them.

5.7 The HWB is required to publish the PNA by April 2015 and a revised assessment must be published within 3 years or as soon as reasonably practicable after identifying significant changes to the availability of pharmaceutical services unless it is satisfied that making a revised assessment would be a disproportionate response to those changes. The

HWB must ensure that the National Health Service Commission Boardhas access to the PNA.

5.8 In developing the PNA, the HWB must have due regard to the public sector equality duty under the Equalities Act 2010. The duty is set out at section 149 of the Equality Act 2010. It requires the Council, when exercising its functions, to have 'due regard' to the need to eliminate discrimination (both direct and indirect discrimination), harassment and victimization and other conduct prohibited under the Act, and to advance equality of opportunity and foster good relations between those who share a 'protected characteristic' and those who do not share that protected characteristic.

5.9 An equalities analysis should be carried out to consider in detail what impact the proposals could have on the protected characteristics (age, disability, gender re-assignment, pregnancy, maternity, race, religion or belief, gender and sexual orientation) of people in Tower Hamlets and action that will be taken to mitigate the risk of disproportionate impacts upon protected characteristics. That analysis should take into account the results of consultation.

6. ONE TOWER HAMLETS CONSIDERATIONS

6.1. The gathering of information for the Report has specifically brought together evidence across the Borough services by ethnicity, age, gender, sexual orientation and different geographical locations to inform the decisions.

7. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

7.1 Not applicable

8. RISK MANAGEMENT IMPLICATIONS

If the report is not finalised by March 2015 then the Council will be criticised for failing to deliver

9. CRIME AND DISORDER REDUCTION IMPLICATIONS

9.1 Not applicable

10. EFFICIENCY STATEMENT

10.1 Not applicable at this stage of the PNA

Appendices and Background Documents

Appendices

- **None**

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.

- State NONE if none.

Appendix-Report

Pharmaceutical Needs Assessment

Paper for the Health and Wellbeing Board-November 2014

Purpose

1. This paper sets out the work in hand for the current Pharmaceutical Needs Assessment (PNA) and invites the H&WB Board to
    1. Note the activities in progress
    2. Agree the information to be brought to the next meetings of the Board
    3. Authorise the Director of Public Health to prepare the consultation draft of the pharmaceutical needs assessment and to commence the consultation.

Background

2. There is a statutory requirement to produce, on behalf of the Board, a Pharmaceutical Needs Assessment(PNA) by March 2015. The PNA involves looking at the distribution of pharmacies across the Borough and the services they, provide as well as assessing the population health needs for those services, before recommending any changes in service provision. Also factored in are public views on current services.

3. The Public Health team is working with the Commissioning Support Unit to bring together current evidence, and is undertaking a number of focus groups to gather views of services from different population groups. The JSNA Reference Group has been advising on the process and a Stakeholder Group has been established consisting of NHS England , the Local Pharmaceutical Committee and Local Medical Committee, Healthwatch and the voluntary sector, which is advising on the production of the consultation report.

4. The timetable is tight for completing this work as there is a statutory 60 day minimum period for consulting on the consultation document. Key activities are as follows:
    1. Bringing together evidence on public health and current pharmacy services

2. Information gathering on views of current services.
3. Agreeing emerging issues and recommendations
4. Drafting the consultation report
5. Publishing the consultation document in December 2014
6. Two Month Consultation on report (January /February 2015)
7. Final Recommendations to the Health and Wellbeing Board(March 2015)

5. As part of this timetable the proposal is that the H&WB Board will
    1. In January 2015 have an opportunity to discuss the consultation document and its recommendations
    2. In March 2015 sign off the final recommendations which will take into account the consultation process.

    In addition, in order to meet this plan, the H&WB Board is invited to give delegated authority to Somen Banerjee as Director of Public Health, to issue the consultation report on its behalf.

6. The Health and Wellbeing Board is invited to agree the points in paragraph 1 above and the process in paragraph 5.