HEALTH SCRUTINY PANEL

Wednesday, 20 April 2016 at 7.00 p.m.

MP702, 7th Floor, Town Hall, Mulberry Place, 5 Clove Crescent, London, E14 2BG

This meeting is open to the public to attend.

Members:
Chair: Councillor Amina Ali
Vice-Chair**:** Councillor John Pierce

Councillor Sabina Akhtar, Councillor Abdul Asad, Councillor Craig Aston and Councillor Dave Chesterton

Deputies:
Councillor Danny Hassell, Councillor Denise Jones, Councillor Aminur Khan and Councillor Helal Uddin

Co-opted Members:

David Burbidge	Healthwatch Tower Hamlets Representative
Tim Oliver	Healthwatch Tower Hamlets Representative

[The quorum for this body is 3 voting Members]

Contact for further enquiries:
David Knight, Democratic Services
1st Floor, Town Hall, Mulberry Place, 5 Clove Crescent, E14 2BG
Tel: 020 7364 4207
E-mail: David.Knight@towerhamlets.gov.uk
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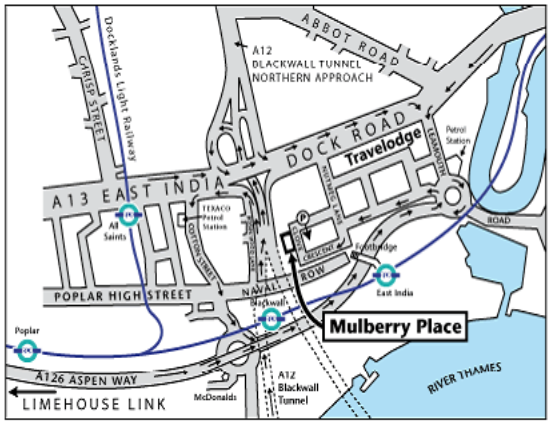

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PAGE NUMBER(S)

APOLOGIES FOR ABSENCE

1. DECLARATIONS OF DISCLOSABLE PECUNIARY INTERESTS

1 - 4

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

2. MINUTES OF THE PREVIOUS MEETING(S)

5 - 14

To confirm as a correct record the minutes of the meeting of the Health Scrutiny Panel held on Wednesday 17th February 2016.

3. REPORTS FOR CONSIDERATION

3 .1 Bart's Health Trust Quality Accounts

Presentation from Jo Carter (Stakeholder Relations Manager Barts Health NHS Trust)

The report provides an overview of the Bart's Health Trust Quality Accounts.

This item will be tabled at the meeting.

3 .2 Healthwatch Tower Hamlets - Community Intelligence Report

15 - 62

Presentation from Diane Barham (Chief Executive Healthwatch Tower Hamlets).

The report provides an opportunity for the Health Scrutiny Panel to review current activities and look at developing new ways of working with the residents of Tower Hamlets.

3 .3 Transforming Services Together

63 - 112

Presentation from Alpa Bisarya (Communications Manager, NEL Commissioning Support Unit)

The report recommends to the Health Scrutiny Panel to:

1. Note the publication of the strategy and engagement plan
2. Provide initial views; and
3. Take part in the engagement period both by making a formal response to the engagement and encouraging others to make their views known.

3 .4 Children & Young People's Mental Health Services Scrutiny Challenge Session **113 - 144**

Presentation from Daniel Kerr (Strategy, Policy & Performance Officer)

This report highlights the challenge session which brought together representatives from the council, Tower Hamlets CCG, Tower Hamlets CAMHS, and community organisations to explore the level of provision and the performance of children and young peoples' mental health services in Tower Hamlets.

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

5. NEXT MEETING OF THE PANEL

The next meeting of the Health Scrutiny Panel will be held on Tuesday, 28 June 2016 at 6.30 p.m. in MP702, 7th Floor, Town Hall, Mulberry Place, 5 Clove Crescent, London, E14 2BG.

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:

Melanie Clay, Director of Law, Probity & Governance & 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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LONDON BOROUGH OF TOWER HAMLETS

MINUTES OF THE HEALTH SCRUTINY PANEL

HELD AT 7.08 P.M. ON WEDNESDAY, 17 FEBRUARY 2016

ROOM C1, 1ST FLOOR, TOWN HALL, MULBERRY PLACE, 5 CLOVE CRESCENT, LONDON, E14 2BG

Members Present:
Councillor Amina Ali (Chair)
Councillor John Pierce (Vice-Chair)
Councillor Dave Chesterton

Co-opted Members Present:

David Burbidge	– Healthwatch Tower Hamlets Representative
Tim Oliver	– Healthwatch Tower Hamlets Representative

Apologies:
Councillor Sabina Akhtar
Councillor Abdul Asad
Councillor Craig Aston

Others Present:

Dr Sam Everington	– Tower Hamlets CCG
Max Geraghty	– Inspection Manager, CQC
Deborah Kelly	– Deputy Chief Nurse
Sandra Reading	– Director of Midwifery & Nursing
Jenny Cooke	– Deputy Director of Primary Care
Dr Isabel Hodkinson	– Tower Hamlets CCG

Officers Present:

Daniel Kerr	– Strategy, Policy & Performance
Dr Somen Banerjee	– Director of Public Health
Sarah Vallelly	– Strategy, Policy & Performance
	– Senior Committee Officer

1. DECLARATIONS OF DISCLOSABLE PECUNIARY INTERESTS

David Burbidge and Tim Oliver declared a personal interest in Item 3.3 Healthwatch Tower Hamlets Review as volunteers at Healthwatch Tower Hamlets.

2. MINUTES OF THE PREVIOUS MEETING(S)

That the minutes of the Health Scrutiny Panel held on 9 December 2015 be approved as a correct record of the proceedings.

3. REPORTS FOR CONSIDERATION

4. MATERNITY SERVICES AT ROYAL LONDON - CQC INSPECTION

Max Geraghty provided the Panel with an overview of the Care Quality Commission's (CQC) findings from their most recent inspection of the Royal London maternity & gynaecology services and informed the Panel of the following: -

- CQC makes sure health and social care services provide people with safe, effective, compassionate, high-quality care and encourages care services to improve;
- CQC monitors, inspects and regulates services to make sure it meets fundamental standards of quality and safety and publishes its findings, including performance ratings to help people choose care;
- CQC is introducing ratings to tell whether an organisation and its main services are outstanding, good, requires improvement or is inadequate;
- CQC publishes reports after every inspection setting out what it has found and includes examples of good practice as well as areas for improvement;
- The CQC asks five key questions on all inspections:
    - are services safe?
    - are they effective?
    - are they caring?
    - are they responsive to people's needs?
    - are they well-led?
- The Quality Report was published in May 2015 and the overall rating for maternity & gynaecology services was "Requires Improvement" and the following concerns were highlighted -
    - Staffing –
        - There was not enough medical and midwifery staff and there was evidence that this compromised the care offered to some women;
        - The Trust did not meet the London Safety Standards recommended minimum birth to midwife ratio of 1 midwife to every 30 births; and
        - Women in labour were prioritised, but this meant that other areas were often short-staffed with an impact on waiting times for other women.
    - Security -
        - CQC also had concerns about the security of mothers and babies because of the high number of visitors at all hours;

        - There was no ward clerk at night, which meant there was further reduced control over visitors;
        - Neonatal security had been identified as a risk on the risk register; and
        - Baby security tags.
    - Leadership -
        - Leadership for maternity and gynaecology services was provided by the Women's and Children's Health Clinical Academic Group (CAG);
        - This did not appear to provide an effective route from ward to Board and neither doctors nor midwives felt that their concerns about safety, or the sustainability of working under pressure were acknowledged by management; and
        - A number of staff perceived the leadership to be remote and unsupportive.
    - Culture -
        - A number of medical and midwifery staff had been in post for several years and enjoyed working at the hospital and spoke well of the way all staff worked together as teams, both doctors and nurses;
        - Staff were positive about management at service level; and
        - Staff valued the teamwork and shared values on the ground to keep patients safe.
    - CQC will continue to engage with Barts Health NHS Trust as part of the wider stakeholder involvement.

The Chair, Councillor Amina Ali invited the representatives from the Royal London Maternity Services to respond to the CQC report.

Sandra Reading (Director of Midwifery) and Deborah Kelly (Deputy Chief Nurse), provided a written response to the CQC report and highlighted the following key actions –

- Maternity Services Action Plan –
    - Uplift in mother to midwife ratio of 1:28 – this is an increase of 22 midwives (whole time equivalents)
    - Reduce temporary staff by ensuring 95% of staff are permanent
    - Improved consultant presence
    - Reviewed baby tagging system, and implementing new system by April 2016
    - Immediately improved security on the wards, through installing swipe access, introducing 24/7 clerical reception desk cover and reviewed and amended visitor and discharge policy
    - Improved access to data through maternity performance dashboard for staff
    - Two new ultrasound machines procured to ensure image quality
    - Progress work on midwifery – led unit

- Improving women's experience -

  - Focus on changes throughout the maternity pathway
  - Improving information and communication
  - Women and Family Centred Care
  - Focus on safe and compassionate care
  - New leaflet to get more detailed feedback

- Maternity information pathway
  - One stop booking//pregnancy information pack
  - Referral to Vulnerable team/maternity mates
  - Bump start project for further information on community support
  - New women's information range
  - Weight management and GDM sessions
  - Birth plan/antenatal class
  - VBAC/birth options clinic

- New Developments –
  - Induction of Labour (IOL) pathways including OPIOL and timing of admission for high risk IOL
  - Co-located birth centre opening in Summer 2016
  - Postnatal information improvement project
  - Joint project with Lead Nurse for neonates and neonatologist to review TC and reduce length of stay – possibility of care in the community
  - Enhance continuity of care with opening of co-located birth centre and increase in integrated teams
  - New consultant posts – 1 post with special interest in fetal medicine
  - Transforming Services Together plan – with 30% of all births to be out of Consultant led unit over next few years
  - Design of a maternity app planned – link to new birth centre and information for women

- Listening and responding to feedback –
  - Review of staffing
  - Increase in funding – up to 22 midwives
  - Recruitment days
    - 26 applied – 6 hired
  - Improve hours – 2 consultants and tertiary unit
  - Achieving over 95%
  - Full review of security arrangements
    - Baby tagging
    - Different swipe system
    - 24/7 administration
    - Change of access
    - Discharge policy
  - Live data – more accurate
  - Capacity – extremely busy

Members considered the presentation and made the following comments –

- Where does women and their views feature in the response to the CQC
- If the staff have been listened to, what has changed
- The HSP recently had a site visit to the hospital and there were still some negative comments
- It is as though a culture of fear within the patients has been developed
- Patients also fed back that some of the comments being made by nursing professionals were unacceptable and in some cases derogatory to the patients
- It is all about the public perception
- Is there anyway for the CQC to provide additional feedback to the hospital as to where they are up to currently
- The findings report that the HSP have to write will need to be read by mothers in the Borough and reflect their experiences, but to date it is a worry about what the content of the report will contain unless there is some radical cultural changes and changes in perception quite quickly.

Deborah Kelly commented that the patient experience in the maternity unit has been poor, but they are listening and responding to the negative feedback by providing patient feedback, conducting patient surveys and having friends and family testing. The services are hoping to engage more with patients and to change the culture by launching a Patient Experience and Engagement Strategy shortly. She also stated that improvements are being implemented to the Governance and Accountability framework with programmes being developed on trust, expectations and leadership. She also stated that there is a change of leadership underway at the Board level with a significant programme of change being negotiated with staff. Changes are being made to the culture, environment, training, awareness and staff.

Dr Sam Everington informed the Panel that the hospital is operating at a deficit of £135m which is a challenge across the sector. He also stated that the National Maternity Report due out in late February is proposing to increase home births/community births by up to 20%, which would contribute even further to the existing challenges. There needs to be some acknowledgement at the hospital that there is a generic cultural issue from the top down and there needs to be a more modern approach from the team.

Healthwatch representatives commented that Healthwatch operate a complaints and comments website and to date they have not had any evidence of patients being ill-treated.

Max Geraghty informed the Panel that if the Inspectors were to engage with the hospital at this stage there would be further risks of issues being identified for improvement. The next inspection is likely to take place at the end of quarter 1.

RESOLVED THAT –

1. The presentations and reports be noted; and

2. The Chief Executive of the hospital be invited to the next meeting.

5. PRIMARY CARE STRATEGY

Jenny Cooke (Deputy Director of Primary Care) provided the Panel with an overview of the Primary Care in Tower Hamlets and informed the Panel of the following: -

- In February 2015 THCCG successfully applied to take on fully delegated responsibility for the commissioning of primary medical services in the Borough;
- Since April 2015, THCCG has assumed responsibility for the commissioning, procurement, management and monitoring or primary medical services contracts, with the on-going support of NHS England;
- A Primary Care Committee has been established to over-see the delegated functions and manage conflicts of interest;
- Co-Commissioning has the opportunity to lead to greater consistency between outcome measures and incentives used in primary care services and wider out of hospital services;
- Challenges –
    - Population is growing rapidly;
    - Patient experience remains a challenge;
    - A need for care to become better integrated;
    - Workforce deficit with nursing recruitment problems; and
    - Financial.
- Response –
    - Building resilience in GP; and
    - Primary Care Transformation.

Members considered the presentation and made the following comments –

- Does Public Health link into Primary Care?
- Public Health is all about prevention e.g. smoking cessation, it is not about advertising services, but moreso about improving health in the community.
- The Local Plan is about planning for the future, 15-20years ahead, so there are challenges to be faced in the future in the health sector with systems and finance. It is a good opportunity to feed into the Local Plan now for the future wellbeing of the community.

Dr Sam Everington commented that major funding is an issue, but most TH GPs enjoy working in the Borough, however, most practices are struggling to recruit at the moment. He also stated that GPs are choosing to retire early in comparison to 10 years ago when GPs would work till around 80 years old, but now are going abroad or even to Scotland and Wales where there is no CQC inspection. The Borough has a different population now and needs a new model of working.

Dr Isabel Hodkinson commented that information is gathered based upon electronic record from GP Practices and that data is now fully electronic through a very sophisticated “vanguard board”. You can even book your own appointment and see your own medical records and it is the intention to move to “real time” data in the future.

Jenny Cooke commented that Public Health was already involved in Primary Care.

RESOLVED THAT the presentation be noted.

6. HEALTHWATCH TOWER HAMLETS REVIEW

Sarah Vallelly (Strategy, Policy and Performance Officer) provided the Panel with an outline of the methodology for the review and timetable for reporting on the findings and commissioning of the new Healthwatch Tower Hamlets (HWTH) contract and informed the Panel of the following –

- The aim of the review is to develop a model for HWTH which builds on existing strengths, identifies areas of improvement and incorporates good practice from other local HW organisations;
- The existing contract was due to expire on 31st March 2016 but this has now been extended by one year till 1st April 2017;
- HWTH undertakes the following key activities –
    - Provides information, sign-posting and advice to the public about accessing health and social care services and choice in relation to aspects of those services;
    - Obtains the views of people about their needs for and experience of local care services and makes those views known to those involved in the commissioning, provision and scrutiny of care services;
    - Promote and supports the involvement of people in the monitoring, commissioning and provision of local care services;
    - Influence the commissioning and provision of services through producing evidence-based reports and recommendations about how those services could or should be improved;
    - Local HW have a statutory seat on the local Health & Wellbeing Board to help them to do this effectively;
    - Makes the views and experiences of people known to Healthwatch England helping it to carry out its role as national champion; and
    - Makes recommendations to HW England to advise the Care Quality Commission to carry out special reviews or investigations into areas of concern

Members considered the report and made the following comments –

- There is a need to reflect on what HW currently do and whether there is an opportunity to do more deeper and specific work and if there is a capacity to do it e.g. the work in maternity services currently underway;
- Not many residents know about HW, so how can they advertise more and promote their services better;
- HW has a rich insight into the patient experience so can suggest ways to improve it and make the service better with practical ideas; and
- There is an opportunity to develop the capacity in HW through future funding by commissioning contracts.

Dr Isabel Hodkinson suggested that each GP must complete a 6 week check on new-born babies and that consult could be used to complete a form or fill in a survey about their experiences on the maternity unit or to raise awareness about HW, parental smoking and breastfeeding etc.

David Burbidge commented that HWTH has 1 director and 1.5 staff, with a small budget and a large remit. He also stated that HWTH has no resources to advertise its services, but they usually do a “tea poster campaign” and some advertising within the Council and through the HW website. Each HW across England is managed differently based upon resources and capacity. Council Tax bills will also be circulated to all residents in the Borough shortly and there is an opportunity to use this mail-out to advertise HWTH.

Sarah Vallelly commented that Healthwatch is not a complaints body, just an advocacy service to signpost and give the patients a voice. It is an independent organisation that values scrutiny and can influence commissioners.

RESOLVED THAT:

1. The presentation and report be noted.

2. The information provided by Dr Isabella Hopkinson relating to the “6 week new-born baby checks” be researched further with an update being provided to a future meeting.

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

Somen Banerjee informed the Panel that Councillor Amy Whitelock Gibbs should be invited to future Health Scrutiny Panel meetings to observe/for input, and that the Panel should consider looking into the relationship between the Health & Wellbeing Board and Health Scrutiny to ensure there isn't duplication and the remits / scope of the two groups are clear.

The Panel agreed.

8. NEXT MEETING OF THE PANEL

The next meeting of the Health Scrutiny Panel will be held on Wednesday 20 April 2016 at 7.00pm in MP702, 7th Floor, Town Hall, Mulberry Place, 5 Clove Crescent, London, E14 2BG.

The meeting ended at 9.16 p.m.

Chair, Councillor Amina Ali
Health Scrutiny Panel

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Committee:	Date: 20/04/2016	Classification	Report No. 2	Agenda Item No. 3.2
Health Scrutiny Panel		Unrestricted		
Report of: Healthwatch Tower Hamlets **Originating Officer:** Dianne Barham (Chief Executive Healthwatch Tower Hamlets)		**Title:** Healthwatch Tower Hamlets – Community Intelligence Report		

1. SUMMARY

1.1. The Tower Hamlets Community Intelligence Bursary is a programme that was developed in a partnership between Healthwatch Tower Hamlets, NHS Tower Hamlets Clinical Commissioning Group (CCG), Tower Hamlets Citizens, Queen Mary University and Tower Hamlets Council for Voluntary Services (CVS), to ensure that the needs and views of the local community directly affect how health and social care services are designed, commissioned and delivered within Tower Hamlets.

1.2. The recommendations from these reports shows that local people want to work with commissioners to develop priorities and outcomes to support wellbeing, but also to develop their own services. Making it less about provider partnerships and more about partnerships with patients, carers, families and communities.

1.3. This report is for commissioners, providers, their partners and community organisations to review current activities and look at developing new ways of working with the residents of Tower Hamlets.

2. RECOMMENDATIONS

2.1 To be noted by the Health Scrutiny Panel

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healthwatch Tower Hamlets

thcvs Council for Voluntary Service

TOWER HAMLETS

NHS Tower Hamlets Clinical Commissioning Group

Tower Hamlets Community Intelligence Report 2016

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Introduction

The Tower Hamlets Community Intelligence Bursary is a programme that was developed in a partnership between Healthwatch Tower Hamlets, NHS Tower Hamlets Clinical Commissioning Group (CCG), Tower Hamlets Citizens, Queen Mary University and Tower Hamlets Council for Voluntary Services (CVS), to ensure that the needs and views of the local community directly affect how health and social care services are designed, commissioned and delivered within Tower Hamlets.

This Community Intelligence Bursary project has developed a core group of local citizens from a wide range of communities and backgrounds who have demonstrated the desire and the passion to support and develop new relationships. The recommendations from these reports shows that local people want to work with commissioners to develop priorities and outcomes to support wellbeing, but also to develop their own services. Making it less about provider partnerships and more about partnerships with patients, carers, families and communities.

The individual reports from the voluntary and community partner organisations, together with the outcomes from the public engagement event held in September 2015, have been used to inform the outcomes and recommendations that appear in section two of this report.

It is essential that the energy and commitment of these local citizens is harnessed and changes made that improve their health and well-being.

This report is for commissioners, providers, their partners and community organisations to review current activities and look at developing new ways of working with the residents of Tower Hamlets.

Section One: The Community Intelligence Bursary

Developing the Community Intelligence Bursary

In 2014/15, NHS Tower Hamlets Clinical Commissioning Group (CCG) and Healthwatch Tower Hamlets in partnership with Tower Hamlets Citizens, Queen Mary University and Tower Hamlets CVS ran the Community Intelligence Bursary (CIB) where local voluntary and community sector organisations were invited to undertake research projects that could help improve services, address health inequalities across the borough and find new ways of involving patients and the public in improving health.

The aim of the Community Intelligence Bursary programme was to ensure that the needs and views of the local community directly impact on how services are designed, commissioned and delivered in Tower Hamlets.

In order to achieve this, 17 local community and voluntary sector organisations from across the borough were trained in research skills by Queen Mary University and Tower Hamlets Citizens through a series of workshops and mentoring in order to reach the unheard voices in the borough.

This created a network of community researchers who not only had the skills but also had the contacts to carry this research out. There were a total of 33 researchers who were either staff members or volunteers of users from the different organisations. They were awarded certificates for their skills, experience and work at the end of the training.

Community Intelligence Bursary Process	Application Process
1. Bursary is open to voluntary and community organisations and individuals (supported by local organisation).	1. The Bursary is advertised widely through voluntary and community sector channels.
2. Successful groups take part in skills development programme and support.	2. Groups and individuals (supported by a local organisation) are invited to submit a project proposal.
3. All research gathered is combined into a single intelligence report.	3. A panel of Healthwatch, CCG, VCS Health and Wellbeing Forum, LBTH short list and make decisions on the final projects. Applicants may be asked to an interview or be asked to work more closely with relevant partner organisations to refine their applications.
4. All groups/individuals who receive the bursary review the final intelligence report with key stakeholders and agree key issues and recommendations.	4. An independent evaluation of the programme is undertaken to enable learning to be applied to any future Bursary programmes.
5. The final community intelligence report together with key findings and recommendations goes to: - JSNA Board - CCG Governing Body - Health and Wellbeing Board - Health Scrutiny Panel - VCS Health and Wellbeing Forum	
6. The impact of key findings/recommendations is reported back to the community.	

What were the key priorities

NHS Tower Hamlets CCG and Healthwatch consulted with public health, social services and the voluntary community sector as to the type of intelligence that would have the greatest impact on commissioning and service design over the next two to three years. These priorities became the areas of research for the community organisations.

The priorities areas were:

1. Carers
2. Older people
3. Children and young people
4. General Practice
5. Integrated care
6. Equality and diversity
7. Dual Diagnosis

What was achieved

The bursary achieved a number of positive outcomes. Through these projects over 1,200 local people have been engaged with and a richness of information from all genders, ethnicities and ages has been captured. A network of community research has been created and a database of contacts within a variety of third sector organisations and local community groups. There has also been a number of peer support groups created as a result of the research being conducted.

As a validation exercise following the research undertaken by local community groups, a public engagement event took place in September 2015 bringing members of the public together with the organisations that had delivered the project, commissioners, Tower Hamlets Health and Wellbeing Board, Tower Hamlets Public Health, voluntary and community groups and other key stakeholders.

Crosscutting themes

There were a number of key common themes that emerged across the different reports which we used as key focus points at the public engagement event.

Capturing patient experience

The need to better understand and to capture patient experience came across throughout the research.

Cultural awareness and accessibility

Several reports cited evidence of health services not being sufficiently responsive to the needs of citizens and incidences where cultural insensitivities affected patient outcomes.

Issues around awareness and accessibility of services are recurring themes in Tower Hamlets given its cultural diversity. The research highlights some of the groups missed by current services, where outreach and culturally appropriate services might be targeted in order to combat specific gaps. These populations include Asian carers, Somali elders in need of residential care, and pregnant eastern European women.

Impact of funding cuts

There are a number of stories that suggest the financial strains the NHS is under are having a negative impact on specific groups. The research pinpoints long waiting times for people needing sensory aids and

long waiting times for statutory mental health services that, one report suggests, are putting people off. The financial hardships faced by many people experiencing cancer were another finding.

There is also an acknowledgement that funding cuts are having an impact on local voluntary sector infrastructure and this is putting existing community services at risk. The impact is likely to be felt most by older people, and highlights a challenge for both voluntary and public sectors to ensure that provision remains available to meet demand.

Wider social determinants

The impact of the 'wider social determinants' of health, particularly unemployment and housing, on health outcomes, recur through the reports. Lack of employment opportunities for working age men is cited as a major contributory factor to their experience of mental health problems. The impact of the wide availability of cheap fast food is flagged by another as a key determinant of poor diet choice.

Work of our carers

Several of the reports call for recognition of the role of carers and the burdens placed on carers by their caring responsibilities.

Working alongside voluntary and community groups

Many of the reports draw attention to the richness of voluntary and community sector resources in the borough. The reports suggest areas where the marginal benefit/cost ratio of linking in to voluntary and community sector, by social prescribing and in other ways, are high – such as peer support for cancer patients, those experiencing dual diagnosis, and for people experiencing loneliness. The report flags the potential for more services to be delivered out of community buildings and mosques.

There is an opportunity to look to our residents for solutions to the problems that our local health economy faces and work with them to develop resilience within health services and create mutually supportive long-term relationships.

Section Two: Reports and recommendations

Overarching recommendations

The intelligence gathered by the organisations and individuals involved in the Community Intelligence Bursary demonstrates the strengths and capabilities of our local communities and the significant contribution they make to the care system. The reports show how patients, carers and wider family networks currently provide wide ranging support and services themselves and suggests what is required for them to continue to provide this vital role.

The reports suggest that the current system focuses more on what services are currently available to patients and families, rather than identifying the support they need to continue to deliver care. Consideration should be given as to how timely support can be provided and information made available to enable people to better manage their own care.

There is a benefit in transforming people from passive recipients of services to equal partners in caring for themselves and loved ones where they feel supported, confident and empowered to be able to care not only for themselves, but for their loved ones, families and neighbours. Timely support will enable them to care effectively as well as bring significant savings.

The reports suggest that future work should include training, access to information and assistive technology, and should support carers in developing service models and services. Giving support rather than providing services will require shared decision making and could help remove the distinction between professionals and recipients and shift responsibility, requiring the development of new skills for both patients and professionals.

The ability for patients to be able to access to their own medical records and care plans is recommended. Patients believe that their views could be given equal consideration as those of health professionals in making care decisions for their own health and wellbeing. Having a joint directory of services that draws on various sources of information and is accessible through a wide range of access points as well as developing new tools for delivering information that targets different ways of learning and different communities (e.g. video clips, animation diagrams, interactive online self-management programmes), would help patients access the kinds of information that would support them in looking after their own health and wellbeing.

The extensive and diverse voluntary and community sector in Tower Hamlets has the ability to reach large sections of the community, including our strong Black and minority ethnic, immigrant and faith communities and is a connection that can be utilised in sharing information. With a young population, schools have the ability to play a central focal point for all communities. Whilst GP practices are often used as access and information points for care services, peer networks such as football clubs, diabetes groups, or mums' networks can be as equally or more effective in reaching people who are not in the statutory system.

Building knowledge and confidence – signposting and information

Almost all of the reports mention the importance of people being able to access the right information at the right time in order to manage their health needs. This was seen as a prerequisite for good self-management and care and included:

- Patients and their families knowing what is available, who does what and where and how to get into the system.
- Having information in a format that is comprehensible to patients and their families.

- Understanding what was likely/might happen in the future and feeling prepared and confident that they could deal with it when it happened. The right information could prevent years of chaos and struggle.
- Information for the right people in an appropriate medium, this includes patients, carers, children, wider family, and informal support networks (friends/neighbours).
- Recognising that young people often access online sources of information on behalf of other family members.
- Recognising that people are not all the same and that we need to target different people at different times for different things.
- Better understanding of where communities currently access information rather than just putting out more information and expecting local people to find it.
- Not relying solely on electronic modes of communication to disseminate information, however an up-to-date common directory of services and information available to both professionals and service users.
- Strong support for models of social prescribing being adopted across the borough's GP practices, and for GP practices to have a stronger role in education, signposting, and referrals to non-medical related services.

Building capacity – recognising and using community assets and developing responsibilities

Within some communities it could be more beneficial to take a family centred rather than a 'person' or 'patient and carer' centred approach, recognising the local community and strong family networks and the contribution that they make to the care system. Families should be supported to feel confident and empowered to care well. This could include:

- Training, access to information and assistive technology and home adaptions.
- Encouraging them to get involved in the development of service models and services.
- Talking about 'wellbeing' rather than 'health and social' care carries less stigma, is more holistic and implies more accountability.
- Schools and after school clubs are seen as acceptable places of learning for all communities. They are excellent places to provide after school family homework and health clubs. Greater use of these facilities together with stronger partnerships with GP practices and parents could have a significant impact on community health and health habits.

Recommendations against priority areas

Below are the key recommendations that have come from the organisation reports that focus on the seven priority areas previously mentioned. The full reports from each organisation follow.

Carers

- Recognise and value the contribution that carers make to the health economy.
- Acknowledge and support carers as experts and partners in patient care and invite them to be included in appointments, care planning and information.
- Celebrate and promote caring, raise awareness of who carers are and what support is available to them.
- Specify and strengthen the role of primary care to identify carers, provide (supportive) signposting to services and check and update support in accordance with changing needs over time.

- Support given to carers to learn more about conditions, diagnosis, and likely short, medium and long term changes in order to plan and manage effectively.
- Run a targeted campaign for Bangladeshi and Somali women to help them understand available services.
- More information available in community languages in the form of translations, TV channels or touch screens.
- Work with young people and schools in minority communities to educate them around accessing health information so they are able to spread messages to older members of the family.
- Increased access to training e.g. first aid, moving and handling, financial management and understanding benefits and support services. Possibly with ESOL.
- Tackle the issue of social isolation and stress by improving access to counselling and mental health support, especially for particular groups who have cultural issues.
- Provide support to the family unit alongside the primary carer and the person being cared for to spread workload and responsibility.
- Establish a clear difference between carer, care worker and caring neighbour roles and how people negotiate around them.
- Provide more co-ordinated support including joining up the current fragmented support/services offered, particularly by the voluntary sector to provide a holistic service offer.
- Enable further development of peer support particularly around common health conditions, groups of interest e.g. carers of children or people with mental health conditions or ethnic and cultural communities.

Older people

- Provide education for families within communities on how they can support older family members to remain at home.
- Provide ongoing access to information and advice when they need it. Include awareness, access and training on new technology and home adaptions.
- Support communities and older people to develop and deliver their own care services and peer support. A citizen's forums could develop this idea, identify need, design and commission and/or deliver services.
- Prepare and encourage older people to plan for what they may need to do to stay in their home. This could be training courses, since knowing what to expect is reassuring for some people.
- Develop a workforce that reflects the local community and employs the local community.
- Offer more activities to take people out of the home and reduce social isolation.
- Develop closer working with housing associations to link older people to the community.
- Support family and neighbours to check and challenge if there are issues with care.

Integrated care

- Improve information sharing with everyone involved in a person's care including carers, wider family and housing providers.
- Provide educational programmes for professionals on how to have conversations about what is important to people and their families - not just what is important to treating their condition. The question should become "What matters to you?" not 'What's the matter with you?'
- Take into account religious and cultural issues and develop user-led training on how to provide care/services.
- Improve the attitudes of local families to end-of-life issues, with some cultural and religious focus.

- Provide a cohesive engagement programme that pulls together all of the current programmes that fit under the integrated care umbrella and start a dialogue from a needs and need-to-know basis.
- Develop a narrative that demonstrates to local people how the wide range of integrated care programmes in the borough are focused on meeting their and their family's needs. These programmes include:
    - Integrated care, personal health and social care budgets.
    - THIPP and the vanguard.
    - Prime Minsters Challenge Fund.
    - The GP Care Group.
    - CAMHS and mental health strategy.
- Monitor and evaluate programmes to make sure they are meeting needs of all members of the communities they are meant to serve.
- Integrate engagement to promote programmes using:
    - Patient leaders.
    - CIB peer researchers.
    - Health trainers and health champions.
    - Care planners and care navigators.
    - Public health sign posters.
    - Healthwatch sign posters.
    - Social prescribers.
    - VCS HWB forum and members.
    - Healthwatch members.

Children and young people

- Provide guidance for children, young people and parents on how to care for their mental and physical wellbeing.
- Work with schools as an access point to empower parents and families.
- Run after school family homework clubs and combine info about health and wellbeing, making healthy snacks, how to use the health system etc., and involve health professionals in delivery of education programmes.
- Develop mechanisms to tackle bad after school eating habits. Educate parents on the impact of poor eating habits to their child's health and academic achievement and the importance of establishing lifetime healthy eating habits.
- Offer cooking classes for parents around creating cheap healthy snacks, more ideas for snacks, recipe cards and articles in school newsletters.
- Increase understanding that improving academic achievement is directly linked to healthy eating and exercise.
- Involve children and young people in co-producing a peer led health and wellbeing campaign to raise awareness of:
    - the importance of looking after your physical and mental health
    - tackle the stigma around mental health
    - tackle issues like exam pressure, bullying and family pressures
    - build on existing resources and activities in other areas

General Practice

- GP practices used as a valuable education, access and referral point for wider wellbeing services and support.

- Broaden the capacity of GP practice's to act as Health and Wellbeing Centres.
- Use less expensive staff to do signposting and coaching.
- Link to afterschool family education programmes. Primary care health professionals could go to schools to talk to children, young people and parents.
- Empower patients, particularly women from BAME communities, to better manage their own and their family's health. This could include more health focused ESOL classes, either at GP practices or at afterschool family homework clubs.
- More flexible/longer appointments for people with long-term conditions.
- Greater community involvement with GP practices.
- Continue work with patient participation groups at GP practices to help improve primary care.
- Encourage GPs to recognise the strengths of their local community and work in partnership them.
- Make better use of community assets including faith leaders to promote health awareness and how to best use the GP/health system.
- Support and encourage greater sharing of best practices between GP practices and practice networks.

Equality and diversity

- Information about health care services for people from the East European Community (EEC) is available in accessible formats (language, electronically via websites, literature in accessible venues), specifically Polish and Russian. We should extend the hospital telephone translation into Bengali, Polish and Russian.
- Registration at health care practices is explained or accessible in written information in EEC languages, or provide alternative information regarding where people can go if they are not eligible to register with a particular practice.
- Different language options on the phone-lines and new patient information leaflets which reflect the increasingly diverse population of Tower Hamlets.
- Promote patient rights through "Rights Awareness" campaigns – frontline staff, patients and public all have a responsibility. Rights awareness should form part of induction and on-going education for front line staff.
- Train health care professionals on the intricacies of the EU regulations and health care in the UK for EEC nationals.
- Clamp down on unregulated and underground "healthcare".
- Length of appointments adapted when a translator is required as it can take double the amount of time or more.
- Promote multi-lingual and multi competency health advocates.
- Build community cohesion – bring people together to understand the cultures and communities within their neighbourhood.
- Facilitate access to language lessons to allow better integration into society.
- Provide better cross-agency and interdepartmental awareness of what work is being done.
- Translation services available for EEC pregnant women throughout their whole pregnancy, including written information about stages of care.
- Provide advocacy and support from specific agencies who understand EEC issues.
- Ensure that lessons and good practice are being shared across the sectors. Some organisations are already putting into practice ways to improve access to health care for their service users.
- Ensure that the needs of disabled patients are clearly understood.

Dual diagnosis

- Raise awareness of the dual diagnosis service in the borough and expand the service to a wider cohort. It is currently aimed exclusively at those with serious mental illness and on the Care Programme Approach.
- Increase peer orientated support within treatment services (both substance misuse and mental health) to facilitate recovery from the perspective of demonstrable recovery by peer supporters.
- Reduce focus on substitute medication (for opioid addiction) and establish more activity based provision that provides meaningful day and evening activities for service users and promotes education, employment and training.
- Look at a recovery centre for women in the borough. Male clients can access Riverside House, which is an abstinence-based hostel with a recovery focus, there is however no such facility for women.
- Place an emphasis on training front line staff in health, social care, housing, job centre plus, third sector, etc. on dual diagnosis and that the training should be structured a permanent feature of the service and not a one off.

Carers

Account 3 – "Who Cares?"

Organisation

Account3 Ltd is a Black Minority Ethnic (BAME) women led, training and development social enterprise that was founded in 1991. They focus on finding innovative solutions to social issues and problems which hinder the economic development of local people. The company operates a one-stop shop approach to providing advice, support, resources and education to local people.

Summary

The research aimed to understand the experience of informal carers, their expectations and perceived barriers with regards to services. Also the effects that caring responsibilities have on their health, social and economic circumstances. Ultimately, asking the question "who cares for them?"

Account3 collected the views of 40 informal carers through a series of interviews and focus groups using participatory methods. They worked with St Hilda's, Black Women's Health and Family Support, The Carers Centre, The Somali Integration Team, and the Welfare Rights Advisor in order to ensure diversity of participants. All research questions were designed by informal carers who also led focus groups.

Key findings

The findings identify carers' journeys as emotional and psychosocial experiences that are at times completely shocking, baffling, overwhelming but also rewarding. The key issues that the research found were as follows.

Recognition for informal carers

Many of the informal carers did not feel health and social care professionals acknowledged them as experts or "co-workers," despite them seeing themselves as full time workers. This led to a negative impact on their mental well-being, as they felt "worthless."

> *"I started to care for my mum since the age of 15, but I have been doing it properly since dad passed away, it is now 18 years." - Female informal carer.*

Support for carers

From the discussion it was evident that there was psychological distress and an overall deterioration in health endured by the informal careers. Isolation and lack of support might prove a high burden and can result in distress or mental health problems.

> *"My marriage broke down as a result of me trying to care, the best I can for my daughter. It was too much for him to take. Her condition and my time spent in caring for her, he could not handle it." - Female informal carer.*

Carers frequently incur care-related costs. Many of them have experienced difficulties in obtaining either the Attendance Allowance or Disability Living Allowance. The reasons varied from the lengthy process, the number of hours required or difficulties obtaining a formal diagnosis. This resulted in the carer using their own money.

> *"I often had to make financial sacrifices…once I had to choose between my mum's needs and my daughter's needs for new shoes for school..." - Female informal carer.*

From the research, it was clear that there are major issues around awareness of and access to health services. Many of the respondents found that they had problems either not knowing of the services available or issues with accessing the services.

Recommendations

The following recommendations have been put forward by the 40 informal carers:

- To explicitly acknowledge informal carer's expertise and knowledge of the person they are looking after as part of building a carer's confidence and resilience.
- To support the informal carers' own health and well-being.
- Talk about and offer information and support around the carer's needs. Carers often think that their health needs are secondary to those of the person they assist.
- Their levels of stress are alarming, and some were crying out for counselling. Their psychological strain should be addressed with support, counselling, and/or cognitive-behaviour interventions.
- Better identification and signposting. An over reliance on "self-identifying" means many continue to miss out on vital support services which they have a right to as carers.
- Need for simplification of forms.
- Need for training. Informal carers requested access to training to enable them to perform their role better. Training suggested by participants in this study included training in raising confidence, First Aid, moving and handling.
- To improve the taxi service that is currently being run out of a call centre based in Scotland. Those taking the calls have no local knowledge and drivers often do not understand the needs of the passengers with care needs, mobility issues etc.
- Financial help for carers. The financial burdens often put informal carers into a precarious situation, despite their role within the local and wider economy. Informal careers should be given extra financial help, failing to do so; can and does sometimes put the carer below the poverty line.

Black Women's Health and Family Support – "How do carers find out about local services?"

Organisation

Black Women's Health and Family Support (BWHAFS) is a community-embedded organisation which was created by local women of Somali heritage three decades ago. Its range of services includes health advocacy for BAME, African and Somali-speaking women (many of whom are lone heads of households), their families and refugees. It supports on average 2,900 vulnerable service-users each year.

Summary

BWHAFS noted a growing number of isolated older women, widows and carers who had no first-hand contact with the borough's statutory or third sector services established to address their welfare, social and health care needs.

The research focused on how women from Somali heritage, accessed health services by undertaking one-to-one and group surveys with 30 hard-to-reach older female carers of Somali heritage. They also sought to understand their health and caring needs and priorities.

Key findings

Of 30 respondents, 27 older women interviewed were in contact with voluntary sector services including the Brady Arts Centre, Granby Hall, Wadajir, Ocean Somali Community Association (OSCA), Somali Integration Team, the Bromley-by-Bow Centre, Oxford House and the Legal Centre. Six had learnt of these services

from family members, two through friends, and one via a community centre, two via their GPs and two through emergency services, while five undertook internet searches.

When asked how health talks should be delivered, a majority of respondents suggested they should be delivered with support from bilingual interpreters, that illustrations should be featured and that they could also be publicised on screens in GP services. Some suggested regular talks.

Case study: Asha's story

Asha is of Somali heritage and over 65 years of age.

> "*My son is ill. He suffers from mental illness. It came as a shock as all this was not communicated to me whilst I was in Somalia. I immediately started caring for him.*
>
> *"At that time, refugees from Somalia were mostly concerned with their immigration status. There were no Somali organisations where I could go and no one supported me to get the right advice.*
>
> *"My son was hospitalised in a mental institution several times. I became so worried and stressed that I became ill. I struggled for years to care for him without any outside support. I didn't know where to go for help and my English skills were poor.*
>
> *"My son became suicidal. He attempted to kill himself several times. At that stage he did not have a permanent address in the UK and was not receiving any state benefits. On one occasion he became violent and pushed me. I fell and broke my arm.*
>
> *"In 2007, he was hospitalised once more. This time Social Services appointed a social worker for him. The social worker supported him in getting welfare benefits and my son and I were referred to organisations for help.*
>
> *"I am an elderly person and I still care for my son but I also need to take care of myself. Because of language barriers, I could not go anywhere to access support.*
>
> *"A friend of mine told me about Black Women's Health and Family Support (BWHAFS) and the work they do for carers. Since then I have been attending the centre for general enquiries and support with my son's needs. I visit BWHAFS three times a week to socialise with other carers. I take part in their advice sessions, book my son's GP appointments and have joined the Lunch Club and sewing classes. Since attending my health has improved and I feel much happier within myself."*

Overall, the research found that current services were not reaching these particularly vulnerable older women and carers due to technological and language constraints. These groups predominantly favoured the delivery of face-to-face information through community centre talks and GP services.

Recommendations

- Health service information should be targeted at women as they are the primary health and caring providers in families.
- Important health messages should be promoted by the CCG and Healthwatch through a range of approaches. These should include partnerships with grassroots services that are able to engage with women from communities that are poorly served by current services including carers.
- Priority must be given to those from particularly disenfranchised communities such as those of Somali heritage who rely on oral traditions of communication and have limited reading, digital and English language skills. We think these groups could particularly benefit from health awareness activities and health talks and these could be provided through statutory/voluntary sector collaboration.

- Health messages should be promoted through TV channels and touch screens at GP services in appropriate community languages so as to reach disenfranchised women and families through a range of approaches.
- The CCG and Healthwatch should continue to work in partnership with small organisations to undertake further research into the changing needs of the borough's most vulnerable women and carers so as to support them in maintaining good health for themselves and their families and dependents.

Asian People's Disability Alliance – "Hidden Carers"

Organisation

Asian People's Disability Alliance is a grass roots disabled people's organisation. It is a user-led, needs-led, non-governmental and non-denominational organisation in its service delivery and campaigning. It provides culturally appropriate services to Asian disabled people, their carers and their families that mainstream services are often unable to provide.

Summary

The research was aimed at identifying Asian hidden carers who currently provide care and support to another person, yet are unrecognised for their commitment and do not have the formal support they require for their own physical and mental health needs. The research looked at unsupported health needs for female Asian hidden carers.

Many of the hidden carers were isolated and largely disenfranchised. Informal one to one interviews and small focus groups were held to gather their views. A total of 22 interviews were conducted.

Key findings

The key themes that researchers noted are as follows:

- Lack of control and choice, especially in regards to finances.
- No time for their own health and wellbeing.

> *"I am not able to always communicate, expressing myself, I am disregarded and my wife has to be called, which makes me feel demoralised, belittled."*

- Often not caring through choice, more as an expectation. Caring as a duty.
- No one asking them about how they feel, only this research.

> *"I felt lonely, there wasn't a shoulder to cry on, didn't want kids to see me"*

> *"For services and support to offer a holistic approach that includes the needs of the carer and the person cared for and takes into account the carer's other responsibilities."*

> *"As a carer when I seek support, it is only prescribed for my eldest son, who is under the adult disability team, however I have other children with medical conditions who need support physically and emotionally who are disregarded in receiving holistic care."*

Case Study

A couple have four children, all with healthcare needs. The eldest has been diagnosed with having autism, potocki-lupski syndrome, is partially deaf in right ear, has arthritis, and his cartilages have not developed. He has a care package with social care.

Their second child has type 1 diabetes, rheumatism, anxiety and hypermobility. Their third child also has type 1 diabetes, suffers from urine infections and has a cyst on the left eye. Their fourth child has speech and language needs.

They only receive care support for their first child.

The mother suffers from enclosing spondylitis, osteoporosis, endometriosis, incontinence and their father suffers from chronic prostatitis, kidney stones, depression and anxiety. They are both carers for their children.

Recommendations

Short term recommendations:

- Drop in sessions to identify hidden carers and raise awareness of disability conditions and the support available.
- Training for hidden carers in health conditions, disabilities and caring roles.

Medium term recommendations:

- Review the current mental health support services, and whether they are fit for purpose for the Asian community in Tower Hamlets.
- Develop a more holistic approach in health and social care support that takes into account the needs of carers, the person cared for and the family unit.
- A language appropriate campaign to raise understanding and awareness of hidden carers and the value of caring. This should use translated documents.

Long term recommendations:

- A more culturally suitable informal and open service approach to support the physical and mental health needs of Asian carers and hidden carers.

Older people

Somali Senior Citizens Club – "Health and social care for older Somali people"

Organisation

The Somali Senior Citizens' Group is an organisation that runs a number of services for the Somali community within Tower Hamlets.

Summary

Somali Senior's Citizen Club was commissioned to undertake an assessment of the present and future health and social care needs of older people (aged 55+) from the Somali community. The assessment also covered health, housing and other welfare needs which impact on the need for social care.

The objectives of the project were to gather the views of older men and women in order to:

- Learn what the Somali community understands about care home services.
- Establish why the Somali community do not easily access care home services.

Key findings

The majority of participants were mistrustful of care home services and providers. The primary barriers to accessing services included; lack of information, language barriers and access to a culturally appropriate service.

The following organisations provided outreach and venue support to the research:

- Al-Huda Mosque and Cultural Centre.
- Bustaan Radaa (Gate Housing Association).
- Queen Victoria's Seaman's Rest House.
- Somali Senior Citizen Club.
- Somali cafes.

Seventy-five older Somali people took part in the research via interviews and focus group discussions (24 women and 51 men). An overwhelming majority of these participants stated clearly that they don't want to go to care homes unless there is improvement in a number of areas. Five participants currently live in care homes and are happy there. Fifty-five wanted to see care homes run by staff with similar backgrounds. Fifteen others don't want to go to care homes at all.

Case Study 1

Mr Ali is an 82 year old Somali man who lives in a care home in the borough.

When asked how he would like to see the care home in the future his answer was that he has been here for the last three years and has wished since moving in that one day he would come across a Somali speaking person who can understand his needs.

> *"At many times I became angry and agitated because nobody speaks the same language as me. That is why I like to be left alone in my room. Having someone who can speak my language will help me. I can tell my problems in my own language. This will help me and help reduce the isolation and loneliness I experience."*

Case Study 2

Ms Y, a 78-year-old who lives in shelter home is very reluctant to go to home care as she thinks the home care is only for the people who have been abandoned by their families. She also believes that in a care home environment personal services can be delivered by anyone, regardless of their gender, which is religiously and culturally inappropriate.

> *"I don't want a man to wash me up, this is an embarrassing and very shameful."*

Recommendations

- In-depth and detailed information to be made available about current care homes and care providers.
- More Somali speaking staff to be recruited to work in care homes and care services to address cultural and language barriers.
- A consultation with a person's family must be standard before a final decision over their care is made.
- Engage with community organisations that are able to reach out to individuals who may be left out and in need.
- Somali organisations to run care home awareness sessions regularly in order to deliver appropriate messages to the wider Somali community.

Year Here – "How do you want to live when you're 100 years old?"

Organisation

Year Here is a full-time postgraduate course in London designed to cultivate entrepreneurial approaches to entrenched social problems. It is immersive, action-oriented, and grounded in the daily experience of those at the frontline of inequality.

Summary

The research focused on how residents of Tower Hamlets experience ageing, use health care providers and engage with wider social support services. It looked into their needs and preferences of health and social care. They approached:

- People with limited social networks (and so are at risk of becoming isolated).
- People with moderate physical, mental health and mobility issues that restrict their ability to socialise and engage with the community.
- People who are currently facing social isolation and/or loneliness.

A total of 52 stakeholders were engaged through this research.

Key findings

The key findings from the research were:

Wider social support

Every participant made a reference to the value that using wider social support services brings to their lives. Phrases such as "it has saved my life" and "it's my favourite part of the week" came up many times in the transcripts.

A few participants (17%) spoke about their experiences of having to fight for funding. With this theme frequently came feelings of being "undervalued", "not cared about" or "forgotten about".

John, aged 87, spoke about a men's club he belongs to. He describes it as "fundamental to our lives – because we ain't got much goin' for us these days". The men meet weekly at Brownfields community centre for a 'Men in Sheds' type group. They do activities such as woodwork alongside socialising and trips. The men that visit the club need more support as some suffer from mental and physical health problems. He spoke about their struggle to keep the club going because funding was being cut and he described how this makes him feel.

> *"Basically how it goes is – I used to live in the future when I was young and that. Then I lived in the present. Now I live in the past and no one cares about people that live in the past. They figure we're not worth it, that we don't really know what we're on about. So they close our stuff down."*

If wider social support services are unsuccessful in their endeavour to stay open, then service users are more likely to become lonely or isolated as their contact hours with services will decrease. In our research we found that lonely people are almost twice as likely to visit their GP compared with patients who are not lonely and are more likely to visit A&E departments.

Maintaining dignity and autonomy in older age is vital when providing good quality health and social care. They wanted face-to-face communication first, and then communication via the phone and then post as it would logistically work well occurred six times throughout the interviews. When asked if there was a place that they visited regularly to collect information GP surgeries was the only place that was mentioned more than once.

Having limited social networks has resulted in participants becoming lonely and suffering from mental health issues such as depression and anxiety.

Case Study

Rose is 87 and lives in Poplar. She's suffered from multiple bouts of cancer, which she has beaten. She goes to one lunch club a week but struggles to get out due to her mobility. She has lost the motivation to leave her house on a more regular basis because of her anxiety.

> *"I'm just lonely and depressed and have panic attacks. Sometimes I pick up the phone just because I want to hear voices… I don't really know what else to do with my time. Apparently I might get an escort through the NHS (she laughs) not like one of those ones. Someone to take me out."*

Rose has a counsellor however she has only seen her counsellor twice. She said it hasn't really helped her but she has really appreciated talking to an outreach worker who helps out at the 'Neighbours in Poplar' lunches. "It feels less formal". She explains that the informality of a chat is much more likely to engage her and inspire her to open up.

Health Care Appointments

A large majority (92%) of participants expressed their fondness of being treated by their own GP every time they visited their practice. A third of these people spoke about times they had been seen by a different GP recently. This caused problems such as misdiagnosis and patients becoming agitated due to a "shake-up" of routine. A third of people also said they have experienced long waiting times (anything from two days to two weeks).

Three interviewees raised the issue of having appointment times and dates pushed back to later dates. In all three cases this led to their health issues worsening and impacting their day-to-day lives.

Case Study

Arnold lives in Poplar with his son. For the past five years he has been suffering with glaucoma, he has partially lost sight in his right eye. He began to lose sight in his left eye, and his GP referred him to Moorefield Eye Hospital.

His appointment was scheduled for 5 February 2015 this appointment was cancelled a week before and rescheduled to 14 July. Whilst waiting for his next appointment Arnold lost sight completely in his left eye and has now been told that it is unlikely that he will regain his sight.

> "*What can I do, everything's gone wrong. The only thing that makes me happy is reading – I love books I could read all day… I ended up in hospital cos of my mental state, I was ill. And now I don't know what feels worse, now I can't read because I can't see. I can't do the thing I love.*"

General Practitioners

There are systematic, social and economic barriers to receiving GP care. From language barriers to financial situations and mobility combined.

Carers

Of 24 one-to-one interviews with people being cared for at home, 70% of participants receive care from family members. We found evidence that this puts carers under a lot of pressure.

Support and outreach workers

Outreach and support workers were interviewed. The issues raised included:

- Issues with pride from the elders
- Better contact routes
- Navigators can be useful
- Housing issues for elderly
- Social isolation
- Carers have limited responsibility
- Family moving away.

Recommendations

- Encourage collaborative funding. Organise networking events for services to discuss further growth and innovation together.
- Citizens' Forums, so that they can have autonomy on how things are run and on how money is spent.
- Train support staff in signposting.
- Older patients drop in days at GP surgeries. There should be opportunity at least one day a week for the over 60's to get priority for an urgent appointment and reduce the waiting time between standard appointments.
- Give younger patients a named GP. Having a named GP to go through the process of treatment with is very important for older patients, yet named GP's are only allocated after the age of 75.
- GP Checklist, a small form that a patient can fill in whilst at home or in the waiting room before an appointment. It acts as a reminder for listing all the issues that need to be raised during an appointment.
- Intermediate job role in GP centres. Someone who can engage with patients on a more social level within waiting rooms would help many patients overcome issues of social isolation and loneliness.

The Collective of Bangladeshi School Governors in Tower Hamlets

Organisation

The Collective of Bangladeshi School Governors (CBSG) in Tower Hamlets.

Summary

The aim of the research was to gather the views of the middle-aged people of the Bangladeshi community on the types of health and social care services they would like to see available to them in the future.

They conducted interviews, surveyed through questionnaires, and held a workshop to gather the views of Bangladeshi people (aged between 45 and 60). A total of 50 people were interviewed - 21 of whom were female and 39 males. They also carried out a workshop which took place in the CBSG office in Brick Lane which 25 people aged between 45 and 60 attended.

Key findings

A number of improvements were suggested for GP services such as more GPs at the surgeries, shorter waiting times, more availability of appointments, organised and trained reception staff, telephone calls answered more quickly, thorough examinations where GPs do not rush, the need to explain prescribed medication, i.e. what it is for and how to take it, more interpreters, more female GPs and also GP surgeries to work on stressing the importance of cancelling appointments so they can be used by someone else.

Many people mentioned past experiences of finding it very stressful to wait for long periods of time before being seen by the nurse or doctor.

- Fourteen people suggested technology/equipment provision for patient use at home.
- Seven suggested supported housing/adaptations.
- Twelve suggested hospital letters to be sent in preferred language on request (Bengali).

A participant said that he had been dismissed from physiotherapy and given medication instead to help with his diabetic neuropathic pain, which has many side effects. He would prefer to go to physiotherapy instead and believes due to the shortage of physiotherapy services he is no longer able to attend thus he would like to see more physiotherapist places available in future.

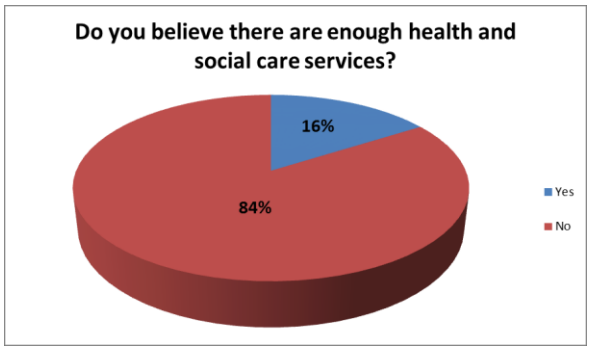


Figure 1. Do you believe there are enough health and social care services?

Recommendations

- Better technological support and equipment as a way of retaining autonomy for patients, but also a need to train them to use the equipment effectively.
- Home adaptions.
- Care homes to be accessible to BAME groups – by using bilingual carers.

- Interpretation services available in health services.
- Better access to GP services.
- Improved GP service.

St Hilda's East Community Centre – Older people's views on social care in Tower Hamlets

Organisation

St Hilda's is a lively community centre based on Club Row in the Weavers Ward of Tower Hamlets. It has various projects under one roof with excellent relationships with the age 55+ communities, as well as links to neighbouring community organisations across the borough.

Summary

The research looked at what older people (55+) thought about current older people's services and their expectations from Tower Hamlets as they get older. They collected views from the Caribbean, Bangladeshi and White British communities.

Interviews were conducted at various lunch clubs, centres and sheltered accommodation venues across the borough including:

- St Hilda' East
- The Older People's Project Day Centre and Lunch Club.
- Boitok group, Bangladeshi Elders lunch club.
- Bondhon Project, supporting Bangladeshi women who are socially isolated and experiencing mental health issues.
- Food Co-op customers who met the criteria.
- Sonali Gardens Day Care Centre, providing person centred care for Bangladeshi and other communities in Tower Hamlets.
- Shebadan Project, providing home care services to Bangladeshi and other communities.
- LinkAge Plus, offering residents a range of social and health related activities
- The Sundial Centre, day care and activities for older people.

Several focus groups and one-to-one questionnaires were held at sheltered accommodation venues across the borough including:

- Hogarth Court, general needs/independent living.
- Donnybrook, extra care.
- Sue Starkey House, extra care

Key findings

When asked where participants would go if they were to need extra support in their home, there was a large number who said they would go to their family in the first instance. Social workers, social services and GPs were other options mentioned.

There was an overwhelming importance of community organisations and services, because of the connection and trust service users have to them and their staff.

Just 32 participants out of 102 knew about all the services that were mentioned. Sixty four participants did not know about services or just knew about some services. Therefore, better promotion of services is needed and more outreach work.

When asked about the services that the participants thought would help the elderly, these included lively, sociable activities including those that keep people active. Things that would involve members of society.

When asked what were the most important factors when considering care in the future the three most important aspects people mentioned were participating in decisions about their care, and being able to stay in their own home and being close to family and friends.

When asked about their expectations of care, as they get older, 57 said they would like to be cared for/looked after/supported/have extra support, adding comments such as “with respect and care”, and “like an individual.”

Case Studies

Rabban Khan, Age 62

In 2001 Rabban became sick after an accident at work and has not worked since. He separated from his family and lives alone. He became quite depressed due to his family situation, deteriorating health and being at home alone.

Mr Khan was referred by his GP to Community Options. He has a good relationship with his support worker, who he believes treats him with respect and communicates with him well. He feels in general though, that not all services are as understanding of his needs or mental health issues and sometimes feels professionals are not as caring. Without the social services he attends Mr Khan knows he would be isolated and feel more depressed. Attendance and socialisation at these events offsets his depression and is good for his wellbeing.

> Without them “*I would feel so alone and sad. I don’t like lonely*” Mr Khan says.

Alvin Davidson, Age 89

Alvin has a daily carer in the morning that he has had for some time now. Initially he had different people, which he did not like:

> *“Some of them did not know how to care, some did not even know how to make a cup of tea. Things would go missing from my house and people get away with it and I cannot prove anything with all different people chopping and changing.*”

Alvin was not treated as individual. There was no scope for a relationship with his carer to flourish. He is more satisfied with his regular carer now, though he is often pushed for time and any added trips to the shops or to top up his electricity key rely on his carer’s goodwill and time.

Recommendations

- Should include staff training which seeks to build a relationship-based practice and a continuity of staff.
- Time with carers could be better matched to the needs of the individual.
- There could be more services and activities to take people outside of their homes.
- Outreach work.
- Better advertising of services.
- Sheltered accommodation - Clinics/advice sessions held weekly/monthly at sheltered accommodation venues. This will allow residents to be listened to and signposted where needed.
- Support that prepares older people for staying in their homes.

Children and Young People

Bangladesh Football Association – "healthy eating research project"

Organisation
The Bangladesh Football Association UK.

Summary
Research with children six to 11 year olds to find out their existing knowledge around healthy eating, their eating habits after school and before bedtime, and their reasons for eating chicken and chips, and their parents' attitudes to food.

The project worked with 30 children that regularly attend the football academy. They used a series of football exercises/activities to gather the information and also conducted surveys with 15 parents.

The following methods were used to get feedback from children and their parents:

Warm up – Children were asked to do a stretch while warming up and answer, "What is healthy?" Children took turns to do a stretch and say something related to healthy eating.

Drink run – After a running drill, children chose drinks from three different boxes, one contained water, one contained fizzy drinks and one contained juices. Once they chose a particular drink they were asked to give a reason why they choose that drink.

Dribble to healthy eating – Children were asked to dribble with a ball and go to the appropriate station when called. Stations were labelled healthy and unhealthy. Each station had different types of food.

Penalty shoot-out – Children took turns taking penalties. Afterwards they were asked if they ate chicken and chips after school. Every time they scored they had to give a reason why they ate chicken and chips. The aim was to get at least 2-3 answers from each child as to why they eat chicken and chips.

Food chart – Children were given a food chart to record what they eat between 3.15pm and 9.00pm for a week. This was to help find out what they were eating after school, how much and the frequency.

Focus group – After collecting the weekly food chart and doing the above exercises a group of eight to ten children were chosen and asked why they "really" eat chicken and chips, why they eat high amounts of food after school, what they drink a lot of at home, what their parents offer them, and whether their parents are encouraging them to eat all the time. This was to get in-depth information about the reasons for their eating habits.

Survey with parents - A short survey was conducted with parents whose children participated in the project to find out their attitudes to food and healthy eating (and any barriers to healthy eating). They were asked questions in relation to their child's food chart for example, why they buy chicken and chips and what their child consumes during the evening.

Key findings
Baseline knowledge about healthy eating

Children are very knowledgeable, educated and have a good understanding of what food and drink is healthy for them and what is bad for them. The question is how many of them follow their understanding when buying food. Do they opt for a sandwich or McDonalds or do they order water/juice with their meal instead of cola? This is an area where more research needs to be done and some kind of education needs

to follow where children are encouraged to implement what they learn. If children are encouraged to follow what they learn then they can influence their parents.

Eating habits after school

The food chart and the parent's survey were very similar. The food chart revealed around 20% of children had small snacks after school and a main meal around 7.00-8.00pm. The rest (80%) had snacks, a mini meal and later a main meal. Those who had a main meal around 4:30pm had snacks up to bedtime.

From speaking to the parents the research found that around 40% of parents gave food straight after school and another 25% on the way home. However the vast majority (75%) gave food at home as snacks but included a meal sometimes to keep the hunger away until the main meal at 7.00-8.00pm. The other 25% gave food as main meal and later snacks before bedtime. We feel the snacks and mini meals before the main meal is a contributing factor to increase in obesity in primary school children. Parents are also creating the lifetime habit which children will later find difficult to break.

Type of food and the amount children eat

The food children eat at meal times is generally healthy and wholesome and not much junk or fried food. Occasionally there is chicken and chips on the menu but on the whole children are eating cooked food such as spaghetti, pasta, chicken and mash potato, rice and curry, and tuna salad. However, the concern is the snacks they are consuming – crisps, biscuits, chocolate, chicken and chips, and pizza. They are also eating fruits and sandwiches in addition to this as a healthy option. We could not measure the amount children were eating and generally because it was a healthy eating research project parents and children did not want to be seen as unhealthy or overeating.

Reasons for eating chicken and chips

From children's point of view it tasted good, and parents gave it as lunch or dinner and as a treat. From the parent's point of view the children wanted it/liked it, it was convenient, cheap, filing, and as a family they ate it as well when they did not cook. It was difficult to find alternatives and there were very few other food outlets and alternative food was expensive especially for families who wanted a quick meal.

Parent's attitudes to food

Generally parents were well educated and placed importance on healthy eating. They wanted to give a balanced diet to their children. Around 10% felt they may be encouraging overeating in their children and they made sure their children finish their meal. The other 90% said they were more relaxed. They made sure their children did eat but did not encourage overeating. They said children were hungry after school and it was a task to find them healthy food to keep their hunger at bay until meal time. This was a challenge for them.

Recommendations

- Continue healthy eating education. However, there needs to be more focus on whether children are implementing their learning when making decisions about food when they are out and about i.e., when they go shopping do they end up in McDonalds or a healthy cafe/food outlet? Do they order water or order a cola?
- Education to focus on implementation and encouraging children to eat healthily which will then influence parents. If children refuse to eat chicken and chips their parents will provide alternatives.
- Educate parents on overeating/snacks.
- Research on exercise and active living. There needs to be a separate piece of research on how much exercise children are doing after school.

- More healthy food outlets in the borough. It should be easier to attain planning permission to open new healthy food outlets around primary and secondary schools and no more unhealthy food outlets to be permitted, especially on streets dominated by fast/fatty food outlets
- Tax relief and other incentives given to cafes and shops selling healthy food at lower prices for children and families. Businesses participate in the scheme and get incentives to do so. Also, start a scheme where existing chicken shops participate and introduce healthy food like sandwiches, wraps, deli food, more juices, etc. and they are given incentives to buy equipment and to enable them to sell healthy alternatives at a lower price.
- Provide after school food packs including fruits, snacks and light healthy food, so children are not given unhealthy snacks on the way home or when they go home. This should keep their hunger away until their meal time.

Leaders in Community – "Young people's mental health"

Organisation

Leaders in Community Consultancy (LiC) is a pan-London youth led social enterprise that was established six years ago. They are passionate about creating avenues for young people to drive social change in their environment. Their aim is 'to inspire and empower a generation of young leaders to influence positive change within local communities and organisations.'

Summary

The research surveyed young people to better understand their awareness levels and attitudes towards mental health, and gather suggestions on how best to tackle issues related to young people and mental health. Healthwatch youth panellists received training through the CIB process to become peer researchers and undertake the fieldwork research.

Young people have greater access to their peers so they were in the best position to conduct the research. They surveyed a total of 237 young people across the borough aged between 15 and 24 years old.

Key findings

More teenage young men stated that mental health was an important issue to them than men aged over 20 years. The opposite trend can be seen for female respondents.

The vast majority of young people were unaware of both the national and local mental health services available to them. Aside from GP's, hospitals, Childline and Talk to Frank, awareness of other services that were presented to respondents was extremely low.

> *"My grandmother suffers from one form of mental health issue which is depression and one of my friends had previously been in depression, so it's quite close and meaningful to me. It is also significant to me because I want to be able to help my friends and family if a situation arises in the future and the fact that mental health is something which is under-addressed worldwide even though it plays a major part in everyone's wellbeing."*

The biggest factor that may deter them from seeking support after experiencing mental health issues was the stigma (41%) attached to mental health illnesses, and fearing the possible adverse reaction of their loved ones (16%) if they were to discuss mental health issues with them.

Twenty one per cent of those surveyed stated that simply not knowing where to receive support would be a barrier for them in trying to access help.

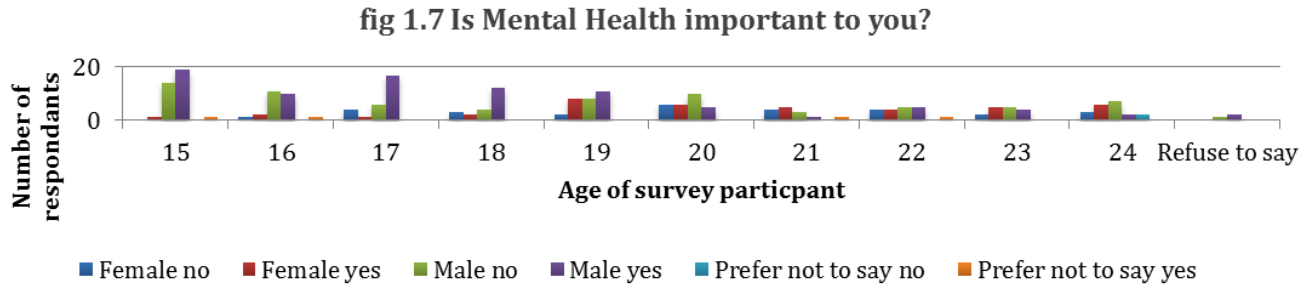


Figure 2. Is mental health important to you?

Recommendations

- Healthwatch and LiC to train more peer researchers from the Healthwatch youth panel so that they can build a social action campaign together on this issue.
- Youth panel meet with service heads from bodies such as the CCG, Child and Adolescent Mental Health Services (CAMHS) and Public Health LBTH to discuss possible collaborative work as well as offer the services of the peer researchers to assist with on-going/external projects.
- LiC to liaise with Youth Services LBTH/Young Mayor's team to work collaboratively on the next steps of the mental health awareness campaign to ensure as wide an audience as possible is reached.

Integrated Care

Toynbee Hall – "What makes the biggest difference: supporting cancer patients."

Organisation

Toynbee Hall is a 130-year-old community settlement that gives some of the country's most deprived communities a voice, providing access to free advice and support services, and working with them to tackle social injustice.

For the last four years, Toynbee has provided Macmillan benefits advice services for cancer patients and their families living in Tower Hamlets.

Summary

The research aimed to explore the kinds of support that would make the biggest difference for people with cancer and their families.

The following questions were asked:

- What support do cancer patients require?
- What services are available?
- How can services be improved to provide greater support?

They also conducted interviews and a focus group with cancer patients and their families. Sixteen people took part. They came from diverse backgrounds and varied in terms of age, gender, ethnicity, marital status, stage of cancer and cancer type.

Thirteen of these respondents were cancer patients and three were patients' family members.

Key findings

The Geographical Information Systems (GIS) map (figure 3.) provide a visual overview of where cancer support services are based.

They mapped the locations of 1,182 anonymised Toynbee Hall clients, approximately 200 of whom live in Tower Hamlets, and then added another layer to show the poverty in Tower Hamlets based on the index of multiple deprivation (Department for Communities and Local Government, 2011).

Different types of services were then identified in the map to show their availability in socially-excluded areas in Tower Hamlets.

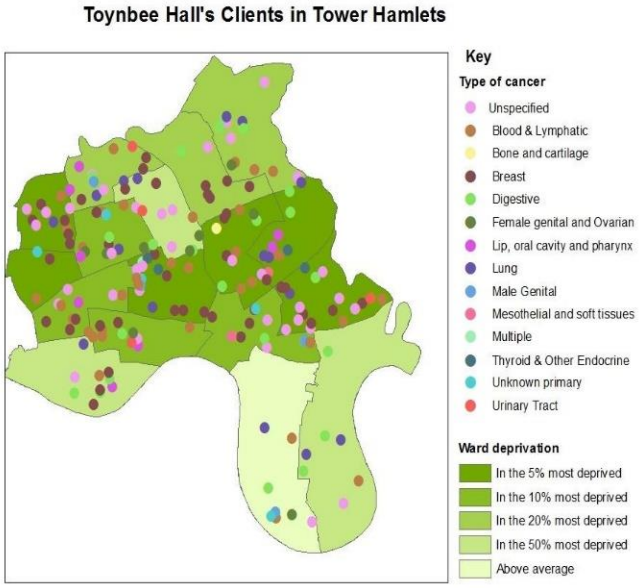


Figure 3. Toynbee Hall clients in Tower Hamlets

Case Study

Linda is a Cypriot woman in her 60s who lives alone. She was diagnosed with cervical cancer in 2009 and Non-Hodgkin lymphoma in 2013. Following the researcher's introduction, Linda's recollection of her cancer journey focussed on a lack of support:

> *"Nobody came to see me, nobody asked me if I needed anything, nobody helped me in any way at all. … No services at all. … It chokes me up just to think about it."*

Sharing how she was told about her first cancer, Linda said:

> *"When I opened the door, she [my GP] didn't ask if I was with anybody, she didn't ask me to sit down. … You can imagine my shock: I'm standing at the door and this doctor is telling me that I've got cancer. What do you do? "*

Cancer has changed Linda, from "*a very outgoing person*" to someone who does "*not leave the house."*

> *"If I don't go out anywhere, I don't spend any money. And when I go shopping… I can't spend more than £20. So I make sure what I buy is enough to see me for the whole week."*

For Linda, fear for her health and financial difficulties mean she has to "*stay at home 24/7*" Her account strongly calls for financial assistance as well as psychological and social support for her, especially considering she does not have close contact with family and friends.

Understanding and positivity

The participants noted that 'sincerity' and 'positivity' help them cope better with the draining physical impact. Health professionals play a big part of their journeys, so doctors' and nurses' accounts placed great importance on this need and this research suggests that they are largely helpful.

Some participants talked about the importance of clear communication, with positive accounts of the step-by-step explanations provided, and more negative descriptions stressing the lack of clarity. Different experiences suggest the importance of patient-centred care that provides information that patients require and communication that suits their needs. Robert, a bladder cancer patient, for instance, described a negative experience. He felt treated "*as a body"* rather than as a person. His examination was intrusive and onerous to the extent that he delayed re-examination when he noticed symptoms returning.

> *"It makes my eyes water thinking about it [the examination]. They've got to put a camera up your penis … and you're lying down, and there's like, four or five people round you. …You feel bad in yourself for letting all these people round you messing with you."*

For a few other respondents, understanding their needs meant understanding their difficulty of waiting for three hours for a chemotherapy session. They said that it takes six hours to complete a session of treatment and they are often exhausted by the time they complete the treatment and make their way home. Reducing the waiting time would have been a clear improvement for them. St Bartholomew's Hospital, for instance, has been making efforts to do so.

Having someone to talk to

Some respondents highlighted the importance of psychological therapy and workshops. But sometimes, other patients can also be a good source of psychological and social support. This was emphasized in our interview with Joseph, a fiercely independent older man who had previously worked as a nurse:

> *"By speaking with the patients who had the same cancer treatment … you feel much better, you talk it out."*

From this map (Figure 5.), we would also like to draw attention to the lack of psychological and social support services for people with cancer in three wards, Spitalfields and Banglatown, Mile End East, and East India and Lansbury. These three are among the 5% most deprived wards in London, suggesting a greater need for local service provision.

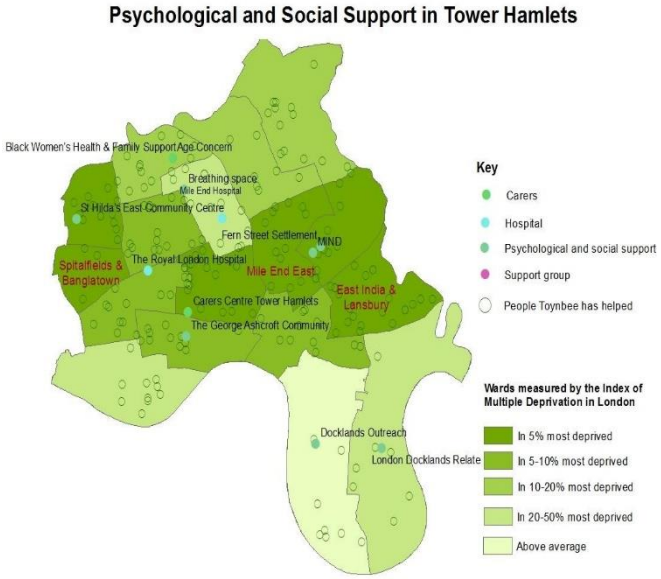


Figure 4. Psychological and social support in Tower Hamlets

Resolving money worries

In this study, apart from those who had already retired or been unable to work because of other illnesses, all the cancer patients and family members had to either stop working or reduce working hours. They therefore believed that it was 'foundational' to receive help in resolving their money worries.

Integration of services

Most respondents had multiple needs and issues. Many of them had benefits issues, three participants had housing problems, and one had a child care issue because her five-year-old daughter was not allowed in the hospital. These range of issues demonstrate the variety of needs among people affected by cancer. Integrated services are required to provide 'one-stop' access to support.

Recommendations

Short term:

- Hospitals to develop strategies to reduce patients' waiting time for treatment sessions, such as chemotherapy.
- Hospitals to start a support group in the borough or build on existing social groups.
- Information pack made available which is updated regularly. The pack should include main services such as psychological and social support services, generalist, benefits and debt advice, exercise groups and older people's services. This information pack can be given to the patients at the point of diagnosis.

Medium term:

- Further training provided to help both doctors and nurses understand patients' experiences and develop better and more positive communication skills.
- Hospitals, Macmillan or other support services could set up a befriending scheme where volunteers who have recovered from cancer support patients in the hospital.
- Macmillan can act as an initial point of contact and be more proactive in referring people onwards to other services.

Long term:

- Health providers work with the media, encouraging positive thinking on living with cancer.

Eden Care – "The voiceless"

Organisation

Eden Care's objective is to work in partnership with other providers. They plan to engage service users in a culturally inclusive manner to increase and enhance their quality of life through friendship and advocacy. Their befriending and advocacy service works with adults and young people who are terminally ill or reaching the end of their lives.

Summary

Eden Care's research method was based on obtaining qualitative data through interviewing ten service users from a BAME background who had differing health needs. By using a 'one on one' interview method of gathering data researchers acquired first-hand information on how service users felt about NHS services.

Key findings

Case Study 1

Almas Miah - Father of Mahima Begum

Condition - Cerebral Palsy

Almas strongly believes that the lack of communication between hospital staff and his family were contributing factors to the ill health of Mahima on the day she was born. He is now faced with caring for his daughter for the rest of her life and struggles to meet all of her needs including providing all night supervision due to the risks of Mahima choking during the night. He also struggled to understand the complexity of words, medical acronyms and terminology used by some of the NHS staff. For Almas' wife, English was not her first language and to compound matters further, she also found their use of medical terminologies difficult to understand. Almas' wife would have benefitted from pre-natal classes delivered in the Bengali language in order to understand the process in having a baby and to become familiarised with the services on offer at the hospital.

> *"I and my wife have to take turns staying awake at night time, in case she chokes, and she has an epileptic fit, her medication has to be done on the spot.*
>
> *"I could do with a lot more help, the only care my daughter needs is 24 hours care, throughout the rest of her life."*

Case study 2

Rushna Khanam - Sister of Shopna Khanom

Condition - Terminal Cancer

In a desperate attempt to treat Shopna's illness her family took her abroad to Bangladesh and India to receive traditional folk medicine which was ineffective. This exacerbated the problem as the treatments given had almost killed her. Rushna believed that if the NHS had played a more active role in persuading the family not to seek treatment abroad this could have saved the family from the unnecessary journey.

Rushna also believes that there is a lack of awareness of the symptoms and conditions related to cancer especially around prevention, it's detection at the earliest stage and in how to cope with these life changing conditions.

> *"The GPs kept on saying that it's probably nothing... gastric pains… they said it was kidney stones.*
>
> *"They found out (after 6 months) that she doesn't have kidney stones, she's actually got stage three cancer".*

Case study 3

Abu Mumin – Son of Late Saleha Begum

Condition - Died of Heart Failure

Abu Mumin's account in the shortfalls of the care provided to his mother where cultural and religious sensitivities have been overlooked goes to show that there is still a long way to go in order to truly make our health services more inclusive for our boroughs diverse needs.

In an interview, the Imam of East London Mosques, Shaykh Abdul Qayyum reinstated the importance of meeting the needs of the Muslim and wider community during their time of need.

> *(Whilst in hospital) "She wasn't well and was on lots of medication, she needed a wash and all of our family members were there, and to our shock and surprise, two male nurses came to give my mother a full wash, we were horrified and shocked…Why was her dignity and care not a priority?"*

Recommendations

Promote bilingual services

Translation services for Bengali speakers promoted extensively throughout Bengali and Muslim media channels including TV, radio stations and print media to help raise awareness for patients to use the bilingual services on offer and to feel more confident in using NHS services independently.

Culturally inclusive training

NHS staff given culturally inclusive, local training in order to understand Muslim sensitivities, especially when personal hygiene care is given by nurses of the same gender and not the opposite as this can easily offend.

Greater emphasis to be given to disabled patients

More awareness training for NHS staff to understand the unique needs for disabled patients. This awareness could be relayed through a scheme in where staff can have immediate access to patients' specific needs.

Community empowerment through locally delivered services

More services delivered through local organisations such as mosques and community centres being trained in delivering awareness on campaigns on preventing common health illnesses.

Senior management team at the Royal London Hospital

To advance greater care, The Royal London Hospital staff should be more reflective of the local community including the senior management team.

Stalwart Communities Limited

Summary

This study was designed to assess the need for, and possible benefits of, provision of a personalised educational health information service for families that have individuals with serious illness and chronic conditions. It aimed to provide an initial step towards evaluation of the resources that might be needed to deliver it. The family of interest is the group of related individuals whose lives are, or are likely to be, most affected by a health disorder – for practical purposes, the group living at the sufferer's home.

Researchers conducted a series of interviews with each family, with family members together and individually. Each family was asked to assess how well or otherwise it had been advised about the patient's problem and the future, and to give an idea where the best advice came from. Families were asked a series of questions to understand the family's feelings.

Twenty-six families were admitted into the study, ranging in size from more than ten down to four members. Seven families gave their region of origin as in the United Kingdom, 11 in Asia, five in Africa, two in the Caribbean, and one claimed origin in more than one of these regions.

Key findings

- Most of the information that families knew about the illness was from their doctors.
- It was found that 92.3% said that their families' problems affected them a lot.
- Over half of the families have said that they wanted to know more about their family member's disorder/illness.
- While a majority of families drew information from both hospital-based doctors and general practitioners, individuals did so to a rather smaller extent, perhaps suggesting that access to doctors for all but the 'principal' caring family member may be more difficult.
- A majority of the individuals studied are themselves made vulnerable by the contrast between satisfaction from factual information they gather and constant anxieties prompted by the suffering they see close at hand. Inevitably, some of them will fail to respond to some other of contemporary life's challenges. They may themselves become the patients of tomorrow.

Recommendations

- Further interviews should be carried out as soon as possible, and a more thorough analysis, wider discussion, engagement with professionals and the third sector undertaken and the results put together in the near future.

General Practice

Al-Ishaara

Organisation

Al-Ishaara is a local charitable company that has worked with and for deaf and hard-of-hearing people since 2008. They provide a broad selection of deaf friendly services in Tower Hamlets ranging from children's and adults' Islamic classes, a Friday community sermon translated into British Sign Language (BSL), a deaf youth service, marriage service, a dedicated deaf employment service and multiple events across the year to improve community cohesion across the UK.

Summary

The research sought to investigate access to GP practices for the deaf community living in Tower Hamlets and also how GP practices could play a greater role as places to receive wider health and wellbeing support, i.e., linking patients into health programmes, community services, welfare support, social activities etc.

This research also sought to identify communication barriers and highlight the needs of the deaf and hard of hearing (HOH) community when accessing GP services.

Al-Ishaara gathered the views of parents and children with special education needs on how services could work better together to improve the quality of their care. A combination of methods was used to gather information, from surveys, to focus groups.

Key findings

Key questions were asked to parents or adults who were deaf. They included the following:

Parents were asked what difficulties they face when visiting the GP as a deaf person or parent of a deaf child. The issues were:

- Need to book BSL interpreter communications problem.
- Communication barriers need to communicate in BSL.
- Want to book interpreter but they didn't provide one.
- Community Support Worker (CSW) level three is wrong should be interpreter level C.
- Communication problem with GP without interpreter.

> *"I needed British Sign Language interpreter at GP appointment but they sometimes don't provide a BSL Interpreter for me."*

Which health programmes are you aware of that benefit your child or yourself?

Most health programmes are not deaf friendly. They need to provide visible hand or BSL interpreter.

Have you received any information from your GP regarding health programmes suitable for the deaf?

From the focus groups, it was found that both the hard-of-hearing and deaf groups received no information from their GP regarding health activities that are suitable for those that are deaf.

> *"Very difficult [to make appointment], as I have to drive there because I can't use Type Talk and doctor doesn't have a text phone."*

The deaf community is facing constant difficulty with telephone appointment booking systems, verbal prompts when their doctor is ready to see them, and rarely have a clear understanding of their diagnosis and treatment.

Waiting times for interpreters in GP appointments seems to be a massive problem. At the moment many people have to wait weeks to book a sign language interpreter who can make sure the patient and clinician are able to communicate clearly. There is an obvious link between these delays and poorer general health.

Recommendations

- The views of the local deaf and hard of hearing community need to be listened to about how GP practices could play a greater role as places to receive wider health and wellbeing support.
- The views of parents of children with special education needs and children themselves need to be listened to on how services could work better together to improve the quality of their care.
- Better forms of communication from all services through leaflets, videos and information boards in practices. Provide trained professionals in BSL to communicate effectively about the needs of the service user.

Asian Women Lone Parent Association

Summary

Through a focus group/workshop and one to one's, 13 women were consulted on how to improve Asian lone mothers' access their GPs for their health and wellbeing needs, what would they like from their GP and what are the barriers to them accessing health services in Tower Hamlets.

The women ranged from 18 to 45 years old and consisted of a mixture of Indian, Bengali, Sri Lankan and Pakistani women who arrived in the UK both through marriage and those born and brought up in the UK. Most of the women attended GPs in the Limehouse, Poplar and Gill Street areas.

Key findings

In general it was found that the women had a positive experience in Tower Hamlets with health services for them and their children. The main use of health service was of their GP. Frequency of accessing their GPs varied for the women and much of this depended on their children's health needs.

It was found that the biggest challenges faced in trying to help women and their children to be healthy and well were in relation to access and support services including getting their children into a good school, support to find a job/volunteering, knowledge and support to access local exercise services for themselves and their children, wanting to swim but not knowing how to, finding healthy food expensive, managing their child's fussy eating habits particularly around not eating fruit and vegetables. Stress was a common challenge with two women saying they would like help to go on holiday so they and their children can feel better, managing own illnesses such as tuberculosis and eating habits.

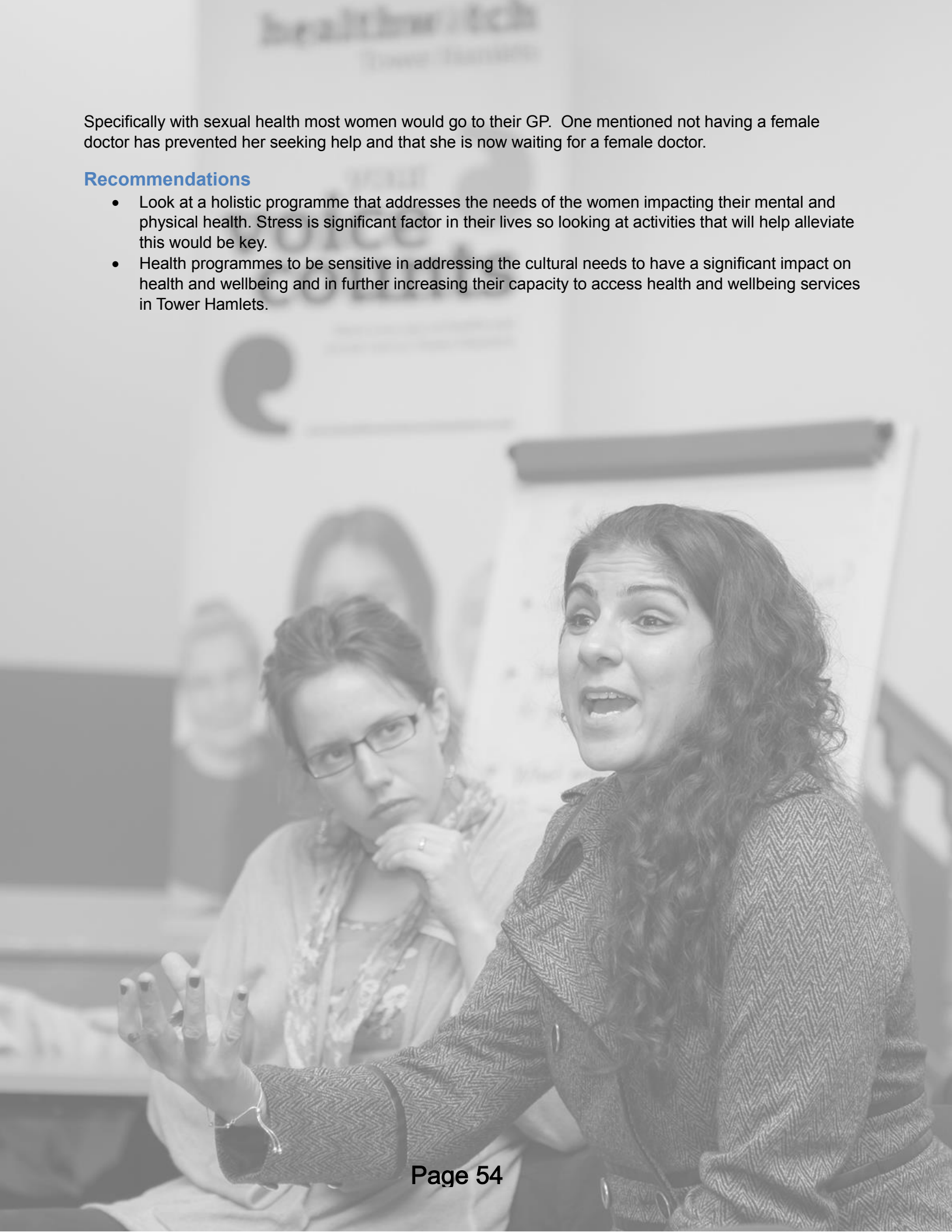
With regards to mental health, most of the women knew what this meant in that it related to 'your mind'. Four women did not know what this was. Interestingly over half did not know where to go to access mental health services. Three mentioned their GP as a source of help and one mentioned counselling.

Getting housing and a job were seen as the most common needs in regards to improving general health and wellbeing, examples given included getting a good permanent home, support with childcare, a positive change programme for women, help with jobs and support with housing to alleviate stress and help with mental health.

Specifically with sexual health most women would go to their GP. One mentioned not having a female doctor has prevented her seeking help and that she is now waiting for a female doctor.

Recommendations

- Look at a holistic programme that addresses the needs of the women impacting their mental and physical health. Stress is significant factor in their lives so looking at activities that will help alleviate this would be key.
- Health programmes to be sensitive in addressing the cultural needs to have a significant impact on health and wellbeing and in further increasing their capacity to access health and wellbeing services in Tower Hamlets.



Equality and Diversity

Drug and Alcohol Services for London – "Research into the healthcare needs of people from the Eastern European Community in Tower Hamlets"

Summary

Drug and Alcohol Services for London (DASL) aimed to acquire a mixture of feedback both from prospective health care service users and professionals who have worked with people from the Eastern European Community (EEC).

DASL worked with EEC service users and staff from Providence Row, NHS health visitors, the Fellow Centre, Doctors of the World, Vision Care for the Homeless, Tower Hamlets community mental health teams, substance misuse services and GP practices and healthcare centres.

They used two questionnaires, one for individual service users and one for professionals. The service users were interviewed on a one-to-one basis and also in groups.

Key findings

All had accessed some form of health care, with the majority accessing a GP practice, NHS hospital and dental care.

Forty per cent stated that the registration process for GP's was complex and lengthy, some waiting months before they were informed that they had been successfully registered.

Women who had been pregnant said they were unaware of any antenatal care or what they could access in the way of pregnancy support. One woman stated that she felt alone and frightened and didn't know where to turn for help.

Most stated that language was the biggest barrier with 77% saying this caused problems when trying to access health care along with the second being homelessness, with 45% saying they experienced problems.

Antenatal care was raised by the women we interviewed and also by some of the professional agencies. It was stated that women at any stage of pregnancy were not aware of health care, antenatal classes, activities or follow up care required during pregnancy. Those that had accessed support found the language barrier confusing and felt they were unsure of health care requirements.

Some people we interviewed felt that a lack of adequate identification (e.g., passports, birth certificates, NI cards, etc.) was a barrier to accessing health care and registering with a GP practice. Concerns were raised by one professional agency that when a person is trafficked or endured forced labour, very often they flee without any documents or identity.

Recommendations

- Information about health care services for people from the EEC be available in accessible formats (language, electronically via websites, literature in accessible venues), specifically Polish and Russian. Extend the hospital telephone translation into English, Bengali and Polish and Russian.
- Translations be available for pregnant women throughout their entire pregnancy – including written information about stages of care.

- Registration at health care practices is explained or accessible in written information in EEC languages, or alternative information about where people can go if they are not eligible to register with a particular practice.
- Better advocacy and support from specific agencies who understand EEC issues.
- Some organisations are already putting into practice ways to improve access to health care for their service users, lessons and good practice should be shared across the sectors.
- Training for health care professionals on the intricacies of the EU regulations and health care in the UK for EEC.

Dual Diagnosis

East London Radio– “Somalia Men – small problem or a big issue?”

Organisation

East London Radio (media) and Meducate Healthcare (public health) collaborated on this hugely important topic regarding dual diagnosis: mental health and substance abuse in regards to Somali men’s health.

Summary

This project set out to investigate the potential link between mental health and substance abuse and the current service provision in a hard to reach group – the male Somali community in Tower Hamlets.

The aim was to answer three questions:

1. What are the experiences of people who have mental illness and a pattern of substance misuse?
2. What are the issues in relation to accessing services?
3. What would help people to move forward in their lives?

The research used face-to-face open questionnaires with the community. Additional case histories were transcribed, as the interviewees (45 interviews were conducted) wanted their stories told. Two podcasts were selected, as the narratives required a public platform. The age range of the participants was from 25 years to 79 years with a mean age of 42 years.

Key findings

On questioning the male Somali community face-to-face the project became aware that the fundamental issue was not about a mental health diagnosis, but lay in an absence and misunderstanding of its manifestation.

Loneliness was expressed as a common state of ‘mental health.’ Isolation, worthlessness and hopelessness were given as descriptors of current ‘feelings’. Prescription and over the counter medicines (analgesia) in particular were taken to dull sensory pain, like ‘feelings’. The men expressed themselves in terms of feeling marginalised by lack of work opportunities, changing roles within their families and parenting gaps. Even in their own communities, they recognise that it is a spiral of decline that needs to be challenged.

The Somali community continues to feel relegated in Tower Hamlets, due in part to written language difficulties. Somali language is an oral language, hugely descriptive and pictorial.

We cannot accept that mental health is just a medical problem. However, we can give testimony to the shortage of untapped skills and experience that already exists in the community. This should be explored, harnessed and utilised. There is an absence of career or coaching for this cohort, and the Job Centre and benefits trail has failed to harness their previous expertise, skills and knowledge.

In general, services seemed adequate, flexible and easy to access. Mental health seemed to be the more prevalent of the two topics (alongside substance abuse) and evidence suggested collaboration between other services to meet medical, social and psychological conditions.

Ninety-three per cent were currently unemployed and the length of time was between one year and twelve years. However, ‘feelings’ were frequently mentioned. Descriptors around unemployment included ‘hopeless’, ‘waste’, ‘sad’, ‘angry’ and ‘unhappy’ as the most common themes.

Two per cent of the participants declared they had mental health problems. Diagnosis was given medically and they were on antidepressant medication.

"I'm on tablets. My friends know. It helps me. When I had a job, I wasn't on tablets."

- S.M 39 years, E1.

Few knew how to start a conversation with their GP about how they were feeling.

"The doctor ask me what wrong, I say I have pain, he say where…..? I get tablets for pain in head"

- O.H, E14

Mental health remains a taboo topic within the community (use of language, 'mad, bad') and is still misunderstood.

"I go to Germany. I have family there. Nobody knows me. I have bad demons."

- A.M, 55 years, E2.

Loneliness and feelings of 'sadness' and 'despair' is often treated with painkillers, often prescribed, but more frequently self-medicated

Recommendations

The community wants to become empowered to be more responsive to their care needs.

Development of an App (software application) that is both written and pictorial telling people how to recognise symptoms of mental health/substance abuse. This could be developed in the schools within the science and technology curricula or indeed within Queen Mary University (computing) and the community could have a say. An example of such an App is one that has been put together by "One in Four" aimed at teenagers. It addresses the difficult issue 'what to say to the doctor' when you are feeling depressed, lonely etc.

The need for formal education, such as English for Speakers of Other Languages (ESOL) in a place of study, not a community facility.

Queen Mary University was identified as most appropriate. This could create a revenue stream for the institution and potential employment of tutors. This visibility would enable them to engage in a mixed community and share a life-long learning platform.

Parenting skills were identified as a key issue. Grandfathers, uncles, brothers and fathers all stated they felt a cultural gap due, in part to language.

Formal parenting classes, particularly for men, many of whom have adopted many childcare responsibilities.

Football is a national sport in Somaliland. It is played in small groups within the community in public spaces within the borough.

Football league is set up. The local authority could sponsor the kit. This would give out a clear message of 'health for all' It would create a platform for stronger family bonds, time to talk and the added health benefits of engagement.

Men expressed an interest in their history and culture being on the school's curriculum and were willing to give their time voluntarily.

Participation in Black History month in the schools and perhaps access to the Whitechapel Gallery, to tell their stories.

There is a need to engage with the wider community in the borough and participate in the voluntary sector. This would enable them to create a working profile whilst they gain experience and build skills.

Meeting care needs alongside an ageing population, it was felt that keeping fit and active was very important as its benefits include mental health.

A designated care agency set up in the borough would benefit the community, in keeping people independent in their own homes whilst providing additional employment opportunities. This initiative may attract government funding and business loans and potential private investors.

Providence Row Housing

Summary

The research explored the experiences of people with dual diagnosis in Tower Hamlets. A participatory research project was conducted by Providence Row Housing Association's peer consultancy team.

Dual diagnosis refers to people who are experiencing mental health difficulties and use drugs and/or alcohol at the same time. This has long been a challenging area for support providers who struggle to define which should be viewed as the predominant underlying need and which should therefore be treated first. As a result, people with dual diagnosis have often found themselves being bounced back and forth between mental health and substance misuse treatment services.

Eleven separate target groups were identified for the community intelligence program. We chose to target people with dual diagnosis from homeless or insecurely housed populations.

Providence Row investigated the following questions:

1. What are the experiences of people who have mental illness and a substance misuse and/or alcohol issues (often referred to as dual diagnosis)?
2. What are the issues of accessing services?
3. What would help people to move forward in their lives?

The research team (three women and three men) all had lived experience of requiring support for a range of presenting needs.

The methods used in the research included:

Group Work: Participatory Appraisal (PA) is a series of interactive, visual tools and techniques that can be used to help overcome barriers such as formal literacy and numeracy. PA sessions were delivered at ten different sites across the borough. Fifty six people attended the sessions, 34 male and 22 female.

Interviews were also used in this research: Two men were interviewed. One is White British and the other of mixed heritage. One woman was also interviewed. She was White British.

Key findings

Relationships - people placed a great deal of emphasis on feeling able to 'relate' to or feel some affinity with their human points of contact through the various services they interacted with. A sense of commonality and understanding was deemed a strong determinant of the level of success achieved in both drug and alcohol and mental health services. It appears that there is a direct correlation between caring and empathy, the building of a relationship, and the perceived quality of support received.

Housing - “Warehousing” people with similar problems together has a negative impact on recovery. It is more difficult to stop using drugs and alcohol and remain abstinent when surrounded by others who are using heavily. This in turn has a negative impact on mental health.

Another important factor that arose was the 'moving on' process. Many of our participants felt that they had been 'forgotten about' once placed in a hostel. With some reporting little or no structured support or advice around re-housing.

Access to support - Many people felt that they didn’t know about all the services they could access. They also spoke about the challenge of having to navigate help for different presenting needs and the difficulty of having to repeat their story every time they meet someone new.

Waiting times - There appeared to be a vast difference in the waiting times for initial contact with certain services. For instance the waiting time for an assessment for statutory mental health services was often felt to be overly long, whereas the waiting time for an assessment for drug or alcohol services was found to be short in comparison.

Formality of services - Participants felt that drug and alcohol services tended to be less formal which made access and engagement easier for them. Statutory mental health services on the other hand were thought to be too structured and formal. This meant people often felt more comfortable seeking help from drug and alcohol services.

Communication - Communication of information between services was felt to be poor. Service users found themselves repeating their stories over and over again across a range of services. Many found this frustrating and disheartening. The fact that there doesn’t seem to be any central information hub or collection point for services users’ information was a recurring theme in our research.

Peer support - Almost every participant through the research spoke of the value of lived experience in the delivery of services.

Use of time - Participants who had stopped using drugs and alcohol and felt their mental health was stable spoke overwhelmingly about the importance of having something positive to do with their time.

Understanding dual diagnosis - Many participants had been passed from service to service until they found one that 'fits' their support needs. Instead people feel they require help for a set of problems that all impact on each other.

Recommendations

- Statutory mental health services should consider how to become more effective at engaging those with dual diagnosis who are unable to access overly structured support. An example of this would be to provide in-reach to hostels and other homelessness services.
- Drug and alcohol and other mental health services should also be providing in-reach to hostels. This will help initiate contact for those requiring support.
- Staff in voluntary sector services should be enabled to understand how to engage people with dual diagnosis more effectively. This could be done through the provision of training and networking by statutory mental health services, which would also facilitate more effective joint working and information sharing.
- A better relational approach should be adopted by services offering support to people with dual diagnosis. A good working example of this is the Enabling Environment (EE) and Psychologically Informed Environment (PIE).
- A single point of assessment and access to support for people with dual diagnosis.

- Lived experience should be incorporated into service delivery wherever possible. This could be done in several ways:
    - Employing more people with lived experience within services.
    - Expanding the Recovery Club model to be used within more services.
    - More peer delivered support services.
    - More service user involvement in commissioning and designing of services.

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Committee:	Date: 20/04/2016	Classification	Report No. 3	Agenda Item No. 3.3
Health Scrutiny Panel		Unrestricted		
Report of: Transforming Services Together (Tower Hamlets, Newham and Waltham Forest CCGs) **Originating Officer:** Don Neame, Director of Communications, NEL CSU & Transforming Services Together		**Title:** Transforming Services Together		

1. SUMMARY

1.1. Transforming Services Together (TST), a partnership programme of work between Tower Hamlets, Waltham Forest and Newham CCGs and Barts Health Trust has published its Strategy and Investment Case. A period of public engagement began on 29 February and will run to 22 May 2016. Given the potential impact, Tower Hamlets CCG, patient representatives, the London Borough of Tower Hamlets and others (e.g. clinicians) have been involved. The Strategy and Investment Case recommends investing in care closer to home, new models of care at our hospitals, more modern facilities and developing new ways of working.

1.2. The TST Strategy and Investment Case has been developed by over 1,000 clinicians, managers, staff and public and patients. It has been approved by the three CCG governing bodies and Barts Health board. It is a response to the agreed Case for Change published in December 2014.

2. RECOMMENDATIONS

The Health Scrutiny Panel is recommended to:

- Note the publication of the strategy and engagement plan
- Provide initial views; and
- Take part in the engagement period both by making a formal response to the engagement and encouraging others to make their views known.

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Transforming Services Together

Strategy and investment case

Part 1: Summary

NHS Newham Clinical Commissioning Group

NHS Tower Hamlets Clinical Commissioning Group

NHS Waltham Forest Clinical Commissioning Group

Barts Health NHS Trust


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Contents

Foreword

Transforming Services Together aims to improve local health and social care in Newham, Tower Hamlets and Waltham Forest – very much in line with the challenges of the NHS Five Year Forward View[1], local and regional plans and guidance[2].

Celebrating success

This document focuses on where we need to improve. But it's important to recognise some of the NHS's huge achievements in the past 20 years and appreciate the efforts of everyone working in health and social care.

For example, at the Royal London Hospital, we have one of the best trauma centres not just in the country, but in the world. We've also improved the quality and accessibility of our primary care services. Our services for tuberculosis, mental health, carers, and our websites and management have all been nationally recognised.

Stroke care is exceptional and survival ratios at our hospitals (a key measure of how safe services are) are among the country's best.

By working together we are ensuring local people are far more likely to survive conditions like heart disease than people in many other parts of the country[3].

A partnership approach

However, we also face complex challenges: a rising population; financial and workforce pressures; and in some cases poor patient care, buildings and infrastructure.

Where we live, our environment and our socio-economic situation are critical for wellbeing. We recognise the responsibility of local authorities for the health and wellbeing of their populations. We also recognise the responsibility of patients to make efforts to stay well, and how this could reduce the burden on the health service.

Together we have developed proposals that respond to some of the challenges and take advantage of the opportunities we face. Clinicians have led the discussions, in partnership with key stakeholders and members of the public. We welcome the honesty everyone has shown in reflecting on what is wrong with the existing system. We also welcome their dedication to developing new ideas on how to make the changes that are clearly needed.

We are encouraged by the enthusiasm for change, the willingness of all partners to work together and the strong belief that solutions can be found. More than a thousand people have taken part so far – we thank every one of them.

1 NHS England www.england.nhs.uk/ourwork/futurenhs/
2 London Health Commission www.londonhealthcommission.org.uk/better-health-for-london/
3 Health and Social Care Information Centre. January 2015 www.hscic.gov.uk/pubs/shmijul13jun14

We want to develop a new partnership with local people: it is your NHS, and we know it is a much-valued and respected institution. The health service, staff, partners, patients and residents need to work very differently with each other, and everyone has a part to play.

Our plan

This document outlines the main health and social care changes and investments needed in East London. We have set out a credible plan to transform the services that almost one million people (and rising) rely on. We must ensure we provide the patient experience that people expect, and the services that keep them well and safe. Most importantly, these changes will reset the system on a path towards financial sustainability.

We look forward to hearing from you.

Dr Prakash Chandra
Chair, Newham CCG

Dr Sam Everington
Chair, Tower Hamlets CCG

Dr Anwar Khan
Chair, Waltham Forest CCG

John Bacon
Chair, Barts Health NHS Trust

About Transforming Services Together

The Transforming Services Together programme is run by Newham, Tower Hamlets and Waltham Forest Clinical Commissioning Groups (CCGs) in partnership with Barts Health NHS Trust.

How you can help

We are now testing our ideas with staff, local communities, partners and patient representatives through drop-in events, focus groups, meetings and other methods.

This summary and the full document are intended to stimulate debate. To get involved or make your views known, please contact us:

☎ **020 3688 1540**

✉ **TransformingServicesTogether@nelcsu.nhs.uk**

www.transformingservices.org.uk

or fill in the questionnaire at the back of this summary.

We look forward to hearing from you.

Deadline for comments

We'll continue to involve people as these proposals develop, but we'll be finalising this Strategy and Investment Case in the summer of 2016. So we need your comments back by **22 May 2016** to help us at this stage of the process.

How to see the full document

To view the full document, please look at our website or contact us for a paper copy.

Who helped to develop the plan?

The plan has been developed with patients, the public and their representatives across East London. By 'East London', we mean the boroughs of Newham, Tower Hamlets and Waltham Forest, which are the focus of this strategy.

Over 300 health and social care staff (for instance surgeons, pharmacists, midwives, nurses, GPs, practice managers, healthcare assistants and managers) have also been involved from Barts Health; neighbouring CCGs (in particular, City and Hackney CCG, Barking and Dagenham CCG, Havering CCG and Redbridge CCG); Homerton University Hospital NHS Trust; East London NHS Foundation Trust; North East London NHS Foundation Trust; local authorities (including their public health teams) – in particular the London boroughs of Newham, Tower Hamlets, Waltham Forest, and Redbridge; NEL Commissioning Support Unit; NHS England – responsible for specialised commissioning; and the Trust Development Authority.

Challenges we face

The future challenge means the NHS and social care has to change

Our population is projected to grow considerably. Over the next 15 years, the population of Newham, Tower Hamlets and Waltham Forest will probably grow by 270,000 – the size of a new London borough. We anticipate thousands more births each year and, as people live longer, so their health and social care needs will also increase.

But we are close to reaching the capacity of our buildings if we continue working in the same ways. If we don't change, we'll need 550 more hospital beds in the next 10 years and capacity for over a million more GP appointments. Extra funding from the population increase will not cover this cost, and in any case it would be wasteful. We need to redesign services to help people stay well, reduce the need to use hospital services, and join up our services to make them more efficient.

There are always changes that will affect how our services operate. For instance, King George Hospital's emergency department is expected to close, which will mean an increase in demand at Whipps Cross and Newham hospitals.

Over the next 15 years, the population of Newham, Tower Hamlets and Waltham Forest will probably grow by 270,000

We need to improve the quality of care and patient experience

Existing challenges

On their own, these future problems would take great efforts to solve. But the NHS in our area is already facing other serious challenges.

Health and social care budgets are being squeezed. The spending freeze on NHS budgets, and spending cuts to local authority budgets, are placing great financial strain on services – in particular in areas of care where integrating health and social care is so important. Clinical Commissioning Group finances are currently in balance, but are predicted to worsen rapidly over the next five years. Barts Health already has the largest expected deficit of any trust in England (about £135 million for 2015/16).

We need to improve the quality of care and patient experience. There are problems about access to, and experience of, primary care and other services in the community. Around 40% of respondents to the GP National Patient Survey said they could not see a GP of their choice and over 30% found it difficult getting through on the phone. Some of our health services are world class, but too many are not. Barts Health is struggling to meet the London Quality Standards[4]. In June 2015 the Care Quality Commission assessed patient outcomes at Barts Health as being at, or better than, the national average in most medical and surgical wards at the hospital. But it also highlighted a lot of areas where improvements are needed. It rated the trust 'inadequate'[5]. In response, the trust published Safe and Compassionate[6], which describes how, by working with staff, patients and partners, it will deliver lasting improvements.

4 www.england.nhs.uk/london/our-work/quality-standards/
5 www.cqc.org.uk/provider/R1H
6 www.bartshealth.nhs.uk/media/286492/150915%20BH_Improvement_Plan_FINAL.pdf

■ **Our workforce is stretched**. We struggle to recruit and keep the staff we need. For example, a shortfall of more than 730 nurses (around 13% of the total) exists in East London NHS care providers. There is higher-than-average staff turnover[7] (some 2,800 staff leave our hospitals each year – about 15% of the total). Significant staff shortages exist in some critical specialist roles (such as in emergency medicine and paediatrics) and in primary and community care too – 40% of male GPs in Newham and Waltham Forest are nearing retirement age. We already spend too much on agency staff to plug the gaps.

We need to tackle the high costs of living, low staff morale in some places, and lack of clear training and development routes.

■ **We need to change the social culture of over-reliance on medical (and often emergency) services**. Life expectancy is worse than in the rest of England – environmental factors and deprivation are very important in this and need to be tackled. Supporting people to look after themselves, and better prevention of illness, would make the most significant difference to people's health. Yet we do not prioritise it. Persuading people to change is difficult, given the diversity and transient nature of the population, but it is possible.

■ **Our facilities and IT systems are not always set up to deliver high-quality or efficient care**. We have some of the most modern and high-tech facilities in the country – such as the new Royal London Hospital and the Sir Ludwig Guttmann Centre in Newham. However, many of our community facilities are under-used or unsuitably fitted out, too small, or in the wrong place for the services we need to give. We have many old buildings that need heavy investment just to maintain them – Whipps Cross needs over £80m of building investment.

Our IT systems are not fit for purpose. The equipment is poor. Some systems won't connect to each other. So greater efficiency and better services are held back.

What will happen if we allow things to continue as they are?

■ We'll need an extra 550 inpatient beds by 2025 (costing about £450 million to build and £250 million a year to run). Overall our organisations will be in deficit by almost £400 million by 2021/22. We won't be able to recruit the workforce to staff these beds, and we know that hospital is not the right place for many people[8].

■ Patient experience will decline and patient safety will be put at risk. People will face a confusing health system, and will need to wait longer for operations or travel outside the area for some planned care. People with a mental health illness will continue to be poorly treated compared to patients with a physical illness. Too many people will continue to die in hospital rather than in homely surroundings. Patients and staff will have to cope with poor environments. We won't be able to bring care close to home. We'll miss opportunities to raise morale in our workforce. And our finances will worsen[9].

We struggle to recruit and keep the staff we need

7 Compared with the Health Education North Central and East London area. HSCIC workforce statistics July 2015 www.hscic.gov.uk
8 Audits show that up to 40% of beds are occupied by people who do not need hospital care.
9 The Review of Operational Efficiency in NHS Providers (June 2015) suggested that the NHS could save £5 billion a year by making efficiencies in workforce and productivity; and improved medicines, estates and procurement management.

How we could create high-quality, safe and sustainable services

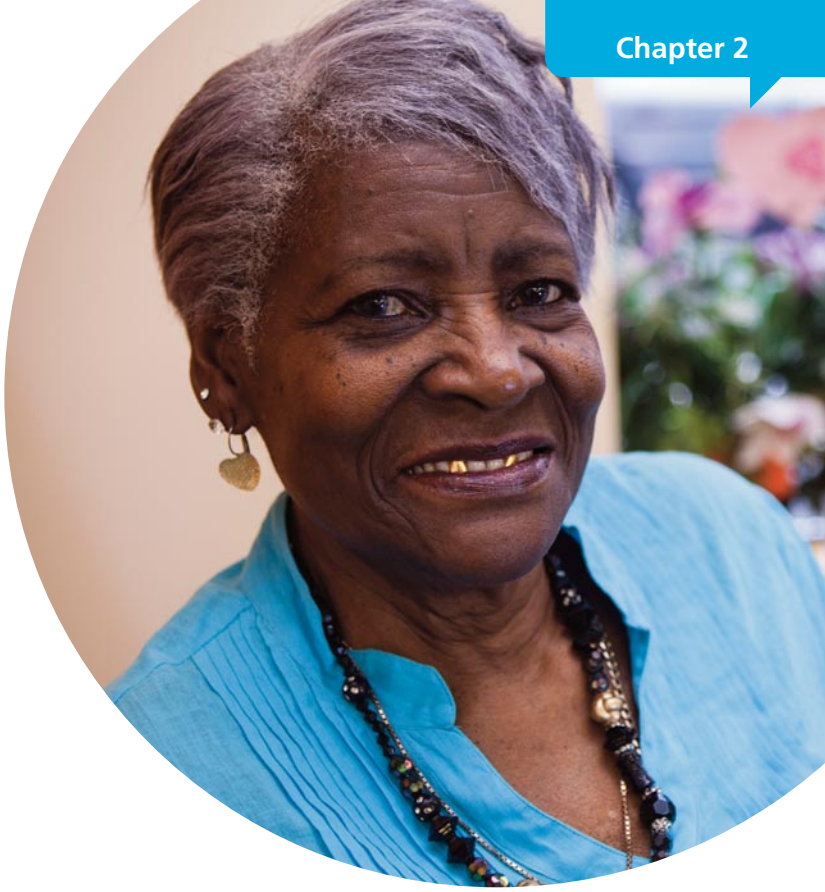
Our strategy

Our strategy aims to:

- support the **health and wellbeing** strategies of our boroughs, helping people to stay healthier and manage illness; and to access high-quality, appropriate care
- **change the culture** of how we commission and deliver care
- **increase involvement of patients and carers** in co-designing services and being part of shared decision-making
- **maximise the use of the assets** (for instance, buildings and the voluntary sector) in our communities
- commission activity to be in **fit-for-purpose care settings, often close to home**
- **focus some surgery in fewer locations** to improve patients' outcomes and experiences and increase efficiency
- acknowledge the importance of supporting people's **mental health** and well-being
- **ensure the system is flexible** enough to respond to changing demands
- help set our **finances on a path of sustainability.**

To meet these aims, we have created three 'clusters' – which are responsible for the overall delivery of the programme. Each cluster has developed specific initiatives that tackle important priorities for change.

Cluster	Initiatives
Care close to home	Improve access, capacity and coordination of primary care
	Expand **integrated care** to those at medium risk of hospital admission
	Put in place a more integrated urgent **care** model
	Improve **end-of-life care**
Strong sustainable hospitals	Establish **surgical hubs**
	Establish **acute care hubs** at each hospital
	Increase the proportion of **natural births**
Working across organisations	Reduce **unnecessary testing**
	Transform the **patient pathway and outpatients services**
	Develop a strategy for the future of **Mile End Hospital**
	Develop a strategy for the future of **Whipps Cross**
	Deliver **shared care records** across organisations
	Explore the opportunity that **physician associates** may bring



The initiatives are supported by work on organisational development, information technology, buildings and communications. Three important themes are built in to all the initiatives, namely:

- helping people manage their health better
- mental health
- children and young people.

Expected outcomes

If we deliver these initiatives through a coordinated, integrated plan over the next five years alongside productivity improvements, they will create the following results:

- A fairer service, treating the needs of everyone in society.
- A healthier population and patients who experience better care.
- More care being delivered close to home, in more efficient settings.
- A workforce that is more suited to providing efficient and effective modern healthcare – staff who better understand their role, who feel supported, and who are enthused about their job, healthcare and the NHS.
- Hospitals that can relieve the pressure on beds; can cope with the increase in population and long-term conditions; and can reduce waiting times or create new ways of raising income.
- Improvements in clinical quality. We expect these proposals to directly support the Safe and Compassionate improvement programme and the lifting of Barts Health out of special measures.
- Net savings from the Transforming Services Together programme of £104 million to £165 million over five years. From year five onwards, the annual saving will be £48 million. We aim to deliver the changes described in this summary, as well as internal cost improvement programmes (CIPs), and quality, innovation, productivity and prevention (QIPP) programmes. Probably this would leave some organisations in surplus and some in deficit. But there would be an overall balance in the local health economy.
- A significant drop in the need for capital funds. The Transforming Services Together programme proposes a budget for buildings and infrastructure of £72 million by 2021 (excluding essential estates and IT work). Without the programme, we would need £250 million.

Fixing the basics

Patients have told us that getting the basics right improves their clinical care and makes them happier. Patients want to be treated in well-maintained buildings. They don't want to tell their story to every member of staff they meet because our IT systems aren't joined up. They want staff to coordinate care, and to show empathy as well as being competent. They also want staff to understand that little things mean a lot, and above all to recognise that every person is different.

Our buildings

We need a flexible and fit-for-purpose estate. It will be actively managed and well used, and we'll take opportunities to share space with other services that benefit the public.

Primary and community care

The traditional model of small GP surgeries is no longer suitable. GP practices should cater for 10,000-15,000 patients or be on the same site as other practices or work as part of a network of practices. This would enable a greater range of primary and community care services to be provided in efficient and modern settings. Primary care hubs for over 30,000 patients should have on-site minor surgery units, sexual health clinics, a greater range of test facilities, and learning areas with access to nutritionists, health coaches and community groups.

Newham: The Vicarage Lane site in the north west would be a good place for a primary care hub. Other possible sites are the Sir Ludwig Guttmann Health Centre in Stratford; the Centre Manor Park; and two further hubs in Royal Docks ward and Canning Town.

Tower Hamlets: The hubs could be at St Andrew's Health Centre; Barkantine Centre; East One Health Centre; Blithehale Health Centre; and a further hub in Whitechapel.

Waltham Forest: Wood Street and Comely Bank could be a good location for a primary care hub. Other sites include St James Health Centre; around the adjoining Ainslie Therapy / Rehabilitation and Highams Court sites; Highams Hill; and Thorpe Combe Hospital.

Acute care[10]

Barts Health includes some of the most modern and efficient facilities in London, but also some of the worst. There are opportunities to improve many facilities, make better use of parts of the buildings and land and dispose of other parts that are inefficient.

St Bartholomew's Hospital: Complete the phased redevelopment of parts of the site; develop and preserve elements of the historic, heritage aspects.

Royal London Hospital: Increase the density (and therefore efficiency) of services in the building and improve the clinical co-location of services on the site; progress the sale and transfer of the old Royal London hospital to the London Borough of Tower Hamlets; and progress plans to develop two further plots of land into a life sciences specialist centre, in partnership with local education partners.

Mile End Hospital: There is an opportunity to consider more integration of acute, community, mental health and primary care services. A strategy is needed to define the most suitable use of the site.

10 Acute care is normally provided in hospital, where the patient requires 24/7 nursing under the care of a hospital consultant

Newham University Hospital: Develop the Gateway surgical centre on the site to allow more activity, in particular orthopaedic surgery.

Whipps Cross University Hospital: There is a continuing (and growing) demand for acute and emergency services on the site. We could work with local partners including the local authority and community based services to create a long-term strategy for the site.

Information Technology

The NHS collects vast amounts of data. We can use it much more intelligently. Developing joined-up information systems will support more effective, integrated healthcare.

We want people to experience services that are truly seamless, with clear signposting, co-ordination of care and exchange of information supporting every patient's journey. All clinicians should have access to important patient data when making decisions, thus reducing the risk of mistakes. We'll focus on ensuring that:

1. the infrastructure (computers, cables, services) is up to the job of supporting reliable, fast access to systems
2. wherever a patient is seen or a decision made in the health and care system, the appropriate data from every responsible health and care organisation is available safely in a real-time, easy-to-use way
3. we can combine data from every organisation to inform and prompt changes to treatments and care pathways
4. patients get access to their records so they can take control of their own health.

Our workforce

The limited labour supply in East London is further squeezed by high turnover and retirement rates. We struggle to recruit to important roles, such as nurses, social workers, allied health professionals and emergency consultants. With few incentives for key workers – such as affordable housing – rising costs are making local living impossible for many nurses and support staff. So we'll encourage the recruitment and retention of staff as follows:

- **Recruitment**. We'll work with universities and other education providers to offer courses to qualify in new roles, e.g. physician associates[11] and advanced nurse practitioners. We'll encourage young people to work in the NHS by connecting with local schools and other education providers. We'll develop apprenticeships and internships. We'll market the attractiveness of working in the NHS in East London.

- **Retention**. We'll help with this through training and development opportunities, flexible working options and financial incentives. These could include 'golden hellos' or 'golden handcuffs'; support with the high cost of London living and transport; key-worker housing; bursaries or student loans to help fill hard-to-fill vacancies. We'll also see if we can remove incentives to leave, such as the high amounts we pay for bank and agency staff.

Joined-up working is also needed in the community, with GPs, pharmacies, dental, community health and social care services (all connected by IT systems) working together to provide an integrated urgent-care response, closer to where people live.

11 Physician associates, though not doctors, must have a science degree and a two-year postgraduate diploma. They can perform a large part of a doctor's tasks at a reduced cost – meaning doctors can focus on the patients and illnesses that need their skills.

Our detailed proposals

Preventing ill health

Life (and healthy life) expectancy is shorter in East London than in the rest of the country. We aim to change the existing culture of over-reliance on medical/hospital services to one where prevention of ill health gets greater priority, and people take more responsibility for their own health. However, this cannot be done by health services alone. The NHS must work with a range of organisations, including those in social care and the voluntary sector to:

- support people to live healthier lives
- make our schools and workplaces healthier
- identify ill health earlier – for instance through screening programmes.

Doing this would mean a healthier population. People would have a better quality of life. They would visit emergency departments and be admitted to hospital less often. We'd be able to provide more supportive care. And we'd have healthier staff working under less pressure.

Over the next five years the NHS will invest more in primary care

Providing care close to home

GPs with a registered list of patients are the bedrock of NHS care and will remain so. Over the next five years the NHS will invest more in primary care. The number of GPs in training needs to rise as fast as possible, and we need to provide new ways of encouraging them to stay.

We need to integrate emergency and ambulance care, GP out-of-hours services, urgent-care centres and NHS 111 so that people can get the right care in the right place at the right time.

Too many people go into hospital or stay in hospital longer than necessary. Early, co-ordinated support that focuses on their wellbeing as well as their health and social care can reduce their dependency on services in the long run. It can also ensure they are admitted to hospital only when it's really needed. This means we need new partnerships with local authorities, communities and employers. And we need to act decisively to break down barriers between GPs and hospitals, physical and mental health services, and health and social care.

New integrated providers will enable the NHS to take a more rounded view of patient care. We're also committed to developing new payment schemes that support providers to work better together to create innovative solutions to local problems.

Making these changes could significantly improve health, reduce health inequalities, improve patient experiences, and create a more efficient service. It could also enable the NHS to cope with the expected rise in attendance at hospitals, GP surgeries etc. Here are some other changes that will help:

- Some activity in GP surgeries could be provided in pharmacies and by supporting self-care.
- Around 180,000 outpatient appointments a year could be provided in other ways that patients would find more convenient.
- The 92,000 extra attendances that are expected at Barts Health emergency departments a year (by 2020) could be managed by shifting activity to primary care and improving patient pathways and system efficiencies.

To provide care close to home, we have prioritised several important initiatives:

Initiatives and the case for change	What we propose	What we'll deliver within the next five years
Primary care There is an increasing (and ageing) population, a rising burden of disease and a shortage of GPs. Patients find access and quality of care unsatisfactory. The population has some of the poorest public health outcomes in the country (for example, survival of cancers and cardiovascular disease, and life expectancy).	Improve access to general practice, pharmacies, dentists and optometrists, for instance by providing supportive online tools or Skype appointments. Establish proactive care by: • empowering patients to take more control of their health, and • offering wellbeing inductions for new patients. Coordinating care. We will make sure 20% of appointments are longer, to suit the needs of patients with complex conditions. And we will continue to connect our IT systems to each other. We believe co-ordinated, proactive, accessible primary care can be given only by a broader range of professionals (for example, by creating physician associate roles or by having pharmacists working alongside GPs) in: - primary care practices serving over 10,000 patients - smaller practices working together in collaborative provider networks that serve at least 10,000 patients, or on a shared primary care site 'a hub'.	The whole population will be healthier. People will find appointments are more convenient, so minor ill health can be resolved quickly and easily. More services will be available in the community, often in the same building, so patients will have less need to go to hospital. We'll have more primary care staff. Patients will be more able to choose a female or male GP. We'll reduce patient complaints by 50%.
Integrated care Too many people go into hospital or stay there longer than necessary.	Integrated care gives co-ordinated health and social care in patients' own homes or in the community to help them stay well or manage their illness. We want to improve our services and extend integrated care to people at moderate risk of going into hospital (today it's available only to those at high risk of it).	People with moderate risk of going into hospital will manage their health better, stay well, be able to live in their own home or the community (rather than have long spells in hospital) and reduce their reliance on urgent care services.

Initiatives and the case for change	What we propose	What we'll deliver within the next five years
Urgent care People find it difficult and confusing to access urgent care – so they often end up going to emergency departments or calling an ambulance, which diverts attention from people with more serious and life-threatening problems.	Simplify and integrate urgent care by: - developing a simple online directory of services - integrating NHS 111 with the urgent-care system so there is one place where people can get advice or book urgent appointments at a primary care hub, their GP or other providers - replacing standalone walk-in centres with primary care hubs that will provide a greater range of services. Provide more urgent-care appointments in the community, including in the evenings and at weekends. Provide a more comprehensive service in urgent-care centres at the front door of emergency departments.	Patients will get the care they need in a timely, easily understood and convenient way. This will help them return to health without needing to visit an emergency department. Around one in four patients attending an emergency department will be treated in an urgent-care setting, meaning emergency departments will be better able to give the best possible care to those most in need.
End-of-life care One in three people admitted as emergencies to a hospital are receiving end-of-life care. However, most people would prefer to die in the place that they usually live.	Identify earlier the need for end-of-life care. Have supported conversations with patients. Have better recording and sharing of patients' preferences and care plans. More community-based end-of-life services with 24/7 access Better partnership working across the health, social care and voluntary sector – including making more use of community facilities such as hospices.	People will be able to make better choices about their end-of-life care and their experience of end of life will improve. A 30% reduction in use of hospital beds during the last year of life. Half the number of emergency hospital admissions for people at the end of their life.

Strong, sustainable hospitals

We will focus on helping people stay fit and healthy and providing care close to home. But we need to ensure that when people fall seriously ill or need emergency care, local hospitals will provide strong, safe, high-quality and sustainable services.

Some of our proposals are relatively small and will cost nothing. Others need organisations, staff and the public to work together.

To provide high-quality local care, we'll need to keep the existing emergency departments and maternity units. But to cope with the expected extra activity, we'll need to change the way we work, as follows:

Improved local care with specialisation if this improves outcomes and provides safer care

To provide care effectively for the growing populations, we need to ensure Newham and Whipps Cross can provide high-quality care for the vast majority of conditions likely to occur locally.

We also need the Royal London to work effectively to serve its local community and a wider population in its role as a specialist centre. This doesn't really happen now as the site is often too busy treating emergency and very unwell patients to cater for the day-to-day needs of local people. This results in large amounts of planned surgery being cancelled and patients staying in hospital longer than they should, affecting local people and patients who have been transferred from further away.

More integration with community and social care

Our hospitals need to be better integrated with the community as well as forming stronger partnerships with charitable and voluntary organisations. We need to ensure local services run as effectively as possible alongside other clinical teams both on and off the hospital sites.

Working in networks across our sites and more widely

We need to be far better at organising and simplifying our acute and emergency care system and network arrangements. Our proposals will achieve this, standardising and improving the system and the standards of care.

The three main acute sites do not consistently meet London quality standards. For example, we know that only the Royal London site offers access to emergency interventional radiology in under an hour. Our approach outlines where we need to look across sites and in some cases change the arrangements for life- or limb-saving specialist services.

Pictured: Newham Gateway Surgical Centre

We have prioritised several key initiatives to develop strong, sustainable hospitals:

Initiatives and the case for change	What we propose	What we'll deliver within the next five years
Acute care hubs Too many people are admitted to a hospital ward as this is the only way they can get rapid medical specialist opinion and tests. This means patients who do not need 24/7 nursing care sometimes stay in hospital unnecessarily.	Bring together the clinical areas of the hospital that focus on initial assessment, rapid treatment and recovery at each site to work as 'acute care hubs'. This would mean the majority of patients being treated without being admitted. We'd admit to a specialist ward only patients needing 24/7 nursing/medical care.	Fewer patients will need a hospital bed – avoiding unnecessary stays in hospital and avoiding the need to build more hospital capacity. More emergency consultant cover and quicker treatment. Improved care for adults, young people and children with physical or mental health problems.
Maternity – increase the proportion of natural births Over the next 10 years the number of births will increase – thousands more every year. Women report some of the worst experiences of care in London. Too many women don't have real choice of where they have their baby – often giving birth in an obstetric-led ward that puts them at higher risk of interventions and operations compared with planned midwife-led births.	Introduce new ways of working that provide more informed choice and promote more natural delivery. We want women to have real continuity of care so they are supported throughout their pregnancy and can have a more natural birth in midwife-led settings.	Women will feel better supported through their pregnancy with an improved experience of care. We'll give better, safer care and make fewer unnecessary interventions. A third of women will choose a midwifery-led birth rather than an obstetric-led birth. We'll be able to care for women and their babies without having to build more hospital capacity.
Surgical hubs The quality of surgery could be improved. Too many people stay longer in hospital than necessary. A lack of coordination means planned surgery sometimes affects emergency surgery and vice versa. Many patients are waiting far too long for operations.	Create surgery centres of excellence ('hubs'). Newham, Royal London and Whipps Cross would each specialise in a number of specialties. This would: - reduce waiting times and the number of patients having to go outside East London for surgery - improve emergency and planned surgery - reduce the number of cancelled operations. New pre-operative pathways will deliver care as locally as possible and focus on recovery and long-term health improvement.	A better quality of care. Better use of specialist equipment and staff; shorter waiting times for patients; and fewer cancelled operations. Better patient experience – for example, a 10% reduction in length of stay for planned admissions. Better efficiency – for example, operating-theatre use improved by around 12%. Proper support for emergency and maternity services and less-complex surgery at each of the three hospitals.

Investing in children's health is investing in the future. A good, healthy start in life is essential if we are to increase life expectancy

Working across organisations to continually improve care

Many of our initiatives will need organisations to work together closer than ever. For example, clinicians from primary, community and secondary care organisations need to work together to agree pathways that speed up patients' diagnosis and treatment. We also need to work together to increase the number of physician associates, and to define strategies for the future of Mile End Hospital and Whipps Cross Hospital.

Two themes are weaved through all our initiatives:

Mental health

- A quarter of the population will suffer from a mental health problem at some point in their lives.
- Three quarters of people with mental health problems never get treatment.
- On average, people with serious mental health illnesses die 20 years earlier than people without them.

We'll prioritise improving services for expectant mothers and their partners; children and adolescents; people in crisis; and people with dementia. While doing so, we'll review the whole mental health system and develop a five-year strategy.

Children and young people

Investing in children's health is investing in the future. A good, healthy start in life is essential if we are to increase life expectancy and the number of healthy years people live. We need to get better at:

- co-ordinating services and joint working. Young people needing healthcare are getting passed between too many people and organisations
- identifying when a child or young person's conditions could be better and more quickly treated in a community setting. There are too many referrals to hospitals
- supporting children and their parents/carers to self-care, and to access services when necessary.

We'll involve children and young people in designing and commissioning services. We'll work with schools, children's centres and youth services, which are vital settings for improving health. And we'll improve the way young people move into adult services.

We'll redesign children's mental health services to make them less fragmented. We'll work with schools to make sure mental health problems are identified earlier so that young people get the support they need more quickly.

We have prioritised several key initiatives to improve health in East London:

Initiatives and the case for change	What we propose	What we'll deliver within the next five years
Transform the patient pathway and outpatients We are struggling to manage the number of outpatient appointments. However: - up to 20% of referrals to hospitals are not needed - up to 20% of patients do not attend their appointments - the referral process is complicated - the way follow-up appointments are arranged can be ineffective – there are often better ways for patients to access specialist advice - we don't always help patients to manage their own conditions.	Redesign the patient pathways for some of the most common: • long-term conditions (for example cardiovascular disease, respiratory disease and type 2 diabetes) • planned care services (for example musculo-skeletal and dermatology). Make better use of technology. Develop new processes for outpatient treatment and follow-up and improve referral processes so that when they need specialist advice, patients get the care they need as quickly as possible.	There will be a 20% drop in hospital-based outpatient appointments as unnecessary ones are not made and other methods are developed, for example using phone, email and Skype clinics. Patients will find the system easier to navigate and be better cared for closer to their home.
Reduce unnecessary testing About a quarter of tests on patients aren't needed. Some East London GPs order over 50% more high-cost tests than other GPs. This wastes resources, delays the diagnosis and treatment of patients who need tests, and subjects people to unnecessary inconvenience and worry.	Standardise processes and reduce unnecessary testing in the community and in hospitals. Consider enabling GPs to refer straight to tests in hospitals (rather than having to wait to see a hospital specialist first). Improve IT to share test results between GPs and hospitals, so tests aren't repeated.	Patients won't have to attend (and be subjected to) unnecessary tests and appointments. By 2020/21, there will be a 20% drop in spending on the top 20 most costly GP-generated tests.
Shared care records There has been significant progress in sharing patient records but there is still: - a lack of connectivity between all care providers - a need for a more comprehensive system, for example being able to book services through the system, and everyone being able to add information (not just 'read only') - a need to make access intuitive and simple, and to make records up to date and accurate, otherwise health and social care staff will not use them.	Better understand what needs to be shared and how it can be made accessible, secure and useful to staff who need it and to patients. Increase the use of shared records. Increase the amount of information available. Increase the number of staff in health and social care organisations who can access shared records. Work with patients to gain their support and consent to view their records.	Our shared care record infrastructure will be in place. There will be quicker, more coordinated care. Patients will not have to keep repeating their story and will be better able to self-care or receive care in their own home. Staff will be able to provide better care as they will better understand the patient's history. We'll get more efficient as we reduce our reliance on paper.

Initiatives and the case for change	What we propose	What we'll deliver within the next five years
Physician associates The area needs an extra 125 GPs in five years and almost 200 in ten years – but there is already a national shortage of GPs. Physician associates can perform a large proportion of a doctor's tasks at a reduced cost – meaning doctors can focus on the patients and illnesses that need their skills.	As well as developing different ways of working and effective ways of recruiting and keeping staff, we'll use more physician associates.	We'll have developed the role of physician associate. GPs and other clinicians can spend their time giving high-quality healthcare. Staff skills will be better suited to their jobs and patients' needs. This will breathe new life into the workforce, improving staff satisfaction and motivation. Patients will get faster, more effective services.
Mile End hospital The Mile End site offers a range of services from different providers. Barts Health has two acute inpatient wards, but these are separate from the rest of the Royal London site. This makes it hard for them to provide high-quality care, as well as making them hard to manage.	We'll continue to provide acute mental health services at Mile End but will seek to change other inpatient services. Barts and the local health economy should develop a longer-term strategy for the site, which could include more facilities that are less intensive than being treated in a hospital but more intensive than services offered in the community, mental health or community service facilities, or the sale of underused parts of the site for educational or residential use.	A health economy strategy to define the long-term future for the site. Improved efficiency, for instance shorter travel times for clinicians and better sharing of facilities. Improved outcomes and patient satisfaction, as clinicians will better understand their patients' needs, and will be able to discharge patients in a timely manner.
Whipps Cross hospital - The buildings need about £80million just to keep them safe and meeting minimum requirements. - The buildings are not designed to provide modern healthcare. For instance, the maternity unit is not connected to the main site, so emergencies need an ambulance to transport mothers and babies. - Whipps Cross has one of the largest sites in London but is used very inefficiently. It is a wasted resource.	We'll work with partners across health and social care to develop a robust strategy for the site's long-term future.	We'll set out a clear strategy, defining the site's long-term future; we'll decide how the transformation will be done; and we'll get started on making the changes we need.

Finance and sustainability

Net running costs and savings

(five years, upper and lower estimates for the 13 initiatives)

	Upper £m	Lower £m
Care close to home		
Primary care	34.5	30.7
Urgent care	5.8	2.5
Integrated care	6.6	4.2
End of life care	3.4	1.6
	50.3	39.0
Strong sustainable hospitals		
Acute care hubs	35.7	22.6
Surgical hubs incl. Interventional Radiology	4.3	0.0
Normalising births	(13.8)	(14.1)
	26.3	8.6
Cross-cutting themes		
Pathway redesign	82.4	64.9
Reduce unnecessary testing	25.5	20.7
Shared care records	(11.1)	(12.3)
Physician associates	(3.2)	(11.5)
Mile End hospital	-	-
Whipps Cross hospital	(5.1)	(5.1)
	88.4	56.8
Net TST programme savings	164.9	104.4

* Figures in blue are investments

By year five the saving is £48 million per year

Transforming Services Together initiatives will go a long way towards solving the big strategic challenges we face

Capital costs

We have also included the expected capital cost to the local health system if the TST programme isn't implemented and we have to build a new 550-bed hospital instead.

Capital funding sources to rebuild Whipps Cross Hospital require further thinking and could include bidding for national funds or selling assets and would include a reduction in Barts Health backlog maintenance.

	5 years 2016 to 2021 (£m)		10 years 2016 to 2025 (£m)	
	WITHOUT the TST programme	**WITH** the TST programme	**WITHOUT** the TST programme	**WITH** the TST programme
Minimum costs of essential IT and estates works in primary care and at Barts Health	102	102	152	152
Cost of redesign and complete rebuild of Whipps Cross (to retain existing 600 beds)	41	41	453	453
Costs of building new hospital and primary care facilities (including an extra 550 beds)	174		471	
Capital costs of implementing TST programme		31		31
Costs of land for a new hospital site	35		35	
Capital costs	**352**	**174**	**1,111**	**636**

The local health economy

Transforming Services Together initiatives will go a long way towards solving the big strategic challenges we face. But several other initiatives need to be delivered in partnership if we are to transform the health of our population and the health and social care system.

For instance:

- better prevention of illness – this needs to happen in partnership with local authorities and Public Health England
- other savings – even if the health and social care economy can achieve the improvements and efficiencies detailed here, by 2021 there will still be an historic deficit that will need external investment, as will any rebuilding at Whipps Cross
- changes to other health and social care services, for example specialist services.

Next steps

Success in these initiatives will depend on continuing the strong working relationships we have developed over the past year with all key partners.

Our greatest challenge is how we develop the enthusiasm, collective responsibility, and (once they are finalised) clear, achievable plans, to implement the solutions that we know people need. From February to May 2016 we will:

- engage with staff, stakeholders, patients and the public to test these proposals
- further develop our ideas
- develop implementation plans with a phased and prioritised programme of change. This will include working on the links between these proposals and the Care Quality Commission's improvement plan at Barts Health; between the different workstreams, including IT, estates and workforce; and between the different funding mechanisms/incentives
- assess the impact of our proposals on travel, the environment and equalities
- strengthen the leadership and capability to support the next phase of the programme
- agree how we can measure, monitor and support progress towards the objectives.

We know some of our proposals may have to change, and that external pressures will require new thinking. It is certain that not every proposal will be fulfilled in the way we describe. The strategy will need to be continually monitored and reviewed as challenges and opportunities present themselves. However, we are clear that not taking action now would be catastrophic for the health economy. We believe that the strategy sets the health economy on a path to deliver the changes we need to achieve clinical and financial sustainability, and better health for the population we serve.

We believe that the strategy sets the health economy on a path to deliver the changes we need to achieve clinical and financial sustainability, and better health for the population we serve

Questionnaire

Please fill in this questionnaire online at **www.transformingservices.org.uk** or fill it in here and post to: **TST, 5th Floor, Clifton House, 75-77 Worship Street, London EC2A 2DU**

We welcome your comments on any aspect of our proposals. However, you may wish to think particularly about:

1 Our strategy	**Prompts**: Have we correctly set out the challenges? Is our overall strategy right? Are there issues we have not addressed well enough or at all?
2 Our investment case	**Prompts**: We plan to spend about £140 million over the next five years. We think this will help us meet the challenge of population growth and growing demand, make significant improvements and save the NHS around £300 million. Is this the right level of investment? Should we be more or less ambitious? Are our proposals achievable? Are any of them unnecessary?
3 The 13 high-impact initiatives	**Prompts**: Will these initiatives focus on the biggest challenges or on where they will make the biggest improvements? What issues should we bear in mind if we take them forward in their current format?
4 Do you have any other comments?	

About you

We would find it useful if you could answer the questions below so we can see the type of people who are responding and whether different groups think differently about the proposals. We also want to know if any groups are not represented in our engagement.

Name: _____

You don't have to give us your name if you don't want to and we will still take your views into account.

Would you like to be kept up to date with information about this engagement?

☐ Yes ☐ No

If yes, please give us your email or postal address _____

_____

Gender:

☐ Male ☐ Female ☐ Other ☐ Prefer not to say

How old are you?

☐ Under 16 ☐ 16-25 ☐ 26-40 ☐ 41-65 ☐ 66-74 ☐ 75 or over ☐ Prefer not to say

Do you consider yourself to have a disability?

☐ Yes ☐ No ☐ Prefer not to say

Do you identify as:

☐ Heterosexual ☐ Homosexual ☐ Other ☐ Prefer not to say

What is your ethnic background?

White:

☐ White British ☐ White Irish ☐ Any other white background

Mixed:

☐ White and Black African ☐ White and Black Caribbean ☐ White and Asian

☐ Any other mixed background

Asian:

☐ Asian British ☐ Indian Bangladeshi ☐ Pakistani ☐ Chinese

☐ Any other Asian background

Black:

☐ Black British ☐ Black African ☐ Black Caribbean ☐ Any other Black background

☐ Any other ethnic group ☐ Prefer not to say

Which belief or religion, if any, do you most identify with?

☐ Agnosticism ☐ Atheism ☐ Buddhism ☐ Christianity ☐ Hinduism ☐ Islam

☐ Judaism ☐ Sikhism ☐ Other ☐ Prefer not to say

Thank you for your time. Your help will make a difference.

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TST overarching communications and engagement strategy and plan

(Approved at TST, CCG and Barts Health Boards in Jan/Feb 2016)

January to May 2016

Contents

1. Aims and objectives

This communications and engagement plan sets out how Newham, Tower Hamlets, Waltham Forest and neighbouring CCGs, supported by NEL CSU and working with Barts Health NHS Trust, other providers, local authorities and NHS England aim to engage and communicate effectively with patients, the public and relevant stakeholders about transforming healthcare services in east London. Engagement activities will involve local people and stakeholders, particularly those likely to have an interest in these services so that:

- Staff, patients, the public and stakeholders:
    - have the opportunity to make their views known
    - are clear about any proposed changes
    - are positive about the changes
    - are not unnecessarily worried about the changes
    - can ‘sign up to’ engaging in the future
- The CCGs meet their legal/statutory obligations.

We want meaningful engagement with local people and other stakeholders. We will know that we have achieved this if people:

- feel informed and listened to
- have given their views
- provide feedback that improves the development of the service
- support the changes.

All communications and engagement will be planned, clear and informative so that stakeholders are reassured and their needs are managed.

2. Statutory responsibilities

Newham, Tower Hamlets and Waltham Forest CCGs (the CCGs) have been responsible for engaging with stakeholders to ensure their views help shape any changes.

The CCGs are also responsible for ensuring that public involvement is carried out properly (as outlined in section 14Z2 of The NHS Act 2006, as amended). NHS England's guidance: *Planning and delivering service changes for patients* (December 2013) is also relevant.

The CCGs will be supported by NEL CSU to plan and deliver:

- **Phase one:** Communications and engagement activities in the period following the publication of the Strategy and Investment Case (SIC) including analysis of feedback from engagement
- **Phase two:** Any required consultation(s) on significant changes arising from the SIC. This will potentially be based on proposals for significant surgery changes, Whipps Cross and Mile End hospitals later in 2016 or in 2017.

The CCGs' governing bodies are responsible for decision-making regarding the engagement.

3. Challenges and opportunities

The key communications challenges, opportunities and risks include:

Challenge / opportunity / risk	Proposed plan
• **Engage staff** in this transformational change – some may see this as another reorganisation, when many of them are already de-motivated (see CQC report).	• Clear internal communication and engagement of leaders and change leaders. • Work with the OD programme and Barts Health. Aim for similar integration and alignment in primary care, integrated care etc.
• Ensure the engagement provides the partners with the **legal authority** to make changes when consultation is not required.	• Develop a clear communications action plan, agree with key partners; ensure communications is seen as central and critical to the success of the programme and aligned with workstreams. • Discuss with the inner north east London Joint Overview and Scrutiny Committee (JOSC) and the outer north east London JOSC so there is a unified scrutiny arrangement and/or a unified view.
• **Ensure changes are not viewed as downgrading by managing public perceptions but are seen as positively taking the NHS forward.**	• Ensure proposals are discussed and agreed by staff (who have considerable influence on public opinion) and Boards • Build trust in the NHS; putting clinicians

	(especially) and managers in front of the public to explain the proposals • Build on the relationships we have in place with our local NHS (members of the Transforming Services Together programme meet regularly with CCG, Barts Health and other colleagues). • Develop lines to describe the benefits for each hospital (and the group of hospitals). Whilst this is a strategic plan, we cannot ignore the fact that the public are interested in *their* local hospital.
• **Positively engage with the section of public and stakeholders** who are negatively predisposed as they have: o seen reconfigurations (Fit for the Future, Health for NEL) leading to consultation fatigue and lack of belief that things will change o seen criticism of existing NHS services (e.g. CQC reports – so they lack trust in the NHS to make good decisions/changes) o fixed views on finances, PFI, privatisation etc (e.g. 38 degrees, Save our NHS).	• Build leadership and change leaders. • Make it clear how change is (and must be) continuous and that proposals build on previous (successful) work. • Explain that TST is part of the solution to the problems. • Recognise failings where they are clear but correct inaccurate criticism. • Brief stakeholders and ensure we understand their aims / objectives. How do we give them what they want? • Recognise that some critics will not change their mind. But we should not distance them from the programme, rather we need to listen to the issues to take them into consideration, amend our plans if necessary, and build a community of supporters around them.
• Manage the **political sensitivities.** E.g. ensure that any proposals are not used as a political football – particularly given the London elections in May.	• It is essential that we engage on the issues and options that are possible. Including all stakeholders in the planning process.

4. Key messages – case for change

We want to make a difference in east London and:

- address inequalities. Many of our residents receive excellent care, but the quality and availability of some of our services could be improved. The health of some of our residents is poor, with life expectancy in some parts of east London significantly lower than the England average.
- help patients to be in control of their own health and lead longer, healthier lives.

We have a huge challenge in east London and must plan ahead to address it.

- Our population is growing and in 15 years it is estimated we will have an additional 270,000 residents – equivalent to another London borough or a city the size of Southampton. If we carry on as we are, the East London organisations will be around £400 million in debt and would need a further 550 hospital beds – the equivalent to another hospital. This would be unaffordable to build and run.
- When we published our Case for Change in July 2014, we said that emergency and maternity services would be retained on each of the three main Barts Health sites. Since that time we have established that we face the opposite challenge. We need to maintain these services on each site, and cope with the anticipated increase in healthcare needs – but without having to build a new hospital.
- Health and social care budgets are being squeezed.
- We are struggling to recruit and retain the numbers of staff we need while many staff, particularly in primary care are nearing or past retirement age.
- Some of our buildings and IT are not fit for purpose – Whipps Cross needs more than £80 million of capital investment as a minimum. Much of the primary care estate is also unsuitable for the safe delivery of healthcare.
- CCG finances are currently in balance, but Barts has the largest deficit in the NHS.

This is not the start of the process; there is lots of work already underway to improve healthcare services

- Improvements put in place at Barts Health mean it has one of the lowest mortality rates in the UK (4th lowest). For example, performance in stroke and major trauma care are exceptional - these changes are saving lives.
- Over the past three years, £21 million has been invested in the Whipps Cross estate and we have some of the most modern and high-tech facilities e.g. the Sir Ludwig Guttmann Health & Wellbeing Centre or The Centre (Manor Park) in Newham.
- Integrated care is being provided to thousands of residents across east London, putting them more in control of their health and reducing admissions to hospital
- Our IT systems are getting better and more connected. For example, more hospital clinicians in Barts Health are able to see primary health records, and vice versa, resulting in a quicker and more streamlined service for patients.

5. Key messages – our proposals

The TST programme offers the opportunity to develop solutions:

- locally where necessary (but sharing learning and resources)
- in partnership with different organisations
- once across the three boroughs, where it is efficient and effective to do so.

Taken together, the changes would transform health and care in East London. In particular we need to focus on changing the social culture of over-reliance on medical services.

Care closer to home

- More **integrated care** for more people at risk of going into hospital, so that they can be cared for at home and stay out of hospital.
- A simplified and integrated **urgent care** system, so that people don't always turn up to emergency departments. We need to integrate NHS 111 with the urgent care system so patients can get advice, get a prescription, book an urgent or planned appointment with their GP – a one stop shop.
- Earlier identification of the need for **end of life care**, supported conversations and recording and sharing preferences. To enable this there needs to be shared care plans and enhanced community and palliative services delivered by better partnership working across the health, social care and voluntary sector.
- Making **primary care** more accessible; more proactive – helping people to take control of their own health and to be healthier; and more coordinated (with joined up IT systems so that care givers can provide better, quicker advice and services often in the same building). To do this we need fewer smaller GP practices. GP practices in the future should have list sizes over 10,000, or if they are smaller, work together in integrated provider networks, or on the same site as other practices.

Strong sustainable hospitals

We need three strong and sustainable hospitals providing emergency and acute care for our growing populations. Each needs a well-functioning emergency department and in the future, they will need to work more closely together and provide different services. We need to address the belief that having all services at a local hospital is a necessary 'security blanket'.

- Develop **surgery centres of excellence (surgical hubs)** at each of Newham hospital, Whipps Cross hospital and The Royal London. This would a) support the viability of these hospitals b) release capacity at Royal London, which is over-capacity c) provide a better patient experience (and outcomes), reducing cancellations and waiting times. Pre-operative and post-operative care would be at the patient's local hospital.
- Develop **acute care hubs** at each hospital site (Newham, Whipps Cross and The Royal London), bringing together more specialists and test facilities to the front door of hospitals so that patients can be diagnosed and treated more quickly and fewer patients will need to be admitted to a hospital ward.

- Provide more choice and continuity of care to **increase the proportion of natural births** (for instance in midwife-led settings). This will help us to cope with the expected 5,000 more births a year across north east London in the next 10 years.

Working across organisations

- Reduce the number of hospital-based **outpatient appointments** by improving the quality of referrals and improving Skype, telephone and other access.
- **Reduce unnecessary testing and sharing care records.** Consider GPs being able to directly refer patients for hospital tests (rather than to a hospital consultant who then does the referral) and at the same time, investigate why some GPs refer far more people for high-cost tests than other GPs.
- Develop new roles, different ways of working and effective ways of recruiting and retaining staff. For example, we will **introduce more physician associates**, health coaches and other roles who will be able to take on much of the day to day work of a GP. This will free up GPs (who are in short supply) to concentrate their expertise where it is needed most.
- Develop a strategy for making better use of **Mile End Hospital**. This could include more step-up/step-down facilities, mental health or community service facilities or even sale of underused parts of the site for educational or residential use
- Develop a strategy with partners, for the long-term future of **Whipps Cross.**
- We must improve the health, life expectancy and **care of people with mental health difficulties**, particularly focusing on rapid treatment early in life when the majority of symptoms first appear.
- We will work with schools, children's centres and youth services which are vital settings for improving the **health of young people**; and we will improve the way young people transition into adult services. We will redesign children's mental health services to make them less fragmented and work with schools to make sure mental health problems are identified earlier, leading to young people getting the support they need more quickly.

The expected outcomes

The combined impact of these initiatives, if they are all delivered through a coordinated, integrated delivery plan over the next five years, alongside productivity improvements, will be:

- a significant increase in activity being delivered closer to home, in more efficient care settings
- a healthier population, and patients who experience better care
- a workforce that is more appropriate for delivery of efficient and effective modern healthcare; staff who better understand their role, who feel supported and who are enthused about their job, healthcare and the NHS
- that hospitals are able to relieve the existing pressure on beds; can cope with the increase in population and long term conditions; and help to reduce waiting times, or create opportunities for new income streams
- improvements in the clinical quality of services and the physical and mental health of the whole population. We expect these proposals to directly support the Safe and

Compassionate improvement programme and the transition of Barts Health out of special measures

- net savings from the TST programme of between £104 million and £165 million over five years to 2020/21. The expected annual recurrent net saving by 2020/21 is £48 million. The most likely position if we deliver the changes described in this document; internal cost improvement programmes (CIPs); and quality, innovation, productivity and prevention (QIPP) programmes, is one of overall health economy balance with some organisations being in surplus and some in deficit.
- a significant reduction in the capital spend required. The TST programme proposes a budget for buildings and infrastructure of £72 million by 2021 (excluding essential estates and IT works), but the requirement if TST is not put into action is £250 million.

TST key messages on a page

Transforming Services Together is a joint agreement between Clinical Commissioning Groups (CCGs) in Newham, Tower Hamlets and Waltham Forest and our main local hospital trust Barts Health, to invest over £100 million in new health services and buildings over the next five years

1. We need to help people take responsibility for their own health, managing their health and illnesses better and to use health services appropriately
2. We are expecting 270,000 more people in our three boroughs. People will live longer. Drugs and treatments will get more expensive. We already struggle to recruit staff.
3. We need to strengthen our three main hospitals (Royal London, Whipps Cross and Newham). For instance, centres of excellence on each site will improve surgery. Acute hubs will reduce the number of people unnecessarily admitted to hospital and reduce the time patients are in hospital. Both these initiatives will strengthen the existing A&Es and maternity units
4. We will develop joined up services closer to people's homes. For instance, we will improve our sharing of records between different parts of the NHS, integrate care between different organisations and reduce unnecessary testing. There will be fewer small GP practices or they will work in networks or on sites with other practices so that they can offer better access, more services to help people manage their health better and to reduce costs.
5. We will work together to: develop services and plans for developing Whipps Cross and Mile End hospitals; develop new roles to meet the workforce challenges together (e.g. physician associates); and develop our IT
6. Our plan aims to save around £300 million over five years and around £800 million over ten years

These services will need to benefit the whole community, reduce health inequalities and address mental health, as well as physical health problems.

Our strategy

Our strategy aims to:

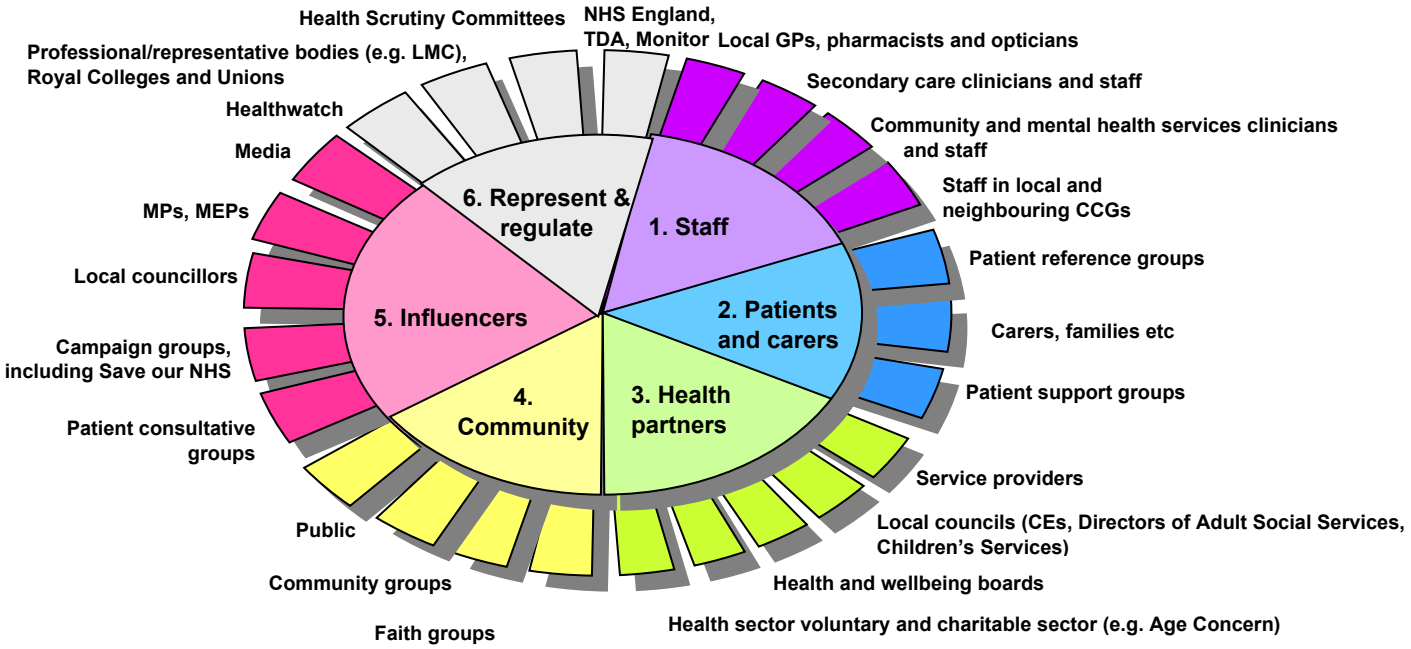
- embrace and support the health and wellbeing strategies of each borough;
- promote health and well-being by developing the knowledge, skills and confidence to self-manage through collaborative care and support planning
- change the culture of how we commission and deliver care and support a learning healthcare system
- increase involvement of patients and carers in co-production and decision-making
- maximise the use of the significant assets in our communities and voluntary sectors
- commission services in fit-for-purpose settings of care, often closer to home

- help people to stay healthier and manage illnesses; to access high quality, appropriate care earlier and more easily
- focus some specialisms in fewer locations to improve patient outcomes and experiences and drive up efficiencies
- value the importance of continuity and therapeutic relationships, acknowledging the importance of supporting people's mental health and well-being needs
- ensure the system can respond to the changing demands on our services that we have predicted as part of our *Case for Change*
- help set our finances on a path of sustainability in a challenging environment.

6. Stakeholders

There are a number of people and organisations who/which are involved, or interested in proposed changes to healthcare services in east London. They key external and internal audiences include:

- NHS England
- Neighbouring CCGs - in particular, City and Hackney, Barking and Dagenham, Havering, Redbridge and where appropriate, north central London CCGs
- NEL Commissioning Support Unit
- Homerton University Hospital NHS Trust
- East London NHS Foundation Trust
- North East London NHS Foundation Trust
- Third sector organisations
- Local authorities and public health teams; City of London; London boroughs of Hackney; Newham; Tower Hamlets; Waltham Forest; Redbridge; Barking and Dagenham; and Havering.



7. Our engagement strategy

- We are not consulting, we are engaging
- We are not asking permission to implement these programmes of work (except where the proposals is so new as to be a change in service), we are testing them, and asking for views on implementation. We should also be asking people to get involved in future work
- The breadth of TST means that there is a very limited number of people who will be interested in all aspects of the programme. Therefore **the majority of engagement will be at a local level about specific proposals** (initiatives) about what is important to local communities.

Responsibilities

TST programme communications

- Overarching key messages and collateral to introduce TST
- Establishment of communications framework (e.g. this strategy and plan)
- Coordination of three borough stakeholder meetings (e.g. JOSCs) and where a coordinated approach would add consistency and economy e.g. LMCs
- Establishment and coordination of methods of collation
- Facilitation of PPRG

TST programme (clusters and workstreams)

- Develop an engagement plan
- Develop cluster/workstream collateral to explain concepts and gain appropriate engagement
- Work with key stakeholders, staff, members of the public and patients to test and develop the proposals. This could be through focus groups, workshops or established groups

CCG communications teams

- Develop local collateral to explain how TST fits in with local plans
- Work with TST programme project managers to develop a locally appropriate engagement plan that dovetails with existing local engagement and meetings

Barts Health communications team

- Work with any/all of the above, to develop and deliver an engagement plan to staff
- Work with any/all of the above to assist in providing clinicians to speak at various forums

8. Alignment with other strategies / policies / issues

a) This communications and engagement strategy will need to align closely with the **organisational development and clinical leadership strategy**, to ensure the impact of both strategies is maximised

   An example of how this could work in practice is that the organisational development and clinical leadership strategy will need to take ownership of the programme to ensure it is delivered and implemented effectively. This will help to meet the aim of engaging CCG and Barts Health staff in the programme.

b) This implementation of this strategy will need to align with the **communications and engagement strategies of Newham, Tower Hamlets and Waltham Forest CCGs**.

c) All three CCGs (Newham, Tower Hamlets and Waltham Forest) have been approved to take on **fully delegated commissioning of local GP services**. The three CCGs have agreed to work together and will be developing a joint advisory board to oversee commissioning decisions. This should provide opportunities to better integrate care across the whole east London population – but will need to be explained.

d) **CQC inspections of Barts Health**. The trust is in special measures. The essential focus on these immediate issues may detract and/or complicate the focus on TST. The messaging has been (and continues to be) that TST addresses some of the underlying problems in the system and therefore has to be seen as part of the long term solution. It will also be important to highlight the positive aspects of Barts' care e.g. low mortality rates; some of the best stroke and major trauma care in the world; the Barts Heart Centre. Maintaining staff morale will be critical to the success of the trust and to the programme as a whole.

9. Our engagement plan

- The Strategy and Investment Case (SIC) was approved at the CCG governing body meetings in Tower Hamlets (26 January), Waltham Forest (27 January) and Newham (10 February); and at the Barts Health board on 3 February.
- The engagement will run for 12 weeks (29 February to midnight 22 May 2016).
- There are three documents:
    - Part 1: a summary to be tested with the Patient and Public Reference Group
    - Part 2: the main report
    - Part 3: the detail of the proposed high impact initiatives

We have already received feedback as the document has been drafted. Once the full document is publically available we will continue to invite comments from interested parties.

By engaging with stakeholders, we will be able to ensure commissioning decisions take into account public, patient and clinical views to ensure a safe service and excellent patient experience.

All engagement will build on links and relationships developed during previous engagement programmes (in particular Transforming Services, Changing Lives Case for Change (2014)).

Activity

The engagement plan includes:

- Drop-in sessions in each hospital
- A range of meetings / workshops and focus groups in each borough with staff, community and patient groups and representatives, and public to ask for their views.
- Media releases and adverts to be placed in the local press
- Offer of attending Overview and Scrutiny Committee meetings in each borough
- Offer to meet with Healthwatch, LMC and other stakeholders in each borough
- Monthly meetings with the Patient and Public Reference Group (PPRG)
- Production of a newsletter providing monthly updates on the programme
- Mail outs to interested parties asking for their views and the offer of a meeting (and requesting organisations mail out to their stakeholders e.g. council databases)

Collateral

A number of materials will be available throughout the engagement process to inform the public about the programme. These will include this engagement plan and:

- The Strategy and Investment Case
    - Part 1 – the summary
    - Part 2 – the main document
    - Part 3 – detail of the high impact initiatives
- Core presentation
- Advertisements and media releases
- Website and newsletters
- Questionnaire (on website and in the summary version to encourage feedback)
- Posters/banners for patient/public areas.

10. The high-level questions

We welcome your comments on any aspect of our proposals. However you may wish to think particularly about:

1. **Our strategy**	Prompts: Have we correctly set out the challenges? Is our overall strategy right? Are there issues we have not addressed well enough or at all?
2. Our investment case	Prompts: We plan to spend about £140 million over the next five years. We think this will help us meet the challenge of population growth and growing demand, make significant improvements and save the NHS around £300 million. Is this the right level of investment? Should we be more or less ambitious? Are our proposals achievable? Are any of them unnecessary?
3. The 13 high-impact initiatives	Prompts: Will these initiatives focus on the biggest challenges or on where they will make the biggest improvements? What issues should we bear in mind if we take them forward in their current format?
4. Do you have any other comments?	

Group	Engagement	Objectives	Responsibilities	Timescale
1. Staff	CCG engagement: • The CCGs and the three chief officers will lead on the engagement in each borough. This will include updates at staff meetings and briefings in staff newsletters and other internal communication channels.	To hear staff views Ensure a sense of ownership in each CCG about the TST programme so the proposals can be taken forward	CCG/TST/Comms	Ongoing
	• Ensure any engagement that is already happening locally in the CCGs is aligned to the TST strategy. This will be achieved through regular contact with the communications and other staff at the CCGs.	Ensure staff feel they have been involved in the programme and that TST is not just 'another thing'	CCG/Comms	Ongoing
	• Some of the changes will increase activity in primary care (e.g. moving some hospital appointments for patients with long-term conditions into primary care, where appropriate and where it will benefit the patient). The changes will occur at a time when primary care staff are already feeling overworked and demoralised. We will attend LMC meetings in each CCG area to engage with GPs	Develop NHS staff as potential ambassadors and drivers for change Help staff understand the impact of the proposals and allay fears they may have fears about the their jobs and understand the benefits for their future careers	GPs/TST/Comms	Ongoing
	Barts Health engagement: • Communicating with Barts Health staff is the responsibility of the trust; however the TST programme needs to work closely with communications and other staff at	Ensure a sense of ownership within the Trust about the TST programme so the proposals can be taken	BH/TST/Comms	Ongoing

	Barts Health to ensure their staff are informed about the programme and have the opportunity to engage. This will include providing materials and information for use within their internal channels, and working with them to arrange events and briefings. • Drop-in sessions will be held at each hospital site to inform staff, patients and carers about the programme	forward Ensure staff feel they have been involved in the programme and that TST is not just 'another thing' Allay fears staff may have about the their jobs and understand the benefits for their future careers Align key message with BH's safe and compassionate plan	BH/TST/Comms	During engagement process
2. Patients and carers	• Regular meetings of the TST patient and public reference group (PPRG) • Drop- in sessions at each hospital site to inform patients and carers about the programme • Drop-in sessions in each borough. These will be hosted by staff and clinicians involved in the TST programme and will be an opportunity for the public to have their questions	Hear the views of patients and carers Emphasise the message that this is not another NHS case of 'change for change's sake' Allay fears over potential extra travel to different sites for treatment Provide reassurance of the NHS commitment to clinical quality and patient care Help prevent ill health and improve the health of residents	TST/Comms BH/TST/Comms CCG/TST/Comms	Every month During engagement process During engagement process

3. Health Partners (local authorities, health and wellbeing board, charity and voluntary sectors)	• Regular updates through meetings and other communication channels • Attendance at key events	Ensure any impact on health partners are fully explored Utilise specialist knowledge of issues and opportunities Ensure synergy with partners' developments and announcements	Comms/TST Comms/TST	Ongoing Throughout engagement process
4. Community	• Drop-in sessions for the public. These will be hosted by staff and clinicians involved in the TST programme and will be an opportunity for the public to have their questions answered. One session will be held in each of the three boroughs and at each Barts Health site • Workstreams and additional events and workshops as necessary which will be focused on particular areas of the programme • Newsletter – several editions of a newsletter have been produced which provides updates on the TST programme. This will continue throughout the engagement process • Take out adverts in local papers • Website – the website http://www.transformingservices.org.uk/	Encourage members of the public to attend events to understand their needs Build trust in the NHS as effective caretakers of the health of the local population Help the public understand how the NHS works and the different services on offer Understand the needs of the residents Ensure their views are listened to	TST/Comms TST/Comms Comms Comms	Throughout engagement process Throughout engagement process Monthly Start and end of engagement process

	will be updated and continue to be a source of information for anyone with an interest in the TST programme		Comms	29 February
	• Literature and posters to be mailed out to Healthwatch and other stakeholders asking them to distribute and advertise in public areas		Comms	Start and throughout
	• Media release to inform members of the public		Comms	Throughout (see below)
	• Provide updates to CCG meetings with the public		CCG/Comms	Ongoing
5. Influencers (media, Mayor's office and London Assembly members, borough councillors)	• Adverts will be taken out in local papers	Ensure their views are listened to	Comms	29 February
	• A reactive statement will be agreed to respond to any questions on publication of the SIC on 20 January 2016	Facilitate them into providing reliable information to their readers/constituents	Comms	20 January 2016
	• A further, proactive release will be prepared which will outline the programme and the engagement in more detail		Comms	29 February
	• Another proactive release (half way through the engagement) will encourage people to get involved		Comms	Half way through engagement process
	• A final media release will be issued immediately following the closure of the engagement period		Comms	End of engagement process

	• Documents will be emailed to MPs and we will offer to meet with them to discuss further • Meetings with campaign groups such as Save our NHS • Details of the programme will be emailed to voluntary organisations and charities and we will offer to meet with them		Comms TST/Comms TST/Comms	29 May Throughout engagement process Throughout engagement process
6. Represent and regulate	• Attend meetings with the LMCs, NHS England, Royal Colleges, scrutiny committees and Healthwatch	Provide information as required under the NHS Act (OSCs) Receive independent endorsement for proposals and provide reassurance for relevant audiences Receive critical challenge and objective examination	TST/Comms	Throughout engagement process

11. FAQs

Q: Is this about closing hospitals?

A: No. Closing hospitals can save money and improve the quality of services but in East London, because of the expected extra 270,000 people, this would not be appropriate. Nor would opening a new hospital. We need to live within our means and reduce our reliance on hospital-based care.

Q: Will the Transforming Services Together programme solve the funding gap in this area?

A: Not completely – but it would play an important part in restoring balance.

Q: Will people have to travel further if you are proposing to consolidate some surgery?

A: Some people may have to travel further for their operation. However pre and post-operative assessments would mainly be done at the patient's local hospital. The proposals would reduce the number of cancelled operations and bring many services (such as outpatient) closer to home. So for most patients there will be a reduction in the need to travel. Patients would also benefit from shorter waiting times for surgery and improved outcomes.

12. Timeline

The engagement process will begin on the 29th February and last for 12 weeks. Analysis of the engagement period will then be incorporated into an engagement report for 17th June.

13. Risks and mitigations

Risk	Mitigation
1. Any proposed service moves from one hospital to another will be seen as 'downgrading'	• Lines to take will be developed to make it clear that all moves strengthen the offer at each site
2. Not all decision-makers fully understand the requirements for engagement and consultation, so services are changed prior to approval	• NEL CSU communications team attend programme meetings to advise decision-makers and others (as appropriate) on legislation, guidance and best practice in relation to service change
3. Everything focuses on small contentious changes when most of the programme is about being more efficient; making small-scale changes to streamline services and improve patient care	• Develop narrative around the smaller scale changes (such as new protocols) and the benefits they will bring, and emphasise in all communications to stakeholders

4. Impact of Barts Health being put into special measures, following publication of the CQC report on Whipps Cross Hospital. The need to address immediate issues may detract from the longer-term vision	• Continue to emphasise that action to address the immediate issues is crucial, but so is developing the longer term strategy, as this will address some of the root causes of the current challenges.
5. That ONEL/INEL JOSC do not support the proposals	• Send the documentation and plans to the JOSCs prior to engagement asking for comment; offer to meet with chairs and/or committees in advance; offer to meet with committees during the engagement
6. Risk of loss of momentum	• Ensure ownership of programme through engagement and getting staff members to present/discuss at every opportunity

As phase two of this programme may involve consultation on service changes, it is important to be mindful of the reasons why proposals for health service change in England are contested. The Independent Reconfiguration Panel advises that one of the most common reasons why proposals are referred is:

8. Health agencies caught on the back foot about the three issues most likely to excite local opinion – money, transport and emergency care	• The financial implications will be clearly laid out • The clinical workstreams are asked to consider implications for travel in their impact analysis • There is an urgent and emergency care coordination workstream in place. There is clear consensus within this group that emergency care needs to be retained on all sites.

14. Evaluation

The success of the formal engagement will be measured by:

- Meeting milestones and adherence to action plan
- Key stakeholders (including patients) are aware and understand the issues
- Respondents' views on quality of proposals and of the process
- Relevance of views expressed and the improvements made on the proposals
- Processes are sound and do not allow successful legal/quasi-legal challenge.

These align with the aims and objectives outlined in part 2 of the Strategy and Investment Case.

Committee:	Date:	Classification:	Report No.	Agenda Item No.4
Health Scrutiny Panel	**20/04/2016**	Unrestricted		
Report of: London Borough of Tower Hamlets **Originating Officer:** **Daniel Kerr** **(Strategy, Policy & Performance Officer)**		**Title: Scrutiny Challenge Session: Children & Young People's Mental Health Services (CAMHS)** **Wards:** All		

1. SUMMARY

1.1 This paper submits the report and recommendations of the Health Scrutiny Panel Challenge Session on Children & Young People's Mental Health Services. This challenge session brought together representatives from the council, Tower Hamlets CCG, Tower Hamlets CAMHS, and community organisations to explore the level of provision and the performance of children and young peoples' mental health services in Tower Hamlets. The session focused on how accessible mental health services are for service users from a wide range of backgrounds, how effectively services are promoted and engage with a diverse range of services users, and what gaps there are in the current service provision. The report makes a number of recommendations to improve CAMHS in Tower Hamlet's.

2. RECOMMENDATIONS

2.1 The Health Scrutiny Panel is asked to note the report and agree the recommendations.

3. COMMENTS OF THE CHIEF FINANCIAL OFFICER

3.1 This report contains recommendations which will be implemented within CAMHS, the key stakeholders have been consulted on the recommendations and will need to ensure they are implemented within existing budgets. The total budget for CAMHS in 2016/17 is £1.081m.

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

4.1. In respect of the recommendations contained in the report, the Council has a duty to make arrangements to secure continuous improvement in

the way in which its functions are exercised, having regard to a combination of economy, efficiency and effectiveness by virtue of section 3 of the Local Government Act 1999. This is known as its Best Value Duty.

4.2. The Council's functions in relation to children include a duty under section 11 of the Children Act 2004 to make arrangements to ensure that its functions are discharged having regard to the need to promote the welfare of children. Section 17 of the Children Act 1989 introduced a general duty for local authorities to promote the welfare of children within their area who are in need, including children with disabilities, which includes any form of mental disorder. Additionally, section 1 of the Childcare Act 2006 ("the 2006 Act") imposes a general duty to (a) improve the well-being of young children in their area; and (b) reduce inequalities between young children in their area in respect of various matters, including physical and mental health and emotional well-being, protection from harm and neglect, education, training and recreation, the contribution made by them to society and social and economic well-being.

4.3. In the exercise of its functions, the Council must with the public sector equality duty to eliminate unlawful conduct under the Equality Act 2010, the need to have regards to equality of opportunity and the need to foster good relations between persons who share a protected characteristic, including ethnicity, and those who do not.

5. APPENDICES

Appendix 1: Scrutiny Challenge Session: Children & Young People's Mental Health Services (CAMHS) Report

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

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

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Health Scrutiny Panel

Children & Young People's Mental Health Services
Scrutiny Challenge Session

London Borough of Tower Hamlets
April 2016

Contents

1. Chairs Foreword

Good mental health and resilience are fundamental to our physical wellbeing, our relationships, our education, our training, our employment and to realising our full potential. Many mental health issues appear in childhood and if left untreated have a profound and lasting impact throughout adulthood. The Health Scrutiny Panel wanted to investigate the performance of children and young people's mental health services in Tower Hamlets to ensure children are able to access the appropriate services at the earliest opportunity possible.

National evidence suggests that the rising rates of children and young people presenting with mental health conditions are not being met by professional intervention that is both timely and suitable. Children and young people are being left untreated at a time when there is a higher number in a state of emotional suffering than ever before. Available data shows that increasing numbers of young people are turning to self-harm with hospital admissions over the last five years rising by almost 93% among girls and 45% among boys[1]. There are also more young people considering suicide and an increasing number of young people are being treated for eating disorders.

Successful and effective treatment of mental health requires many different partners to work well together and as such the Health Scrutiny Panel wanted to invite representatives from the council, Tower Hamlets Clinical Commissioning Group, Child and Adolescent Mental Health Services, and leading third sector organisations to discuss how they are working in partnership to improve outcomes for children and young people suffering from a mental health issue.

I am pleased to present this report which explores the challenges facing children with a mental health issue, and the challenges to delivering high performing children's mental health services. The report makes a number of practical recommendations for the council and its partners for improving the access to, and performance of, children and young people's mental health services in Tower Hamlets.

I would like to thank the officers that contributed to the challenge session, especially Nasima Patel, Martin Bould, Simon Twite, Percy Aggett, Jennifer Fear, Shamsur Choudhury, and Runa Khalique for their presentations. I am also grateful to my Health Scrutiny colleagues for their support, advice and insights.

Councillor Amina Ali,
Health Scrutiny Panel Chair

[1] Health and Social Care Information Centre (2016)

2. Recommendations

Recommendation 1:
That the council and Tower Hamlets Clinical Commissioning Group (THCCG) work with the voluntary and community sector to support and strengthen early intervention services in the borough.

Recommendation 2:
That the council, CCG, specialist CAMHS and local services raise awareness of mental health issues, before children and young people reach specialist services, by promoting patient stories and examples of what mental health issues can turn into, with particular focus on BME communities.

Recommendation 3:
That the council ensure all frontline professionals who come into contact with children regularly or/and in a professional capacity (not just mental health professionals) are able to identify children with mental health issues and know what to do once they have identified a vulnerable child.

Recommendation 4:
That the council reviews the data it holds on care leavers and pregnancy to investigate if there is a link between care leavers, teenage pregnancy and mental health issues.

Recommendation 5:
That the council undertakes further work with young care leavers to educate them on sexual health.

Recommendation 6:
As part of any future re-fresh of the Local Transformation Plan, the council, CCG and partner agencies should consider how services can be improved for children and young people who are in contact with criminal justice services, and who have a higher vulnerability to mental health problems.

Recommendation 7:
That the council and THCCG strengthen engagement and training for CAMHS service users to empower them with the skills and knowledge to effectively contribute to service development.

Recommendation 8:
That the THCCG work with CAMHS to review GP training in children and young people's mental health, including raising awareness of referral pathways for service users.

Recommendation 9:
That the council, THCCG, and Tower Hamlets CAMHS work with community leaders to improve cultural understanding of mental health and raise

awareness of the services in place to support residents with a mental health need.

Recommendation 10:
That the council, THCCG and CAMHS undertake work to reduce the stigma of mental health including rebranding and renaming services.

Recommendation 11:
That CAMHS consider ways to make the service more accessible through reviewing their workforce to ensure it is reflective of the community.

Recommendation 12:
That the council, THCCG and CAMHS improve engagement with children and families in order to increase awareness of mental health in all communities in the borough.

Recommendation 13:
That the council undertakes an audit to check the usage and success of the CAF system in Children Centres and other universal services.

Recommendation 14:
That the council and THCCG raise awareness about mental health and support services amongst non-MH staff working with young people to improve accessibility to appropriate support.

3. Introduction

3.1. Mental health problems pose a significant challenge on both a national and local level, and are estimated to disadvantage the UK economy by £105 billion a year. Mental health conditions are widespread, with one in four adults diagnosed with a mental health problem in any one year and treatment costs projected to double in the next 20 years.

3.2. Many mental health conditions first present during childhood and if left untreated can develop into conditions which need regular care and have long lasting effects throughout adulthood. Nearly half of all mental health conditions emerge before the age of 14, and 75% emerge before the age of 24.[2] One in ten children between the ages of five and sixteen have a diagnosable mental health problem – with children from low income families three times more likely to be affected than those on a high income. Approximately 200,000 young people between the ages of 10 to 18 are referred to specialist mental health services each year[3], but evidence suggests that nationally the rising rates of young people presenting with serious mental health problems are not being sufficiently met by appropriate service interventions.

3.3. Child and Adolescent Mental Health Services (CAMHS) across the country have been struggling to manage increasing referrals to their services within limited budgets. As a result, many areas have either tightened or redefined their eligibility criteria and have raised thresholds in order to manage demand, potentially leaving many children and young people who fall outside of this threshold with no viable or effective means of treatment.

3.4. As part of its work programme the Health Scrutiny Panel was keen to explore the level of provision and the performance of children and young peoples' mental health services in Tower Hamlets. A scrutiny challenge session was held on Tuesday 25th February at the Children and Young People Centre. The challenge session aimed to develop an understanding of:

- The availability of mental health services for children and young people in Tower Hamlets
- The performance of children's and young people's mental health services, particularly in terms of how accessible the services are for young people, how these services are promoted, and how the services actively engage service users with a wide range of mental health needs.

[2] LBTH Joint Strategic Needs Assessment (2016)
[3] The Children's Society: *Access Denied; A teenagers Pathway through the mental Health System* (2015)

- The gaps in the current service provision, and the areas of good practice and success which can be developed further.

3.5. This session was attended by the following stakeholders:

Councillor Amina Ali	Health Scrutiny Panel, Chair
Councillor Dave Chesterton	Member of the Health Scrutiny Panel
Councillor Danny Hassell	Scrutiny Lead for Children's Services
Councillor Amy Whitlock Gibbs	Cabinet Member for Health & Adult Services & Lead for Mental Health
David Burbidge	Member of the Health Scrutiny Panel
Nasima Patel	Service Head Children's Social Care, LBTH
Karen Badgery	Children Commissioning Manager, LBTH
Simon Twite	Senior Public Health Strategist, LBTH
Carrie Kilpatrick	Deputy Director of Mental Health and Joint Commissioning, THCCG/LBTH
Martin Bould	Senior Joint Commissioner, THCCG
Billy Williams	General Manager, CAMHS, ELFT
Percy Aggettt	Psychological Therapies & Clinical Team Lead/Lead Clinician, CAMHS, ELFT
Shamsur Chowdhury	Healthwatch Tower Hamlets
Jennifer Fear	CEO, Step Forward
Runa Khalique	Docklands Outreach
Afazul Hoque	Senior Strategy Policy & Performance Officer, Corporate Strategy & Equality, LBTH
Daniel Kerr	Strategy Policy & Performance Officer, Corporate Strategy & Equality, LBTH

4. National Policy

4.1. In 2011, the Government published its mental health strategy *No Health without Mental Health: a Cross-Government Outcomes Strategy for People of All Ages.* This strategy aimed to improve mental health in all ages, and people from all backgrounds. It had six objectives:

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

4.2. In 2014, the House Of Commons Health Select Committee held an enquiry into CAMHS services which concluded that there were significant problems with children waiting for hospital beds, cuts to early intervention

services and waiting times for CAMHS. Moreover the Committee concluded that there was a lack of reliable and up to date information about children's and adolescents' mental health, that there were insufficient levers in place at a national level to drive essential improvements to CAMHS services, and that more training was needed for GPs and school teachers to provide them with the knowledge and confidence to support children and young people with a mental health issue.

4.3. The NHS England policy document for promoting, protecting and improving children and young people's mental health, *Future in Mind*, was published in February 2015. This set out an ambitious programme of change, and introduced the intention to require every area in England to develop a local Transformation Plan. The implementation of the Transformation Plan is the responsibility of the Clinical Commissioning Group.

4.4. Most of the changes in *Future in Mind* and much thinking about service transformation have been based on different ways of doing business within existing resources. However, the need for some additional financial support was recognised and the Government announced its strategic intention to invest £1.25bn over 5 years (from 2015/16) in children and young people's mental health services in England.

5. Local context- background to Children's and Young People's Mental Health in LBTH

5.1. Mental ill health is consistently associated with deprivation, low income, unemployment, poor education, poorer physical health and increased health-risk behaviour.

5.2. Mental ill health is a prevalent issue for children and young people nationally, with 10% of children and young people diagnosed with a clinically recognised mental disorder, 6% of 5 to 16-year-olds diagnosed with a conduct disorder, 18% diagnosed with a 'sub-threshold' conduct disorder and 4% an emotional disorder.

5.3. Socio-economic status and parenting are two key determinants of mental health throughout the early years and childhood, and deficits in either are clearly associated with poorer outcomes for children. Children and young people in the poorest households are three times more likely to have a mental health problem than those in better-off homes.

5.4. Most mental health issues begin before adulthood and often continue through life. Cost-effective interventions exist to both prevent mental ill health and to promote wider population mental health initiatives that complement the treatment of mental ill health. Improving mental health early in life will reduce inequalities, improve physical health, reduce

health-risk behaviour and increase life expectancy, economic productivity, social functioning and quality of life.

5.5. Looked after children, children with disabilities (including learning disabilities), and children from BME groups have been identified as being particularly vulnerable to developing a mental health issue. The following risk factors have been identified as disproportionately affecting the mental health of all children: reduced levels of 'school readiness', child poverty, lower levels of parental education and employment, and bullying.

5.6. The council has a number of projects in place to help prevent mental ill health in children and young people:

- The *Family Nurse Partnership* provides specialist health support for young mothers pregnant with their first child;
- The *School Nursing Service* is responsible for delivering the healthy child programme;
- *The Education Psychology team* provides a range of support to children and families in education establishments, e.g. children in pupil referral units, children with special needs, and children with language difficulties;
- *Better Beginnings* is a pilot peer support programme which provides support to parents throughout pregnancy and up to the point their child turns 2 years old;
- The *Mindful Schools Programme* is a pilot programme in partnership with the LBTH Educational Psychology team which is testing how effective it is to work in schools to support children's emotional wellbeing.

5.7 Tower Hamlets' specialist CAMHS provision offers assistance and support to children, young people and their families with significant emotional, behavioural and mental health difficulties. CAMHS services include multi-disciplinary teams comprising of psychiatrists, psychotherapists, psychiatric social workers, psychologists, specialist community mental health nurses and family therapists. The term CAMHS is used to refer to services provided by a whole range of agencies in Tower Hamlets, however specialist CAMHS are jointly commissioning by THCCG and LBTH, and provided by the East London Foundation Trust.

5.8 CAMHS is still often thought of in terms of four tiers; (1) universal, (2) targeted, (3) specialist and (4) residential:

- Universal services (tier 1). Provided by practitioners who are not mental health specialists and this includes GPs, health visitors, school nurses, teachers, social workers, youth justice workers and voluntary agencies. Practitioners will be able to offer general advice and

treatment for less severe problems, contribute towards mental health promotion, identify problems early in their development, and refer to more specialist services;

- Targeted services (tier 2). Provided by practitioners who are CAMHS specialists working in community and primary care settings, such as primary mental health workers, psychologists and counsellors working in GP practices, paediatric clinics, schools and youth services. Practitioners offer consultation to families and other practitioners, outreach to identify severe or complex needs which require more specialist interventions, assessment (which may lead to treatment at a different tier), and training to practitioners at tier 1;

- Specialist services (tier 3). Provided through specialist CAMHS provision and are targeted at children and young people with more severe, complex and persistent disorders;

- Inpatient, day and residential services (tier 4). Highly specialised services for children and young people with the most serious problems. These are essential tertiary level services such as day units, highly specialised outpatient teams and in-patient units. These can include secure forensic adolescent units, eating disorders units, specialist neuro-psychiatric teams, and other specialist teams.

6. LBTH - Children's Social Care

6.1. The NHS has statutory responsibility to commission and provide specialist CAMHS, and the local authority duty is to ensure that the emotional health and wellbeing needs of vulnerable children are met through co-operation of key partners which includes key funding arrangements.

6.2. The council is working with partners to deliver the Mental Health Strategy and has made a commitment to review the LBTH CAMHS service. The work the council has been undertaking has been guided by a number of principals which are set out in a national policy document called *Future in Mind* (see 4.3).

6.3. The underpinning principles guiding the council in relation to children and young people's mental health are resilience, prevention and early intervention. The council's aim is to work with families and children at the earliest stages of identification of a mental health issue, as when symptoms are left to escalate the outcomes are markedly exacerbated. Moreover the council wants to strengthen the support structure in place for children to help prevent mental ill health.

6.4. The council invests approximately £1.6 million a year into mental health services. £1.3 million is allocated to the East London Foundation Trust to deliver CAMHS.

6.5. From a children's social care perspective its clinical partnership with CAMHS is of the highest importance. There are approximately 2,500-3,000 vulnerable children within the remit of Children's Social Care at any given time and a high proportion of these will exhibit early signs of emotional distress and mental health issues, or will come from families where adults exhibit these symptoms. A key ambition for the council is to integrate CAMHS into their mainstream offer. The council is currently reviewing their investment with CAMHS and is exploring the possibility of embedding CAMHS within the social work team in the council.

7. THCCG - Local Transformation Plan

7.1. NHS Tower Hamlets Clinical Commissioning Group (THCCG) and its partner organisations, including the council, are currently working on a number of local initiatives that will improve the mental health and wellbeing of children and young people in Tower Hamlets through the transformation of local services. The local Transformation Plan seeks to improve the mental health and wellbeing of children and young people through developing a system which responds to residents needs with evidence based interventions (See Appendix 1 for a detailed summary of the 2015/16 Transformation Plan initiatives.)

7.2. As part of the Transformation Plan THCCG commissions the following children and young people's mental health services (2014/15 spend): East London Foundation Trust Specialist CAMHS (£3,292,900 pa), inpatient (East London) and medium secure (West London) services (£1,082,411 pa), CHAMP (children's social workers with adult CMHTs): £56,375 pa, Perinatal services (delivered by ELFT adult services): £326,163.

7.3. The THCCG is engaging children and young people in a number of ways to ensure the services it commissions reflect the needs of service users and provides them with an opportunity to shape the service they use. Significantly a shared outcomes framework has been developed involving service users and key stakeholders. This was developed in order to determine what is important to young people and to talk in a language which young people understood. Consultation was carried out through six listening events, which were attended by 56 children, young people, parents and carers as well as 25 key stakeholder organisations. Through this engagement twenty outcomes have been developed to meet three ambitions for children and young people's mental health, which are; improve health and wellbeing, improve resilience and enable flourishing lives, reduce inequalities for those affected by mental health issues. This has produced a list of 20 core outcomes and the next challenge for the THCCG is to consider how they implement these across all partner agencies to begin to measure the success of the system as a whole. *See appendix 2 for an outline of the Tower Hamlets Shared Outcomes Framework for Children and Young People's Mental Health.*

7.4. In regard to the engagement and promotion elements of the Transformation Plan, the THCCG will sponsor Healthwatch Tower Hamlets Young People's

Panel to create their own video on mental health and to lead a peer evaluation awareness campaign. There is also an agreement in place to work with the Parent and Family Support services and through them with bodies like the Parent and Carer Council and the SEND Forum. The THCCG and the council hope to promote engagement through schools and the youth council and hope to set up an ongoing child and young people advisory group for transformation.

7.5. The THCCG has commissioned Youthnet (recently renamed The Mix) to develop a trial portal for mental health information with the aim of connecting with a wider range of children and young people who are currently not accessing information.

8. Tower Hamlets Child and Adolescent Mental Health Services (CAMHS)

8.1. The specialist CAMHS provision in the borough is delivered by East London Foundation Trust and is jointly commissioned by the THCCG and LBTH.

8.2. Tower Hamlets CAMHS provides a targeted and specialist assessment and intervention service to children and young people aged up to 18 years old who are at risk for urgent, persistent, complex and severe mental health difficulties. The service receives referrals from schools, community health services, GP's, social care teams and third sector organisations. The service receives approximately 1,700 referrals per year and currently employs 37 staff (whole time equivalent). There are a large number of young people in need of specialist CAMHS which stretches beyond the current capacity, hence there is a heavy reliance on partnership working to ensure everyone receives effective treatment.

8.3. CAMHS is trying to ensure all patients are seen quickly, with the current waiting time at just over five weeks for routine referrals. For moderate risk cases they are trying to see people for 6-12 sessions, and these might take the form of generic counselling, working with the family, and/or liaising with the network. Moreover there are specific therapies which they have to deliver; these might be 25 sessions for depression, cognitive behaviour therapy, or long term family therapy. Finally they have to work with high risk looked after children who are considered most vulnerable. CAMHS is trying to provide a service which delivers each of these four things to a very high level, with each of placing different demands on the service.

8.4. CAMHS is currently trying to improve access to the service through developing a website. Bilingual workers are used to make the service easier to navigate if the service user has a language need. Service users are included on interview panels presenting them with the opportunity to shape the service they use. CAMHS is also creating email networks for their stakeholders and are developing a better sense of who their referrers are.

8.5. CAMHS is trying to create a 'provider alliance' which will compose of a network of stakeholders such as City Gateway, the PRU, Docklands Outreach, YOT, FIB, Parenting Services/third sector and specialist CAMHS. Previously children were moving between these groups and if they missed an appointment their case would be closed. However with the 'alliance' providers will not be able to unilaterally close high risk cases without consultation with other agencies first. This idea is currently in its early stages however results are indicating that it is effective and the aim is to roll this out to other areas and involve more key stakeholders.

9. Community Perspective

9.1. Healthwatch Tower Hamlets

9.1.1. Healthwatch Tower Hamlets set up a Youth Panel three years ago to help them engage with young people. The Panel consist of 20 young people and they decide annually on a set of priorities and the topics they want to work on. They have previously worked on the issue of diabetes, the output of which will be published in a journal, and shisha consumption –creating an awareness video that is currently used in schools.

9.1.2. Healthwatch Tower Hamlets Youth Panel undertook a survey amongst young people to better understand young peoples' awareness levels and attitudes towards mental health, as well as receiving suggestions on how best to tackle issues related to young people and mental health. The surveys were carried out by 4 Youth Panel members that received training in order to become 'Peer Researchers'. A total of 237 young people across Tower Hamlets aged between 15 and 24 years old took part in the survey. The young people presented their work and their recommendations to the Health and Wellbeing Board in November 2015.

9.1.3. Their research found that there was a generally a lack of awareness about what constitutes mental ill-health including key symptoms and its possible impact. Stigma was identified as a key factor in preventing young people from talking about mental health concerns and avoiding help, with participants citing family and community barriers as contributing to this. For example, within certain communities such as the Bangladeshi and Somali communities, mental health is not widely recognised as requiring professional intervention, and there is a more limited recognition of the impact it can have on young people's overall wellbeing. There is an overwhelming feeling that schools should provide more support for young people. The term 'Mental Health' is not viewed positively, as it has associations with stigma. There is a preference for using the term 'Mental Wellbeing'. There is a lack of awareness around local support services that can help young people. Family and support systems was identified as a major factor in contributing to young people's mental health.

9.1.4. The Youth Panel made the following recommendations:

- Awareness raising amongst young people the need to care for their mental as well as their physical wellbeing;
- Work with schools and community groups as an access point to empower parents and families to promote good wellbeing for young people;
- Involve children and young people in co-producing a peer led health and wellbeing campaign to:
  - raise awareness of the importance of looking after your physical and mental health,
  - tackle the stigma around mental health,
  - tackle issues like exam pressure, bullying and family pressures,
  - build on existing resources and activities in other areas.

9.1.5. Tower Hamlets THCCG have taken most of the recommendations on board as part of their 'Transformation of children and young people's mental health and wellbeing in Tower Hamlets' programme. Healthwatch Tower Hamlets Youth Panel has received £15,000 of funding from the THCCG to undertake the following work as part of the overall awareness campaign:

- To produce a video on mental health awareness for children and young people in Tower Hamlets. The video is one of the tools that will be used as part of a wider awareness raising campaign;

- To undertake a peer evaluation survey on the impact of the overall awareness raising campaign.

Both pieces of work will be completed by November 2016.

9.2. **Step Forward**

9.2.1. Step Forward is an independent charity organisation which aims to improve the health, wellbeing and life chances of local young people. They deliver a range of free therapeutic, psychosocial support services, and sexual health support services. Step Forward's services are developed directly as a result of what their service users' needs are, and they started to provide sexual health support services 14 years ago as a direct result of service users expressing a need for it.

9.2.2. The demand placed on Step Forward has grown significantly in the last two years and is indicative of the level of need the borough is dealing with. There has been a 300% increase in health service referrals since 2013, with 25-30 referrals per month in 2015.The demand for services continues to increase and Step Forward now has a waiting list for people who want to access the service. There is an increase in the severity and complexity of issues young people present with and the time young people need support for.

9.2.3. There is a diverse range of people accessing Step Forward with a wide range of issues. The most prevalent problems for the children and young people involved with Step Forwards Youth Access Counselling are

generalised anxiety (92%), depression/low mood (91%), family relationship difficulties (77%), poor peer relationships (67%), anxious in social situations (61%), disturbed by traumatic event (52%), self-harm or have suicidal ideation.

9.2.4. In regards to the complexity factors of young people accessing counselling 47% have experience of abuse of neglect, 25% have experienced sexual violence, 23% are living within financial difficulty, 17% live with parents who have health issues, 18% identify as having a disability, 33% have additional issues at home , and 29% have additional issues in education/work/training.

9.3. **Docklands Outreach**

9.3.1. Docklands Outreach delivers targeted work with vulnerable young people who do not access mainstream services on a regular basis. They are linked in with Tower Hamlets CAMHS. Docklands Outreach developed a Detached Street-Work, Outreach & Advocacy model (DSOA) to meet this gap and have been delivering this model of work since 1997.

9.3.2. This model works with those who are affected by, or at risk of alcohol/substance misuse, poor sexual health, youth violence, anti-social behaviour and other social and mental health issues. Positive relationships are built, advice and information is given out on the streets, estates and community and statutory venues, and is reinforced by advocacy, therapeutic and practical support.

9.3.3. An extension of this model is the A&E Intervention at the Royal London Hospital. This project aims to support children, young people and their families/carers, who have presented at the A&E following traumatic incidents. It also offers support and mediation between friends and families of patients and hospital and security staff to ensure that situations remain calm and do not escalate. Moreover it provides follow on support through engagement, assessment, therapeutic interventions such as Cognitive Behavioural Therapy (CBT) and systemic family practice, and it makes referrals (internal and external), and supports them into accessing specialised services according to need.

9.3.4. Through the information collected from the A&E sessions Docklands Outreach deliver targeted street-work, engaging with young people on streets, parks, and estates, who are at risk of alcohol and substance misuse, anti-social behaviour and youth violence, and deter them away from at risk activities and future A&E admissions.

9.3.5. The intervention is a small pilot at present with 2 staff (WTE), but has had over 150 referrals from the hospital, street-work and outreach since May 2015.

10. Key Findings and Recommendations

10.1. National and local policy work illustrates that the way services in CAMHS are currently configured are not the best way to meet the needs of children and young people with mental health problems. This is particularly the case for young people in schools, pupil referral units (PRUs) and in non-specialist settings where they spend a lot of time with professionals. For vulnerable young people in these spaces who are suffering from a mental health problem, the service response is sometimes insufficiently robust. When specialist CAMHS get referrals there is a cohort of approximately 13% who do not reach the threshold for treatment and a less specialist service is required to treat this group. CAMHS has a higher threshold for mental health treatment and a lot of emotional difficulties presented by young people in the spaces formerly referred to as 'tier two' do not often present as a mental health issue. Some young people are self-harmers and suicide risks and they will receive a CAMHS service. However other young people present in different ways and some of their symptoms can be invisible, especially in cases of child abuse and sexual exploitation. The professionals working at 'tier two' need to work in partnership with specialist mental health professionals to recognise individuals who are suffering from mental health issues and refer them to the right service at the right time. The Transformation Plan is designed to respond to this gap in service provision and provide a more accessible and flexible response.

10.2. More support is required to support the 13% of children and young people who do not meet the specialist CAMHS threshold. Early intervention mental health services at tier 2 can be delivered by CAMHS, voluntary sector providers or other agencies. These provide mental and emotional health services for children and young people who require support, but who do not require more highly specialised tier 3 services. Early intervention services can make a crucial contribution to preventing mental health problems, providing timely support to children and young people before mental health problems become entrenched and increase in severity, and preventing, wherever possible, the need for admission to inpatient services.

Recommendation 1:
That the council and Tower Hamlets Clinical Commissioning Group (THCCG) work with the voluntary and community sector to support and strengthen early intervention services in the borough.

Recommendation 2:
That the council, CCG, specialist CAMHS and local services raise awareness of mental health issues, before children and young people reach specialist services, by promoting patient stories and examples of what mental health issues can turn into, with particular focus on BME communities.

10.3. There is a need to improve access to effective support and provide a more seamless service between different service levels, as currently the provision is disparate and difficult for service users to navigate which could potentially cause some to be left untreated.

10.4. The council has a duty to care for the most vulnerable and there is a need to improve the mechanisms in place to help identify those most at risk to ensure they receive the correct help. A significant risk which was identified by a recent external review of the service is that front line professionals do not like to stigmatise and therefore do not involve the psychologist and psychiatrist as quickly as they should, instead continuing to offer the standard generic service, which is not an effective treatment method for those children and young people who are most vulnerable. The council needs to equip frontline practitioners with the skills and knowledge to realise that when they need to refer to more specialist CAMHS, and in turn CAMHS need to respond to such referrals in a timely and efficient way.

Recommendation 3:
That the council ensure all frontline professionals who come into contact with children regularly or/and in a professional capacity (not just mental health professionals) are able to identify children with mental health issues and know what to do once they have identified a vulnerable child.

10.5. In order to ensure the service is accessible for all children and young people the council is aiming to develop a service which is built through images and with language they understand and find familiar. The traditional council model of service delivery is office and appointments based, which works against the principles of some of the most innovative and successful delivery approaches. Assertive outreach and persistence work, and the council is aiming to mainstream these skills so that all professionals can use them to engage young people in a more innovative way. Furthermore there is a need to eliminate a 'do not attend culture' which sees young people removed from the service if they do not attend an appointment and are subsequently left untreated.

10.6. The Health Scrutiny Panel expressed their concern relating to young parents (particularly mothers) with mental health issues, many of whom have been in care themselves and who require the local authority to respond to the consequences of failed, historic service interventions. If the young parents had their mental health issues addressed when they were a looked after child it is less likely that the council would need to intervene and take another child into care in later years.

10.7. Nasima Patel stated that the teenage pregnancy rate in Tower Hamlets is low compared to the England average, the inner London average and the Greater London average (conception rates for under-18s fell from 57.8 per 1,000 in 1998 to 18.1 per 1,000 in 2014). However the council can

undertake research to further understand the relationship between care leavers and pregnancy. A proportion of looked after children come from early years abuse and non-treatment. The council needs to improve early identification of abused children and provide them with a positive in-care experience. Tower Hamlets often takes children into care late in their childhood, which means that the ability for the in-care experience to have a significant impact is limited. Work is being undertaken to embed a CAMHS team within Children's Social Care to help address this. Additionally the council is going to ensure that every child who becomes looked after has an early mental health screening. This is currently being undertaken with some looked after children but it will be implemented systematically going forward. There is more work which needs to be carried out around sexual health and young people in care and Children's Social Care is working with Public Health to equip social workers with the skills and confidence to talk about sexual health issues, as this has been identified as a weakness in the current workforce.

Recommendation 4:
That the council reviews the data it holds on care leavers and pregnancy to investigate if there is a link between care leavers, teenage pregnancy and mental health issues.

Recommendation 5:
That the council undertakes further work with young care leavers to educate them on sexual health.

10.8. The Health Scrutiny Panel asked what measures are being taken to specifically support children in the youth justice system with a mental health issue. The youth offending teams nationally conclude that between 60% - 80% of children appearing in the youth court have mental health issues, and for those that are in custody the rate is around 70%. This figure is taken from neighbouring European countries who undertake CAMHS equivalent mental health assessments for children in the youth justice system, which doesn't happen in the UK. The impact that these children have on our communities is significant and the Health Scrutiny Panel is concerned about care proceedings, the cost and damage caused by this group, and our failure to adequately engage with children who are caught up in youth offending.

10.9. The Health Scrutiny Panel stated that in terms of outcomes in youth justice the ultimate aim is for a reduction of re-offending, however three quarters of all children will be reconvicted for a further offence within a year. This means there are children and young people who have a known mental health need and are stuck in a pattern of criminal activity. The Panel commented that CAMHS should look to improve outcomes for this group and suggested that lessons could be learned from experience in Europe in reducing youth recidivism though better mental health interventions.

10.10. In regards to Youth Justice there is a cohort of young people that are not identified and supported early and this leads to them committing criminal activity. There has been work recently undertaken focusing on gangs and one of the things recognised is that some of the young people in youth justice come from families where there is a history of domestic violence. There is a need to pair traditional social work with youth justice, which has already started, with the council undertaking joint projects between Youth Justice and the Troubled Families work. To further compound the challenge in supporting these service users, the Heath Scrutiny Panel noted that approximately three quarters of all children appearing in the youth justice system have a serious speech or language difficulty.

10.11. The Health Scrutiny Panel asked how service users are engaged in the development of services. Martin Bould stated that there is more work to be done to engage service users and one of the reasons the THCCG has established a partnership with the Parenting Support Service is so that the issue of mental health can be addressed by the existing consultative forums. They want to build on the work engaging young people and establish an advisory group for the Transformation Plan which will be ongoing. The CCG have just begun to talk with young people about specifications for new services and they will be involved in bidder selection, which is something they have not previously been able to do. The additional resources from the Transformation Plan have allowed this. Moreover Percy Aggett indicated that more work needs is being undertaken to collect feedback on the service and CAMHS will be setting up service user groups, particularly with service users who have dropped out after one appointment. The Health Scrutiny panel stated that one of the problems when dealing with this specific group of service users is training and empowering the group because they may have difficulty comprehending questions asked of them and may have no idea about the health (CAMHS) system or where they fit in. To this end they need training and support to be able to ask the right questions and effectively engage with the service.

Recommendation 6:
As part of any future re-fresh of the Local Transformation Plan, the council, CCG and partner agencies should consider how services can be improved for children and young people who are in contact with criminal justice services, and who have a higher vulnerability to mental health problems

Recommendation 7:
That the council and THCCG strengthen engagement and training for CAMHS service users to empower them with the skills and knowledge to effectively contribute to service development.

10.12. The Health Scrutiny Panel expressed concern about GPs ability to refer patients to mental health services, with some GPs not referring patients to the appropriate service when it is required. The Panel identified primary care as an important element in tackling mental health issues and an area

where improvements can be made. GPs provide universal services which are available to all children and young people without prior referral, and because of this, they may be one of the first places children or their parents turn to when they are experiencing mental health problems. The Panel identified problems of communication, especially in regards to language issues, as a key barrier to identifying a mental health issue. Many GPs are unequipped and lack the confidence in dealing with children and young people mental health issues. Moreover some GPs are not well informed of what local services are available and what the correct pathways to refer patients onto are. Martin Bould stated that the THCCG want to work more closely with GPs and that CAMHS will be arranging a meeting between their psychiatrists and psychologists and local GPs in order to develop knowledge and improve communication about referrals.

Recommendation 8:
That the THCCG work with CAMHS to review GP training in children and young people's mental health, including raising awareness of referral pathways for service users.

10.13. The Health Scrutiny Panel asked what services are in place to help children who are emotionally impacted by FGM. Nasima Patel stated that within Social Care there is a MOPAC funded project to address both the physical and mental symptoms of FGM, and there is a full time worker placed at the hospital picking up case work. The challenge for FGM has been long standing and a clear gap remains in identifying the total number of people who have been impacted by this.

10.14. The Health Scrutiny Panel stated that there is a clear stigma around mental health for some BME communities and asked if this has led to the reported increase in exorcisms, with some people in particular BME communities going to witch doctors for treatment. Percy Aggett stated that it is an issue and CAMHS work with Imams and the Muslim Families Group to tackle this. Bill Williams stated that there is more work to do around the cross cultural understanding and definitions of mental ill health. Providers need to work with community leaders, specifically Imams to develop an understanding of when it is appropriate for a young people to seek support from an Imam (or other religious leader) and when it is appropriate to be referred to a specialist CAMHS.

Recommendation 9:
That the council, THCCG, and Tower Hamlets CAMHS work with community leaders to improve cultural understanding of mental health and raise awareness of the services in place to support residents with a mental health need.

10.15. Nasima Patel stated that there are many services in the borough to support children with mental health issues however there are still many service users whose needs are not being met, partly because we are relying on professionals telling us and leading the way and partly because we are

relying on families presenting with issues, and neither mechanism is sufficient to identify all those with a mental health issue. The Health Scrutiny Panel asked where mental health services for children and young people are being advertised, because in their experiences a lot of parents are unaware of the support available. Nasima Patel stated that the Parent and Family Support Service is used by a large number of residents and this is particularly true for BME families, however the problems stem from the service failing to engage the most vulnerable clients. The Health Scrutiny Panel stated that in the Youth Court, for any parent of a child under 16, it has to consider a parenting order. This is a Court Order which is designed to provide parents with support and guidance. It aims to help parents prevent their child from offending and committing antisocial behavior, and helps parents get their child to attend school every day and address issues of behavior at school after they have been excluded. However the Tower Hamlets Youth Offending Service has advised the Youth Court against taking such action and this is something which needs to be re-evaluated.

10.16. There are cultural and stigma issues attached to mental health issues for BME communities and this is an area which needs to be addressed in Tower Hamlets. Furthermore at a national level we know there are gender barriers restricting access to the service and consequently work has been undertaken to overcome the gender barriers in Tower Hamlets.

Recommendation 10:
That the council, THCCG and CAMHS undertake work to reduce the stigma of mental health including rebranding and renaming services.

10.17. East London Foundation Trust data shows that only 36% of young people seen at Tower Hamlets specialist CAMHS are Bangladeshi. Given that the schools data indicates that approximately 60% of children and young people in schools are of Bangladeshi origin it is evident that they are significantly underrepresented. There is evidently an unmet need in the Bangladeshi community which could also be reflected among other ethnic minorities which may be hard to reach if only traditional mainstream approaches are used. The Health Scrutiny Panel commented that services need to do more work to ensure they are representative of the community. It will be more effective for services if they recruit people from backgrounds which are representative of Tower Hamlets as people are more likely to engage with people from their own background and culture, especially given the stigma attached to mental health in BME communities.

Recommendation 11:
That CAMHS consider ways to make the service more accessible through reviewing their workforce to ensure it is reflective of the community.

Recommendation 12:
That the council, THCCG and CAMHS improve engagement with children and families in order to increase awareness of mental health in all communities in the borough.

10.18. The Health Scrutiny Panel commented that a lot of the work performed by Docklands Outreach should be performed within the council by Youth Services. The council's Youth Services need to engage more young people on the streets through actively walking the streets and meeting them in places where they are comfortable. Runa Khalique stated that Docklands outreach have been working in partnership with the council's Youth Services by delivering street and outreach services that compliment centre based provision. As a trusted organisation most young people feel more comfortable talking to Docklands staff about sensitive issues like mental health, and they are trained in various forms of detached work like drugs & alcohol, sex & relationships, conflict & mediation and some clinical interventions in addressing low mood, anxiety and depression. Karen Badgery stated that there is currently a review of Youth Services with the aim of redesigning it to better meet the needs of service users. The Health Scrutiny Panel feels it is imperative for a representative from CAMHS to be involved in the review of Youth Services.

10.19. The Health Scrutiny Panel asked about the role of the Children Centres in supporting the emotional wellbeing needs of children and parents, and how well equipped staff in these a centre are to identify children who may have a mental health issue and be in need of additional support. Nasima Patel stated that health visitors are placed in Children Centres to act as a safety net and ensure families and children receive the correct support. All staff in Children Centres use the Common Assessment Framework (CAF) to recognise when a child requires additional support or referral to further CAMHS. The Health Scrutiny Panel asked how good youth services and other universal services are at using the Common Assessment Framework (CAF) to refer cases. Nasima Patel stated they are not as good as Children Centres and there is more work which needs to be done in this area.

Recommendation 13:
That the council undertakes an audit to check the usage and success of the CAF system in Children Centres and other universal services.

10.20. A key challenge for the council is developing the skills and knowledge of not just the mental health workforce but the wider workforce of teachers, youth workers and council officers. This remains a core target for the council and has already been achieved in small pilot projects however the challenge is mainstreaming this model in an effective way across a varied workforce.

Recommendation 14:
That the council and THCCG raise awareness about mental health and support services amongst non-MH staff working with young people to improve accessibility to appropriate support.

NHS
Tower Hamlets
Clinical Commissioning Group

Take-off to transformation

A series of local initiatives for children and young people's mental health services in Tower Hamlets
(January to September 2016)

NHS Tower Hamlets Clinical Commissioning Group (THCCG) and its partner organisations are currently working on a number of local initiatives that will improve the mental health and wellbeing of children and young people in Tower Hamlets through the transformation of local services.

Campaign to help increase awareness and reduce stigma

We will soon be planning and running a mental health awareness and anti-stigma campaign for children and young people and their families in the borough. Children and young people will be actively involved in this.

We have had an initial planning meeting with the voluntary sector forum to get feedback on the key messages and themes and we had a meeting for young people across the borough on 28 January in order to help plan the campaign. We have invited organisations to quote for campaign materials, reaching out to the Bangladeshi community, and engaging groups with higher vulnerability to mental health problems

Involving children, young people and their families

We will be setting up an advisory group of young people who will be able to suggest ways we can make the most of our transformation opportunities. Tower Hamlets Parent and Family Support Service will help us get this started.

As well as the advisory group, there will be opportunities to include young people in:

- Improving information about eating disorders and how to get help
- A review of local services for young people in crisis
- Testing out digital access and shaping mental health services in the future
- Development and evaluation of our awareness campaign

Improving information

We will soon be developing a digital platform localised for Tower Hamlets through which children, young people and parents can find out information about services, contact services, and get information about early signs of difficulties and tips for dealing with them.

Partnership and feedback project for specialist CAMHS

This service will increase efforts to gather feedback from users of specialist Children and Adolescent Mental Health Services (CAMHS). We intend to double the number of children and young people responding from 15 to 30%.

Young people in care and children at the Pupil Referral Unit (PRU) will benefit from in-depth studies undertaken by specialist CAMHS and the Tower Hamlets Council. We will use the information about their needs to improve the support they get, including for those known to the PRU at risk of social isolation.

Specialist CAMHS will support their staff in a capacity-building project to get feedback from families and to involve partner organisations in a new way of working together on promotion and prevention so children and young people thrive, following the principles of the 'Thrive' model developed by the Anna Freud Centre (a mental health research and training charity).

Working with local schools and GPs

Twenty-four schools in Tower Hamlets are taking part in local workshops run by the Anna Freud Centre to improve links between specialist CAMHS and schools, as part of a national initiative announced late last year*.

In addition, training sessions on mental health and emotional wellbeing are being offered to school governors. We also plan a fact-finding initiative to identify how children can get the best joined up support from physical and mental health services, so they can make the most of their education.

East London NHS Foundation Trust (ELFT) will be organising workshops for GPs to talk through when and how to refer a child or young person for more specialist help around mental health.

We will also be undertaking some specific awareness raising about eating disorders.

New services planned for 2016

The THCCG commissioning intentions include the following new services:

- A community eating disorder service for children and young people, as part of our local specialist CAMHS, offering treatment within a week for urgent cases and four weeks for everyone, following assessment by an eating disorder specialist team
- A new mental health service for young people, working with existing local youth organisations

A telephone advice service for professionals wanting to refer children and young people to specialist CAMHS has already been piloted by ELFT in 2015.

We have also identified priority areas for new service development:

- Children with higher vulnerability to mental health problems – including looked after children, those in touch with the criminal justice system, and those who have been abused
- Teenagers with severe and persistent conduct disorder
- Perinatal and neurodevelopmental mental health services

Outcomes based commissioning

We have already agreed a shared outcomes framework and a set of outcome measures based on the views of children and young people about what is important, and those of professionals. We will be working with staff in organisations to develop their awareness and understanding of those outcomes and how to measure them.

We will be testing out digital ways of easily measuring those outcomes and collecting the data so we can see if there is improvement in children and young people's mental health in the borough. We are also commissioning an expert study to help us define the outcomes universal children's services should be aiming for, if they are going to give children the best chance of avoiding mental health difficulties in later life.

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	Outcome cluster	Outcomes
Individual	Symptom improvement / maintenance	1. My issues with mental health are reduced
	Functioning	2. I can carry out the daily activities expected of me
		3. I lead a healthier lifestyle
	Achievement of goals	4. I am able to take part in activities that are important to me
		5. I am working towards developing my potential
	Empowerment: Self-determination	6. On balance, I feel good about myself
		7. My life has a sense of purpose
	Empowerment: Self management	8. My family / carers and I have a better understanding of my mental health
		9. I am able to manage when things get difficult
Interpersonal	Improved interpersonal relationships	10. I am able build and maintain good relationships
		11. I am able to express my feelings
	Family / carers	12. I am supported as part of a family
Whole System	Improved experience	13. My family and I have a positive experience of the services
		14. My family and I feel listened to by the services
		15. I feel safe from harm
	Improved access and early intervention	16. My family and I can access services when we need it
		17. My family and I know where to go when I want help
		18. My physical health needs are considered alongside my mental health needs
	Reducing exclusion and stigma	19. My family and I do not feel we are treated differently on account of my mental health
		20. My cultural and religious needs are met

1. Improve health and wellbeing
2. Improve resilience enabling flourishing lives
3. Reduce inequalities for those affected by mental health issues

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