TOWER HAMLETS HEALTH AND WELLBEING BOARD

Wednesday, 26 July 2017 at 6.30 p.m. Committee Room MP702, 7th Floor, Mulberry Place, 5 Clove Crescent, London E14 2BG

This meeting is open to the public to attend.

Members:		**Representing**
Chair:	Councillor Rachael Saunders	(Deputy Mayor and Cabinet Member for Health & Adult Services)
Vice-Chair:	Dr Sam Everington	Chair, Tower Hamlets Clinical Commissioning Group
Councillor Amy Whitelock Gibbs		Cabinet Member for Education and Children's Services
Councillor Danny Hassell		Non - Executive Group Councillor
Councillor David Edgar		Cabinet Member for Resources
Councillor Gulam Robbani		Independent Group - Largest Minority Group on the Council
Councillor Sirajul Islam		Statutory Deputy Mayor and Cabinet Member for Housing Management & Performance
Dr Somen Banerjee		Director of Public Health, LBTH
Simon Hall		Acting Chief Officer ,NHS Tower Hamlets Clinical Commissioning Group
Co-opted Members		
Charlie Ladyman		Co-Chair Healthwatch Tower Hamlets
Fahimul Islam		Young Mayor
Dr Ian Basnett		Public Health Director, Barts Health NHS Trust
Jackie Sullivan		Managing Director of Hospitals, Bart's Health Trust
Dr Navina Evans		Chief Executive East London NHS Foundation Trust
Sue Williams		Borough Commander - Chief Superintendent
Patrick Goulbourne		Borough Commander for London Fire Brigade
Jane Ball		Representative from Tower Hamlets Housing Forum

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

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

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

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Tel: 02073645554
E:mail: anthony.jackson@towerhamlets.gov.uk
Web: http://www.towerhamlets.gov.uk/committee

Role of the Tower Hamlets Health and Wellbeing Board.

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

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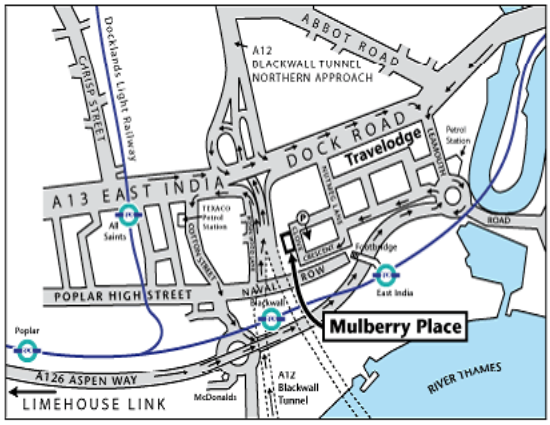

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PAGE NUMBER(S)

1. STANDING ITEMS OF BUSINESS

1 .1 WELCOME, INTRODUCTIONS AND APOLOGIES FOR ABSENCE

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

1 .2 MINUTES OF THE PREVIOUS MEETING AND MATTERS ARISING 1 - 10

To confirm as a correct record the minutes of the meeting of the Tower Hamlets Health and Wellbeing Board held on. Also to consider matters arising.

1 .3 DECLARATIONS OF DISCLOSABLE PECUNIARY INTERESTS 11 - 14

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

1 .4 FORWARD PLAN 15 - 16

ITEMS FOR CONSIDERATION

2. TERMS OF REFERENCE, QUORUM, MEMBERSHIP AND DATES OF MEETINGS 17 - 26

3. HEALTH AND WELLBEING BOARD STRATEGY 2017-20 - DELIVERING THE BOARDS PRIORITIES

3 .1 DELIVERING INTEGRATED SYSTEMS - PRESENTATION

3 .2 HEALTH AND WELLBEING STRATEGY - DELIVERING THE PRIORITIES: HEALTHY PLACE (Pages 27 - 36) 27 - 36

3 .3 SHARED OUTCOMES FRAMEWORK (Pages 37 - 46) 37 - 46

4. INITIAL DRAFT OF THE ADULT LEARNING DISABILITY STRATEGY 47 - 74

5. SUICIDE PREVENTION PLAN - DRAFT FOR CONSULTATION 75 - 132

6. IMPROVED BETTER CARE FUND 2017-19 - NEW ADULT SOCIAL CARE MONIES 133 - 144

7. RE-COMMISSIONING OF THE SCHOOL OF THE SCHOOL HEALTH SERVICE AND CHILD AND FAMILY WEIGHT MANAGEMENT SERVICE 145 - 152

8. ANY OTHER BUSINESS

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

9. DATE OF NEXT MEETING

Tuesday, 5 September 2017 at 5.30 p.m. in MP702, 7th Floor, Mulberry Place, 5 Clove Crescent, London, E14 2BG.

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LONDON BOROUGH OF TOWER HAMLETS

MINUTES OF THE TOWER HAMLETS HEALTH AND WELLBEING BOARD

HELD AT 5.43 P.M. ON TUESDAY, 18 APRIL 2017

MP701, 7TH FLOOR, TOWN HALL, MULBERRY PLACE, 5 CLOVE CRESCENT, LONDON, E14 2BG.

Members Present:

Councillor Amy Whitelock Gibbs (Chair)	(Cabinet Member for Health and Adult Services)
Dr Sam Everington (Vice-Chair)	(Tower Hamlets Clinical Commissioning Group)
Councillor Rachael Saunders (Member)	(Cabinet Member for Children's Services)
Councillor David Edgar (Member)	(Cabinet Member for Resources)
Councillor Sirajul Islam (Member)	(Statutory Deputy Mayor and Cabinet Member for Housing Management & Performance)
Councillor Danny Hassell (Member)	(Non-Executive Group Councillor)
Dr Somen Banerjee (Member)	(Director of Public Health)
Debbie Jones (Member)	(Corporate Director, Children's Services)
Denise Radley (Member)	(Director, Health, Adults & Community Services)
Simon Hall (Member)	(Acting Chief Officer, NHS Tower Hamlets Clinical Commissioning Group)

Co-opted Members Present:

Jackie Sullivan	(Barts Health, NHS)

Apologies:

Dr Ian Basnett	(Public Health Director, Barts Health NHS Trust)
Dr Navina Evans	(Chief Executive, East London NHS Foundation Trust)
Fahimul Islam	(Young Mayor)

Others Present:

Manawuba Eka	Tower Hamlets Together

Officers in Attendance:

Sarah Williams	(Team Leader Social Care, Legal Services, Law Probity & Governance)
Kate Smith	(Head of Healthy Lives, LBTH)
Simon Twite	(Strategist,Tower Hamlets Public Health)

1. STANDING ITEMS OF BUSINESS

1.1 Welcome, Introductions and Apologies for Absence

The Chair, Cllr Amy Whitelock-Gibbs welcomed everyone to the Health and Wellbeing Board.

The Chair put forward her request to add the local Borough Commander for Fire and Health Safety to the membership of the Health and Wellbeing Board as Fire Officers play an important community wellbeing role.

Members of the Board **AGREED** with the suggestion.

The Chair also stated the progress of the North East London Sustainability and Transformation Plan (NEL STP) would be further discussed at the Health and Wellbeing Board and Cabinet in the near future.

Apologies for absence were received from Sue Williams – Borough Commander Metropolitan Police, Dr Ian Basnett – Public Health Director, Barts NHS Trust, Dianne Barham – Director of Healthwatch Tower Hamlets and Jamal Uddin, Strategy, Policy and Performance Officer, LBTH.

1.2 Minutes of the Previous Meeting and Matters Arising

The minutes from the Board meeting of 21st February 2017 were agreed and approved as an accurate record of the meeting subject to the following matter arising.

Page 3 – The organisational development workshop did not take place on the 21st March 2017, and will now take place on the 31st May 2017.

1.3 Declarations of Disclosable Pecuniary Interests

No member of the Board declared an interest.

1.4 Forward Plan

Board Members were asked to **NOTE** the forward work programme for the Health and Wellbeing Board for the forthcoming municipal year of 2017/18.

Cllr Hassell asked if the 'Physical activity and sport strategy' scheduled for the 7th November could come to the September meeting of the Board, as views and comments could then be fed to Cabinet, who are to sign off the strategy on the 28th November.

The Chair and Board Members **AGREED** to the amendment.

Action: The Chair and Vice-Chair of the Health and Wellbeing Board to meet separately to discuss the forward work programme and to agree any other items that may need to be added.

2. HEALTH AND WELLBEING BOARD STRATEGY 2017-20 - DELIVERING THE BOARDS PRIORITIES

The Chair stated the following work streams of the Health and Wellbeing Strategy were to be discussed at this meeting.

She said the monitoring of the Strategy would be by the Health and Wellbeing Board however stakeholders may want to consider how they might monitor the Strategy, in their own organisations.

2.1 Communities Driving Change

Cllr Racheal Saunders, Cabinet Member for Education and Children's Services, and Board Champion for this priority stated the working group had identified a number of actions which were essential to ensure residents were empowered to drive change and improve health outcomes for themselves.

She said residents dealing with various agencies, needed a connected and cohesive response from stakeholders and information need to be shared more widely. For example, feedback from surveys needed to be available in a data bank of information. However she warned about the risk of being over focussed on Public Health outcomes and loosing what local communities really wanted.

The actions identified by this Priority are:

Action 1.1: Implement a 'health creation' programme in which residents:

- identify issues impacting on health and wellbeing that matter to local people
- recruit other residents who have the energy and passion to make a difference develop and lead new ways to improve health and wellbeing locally

Action 1.2: Implement a programme across the partnership to promote a culture in their organisations that empowers people to be in control and informed about how to improve their health

Action 1.3: Engage local residents with the work of the Board and to deliver this strategy by:

- hosting an event in each area at least one month prior to our Health and Wellbeing Board meetings
- following this up with a further meeting with the public to report back

- using social media to communicate more regularly and creatively with a wider range of local people.

The Board members made the following comments:

- The Chair stated she was not expecting residents to attend Health and Wellbeing Board meetings however the Board needed to be outward facing, meeting residents and engaging with them when discussing topics/ideas.

- Members suggested HWBB meetings could be held at different locations such as Schools, Police and Fire Stations, Canary Wharf (for Employment and Health priority) and meetings could be themed to make them relevant to the location and local people.

- Need to ensure opportunities to engage with others is fully utilised. For example the co-chair for Learning Disability will have an interest in Learning Disability and access and should be invited to the HWBB when this is discussed.

- There are clear links with the Strategy and the 'Tower Hamlets Together' programme.

- A repository where data and intelligence is collated in one place is required with a dedicated resource, to ensure it is up to date and accurate.

Action: HWBB Officers of the 'Executive Officer Group' to discuss if 'Tower Hamlets Together' should host the resource and how this will function.

Action: Simon Hall and Denise Radley to take forward Action 1.2

Action: Work stream needs to work in partnership with Healthwatch in taking forward Action 1.3

2.2 Employment and Health

The Chair introduced this work stream stating Employment and Health encompassed a wide range of items however the working group had concentrated on two main areas (1)Back to work support and (2) Leaders and employers providing a healthy working environment.

She referred Members of the Board to page 27 of the agenda pack and the actions listed:

Action 3.1: We aim to strengthen the integration between health and employment services by:

- Using social prescribing as a lever to strengthen links between health and employment services
- Reviewing best practice elsewhere
- Shaping and ensuring effective local delivery of the Department of Works and Pensions Work and Health programme.

Action 3.2: We aim to sign up our partner organisations to the London Healthy Workplace Charter and to:

- undertake self-assessment
- identify priorities for improvement and shared priorities for action to improve the level of healthy improvement

She said it was imperative to build on the 'Workpath' and 'Social Prescribing' initiatives.

Members of the Board made the following comments:

- Cllr Hassell asked how the partnership was to engage with the DWPs work and health programme, page 30 of agenda pack.
- Social Prescribing needs to be introduced to other services within the borough - employees need an understanding of what it is and how to apply it.
- Work stream has parallels with the NEL STP, Mental health – "Time for Change" initiatives and the Board needs to build on this. Bart's 'Healthy Workplace Charter' should be shared widely with other stakeholders.
- Dr Everington stated the STP workshop held on the 27th March looking at Social Prescribing had identified recommendations which could be incorporated into this work stream.
- Workpath needs to ensure it includes homeless people, who loose connection with services and how to get them back into work.
- Simon Hall stated the staff shortage in the health and care sector could be filled by local people, who were skilled up to take on varying roles.
- To encourage local employees to provide 'work placements' and 'internships' to those who are interested in the health and care sector.

Action: Conduct a review of Best Practice to identify what other practical solutions can be found to bridge the gap between employment and health.

2.3 Children's weight and nutrition

Dr Sam Everington, introduced this work stream stating the group had identified various ideas such as the introduction of a health expert on every Governing Body and the promotion of Health and Happiness within schools to having a clear community engagement and communications strategy. He said

it was important to educate parents and head teachers about mental health and child wellbeing and to drive up the quality and standard of care in schools.

Debbie Jones added figures for nutrition and child weight were poor and this challenge was something the Board needed to address.

The actions put forward by this work stream are:

Action 4. 1
We aim to strengthen existing school programmes by:

- identifying and supporting a 'health representative' on the governing body of every school
- telling parents what each school is doing for their child's health and wellbeing
- promoting the 'Healthy Mile' in schools, which is a scheme that ensures pupils run for a mile a day
- inviting a representative from the Tower Hamlets Education Partnership into the Health and Wellbeing Board

Action 4.2

- Develop and implement a community engagement and communications strategy around healthy weight and nutrition, with particular emphasis on high risk groups

Board Members made the following comments:

- Members agreed there should be health representations on Governing Boards.
- Information on how schools were preforming against public health targets – showing if they were on or off track needs to be provided. Need to question what we are doing to change the outcome – a logic model on every theme was proposed.
- New School Nursing contract needs to provide challenge and needs to be integrated with the wider offer. Simon Hall stated the contract was be re-commissioned and Member input would be welcomed.
- School nursing needs to be provided in a more holistic way.

Action: An action log was required to track the progress of each recommendation put forward by the work streams so the Board does not lose sight of what has been agreed.

3. LOCAL GOVERNMENT DECLARATION ON SUGAR REDUCTION AND HEALTHIER FOOD

Dr Somen Banerjee presented this report. He said the purpose of the Local Government Declaration on Sugar Reduction and Healthier food was a Government backed initiative designed to reduce sugar intake and promote healthier lifestyles.

He referred Members of the Board to point 3.5 of the report which stated "Average intakes of sugar in England are three times higher than the maximum recommended level in school-aged children and teenagers and around twice the maximum recommended level in Adults."

The Scientific Advisory Committee on Nutrition (SCAN) had identified six areas for improvement and these were areas that the HWBB could take forward.

Member of the Board made the following comments:

- Labelling should not state 'reduce sugar', as this deters people from buying the product.
- Council needs to be proactive in monitoring health impacts and Health impact assessments should feature on all reports coming to the council, as they do for planning applications.
- Consideration needs to be given to developing a process whereby planning applications are referred to Public Health, for comment and input.

Action: Sarah Williams to inform the Head of Legal Services about the HWBB's request to have an 'Health Implications' paragraph inserted to council reports and guidance on how Officers complete Health Impact Assessment for reports they submit.

Action: Dr Somen Banerjee to feedback to Sustain the comment made regarding labelling and the need to include other partners, not just local government, in the dissemination of their research findings.

Action: Bart's NHS Trust to share the findings of the research with their new Catering and facilities provider.

The Health and Wellbeing Board

1. Noted the recommendations being considered by the Mayor in Cabinet, to agree
   (a) To sign up to the Local Government Declaration on Sugar Reduction and Healthier Food and agree which specific actions should be recommended for 2017/18.
   (b) That the formal sign up to the Declaration to be used as a publicity opportunity, and
   (c) A cross council work programme to ensure that the agreed actions are implemented during 2017/18 and to provide progress report at the end of the year.

2. Partner agencies of the Health and Wellbeing Board are invited to consider whether they could sign up to a similar declaration of commitments.

4. BETTER CARE FUND 2017 UPDATE

Denise Radley, Corporate Director for Health Adults and Community updated Board members with regard to the Better Card Fund 2017.

She said the guidance from NHS England had been delayed and was published on the 31st March 2017.

The interim Better Care Fund had been connected with the Adult Social Care money and to complicate matters there was also the 'Improved' Better Care Fund, which the government was releasing in two tranches. Tower Hamlets was a net looser with regard to the first tranche of monies, with the second tranche being ring-fenced to be spent on Adult Social Care.

The Board had agreed to delegate responsibility to Denise Radley and Simon Hall, as co-chairs of the Joint Commissioning Board to sign off the Better Care Fund Plan and the intention is to get the plan approved by Cabinet for 27th June, with submission to NHS England in early July.

The Health and Wellbeing Board **NOTED**

The further delay in the publication of the BCF guidance and received an oral update at the meeting.

5. ANY OTHER BUSINESS

Community Health Services – Alliance Partnership Agreement between CCG and GP Care Group, Barts Health and East London Foundation NHS Trusts

Simon Hall, Acting Chief Officer of Tower Hamlets Clinical Commissioning Group informed Board Members the alliance partnership agreement between the three local healthcare providers had been agreed on the 31st March 2017, after a three year journey.

He said the agreement will mean integrated services and a better outcome for patients. Tower Hamlets Together and local people had been involved in the design of the care pathways in an effort to reduce duplication where possible.

The Health and Wellbeing Board **NOTED**

1. The report and will ensure the dissemination as appropriate within organisations represented by the Board.

6. DATE OF NEXT MEETING

Members of the Health and Wellbeing Board were asked to note the next meeting of the Board was for the 4th July 2017.

The meeting ended at 7.18 p.m.

Chair, Councillor Amy Whitelock Gibbs
Tower Hamlets Health and Wellbeing Board

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DECLARATIONS OF INTERESTS - NOTE FROM THE MONITORING OFFICER

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

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

Interests and Disclosable Pecuniary Interests (DPIs)

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

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

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

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

Effect of a Disclosable Pecuniary Interest on participation at meetings

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

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

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

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

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

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

Further advice

For further advice please contact:-

Asmat Hussain, Corporate Director, Governance & Monitoring Officer,
Telephone Number: 020 7364 4800

APPENDIX A: Definition of a Disclosable Pecuniary Interest

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

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

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Health and Wellbeing Board Forward Plan				
Date: 5 September 2017				
	Report Title	**Lead Officer**	**Reason for submission**	**Time**
Public Questions	Public Questions			
Standing Items	Apologies & Substitutions Minutes & Matters Arising Forward Plan	Chair		10 mins
Health and Wellbeing Strategy - priority (mid-point review)	Communities driving change - update	Flora Ogilvie		20 mins
	Employment and Health - update	Flora Ogilvie		20 mins
	Children's weight and nutrition update	Esther Trenchard Mabere		20 mins
Discussion Items	Draft Local Plan		To provide update on draft Local Plan post Regulation 18 and receive any comments. This will include new evidence based studies on Tall Buildings, Water Space etc. The consultation period for Regulation 19 will begin on the 2nd October.	
	Adults Learning Disability Strategy (FINAL)	Lonica Vanclay		
Any Other Information				5 mins
Date: 7 November 2017				
	Report Title	**Lead Officer**	**Reason for submission**	**Time**
Public Questions	Public Questions			
Standing Items	Apologies & Substitutions Minutes & Matters Arising Forward Plan	Chair		10 mins
Health and Wellbeing Strategy - priority (mid-point review)	Developing Integrated System - update	Denise Radley		20 mins
	A Healthier Place - update	Somen Banerjee		20 mins
	Outcomes Framework - update	Somen Banerjee / Jamal Uddin		20 mins
Discussion Items	BCF - quarterly update	Denise Radley		20 mins
				5 mins
Any Other Information				5 mins
Date: 20 December 2017				
	Report Title	**Lead Officer**	**Reason for submission**	**Time**
Public Questions	Public Questions			
Standing Items	Apologies & Substitutions Minutes & Matters Arising Forward Plan	Chair		10 mins
Health and Wellbeing Strategy - priorities (Initial assesment/ evaluation)	Communities driving change - update	Flora Ogilvie		20 mins
	Employment and Health - update	Flora Ogilvie		20 mins
	Children's weight and nutrition - update	Esther Trenchard Mabere		20 mins
Discussion Items	Physical activity and sport strategy	Thorsten Dreyer	Sign off required ahead ofCabinet approval scheduled for 28 November 2017.	
Any Other Information				5 mins
Date: 20 February 2018				
	Report Title	**Lead Officer**	**Reason for submission**	**Time**
Public Questions	Public Questions			
Standing Items	Apologies & Substitutions Minutes & Matters Arising Forward Plan	Chair		10 mins
Health and Wellbeing Strategy - priorities (Initial assesment/ evaluation)	Developing Integrated System - update	Denise Radley		20 mins
	A Healthier Place - update	Somen Banerjee		20 mins
	Outcomes Framework - update	Somen Banerjee / Jamal Uddin		20 mins
Discussion Items				

Any Other Information				5 mins
Date: 20 March 2018				
	Report Title	**Lead Officer**	**Reason for submission**	**Time**
Public Questions	Public Questions			
Standing Items	Apologies & Substitutions Minutes & Matters Arising Forward Plan	Chair		10 mins
Health and Wellbeing Strategy - priorities (Annual Review)	Health and Wellbeing Strategy - annual review of delivery plans: - Communities Driving Change; - Employment and Health; - Children's healthy weight and nutrition - Developing an integrated system; - A healthier place; - Outcomes Framework		End of year reflections from each of the delivery work streams.	45-60 mins
Discussion Items				
Any Other Information				5 mins

Health and Wellbeing Board Wednesday 26th July 2017	Tower Hamlets Health and Wellbeing Board
Report of the London Borough of Tower Hamlets	**Classification:** Unrestricted
Tower Hamlets Health and Wellbeing Board Terms of Reference, Quorum, Membership and Dates of Meetings	

Lead Officer	Somen Banerjee, Director of Public Health
Contact Officers	Jamal Uddin, Strategy, Policy & Performance Officer
Executive Key Decision?	No

Summary

This report sets out the Terms of Reference, Quorum, Membership and Dates of meetings of the Tower Hamlets Health and Wellbeing Board for the Municipal Year 2017/18 for the information of members of the Board.

Recommendations:

The Health & Wellbeing Board is recommended to:

1. Note the Terms of Reference, Quorum, Membership and Dates of future meetings as set out in Appendix 1 and 2 of this report.

2. Note that Cllr Rachael Saunders is the new chair of the Health and Wellbeing Board following the announcement of the Mayors' Executive Team at the Annual Meeting of the Council held on 17 May 2017.

3. Welcome Borough Commander of London Fire Brigade - Patrick Goulbourne to the board as a co-opted member. This appointment will support the boards' priorities around community safety and health.

1. REASONS FOR THE DECISIONS

It is necessary for all Council committees including the Health and Wellbeing Board to note its Terms of Reference, Quorum, Membership and Dates of meetings for the forthcoming Municipal Year.

2. ALTERNATIVE OPTIONS

2.1 The Board could choose not to consider the Terms of Reference but it is not recommended as the Health and Wellbeing Board is expected to meet all the stated requirements in the Terms of Reference.

3. DETAILS OF REPORT

3.1 It is traditional that following the Annual General Meeting of the Council at the start of the Municipal Year, at which various committees are established, that those committees note their Terms of Reference, Quorum and Membership for the forthcoming Municipal Year. These are set out in Appendix 1 to this report.

3.2 At the Annual Meeting of the Council a written record of delegations were made by the Mayor under the new Executive Scheme of Delegation for inclusion in the Council's Constitution. Under the new composition of the Mayor's Executive, Cllr Amy Whitelock Gibbs is now appointed as Cabinet Member for Education and Children's Services and Cllr Rachael Saunders has been appointed as Deputy Mayor for Health and Adults Services. This means that Cllr Rachael Saunders will now be the chair of the Health and Wellbeing Board going forward.

3.3 The Board's meetings for the remainder of the year, as agreed at the meeting of the Council on 17th May 2017 are as set out in Appendix 2 to this report. In accordance with the agreed calendar, meetings of the Board are scheduled bi-monthly to take place on Tuesdays at 5.30pm where possible. This means there are six meetings of the board held in a year. There are also two development sessions scheduled in a year.

3.4 It is clear from the Health and Social Care Act 2012 that health and wellbeing boards are different to other section 102 committees, in particular in relation to the appointment of Councillors. The regulations disapply the requirement for political proportionality and enables Directors of the Local Authority to become members of the board. In the 'HWBB a practical guide to governance and constitutional issues'[1] the following is the core membership that health and wellbeing boards must include:

[1] The source of 'HWBB a practical guide to governance and constitutional issues' is http://www.olderpeoplescouncil.org/docs/projects/HWB%20governance%20and%20constitutional%20issues.pdf

- at least one councillor from the relevant council
- the director of adult social services
- the director of children's services
- the director of public health
- a representative of the local Healthwatch organisation
- a representative of each relevant clinical commissioning group (CCG)
- any other members considered appropriate by the council

3.5 The membership of the Board in Tower Hamlets reflects the requirements of the Health and Social Care Act 2012 and allows other members that Tower Hamlets regard as important to the Health and Wellbeing of its residents.

3.6 This in effect means the board is able to review its membership and make necessary changes to appointments of the board to reflect health and wellbeing priorities in Tower Hamlets. There is more than one elected councillor on the board but there is no restriction on the total number of elected members that can be board members. The council is free to decide, in consultation with the health and wellbeing board, which members of the health and wellbeing board should be voting members.

3.7 At the Health and Wellbeing board meeting in April 18 2017, the inclusion of Borough Commander, London Fire Brigade as a co-opted member was approved by the board to support its priorities around community safety and health.

4. COMMENTS OF THE CHIEF FINANCE OFFICER

4.1 There are no financial implications directly relating to this report.

5. LEGAL COMMENTS

5.1 Section 194 of the Health and Social Care Act 2012 requires the establishment of a Health and Wellbeing Board (HWBB) and sets out who the HWBB must consist of. The existing Membership meets those requirements.

5.2 The information provided for the Committee to note is in line with Part 3.3.23 of the Council's Constitution and the resolutions made by Council on 17th May 2017.

5.3 Any changes to the Terms of Reference must be agreed by Council pursuant to Article 4.02(d) of the Constitution.

6. ONE TOWER HAMLETS CONSIDERATIONS

6.1 When drawing up the schedule of dates, consideration was given to avoiding school holiday dates and known dates of religious holidays and other important dates where at all possible.

7. BEST VALUE (BV) IMPLICATIONS

7.1 There are no specific Best Value implications arising from this noting report.

8. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

8.1 There are no specific sustainability implications arising from this noting report.

9. RISK MANAGEMENT IMPLICATIONS

9.1 There are no specific risk implications arising from this noting report.

10. CRIME AND DISORDER REDUCTION IMPLICATIONS

10.1 There are no specific crime and disorder implications arising from this noting report.

Linked Reports, Appendices and Background Documents

Linked Report

- NONE

Appendices

1. Health and Wellbeing Board Terms of Reference
2. Health and Wellbeing Board - Dates of Meetings 2017-18

Local Government Act, 1972 Section 100D (As amended)
List of "Background Papers" used in the preparation of this report
List any background documents not already in the public domain including officer contact information.

- NONE

Officer contact details for documents:
Jamal Uddin
Strategy, Policy and Performance Officer, LBTH
020 7364 4742

Appendix 1

Tower Hamlets Health and Wellbeing Board – Terms of Reference, Quorum and Membership

The Health and Wellbeing Board will lead, steer and advise on strategies to improve the health and wellbeing of the population of Tower Hamlets. It will seek to do this through joint work across services in the Borough and the greater integration of health and social care as well as with those accessing services that can help to address the wider determinants of Health. The Board continues to support the ambitions of the Tower Hamlets Partnership outlined within the Tower Hamlets Community Plan.

The Health and Wellbeing Board has the following functions:

1. To have oversight of assurance systems in operation
2. To encourage integrated working between persons who arrange for the provision of any health or social services in Tower Hamlets for the advancement of the health and wellbeing of the people in Tower Hamlets.
3. To provide advice, assistance or other support in order to encourage partnership arrangements under Section 75 of the NHS Act 2006.
4. To encourage those who arrange for the provision of any health-related services in Tower Hamlets (e.g. services related to wider determinants of health, such as housing) to work closely with the HWB.
5. To encourage persons who arrange for the provision of any health or social care functions in Tower Hamlets and those who arrange for the provision of health-related services in Tower Hamlets to work closely together.
6. To identify needs and priorities across Tower Hamlets and publish and refresh the Tower Hamlets Joint Strategic Needs Assessment (JSNA) so that future commissioning/policy decisions are based on evidence.
7. To prepare the Joint Health and Wellbeing Strategy.
8. To develop, prepare, update and publish the local pharmaceutical needs assessments.
9. To be involved in the development of any CCG Commissioning Plan that applies to Tower Hamlets and to give its opinion to the CCG on any such proposed plan.
10. To communicate and engage with local people on how they could achieve the best possible quality of life and be supported to exercise choice and control over their personal health and wellbeing. This will involve working with Local HealthWatch to make sure there's a continuous dialogue with the public to ensure services are meeting need.
11. Consider and promote engagement from wider stakeholders.
12. To have oversight of the quality, safety, and performance mechanisms operated by member organisations of the Board, and the use of relevant public sector resources across a wide spectrum of services and interventions, with greater focus on integration across outcomes spanning health care, social care and public health. Areas of focus to be agreed from time to time by members of the Board as part of work planning for the Board.
13. Such other functions delegated to it by the Local Authority.
14. Such other functions as are conferred on Health and Wellbeing Boards by enactment

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

Membership The membership of the Board is as follows:

Chair

- Cabinet Member for Health and Adult Services (LBTH)

Vice Chair

- Representative of NHS Tower Hamlets Clinical Commissioning Group (CCG)

Elected Representatives of LBTH

- Cabinet Member for Education & Children's Services
- Cabinet Member for Housing Management and Performance
- Cabinet Member for Resources
- Non-executive majority group councillor nominated by Council

Local Authority Officers- LBTH

- Director of Public Health
- Corporate Director of Children's Services
- Corporate Director of Health, Adults and Community

Local HealthWatch

- Chair of local Healthwatch

NHS (Commissioners)

- Chair - NHS Tower Hamlets Clinical Commissioning Group
- Chief Officer – NHS Tower Hamlets Clinical Commissioning Group (CCG)

Co-opted Members (Non-Voting)

- Council
  - Corporate Director of Place(CLC)
  - Corporate Director of Governance
- Health Providers
  - Chief Officer - Barts Health
  - Chair of Tower Hamlets - Council for Voluntary Services
  - Regional Managing Director - East London and the Foundation Trust
- Other Partners
  - Borough Commander for Metropolitan Police
  - Borough Commander for London Fire Brigade
  - Representative from the Tower Hamlets Housing Forum.
  - Chair of the Complex Adult Working Group (CCG)
  - Chairs of the Adults and Children's Working Group (CCG)
  - The Young Mayor (LBTH)

Stakeholders that may attend the Board from time to time but are not members:

- Councillor nominated by Council from the largest opposition group
- Representative of NHS England/Public Health England
- Chairs of Tower Hamlets Safeguarding Boards (Adults and Children's)
- Chair of the LBTH Health Scrutiny Sub-Committee

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Appendix 2:

Dates of Health and Wellbeing Board Meetings, 2017-18

- Tuesday 5th September 2017
- Tuesday 7th November 2017
- Wednesday 20 December 2017
- Tuesday 20 February 2018
- Tuesday 20 March 2018

The above meetings start at 5.30pm and are normally held at the Town hall – Mulberry Place, 5 Clove Crescent, E14 2BG. The board will try to hold at least two meetings across the borough in suitable community facilities to enable the board meetings to be more accessible to local residents.

There will be two additional development sessions planned in the year. The dates are yet to be agreed.

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Health and Wellbeing Board Wednesday 26th July 2017	Tower Hamlets Health and Wellbeing Board
Report of the London Borough of Tower Hamlets	**Classification:** Unrestricted
Health and Wellbeing Strategy - Delivering the Priorities: Healthy Place	

Lead Officer	Somen Banerjee, Director of Public Health
Contact Officers	Flora Ogilvie, Acting Associate Director of Public Health
Executive Key Decision?	No

Executive Summary

This action plan was developed by the Board Champion Group for the Healthy Place priority of the Health and Wellbeing Strategy consisting of:

- Cllr David Edgar
- Cllr Danny Hassell
- Judith St John (Sports, Leisure and Culture)
- Flora Ogilvie (Public Health)
- David Tolley (Environmental Health and Trading Standards)
- Somen Banerjee (Public Health)

The plan sets out what will have been achieved by March 2018; the overall plan for the year; what we will do in the next three months and how we will measure success, for each of the actions within the Healthy Place priority area:

Action 2. 1: We aim to identify three areas in the borough where there is a particular need to improve the physical environment (e.g. lack of green space, population growth) and engage with residents and local organisations on priorities for improvement to benefit health and wellbeing

Action 2.2: Develop a process to ensure that the impacts on health and wellbeing made by major developments are routinely assessed and considered in planning decisions

Action 2.3: Support the council's Air Quality Plan and implement an air quality communications campaign across the partnership targeted at residents to:

- increase awareness of poor air quality, how to minimise exposure and adopt less polluting behaviours
- introduce pledges from organisations to minimise their impact on air pollution

Recommendations:

The Health and Wellbeing Board is recommended to:

1. Review and comment on the action plan

1. REASONS FOR THE DECISIONS

1.1 The report sets out the proposed action plan for the Healthy Place priority with the Health and Wellbeing Strategy in order to realise the ambition of the strategy. The action plan has been developed based on knowledge of the existing work that is already ongoing and what is thought to be realistically achievable within existing budgets.

2. ALTERNATIVE OPTIONS

2.1 The alternative option would be not use the strategic asset of the Health and Wellbeing Board, its members and networks to realise the ambition within the Health and Wellbeing Strategy

3. DETAILS OF REPORT

3.1 See attached report

4. COMMENTS OF THE CHIEF FINANCE OFFICER

4.1. The proposed action plan sets out the delivery of the Healthy Place priority of the Health and Wellbeing Strategy.

4.2. The proposed action plan will be delivered through existing officer capacity and within the division's existing budget. There are no additional resources required for the delivery of the action plan.

5. LEGAL COMMENTS

5.1. The Health and Social Care Act 2012 ("the 2012 Act") makes it a requirement for the Council to establish a Health and Wellbeing Board ("HWB"). S.195 of the 2012 Act requires the HWB to encourage those who arrange for the provision of any health or social care services in their area to work in an integrated manner.

5.2. This duty is reflected in the Council's constitutional arrangements for the HWB which states it is a function of the HWB to have oversight of the quality, safety, and performance mechanisms operated by its member organisations, and the use of relevant public sector resources across a wide spectrum of services and interventions, with greater focus on integration across outcomes spanning health care, social care and public health.

5.3. Section 116A of the Local Government and Public Involvement in Health Act 2007 places a duty on the HWB to prepare and refresh a joint strategic health and wellbeing strategy in respect of the needs identified in the Joint Strategic Needs Assessment, so that future commissioning/policy decisions are based on evidence. The duty to prepare this plan falls on local authorities and the Clinical Commissioning Group, but must be discharged by the HWB.

5.4. When considering the recommendation above, and during the review itself, regard must be given to the public sector equalities duty to eliminate unlawful conduct under the Equality Act 2010. The duty is set out at Section 149 of the 2010 Act. It requires the Council, when exercising its functions, to have 'due regard' to the need to eliminate discrimination (both direct and indirect discrimination), harassment and victimization and other conduct prohibited under the Act, and to advance equality of opportunity and foster good relations between those who share a 'protected characteristic' and those who do not share that protected characteristic.

6. ONE TOWER HAMLETS CONSIDERATIONS

6.1. The Healthy Place priority aims to target action to improve health and reduce health inequalities where the need is greatest through targeted action around environmental determinants of health

7. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

7.1 Sustainability and environmental improvement to support health are closely aligned e.g. air quality, green space. The actions within this priority therefore impact on sustainability and health.

8. RISK MANAGEMENT IMPLICATIONS

8.1. Actions proposed will be carried out within existing budgets and no specific risks are identified

9. CRIME AND DISORDER REDUCTION IMPLICATIONS

9.1 Improving the physical environment may have an impact on both health and crime and disorder.

10. EFFICIENCY STATEMENT

10.1 Not applicable

Appendices and Background Documents

Appendices

- Action plan for Healthy Place priority

Background Documents

- NONE

Officer contact details for background documents:

- Somen Banerjee, Director of Public Health, LBTH 020 7364 7340 somen.banerjee@towerhamlets.gov.uk

Health and Wellbeing Strategy Board Champion Group - Action Planning

Priority Area Two: Healthy Place

This action plan was developed by the Board Champion Group for the Healthy Place priority of the Health and Wellbeing Strategy consisting of:

- Cllr David Edgar
- Cllr Danny Hassell
- Judith St John (Sports, Leisure and Culture)
- Flora Ogilvie (Public Health)
- David Tolley (Enviromental Health, Trading Standards)
- Somen Banerjee (Public Health)

The plan set out overleaf sets out what will have been achieved by March 2018; the overall plan for the year; what we will do in the next three months and how we will measure sucess, for each of the actions within the Health Place Priority area (p15 of Strategy)

Action 2. 1: We aim to identify three areas in the borough where there is a particular need to improve the physical environment (eg lack of green space, population growth) and engage with residents and local organisations on priorities for improvement to benefit health and wellbeing

Action 2.2: Develop a process to ensure that the impacts on health and wellbeing made by major developments are routinely assessed and considered in planning decisions

Action 2.3: Support the council's Air Quality Plan and implement an air quality communications campaign across the partnership targeted at residents to:

- increase awareness of poor air quality, how to minimise exposure and adopt less polluting behaviours
- introduce pledges from organisations to minimise their impact on air pollution

Action 2. 1

We aim to identify three areas in the borough where there is a particular need to improve the physical environment (eg lack of green space, population growth) and engage with residents and local organisations on priorities for improvement to benefit health and wellbeing

What will we have achieved by the end of March 2018?

- The Open Space Strategy, which identifies where there are gaps in the provision of open space, and the Green Grid Strategy, which makes suggestions for the improvement of specific spaces within the borough, will be formally adopted as strategies which contribute to the Local Plan.
- A new Physical Activity Strategy will have been developed, which focusses on getting people to be active as part of their everyday lives, including identifying improvements that need to be made to the physical environment in order to encourage greater levels of physical activity.
- The locations that have already been identified for improvements to the physical environment (such as tree planting, pocket parks and urban gyms) will be brought together into a single, prioritised framework and action plan.
- A mechanism will be in place, in line with the process established by the Local Infrastructure Forum, for involving residents in decision making about which locations are prioritised and the specific improvements that are implemented in chosen locations.
- A mechanism will be in place to ensure efficient procurement and delivery of improvement works, where similar works are being carried out in different parts of the borough.

What is the overall plan for the year?

The first half of the year will be spent ensuring that the strategies that are in development are finalised in a way which makes it easy for future decisions to be made on investment in the physical environment in order to support health and wellbeing. We have currently submitted an expression of interest to Sport England for £13million pounds of funding, which if we are successful could be used to further support this work.

We will also ensure that we engage in a systematic way with other strategies throughout the borough, such as the Town Centre Strategy, the CCG Draft Estates Strategy and the work of Registered Social Landlords, to ensure that all potential opportunities to improve physical space within the borough are harnessed.

What are we going to do in the next three months?

In the next three months, the focus will be on finalising the Open Space and Green Grid Strategies, and on understanding the list of locations that have already been identified for investment, and drawing these into a single framework which will allow further prioritisation and community involvement in detailed design.

How will we measure success?

By monitoring:

- The amount of green space delivered
- The number of people using outdoor space for health and wellbeing (PHOF indicator)
- The number of physically active adults (PHOF indicator)
- The number of children in year 6 who are of a healthy weight (PHOF indicator)

In addition we will collect qualitative data on people's perception of the quality of the physical environment, as well as on their experience of being involved in the decision-making process.

Are there any further issues to share with the Board at this point?

The Health and Wellbeing Board needs to consider the most appropriate way for it to influence the future allocation of Section 106, Community Infrastructure Levy, and other sources of funding in order to ensure adequate funding is obtained to fund the physical environment improvements that have been prioritised.

Action 2.2

Develop a process to ensure that the impacts on health and wellbeing made by major developments are routinely assessed and considered in planning decisions

What will we have achieved by the end of March 2018?

- The Local Plan, including the specification that developments of a certain size must include a Health Impact Assessment, will be adopted
- The Local Plan will be accompanied by guidance for developers on the scope of Health Impact Assessment that is required
- A process will be established for the review of Health Impact Assessments submitted by developers, to ensure they are of adequate quality
- A process will be established to audit whether the mitigations recommended in Health Impact Assessment are being put into place

What is the overall plan for the year?

The overall plan for the year is to review the existing processes within the planning system, eg. requirement for Environmental Impact Assessment and Equality Impact Assessment in order to assess where Health Impact Assessment can best fit alongside existing processes.

Existing guidance for Health Impact Assessment, including the Healthy Urban Development Unit framework, will be reviewed in order to understand whether these are sufficient to provide directly to developers or whether they need to be adapted for local use.

We will also consider the scope for community involvement in the Health Impact Assessment Process, in line with the Communities Driving Change Priority of the Health and Wellbeing Strategy.

What are we going to do in the next three months?

We will scope the likely volume of Health Impact Assessments that will be required to be carried out / reviewed on an annual basis in light of the new Local Plan guidance, and we will assess the best way for this workload to be accommodated.

How will we measure success?

By monitoring the number and quality of Health Impacts Assessments that are submitted, as well as monitoring whether the mitigations recommended by the Health Impact Assessments are in fact carried out.

Action 2.3

Support the council's Air Quality Plan and implement an air quality communications campaign across the partnership targeted at residents to:

- ***increase awareness of poor air quality, how to minimise exposure and adopt less polluting behaviours***
- ***introduce pledges from organisations to minimise their impact on air pollution***

What will we have achieved by the end of March 2018?

- The Air Quality Plan will be fully implemented
- We will have launched an air quality communications campaign, in-line with pan-London messages, in order to:
    - Encourage people to adopt less polluting behaviours
    - Reassure people about what activities are 'safe' even in areas of high air pollution
    - Advise people, including high-risk groups, on measures they should take to protect their health in areas or on days of particularly high air pollution
- We will have established a system whereby local organisations can pledge to reduce their contribution to poor air quality, ensuring that this system is linked where possible to existing mechanisms for businesses to pledge to improve their environmental impacts
- We will advocate on behalf of the borough at pan-London level, for example by asking that Transport for London prioritises the introduction of Low Emission Zones / Low Emission Bus routes within the borough

What is the overall plan for the year

- The initial plan is to ensure that we are strategically linked up with existing pan-London information and resources, so that we can build on / customise these for our local population rather than producing these from scratch
- In the absence of existing information, we will carry out additional research (from the literature as well as from local insight) to ensure we have an understanding of what local people currently understand about air quality, in order to create an effective communications campaign, which may include:
    - Promoting the existing Air Quality alerts to residents
    - Holding an all-members seminar on Air Quality in order to achieve high-level political buy-in for the messages we want to disseminate in the community
- Consider any additional measures that could be taken by the council to reduce levels of poor air quality, and ensure the Air Quality Action Plan is updated accordingly, for example opportunities relating to the sustainable design of new buildings and waste collection systems

What are we going to do in the next three months?

- In the first three months we will focus on ensuring we fully understand the pan London resources that are available (and any opportunities to influence the development of future pan-London resources)

How will we measure success?

- By monitoring levels of air pollution in the borough, particularly those in areas of high risk, such as schools.

Health and Wellbeing Board Wednesday 26th July 2017	Tower Hamlets Health and Wellbeing Board
Report of the London Borough of Tower Hamlets	**Classification:** Unrestricted
Implementing the Health and Wellbeing Strategy **Tower Hamlets Together - Shared Outcomes Framework**	

Lead Officer	Somen Banerjee, Director of Public Health
Contact Officers	Somen Banerjee
Executive Key Decision?	Yes

Summary

The foundation of the Tower Hamlets Health and Wellbeing Strategy is a shared outcomes framework that articulates the partnership aspiration for improvement of health and wellbeing in the borough. The Board has previously received presentations on how this is being developed as part of the Tower Hamlets Together Vanguard programme.

The work commissioned by Tower Hamlets Together in 2016/17 involved working with partners and the public on identifying a set of primary outcomes expressed as 'I statements' and primary and secondary indicators to track progress against primary outcomes.

This paper sets out the plans for 2017/18 to establish the Outcomes Framework as a foundation and central point of reference and logic modelling for driving improvement in health outcomes.

Recommendations:

The Health & Wellbeing Board is recommended to:

1. Review and comment on the action plan

1. REASONS FOR THE DECISIONS

1.1 The purpose of the Outcomes Framework is to develop a shared set outcomes across the health and care economy

2. ALTERNATIVE OPTIONS

2.1 If this did not happen, partners would not necessarily be working to aligned outcomes and this would miss opportunities to address inefficiencies and synergies for service redesign

3. DETAILS OF REPORT

3.1 Please see attached report

4. COMMENTS OF THE CHIEF FINANCE OFFICER

4.1 The establishment of a Shared Outcomes Framework will ensure partners within the Health and Social care system are focussed on aligned outcomes.

4.2 There are no anticipated additional resource(s) required for the delivery of this project as funding has been provided through the Vanguard initiative funded by the Department of Health.

5. LEGAL COMMENTS

5.1. The proposals in this report are consistent with the Council's 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.

5.2. The Health and Social Care Act 2012 ("the 2012 Act") makes it a requirement for the Council to establish a Health and Wellbeing Board ("HWB"). Section 195 of the 2012 Act requires the HWB to encourage those who arrange for the provision of any health or social care services in their area to work in an integrated manner.

5.3. This duty is reflected in the Council's constitutional arrangements for the HWB which states it is a function of the HWB to have oversight of the quality, safety, and performance mechanisms operated by its member organisations, and the use of relevant public sector resources across a wide spectrum of services and interventions, with greater focus on integration across outcomes spanning health care, social care and public health.

5.4. Section 2B of the National Health Service Act 2006 (as amended by section12 of the Health and Social Care Act 2012) introduced a new duty for all local authorities in England to take appropriate steps to improve the health of the people who live in their areas. The Council is therefore responsible for

improving the health of its local population and for public health services including services aimed at reducing inpatient provision and enhance community services.

5.5. This is consistent with the Council's duties under sections 1-7 of the Care Act 2014, including a duty to promote integration of care and support with health services and a duty under section 6 to co-operate generally with those it considers appropriate who are engaged in the Council's area relating to adults with needs for care and support. Further, there is a general duty under to prevent needs for care and support from developing.

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

6. ONE TOWER HAMLETS CONSIDERATIONS

6.1 The monitoring of outcomes and the impact on health inequalities of programmes to address these outcomes is fundamental to the purpose of the framework.

7. BEST VALUE (BV) IMPLICATIONS

7.1 Best value is a key driver of the framework as working to a shared outcomes framework would provide a basis for identifying inefficiencies and duplication within the health and care system.

8. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

8.1 The framework incorporates outcomes around air quality and improving the physical environment.

9. RISK MANAGEMENT IMPLICATIONS

9.1 The framework principally mitigates the risk of health and care system not working together around common outcomes and the impacts for residents of a system that is uncoordinated and fragmented.

10. CRIME AND DISORDER REDUCTION IMPLICATIONS

10.1 The framework makes a link between crime and disorder, a sense of safety and health wellbeing

Linked Reports, Appendices and Background Documents

Linked Report

- NONE

Appendices

- Report - Tower Hamlets Together Outcomes Framework
- Appendix - Poster of Tower Hamlets Together 'I' statements

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

- NONE

Officer contact details for documents:

- Somen Banerjee, Director of Public Health, somen.banerjee@towerhamlets.gov.uk

Implementing the Health Wellbeing Strategy – Shared Outcomes Framework Priority

Tower Hamlets Together Outcomes Framework

Background

The foundation of the Tower Hamlets Health and Wellbeing Strategy is a shared outcomes framework that articulates the partnership aspiration for improvement of health and wellbeing in the borough. The Board has previously received presentations on how this is being developed as part of the Tower Hamlets Together Vanguard programme. This paper sets out the plans for 2017/18 to establish the Outcomes Framework as a foundation and central point of reference and logic modelling for the health and care system

The work commissioned by THT in 16/17 involved working with partners and the public on identifying a set of primary outcomes expressed as 'I statements' and primary and secondary indicators to track progress against primary outcomes. The 'I statements' are set out visually in appendix one.

What will we have achieved by the end of March 2018?

In the long term, we aim to:

- Have an established health and wellbeing outcomes framework that has been coproduced and validated with the public and that is the central point of reference for strategy, commissioning, provision and monitoring across the health and care
- Ensure that the framework is being integrated into commissioning across the health and wellbeing economy (eg into contracts)
- Ensure that provision across the health and care is aligned to the outcomes framework and that providers are aware of the framework
- Drive integrated partnership working across health and care around shared outcomes

How will we measure success?

- Evidence that that framework has emerged through a process of coproduction
- Contracts referencing the outcomes framework
- Case studies of how the framework has been applied to provision to drive better outcomes
- Progress against outcomes

What is the overall plan for the year?

The progress so far is that wei have develop an outcomes framework that has been developed with providers and the public including a workshop with the Health and Wellbeing Board and engagement events as part of the Health and Wellbeing consultation.

The tasks for 17/18 are as follows:

- Undertake further engagement with the public to ensure the outcomes framework accurately represents what is most important to them, in particular with a focus on hard to reach and excluded groups, including people who are housebound, have a mental health problem or learning disability, and children and young people and their families
  (June – September)

- Undertake further engagement with professionals to ensure that where appropriate the outcomes framework is sufficiently evidence-based
  (June – October)

- Develop a plan for shadow-testing the outcomes framework, selecting relevant outcomes from the framework to monitor during the period and developing the infrastructure necessary to support regular reporting
  (July- September)

- Develop an approach to capturing, analyzing and reporting Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs) consistently across the health and care system. Beginning with those required in the CHS Outcomes Framework, but with the flexibility to be adapted to capture PROMs and PREMs in the THT Outcomes Framework more generally, and across THT commissioned and provided services, including the voluntary sector
  (From September)

What are we going to do in the next three months?

- In the next three months we are focussing on the engagement elements outlined above and we have commissioned an engagement partner to work with us (the New Economics Framework) and validating/modifying the framework in response to this.
- We are working with the Corporate Strategy Policy and Performance team in the council to explore how we can align the residents survey with the primary 'I statements' that have been identified in the framework
- We will be exploring the process for monitoring indicators in the context of developing a shared intelligence function for Tower Hamlets Together as part of the Population Health workstream

Are there any issues to share with the Board at this point?

- As the engagement programme is implemented, Board members may be asked for help identifying networks to support the work.
- For information, the programme is overseen by a small steering group with representation from the CCG, Council and Tower Hamlet Together reporting to the Systems Delivery Group that reports to the THT Steering Group (which in turns report to the THT Programme Board)

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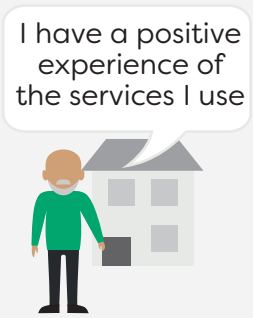
TOWER HAMLETS TOGETHER



Tower Hamlets Health and Wellbeing Board

TOWER HAMLETS TOGETHER

Tower Hamlets Health and Wellbeing Board

Health and Wellbeing Board Wednesday 26th July 2017	Tower Hamlets Health and Wellbeing Board
Report of the London Borough of Tower Hamlets	**Classification:** Unrestricted
Initial draft of the Adult Learning Disability Strategy	

Lead Officer	Denise Radley, Director of Adults, Health and Community, LBTH
Contact Officers	Lonica Vanclay, Interim Project Manager, Joint Commissioning, Tower Hamlets CCG
Executive Key Decision?	No

Summary

This is a near final draft of the adult learning disability Strategy with information about the process and timescale for completion. The aim is to provide the Board with an opportunity to input to and guide the Strategy.

Recommendations:

The Health & Wellbeing Board is asked to:

1. Give any comments and steer on the Strategy.
2. Agree that the Strategy use Health and Wellbeing Board branding.
3. Advise on whether the joint Chairs of the Board wish to have a foreword under their signature in the Strategy.
4. Note that the final designed version will come to the Board for approval on 5 September 2017 (then to CCG Governing Body on 6 September and Cabinet on 19 September).
5. Agree that the Learning Disability Partnership Board report to the Board through the Joint Commissioning Executive.

1. REASONS FOR THE DECISIONS

1.1 Tower Hamlets has an estimated 4,848 people aged 18 and over who have learning disability. They experience poorer life outcomes than the general population, including for physical health, mental health, employment and life expectancy. Learning disability is a protected characteristic. Following Winterbourne, there is a significant drive in national health and social care policy to improve outcomes for this group of people.

1.2 There has not been a Tower Hamlets adult learning Strategy previously. There are a range of plans and initiatives underway and a commitment has been made to develop an overarching Strategy, drawing these together within a coordinated framework that sets out ambitions and priorities for the next three years to 2020.

1.3 The Strategy will set out how the Health and Wellbeing Strategy priorities are implemented and achieved for adults with learning disability. It will be developed with a co-production approach with service users, carers, professionals and local organisations. It will focus on how to improve outcomes for adults with learning disability in the borough over the next three years, with an action plan for the delivery of the strategy.

2. ALTERNATIVE OPTIONS

2.1 There are no alternative options. It is essential for the Health and Wellbeing Board to have an adult learning disability Strategy in place. It has been discussed and requested by partners for some time.

3. DETAILS OF REPORT

3.1 **Strategy**: The initial draft of the strategy is attached to this report. This initial draft will be reviewed and developed at the Learning Disability Partnership Board meeting on 13 June; then sent out for comment by stakeholders and the public (including giving the web address in an article in Our East End in June) until 7 July. The approval stages are as follows:

- LBTH DMT 3 July
- CCG SMT 10 July
- Tower Hamlets Together Complex Adults Working Group 20 July.

The Strategy will be finalised and designed between 4 and 21 July. Approvals of the final version are scheduled as follows:

- LDPB 18 July
- LBTH CMT 19 July
- JCE 28 July (in designed format)
- MAB 8 August
- HWB 5 September
- CCG Governing Body 6 September
- Cabinet 19 September.

3.2 In addition, there are several other strands of work alongside the Strategy development.

3.3 **Background Information Document, Equality Impact Assessment and outcomes measurement framework**: Drafting has started. They will be completed in July in line with the timetable for the final version of the Strategy.

3.4 **Learning Disability Partnership Board**: See attached structure chart. The membership has been set out. The Corporate Director Adults, Health and Community Wellbeing will chair this (her deputy when she cannot attend is Carrie Kilpatrick) with a user Co-Chair. All membership posts are filled except for 1 of the 2 carers. The first meeting is 13 June. Bi-monthly meetings for the rest of the year have been set. The terms of reference have been drafted. The proposed subgroups are:

- Health – this is established and meets regularly
- Accommodation – this is established and meets regularly
- Employment and training (joint with children's covering 14 years onwards) – to be established soon.
- Day opportunities – not yet established.
- Respected and safe – will propose the Safeguarding Adults Board and/or Community Safety Partnership take these actions forward.
- Choice and the right support – still to be considered.
- Transforming Care – although this is not a priority outcome and all outcomes apply to this subset of the adult learning disability population, there is a workplan reflecting the INEL plan submitted to NHSE. We are considering whether a specific group is needed to oversee this.

3.5 **Co-production development project**: A project outline with expression of interest form for a partnership application was sent out to all local organisations working with adults with learning disability. No applications were received. Follow up questioning as to why to 3 organisations highlighted that they felt they did not have the capacity or experience of partnership working to lead and develop such an approach. This reflects the low base of involvement and partnership working in the adult learning disability sector. Recently, it has been confirmed that £100,000 from the CCG has been agreed for a quality checker scheme. Hence, the project plans are now being reconsidered.

3.6 **Strategy action plans**: Work on setting out an action plan for each of the 6 priority outcomes and the subgroups to be responsible for overseeing the implementation of those plans has commenced. The action plans will have a simple structure, focusing on what needs to be done, by when, by who and what the desired outcome is. Subgroups will be responsible for ensuring implementation and progress will be reported regularly to the LDPB and annually to the Health and Wellbeing Board. A simple highlight reporting structure will be developed to support these reporting arrangements.

3.7 **Market Position Statement**: A draft MPS following the Local Authority template has been initiated by the Strategic Commissioning Team: Cross-

cutting and Carers. This will be finalised during June/July to reflect the draft Strategy and joint commissioning plans.

4. COMMENTS OF THE CHIEF FINANCE OFFICER

4.1 The Adult Learning Disability Strategy, supporting action plan and market position statement will need to be within the Council's medium term financial strategy (MTFS) and the CCG's financial plan budgets.

4.2 The Council and the CCG are currently in the process of agreeing the three-year financial envelope available to develop and deliver this strategy. Once agreed the strategy will be delivered within the funding available. The agreed budget will be reported to the September Board meeting. The delivery plan will set out the source of funding for all actions in the Strategy and will be available for information as a linked document.

5. LEGAL COMMENTS

5.1. This Strategy is informed by the Joint Strategic Needs Assessment ('JSNA'). The updated information collected as part of the process will inform the next iteration of the Learning Disability Factsheet that accompanies the JSNA.

5.2 The Disability Discrimination Act (2005) and the Equality Act (2010) state that people with learning disabilities must be supported to live an ordinary life in the community in line with human rights legislation and that the public sector has a duty to advance equality of opportunity and foster good relations between persons who have a protected characteristic (which learning disability is) and those who do not. The Strategy will help demonstrate how the Local Authority and CCG are fulfilling those requirements for adults with learning disability.

5.3 Other key policies relevant to adult learning disability are set out below. Their requirements and implications are reflected in the Strategy.

a) Valuing People: A New Strategy for Learning Disability for the 21st Century (2001), and subsequent strategies, Valuing People Now (2009) and Valuing Employment Now (2009). These focused on promoting and delivering advocacy, employment support, person-centred planning, care coordination and partnership working to improve the lives of people with learning disabilities. They reflected the themes in the Putting People First suite of documents about transforming wider adult social care provision which also emphasised better information, better quality of service, more emphasis on prevention and personalised provision with more choice and control for people themselves.

b) Transforming Care: A national response to Winterbourne View Hospital (2012) and the accompanying Winterbourne View Review: Concordat: A Programme of Action (2012) set out to transform services for people with learning disabilities or autism and mental health conditions or behaviours

described as challenging. This included a programme of action to ensure that vulnerable people no longer live inappropriately in hospitals and are cared for in line with best practice, including consideration of supported living options. It highlighted the need for families to be centrally involved in discussions and decisions about care arrangements.

c) The Care Act 2014 legally requires local authorities with social services responsibilities to assess the care needs of any person who appears to be in need of care and support and decide whether services should be provided to that person. The guiding principles are to:

- focus on people's wellbeing and support them to stay independent for as long as possible;
- introduce greater national consistency in access to care and support;
- provide better information to help people make choices about their care;
- give people more control over their care;
- improve support for carers;
- improve the quality of care and support;
- improve integration of different services; and
- strengthen the transition process.

d) In Building the Right Support (2015), a clear national plan and new service model were set out to develop community services for adults with learning disability or autism and mental health conditions or challenging behaviour. The accompanying document , Transforming Care for people with learning disabilities – next steps (2015), set out a programme of work to be led by cross borough Transforming Care Partnerships which were to support discharge and prevent admission through holding Care and Treatment Reviews for individuals at risk, providing more personalised community support and developing the workforce.

5.4 The themes running through all these policies and the whole national policy and legal framework emphasise the importance of providing quality services in response to individual need, which promote independence, choice and control, and also achieve effective use of resources. These themes have informed the development of this Strategy.

5.5 The Council is required when exercising its functions to comply with the duty set out in section 149 of the Equality Act 2010, namely to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity between those who share a protected characteristic and those who do not, and foster good relations between those who share a protected characteristic and those who do not. Information relevant to meeting this duty is set out in the One Tower Hamlets Considerations Section of the report below.

6. ONE TOWER HAMLETS CONSIDERATIONS

6.1 The strategy details commitments to improve outcomes and support for adults with learning disability (a protected characteristic), including:

- Improving access to mainstream services for adults with learning disability
- Developing the awareness and understanding of children and young people, the community as a whole, and mainstream services of adult learning disability so there is better communication, involvement and understanding.

7. BEST VALUE (BV) IMPLICATIONS

7.1 The Strategy and the associated Market Position Statement promote collaboration and co-ordination between local organisations; an improved response from mainstream organisations and reflect Local Authority business cases for savings through plans to ensure more effective use of available resources. The emphasis on promoting healthy living, early and preventative intervention and increased use of community services will also help reduce the need for more expensive specialist services further down the line.

8. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

8.1. The Strategy details no specific commitments. However, through promoting travel training so more people are able to and feel safe to use public transport rather than Council or community transport and by bringing people from out of borough placements back into borough, it will help promote sustainability.

9. RISK MANAGEMENT IMPLICATIONS

9.1. The Strategy details commitments to improve outcomes and support for adults with learning disability, ensuring that the duty of both the Council and the CCG to provide support for this group is delivered safely and effectively.

10. CRIME AND DISORDER REDUCTION IMPLICATIONS

10.1 Actions to achieve the “be respected and safe” outcome and the associated action plan will help contribute to the reduction of crime and disorder.

Linked Reports, Appendices and Background Documents

Linked Reports

- None

Appendices

- Living Well in Tower Hamlets: the adult learning disability Strategy 2017 to 2020.

- The Learning Disability Partnership Board Structure and Membership

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

A Background Information paper is being prepared to accompany the Strategy. It draws on the Learning Disabilities Factsheet 2015 that is part of the Joint Strategic Needs Assessment suite of documents.

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LIVING WELL IN TOWER HAMLETS:

THE ADULT LEARNING DISABILITY STRATEGY 2017 to 2020

FINAL DRAFT

1. Hello and Welcome

Welcome to the Strategy. This is a partnership Strategy for everyone. It says what we will do together to support all adults with learning disability in Tower Hamlets to live well. It builds on the Health and Wellbeing Strategy priorities of

- Communities driving change;
- Creating a healthier place;
- Employment and health;
- Developing an integrated system;

and says more about achieving those for adults with learning disability.

We looked at national and local policy and research and what happens in other places to understand what we have to do and what works well. Many local people, staff and organisations gave their ideas. Most importantly, it was the views of many adults with learning disability and their families and carers that determined the key things we will do.

People with learning disability have the right to be treated equally and to control their own life. The Equality Act says adults with learning disability must be supported to live an ordinary life in the community. Many people are supported in the community by family and friends. People have told us that overall, the support in Tower Hamlets is good but there are areas which need improvement. Too many people live in residential care outside the borough and too few have jobs. The right support is not always there at the right time.

Government learning disability policies say that the Council and the NHS have to:

- reduce health inequality;
- reduce the number of people who are in hospital or registered care homes and how long they stay there;
- improve the quality of hospital and community provision;
- have more community services; and
- increase employment.

This Strategy says how we will do that in Tower Hamlets. It covers:

- ✓ What adults with learning disability said is important in their life;
- ✓ What we have been doing to support that;
- ✓ What we will do next and how we will know it is working.

The Background Information document explains in more detail why and how the outcomes and actions were decided. *(insert weblink if/when it is on the Council's website)*

The Council, the NHS and other organisations have limited resources. So, we have talked about the most important things to do. This Strategy says what they are.

Many people from local organisations, the Council, the NHS, private companies and community groups will have to work with each other and with adults with learning disability and their families and carers to make improvements happen. We know that when people work together for something they believe is important they can do a lot. We want to

encourage everyone in Tower Hamlets to play their part and work together to make sure that adults with learning disability in Tower Hamlets live well.

2. What happens in Tower Hamlets now?

The Learning Disabilities Factsheet that is part of the Joint Strategic Needs Assessment gives a lot of information. It is available here – //www.towerhamlets.gov.uk/Documents/PublicHealth/JSNA/Learning_Disabilities_JSNA_2016.pdf Further information is also given in the Background Information document.

We know from national estimates that 2.17% of the adult population would be expected to have learning disability. This would be 4,848 people in Tower Hamlets.

The number of adults with learning disability will increase because the total Tower Hamlets population will grow by an expected 22% from 2016 to 2026 and because people with learning disability are living longer.

In March 2017, 961 people were registered with GPs in Tower Hamlets as having learning disability. 46% of these were of Asian background, mostly Bangladeshi.

Not everyone with learning disability will need or want support from specialist services. In June 2017, 882 people were known to the Community Learning Disability Service (CLDS) in Tower Hamlets. This is below the national estimate that 0.5% of the adult population are expected to be known to local Council or health learning disability services, which would be 1,100 people in Tower Hamlets.

People have different levels of care and support depending on their needs. 659 had paid support from CLDS in June 2017. 134 people received a direct payment in 2015-16. *(to be replaced with updated figure when obtained).* 20 people with the most complex needs have a continuing healthcare package.

Adult services work with people over 18. The law says that children's services should continue to support young people with a disability until they are 25. So the Children and Young People Plan and the Children's SEND Strategy is also relevant for people aged 18 to 25 and children and adult services have to work together to meet their needs. A review looking in detail at transition from age 14 has just started and will report in the autumn.

The Ageing Well Strategy covers plans for improving outcomes and support for all people over 55, including those with learning disability, so it is also relevant. There is a separate Autism Strategy. The Carers Strategy outlines plans to improve support for all carers, including those of adults with learning disability.

Adults with learning disability are equal to everyone else with the same rights to participate in and be included in the community. The Equality Act 2010 says is a protected

characteristic and organisations have to make reasonable adjustments and include adults with learning disability. There are many other plans and Strategies that talk about improving things for everyone. These plans include:

- The Community Plan
- The Housing Strategy
- Economic Development and Employment Strategies
- The Community Safety Plan
- London Adult Safeguarding Procedures
- The North East London Sustainability and Transformation Plan.

We will work together with the people responsible for these plans and Strategies to make sure they understand and include the specific needs and concerns of adults with learning disability and follow the priorities and plans in this Strategy.

Adults with learning disability can get support from different levels of service. At each level there are things for everyone and things specially for people with learning disability. In Tower Hamlets there are many different types of support at all levels.

- Family and Community: such as family members, partners, neighbours, community members and groups, self help groups and advocates.
- Primary or Universal: services for all such as information and advice; general practices, Idea stores, leisure centres and community centres.
- Secondary: services for people with more needs such as supported housing, care packages and specific group activities and day centres.
- Tertiary: services such as placement in registered accommodation.

The Council and NHS will keep making sure there are many different places in the community where adults with learning disability can get good quality support. Community groups and voluntary organisations give a lot of the support and add extra resources themselves such as grants from trusts and donations. We will encourage businesses to give resource and support too.

The total amount of local NHS and Council money that will be used for specific services for adults (over 18) with learning disability in 2017-18 is given in the diagram below.

Council – social care supported accommodation and care £22.3 million (of which £9.9million is spent on out of borough residential care); £X on additional support including respite; £X for the 134 people receiving a direct payment; home care packages £X; community/day and employment support £4.9 million and £50,000 for specific projects.

NHS (CCG) - £2.230 million for community assessment and care, £2.359 million for continuing care packages and £124,000 for specific projects.

[DO AS DIAGRAM WHEN ALL FIGURES OBTAINED – in the designed version]

The actions to improve things depend on building independence and community support, using money differently and changing ways of working rather than just spending more money because this is the right way forward.

The plans, actions and outcomes set out in this Strategy need to be delivered within the agreed resources available in future years and therefore, may need to be adapted

3. What people said

(Note: in the designed version we will use speech bubbles and edit/combine points so this is less long lists. Fuller comments are in the Background Information document)

In discussions and surveys between 2014 and 2016, people said:

- Care is not joined up.
- There is too much staff change in Tower Hamlets - having the same people work with you is important.
- We need to change perceptions about people with learning disability.
- We need to promote a culture of user involvement.
- We must recognise and support carers with their vital role in meeting needs and promoting independence.
- We need to do more to make sure everyone knows what is available.
- It is hard for people to access some services. Not all services have staff who can communicate well with adults with learning disability, especially non-verbally.
- Personal safety including on public transport is a concern.
- We need more support earlier on to help with the difficult change from being a child and young person to adulthood.

In spring 2017 to inform this Strategy, we asked people what is important in their life, what they can do themselves to achieve that and what ideas they had to better support adults with learning disability to achieve those outcomes.

The general feedback was that there was good support in Tower Hamlets and it should be maintained. People said very much the same things as was said before.

We had responses from 106 adults with learning disability living in the borough (11 by online survey, 62 by easy read questionnaires and 33 in face to face discussions). 46 supported having “live well” and 43 supported having “a full life” as the vision. Several favoured both. They said that the things that are important to them are:

a) More leisure activities, sports and physical exercise that is affordable.
b) Having friends, family support and relationships.
c) Being able to do a wide range of activities - open social clubs and community activities as well as those just for adults with learning disability. Have places to go and things to do in the evenings and weekends.
d) Choosing what you want to do and where you want to live.

e) Improving communication so people do not ignore you and understand you.
f) Living locally near family and friends and not having to travel far.
g) Getting information from staff and support with diet and exercise to be healthy.
h) Having a job with help to it and there should be more jobs.
i) Having training including courses for independence – life skills.
j) Having more easy to read information in people's language with more pictures and less words.
k) Being listened to, respected and heard by professionals and being treated as an individual.

Forty seven carers and seven carer support workers attended discussions and 1 completed the online survey. They said:

a) Some people slip through the nets. Services need to reach out so they don't.
b) Staff should communicate directly with people in simple language and use Makaton more.
c) Continuity of the worker. Staff should be clear and say what they will do and when and keep to that.
d) Need more accessible, easy ways to find out what is available.
e) Personalise provision more and respond to individual's interests and needs.
f) Integrate services better and share information.
g) More mental health support for adults with learning disability.
h) More local and community support for carers is needed – emotional support, peer support and individualised advice and information provided by consistent staff who speak their language. Staff should communicate better with carers.
i) More health promotion.
j) Activities for older people with learning disability.
k) More coordination and joint working between children and adult services at transition and information sharing with carers.
l) Prepare the adult for when their parent carer is no longer here.
m) Value staff - the people who deliver services and support are very important.

Key points from the 116 service staff and members of the public who gave views in interviews (29), workshops (68) or by survey (19) are as follows.

a) Work with companies so there are more jobs for people and provide more supported employment through social enterprises.
b) People in work need somewhere/one to go to for early advice and support to prevent them getting stressed and into financial difficulty.
c) Do more to build people's independence and self esteem.
d) Help people feel safe, prepare for moving into independent living and travel on their own.
e) Staff and services do not work together – provision needs to be integrated. Reviews do not always happen and people are not involved with them.
f) Providers need to share information more and clarify who the lead is when someone is in touch with several organisations so there is one common plan.

g) Reach people in the community who are not in touch with services.
h) Campaign to remove the stigma of learning disability and make it OK to talk about.
i) Champion respect for people, promote their positive contribution and include them in mainstream community activities and primary care services with reasonable adjustments, treat them equally. Build community capacity to support people.
j) Make sure there is support when people have a death in the family or are sad.
k) Provide help with improving reading and writing that starts from where people are and is pitched at their level.
l) Recognise the individuality of people and provide support, enabling them to have some separate time away from their family.
m) Involve people in planning their own support and care and train and support them to make informed choices. Make sure there is more advocacy support.
n) Give more emphasis to health - training for healthy lifestyle - diet, exercise, health checks and use data to target improvements
o) Develop more housing and support options and give clear information so people have choice. Make sure each new build housing development includes some flats for people with learning disability.
p) Make sure strategy actions are implemented.

(The following will be pictorially presented in the final designed version – eg figure of person with outcomes round them)

4. What are our aims?

OUR GOAL (VISION) is that – Adults with learning disability in Tower Hamlets live well.

This means that they will:

- Be happy and healthy
- Live locally
- Be part of the community and involved in activities
- Work or volunteer
- Have choice and the right support
- Be respected and safe

These are the **outcomes** we want to achieve. They reflect the Tower Hamlets Outcomes Framework.
To achieve these outcomes, the Strategy has **objectives** to

- Reduce health inequality and the length of stay in hospital
- Increase the number living locally
- Increase the number involved in the community and local activities
- Increase the number who work or volunteer
- Increase the number reporting they have choice and the right support
- Increase the number reporting they feel respected and safe

Everyone has to support the **values and principles** of the Equality Act and UN Convention on the Rights of Persons with Disabilities and work in ways that show this.

- Treat people with respect and dignity and recognise them as rights-holders.
- Recognise people as independent and entitled to make their own choices and decisions and to give consent and facilitate this with access to appropriate advocacy when required.
- Communicate effectively and provide information in accessible and easy read formats in line with the accessible information standard.
- Actively encourage and facilitate the meaningful and effective participation of people, ensuring they have influence.
- Actively promote inclusion and empower, consult and engage with people with disabilities.
- Ensure people can effectively access the full range of support including information, communications, facilities and services and the physical environment.
- Respect people's differences, accept people for who they are, recognise and value their strengths and ensure people have the same opportunities as everyone else.

5. Be happy and healthy

Key points

a) People with learning disability have poorer health and die younger with a lifespan that is 14 years less for males and 18 for females.
b) Adults with learning disability should have a health check every year but in Tower Hamlets last year only 57% of people did; above the national average of 46%.
c) When adults with learning disability have physical health problems, support staff do not always understand their needs. Health services do not always communicate well with the adults, their carers and other staff. The right care is not always given.

What we have done and are still doing

a) It is now part of the job of CLDS (the community learning disability service) to help universal health services develop the awareness and skills of their staff so they can better support adults with learning disability. CLDS now also support staff in all local organisations to talk about healthy living with the adults they work with.
b) We funded a learning disability nurse for a year. She gave lots of training to general practices about health checks for adults with learning disability and did a lot of work on the data systems. Health checks have increased by 10% since 2015-16. CLDS now help make sure everyone has an annual health check and a health action plan.
c) A plan to improve support for adults with learning disability admitted to hospital with mental illness has been developed and is being implemented.
d) We joined a national pilot and do local reviews of deaths of adults with learning disability to use the learning to improve the quality of health services.

What we will do next

a) Make sure family and staff encourage people to have vaccinations and screening and go to the dentist. Give information and support about nutrition and exercise.
b) Make sure family/carers, social care and other services know about annual health checks and health action plans and encourage people to have them. Be more flexible about doing them.
c) Make sure when people feel sad or on edge they can get early counselling help from staff trained to work with people with learning disability.
d) Make sure that when people go to hospital, their family/carers can also go so they continue to be supported by a familiar and trusted person.
e) Introduce a card with key information and redesign hospital passports so hospital staff can access them and use them to understand and respond to people's needs.
f) Make sure the outcome from all health contacts is shared with people in a way that is easily understandable to them.
g) Introduce a health quality checker scheme so adults with learning disability review services against high quality care standards.

How we will know it is working

a) 75% of people have an annual health check and a health action plan.

b) An increased number of adults with learning disability have health screening and immunisations, have a healthy weight and are happy and involved so live longer.
c) Adults with learning disability spend less time in hospital and have the right care.
d) Adults with learning disability have easy access to high quality health care.

6. Live locally

Key points

a) People said they want to live in their own community near family and friends. In 2016-17 and 2015-16, 69% of adults with learning disability lived in their own home or with their family. This is close to the London average of 66.8% and below the national average of 73.9% in 2016-17.
b) However, 123 of the 132 people placed in a registered care home by the Council are not in Tower Hamlets. 12 are in supported accommodation out of borough.
c) It is difficult for the 46 young people aged under 25 in residential care out of borough to come back as there are not enough suitable places to live locally.
d) Five young people are ready to move out of their out of borough residential education placement each year.

What we have done and are still doing

a) We made detailed plans to develop more accommodation in Tower Hamlets that offers different levels of support for adults with learning disability. We are now starting on the actions.

What we will do next

a) Working with their family, review the needs of people living out of borough and plan for those who want to come back to live locally.
b) Develop more accommodation and support options locally so there is a greater range of accommodation and support available and people can live in the local community. This should include:
    - women only supported living;
    - independent places for adults with learning disability within new housing developments;
    - a new housing support service for young people now in residential placement out of borough;
    - setting up a scheme where local community members offer respite in their homes (Shared Lives).
c) Make sure people are given clear information and have choice about where to live.
d) Make sure there is enough local support for people who come back to the borough.
e) Foster culture change in staff so that they develop support plans for people to live an ordinary life in the local community as the usual option rather than look to place people in supported accommodation out of borough.

How we will know it is working

a) 59 people (including young people) who live out of borough will come back to live locally over 5 years.
b) 55 day placements and 500 nights of respite are provided by the Shared Lives scheme over three years.

6. Be part of the community and involved in activities

Key points

a) There is no existing system wide framework that makes sure adults with learning disability are involved in planning, commissioning and delivery of support.
b) People said they wanted to be involved in a variety of community activities near to where they live.
c) Community members have said they want adults with learning disability to be more included within general local activities.

What we have done and are still doing

a) Plans were made for a co-production development project to make sure adults with learning disability are involved and supported as members of the Learning Disability Partnership Board and its subgroups and in all aspects of the planning, commissioning and delivery of support.
b) In 2016-17, 250 people were supported to participate in activities provided by several day centres across Tower Hamlets or by individually tailored support.
c) The Accessible Transport Forum work closely with TfL and the DLR to support them to make their transport accessible. The Council's own transport and community transport also help those who need it to get to activities and support.

What we will do next

a) Support people to be involved in planning, running and reviewing activities and quality checking services - start the co-production project.
b) Offer a wider range of more flexible and personalised activities in the day, evenings and weekends and specifically for older and younger people and women, so people have choice and can join in general community activities such as gyms, community centres and in the Idea Stores as well as those in day centres especially for adults with learning disability.
c) Promote local activities with fewer words and more pictures.
d) Help community members and services to understand, respect and include people with learning disability and treat them as equals.
e) Help people learn to manage their money by using pictures.
f) Help people develop independent travel skills.

How we will know it is working

a) An increased number of people will participate in a wider range of community activities.

7. Work or volunteer

Key points

a) Many adults with learning disability said through the consultation that having a job or volunteering was very important to them so they can be involved and contribute as much as to earn money.
b) They said there is a lot of good support and training locally but not enough jobs.
c) 4.9% of adults with learning disability were in paid employment in 2015-16, which is below the London average of 7.5% and the national average of 5.8%.

What we have done and are still doing

a) Several organisations provide skills development, employment training, support and experience for people with learning disability. Some 60 people per year are supported into employment currently.

What we will do next

a) Work actively with local businesses and employers to create more and flexible jobs internships, apprenticeships, supported work and volunteering opportunities that are available for people with learning disability.
b) Workpath (the Council's employment support service) with the Careers Service and other commissioned local employment support services, will give people advice and support to make sure more people have an apprenticeship and job.
c) From school onwards, encourage families, services and people themselves to aim high and support them to get and keep a job and not rely on services.
d) Make sure a range of education, training and work experience is available locally and accessible to people with learning disability. Help people to take these up so they have experience and are supported into work.
e) Develop peer support to help people get and keep jobs.
f) Make sure people and their family/carers understand what they earn and the effect on their benefit.
g) Education is the gateway to employment and community involvement – so develop local learning that is accessible to adults with learning disability and adapted to their needs. This should include reading, writing and numbers.

How we will know it is working

a) 110 people will be supported into employment per year for 4 years so that there will be 11% in paid employment in 3 years time.

8. Have choice and the right support

Key points

a) Most adults with learning disability have their needs assessed and are well supported in the community. No-one has been admitted to an assessment and treatment unit in the last five years. This is very positive compared to other areas.
b) People said professionals and services do not work together and pathways and care are not joined up. Annual reviews do not take place and people are not involved. The support on offer to people is not clear.
c) Many people also said they do not know what is available to support them.
d) Although 92% service users with learning disability are identified by Social Care as having self directed support, many people said in consultations they do not always have a choice about the support they receive.
e) Adult and children's services have different approaches. Many people said in the consultations that joint planning does not start early enough and they do not have enough information about the changes. So the 30 or 40 young people who come into adult services each year and need ongoing support, experience difficulties.
f) Carers say they have to fight to get support for themself and the adult they care for.

What we have done and are still doing

a) All adults with learning disability have a needs assessment, a personalised care and support plan and have more choice and say in that.
b) Tower Hamlets started trying out a new way where people can use their social care and health budgets together in one care and support plan and can choose and manage that support themselves. This is called Integrated Personal Commissioning (IPC). We are one of eighteen test sites in England.
c) Advocacy is offered to all adults with learning disability who are in Mile End hospital with mental illness and local MIND deliver this. REAL offer advocacy to people when they need someone to help them get the necessary support. Powher also give support to make sure that people who cannot make decisions themselves are heard as part of the DoLS (deprivation of liberty) process.
d) A review of transition from children's to adult disability services has started.
e) 93 people who also have multiple longterm conditions became part of the Integrated Care Project. They have a care coordinator and a personalised care plan and participate in multi-agency discussions to ensure a coordinated response.
f) A Carers Strategy has been developed. Carers are involved in co-producing specifications for new services.

What we will do next

a) Make sure there is simple, jargon free and clear information using pictures about the local support available for people and their family/carer. It should be easily available and up-to-date. Include it in the Local Offer and Community Catalogue so people can easily get the information with support and advice from the Idea Stores.

b) Make sure that support and information is culturally relevant to people and their family/carer and that it is accessible to those whose first language is not English.
c) Make sure more people, their family/carers and support staff know about and can quickly use the independent, issue based advocacy support including from REAL.
d) Make sure people can get expert advice from someone who knows about learning disability, can explain the choices and options they have and help build their confidence to make choices. It is especially important for people who do not have family or service support, but also builds the independence of everyone.
e) Make sure people and their family/carer are involved in their personalised assessment, in decision making about their individual support plans and in reviews of those plans – and that regular reviews happen.
f) Make sure staff work together and share information so people have joined up care and support and do not have to repeat their story.
g) As part of Integrated Personal Commissioning, offer people a joint person centred plan and an integrated personal budget so they can actively manage their needs.
h) Start multi-agency planning and preparing for adulthood jointly across adult and children's services with young people and their family/carer from age 14.
i) Champion culture change, promoting a rights based response to the needs of adults with learning disability, so that all organisations ensure their services are accessible, make reasonable adjustments, follow the accessible information standard and train their staff to understand, communicate well with and be responsive to adults with learning disability.
j) Make sure all policies and Strategies developed for people in Tower Hamlets include and address the needs of people with learning disability. These include:
    - the Tower Hamlets Together plan for GPs, hospitals and community services to work together to join up services better and to have a 24/7 single point of access for all care needs;
    - the Tower Hamlets Together transformation and system redesign work for acute care, crisis, community health services and support for adults with complex needs and long term conditions;
    - dementia services, older people's services including accommodation and end of life care.
k) Make sure carers (especially those for whom English is not the first language) know about and get the support they need including respite. Encourage people to plan together for when older family members/carers can no longer provide support.
l) Support recruitment drives so more, younger male and female care staff are attracted to work locally and people can have choice about their keyworker.
m) Value, develop and support staff to work with care and compassion and to stay so people have continuity.

How we will know it is working

a) 245 people have a joint plan that covers health and social care needs and 49 people have a jointly funded integrated personal budget by March 2018, to increase each year towards the ambition that 100% of care plans are joint and 20% have a personalised integrated budget.
b) More people each year report they have choice and the right support.

c) Routine reporting by all services shows people report positively on their experience and service quality.

9. Be respected and safe

Key points

a) People have said they do not feel safe in the community or on public transport.
b) Not all staff in services understand and follow the principles for safeguarding vulnerable adults or “hear” and respond to what adults with learning disability say.
c) Many people said they have been bullied. Staff report that adults and young people with learning disability are vulnerable to and have experienced hate crime, being forced to marry, being sexually exploited and being drawn into illegal activity. However, data reports do not show this.
d) People are vulnerable to financial exploitation. Twelve people in one year went to one agency for debt advice.

What we have done and are still doing

a) The safeguarding guidelines for staff have been rewritten and staff are having continuing safeguarding training.
b) CLDS run a money skills group several times each year and are developing a project to work with parents and carers to teach them to develop financial skills in the people they are supporting.

What we will do next

a) Support staff to use events, easy to read information, pictures and technology so they make sure people have a good understanding of how to keep themselves safe and who to go to if they feel unsafe.
b) Promote a culture of respect for people with learning disability among the community, schools and local organisations.
c) Raise the awareness of staff in organisations about how to make sure that people are not vulnerable to hate crime, exploitation, violence or radicalisation.
d) Make sure more people are helped with financial management and that agencies do not send generic letters to people who are identified as having learning disability.
e) Ensure that improving the quality of the service response to the safeguarding needs of people with learning disability is specifically addressed within the Safeguarding Improvement Plan.

How we will know it is working

a) An increasing number of people each year report they feel respected and safe.

10. Transforming Care

Key points

a) The government asked each area to focus on how to improve community services for adults with a learning disability and/or autism with behaviour that challenges, including those with mental illness, so they do not have to be in hospital. This is called Transforming Care.
b) In Tower Hamlets 143 people were identified as being in this group. Everyone in this group should have a named contact person.
c) Of these, 21 people have the highest needs; with 8 in registered care and 13 identified as being at risk of admission to registered care. In April 2017, just 3 people were in specialised facilities funded by the regional NHS Specialist Commissioning Group and 1 person was in a secure learning disability hospital. 4 people were in Mile End Hospital with mental illness and a total of 7 were admitted in 2015-16. This compares positively to other areas, and we believe this shows that in Tower Hamlets, people are well supported in the community.
d) The government said all those with the highest needs (21 in Tower Hamlets) should have an individual care and support plan, behaviour support, plans for what to do in a crisis and a communication passport. Intensive 24/7 multidisciplinary health and social care support, specialist respite and crisis support and local accommodation should be available to them.
e) The government also said all staff in all services for people with learning disability and in mainstream services should have training so they can positively support people whose behaviour is challenging.

What we have done and are still doing

a) We looked at what is happening in Tower Hamlets with this group against the 9 principles of good practice. From this and the views of over 100 people, we agreed to concentrate on increasing local accommodation and developed a plan for this.
b) CLDS started checking that everyone with challenging behaviour has a plan that matches best practice.
c) CLDS meet with the whole family when people are at risk of going into registered accommodation and, where possible, agree a support plan that keeps them in the community.
d) All staff in the CLDS had positive behaviour support training so that they can better meet the needs of this group.
e) Two sets of training were held so all the different people supporting a number of individual adults with learning disability with challenging behaviour developed a common understanding of and approach to positive behaviour support.

What we will do next

a) Make sure that accommodation suitable for people with challenging behaviour is developed locally so people now in out of borough residential care can come back into the local area. (See section 6 of this Strategy).

b) Offer training in positively managing challenging behaviour to families, supporters and staff working with them from a range of local organisations.
c) Make sure that service specifications and contracts include the requirement that providers positively and effectively support people with challenging behaviour.
d) Make sure that mainstream services such as IAPT and crisis care support this group of people.
e) Keep making sure everyone in this group has a personalised plan as outlined above.

How we will know it is working

a) Fewer people with challenging behaviour have to move more than 10 miles from the patch (Inner North East London) because there is no suitable accommodation and support for them locally.
b) There is a 20% reduction in the use of hospitals by this group.
c) Nobody from this group is placed in hospital away from the area or readmitted within two years.
d) All individuals in this group have a personalised care plan that fits the good practice principles.

11. Making it all happen

The Learning Disability Partnership Board (LDPB) will make sure the actions in this Strategy happen. The members are adults with learning disability, carers and staff from the Council the NHS and local provider organisations.

A wider Reference and Engagement Group will be set up so that adults with learning disability and their family and carers are fully involved in making decisions about all local strategic and service planning and delivery. A co-production project is starting to make sure this happens and to support the adults to be fully involved.

There is a delivery plan for this Strategy which sets out, for each outcome, details of the actions that will be completed, by who and by when for the things the Strategy says we will do next. It also sets out how the results will be measured.

Some actions will be for individual organisations, such as the Council or Community Learning Disability Service, to do. Others will be done by different organisations working together in the subgroups of the LDPB.

There will be a subgroup for each outcome area which will have the responsibility for making sure the actions are completed and there is improvement in each outcome area.

There will be two specific discussions each year with the Tower Hamlets Together Complex Adults Programme Board to make sure that the Transforming Care, health and right support actions are completed and the outcomes are achieved.

An important next step is to develop an adult learning disability outcomes measurement framework that is shared across the partnership and part of the overall Tower Hamlets outcomes framework. All local providers would use this and their actions and outcomes would contribute to it. It would be part of their contracts that they did this.

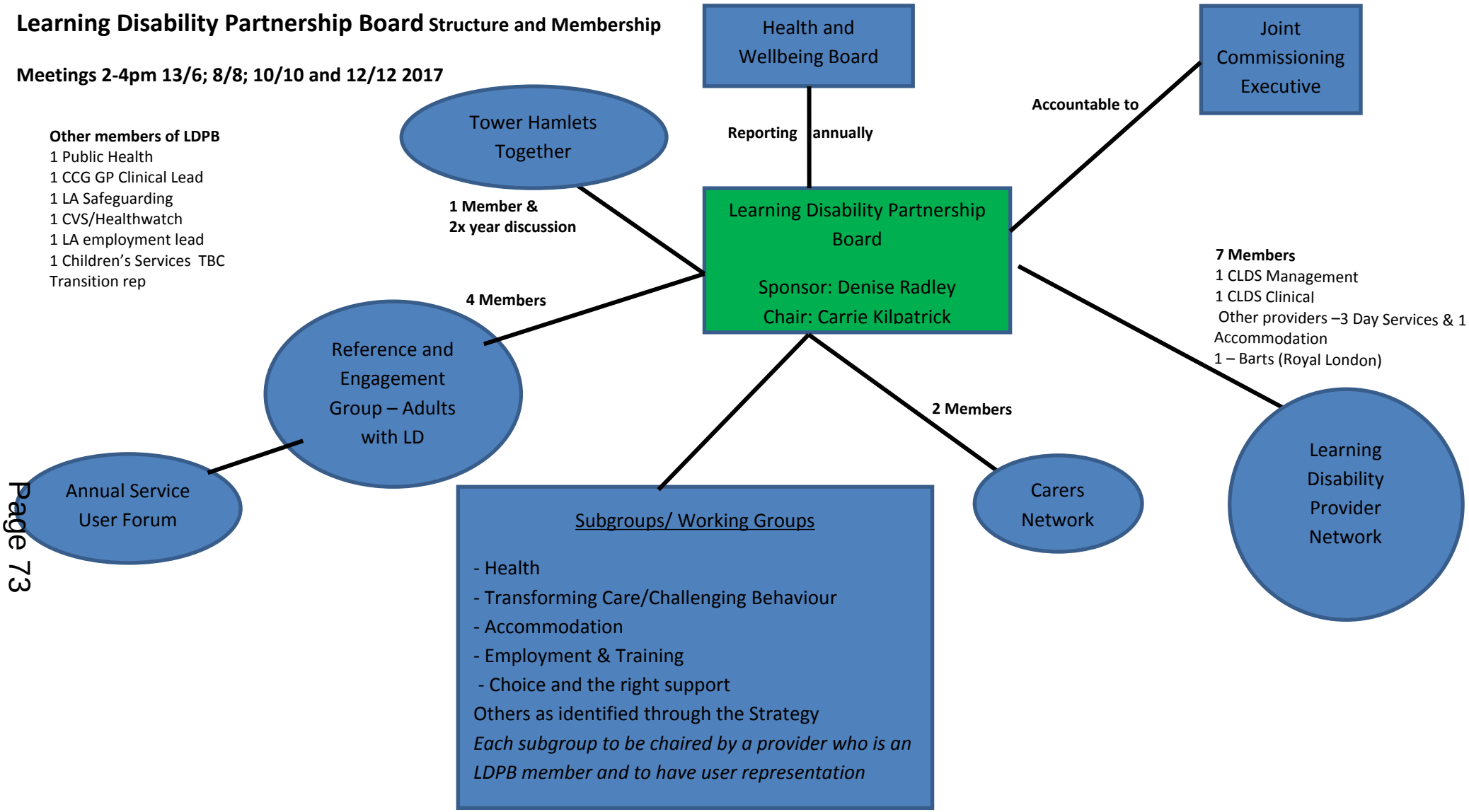
The LDPB will check every year to see how things have progressed and what difference it has made. It will study the data collected to help measure how things have changed and review whether the outcomes for adults with learning disability have improved and the goals of the Strategy are being achieved.

Every year, the LDPB will report on progress to the Health and Wellbeing Board and to a forum for adults with a learning disability.

The LDPB will also update the action plans for each outcome every year and this Strategy in three years.

Learning Disability Partnership Board Structure and Membership

Meetings 2-4pm 13/6; 8/8; 10/10 and 12/12 2017



Other members of LDPB
1 Public Health
1 CCG GP Clinical Lead
1 LA Safeguarding
1 CVS/Healthwatch
1 LA employment lead
1 Children's Services TBC
Transition rep

7 Members
1 CLDS Management
1 CLDS Clinical
Other providers –3 Day Services & 1 Accommodation
1 – Barts (Royal London)

Key Functions of the Learning Disability Partnership Board

Inform, implement and monitor the impact of the Strategy and ongoing strategic developments to improve outcomes for adults with learning disability.
Ensure the involvement of adults with learning disability in all aspects of strategic and operational activity.
Ensure all services respect and involve people with learning disability, are easy to use and communicate well and give the right support.

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Health and Wellbeing Board Wednesday 26 July 2017	Tower Hamlets Health and Wellbeing Board
Report of the London Borough of Tower Hamlets	**Classification:** Unrestricted
Suicide Prevention Plan – draft for consultation	

Lead Officer	Somen Banerjee, Director of Public Health
Contact Officers	Hannah Emmett, Specialty Registrar in Public Health
Executive Key Decision?	No

Summary

The national Five Year Forward View for Mental Health[1] requires that all local authorities should have a multi-agency suicide prevention plan in place by 2017 and reviewed annually thereafter.

The Tower Hamlets Suicide Prevention Plan Draft for Consultation has been developed by the Public Health department, with input from the multi-agency suicide prevention steering group. Five priority areas for action have been identified:

1. Early intervention and prevention
2. Improving help for those in crisis
3. Identifying the needs of vulnerable people
4. Addressing training needs
5. Communications and awareness

The action plan outlines collective work that addresses these priorities over the next year (2017-2018). The background document provides additional national and local data, and the outcomes of discussion and consultation.

Monitoring and implementation of the action plan will be via a steering group on a quarterly basis. Progress will be reviewed by the Public Health senior management team. Overall oversight will sit with the Health and Wellbeing Board (HWB).

Recommendations:

The Health & Wellbeing Board is recommended to:

1. Consider whether these are the correct priorities
2. Consider whether the action plan addresses the priorities
3. Consider whether the monitoring arrangements are sufficient
4. Request the Suicide Prevention Plan to return post consultation to the September HWB for adoption.

[1] https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

1. REASONS FOR THE DECISIONS

1.1 All areas are recommended to have a suicide prevention plan by 2017.

1.2 The suicide rate in Tower Hamlets is higher than that of London as a whole.

1.3 Every suicide has a wide-ranging impact on those involved.

1.4 We have an opportunity to reduce suicide risk in the Borough and to reduce the number of people who die by suicide.

2. ALTERNATIVE OPTIONS

2.1 To not adopt the strategy.

3. DETAILS OF REPORT

What is the issue?

3.1 The national Five Year Forward View for Mental Health[2] recommends that all local areas should have multi-agency suicide prevention plans in place by 2017 and that these should be reviewed annually thereafter.

3.2 Although there is a wealth of work on suicide prevention in Tower Hamlets, this has not been formalised into a suicide prevention plan.

3.3 National guidelines recommend six key areas of action:

1. Reduce the risk of suicide in key high-risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved or affected by suicide
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection and monitoring

Why is this important?

3.4 Although the number of deaths is relatively small, the effect on family and friends can be devastating, with many others involved in providing support and care also feeling the impact. The rate of suicide in Tower Hamlets is 9.5/100,000 population (2013-2015), higher than the London average (8.6) for the same time period.

3.5 We have also been made aware of a number of recent suicides in vulnerable individuals known to statutory services; there is therefore a drive from service providers to ensure a suicide prevention plan is developed and implemented.

[2] https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

What are we already doing?

3.6 The Council, NHS and voluntary sector partners currently have a number of initiatives in place to improve and support good mental health and wellbeing, including:

- Mental Health Strategy 2014-2019
- Support of: Local Authority Mental Health Challenge; Time to Change Employers' Pledge; London Healthy Workplace Charter
- Provision of Mental Health First Aid (MHFA) training
- Commissioning a range of interventions that support mental wellbeing in children and their families
- Commissioned 'Flourishing Minds' programme to address Mental Health (MH) stigma in groups of Somali women, young people not in education or training and male offenders
- Commissioned research and volunteering programme to address loneliness
- Recently hosted public and internal staff events to raise awareness of suicide
- Recovery and Wellbeing Service will operate from January 2017, including Recovery College courses for those who have used mental health services, their carers and families, and staff working in the borough from the NHS and voluntary sector

3.7 There is a wide range of statutory and voluntary sector services provided in Tower Hamlets for people experiencing suicidal thoughts and mental ill-health. Their providers are represented in the multi-agency suicide prevention steering group.

3.8 The steering group has identified key local concerns on themes of information sharing, crisis services, vulnerable people, referral pathways, and training needs.

Development of the plan

3.9 With input from the steering group, a plan has been written with five priority areas of action:

- Early intervention and prevention
- Improving help for those in crisis
- Identifying the needs of vulnerable people
- Addressing training needs
- Communications and awareness

3.10 An action plan has been developed detailing what multi-agency work will be carried out in the next 12 months to address the priority areas of action. Following annual review of the plan further actions plans will developed for the next period.

3.11 Monitoring and implementation of the action plan will be via a multi- agency steering group on a quarterly basis. Progress will be reviewed by the Public Health senior management team. Overall oversight sits with the Health and Wellbeing Board.

3.12 The plan has been discussed at Mental Health Partnership Board and the council's Health, Adults, and Community, Children's Services, and Place Directorate Management Team (DMTs). Recommendations include using safeguarding reports as an 'early' data set for monitoring purposes, engaging with the probation service, including more evidence around effective interventions for children and young people, including more actions specific to children and young people, involving the council's Human Resources in training sessions, and identifying high-risk sites in the borough for physical intervention e.g. placing Samaritan signs on high rise buildings or barriers to prevent access.

3.13 The public-facing plan, the background document, and the action plan are attached.

4. COMMENTS OF THE CHIEF FINANCE OFFICER

4.1 The national Five Year Forward View for Mental Health requires LBTH to have a multi-agency suicide prevention plan in place by 2017 and for it to be reviewed annually thereafter.

4.2 LBTH has rightly adopted a multi-agency approach in its suicide prevention plan and action plan with the delivery costs of the plan to be met by LBTH and its partner organisations. All the work to be led by LBTH within the action plan in 2017 will be covered by existing staff within the department so no addition resource(s) is anticipated in the delivery of this plan in 2017/18.

5. LEGAL COMMENTS

5.1 Section 195 of the Health and Social Care Act 2012 requires the Health and Wellbeing Board (HWB) to encourage those who arrange for the provision of any health or social care services in their area to work in an integrated manner. Section 116A of the Local Government and Public Involvement in Health Act 2007 places a duty on the HWB to prepare and refresh a joint strategic health and wellbeing strategy in respect of the needs identified in the Joint Strategic Needs Assessment (JSNA), so that future commissioning/policy decisions are based on evidence. The duty to prepare this plan falls on local authorities and the Clinical Commissioning Group, but must be discharged by the HWB. The Suicide Prevention Strategy should therefore be devised to address needs identified within the local area and be linked to related strategies, such as the community plan and Health and Wellbeing Strategy.

5.2 The prevention strategy outlined above reflects the priorities and matters identified within the National Strategy for Suicide Prevention.

5.3 Section 6(1) Human Rights Act prohibits any public body from acting in a way that breaches rights protected under the European Convention on Human Rights. In line with these duties the Local Authority and statutory partners have positive obligations to act to protect life, including where the risk to life is through the actions of the individual where the risk of self-harm or suicide was known or ought to have been known[3]. Section 42 of the Care Act 2014 requires the Local Authority to make enquiries where they believe that an individual in need of care and support is at risk of abuse or neglect and unable to protect themselves. This statutory duties requires that the local authority act as lead agency in such enquiries and that they determine what needs to be done and by whom to protect the individual. Section 44 of the Care Act requires the Safeguarding Adult Board to also conduct reviews to learn lessons and monitor the implementation and impact of the recommendations from those reviews.

5.4 The strategy seeks to meet these obligations by ensuring staff within the local authority and across statutory partners and third sector providers identify risks appropriately and have access to information to signpost and support individuals to access specialist mental health support.

[3] *Osman v United Kingdom* [2000] 29 EHRR 245 and *Rabone & Anor v Pennine Care NHS Trust* [2012] UKSC 2

5.5 The HWB should ensure they are satisfied that the plan adequately recognises the risk factors pertinent to the local area, as identified within the JSNA. It should also ensure that systems are in place to robustly record and report data, specifically in respect of attempted suicides as this will not be routinely collected by the Coroner. They should also ensure that identified measures of success accord with operational service delivery plans and that mechanisms are in place to effectively monitor the implementation of the strategy's impact.

5.6 The HWB may want to give consideration as to whether there is scope for developing systems or utilising existing mechanisms set up by the Safeguarding Adults Board to meet their statutory duties under section 44 of the Care Act and related guidance for monitoring the effectiveness of multi-agency systems in meeting needs of those at risk of harm.

5.7 When considering the recommendation above, and when finalising the suicide prevention plan, regard must also be given to the public sector equalities duty to eliminate unlawful conduct under the Equality Act 2010. The duty is set out at Section 149 of the 2010 Act. It requires the HWB, when exercising its functions, to have 'due regard' to the need to eliminate discrimination (both direct and indirect discrimination), harassment and victimization and other conduct prohibited under the Act, and to advance equality of opportunity and foster good relations between those who share a 'protected characteristic' and those who do not share that protected characteristic.

6. ONE TOWER HAMLETS CONSIDERATIONS

6.1 There is national evidence that some people from groups with protected characteristics may have higher rates of suicide. Reducing suicide rates and addressing risk factors will help meet the objectives of One Tower Hamlets and reduce health inequalities.

6.2 Data on suicides has been analysed in terms of the nine protected characteristics where possible.

7. BEST VALUE (BV) IMPLICATIONS

7.1 The strategy addresses the issue of suicide in Tower Hamlets by taking an evidence based approach to improve the mental wellbeing of its residents. Improving mental wellbeing and reducing suicide will reduce the significant cost to society of suicides and in doing so meet the public sector duty of best value.

7.2 The strategy has been developed with input from service providers, the voluntary sector, and patient representatives via People Participation at East London NHS Foundation Trust. It will also go out for public consultation.

8. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

8.1 Promoting physical activity, active transport and improving open spaces are known to help improve mental wellbeing. The wider objectives of the suicide prevention plan of promoting mental wellbeing will have a positive effect on air quality, sustainability and availability of green spaces.

8.2 No negative environmental implications have been identified.

9. RISK MANAGEMENT IMPLICATIONS

9.1 There is a risk that the strategy's priorities do not adequately address the issue of suicide. However, this is being addressed through multi agency input into the development of the plan, public consultation and ongoing robust review and monitoring on a quarterly basis.

10. CRIME AND DISORDER REDUCTION IMPLICATIONS

10.1 The strategy references contact with the criminal justice system as a risk factor for suicide, and the Criminal Justice Mental Health Liaison Service have been involved in the development of the strategy.

Linked Reports, Appendices and Background Documents

Linked Report

- None

Appendices

- 1 – Draft Suicide Prevention Strategy
- 2 – Suicide Prevention Action Document
- 3 – Suicide Prevention Action Plan

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

- None

Officer contact details for documents:

- N/A

Tower Hamlets Suicide Prevention Strategy 2017-2020

Draft for consultation

Tower Hamlets Health and Wellbeing Board

Contents

Foreword

Introduction

The Tower Hamlets Suicide Prevention Strategy takes a broad approach to improving the mental health and wellbeing of people living in the borough, and to tackling the social factors that increase suicide risk.

Why do we need a strategy?

Suicide is often the culmination of a complex array of risk factors, mental ill-health, and distressing life events; however, it is not inevitable. By working together, we can lower the risk of suicide in the borough.

The government recently published their Five Year Forward View for Mental Health. It outlines a number of recommendations which are relevant to suicide prevention, including the development of a local plan. Although there is already work on suicide prevention in Tower Hamlets, we need to formalise this into a strategy.

In writing this strategy, we have taken into consideration national aims, guidelines, and evidence, including those set out in the National Suicide Prevention Strategy.

The national target is a reduction in the suicide rate by 10%, over the period 2016 to 2021. Preventative work in Tower Hamlets will contribute to this goal.

How have we written the strategy?

Experts from across the borough have been working collaboratively to reduce the risk of suicide, including:

- Tower Hamlets Council: public health, adults' and children's social care, safeguarding, housing, and the drugs and alcohol team
- NHS: Tower Hamlets Clinical Commissioning Group, East London NHS Foundation Trust and Barts and the London NHS Trust
- Metropolitan Police and British Transport Police
- Queen Mary University of London
- Transport for London
- the voluntary sector: Mind in Tower Hamlets and Newham, Samaritans, Step Forward, and others
- patient representatives

This strategy answers the following questions:

- Why do we need to address suicide?
- What are our long-term aims?
- Why have we chosen these priorities?
- What is our immediate work?
- How will we know if our work is successful?

Addressing suicide

Suicide is the act of deliberately ending one's own life.
In reality, it is difficult to fully understand a victim's intentions after the event, and we know that the suicide rate cannot reflect the true extent of the issue.

Suicide is the leading cause of death in people aged 20-34 in the UK[1].

There are well-recognised factors that contribute to suicide risk, which are outlined in the National Suicide Prevention Strategy and in guidance from Public Health England[2]. These may be long term circumstances or acute life events. There are also risk factors which are specific to children and young people.

Risk factors – long-term circumstances

- Male, young to middle-aged adults
- History of drug or alcohol abuse
- Chronic mental or physical illness
- History of self-harm
- Inpatients under the care of mental health services
- Access to means of committing suicide

Risk factors – acute life events (stressors)

- Bereavement
- Relationship breakdown
- Debt
- Loss of employment
- Imprisonment or contact with the criminal justice system
- Loss of housing

Risk factors – children and young people

- Mental illness, substance misuse and domestic violence in family members
- Academic and exam pressures
- Physical, emotional or sexual abuse, or neglect
- Social isolation or withdrawal
- Bereavement in a family member or friend
- Physical health conditions that are long-standing or have a social impact
- Bullying, either in person or online impact
- Excessive alcohol use or illicit drug use
- Suicide-related internet use
- Mental ill health, suicidal ideation, self-harm

Addressing suicide

Prevention work

National evidence and guidance suggests targeting prevention work around six key areas for action:

Reduce the risk of suicide in key high-risk groups	**Reduce access to the means of suicide**	**Support the media in delivering sensitive approaches to suicide and suicidal behaviour**
Tailor approaches to improve mental health in specific groups	**Provide better information and support to those bereaved or affected by suicide**	**Support research, data collection and monitoring**

We know that preventative measures can work. The national suicide rate had been declining from 1980 onwards thanks to prevention campaigns and a reduction in access to means; however, there has been a worrying increase since 2008.

A review of national evidence[3] indicates that the best interventions are those targeted at specific vulnerable groups. For example, it demonstrates the need to increase the availability of drug and alcohol services, and to take an innovative approach to delivering healthcare services to groups who are typically harder to reach, such as informal settings for men. Children and young people face unique pressures and it is vital that preventative work begins in early years. A 'cumulative effect', where multiple risk factors build up over time, is common in deaths by suicide at this age. We need to address each of these risk factors, and be aware of events which may act as a 'final straw'[4].

We know that a society with the lowest risk of suicide is one with less physical and mental illness, better managed long-term conditions, individuals who are emotionally resilient, and less deprivation.

The local picture

The suicide rate in Tower Hamlets is currently lower than that of England, but higher than the London average.

In the borough, there have been on average 20 deaths by suicide per year over the past decade. Four in five suicide victims are men, and over half of all suicides are men and women aged 20-39. A number of deaths have been in the student population, and a significant number have been people not registered with a GP surgery.

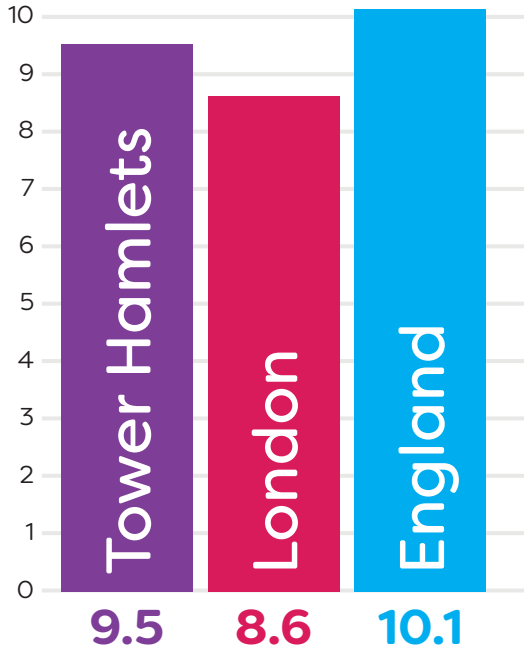
We know that these figures do not tell the complete story. More people attempt suicide than die from it, and some deaths are not classified as suicide but are nonetheless a result of the same risk factors. Further preventative work is vital.

Tower Hamlets is a relatively young borough, with almost a quarter of its residents aged 10-25. We need to ensure our suicide prevention work takes the needs of children and young people into account.

Public Health England has identified a number of indicators to measure suicide risk[5]. Of these, Tower Hamlets has higher estimated drug use, more alcohol-related hospital admissions, more homelessness, more children in the criminal justice system, and higher unemployment than the England average.

Our aim is to prevent people from being exposed to these risk factors where possible, and to provide support to help them cope when they are.

Rates of suicide 2013-2015
per 100,000



Work on suicide prevention is already happening in Tower Hamlets, including:

- specialist services targeting high risk groups provided by the NHS and voluntary sector.
- training delivered by the council.
- preventative work and data collection by the police and transport services.
- counselling services, including for the bereaved.

A local audit of suicide rates including more detailed information on current work is available in the background document.

What we intend to do

Although the number of suicides is small compared to other causes of death, every suicide has a wide-ranging impact on the families, friends, colleagues and healthcare workers associated with the victim. It is both a personal tragedy and a loss for society. Suicide is not inevitable. Over the past 30 years, national measures have dramatically reduced suicide occurences, but more can always be done.

The national target is a reduction in the suicide rate by 10%, over the period 2016 to 2021. Preventative work in Tower Hamlets will contribute to this goal.

Though we may prioritise work around the national six key areas for action in the future, our initial work in Tower Hamlets will be to take stock of our existing suicide prevention work. We also need to carry out scoping activities to better understand the needs of people living in the borough. By working to improve the mental wellbeing and resilience of our population, we can reduce the risk of suicide.

We have identified five priority areas of action to help us to do this:

- **Early intervention and prevention**
- **Improving help for those in crisis**
- **Identifying the needs of vulnerable people**
- **Addressing training needs**
- **Communications and awareness**

For each of these priority areas we describe why it is important, what our long-term aims are, and what our immediate work will be.

Priority 1
Early intervention and prevention

Why is this important?

Suicide is often the culmination of a complex array of risk factors, mental ill-health, and distressing life events.

Working to prevent people from being exposed to these risk factors, and helping them to cope when they are, is vital in reducing suicide risk.

Nationally, only one in four victims of suicide are known to mental health services prior to their death[6]. It is crucial that more at-risk individuals access these services early. We need to take advantage of the fact that many people are in touch with non-clinical statutory services, as covered in Priority 3.

We know that building resilience into our population from an early age will help them to cope with any stressors they may experience later on.

What are we already doing?

- Plans are being developed by the CCG to improve the early care of specific high-risk groups, such as children and young people, and women during and after pregnancy.
- The Tower Hamlets Early Detection Service provides mental health assessments and helps build emotional resilience in young people.

What will we do in the next year?

- We will work to improve specialist mental health services for targeted groups, in line with the Mental Health Five Year Forward View, with a view to improving mental health and wellbeing in children and young people.
- The signposting of our existing preventative work will also be improved.

What are our long-term aims?

We would like more people in Tower Hamlets to:

- access appropriate services in the early stages of mental illness.
- be assessed for mental illness at the stages of their life when they are most at risk of suicide.
- have the personal tools to help them cope with social stressors and traumatic life events.

How will we know if it's working?

- There will be an increased uptake to the Improving Access to Psychological Therapies (IAPT) service .
- An increased number of children and young people will be diagnosed with a mental health condition and be under the care of mental health services.
- An increased number of perinatal women will receive specialist mental health care.
- The number of suicide attempts will decrease.

Priority 2

Improving help for those in crisis

Why is this important?

Many people experiencing a mental health crisis will seek emergency clinical help.

Service providers have raised concerns that there are too few options for referral in these circumstances. Patients are regularly taken or referred to A&E, a busy environment not well suited to those in distress and which may also make them feel worse.

Nationally, 68% of patients who die by suicide have a history of self-harm[7]. However, only half of patients who attend A&E through self-harm receive a psychosocial assessment[8].

What are we already doing?

- A number of specialist NHS services are looking after people in mental health crisis, from emergency presentation in hospital to follow up care in the community.
- Work is underway to make A&E a more suitable environment for people experiencing mental distress.
- Samaritans are providing a freephone helpline to those in distress and a walk-in branch office in central London.

What will we do in the next year?

- We will examine the specific needs of people attending A&E who have attempted suicide, self-harmed, or who are in mental health crisis.
- We will map the current crisis referral pathway, address any gaps, and make the results available to all relevant bodies.
- We will work with schools to ensure students receive appropriate support following traumatic events.

What are our long-term aims?

We would like more people in Tower Hamlets to:

- feel more in control of their mental health.
- know how to access help when they need it.
- be able to access mental health services in an appropriate setting.

How will we know if it's working?

- There will be improved feedback from those attending A&E in crisis, and fewer patients absconding before assessment.
- More prominent signposting will be provided on a range of services for people in crisis.

Priority 3

Identifying the needs of vulnerable people

Why is this important?

Frontline staff in services such as the housing team and job centres often see service users experiencing multiple social stressors, but may not be trained to recognise or manage signs of mental illness or suicidal behaviour.

There have been issues around reporting or escalating people with suicidal ideas due to a fear of breaching confidentiality.

Children and young people face unique social pressures. In particular, concerns have been raised about the risk of exam stress, and self-harming behaviours promoted via online content.

A number of safeguarding issues have been identified in young adults who have been housed in temporary accommodation. It is not always clear where the health and social care responsibilities lie for people who move across borough boundaries.

What are we already doing?

- The local authority safeguarding team carries out safeguarding assessments and interventions for vulnerable and temporarily vulnerable adults.
- The Child Death Overview Panel investigates all child deaths and makes safeguarding recommendations accordingly.
- Job Centre staff follow a six point plan for managing service users in crisis, and are equipped with a brief guide to available mental health services.

What will we do in the next year?

- Lessons learnt from safeguarding reviews will be collated and widely shared amongst service providers.
- Improve practice in non-clinical statutory services, and provide increased support for frontline staff.
- Improve support for specific vulnerable groups, such as children and young people.

What are our long-term aims?

We would like:

- frontline staff to feel confident in supporting service users and to recognise signs of mental illness.
- frontline staff to have a range of referral options for service users.
- service users who are placed in temporary accommodation to be followed up appropriately.
- responsibility for service users housed outside the borough to be clear amongst statutory service providers.

How will we know if it's working?

- Fewer deaths and self-harm incidents will occur in temporary housing.
- Fewer vulnerable people will be sent to A&E.

Priority 4
Addressing training needs

Why is this important?

Effective training underpins our work in other areas.

Non-clinical frontline staff have felt unequipped to manage service users expressing suicidal ideas.

Many patients leave hospital before being seen by specialist staff, therefore it is vital that all clinical staff are capable of performing mental health assessments.

What are we already doing?

- 200 members of staff have been trained in Mental Health First Aid and a further 12 have been trained to train others.
- Funding has been secured to provide evidence-based suicide prevention training through the ASIST model.
- Informal inter-departmental training and skills-sharing already takes place across statutory and third sector services.
- Making Every Contact Count training is provided to frontline staff.

What will we do in the next year?

- We will provide the first phase of suicide prevention training to frontline staff in the housing office.
- We will address general mental health training needs.

What are our long-term aims?

We will:

- ensure that suicide prevention is embedded in the wider community.
- ensure non-clinical frontline staff who are confident in recognising and assisting those in mental health crisis are retained.
- meet the training needs of clinical staff.

How will we know if it's working?

- We will have a network of staff and residents trained in suicide prevention.
- Staff will be able to recognise people at risk of suicide, and apply the four-step suicide alertness model TALK – tell, ask, listen, keep safe.
- Staff will formulate a suicide prevention plan in collaboration with the at-risk person.

Priority 5
Communications and awareness

Why is this important?

There is evidence that the effective use of media can combat the stigma surrounding suicide and may help prevent 'copycat' behaviour.

Although there are national guidelines for the media on responsible reporting of suicide, a recent study has shown that almost 9 in 10 online news stories relating to suicide fails to meet at least one of these standards[9].

There are services and projects in the borough which could be better publicised to residents.

What are we already doing?

- We are promoting the Five Ways to Wellbeing, a set of simple actions people can take to maintain good wellbeing.
- The Tower Hamlets' website provides information on a wide range of local mental health and wellbeing services.
- The council is signed up to the Local Authority Mental Health Challenge and to the Time to Change pledge.

What will we do in the next year?

- We will identify sites where suicides occur and install Samaritans' signs.
- Social media will be used to foster publicly visible links between statutory and third sector services.
- We will support national and regional suicide prevention campaigns.

What are our long-term aims?

We will:

- put in place a communications strategy that promotes local work and supports relevant national campaigns.
- support responsible reporting of suicide in the media.

How will we know if it's working?

- Local reporting of suicide will be in a sensitive manner and meet national guidelines.
- Local services will be publicised effectively.
- There will be an increase in self-referrals to relevant services.

Implementation and monitoring arrangements

The Tower Hamlets Suicide Prevention Strategy has a three year timeframe.

Actions will be monitored quarterly and priorities reviewed annually by the Suicide Prevention Steering Group, which reports to the Tower Hamlets Health and Wellbeing Board.

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Tower Hamlets Suicide Prevention Strategy 2017-2020

Background Document

Tower Hamlets Health and Wellbeing Board

Contents

1. Introduction

1.1. 6,188 people died due to suicide in the United Kingdom in 2015. Nationally, it is the leading cause of death in adults aged 20-34[1,2]. It is one of the 20 leading causes of death worldwide[3].

1.2. Every suicide has a wide-ranging impact on the families, friends, colleagues, and healthcare workers associated with the victim. An estimated 60 people are affected by each suicide[4]. It is both a personal tragedy and a loss for society. The estimated financial cost of an individual suicide in a working age person is £1.67m[5].

1.3. Suicide is not inevitable. Public health measures to reduce access to means and improve care for those who are at risk of suicide have contributed to a reduction in the national suicide rate since the 1980s. However, there has been an upturn in deaths by suicide since 2008; there remains a need for preventative work.

2. Policy context

2.1. In 2013 public health was transferred from the NHS to local government, placing suicide prevention work in the remit of the local authority.

2.2. In 2012 the National Suicide Prevention Plan (NSPS) Preventing Suicide in England: A Cross Government Outcomes Strategy to Save Lives identified six key areas of action[6]:

1. Reduce the risk of suicide in key high-risk groups

- Men
- People with a history of self-harm
- People with a history of alcohol and drug misuse
- People under the care of mental health services, including inpatients
- People in contact with the criminal justice system
- Specific occupational groups

2. Tailor approaches to improve mental health in specific groups
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved or affected by suicide
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection and monitoring

2.3. In 2014 Preventing Suicide in England 'One Year On' suggested the following local actions[7]:

- Develop a suicide prevention action plan
- Directors of Public Health to monitor local data and trends
- Engage with local media regarding suicide reporting
- Work with transport and the health and wellbeing board to map local 'hotspots'
- Work on local priorities to improve mental health

2.4. In 2015 Preventing Suicide in England 'Two Years On' was published. In line with the All-Party Parliamentary Group on Suicide and Self-Harm Prevention, it identified three elements key to local implementation of the national strategy[8]:

- Carrying out a suicide audit through sources such as the coroner's office and health records
- Developing a suicide prevention action plan detailing specific actions to reduce suicide and suicide risk in the local community
- Establishing a multi-agency suicide prevention group involving key statutory agencies and voluntary organisations

2.5. In 2016, the Five Year Forward View for Mental Health made it a requirement of all local authorities to have a suicide prevention strategy in place, with the aim of reducing the national suicide rate by 10% from 2015/16 to 2020/21[9].

3. Aims

3.1. Local needs are identified through the multi-agency suicide prevention steering group, and an audit of suicide in Tower Hamlets. National guidance, as detailed in Public Health England's (PHE) Local Suicide Prevention: a practice guide[10], has been taken into account.

3.2. The strategy sets out how reducing suicide risk in Tower Hamlets will be addressed. The action plan outlines the specific work that will achieve this.

3.3. The strategy takes a broad approach to improving mental health and wellbeing in order to reduce suicide risk. It focuses on five priority areas of work:

- Early intervention and prevention
- Improving help for those in crisis
- Identifying the needs of vulnerable people
- Addressing training needs
- Communications and awareness

3.4. Although there is overlap, these priorities differ from the key areas of action identified in the NSPS (see section 2.2 above). They are reflective of the collective priorities of the agencies working on suicide prevention in Tower Hamlets. Individual organisations will also be carrying out work which may not be directly reflected in the priorities.

4. Discussion and consultation

4.1. Discussion

Prior to public consultation, the Suicide Prevention Strategy was discussed at directorate management teams across the council: Health, Adults, and Community; Children's Services; and Place.

4.2. Zero suicide

The zero suicide approach originated in the USA, where a mental health service developed a system of 'perfect depression care', which saw the suicide rate amongst its patients drop by 75% in ten years, including a year without any suicide[11]. The approach takes the premise that no suicide is unavoidable.

Adopting such an approach requires a fundamental shift in how suicide is viewed, from being a part of mental health care in general, to becoming a 'never event'. Areas which have implemented the zero suicide approach have created dedicated suicide prevention teams, increased access to same-day mental health services, lowered the threshold for what is considered to be suicide risk, and developed live reporting of suicide.

It has been suggested that zero suicide is an unrealistic goal which ultimately sets clinicians up to fail. However, health services in which this approach has been applied to good effect have reported that having such a bold goal helped to focus their efforts.

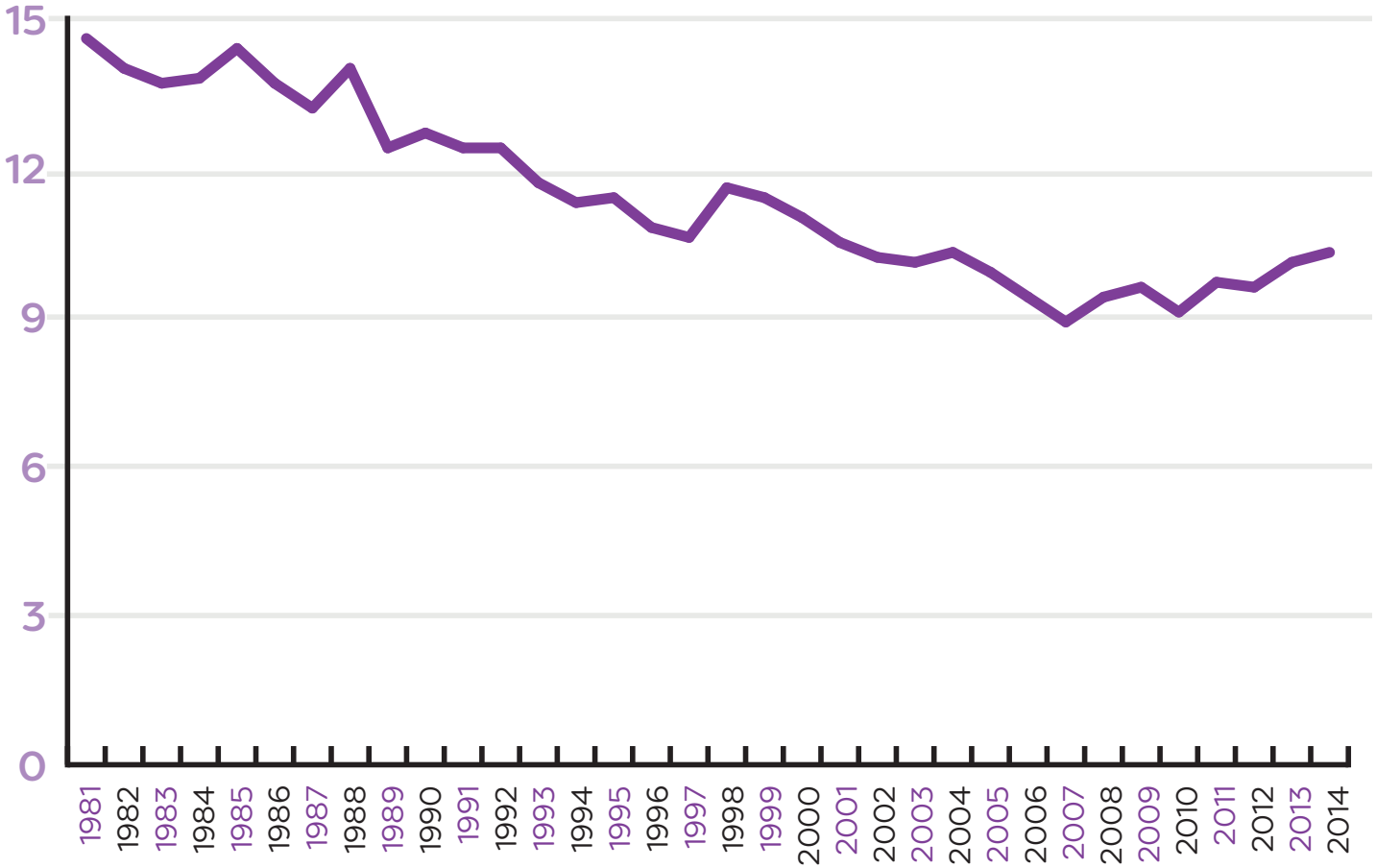
Concerns have also been raised about the language used, with 'zero suicide' echoing policies such as 'zero tolerance' on drugs and violence. It is clear that the way in which any aspiration is expressed must not contribute to the stigma already surrounding suicide.

5. National background

5.1. 6,188 people died by suicide in the United Kingdom in 2015[12].

5.2. The suicide rate in England is currently 10.1/100,000 population[13]. Although the rate had been declining steadily since 1980, there has been an increase since 2008.

Figure 1: Suicide rate in England 1981-2014

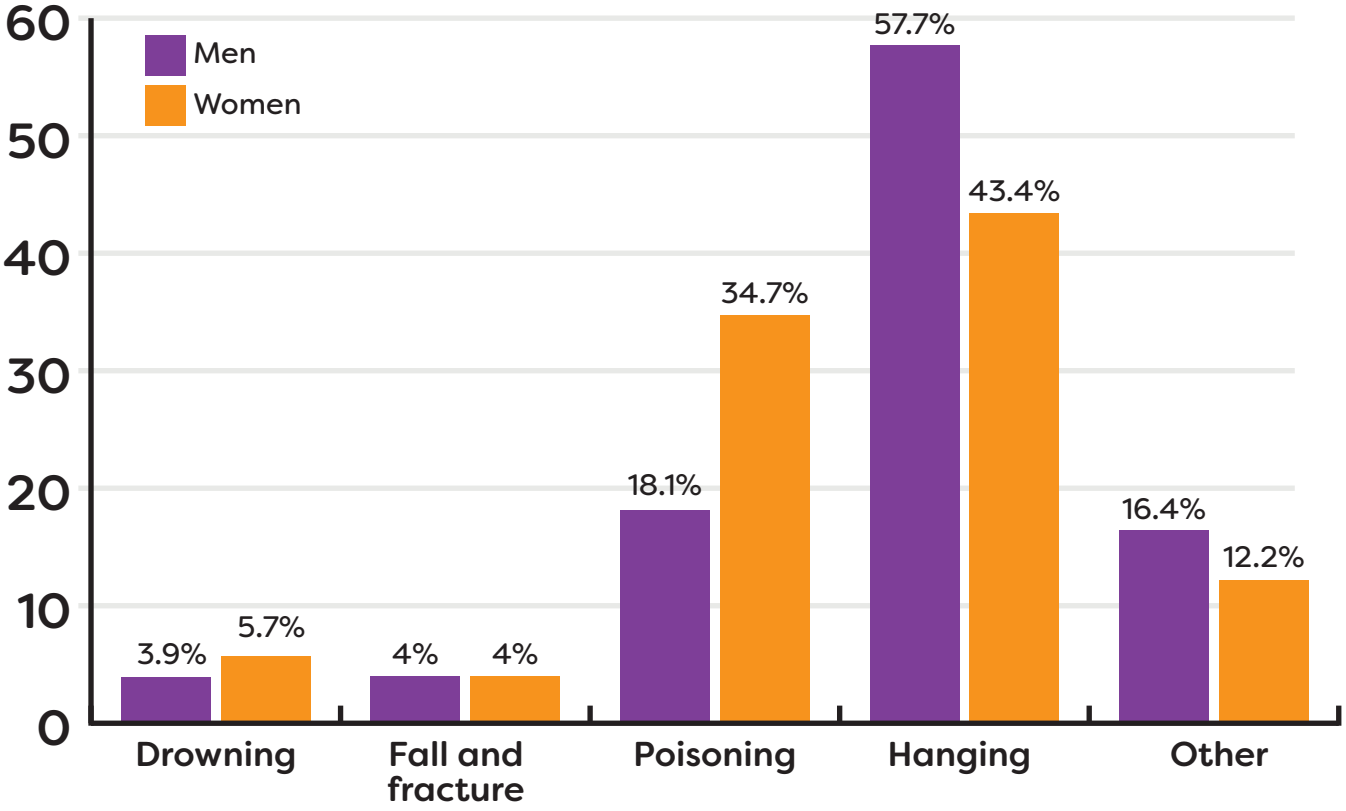


5.3. Suicide is the leading cause of death in young people aged 20-34[14]. The rate amongst males is consistently three times that of females[15].

5.4. The most common method of suicide in England and Wales is hanging or suffocation, followed by overdose or poisoning[16].

Figure 2: Methods of suicide by percentage in men and women in England and Wales

Office for National Statistics 2015



5.5. Recognised risk factors for suicide include[17, 18, 19]:

- Male, young to middle-aged adults
- History of self-harm
- Inpatients under the care of mental health services
- Chronic mental or physical illness
- Contact with the criminal justice system
- Occupational or geographical access to means

5.6. Acute events which increase the risk of suicide include[20, 21]:

- Bereavement
  Bereavement by suicide is known to increase the risk of suicide attempts in young adults compared to bereavement through sudden death by natural causes[22].
- Loss of employment
- Relationship breakdown
- Imprisonment
- Debt

6. Children and Young People

6.1. Suicide is a leading cause of death in children and young people (CYP), and is traumatic for all those affected. Although many of the risk factors already explored apply to this age group, there are also specific factors to be aware of. The Suicide by Children and Young People in England report from the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) offers a comprehensive review of these risks[23].

6.2. The report identifies ten key themes common to many of the deaths by suicide in the under-20s:

Figure 3: NCISH key themes of suicide in children and young people

6.3. Concerns have been raised locally about the possible negative impacts of social media on CYP. Almost a quarter (23%) of deaths in under 20s were preceded by 'suicide-related internet use', including searching for methods, and discussing suicidal ideation online[24]. Social media is a rapidly growing platform and its impact on young people's mental health is not fully understood[25].

6.4. Of note, nearly half (43%) of under 20s who died by suicide were not known to any statutory service (including mental health services, social care, or the criminal justice system).

6.5. More than half (54%) of under 20s who died by suicide had a history of self-harm. The rate of self-harm in CYP is increasing. In England hospital admissions as a result of self-harm in 10-24 year olds increased by 24% between 2010 and 2015[26]. Self-harm and suicide share a profile of risk factors, including chronic illness, social isolation, emotional trauma, and alcohol and drug misuse.

6.6. A key message from the report is that many (43%) CYP who die from suicide have not recently expressed suicidal ideation. Key to reducing risk is recognising the cumulative effect of multiple risk factors over time, and being aware that any single event may act as the 'final straw'. The NCISH report offers this model:

Figure 4: NCISH model of cumulative risk

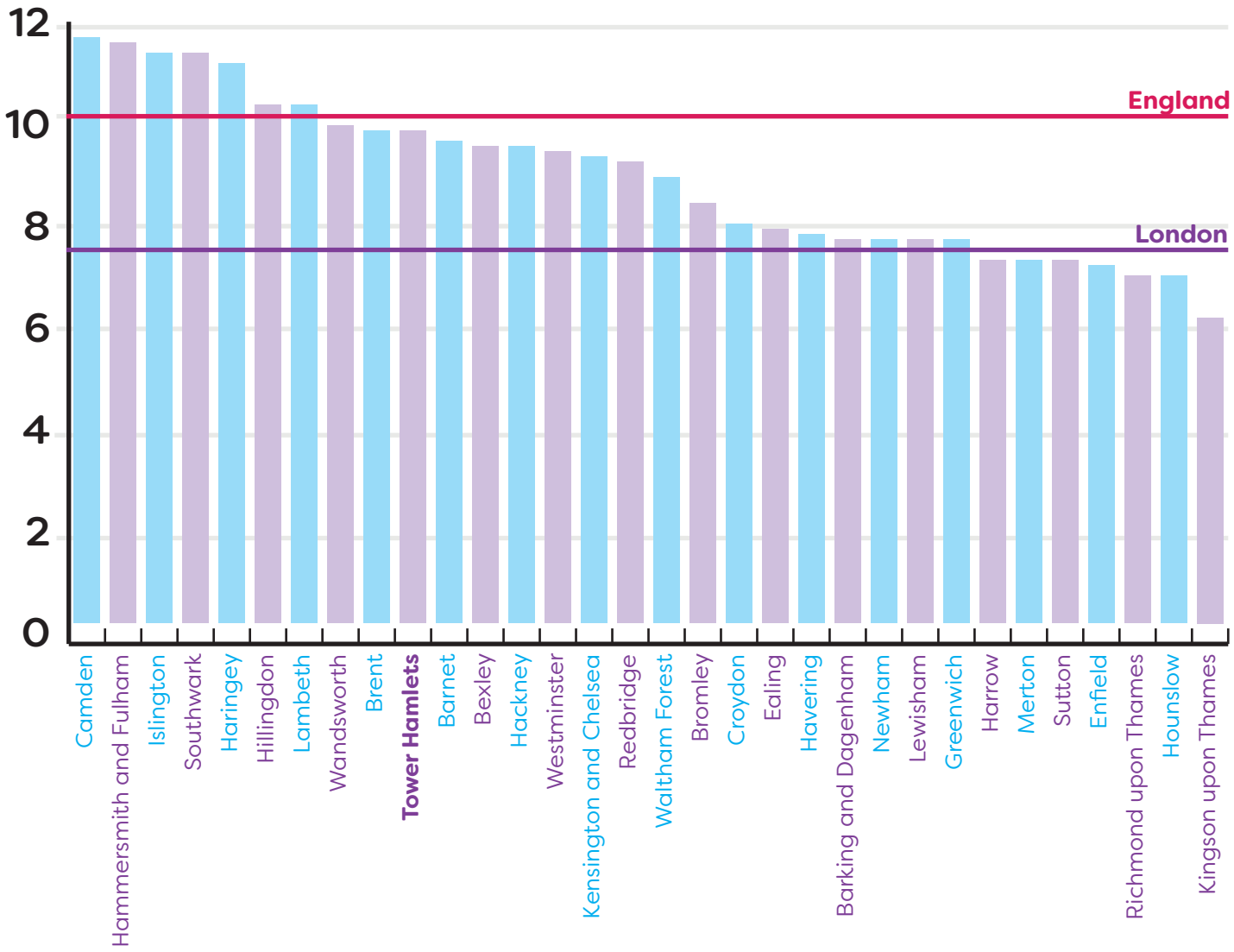
6.7. It is also important to note that many of the common factors in the deaths examined in the NCISH report are also common to the CYP population at large; an illness such as asthma cannot be viewed as a predictive factor for suicide. Some risk factors may be under-reported if of a sensitive nature (e.g. abuse), or over-reported by friends or family seeking a cause for the death (e.g. exam stress)[27].

7. Local data

7.1. The suicide rate in Tower Hamlets is currently 9.5/100,000 population; the London rate is 8.6 and the England rate is 10.1[28]. In the years 2013-2015, Tower Hamlets had the tenth highest rate amongst the London boroughs.

Figure 5: Suicide rates 2013-2015

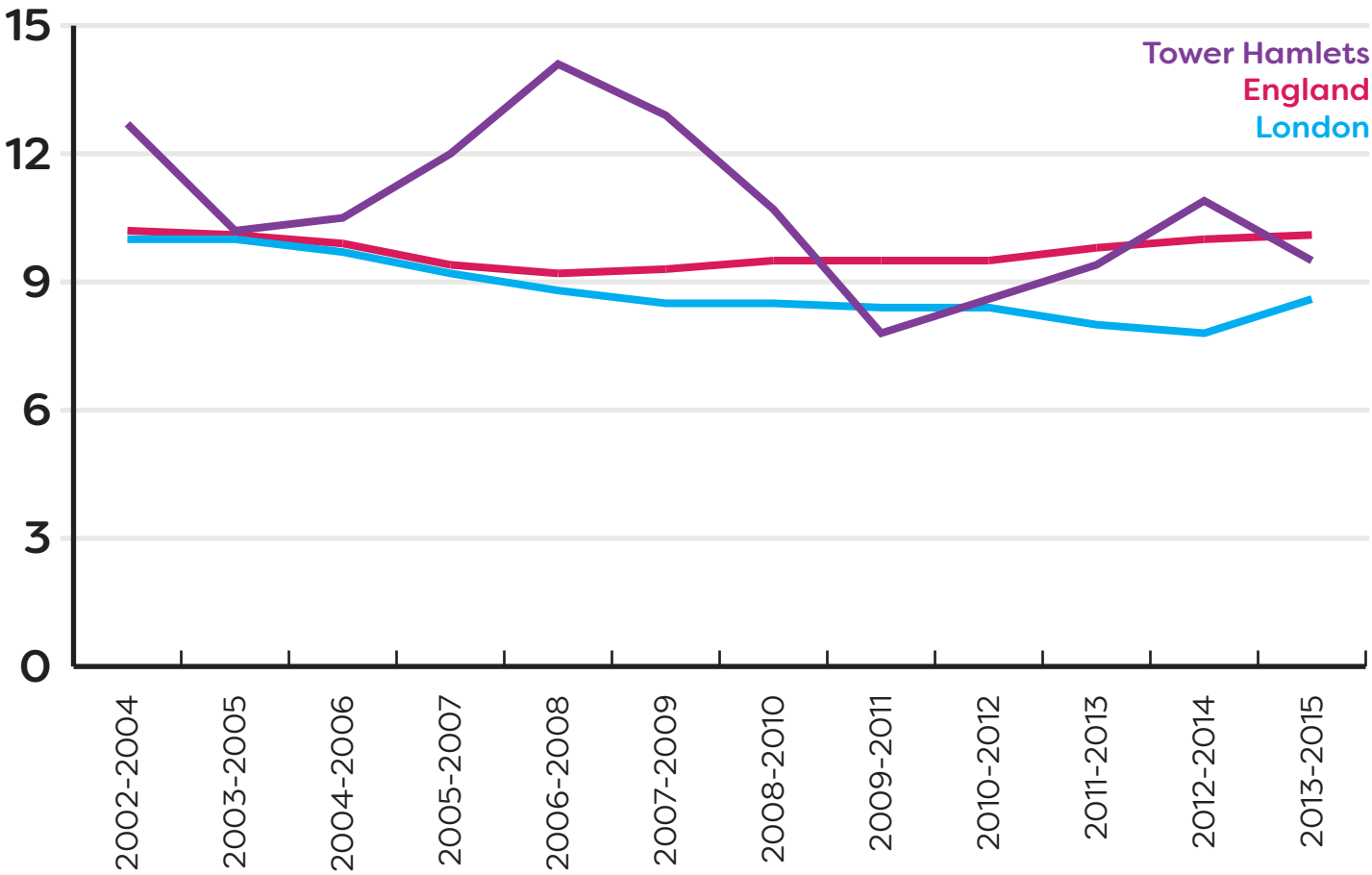
Three-year aggregate age-standardised suicide rates in London boroughs, London, and England. Office for National Statistics 2013-2015



7.2. The suicide rate in London has been decreasing gradually over the past ten years. The local rate has fluctuated. The small numbers involved preclude a trend being identified.

Figure 6: Suicide rates per 100,000

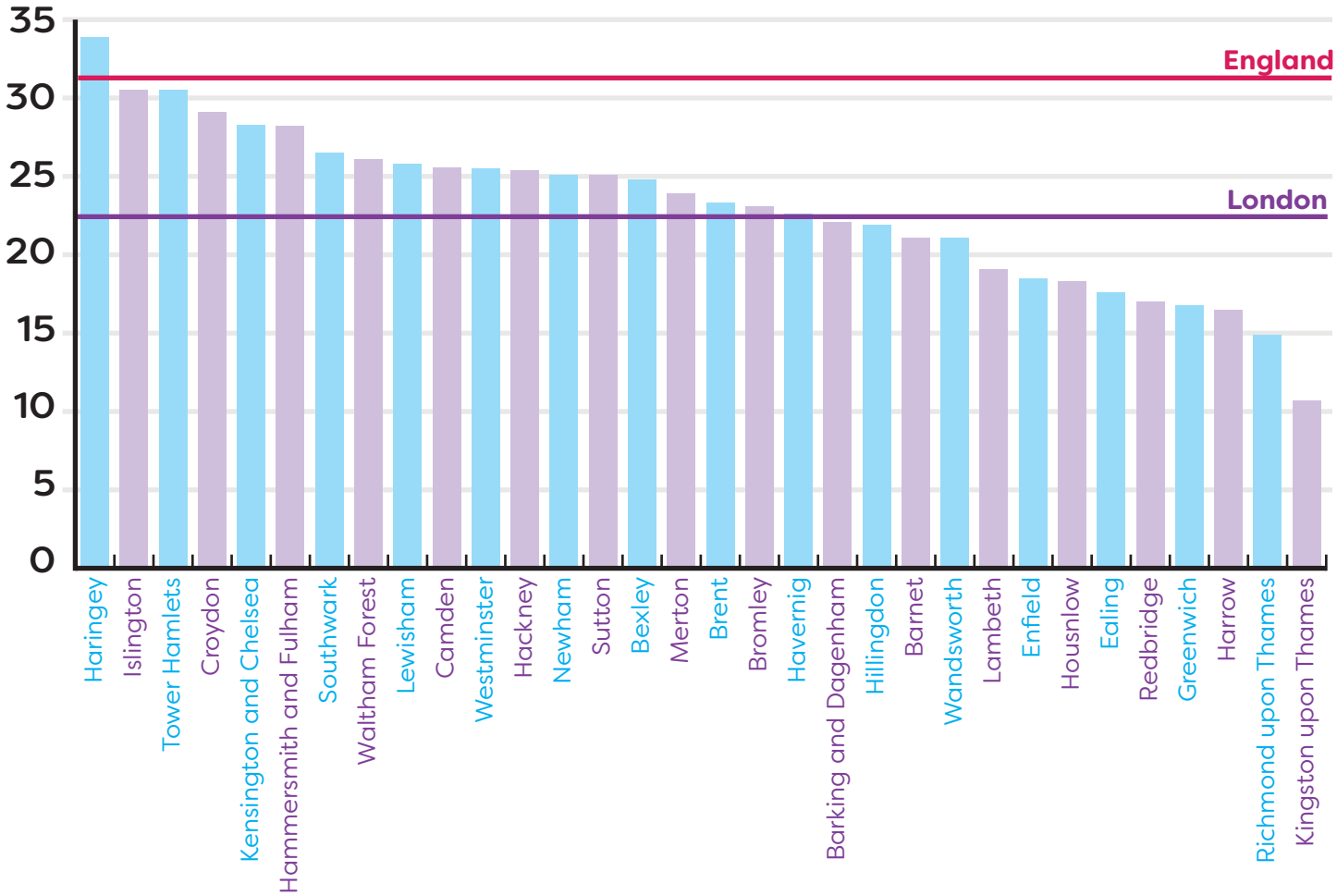
Three-year aggregate suicide rates per 100,000 persons in Tower Hamlets, London and England. Office for National Statistics 2002-2004, 2013-2015



7.3. The rate of years of life lost per 10,000 population is 30.5. It is reflective of the relatively young population in Tower Hamlets.

Figure 7: Years of life lost due to suicide (15-74) per 10,000 2012-2014

London boroughs, London, and England. Office for National Statistics, 2012-2014



7.4. PHE identifies public health outcomes associated with an increased suicide risk. Tower Hamlets has a rating significantly worse than the national average for several of these. Of note:

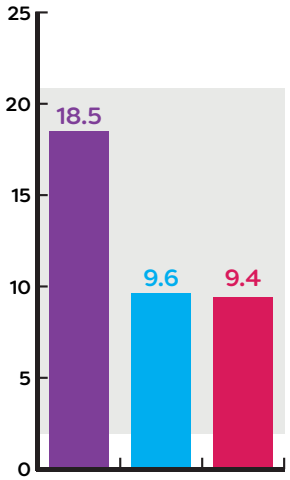
Figure 8: Public health outcomes associated with an increased suicide risk

Tower Hamlets London England

National range

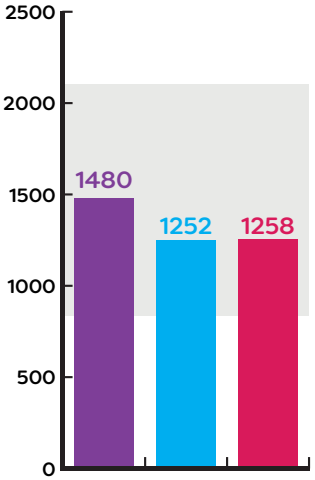
Drug use

Estimated prevalence of opiates and/or crack cocaine use: rate per 1,000 aged 15 – 64 2011/2012



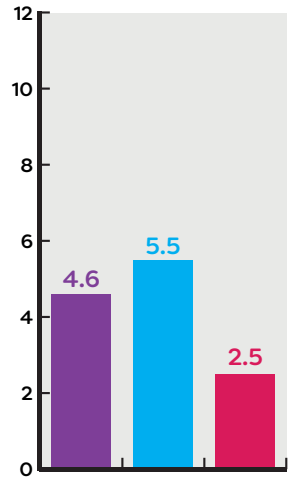
Alcohol

Alcohol-related hospital admission (broad): directly age standardised rate per 100,000 persons 2014/2015



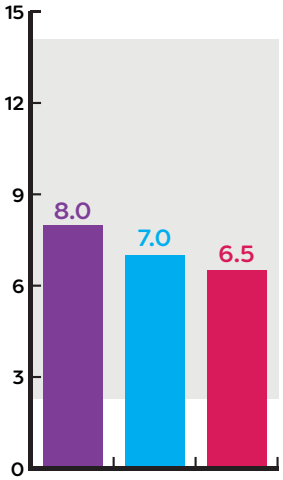
Homelessness

Statutory homelessness rate per 1000 households 2015/2016



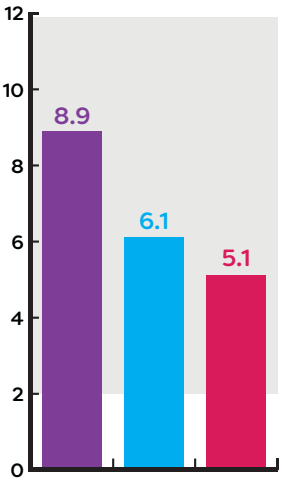
Youth justice

Children in the youth justice system: rate per 1000 aged 10-18 2014/2015



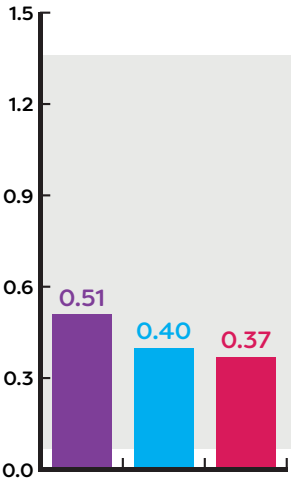
Unemployed

Unemployment: percentage of working age population 2015



Long-term Unemployed

Long-term unemployment: percentage of working age population August 2016



7.5. Key concerns raised by the Suicide Prevention Steering Group include:

- A number of serious incident reviews have been conducted but learning has not been collated and shared between agencies.
- There have been multiple suicides and deaths of unknown intent in young adults who have been housed in temporary accommodation.
- There is at least a perceived lack of information on what crisis services are available.
- There is a lack of clarity over referral pathways, within and between statutory and voluntary sector agencies.
- Non-clinical frontline staff, such as those in the housing department, benefits office, and job centre, do not feel equipped to deal with mental health crises.
- There have been instances where staff, for example in hospitals and schools, have hesitated to report concerns either because they are unsure of who to report to, or due to a fear of breaching confidentiality.
- There is no consistent access to detailed information from the coroner.
- Working towards a 'zero-suicide' target should not be pursued by increasing the number of patients who are under mental health sections or hospitalised.

7.6. Tower Hamlets suicide audit 2006-2016
It is a recommendation of the NSPS and its 2015 follow-on report that a local suicide audit is conducted. Its aim is to provide data which will inform a local suicide prevention strategy. Given the small numbers involved locally, this data should be used alongside national and international evidence to inform targeted local actions.

Methodology
In line with best practice, four sources of data were considered[29]:

- The local coroner's office: Inner North London
- Local accident and emergency (A&E) departments
- The Primary Care Mortality Database (PCMD)
- Data compiled and published nationally by the Office for National Statistics (ONS)

The Inner North London coroner's office was contacted with a view to forming a data sharing partnership. This has so far been declined due to confidentiality concerns. Local A&Es do not routinely audit suicide and self-harm.

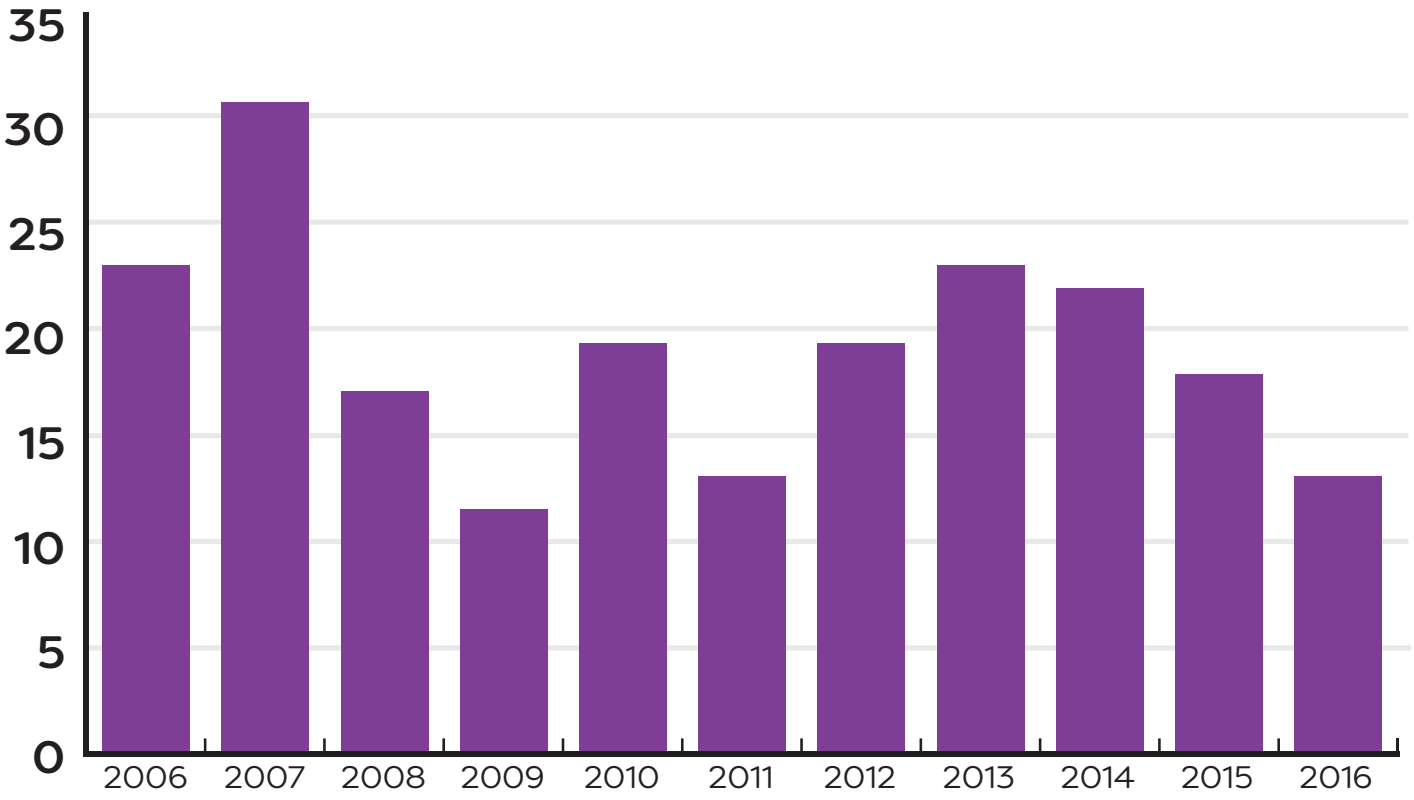
Data from the PCMD has been used to examine deaths recorded as suicide. These have been examined in terms of gender, age, method, location, residency, and country of birth. Data would ideally be broken down by the nine protected characteristics[30], and the nationally recognised risk factors for suicide, but this is not routinely recorded on death certificates. The data fields collected in the PCMD are listed in full in Appendix 1. National data from the ONS has been used to make comparisons with other areas.

Extraction of data from the PCMD:

- There were 11569 deaths of Tower Hamlets residents between January 2006 and September 2016.
- 218 deaths were assigned an ICD-10 code for suicide. This is the population used in the audit.
- 85 deaths assigned an ICD-10 code for suicide were open verdicts; 133 were not.

Demographics

Figure 9: Yearly suicide counts in Tower Hamlets



Gender

Over the ten year period, 81.2% of suicides have been in men and 18.8% in women, a ratio of 4:1.

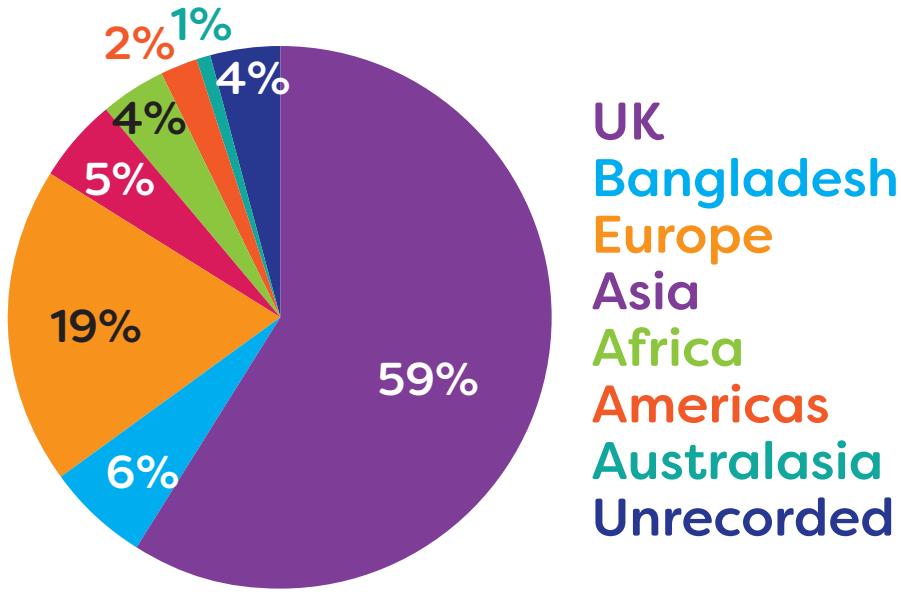
Age

Over half of all suicides in both males and females are in the age range 20-39. A quarter of all suicides are committed by males aged 30-39. There have been no suicides in females over the age of 60.

Country of birth

Death certificates do not record ethnicity. The closest approximation of this is country of birth. 59% of all suicides were by people born in the UK. 6% were by people born in Bangladesh.

Figure 10: Percentage of suicides 2006-2016 by country of birth



Deprivation

It is recognised nationally that there is a positive correlation between suicide rate and deprivation. However, on a ward level in Tower Hamlets this is not apparent:

- Bow East has had the highest number of suicides in the past decade, both by count and rate per 1000 population[i], but is the 12th most deprived of 20 wards in the borough.
- Poplar and Limehouse have the joint lowest suicide counts, and equal rates per 1000 population, but are the 9th and 16th most deprived wards respectively.
- 4% of deaths in Blackwall and Cubitt Town are due to suicide, the highest proportion in the borough. It is the third least deprived ward.

i Based on the current population count

Occupation

PHE's advice on local suicide prevention identifies high-risk occupations as:

- Doctors
- Nurses
- Farmers and agricultural workers
- Veterinary workers
- Roles with poor working conditions and low job security

Of the 135 suicides with a recorded occupation, there were two nurses and one doctor. The association between certain occupational groups and suicide is not represented in Tower Hamlets.

Of note, although not identified nationally as a risk group, 14 students have died by suicide over the past decade, accounting for 6.4% of suicides.

Registration with a GP

25 people who died by suicide were not registered with a GP surgery: 11.5%.

Method

Injury (comprising 'injury', 'multiple injury', and 'wound') and hanging are the most common methods of suicide in Tower Hamlets, accounting for 36% and 31% of suicides respectively. Nationally, hanging is the most common method.

Suicides caused by injury are more likely to have an open verdict, even if they are also assigned an ICD-10 code for suicide, than suicides by hanging. This is reflective of the difficulty in determining intentions after a person's death.

Poisoning, including by opiate drugs, makes up the greatest proportion of suicides in women; injury makes up the greatest proportion of suicides in men.

Figure 11: Percentage of suicides by method in females, 2006-2016

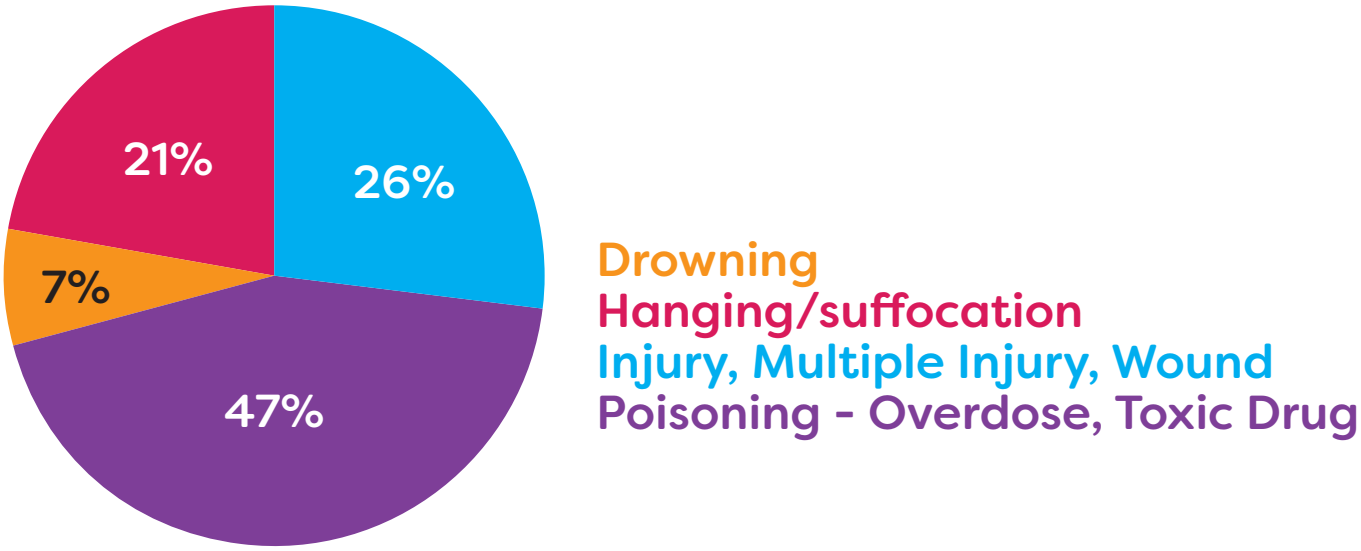
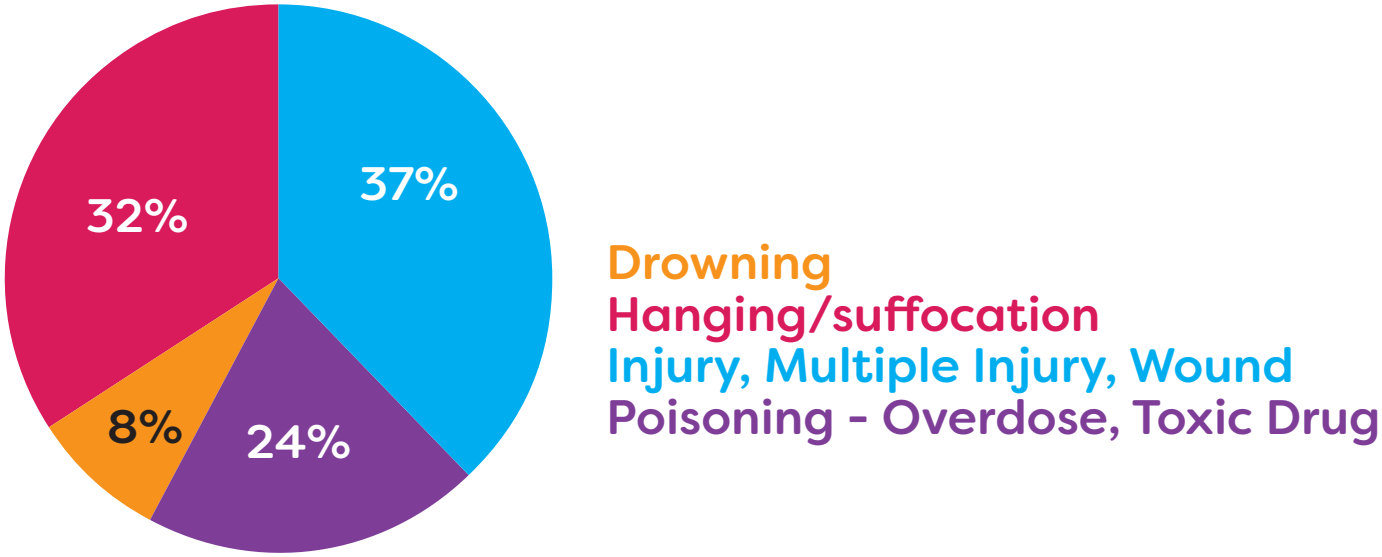


Figure 12: Percentage of suicides by method in males, 2006-2016



Location of death

88 deaths occurred in the home of the victim.

43 deaths occurred in hospital. In the vast majority of these cases, the victim had undertaken the act of suicide elsewhere, and later died in hospital.

Three cases were identified as hangings in healthcare settings.

There were 13 deaths at train or underground stations, of which seven were within the borough.

Hotspots

Two sites are identified where more than one person has died by suicide in the past decade:

- Bethnal Green Underground Station
- Mile End Underground Station

British Transport Police data shows three suspected suicides and one injurious attempt at Mile End Underground Station between April 2015 and February 2017[31]. This does not correlate with PCMD data; suspected suicides will not necessarily be given a suicide verdict by the coroner.

Limitations

The findings are limited by:

- Restricted access to data sources e.g. coroner's records
- The way in which data is recorded
- The small size of the data set

The data presented here is from the PCMD, and is therefore limited by what variables are included in the database and how fully each of these has been populated.

Data is also limited by what is recorded on a death certificate. Neither the death certificate nor the PCMD record information on seven of the nine protected characteristics:

- Disability
- Gender reassignment
- Marriage/civil partnership
- Maternity/pregnancy
- Race
- Religion
- Sexual orientation

PHE guidance on suicide prevention planning recommends reducing the risk of suicide in key high-risk groups. Information relevant to these groups is not included in the PCMD:

- Recorded history of self-harm
- Recorded history of misuse of drugs and alcohol
- Known contact with mental health services
- Contact with the criminal justice system
- Occupation is often incompletely recorded

Data is not routinely collected on attempted suicide; no distinction is made in hospital data between self-harm and suicide attempt incidents.

Local data from the PCMD offers an insight into suicide in Tower Hamlets, but should be considered in conjunction with national data due to the small numbers involved.

The demographics of the Tower Hamlets population should be considered when looking at high suicide risk groups. There have been several suicides in the student population which is not identified as a high risk group in national guidance. Students make up 15.4% of the 16-74 year old population in Tower Hamlets[32]. The specific occupational groups identified in national guidance such as agricultural workers are not relevant to the local population.

8. Current work

8.1. Work on suicide prevention is already ongoing in Tower Hamlets. Key services and work, beyond the statutory mental health services, are summarised below.

8.2. Work from London Borough of Tower Hamlets:

- Mental Health Strategy 2014-2019
- Provision of Mental Health First Aid (MHFA) training to around 200 local staff and further training for 12 local staff to become MHFA trainers
- Community perspectives on loneliness in the over-50s project
- Provision of mental health safeguarding workshops for frontline staff in adult social care
- The Recovery and Wellbeing Service, operating from January 2017
- The council is signed up to the Local Authority Mental Health Challenge and to the Time to Change Employers' Pledge

8.3. Specialist services provided by East London NHS Foundation Trust:

- Rapid Assessment, Interface, and Discharge (RAID)
- A model for psychiatric care which provides rapid assessments to those in mental health crises both in A&E and as inpatients.
- Tower Hamlets Early Detection Service (THEDS)
- A service for young people aged 16-25 who are concerned about their own mental health. Patients can be referred by non-health professionals and can self-refer. The service provides mental health assessments and offers sessions with an emphasis on building emotional resilience.
- Criminal Justice Mental Health Liaison Service (CJMHLS)
- A service for people who are in contact with the criminal justice system. The service provides healthcare professionals to assess those in a custodial setting (police stations, courts, and prisons) for suicidal ideation, mental health conditions, and learning disabilities.

8.4. Voluntary sector work

- **City and East London Bereavement Service (CELBS)**
  A voluntary sector organisation which has been commissioned to provide bereavement counselling, including for those as a result of suicide. This service is accessible to any patient living in Tower Hamlets, or whose relative or friend died within a Barts Health NHS Trust hospital. Patients can be referred from primary care, IAPT, or can self-refer.

- **Samaritans**
  Provides a free 'listening service' over the phone, by email, or face to face in central London. They have distributed literature on suicide prevention and emotional resilience to all secondary schools in the borough.
- **Look Ahead**
  Provides crisis and recovery houses as an alternative to hospital admission.
- **Compass**
  Provides Improving Access to Psychological Therapies (IAPT) service, and provides counselling focusing on wellbeing and emotional resilience.
- **Mind in Tower Hamlets and Newham**
  Provides counselling, training, and a diverse range of activities to improve mental health and wellbeing.
- **Inspire Mental Health Consortium**
  Delivers mental health and wellbeing services including housing, support, and training.
- **Campaign Against Living Miserably**
  Provides a free listening service by phone or online, specialising in assisting men.
- **Papyrus UK**
  Provides HOPEline, a free telephone service aimed at young people (16-30).

8.5. Transport services

- Railways and London Underground staff are trained in suicide prevention via Transport for London, British Transport Police, and Network Rail.
- Network Rail and the British Transport Police collect information regarding deaths on railways and TfL sites. Three incidents or more at one site within a twelve month period are automatically escalated to the local authority.

8.6. Education

- **Queen Mary's University of London**
  Provides counselling sessions for students and is conducting research into suicidal behaviour

8.7. Much of this work can be mapped to the six key areas of action identified by PHE and the NSPS. However, the multi-agency steering group has decided Tower Hamlets should have slightly different priorities over the next three years.

9. Next steps

9.1. Taking into consideration the concerns raised by stakeholders, local mortality data, and national guidance, the steering group decided on five priorities for collective work.

9.2. The priorities, why they were chosen, and the long and short term aims are outlined in the Tower Hamlets Suicide Prevention Strategy.

9.3. The specific actions to take over the next year are details in the Tower Hamlets Suicide Prevention Action Plan.

10. Appendix 1: PCMD variables

1. Anonymised ID
2. First all-numeric NHS number
3. Date of birth
4. Date of death
5. Place of death text
6. Usual address of deceased in text
7. Postcode of usual address
8. Cause of death text lines 1 to 8
9. Strategic Health Authority code of residence
10. Primary Care Trust or Local Health Board code of residence
11. Date of registration
12. Sex
13. Underlying cause of death ICD code
14. Cause of death ICD Codes 1 to 8
15. Certifying Doctor
16. GP Code that the deceased was registered with
17. GP Practice Code that the deceased was registered with
18. CCG code for the GP practice that the deceased was registered with
19. Place of death code
20. Postcode of place of death
21. Clinical Commissioning Group code for place of death of deceased
22. Upper tier Local Authority code for place of death
23. Primary Care Organisation code for place of death

24. NHS Establishment indicator
25. Establishment type where death occurred
26. Postcode imputation indicator
27. Calculated age of deceased
28. Calculated age unit
29. Occupation of deceased in text
30. Occupation of husband or father of deceased juvenile (text)
31. Occupation of mother of deceased juvenile (text)
32. Occupation type
33. National Statistics Socio-economic Classification (NS-SEC) for deceased or mother of deceased juvenile
34. National Statistics Socio-economic Classification (NS-SEC) for husband or father of deceased juvenile
35. 2010 Standard Occupation Classification of deceased or mother of deceased juvenile
36. 2010 Standard Occupation Classification of husband or father of deceased juvenile
37. Retired indicator for deceased or mother
38. Retired indicator for husband or father
39. Place of birth text (for deceased)
40. Country code of place of birth of deceased
41. Government Office Region code of usual residence of deceased
42. Upper tier Local Authority code of usual residence
43. County code of usual residence of deceased
44. County district code of usual residence of deceased
45. Clinical commissioning group code of usual residence of deceased
46. Lower super output area of usual residence of deceased
47. Ward code of usual residence of deceased
48. Name of coroner
49. Coroner's area where inquest has been held
50. Date of inquest text
51. Nature of injury code where the underlying cause of death (ICD10U) is an external cause (secondary cause code)
52. Cause of death row positions 1 to 8

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Tower Hamlets Multi-Agency Suicide Prevention Strategy: Action Plan

Duration	2017-2018
Related strategies/action plans	Tower Hamlets Mental Health Strategy 2014-2019 Health and Wellbeing Strategy 2017-2020 Drug-Related Death Plan 2017-2018 Child Death Overview Panel
Responsibility for governance	Health and Wellbeing Board
Ownership	LBTH Public Health
Implementation date	September 2017
Review date	March 2018

PRIORITY 1: Prevention and Early Intervention					
No.	**Actions**	**Lead(s)**	**Timeframe**	**Progress review/RAG status**	**Completed?**
Work to improve specialist mental health services for specific groups in line with the Five Year Forward View for Mental Health					
1.1	Increase the percentage of children and young people with a diagnosable mental health condition who are diagnosed and treated from 25% to 35%	CCG – Martin Bould	2021		
1.2	Improve the perinatal mental health pathway and specialist perinatal mental health services	CCG	2021		
1.3	Engage with educational psychologists to improve support for children and young people	Educational Psychology			
Better signpost our existing preventative services					
1.4	Incorporate signposting of local services into ASIST suicide prevention training sessions	LBTH PH			

PRIORITY 2: Improving help for those in crisis					
No.	**Actions**	**Lead(s)**	**Timeframe**	**Progress review/RAG status**	**Completed?**
Scope and address the specific needs of people attending A&E who have attempted suicide, self-harmed, or who are in mental health crisis					
2.1	Development of the 'Hope Wall' at Royal London Hospital's A&E department to provide a more suitable space for those in mental health crisis.	Melanie King – ELFT RAID		April 2017 Funding secured	
2.2	Conduct an audit of patients presenting with self-harm in A&E	LBTH PH Melanie King – ELFT RAID	March 2018		
2.3	CAMHS crisis transformation project: review of service provision for CYP under CAMHS, RAID and Royal London Hospital	Martin Bould – CCG	May 2017 – January 2018		
Map the current crisis referral pathway and address gaps in service provision					
2.4	Mapping exercise of the current crisis referral pathway for statutory services.	Carrie Kilpatrick - CCG			
2.5	Mapping exercise of third sector services.				

PRIORITY 3: Identifying the needs of vulnerable people					
No.	**Actions**	**Lead(s)**	**Timeframe**	**Progress review/RAG status**	**Completed?**
Lessons learnt from safeguarding reviews will be collated and shared amongst service providers					
3.1	Conduct safeguarding reviews and collate lessons learnt for wider sharing	Lisa Mathews			
3.2	Respond to reports and recommendations from the Child Death Overview Panel	LBTH PH – Associate Director/ CDOP Chair	As per recommendation		
Improve practice in non-clinical statutory services and provide increased support for frontline staff					
3.3	Review discharge planning and continuity of care for homeless and temporarily housed people with a view to forming partnership working between HOST and ELFT.	HOST ELFT (MEH)			
3.4	HOST and Inspire Consortium to work in partnership to provide support to people in temporary housing at risk of suicide or deterioration in mental health.	HOST Inspire			
3.5	Create a guide advising frontline staff on best options for signposting or crisis intervention, for staff in housing, DWP, and probation offices.	LBTH PH - Hannah Emmett DWP – Stephen Hanshaw			
3.6	Review mechanisms for identifying service users at risk of suicide	DWP – Stephen Hanshaw			
3.7	Review of Pathway service for homeless inpatients in the Royal London Hospital to link substance misuse and trauma related needs to self-harm and suicide.	Hannah Emmett – LBTH PH	Aug 2017		
Improve support for specific vulnerable groups					
3.8	Develop broader range of prevention strategies acting at different levels within the school context	School Health Service CAMHS			

PRIORITY 3: Identifying the needs of vulnerable people					
No.	**Actions**	**Lead(s)**	**Timeframe**	**Progress review/RAG status**	**Completed?**
3.9	Apply for funding to implement a culturally responsive preventative programme for recent migrants and asylum seekers	Erminia Colucci - QMUL			
3.10	Improve postvention work including counselling in schools	School Health Service			
3.11	Respond to local and national intelligence on online content promoting self-harm and suicide	On case by case basis	Ad hoc		

PRIORITY 4: Addressing training needs					
No.	**Actions**	**Lead(s)**	**Timeframe**	**Progress review/RAG status**	**Completed?**
Provide the first phase of suicide prevention training to frontline staff					
4.1	Provision of evidence-based ASIST suicide prevention training to frontline staff in statutory services using CEPN funding	CEPN LBTH PH – Nicola Donnelly			
4.2	Provision of a half day workshop on suicide prevention based on the ASIST course for frontline staff using CEPN funding	CEPN LBTH PH – Nicola Donnelly			
Address general mental health training provision in order to ensure inclusion of suicide prevention					
4.3	Review mental health training provision in schools	LBTH PH			
4.4	Reformulation of staff training programme at Queen Mary University of London for staff on recognising and assisting students displaying symptoms of mental illness, distress, or suicidal ideation.	QMUL – Niall Morrissey			

PRIORITY 5: Communications and Awareness					
No.	**Actions**	**Lead(s)**	**Timeframe**	**Progress review/RAG status**	**Completed?**
Work to install signage at at-risk sites					
5.1	Collaborative work with City of London and Samaritans to place signs with contact details for Samaritans on high-risk sites	LBTH PH – Chris Lovitt			
5.2	Compile list of high-risk sites in the borough	LBTH Place DMT			
Use social media to foster publicly visible links between statutory and third sector services					
5.2	To use social media to maintain links between the council and third sector organisations	LBTH Communications – Anna Wilson			
Support national and regional suicide prevention campaigns					
5.3	Commitment to local support of Samaritans guidelines for responsible reporting of suicide	LBTH Communications			

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Health and Wellbeing Board Wednesday 26th July 2017	Tower Hamlets Health and Wellbeing Board
Report of: Joint Commissioning Executive	**Classification:** Unrestricted
Improved Better Care Fund 2017-19 – New Adult Social Care Monies	

Lead Officer	Denise Radley, Corporate Director, Health, Adults and Community
Contact for information	Steve Tennison, Senior Strategy, Policy and Performance Officer – Integration Lead, LB Tower Hamlets

1. RECOMMENDATIONS

1.1 To note the current position concerning the development of the Improved Better Care Fund programme for 2017-19.

1.2 To approve the approach being followed and the proposed programme summarised in Appendix 2.

1.3 To agree that oversight of the final programme should be delegated to the Joint Commissioning Executive.

1.4 To agree that, subject to agreement by the Joint Commissioning Executive, the proposed contingency provision should be allocated to further initiatives.

1.5 To agree that, subject to the finalisation of the proposals, schemes should be initiated with immediate effect.

2. BACKGROUND

2.1. In June 2013, the Government Spending Round set out plans for new funding arrangements, now referred to as the Better Care Fund (BCF). The aim of the BCF is to deliver better outcomes and secure greater efficiency in health and social care services through better integration of provision, and to accelerate health and social care integration across the country.

2.2. The majority of BCF resources is allocated to the CCG, the exception being the Disabled Facilities Grant, which is allocated to the Council by the Department for Communities and Local Government. Access to 'core' BCF resources is dependent on the production of a Better Care Fund Plan that is submitted to NHS England jointly by the CCG and the council.

2.3. Improved Better Care Fund (IBCF) is additional funding that is allocated direct to the Council. Its purpose is 'to provide support to local authorities in England towards expenditure lawfully incurred or to be incurred by them' in relation to 'meeting adult social care needs; reducing pressures on the NHS, including supporting more people

to be discharged from hospital when they are ready; and ensuring that the local social care provider market is supported.'

2.4. An initial tranche of IBCF was announced in the Government's 2015 Spending Review. This was allocated in the council's medium term financial plan 2017-20, which approved significant additional investment in adult social care to meet demographic growth, inflationary pressures, the costs of the ethical care charter and additional investment into safeguarding and Mental Capacity Act/Deprivation of Liberty Standards assessments. (It is worth noting that this tranche of money was top-sliced from existing resources - the New Homes Bonus - and Tower Hamlets was a net loser financially.) Subsequently, the government provided additional funding in the 2017 budget, as shown in the table below.

Tower Hamlets	**2017-18 Additional funding for adult social care (£m)**	**2018-19 Additional funding for adult social care (£m)**	**2019-20 Additional funding for adult social care (£m)**
2015 Spending Review	1.6	7.7	12.8
2017 Budget	7.0	4.2	2.1
Total	8.7	11.9	14.9

2.5 As can be seen from the table, the additional resources announced in the 2017 budget tail off rapidly, whilst those announced in the Spending Review of 2015 rise over the three year period. As the 2015 spending review allocations were taken into account in the council's Medium-Term Financial Strategy, the Health and Well-Being Board is only asked to consider the additional resources announced in the government's 2017 budget.

2.6 The IBCF is not subject to the same governance rules as the 'core' BCF. For example, there is no need to wait for NHSE approval before spending the grant. The new monies came about following extensive lobbying by the Local Government Association and the Association of Directors of Adult Social Services (as well as many other groups) regarding the crisis point which had been reached in adult social care, particularly the sustainability of both domiciliary and residential/nursing care markets. The government Determination, which governs the usage of the IBCF, states that:

> 'part of this funding is intended to enable local authorities to quickly provide stability and extra capacity in local care systems. Local authorities are therefore able to spend the grant, including to commission care …. as soon as plans for spending the grant have been locally agreed with the Clinical Commissioning Groups involved in agreeing the Better Care Fund plan.'

2.7 Thus, the sign-off process and timetable is different from the 'core' BCF and associated Section 75 agreement, even though the IBCF funding will be pooled within the Section 75. The much delayed main BCF guidance for the period 2017-19 was finally published in July 2017 and the borough is now producing a BCF Plan for submission to NHS England.

2.8 The current revised BCF section 75 agreement recognises that the Partners to that agreement wished to extend the use of Pooled Fund to include funding streams from outside of the Better Care Fund, and work is proceeding on that basis for 2017-18. The current draft agreement includes authority for the Joint Commissioning Executive to authorise a Lead Commissioner to enter into any contract for services necessary for the provision of services under an Individual Scheme, within the limitations of delegated authority for its members.

3. FUNDING PROPOSALS

3.1 Local authority managers, in conjunction with colleagues from the health service, have developed a number of possible IBCF initiatives. The suggestions received varied widely and cover all three of the specified purposes, namely:

- ensuring that the local social care provider market is supported
- reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready
- meeting adult social care needs

3.2 A condition of receipt of BCF is the implementation by local authorities and CCGs of each of the best practices set out in the High-Impact Change Model for reducing delayed transfers of care that has been developed by the Local Government Association, NHS England and NHS Improvement (see Appendix 1). These will need to be addressed in the BCF Plan.

3.3 It is intended to continue to refine the proposed schemes over the coming weeks in order to secure the best outcomes.

3.4 Appendix 2, below, summarises, at a high level, the initiatives currently under consideration for funding via the IBCF. Work is continuing on the development of many of the proposals, including the production of more precise costings. In almost all instances, expenditure in 2017-18 will only cover part of the year.

3.5 The HWBB is asked to approve the approach being followed and the proposed programme and financial allocations summarised in Appendix 2. In particular, it is asked to authorise those initiatives which exceed the delegated authority for council chief officers under the council's financial scheme of delegation. It also asked to agree that oversight of the final programme should be delegated to the Joint Commissioning Executive, in line with powers conferred under the revised BCF section 75 agreement, and that, subject to the finalisation of the proposals, schemes should be initiated with immediate effect.

3.6 The Board is also asked to note that the present proposals include a contingency provision for service developments linked to the roll out of a new operational model for Adult Social Care; a contingency for home care providers and provision for the implementation of transformation initiatives. The Board is further asked to agree that, subject to agreement by the Joint Commissioning Executive, the contingency provisions should be allocated to further initiatives.

4. FINANCE COMMENTS

4.1 As detailed in Appendix 2, planning is underway for the 2017-18 Improved Better Care Fund (IBCF). The Tower Hamlets IBCF allocations are set out in the Table below paragraph 2.4.

4.2 The original tranche of IBCF funding has been allocated in the council's Medium Term Financial Strategy. The second tranche is over three years and non-recurring. The 2017-18 original approved IBCF allocation of £1.6m has been allocated in the council's base budget.

4.3 The proposed schemes in Appendix 2 require further work to ensure that these do not create future budget pressures and/or can demonstrate that on-going costs can be funded through the efficiencies generated.

4.4 Work is underway on identifying additional schemes that meet the grant requirements. It is currently projected that all 2017-18 funding will be fully utilised in-year. In the event of slippage, further guidance is required to confirm if funding can be rolled forward into future years.

4.5 All expenditure will be monitored and reported in line with guidance, including the updating of the section 75 pooled budget agreement to reflect the additional IBCF funding.

4.6 All recommendations within this report will need to be delivered in the context of the Council's Medium Term Financial Strategy.

5. LEGAL COMMENTS

5.1 The proposals in this report are consistent with the Council's 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

5.2 Governance arrangements for Adult Social Care and Health integration initiatives under the BCF has been subject to specific contractual arrangements between relevant partners and the council pursuant to s75 of the National Health Service Act 2006 powers. Overall specific projects have developed on a case by case basis and, in the main, required Council officers and partner agencies to refer to their own individual governance structures and schemes of delegation for political approval. Member level agreement is sought from the Health and Wellbeing Board to endorse the direction of travel on a wide range of partnership working around the health and social care integration, given the strategic role the Board plays in the integration of health and social care services.

5.3 The revised s75 agreement will, once ratified, permit the Joint Committee Executive to 'review and agree all BCF and joint commissioning business cases' [cl.2.1.6 of sch 2] and authorise a Lead Commissioner to enter into any contract for services necessary for the provision of Services under an individual scheme within the limitations of delegated authority for its members [cl.5.1.2 of Sch 2].

5.4 The Board will therefore be required to recommend the adoption of the revised clauses to the s75 agreement to permit the IBCF monies to be included within the pooled fund and to the delegation of decisions to the Joint Executive Commission. The may also agree to delegate authority to the relevant Council chief officer, namely the Corporate Director, Health, Adults and Community, to ratify the amended s75 agreement in respect of those terms.

5.5 The Board will also be required to authorise funding for those schemes above the financial limits of delegated authority of the relevant Council chief officer, namely the Corporate Director, Health, Adults and Community. The Board has powers, set out in their terms of reference to authorise such schemes, as an executive decision-making body of the Council.

5.6 It is important that a distinction is made between health functions, social care functions and local authority health related functions because of the prohibition set out in s22 Care Act 2014 on the Local Authority providing health services. This does not prevent the Local Authority from entering into agreements under s75 National Health Service Act 2006 with Partners for the joint delivery of Local Authority health related functions or the pooling of funds to meet the cost of provision. Nor does it prevent the transfer of staff to ensure that the functions are effectively delivered, provided arrangements for staff comply with expectations set out in schedule 18 NHS Act 2006.

5.7 However, the Health and Wellbeing Board should ensure that, within any arrangements, the health and social care functions are clearly distinguished so as to ensure that accountability for those functions remains with the relevant body and a clear line of responsibility exists for the effective delivery of those functions, should legal challenges arise during the course of the scheme. In addition, this distinction will be important if future funding arrangements vary.

6. ONE TOWER HAMLETS CONSIDERATIONS

6.1 The Improved Better Care Fund is concerned with better integrating health and social care services to people with a diverse range of illnesses and conditions. These include people with mental health and drug and alcohol problems, and, in particular, elderly people at risk of being admitted to, or able to be discharged from, hospital, with appropriate support. It also funds services concerned with Reablement - supporting people to learn or relearn skills necessary for daily living following ill-health or disability, and the training of staff to support them to provide appropriate support to service users.

7. BEST VALUE (BV) IMPLICATIONS

7.1 The Improved Better Care Fund is concerned with achieving best value in the health and social care economy, by ensuring that services are provided most appropriately across the system. In a number of instances, proposed initiatives are intended to support efficiency improvements, as well as better outcomes for service users. The IBCF also funds social care activity that reduces pressures on the NHS, not least, via the provision of support to people that enables them to be discharged from hospital as soon as they are ready.

8. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

8.1 The Improved Better Care Fund has no direct implications for the environment.

9. RISK MANAGEMENT IMPLICATIONS

9.1 The IBCF programme will be monitored within the council. It will be incorporated into the BCF Section 75 agreement.

10. CRIME AND DISORDER REDUCTION IMPLICATIONS

10.1 The Improved Better Care Fund has no direct implications for crime and disorder reduction. However, a number of initiatives are designed to support vulnerable people who are disproportionately likely to come into contact with the police.

Appendices

- Appendix 1
- Appendix 2

Appendix 1

Main Themes of High-Impact Change Model for Reducing Delayed Transfers of Care

Change 1: Early Discharge Planning. In elective care, planning should begin before admission. In emergency/unscheduled care, robust systems need to be in place to develop plans for management and discharge, and to allow expected dates of discharge to be set within 48 hours.

Change 2: Systems to Monitor Patient Flow. Robust Patient flow models for health and social care, including electronic patient flow systems, enable teams to identify and manage problems (for example, if capacity is not available to meet demand), and to plan services around the individual.

Change 3: Multi-Disciplinary/Multi-Agency Discharge Teams, including the voluntary and community sector. Co-ordinated discharge planning based on joint assessment processes and protocols, and on shared and agreed responsibilities, promotes effective discharge and good outcomes for patients

Change 4: Home First/Discharge to Access. Providing short-term care and reablement in people's homes or using 'step-down' beds to bridge the gap between hospital and home means that people no longer need wait unnecessarily for assessments in hospital. In turn, this reduces delayed discharges and improves patient flow.

Change 5: Seven-Day Service. Successful, joint 24/7 working improves the flow of people through the system and across the interface between health and social care, and means that services are more responsive to people's needs.

Change 6: Trusted Assessors. Using trusted assessors to carry out a holistic assessment of need avoids duplication and speeds up response times so that people can be discharged in a safe and timely way.

Change 7: Focus on Choice. Early engagement with patients, families and carers is vital. A robust protocol, underpinned by a fair and transparent escalation process, is essential so that people can consider their options, the voluntary sector can be a real help to patients in considering their choices and reaching decisions about their future care.

Change 8: Enhancing Health in Care Homes. Offering people joined-up, co-ordinated health and care services, for example by aligning community nurse teams and GP practices with care homes, can help reduce unnecessary admissions to hospital as well as improve hospital discharge.

Appendix 2

Initiative	Indicative Full Year Budget (£)	High Impact Change Model	IBCF Criteria
Social Care Market Sustainability			
Increasing nursing home provision in the borough, as part of a broader approach to ensure the sustainability of the local social care market – secure an additional 10 places immediately	500,000	Focus on Choice Enhancing Health in Care Homes	Market Sustainability
Raising standards in local social care providers (domiciliary care) and the provision of specialist occupational therapy input to Tower Hamlets Day Services, including training in Reablement and occupational therapy interventions.	171,000	Home First/Discharge to Access	Market Sustainability
	671,000		
Reducing pressures on the NHS			
Mental health resilience for people at risk of self-neglect, self-harm/ suicide and anti-social behaviour	100,000	Multi-Disciplinary/Multi-Agency Discharge Teams	Reducing pressures on the NHS
Enhancing assistive technology provision to facilitate rapid discharge from hospital, and supporting people to remain at home, via a mobile service, operating seven days a week.	81,000	Early Discharge Planning Seven-Day Service	Reducing pressures on the NHS
The enhancement of the Hospital Social Work Team, by increasing social worker and occupational therapist capacity; improving links with Reablement provision.	378,000	Early Discharge Planning Multi-Disciplinary/Multi-Agency Discharge Teams	Reducing pressures on the NHS
Increasing the borough's Extra Care Sheltered Housing capacity	60,100	Early Discharge Planning Focus on Choice Enhancing Health in Care Homes	Reducing pressures on the NHS
Implementation and Development Manager	82,000	Early Discharge Planning. Systems to Monitor Patient Flow. Multi-Disciplinary/Multi-Agency Discharge Teams Home First/Discharge to Access	Reducing pressures on the NHS
The development of improved provision for people with an acquired brain injury	200,000	Multi-Disciplinary/Multi-Agency Discharge Teams	Reducing pressures on the NHS
The development of training for frontline staff across	75,000	Focus on Choice	Reducing pressures on the NHS

Primary Care, Social Services and Community Health Services on dealing with medically unexplained symptoms			
Additional support to vulnerable clients at risk of falls, including people who hoard to the detriment of their personal safety and wellbeing	300,000	Focus on Choice	Reducing pressures on the NHS
Extend the Dementia pathway into the post diagnostic period via a quick response service to manage the consequences of a dementia diagnosis from the Memory Clinic	111,800	Multi-Disciplinary/Multi-Agency Discharge Teams Focus on Choice	Reducing pressures on the NHS
	1,387,900		
Meeting adult social care needs			
A health and social care partnership project to prevent suicide in vulnerable young adults transitioning from children's services or vulnerable adults moving to new accommodation or across boroughs.	229,000	Multi-Disciplinary/Multi-Agency Discharge Teams	Meeting adult social care needs
The empowerment of people with mental health problems, older people, care leavers, young disabled adults, parents with learning disabilities, people who misuse substances and offenders.	39,900	Focus on Choice	Meeting adult social care needs
Tackling Mental Health and Antisocial Behaviour (Community Anti Social Behaviour Multi-Agency Risk Assessment Case Conference and ASB Specialist Mental Health Worker)	120,000	Multi-Disciplinary/Multi-Agency Discharge Teams	Meeting adult social care needs
Additional social work support to strengthen social work assessment as part of the continuing healthcare process, with a view to developing a new model in the medium term.	164,500	Early Discharge Planning Multi-Disciplinary/Multi-Agency Discharge Teams	Meeting adult social care needs
Reducing isolation among vulnerable older people through improved transport services and better access to information and well-being activities.	131,000	Focus on Choice	Meeting adult social care needs
Additional social workers in primary care/GP surgeries to enable support to be provided to more people on the integrated care pathway	269,500	Early Discharge Planning Multi-Disciplinary/Multi-Agency Discharge Teams	Meeting adult social care needs
The co-location, on a test and learn basis, of a social care information and advice officer within the Single	205,000	Seven-Day Service	Meeting adult social care needs

Point of Access Service being developed by Tower Hamlets Together.			
Improving the Reablement service, including reducing the waiting list	149,000	Early Discharge Planning Home First/Discharge to Access	Meeting adult social care needs
A crisis intervention safeguarding project, working in custody suites and in response to police referrals to identify adults at risk of self-neglect, self-harming behaviours or involvement in the criminal justice system due to substance misuse, to support them to access a range of health and voluntary sector resources to reduce the harm posed by their substance misuse problems.	133,000	Focus on Choice	Meeting adult social care needs
Developing Capacity in Adult Learning Disability by establishing a development team to provide training and advice to staff; support the development of a family and carer peer support network and work with local community services, activities and groups to develop awareness, capacity, outreach and the inclusion of adults with learning disability.	171,200	Focus on Choice	Meeting adult social care needs
Commission additional support to address assessment and review backlogs in adult social care	500,000	-	Meeting adult social care needs
Additional social work resources to support the Reablement service and thereby resolve safeguarding and chronic social issues, and support planning interventions following a period of Reablement	94,000		Meeting adult social care needs
Volunteer co-ordinator and front line response person for all appropriate adult requests from the police, with the service operating on a 24x7 basis.	35,000		Meeting adult social care needs
	2,241,100		
Other			
Transformation initiatives.	550,000	Focus on Choice	Meeting adult social care needs
Contingency linked to the rollout of the new adult social care operational model	TBD	Focus on Choice	Meeting adult social care needs
Contingency for home care providers	TBD	Focus on Choice	Meeting adult social care needs
Initiative relating to homeless people leaving hospital	TBD	Early Discharge Planning	Reducing pressures on the NHS
	550,000		

TOTAL	**4,850,000**		

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Health and Wellbeing Board Wednesday 26th July 2017	Tower Hamlets Health and Wellbeing Board
Report of the London Borough of Tower Hamlets	**Classification:** Unrestricted
Briefing on re-commissioning of the School Health service and Child and Family Weight Management service	

Lead Officer	**Abigail Knight, Associate Director of Public Health, Children and Families**
Contact Officers	As above
Executive Key Decision?	No

Summary

The School Health service and the Children and Family Weight Management service are funded from the local authority public health grant and are both moving into the final year of three year contracts and so will need to be re-commissioned. The contract for the School Health service ends on 30th April 2018 and the contract for the Child and Family Weight Management service ends on 31st January 2018.

A business case was agreed at Adults DLT and Cabinet, November – December 2016, that proposed that in the region of £265,000 savings should be made from these two contracts and that, by developing a specification for a new integrated service, efficiencies could be made to mitigate some of the impact of making this level of savings. This would build on partnership working that has already been developed across these two services.

It is proposed that funding for the core School Health service should not be reduced as this is an essential Universal service that carries high levels of risk and is experiencing increasing demand as the number of schools increase.

It is therefore proposed that these savings should be found by changing the approach to child and family weight management where, despite good performance from the current provider in terms of partnership development and service delivery, outcomes in term of maintenance or reduction of body mass index (BMI) remains poor. This would appear to reflect the intrinsic difficulty in achieving weight loss once a child has become overweight and reinforces the need for a preventive and system-wide approach, strengthening the capability of frontline staff across services (including health, schools, local authority and community organisations) to provide consistent messages and support on child nutrition, physical activity and healthy weight.

This approach is consistent with our strategy of taking a 'whole systems' approach to tacking childhood obesity. The school health service would then become a

coordinating function to upskill staff across the system and provide a point of contact for children and parents.

Recommendations:

The Health & Wellbeing Board is recommended to:

1. Review the briefing and comment on the proposed new model.

1. REASONS FOR THE DECISIONS

1.1 There is no specific decision for the Board. The purpose of the paper is to consult on the proposed new model for school health and child weight management services.

2. ALTERNATIVE OPTIONS

2.1 The alternative option would be to not bring this to the Board. Given the importance of the school health and child weight management services, this would miss a significant opportunity to consult with key stakeholders on a new service model.

3. DETAILS OF REPORT

3.1 The current annual contract values are School Health service £1,580,919 and Child and Family Weight Management service £386,615. It is proposed that the contract value for the new integrated School Health and Wellbeing service should be approximately £1,640,000.

3.2 The current Child and Family Weight Management service also includes a service for post natal mothers and children aged under-5 years. It is proposed that a new specification for this aspect of the service should be developed, with an approximate annual value of £60,000, and added to the Health Visiting service as a contract variation in 2018/19. This will then be included in a new integrated specification that will include the Health Visiting service and Family Nurse Partnership that will be developed during 2018/19.

3.3 There is a three month gap between the end of the Child and Family Weight Management service contract and the end of the School Health service contract. A decision will have to made on whether to have a short break in service for child and weight management or to extend the contract. If the decision is made for a short contract extension, this could be for the aspects of the service that will be incorporated into the new specifications, rather than for the whole service.

3.4 Proposed additions to the School Health and Wellbeing contract include:

- Reviewing the current School Health service to ensure good practice is incorporated in the new service;
- Child weight management coordination and nutrition input;
- Training delivered to school nurses on healthy weight and nutrition;
- Building on the existing “care pathway” from the national child measurement programme that weighs children ages 5 and 10-11 with a greater focus on family involvement;
- Working closely with Head Teachers and staff and improving communication about children`s health to parents and within school;
- Closer working with the Council`s Healthy Lives (Schools) team on the adoption of an approach to healthy weight in children that engages all a school`s departments and staff.

3.5 Proposed additions to the Health Visiting contract include:
- Additional resource for coordination, and nutritional advice;
- Training for staff on nutritional and weight management support.

3.6 A number of other London Boroughs have taken or are considering a similar approach, i.e. integrating school health and child weight management, and it will be important to learn from their experience. There is a London Children and Young People Public Health network that provides a useful forum for sharing this type of learning. We are also contacting a number of Boroughs directly to request examples of new integrated service specifications and any available evaluation or data on service outcomes.

3.7 There will be a public consultation on the new service model to specifically include children, parents, postnatal women, head teachers and children and families partnership services. Recommendations from the previous engagement process (The Healthy Child Review) are still be relevant and will be revisited as part of this re-procurement.

4. COMMENTS OF THE CHIEF FINANCE OFFICER

4.1 The integration of the Schools Health contract with the Child and Family Weights Management service contract as part of the re-commissioning of both contracts in 2018 will help build on partnership working that has already been developed across these two services whilst also allowing for the realisation of a financial savings of £265,000.

4.2 Due to the end dates of the Schools Health contract and the Child and Family Weights Management service contract not being conterminous, a decision needs to be made early to give notice to the Child and Family Weights Management service provider on whether the contract will be extended for a short period or if there will be a short break in service till the proposed integrated contract is procured.

4.3 Although there may be a service delivery risk by integrating both services into one contract, learning from other boroughs that have adopted similar models may help mitigate such risks by ensuring the service specification is robust.

4.4 There is also a risk that the proposed contract value (£1,640,000) for the integrated contract will not be sufficient to attract the right number of providers to tender for it considering the number of proposed additions to the contract terms. This is a risk that will be managed during the procurement process and should there be a significant difference between the proposed contract price and the current budget, this will need to be reviewed as part of the budget management process.

5. LEGAL COMMENTS

5.1 The Council has an obligation as a best value authority under section 3 of the Local Government Act 1999 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". This obligation extends to the purchase of all goods works and services. The Council meets this obligation by subjecting the purchase to the appropriate level of competition.

5.2 Local authorities became legally responsible for the commissioning and delivery of certain public health functions in accordance with the Health and Social Care Act 2012. This implemented a change to the National Health Service Act 2006 and in particular the insertion of section 2B which provides both the power and the obligation on the Council to "take such steps as it considers appropriate for improving the health of the people in its area". Also entering into a contract for the provision of these services is either in pursuit of that function or is to "facilitate, or is conducive or incidental to, the discharge of" that function in accordance with section 111 of the Local Government Act 1972.

5.3 The Council is obliged by the Public Contracts Regulations 2015 to submit certain procurements to advertising and methods of procurement in accordance with these regulations. However, these services are of a type which falls into Schedule 3 of the regulations which means that whilst the regulations still apply the formalities of the procurements are less stringent.

5.4 In respect of Schedule 3 services the regulations apply to a procurement that has a value greater than £589,148. Therefore, the regulations apply to this procurement and so the opportunity must be advertised at a European level

5.5 However, in these circumstances Schedule 3 services' procurements are only subject to a "light touch regime". It is still poorly defined in the law as to what counts as a "light touch regime", but broadly speaking this means a procurement process whose parameters in all respects (time for response, evaluation criteria, evaluation methodology as examples) were simply those that were fair open and transparent.

5.6 In order to satisfy the Best Value duty in accordance with Section 3 Local Government Act 1999 as detailed above, the Council must ensure that it awards the contract on the Most Economically Advantageous Tender basis. This means awarding to the provider that has attained the best score on a blend of quality and price and in accordance with the advertised evaluation criteria. Also, the Council should ensure that appropriate clauses are present in the contract and appropriate resources have been allocated to provide for the monitoring of the contract to ensure that the outcomes detailed in the specification are achieved.

5.7 Consideration must be given to a short term one off contract for a period of three months that would be required in order to ensure both contracts co-terminate prior to the commencement of this integrated service. An unprocured short term contract would be a technical breach of the Council's Procurement Law duties. However, it is notable that the intention behind the short term contract is to allow for a practical approach to the subsequent

procurement rather than to specifically avoid competition. Also, bearing in mind that the new Procurement itself is underway, in the event that any challenge is mounted based upon the loss of business opportunity such a challenge would only be transitory in nature and represent little financial risk to the Council.

5.8 When carrying out the procurement exercise, the Council must have due regard to the need to eliminate unlawful conduct under the Equality Act 2010, the need to advance equality of opportunity and the need to foster good relations between persons who share a protected characteristic and those who don't (the public sector equality duty).

5.9 The nature of the public sector equality duty is that the Council must carry out all reasonable activities to ensure that it has a proper understanding of how the effects of any changes in contracting affect any person who have a protected characteristic and to have regard for such effects when making the decisions.

5.10 Such activities may include desktop assessments and consultation with affected persons, and their families in order for the Council to gain the proper understanding required to absolve this duty.

6. ONE TOWER HAMLETS CONSIDERATIONS

6.1.1 While there are differences in the prevalence of overweight and obesity between ethnic groups, by gender and by socio-economic group, with the highest prevalence in Tower Hamlets seen in Bangladeshi boys, Black boys and girls and children from low income families, this is an issue that affects all population groups and so needs to be addressed through universal services. It will also be important to monitor the impact of these proposed service changes on inequalities and to consider how to target training and support to services and organisations that have closest links with high risk groups.

7. BEST VALUE (BV) IMPLICATIONS

7.1.1 These proposed savings are required to meet the savings targets in the Medium Term Financial Strategy (MTFS).

8. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

8.1 There are no direct implications

9. RISK MANAGEMENT IMPLICATIONS

9.1 This proposal will result in a loss of services as there will no longer be the capacity to run child weight management groups. There is a risk that this could reduce our ability to halt or slow down the increase in child overweight and obesity.

This will be mitigated by expertise on child nutrition, physical activity and healthy weight being integrated into a wider range of frontline services supported by specialist posts that will focus on system leadership and training.

10. CRIME AND DISORDER REDUCTION IMPLICATIONS

10.1 No specific actions

Linked Reports, Appendices and Background Documents

Linked Report
NONE

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