TOWER HAMLETS HEALTH AND WELLBEING BOARD

Thursday, 6 February 2014 at 5.15 p.m. Committee Room 1, 1st Floor, Mulberry Place,Town Hall, 5 Clove Crescent, London, E14 2BG

This meeting is open to the public to attend.

Members		**Representing**
Mayor Lutfur Rahman	–	(Mayor)
Councillor Abdul Asad	–	(Cabinet Member for Health and Wellbeing)
Councillor Alibor Choudhury	–	(Cabinet Member for Resources)
Councillor Oliur Rahman	–	(Cabinet Member for Children's Services)
Councillor Gulam Robbani	–	(Executive Advisor to the Cabinet and Mayor on Adult Social Care)
Councillor Denise Jones		
Robert McCulloch-Graham	–	(Corporate Director, Education Social Care and Wellbeing)
Dr Somen Banerjee	–	(Interim Director of Public Health, LBTH)
Dr Amjad Rahi	–	(Healthwatch Tower Hamlets Representative)
Dr Sam Everington	–	(Chair, Tower Hamlets Clinical Commissioning Group)
Jane Milligan	–	(Chief Officer, Tower Hamlets Clinical Commissioning Group)
Co-opted Members	–	
Alastair Camp	–	(Non-Executive Director, Barts Health and Chair of the Integrated Care Board)
Sharon Hanooman	–	(Vice-Chair, Tower Hamlets Community Voluntary Sector)
Sue Lewis	–	(Chief Operating Officer, Barts Health NHS Trust)
Steve Stride	–	(Representative of Housing Forum)
John Wilkins	–	(Deputy Chief Executive, East London and the Foundation Trust)
Mahdi Alam	–	(Young Mayor)

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**.**

Public Questions

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

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

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Role of the Tower Hamlets Health and Wellbeing Board.

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

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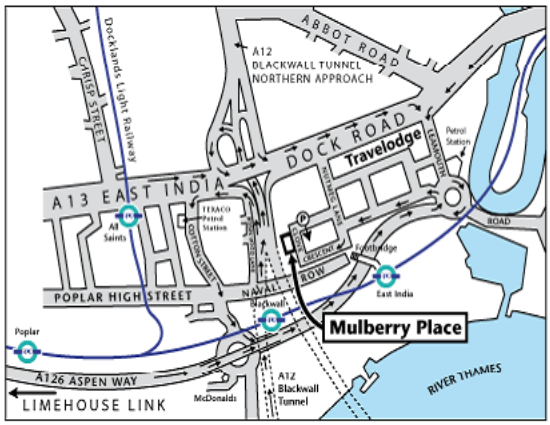

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WELCOME, INTRODUCTIONS AND APOLOGIES FOR ABSENCE

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

1 .1 Declarations of Disclosable Pecuniary Interests **1 - 4**

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

1 .2 Forward Programme **5 - 8**

Recommendation: To consider and comment on the Forward Programme.

Lead for item: Deborah Cohen, Service Head, Commissioning and Strategy, Education, Social Care and Wellbeing, LBTH.

2. ITEMS FOR CONSIDERATION

2 .1 Tower Hamlets Health and Wellbeing Board, Terms of Reference, Quorum, Membership and Dates of Meetings. **9 - 12**

Recommendation: To note the Tower Hamlets Health and Wellbeing Board (HWBB) Terms of Reference, Quorum, Membership as attached to this report and future meeting dates.

2 .2 Healthwatch Update **13 - 24**

Recommendation: To note the contents of this report.

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

3. HEALTH AND WELLBEING STRATEGY

3 .1 Tower Hamlets Mental Health Strategy **25 - 140**

Recommendation: The Health and Wellbeing Board is recommended to approve the Tower Hamlets Mental Health Strategy.

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

3 .2 Tower Hamlets Health and Wellbeing Strategy 2013-16 **141 - 268**

Recommendations: To agree the strategy, delivery plans, proposed outcome measures and targets.

To agree the delivery and performance monitoring arrangements set out in section 3 of the report.

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

3 .3 Joint Strategic Needs Assessment (JSNA) - Key Findings **269 - 300**

Recommendation: To note and comment on the findings and raise any areas that could be considered for future work of the JSNA reference group

Lead for Item: Somen Banerjee, Interim Director Public Health LBTH

3 .4 Clinical Commissioning Group (CCG) Operational Plan - To Follow

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

4. REGULATORY OVERSIGHT

4 .1 Better Care Fund **301 - 342**

Recommendation: To agree the DRAFT Better Care Fund Planning Template be submitted to the LGA and NHS England

Lead for Item: Deborah Cohen, Service Head for Commissioning and Health, Education, Social Care and Wellbeing, LBTH.

4 .2 Adults Health and Wellbeing Board -Section 256 Funding 2013-14 **343 - 366**

Recommendations: To note the requirements of the transfer from NHS England to LBTH.

To approve spending plans for the 2013/14 allocation as agreed between Tower Hamlets CCG and London Borough of Tower Hamlets, as detailed in Appendix 1 of the report.

Lead for Item: Deborah Cohen, Service Head for Commissioning and Health, Education, Social Care and Wellbeing, LBTH.

4 .3 Disabled Children's Charter **367 - 402**

Recommendations: To consider the position statement in relation to each of the commitments in the Charter and agree to the Tower Hamlets Partnership signing up to the Charter;

To note the Joint Strategic Needs Assessment attached as an appendix to the report.

Lead for Item: Robert McCulloch-Graham, Corporate Director, Education Social Care and Wellbeing, LBTH

4 .4 Winterbourne Actions - Update report to HWBB **403 - 412**

Recommendation: To note the Tower Hamlets compliance with the Winterbourne actions and to receive annual updates on future review activity related to people in assessment and treatment centres and the longer term development of local housing and care support.

Lead for Item: Deborah Cohen, Service Head for Commissioning and Health, Education, Social Care and Wellbeing, LBTH.

4 .5 2013 Adult Autism Self-Assessment Framework (SAF) **413 - 440**

Recommendations: To note the content of the report and the final Autism Self-Evaluation document (provided as Appendix One).

To include the questions contained within Appendix Two into quarterly HWB performance reports.

Lead for Item: Deborah Cohen, Service Head for Commissioning and Health, Education, Social Care and Wellbeing, LBTH.

5. ANY OTHER BUSINESS

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

Date of Next Meeting:
The date of the next meeting is Monday, 24 March 2014 at 5pm to be held in Committee Room MP701, 7th floor, Town Hall, Mulberry Place, 5 Clove Crescent, London, E14 2B

DECLARATIONS OF INTERESTS - NOTE FROM THE MONITORING OFFICER

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

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

Interests and Disclosable Pecuniary Interests (DPIs)

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

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

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

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

Effect of a Disclosable Pecuniary Interest on participation at meetings

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

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

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

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

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

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

Further advice

For further advice please contact:-

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

APPENDIX A: Definition of a Disclosable Pecuniary Interest

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

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

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Health and Wellbeing Board Forward Plan

Date: February 2014- Extraordinary Meeting , 6 February 2014, Committee Room 1, 5.15pm				
	Report Title	**Lead Officer**	**Reason for submission**	**Time**
Public Questions	Public Questions	Chair		15 mins
Standing Items	Chair's Opening Remarks - Public Board Apologies & Substitutions Minutes & Matters Arising Forward Plan			15 minutes
Public Board	Terms of Reference	Deborah Cohen/ Zoe Folley		5 mins
Updates	Healthwatch Update	Di Barham		5 mins
Health and Wellbeing Strategy	Mental Health Strategy	Richard Fradgley		10 mins
	HWB Strategy Formal Ratification	Louise Russell		10 minss
	JSNA Key Findings	Somen Banerjee		10 mins
	CCG Operational Plan	Jane Milligan		10 mins
Regulatory Oversight	Better Care Fund	Deborah Cohen	First draft must be submitted by February 14th	10 mins
	Section 256 Report	Deborah Cohen		10 mins
	Disabled Children's Charter - Sign Up	Robert McCulloch Graham		5 mins
	Winterbourne	Deborah Cohen		5 mins
	Autism Stocktake	Deborah Cohen		5 mins

Date: 23 March 2014				
	Report Title	**Lead Officer**	**Reason for submission**	**Time**
Standing Items	Apologies & Substitutions Minutes & Matters Arising Forward Plan			
Public Questions	Public Questions			
Health and Wellbeing Strategy	CQC Feedback on Barts Health inspection	Michele Golden		
	Assistive Technology Strategy	Rob Driver		
	Maternity Services	Judith Littlejohns and Catherine Platt	May take this in June	
	Commissioning of Primary Care services	Vanessa Lodge/NHS England	postponed from December	
	Dental Services	Desmond Wright		
Regulatory Oversight	Better Care Fund	Deborah Cohen	Final draft must be submitted by end of March	
	SEN Reforms	Anne Canning /David Carroll		

Health and Wellbeing Board Workshop Forward Plan

Date: New Year 2014, 15:00 - 17:00, Room TBC				
	Report Title	**Lead Officer**	**Reason for submission**	**Time**
4th February 2014	Health and Housing	Louise Russell		1hr 30mins
Date: tbc in Spring 2014, 15:00 - 17:00, Room TBC				
	Report Title	**Lead Officer**	**Reason for submission**	**Time**
	Better Care Fund Workshop	Deborah Cohen		
	Assistive Technology	Robert Driver		

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Committee Tower Hamlets Health and Wellbeing Board	Date 6th February 2014	Classification Unrestricted	Report No.	Agenda Item No.
Report of: Service Head, Democratic Services **Originating Officer(s) :** Democratic Services		**Title :** Tower Hamlets Health and Wellbeing Board Terms of Reference, Quorum, Membership and Dates of Meetings. **Ward(s) affected:** N/A		

1. Recommendation

1.1 To note the Tower Hamlets Health and Wellbeing Board (HWBB) Terms of Reference, Quorum, Membership as attached to this report and future meeting dates.

2. Background

2.1 At its meeting on 4th December 2013, the Cabinet approved the, establishment of the Tower Hamlets Health and Wellbeing Board with the terms of reference set out in the attached report. Following which, Council on 22 January 2014, formally approved the membership of the Board.

2.2 The Board is therefore asked to note their Terms of Reference, Quorum and Membership for the forthcoming Council Year.

2.3 The next scheduled meeting of the HWBB will be held on Monday 24th March 2014 at 5:00pm. The meeting dates thereafter for the next Council year is to be provisionally considered by Full Council on 26th March 2014.

3. Comments of the Chief Financial Officer

3.1 There are no specific comments arising from the recommendations in the report.

4. Legal Comments.

4.1 The information provided for the Board is in line with resolutions made by the Cabinet on 4th December 2013 and Council on 22nd January 2014.

5. One Tower Hamlets Considerations

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

6. Sustainable Action for a Greener Environment (SAGE)

6.1 There are no specific SAGE implications arising from the recommendations in the report.

7. Risk Management Implications

7.1 The Council needs to have a programme of meetings in place to ensure effective and efficient decision making arrangements.

8. Crime and Disorder Reduction Implications

8.1 There are no Crime and Disorder Reduction implications arising from the recommendations in the report.

9. Efficiency Statement

9.1 There are no implications arising from the recommendations in the report.

LOCAL GOVERNMENT ACT, 1972 SECTION 100D (AS AMENDED)
LIST OF "BACKGROUND PAPERS" USED IN THE PREPARATION OF THIS REPORT

None.

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
- Mayor of London Borough of Tower Hamlets (LBTH)

Elected Representatives of LBTH
- Cabinet Members for Health & Wellbeing and Children's Services (2)
- Cabinet Member for Resources
- Executive Advisor on Adult Social Care
- Non-executive majority group councillor nominated by Council

Local Authority Officers- LBTH
- Corporate Director - Education, Social Care and Wellbeing (Director of Adult Social Services and Children Services) - LBTH
- Director of Public Health - Tower Hamlets

Local HealthWatch
- Chair of local Healthwatch

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

Co-opted Members (Non-Voting)

- Health Providers
- Chief Operating Officer - Barts Health
- Chair of Tower Hamlets - Council for Voluntary Services
- Deputy Chief Executive - East London and the Foundation Trust

- Representative from the Housing Forum.
- Chair of the Integrated Care Board
- The Young Mayor

Stakeholders that may attend the Board from time to time but are not members:
- Representative of NHS England
- Chairs of Tower Hamlets Safeguarding Boards (Adults and Childrens).
- Chair of the LBTH Health Scrutiny Panel
- Local Liaison Officer for National Commissioning Group.

Health and Wellbeing Board 6th February 2014	Tower Hamlets Health and Wellbeing Board
Report of: Healthwatch	**Classification:** Unrestricted
Healthwatch summary of patient feedback on Barts Health	

Contact for information	Dianne Barham – Director of Tower Hamlets Healthwatch

Executive Summary

A summary of patient feedback on Barts Health Trust between September 2012 – October 2013

Recommendations:

The Health and Wellbeing Board is recommended to:

1. To note the contents of this report

1. DETAILS OF REPORT

1.1. A summary of patient feedback on Barts Health Trust between September 2012 – October 2013

2. FINANCE COMMENTS

2.1. N/A

3. LEGALCOMMENTS

3.1. N/A

6. IMPLICATIONS TO CONSIDER

6.1. N/A

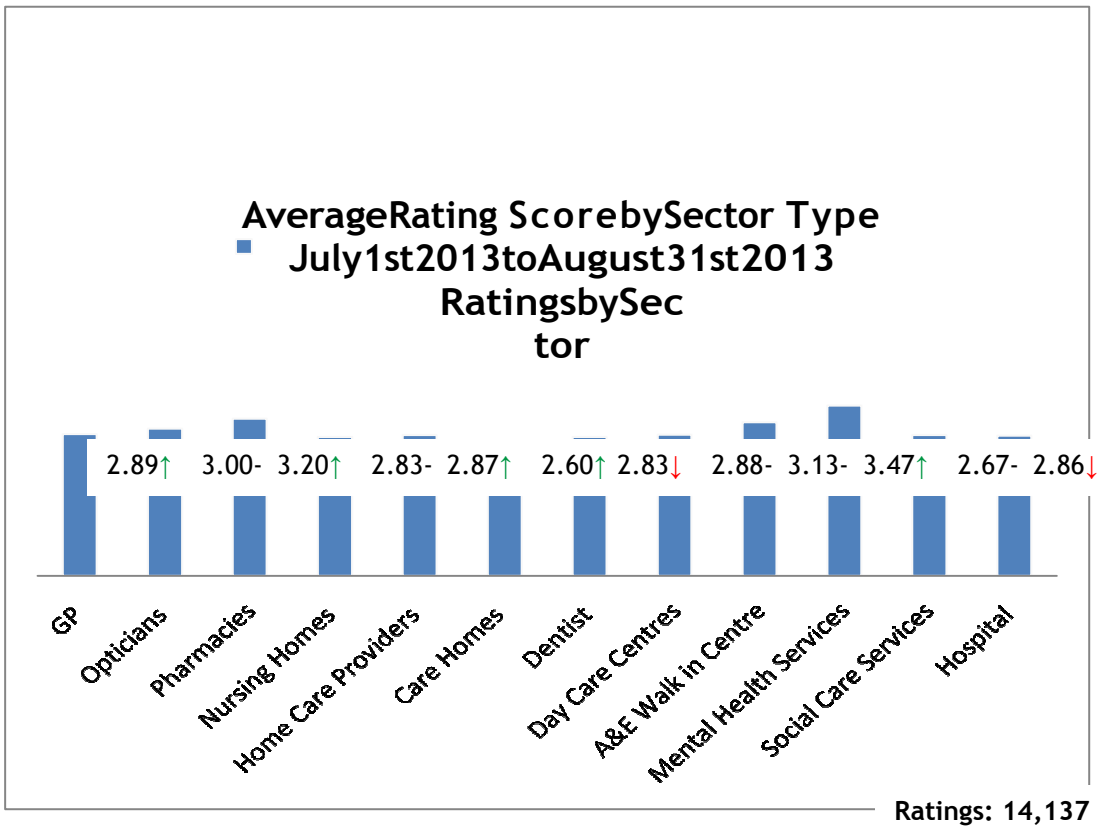
Appendices

Appendices

- NONE

Dashboard

Rate OurService-July2013toSeptember2013



Healthwatch summary of patient feedback on Barts Health
Sept 2012-October 2013

1. Background

1.1 This report is based on the analyses of patient feedback from:

- four Enter and View visits undertaken by Healthwatch members over October and September 2013 to:
  1. **Ambrose King** Centre (Sexual Health) Royal London Hospital
  2. **Renal Unit** Royal London Hospital: Outpatients, Haemodialysis Unit and Inpatient – Renal Transplant Ward (9F)
  3. **Fracture Clinic** (Outpatients) Royal London Hospital
  4. **Rahere Ward** (Cancer) St Barts Hospital
- 900 comments collected between September 2012 and October 2013 from local patients at community events, online on the Healthwatch website and Rate Our Service, workshops and phone feedback and interviews.

2. What is good?

2.1 Generally patient comments present a very positive view of the clinical care provided at the Royal London Hospital.

"I think doctors do their jobs well I always understand what they say and I feel as if they really care for me in a special way. They are friendly and loyal, and I feel I get excellent service therefore I'm very happy with the doctors."

"I have to mention how very impressed I was with the professionalism and knowledge of the doctors and nurses at the new Royal London hospital. .. Overall it was a top service I received from them and I was very pleased."

2.2 Things that were mentioned when describing a good service were:

- seeing the same consultant
- seeing the senior consultant that you asked for at least once
- having the right test results when you see the consultant
- having enough information and time to ask questions
- being seen on time, given further advice and being kept updated
- people being friendly, smiling, taking the time to say hello or welcome you
- getting an appointment straight away
- giving advice in a non judgmental

"I have a regular consultant that I see. He is brilliant. He talks and he listens and he's helped get my condition stable."

2.3 Particular areas and actions that received a number of positive comments were:

- Children's services both A&E and general.
- A&E service - but not the waiting times. People feel that they are given a more thorough examination at the hospital by more specialist doctors.
- The stroke team and cardiology teams although patients also mentioned problems on discharge and appointments.
- Text reminders about appointments and being able to book appointments online.
- Hospital cleanliness and the quality of rooms

"My neighbour had gynaecological surgery at the Royal London six or seven weeks ago and was at her third Pilate's class! Nurses were pushed but were very good. They put her in a single room across from the nurses' station as she was probably the oldest patient on the ward. She felt the care was very good and liked having a single room."

3. Top 10 concerns

3.1 The most common concerns raised by Tower Hamlets patients were:

1. Administration and referral processes
2. Shortage of nursing staff
3. Maternity – aftercare and discharge
4. Waiting times in A&E
5. Food
6. Environment
7. Slow and poor discharge processes
8. Hospital Transport

9. Incontinence service
10. Complaints processes

4. Administration and referral processes

4.1 The problem raised by the largest number of patients was not the quality of clinical care but the administrative systems around appointments. This included poor referral processes from the GP, long waiting lists/times to get an appointment, poor administrative processes (letters late, wrong appointment times, wrong phone numbers, wrong patient, wrong location) and appointments frequently being postponed.

"You receive a letter that tells you to phone a number within five days to make an appointment. You can't get through on the phone or you get through and they say you're in queue. Then it's "you are number five in the queue, you are number four in the queue . . ." Somebody finally answers and asks you what department you want and then says that this is the wrong department. My GP phoned the consultants clinic and they said that the clinic was full for weeks. He phoned again an hour later and was told the list was open again. . . .. My doctor referred me to the foot clinic they saw me once and told me they will call me for another appointment however it has been over three months and I haven't heard since. But I did find the foot clinic to have a very good service. Doctor was very helpful and he knew what he was talking about and I was satisfied with care."

4.2 From a patient's perspective the current systems couldn't be further away from being patient centred. People feel that they are not being given fair access to appointments and that the system is the problem. Many feel that it is incumbent on them to try and navigate through a complicated system, often needing to complain to get results. This can have a very detrimental impact on their health and their recovery.

"I've not been here for a while as I have spent the last two years trying to get an appointment for someone to resolve my lower back problems - the only reason why I was seen today was because I went through the Complaints' Department. I had my surgery in August 2011 and was seen six weeks later by the Physiotherapy Department (Royal London Hospital) and was told that I will receive an appointment at the Pain Clinic at Mile End Hospital. I waited for a couple of weeks, but never received an appointment. I tried to chase-up my appointment, just to be told that I missed it (this bearing in minded I never received the appointment letter in the first place). So far it's been a bit of a nightmare to get an appointment..."

4.3 This frustration is compounded further by having to wait long periods when you actually do make it to the relevant clinic for your appointment.

"Few months ago I went for my outpatient appointment in cardiology department at RLH for 3 o'clock appointment but was seen at 5pm. No one came out to say why the appointment was running late. Due to my lack of confidence I did not show my frustration."

4.4 Then often the consultant doesn't have the right test results when you are finally seen or they explain it's an exploratory appointment and you'll have to come back and see another person and the whole appointments process nightmare starts over again. People are waiting years for something that could be sorted in a couple of months if the administration systems worked effectively. This often compounds illness and injury and leads to more expensive treatment further down the line. It is surely also a massive waste of resources as tests are often repeated unnecessarily as appointment are arranged at the wrong times.

4.5 One suggestion from a patient was that certain treatments may not need to be undertaken in hospital and should be made available more in the community.

"I had an appointment at Therapies Outpatients Department, Barts Musculosketal Therapies. It had taken four months to get the appointment and it was then for in a month's time. I had had a hip replacement eight months ago. The letter said that the appointment was at 9.15. When I got there (which it is difficult to get anywhere that time of the morning) the receptionist told me that the computer said my appointment was at 9.45. I showed her the letter with 9.15 on it but she didn't seem to care. The doctor or physio said I had to come and do exercises for six weeks. I said why don't you just show me the exercises I have to do and I'll do them at home. I don't want to have to travel in every week when I could just as easily do them at home. He said that was fine and did some stick figure drawings of exercises that I could do at home. Why don't they do that for more people? It would free up the waiting lists and people would get seen when they need to and not 5 or 6 months later. Why couldn't they just go to their local gym and do it."

5. Perceived shortage of nursing staff

5.1 We received far fewer comments this year regarding the poor attitude of nursing staff compared to previous years. Comments tend to now focus on a perceived shortage of nursing staff on the wards.

5.2 The perception from many patients is that there is inadequate staff in a lot of areas and that there is a problem with bank staff and supply nurses.

"I feel that 7F is short of staff and they always take on additional agency staff; I am not happy with the agency staff as it seems like they don't know what they are doing (i.e. don't know how to put on a medicine pack on my son)...agency staff should be trained properly before they're sent to specialised wards...when I see agency staff I don't ask for their help as I don't feel reassured that they can do their job properly."

"The day after my operation I was high on morphine, firstly I didn't know where the alarm was and when I did find it I couldn't get to it. I couldn't see the nurse and nobody came in. In the end I called my family on my mobile phone to get a nurse to come and see me. The staff are very helpful though"

"..due to staff shortages sometimes I have not been given my dinner as I have been unable to walk to get my dinner from the ward corridor."

5.3 We understand the new ward layouts can leave patients with the perception that there are fewer nurses even if nursing levels have remained the same. However it is true that nurses are not able to keep an eye on as many patients as they were in the old wards and they are less visible to patients. This has the potential to leave patients feeling isolated which leads to them feeling unsafe and increases anxiety. You lose the sense that nurses are always around and patients feel insecure.

5.4 This also leads to the nurses being overworked which leads to them appearing or being rude and abrupt to patients who would just like a bit of reassurance. It also leads to a deterioration of staff moral and there is a sense that in some wards good staff are leaving.

"You can't complain about a nurse who is looking after about seven patients all on her own. You just have to give them credit for their hard work and effort."

5.5 We also picked up comments about patients feeling that the wards were short staffed at night and at weekends.

5.6 The financial review is suggesting nurse to patient ratios at one nurse to seven patients. It is clear that patients in the majority of cases do not feel that this will provide them with the compassionate as opposed to clinical care they would desire. We also feel that this will impact on patient safety.

6. Maternity Services

6.1 Generally mothers are very positive about the surroundings of the new maternity wards and feel that the Royal London maternity services have improved. We received very few negative comments about the care during labour.

"I gave birth at the old Royal London hospital and the service was really good. The support from the midwife at the hospital was wonderful and I also got support when I went home as they came to visit me at home."

6.2 The most common negative theme from mothers related again to a sense that there were insufficient staff particularly in relation to aftercare.

"I felt that the nurses where working very hard to keep every patient happy. It's not an easy job so I have to give them credit".

"The staff seem very busy there and if you call them for their assistance they would say 'give me two minutes' and it will take two hours for them to return."

6.3 Staff shortages may also go some way to explaining some of the issues relating to poor discharge that we picked up.

"I waited four days to be discharged from the hospital and there was nothing wrong with me."

"I was discharged by a student nurse . . . and she also gave me all my files that the hospital should've kept. I even had to call a community nurse as no midwife or nurse checked me before or after my birth."

"The new Royal London hospital lost my files which meant according to their system my baby wasn't born and I was forced to stay in the hospital for an extra night. My files were later found in the triage ward and I couldn't wait to leave the hospital as I wasn't getting the support I needed there."

"After I had my baby I was asked to leave the room, discharged home very quickly as they needed the room for another patient. I had to sit in the triage corridor with my suitcase, baby on my lap, on a plastic chair surrounded by moaning women until my husband came to pick us up."

6.4 We are still picking up issues about a different quality of midwifery care being provided to non-English speakers.

"When I gave birth at the Royal London hospital the staff thought I couldn't speak English and were very rude to me. But when I spoke up for myself the staff realised that I could speak English and their behaviour towards me changed. The staff became a lot friendlier and treated me well. I know they treat patients who cannot speak English badly and this is really bad and unfair treatment"

7. Waiting times in A&E

7.1 Patients are very positive about A&E services at the Royal London. "*It's quicker to go to A&E and you seem to get a proper assessment and tests there and then."*There is difficulty getting appointments at some GPs and people feel the quality of assessment is not always good. "*You are assessed better at A&E".*

7.2 However waiting times are a major issue especially for people who are in pain. "*I had to wait about 3-4 hours and I was in a lot of pain therefore, wanted to be seen as soon as possible but I had to wait."* One patient mentioned being delayed for six hours at the hospital A&E for a sickle cell attack resulting in premature labour of her son.

7.3 People with long-term conditions felt they should have more consideration for people who may be frequent visitors "*... more sympathetic staff at A+E to hear patient's needs who have multiple illnesses and need more care".* And that there should be come mechanism to fast track frequent visitors "*every time my son is not well he has to be readmitted as a inpatient to 7F, however in order to readmit him we have to always go through A&E, we can't come direct to the ward. And every time we go to A&E they ask the same questions again and do all the tests again; this is very frustrating for us, on one occasion there was a two day gap between discharge and readmission and we had to go through the whole A&E process...why can't*

they just let us go to the ward?..This process usually is very stressful to my son."

8. Food

8.1 There are mixed views about the food provided. Some patients commented that they do not like the food due to blandness of taste and lack of variety on the menu and other patients feel patients should not expect too much from a hospital, therefore the standard is ok and at least you are given a choice.

8.2 In some areas it was not so much about the quality of food but about:

- not enough food,
- food being cold when it arrived,
- food running out before it reaches patients, and
- patients not being given enough time to eat or not being given enough help to eat with food being taken away without being touched.

8.3 Not all patients have family to bring in extra food and there is a sense that this is necessary.

"After my operation I was on a ward for seven days, on three of the days I didn't get the food that I ordered, on one day I got no food at all apart from sandwiches, and I certainly don't want cold food when I'm in hospital. Out of the seven days I was on ward, only on three of those days I got the food I ordered, and even then it really wasn't very nice."

"The food is awful, not appetising and bland. The halal food is always curry. Not all Muslims are south Asian and I don't like the curry."

9 Discharge

9.1 Patients being discharged when they or their family felt it was too early or before appropriate care packages were in place

"It seems hospitals want to discharge patients quickly...they discharged my father and he was not well enough to be discharged...although we highlighted that he was not feeling better, they insisted on discharging him... so we took my father home, but he could not cope due to the pain, we took him to the doctors and the doctor said that he should return to the hospital - this whole situation could have been avoided if the hospital doctors decided that he was not ready for discharge- it seems once they make their minds up, the decision has to stick!!"

9.2 Patients self discharging because of the noise, temperature on the ward and lack of air.

9.3 We have heard of several patients self discharging. One was in the cardiovascular ward, they left because it was very noisy with all the monitoring equipment and they couldn't get any sleep. Other people have left because of the temperature on the wards being too hot and stuffy and they felt as if they couldn't get any air. This seems to be a fairly significant safe guarding issue as there is obviously a reason that they are in hospital in

the first place and to get up and leave could, one would think, have potentially life threatening consequences. We have raised this issue with the Chief Nurse and understand that an audit of the number of patients self discharging is currently taking place and we will receive a copy of the audit.

9.4 Patients having to wait a long time to be discharged on the day they were leaving and being left to wait in the discharge lounge while prescriptions were being filled.

"My mother was discharged in the morning but had to sit around and wait all day until 12 at night for her prescription to be filled."

10. Incontinence service

10.1 Over the past 12 months we have picked up issues with the adult incontinence service.

"My mother had a very bad experience with district nurses and the Incontinence service once discharged from hospital- my mother was without incontinence pads (& correct size pads) for almost two months due to problems of communication between the District Nurse and the Incontinence service . . . the nurse was blaming the incontinence service for this mistake and the incontinence service blamed the nurse for this mistake. Currently we are still waiting for the incontinence pads for the last two months we have been borrowing from other people."

"Getting through to the incontinence service is very difficult as no one answers the phone, it seems only 10% of calls are answered and if you leave a voicemail it takes them two days to get back to you- based on my experience I would say the incontinence service is not that good for the reasons that is difficult to access the service and once you get through no one can be held accountable for their actions/ lack of actions; it's very frustrating!!"

11. Hospital Transport

11.1 We continue to receive many comments about the reliability and lateness of the patient transport service. *"Hospital patient transport is not reliable, sometimes they come early, sometimes they come late, but they never arrive on time..."*

"I often have to wait about 55 minutes for the driver to come and pick me up after leaving the ward. However I do think the drivers are very helpful, and always help me get in and out of the car. Getting to the hospital is not as bad, as the drivers often turn up on time but the problem occurs when leaving the hospital."

"Patient transport is generally good; I use this service regularly and I am grateful I am offered the service... however they are always late by an hour from the appointment time given to you, but I can understand why they are always late they have to pick up so many people along the way...the delay by patient transport also delays your appointment time at the hospital, as you get seen later than the time given to you...it would

also be useful if patient transport can pick you up straight away after a hospital appointment- you normally have to wait an hour...and whilst you are waiting no one attends to you- it would be nice to get a cup of tea!!"

12. Environment issues

12.1 Most people are very complementary about the new hospital mentioning it is clean, modern and spacious. But there are a number of issues frequently raised:

- **Layout** is complicated, there needs to be better signs to direct patients.
- **Lifts -** People find them hard to use and confusing
- **Temperature** – some wards are hot (High dependency Unit) and some are freezing from a patient perspective (Renal Outpatients)
- **Lack of air** – not being able to open the windows makes it very stuffy and sometimes stifling
- **Noise** – monitoring equipment makes a lot of noise at night making it difficult to sleep.

13. Complaints and PALS procedures

13.1 Patients have complained to Healthwatch Tower Hamlets about:

- difficulty finding out the complaints procedure and who to contact to make a complaint
- the timeframe for responding to complaints?
- procedure being too complicated, hard to navigate through and too long

13.2 PALS

13.3 Recently we received concerns that patients are finding it difficult to access the PALs service i.e. patients are telling us that they find it difficult to get through to PALs service on the phone and when they do manage to get hold of them they are requested to make an appointment to see them, which can take a long time. Patients that have used PALs service in the past have said that they prefer the drop in option as it was accessible when they felt distressed and needed to see someone quickly for support or advice.

13.4 Also PALs signposting does not appear to be very good, for example patients are still turning up to Trust Offices (Mile End Hospital) to see a PALs officer and in some cases they have been advised to turn up to Trust Offices on the advice of hospital staff both at Royal London and Mile End Hospital.

13.5 We were notified in July 2013 that Barts set up a call hub that will deal with all PALS calls. In addition the drop-in service for the public at The Royal London, Whipps Cross and Newham was being replaced by a booked appointment system for patients. Apparently this system would be piloted for three months.

14. Next Steps

This report along with questions and recommendations will be circulated to:

- Barts Health Board, Chief Nurse, Deputy Chief Nurse and the relevant Clinical Academic Groups
- Care Quality Commission
- Tower Hamlets Clinical Commissioning Group
- Tower Hamlets Health Scrutiny Panel
- Healthwatch England

Under Section 224 of The Local Government and Public Involvement in Health Act 2007Healthwatch Tower Hamlets has a statutory right to receive a response to our requests for information and recommendations within 20 working days.

Health and Wellbeing Board 6th February 2014	Tower Hamlets Health and Wellbeing Board
Report of the London Borough of Tower Hamlets	**Classification:** Unrestricted
Tower Hamlets Mental Health Strategy	

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

Executive Summary

The Tower Hamlets Mental Health Strategy sets out our vision for improving outcomes for people with mental health problems in Tower Hamlets. Mental Health is one of the four priorities of the Health & Wellbeing Board within the Health & Wellbeing Strategy.

It sets out how, over the next five years, we will work together to promote mental health and well-being in our communities, prevent Tower Hamlets residents from developing more significant mental health problems, and ensure that when people do need them, mental health services are of the highest possible quality, proactively supporting people to recover. It demonstrates our ambition to deliver against the National Outcomes Framework for Mental Health contained in *No Health Without Mental Health*

Recommendations:

The Health and Wellbeing Board is recommended to **APPROVE** the Tower Hamlets Mental Health Strategy.

1. REASONS FOR THE DECISIONS

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

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

2. ALTERNATIVE OPTIONS

There are no alternative options. It is essential for the Health and Wellbeing Board to have a Mental Health Strategy in place.

3. DETAILS OF REPORT

The Tower Hamlets Health and Well-Being Board, NHS Tower Hamlets Clinical Commissioning Group, and the London Borough of Tower Hamlets are committed to improving outcomes for people with mental health problems. Mental health is one of the Boards four priorities in the Health and Wellbeing Strategy.

3.1 National context

Mental health rightly currently has an extremely high national profile. The *2012 Health and Social Care Act* for the first time ever in English law, requires the Secretary of State for Health to secure improvement in the physical ANDmental health of the people of England, and in the prevention, diagnosis and treatment of physical AND mental illness. Commonly referred to as “parity of esteem between mental and physical health”, the significance of this is profound: the NHS is required to deliver standards of care for people with mental health problems that are at least as good as those for people with physical health problems. The NHS Mandate 2014-15 and the NHS England 2014-19 planning guidance to the NHS places further emphasis on the requirement of Clinical Commissioning Groups, and other NHS bodies, to work towards achieving parity of esteem between mental health and physical health.

The National Strategy, *No Health Without Mental Health*defines the outcomes that health and social care commissioners must seek to achieve for their populations, along with a series of recommendations for action. The Strategy in particular lays out a series of actions for Health and Well-Being Boards, Clinical Commissioning Groups, local authorities and other bodies, to improve outcomes for people of all ages.

Local authorities have over the past few years been working towards personalization of services for all users of adult social care services. *Making it Real,* the Think Local Act Personal framework for action, defines the national consensus vision on personalized social care. Take up of personal budgets, as an aspect of personalization, however, has traditionally been low amongst mental health service users.

The *Care and Support Bill* 2012 confirms a statutory duty on local authorities to promote mental health and emotional well-being, embeds the promotion of individual well-being as the driving force underpinning the provision of care and support and places population-level duties on local authorities to provide information and advice, prevention services, and shape the market for care and support services. These will be supported by duties to promote co-operation and integration to improve the way organisations work together. The Bill also sets out in law that everyone, including carers, should have a personal budget as part of their care and support plan, and gives people the right to ask for this to be made as a direct payment.

The Children and Families Bill, due to receive Royal Assent in early 2014, will come into force in September 2014. The Act will require local authorities and other partners to ensure services are available for children and young people with special educational needs from 0 to 25.

The publication of the *Final Report of the Independent Inquiry Into Care Provided By Mid Staffordshire NHS Foundation Trust (the Francis Report),* which examined the high mortality rate, and poor patient and carer experience at Mid Staffordshire Foundation Trust between 2005-2008, and the *Winterbourne View* report following the Panorama programme on abuse of people with learning disabilities at a private hospital, have renewed the national focus on quality, with tumultuous change to the regulation of health and social care, and an imperative on both commissioners and providers to ensure that patients are at the heart of everything that they do. Furthermore, the Keogh Report and the Berwick Report make clear recommendations for developing the learning culture of the NHS as part of an overall approach to quality.

3.2 Local context

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

Tower Hamlets has a high prevalence of mental health problems. We have the fourth highest proportion of people with depression in London, the fourth highest incidence of first episode psychosis, and the highest incidence of psychosis in east London according to GP registers. In total there are approximately 30,000 adults estimated to have symptoms of a common mental health problem in the borough, with around 15,900 people known to their GP to have depression, and 3,300 known to have a serious mental illness, with a prevalence of c. 1150 people with dementia. Local

information on prevalence of mental health problems in children is not known, however we would anticipate between 3,400 and 15,000 children at any one time to be in touch with some part of the health, social care and education systems due to concerns about their mental health

Service use is also high. We have the second highest proportion of adult service users in touch with secondary care mental health services in London, a high number of people on the Care Programme Approach, and the third highest number of emergency admissions for psychosis. If you are known to secondary care mental health services however, you are comparatively less likely to be admitted to hospital than many other London boroughs. We have the highest prescribing rate for anti-psychotic medication in primary care, and the third highest prescription rate of anti-depressants in London.

3.3 Developing our Strategy

To inform the development of the Strategy, we have held a series of workshops with children and young people, parents, adults of working age, older people, and clinicians and practitioners from a variety of services. These workshops have helped to inform the priorities in the Strategy, and in particular influenced a series of evidence reviews we have undertaken to identify best practice. The evidence reviews are published alongside this Strategy.

We have also interviewed senior leaders in stakeholder organizations, not just those that have a direct interest in mental health, such as East London NHS Foundation Trust, Barts Health, the Metropolitan Police, the Clinical Commissioning Group and the Council. We have also interviewed leaders of organizations that have an interest in mental health more generally, including schools, the Inter-faith Forum, the CVS and Tower Hamlets Homes. The Interview Report is published alongside this Strategy.

Finally, in order to understand the full range of information about mental health in the borough, we have developed a mental health specific Joint Strategic Needs Assessment (JSNA). This JSNA summarizes what we know about our population, risk factors for mental health problems, service use, and our investment. The JSNA is published alongside this Strategy.

In October 2013 we carried out a consultation on the draft Strategy. There were 79 respondents to the draft Strategy, the large proportion of whom were positive about the general direction of the Strategy, in particular the life course approach. A report of the consultation is available separately. Key issues arising from the consultation have been incorporated into the strategy.

It is our intention that this is a live strategy. In line with the requirements of the 2014/15 NHS England planning guidance, the action plan detailed at Appendix One of the strategy details actions we will take to deliver the strategy's commitments in years one and two of the strategy, 2014-16. We will review the action plan at an annual mental health summit in the Autumn of each year in order to refresh the action plan for the year ahead.

The strategy takes a life course approach to mental health. It therefore considers:

- The whole population mental health of children and young people under the age of 18
- The whole population mental health of adults, including older adults
- The mental health needs of, and services for, children and young people under the age of 18, excluding in-patient services
- The needs of, and services for, people with dementia.

3.4 The strategic vision

Our Mental Health Strategy sets out our vision for improving outcomes for people with mental health problems in Tower Hamlets. It sets out how, over the next five years, we will work together to promote mental health and well-being in our communities, prevent Tower Hamlets residents from developing more significant mental health problems, and ensure that when people do need them, mental health services are of the highest possible quality, proactively supporting people to recover. It demonstrates our ambition to deliver against the National Outcomes Framework for Mental Health contained in *No Health Without Mental Health.*

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

Our vision is built around the three pillars, of building resilience in our population, ensuring high quality treatment and support, and supporting people to live well with a mental health problem. The foundations of the Strategy lie in the shared values that underpin a whole person approach and the principle that mental health is everybody's business. The overarching principle that governs the Strategy is that it takes a lifecourse approach, actively considering how the whole population can be supported to be mentally healthy from cradle to grave. We believe that in delivering the commitments that we will detail in this Strategy, we will measurably improve outcomes for people with mental health problems and their carers.

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

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

It is the intention that this is a live strategy, which will adapt, within the context of the principles and commitments outlined within this document, over the next five years. In line with the requirements of the 2014/15 NHS England planning guidance, the action plan details actions we will take to deliver the strategy's commitments in years one and two of the strategy, 2014-16. We will review the action plan at the annual mental health summit in the Autumn of each year in order to refresh it for the year ahead.

Key actions for the delivery of the Strategy over the 2014-15 year include:

- We will develop a public mental health and well-being programme which will include a portfolio of evidence based public mental health interventions, which

will identify how we will deliver this, alongside other public mental health commitments over 2014/16

- We will map current services available to support maternal and infant mental health in order to identify gaps, improve access for groups at higher risk, improve coordination across services and develop proposals to strengthen the universal tier of the service (including Maternity services, Health Visiting and services delivered from Children's Centres, primary care and by voluntary and community organisations)

- We will ensure that the roles of school nurses in relation to emotional health and well-being are clearly articulated in specifications for the reprocurement of the School Health service

- We will develop a refreshed service model for child and adolescent mental health services. A project board will be set up across all stakeholders to oversee this work including the development of a set of service specifications to deliver the refreshed service model. This will include consideration of the impact of potential changes to the CAMHS service model to services for adults of working age. We will develop a refreshed model for the delivery of day opportunity and support services, with an accompanying procurement plan

- We will continue the work to remodel and recommission resettlement and rehabilitation team pathways

- We will review talking therapies providers, and develop a commissioning plan for future talking therapies pathways

- We will develop a refreshed service and activity model for the primary care mental health service (including social care)

- We will re-procure tobacco cessation and obesity services to explicitly include access for people with a serious mental illness

- We will review the model for in-patient care of older adults with a functional mental health problem

- We will develop a specification for mental health support in the community health service locality teams (within the Integrated Care Programme)

- We will review community mental health services for older adults in the context of our work to develop integrated care

- We will commission more dementia cafes

- We will develop a new web resource summarising information on mental health services in the borough for service users and professionals

- We will develop a rolling programme of training for GP's and other primary care staff.

3.5 Conclusion

This mental health strategy has been developed through an analysis of local need, review of the evidence base for effective intervention, and listening to the views of local stakeholders.

The strategy sets out our commitments for the delivery of better outcomes for people with mental health problems in Tower Hamlets over the next five years. By working across the lifecourse, with a commitment to achieving parity of esteem, enhancing recovery and sharing a common set of values aboutpromoting high quality, outcome driven services, we believe that there is the opportunity to achieve change. This will need to happen within a more constrained financial settlement and will require partnership at all levels if we are to succeed.

The full strategy details our commitments, and, in brief, the rationale and evidence base to support why we have chosen these commitments. A brief document will be prepared that will summarise the strategy, in a similar format to the consultation document, attached to this report for information.

4. COMMENTS OF THE CHIEF FINANCE OFFICER

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

5. LEGALCOMMENTS

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

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

5.3. In preparing this strategy, the Board must have regard to whether these needscould better be met under s75 of the NHS Act 2006. Further, the Board must have regard to the Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies published on 26 March 2013, and can only depart from this with good reason. The guidance sets out that mental health must be given equal priority to physical health.

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

6. ONE TOWER HAMLETS CONSIDERATIONS

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

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

7. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

7.1 No implications.

8. RISK MANAGEMENT IMPLICATIONS

8.1. The Strategy details commitments to improve mental health services including crisis pathways, ensuring that the councils duties to provide support for people with mental health problems are delivered safely and effectively.

9. CRIME AND DISORDER REDUCTION IMPLICATIONS

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

10. EFFICIENCY STATEMENT

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

Appendices and Background Documents

Appendices

- Tower Hamlets Mental Health Strategy, full version
- Tower Hamlets Mental Health Strategy Delivery Plan, 2014-16
- Tower Hamlets Mental Health Strategy Consultation Document

Background Documents

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

- State NONE if none.

Officer contact details for background documents:[delete if not required]

- Richard Fradgley

Tower Hamlets Mental Health Strategy 2014 - 2019

February 2014

Contents

Forewordby Mayor Lutfur Rahman

As the first directly elected Mayor of Tower Hamlets, I am determined to make a positive difference to the lives of people in our community who are vulnerable, whether this is through ill health, economic hardship or any other kind of disadvantage.

One of the most vulnerable groups in our community are those who face mental ill-health and I believe that all partners in the borough have a duty to improve services and life outcomes for this group.

This is why the Health & Well-Being Board has identified mental health as one of its four key priority areas, and why we have developed this, our Mental Health Strategy, as the vision and approach through which we will aim to work together to improve mental health support over the next five years.

This strategy takes a lifecourse approach. This means that it focuses on the needs of children and young people, adults of working age, and older people. I believe strongly that to support our community to flourish in the future, we have to invest now in our children and young people, and that supporting children to develop the resilience that they can carry through into later life is key, as is supporting families when they have difficulties, including where the parent has a mental health problem.

Two priorities for this strategy are tackling the wider determinants of mental ill-health and challenging the stigma and discrimination around mental health.

With Public Health now part of the Council, we have an opportunity to work together to target the other areas which affect mental health, for example working to improve poor housing, tackling crime, and improving educational outcomes. It will be our aim, in the Council, to ensure that mental health really is everybody's business.

In 2012 I signed the Time to Change pledge, a national anti-stigma programme, spear-headed by MIND and Rethink. I signed the pledge out of a deeply held conviction that the Council can make a real difference to the stigma and discrimination that people with mental health problems still too often experience. I am very pleased indeed that the Tower Hamlets Health and Wellbeing Board was the first in the country to sign the Time to Change Pledge, on World Mental Health Day in October 2013.

I believe this Strategy and approach demonstrates our collective commitment in Tower Hamlets to make a real difference to the lives of people with mental health problems and their families.

Forewordby Dr. Sam Everington, Chair of NHS Tower Hamlets Clinical Commissioning Group, and Dr. Judith Littlejohns, Mental Health Lead for NHS Tower Hamlets Clinical Commissioning Group

Mental health is something that affects us all - how we think and feel about ourselves and others, how we cope with difficult situations and how we manage our lives. NHS Tower Hamlets Clinical Commissioning Group understands how widespread mental health problems are – from someone experiencing a period of depression due to a personal hardship, to an individual living with long-term psychosis. This is why improving mental health outcomes for local people remains one of our top priorities.

Stigma and discrimination often means that mental health problems are not openly talked about. However, illnesses linked to mental health account for a third of GP consultations, and research shows mental health issues are closely associated with poorer outcomes for employment, personal relationships and physical health. This is why the CCG, including our GP members, is committed to working with partners in the borough, to improve the way in which people with mental health problems are supported and cared for in Tower Hamlets.

We know that improving life experiences of people with mental health issues is not something that can be managed just within the NHS. Instead, we must work with other health and social care agencies, the voluntary sector, patients, carers and the public, to look at services needed to enable people to live stable and happier lives, where they feel supported and in control of their own mental health and recovery.

This means ensuring that mental health becomes a part of everyday conversation and is something that everybody is aware of and cares about. Whether it is a midwife supporting a mother through the birth of a child, a school nurse helping children to develop emotional literacy, or a member of our new integrated community health and social care teams working with an older person just out of hospital. It also means making sure we remain focused on quality, safety and patient choice, sharing decisions between service users and clinicians so that people receive the responsive care they need, in the right place, at the right time.

Our strategy also sets out our commitment to improve mental health services and support for children and young people. This is because stakeholders have often told us that this needs to be a priority. The evidence is clear – if we want to make a real difference to the future mental health of the local community, we need to lay good foundations. This begins with helping children and young people to build resilience, emotional awareness and self-regulation at an early age. This approach is incredibly effective; it has been shown to improve educational outcomes, result in stronger relationships and produce greater employment opportunities for the future.

We are committed to improving the mental health of people in Tower Hamlets and look forward to working together with you to make this vision a reality.

Executive Summary

Mental Health is one of the four priorities for Tower Hamlets Health and Wellbeing Board as set out in the Health & Wellbeing Strategy. This Mental HealthStrategy sets out the vision forimproving outcomes for people with mental health problems in Tower Hamlets. It sets out how, over the next five years, NHS Tower Hamlets Clinical Commissioning Group and the Council will work together and with partners to promote mental health and well-being in our communities, prevent Tower Hamlets residents from developing more significant mental health problems, and ensure that when people do need them, mental health services are of the highest possible quality, proactively supporting people to recover. It demonstrates our ambition to deliver against the National Outcomes Framework for Mental Health contained in *No Health Without Mental Health*[1]and the priorities detailed in*Closing the Gap: Priorities for essential change in mental health*[2]*.*

One in four people will experience a mental health problem at some point in their lifetimeand one in six adults have a mental health problem at any one time[3].Among people under 65, nearly half of all ill health is mental illness. In other words, nearly as much ill health is mental illness as all physical illnesses puttogether[4].

Mental health problems can have a wide ranging impact for individuals in a number of areas of their lives including housing, education, training, employment, physical health and relationships with family and friends. It affects people of all ages and all cultural backgrounds. For example, over 45% of people claiming incapacity benefit in Tower Hamlets do so due to a mental health problem. People with a serious mental illness die on average 20 years earlier than the general population.[5]

Tower Hamlets has a young population with a larger than average proportion of the population aged between 20 and 39 years.[6] It is also ethnically diverse; 32% of the population are Bangladeshi, and 31% White British, with smaller but significant Somali, eastern European, and Chinese and Vietnamese communities also in the borough[7]. There is some variability in take up of services by our different communities, and this strategy will lay out our commitments to trying to understand and tackle this.

The strategyunashamedly takes a lifecourse approach. A large body of evidence now ties experiences in early childhood with health throughout life[8], and the evidence that the impact of laying the foundations of good mental health in children and young people has on their life chances later in life is overwhelming[9]:half of people with lifetime mental illness first experience symptoms by the age of 14[10], and 75% before their mid-20's[11],

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[1]https://www.gov.uk/government/publications/the-mental-health-strategy-for-england
[2] https://www.gov.uk/government/publications/mental-health-priorities-for-change
[3]McManus S, Meltzer H, Brugha T et al. (2009) *Adult Psychiatric Morbidity in England, 2007: Results of a household survey* Leeds: NHS Information centre for health and social care
[4]The Centre for Economic Performance's Mental Health Policy Group (2012) *How Mental illness loses out in the NHS:* London School of Economics
[5]No Health Without Mental Health Department of Health 2011
[6] Tower Hamlets Mental Health JSNA 2013 – compared to London average
[7] ibid
[8]*Overcoming Obstacles to Health: Report From the Robert Wood Johnson Foundation to the Commission to Build a Healthier America.* Braveman P and Egerter S for the Robert Wood Johnson Foundation, 2008
[9] Issue brief 1: early childhood experiences and health, Braveman P for the Robert Wood Johnson Foundation, 2008
[10]Kim-Cohen J, Caspi A, Moffit T et al. *Prior juvenile diagnosis in adults with mental disorder: developmental follow-back of a prospective-longitudinal cohort. Archives of General Psychiatry 60. 709–717* (2003).(as quoted in No Health Without Mental Health, DH 2011)
[11]Kessler R and Wang P (2007) The descriptive epidemiology of commonly occurring mental disorders in the United States. Annual Review of Public Health 29: 115–129..(as quoted in No Health Without Mental Health, DH 2011)

with huge potential consequences for their educational, employment, relationship and physical health outcomes.Tower Hamlets has a proportionately higher population of children and young people than London and England, and this strategy therefore purposefully places children and young people at its heart, with a particular focus on developing preventative services to support schools, and ensuring that child and adolescent mental health services provide high quality support that is quickly accessible.

Tower Hamlets has amongst the highest levels of mental health need in England. Population risk factors for mental ill-health are significant, but the dynamism of our voluntary sector, steeped in the national history of community activism, presents us with opportunities for developing our approach to mental health promotion and prevention, and in implementing this strategy we will seek wherever possible to capitalize on the strengths of the voluntary sector.

In recent years the health and social care partners in Tower Hamlets have worked together to make improvements to local services by delivering on the objectives of the *National Service Framework for Mental Health* and its successor strategy*New Horizons*. This has resulted in a range of community and hospital based services that are more accessible and of better quality. *No Health Without Mental Health*, the new mental health strategy for England provides a clear framework for the next phase of improvement, focusing on population mental health and wellbeing rather than simply on mental illness. In addition, there has recently been significant national policy emphasis on the responsibilities of CCG's to deliver parity of esteem between mental and physical health in the revised NHS Mandate[12] and the NHS England planning guidance[13].

At present, we believe that our secondary care mental health services for adults of working age are largely working well. Despite having amongst the highest levels of secondary mental health service use for adults of working age in the country and the third highest number of emergency admissions for psychosis in London, the 2013 national community mental health survey of service users demonstrated satisfaction ratings that were in the top ten in the country[14], total bed days for working age adults are low, and occupancy is within national guidelines. However there are significant opportunities for improvement, to deliver better health and social care outcomes for service users, to improve experience, and to improve productivity. In particular, the physical health of service users with a serious mental illness is an absolute priority: if you have a serious mental illness in Tower Hamlets, you are three times more likely to be obese than the general population.

As part of our engagement to develop this strategy, adult service users have told us that the quality of services, and in particular the quality of relationships with staff, is absolutely key. They have told us that they want to have better information, better communication, better access to services, more choice and control over their care, and more opportunities to actively direct their own support through user led services. The experience of stigma and discrimination has been a major area in which service users would like to see concerted action.

Through the delivery of our *Commissioning Strategy for People with Dementia and their Carers* over the past three years, we now have high performing dementia services, which have won a national award and attention. Our next steps for older people,

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[11]Kim-Cohen J, Caspi A, Moffit T et al. *Prior juvenile diagnosis in adults with mental disorder: developmental follow-back of a prospective-longitudinal cohort. Archives of General Psychiatry 60. 709–717* (2003).

[12] https://www.gov.uk/government/publications/nhs-mandate-2014-to-2015
[13] http://www.england.nhs.uk/ourwork/sop/
[14]http://www.eastlondon.nhs.uk/News-Events/News/Two-Greens-for-the-Trust-in-Community-Mental-Health-Survey-2013.aspx

identified in this strategy, will build mental health into our tremendously ambitious integrated care programme, which has been designated “Pioneer Status” within the national Better Care Fund programme[15]. Through this work we intend to wrap community based health and social care around the service user in a genuinely seamless care and support service.
The financial climate is as challenging as it has ever been for the public sector. For the NHS, whilst the government committed to maintain growth of 0.1% in real terms to 2015/16, there are also major challenges, not least the estimated £30bn funding gap by 2020[16], in addition to a short term requirement to continue to deliver the “Nicholson challenge” of circa 4% per year efficiencies for providers, and for Clinical Commissioning Groups to part fund a £3.8bn integration fund and deliver 10% management efficiencies into 2015/16.[17].

In the context of the 2010/11 Comprehensive Spending Review, the Council has had to make significant savings to date, and, in response to the 2013/14 Comprehensive Spending Review is faced with having to make major additional savings in 2015/16 and beyond.

Through this Strategy, the Clinical Commissioning Group will where possible identify opportunities to reinvest efficiency savings into the mental health programme, with the aspiration, over the course of the five years of the Strategy, of increasing our proportionate spend on mental health. In addition, the partnership have identified funding for mental health within the Better Care Fund.

We believe that this strategy is the start of a process of development, innovation and delivery that will help to:

- Promote population mental health and wellbeing
- Improve the range of and access to mental health services
- Achieve national and local policy imperatives
- Deliver good outcomes and improved value.

[15] http://www.england.nhs.uk/2013/11/01/interg-care-pioneers/
[16] http://www.hsj.co.uk/news/kelsey-nhs-faces-30bn-funding-gap-by-2020/5060745.article
[17] http://www.theguardian.com/society/2012/aug/07/mental-health-spending-falls

1. Introduction

The Tower Hamlets Health and Well-Being Board, NHS Tower Hamlets Clinical Commissioning Group, and the London Borough of Tower Hamlets are committed to improving outcomes for people with mental health problems.

This Mental Health Strategy sets out our vision for improving outcomes for people with mental health problems in Tower Hamlets. It sets out how, over the next five years, we will work together to promote mental health and well-being in our communities, prevent Tower Hamlets residents from developing more significant mental health problems, and ensure that when people do need them, mental health services are of the highest possible quality, proactively supporting people to recover. It demonstrates our ambition to deliver against the National Outcomes Framework for Mental Health contained in *No Health Without Mental Health*and the priorities detailed in *Closing the Gap: Priorities for essential change in mental health.*

To inform the development of the Strategy, we have held a series of workshops with children and young people, parents, adults of working age, older people, and clinicians and practitioners from a variety of services. These workshops have helped to inform the priorities in the Strategy, and in particular influenced a series of evidence reviews we have undertaken to identify best practice. The evidence reviews are published alongside this Strategy.

We have also interviewed senior leaders in stakeholder organizations, not just those that have a direct interest in mental health, such as East London NHS Foundation Trust, Barts Health, the Metropolitan Police, the Clinical Commissioning Group and the Council. We have also interviewed leaders of organizations that have an interest in mental health more generally, including schools, the Inter-faith Forum, the CVS and Tower Hamlets Homes. The Interview Report is published alongside this Strategy.

Finally, in order to understand the full range of information about mental health in the borough, we have developed a mental health specificJoint Strategic Needs Assessment (JSNA). This JSNA summarizes what we know about our population, risk factors for mental health problems, service use, and our investment. The JSNA is published alongside this Strategy.

In October 2013 we carried out a consultation on the draft Strategy. There were 79 respondents to the draft Strategy, the large proportion of whom were positive about the general direction of the Strategy, in particular the life course approach. A report of the consultation is available separately.

It is our intention that this is a live strategy. In line with the requirements of the 2014/15 NHS England planning guidance, the action plan attached to the strategy details actions we will take to deliver the strategy's commitments in years one and two of the strategy, 2014-16. We will review the action plan at an annual mental health summit in the Autumn of each year in order to refresh the action plan for the year ahead.

2. The scope and organization of this strategy

2.1 The scope of the strategy

As outlined in the introduction, this strategy takes a life course approach to mental health. It therefore considers:

- The whole population mental health of children and young people under the age of 18
- The whole population mental health of adults, including older adults
- The mental health needs of, and services for, children and young people under the age of 18, excluding in-patient services[18]
- The needs of, and services for, people with dementia.

2.2 The organization of the strategy

This strategy lays out our commitments to deliver better outcomes for people with mental health problems, whatever their age, over the next five years. The strategy briefly lays out the national and local context for the strategy, defines our vision, and goes on to detail our commitments to deliver the vision, with a brief accompanying rationale for each commitment.

The vision is built around the three pillars, of building resilience in our population, ensuring high quality treatment and support, and supporting people to live well with a mental health problem. This strategy document is structured against these three pillars, with a chapter covering each. Our commitments for each stage of the lifecourse are interwoven through each chapter (there are not separate chapters for each stage of the lifecourse), but commitments specific to each stage of the lifecourse can be identified through the code at the end of each commitment, ie.:

Code	Commitment Description
P	Principle: A principle that will govern the way in which we as commissioners will deliver the strategy. As principles, these do not have associated actions per se, but we will give evidence of how we have worked in line with these principles at the annual mental health summit (described below). These are coloured pink in the strategy.
G	General: A general commitment that covers all stages of the life course. These commitments will have associated actions and are coloured light blue in the strategy.
CYP	Children and young people: A commitment that relates primarily to children and young people. These commitments will have associated actions and are coloured light green in the strategy.
AWA	Adults of working age: A commitment that relates primarily to adults of working age. These commitments will have associated actions and are coloured light

[18] In-patient services for children, and a number of services for adults including in-patient and community forensic services, are the responsibility of NHS England Specialist Commissioning Team. Whilst we will, through this Strategy, seek to join up our commissioning approach with specialist commissioners, the design of services commissioned by NHS England falls outside of this Strategy.

	purple in the strategy.
OP	Older people: A commitment that relates primarily to older people. These commitments will have associated actions and are coloured light brown in the strategy.

It is the intention that this is a live strategy, which we will adapt, within the context of the principles and commitments outlined within this document, over the next five years. Attached to the strategy is an action plan. In line with the requirements of the 2014/15 NHS England planning guidance[19], the action plan details actions we will take to deliver the strategy's commitments in years one and two of the strategy, 2014-16. We will review the action plan at the annual mental health summit in the Autumn of each year in order to refresh it for the year ahead.

[19] http://www.england.nhs.uk/2013/12/20/planning-guidance/

3. National context

3.1 Legislative and policy context: Mental health

Mental health rightly currently has an extremely high national profile.The *2012 Health and Social Care Act* for the first time ever in English law, requires the Secretary of State for Health to secure improvement in the physical ANDmental health of the people of England, and in the prevention, diagnosis and treatment of physical AND mental illness[20]. Commonly referred to as "parity of esteem between mental and physical health", the significance of this is profound: the NHS is required to deliver standards of care for people with mental health problems that are at least as good as those for people with physical health problems.

The *NHS Mandate*, the Secretary of State's instructions to NHS England, has recently been refreshed with a renewed emphasis on the delivery of parity of esteem, in particular on ensuring crisis services are responsive and high quality, that people admitted to general hospital have access to good mental health care, that talking therapies are accessible to children and people from BME communities.

The NHS England 2014-19 planning guidance to the NHS places further emphasis on the requirement of Clinical Commissioning Groups, and other NHS bodies, to work towards achieving parity of esteem between mental health and physical health, in particular the resources CCG's allocate to mental health to achieve parity of esteem, the identification and support for young people with mental health problems and plans to reduce the 20 year gap in life expectancy for people with severe mental illness.

The National Strategy, *No Health Without Mental Health*defines the outcomes that health and social care commissioners must seek to achieve for their populations, along with a series of recommendations for action. The Strategy in particular lays out a series of actions for Health and Well-Being Boards, Clinical Commissioning Groups, local authorities and other bodies, to improve outcomes for people of all ages, as summarized in the box below.

NO HEALTH WITHOUT MENTAL HEALTH HEADLINES

- A life course approach, in particular focus on laying the foundations of good mental health for later life in children and young people
- Tackling stigma and discrimination
- Promoting early intervention
- Tackling health inequalities by protected characteristic
- Improved access to talking therapies, including children and young people and people with a serious mental illness
- Improving offender mental health
- Developing a recovery culture in mental health services
- Developing new models including core responsibilities for mental health in school nursing and health visitors
- Supporting clinical commissioning groups with developing mental health commissioning capability.

[20] Para One, Health and Social Care Act 2012, http://www.legislation.gov.uk/ukpga/2012/7/section/1/enacted

Closing the Gap: Priorities for essential change in mental health, published in January 2014, outlines 25 key government priorities for change across the system to promote better outcomes for people with mental health problems.

Finally, the Prime Minister has highlighted, in the*Challenge on Dementia*[21], the need to build on *Living Well with Dementia – a National Strategy*[22] in improving diagnosis rates and quality of life, for people with dementia.

3.2 Legislative and policy context: integrated care

More generally, NHS England, and Clinical Commissioning Groups have a statutory duty[23] to work with local authorities to promote integrated health and social care, making person-centred coordinated health and social care the norm for people with multiple health problems, including mental health problems, with a focus on supporting people with multiple health problems outside of hospital seamlessly. In his Spending Review Statement on 26th June 2013, the Chancellor of the Exchequer promised that integrating health and social care would be "*no longer a vague aspiration but concrete reality*". The creation of the Better Care Fund, a fund to promote integrated care that is overseen by Health and Wellbeing Boards is intended to support the delivery of this vision.

Integrated working can offer the opportunity for health and social care to operate equally, breaking down traditional barriers and creating seamless services. In particular, it provides the chance for the role of social care to be enhanced and recognised as a key contributor to the planning and delivery of services. Additionally the role of the third sector as an increasingly important partner in the planning and delivery of services creates a powerful triumvirate for local health and social care economies. The National Voices *Narrative for Person-Centred Coordinated ('Integrated') Care*[24] defines the service user vision for integrated care.

3.3 Legislative and policy context: social care

Local authorities have over the past few years been working towards personalization of services for all users of adult social care services. *Making it Real*[25]*,* the Think Local Act Personal framework for action, defines the national consensus vision on personalized social care. Take up of personal budgets, as an aspect of personalization, however, has traditionally been low amongst mental health service users[26].

A draft *Care and Support Bill* was published in 2012, which proposes a single legislative framework for adult social care, replacing the current complex framework of adult social care law[27]. The Bill confirms a statutory duty on local authorities to promote mental health and emotional well-being, embeds the promotion of individual well-being as the driving force underpinning the provision of care and support and places population-level duties on local authorities to provide information and advice, prevention services, and

[21] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/200030/9535-TSO-2900951-PM_Challenge_Dementia_ACCESSIBLE.PDF
[22] https://www.gov.uk/government/publications/living-well-with-dementia-a-national-dementia-strategy
[23] http://www.legislation.gov.uk/ukpga/2012/7/pdfs/ukpga_20120007_en.pdf, para 14Zi
[24] http://www.nationalvoices.org.uk/
[25] http://www.thinklocalactpersonal.org.uk/
[26] http://www.communitycare.co.uk/articles/06/08/2013/102669/direct-payments-personal-budgets-and-individual-budgets.htm
[27] http://careandsupportbill.dh.gov.uk/home/

shape the market for care and support services. These will be supported by duties to promote co-operation and integration to improve the way organisations work together. The Bill also sets out in law that everyone, including carers, should have a personal budget as part of their care and support plan, and gives people the right to ask for this to be made as a direct payment.

3.4 Legislative and policy context: public health

Public health is about improving the health of the population through preventing disease, prolonging life and promoting health.[28] Local Authorities now have lead responsibility for public health, including public mental health. . Commissioning responsibility for a number of services that have a role in delivering mental health prevention and support has shifted to local authorities, including school health, health visitors (by 2015) and drug and alcohol services. This shift provides a platform for a more integrated approach to improving public health outcomes including tackling the wider determinants of mental ill-health

3.5 Legislative context: other

The Children and Families Bill, due to receive Royal Assent in early 2014, will come into force in September 2014. The Act will require local authorities and other partners to ensure services are available for children and young people with special educational needs from 0 to 25. Some local authorities with partners are currently considering how CAMHS and Adult Mental Health services may be redesigned to align with the expectations of Children and Families Bill.

The Welfare Reform Act[29] legislates for a range of changes to the welfare system some of which will have a direct effect on people with mental health problems. It introduces a wide range of reforms including the introduction of Universal Credit, and changes to housing benefit. There has been concern amongst a range of mental health stakeholders nationally about the impact of welfare reform on people with mental health problems[30].

3.6 Quality

The publication of the *Final Report of the Independent Inquiry Into Care Provided By Mid Staffordshire NHS Foundation Trust (the Francis Report)*[31], which examined the high mortality rate, and poor patient and carer experience at Mid Staffordshire Foundation Trust between 2005-2008, and the *Winterbourne View*[32]report following the Panorama programme on abuse of people with learning disabilities at a private hospital, have renewed the national focus on quality, with tumultuous change to the regulation of health and social care, and an imperative on both commissioners and providers to ensure that patients are at the heart of everything that they do. Furthermore, the Keogh Report[33] and the Berwick Report[34] make clear recommendations for developing the learning culture of the NHS as part of an overall approach to quality.

[28] Guidance for commissioning public mental health services JCP-MH 2012
[29]http://www.legislation.gov.uk/ukpga/2012/5/contents/enacted
[30] http://www.rcpsych.ac.uk/policy/projects/live/welfarereform.aspx
[31]http://www.midstaffsinquiry.com/index.html
[32]https://www.gov.uk/government/publications/winterbourne-view-hospital-department-of-health-review-and-response
[33] http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf
[34] https://www.gov.uk/government/publications/berwick-review-into-patient-safety

3.7 Focus on Outcomes

The National Outcomes Frameworks for the NHS[35], the Commissioning Outcomes Framework for Clinical Commissioning Groups[36], and the Adult Social Care Outcomes Framework[37] and Public Health Outcomes Framework[38] for councils, all include outcomes that both directly and indirectly relate to mental health. These can be found at Appendix One.

The National strategy, *No Health Without Mental Health* defines the outcomes that health and social care commissioners must seek to achieve for their populations, along with a series of recommendations for action. The strategy places emphasis on laying the foundations of good mental health in children and young people, integrated health and social care services that support early intervention, and high quality productive services.

NO HEALTH WITHOUT MENTAL HEALTH OUTCOMES

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

3.8 The mental health market

Although the NHS has traditionally been the predominant provider of local mental health services, a number of independent and voluntary sector organisations have played a key part in delivering specific services to complement those in the statutory sector. The new *NHS Procurement Patient Choice and Competition Regulations*[39] place requirements on commissioners to improve the quality and efficiency of services by procuring from the providers most capable of meeting that objective and delivering best value for money. The market environment in the NHS and social care will expand to admit a wider range of providers. This greater plurality of providersmeans that the NHS may no longer be the defaultoption for commissioners and enable independent including third sector providers to deliver a greater range of services.

3.9 Finance, efficiency and productivity

No other health condition matches mental ill health in the combined extent of

[35]www.gov.uk/government/publications/nhs-outcomes-framework-2013-to-2014
[36]www.england.nhs.uk/wp-content/uploads/2012/12/ois-fact.pdf
[37]www.gov.uk/government/publications/the-adult-social-care-outcomes-framework-2013-to-2014

[38]www.gov.uk/government/publications/public-health-outcomes-framework-update
[39]http://www.legislation.gov.uk/uksi/2013/257/contents/made

prevalence, persistence and breadth of impact.[40] The annual cost of mental ill-health in England is estimated at £105 billion[41]. By comparison, the total costs of obesity to the UK economy is £16 billion a year[42] and cardiovascular disease £31 billion[43]. In 2010/11, £12 billion was spent on NHS services to treat mental disorder, equivalent to 11% of the NHS budget[44].

The financial climate for the public sector in England has rarely been as challenging, for either the NHS or for councils. For the NHS, whilst the government has committed to maintain growth in real terms of 0.1% to 2015/16, there are also major challenges, not least an estimated £30bn funding gap by 2020[45], in addition to a short term requirement to continue to deliver the Nicholson challengeof circa 4% per year efficiencies for providers to 2014/15, and for Clinical Commissioning Groups to part fund a £3.8bn integration fund and deliver 10% management efficiencies into 2015/16.

The June 2013 Comprehensive Spending Review requires very significant savings from local government into 2015/16, including a likely average additional 10% saving on local government in addition to three years to date of intensive savings measures. This is expected to have a significant impact in Tower Hamlets.

In mental health, work continues on developing Payment by Results specific to mental health, a new payment mechanism based on actually delivered care. At present it is anticipated that PBR will be in place in shadow form from 1st April 2014and in place fully by1st April 2015.

[40] Promoting mental health & preventing mental illness, Freidli, L & Parsonage, M 2009
[41] The Economic and Social Costs of Mental Health Problems in 2009/10 Centre for Mental Health 2010
[42] Tackling obesities: future choices. Project report Government Office for Science Foresight 2007
[43] Prevention of cardiovascular disease at population level NICE 2010
[44] Programme budgeting tools and data. National expenditure data Dept of Health 2012
[45] http://www.hsj.co.uk/news/kelsey-nhs-faces-30bn-funding-gap-by-2020/5060745.article

4. Local context

Tower Hamlets is a uniquely vibrant borough, with a young and diverse population, with an established sense of itself as a set of connected communities and neighborhoods.

The population of Tower Hamlets has grown more than any borough in England between the 2001 and 2011 Census, with growth in particular in 0 to 18 year olds and 25 to 39 year olds. The largest community by ethnicity in the borough are Bangladeshi (32%), followed by White British (31%) and 14% White Other. Approximately 55% of under 19's are of Bangladeshi origin. There is high population mobility, with a turnover in GP practice registers of around 19% every year, and around 15,000[46] new national insurance registrations per year (i.e. for people who are new to the country settling in Tower Hamlets). In terms of the future, the growth in the population is set to continue, with continued proportionate growth in children and young people and people of early middle age, and in addition people aged 80 and over.

The growth and structure of the population is highly significant for planning mental health services, with a need to ensure that services are commissioned to meet demand, to meet the population's language and cultural needs, and to ensure that it is appropriately balanced to the age profile of the population.

Tower Hamlets has a high prevalence of risk factors that can contribute to the development of mental health problems in individuals, for example child poverty, long term unemployment, older people living in poverty, overcrowded households, population density, homelessness, crime including hate crime against specific communities, carers working over 50 hours per week, harmful alcohol use[47]. The distribution of the socio-economic risk factors for mental health problems is focused in particular geographical localities within the borough, with some very prosperous neighborhoods next to some of the most deprived areas in England.

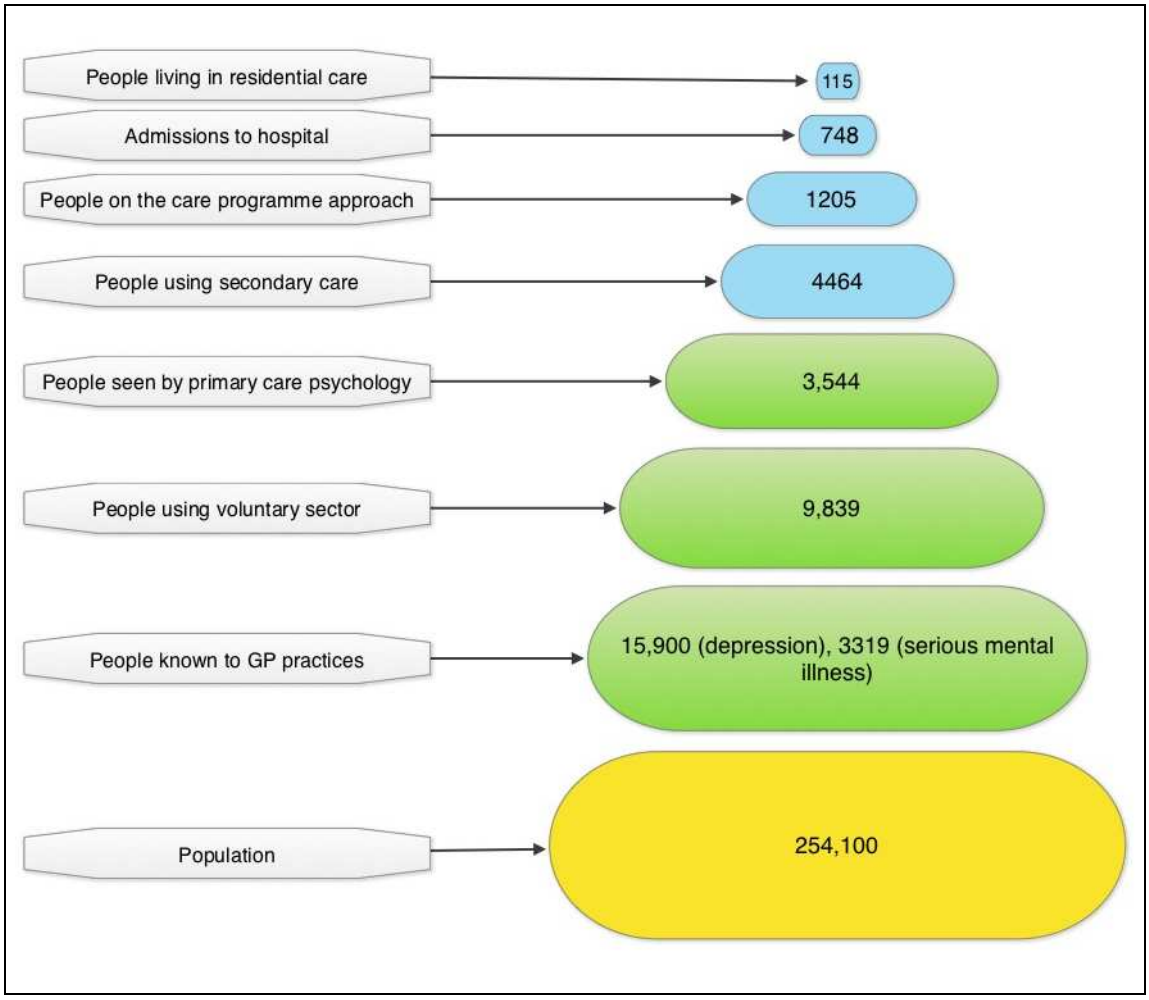
Whilst the borough has a comparatively high number of people actively participating in religious practice (a protective factor for mental health problems), the borough also has limited green space, and poor physical activity amongst the population. The borough has a long established heritage of voluntary sector activism and involvement, in supporting people who are experiencing hardship, for whatever reason, dating back to the early days of Toynbee Hall and William Beveridge.

Tower Hamlets has a high prevalence of mental health problems. We have the fourth highest proportion of people with depression in London, the fourth highest incidence of first episode psychosis, and the highest incidence of psychosis in east London according to GP registers. In total there are approximately 30,000 adultsestimated to have symptoms of a common mental health problem in the borough, with around 15,900 people known to their GP to have depression, and 3,300 known to have a serious mental illness, with a prevalence of c. 1150 people with dementia. Local information on prevalence of mental health problems in children is not known, however we would anticipate between 3,400and 15,000 children at any one time to be in touch with some part of the health, social care and education systems due to concerns about their mental health[48]. Our lack of accurate information on need amongst children and young people in the borough is a key driver for a need to improve intelligence in this area.

[46] JSNA
[47] JSNA
[48] All data from JSNA.

Service use is also high. We have the second highest proportion of adult service users in touch with secondary care mental health services in London, a high number of people on the Care Programme Approach, and the third highest number of emergency admissions for psychosis. If you are known to secondary care mental health services however, you are comparatively less likely to be admitted to hospital than many other London boroughs. We have the highest prescribing rate for anti-psychotic medication in primary care, and the third highest prescription rate of anti-depressants in London.

A summary of current numbers of adults using services is in the table below[49]:

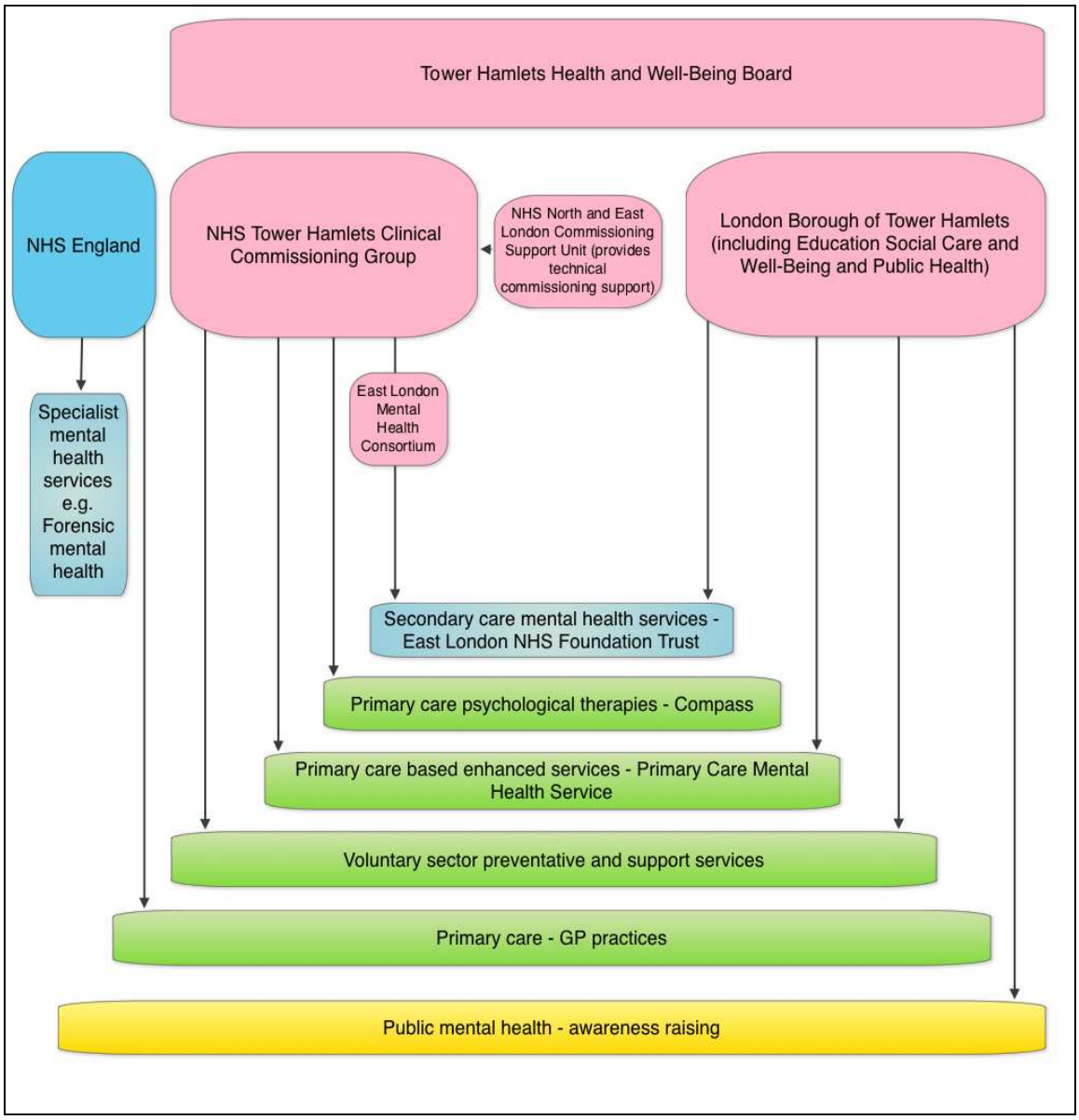


The mental health partnership is already working on delivering improved accommodation for people with mental health problems in the borough, with the aim of dramatically improving the number and quality of in-borough supported accommodation to support people closer to home and in particular reduce our reliance on out of borough residential care[50]

[49] The data is drawn from a variety of sources, all included in the JSNA. The secondary care data excludes older people and people with dementia.
[50] http://www.towerhamlets.gov.uk/default.aspx?page=16535

In the context of the demographic change and pressures, high population risk factors for and high prevalence of mental health problems in the borough, in addition to high service use, the Tower Hamlets Health and Well-Being Board has identified mental health as one of its four key priorities for action.

Commissioning arrangements for services that support people with mental health problems are detailed in the diagram below.



5. Our vision and key objectives

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

The Strategy to deliver our visionis summarised in the key outcome objectives identified in the figure below. It is built around the three pillars, of building resilience in our population, ensuring high quality treatment and support, and supporting people to live well with a mental health problem. The foundations of the Strategy lie in the shared values that underpin a whole person approach and the principle that mental health is everybody's business. The overarching principle that governs the Strategy is that it takes a lifecourse approach, actively considering how the whole population can be supported to be mentally healthy from cradle to grave. We believe that in delivering the commitments that we will detail in this Strategy, we will measurably improve outcomes for people with mental health problems and their carers.

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

5.1 A lifecourse approach to mental health and well-being

In line with the overarching Health and Well-Being Strategy, this Strategy takes a life course approach. This means that throughout the strategy we will commit to improving outcomes for people with, or at risk of, mental health problems whatever their age. It means understanding the impact of poor mental health and wellbeing from birth and through childhood, into adulthood and into older age. It also means recognizing the determinants of poor mental health and wellbeing, taking steps to address them and ensuring the provision of high quality services for people, based on need rather than age, across the span of their lives.

In many ways, the single biggest action that we can take to secure better outcomes for the people and communities who live in Tower Hamlets for the future is to support children and young people, their parents, families and communities, to develop the building blocks of good mental health through building resilience, *laying the foundations of good mental health for later life.*

In particular, there is national consensus that to reduce inequalities in health, including inequalities experienced by people with mental health problems, the single most important action is to focus on "*giving every child the best start in life*" , beginning before birth and following up throughout childhood[51].

Our Strategy therefore consciously places a very high emphasis on the mental health of children and young people and their parents.

> We will prioritise work to develop new pathways to support children and young people with a mental health problem. To do so, we will develop a time limited partnership board dedicated to overseeing a project to design new pathways (CYP)

5.2 Building good foundations: Shared values, a whole person approach

Values are the convictions and beliefs which shape the way we think about the world, our work, our relationships. They inform the way we interact with each other, either as

[51] Marmot (2010) *Fair Society, Healthy Lives.*

private individuals, or in the context of a therapeutic relationship. Values also inform our strategic thinking and the way in which we plan mental health services for the future[52]. A number of positive 'values' underpin this Strategy including:

- A focus on the whole person approach, regarding people as unique individuals who are not defined by their mental health problem or diagnosis
- Placing importance on the role of service users as co-producers, not only in terms of input to service development and review, but also in respect of care planning and setting their recovery outcomes
- A focus on recovery and enabling people to achieve their potential
- Whilst different therapeutic interventions such as medicines, talking therapies, family interventions etc will work differently for different people, the key to achieving improved outcomes lies in the strength of the '*therapeutic alliance'* between service users and professionals.

5.3 Building good foundations: Mental health is everybody's business

We believe that by working together, across health, social care, education, the voluntary sector and with service user and carers we can more effectively develop and deliver the range of services and interventions that can help to alleviate the impact of mental health problems on individuals, families and communities within the borough. There are a range of other service providers who also have a significant impact on mental health, for example the Metropolitan Police, the Fire Brigade, the Department of Work and Pensions, registered social landlords.

To support effective working across the partnership with the wider range of stakeholders, we will hold an annual autumn Tower Hamlets Mental Health summit, to enable all stakeholders to come together to consider the Strategy action plans for the year ahead (G)

[52] Values Based Commissioning, England, Dr. E. RCPsych 2011

In particular within the Clinical Commissioning Group, we will identifyand secure opportunities for supporting people with mental health problems in each of our major workstreams, including:Maternity, Children and young people, Urgent care, Planned care, Integrated care, Long term conditions, Last years of life, Information and technology, Prescribing, Primary care development (G)

In particular, within public health, we will identify and secureopportunities for supporting people with mental health problems in each of our major workstreams, including Healthy communities and environment, Maternity, early years and childhood, oral health, tobacco cessation and long term conditions (G)

We will, across the Council and the CCG, as the two main public sector commissioning bodies in the borough, use the Time to Change pledge to encourage our suppliers to provide a mental health friendly workplace for their employees (G)

5.4 Focus on quality improvement

Our delivery of this Strategy will be supported by a sustained focus on quality and outcomes. Our approach is driven both by the findings of the Francis Report, but also our overriding commitment to improving standards. In particular, we will aim to develop a strong focus on quality improvement across the system as the main focus of our performance management of the variety of mental health contracts we hold.

We will use the opportunities available to us within our relationships with providers, and in the contracting process, to ensure that we focus on quality improvement (P)

Building on our ground-breaking approach to developing CQUIN incentives[53] for the mental health trust during 2013/14, we will ensure that service user and carer views are at the heart of our approach to quality improvement (P)

[53] CQUIN means Commissioning for Quality and Innovation. It is in effect a mechanism that allows NHS commissioners to provide financial incentives to providers for delivering quality improvement and innovation. As part of the 2013/14 contract with East London NHS Foundation Trust, informed by the views of local service users, we have developed a CQUIN to involve service users in 360 degree appraisal of nurses, and a CQUIN to roll out the Friends and Family Test in in-patient settings. These CQUIN's are ground-breaking, as ELFT is one of the first Trusts in the country to develop 360 degree appraisal including service user feedback for nurses, and one of the first mental health trusts to pilot the Friends and Family test.

We will work across the east London Mental Health Consortium to ensure that we use CQUIN and other contractual levers to develop our focus on quality improvement (P)

We will use the national outcomes frameworks for the NHS, adult social care, Public Health England in addition to locally determined outcome indicators to help us know what we are doing well, where we a making a positive impact and where we need to improve.

We will develop an outcomes dashboard to track the delivery of this Strategy, which will be published on the CCG website (G)

5.5 Building good foundations: Commissioning with commitment

The delivery of this strategy will adhere to the principles in the Health and Wellbeing Strategy that say:

- All services must be culturally sensitive
- We will seek to work with our providers to achieve a balance of value for money and risk that is sustainable for the provider as well as the commissioner
- We will seek to use our purchasing power to stimulate the local economy and maximise employment opportunities for local people, taking into account the provisions of the Public Services Social Value Act 2012
- Wherever possible, we will encourage local, smaller providers in complex procurements to ensure they are not disadvantaged.
- We would always ask that unless there are good market reasons not to do so, all contractors should pay the London Living Wage. Unless an exception is made contracts will be let with this stipulation.

5.5.1 Joint commissioning for mental health

We believe that a joint commissioning approach across health and social care,with aligned resource mobilized through a single health and social care commissioning team with links both into the CCG and the Council, is the most effective means of securing high quality mental health services for our population. We believe that clinical leadership in commissioning is of critical importance, and to this end have an identified CCG Board lead for mental health, who is actively involved in leading the mental health commissioning partnership, supported by a GP clinical lead.

We also believe that intelligent use of data and information is key to supporting effective commissioning. We have an identified Public Health Consultant with specific responsibility for mental health, supported by a Senior Public Health Strategist. We have also secured health informatics and contracting support from the North East London Commissioning Support Unit.

5.5.2 Service user and carer involvement

Service user involvement has moved from being an exception to an expected part of service planning and delivery.[54] Service users are 'experts by experience' who must be involved in the development, planning, delivery and review of local services to ensure that they are relevant and effective.

Our joint commissioning approach is underpinned by our absolute commitment to ensuring that service users are centrally involved in planning mental health services for the future. Whilst we currently have a range of mechanisms through which we aim to ensure that service users are involved in mental health service planning, we believe that there are opportunities to strengthen the current arrangements. NICE has issued a quality standard on the service user experience that we will continue to refer to as we develop the means of engagement locally.[55]

> We will review our service user involvement structures against the NICE Quality Standard and work with service users, Healthwatch, and voluntary sector groups to identify and provide opportunities to support service users who wish to become more involved in planning mental health services in the future (G)

5.5.3 Market development

Ensuring that there are high quality, safe and effective mental health services to meet the needs of the population is the central task of mental health commissioning. We know that Tower Hamlets has amongst the highest levels of mental health need in the country, and as a consequence there is a large demand for mental health services. We also know that need and demand will continue to rise in the future.

Whilst Payment by Results will in the near future help to ensure that providers of statutory mental health service are paid for the activity they deliver, we will across the healthcare system need to ensure that people with mental health problems are offered support at the right place and at the right time to ensure that demand is managed appropriately. Part of our overall strategic approach to demand management involved our focus on building resilience and prevention and ensuring capacity and capability in primary care.

> We will ensure that people are offered clinically appropriate support by cost effective providers, as close to home as possible, with a focus on developing primary care and community based services (P)

Ensuring the best possible mental health services for the population of Tower Hamletsmeans using our resources effectively to secure high quality and productive services. Where it is appropriate, we will seek to use the opportunities available to us to procure services from the market. We know that service users in particular place very high value on the support that they receive from voluntary sector services. We have also achieved great success with our approach to contracting for dementia services, where the mental health trust as a lead provider manages a care pathway which includes services provided by the Alzheimers Society. We also know that service users place very

[54] Making Service Involvement Effective Mental Health Foundation
[55] Service user experience in adult mental health (QS14) NICE 2011

high value on the opportunity to direct their own support that is afforded by the annual user-led grant process for small groups.

> We will use opportunities available to us to develop the local market, with a focus where appropriate on voluntary sector services, and developing opportunities for self-directed support through small groups (P)

> We will aim to capitalize on the strengths of the voluntary sector in the more effective coordination of care pathways in the context of the development of Payment by Results in mental health (P)

5.5.4 Consortium commissioning

The Clinical Commissioning Group has formed into a consortium with City and Hackney and Newham Clinical Commissioning Groups to manage the contract with East London NHS Foundation Trust for mental health services.

> We will identify and secure opportunities for quality improvement and productivity across the Trust through the Mental Health Commissioning Consortium (P)

5.5.5 Finance

In 2011/12, approximately 11.4% of Tower Hamlets PCT[56] spend was on mental health.[57]Over the last two years, spend nationally on mental health has fallen for the first time in ten years. The proportion of NHS Tower Hamlets PCT total spend committed to mental health has reduced marginally over the last three years, from 11.72% in 2010/11 to a projected 10.85% in 2012/13. In comparison with the seven London Centre ONS comparator boroughs, Tower Hamlets spent the lowest proportion on mental health in 2011/12.[58]There are a number of complexities in measuring the overall balance of programme area spend against the needs of the population, and then comparing spend with other similar areas. However there are currently some tools emerging that might help CCG's to review the overall balance of spend by programme area to inform future strategic financial planning.

[56] NHS Tower Hamlets PCT was the previous NHS body responsible for commissioning health services for Tower Hamlets, prior to the authorisation of NHS Tower Hamlets Clinical Commissioning Group.
[57] Tower Hamlets Mental Health JSNA 2013
[58] Tower Hamlets is grouped in programme budgeting with "London Centre" boroughs, as having comparable populations and therefore health need, including Westminster, Camden, Islington, Kensington & Chelsea, Wandsworth and Hammersmith and Fulham. Whilst some of the London Centre boroughs are known to have comparatively high levels of mental health need, for example Camden and Islington, there are other London boroughs, such as Hackney and Lambeth, where need may be more in line with Tower Hamlets than other London Centre boroughs. It should also be noted that the demographic profile, particularly around age and ethnicity, varies significantly across the London Centre boroughs, with Tower Hamlets having a particularly high BME population.

We will examine opportunities to review the overall balance of spend by programme area to inform future strategic financial planning (P)

For the NHS, whilst the government committed to maintain growth of 0.1% in real terms to 2015/16, there are also major challenges, not least the estimated £30bn funding gap by 2020[59], in addition to a short term requirement to continue to deliver the "Nicholson challenge" of circa 4% per year efficiencies for providers, and for Clinical Commissioning Groups to part fund a £3.8bn integration fund and deliver 10% management efficiencies into 2015/16.[60].

In the context of the 2010/11 Comprehensive Spending Review, the Council has had to make significant savings to date, and, in response to the 2013/14 Comprehensive Spending Review is faced with having to make major additional savings in 2015/16 and beyond.

Although there are different ways of measuring spend on mental health at borough level, Tower Hamlets currently spends less than Office for National Statistic comparators[61] on mental health compared to other areas of health care spend. The current and medium term economic climate suggests that new investment will be limited and that Tower Hamlets, in common with other health and social care economies will have to continue to plan for increasing demand allied to a constrained funding position. However, in view of the very high levels of mental health need and service use in Tower Hamlets, and in the context of the creation of the Better Care Fund, the Clinical Commissioning Group will where possible identify opportunities to reinvest efficiency savings into the mental health programme and consider opportunities arising from the Better Care Fund.

Through this Strategy, the Clinical Commissioning Group will where possible identify opportunities to reinvest efficiency savings into the mental health programme, with the aspiration, over the course of the five years of the Strategy, of increasing our proportionate spend on mental health. In addition, the partnership have identified funding for mental health within the Better Care Fund (P)

The requirement to commission the most clinically effective and cost effective services is now greatly intensified, in part as a consequence of more constrained public finances and the associated drive to deliver efficiencies and savings. New developments and existing service models are being scrutinised even more closely to ensure that they are evidence based, clinically effective and provide good value for money[62].

We will ensure that only services that demonstrate high quality cost effective approaches to supporting service users continue to be commissioned (P)

Payment by Results is currently due to be introduced in shadow form in mental health in

[59] http://www.hsj.co.uk/news/kelsey-nhs-faces-30bn-funding-gap-by-2020/5060745.article
[60] http://www.theguardian.com/society/2012/aug/07/mental-health-spending-falls
[61] Tower Hamlets is grouped with Westminster, Camden, Islington, Wandsworth, Kensington & Chelsea, Hammersmith & Fulham and Lambeth as the boroughs that are most similar in England in terms of demographic profile.
[62] Via the Nicolson Challenge requirement to deliver year on year efficiencies, and the QIPP challenge to drive efficiency for commissioners through developing more effective and productive clinical pathways

2014/15, with full implementation by 2015/16. Whilst PBR in mental health has been due for implementation for some time now, we will aim to use its likely introduction in the future as an opportunity to develop clear clinically effective health and social care pathways, and to support service users to make choices about their care and support.

> We will use the introduction of Payment by Results into mental health as clear clinically effective health and social care pathways, and to support service users to make choices about their care and support (G)

Within the CCG we will also need to ensure that we have in place the right infrastructure to support service users to make choices between mental health providers, in line with the commitments of *Closing the Gap.*

> In line with national guidance, we will ensure that people with mental health problems are able to make choices between mental health providers.

The introduction of PBR may present risks for commissioners, if as a consequence there are significant changes in funding flows and the aggregate cost of services.

> The partners will monitor and track the impact of PBR closely to ensure that this fits within the overall strategic approach set out in this strategy (P)

5.5.6 Information

The availability, and intelligent use, of good quality information about population need and service use is critical to effective commissioning. Whilst traditionally data in mental health has been poor, the introduction of payment by results is sharpening the quality of data. The use of high quality data is particularly helpful in understanding the use of services by people by protected characteristic, thereby helping to understand how we can develop services that genuinely promote equality of access.

> We will develop our capability in using data to drive our commissioning practice, in particular in tackling inequality of access by protected characteristic (G)

In the context of our work to develop integrated care teams more generally, we are using risk stratification as an approach to identifying people who may be at risk of needing admission to hospital, to proactively offer them more intensive care and support at home. However current models do not routinely take account of mental health problems. In addition, whilst there are a variety of risk stratification tools available to support integrated care, it is an approach that is less developed specific to mental health. We will

monitor developments in this area, with a view to considering opportunities for developing a risk stratification model specific to mental health.

> We will identify and use opportunities for developing risk stratification models to help plan future mental health services (G)

6. Building resilience: mental health and wellbeing for all

Tower Hamlets has a high incidence of many of the socio-economic risk factors that contribute to mental health problems in individuals. Tackling these risk factors is key to supporting the individuals and communities in the borough to develop resilience. Whilst specific commitments to tackling the things that contribute to the development of mental health problems are beyond the scope of this Strategy, they are very high in the Council's priorities. Some of the most important related areas of action include those below:

- Mayoral priorities[63]: Housing, education, jobs, community safety, cleanliness
- The Tower Hamlets Strategic Plan[64], including Homelessness Statement, Financial Inclusion Strategy, Children and Families Plan, Employment Strategy
- Substance misuse strategy[65]

6.1 Fewer people will experiencestigma and discrimination

Tackling stigma and discrimination is one of the areas of highest priority that service users told us should be included in this strategy.Many people with mental health problems experience stigma and discrimination. Nationally 87% of service users reported the negative impact that stigma and discrimination had had on their lives, including discrimination by other people, employers, and self-stigma which significantly impacts on self-esteem and confidence.[66]There are many misconceptions and myths about mental health that are all too readily reinforced by the media, and there are also a number of important cultural factors that influence attitudes to mental health. Stigma and discrimination have a significant impact because very often they:

- Prevent people seeking help
- Delay treatment
- Impair recovery
- Isolate people
- Exclude people from day-to-day activities and stop people getting jobs.[67]

Stigma and discrimination can be magnified for specific communities, where mental health problems may be considered taboo, for example some Black and Minority Ethnic communities, or where people already experience stigma and discrimination on account of a protected characteristic, for example the Lesbian Gay Bisexual and Transgender community.

Time to Change is a national anti-stigma campaign run by Mind and Rethink Mental Illness[68].The Mayor of Tower Hamlets signed the Time to Change Pledge on behalf of

[63] http://www.towerhamlets.gov.uk/lgsl/1001-1050/1002_mayor/mayors_priorities.aspx
[64] http://www.towerhamlets.gov.uk/lgsl/20001-20100/strategic_plan_2013-14.aspx
[65] http://www.towerhamlets.gov.uk/pdf/Draft%20Substance%20Misuse%20Strategy%20Summary.pdf
[66] ibid
[67] Stigma Shout Time to Change 2008
[68]Funded by the Department of Health and Comic Relief, Time to Change is now in its second phase, running to the end of March 2015.www.time-to-change.org.uk

the Council in 2012, since when the Council has made progress in promoting mental health amongst employees, and reviewing employment policies and practice.

Using the Time to Change pledge, we will continue to use the leadership of the Health and Wellbeing Board to tackle stigma and discrimination by raising awareness and promoting positive perceptions of mental health across the Borough (G)

We will develop our strategic partnership across the public and private sector to combat discrimination, encouraging local statutory organisations and local employers to sign the Time to Change pledge, and become mindful employers (G)

We will develop a local anti-stigma campaign. It will have a specific focus on BME communities, faith communities, and the LGBT community, where we have been told locally there is a need for focus (G)

As part of our coordinated work to design new pathways of support for children and young people, we will work across the Partnership to develop an anti-stigma campaign specific to children and young people[69](CYP)

Tackling stigma and discrimination through multi-agency working and by utilising the Time to Change partnership model is the best means to achieve change. However, we will be realistic about how quickly we can bring about change and how it can be effectively measured.

6.2 People will have access to improved information on what services are available

Service users have told us that finding information about the services that are available and how to access them can be confusing and difficult for people, their families or friends.

Having access to up to date, accurate and accessible information about services and how to get help and support is an important part of reducing stigma, enabling access and raising awareness.

We will develop a new web resource that will provide easily accessible information on mental health services for children and young people, adults, and older people. The resource will act as a directory of mental health services for the borough, and an up to date repository of information about mental health related activities and events in the borough (G)

[69] Tower Hamlets stigma & discrimination literature review 2013

We recognize that the internet is not accessible for all our communities, particularly where English may not be a first language.Internet access is less in particular amongst people of Bangladeshi origin.

> We will ensure that the web resource is publicized with community groups and services that support people who may not use the internet, so that people can be supported to access the information the web resource will hold. We will also ensure that providers publish relevant information in appropriate languages (G)

6.3 Mental health awareness across our communities, schools and employers and in the health, social care and education workforce will improve

Awareness of mental health problems is closely related to stigma and discrimination. If people are more aware of mental health problems, stigma and discrimination is less likely. Many mental health awareness programmes, for example Time to Change, and Australia Mental Health 2020[70], combine mental health awareness with tackling stigma and discrimination.

We have through our Mental Health Promotion Strategy, 2008-2011, delivered a wide range of activities to promote mental health awareness in our communities, including schools and employers. This has included events in schools, media articles, a Faith in Health programme through which we trained religious leaders in mental health, the development of a mental health directory, and Dementia Information Guide, and through coordinated voluntary sector engagement with communities, for example through the development of a Somali Mental Health Needs Assessment.

> We will deliver our approach to raising mental health awareness through the commitments identified to tackle stigma and discrimination, as above (G)

> We will continue to work specifically to raise awareness of dementia (OP)

It is our ambition to ensure that staff working in general health and social care settings like hospitals and other key settings such as schools and housing, have appropriate awareness, skills and knowledge in mental health. We have already started a process of developing a much greater presence of mental health staff in general settings, as identified in this strategy, for example the development of the liaison mental health service at the Royal London, Mile End and London Chest hospitals, the improvements we have made to the interface between primary care and secondary care mental health services through the regular practice based multi-disciplinary team mental health meetings which are now in place, and the pilot of mental health staff working in community health services.

[70] http://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=3&ved=0CEYQFjAC&url=http%3A%2F%2Fwww.mentalhealth.wa.gov.au%2FLibraries%2Fpdf_docs%2FMental_Health_Commission_strategic_plan_2020.sflb.ashx&ei=6H8LUu-uCaOg0wXRqYDIAQ&usg=AFQjCNGo4Mv0rE1rLntZgMgbzkUPPtaTUg&bvm=bv.50723672,d.d2k

We recognize, however, that we need to go further in developing awareness, skills and knowledge around mental health across our workforce, including further training for GP's on specific aspects of mental health, for example on the mental health of children and young people, which the Royal College of GP's has recently identified as a priority[71].

> We will develop a rolling programme of training for GPs and other primary care staff on specific aspects of mental health (G)

It is equally important to ensure that staff working in other settings, particularly in housing and social care including home care and day care services, have good mental health awareness. We have already developed specific requirements on home and day care providers to ensure that their staff have access to appropriate training on dementia.

> We will work with housing providers to improve mental health awareness with staff who work in and around housing (G)

> We will work with providers of home care and day care to improve mental health and dementia awareness with their staff (OP)

6.4 People will have access to a range of preventative and health promotion services

Public mental health and wellbeing, and interventions associated with it are known to help deliver a range of benefits including reduced emotional and behavioural problems in children and adolescents,increased resilience in children, families and communities, reduced levels of mental health problems in adulthood, reduced suicide risk, better general health, less use of health services and reduced mortality in healthy people and in those with established illnesses.[7273] The more people there are with robust emotional, psychological and social wellbeing in a community, the better able the community is to support those with mental health problems.[74] Investment in effective prevention makes sense, both in terms of promoting better outcomes for service users, and in terms of promoting value for money.[75]

There is evidence[76] to support preventative approaches with children and young people (for example the Targeted Mental Health in Schools programme), adolescents at risk of developing psychosis (for example Early Detection Services), adults of working age (for example self-help resources in libraries for people with mild mental health problems) and older people (for example Link Age +).

[71] http://www.rcgp.org.uk/news/2014/january/gps-make-youth-mental-health-a-priority.aspx
[72] http://www.mentalhealth.org.uk/content/assets/PDF/publications/building-resilient-communities.pdf
[73] Guidance for commissioning public mental health services JCP-MH 2012
[74] Mental health, resilience and inequalitiesCopenhagen: WHO Regional office for EuropeFriedli L 2009
[75] Guidance for commissioning public mental health services JCP-MH 2012
[76] Tower Hamlets prevention literature review 2013

In our public mental health programme we will target health promotion interventions at all ages. We will seek to make them culturally relevant to our diverse population. We will ensure that commissioning focuses on improving the linkage between physical and mental health and contribute to the achievement of parity of esteem (G)

There is overwhelming evidence that supporting children to develop emotional regulation in the early years of life through effective parenting is critical to emotional health and well-being in later life[77]. The Council currently commissions a co-ordinated range of support options for parents, as identified in our Children and Families Partnership Parental Engagement and Support Policy.[78]We know that children who live in families where the parent has a mental health problem can be at particular risk, and as part of our targeted support for children living in vulnerable circumstances, in line with the Partnerships Family Well-Being Model of coordinated care and support for families[79], we currently commission a range of parenting support options for families where the parent or child has a mental health problem, including support from our Children's Improving Access to Psychological Therapies project.

As part of our coordinated work to design new pathways of support for children and young people, there are particular opportunities to build on our new programme of Emotional First Aid[80], which provides support for parents to help understand how emotional health and well-being impacts on children and young people.

We will, across the Council and the CCG, as the two main public sector commissioning bodies in the borough, use the Time to Change pledge to encourage our suppliers to adopt an Emotional First Aid programme for their employees (G)

The 2012 CQC/Ofsted inspection of childrens services[81] notes that there is a need to ensure focus of adult mental health teams on supporting families where there is a parent with a mental health problem. We have already begun to work with East London NHS Foundation Trust on improving identification of, and support to, children living with a parent with a mental health problem through our 2013/14 CQUIN on parental mental health[82].

We will develop a model for taking a family orientated approach to mental health across the partnership to be integrated into practice, where people with a mental health problem are parents (CYP, AWA)

In our review of the School Health Service, we will ensure that promotion of emotional health and well-being health is considered as

[77] Tower Hamlets prevention literature review 2013
[78] http://www.towerhamlets.gov.uk/lgsl/51-100/parent__family_support_servic.aspx
[79] http://webfronter.com/towerhamlets/inclusion/menu2/CAF/FWM_Practitioners_version.pdf
[80] Emotional First Aid
[81] http://www.cqc.org.uk/sites/default/files/media/reports/20120824%20NHS%20Tower%20Hamlets%20CQC%20Final%20Report.pdf
[82] This CQUIN incentivises the collection of information regarding children in families where the parent has a mental health problem, and the development of staff competencies in working with families.

a central component of future commissioned services. We wil in 2015 and beyond consider the role of health visitors in promoting emotional health and wellbeing (CYP).

We already commission an Early Detection Service, to identify and support young people at risk of psychosis, as part of our effective Early Intervention Service pathway, provided by East London NHS Foundation Trust.

For adults of working age, there are many opportunities for preventing mental health problems. From prompt access to support in the event of a significant life event, to support from targeted universal voluntary sector services and access to self-help resources when necessary.

We will refresh our review of voluntary sector day opportunity and support services, with a view to considering how the expertise and dynamism of voluntary sector services, and their closeness to the various communities of Tower Hamlets, can support our aspiration for more accessible targeted prevention services for all communities (AWA)

We will work with the Ideas Stores to capitalize on opportunities for improving access to self help support and bibliotherapy (AWA, OP)

For some service users, particularly older people, loneliness has been identified as a major risk factor for mental health problems. Loneliness has been defined by social researchers as the subjective, unwelcome feeling of lack or loss of companionship.[83]Loneliness is a bigger problem than a simply an emotional experience. Researchers rate loneliness as a similar health risk as lifelong smoking, with links between a lack of social interaction and the onset of degenerative diseases such as Alzheimer's; an illness which costs the NHS an estimated £20 billion a year. Loneliness has also been linked in medical research to heart disease and depression.

We recognise that loneliness can affect anyone who has a mental health problem, in particular those who become socially isolated and older adults who may have smaller social and family networks.

We will consider the findings of the Campaign to End Loneliness report and project, as well as other initiatives such as those developed by Age UK. Having done so we will work to develop our plans to tackle loneliness, with a particular focus on older people (OP)

6.5 Families and carers will feel more supported

Carers play a vital role in the lives of many people with a mental health problem. Up to 1.5 million people in the UK care for someone with a mental health problem.[84]In Tower

[83] www.campaigntoendloneliness.org.uk
[84] The Princess Royal Trust for Carers www.carers.org/key-facts-about-carers

Hamlets, there are an estimated 20,700 carers. 3,200 carers in Tower Hamlets provide 20-49 hours of unpaid care per week, morethan the London or England average, and 5,700 carers in Tower Hamlets provide 50 hours or more of unpaid care per week, higher than any other Inner London borough. Being a carer is a risk factor for mental health problems[85]:

- 40% of carers experience psychological distress or depression, with those caring for people with behavioural problems experiencing the highest levels of distress
- 33% of those providing more than 50 hours of care a week report depression and disturbed sleep
- Those providing more than 20 hours of care a week over an extended period have double the risk of psychological distress over a two year period compared to non-carers. Risk increases progressively as the time spent caring each week increases
- Caring can also limit carers' ability to take time out to exercise. Reduced income and lack of cooking skills may contribute to excess weight gain or loss. As many as 20% of adult carers increase their alcohol consumption as a coping strategy
- Emotional impacts such as worry, depression and self-harm have been identified in young carers.

The *Carers and Disabled Children's Act 2000* states that all carers aged 16 or above, who provide a 'regular and substantial amount of care' for someone aged 18 or over, have the right to an assessment of their needs as a carer.[86]In our joint CCG and Council 2012 Carers Plan[87], we have already committed to:

- Provide information and training for carers of people with severe and enduring mental health problems
- All carers should be able to access appropriate psychological care, with any mental health needs (as well as physical health needs) identified at assessment or review, or through the carers' health checks. This is particularly applicable to carers of people with dementia or mental health conditions.

We will develop a specific plan for young carers of parents with a mental health problem as part of our work to develop family orientated care and support (G)

We will ensure the delivery of the Young Carers Plan, and associated milestones, as they relate to young carers of people with mental health problems (G)

[85]Royal College of GP's (2013): http://www.rcgp.org.uk/~/media/Files/CIRC/Carers/RCGP-Commissioning-for-Carers-2013.ashx

[86]Carers and Disabled Children's Act HMSO 2000

[87]http://moderngov.towerhamlets.gov.uk/documents/s28453/Carers%20Plan%20Cabinet%20Report%20May%202012%20FINAL%20310512.pdf

As part of our work to develop the Carers Plan, carers of people with mental health issues highlighted a feeling a lack of respect shown towards them by health professionals. They reported that often they were not invited to meetings with Community Psychiatric Nurses and Psychiatrists and if they were invited, they felt expected not to express their views. They reported that family members are used inappropriately as interpreters and assessments go ahead with service users, who have limited English language skills, without interpreters.

In 2013/14 we have used CQUIN to incentivize the Mental Health Trust to provide support to carers by telephoning carers of people on the Care Programme Approach in their own right a minimum of once a month, and to ensure that carers are contacted at the point of a service user's discharge from hospital. We have also used CQUIN to incentivize the development of staff skills in working with families, where there is a parent with a mental health problem.

> We will use the contractual levers available to us to improve the experience of carers of people with mental health problems (G)

6.6 People will experience smooth transitions between services

Poor transition between stages of the life course, or services, can contribute to poor outcomes in the short, medium and long term. It can impact upon a person's chance of achieving employment, accessing education, maintaining independence, moving on from services or accessing services in the future. Conversely, effective transition can have a positive effect on peoples' life chances and their future mental health and wellbeing[88].

Transition for young adults is particularly important. Its aim should be to help to improve the chances of recovery and independence through the provision of high-quality, effective health and social care services that continue seamlessly as the individual moves from adolescence to adulthood.[89] We want to ensure that the transition for children and young people to adult mental health services and the transition for adults to older people's mental health services is improved as part of our life course approach to mental health and wellbeing.

> As part of our coordinated work to design new pathways of support for children and young people, we will ensure that they take account of the life events that impact on young people with mental health problems, including leaving education, leaving home, leaving family, emerging autonomy[90] (CYP)

The Children and Families Bill, due to receive Royal Assent in early 2014, will come into force in September 2014. The Act will require local authorities and other partners to ensure services are available for children and young people with special educational needs from 0 to 25. Some local authorities with partners are currently considering how

[88] All JSNA Evidence Review on transition.
[89] Tools for Transition Anderson, Y. HASCAS
[90] Transition: Filling the Void? - Hewson, Dr L. National Advisory Council, February 2010

CAMHS and Adult Mental Health services may be redesigned to align with the expectations of Children and Families Bill, including consideration of how the current age boundary between CAMHS and Adult mental health services may change, with some areas proposing a "soft" transition point[91] of age 25.

> As part of our coordinated work to design new pathways of support for children and young people, we will ensure that they take account of the requirements of, and emergent good practice in relation to, the Children and Families Act 2014[92] (CYP)

Given the relatively young population in Tower Hamlets, the issues surrounding transition for that group must form an important part of the way in which we need to shape local services. The transition for existing adult service users to older adult community provision is an area that requires further focus, allied to thinking about those people who may develop organic disorders such as dementia.

> We will review current community pathways for older adults with a functional mental health problem, in the context of our developing plans for integrated care in the borough (OP)

6.7 At risk communities will have access to targeted preventative support

6.7.1 Looked after children

As of 31/3/13, the Council was the corporate parent for 295 children.Looked after children are known to be at very high risk of developing mental health problems.[93] Whilst there is a specialist post in the Child and Adolescent Mental Health Service to provide mental health support for looked after children, and responsible commissioner arrangements ensure that children placed out of borough receive support from local CAMHS services, the 2012 CQC/Ofsted inspection found that reviews of children placed out of borough do not always take full account of mental health and emotional well-being.

> As part of our coordinated work to design new pathways of support for children and young people, we will consider how to most effectively provide support to children at risk, including looked after children, and in particular how to most effectively support children's social care staff with developing knowledge and skills around mental health (CYP)

[91] This is a "soft" boundary in the sense that it is driven by the needs of the individual service user.

[92] Transition: Filling the Void? - Hewson, Dr L. National Advisory Council, February 2010

[93] JSNA

6.7.2 The mental health of offenders

The health of offenders is now a recognised major public health issue. The connections between mental illness and social exclusion are as well known as they are between deprivation and offending behaviour.[94] People with mental health problems are over represented in prison and across the criminal justice system. The Bradley review[95] laid out a series of recommendations aimed at improving the health of offenders, and placed a strong emphasis on mental health. The national *Offender Personality Disorder Strategy[96],* details in particular proposals to improve the recognition and support for people with personality disorder in the criminal justice system.

The landscape of offender management is current changing significantly. Whilst some forensic services are the responsibility of NHS England specialist commissioners, including in-patient services and some community outreach services, general mental health services for people with a mental health problem and a forensic history are the responsibility of the Clinical Commissioning Group and the Council. At the same time, there is significant proposed change to the organization of probation services across the country[97].

The Thames Magistrates Court is based in the borough. Commissioning responsibility forcourt diversion services has transferred to NHS England. As of February 2013, there were 1080offenders in the borough at any one time, 425 of whom were in custody, 259 on licence and 397 on community and suspended sentence orders. We believe there are opportunities for a more in depth understanding of the health, including mental health needs, of offenders in the borough to inform the development of a future commissioning plan.

> With NHS England and public health within the Council, we will develop a JSNA factsheet specific to the mental health needs of offenders to help inform future commissioning arrangements (G)

Whilst the future arrangements for the delivery of probation services are still emerging, there are opportunities in the context of the changing landscape to ensure that our existing local investment is deployed effectively.

> We will review our existing investment into supporting service users via the Forensic Mental Health Practitioner and the Link Worker Scheme, to ensure it is optimally deployed (AWA)

The London Pathways Project is part of the local delivery of support to the Probation Service to recognize and support offenders with a personality disorder. Its primary aim is to support the probation workforce to develop their skills and knowledge in working with

[94] Social Exclusion and Mental Health, ODPM, 2004

[95] http://www.prisonreformtrust.org.uk/ProjectsResearch/Mentalhealth/TroubledInside/Bradleyreviewcallsfornewapproachtoofenders

[96] http://www.personalitydisorder.org.uk/criminal-justice/about-dspd-programme/

[97] http://www.justice.gov.uk/transforming-rehabilitation

people with a personality disorder, to improve screening for personality disorder, and develop more psychologically informed environments.

> We will work with probation and mental health service providers to ensure the successful delivery of support for offenders with mental health problems including personality disorder (AWA)

6.7.3 People who are homeless

Good quality, affordable, safe housing underpins our mental and physical wellbeing. All too often, severe mental ill health can lead to homelessness, and people with mental health problems, particularly those with a serious mental illness can sometimes find it difficult to secure and maintain good quality accommodation.

Many homeless adults have chaotic lives and therefore require holistic and co-ordinated support to live independent and empowered lives. Vulnerable adults often have multiple needs and experience multiple levels of exclusion. A report by the charity Homeless Links showed that 8 out of 10 homeless clients have one or more physical health need and 7 out of 10 clients have one or more mental health need.[i]

In Tower Hamlets, Locally, the majority of single homeless approaches to the Council are assessed as having a low level support need which may include depression or minor intellectual impairment, with a small, but important number having high level mental health needs. Around 46% hostel users in the borough have some form of mental health support need.

In Tower Hamlets we have the Health E1 practice, which provides primary care for people who are homeless. The practice supports a very high number of people with a serious mental illness, and also people who have problems with drugs and alcohol.

We currently commission additional mental health staff within the practice to support the high mental health needs that the practice supports. We are also piloting additional staffing to support reduced use of A&E and secondary care mental health services at the practice. We are also working to develop a redesigned hostel pathway, and will ensure that hostels are appropriately commissioned to support people with mental health problems.

> We will implement the Hostels Strategy to ensure that appropriate support for people with mental health problems who are in hostels is built into the re-design of hostels (AWA, OP)

6.7.4People from BME communities

There are different nuances to the ways people from different communities and cultural backgrounds understand and respond to mental health problems in themselves, their families and communities. Equally, professionals might not always understand the sometimes subtly different way in which mental health problems might present in some individuals from some communities, and some services may not be configured in a way that feels accessible to people from BME communities. As a consequence, the take up

of mental health services is not always as we might expect it to be in line with the demographic breakdown of our communities.

For example, take up of CAMHS community services by children and young people of Bangladeshi origin is around 37%, against a population of under 19's of 55%. Admissions to in-patient care for people from Black communities is 20%, against a population of 6.6%.

Ensuring that mental health awareness raising activity is specifically designed to meet the needs of our diverse communities, as identified above, is particularly important as is ensuring that there are appropriate voluntary sector services close to communities to provide sign-posting and support. Ensuring that services provide culturally and language appropriate support in statutory services to promote access is key. Specific areas for action are identified in the course of the Strategy.

> We will develop as part of our responsibilities under the Public Sector Equalities Duty, a dashboard for access to services by race and other equality strand, to inform future commissioning (G)

6.7.5People from the LGBT community

There are no clear figures indicating how many gay, lesbian bisexual or transgender[98]residents there are in Tower Hamlets. National estimates indicate that between 5 – 7% of the population is gay, lesbian or bisexual, and that the proportions may be higher in London than elsewhere in the UK. People from the LGBT community are more likely to experience depression, anxiety, self-harm and suicidal behaviour[99]. Locally, recording of sexual orientation by statutory and voluntary sector services is often poor, so it is difficult to establish the extent to which services are accessible to people from the LGBT community, although anecdotally LGBT service users note that there is only one small user-led group specific to the needs of the LGBT community in Tower Hamlets.

> We will work with providers to improve recording of sexual orientation as part of equalities monitoring requirements to inform future commissioning (G)

6.7.6People who are new to the Borough

Tower Hamlets has the second highest proportion of people known to secondary care mental health services in London. If you are known to secondary care mental health services, you are comparatively less likely to be admitted to hospital than in many other London boroughs. However Tower Hamlets also has the third highest rate of emergency admissions to hospital for psychosis. Around 18% of admissions are people who are appear to be completely new to the borough's mental health services, and possibly to the borough. This may include a number of service users who are registered at the Health E1 practice, which provides primary care for people who are homeless.

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[98]The expression trans is often used synonymously with transgender in its broadest sense. Where trans people have transitioned permanently, many prefer to be regarded as ordinary men and women, without any reference to their former gender role or previous trans status. (Gender Identity Research and Education Society website)

[99] http://www.spn.org.uk/index.php?id=1023

We will work with East London Foundation Trust to carry out a prospective audit of people who are admitted to hospital who were recorded as not previously known to mental health services in the borough. We will use this information to help plan how to better support early access to community services for this group of people in the future (AWA)

6.7.7 People with autism or a learning disability combined with a mental health problem

The Learning Disability Joint Strategic Needs Assessment factsheet[100]notes that there areapproximately 6,000 adults with learning disabilities in Tower Hamlets, a small percentage of whom are known to health and social care services, with around 1,880 adults expected to have autistic spectrum disorder, of whom 765 adults have ASD and no other learning disability.Around 1,000 people aged 14 and over are known to learning disability services in Tower Hamlets.

People with a learning disability are more likely to have asthma, diabetes, dementia, depression, epilepsy and stroke than the general Tower Hamlets population. The rate of seriousmental illness is ten times higher in people with a learning disability in Tower Hamlets than in the general population.

The integrated health and social care Community Learning Disability Service managed by the Council and Barts Health works with East London Foundation Trust (ELFT) to offer specialist assessment, interventions and therapy for mental illness, behaviour and emotional problems, emotional distress, vulnerability, abuse, promotion of good mental health and psychological well-being and provision of education, consultation and advice.

We will develop a refreshed learning disability commissioning plan which will include consideration of the needs of people with a learning disability and mental health problem (G)

6.7.8 People with autism spectrum disorder

Historically, people with ASD often fall outside the eligibility for adult social care and mental health services. A new ASD assessment and diagnosis will be available from April 2014. The service design includes close working protocols with community mental health and learning disability services to ensure the broader needs of individuals are met. This includes liaison duties across both services to provide advice and guidance in relation to ASD.

The service will offer an open referral pathway for people who require an ASD specialist assessment and diagnostic service. Further assessment, diagnosis and post diagnosis support will be available. This will ensure a bespoke pathway according to individual needs will reduce the number of people falling through the net without appropriate intervention.

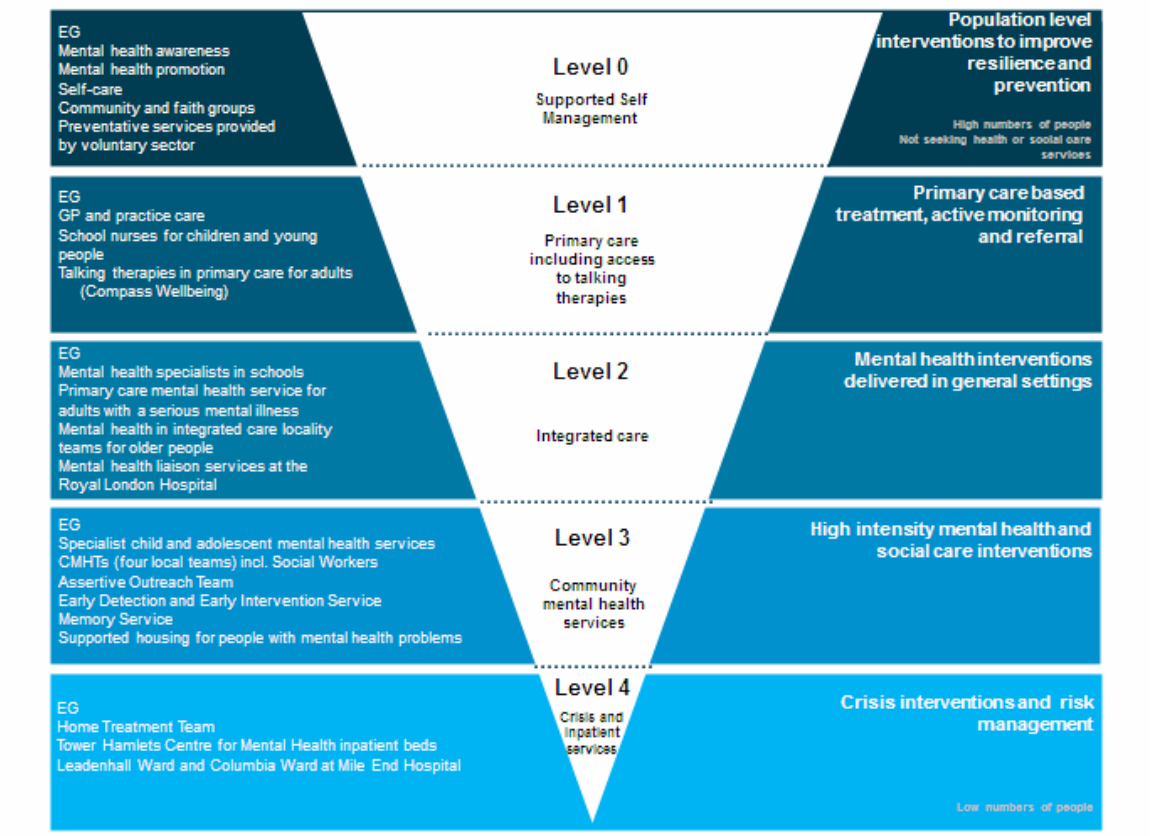
[100] http://www.towerhamlets.gov.uk/lgsl/701-750/732_jsna.aspx

We will develop a referral and diagnostic pathway for people with ASD who are not eligible for mental health services, with clear thresholds for where people may require mental health services (AWA).

7. High Quality Treatment and Support

7.1 A stepped approach to care

In commissioning mental health services to meet the needs of the population, we aim to ensure that there are services available to support people with appropriate interventions tailored to their level of need, as detailed in the diagram below. This model applies for children and young people, adults of working age and older people.



It is our particular aim, as detailed in this Strategy, to develop and improve services within Level 2, mental health interventions delivered in general settings, to support more people with mental health problems to recover and to access low intensity support across a range of health, social care, and educational settings.

7.2 People in general settings like schools and hospitals will have access to mental health support

There are currently 12 childrens centres[101], 74 nurseries and primary schools, 17 secondary schools and 6 special schools in Tower Hamlets[102]. Throughout our engagement to develop this Strategy, community settings for children and young people, most notably schools, have consistently been raised by stakeholders as a key area for developing more capacity and capability in targeted specialist support (Tier 2 CAMHS).

[101] http://www.towerhamlets.gov.uk/lgsl/851-900/888_early_years_and_childcare/childrens_centres.aspx
[102] http://www.towerhamlets.gov.uk/lgsl/1-50/schools/schools_in_tower_hamlets.aspx

This perspective is supported by the 2012 CQC/Ofsted Review of Childrens Services, which found that whilst CAMHS teams work closely with partner agencies, there are gaps in preventative capacity, and that whilst counselling is available in some schools, it is uneven across the borough.

> As part of our coordinated work to design new pathways of support for children and young people, we will develop a new model of Tier 2 mental health support to schools, childrens centres, colleges and youth services. This will incorporate specialist mental health support, mentoring programmes, and generic support provided via the Healthy Child and Nutrition Programme. We will review the evidence base which underpins interventions. This will also include consideration of formal and informal training needs of the school nursing service and the school workforce around mental health, and standards for school counseling. We will consider the possibilities of using social media and new technologies in developing our offer to schools (CYP)

As part of the Clinical Commissioning Group's plans for 2013/14, we have commissioned a two year pilot of a new single fully constituted multi-disciplinary liaison psychiatry team at the Royal London Hospital. This flagship service will provide specialist advice and support for people with a mental health problem who are admitted to the Royal London Hospital, the London Chest and Mile End Hospital, with the express purpose of improving mental and physical health outcomes for service users, and reducing length of stay. The Service is responsible for training the general health care workforce at the hospital in mental health awareness. We are working with an academic partner to evaluate the impact of the service.

> We will evaluate the effectiveness in improving mental and physical health outcomes of our new liaison psychiatry team pilot at the Royal London Hospital (AWA, OP)

It is important that supported housing, residential and nursing care providers for people with mental health problems, including dementia, have access to specialist support. We have over the past few years commissioned a Resettlement Team for adults of working age with a mental health problem, which provides specialist support to the range of housing options that adults of working age may use.

> In the context of our Mental Health Accommodation Strategy, we will review our resettlement and rehabilitation team pathways in order to ensure they are working effectively, and in this context that specialist accommodation providers are appropriately supported by specialist services (AWA)

7.3 People will have access to high quality mental health support in primary care, including GP practices and primary care psychology

7.3.1 Primary care services for people with a common mental health problem

Tower Hamlets has a comparatively high number of people with common mental health problems.

We currently commission a small number of talking therapy services from third sector providers, including those specific to BME communities and for bereavement counselling.Our primary care psychology service, managed by Compass, provides talking therapies for people in a primary care setting, including Tiers 2 and 3 of the national Improving Access to Psychological Therapies programme, and Tier 4 interventions with a clinical psychologist. We also commission a fast access Crisis Intervention Service for people in psychosocial crisis from East London NHS Foundation Trust along with secondary care talking therapies.

Our primary care psychology service has a target of 15% of the total number of people estimated to have depression and anxiety in the borough entering treatment by 2014/15.

Pathways for service users within and between talking therapy services can sometimes be complex and unclear, and it does not appear to be the case that service users always access talking therapy services in line with their need. In addition, it does not appear that either older people or people from BME communities access some talking therapies at the rate that we would expect.

> We will review talking therapies pathways across all providers of talking therapy services to inform future commissioning. We will in particular consider access to talking therapies for older people and people from BME communities (AWA, OP)

In the context of the above, and the section below regarding prescribing, we believe there is a potential case for developing a primary care depression service, to provide time limited expert advice and support to primary care on the management of depression. In the context of the high rate of long term unemployment in Tower Hamlets and the known links between unemployment and depression[103], any future primary care based mental health services would need to ensure they provide effective support for service users wishing to return to or retain work.

> In light of our work on talking therapies pathways and anti-depressant prescribing, we will consider the case for developing a primary care depression service, including support for employment (AWA, OP)

7.3.2 Primary care mental health service for people with a serious mental illness

In partnership with East London NHS Foundation Trust, the Clinical Commissioning Group and Council have over the past year developed a new Primary Care Mental Health Service. The Service is to support service users who have a serious mental illness but who are now stable in primary care. Approximately 300 service users have now been discharged from secondary care mental health services and are now using this service.

[103] JSNA

Whilst in the context of our overall mental health system, in particular the fact that we have high numbers of people known to secondary mental health services who are less likely to be admitted than other boroughs, and therefore should proceed cautiously, we will aim to increase the number of people who can access the primary care mental health service, particularly including those who require depot medication or who are in receipt of a commissioned social care service.

> We will increase the capacity of the Primary Care Mental Health Service to support more clinically appropriate service users to access its support, including service users who require depot medication or who are in receipt of a commissioned social care service (AWA)

A particular success in the development of the primary care mental health service has been the development of regular practice based multi-disciplinary team meetings with consultant psychiatrists. This has helped todevelop good working relationships between primary and secondary care.

> We will work with East London NHS Foundation Trust to further develop the interface between primary and secondary care, with a particular focus on provision of population based advice and support to practices, and the development of primary care consultation by consultant psychiatrists and other mental health professionals (AWA, OP)

Service users have told us that they would like to see more specialist support being delivered in primary care settings, and some practices are keen to see secondary care clinics and CPA meetings being held in practices, where there is appropriate clinical space.

> With East London NHS Foundation Trust, we will further develop opportunities for practice based clinics (AWA)

Service users have told us that consistency in the GP that they see is very important.

> We will work with NHS England, networks and practices to ensure that people who have a serious mental illness have access to a “usual GP” (AWA, OP)

7.3.3 Primary care prescribing

Prescribing practice has frequently not formed part of mental health commissioning activity. However, since medicines are such a central component of the treatment of mental illness, we are determined to understand patterns of prescribing in the borough. Information from NHS England appears to place Tower Hamlets at the top of London for

prescription of anti-psychotic medication, and second highest for prescription of anti-depressant medication, not including prescriptions issued in secondary care[104].

There are currently a number of disparate, often disconnected sources of information available about prescribing, with a number of gaps, and taken together these factors mean that the interpretation of actual prescribing activity is far from straightforward. We believe that medicine useshould not be looked at in isolation, but requires consideration by agencies, professions and service users to properly understand it in context.

> We will develop a more complete understanding of prescribing activity for anti-psychotic and anti-depressant medicine in the borough. Led by our Commissioning Support Unit Medicines Optimisation Team, we will work across the Clinical Commissioning Group, East London NHS Foundation Trust and the Clinical Effectiveness Group at Queen Mary University to identify available meaningful information about prescribing practice, and triangulate this across primary care and secondary care to inform future commissioning and practice development, including the development of more robust care packages including shared care arrangements (G)

We are currently piloting an approach to social prescribing in some practices in the borough, through which GP's can refer service users directly to social and community services. This approach, if adopted more comprehensively across the borough, may help service users to access the range of voluntary sector including mental health services in the community in the borough.

> We will extend social prescribing to mental health (G)

7.4 People will receive a diagnosis and appropriate support as early as possible

Early Intervention as a principle means identifying needs, risks and issues which may escalate into more serious problems, then taking action to provide help for children, young people and families to prevent future problems. We do this by building on people's existing strengths, helping them to achieve good outcomes and ensuring that individuals, families and communities achieve their full potential.[105] Early intervention is a theme that runs through this Strategy, whether it is our approach to developing preventative services for children and young people, or whether it is ensuring that people from BME communities access services at the rate we would expect.

Early intervention teams specifically support people aged between 14 and 35 who are experiencing psychosis for the first time. Early intervention can mean improving outcomes in established cases of psychosis by facilitating and consolidating recovery, identifying untreated cases in the community, or preventing the emergence of psychosis

[104] Primarily prescriptions for in-patients, clozapine, a large proportion of depot medication and initial prescribing of anti-dementia medicine.
[105] Wokingham Borough Council

through pre-psychotic interventions.[106] We know that early intervention services offer an evidence-based outcome approach to supporting people with first time psychosis.[107] Our Early Intervention Team, along with the Early Detection Service are critical to supporting people experiencing symptoms of psychosis for the first time.

[106]Early interventions in psychosis: obstacles and opportunities Swaran, P. Singh & Helen L. Fisher 2005
[107]Briefing: Early intervention in psychosis services, Issue 219 Mental Health Network NHS Confederation May 2011

7.5 Timely access to high quality specialist services

Community service provision in mental health has developed significantly over the past 15 years. The emergence of crisis resolution and home treatment teams, assertive outreach and reshaped community mental health teams, both for adults and older people have become a key feature of effective mental health service provision.

We believe that community based services represent the best means to deliver services to the population of the borough, but that with the direction set out in *No Health Without Mental Health*, the time is right to re-examine the nature, scope and model for these services.

In particular we believe these services should remain multi-disciplinary and integrated across health and social care, and in terms of the professionals who work in them, utilising the skills and expertise of medical doctors, nurses, social workers, psychologists, occupational therapists and other associated health and social care professionals. The development of care packages for Payment by Results presents us with a joint opportunity for commissioners and providers to work together to define the relevant content of the package of care for people using secondary care services. In particular, it provides an opportunity to consider the contribution of social work, and social care, to the mental health care packages, and in particular in relation to the delivery of self-directed support.

> We will work across health and social care commissioners and providers to develop care packages for payment by results, and in particular will consider the contribution of social work and social care (AWA, OP)

We want to strengthen these services for children, young people and in particular for adults. We want to ensure that they are designed to deliver high quality assessment, treatment and support. We also want to make sure people who need these services can access them quickly and at the times when they require them, particularly at times of crisis. With the development of Payment by Results in mental health, it is likely that in the near future service users may be able to choose at least some mental health services from different providers. We want to work together to ensure that local services provide excellent high quality person centred care that service users choose to use.

In this context, and in the context of the national commitment to ensure waiting times for mental health that are at least equal to waiting times for physical health services.

> We will ensure that waiting times for mental health services are minimized, and we will publish waiting times for key services as part of our partnership dashboard (G)

7.5.1 Perinatal services

As noted in the Joint Commissioning Panel Guidance for perinatal mental health, pregnancy and the perinatal period is a time of particular risk to women's mental health. It is a time associated with a substantial

psychiatric morbidity including the risk of developing postpartum psychosis and severe depressive illness and the recurrence of bipolar illness and severe depressive illness and exacerbation of symptoms of schizophrenia. Early identification and support for women at risk is critical and timely access to specialist mental health support for new and expectant mothers is extremely important in promoting a good start to a child's life. We currently commission perinatal mental health services from East London NHS Foundation Trust, with some additional support available to the maternity wards from the Royal London Hospital Psychiatric Liaison Team.

> We will review the recent national guidance for the commissioning of perinatal mental health services published by the Joint Commissioning Panel for Mental Health, and the implementation of NICE ante and postnatal guidance. This will inform our strategic thinking about how best to ensure suitable and effective services for this group (AWA)

There is substantial emerging evidence that the first three years of a childs life are critical to their overall life outcomes, with the development of infant attachment, parent infant communication and support for the infant to learn emotional regulation for life long emotional resilience and risk of mental illness. In Tower Hamlets we wish to ensure that we work across the partnership to give every child the best start in life.

> As part of partnership work across health, local authority, voluntary and community sectors we will improve the availability and consistency of support during pregnancy and in the first year of life to promote parent/infant attachment, parent and infant communication and emotional regulation in order to promote lifelong resilience and mental health and wellbeing (CYP).

7.5.2 Services for children and young people

As noted throughout this document, we will co-ordinate work to design new pathways for children and young people with mental health problems. This will include Tier 2, and 3 CAMHS services currently provided by East London NHS Foundation Trust. In particular we will wish to ensure that children and young people and their parents have to wait as little as possible for an appointment, that people who do not attend are robustly followed up, and that communication back to referrers is timely.

> As part of our coordinated work to design new pathways of support for children and young people, we will consider Tier 2 and 3 CAMHS services, with the aim of ensuring that waiting times are as little as possible, that people who do not attend are robustly followed up, and that access to services by BME communities are in line with what we would expect (CYP)

7.5.3 Community services for adults of working age

We believe that pathways for adults of working age are broadly stable at present. This is in the context of the comparatively low rate of admissions to hospital of adults with a mental health problem, and the consequent occupancy. It is also in the context of the 2013 national community survey, which found East London NHS Foundation Trust to be in the top ten Trusts in the country for positive reported service user experience, and from feedback from a recent GP survey which found that on the whole, GP's are very satisfied with community mental health services as they currently are.

As noted above, the introduction of the Children and Families Bill, and the potential development of services for children and young people which extend to the age of 25, and in the context of the development of primary care mental health services and the review of community mental health services for older people detailed below, we will consider the configuration of community mental health services for adults of working age.

> We will consider the configuration of adult community mental health services in light of work to develop CAMHS services and our review of older adults mental health services (AWA)

There are some areas where we believe services can be considered, and improved, and some outstanding questions which we will consider during the implementation of the Strategy. For example, the JSNA has highlighted the pressure placed on the current system by the needs of people with a dual diagnosis of mental illness and substance misuse, the increase in referrals from A&E, the high number of people referred to community services recorded as not previously known, and a high percentage of referrals to community services who do not get as far as an assessment. We will review these though our regular dialogue with providers and service users and carers.

> With the Drug and Alcohol Action Team we will review the design of support for people with a dual diagnosis including a serious mental illness and a substance misuse and/or alcohol problem (AWA)

Community mental health teams will remain the primary team in which the initial assessment and support of people with a serious mental health problem is delivered. The CMHT's are linked in with, and provide a single point of access for referrals from, GP networks and practices, and this arrangement will remain in place as the basis for any pathway improvements. There has been some mixed feedback from stakeholders whilst developing this Strategy that there may be a case for a single point of access to mental health services in the borough. However this would also potentially impact on the significant progress that has been made between GPs, CMHT's and consultant psychiatrists over the past two years. In addition, there has been mixed feedback regarding whether CMHT's should provide extended hours, mirroring GP practice hours, and weekends. It is not clear whether extended hours mental health teams have provided any better outcomes for service users[108], however2013/14 NHS England planning guidance notes commissioning extended hours services generally as a priority.

> We will pilot an extended hours CMHT service to evaluate the extent to which it would deliver better outcomes for service users (AWA)

[108] http://onlinelibrary.wiley.com/doi/10.1046/j.1440-1584.2003.00513.x/abstract?deniedAccessCustomisedMessage=&userIsAuthenticated=false

There are, however, a number of areas where we believe community mental health services for adults of working age can be improved. Many of the themes of Section 8 below, living well with a mental health problem, are relevant here, so in this section we will only detail areas that do not appear in Section 8.

As noted above, current relationships and working practice between CMHT's and primary care are generally considered to be working effectively by GP's. There are opportunities for building on this, as identified in Section 6.3 above. There are also opportunities for improving operational systems and processes, in particular communication around medication, and physical health tests where people are on anti-psychotic medicines. We included a CQUIN to improve electronic communication in the contract with East London Foundation Trust during 2013/14.

> We will develop the interface between primary and secondary care, with a particular focus on further developing the presence of secondary care clinicians in a primary care setting, as detailed elsewhere in this strategy (G)

> We will improve communication and the flow of clinical correspondence (G)

As noted below, our Accommodation Strategy for Adults of Working Age with a mental health problem is currently being implemented. As part of this Strategy we have for the past three years commissioned a Resettlement Team to provide specific support for adults living in a supported housing or residential care placement, alongside the existing Community Rehabilitation Team, which provides sub-contracted clinical support to the Tower Hamlets Rehabilitation House, provided by Lookahead Housing and Care. In addition, within the East London NHS Foundation Trust contract, we purchase three rehabilitation beds on Jade ward at the Newham Centre for Mental Health.

> To ensure that we commission appropriate rehabilitation and resettlement care pathways, with appropriate clinical support to supported housing and residential care providers in the borough, we will review the entire resettlement and rehabilitation pathway (AWA)

The Assertive Outreach Team has recently taken on a greater responsibility for service users with a forensic history. As noted above, we will develop a JSNA factsheet specific to the mental health needs of offenders to help inform future commissioning of community services for people with a mental health problem and a forensic history.

7.5.4 Dementia

Dementia is a key national priority. Over the past three years, we have delivered significant improvements in services for people with dementia and their carers in line with the priorities set out in the national strategy. As a consequence our community dementia pathway won the national 2013 Local Government Chronicle Health and Social Care Award, for its demonstration of how integrated health and social care can contribute to improved outcomes and experience for service users and carers, whilst

delivering efficiencies into the health and social care economy.

Despite our successes, we still have a number of ambitions to continue to improve services for people with dementia and their carers.

In particular, we believe that the national Direct Enhanced Service for GP's which comes into place in October 2013 will help to further drive up our already impressive improvement in diagnosis rate. We believe there are opportunities to improve coding practice for people with dementia in primary care, and have set our ambition at 65% of the 1150 prevalence of people with dementia in the borough being coded as having dementia in primary care by 2015. We also wish to have clearer information on the extent to which people with dementia are prescribed anti-psychotic medicine, to help inform future commissioning.

> We will work with the Clinical Effectiveness Group at Queen Mary University to audit coding of people with dementia in primary care, and prescribing of anti-psychotic medicine to people with dementia, to enable us to understand patterns of prescribing in more detail, to inform future commissioning (OP)

We believe that we can do more to support people with dementia and their carers to live well with dementia, in particular in accessing peer support, in making flexible respite services available for people in their own homes, via carers personal budgets, and through commissioning high quality support for people with dementia when they do need care in supported accommodation or nursing home settings.

> We will commission more dementia cafes to provide peer support for people with dementia and their carers (OP)

> We will develop a range of respite options appropriate for people with dementia, for carers to choose from (OP)

> We will review pathways into services, and service specifications for commissioned residential, nursing and continuing care for people with dementia to improve the quality of these services (OP)

There are no specific services for people with dementia related to alcohol use in Tower Hamlets, although the prevalence of alcohol misuse is high.

> We will review pathways for people with alcohol-related dementia, and will consider the review to inform future commissioning (OP)

People with dementia are highly likely to be at risk of admission to hospital, and therefore are highly likely to be eligible for support via our new integrated health and

social care teams. As noted in Section 6.5 above, we will ensure that support for the teams around mental health, including dementia, is at the heart of our integrated care model.

7.5.5 Services for older people with functional mental health problems

Although age-related decline in mental well-being should not be seen as inevitable, older people form the majority of people using health and social care services. Older people are not a homogenous group and this is reflected in the range of services required to meet their needs. Mental health of older people is not just about dementia but also about, depression, schizophrenia, suicide, and substance misuse.

The impact of older people's mental health needs is wide ranging, having an effect not only on the person themselves, but also on their family, friends and carers. The demand for services in Tower Hamlets may remain reasonably static, given that the JSNA shows that people aged 65 and over make up a relatively small proportion of the population in comparison to London as a whole, although the population of people aged over 85 is set to increase significantly.

We recognise that for older people, the skill set of staff may be different from those working with younger adults and the needs of the two groups may be different.[109] However we also believe that there are opportunities for re-considering the current model of CMHT for Older People, in particular considering how mental health care of older people services may be more fully integrated within our proposed integrated health and social care teams where service users have complex co-morbidities. The JSNA notes that current methods of collecting and monitoring data have not focused on services received by older people with schizophrenia or with depression, and reports concerns from service users and carers about support from primary care and a perceived reliance by all NHS providers on prescribing medication.

> We will review the current arrangements for community services for older people with functional mental health problems, to ensure that opportunities for integrated care are maximized, in the context of the development of our integrated care model (OP)

> We will ensure that older people have access to the Primary Care Mental Health Service (OP)

Improving access to the right range of interventions for older people is important. There growing evidence that psychological therapies are effective with older people and their carers in the management of a wide range of mental and physical conditions, [110] as identified in Section 6.3 above.

[109] Minshull, 2007

110 *Effectiveness of psychological interventions with older people* Woods, B et al 2005in *What works for whom?* Roth and Fonergay eds. NY Guilford Press 2006

7.6 People will be able to access timely crisis resolution, close to home

People in mental health crisis should be able to access mental health services with the same speed as if they had a physical health problem. Crisis support is a national priority, and good practice in crisis pathways will shortly be summarized in a national Crisis Concordat, which is pending publication. In Tower Hamlets, our crisis care pathway, constituting primarily the Accident & Emergency department at the Royal London Hospital supported by the new mental health liaison service, the Home Treatment Team and crisis house, and inpatient wards at the Tower Hamlets Centre for Mental Health, is largely working effectively.

> We will review our crisis pathway against the Crisis Concordat when published to ensure that we are compliant (G).

With commissioning consortium colleagues, we are currently reviewing Home Treatment Team practice across East London. We have also commissioned an evaluation of the ten bedded Crisis House we currently commission from Look Ahead Housing and Care in Tower Hamlets.

> We will use the east London wide Home Treatment Team review and our local review of the Tower Hamlets Crisis House to inform our future commissioning of community crisis pathways (AWA)

7.6.1 Crisis Management

The role of the Police in mental health is very important. Police are often on the front line of managing mental health crises, either in mental health act assessments, or in the exercise of their duties under s. 136 of the Mental Health Act. The recent Independent Commission into Mental Health and Policing[111] found a number of opportunities for the Police to improve their practice around mental health. Equally, the Report found opportunities for the London Ambulance Service to improve responsiveness in the management of mental health problems.

> We will invite the Police and London Ambulance Service to participate in the Tower Hamlets Mental Health Partnership Board, to ensure that there is a strategic overview of the management of mental health crises for Tower Hamlets residents (G)

7.6.2 Inpatient services for adults of working age

Acute adult inpatient wards provide care with intensive medical and nursing support for patients in periods of acute psychiatric illness.[112] Some people go into hospital voluntarily, whilst some are detained under the provisions of the Mental Health Act 1983 (amended 2007).

[111] http://www.wazoku.com/independent-commission-on-mental-health-and-policing-report/

[112] www.nepho.org.uk/uploads/doc/vid_6341_AMHMappingAtlas2000.pdf

In 2010, there was a homicide on Roman Ward at the Tower Hamlets Centre for Mental Health. This tragic incident, with such terrible consequence for the victim and their family, has resulted in a relentless focus on the safety and quality of in-patient care at the Tower Hamlets Centre for Mental Health and across East London Foundation Trust over the past three years. Squarely focused on improving clinical leadership, staff skills, knowledge and compassion, and staff capacity, East London Foundation Trust, with the support of commissioners, has made dramatic improvements to in-patient care. Additional Psychiatric Intensive Care capacity, most recently for women, has added to the ability of the in-patient teams to support service users who are very unwell and at their most vulnerable.

Whilst the number of admissions is low compared to other boroughs in the Trust, admissions have gone up over the last two years, and the number of people admitted under the Mental Health Act has also increased. However occupancy in Tower Hamlets has remained stable at safe levels over the course of the last year, pressure on in-patient beds remains a concern across the Trust. As a consequence, we are working with the Trust across the Consortium to identify opportunities for improvements to bed occupancy. In City & Hackney, a women's only ward with dedicated consultant leadership is currently being piloted. In Newham, a triage admissions ward is currently being piloted.

Understanding how inpatient beds and community services can best be utilised as part of coherent crisis pathways is critical to ensuring safe and effective mental health services.

> In the context of the pilot work detailed above, we will work across the Consortium with East London NHS Foundation Trust to consider the current crisis pathways, and identify any options for the future design of services that optimize safety, outcomes for service users, and value for money (AWA, OP)

7.6.3 In-patient services for older people and people with dementia

In 2012 we ran a successful consultation on proposals to create a new assessment ward for people with dementia at Mile End Hospital to support the population of east London, in the context of the considerable improvement in community services for people with dementia and rapidly falling occupancy of inpatient wards as a consequence. There has over the last year been a similar reduction in occupancy in inpatient services for older adults with functional mental health problems.

> In the context of current occupancy across East London wards, we will review in-patient services for older adults with functional mental health problems(OP)

7.7When they need to access multiple services, people will feel that they are joined up

7.7.1 The mental health of people with long term conditions and integrated care

We know that around 30% of the population of England has a long term condition, and that people with long term conditions are 2 to 3 times more likely to have a mental health problem. It is particularly likely that people with cardiovascular disease, diabetes, chronic obstructive pulmonary disease and some musculo-skeletal conditions will have a mental health problem. It has been estimated that between 12 – 18% of all expenditure on long term conditions is linked to mental health[113].

Through our development of liaison services at the Royal London Hospital, East London NHS Foundation Trust will work with Barts Health to ensure that mental health problems in people admitted for a physical health problem are identified, offered appropriate treatment, and sign-posted into appropriate community services on discharge.

Through our work to build a "mental health is everybody's business" culture within the Clincial Commissioning Group, we will ensure that relevant chronic disease workstreams consider opportunities for better integrating mental health support with primary care and chronic disease management programmes, with closer working between mental health specialists and other professionals.

Through our work to develop an integrated care system to support people who have the most complex health and social care problems, including those who are most at risk of admission to hospital, we are currently developing with Barts Health and the Local Authority new integrated locality health teams, that are linked into primary care networks, alongside a new Network Improved Service[114] through which primary care clinicians will provide additional support older people with complex needs. We are determined to ensure that mental health is at the heart of our plans for integrated care, and to this end, are currently piloting half a post community mental health nurse in each locality team. The role of the nurse is to provide mental health expertise to the teams providing support for people with complex health and social care needs, ensuring that mental health problems are identified, and supported, and that where appropriate service users are supported to access specialist pathways.

> We will commission specialist mental health input into the new community integrated care service to ensure that services can address the holistic needs of patients and service users in one place (OP)

Effective communication through shared IT platforms is critical to the success of integrated care. Whilst there are some complexities around information governance, and the utility of technical solutions, it is critical that mental health providers participate in the development of the WELC Pioneer IT strategy.

[113] http://www.kingsfund.org.uk/publications/long-term-conditions-and-mental-health
[114] A contract with networks of GP practices for services that are over and above primary medical services.

We will work with East London NHS Foundation Trust to ensure that our IT Strategy is inclusive of mental health (P)

7.8People with a mental health problem will have high quality support with their physical health

People with severe mental illness die on average 20 years younger than the general population, often from preventable physical illnesses.[115] People with mental illness have a higher prevalence of smoking, drug and alcohol misuse, an increased risk of physical illness andreduced life expectancy. 42% of all tobacco consumed in England is smoked by people with mental disorders.[116]As a further example, depression is associated with a 50% increased mortality from all diseaseand reduced life expectancy of around 11 years in men and seven years for women. Schizophrenia is associated with increased mortality from all diseaseand a reduced life expectancy of around 21 years for men and 16 years for women.[117]People with mental health problems are almost twice as likely to die from coronary heart disease as the general population and four times more likely to die from respiratory disease[118119120].

In Tower Hamlets, people with a serious mental illness are significantly more likely to smoke, be obese, and have cardiovascular disease[121]. Improving the physical health of people with a serious mental illness is therefore a central priority of this Strategy.

We have already worked across the Partnership to develop our approach to improving the physical health of people with a serious mental illness. Information on physical health is now routinely shared across primary and secondary care. A GP assesses all people who are admitted to the mental health wards at Mile End Hospital. East London NHS Foundation Trust has worked hard to improve the knowledge and skills of staff, and assessment processes, to ensure that physical health needs are identified and appropriately assessed. We have also begun to work with the voluntary sector and providers of specialist healthy living services, the health trainers, smoking cessation, obesity services and sexual health, to identify the most appropriate service models and practice to support people with mental health problems to lead healthy lifestyles. The Council's current review of the public health healthy lifestyles programmes, in the context of their proposed re-commissioning, offers opportunities to ensure that mental health is mainstreamed.

In the review of the Healthy Lifestyles programmes, including healthy community and environment; maternity, early years and childhood; oral health, tobacco cessation; long term conditions, we will ensure that the specific barriers to access for people with a serious mental illness are addressed (G)

[115] 20 Years too Soon Rethink 2012
[116]Cigarette smoking and mental health in England Data from the Adult Psychiatric Morbidity Survey. London: National Centre for Social Research.McManus S, Meltzer H, Campion J 2010
[117]Guidance for commissioning public mental health services JCP-MH 2012
[118] Brown S, Inskip H and Barraclough B. Causes of the excess mortality of schizophrenia British Journal of Psychiatry,2000; 177: 212.
[119] Cohen A and Phelan M. The physical health of patients with mental illness: a neglected area, Mental Health Promotion Update, 2001; 2: 15-6
[120] Nocon A. Background evidence for the DRC's formal investigation into health inequalities experienced by people with learning difficulties or mental health problems, Disability Rights Commission (www.drc-gb.org) London; 2004.
[121] JSNA.

We will in particular ensure that in the re-commissioning of tobacco cessation and obesity services,that access for people with a serious mental illness isaddressed (AWA)

8. Living well with a mental health problem: a recovery culture

8.1 People will feel that mental health services treat them with dignity and respect, and inspire hope and confidence

The single highest priority for service users of working age in the development of this Strategy is to build a recovery culture across Tower Hamlets mental health services.

In mental health, recovery does not always refer to the process of complete recovery from a mental health problem in the way that we may recover from a physical health problem. Recovery means the process through which people find ways of living meaningful lives with or without ongoing symptoms of their condition.[122]The guiding principle is the belief that it is possible for someone to regain a meaningful life, despite serious mental illness. Recovery emphasises that, while people may not have full control over their symptoms, they can have full control over their lives.[123]

Tower Hamlets is committed to taking forward plans to make recovery and living well with a mental health problem a key pillar of our approach to commissioning and providing services. There are several building blocks that we set out in this strategy that we believe are a central to this way of working. Many of the commitments in this Strategy are linked to the concept of recovery, from the delivery of preventative services, to compassion in care, to peer support.

8.1.2 Compassion, respect and dignity

As made clear it is our core collective value that service users should at all times be treated with, and feel that they have been treated with, compassion, dignity and respect. It is the responsibility of all professionals working in health and social care to ensure that they relate to service users in this way. In many ways, in mental health these principles are even more important, since service users tell us that the single most important thing to them in their care and treatment is the therapeutic alliance that they have with the professionals with whom they work, and many service users report stigma and discrimination, including by health and social care professionals.

As commissioners, we have included CQUIN incentives in our contract with East London NHS Foundation Trust during 2013/14 to measure service user experience through the Friends and Family Test, and to pilot 360 degree appraisal incorporate service user feedback into staff appraisal.

Across the Consortium, we will evaluate these CQUIN pilots to consider extending them both within the ELFT contract and to other providers (G)

As staff experience and satisfaction is so key to an organizations ability to provide compassionate care, we will work locally and across the Consortium to consider potential measures of staff experience

[122] Supporting recovery in mental health NHS Confederation 2012
[123] Recovery definition Mental Health Foundation

into contractual arrangements with mental health service providers in the future (G)

8.1.3 A strong recovery culture

The *Implementing Recovery through Organisational Change (ImROC)* project is an approach to helping people with mental health problems that aims to change how the NHS and its partners operate so that they can focus more on helping those people with their recovery.[124] It is a national project led jointly by the NHS Confederation and the Centre for Mental Health.

ImROC has identified three key principles that agencies should consider in relation to recovery:

- The continuing presence of hope that it is possible to pursue one's personal goals and ambitions
- The need to maintain a sense of control over one's life and one's symptoms
- The importance of having the opportunity to build a life 'beyond illness.

ImROC has also developed a structured approach to supporting partnerships to self-assess their recovery orientation, and develop plans for further developing a recovery culture.

We will work across the Partnership to self-assess our commissioning practice and service provision by statutory and voluntary sector partners, using the ImROC approach, as the starting point in the delivery of our ambitions to develop a recovery culture (AWA)

8.1.4 Recovery College

Recovery Colleges deliver comprehensive, peer-led education and training programmes within mental health services. In recent years many health and social care organisations have begun to develop recovery colleges, many are still pilot schemes but there is an emerging evidence base for the effectiveness of this approach.

Recovery colleges should be run like any other college, providing education as a route to recovery, not as a form of therapy. Courses are co-devised and co- delivered by people with lived experience of mental illness and by mental health professionals. Their services should be offered to service users, professionals and families alike, with people choosing the courses they would like to attend from a prospectus. As well as offering education alongside treatment for individuals they also change the relationship between services and those who use them; they identify new peer workers to join the workforce; and they can replace some existing services.[125]

The power of Recovery Colleges is two-fold. First, they assist the individuals whom they serve in their personal and collective journeys of recovery. Second, they assist organizations and services to become more recovery-focused.[126]

[124] Supporting recovery in mental health NHS Confederation 2012
[125] NHS Confederation http://bit.ly/11gPzbk
[126] ImROC: Recovery colleges Perkins, R. Repper, J. Rinaldi, M. Brown, H. Centre for Mental Health 2012

We will commission, via non-recurrent funds, a provider or consortium of providers to develop a self-sustaining recovery college (AWA)

8.1.5 Day opportunities services

Access to meaningful activity during the day is for many people a very important component of a fulfilling life. This may mean employment, training and education, or using the variety of leisure and supportive opportunities that there are in the borough. Wherever possible, the aim should be for service users to feel supported to access mainstream services. For some, however, services specific to people with mental health problems will be most appropriate.

In our refresh of our review of voluntary sector day opportunity and support services, we will consider the appropriate range and balance of day opportunities services that should be provided in the borough (AWA)

8.2 People will have access to support from peers and service user led services

We know that current and former service users can help to support people who currently experience problems with their mental health. Peer Support is one way of helping people recover from mental distress and its impact on their lives. It enables people to provide knowledge, experience, and emotional, social or practical help to each other. Peer support relies on the assets, skills and knowledge in the community, and the recognition that local people can offer help in ways that are sometimes more effective than professional help. There is a emerging evidence base that peer support is an effective and cost effective means of delivering support for mental health service users.[127]

Locally, we know that our annual programme of user-led grants for mental health service users to have choice and control to develop their own ideas about how to support each other is a tremendous success. Equally, some of our supported housing providers are actively developing peer support groups. We believe there are opportunities for user led peer support groups to be a very effective means of engaging people who may otherwise be hard to reach.

We will strengthen our approach to commissioning user-led grants to enable more service users to see their ideas for peer support realized in practice. We will also examine opportunities for service users to pool their personal budgets (health or social care) to form user led groups (G)

[127] Wellbeing Enterprises CIC/NTA/NHS Nottinghamshire

In particular, we will explore how peer support may be delivered as part of the new primary care mental health service, and how applications for user led grants can be encouraged from hard to reach groups (AWA, OP)

We will include in future specifications for relevant and appropriate services a requirement that an element of the service be delivered through peer support. This may include services delivered both by statutory and voluntary sector services (G)

8.3 People will be able to make choices about their care, including through personal budgets

At the heart of a person-centred recovery-orientated approach to mental health support, is the notion that service users should have choice and control over their care and support options[128].

This includes shared decision making[129], where service users are involved in making decisions about their clinical care and support. It includes the emergent thinking about personal health budgets[130] for which there have been successful pilots in mental health. It also includes accessing a personal budget to support direct decision making to purchase social care support to meet eligible needs.

We will work across the Consortium to consider opportunities for developing, and commissioning, the shared decision making approach in practice (AWA, OP)

We will develop capacity and capability for personal health budgets for people in receipt of continuing care funding, including mental health. We will look to pilot personal health budgets more generally in mental health, as more evidence accumulates nationally (AWA, OP)

Take up of personal budgets for commissioned social care by people with mental health problems has progressed over the last eighteen months. However as noted above, we believe that there are opportunities for developing greater clarity on how Payment by Results may work alongside social care payment systems in the context of self-directed support. Can we have an action box about promoting this.

8.4 People will feel supported to develop relationships and connections to mainstream community support

Throughout this Strategy, we have emphasized the importance of connectedness

[128] Whilst service users detained under the Mental Health Act clearly have limits on choice and control, there are still opportunities for delivering choice and control within parameters.
[129] http://www.rightcare.nhs.uk/index.php/shared-decision-making/
[130] http://www.personalhealthbudgets.england.nhs.uk/

and relationships, whether this is in the compassion of a therapeutic relationship between a mental health nurse and a service user in crisis, or in the peer support groups that we will commission to support service users to support each other, or in our approach to working across the partnership to combat loneliness.

8.5 People will have access to support to find employment, training or education

Many people who experience mental health problems face difficulties in gaining and maintaining employment. They often face stigma and discrimination that sometimes results in losing their job or challenges in getting a job. People who experience severe and enduring mental health problems have one of the lowest employment rates. Only one user in five of specialist mental health services either has paid work or is in full-time education.[131]

The proportion of people claiming Incapacity Benefit (IB) for mental health problems nationally rose from 26% to 41% between 1996 and 2006.[132] In Tower Hamlets during 2010/11 the rate of working age adults that were unemployed (per 1,000) was 104.3, which is significantly worse than both London (69.9) and England (59.4).[133] Mental health issues and behavioural disorders accounted for 45.4% of all IB/SDA claims and 44.7% of ESA claims. Taken together, this accounted for 44.8% of all claims for a work limiting illness.[134]

Helping people to maintain or gain employment is therefore an important part of recovery and building independence. Tower Hamlets is committed to refocusing current services and developing new forms of support to help people find and keep work.

Through our collective approach to implementing the Time to Change pledge we hope, over time, to build a coalition of suppliers who recognize the benefits of being a mindful employer, and use the opportunities to combat stigma and discrimination in the workplace and thereby open up opportunities for people with mental health problems.

We also recognize the need for specific employment related support for people with mental health problems, to retain employment and to secure employment. This is the case not just for people with a serious mental illness, but also people with a common mental health problem.

> We will review the services we jointly provide and commission to support people into employment. We will ensure that we consider the evidence on what works in our refresh of our review of voluntary sector day opportunity and support services(AWA)

[131] Removing barriers: the facts about mental health and employment Centre for Mental Health 2009
[132] ibid
[133] Tower Hamlets Mental Health JSNA 2013
[134] ibid

8.6 People will have access to accommodation that meets their needs, in the borough

Good quality, affordable, safe housing underpins our mental and physical wellbeing. All too often, severe mental ill health can lead to homelessness. People with mental health problems, particularly those with a serious mental illness can sometimes find it difficult to secure and maintain good quality accommodation.

A settled home is vital for good mental health. When it is part of an effective recovery pathway, housing provides the basis for individuals to build a more independent life, in many cases returning to work or education, whilst still receiving the support and help they need. By working together, mental health and housing providers can make those transitions easier and provide advice and support to help people navigate the system.[135]

People with mental health problems are far less likely to be homeowners and far more likely to live in unstable environments. Homeless populations are a vulnerable 'marker' group in several respects; they have poorer physical and mental health status.

Housing with support can improve the health of individuals and help reduce overall demand for health and social care services. When housing is part of an effective recovery pathway, it provides the basis for individuals to build a more independent life, in many cases returning to work or education, whilst still receiving the support and help they need.[136]

There are compelling arguments for both the increased investment in housing and the reconfiguration of services in mental health to include a stronger housing element. There has been recognition of this locally and a reconfiguration of hostel provision is being proposed currently to better meet these needs. There are a number of ways in which housing and housing related support services contribute to improved outcomes at lower cost. For people with mental health problems this means a focus on four areas:

- Risk reduction;
- Prevention and demand management;
- Early discharge from acute settings to step-down facilities;
- Ending of out borough placements.

Through our *Commissioning Strategy for the Accommodation of Working Age Adults with a Mental Health Problem*, we have significantly increased the number of high support units of supported accommodation for people with mental health problems in the borough, with new forensic and complex needs schemes due to open later this year. For people with dementia, as part of our Commissioning Strategy for People with Dementia and their Carers, we have developed a new Extra Care Sheltered Scheme for people with dementia. More generally, we are currently developing new proposals for hostel accommodation.

We will continue to implement our Commissioning Strategy for the Accommodation of Working Age Adults with a Mental Health Problem (AWA)

[135] Housing and mental health Appleton, S. Molyneux, P. NHS Confederation 2011
[136] Understanding the housing landscape and the opportunities of working with housing associations National Housing Federation (to be published May 2013)

These developments will link closely with our work across east London to consider future design of inpatient beds, to ensure the right balance between hospital and community based services, including non-health support services such as housing and housing based support.

9. How the strategy will help meet the objectives in the national mental health strategy*No Health Without Mental Health*

This Strategy is one of the four priority areas with the Tower Hamlets Health and Wellbeing Strategy. The indicators set out below are included within the local Strategy's dashboard and these are monitored by the Board every six months.
national *No Health Without Mental Health*Mental Health Strategy.

The diagram below summarises how we believe our objectives will deliver against the national outcome indicators, and details the links to the national NHS, Public Health, and Adult Social Care Outcome Framework indicators.

No health without mental health outcome	**Vision statement objectives**	**Linked indicators from national outcomes frameworks**
More people will have good mental health	People will have access to a range of preventative and health promotion services Mental health awareness across our communities, schools and employers and in the health, social care and education workforce will improve At risk communities will have access to targeted preventative support People will have timely access to specialist mental health services	People with dementia prescribed anti-psychotic medication People in prison who have a mental illness or significant mental illness Emotional well-being of looked after children Self-reported wellbeing Suicide rate
More people with mental health problems will recover	People will have access to high quality mental health support in primary care, including GP practices and primary care psychology People will have timely access to specialist mental health services People will receive a diagnosis and appropriate support as early as possible People will be able to access timely crisis resolution, close to home People will have access to support from peers and service user-led services People will be able to make choices about their care, including through personal budgets People will feel supported to develop relationships and connections to mainstream community support	Access to community MH services by people from BME groups Access to psychological therapy services by people from BME groups Placeholder: Access to psychological therapies Recovery following talking therapies (all ages and >65) Estimated diagnosis rate for people with dementia Proportion of adults in contact with secondary mental health services in paid employment Placeholder: Dementia, measure of effectiveness of post-diagnosis care in sustaining independence and improving QoL

	People will have access to support to find employment, training or education People will have access to accommodation that meets their needs, in the borough	Mental health readmissions within 30 days of discharge Proportion of adults in contact with secondary mental health services in paid employment Adults in contact with secondary mental health services who live in stable and appropriate accommodation
More people with mental health problems will have good physical health	People in general settings like schools and hospitals will have access to mental health support When they need to access multiple services, people will feel that they are joined up People will have access to high quality mental health support in primary care, including GP practices and primary care psychology People with a mental health problem will have high quality support with their physical health Mental health is everybody's business	People with severe mental illness who have received a list of physical checks Severe mental illness: smoking rates Excess under 75 mortality in adults with serious mental illness Health-related quality of life for people with a long-term mental health condition
More people will have a positive experience of care and support	People will have access to improved information on what services are available People will feel that mental health services treat them with dignity and respect, and inspire hope and confidence Families and carers will feel more supported People will experience smooth transitions between services	Patient experience of CMH services
Fewer people will suffer avoidable harm	Focus on quality improvement	Hospital admissions as a result of self-harm
Fewer people will experience stigma and discrimination	Fewer people will experience stigma and discrimination Mental health awareness across our communities, schools and employers and in the health, social care and education workforce will improve Shared values: a whole person approach	

10. Conclusion

This mental health strategy has been developed through an analysis of local need, review of the evidence base for effective intervention, and listening to the views of local stakeholders.

This strategy sets out our commitments for the delivery of better outcomes for people with mental health problems in Tower Hamlets over the next five years. By working across the lifecourse, with a commitment to achieving parity of esteem, enhancing recovery and sharing a common set of values aboutpromoting high quality, outcome driven services, we believe that there is the opportunity to achieve change. This will need to happen within a more constrained financial settlement and will require partnership at all levels if we are to succeed.

It is our intention that this is a live strategy. We will review the action plan at an annual mental health summit in the Autumn of each year in order to refresh the action plan for the year ahead. Our action plan for the delivery of the strategy over the next two years is available separately.

Appendix One: Summary of mental health specific indicators in the NHS, Public Health and Adult Social Care Outcomes Frameworks

Frame work	Domain	Indicator (note indicators highlighted in orange are in the CCG outcome indicator set)
NHS Outcomes Framework	Domain 1: Preventing people from dying prematurely	People with severe mental illness who have received a list of physical checks
		Severe mental illness: smoking rates
		1.5 Excess under 75 mortality in adults with serious mental illness
	Domain 2: enhancing QoL for people with LTC	Access to community MH services by people from BME groups
		Access to psychological therapy services by people from BME groups
		Recovery following talking therapies (all ages and >65)
		Health-related quality of life for people with a long-term mental health condition
		2.6i Estimated diagnosis rate for people with dementia
		People with dementia prescribed anti-psychotic medication
		2.5 Employment of people with mental illness
		Placeholder: Measure of effectiveness of post-diagnosis care in sustaining independence and improving QoL
	Domain 3: Helping people to recover from episodes of ill health/injury	Placeholder: Access to psychological therapies
		Mental health readmissions within 30 days of discharge
		Proportion of adults in contact with secondary mental health services in paid employment
	Domain 4: Ensuring people have a positive experience of care	4.7 Patient experience of CMH services
Public Health Outcomes Framework	Domain 1 Improving the wider determinants of health	Adults in contact with secondary mental health services who live in stable and appropriate accommodation
		People in prison who have a mental illness or significant mental illness
		Employment for those with a long-term health condition including those with a learning difficulty/disability or mental illness
	Domain 2: Health improvement	Hospital admissions as a result of self-harm
		Emotional well-being of looked after children
		Self-harm
		Self-reported wellbeing
	Domain 4: Healthcare public health and preventing premature mortality	Excess under 75 mortality in adults with serious mental illness
		Suicide rate
		Estimated diagnosis rate for people with dementia
Adult Social Care Outcomes Framework	Domain 2: Enhancing QoL for people with care and support needs	1F. Proportion of adults in contact with secondary mental health services in paid employment
		1H. Proportion of adults in contact with secondary mental health services living independently, with or without support
	Domain 2: Delaying and reducing the need for care and support	2F: Placeholder. Dementia: A measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life.

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TOWER HAMLETS

NHS
Tower Hamlets
Clinical Commissioning Group

A summary of the draft

Tower Hamlets Mental Health Strategy

Tell us what you think

Tower Hamlets Health and Wellbeing Board

Foreword from London Borough of Tower Hamlets

Lutfur Rahman
Mayor

As the first directly elected Mayor of Tower Hamlets, I am determined to make a positive difference to the lives of people in our community who are vulnerable, whether this is through ill health, economic hardship or any other kind of disadvantage.

One of the most vulnerable groups in our community are those who face mental ill-health and I believe that all partners in the borough have a duty to improve services and life outcomes for this group.

This is why the Health and Wellbeing Board has identified mental health as one of its four key priority areas, and why we are now consulting on this, our mental health strategy, as the vision and approach through which we will aim to work together to improve mental health support over the next three years.

This strategy takes a life course approach. This means that it focuses on the needs of children and young people, adults of working age, and older people. I believe strongly that to support our community to flourish in the future, we have to invest now in our children and young people, and that supporting children to develop the resilience that they can carry through into later life is key, as is supporting families when they have difficulties, including where the parent has a mental health problem.

Two priorities for this strategy are tackling the wider determinants of mental ill-health and challenging the stigma and discrimination around mental health.

With Public Health now part of the Council, we have an opportunity to work together to target the other areas which affect mental health, for example working to improve poor housing, tackling crime, and improving educational outcomes. It will be our aim, in the Council, to ensure that mental health really is everybody's business.

In 2012 I signed the Time to Change pledge, a national anti-stigma programme, spear-headed by MIND and Rethink. I signed the pledge out of a deeply held conviction that the Council can make a real difference to the stigma and discrimination that people with mental health problems still too often experience.

I am very pleased indeed that we will be closing the consultation on this strategy with an event to mark the next stage of our work to reduce stigma and discrimination in the Borough, at an event on 10th October 2013, World Mental Health Day, when the Health and Wellbeing Board as a body, with major local stakeholder organisations, will be signing the Time to Change pledge together.

I believe this strategy and approach demonstrates our collective commitment in Tower Hamlets to make a real difference to the lives of people with mental health problems and their families. I would very much welcome your comments on the strategy.

Foreword from NHS Tower Hamlets Clinical Commissioning Group

Dr. Sam Everington
Chair

Dr Judith Littlejohns
Mental Health Lead

Mental health is something that affects us all — how we think and feel about ourselves and others, how we cope with difficult situations and how we manage our lives. NHS Tower Hamlets Clinical Commissioning Group understands how widespread mental health problems are — from someone experiencing a period of depression due to a personal hardship, to an individual living with long-term psychosis. This is why improving mental health outcomes for local people remains one of our top priorities.

Stigma and discrimination often means that mental health problems are not openly talked about. However, illnesses linked to mental health account for a third of GP consultations, and research shows mental health issues are closely associated with poorer outcomes for employment, personal relationships and physical health. This is why the CCG, including our GP members, is committed to working with partners in the borough, to improve the way in which people with mental health problems are supported and cared for in Tower Hamlets.

We know that improving life experiences of people with mental health issues is not something that can be managed just within the NHS. Instead, we must work with other health and social care agencies, the voluntary sector, patients, carers and the public, to look at services needed to enable people to live stable and happier lives, where they feel supported and in control of their own mental health and recovery.

This means ensuring that mental health becomes a part of everyday conversation and is something that everybody is aware of and cares about, whether it is a midwife supporting a mother through the birth of a child, a school nurse helping children to develop emotional literacy, or a member of staff in our new integrated community health and social care teams. It also means making sure we remain focused on quality, safety and patient choice, sharing decisions between service users and clinicians so that people receive the responsive care they need, in the right place, at the right time.

Our strategy also sets out our commitment to improve mental health services and support for children and young people. This is because stakeholders have told us that this needs to be a priority. The evidence is clear — if we want to make a real difference to the future mental health of the local community, we need to lay good foundations. This begins with helping children and young people to build resilience, emotional awareness and self-regulation at an early age. This approach is incredibly effective; it has been shown to improve educational outcomes, result in stronger relationships and produce greater employment opportunities for the future.

We are committed to improving the mental health of people in Tower Hamlets and look forward to working together with you to make this vision a reality.

About this document

The Tower Hamlets Health and Wellbeing Board, NHS Tower Hamlets Clinical Commissioning Group and the London Borough of Tower Hamlets have developed a draft **Tower Hamlets Mental Health Strategy**.

This document summarises the strategy and asks for your views.

The strategy sets out a three-year vision for improving the quality of life of people with mental health problems in Tower Hamlets. We believe that by working together, across health, social care, education, the voluntary sector and with service users and carers, we can more effectively develop and deliver support for people with mental health problems in Tower Hamlets.

The strategy shows how we will:

- work together to promote mental health and wellbeing in our communities
- prevent Tower Hamlets residents from developing more significant mental health problems
- ensure that when people do need mental health services, they are of the highest possible quality
- proactively support people to recover.

The strategy demonstrates our ambition to meet the requirements of the national outcomes framework for mental health in **No Health Without Mental Health** (Department of Health, 2011), the national mental health strategy. The strategy also outlines how we will aim to ensure that our services are efficient and productive.

In preparing the strategy, we have spoken to a wide range of people, including children and young people, parents, adults of working age, older people, service users, carers and families, and clinicians and practitioners from a variety of services. We spoke to senior leaders in key organisations (not just those that have a direct interest in mental health), voluntary sector groups and other local organisations with an interest in mental health such as schools, housing and faith groups.

We now want to hear from you on what you think about the strategy. Please let us have your views using the form at the back of this document, or by emailing us at mentalhealth@towerhamletsccg.nhs.uk.

If you need help with translating this document, please see page 15 for further details.

We would be grateful for responses by **11th October 2013**.

Depression[1]

MIND note that In its mildest form, depression can mean just being in low spirits. It doesn't stop you leading your normal life, but makes everything harder to do and seem less worthwhile. At its most severe, major depression (clinical depression) can be life-threatening, because it can make you feel suicidal or simply give up the will to live.

http://www.mind.org.uk/mental_health_a-z/7980_depression

Psychosis[2]

MIND note that psychosis is a psychiatric term, which describes experiences, such as hearing or seeing things or holding unusual beliefs, which other people don't experience or share. For many people, these experiences can be highly distressing and disruptive, interfering with everyday life, conversations, relationships, and finding or keeping a job.

http://www.mind.org.uk/mental_health_a-z/8043_psychotic_experiences

Dementia[3]

The Alzheimer's Society note that the term 'dementia' describes a set of symptoms which include loss of memory, mood changes, and problems with communication and reasoning. These symptoms occur when the brain is damaged by certain diseases, including Alzheimer's disease and damage caused by a series of small strokes.

http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=106

Why do we need a mental health strategy?

Nationally, one in four people will experience a mental health problem at some point in their lifetime and one in six adults have a mental health problem at any one time.

Half of people who experience a mental health problem at some point in their lives first experience symptoms by the age of fourteen. Mental health problems in children and young people can have a profound effect on their family relationships, education, and future employment.

Among people under 65, nearly half of all ill health is mental ill-health. Over a third of GP consultations relate to mental health, with depression[1] and anxiety a very common condition. Illnesses involving psychosis[2], commonly referred to as "serious mental illness" affect roughly 1 in 100 people nationally, and people with a serious mental illness often experience a range of health and social problems that have a significant effect on their life chances: people with a serious mental illness are known to have much poorer physical health than the general population and often experience social isolation, stigma and discrimination.

Around 1 in 17 people aged over 65 have dementia[3] in England. Dementia can have a devastating effect on individuals and their carers and families, which is why there is currently significant national attention on improving services for people with dementia and their carers.

Tower Hamlets has amongst the highest levels of mental health need in the country. Whilst our growing and diverse population has many factors that protect individuals and communities from mental health problems, we also face many of the issues common to other inner city boroughs, like poverty, a high population turnover, and alcohol and substance misuse, all of which can have a significant impact on the mental health of the population. As a result, demand for mental health services in the borough is high.

The Health and Wellbeing Board wants to make the most of recent changes in the NHS and the Council to work together to improve the mental health of local people. This is an opportunity to develop our approach to mental health, to try new and innovative ways to make improvements, to help people to manage their own mental health and wellbeing, and to ensure that there are high quality, safe and effective mental health services to meet the needs of Tower Hamlets residents.

About the national mental health strategy

The national strategy, **No Health Without Mental Health** defines the outcomes that health and social care organisations must seek to achieve for their populations, along with a series of recommendations for action. Most importantly, the recent **Health and Social Care Act (2012)** requires the NHS to work to deliver "parity of esteem" between mental and physical health. This means that the NHS is required to deliver standards of care for people with mental health problems that are at least as good as those for people with physical health problems.

No Health Without Mental Health requires health and social care organisations to show how they will deliver better outcomes for people with mental health problems, as follows:

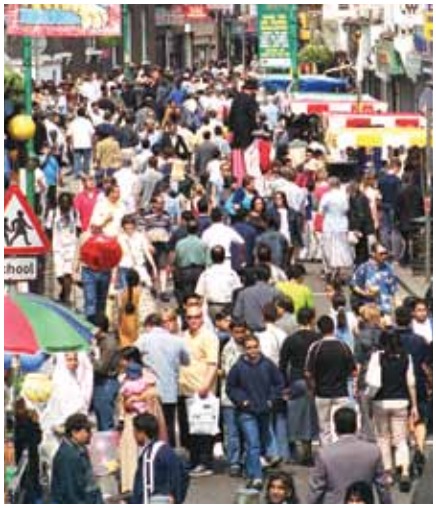
NO HEALTH WITHOUT MENTAL HEALTH OUTCOMES

1. More people will have good mental health.
2. More people with mental health problems will recover.
3. More people with mental health problems will have good physical health.
4. More people will have a positive experience of care and support.
5. Fewer people will suffer avoidable harm.
6. Fewer people will experience stigma and discrimination.

In particular, the national strategy says that health and social care organisations should:

- take a life course approach, with a strong focus on laying the foundations of good mental health for later life in children and young people
- Address stigma and discrimination
- Promote early intervention
- Address health inequalities experienced by disadvantaged communities
- Improve access to talking therapies, including for children and young people and people with a serious mental illness
- Improve the mental health of offenders
- Develop a recovery culture in mental health services
- Ensure that mental health is everybody's business.

About Tower Hamlets



Care Programme Approach*

The national framework for mental health services assessment, care planning, review, care co-ordination, and service user and carer involvement focused on recovery.

Tower Hamlets has a young, diverse and rapidly growing population. 32% of the population is of Bangladeshi origin, and 31% White British, with smaller but significant Somali, eastern European, and Chinese and Vietnamese communities.

Approximately 55% of people aged under 19 are of Bangladeshi origin. There is high population mobility, with a turnover in GP practice registers of around 19% every year, and around 15,000 new national insurance registrations per year (i.e. people who are new to the country settling in Tower Hamlets).

When planning mental health services, there is a need to ensure that services are commissioned to meet demand, to meet the population's language and cultural needs, and to ensure that it is appropriately balanced to the age profile of the population. There is some variability in take up of services by our different communities, and the strategy sets out our commitments to trying to understand and tackle this.

Mental health in Tower Hamlets

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

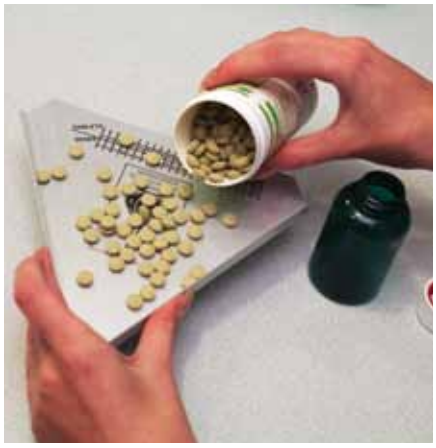
While the borough has a comparatively high number of people actively participating in religious practice (a protective factor for mental health problems), the borough also has limited green space, and poor levels of physical activity.

Tower Hamlets has a high prevalence of mental health problems. We have the fourth highest proportion of people with depression in London, the fourth highest incidence of people experiencing psychosis for the first time, and the highest incidence of psychosis in east London according to GP registers.

There are approximately 30,000 adults estimated to have symptoms of a common mental health problem in the borough, with around 15,900 people known to their GP to have depression, and 3,300 known to have a serious mental illness, with about 1150 people with dementia. Over 45% of people claiming unemployment benefits due to ill-health in Tower Hamlets do so because of a mental health problem.

Use of mental health services in Tower Hamlets is high. We have the second highest proportion of adult service users in touch with secondary care mental health services in London, a high number of people on the **Care Programme Approach***, and the third highest number of emergency admissions for psychosis. We also have a high prescribing rate for anti-psychotic and anti-depressant medication.

Mental health problems can have a wide ranging impact for individuals in a number of areas of their lives including housing, education, training, employment, physical health and relationships with family and friends. It affects people of all ages and all cultural backgrounds.



About current mental health services

In recent years Tower Hamlets health and social care organisations have worked hard to improve the range and quality of services for people with mental health problems in the borough. From awareness raising, to primary care mental health support, talking therapies, voluntary sector services and more specialist services for people with more serious mental health problems, we believe that many of our mental health services are now working effectively, with better access and higher quality.

However we believe that there are significant opportunities for improvement, to deliver better health and social care outcomes for service users, to improve experience, and to improve efficiency. The strategy lays out the things we think we need to do to improve the mental health system further.

About what people have told us

In preparing the strategy, we have spoken to a wide range of people, including children and young people, parents, adults of working age, older people, service users, carers and families, and clinicians and practitioners from a variety of services. We spoke to senior leaders in key organisations (not just those that have a direct interest in mental health), voluntary sector groups and other local organisations with an interest in mental health such as schools, housing and faith groups.

People have fed back overwhelmingly that they would like the strategy to focus on the mental health of children and young people, to think about how we support children and young people at risk of developing mental health problems, and to ensure high quality seamless access into care and support.

Service users have told us that the quality of services, and in particular the quality of relationships with staff, is absolutely key. They have told us that they want to have better information, better communication, better access to services, and more choice and control over their care and a focus on recovery. The stigma and discrimination people with mental health problems have experienced is a major area in which people would like to see concerted action.

Across all age ranges, people have told us that one of the most important things is to have joined up services that address the range of health and social care needs people might have. We call this integrated care, and it is one of the major areas of focus of the strategy. In addition, people have also told us that the place great value on the support that they receive from voluntary sector services.

Our vision

"Our vision is to commission integrated mental health services that are safe and effective, with friendly staff that inspire confidence in the people and families using them, and which help people to take control of their own lives and recovery."

Our strategy is summarised in the diagram below. It is focussed on the three pillars of building resilience in our population and promoting mental health and wellbeing for all, ensuring high quality treatment and support for people who need it, and supporting people to live well with a mental health problem. More details on the diagram can be found in the full strategy document.

Taking a life course approach to mental health and wellbeing

Building resilience: mental health and wellbeing for all	High quality treatment and support	Living well with a mental health problem
Fewer people experiencing stigma and discrimination	Mental health awareness in health and social care and education workforce	A recovery culture
More accessible and accurate information	Specialist support for general settings like schools and hospitals	Peer support
Improved mental health awareness across our communities, schools and employers	Primary care and community based mental health services for people with common mental health problems	Self-directed support
Streamlined preventative support	Early intervention	Connections and relationships
Support for families and carers	Integrated approaches to mental and physical health and social care	Support into employment
Good transitions	Timely access to high quality specialist services	Improving accommodation options
Support for at risk communities	Timely crisis resolution, close to home	

Shared values: a whole person approach

Mental health is everybody's business

Focus on quality

Commissioning with commitment

Improved outcomes

Our commitments: across the life course

The strategy takes a life course approach. This means that throughout the strategy we commit to improving outcomes for people with, or at risk of, mental health problems whatever their age. It means understanding the impact of poor mental health and wellbeing from birth and through childhood, into adulthood and into older age.

We know that stigma and discrimination is a major issue for many people with mental health problems, whether it is in the playground, at work, or on the street. To tackle this, we will develop further our partnership commitment to tackling stigma and discrimination through the Health and WellBeing Board signing the Pledge on World Mental Health Day in October 2013. We will aim to develop a strategic partnership across the public and private sector to combat discrimination, encouraging local statutory organisations and local employers to sign the Time to Change pledge, and become mindful employers.

We know that many people think that information about mental health support is not very accessible. To improve this, we will develop a new web resource that will provide easily accessible information on mental health services for children and young people, adults, and older people.

At the heart of the strategy is the substantial evidence that prevention works in mental health, if approaches to prevention are properly joined up across statutory and voluntary sectors, communities and individuals. We will therefore ensure that the range of interventions we commission to improve the wellbeing of residents, such as healthy living, healthy families and healthy schools projects, all take mental health into account. As part of our public mental health work we will collect information about how far people at higher risk of mental illness are using the services of all ages, so we can join them up more effectively, including for vulnerable children, people who are homeless, people from BME and LGBT communities, and people who are in touch with the criminal justice system.

The life course approach

Wider determinants of health

Deprivation, Education, Employment, Housing, Air Quality, Open Spaces, Regeneration, Business and Development, Community Cohesion, Road Safety.

Before birth

Growing up: The early years

The Francis Report

The Francis Report is a high profile review of the care provided at Mid Staffordshire Foundation Trust. The review makes a number of recommendations for ensuring that the NHS provides high quality and safe care for patients.

NICE

NICE (the National Institute for Health and Care Excellence) provides national guidance on the evidence base to support particular kinds of care and treatment.

A key principle of the strategy is that it takes a whole person approach. This means that we want to commission services that work with people, not just the symptoms of mental illness. We will place importance on the role of service users as co-producers, not only in terms of input to service development and review, but also in shared decision making about their care and treatment.

We are committing through this strategy to make mental health everybody's business. From children's centres, schools and nurseries, through to the way we work as employers, and the care and support we commission and provide for people with multiple health problems, we want to make sure that mental health becomes part of an everyday conversation, and that staff have good mental health awareness, both as colleagues and, where appropriate, as health or social care professionals. In particular, we will ensure that through our already established joint Carer's Plan, we will provide information and training for carers of people with severe and enduring mental health problems and ensure that carers are able to access appropriate psychological care, with any mental health needs (as well as physical health needs) identified at assessment or review, or through the carers' health checks.

Our delivery of this Strategy will be supported by a sustained focus on quality and outcomes. Our approach is driven both by the findings of the **Francis Report**, but also our overriding commitment to improving standards, including where there are national quality standards in place, for example **NICE guidelines**. In particular, we will aim to develop a strong focus on quality improvement across the system as the main focus of our performance management of the variety of mental health contracts we hold, using the levers available to us to continually drive up the quality of services.

Growing up: Children and young people

Adulthood

Growing older

Children and young people

In many ways, the single biggest action that we can take to secure better outcomes for the people and communities who live in Tower Hamlets for the future is to support children and young people, their parents, families and communities, to develop the building blocks of good mental health through building resilience, laying the foundations of good mental health for later life.

Our strategy therefore consciously places a very high emphasis on the mental health of children and young people and their parents, and says that we will start a piece of work to examine how we can improve mental health support for children and young people so that they and their parents understand what help is available, and receive the right support as quickly as possible. This will involve working across the NHS and the Council, including public health, to consider how we can develop services for children and young people, including in schools and other settings. It will also involve thinking about how we can improve services for families where there is a parent with a mental health problem.

Adults of working age

The strategy suggests that mental health services for adults of working age are broadly stable at the present time. However there are opportunities for further improvement and development.

In particular we will continue to work to develop the relationship between GPs and secondary care mental health services, developing more services in primary care where this is appropriate. We also want to ensure that talking therapy services are working effectively across the range of current providers.

We want to ensure that crisis services are working as effectively and efficiently as possible, so that people in crisis are supported as close to home as possible, but that when they do need to go to hospital, it is a safe, high quality and cost-effective service.

We also want to ensure that all mental health services work together to promote choice and control for service users and carers. This will mean adopting some of the activities that are commonly referred to as "the recovery approach", including compassion respect and dignity, shared decision making, and a culture that encourages and embraces hope and trust. We will also want to look at our rehabilitation and accommodation services to ensure that the provide effective support.

As part of the implementation of the strategy, we will consider evidence based approaches to commissioning for recovery, including peer support, the recovery college approach, and our day opportunities and support services.

Critically, we want to make mental health everybody's business.
The evidence about the poor physical health experienced by people with mental health problems is overwhelming, and we want to work concertedly across all the NHS and the Council to do our very best to change this, to really work towards "parity of esteem" between mental and physical health. This will mean reviewing our current physical health workstreams to ensure that they properly take account of mental health.

Older people

We believe our community services for people with dementia are currently working effectively. However we want to ensure that people with dementia and their carers have more choice and control, better access to peer support, and to personalised support options at home. We also want to ensure that people with dementia who live in care homes receive the best possible care, and will consider how we can do this most effectively.

We also want to ensure that older people with mental health problems other than dementia receive the best possible support, including access to talking therapies.

Most importantly for older people, we want to ensure that the support they receive is properly integrated and wrapped around the person. This means that we will want to make sure that mental health is right at the heart of the work we are doing to develop integrated health and social care teams across the borough.

Tell us what you think

We want your views

The draft mental health strategy has been developed through listening to the views of local stakeholders, analysing local need and reviewing local and national guidance and information.

It sets out our plans for the future delivery of mental health and wellbeing services in Tower Hamlets. By working across the life course, with a commitment to achieving parity of esteem, enhancing recovery and sharing a common set of values about promoting high quality, outcome-driven services, we believe we can achieve change.

We are now asking people to comment on the strategy before we refine our vision and agree the necessary actions for the years ahead.

Mental health is something that affects us all — how we think and feel about ourselves and others, how we cope with difficult situations and how we manage our lives. We will use your feedback to make sure our focus reflects what local people want.

1. Are you responding as a:

☐ Service user ☐ Carer
☐ Local resident ☐ Health or social care professional
☐ Other ☐ Prefer not to say

2. Do you agree with our vision?

☐ Yes ☐ No

3. Do you agree with our commitments regarding children and young people?

☐ Yes ☐ No

4. Do you agree with our commitments regarding adults of working age?

☐ Yes ☐ No

5. Do you agree with our commitments regarding older people?

☐ Yes ☐ No

6. Do you have any comments on the specific proposals detailed in the main strategy document?

7. Do you think there are any important areas the strategy hasn't covered? If so, please let us know what.

About you

(This section is not compulsory)

Please tell us a little about yourself. If you wish to remain anonymous, your views will still be taken into account, however we would be grateful if you would fill this in so we can assess what sections of the community are represented and whether there different groups of people give different answers.

Please share your comments with us by **Friday 11 October 2013**.

Name:

.....

1. Do you live or work in Tower Hamlets?

   ☐ Yes ☐ No

2. Are you employed by the NHS or by the London Borough of Tower Hamlets?

   ☐ Yes ☐ No

3. Would you like to be kept up to date with information about the NHS, including this strategy?

   ☐ Yes ☐ No

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

   .....

   .....

   .....

   .....

4. Are you:

   ☐ Male ☐ Female

5. Age:

   ☐ 18–35 ☐ 36–50 ☐ 51–65 ☐ 65+
   ☐ Prefer not to say

6. How would you describe your ethnic origin?

   Asian or Asian British

   ☐ Bangladeshi ☐ Indian ☐ Pakistani ☐ Any other Asian background

   Black or Black British

   ☐ African ☐ Caribbean ☐ Any other Black background

   Mixed

   ☐ White & Asian ☐ White & Black African
   ☐ White & Black Caribbean ☐ Any other mixed background

   White

   ☐ British ☐ Irish ☐ Any other White background

   Other Ethnic Groups

   ☐ Chinese ☐ Any other ethnic group
   ☐ Prefer not to say

7. What best describes your sexuality?

   ☐ Lesbian ☐ Gay ☐ Bisexual ☐ Heterosexual
   ☐ Prefer not to say

8. What is your religion or belief?

   ☐ Atheism ☐ Buddhism ☐ Christianity ☐ Islam
   ☐ Jainism ☐ Sikhism ☐ Hinduism ☐ Judaism
   ☐ Other ☐ Prefer not to say

9. Do you consider yourself to have a disability?

   ☐ Yes ☐ No
   ☐ Prefer not to say

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We would like to hear from you

To find out more about us, please contact us using the details below:

Write to
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NHS Tower Hamlets Clinical Commissioning Group
2nd Floor Alderney Building
Mile End Hospital
Bancroft Road
London E1 4DG

Email
mentalhealth@nhstowerhamletsccg.nhs.uk

To access the Tower Hamlets Mental Health Strategy consultation documents please go to
http://onel.nhs.sitekit.net/ONELTowerHamlets/Get-involved/mental-health-consultation.htm

For general information visit our websites
www.towerhamletsccg.nhs.uk
www.towerhamlets.gov.uk

The NHS belongs to the people

It is there to improve our health and wellbeing, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can to the end of our lives. It works at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health. It touches our lives at times of basic human need, when care and compassion are what matter most.

The NHS is founded on a common set of principles and values that bind together the communities and people it serves – patients and public – and the staff who work for it.

The NHS Constitution

Design by **Sparrow**, a social enterprise based at the Bromley by Bow Centre.
www.sparrow–studio.com

Tower Hamlets Mental Health Strategy Delivery Plan 2014-16

Pillar	Commitment	Action	Lead officer	Timescale
BEING BORN AND GROWING UP IN TOWER HAMLETS				
Building resilience: mental health and wellbeing for all	As part of our coordinated work to design new pathways of support for children and young people, we will work across the Partnership to develop an anti-stigma campaign specific to children and young people (CYP)	We will develop a public mental health and well-being programme which will include aportfolio of evidence based public mental health interventions, which will identify how we will deliver this, alongside other public mental health commitments over 2014/16	Paul Iggledun, Public Healh Consultant, LBTH	September 2014 for plan
Building resilience: mental health and wellbeing for all	As part of partnership work across health, local authority, voluntary and community sectors we will improve the availability and consistency of support during pregnancy and in the first year of life to promote parent/infant attachment, parent and infant communication and emotional regulation in order to promote lifelong resilience and mental health and wellbeing.	We will map current services available to support maternal and infant mental health in order to identify gaps, improve access for groups at higher risk, improve coordination across services and develop proposals to strengthen the universal tier of the service (including Maternity services, Health Visiting and services delivered from Children's Centres, primary care and by voluntary and community organisations) (CYP)	Esther Trenchard-Mabere, Public Health Consultant, LBTH	March 2014 complete mapping and prioritisation June 2014 proposal for training programme to support universal tier of service plus recommendations for strengthening targeted services
High Quality Treatment & Support	We will develop a model for taking a family orientated approach to mental health across the partnership to be integrated into practice, where people with a mental health problem are parents (CYP, AWA)		Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	December 2015
Building resilience: mental health and wellbeing for all	In our review of the School Health Service, we will ensure that promotion of emotional health and well-being health is considered as a central component of future commissioned services. We wil in 2015 and beyond consider the role of health visitors in promoting emotional health and wellbeing (CYP).	We will ensure that the roles of school nurses in relation to emotional health and well-being are clearly articulated in specifications for the reprocurement of the School Health service.	Esther Trenchard-Mabere, Public Health Consultant, LBTH	December 2014
High Quality Treatment	As part of our coordinated work to design new pathways of support for children and young people, we will ensure that they take account of the life events that impact on young people with	We will developa refreshed service model for child and adolescent mental health services. A project board will be set up	Richard Fradgley, Deputy Director	Project board in place by end March 2014; service model

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

Pillar	Commitment	Action	Lead Officer	Timescale
BEING AN ADULT IN TOWER HAMLETS				
Building resilience: mental health and wellbeing for all	We will refresh our review of day opportunity and support services, with a view to considering how the expertise and dynamism of voluntary sector services, and their closeness to the various communities of Tower Hamlets, can support our aspiration for more accessible targeted prevention services for all communities (AWA)	We will develop a refreshed model for the delivery of day opportunity and support services, with an accompanying procurement plan.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	Service model and procurement plan in place by September 2014
Building resilience: mental health and wellbeing for all	We will work with the Ideas Stores to capitalize on opportunities for improving access to self help support and bibliotherapy (AWA, OP)	We will develop a public mental health and well-being programme which will include aportfolio of evidence based public mental health interventions, which will identify how we will deliver this, alongside other public mental health commitments over 2014/16	Paul Iggledun, Public Healh Consultant, LBTH	June 2014 for plan; commitment commissioned by end March 2015
Building resilience: mental health and wellbeing for all	We will review our existing investment into supporting service users via the Forensic Mental Health Practitioner and the Link Worker Scheme, to ensure it is optimally deployed (AWA)	Following the development of the Offender health JSNA factsheet; we will review the Forensic Mental Health Practitioner and the Link Worker Scheme	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG and Carrie Kilpatrick, Service Manager, Accommodation, LBTH	Review complete by March 2015
Building resilience: mental health and wellbeing for all	We will work with probation and mental health service providers to ensure the successful delivery of support for offenders with mental health problems including personality disorder (AWA)	We will work with the Reducing Reoffending workstream of the Community Safety Partnership to ensure that mental health support is included within plans for Integrated Offender Management.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	March 2016
Building resilience: mental health and wellbeing for all	We will implement the Hostels Strategy to ensure that appropriate support for people with mental health problems who are in hostels is built into the re-design of hostels (AWA, OP)	We will implement the Hostels Strategy.	Carrie Kilpatrick, Service Manager, Accommodation, LBTH	March 2016
Building resilience: mental health and wellbeing for all	We will work with East London Foundation Trust to carry out a prospective audit of people who are admitted to hospital who were recorded as not previously known to mental health services in the borough. We will use this information to help plan how to better support early access to community services for this group	We will carry out a prospective audit of people who are admitted to hospital who were recorded as not previously known to mental health services in the borough.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning,	Audit complete by June 2015

Pillar	Commitment	Action	Lead Officer	Timescale
	of people in the future (AWA)		THCCG and Paul Iggledun, Public Healh Consultant, LBTH	
Building resilience: mental health and wellbeing for all	We will develop a referral and diagnostic pathway for people with ASD who are not eligible for mental health services, with clear thresholds for where people may require mental health services (AWA)	We will review and evaluate the new commissioned service mid way through the contract (at 18 months)	Barbara Disney, Service Manager, Strategic Commissioning, LBTH	Referral pathway developed by March 2015
High Quality Treatment & Support	We will evaluate the effectiveness in improving mental and physical health outcomes of our new liaison psychiatry team pilot at the Royal London Hospital (AWA, OP)	We will evaluate the effectiveness of our new liaison psychiatry team pilot at the Royal London Hospital	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	Evaluation complete by December 2016
High Quality Treatment & Support	In the context of our Mental Health Accommodation Strategy, we will review our resettlement and rehabilitation team pathways in order to ensure they are working effectively, and in this context that specialist accommodation providers are appropriately supported by specialist services (AWA)	We will continue the work to remodel and recommission resettlement and rehabilitation team pathways.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	Review and commissioning plan complete by April 2014
High Quality Treatment & Support	We will review talking therapies pathways across all providers of talking therapy services to inform future commissioning. We will in particular consider access to talking therapies for older people and people from BME communities (AWA, OP)	We will review talking therapies providers, and develop a commissioning plan for future talking therapies pathways.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	Review and commissioning plan complete by September 2014
High Quality Treatment & Support	In light of our work on talking therapies pathways and anti-depressant prescribing, we will consider the case for developing a primary care depression service, including support for employment (AWA, OP)			
High Quality Treatment & Support	We will increase the capacity of the Primary Care Mental Health Service to support more clinically appropriate service users to access its support, including service users who require depot medication or who are in receipt of a commissioned social care service (AWA)	We will develop service and activity model for the primary care mental health service (including social care)	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	Refreshed service model design in place by June 2014
High Quality Treatment & Support	We will work with East London NHS Foundation Trust to further develop the interface between primary and secondary care, with a particular focus on provision of population based advice and support to practices, and the development of primary care consultation by consultant psychiatrists and other mental health			

Pillar	Commitment	Action	Lead Officer	Timescale
	professionals (AWA, OP)			
High Quality Treatment & Support	With East London NHS Foundation Trust, we will further develop opportunities for practice based clinics (AWA)			
High Quality Treatment & Support	We will consider the configuration of adult community mental health services in light of work to develop CAMHS services and our review of older adults mental health services (AWA)	To be considered in the context of the CAMHS service design and older adults review.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	March 2016
High Quality Treatment & Support	We will work across health and social care commissioners and providers to develop care packages for payment by results, and in particular will consider the contribution of social work and social care (AWA, OP)	We will ensure that all preparatory work for payment by results is in place during the 2014/15 shadow year and monitor its impact.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	March 2015
High Quality Treatment & Support	We will review the recent national guidance for the commissioning of perinatal mental health services published by the Joint Commissioning Panel for Mental Health, and the implementation of NICE ante and postnatal guidance. This will inform our strategic thinking about how best to ensure suitable and effective services for this group (AWA)	We will review perinatal services.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	Review complete by March 2016
High Quality Treatment & Support	With the Drug and Alcohol Action Team we will review the design of support for people with a dual diagnosis including a serious mental illness and a substance misuse and/or alcohol problem (AWA)	We will review the dual diagnosis service model.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG and Rachael Sadegh, DAAT Coordinator, LBTH	Review complete by March 2016
High Quality Treatment & Support	We will use the east London wide Home Treatment Team review and our local review of the Tower Hamlets Crisis House to inform our future commissioning of community crisis pathways (AWA)	Pending receipt of final evaluation, we will re-procure the Tower Hamlets crisis house.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	June 2016
High Quality Treatment & Support	In the context of the pilot work detailed above, we will work across the Consortium with East London NHS Foundation Trust to consider the current crisis pathways, and identify any options for the future design of services that optimize safety, outcomes			

Pillar	Commitment	Action	Lead Officer	Timescale
	for service users, and value for money (AWA, OP)			
High Quality Treatment & Support	We will in particular ensure that in the re-commissioning of tobacco cessation and obesity services, that access for people with a serious mental illness is addressed (AWA)	We will reprocure tobacco cessation and obesity services to explicitly include access for people with a serious mental illness.	Chirs Lovitt, Public Health Consultant LBTH, and Esther TrenchardMabere, Public Health Consultant, LBTH	June 2014
Living well with a mental health problem	We will work across the Partnership to self-assess our commissioning practice and service provision by statutory and voluntary sector partners, using the ImROC approach, as the starting point in the delivery of our ambitions to develop a recovery culture (AWA)	We will purchase the ImROC support pack to self-assess our recovery orientation across the partnership.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	March 2015
Living well with a mental health problem	We will commission, via non-recurrent funds, a provider or consortium of providers to develop a self-sustaining recovery college (AWA)	We will test the viability of this approach to commissioning a recovery college.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	June 2014
Living well with a mental health problem	In our refresh of our review of voluntary sector day opportunity and support services, we will consider the appropriate range and balance of day opportunities services that should be provided in the borough (AWA)	We will develop a refreshed model for the delivery of day opportunity and support services, with an accompanying procurement plan.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	Service model and procurement plan in place by September 2014
Living well with a mental health problem	In particular, we will explore how peer support may be delivered as part of the new primary care mental health service, and how applications for user led grants can be encouraged from hard to reach groups (AWA, OP)			
Living well with a mental health problem	We will work across the Consortium to consider opportunities for developing, and commissioning, the shared decision making approach in practice (AWA, OP)	As part of self-assessing our recovery orientation across the partnership, we will review the extent to which service users feel they have control over care planning processes.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	March 2016
Living well with a mental health problem	We will develop capacity and capability for personal health budgets for people in receipt of continuing care funding, including mental health. We will look to pilot personal health budgets more generally in mental health, as more evidence accumulates	We will pilot personal health budgets in mental health and ensure that revised service specifications promote and incentise the take up of direct payments for social	Richard Fradgley, Deputy Director of Mental Health and Joint	March 2016

Pillar	Commitment	Action	Lead Officer	Timescale
	nationally (AWA, OP)	care.	Commissioning, THCCG	
Living well with a mental health problem	We will review the services we jointly provide and commission to support people into employment. We will ensure that we consider the evidence on what works in our refresh of our review of voluntary sector day opportunity and support services (AWA)	We will develop a refreshed model for the delivery of day opportunity and support services, with an accompanying procurement plan.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	Service model and procurement plan in place by September 2014
Living well with a mental health problem	We will continue to implement our Commissioning Strategy for the Accommodation of Working Age Adults with a Mental Health Problem (AWA)	The existing accommodation strategy continues until 2016.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	Delivery of strategy by 2016

Pillar	Commitment	Action	Lead Officer	Timescale
GROWINGOLD IN TOWER HAMLETS				
Building resilience: mental health and wellbeing for all	We will continue to work specifically to raise awareness of dementia (OP)	We will develop a public mental health and well-being programme which will include aportfolio of evidence based public mental health interventions, which will identify how we will deliver this, alongside other public mental health commitments over 2014/16	Paul Iggledun, Public Healh Consultant, LBTH	June 2014 for plan; commitment commissioned by end December 2014
Building resilience: mental health and wellbeing for all	We will work with providers of home care and day care to improve mental health and dementia awareness with their staff (OP)		Paul Iggledun, Public Healh Consultant, LBTH	June 2014 for plan; commitment commissioned by end December 2014
Building resilience: mental health and wellbeing for all	We will consider the findings of the Campaign to End Loneliness report and project, as well as other initiatives such as those developed by Age UK. Having done so we will work to develop our plans to tackle loneliness, with a particular focus on older people (OP)		Paul Iggledun, Public Healh Consultant, LBTH	June 2014 for plan; commitment commissioned by end December 2014
High Quality Treatment & Support	We will review current community pathways for older adults with a functional mental health problem, in the context of our developing plans for integrated care in the borough in the context of the development of our integrated care model (OP)	We will review the older adults CMHT.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	Review complete by June 2015
High Quality Treatment & Support	We will work with the Clinical Effectiveness Group at Queen Mary University to audit coding of people with dementia in primary care, and prescribing of anti-psychotic medicine to people with dementia, to enable us to understand patterns of prescribing in more detail, to inform future commissioning (OP)	We will carry out an audit of anti-psychotic prescribing in care homes.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG and Bill Sandhu, Head of Medicines Management, NELCSU	Complete by December 2014
Hight Quality Treatment & Support	We will review pathways for people with alcohol-related dementia, and will consider the review to inform future commissioning (OP)	We will review pathways for people with alcohol related dementia.	Richard Fradgley, Deputy Director	Review complete by December 2014

Pillar	Commitment	Action	Lead Officer	Timescale
			of Mental Health and Joint Commissioning, THCCG	
Hight Quality Treatment & Support	We will ensure that older people have access to the Primary Care Mental Health Service (OP)	We will develop a refreshed service and activity model for the primary care mental health service	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	Refreshed service model design in place by June 2014
Hight Quality Treatment & Support	In the context of current occupancy across East London wards, we will review in-patient services for older adults with functional mental health problems (OP)	We will review the model for in-patient care of older adutls with a functional mental health problem.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	Review complete by June 2015
Hight Quality Treatment & Support	We will commission specialist mental health input into the new community integrated care service to ensure that services can address the holistic needs of patients and service users in one place (OP)	We will develop a specification for mental health support in the community health service locality teams.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	Specification in place by June 2014
Living well with a mental health problem	We will commission more dementia cafes to provide peer support for people with dementia and their carers (OP)	We will commission more dementia cafes.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	April 2014
Living well with a mental health problem	We will develop a range of respite options appropriate for people with dementia, for carers to choose from (OP)	We will develop a range of respite options appropriate for people with dementia.	Barbara Disney, Service Manager, Strategic Commissioning, LBTH	March 2015
Living well with a mental health problem	We will review pathways into services, and service specifications for commissioned residential, nursing and continuing care for people with dementia to improve the quality of these services (OP)	We will develop a refreshed service model for residential, nursing and continuing care for people with dementia.	Richard Fradgley, Deputy Director of Mental Health	Service model developed by March 2015

Pillar	Commitment	Action	Lead Officer	Timescale
			and Joint Commissioning, THCCG	

Pillar	Commitment	Action	Lead Officer	Timescale
GENERAL				
Foundations: Commissioning with commitment	To support effective working across the partnership with the wider range of stakeholders, we will hold an annual autumn Tower Hamlets Mental Health summit, to enable all stakeholders to come together to consider the Strategy action plans for the year ahead (G)	We will hold an annual mental health summit.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	First summit November 2014
Foundations: Commissioning with commitment	We will develop an outcomes dashboard to track the delivery of this Strategy, which will be published on the CCG website (G)	We will develop an outcomes dashboard.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG and Paul Iggledun, Public Health Consultant, LBTH	Outcomes dashboard in place by December 2014
Foundations: Commissioning with commitment	We will review our service user involvement structures against the NICE Quality Standard and work with service users, Healthwatch, and voluntary sector groups to identify and provide opportunities to support service users who wish to become more involved in planning mental health services in the future (G)	We will review current user involvement structures and develop a revised model.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	Review complete and revised model in place by June 2015
Foundations: Commissioning with commitment	We will develop our capability in using data to drive our commissioning practice, in particular in tackling inequality of access by protected characteristic (G)	With the development of payment by results we will proactively use the Mental Health Minimum Dataset to monitor activity by protected characteristic to inform future commissioning, and publish specific reports on our website.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	2016
Foundations: Commissioning with commitment	We will identify and use opportunities for developing risk stratification models to help plan future mental health services (G)	We will monitor the literature on this emergent area.	Richard Fradgley, Deputy Director of Mental Health and Joint	2016

Pillar	Commitment	Action	Lead Officer	Timescale
			Commissioning, THCCG	
Foundations: Commissioning with commitment	We will invite the Police and London Ambulance Service to participate in the Tower Hamlets Mental Health Partnership Board, to ensure that there is a strategic overview of the management of mental health crises for Tower Hamlets residents (G)	We will review the Mental Health Partnership Board to ensure appropriate membership.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	June 2014
Foundations: Commissioning with commitment	As staff experience and satisfaction is so key to an organizations ability to provide compassionate care, we will work locally and across the Consortium to consider potential measures of staff experience into contractual arrangements with mental health service providers in the future (G	We will monitor the literature on this area.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	2016
Building Resilience: mental health and wellbeing for all	We will, across the Council and the CCG, as the two main public sector commissioning bodies in the borough, use the Time to Change pledge to encourage our suppliers to provide a mental health friendly workplace for their employees (G)	We will review our contracting documents and processes to incorporate provisions regarding mental health friendly employment.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG and Paul Iggledun, Public Health Consultant, LBTH	March 2015
Building Resilience: mental health and wellbeing for all	Using the Time to Change pledge, we will continue to use the leadership of the Health and Wellbeing Board to tackle stigma and discrimination by raising awareness and promoting positive perceptions of mental health across the Borough (G)	We will develop a public mental health and well-being programme which will include aportfolio of evidence based public mental health interventions, which will identify how we will deliver this, alongside other public mental health commitments over 2014/16	Paul Iggledun, Public Healh Consultant, LBTH	June 2014 for plan; commitment commissioned by end December 2014
Building Resilience: mental health and wellbeing for all	We will develop our strategic partnership across the public and private sector to combat discrimination, encouraging local statutory organisations and local employers to sign the Time to Change pledge, and become mindful employers (G)		Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG and Paul Iggledun, Public Health Consultant, LBTHand Paul Iggledun, Public Healh Consultant, LBTH	June 2014 for plan; commitment commissioned by end December 2014
Building Resilience: mental health and	We will develop a local anti-stigma campaign. It will have a specific focus on BME communities, faith communities, and the LGBT		Paul Iggledun, Public Healh	June 2014 for plan; commitment

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

Pillar	Commitment	Action	Lead Officer	Timescale
Building Resilience: mental health and wellbeing for all	We will, across the Council and the CCG, as the two main public sector commissioning bodies in the borough, use the Time to Change pledge to encourage our suppliers to adopt an Emotional First Aid programme for their employees (G)		Paul Iggledun, Public Healh Consultant, LBTH	June 2014 for plan; commitment commissioned by end December 2014
Building Resilience: mental health and wellbeing for all	We will develop a specific plan for young carers of parents with a mental health problem as part of our work to develop family orientated care and support (G)	We will develop a specific plan for young carers of parents with a mental health problem.	Karen Badgery, Service Manager, Childrens Commissioning, LBTH	March 2015
Building Resilience: mental health and wellbeing for all	We will use the contractual levers available to us to improve the experience of carers of people with mental health problems (G)	We will consider options for CQUIN and quality indicators for improving carer support.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	2016
Building Resilience: mental health and wellbeing for all	With NHS England and public health within the Council, we will develop a JSNA factsheet specific to the mental health needs of offenders to help inform future commissioning arrangements (G)	We will develop a JSNA factsheet specific to the mental health needs of offenders	Paul Iggledun, Public Healh Consultant, LBTH	March 2015
Building Resilience: mental health and wellbeing for all	We will develop as part of our responsibilities under the Public Sector Equalities Duty, a dashboard for access to services by race and other equality strand, to inform future commissioning (G)	We will monitor activity by protected characteristic to inform future commissioning, and publish specific reports on our website.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	2016
Building Resilience: mental health and wellbeing for all	We will work with providers to improve recording of sexual orientation as part of equalities monitoring requirements to inform future commissioning (G)	We will monitor activity by protected characteristic to inform future commissioning, and publish specific reports on our website.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	2016
Building Resilience: mental health and wellbeing for all	We will develop a refreshed commissioning plan for people with a learning disability and mental health problem (G)	We will develop a refreshed commissioning plan.	Barbara Disney, Service Head, Stratrgic Commissioning, LBTH	Plan in place by June 2014
High Quality Treatment and Support	We will develop a more complete understanding of prescribing activity for anti-psychotic and anti-depressant medicine in the borough. Led by our Commissioning Support Unit Medicines Optimisation Team, we will work across the Clinical Commissioning Group, East London NHS Foundation Trust and the Clinical	We will develop a methodology to understand prescribing activity and undertake a review.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning,	Complete by March 2015

Pillar	Commitment	Action	Lead Officer	Timescale
	Effectiveness Group at Queen Mary University to identify available meaningful information about prescribing practice, and triangulate this across primary care and secondary care to inform future commissioning and practice development, including the development of more robust care packages including shared care arrangements (G)		THCCG and Bill Sandhu, Head of Medicines Management, NELCSU	
High Quality Treatment and Support	We will use the introduction of Payment by Results into mental health as an opportunity to develop clear clinically effective health and social care pathways, and to support service users to make choices about their care and support (G)	We will ensure that all preparatory work for payment by results is in place during the 2014/15 shadow year.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	March 2015
Building Resilience: mental health and wellbeing for all	We will extend social prescribing to mental health (G)	We will consider the outcomes of the social prescribing pilot to establish the case for commissioning the pilot into mental health.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	2016
High Quality Treatment and Support	We will ensure that waiting times for mental health services are minimized, and we will publish waiting times for key services as part of our partnership dashboard (G)	We will publish waiting times for key services as part of our partnership dashboard.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	
High Quality Treatment and Support	We will develop the interface between primary and secondary care, with a particular focus on further developing the presence of secondary care clinicians in a primary care setting, as detailed elsewhere in this strategy (G)	We will develop a refreshed service and activity model for the primary care mental health service	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	Refreshed service model design in place by June 2014
High Quality Treatment and Support	We will review our crisis pathway against the Crisis Concordat when published to ensure that we are compliant (G)	We will review our crisis pathway against the crisis concordat when published.	Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG	Review complete by June 2014
High Quality Treatment and Support	In the review of the Healthy Lifestyles programmes, including healthy community and environment; maternity, early years and childhood; oral health, tobacco cessation; long term conditions, we will ensure that the specific barriers to access for people with a serious mental illness are addressed (G)	We will ensure that the specific barriers to access for people with a serious mental illness are addressed	Paul Iggledun, Public Health Consultant LBTH, and Esther TrenchardMabere,	December 2014

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

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Health and Wellbeing Board 6 February 2014	Tower Hamlets Health and Wellbeing Board
Report of the London Borough of Tower Hamlets	**Classification:** Unrestricted
Tower Hamlets Health and Wellbeing Strategy 2013-16	

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

Executive Summary

This report outlines the approach taken to develop the Tower Hamlets Health and Wellbeing Strategy. All Health and Wellbeing Boards have a duty to publish and deliver local health and wellbeing strategies. This strategy has been developed through a partnership approach, consulted on, presented to the CCG Board, Shadow HWBB and endorsed by the Council's Cabinet.

Formal approval of the Health and Wellbeing Strategy and its delivery plans is now sought from the Health and Wellbeing Board. Once approval has been given, the Strategy will then be published.

Recommendations:

The Health and Wellbeing Board is recommended to:

1. Agree the strategy, delivery plans, proposed outcome measures and targets. These will be the measures used to track progress on the plan and on which performance will be reported to the Board. The measures are drawn from the social care, public health and NHS outcomes frameworks to reflect our strategic priorities.
2. Agree the delivery and performance monitoring arrangements set out in section 3 below.

1. REASONS FOR THE DECISIONS

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

2. ALTERNATIVE OPTIONS

2.1 All Health and Wellbeing Boards are required to publish a health and wellbeing strategy. Alternative options for the content of the strategy have been considered through the consultation and approval process.

3. DETAILS OF REPORT

3.1 Introduction

3.1.1 A consultation on the draft Outline Health and Wellbeing Strategy was undertaken during August 2012 through widespread circulation to key stakeholders and local publicity. Responses were sought through an online survey and a revised outline strategy agreed by the Board in September 2012.

3.1.2 Delivery Planning activity has since taken place around the key themes, including delivery planning workshops with key stakeholders and discussions around the wider determinants.

3.1.3 The strategy has been revised to reflect these and Delivery Plans have been developed for the key themes, with the exception of Mental Health where the delivery plan will be developed in response to the Mental Health strategy which will be completed shortly.

3.1.4 The Shadow Board reviewed and agreed a final draft last year. Since then, the Delivery Plans have been finalised and targets for key outcome measures have been set in consultation with key partners.

3.1.5 The Strategy, outcome measures and targets have been endorsed by the Council's Cabinet in May 2013 and the borough's Clinical Commissioning Group.

3.1.6 A more accessible summary version of the strategy has been drafted and is also attached. Once endorsed by the Board, the Strategy and summary version will be formally published online and communicated via press release and directly to relevant stakeholders. A dissemination/communication plan is being developed.

3.1.7 The Board has agreed a set of delivery and performance monitoring arrangements for the Strategy. These are set out in section 3 below.

3.2 Key decisions for the Board

3.2.1 The Board is asked to

- Agree the strategy, delivery plans, proposed outcome measures and targets. These will be the measures used to track progress on the plan and on which performance will be reported to the Board. The measures are drawn from the social care, public health and NHS outcomes frameworks to reflect our strategic priorities.
- Agree the delivery and performance monitoring arrangements set out in section 3 below.

3.3 Delivery and Performance Monitoring

3.3.1 A workshop of the HWB Board Strategy sub-group agreed to propose the following arrangements to the Board:

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

- The Council's Corporate Strategy and Equality team, on behalf of the Strategy sub-group, will liaise with agreed leads to oversee the monitoring of progress of the strategy compiling six monthly reports to the Board on progress with key outcome measures and an annual report on progress against the delivery plans;

- Delivery of cross-cutting activity in the Strategy in relation to wider determinants or enablers will be overseen by the Strategy sub-group which will meet bi-monthly to progress this work, liaising with other Boards and Community Plan Delivery Groups as required. The sub-group's first meeting will focus on taking forward joint work in relation to Housing;

- Performance reports to the Board will ensure performance on key measures is benchmarked annually and targets reviewed for the 2 years ahead;

- Healthwatch will also make regular dashboard reports to each quarterly Board meeting identifying key issues from patient and resident experiences of health and social care services, as well as a more in-depth examination of a key issue related to the HWB agenda; and

- Based on the regular review of performance and patient experience data, the Board may identify areas for improvement and request 'spotlight' sessions on specific issues of concern or local significance. These sessions will seek to understand improvement plans in place and identify areas where partnership working might help to resolve blockages.

4. COMMENTS OF THE CHIEF FINANCE OFFICER

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

5. LEGALCOMMENTS

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

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

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

6. ONE TOWER HAMLETS CONSIDERATIONS

6.1 An equalities assurance exercise has been undertaken as part of the strategy developmentthe strategy was informed by a detailed assessment of equalities impacts on health attached as appendices 6 and 7. Key considerations emerging include:

7. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

7.1 There is a wealth of evidence, most recently compiled and presented within the Marmot review of health inequalities, identifying the considerable impact on health of wider social, economic and environmental impact on health, in particular housing, educational attainment, employment and the physical environment. These are addressed as wider determinants of health within the Health and Wellbeing Strategy.

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

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

8. RISK MANAGEMENT IMPLICATIONS

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

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

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

9. CRIME AND DISORDER REDUCTION IMPLICATIONS

9.1 Health issues, in particular in relation to mental health, alcohol and drugs misuse have a significant impact on crime and disorder. The Health and Wellbeing Strategy identifies key opportunities where it could work with

partners and the Crime and Disorder Partnership, including around substance misuse, domestic abuse and the health needs of sex workers.

10. EFFICIENCY STATEMENT

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

Appendices and Background Documents

Appendices

- Tower Hamlets Health and Wellbeing Strategy
- Tower Hamlets Health and Wellbeing Summary
- Maternity and Early Years Delivery Plan
- Healthy Lives Delivery Plan
- Long Term Conditions and Cancer Delivery Plan
- Equalities Assurance Checklist
- Equalities Insights

Background Documents

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

- Consultation responses and insights

Tower Hamlets Health and Wellbeing Board

Towards a Healthier Tower Hamlets

Contents

Foreword from the Mayor of Tower Hamlets

Welcome to *Towards a Healthier Tower Hamlets*, Tower Hamlets' Health and Wellbeing Strategy. This document seeks to provide a framework for improving the health and wellbeing of the local population.

The aims of the strategy are to improve the health and wellbeing of local residents while reducing health inequalities and promote choice, control and independence.

It was developed following wide-ranging discussions and consultation with local residents, patient groups, carers, and health and care professionals. The extensive dialogue identified four main priorities for the strategy: maternity and early years; healthy lives; mental health; and long-term conditions and cancer.

The squeeze on public sector expenditure, coupled with the poverty and deprivation in Tower Hamlets, means that there are major challenges ahead if we are to deliver on the strategy's aims. However, I'm confident that the strategy and associated delivery plan present a solid framework for delivering on those aims.

Progress will be evaluated against the strategy's delivery plan: by tracking the outcome measures and monitoring progress against the key activities. Thesewill be reported to the Health andWellbeing Board on a regular basis where board members will hold service providers and commissioners to account and ensure they are playing their part in improving the health and wellbeing of the residents of Tower Hamlets. This will also allow local residents to see for themselves how the partners who make up the Health andWellbeing Board have performed against the delivery plan.

These are challenging times for the public sector; health in particular. The scale of the change and the rapid pace has caused some, myself included, to be concerned about the impact they will have on our health services and on local people. However, the *Health and Social Care Act*requirement for Health andWellbeing Boards and joint Health and Wellbeing Strategies provide an opportunity for a strategic response to some of the problems that our residents face in the health and care domain.

The Act also ushers in a welcome mechanism for democratic oversight of our health services. My role, as chair of the HWB Board, provides me with a unique opportunity to facilitate the accountability of our health services on behalf of local people.

I know that health and wellbeing is an important issue for local people. Good health and wellbeing enables residents to live long, healthy and fulfilling lives. The priorities for my administration all impact on the health and wellbeing of residents; these

include housing, employment, community safety and education. The strategy recognises this in the section looking at the wider determinants of health.

I sincerely believe that the strong partnership between the members of the Health and Wellbeing Board and the solid framework for our work, provided by the Health and Wellbeing Strategy, will allow us to make transformational changes in the health and wellbeing of local people. I hope you will join me in welcoming this strategy.

Lutfur Rahman
Executive Mayor, London Borough of Tower Hamlets
Chair, Tower Hamlets Health & Wellbeing Board

Introduction

This document, *Towards a Healthier Tower Hamlets,* is the new Health and Wellbeing Strategy for Tower Hamlets. The *Health and Social Care Act 2012*introduced the requirement for Health and Wellbeing Boards to prepare joint Health and Wellbeing Strategies (HWS) for their local areas. The joint Health and Wellbeing Strategy should provide an over-arching framework to ensuring a strategic response to the health and social care needs of the local population.

Tower Hamlets has had a partnership-wide Health and Wellbeing Strategy since 2006. Significant progress has been made in delivering the key priorities of the strategy. There is a strong foundation on which to develop the new Health and Wellbeing Strategy.

The expectations for the new strategy are high – taking account of the health and social care needs of the entire population, it will provide a framework for the commissioning of health and social care in the local area and the means by which the statutory Health and Wellbeing Board seeks to hold health commissioners and providers to account and ensure improvements in key priority areas identified. In addition it will provide a means for working with a range of local agencies to embed consideration of the health impact within wider policy decisions. The strategy will also act as a bridge to all those living in the borough, identifying how we can all take more responsibilityor our health and how we can support community groups and local people to play a central role in addressing identified needs.

The strategy has been informed by review of the key evidence in our local Joint Strategic Needs Assessment (JSNA), review of our existing intelligence from users, carers and 'less heard' groups plus engagement activity with key groups and a publically available online survey providing feedback on our draft key principles and priorities.The strategy has identified four key themes for action: maternity and early years; healthy lives; mental health; and long term conditions and cancer. It includes a set of key outcome measures, an outline of key activities planned,and a delivery plan which will be used to track and monitor progress.

Towards a Healthier Tower Hamlets will set the framework for health and wellbeing in Tower Hamlets for the next three years. The Board will oversee its progress and continue to review the evidence and engage with local people to ensure the priorities and programme of activity remain relevant and timely. The Health and Wellbeing Board alone cannot bring about the changes in local health outcomes which this strategy aspires to. As a result, the board will work closely with local partners – and build on the strengths, skills and commitment of local organisations, communities and individuals so that we work together to ensure on-going improvements in health and wellbeing in Tower Hamlets.

Tower Hamlets Context

Tower Hamlets: The Place

Tower Hamlets is unique; unparalleled in its history of diversity and growth.

In recent times Tower Hamlets has experienced the largest growth in the country and the focal point of regeneration in London. Significant development activities include the 2012 Olympic and Paralympic Games, continued development within the Thames Gateway and the expansion of Canary Wharf. This presents immense opportunities for the borough. There has also been significant residential development, with the borough experiencing the country's highest housing growth over the last few years.

The richness of Tower Hamlets is also evident in its physical and cultural assets. Tower Hamlets boasts extensive waterways, Victoria and Mile End Park, an assortment of museums and markets, and the Tower of London from which it derives its name. All of these contribute to the borough's unmatched sense of place and identity.

Deprivation is widespread in Tower Hamlets and the majority (72%) of areas in Tower Hamlets are amongst the 20% most deprived areas in the country. A significantly higher percentage of residents live in social housing (54%) compared to the rest of London (37%) and, despite the substantial housing growth, high levels of overcrowding persist. The borough also has less green space than the national average with 1.1 hectares per 1000 people compared to 2.4 nationally.

Tower Hamlets: The People

Diversity has always been a key strength of the borough. Tower Hamlets has historically been home to a mix of communities. It now has the fastest growing population in London, estimated to be 254,100 and projected to increase to 339,280 by 2026. This growing population is ethnically diverse, with just overhalf of the borough's population comprising of Black and minority ethnic groups, with the largest of these (32%) being the Bangladeshi community.

Religion continues to play a prominent role in the lives of many of the borough's population, with 65.5% of residents claiming a religious belief. The borough also has a relatively young population with 40.9% of people aged 20-34, compared to 20.3% across England. High population churn sees 29% of the borough's population move in to, out of, or around, the borough per year.

44% of households and 48.6% of children in the borough are in poverty – the highest rate in the country. At the same time the average earnings of those who work in the

borough, but don't necessarily live in it, is £60,000 a year. Unemployment remains an issue with 13% of the working age population unemployed, compared to 9% across London.

3.3% of the borough's population provide more than 20 hours of unpaid care per week and more than half of them provide more than 50 hours of unpaid care.

While there have been improvements, life expectancy remains lower than the rest of the country: male life expectancy is 76.0 years compared to 78.3 nationally and female life expectancy is 80.9 years, compared to 82.3 nationally. Life expectancy varies by 12.0 years in males and 5.4 years in females between the most affluent and most deprived areas.

Tower Hamlets: The Partnership

Tower Hamlets has a long-standing and successful local strategic partnership, the Tower Hamlets Partnership, which brings together the Council, key public sector partners including health and the police, fire service,representatives from the business, voluntary and community sectors and local people. Since 2001 the Partnership has developed a joint Community Plan – the most recent was refreshed in 2010/11 with a vision taking us up to 2020 "to improve the quality of life of everyone living in Tower Hamlets". One of its four key priorities is to work towards a Healthy and Supportive Community. The Health and Wellbeing Strategy is fundamental to taking forward this priority.

Tower Hamlets: Health Needs

Tower Hamlets, like all authorities, undertakes a Joint Strategic Needs Assessment (JSNA) to understand the health and social care needs of the local population. This wealth of evidence and analysis has been used to inform a range of local strategies and programmes, and is the basis from which our Health and Wellbeing strategy stems. Some of the key evidence from the JSNA is summarised below.

Being Born in Tower Hamlets

4,545 children were born in Tower Hamlets in 2011. While infant mortality is not significantly different to the rest of London, a higher percentage of babies are born with low birth weight (9%) when compared to London as a whole (7.5%). Given the correlation between high deprivation and low birth weight, this is not surprising. There are other behavioural risk factors that impact the health of a new born baby such as substance misuse, problem drinking, poor diet and smoking on the part of the mother. 4% of expectant mothers smoke during pregnancy; however, this increases to 16% amongst white mothers. There has been a steady reduction in the teenage pregnancy rate since 1998 and it is now slightly below the London average.

Growing up in Tower Hamlets

There are around 18,700 infants aged under-5 in Tower Hamlets. There are also around 28,700 children and adolescents aged 5-14 and 14,600 aged 16-19. Overall, around 60% of under-20s are Bangladeshi.

48.6% of children in Tower Hamlets live in poverty. By the age of 5, only 46% of infants in Tower Hamlets have achieved a good level of cognitive development compared to 56% nationally. However, when looking at educational attainment, our pupils are performing at or above the national average at Key Stages 1, 2 and 4.

13.1% of children in Reception year are obese – the 6th highest rate in the country– and by Year 6 (10-11 year olds) this increases to 25.1% and is the fourth highest rate in the country. However, it is encouraging that 88% of mothers initiate breast feeding at birth (compared to 73.7% across England) and 71% are still breast feeding at 6-8 weeks (compared to 45.2% across England). In addition, immunisation uptake in under-5s is amongst the highest in the country with 96.6% of children receivingthe second dose of the MMR vaccine.

Being an adult in Tower Hamlets

There are around 125,500 people aged 20-39, 45,000 aged 40-59 and 21,400 over 60living in Tower Hamlets.

Tower Hamlets has amongst the highest premature death rates from the major killers in London. The levels of long term illness/disability are also 34% higher than the national average. The borough has the 4th highest cancer premature mortality rate in London, the second highest cardiovascular disease (heart disease) premature mortality rate and the fifth highest mortality rate for chronic obstructive pulmonary disease (chronic bronchitis or emphysema). Rates of HIV, TB and sexually transmitted infections are amongst the highest in London and nationally.

When looking at some of the factors that lead to or contribute to the major killers, 21.5% of adultsin the borough smoke, compared to 20% nationally. This gap has narrowed in recent years due to our smoking cessation programme delivering the best performance in London. Of the 50% of the adult population who are drinkers, 43% have alcohol consumption patterns that are either hazardous or harmful to their health; around twice the national average. Although levels of physical activity are around the national average, fewer people in Tower Hamlets consume the recommended level of fruit and vegetables (12%) compared to the rest of the country (30%). In addition, the rate of problem drug users (2.3%) is almost double that of the London rate (1.2%).

Growing old in Tower Hamlets

There are around 15,500 people who are 65 or over living in Tower Hamlets. 4,200 of these are 80 or over. 65% are white and 22% of Bangladeshi ethnic origin and, because women live longer, a higher proportion are female (60%).Although not projected to see such a growth in the older population as elsewhere, the numbers of people over 80 in Tower Hamlets is expected to increase by 23% over the next 10 years.

80% of them have at least one chronic condition of which 35% have at least 3 ‘comorbid’ conditions. There are indications of significant under-diagnosis of dementia and the second highest stroke mortality rate in London. In addition, most people in Tower Hamlets do not die in their place of choice – 64% die in hospitals although national surveys suggest that most people would like to die at home.

In line with the general deprivation in the borough, 50% of older people live below the poverty line and a higher proportion live alone (47%) when compared nationally (33%). In addition, only 10% of older people consume the recommended level of fruit and vegetable and only 20% meet recommended physical activity levels.

Last years of life

There are around 1,000 deaths annually with life expectancy at age 65 significantly lower than average for both males and females in Tower Hamlets.

A higher than average proportion of deaths (from all causes) occur in hospital in Tower Hamlets with significant numbers who die in hospital being admitted as emergencies. There are frequent admissions in the last year of life and with longer episodes in hospital. This suggests poor anticipatory care especially as over two thirds of people say they wish to die at home.

Although rare at other stages in the life course, there will be people with needs around death and dying. In early years, for example, there will be premature and neonatal deaths, stillbirths, life limiting childhood conditions, childhood cancers and bereavement needs of parents and children who have lost parents.

Challenges Ahead

The next few years will be challenging for Tower Hamlets. The improved outcomes for local people over the past decade have, in part, been as a result of action to effectively invest public sector resources. We are now experiencing challenging financial times, with the public sector having far less money to spend on services than before. This is happening alongside growing demand for services including a rapidly growing and ageing population.

Tower Hamlets is changing and changing rapidly. The 2011 Census confirmed that the population growth in Tower Hamlets was the highest in the country – a 29.6% increase on the 2001 Census result from 196,000 to 254,100, more than double the rate of population increase (14%) across London as a whole and more than four times the increase in the population of England and Wales. Population turnover and churn remains high with 28.9% of the borough’s population either moving into the borough, out of the borough, or to a new address within the borough. The latest population projections from the Greater London Authority, suggest that the Tower Hamlets population will grow from 254,100 in 2011, to 326,000 in 2026; a rise of 72,000 and a percentage increase of 28 per cent. London’s population is expected to grow by 11% in the same period.

The new national policy context is also important for Tower Hamlets. Policy developments, which include changes to social housing provision, the welfare reform programme, changes to education funding and reform of the health service, pose challenges and opportunities for the borough.

The reform of the welfare system, including changes to benefits, tax credits and support for families, will in particular have a considerable impact on many residents in the borough. The combined effect for many residents will be a drop in household income both immediately and over time. Given the already high levels of poverty and deprivation in the borough, these changes will make it even harder for many households to get by; potentially affecting educational attainment, crime, health and wellbeing in the borough.

In addition, there are significant changes to the health service, both locally and nationally.The introduction of the *Health and Social Care Act 2012* has seen a radical change in the way in which health services are commissioned and delivered. The changes will see the abolition of Primary Care Trusts (PCTs) and Strategic Health Authorities (SHA) and the introduction of Clinical Commissioning Groups (CCGs) whose role it will be to commission hospital and community health care services for their local populations. The CCGs will be clinically led with their membership consisting of mainly healthcare clinicians and local GPs. A CCG Board and Accountable Officer will take over the statutory responsibility from the current PCT. The CCGs will be supported and held to account by a new national body called the NHS Commissioning Board (NHS CB) which will also commission primary care services and some specialist services itself such as screening and immunisation.

The new CCGs will require support to commission effectively and new organisations providing commissioning support services (CSS) are currently being developed to provide commissioning expertise to the newly formed CCGs alongside public health expertise from the council. Clinical leadership will also be provided through Clinical Senates that are expected to bring together clinical leaders across broad areas of the country to give clinical leadership and expert advice for commissioning.

Responsibility for public health transferred from the abolished PCTs to local authorities in April 2013. Currently the Tower Hamlets Public Health team and the local authority are implementing transition plans to shape the future organisation of the public health function in the council.

In terms of ensuring health scrutiny by patients and users of health services, a local HealthWatchhas been commissioned. They can visit health and social care services and report on concerns about services. Theywill also be represented on the local Health and Wellbeing board.

Our strategy is developed against the backdrop of these new opportunities and challenges, seeking to ensure that we continue our journey of improvement in these changed and changing circumstances.

Tower Hamlets: The Potential

Despite the very real health needs and challenges within the borough, Tower Hamlets has some key assets which we can build on and draw on to improve local health and wellbeing outcomes.

There is an existing strong primary care framework with an integrated network of providers with the 36 Tower Hamlets GP practices organised in a federated network model, ensuring planning across local areas, providing opportunities for specialisation and sharing of resources and skills within networks and aligning with local structures of service delivery within the council and other providers.

Social capital and the capacity and skills embedded within our local community are key to this. We have a long and proud history of self-help and a thriving voluntary and community sector with strong community leadership and engagement. Our diversity is also a key strength, and the fact that despite this diversity, there is a strong sense of community cohesion with the vast majority of local people feeling that people from different communities get on well within Tower Hamlets. As a result, innovative solutions to some of the worst social problems have arisen from within local communities, interest and faith groups, often working closely with statutory providers. The Borough has also relatively recently established a directly elected Mayor, ensuring direct representation of, and accountability to, the local community. The Mayor chairs the Health and Wellbeing Board which will oversee delivery of this strategy.

In addition, the people of Tower Hamlets have a strong sense of neighbourhood identity to which local providers have responded, establishing local networks for the delivery of services, giving people a closer relationship to services and ensuring support is better targeted to those who need it.

Regeneration and development in the borough also provides considerable potential – it brings in new money, new ideas and new communities. The borough's housing stock is expected to increase by 46,000 between 2011 and 2026. This represents a projected increase of over 3,000 homes per year. In addition, it is forecast that Tower Hamlets will experience a 44.6% increase in the number of jobs between 2010 and 2031. This is over three times the projected growth for London as a whole. With Canary Wharf and the City fringe, Tower Hamlets is home to one of the most desirable office locations in London. A further increase in office stock between 2012 and 2020 of 26% is predicted, more than double the projected growth in the City of London (9.6%) and five times that of Westminster (5.2%).

Although it also brings challenges which need to be managed, the fact that the borough's physical environment changes much quicker than elsewhere provides

opportunities to make changes which can improve the health and wellbeing of local people. Our challenge is to realise this potential.

Vision and Principles

The evidence in Tower Hamlets demonstrates that we still have a major task ahead of us to maximise health outcomes and reduce the health inequalities associated with poverty and deprivation in Tower Hamlets, particularly given the challenges ahead. Local engagement and feedback also tells us how important choice and control are in supporting independence and enabling people to play a full role in taking responsibility for their own health, in the context of good quality support and services.

Consequently, the vision for this Health and Wellbeing Strategy is:

To improve health and wellbeing through all stages of life to:

- **Reduce health inequalities**
- **Promote choice, control and independence**

Within the context of this broad vision, the board and those engaged to date have also identified some key principles which should inform the new strategy. These are:

- **Focussing on prevention, early identification and early intervention** – intervening as early as possible within the life-course to maximise life chancesand prevent the development of long term conditions, mental health problems and other illnesses.

Focussing on prevention, early identification and early intervention is all about making sure people get the right support at the right time.

- **Putting patients first**– our focus is on ensuring quality of care and dignity across the health and social care system ensuring that patient voice and experience informs all we do and there is a patient-centred approach to health and social care, with particular emphasis on improving this for older people and those with more than one health problem

In our recent survey to residents, one question asked what people thought stopped them from staying healthy. One resident responded:

"The constant focus of health care professionals on one long term condition to the detriment of any other injury/condition."[1]

By integrating care and working better in partnership our aim is to reduce the number of people that have this type of experience. Carers, service user and patients have

[1] LBTH, 2012, Residents Health and Wellbeing Survey

all, through a variety of forums, raised frustration with the lack of joined up working between health and social care staff.

- **Looking across the life course** – a focus on health inequalities demonstrates the importance of considering what actions individuals and health and social care professionals need to take at each stage of the life course, from pregnancy and birth through youth, adulthood to old age and into the last years, months and days, tomaximise life chances and health outcomes. In planning how to achieve our priority outcomes, we will take a life course approach to identifying necessary action at each stage.

- **Taking a family centred approach –** ensuring that where appropriate we consider patients and individuals as part of a family and consider how we can support the health and wellbeing of families jointly, including the key role of parents and other carers, including friends and non-family social networks, particularly recognising the high level of informal care within the family and community in Tower Hamlets.

"I have had a hospital appointment and my son has had one as well...the trouble is the doctors only see you as a patient and don't take into account that you still have your caring role. I'm not an individual I always have to take my son into account." (White Female, Discovery Interview)[2]

- **Ensuring 'health in all policies' –** there is a wealth of evidence, most recently compiled and presented within the Marmot review of health inequalities, identifying the considerable impact on health of wider social, economic and environmental impact on health, in particular housing, educational attainment, employment and the physical environment. The Tower Hamlets Partnership already has a strong focus on these areas through its Community Plan and these areas are also among the key priorities for the borough's directly elected Mayor. The Strategy will consider how the HWB Board should work with the relevant Community Plan delivery groups to ensure the health impact of all policies is considered.

When asked about what helps people to stay healthy residents responded with answers ranging from: family and friends, fresh air, healthy food, exercise to housing, education, and employment, illustrating that a focus on health and wellbeing really should be embedded into all of our policies. Restricting the availability of fast food in the Borough was also raised by people.

- **Understanding and addressing diversity –** Tower Hamlets is a diverse borough and health issues affect different equality groups in different ways. Partners work together to create our Community Plan vision of One Tower

[2]THINk, 2011, A report on the barriers to self-management for people in Tower Hamlets with a long-term condition(s) p 16)

Hamlets – reducing inequality and fostering community cohesion. To deliver this, our analysis has sought to understand the differential health issues for different groups and we have consulted with a range of organisations representing those more disadvantaged groups. In turning our priorities into actions, we will ensure that particular areas of disadvantageor need are addressed. This will include the impacton mental health experienced by certain groups, for example due to the stress and anxiety from the experience or fear of discrimination or prejudice.

- **Building on community potential and capacity –** whilst Tower Hamlets has significant health issues to address, it also has significant advantages in the strength and vibrancy of the voluntary and community sectors and the capacity, skills, knowledge of local communities. There is considerable potential for the strategy to build on this, supporting and facilitating citizens and communities to become the co-producers of health and well-being rather than the recipients of services and promoting community networks, relationships and friendships that can provide caring, mutual help and empowerment. Existing work around mentors and health champions can be further developed and linked with the wider Partnership's work on promoting community champions, neighbourhood forums and neighbourhood agreements.

The residents that responded to our survey thought that having a strong sense of community and peer support are all important for good health and wellbeing.

"Currently, I am a health champion offering a service to my community so I hope that this is helping."[3]

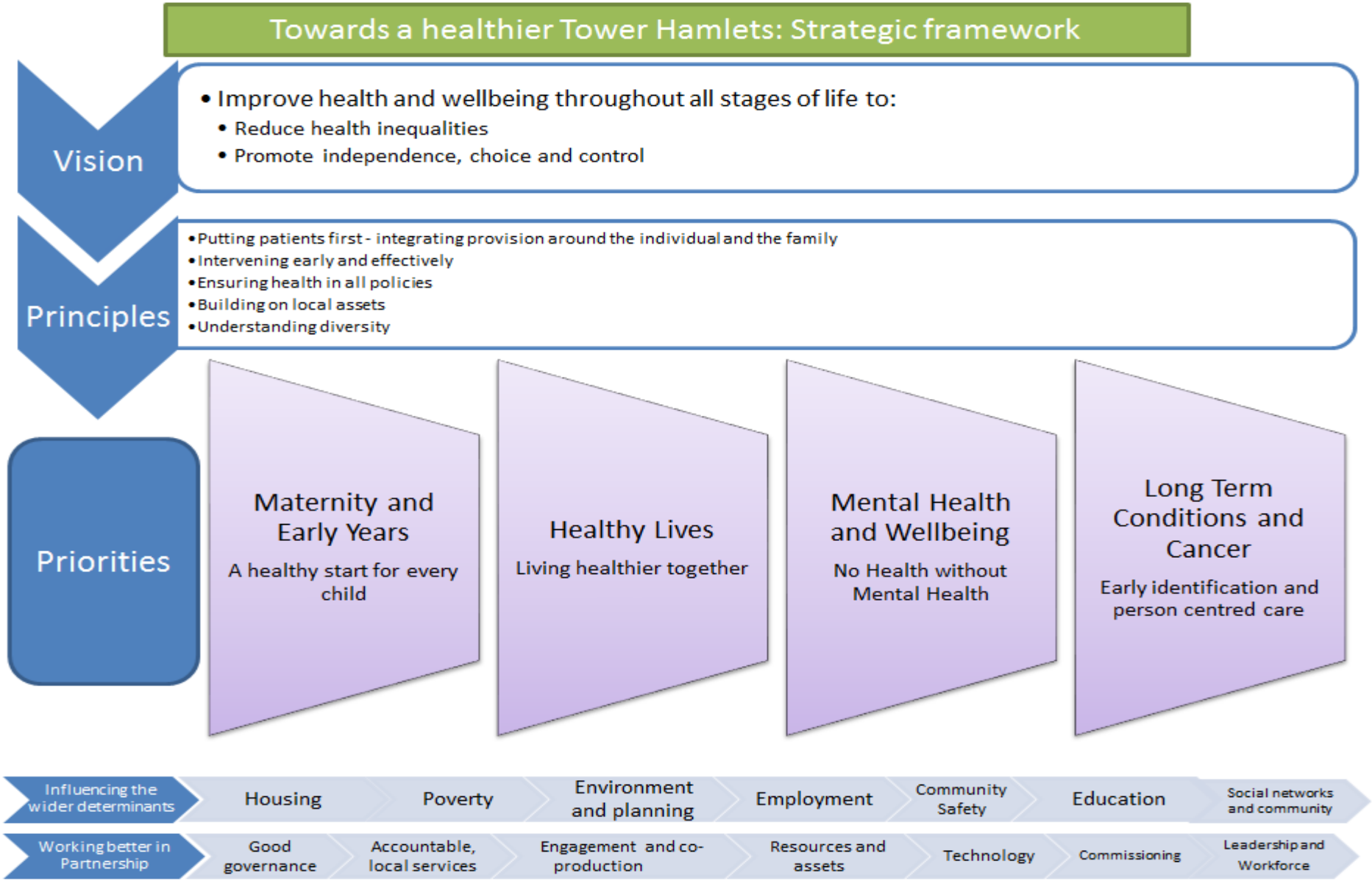
[3] LBTH, 2012, Residents Health and Wellbeing Survey

Framework and Priorities

Within the context of this vision and principles, a broad framework for the Strategy has been developed, identifying:

- some key priority areas for the Board to work on;
- broader social and environmental issues which the Board will want to work with partners to influence; and
- Partnership and accountability issues ensuring we maximise our effectiveness to deliver.

The framework for the strategy is set out overleaf.


Towards a healthier Tower Hamlets: Strategic framework
Vision
• Improve health and wellbeing throughout all stages of life to:
• Reduce health inequalities
• Promote independence, choice and control
Principles
• Putting patients first - integrating provision around the individual and the family
• Intervening early and effectively
• Ensuring health in all policies
• Building on local assets
• Understanding diversity
Priorities
Maternity and Early Years
A healthy start for every child
Healthy Lives
Living healthier together
Mental Health and Wellbeing
No Health without Mental Health
Long Term Conditions and Cancer
Early identification and person centred care
Influencing the wider determinants
Housing
Poverty
Environment and planning
Employment
Community Safety
Education
Social networks and community
Working better in Partnership
Good governance
Accountable, local services
Engagement and co-production
Resources and assets
Technology
Commissioning
Leadership and Workforce

Priorities

Priority 1: Maternity and Early Years

A healthy start for every child

Maternal health, before, during and after pregnancy, and the first few years of a child's life are a critical period for a child's longer term health and well-being. The Marmot Strategic Review of Health Inequalities in England highlighted that social and biological influences on development start at or before conception and accumulate during pregnancy to influence the health of the child at birth. It presents evidence that the accumulation of social, economic, psychological and environmental influences during the early years 'cast a long shadow' over the subsequent social development, behaviour and health and wellbeing of the individual.

Given the level of health inequalities within the borough, a focus on maternity and early years within this strategy, is consequently vital to ensure that we improve the health and wellbeing outcomes in the future. We have made real progress in some key areas:

- Teenage pregnancy and births to teenage parents are decreasing and now lower than average for London and England
- 95% of pregnant women in Tower Hamlets had booked for antenatal care by 12 weeks and 6 days (2011/12)
- Over 95% of infants have received the full range of childhood immunisations for that age
- Obesity in 4-5 year olds has declined year on year since 2006, though still high compared to London and England

Some key areas where the evidence indicates that our levels of need are high and we particularly need to focus are as follows:

- Smoking during pregnancy – our rates are lower than the London and England averages but there are certain groups where rates are higher and rates could increase as the population demographic changes
- High levels of diabetes in pregnancy
- Alcohol use in pregnancy and foetal alcohol syndrome
- Increasing levels of overweight and obesity among pregnant women, increasing risks to mother and child

- High levels of Vitamin D deficiency in pregnant women
- Women at increased risk of domestic violence during pregnancy
- High proportion of low birth weight babies (which may contribute to increased risk for diabetes and cardiovascular disease in later life)
- Despite relatively high overall breastfeeding rates, exclusive breastfeeding rates are still low (i.e. a large proportion of mothers also bottle feed their babies)
- Evidence of poor weaning practices by some parents (likely to be contributing to high levels of obesity and dental decay in 4-5 year olds)
- Despite improvements over the last few years, patient surveys show there is still further improvements needed in patient experience of maternity services
- Female genital mutilation in some communities presents risks in childbirth
- School readiness assessed at the Early Years Foundation Stage, despite recent improvement, is still significantly below the national average

In addition, there are a range of wider factors which impact on early years development.

There are already a number of programmes and strategies to address these issues and as a result our community health services and children's centres have achieved the WHO/UNICEF Baby Friendly Accreditation demonstrating that they have policies and practices in place to support mothers in breastfeeding. Work is also in hand to review and refocus activity where appropriate. The Children and Families Plan also identifies early years as a key focus and its priorities include ensuring all children are healthy.

Outcome objectives

The proposed outcome objectives for maternity and early years are:

- Good and improving maternal health – including maternal nutrition, good mental health, decreasing maternal obesity and decreasing numbers smoking at time of delivery
- Maintain reduction in under 18 conceptions and support teenage parents
- Early detection and treatment of disability and illness and ensure that children achieve positive physical, cognitive and emotional development milestones
- Maintain low infant mortality rates and promote good health in infancy and early years
- Decreasing levels of obese and overweight children in reception year, provide more opportunities for active play and healthy eating
- Reduce dental decay in 5 year olds

Key activities

- **Promoting maternal health and people's experiences of maternity services** – a major activity within this area will be the refresh of the Health Improvement Strategy for Maternity Services, including enabling and empowering local women to have greater involvement in shaping services. Consideration of the needs of women before, during and after birth will also be reflected in the refresh of other related strategies such as the new Healthy Food and Healthy Lives Strategy and Tobacco Control Strategy. Enhancing health education for young people and women of child bearing age is another key feature in promoting maternal health. Partners will work together to better inform women of factors affecting maternal health and the outcome of pregnancy such as nutrition, weight and lifestyle. Alongside improving services for all pregnant women, the strategy will focus on providing intensive and timely parenting support for pregnant women with complex needs, including teenage parents, through initiatives such as the Family Nurse Partnership and the maternity mates programme.

- **Reducing infant mortality and promoting infant health –** a number of activities have been identified to help ensure a healthy start for every child. The quality of antenatal and new born screening programmes will be improved to ensure the early detection of preventable conditions. Although rare, premature and neonatal deaths as well as life limiting childhood conditions occur in Tower Hamlets. This creates bereavement needs for families. Health services will also look to analyse the impact of consanguinity on the prevalence of disability and infant mortality in affected communities and use this to agree appropriate actions. The benefits of breastfeeding, particularly exclusive breastfeeding, to infant health will be promoted by exploring the factors influencing partial breastfeeding rates and improving access to advice and support for appropriate weaning practices through Children's Centres and other services.

- **Ensuring that all children are physically, emotionally, behaviourally and cognitively ready for school –** in order to improve school readiness in the borough, partners will incorporate an Emotional Development and Attachment Relationship Screening tool within the development assessment of all one and two year olds. There will continue to be a focus on reducing childhood obesity by early identifying families at risk of obesity, improving the physical activity opportunities availablefor the under-fives and working with health visitors to improve the recording and reporting of body-mass-index during reviews of two and three year olds.

- Implementing the nationwide 'A Call for Action' improvement programme for health visiting which aims to increase the number of practising health visitors in Tower Hamlets and improve the service model.

From our engagement we have also heard that people would still like to see further improvements in maternity services, this was particularly voiced by the Community and Voluntary sector but has also been raised as part of our wider engagement activity:

Maternity services are better, but, still need improving:

- Staff attitudes especially post natal
- Widening access to the Barkantine Birth Centre (Bangladeshi/Somali)
- Community based post natal care – Health Visitors / Community midwives
- Lack of interpretation services[4]

[4] CVS, 2012, Health and Wellbeing Forum

Priority 2: Healthy Lives

Living healthier together

Living a healthy life prevents illness and enhances wellbeing. We know that people who do not smoke, take adequate physical activity, eat a healthy diet and drink alcohol in moderation have a risk of dying early. That risk is around four times less than those who do not adopt these behaviours. We also know that they tend to have better mental health.

Local authorities, health services and others can do much to support and promote healthy lives. This will require a comprehensive approach to promoting healthy weight, increasing physical activity, stopping smoking or oral tobacco use, promoting sexual health and tackling problem drug and alcohol use. This involves working towards an environment that supports healthy lives. This could mean increasing green spaces, increasing availability of affordable healthy food, reducing availability of illicit or counterfeit tobacco, alcohol or drugs,widening access to sexual health services as well as ensuring that people are informed and empowered to lead healthy lives throughout life. It also means working alongside and within local communities, individuals, families and institutions to develop locally led approaches to support and promote healthy lives.

Although there have been improvements in recent years, we know that there are higher levels of lifestyle risk factors in Tower Hamlets compared to elsewhere. Comparison of national and local intelligence tells us that within the Tower Hamlets population there are higher levels of tobacco use, unhealthy diet, physical inactivity, problem drinking in those who drink alcohol, risky sexual behaviour and drug use.

Some of the key evidence shows that in the Tower Hamlets population:

- 13% of children aged 4-5 are obese (7th highest in the country) and 1 in 4 children aged 10-11 are obese, amongst the highest in the country
- 39% have experience of tooth decay (compared to 31% nationally)
- 40% of under 16s are estimated to have a vitamin D deficiency
- There are 42 junk food outlets per secondary school (the second highest in London)
- 21.5% local people smoke (compared to 20% nationally)
- 88% of local people do not consume the recommended 5 fruit and veg a day (compared to 70% nationally)

- 68% do not meet recommended levels of physical activity (compared to 66% nationally) with significantly lower levels in more deprived parts of the borough and in older people
- 8th highest levels of sexually transmitted infections
- 43% of drinkers have hazardous or harmful patterns of consumption (21% nationally)
- Amongst the highest rates of known drug use in London

There have been a number of programmes and strategies put in place to address these issues including the Healthy Borough Programme, Healthy Weight Healthy Lives, Tobacco Control, Substance Misuse, Sexual Health strategies as well as the LinkAge Plus programme aimed at older people. Key successes include:

- Levels of childhood obesity are stabilising
- In 2011/12, 3600 smokers in Tower Hamlets were helped to quit through local cessation services, the best performance in London

We asked residents what they thought helped them to stay healthy. Healthy food, exercise and environment were the top 3 responses. However, residents have also told us that time, money and knowledge can be barriers to living a healthy lifestyle. Respondents acknowledged the facilities that exist in the Borough like the outdoor gyms and the leisure centres and recognised attempts to make these affordable. There is a sense though that more needs to be done to encourage people to "Get Active" given some of the barriers. For older people, isolation and not knowing anyone can prevent people from being active.

When we asked about the main health concern for local people is obesity came out top. We also asked about what local people could do to improve their health and wellbeing:

"The council to enable and empower local communities to take action in ways that work for them rather than being told what to do and developing enabling environments so that people can be more active, grow their own veg, learn riding bicycles as Bangladeshi women etc., - all really good examples already happening, need more support and use as best practice example to be replicated"[5]

From feedback collected by THINk, patients have also said that they would like more support from their GP on weight loss and exercise programmes and more signposting to local programmes and services

[5] LBTH, 2012, Staff Health and Wellbeing Survey

Outcome objectives

The proposed outcome objectives for healthy lives are:

- Stop the increase in levels of obesity and overweight children
- Reduced prevalence of tobacco use in Tower Hamlets
- Higher rates of physical activity
- Reduced prevalence of sexually transmitted infections and promote sexual health
- Reduced levels of harmful or hazardous drinking
- Reduced rates of drug use

Key activities

- **Tackling obesity and promoting physical activity** – the development of the new Healthy Food and Active Lives Strategy, and engaging local people in its implementation, is a pivotal activity for this priority. It will provide the multi-agency framework for promoting healthy eating and physical activity to support local people to lead healthier lives. Evidence based health food standards to share good practice across partner agencies will also be implemented. Council and health services will work together to ensure that local infrastructure supports and enables healthy living. This includes monitoring the impacts of the implementation of the Local Development Framework on healthy food and active lives;such as the cycling and walking infrastructure and restrictions of new hot food takeaways near schools and leisure centres.

- **Reducing the prevalence of tobacco use and substance misuse –** refreshing and implementing the Tobacco Control Strategy will ensure a co-ordinated approach to smoking prevention, oral tobacco use and smoking cessation in the borough. As part of this, there will be a particular focus on reducing tobacco uptake in adolescents and young people by reviewing and updating the borough's tobacco control plan for young people, including reducing the amount of counterfeit and contraband tobacco available to young people. Problematic alcohol consumption and drug use in the borough will be addressed through the implementation of the Substance Misuse Strategy. Partners will champion an integrated life-course approach to treatment, recovery and re-integration in substance misuse care pathways. This holistic approach to substance misuse will also be reflected in the development of the Integrated Offender Management plan.

- **Promote good sexual health** – in order to reduce sexually transmitted infections, increase access to contraception and encourage better sexual health, partners will develop and implement a three-year sexual health strategy for the borough. As part of the implementation of the strategy, a sexual health needs assessment for high need, vulnerable groups, including looked after children and adults with learning disabilities, will also be delivered. A life-course sexual health promotion plan (including sex and relationship education in schools) will be developed and access to sexual health services and contraception choices promoted among all frontline services.

Priority 3: Mental Health and Wellbeing

No health without mental health

Good mental health and wellbeing is fundamental to quality of life: it impacts on physical health and life expectancy, on family life and relationships, on educational achievement and employment, and on social interaction and participation. At least one in four people will experience a mental health problem at some point in their life and one in six adults have a mental health problem at any one time. In addition, the incidence of mental health problems can increase in times of economic and employment uncertainty.

With a high prevalence of risk factors for poor mental health in Tower Hamlets, including deprivation, inequality, low levels of employment and less access to green space, the actual rate of people with mental health conditions is thought to be higher than the national prevalence rates.

There are some key areas where the evidence indicates that our levels of need are high and where we particularly need to focus:

- The increasing number of children and young people in the borough, and the clear evidence of the impact of laying the foundations for good mental health in later life
- Higher hospital admission rates for adults with a mental illness
- The number of people with dementia is projected to increase significantly in the coming years, in line with an ageing population.
- There is insufficient accurate intelligence on unexpressed need and expressed but unmet need
- There is a need to tackle wider determinants of mental health: poor mental health is associated with other health risk factors including obesity, smoking, problem drinking and problem drug use, all of which have a high prevalence in the borough
- There is a clear link between long term conditions and poor mental health, and a consequent need for improved integration of physical and mental health pathways and from primary, secondary and social care
- There is potential for a greater focus on mental wellbeing as well as mental ill health, including tackling stigma and discrimination

In discussions with community groups, residents and staff, mental health and emotional health are seen as a priority. The Carers Forum, The Tower Hamlets Housing Forum, The Tower Hamlets Inter Faith Forum, The Older People's Partnership Board, The Great Place to Live Community Plan Delivery Group and the Community Voluntary Sector Health and Wellbeing Forum all raised mental health as a priority.
Our engagement highlights different areas of focus for different parts of the lifecourse/circumstances:

Carers: Impact of caring roles on people's mental and emotional health

Young People: transitions from young people's services to adults' services, emotional health and wellbeing and its impact on educational attainment, relationships with parents, substance misuse and bullying.

Being an Adult: GP patients have reported to THINk that they want to feel like they are being treated as a whole person and that their emotional and mental wellbeing is being looked after as well as their physical wellbeing.

Older People: ranging from the impact of social isolation on mental wellbeing to dementia.

There are already a number of programmes and strategies to address these issues, overseen by the Mental Health Partnership Board, which involves key statutory bodies plus the third sector, service users and carers. The Mayor has made a high profile commitment to ending mental health discrimination, signing the 'Time to Change' pledge, committing the Council to tackling the discrimination and stigma associated with mental illness.

The Partnership Board has also overseen the development of an over-arching Mental Health strategy within the context of the Health and Wellbeing Strategy and reporting to the Health and Wellbeing Board.

The Mental Health Strategy sets out our vision for improving outcomes for people with mental health problems in Tower Hamlets. It sets out how, over the next five years, we will work together to promote mental health and well-being in our communities, prevent Tower Hamlets residents from developing more significant mental health problems, and ensure that when people do need them, mental health services are of the highest possible quality, proactively supporting people to recover. It demonstrates our ambition to deliver against the National Outcomes Framework for Mental Health contained in *No Health Without Mental Health.*

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

Our vision is built around the three pillars, of building resilience in our population, ensuring high quality treatment and support, and supporting people to live well with a mental health problem. The foundations of the Strategy lie in the shared values that underpin a whole person approach and the principle that mental health is everybody's business. The overarching principle that governs the Strategy is that it takes a lifecourse approach, actively considering how the whole population can be supported to be mentally healthy from cradle to grave. We believe that in delivering the commitments that we will detail in this Strategy, we will measurably improve outcomes for people with mental health problems and their carers.

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

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

Families and carers will feel more supported	People will be able to access timely crisis resolution, close to home	People will have access to support to find employment, training or education	
People will experience smooth transitions between services	When they need to access multiple services, people will feel that they are joined up	People will have access to accommodation that meets their needs, in the borough	
At risk communities will have access to targeted preventative support	People with a mental health problem will have high quality support with their physical health		
Shared values: a whole person approach			
Mental health is everybody's business			
Focus on quality improvement			
Commissioning with commitment			

It is the intention that this is a live strategy, which will adapt, within the context of the principles and commitments outlined within this document, over the next five years. In line with the requirements of the 2014/15 NHS England planning guidance, the action plan details actions we will take to deliver the strategy's commitments in years one and two of the strategy, 2014-16. We will review the action plan at the annual mental health summit in the Autumn of each year in order to refresh it for the year ahead.

Key actions for the delivery of the Strategy over the 2014-15 year include:

- We will develop a public mental health and well-being programme which will include a portfolio of evidence based public mental health interventions, which will identify how we will deliver this, alongside other public mental health commitments over 2014/16

- We will map current services available to support maternal and infant mental health in order to identify gaps, improve access for groups at higher risk, improve coordination across services and develop proposals to strengthen the universal tier of the service (including Maternity services, Health Visiting and services delivered from Children's Centres, primary care and by voluntary and community organisations)

- We will ensure that the roles of school nurses in relation to emotional health and well-being are clearly articulated in specifications for the re-procurement of the School Health service

- We will develop a refreshed service model for child and adolescent mental health services. A project board will be set up across all stakeholders to oversee this work including the development of a set of service specifications to deliver the refreshed service model. This will include consideration of the impact of potential changes to the CAMHS service model to services for adults of working age. We will develop a refreshed model for the delivery of day opportunity and support services, with an accompanying procurement plan

- We will continue the work to remodel and re-commission resettlement and rehabilitation team pathways

- We will review talking therapies providers, and develop a commissioning plan for future talking therapies pathways

- We will develop a refreshed service and activity model for the primary care mental health service (including social care)

- We will re-procure tobacco cessation and obesity services to explicitly include access for people with a serious mental illness

- We will review the model for in-patient care of older adults with a functional mental health problem

- We will develop a specification for mental health support in the community health service locality teams (within the Integrated Care Programme)

- We will review community mental health services for older adults in the context of our work to develop integrated care

- We will commission more dementia cafes

- We will develop a new web resource summarising information on mental health services in the borough for service users and professionals

- We will develop a rolling programme of training for GP's and other primary care staff

Priority 4: Long Term Conditions and Cancer

Early identification and person centred care

Long term health conditions and cancer, have a significant impact on quality of life; reducing the ability of those experiencing them to participate in employment, social and family life, contributing to the development of disability, reducing life expectancy and affecting mental wellbeing. Tower Hamlets has some of the highest premature death rates from three of the most life threatening conditions; cancer, cardiovascular (heart) disease, and lung disease. Furthermore, at least 50% of the Tower Hamlets population aged over 65 have two or more long term conditions.

People with long term conditions and cancer often report that there is a need for health and social care services to be more joined up and integrated in their approach to delivering care and support. They also identify the need for health and social care professionals to take a holistic and person centred approach to supporting them, especially in cases where individuals are living with more than one long term condition.

There is more to do to improve survival rates, particularly from cancer and a real need to further increase screening, public awareness and early diagnosis to improve survival. Prevalence of diabetes is also high and increasing, linked to high levels of obesity in the population. Early identification of risk and encouragement ofhealthier lifestyles are key to addressing diabetes.This strategy also seeks to improve rehabilitation for those with long term conditions and ensure proactive planning for deteriorations and management of the last years of life.

Typically for an inner city area with high levels of deprivation, there are high levels of infectious diseases with high and increasing levels of tuberculosis (TB), Hepatitis B/C, and HIV.These are conditions that should also be considered as part of the range of long term conditions, especially in the context of the substantial improvements in survival from HIV.

There are also a significant number of people who are living with disability, and significant numbers of people report mobility difficulties. Poor mobility appears to be related to social deprivation, with higher proportions of the Tower Hamlets population reporting mobility difficulties living in social housing or poor quality housing, unemployed, with poor levels of education, literacy or English language. Poor mobility is also strongly correlated to poorer self-reported mental wellbeing.

There is also a higher than average number of people in Tower Hamlets who have a learning disability. Analysis of GP data reveals that if you have a learning disability you are more likely to be affected by other health conditions such as diabetes, asthma, or epilepsy. Similarly there is a 10 times higher recorded prevalence of serious mental illness in the population with learning disabilities compared to the general population.

Not surprisingly, given higher levels of long term conditions and disability, Tower Hamlets has a high numbers of carers – an estimated 9,000 people locally providing 20 or more hours of unpaid care per week. Carers' needs have been recognised in a strategy which seeks to ensure that carers receive the support they require to continue to fulfil this vital role.

Members of the Carers Forum highlighted a particular concern that GPs and other health services often do not always recognise the role and needs of carers. One carer, highlighting his own experience, felt that for himself and others in similar situations, there should be more proactive work by health care services to reach out more to carers.[6]

Through the Transformation of Adult Social Care Programme, the Education, Social Care and Wellbeing directorate in the council is focusing on promoting choice and control for the people who use adult social care services. Personal budgets for children are also being developed. This programme has grown in momentum, as changes have been delivered to enable people to have more choice and control over the support and care they receive such as the introduction of personal budgets. The use of personal budgets increases the amount of choice and control that people have over their own support, and allows much more creativity in how their needs are met.

The Partnership has already made strides in tackling long term conditions and reducing premature mortality. The Tower Hamlets Cancer Strategy 2011-2015 set out a clear vision and set of actions for reducing premature mortality and addressing the inequality between Tower Hamlets and England in terms of survival rates.

The Primary Care Investment Programme (PCIP) which focused on improving primary care provision for vascular and respiratory conditions, as well as immunisations and vaccinations has demonstrated some significant improvements in health outcomes for the residents of Tower Hamlets. These include:

- The highest childhood immunisation rate in London with 95% of the population immunised (compared with just 80% in 2009)
- A 5.4% reduction in emergency hospital admission for those with COPD over the period April 2011 to December 2011
- More people being diagnosed with COPD and managed in a primary and community care setting
- An increase from 92.53% (April 2010) to 96.40% (March 2012) of patients screened for key diabetes indicators such as Hba1c, BP and cholesterol resulting in better managed care and identification of those at risk

[6]Tower Hamlets Equalities Steering Group Minutes, May 2012.

In addition, care package programmes have been introduced to drive improvement in the management and treatment of long term conditions through a standardised approach which places the patient at the centre of care. Where these have been introduced, for example in relation to diabetes and for those at high risk of heart disease, they are already showing improvement.

The roll out of the Community Virtual Ward (CVW) across Tower Hamlets supports this patient centred approach by recognising that the frailest of patients need new ways of delivering services, with an emphasis on developing a new way of working. One which puts them, their families and carers at the heart of the decision making process, keeping that at home when possible, better integration between service providers across health and social care and the community and voluntary sector. Initial developments have included a focus on people living in care homes and those receiving continuing care. Plans include a care planning approach which will provide a framework to deliver personalisation, the development of locality based teams integrating the work of general practice, community virtual ward and district nursing and hopefully social care at a generalist level and building strong supportive links from specialist services.

Users of health and social care services have raised a number of ways in which their experience as patients could be improved:

- People with Long Term Conditions have told us that they want to be more involved in their care and that services need to work better together.

- We've had some feedback to suggest that people find the social care and health systems confusing, particularly related to the number of staff and departments involved, as illustrated by the following quote: "*For normal, ordinary people, you don't really sort of understand who to ask for what and I don't always get the difference. So I think it would be quite helpful to have one particular person that you can contact*"[7]

- A focus on care in the community rather than acute settings: *"Home environment is always better than hospital environment, when you are in a hospital it makes you feel more ill being around others who are ill; it makes you a bit miserable. In your home environment you get to be with your own family, and it is just much more comfortable than being in a hospital. One person said that a lot of people get anxious when they go to hospitals; always start thinking of the worst. With the idea of the Virtual Ward it would eliminate the anxiety of going into the hospital*" [8]

Existing work will be sustained and stepped up with an on-going focus for the Health and Wellbeing Strategy on prevention, early identification and effective treatment for these long term and life threatening conditions.

[7] BLT Discovery Interview, June 2012.
[8] Older People's Reference Group, May 2011

Some of the key areas for the strategy going forward are:

- Identification of people at high risk of cardiovascular disease (CVD) and intervention to reduce risk through the Health Check Programme
- Improving outcomes of people with existing cardiovascular disease (CVD) through early identification and management of risk factors through the CVD care package
- Improving the number of people with controlled hypertension through the hypertension care package
- Improving outcomes of people with diabetes through early identification and management of risk factors through diabetes care package
- Improving outcomes for people with Chronic Obstructive Pulmonary Disease (COPD) through the COPD care package.
- Ensuring that promotion of healthy lives is embedded into clinical and social care pathways through development of the 'Every Contact Counts' programme
- Continuing improvement in cancer screening programmes through close collaborative working with Public Health England (the new commissioners of the service)
- Continuing local work to increase early awareness of the symptoms of cancer, early presentation and early diagnosis
- Continuing to reduce delays in cancer pathways to ensure that all patients access diagnostic and treatment services as early as possible
- A further and accelerated push towards integrated health and social care, working together across providers to enable a better quality of life and care for patients and service users minimising avoidable hospital admissions and the use of residential care
- Appropriate support for those with long term conditions and cancer survivors, including supportto live at home and facilities close to their homes
- Appropriate advanced care planning forend of life care and place of death
- Improve rates for cardiac rehabilitation and reduce emergency admissions and re-admission to hospital
- Increase identification, diagnosis of learning disability and ensure robust and integrated care and support, including a focus on improved housing options and support for young people

- Address gaps in services for adults with autism including a new diagnostic service and a Multi-Disciplinary Teams care pathway
- Improve engagement and understanding of carers by primary care services including improved recognition of specific needs of carers, increased use of carers' registers, and greater provision of health checks

Outcome objectives

The proposed outcome objectives for long term conditions and cancer are:

- Improved patient experience and co-ordination of health, housing and social care for those with single or multiple long term conditions
- Reduced prevalence of the major 'killers' and increased life expectancy
- More people with long term conditions or cancer diagnosed earlier and surviving for longer
- More people with learning disabilities receiving high quality care and support
- More carers having good physical and mental health and feel fully supported

Influencing wider social and environmental factors

The national review of health inequalities conducted in 2010 restated that health is tightly linked to socioeconomic status. The 'wider determinants' such as income, education, poverty, quality of housing, physical environment and community cohesion are profoundly linked to people's health.

Our residents have also told us that things that affect their health and wellbeing are broader than those traditionally "health related". Over 50% of respondents to our survey when asked about what stops them from staying healthy included a reference to wider social and environmental factors.

Tower Hamlets has a strong Community Plan, overseen by the Tower Hamlets Partnership, which is seeking to address a range of these issues through shared targets and delivery arrangements. The Health and Wellbeing Board is committed to working with the other Community Plan Delivery Groups to develop joint areas of work to ensure the health impacts of these areas are addressed. Work is underway to agree joint priorities with the relevant CPDGs.Some of the key areas where we will look to work together are set out in this section of the strategy.

Housing

There are clear links between the housing conditions people live in and their health. Overcrowding, poor quality housing and fuel poverty can all impact on physical and mental health. Access to green/open space within housing developments is also key to both emotional and physical health.

The council has a range of housing policies and initiatives to improve housing conditions. There is a Decent Homes programme which will see all current or former council homes in the borough reach decent homes standards by 2015 and there are major regeneration programmes for larger estates. There have been considerable successes in re-housing overcrowded households through building new homes and re-targeting the Lettings Policy. There are still problems and the council is working with social housing providers and developers to maximise affordable housing provision. The Tower Hamlets Housing Forum, representing all social housing providers in the borough, is also considering a plan to tackle under-occupation to ensure that the best use is being made of all social housing stock.

The private rented sector in Tower Hamlets is also growing fast. Some of the worst housing conditions are found within this sector. We have commissioned an analysis to quantify the health costs of the main hazards found in dwellings in this sector together with identifying those areas in the borough most affected, identifying properties that are likely to be houses in multiple occupation or properties which may have vulnerable occupants such as children or the elderly. A range of interventions are being considered in the private sector for the improvement of conditions and options for private rented sector accreditation and regulation are being explored.

Those with specific needs because of disabilities often rely on special adaptations to enable them to live independently. The council has refreshed its Tenancy Strategy which includes specific provisions to ensure that adapted properties are made available to those who need them most. In addition, the council is developing a new housing statement which considers how best to maximise financial support for adaptations through disabled facilities grants and other grant funding. This work will be developed in conjunction with health and social care providers.

For those in social housing, housing providers and staff can play a key role in promoting more healthy lifestyles. Many social housing landlords in Tower Hamlets already engage in projects such as:

- promoting and enabling employment, volunteering training and social enterprise;
- small scale local projects such as community gardens/allotments;
- facilitation and support for estate based community projects promoting healthy lifestyles or building capacity and awareness around health and wellbeing; and
- targeting frailer older residents and engaging them in estate based activity to make links between residents and reduce isolation.

The Tower Hamlets Housing Forum will work with the Health and Wellbeing Board to further develop these projects, share learning between providers and ensure greater co-ordination between local housing and health related projects.

Homelessness is the most extreme form of housing need impacting on people's health. Tower Hamlets Council and partners have made considerable progress reducing homelessness and improving services for homeless households since the Homelessness Strategy was launched in 2008. This includes preventing over 3,700 households from being homeless; reducing the number of people in temporary accommodation; providing a dedicated service for single homeless people – one of only a handful in London; and making significant progress towards ending rough sleeping in the borough.

There are now significant challenges in building on these achievements to continue to prevent homelessness. These include major changes to the benefit system, social housing reform, prolonged economic uncertainties, and reduced resources for services – likely to continue in the coming years. The council has developed a new Homelessness Statement which aims to meet local needs in light of unprecedented challenges. Key principles underpinning this are multi-agency working; early intervention; and building resilience. Specific initiatives include a whole systems approach to supporting homeless people designed to address their wider support

needs including employment and training, money management and income maximisation, parenting, substance misuse, mental health and domestic violence.

One resident when asked, "What do you think stops you from staying healthy?" responded "Worrying about money, housing and benefits being cut".

For people with long term conditions the accessibility of their home can impact on the health and wellbeing of the individual and their family. This quote illustrates some of the issues:

"I have a shower attached to the wall but I have to climb over the bath and have fallen a few times. The shower broke and I had to have a bath which was a nightmare. I've been in the house 35 years ... They told me they won't give me a walk in shower because they will have to change it again when I leave because the house will go to a family. I can't blame them really"[9]

Education

We are keen to continue our work in promoting understanding of healthy lifestyles in schools and other education settings, particularly given the evidence about the impact on learning and attainment of proper nutrition and physical activity, and supporting schools and colleges to enable this.

The current Healthy Schools Programme aims to increase understanding and awareness leading to positive choices around four key areas in schools:

- Healthy Eating
- Physical Activity
- Emotional Health and Well Being
- Drug Education and Sex Education

The Healthy Lives Team delivers training to schools in all of these areas, and currently 89% of community schools have been assessed as having achieved Healthy Schools status.Schools are also able to apply for Advanced Healthy Schools status and the team is working to enable more schools to achieve this status whereby they:

- create long term, sustainable change in areas where visible and measurable improvement can be seen and quantified;
- commit to two focused projects (LA/NHS priority and school priority); and
- committo a fixed priority of reducing obesity.

[9]THINk, 2011, Patient Quotes specifically regarding Tower Hamlets Local Authority taken from the Long-Term Conditions Project

In addition, Healthy Lives Champions are identified within local schools to carry out targeted work with pupils identified as overweight or obese.

Work is currently being explored around extending some of the training offered to schools to youth centres in order to provide a more holistic approach to education around healthy lives. A new project to raise awareness of health and wellbeing with school governors is also underway.

> *"The biggest impact is the shift in attitude and understanding towards living a healthy lifestyle by the children. The children are talking about healthy choices and show that they want to make those choices." (Staff member, Lawdale Junior School)*
>
> *"There is evidence of more children cycling to school now - there is not enough space in the cycle shed for all the bikes and our site manager has commented on 'needing a bigger shed for all these bikes!"*
>
> *(Staff member, Holy Family Primary)*

Poverty and income

There is a strong association between income and health inequalities. Rates of poverty and child poverty are high within the borough and the links with poor health outcomes are clear. There are particular concerns about the way in which welfare reform changes may exacerbate this. Because of large family sizes and high rent levels, the area will be particularly affected by the benefits cap from April 2013. We currently estimate up to 1600 households, including nearly 5000 children, will be affected by the benefit cap. This is likely to lead to forced moves, with the potential to increase overcrowding and with a clear impact on stress, mental wellbeing and a resultant impact on health and social care services. There is a borough-wide Welfare Reform Task Group, involving the council, health and voluntary sector partners which is working together to raise awareness of the changes and provide mechanisms for getting support to those who need it.A specific current project is considering the impact of welfare reform on disabled people and encouraging take up of disability benefits by those who are entitled to them. Alongside this is a partnership Financial Inclusion Strategy which focuses on addressing poverty through improving financial literacy and capability, access to financial products and services, and provision of debt and money advice.

The Council is committed to supporting small and medium enterprises, for example through its procurement policies, and to paying the London Living Wage. Barts Health NHS Trust and Tower Hamlets Council have signed a memorandum of understanding through which they agree to work together to support economic

development, support for local businesses and employment opportunities for local people.

The Council has also set up an independent Fairness Commission which will hear views from experts and local people and make recommendations about improving fairness in the local area, particularly in the area of housing, employment, and income and welfare policy.

Employment

Employment rates in the borough are low with only 60% of those of working age in employment and high rates of sickness/disability benefit claimants. This identifies two key issues for the strategy – promoting the health benefits of employment, especially in relation to mental health, and the role of GPs and other health services in supporting people back into work.

A number of neighbourhood based programmes in the local area are engaging with GPs in this way. This includes the Raising Aspirations project in East India and Lansbury Ward which is targeting the long term unemployed, most of whom are on disability benefits.Through an invest to save programme, the project seeks to demonstrate that there are financial as well as social and health benefits in getting people back into work.

The role of key health partners as significant employers is also a focus for the strategy, in terms of the role they can play in improving employment opportunities particularly for those with lower skills and promoting employment for those with disabilities and mental health problems. The council has an active local employment and Workforce to Reflect the Community strategy, with a strong focus on apprenticeships and graduate training opportunities for local people. Barts Healthmanages the Community Works for Health programme promoting health through employment, enabling local people to secure and sustain work within the NHS. The adverse effects of worklessness on health are well recognised, and the programme also supports the Trust in recruiting successfully front-line posts, and in providing further in-work development for a proportion of these staff. The success of this work has led to it being shortlisted for a Health Service Journal Award in the Workforce category this year. This programme is being further developed and as part of its joint memorandum with the council, Barts Health is exploring areas such as extending employment opportunities for local people, particularly for non-clinical staff, apprenticeships and how it develops stronger links into local schools, colleges and the community to enable more young people locally to move into health careers in medicine and nursing.

There is evidence that mental health is a significant blockage to employment – 75% of those targeted in the current ‘Raising Aspirations’ pilot identified some form of mental ill health as a barrier. There is a need to improve employment opportunities

for people with Learning Disabilities and the Council is commissioning a Supported Employment Service for people with support needs and their carers.

There is more to do with developing the Board's relationship with Jobcentre Plus and the DWP Work Programme which is working with those on sickness benefits to help them into work.

The Partnership has an Employment Strategy which seeks to ensure a co-ordinated multi-agency approach to getting people into work.This includes the work of Jobcentre Plus, its Work Programme contractors, the council's Skillsmatch job brokerage service, local third sector providers targeting particular communities and the local business community. The Partnership is establishing a new Employment and Enterprise Board to provide renewed high level vigour to addressing employment issues in the borough. A particular issue is extending employment opportunities to those with physical and learning disabilities and mental health problems.The Health and Wellbeing Board has a commitment to encouraging all partners to sign up to the Time for Change mental health pledge.The council has already done so and other partners have made a commitment to working towards this. Once the Employment and Enterprise Board is fully established, it would be useful to develop an area for a joint practically focused project with the Health and Wellbeing Board focusing on health and employment issues.

Unemployment can have a negative effect on Health and Wellbeing but poor quality employment can have a negative effect too. A few respondents to the Health and Wellbeing survey referenced "stress" impacting on their health and wellbeing, this included references to stress at work and work pressure.

Community engagement and development

Engagement in social networks and community can have a positive impact on both physical and mental health and well-being. On top of this, local networks and communities are key assets, providing opportunities for engaging people in health promotion activities, spreading health messages and motivating changes in lifestyle, particularly peer to peer. Tower Hamlets has a strong track record of local communities engaged in neighbourhood activity to take more control of their lives and environment. As part of our Healthy Borough programme, 'Can Do' grants were awarded to community led projects to improve the health and wellbeing of their local community. They supported a wide range of activity including areas such as food growing, developing social networks, promoting physical activity. This community development approach was found to be highly successful in tackling barriers to participation, particularly among groups less engaged with statutory agencies such as black and minority ethnic women.

Currently, there are a number of neighbourhood and community initiatives which are focusing on working with local people to develop solutions to local issues and grow their capacity. Many have a specific health focus – others are focused on improving other aspects of local quality of life likely to have knock on effects for health. Examples include the Well London initiative on the Aberfeldy estate which will recruit and train local community champions and develop specific projects around such themes as healthy eating, physical activities, mental wellbeing, arts and culture, skills to work and healthy spaces and others that emerge from the community engagement. The Well London approach has been used elsewhere in London and has demonstrated significant improvements, including 72% increase in healthy eating, 83% increase in physical activity and 86% improvement in positive feelings amongst participants.

Another example is a pilot of a Community Budget approach in the Bromley-by-Bow and Mile End East area of the borough where a number of agencies, including GPs, schools, local community centre and housing association, are pooling budgets to tackle priorities identified in consultation with the local community. Volunteer Health Makers are being recruited to work with GP practices to tackle issues which impact on health and in particular to support diabetes care packages by addressing wider determinant such as employment, education, language and housing.

The Partnership is also working with local communities to develop a number of Neighbourhood Agreements which provide an opportunity for local communities to come together, identify their priority issues impacting on local quality of life, develop local solutions to these in conjunction with key local stakeholders and enter into an agreement with these stakeholders about how they will work together to deliver the solutions. Projects include the refurbishment for community use of a local community building by local volunteers working with public sector providers. The projects have benefits in their own right but also, by engaging local people and creating a sense of community, are likely to contribute to better health and wellbeing.

The potential of a number of community engagement projects operating in small neighbourhood areas provides the opportunity to review, evaluate and share lessons over the coming months and beyond. The Board has set up a sub-group focusing on Co-Production and the potential is explored further in the next section of this strategy.

The council hascommissioned Healthwatch Tower Hamlets, and it came into existence on 1st April 2013. They have a responsibility to work across health and social care with a particular brief to developing innovative and creative ways of engaging the community to get more involved in the improvement of local health and social care services. This community engagement role of the new Healthwatch function is one we are keen to progress and develop.

Environment and Planning

The quality and nature of the built environment can have a significant impact on health outcomes. This has been recognised for some time in Tower Hamlets. The Core Strategy which provides the spatial vision for the development of Tower Hamlets to 2025 was developed in conjunction with health partners and includes strategic objectives around promoting healthy neighbourhoods that promote active and healthy lifestyles.

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

The borough-wide expansion of the Barclays Cycle Hire scheme provides a significant opportunity for increasing cycling in Tower Hamlets and Tower Hamlets has also benefited from the provision of two Cycle Superhighways running through the borough. In addition, more cycle parking has been installed throughout the borough, especially in the vicinity of the new Cycle Superhighways.

Healthy walking programmes take place in the borough, with weekly walks from health centres and community centres led by health trainers and local volunteers. These walks provide residents with the chance to improve their health and socialise, whilst learning about the local cultural and historical features of the area.

Planning policy also contributes to food environments by limiting the numbers of hot food takeaways which are associated with poor diets. The council's planning policy seeks to limit new hot food takeaways both to appropriate locations such as town centres and to limit their numbers so as not to cause an overconcentration of this type of use. The proximity of any schools is also taken into account in the planning process.

There is a clear objective in the Core Strategy to create healthy sustainable places in the borough and much progress has already been made with for example health impacts being considered as part of environmental impact assessments for larger developments. The spatial planners and public health colleagues will continue to work together to examine available tools and techniques which could help enable the ambition for healthy sustainable places, looking to adopt those which can have a positive impact on this ambition.

Air quality is also a key issue for an inner city borough with major transport routes running through it.Tower Hamlets was declared an Air Quality Management Area under the UK Air Quality Strategy and is exceeding objectives for two health based pollutants: Nitrogen Dioxide and Particulate Matter.

According to the World Health Organisation, air pollution is a major environmental risk to health. Air pollution increases the risk of respiratory and heart disease in the population. Both short and long term exposure to air pollutants have been associated with health impacts. These impacts are more pronounced in people who are already ill. Children, the elderly and people on low income are more likely to beexposured to air pollution. It is currently estimated that air pollution reduces the life expectancy of every person in the UK by an average of 6–8 months, with associated costs of up to £20 billion each year.

The council monitors air pollution concentrations using different monitoring methods. Pollution levels in Tower Hamlets have declined since it was declared an Air Quality Management Area, however in recent years,the levels have stabilised. This trend is evident throughout the Greater London area.

Tower Hamlets has an Air Quality Action Plan which details measures on how the council intends to work towards achieving the stated air quality objectives. This will be through a range of measures including:

- Promoting sustainable modes of transport
- Reducing emissions from domestic sources
- Raising education and awareness on pollution and health impacts

Environmental issues were raised by residents as having a negative impact on their health and wellbeing. These included busy roads, pollution and noise.

Community Safety

Health issues, in particular in relation to mental health, alcohol and drugs misuse have a significant impact on crime and disorder. There is an existing Partnership Substance Misuse Strategy with a plan of action for tackling alcohol and other drug misuse, including the harms related to misuse. The strategy combines behaviour change, prevention, treatment, enforcement and regulation approaches.Achieving a decrease in the serious acquisitive crime rate is identified as a priority action in the Substance Misuse Strategy as analysis indicates that this is strongly associated with drug related offending.

Community safety policy has been linked to this work – for example, a whole borough drinking control zone has been established and we are currently consulting on establishing acumulative impact (‘saturation’) policy to limitthe number of licensed

premises in the Brick Lane area, where the concentration of licensed premises has the potential to lead to public disorder and anti-social behaviour in the area. Health has also been named as a responsible authority for licensing decisions and therefore integrating health impacts into the council's licensing policy is something that is currently being worked on. The licensing and enforcement approach is supported by more widespread identification of individuals experiencing problems with alcohol and this is a key area of work moving forward.

Effective treatment for individuals addicted to drugs is strongly associated with reduced levels of crime and helps to limit the poor health outcomes of long term addiction. Our treatment levels are currently amongst the highest in the country. To ensure maximum benefits from treatment interventions, we have developed an action plan to increase the numbers of individuals successfully completing treatment and leaving treatment services drug free.

Domestic violence is a further area where our community safety and health objectives overlap. There is a multi-agency approach to tackling this, including a new Violence against Women and GirlsStrategy and a policy aimed specifically at safeguarding children at risk from domestic violence. Key areas for development include the need to increase reporting and referring where domestic violence is suspected, from a range of front line health settings including Accident and Emergency, GPs and dentists. The board might seek to sponsor a partnership protocol around this issue to capture and spread best practice and build trust to overcome residual concerns about confidentiality.

It would also be useful to consider the potential for more independent advocates with domestic violence specialisms to be attached to health settings such as maternity services. Timely and professional support to those suffering domestic violence can provide them with more confidence to take action to end the situation.

Perceptions of safety and freedom from anti-social behaviour emerged as key issuesgenerally from consultation with local people. The borough's Community Safety Plan, developed by the multi-agency Community Safety Partnership led by the Deputy Mayor and Borough Commander, demonstrates the commitment of all partners to continue to reduce anti-social behaviour and tackle hate crime.The Community Safety Plan incorporates many of the actions within the Substance Misuse Strategy and ensures the continued delivery of the dealer a day programme as well as on-going test purchases from licensed premises.

Possible delivery actions

There are opportunities to do more to link up health and crime enforcement agencies in tackling drug misuse and other joint issues. Opportunities include:

- Developing data sharing agreements around drug and alcohol related injury and offending and utilise this more routinely for service planning purposes

- Making best use of information on hotspots and emerging trends in alcohol related antisocial behaviour and crime to achieve further reductions.
- Increasing the effective use of screening for drugs and alcohol when offenders are arrested
- Developing the use of the Drug Related Deaths Panel
- Driving forward work on Integrated Offender Management and in particular considering drug treatment needs of offenders, as well the physical and mental health needs of offenders
- Working in partnership to address the ongoing health needs of sex workers

Perceptions of safety in the Borough affect people's decisions and life choices. When people at the THINk AGM were asked about what needed to change to improve health and wellbeing of people growing older in Tower Hamlets, perception of safety was a key concern: *"Older people live in fear and all of these factors affect their health."*

Perceptions of safety is a similar concern for adult social care users with a learning disability in relation to independence:

"Fears were discussed around discrimination, people pointing and making remarks directed at them"[10]

Respondents to the Health and Wellbeing survey also raised concerns about safe play spaces for children:

"Anti-social behaviour - young people hanging out in the children's play areas - is sometimes off putting when I want to take my son there."[11]

[10] LBTH, 2012, Modernising LD Day Opportunities in LBTH: BME Communities – March 2012
[11] LBTH, 2012, Residents Health and Wellbeing Survey

Delivering the Strategy

Accountability and Working in Partnership

Governance

The Health and Wellbeing Board is responsible for the delivery of this strategy. It will do this through a number of subgroups and boards and through the feedback from Healthwatch Tower Hamlets, a statutory member of the board.

The remit of Healthwatch Tower Hamlets includes a requirement to work with the members of the HWBB and to support the subgroups in ensuring public and patient/service user engagement in the different workstreams of the board. Full engagement and involvement of our residents is critical to the delivery of the strategy.

The board, in signing off this strategy, is very conscious that pieces of work of this nature can be very "top-down" and is clear in its expectations that this must be met by "bottom-up" initiatives generated within the communities of Tower Hamlets. This builds on well-established community assets in Tower Hamlets including a strong voluntary and community sector with its own Health and Wellbeing Forum, Neighbourhood Agreements and emerging Neighbourhood Forums.

Accountability for the quality of local services

We need to ensure that there are robust mechanisms in place to ensure health and social care outcomes are achieved and that health and social care services are accountable for the quality of service they provide to local people. This is particularly pertinent at a time when the provider and commissioning framework is changing fast.

Commissioners, including the local authority and the Clinical Commissioning Group, will develop robust performance frameworks to ensure that service quality and responsiveness to patients is monitored and, where necessary, improved. The Mayor and Health and Wellbeing Board will implement an outcome based performance framework setting targets for the key outcomes outlined in this strategy and monitor progress regularly. The leadership of the Mayor and involvement of Cabinet members will strengthen democratic oversight and scrutiny of health provision in the borough. The performance framework will also ensure we monitor progress for different equality groups where our equality analysis has indicated there are currently differential outcomes in particular areas.

In this context, accountability to service users is also key. From April 2013, Healthwatch Tower Hamlets came into existence and provides a mechanism to give people greater influence over their local health and social care services. It will also

lead on supporting the local commitment to ensure health and social care services are accountable to local people and the standard of care is improved or maintained. Healthwatch will be represented on the board and ensure patient views are shared and considered in the decision making process of the board. Theboard will also want to develop a relationship directly with local residents, reporting to them on progress with the key outcomes in this strategy.

Enablers

Supporting delivery of the programme are a number of "enablers" – these are the ways of working and things we need to do to implement the contents of this strategy. These have been identified through a review of current structures and engagement feedback.These are as follows:

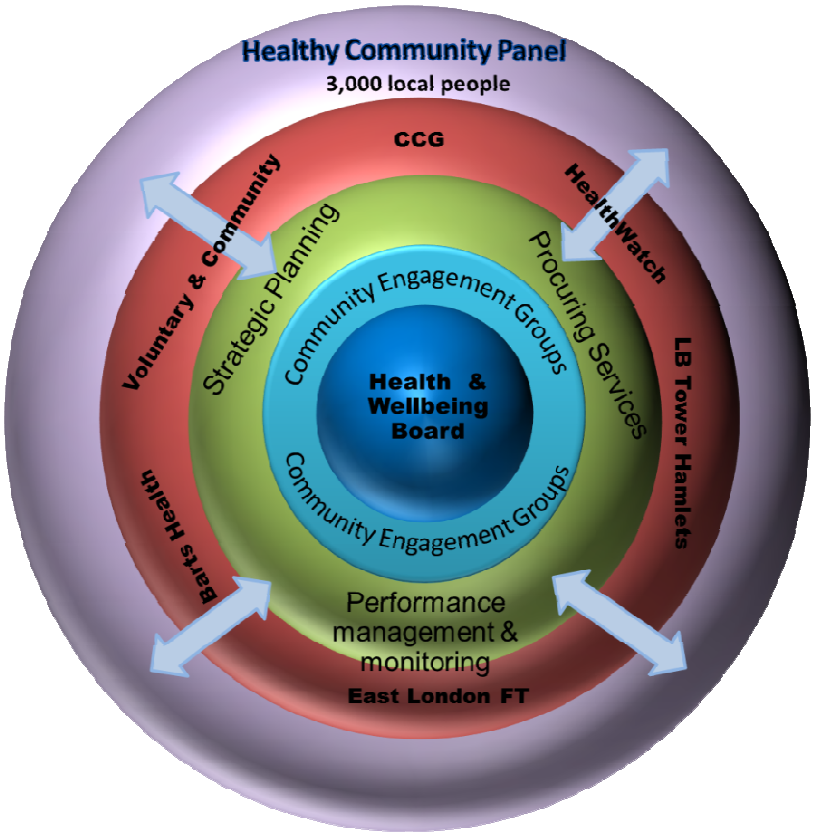
- Community engagement and co-production – a local "out in the community" approach to identifying priorities to improve health and wellbeing and to designing interventions (described above)
- Integrated care – bringing different providers together to deliver joined up holistic packages of care
- Ensuring best use of resources – aligning the funding with new models of service delivery through joint commissioning of services
- Using technology to improve outcomes
- Commissioning with commitment – developing a plurality of provision of health, social care, and wellbeing services through the development of local providers and services
- Leadership and workforce development to make this borough one of the best places to work and to support the changes in service delivery required to achieve a step change in health outcomes

1. Community Engagement and Co-production

Delivery of this strategy is not just about statutory partners and major projects, but also about working in partnership with local residents to co-design and co-produce solutions.

The Health and Wellbeing Board is committed to an approach to community engagement based on a model of the Healthy Community Panel – an existing borough-wide panel of 1000 individuals (consisting of those people who were members of THINk – the predecessor of Healthwatch) who have said they are interested in improving local health and social care services. The HWB aims to work with Healthwatch and the Clinical Commissioning Groups Engagement Groups to build the membership of the Healthy Community Panel to 3,000 over the course of the next three years to reflect the population of the borough. The diagram below

illustrates the model which builds on and uses existing structures for engaging and involving members of the community.



The core of the Healthy Community Panels will be the **Community Engagement Groups** (CEGs). There will be four of these across the borough, each based on two Clinical Commissioning Group (CCG) Network areas, with at least one hundred people in each Network. They will be engaged in:

- Identifying community needs and aspirations
- Promoting and incentivising healthy behaviour
- Tackling Health and Wellbeing strategy priority areas
- Feeding into GP Practices and other health and social care providers on their experience and supporting the practice to improve patient experience
- Tackling local Network priority areas
- Speaking to groups in the community about their experience of services and feeding these into quality performance and monitoring processes
- Collecting people's comments, ideas and aspirations and passing them to relevant health and social care professionals so they impact on service improvement
- Supporting groups in the community to develop healthy initiatives such as a walking club, a carers support group or a time banking initiative

- Supporting better self-management and behaviour change, including encouraging people to pass on key health and social care information to their communities to change behaviour and improve the way they access services.

The remit of the CCG Networks will be explored to incorporate greater focus on community engagement and working with the community and voluntary sector.

In parallel with this, the local authority is developing a network of local **Neighbourhood Forums,** these will be facilitated by local Community Champions drawn from the local community who will engage local people in action around specific areas which make a difference to their lives. They will engage with local service providers to tackle these issues and draw up Neighbourhood Agreements, setting out a contract for future action by the community and partners.

A key principle of the Health and Wellbeing Strategy is to build on these developments and further enhance local community capacity and skills to enable communities to play a key role in the delivery of the strategy. The board is committed to achieving this through accelerating 'co-production'.Co-production means delivering services and solutions in an equal and reciprocal relationshipbetween professionals, people using services, their families and their neighbours. In doing this, we can both improve the health outcomes for those engaged – activisim is in itself a contributor to better health – and improve the design of projects and services ensuring they reflect what is important to local communities not just what professionals think is important to them.

The Health and Wellbeing Board will explore areas such as:

- Community budget approach to tackling specific health issues in particular local areas;
- Neighbourhood Agreements which focus on health services and health related issues;
- Making available small sums of money in grant form to local community groups to develop and test their own solutions to key health issues and wider social factors;
- Co-design with residents in commissioning or re-commissioning new services, for example the planned review of Local Networks.

To explore these initiatives and to facilitate them the Board will have a subgroup with a particular focus on 'Engagement and Co-production'.

2. Integrated Care

Integrated care can help us address local challenges, by empowering patients and service users, improving outcomes and by providing the best quality of care at the minimum possible cost. We aspire to build an integrated care system in Tower Hamlets that empowers patients, provides more coordinated, proactive and

responsive care, and ensures the system operates in an efficient and consistent manner.

Across the borough, several recently established elements of integrated care have already demonstrated impact on quality and outcomes. However, these only target a small section of the population –workingwith our partnersacross the east London region we are now committed to developing further integration to improve outcomes for local people. Initially, this will focus on the areas of discharge support for mental health patients from secondary to primary care, rapid response and short-term reablement, discharge support from acute to community and mental health liaison team intervention in acute wards.

Some of the key areas for driving forward integrated care include:

- Greater empowerment of patients to manage their own health and conditions
- Better co-ordinated joint health and care assessment, planning and case management
- Rapid response providing care packages to support patients at home at time of crisis as an alternative to unnecessary hospital and care home admissions
- Improved liaison between hospitals and mental health services to ensure appropriate diagnosis and referral around areas such as alcohol, substance misuse and dementia
- Better understanding of, and provision to meet, patients' preferences in their last years of life

As well as formal integration of services, there are real opportunities to maximise the value of every contact with health and social care services. This could include ensuring that all frontline health workers, from GPs to home carers, regularly provide advice about healthy diet and activity**.** Improving access to, and responsiveness of, primary and community health services will be critical to ensuring the success of integrated care.

A key driver of this work will be the Better Care Fund (formerly known as the Integrated Transformation Fund). This was announced in June 2013 and brings together nationally £3.8bn of different funding streams largely but not totally from the NHS, with the express purpose of the funding being re-directed locally on health and social care to drive closer integration and improve outcomes for patients and service users and carers.

The Health and Wellbeing Board will have responsibility for setting the direction of travel and priorities for the programme and oversight of progress through its subgroup the Integrated Care Board. The planning for the use of this funding will be expected to show a golden thread to this Health and Wellbeing Strategy and the Joint Strategic Needs Assessment.

3. Ensuring best use of resources

Since 2010, public services have seen reductions in funding and a requirement to deliver significant efficiency savings. The state of the economy and the Government's commitment to reduce the public sector deficit, means that there is no indication that the funding position will improve and every likelihood it will worsen. This is at a time when demands on health and social care are growing due, in the most part, to an ageing population.

The public sector in Tower Hamlets is facing a significant financial challenge over the years to come as a result.

Tower Hamlets Council will need to absorb its share of the 27% cuts to local government introduced by the Government in the 2010 Spending Review. This equates to £90m in savings by the end of 2014/15. At the same time, since 2009, the number of new Social Care assessments has increased by 35% and the number of residents over the age of 85 has increased by 13.5%. The Government has recently indicated that there could then follow a further three years of savings on the same downward trajectory.

From April 1st 2013, Tower Hamlets CCG, with a budget of £336m, has a funding shortfall of £30m over the period 2013/14 to 2015/16. This shortfall is evenly split over the 3 year period. To narrow this gap, the CCG has used various quality, innovation, productivity and prevention initiatives. Specific disciplines such as Planned Care, Urgent Care and CHS have proved to have the capacity for such measures.

The East London Foundation Trust (ELFT) provides mental health services in Tower Hamlets. The Trust has to make 4%, approximately £10m, of efficiency savings in 2012/13, in line with national operating guidance, Tower Hamlets share of this is £450,000. In addition, the East London CCGs made a disinvestment of £3.2m over two years and Tower Hamlets' share of this was £550k.

Barts Health NHS Trust is the NHS Trust that serves Tower Hamlets. With 15,000 staff and a turnover of £1.2 billion, it is the largest NHS Trust in the country. Like all public sector bodies, Barts Health will face similar financial challenges to those faced by the Council, CCG and ELFT.

These reductions in funding and increases in demand are unlikely to be reversed in the years to come. The challenge for the partners on the Health and Wellbeing Board is how to manage those reductions in funding while ensuring the services that local people rely on are protected as much as possible.

Locally, we will continue to make the case about the need for adequate resources to meet local health and care needs. At the same time, we will also continue to

manage services as efficiently as possible to ensure that the increasingly squeezed resources deliver real benefits for local people. In particular, the board will need to work with commissioners and providers to consider how best shared resources can be allocated to priorities to deliver shared outcomes.

This links closely to the development of integrated care (see above) and the need to develop ways to move resources between partner organisations to ensure that funding streams follow the patient/service user.

At the same time, we need to think about the most effective use of physical assets within the health and social care sector, how we manage these most efficiently and ensure that in doing so we are providing modern local venues.There is a continuing need to provide fit for purpose accommodation for services to meet the needs of a growing population and to enable delivery in the most appropriate setting. The potential for strategic use of the Community Infrastructure Levy through feeding into borough-wide infrastructure planning is key. Defining the need for new health infrastructure and providing baseline evidence will be important first steps.A key requirement will be additional space for new or modernised primary care facilities to meet the growing population in the borough in terms of additional GPs and other primary care health professionals.

4. Using technology to improve outcomes- There are 3 ways that we think technology can help improve health and wellbeing services, the questions we will ask ourselves are:

How can technology improve the lives of individuals?

There is a growing body of evidence that supports the use of technology in health and social care settings and the impact this has on utilisation of health services. Health and social care providers face a considerable challenge to provide comprehensive care and support to an increasing number of people with complex care needs. Assistive Technology can be seen as a solution to this challenge, enabling people to live as independently as possible, preventing or reducing the escalation of support needs through providing a service package and choice of technology tailored to meet their individual needs. Technology also means lot of things can be done locally – ranging from mobile units to telemedicine.

How can technology drive forward partnerships?

A consistent theme of user feedback is frustration at having to continually supply the same information to different parts of the health and social care system. We need to think about how we can develop a common record system across health and social care so that from a user perspective, time is not wasted in collecting the same data more than once and from a service provider perspective, resources are not wasted in duplicating activities (e.g. repeating investigations as the findings are not communicated). In addition, we need to plan in a much more integrated way across

the health and social care system - underpinning this is a need to share intelligence across the system and we need to think about how we can establish data sharing agreements that allow this information to be shared more freely between key partners. We need to do this cautiously to ensure that we protect sensitive and personal data appropriately.

How can technology support people taking greater responsibility for their own health?

Increasingly, local people, particularly but not exclusively younger generations, are using new technology to access information and support them organising and living their lives. Smartphone applications (apps), social media sites, Twitter and electronic messaging all provide opportunities to provide information to support healthy living and healthy choices in a host of new ways. In one example, the council has developed an e-market solution to enable those in need of care and support to use web technology to purchase their own services. In addition, technology can support people in feeding back to providers about services.

Tower Hamlets residents are increasingly using the internet as a method of communication; 15% of residents contacted the Council online over the last year, and 25 per cent say they would prefer to use this method in the future[12].

Tower Hamlets had a higher level of online returns to the 2011 Census than any other local authority area in the country at just under 30%.

5. Commissioning with commitment

Tower Hamlets Health and Wellbeing Board includes both the local statutory providers of health services, representation from the community and voluntary sector, and housing providers in recognition of our desire to work across all sectors locally to achieve the best health and wellbeing outcomes. We will work to develop a plurality of provision of health, social care, and wellbeing services through the development of local providers and services

When we commission services jointly we will follow the following principles:

- All services must be culturally sensitive
- We will seek to work with our providers to achieve a balance of value for money and risk that is sustainable for the provider as well as the commissioner
- We will seek to use our purchasing power to stimulate the local economy and maximise employment opportunities for local people, taking into account the provisions of the Public Services (Social Value) Act 2012.
- Wherever possible we will encourage local, smaller providers
- We will fund independent support for smaller potential providers in complex procurements to ensure that they are not disadvantaged.

[12]Annual Residents Survey, 2011-12

- For all joint procurements, including arrangements where one party is commissioning on behalf of the others (lead commissioning), we would always ask that unless there are good market reasons not to do so, all contractors should pay the London Living Wage. Unless an exception is made contracts will be let with this stipulation.

All members of the Health and Wellbeing Board, where they don't already do so, commit to moving towards paying the London Living Wage to all of their own staff and to making this a requirement for their contracts where possible.

6 Leadership and workforce development

Finally, and possibly the most important, is to ensure that we have the workforce and leadership to deliver this strategy. Many of our workforce are also our local residents who use local services – TowerHamlets own "family and friends test".

All partners on the Health and Wellbeing Board have a commitment to workforce development to enable the required changes in working practices to deliver services in ways that are different from the past and to make this borough one of the best places to work and to support the changes in service delivery required to achieve a step change in health outcomes

Conclusion

This Health and Wellbeing Strategy has been informed by widespread local consultation and includes input from a wide range of partners and stakeholders in the borough. The delivery plan will now form the basis of a work programme for key partners over the coming 1-3 years which will be monitored by the board and refreshed on an annual basis.The board remains keen to hear from local residents about issues affecting health and wellbeing in the local area and will work closely with Healthwatch and other partners to ensure that its work is informed by experiences on the ground as it continues to develop its role.

Tower Hamlets Health and Wellbeing Board

HEALTH AND WELLBEING STRATEGY 2013-16

Towards a Healthier Tower Hamlets

Summary

TOWER HAMLETS

TOWER HAMLETS HOUSING FORUM

healthwatch Tower Hamlets

thcvs Council for Voluntary Service

NHS

Introduction from the Mayor of Tower Hamlets

Welcome to *Towards a Healthier Tower Hamlets*, Tower Hamlets' Health and Wellbeing Strategy. This document provides a framework for improving the health and wellbeing of the local population.

The aims of the strategy are to improve the health and wellbeing of local residents while reducing health inequalities and promoting choice, control and independence.

It was developed following wide-ranging discussions and consultation with local residents, patient groups, carers, and health and care professionals. The extensive dialogue identified four main priorities for the strategy: maternity and early years; healthy lives; mental health; and long-term conditions and cancer.

The strategy sets the framework for the Health and Wellbeing Board to work together to improve health and wellbeing in Tower Hamlets for the next three years. The Health and Wellbeing Board represents the key partners involved in improving health locally and this strategy is a statement of how we will work together to achieve improvements in health outcomes for all local people across all stages of life. It builds on the existing strong partnership working within the borough and the evidence within our Joint Strategic Needs Assessment.

Vision and Principles

The over-arching vision for the strategy is to

- **Improve health and wellbeing throughout all stages of life to**
  - Reduce health inequalities; and
  - Promote independence, choice and control

Some key principles underpin this vision – in particular putting patients first, ensuring health is reflected in all policies and understanding and reflecting the diversity of the borough.

Tower Hamlets Context

Tower Hamlets is a borough of rapid change and stark contrasts. In recent years, Tower Hamlets has experienced the largest growth in the country – both in terms of new development and in terms of population size. The borough also has a relatively young population, and just over half the population is from black and minority ethnic groups.

Deprivation and unemployment are high. Nearly half of children in the borough live in poverty – the highest child poverty rate in the country. But at the same time, average earnings of those who work, but don't necessarily live, in the borough is high and there is significant visible wealth in areas such as Canary Wharf and the City fringe.

Tower Hamlets has undertaken a Joint Strategic Needs Assessment (JSNA) to understand the health and social care needs of the local population. This shows that life expectancy in Tower Hamlets is lower than the rest of the country. Premature death rates from the major killers (cancer, heart disease, and lung disease) are amongst the highest in London as are rates of TB and sexually transmitted diseases, including HIV.

Despite this challenging context, Tower Hamlets has tremendous social capital – the voluntary sector is strong with deep roots, community activity is well embedded and innovation is widespread.

The strategy builds on these strengths to develop solutions to tackle the health challenges we face.

Strategic Framework

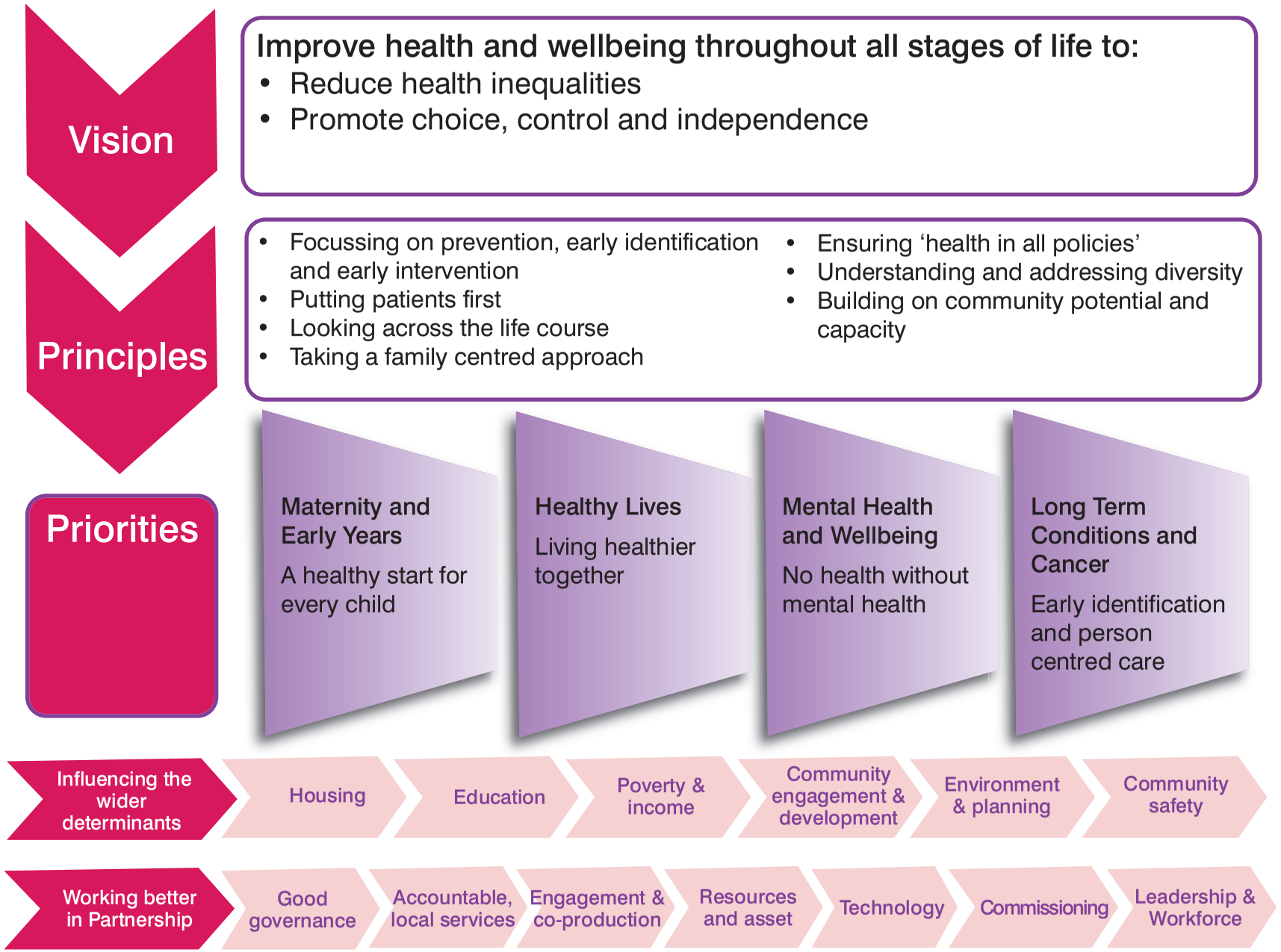
The strategy has four main priorities, which are:

- Maternity and early years – a healthy start for every child
- Healthy lives – living healthier together
- Mental health – no health without mental health
- Long term conditions and cancer – early identification and person centred care

For each of these priorities, the strategy sets out what we want to achieve and how we plan to do this.

The diagram overleaf provides an overview of the framework of the strategy.

Towards a Healthier Tower Hamlets: Strategic Framework



Our Priorities

Priority 1: Maternity and Early Years

A healthy start for every child

Maternal health, before, during and after pregnancy, and the first few years of a child's life are a critical period for a child's longer term health and well-being.

The outcome objectives for Maternity and Early years are:

- Good and improving maternal health – including maternal nutrition, good mental health, decreasing maternal obesity and decreasing numbers smoking at time of delivery
- Maintaining reduction in under 18 conceptions and supporting teenage parents
- Early detection and treatment of disability and illness and ensuring that all children achieve development milestones
- Maintaining low infant mortality rates and promoting good health in infancy and early years
- Decreasing levels of obese and overweight children, providing more opportunities for active play and healthy eating
- Reducing dental decay in 5 year olds

Priority 2: Healthy Lives

Living healthier together

Living a healthy life prevents illness and enhances wellbeing. We know that people who do not smoke, take adequate physical activity, eat a healthy diet and drink alcohol in moderation are four times less likely to be at risk of dying early than those who do not adopt these behaviours. We also know that they tend to have better mental health.

The outcome objectives for Healthy Lives are:

- Stopping the increase in levels of obese and overweight children
- Reduced prevalence of tobacco use in Tower Hamlets
- Reduced prevalence of sexually transmitted infections and promote sexual health
- Reduced levels of harmful or hazardous drinking
- Reduced rates of drug use

Priority 3: Mental Health and Wellbeing

No health without mental health

Good mental health and wellbeing is fundamental to quality of life: it impacts on physical health and life expectancy, on family life and relationships, on educational achievement and employment, and on social interaction and participation. At least one in four people will experience a mental health problem at some point in their life and one in six adults have a mental health problem at any one time.

Due to the wide ranging issues around mental health and wellbeing, a separate Mental Health Strategy is being developed. This is due to be published shortly. The proposed Mental Health and Wellbeing outcome objectives are:

- More people will have good mental health
- More people with mental health problems will recover or maximise their wellbeing, enabling them to live life as fully as possible with their condition
- More people with mental health problems will have good physical health
- More people will have a positive experience of care and support
- Fewer people will experience stigma and discrimination

Priority 4: Long Term Conditions and Cancer

Early identification and person centred care

Long term health conditions and cancer have a significant impact on quality of life; reducing the ability of those experiencing them to participate in employment, social and family life, contributing to the development of disability, reducing life expectancy and affecting mental wellbeing.

The Long Term Conditions and Cancer outcome objectives are:

- Improved patient experience and co-ordination of health, housing and social care for those with single or multiple long term conditions
- Reduced prevalence of the major 'killers' and increased life expectancy
- More people with long term conditions or cancer diagnosed earlier and surviving for longer
- More people with learning disabilities receiving high quality care and support
- More carers having good physical and mental health and feel fully supported

Wider social and environmental factors

Health is affected by a variety of social and environmental factors, including education, poverty, quality of housing, physical environment and community cohesion. This Health and Wellbeing Strategy recognises this and includes actions to work with a range of local partners to tackle these related issues. Proposals include:

- Recognising the role of social housing providers and staff in promoting more healthy lifestyles and a commitment to work with the Tower Hamlets Housing Forum to develop this role;
- Increasing understanding and awareness of healthy living through the council's Healthy Schools programme;
- Monitoring the impact of welfare reform changes on health and supporting the roll-out of the partnership Financial Inclusion Strategy across the borough;
- Promoting the health benefits of employment, especially in relation to mental health, and developing the role of GPs and other health services in supporting people back into work;
- Maximising the impact of the council and key health organisations as significant employers in terms of the role they can play in improving employment opportunities, particularly for those with lower skills, and promoting employment for those with disabilities and mental health problems;
- Developing initiatives such as the Green Grid which seeks to ensure the best use is made of limited open space throughout the borough creating a network of high quality well-connected open spaces to promote bio-diversity and healthy, active lifestyles.

Delivering the strategy

Delivery plans have been developed for each of the priority areas, setting out what partners will do to achieve the agreed outcomes. The Health and Wellbeing Board will oversee progress on delivery of the strategy. Targets have been set for the key priority areas and performance will be monitored regularly by the Board through regular performance updates and feedback from Healthwatch Tower Hamlets, which will ensure the patient and community voice and experiences are heard. This combination of performance data and user experience will be vital to ensure the Board has a clear overview of progress towards outcomes and the quality of local services. This is particularly important at a time when the provider and commissioning framework has undergone significant change.

Supporting delivery of the programme are a number of 'enablers' – these are the ways of working and things we need to do to ensure that the strategy happens. The key ones are:

- Prioritising working with our local communities through engagement activity and co-production;
- Integrating health and social care – bringing different providers together to deliver joined up, patient centred care;
- Ensuring most efficient shared use of resources and physical assets;
- Using technology to improve outcomes;
- Commissioning with commitment – ensuring we use the commissioning of health services to maximise social impact which will improve health outcomes.

The delivery of this strategy, and achievement of our ambitious outcomes, will require all those responsible – the council, local health organisations, the voluntary sector, communities and individuals – to work effectively and enthusiastically in partnership. The strategy sets a clear direction of travel which partners have committed to working towards. The next three years will be vital in ensuring we turn our vision of a healthier Tower Hamlets into a reality. We are keen to hear from local residents about issues affecting health and wellbeing in the local area to ensure that the strategy is informed by experiences on the ground as it continues to develop its key role in improving health and wellbeing in Tower Hamlets.

Produced by Tower Hamlets Council's Communications Unit • TD14612 • September 2013

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

Maternity and Early YearsPriority 1: Maternal and Infant Mental Health and Wellbeing			
C&F PlanOutcome Objective 1: Good and improving maternalhealth – including good mental health, maternal nutrition, decreasing maternal obesity, diabetes and numbers smoking at time of delivery			
C&F PlanOutcome Objective 2: Maintain reduction in under 18 conceptions and support teenage parents			
C&F PlanOutcome Objective 4: Maintain low infant mortality rates and promote good health in infancy and early years			
Proposed outcome measures			
Measure	**Baseline 2011/12**	**Target 2013/14**	**2014/15**
Teenage pregnancy rate	28.5 conceptions per 1,000 women aged 15-17 years (2011)	27.5 conceptions per 1,000 women aged 15-17 years	26.5 conceptions per 1,000 women aged 15-17 years
Proportion of women who smoke during pregnancy	3.9%	3.5%	3.5%
Proportion of mothers who breastfeed at birth	88.35%	88.5%	89%
Proportion of mothers who are breastfeeding at 6-8 weeks	71.1%	71.5%	72%
Rate of infant mortality (children who die before reaching their first birthday)	5.3/1000 live births (2009-11)	5.0/1000 live births (2010-12)	4.8/1000 live births (2011-13)
Action/strategy/programme to deliver	**Leadand key partners**	**Milestones**	**Timescale**
***Maternal and infant mental health*:** Develop partnerships across health, children's centres and community	**Lead: Public Health** (Esther Trenchard-Mabere) **Key partners:**	Map current service provision that supports maternal and infant mental health and ante and post natal depression	December 2013

organisations to support maternal mental health and wellbeing and secure attachment with the baby during the first year of life in the context of promoting the wider health and wellbeing of mother and child	• **CCG** (JudithLittlejohns and Hannah Falvey) • **Compass** / Primary Care Mental Health service) Lucy Marks • **Children's Centres** (Paula Holt) • **Parent and Carers Council** (Jill McGinley) • **Midwifery, Barts Health**(Christine Wood) • **Voluntary sector** (Alex Nelson/Pip Pinhorn) • **Family Nurse Partnership** (Anne Lynch) • **Health Visiting Service, Barts Health** (Rita Wallace)	pathway to identify strengths and gaps	
		Convene wider multi-agency meeting/workshop to scope work across children's centres, voluntary sector and health to agree priority areas for development	January 2014
		Develop proposal to strengthen 'Universal' elements of support for maternal and infant emotional health and wellbeing	March 2014
		Develop proposal for recruiting and training local people to become 'maternal and child health support workers', including training and placements	April 2014
		Review of maternal and child support worker programme	March 2015
Maintain and strengthen ongoing wider partnership work to: • Enhance health education for young people and women of child bearing age including sex and relationships education, pre-conceptual care (including folic acid), factors affecting maternal and newborn health and how to access antenatal care • Ensure vulnerable young mothers have access to support from the Family Nurse Partnership by improving timeliness of referral and links to other services • Early identification of families at risk of obesity, including identification at booking for antenatal care of pregnant women with BMI > 30, to ensure appropriate advice and referral • Identify smoking status of all women at booking and refer smokers for specialist support • Improve data available on maternal and infant health outcomes including mental health • Full implementation of the Healthy Child (0-5) programme including neonatal examination, new baby review, 6-8 week check, 1			

year check (and 2 year check)

- Increase breastfeeding rates including exclusive breastfeeding initiation and maintenance
- Improve uptake of Healthy Start Vitamins amongst mothers and children 0-4 years
- Raise awareness of female genital mutilation (FGM) and its impact on maternal health
- Develop and implement communications plan to raise awareness amongst health professionals, parents and the wider public of key risks identified by the Child Death Overview Panel, including risks of co-sleeping
- Maintain good immunisation coverage at 1 year

Maternity and Early Years Priority 2: Healthy Child Development at 2/2.5 years and 4/5 years			
C&F PlanOutcome Objective 3: Earlydetection and treatment of disability and illnessand ensure that children achieve positive physical, cognitive and emotional development milestones			
C&F PlanOutcome Objective 5: Decreasing levels of obese and overweight children in reception year, provide more opportunities for active play and healthy eating.			
C&F PlanOutcome Objective 6: Reduce dental decay in 5 year olds			
Proposed outcome measures			
Measure	**Baseline 2011/12**	**Target 2013/14**	**2014/15**
Child development at 2-2.5 years (Indicator to be confirmed)	TBC	TBC	TBC
Proportion of babies who receive the MMR vaccination when they are two years old	93.9%	95%	95%
Proportion of children in Reception who are overweight[1]	10.8% (2012)	10.8%	10.8%
Proportion of children in Reception who are obese[2]	13.1% (2012)	13.1%	13.1%
Proportion of children under 5 with tooth decay	39.1% (2007/08)[3]	30.0% (2011/12)	28% (2013/14)

[1] Given the national trend of increasing proportion of overweight and obese children, the goal is to prevent any further increase as a first step to reducing levels of overweight and obese children locally.
[2] As above
[3] This indicator is based on a survey carried out every two years.

Proportion of children accessing dental services	53.4%[4]	62.9%	56%
Action/strategy/programme to deliver	**Lead and key partners**	**Milestones**	**Timescale**
Two year development review**:** building on the 2/2.5 year healthy child development review (health visiting) develop and strengthen partnerships across health, children's centres, nurseries and community organisations to promote children's physical, social, emotional and cognitive development	**Leads:** **Public Health (**Esther Trenchard-Mabere**)** **Learning and Achievement** (Monica Forty) **Key partners:** **Health Visiting Service**, Barts Health (Rita Wallace/Yvonne Dockery) **Voluntary sector** (Alex Nelson/Pip Pinhorn) **Children's Centres** (Jo Freeman/Paula Holt) **Inclusion Team 0-5 years** (Michele Ward) **Childcare Development Quality team** (Sharon Gentry)	Review current referral pathways and partnerships supporting the 2/2.5 year healthy child development review	March 2014
		Negotiate better access to data from the 2/2.5 year review with NHSE and Barts Health	June 2014
		Identify opportunities for wider join up to ensure that children at risk of impaired physical, social, emotional and cognitive development are identified and supported	July 2014
		Review of progress	March 2015
Maintain and strengthen ongoing wider partnership work to: • Ensure good uptake of the Healthy Child 2 year check • Expand uptake and support maintenance of Early Years Accreditation Scheme • Early identification of families at risk of obesity, including identification at 2/2.5 year check and linking to wider services • Improve healthy eating and physical activity opportunities available for under-5s • Deliver the following oral health promotion programmes: Brushing for Life, Smiling Start, Healthy Teeth in Schools (fluoride varnish), Happy Smiles (health promotion in schools programme) and 'train the trainers' • Develop an oral health promotion programme for children with SEN.			

4

- Review and strengthen the early years care pathway for child disability
- Develop and implement communications plan to raise awareness amongst health professionals, parents and the wider public of key risks identified by the Child Death Overview Panel, including how to identify a seriously sick child and when to call emergency services
- Reduce A&E attendance and emergency admissions due to unintentional and deliberate injuries amongst 0--5 year olds
- Maintain good immunisation coverage at 2 and 5 years

Priority: Healthy Lives			
Outcome Objective – Stop the increase in levels of obesity and overweight children			
Proposed outcome measures			
Measure	**Baseline 2011/12**	**Target 2013/14**	**2014/15**
Proportion of children in Reception who are obese[1]	13.1%	13.1%	13.1%
Proportion of children in Year 6 who are obese[2]	25.1%	25.1%	25.1%
Action/strategy/programme to deliver	**Lead**	**Milestones**	**Timescale**
Refresh Tower Hamlets 'Healthy Weight, Healthy Lives' strategy to become Tower Hamlets 'Healthy Food, Active Lives' workstream of Healthy Lives Strategy	**Public Health** (Esther Trenchard-Mabere)	Finalise plan	June 2013
		Present to H&WB board for agreement	TBC
		Identify Board level champion and leads across partner agencies and local authority directorates	TBC
		Report to H&WB Board on implementation	Annually
		Involve Healthwatch/Vol Sector in planning Stakeholder Conference	September 2013
		Review funding for 'Can Do' community led projects and seek partnership commitment to sustain the programme	April 2013 and ongoing

[1] Given the increasing numbers of obese children, maintaining the current rate is a challenging target.
[2] As above

Build on and extend community engagement in the development and implementation of the new strategy	**Public Health** (Esther Trenchard-Mabere) **Healthwatch** (Diane Barham) **VCS H&WB forum** (TBC)	Make links between strategy objectives and wider community development work	April 2013
		Finalise food policy with evidence based standards	April 2013
		Present to H&WB Board	TBC
Agree and implement evidence based health food standards across partner agencies as exemplars of good practice	**Public Health** (Esther Trenchard-Mabere) **Barts Health** (Michele Sandelson)	Agree implementation plans with partner agencies	June 2013
		Presentation to the H&WB Board	TBC
Monitor the implementation of the Local Development Framework and impact on: - Cycling and walking infrastructure - Access to open spaces through Green Grid - Local food growing and urban agriculture - Restrictions on new hot food takeaways near schools and leisure centres	**Public Health** (Tim Madelin) **LBTH, D&R** (Michael Bell)	Progress reports on impact assessment	TBC
		Agree process for strengthening community engagement into spatial planning	TBC
Outcome Objective – Reduced prevalence of tobacco use in Tower Hamlets			
Proposed outcome measures			
Measure	**Baseline 2011/12**	**Target 2013/14**	**2014/15**
Proportion of women who	3.9% (2011/12)	3.5%	3.5%

smoke during pregnancy			
Proportion of adults (18+) who smoke	21.5% (2011/12)	21%	20.5%
Action/strategy/programme to deliver	**Lead**	**Milestones**	**Timescale**
Refresh and implement the Tobacco Control workstream of the Healthy Lives Strategy	**Public Health** (Chris Lovitt)	Finalise plan	June 2013
		Present to H&WB board for agreement	TBC
Review and refresh approach to reducing tobacco uptake in adolescents and young people	**Public Health** (Chris Lovitt)	Incorporate into refreshed plan	June 2013
		Evaluate outcomes for ASSIST programme	Feb 2013
		Review commissioning process and re-commission ASSIST if effective	March 2013
Develop a clear action plan for the borough in order to reduce the amount of illicit tobacco (counterfeit and contraband) available to young people	**Public Health** (Chris Lovitt) **LBTH, CLC** (Dave Tolley)	Incorporate into refreshed plan	June 2013
		Meet quarterly with trading standards at LBTH to receive an update on KPIs re this area	quarterly
		Support and pan London /national campaigns and initiatives	tbc
Embed healthy lives brief advice into all health and social care making every contact	**Public Health** (Paul Iggulden) **~~CCG~~** (~~Jane Milligan~~)	Develop joint action plan with Barts Health (working with	June 2013

counts	**Barts Health** (Ian Basnett) **Education, Social Care and Wellbeing** (Anne Canning)	public health director)	
		Primary care – implement healthy lives locally enhanced services and revise spec for 14/15	Ongoing
		Community pharmacy – develop healthy lives plan with community pharmacists	September 2013
		Social care - develop plan with social care leads in ESW and public health	September 2013
Reduce the use of smokeless tobacco	**Public Health** (Chris Lovitt) **LBTH, CLC**(Dave Tolley)	Consult with stakeholders from the local community including small businesses	June 2013
		Finalise plan	June 2013
Outcome Objective: Reduced levels of harmful or hazardous drinking (PH framework) **Outcome objective: Reduced rates of drug use (PH framework)**			
Proposed outcome measures			
Measure	**Baseline 2011/12**	**Target 2013/14**	**2014/15**
Rate of admissions to hospital that are alcohol-related per 100,000 population[3]	2213 (2011/12)	2,424	2530
Proportion of all in treatment, who successfully completed treatment and did not re-present within 6 months (opiates)	9.97% (2012/13)	11%	12%
Successful completions of	74% (2012/13)	74.5%	75%

[3] The numbers of alcohol related admissions are expected to go up. The trajectory of the target has been set so as not to exceed the projected London rates.

treatment for children and young people (Targets based on a contracted minimum target of 70%)			
Successful completion of alcohol treatment	51% (2012/13)	55%	57%
People arrested and identified as having substance misuse issues who are previously not known to the Drug Intervention Programme[4]	15 per month (Q1 2013/14)	20 per month	25 per month
Number of binge drinking callouts (Incidents where London Ambulance Service have attended someone suffering from an alcohol related illness)[5]	964 (2011/12)	1,273	1,382
Numbers of screenings completed in primary care[6]	30,843	25,000	TBC
Action/strategy/programme to deliver	**Lead**	**Milestones**	**Timescale**
Co-ordination of Substance Misuse Strategy Action Plan	**DAAT Coordinator** (Mark Edmunds) **Public Health** (Chris Lovitt)	Update action plan and review progress of action plan	July 2013
		Agree priorities and review timescales for action plan delivery	September 2013

[4] This indicator is on an upward trajectory as the aim is to increase the level of detection and identification
[5] The numbers of binge drinking callouts are expected to go up. The trajectory of the target has been set so as not to exceed the projected London rates.
[6] 25,000 has been the annual target for this scheme since its inception. It is anticipated that during a transition stage, there may be some fluctuation in the coverage of the service.

		Update HWB (via DAAT Board) on substance misuse action plan	Annually or as appropriate
Ensure a consistent approach across the partnership to messaging around harms caused by misuse of drugs and alcohol	**DAAT Coordinator** (Mark Edmunds) **Public Health** (Chris Lovitt)	Review at DAAT board the agencies that should be involved/included	April 2013
		Develop communication plans which aim to achieve widespread awareness across all agencies on the harms caused by misuse of drugs and alcohol	June 2013
		Take proposal to the DAAT Board/HWB/CSP for agreement and to ensure that the proposal is championed	September- December 2013 (To be reviewed at end of Q2)
Champion an integrated life-course approach to treatment, recovery & re-integration in substance misuse	**DAAT Coordinator** (Rachael Sadegh/Mark Edmunds) **Public Health** (Chris Lovitt)	Review treatment pathways to ensure that they are recovery and re-integration orientated to meet the needs of all clients	August2013
		Identify (where relevant) appropriate changes to the treatment system to ensure that models and pathways are recovery & re-integration orientated	July 2013
		DAAT/CSP to sign off	August 2013
Embed screening and brief intervention around drugs and alcohol into front-line services (beyond A&E)	**DAAT Coordinator** (Mark Edmunds) **Public Health** (Chris Lovitt)	Review the existing screening and brief intervention evidence nationally for drugs and alcohol and lessons from local implementation in Tower	April 2013

		Hamlets	
		Consider from the evidence, the frontline services within which to roll-out screening and brief interventions and ensure sign up	May 2013
		Develop a package for training and implementation for front-line staff, including evaluation	June 2013
Develop and implement the Integrated Offender Management plan	**Police** (TBC with DAAT Board)	CSP/IOM/DAAT Board to review progress of IOM delivery and the development of a more co-ordinated approach to the substance misuse and health needs of offenders	September-December 2013
		Deliver the TH IOM action to address the links between mental and physical health needs of offenders	October 2013
Integrate health impact into the Council licensing policy	**Public Health** (Chris Lovitt) **LBTH, CLC** (Dave Tolley)	Update the health section of the Council's licensing policy to include issues such a minimum price, strength, promotions etc. – consultation paper to be drafted.	April 2013
		Consultation to be carried out with a view for adoption	Consultation – throughout 2013 Adoption – by December 2013
Priority: Healthy Lives			
Outcome Objective – Reduced prevalence of Sexually transmitted infections and promote sexual health			

Measure	**Baseline 2011/12**	**Target 2013/14**	**2014/15**
Rate of people aged 15-24 testing positive for chlamydia[7]	1637 per 100,000 (2011)	1800 per 100,000	2000 per 100,000
Proportion of HIV infections diagnosed late	35%	33%	30%
Teenage pregnancy rate	28.5 per 1,000 females aged 15-17 (2011)	27.5 per 1,000 females aged 15-17 (2011)	26.5 per 1,000 females aged 15-17 (2011)
Action/strategy/programme to deliver	**Lead**	**Milestones**	**Timescale**
Implement Tower Hamlets Sexual Health workstream 2013-16 of the Healthy Lives Strategy	**Public Health** (Chris Lovitt)	Finalise plan	June 2013
		Partnership sexual health adopted and key objectives widely communicated	June to September 2013
		Sexual Health commissioning responsibilities transferred to LBTH	April 2013
		Develop metrics and trajectory on uptake of asymptomatic screening in primary care	June 2013
		Develop metrics and trajectory on treatment for STIs, reinfection rates, partner notification and partner treatment rates	June 2013
Deliver a sexual health needs assessment for high risk,	**Public Health** (Chris Lovitt)	Needs assessment undertaken across care pathways	August 2013

[7]Public Health England recommends that local authorities should be working towards achieving a diagnosis rate of 2,300 per 100,000 population. The trajectory of the targets will mean the target will be met by Q2 2016/17. The purpose of this indicator is to measure the success of sexual health services in diagnosing chlamydia. Increasing the diagnostic rate will reduce complications of infection and reduce the spread of infection.

vulnerable groups including looked after children and adults with learning disabilities		Implementation plan for vulnerable groups	Oct 2013
Develop a lifecoursesexual health promotion plan (including SRE in school) and promote access to sexual health services and contraception choices by all front line services	**Public Health** (Chris Lovitt) **Health Lives Team** (Kate Smith) **Options Team** (LiatSarner)	Lifecourse Promotion and Access Plan developed and adopted	May 2013
		Monitoring of uptake of plan	Oct 2013

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Priority: Long Term Conditions and Cancer			
Outcome Objective – Reduced prevalence of the major 'killers' and increased life expectancy			
Measure	**Baseline 2011/12**	**Target 2013/14**	**2014/15**
Rate of deaths from causes considered preventable of persons under 75	130.1	107.4	96.1
Rate of deaths from all cardiovascular diseases (including heart disease and stroke) of persons under 75	106.1	81.4	71.5
Rate of deaths from cancer of persons under 75	135.1	124.0	117.9
Rate of deaths from respiratory disease of persons under 75	37.7	32.2	29.4
Percentage of people who are eligible for cancer screening who are screened	Breast 65.9% Cervical 72% Bowel 32.5%	Targets to be agreed with Public Health England	Targets to be agreed with Public Health England
Proportion of people who are eligible, who take up the NHS Health Check Programme[1]	20%	+12%	+12%
CARDIOVASCULAR			
Action/strategy/programme to deliver	**Lead**	**Milestones**	**Timescale**
NHS Health Checks to detect onset of cardiovascular disease to appropriately refer onto care packages	Public Health	Quarterly reports to monitor the uptake of the NHS health check.	June/September/December 2013 /March2014
		To evaluate the current programme in relation who is accessing the NHS Health checks.	September 2013
		Identify developments and Implement changes required to ensure the checks are	September – March 2014

[1] The NHS Health Check Programme is a multi-year programme of health checks. The targets have been set to ensure the eligible population is covered over the course of the programme.

		accessed on an equitable basis.	
Finalise review of diagnostics provision including ECG survey and echo. Explore the feasibility of setting up a pilot provision with Barts Health for open access echo and 24hr ECG service at BLT.	TH CCG	Complete exploratory work	July 2013
Review of CVD care package	TH CCG	Review reports and recommendations included in commissioning intentions	October 2013
DIABETES			
Action/strategy/programme to deliver	**Lead**	**Milestones**	**Timescale**
Review diabetes care planning, including the use of high cost insulin	TH CCG	Work with prescribing team in cross-sector prescribing initiative to reduce spend on high cost insulin use	April 2013 and reviewed on a monthly basis
		Seek qualitative feedback from patients on their experience of their care planning consultation within the diabetes care package	September 2013
		Review the diabetes care package to support individual general practices in tighter control of diabetes within their patient population in the first 10 years after diagnosis	October 2013
		Introduce changes	April 2014
HYPERTENSION			
Action/strategy/programme to deliver	**Lead**	**Milestones**	**Timescale**

Review of hypertension care package	TH CCG	Carry out review	April 2013-Sept 2013
		Changes built into commissioning intentions	October 2013
		Changes to care package introduced	April 2014
RESPIRATORY			
Action/strategy/programme to deliver	**Lead**	**Milestones**	**Timescale**
Review of COPD Care Package		Results fed into commissioning intentions	March 2014
Review of whole system care pathways for Childhood Asthma		Findings will be used to inform the future work plans of the CCG and commissioning intentions for 2014/15 and beyond	March 2014
Current provision and needs for AdultsAsthma		Examine JSNA data on asthma admissions, in particular differentiating between adult and children.	August 2013
		Results fed into commissioning intentions	October 2013
Appoint a *Home Oxygen* Specialist to undertake cost benefit analysis of developing a HOSAR, with support from the CSU.		Appointment of specialist	August 2013
		Recommendations to be included in contract negotiations	January 2014
CANCER			
Action/strategy/programme to deliver	**Lead**	**Milestones**	**Timescale**
Early Identification through: • increasing the uptake of breast, bowel and cervical screening using targeted outreach,	Public Health	Link with Public Health England to agree screening targets agree assurance process	July 2013

primary care endorsement, improved practice systems • increasing public awareness of cancer and the need to report symptoms without delay through the small c campaign		Commissioned community organisations will engage directly with at least 2,800 local people in target groups to increase awareness cancer	March 2014
Cancer waiting times, improvement against the 62 day wait standard	CCG	Set local priority for monitoring of 62 day wait	April 2013
		Develop 'flag' when patients reach day 42	September 2013
		Monthly review of performance	April 2013 onwards
MAKING EVERY CONTACT COUNT			
Action/strategy/programme to deliver	**Lead**	**Milestones**	**Timescale**
To develop a public health approach in the health and social care consultations which take place as part of the long-term conditions care packages consultations to "make every contact count".	Public Health	To identify the how public health issues are currently integrated specific long-term conditions consultations. To develop initiatives and implement changes to start to improve content of the consultations with patients within the long-term care packages	October 2013 March 2014

Outcome Objective – Improved patient experience and co-ordination of health, housing and social care for those with single or multiple long term conditions			
Measure	**Baseline 2011/12**	**Target 2013/14**	**2014/15**
Proportion of people feeling supported to manage their condition	89% (2012/13)	91%	93%
Proportion of people who use services and carers who find it easy to find information about services	73% (2012/13)	75%	77%
Overall satisfaction of people who use services with their care and support	64% (2012/13)	66%	69%
Action/strategy/programme to deliver	**Lead**	**Milestones**	**Timescale**
Lead a cultural change programme for professionals and staff about self-care	Health and Wellbeing Board	To be advised	To be advised
Develop an integrated community health and social care contact point (Referral hub in health and First Response)	Integrated Care Board	Sign of of integrated care delivery plan	June 2013
		Design group for integrated community health team commences	June 2013
Improve coordination and consistency between re-ablement and rehabilitation.	Integrated Care Board	Go live of new specification	September 2013
Review evidence of self-care programmes	Public Health	Complete literature review of evidence of cost effective self care programmes, aligned to patient groups targeted by integrated care	September 2013
		Make recommendations for the CCG Board to consider	October 2013
Implement an integrated advanced care plan and record for patients that sit across health and social care	Integrated Care Board	Roll out of ORION pilot	September 2013
		Finalise info sharing agreements	September 2013
		Develop joint care assessment	July 2013

18 month pilot to integrate social workers in the Multi-Disciplinary team meetings for the community virtual ward and co-locate with community matrons	Integrated Care Board	Recruitment and appointment process underway	February 2013
		Co-locate social workers into the locality based clinics	July 2013
Develop and provide robust community-based Geriatric provision focus on admission avoidance, early discharge and effective community-based management of complex and/or vulnerable cases including last years of life.	Integrated Care Board	Recruitment and appointment locum cover	April 2013
		Establish working arrangement to co-locate in the locality based clinics	May 2013
Develop and provide continence service in care homes	Integrated Care Board	Provision of continence equipment	March 2014
Establish jointly chaired forum with health and social care to develop an integrated approach to commissioning the older persons pathway that takes a whole system person centred approach.	Integrated Care Board	Develop workplan for older persons pathway	September 2013
Formalise and make clearer the communication about patient prognosis to patients and between secondary and primary care.	TH CCG	OD with BH	April 2015
		Early adapter groups	
		Shared language re: prognosis	
Engender a cultural shift that 'normalises' death in the community and supports advanced care planning	TH CCG	Use engagement to test where advance care planning could be accessed e.g. when registering with GP / benefit advice etc	April 2014
		Collecting data and qualitative feedback to develop a baseline position to inform developments of advance care planning	April 2104
Improve availability and access to information on healthy dying by embedding in single health and social care information resource system for professionals and residents	Health and Wellbeing Board	Collate directory of support available	TBC

Improve support given to those dying and their carers	TH CCG	Create a checklist of things to consider and where to get support for patients / carers.	April 2014
		Checklist triggered when GP issues DS1500 to patients	April 2014
Review current programmes that support preferred place of death and produce analysis of what works and what doesn't work	TH CCG	Commission research/needs assessment with public health	April 2014

Outcome Objective – More people with learning disabilities receiving high quality care and support			
Measure	**Baseline 2011/12**	**Target 2013/14**	**2014/15**
Overall satisfaction of people with learning disabilities who use services with their care and support	91% (2012/13)	93%	95%
Proportion of adults with learning disabilities in paid employment	7.9% (2012/13)	9%	10%
Proportion of adults with learning disabilities who live in their own home or with their family	60%	65%	70%
Action/strategy/programme to deliver	**Lead**	**Milestones**	**Timescale**
Implement the recommendations from the Learning Disability Self Assessment Framework	Learning Disability Partnership Board and the Clinical Commissioning Group	Oversee implementation of the aims of Valuing People Now and other local objectives to improve the lives of people with learning disabilities in Tower Hamlets, namely:	March 2014
Develop and implement plan for autism services and improvement	Autism Strategy Implementation Group	Autism plan developed and agreed	*March 2014*
		Diagnostic and Intervention Team in place	*March 2014*
Improve housing options for people with learning disabilities in Tower Hamlets	Learning Disability Partnership Board	Commissioning plan for accommodation options agreed	June 2013
		Existing learning disabilities accommodation remodelled where appropriate	April 2014
		Delivery of commissioning plan outcomes within identified timescales in the Commissioning Plan, with the exception of those that are	April 2014

		reliant on decommissioning or procuring buildings	
		New services as identified in the plan in place	March 2016

Outcome Objective – More carers having good physical and mental health and feel fully supported			
Proposed outcome measures Carer-reported quality of life The proportion of carers who report that they have been included or consulted in discussions about the person they care for Health-related quality of life for carers			
Measure	**Baseline 2011/12**	**Target 2013/14**	**2014/15**
Quality of life as reported by carers	33 % (reported feelings of stress,depression and physical strain 2010)	TBC	TBC
Proportion of carers who report that they have been included or consulted in discussions about the person they care for	25% (Carers Survey 2012)	30%	40%
Health-related quality of life for carers	41%(TH Carers Survey 2010 reported their general health to be good)	45%	49%
Action/strategy/programme to deliver	**Lead**	**Milestones**	**Timescale**
Deliver the Carers Plan 2012/15through the following workstreams: Pathways to support for Carers; Information Advice and Prevention; Health support and understanding health conditions; Personalising support and personal budgets and Transforming respite Health Checks for Carers	Carers Programme Board (chair: Service Head – Adult Social Care)	Carers awareness training programme for the Out of Hours Service developed	April 2014
		Carers awareness training programme to include: • GPs • Pharmacists	November 2013

EQUALITY ANALYSIS QUALITY ASSURANCE CHECKLIST

Name of 'proposal' and how has it been implemented (proposal can be a policy, service, function, strategy, project, procedure, restructure/savings proposal)	The Tower Hamlets Health and Wellbeing Strategy – this is being developed by a sub group of the Health and Wellbeing Board and presented to the Board at key stages of its development. The implementation of the strategy will be overseen by the Board.
Directorate / Service	Health and Wellbeing Board
Lead Officer	Louise Russell, Chair of the Health and Wellbeing Strategy
Signed Off By	Health and Wellbeing Board

Stage	Checklist Area / Question	Yes / No / Unsure	Comment (If the answer is no/unsure, please ask the question to the SPP Service Manager or nominated equality lead to clarify)
1	Overview of Proposal		
a	Are the outcomes of the proposals clear?	Yes	The outline strategy has a number of outcomes that it seeks to achieve. Residents, staff and community groups/forums/partners have all been asked for their input through a month long public consultation. The outcomes of which contributed to shaping the Strategy and Delivery Plans. Consultations were undertaken with a broad range of stakeholder groups which ensured that we considered the needs of all protected groups within the strategy in line with the Equality Act 2010 These outcomes will be refined following consultation and how they will be achieved will be thought through in more detail as part of developing the Delivery Plan. Those tasked with delivery the Strategy will also give 'due regard' in action planning and service delivery.
b	Is it clear who will be or is likely to be affected by what is being proposed (inc service users and staff)? Is there information about the equality profile	Yes	The strategy should touch every resident one way or another which is why it has been consulted on so broadly and comprehensively. The Partnership has a good

	of those affected?		understanding of who is living in the Borough and this data has been used to highlight the health needs of certain sections of the community. The Census estimate for the usually resident population in Tower Hamlets on 27th March 2011 was 254,100 residents. **Age** The 2011 census has shown that residents in the 20 to 64 age group have increased from 122,070 in 2001 to 176,400 in 2011, an increase of over 44.5% (54,330 residents). However, in Tower Hamlets the number of residents aged over 65 fell from 18,362 in the 2001 Census to 15,500 in 2011. Tower Hamlets saw reductions in those aged 65 to 79 of 3,164 residents (a fall of 21.9%), but an increase in those aged over 80 which increased by 302 residents (an increase of 7.7%). The Census 2011 tells us that there has been a significant increase in working age population and this is where much of the overall population growth has occurred. The Borough also has the lowest pensioner population in the Country but with proportionately many more of them living alone. **Disability** There are around 9,000 adults (aged 16 years and over) in Tower Hamlets claiming Disability Living Allowance (DLA). In addition, there are 3,640 older people claiming Attendance Allowance (AA). Around 4,560 people receive higher rate mobility award DLA and around 2,575 receive higher rate care award DLA (these are not mutually exclusive categories). Around 1990 people are

			claiming higher rate mobility award AA. (January 2011) **Sex** In 2010, the gender split in the population is 51 per cent male and 49 per cent female, or expressed another way, 105 males for every 100 females. **Religion or belief** The Faith profile of the borough mirrors national trends including a significant decrease in the Christian population now at 27%. There have also been increases in the proportion of the Muslim population which is now the largest faith group in the Borough at 35%. The increase in the number stating 'No Religion' or opting to not to answer the question on religion has been higher than both the significant London and National increases in these categories, and together make up 34% of people in the Borough. The next largest proportionate increase was in the Hindu community which is now 1.7% of the Borough overall (up from 0.8%) and the largest percentage decrease was in the Jewish community from 0.9% to 0.5% in 2011. **Sexual orientation** It is difficult to estimate the size and profile of the lesbian, gay and bisexual (LGB) population in the borough as sexual orientation was not a specific category used in the last census, however: A national survey indicates that LGB people make up around 10% of the population in London. Although the 2011 census did not ask specific questions around sexual orientation, it did ask about those who were living in same sex couples. This revealed that the borough has the fifth largest reported number of cohabiting same sex couples nationally, and the fourth largest in London.

			Ethnicity The results of the Census 2011 reveal that the profile of the borough is one of increasing diversity. The two largest groups are the Bangladeshi (32%) and White British communities (31%) but there are also an increasing number of smaller ethnic groups in the resident population re-affirming the hyper diverse nature of the Borough.
c	If there a narrative in the proposal where NO impact has been identified? Please note – if a Full EA is not be undertaken based on the screen or fact that a proposal has not been 'significantly' amended, a narrative needs to be included in the proposal to explain the reasons why and to evidence due regard	No	All areas of the Health and Wellbeing Strategy identify outcomes for residents of Tower Hamlets. Measurable outcomes have been selected as part of the development of the Delivery Plan – these measures will be monitored by the Health and Wellbeing Board as part of its role in overseeing the implementation of the strategy, where possible these measures will be broken down by Protected Characteristic. As part of the delivery plan partners of the Health and Wellbeing Board are asked to commit to improving the way equalities information is collected and shared to enable analysis by equality strand of both access to health services and health outcomes which will inform decision making. . The Maternity and Early Years priority is delivered through the Children and Families Plan which has its own Equalities Analysis. The Mental Health and Wellbeing priority is delivered through the development of a Mental Health JSNA (across the whole lifecourse) and strategy which is subject to it's own equalities assessment.
2	Monitoring / Collecting Evidence / Data and Consultation		
a	Is there reliable qualitative and quantitative data to support claims made about impacts?	Yes	• JSNA (Summary and Factsheet); • Health Equity in Primary Care in East London and the City; • AHWB Service User Perspectives Factsheets; • Health and Wellbeing Strategy Consultation Analysis; • Health and Wellbeing Strategy Consultation and

			Engagement log; • Draft Rainbow Hamlets Health and Wellbeing Strategy consultation response (awaiting final version); • Children and Families Plan analysis; and • National Outcomes Frameworks Equalities analysis • Tower Hamlets equality schemes. Key insights from this data have been brought together in the attached document 'Equalities Insights for the Tower Hamlets Health and Wellbeing Strategy'. These have been used to inform the strategy and the delivery plans which accompany it.
	Is there sufficient evidence of local/regional/national research that can inform the analysis?	Yes – although there will be gaps which will be highlighted and actions (where appropriate) developed to address)	The strategy has been developed using a wealth of local and national data. The JSNA and our analysis of the engagement and consultation intelligence in particular. An action within the delivery plan for the Health and Wellbeing Strategy is to continue improve the collection and use of shared data to understand needs and outcomes, including by protected characteristic where possible.
b	Has a reasonable attempt been made to ensure relevant knowledge and expertise (people, teams and partners) have been involved in the analysis?	Yes	The development of the Health and Wellbeing Strategy has been guided by a cross partnership sub group with representatives from the Local Authority (cross Directorates, Public Health, THINk and the Clinical Commissioning Group). The Health and Wellbeing Strategy was consulted on during 2013 and has been amended as a result of this and subsequently agreed by the Board. The equalities insights that have been drafted to feed into the delivery plan have been informed by the consultation

			analysis and insights from officers from the Partnership, in particular from CSF, AHWB, One Tower Hamlets, CEX and Public Health The Delivery Plans for the Health and Wellbeing Strategy was developed through a series of workshops involving users and carers, THINk, Public Health, Barts Health, Local authority, CCG, CVS, ELFT etc…
c	Is there clear evidence of consultation with stakeholders and users from groups affected by the proposal?	Yes	The strategy has been informed by: • Feedback from service users, carers and patients that was collected by the Partnership throughout 2011/12. • A specific Health and Wellbeing survey to residents and staff. • Consultation on the outline strategy with residents, partners, staff etc… All of this feedback will be/has been used to inform our thinking about the impact on people from different equality profiles.
3	Assessing Impact and Analysis		
a	Are there clear links between the sources of evidence (information, data etc) and the interpretation of impact amongst the nine protected characteristics?	Yes	Sources of evidence include national and local research, national policy positions which have themselves been equality impact assessed, local performance information and stakeholder experience (please see appendix 1: Equalities insights for the Outline Health and Wellbeing Strategy) **Age** The Health and Wellbeing Strategy takes a lifecourse approach. Each priority will identify actions to improve services where appropriate for the following stages of life: • Being Born

			• Growing Up • Being an Adult • Growing Older. The Health and Wellbeing Strategy should not have a negative impact on any age group. **Disability** The needs of people with disability have been considered throughout the development of the outline health and wellbeing strategy. The Long Term Conditions and Cancer priority is expected to have a positive impact on those with disabilities in particular with specific work to improve experience through better coordination of care and support and supporting people with learning disabilities better in particular. **Gender** Our data about the population shows that men have a lower life expectancy than men and have a higher prevalence of most chronic conditions. The Healthy Lives priority in the strategy sets out the ambition for more focussed activity to address the accumulation of risk factors which should have a positive outcome for men in particular (but not to the exclusion of women). **Religion or belief** The Health and Wellbeing Strategy should improve the health and wellbeing of all residents of all religions and beliefs. There are some examples mental health, sexual orientation where we know religion/belief can act as a barrier to people getting the right support at the right time and the Health and Wellbeing Strategy will aim to reduce these barriers as much as possible. **Sexual Orientation**

			Through our engagement and consultation we have gathered a good level of feedback about the issues facing the LGBT community. Where appropriate these will be addressed through the delivery planning workshops or taken back to individual organisations for action where the partnership is not necessarily needed to influence change. **Ethnicity** The Health and Wellbeing Strategy should achieve positive outcomes for all residents of Tower Hamlets. However, our data shows that the prevalence of many chronic conditions is highest in the white population except for diabetes, Learning Disabilities and Serious Mental Illness.
	Is there a clear understanding of the way in which proposals applied in the same way can have unequal impact on different groups?	Yes	All activity is geared towards the need of the community, targeted actions will be identified through the delivery planning phase as needed.
b	Has the assessment sufficiently considered the three aims of the Public Sector Equality Duty (PSED) and OTH objectives?	Yes	We have considered the 3 aims. The proposal will help partners to eliminate unlawful discrimination, harassment and victimization and other conduct prohibited by the Equality Act 2010; advance equality of opportunity between people from different groups; and foster good relations between people from different groups. The vision for the Health and Wellbeing Strategy is to improve health and wellbeing through all stages of life to: • Reduce Health Inequalities • Promote choice, control and independence. The principles underpinning the strategy are: • Focussing on prevention, early identification and early intervention,;

			• Patient Centre Care; • Looking across the lifecourse; • Taking a family centred approach (including families of choice); • Ensuring Health in all Policies; • Understanding and addressing diversity and • Building on community potential and Capacity The ethos of the strategy is completely aligned to the community cohesion and leadership approach of One Tower Hamlets; supporting people to improve the health of their communities through the grass roots. The four priority areas address particular areas of need identified through needs and equality analysis: • Maternity and Early Years • Healthy Lives • Mental Health; and • Long term conditions and disability Equality considerations have thus been embedded within the strategy.
4	Mitigation and Improvement Action Plan		
a	Is there an agreed action plan?	Yes	The strategy is accompanied by delivery plans which will include specific actions necessary to mitigate unequal impacts identified as part of having due regard.
b	Are all actions SMART (Specific, Measurable, Achievable, Relevant and Time Bounded)	Yes	See above
c	Are the outcomes clear?	Yes	See above
d	Have alternative options been explored	Yes	The delivery plans were developed through workshop consultations which considered a range of options and involved a number of key partners.
6	Quality Assurance and Monitoring		
a	Are there arrangements in place to review or audit the implementation of the proposal?	Yes	The Health and Wellbeing Board will oversee the implementation of the strategy and progress will be

			regularly reported. The Partnership Executive oversees the implementation of the Community Plan, the Health and Wellbeing Strategy supports the implementation of this. To support the oversight of implementation by both the Health and Wellbeing Board and the Tower Hamlets Partnership, a clear set of outcome measures has been developed in line with national frameworks. These will enable the Health and Wellbeing Board to track the progress of the Strategy in achieving what it sets out to do. These measures will be integrated within the Community Plan, and progress against these measures will be regularly reported to both Boards. The Health and Wellbeing Strategy will also be monitored 6 monthly by the Council as part of its Strategic Monitoring.
b	Is it clear how the progress will be monitored to track impact across the protected characteristics??	Yes	The Health and Wellbeing Board will oversee the implementation of the strategy, and performance monitoring arrangements are being agreed with the strategy.
7	Reporting Outcomes and Action Plan		
a	Does the executive summary contain sufficient information on the key findings arising from the assessment?	Yes	The “Equalities insights for the Tower Hamlets Health and Wellbeing Strategy” summarises the key equalities insights that have neen fed into the development of the Strategy and Delivery Plans.
8	Sign Off and Publication		
a	Has the Lead Officer signed off the EA? Please note – completed and signed off EA and Quality Assurance checklists to be sent to the One Tower Hamlets team	Yes	

Appendix 1: Equalities insights for the Health and Wellbeing Strategy

Source key:

C Consultation analysis

SC Specific consultation response

I Officer insight

D Data

E Engagement and consultation log

Overarching insights

- Implications of promoting choice and control for those from different equality strands (I);
- Impact of sexual orientation or gender identity on people's ability to make choices or take control when they don't feel that they have control of who they are (SC);
- Implications of promoting independence on carers and those that don't have appropriate support to do this (C);
- Building on community potential; the community needs to be given the means to fulfil its potential rather than relying on voluntary and community sectors to deliver services – how can we do this so that the impact is equitable? (C & I);
- Importance of public health messages; especially in community languages (C);
- Accessibility of leisure centres both financially and physically (for those with physical disabilities) (C);
- Consultation responses show that respondents think that class, how connected you are in your community and difference are important wider determinants that impact on their health and wellbeing (C);
- Plain english and and well-designed information was raised as important so that people can easily understand and act on the information (C);
- Concern was raised in the consultation that vulnerable groups who could benefit greatly from access to health services can easily be overlooked in the delivery of care and often face barriers to accessing health services (C);
- Importance of end of life care experiences about allowing people to die with dignity and shaping the grieving process of friends and family (C)

Gender:

- Male life expectancy is 76 years compared to 78.3 years nationally. (D)
- Female life expectancy is 80.9 years compared to 82.3 years nationally. (D)
- The life expectancy gap between least and most deprived people in Tower Hamlets is 12.0 years in males and 5.4 in females. (D)
- In males, ward life expectancy varies by ten years. It is 82 years in Millwall and 72 years in Stepney Green. In females it varies by 13 years. It is 92 years in Millwall and 79 years in Mile End East. These variations generally correlate with relative deprivation across the borough. (2004-2008, ONS) (D)
- Healthy life expectancy in men at age 65 is 17.1 years compared to 18.4 years in London (D)
- Healthy life expectancy in females at age 65 is 19.2 years in women compared to 21.2 yearsin London(D)
- Across East London and the City "analysis of selected chronic diseases[1] by gender shows that the main burden of chronic disease falls on the male population… with the exception of obesity, which is higher in women in all three PCT areas."[2]. When looking at Tower Hamlets only this pattern is shown except prevalence of cancer is slightly higher in females than males. Prevalence rates for Tower Hamlets amongst men are statistically significantly worse than the total population prevalence for the following conditions (D):

    - Chronic Obstructive Pulmonary Disease;
    - Coronary Heart Disease;
    - Diabetes;
    - Learning Disability;
    - Serious Mental Illness;
    - Smoking; and
    - Stroke.

[1] Asthma, cancer, chronic obstructive pulmonary disease, coronary heart disease, diabetes, hypertension, learning disability, obesity, serious mental illness, smoking and stroke

[2] NHS East London and the City, Health Equity in Primary Care in East London and the City, p 4

- In summary the JSNA highlights that overall men have higher rates of chronic illnesses and diseases than women. Men also have lower life expectancy (D)
- Good blood sugar control is statistically significantly worse amongst men with diabetes than compared with the total diabetic population (D);
- A greater proportion of females have good blood sugar control compared to males. (D)
- From the healthy lives survey 2009 we found that 34% of males were current smokers compared to 20% of females. There were important gender differences in smoking prevalence by ethnicity. In the White population, the proportion of female smokers and male smokers was not significantly different. However, in the Asian and Black populations a much higher proportion of males smoked than females. (D)
- From the healthy lives survey 2009 we found that men were more likely to eat an inadequate amount of fruit and vegetables than women, which reflects a national trend (HSE 2008). In Tower Hamlets, 92% of men did not reach the 5-a-day target, and 83% of women. This is significantly worse than the national figures – 78% for men and 69% for women. (D)
- "Men in Tower Hamlets have the highest numbers of diagnoses for the key five STIs (Chlamydia, Gonorrhea, Syphilis, ano-genital Herpes, ano-genital Warts). Men who have sex with men (MSM) have disproportionately high levels of STI diagnoses (23% of all male diagnosis) and 74% of them were in white MSM. However, apart from syphilis and anogenital herpes, heterosexual men remain the group most commonly diagnosed with STIs. By age men aged between 20-44 year olds are those mostly affected by STIs."[3] (D)
- "A lower proportion of female deaths in Tower Hamlets occur at home than for males (12.4% for females compared to 19.6% for males) and the same is true nationally (15.9% for females compared to 22.2% for males)."[4] (D)

Age:

[3] Tower Hamlets, 2011, 2010-11 JSNA Factsheet on Sexual Health
[4] Tower Hamlets, 2011, 2010-11 JSNA Factsheet on End of Life Care

- Across East London and the City "analysis by age group shows increasing disease prevalence[5] with increasing age, highlighting the importance of early interventions to prevent disease risk-factors from accumulating."[6](D)
- "the proportion of patients with diabetes and stroke in whom disease management indicators are met is lower amongst young and middle aged patients, than amongst older patients, suggesting opportunities for early interventions to prevent secondary complications of disease are being missed."[7](D)
- In Tower Hamlets for those aged 40+ prevalence of the following conditions is statistically significantly worse than the total population with that condition: (D)

    - Asthma
    - Diabetes
    - Hypertension
    - Obesity
    - Serious Mental Illness
    - Smoking

  And, for those aged 50+ statistically significantly worse for:

    - Cancer
    - Chronic Obstructive Pulmonary Disease
    - Coronary Heart Disease.
- "There is a consistent pattern across the three PCTs, whereby disease management indicators (diabetes or stroke) are achieved for a higher proportion of older patients, than for young and middle-aged patients. This suggests that opportunities for early secondary prevention interventions are being missed, with the risk that young and middle-aged patients will go on to develop disease complications in later life."[8](D);
- Specifically, a disease management indicator for diabetes (blood glucose levels) for those aged 5-15, 19-24, 25-39 and 40-49 (NB. There is no data for 16-18)is shown to be statistically significantly worse than the total population with diabetes. (D)
- Attendance at eye screening[9] (a disease management indicator for diabetes) is statistically significantly worse for those aged 19-24 and 25-39than the total population with diabetes. (D)

[5] Asthma, cancer, chronic obstructive pulmonary disease, coronary heart disease, diabetes, hypertension, learning disability, obesity, serious mental illness, smoking and stroke
[6] NHS East London and the City, Health Equity in Primary Care in East London and the City, p 4
[7] NHS East London and the City, Health Equity in Primary Care in East London and the City, p 4
[8] NHS East London and the City, Health Equity in Primary Care in East London and the City, p 17
[9] Retinopathy screening

- The cholesterol disease management indicator for stroke is statistically significantly worse for those aged 25-39 than the total population who have suffered a stroke. (D)
- Use of the internet has been increasing in recent years: 15% of residents contacted the Council online over the last year, and 25% say they would prefer to use this method in the future[10] and there are concerns about how this form of service delivery may impact older people. When using websites was discussed by the Older People's Reference Group people supported the website and could see themselves using it provided there was sufficient help/teaching and support to learn or alternatively, someone available to access the information with them at home. The group thought there were benefits specifically for Housebound Older People (E);
- From the Healthy Lives Survey 2009 we drew the following insights:
    - Younger people aged 16 to 24 were the highest consumers of fast food. One in twenty members of this age group eat fast food at least once a day (D);
    - Smoking prevalence was highest in Asian and Black males and younger black residents (D);
    - Older people were more likely to be physically inactive than younger people (D);
    - alcohol use and harmful/hazardous use was more common amongst the white population. Young, white men were at particularly high risk.
- The 0 to 5 year old population in Tower Hamlets makes up 9.6% of the total population in the borough and 36.8% of the 0 to 19 population - the largest age group within the 0 to 19 population. The group is expected to grow at a greater rate than other age groups. (D)
- Childhood obesity in Year 6 has plateaued for the last three years, with the current rate at 25.6% for 2011/12, the 2nd highest in London. (D)
- Hospital admissions caused by unintentional and deliberate injuries in under 18s are higher than the London average with a crude rate of 122.5 per 10,000 population aged 0-17 years. (D)
- National evidence shows that 1/10 children aged between 5 and 16 has a clinically diagnosable mental health problem. About half of these have a conduct disorder, 3.7% an emotional disorder (anxiety, depression) and 1-2% has severe Attention Deficit Hyperactivity Disorder (ADHD). (D)
- Nationally, around 60% of Looked after Children and 72% of those in residential care have some level of emotional and mental health problem. (D)
- Smoking amongst young people is similar to the national average and may be increasing amongst girls (Tell Us). (D)
- Chlamydia rates in the borough are lower than average for the 15-24 age group, though women aged 16-19 are considered at risk. (D)

[10] Annual Residents Survey 2012

Ethnicity:

- New migrants and refugees face barriers in accessing healthcare (D);
- National Insurance Number (NINo) registrations are an indicator for economic immigration; data from 2000 onwards show higher levels of NINo registrations from Eastern European and Ascension 8 countries. (D)
- Out of all London NINo registrations, 5.4% registered in Tower Hamlets in 2009/10. 45% of the London NINo registrations by Bangladeshi nationals took place in Tower Hamlets (D)
- There is a lack of data about new migrant groups in the Borough e.g. Eastern European and how this impacts need (I);
- Key issues for migrants accessing are: information about how the 'system' works, how to access services, registering with a GP and then being able to make an appointment, finding and registering with an affordable dentist. (D)
- Teenage refugees and asylum seekers in find it difficult to access mental health services which adequately meet their needs. (I)
- Across North East London and the City "analysis by ethnicity shows that for many chronic diseases[11], particularly smoking associated diseases, prevalence is highest in the White population, with diabetes more prevalent in the Asian population, and hypertension, obesity and serious mental illness more prevalent in the Black population."[12](D)
- In Tower Hamlets the white population has a prevalence of disease higher than the total population for all conditions[13] except diabetes, learning disabilities and severe mental illness. (D)
- In Tower Hamlets prevalence rates for the black population are statistically significantly worse than the total population prevalence in asthma, diabetes, hypertension, obesity and stroke (D).
- "For the majority of disease management indicators, there are no statistically significant differences by ethnicity…However, in Newham and Tower Hamlets, the proportion of diabetic patients with good blood sugar control is higher in White patients than in the total diabetic population…and in all three

[11] Asthma, cancer, chronic obstructive pulmonary disease, coronary heart disease, diabetes, hypertension, learning disability, obesity, serious mental illness, smoking and stroke
[12] NHS East London and the City, Health Equity in Primary Care in East London and the City, p 4
[13] Asthma, Cancer, COPD, Coronary Heart Disease, Hypertension, Obesity, Stroke

PCTs the proportion of diabetic patients with good blood pressure control is lower in Black patients that in the total diabetic population."[14] (D)

- There is a projected and disproportionate increase in learning disabilities for BME residents (D);
- From the Health and Wellbeing consultation one respondent raised the need for more access to nursing courses for BME women (C);
- From the Health and Wellbeing consultation a recommendation was raised to set a priority in dealing with Heart disease and Diabetes amongst Bangladeshis (C);
- One consultation respondent didn't feel there is enough support out there to help people from disadvantaged BME groups (C);
- The promotion of Mental Health in BME communities was raised as important in the Health and Wellbeing Strategy consultation (C);
- Language was raised by the CVS as an important factor for improving health and wellbeing in Tower Hamlets (E);
- The Bangladeshi community have a higher risk of children born at lower birth weight (D);
- There is a high percentage of Black/Black British mothers who smoke during pregnancy (D);
- Asian men/women have low STI diagnosis (D).
- The following insights are from the 2009 Healthy Lives Survey
    - only 2% of residents showed all four indicators of healthy behaviour (not currently smoking, consuming at least five portions of fruit or vegetables on an average day, abstaining from alcohol or moderate drinking,taking part in the recommended minimum 30 minutes of physical activity at least five times a week).White residents were more likely to display these behaviours than their Bangladeshi counterparts, though they are also far more likely to drink alcohol to excess (D);
    - while three in five (60%) of White smokers would like to quit, this proportion rises to four in five Asian smokers (80%) (D);
    - Bangladeshi men are the demographic group most likely to smoke, while Bangladeshi women are least likely. A small minority of residents,

[14] NHS East London and the City, Health Equity in Primary Care in East London and the City, p 17

almost exclusively from Asian ethnic groups, use forms of tobacco other than cigarettes, including paan (4%) and sheesha (2%) (D);

- asian residents are slightly more likely to eat takeaway food at least three times a week compared to White residents. (D)
- alcohol use and harmful/hazardous use was more common amongst the white population. Young, white men were at particularly high risk.
- Abstention from alcohol is closely linked with ethnicity: while 96% of Asian residents say they do not drink alcohol, only 18% of White residents abstain. Likewise, while only 2% of Asian residents are harmful drinkers or at risk of harm, this figure rises to 38% among all Whites. (D)
- there were significant and substantial differences in patterns of fruit and vegetables consumption by ethnicity as shown in Figure 11. Only 2% of Asian men, 3% of Black men and 12% of White men reported eating five-a-day. The Asian population was the least likely to reach the 5-a-day target. (D)

- "Nationally "uptake of routine invitations for breast screening is lower amongst Muslim women than among women in the general population possibly due to fear of a male carrying out the mammogram; and in the first phase of the bowel screening programme overall population uptake was 62% but only 32% for Muslims." (D)
- 69.8% of all young people in drug and alcohol treatment are Asian or Asian British background -similar to the overall ethnic make-up of this age group. (D)

Sexual Orientation:

- Lack of data mapping sexual orientation against health outcomes/access. (D)
- It is difficult to estimate the size and profile of the lesbian, gay and bisexual (LGB) population in the borough as sexual orientation was not a specific category used in the last census, however:
  - A national survey indicates that LGB people make up around 10% of the population in London.
  - Although the census did not ask specific questions around sexual orientation, it did ask about those who were living in same sex couples. This revealed that the borough has the fifth largest reported number of cohabiting same sex couples nationally, and the fourth largest in London (D);

- Research conducted by the One Tower Hamlets Team shows that there is a danger of isolation for older LGBT individuals in Tower Hamlets (D);
- Feedback about the LGBT population (E):
    - That the LGBT community find it difficult to access some health services due to fear of admitting their sexual orientation.
    - Some sections of the LGBT community may not access services due to cultural/religious reasons.
    - The LGBT awareness of GPs has been questioned with a view that GPs see the issues in terms of sexual health.
    - LGBT communities are often not out to their GP's due to fear of discrimination, homophobia and fear that their family and/or wider community will find out as a result of this disclosure;
    - Suicide rates are higher in the LGBT population as are rates of depression, drug and smoking.
    - Tower hamlets has high rates of STI's and HIV, with HIV being more prevalent amongst men who have sex with men. Evidence from the HPA http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/SexualHealthProfilesAndIndex/ has shown growth in HIV transmission and certain STI's amongst the late 30s and 40's
    - For elders in care homes there is the issue of homophobia. LGBT residents complain of poor mental health due to the isolation and discrimination felt due to a lack of recognition of their sexuality or a denial of their sexuality
- LGBT siblings in a family often have to take on caring responsibilities for older family members as they are less likely to have children and are thus expected to be the carer. This can be an isolating experience and not all LGBT carers feel able to access support that is available (E);
- Concern that talking about families is quite excluding to those who aren't part of a "traditional" family. A family-centred approach needs to acknowledge and recognise the wider social networks of people that include family and friends/significant others for some, there is a need to recognise family structures beyond the hetero-normative model to one of "families of choice". There needs to be better promotion of acceptance of alternative lifestyles all being valid ways of living (C);

- Comment made noting that mental health issues stem from people not accepting who they are, or not being able to disclose their personal status openly, which causes stress and tension. This is particularly true for those people who have non-standard sexual and social orientations. A consultation response suggests that as a result of a lack of pro-active promotion of all types of lifestyles as being natural and acceptable, people feel alienated and withdraw from society and the facilities provided. One respondent also noted that "providing a safe environment for people to accept and show their differences - e.g. Coming Out as gay; being open about 'hidden' disabilities; etc…" should be an outcome of the Mental Health Strategy(C);

- One consultation response suggests a need for the Health and WellbeingStrategy to consider LGBT issues holistically (SC);

- For the principle of intervening early and effectively amongst the LGBT community an issue is about preventing self-harm and suicide; *"there is at least twice the risk of suicide in LGB people compared to heterosexuals. This risk increased to four times in gay and bisexual men"*[15](SC);

- Concern raised that LGBT people are overlooked for the purposes of community engagement or consultation (SC);

- One consultation response reminds the partnership that LGBT people can be parents too and that ante-natal, delivery and post-natal services need to be welcoming of LGBT parents. (SC);

- There is some national evidence that LBG people are more likely to smoke and that the use of drugs and alcohol is more widespread among LGB people (SC);

- Implications group based therapy approach on LGBT people and their ability to disclose openly if they're not "safe" spaces from LGBT people (SC);

- One consultation response suggested that research is needed into newly diagnose cases of HIV/AIDS and other sexually transmitted infections to establish more conclusively why infection rates continue to grow (SC);

- National evidence to suggest that there are higher incidences of substance misuse, self-harm, anxiety, depression, suicidal ideation and attempted suicide amongst LGBT people[16]. There are also recurring issues associated with LGBT identity that lend themselves to stress, anxiety and depression(including "coming out", rejection from others post "coming out" and not feeling able to "come out")(SC);

[15] Reference from the draft Rainbow Hamlets response, original source: National Institute for Mental Health, 2007, Mental disorders, suicide and deliberate self harm in lesbian, gay and bisexual people;
[16] Ibid

- One consultation response noted that the development of virtual wards should offer significant benefits to gay men with HIV and aids (SC);
- Harrasment and discrination experienced by older LGBT men in residential homes and fear this could also be the case for transgender (SC);
- Poor data recording of equality strands across health and social care, suggested actions (E):
    - training for staff to know how to approach patients when asking this information;
    - ensuring that patients are aware of what this data will be used for;
    - displaying rainbow flags/targeted information in GP receptions to make LGBT patients more at ease.

Marriage/Civil Partnership:

- Lack of data mapping marriage/civil partnership against health outcomes/access. (D)
- Risk that service delivery is done in a way that's geared towards a particular social structure. Need to recognise non-traditional family types beyond the hetero-normative model to one of "families of choice"– e.g. young carers, informal carers, network of close friends etc. (C)
- One consultation response raises issues about healthcare professionals understanding that the partner of a LGB patient should not be treated differently from the partner of a heterosexual patient (SC);

Religion/Belief:

- Lack of data mapping religion/belief against health outcomes/access. (D)
- Certain social factors around religion can impact mental health i.e. unable to be openly LGB. (I)
- A suggestion made in the consultation for the Health and Wellbeing Strategywas to focus on "healthy faith", because religious faith is so important to such a lot of people in Tower Hamlets it could be a distinct priority as the religious leaders and community reverence to them could inspire healthy living (C);
- Tower Hamlets Interfaith forum expressed desire for more interaction between faith orgs/communities and health in delivering services/messages/outreach - especially in relation to people who may be otherwise hard to reach (E);

- Social factors around religion impacting on health, e.g. LGB people not being out and resultant impact on mental health, young people not accessing sexual health or other taboo services (e.g. alcohol, drugs) due to worries about confidentiality of family GPs. (I)

- Impact of religious belief on Sexual Realtionship Education and resultant impact on sexual health of young people (I)

- Religious taboos about certain disabilities.(I)

- Nationally, "uptake of routine invitations for breast screening is lower amongst Muslim women than among women in the general population…and in the first phase of the bowel screening programme overall population uptake was 62% but only 32% for Muslims."[17] (D)

Pregnancy:

- Strategy to have particular focus on maternity (I)

- Areas of higher fertility roughly correlate with the distribution of deprivation and child poverty across the borough. The higher birth rates occur across the centre of the borough, although higher absolute numbers of births occur in LAPs 1, 7 & 8. (D)

- Locally data on under-18 conception shows that white females are more likely to conceive and also continue with the pregnancy. The Bangladeshi females conceiving are under-represented in comparison to the demographic, but high percentages tend to have abortion rather than continue with pregnancy. (D)

- Anecdotally, domestic violence, mental health problems and drug and alcohol problems seem to be increasing for families of 0-5s.However, this could be a result of better reporting. (I)

- Gypsy and Irish Traveller mothers are 20 times more likely than mothers in the rest of the population to have experienced the death of a child - TH has a small traveller community based in Bow. (D)

- Domestic violence is associated with a raised incidence of miscarriage, low birth weight, prematurity, foetal injury and foetal death. (D)

- A 2005/06 audit found that 81.7% of women with gestational diabetes were Bangladeshi. (D)

- The estimated prevalence of vitamin D deficiency and insufficiency in pregnant women at booking is 74%. (D)

[17] DoH, 2011, Public Health Outcomes Framework: Equalities Analysis

Gender reassignment:

- Lack of data mapping gender reassignment against health outcomes/access. (D)
- Evidence suggests transgendered people suffer from higher levels of poor mental health (I);
- Over focus by practitioners on transgender identity to the exclusion of other aspects (SC);
- Physical activity: evidence to suggest a lack of transfriendly spaces i.e. gender appropriate changing facilities and trans gender perceptions around competitive advantage (SC);
- Interplay between mental health and gender reassignment surgery – mental ill health delaying surgery (SC);
- Issues surrounding appropriate intimate personal care – no evidence of this but suspicion from the community that this could be a source of concern (SC);
- GPs are gatekeepers to gender reassignment surgery (SC);
- Concern raised that LGBT people are overlooked for the purposes of community engagement or consultation (SC);

Disability

- The 2001 census revealed that there are estimated 1.4 million disabled people living in London with 35,000 living in Tower Hamlets:
    - The census also recorded that 17% of Tower Hamlets residents reported that they had a 'limiting long term illness' compared to 15.1% in London.
    - In 2009 over eleven thousand people in Tower Hamlets claimed Incapacity Benefit – 7% of the working age population.
- "Prevalence of the majority of chronic diseases[18] investigated is seen to be higher in those with learning disabilities; serious mental illness; those are deaf-affected, registered blind or housebound."[19](D)
- There is high prevalence of obesity and morbid obesity in those with learning disability or serious mental illness in Tower Hamlets – this is also seen across all 3 North East London Boroughs (D)

[18] Asthma, cancer, chronic obstructive pulmonary disease, coronary heart disease, diabetes, hypertension, learning disability, obesity, serious mental illness, smoking and stroke

[19] NHS East London and the City, Health Equity in Primary Care in East London and the City, p 4

- In Tower Hamlets, the proportion of diabetic patients with serious mental illness who have attended diabetic retinopathy screening is lower than the proportion in the total diabetic population – this is one of the few statistically significant differences shown amongst care groups. (D)

- Local research has found that there are specific issues around the BME population and disabilities. The research showed that there is poor communication around sexual health and isolation for this group (I)

- There is a prevalence of 'informal care' in the borough which has been highlighted at a recent THESG workshop on carers. (I)

- High prevalence of learning disabilities for Bengali groups (D);

- The following insights are from the Healthy Lives Survey 2009:

    - we found that residents with long term conditions and poor mental health were less likely to achieve adequate levels of physical activity (D).

    - people with a long term condition, disability or infirmity were significantly more likely to be physically inactive than those without physical health problems. 47% reported that they were active less than once per week, compared to 20% of other residents (D).

    - poor mental well-being was significantly associated with low levels of physical activity, even after controlling for age, gender and ethnicity. Respondents who were physically inactive scored significantly lower on the mental well-being scale than those who were physically inactive (51.8 compared to 53.9).

- Nationally "there is low uptake of both breast and cervical cancer screening amongst disabled people:

    - Only 19% of women with a learning disability have cervical smears, compared to 77% inthe general population.

    - Access to mobile breast screening units is difficult for womenwith a physical impairment"[20] (D)

- Nationally "the lack of inclusion of disability in routine recording makes it difficult to measure equity of access and treatment for disabled people, and presence of a disability is not recorded ondeath certificates so it is not possible to break down ONS mortality data by disability."[21] (D)

[20] DoH, 2011, Public Health Outcomes Framework: Equalities Analysis
[21] DoH, 2011, Public Health Outcomes Framework: Equalities Analysis

- Research suggests that 80% of children with learning difficulties; 70% of children with autism; and 40% of children with speech and language difficulties are bullied and/or victimised. (D)

Socio economic status

- Tower Hamlets is one of the most deprived areas in the country,it is the seventh most deprived in the country based on most recent IMD 2010 data. Child poverty data for 2009 (released September 2011) shows that levels remain the highest nationally. (D)
- Poverty is high among primary aged children - 46.4% were eligible for Free School Meals in 2011, of which 39% took up FSM. (D)
- Mental health problems are very closely related to many forms of inequality - in the case of psychotic disorders the prevalence among the lowest quintile of household income is nine times higher than in the highest. (D)
- Lack of data mapping socio-economic status against health outcomes/access. (D)
- Disease prevalence for the majority of diseases is seen to be higher amongst those in the most deprived quintiles except for cancer where the reverse is trend is seen.
- There are few statistically significant differences in disease management targets by deprivation.
- The Healthy Lives survey found that residents from socioeconomically deprived groups tend to consume fewer portions of fruit and vegetables than their wealthier counterparts.
- The Healthy Lives survey found that residents living in social housing were more likely to be physically inactive than those living in the private housing sector (31% vs. 20% were active less thanonce per week).
- From the Healthy Lives Survey, residents who eat at least 5-a-day are more likely to live in a less deprived area, to have higher levels of educational qualification and to be employed.

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Apprendix 1: Lifecourse summary

Being Born	There were 4565 babies born to Tower Hamlets mothers in 2010. 45% of births were to Bangladeshi mothers 9% of babies born to Tower Hamlets mothers have a low birth weight compared to 7.5% in London
Early Years	• In 2011 50% of children in Tower Hamlets achieved a good level of development at age 5 compared to 60% in London and 59% in England. We have seen steady improvement in EYFS, improving by 7 percentage points since 2009. However, we have not succeeded in closing the gap with the national average, and remain 9 percentage points below the national figure. • 12.7% are obese (6th highest in the country) • 46.3% have experience of tooth decay compared to 40.1% nationally (although there is evidence that this inequality is declining) [2009] • Local evidence indicates particularly high levels of Vitamin D deficiency in both mothers and children
Children and Young People	• 25.6% 10-11 year olds in Tower Hamlet are obese (4th highest in the country) • the incidence of sexually transmitted infections in young people country is likely to be high (overall Tower Hamlets has the 8th highest rate in the country in all age groups) • 2nd highest rate of admissions of children due to injury at 0-17, 2010/11; statistically significantly higher than London but not England. • Around 1 in 10 children are estimated to have a mental health disorder (similar to national averages)
Adulthood	• Compared to London, Tower Hamlets has: the second highest premature death rate from circulatory disease (fig 8), the fourth highest death rate from cancer (fig 9) and the fifth highest death rate from chronic lung disease (these conditions typically constitute 75% of all premature deaths) • Cancer in Tower Hamlets is higher than elsewhere due to the high incidence of lung cancer reflecting the high prevalence of smoking in the borough
Growing Old	• 56% of 65-84 year olds report long term limiting illness compared to 48% nationally • 80% 65+ have at least one chronic condition of which 35% have at least 3 'comorbid' conditions • A larger proportion of 65+ used social services in 2009/10 compared to London (20% compared to 15%) • Although it is expected that around 7% of the 65+ population would have dementia only around 2% are on dementia registers indicating significant under diagnosis • Stroke is predominantly a condition of older age and Tower Hamlets has the second highest stroke mortality in London • Older people account for 70% of strokes and 90% of caseloads of community heart failure services in the borough

Source: JSNA Summary Document

Appendix 2: Healthy Lives Survey

Table 3 - The findings of the Adult Healthy and Lifestyles Survey emphasise the need to link healthy lifestyle services with services addressing wider determinants of health, integrate them into clinical and social care pathways and target by population segment

Associations	Smoking prevalence	Physical inactivity	Poor diet	Risky drinking
Gender	↑ in Males	No	↑ in Males	↑ in Males
Ethnicity	↑ in Asian males	No	↑ in Asian and Black populations	↑ in White population
Age	↑ in young Black population	↑ in older people	↑ in younger women vs. older women	↑ in young, especially young white men
Deprivation	↑ if more deprived	↑ if more deprived	↑ if more deprived	↑ if more deprived
Education	↑ if lower attainment	↑ if lower attainment	↑ if lower attainment	↑ if lower attainment
Employment	↑ if unemployed	↑ if unemployed	↑ if unemployed	↑ if unemployed
Poor English literacy	↑ if poorer English literacy	↑ if poorer English literacy	↑ if poorer English literacy	No
Housing	↑ if social housing	↑ if social housing	↑ if social housing	↑ if social housing
Long term conditions	↑ if LTC	↑ if LTC	No	↑ if LTC in White population
Mental health	↑ if poorer MH	↑ if poorer MH	↑ if poorer MH	No

Source: Tower Hamlets Adult Health & Lifestyle Survey 2009

Health and Wellbeing Board 6th February 2014	
Report of the London Borough of Tower Hamlets	**Classification:** Unrestricted
Life and Health in Tower Hamlets – JSNA key issues	

Lead Officer	Robert McCulloch-Graham, Education Social Care and Wellbeing, LBTH
Contact Officers	Somen Banerjee – Interim Director of Public Health
Executive Key Decision?	No

Executive Summary

The presentation sets out of a summary of key health issues based on framework structured around people, place and life course (pre-birth, early years, children and young people, young adults, middle age and older age)

Recommendations:

The Health and Wellbeing Board is recommended to:

1. To note and comment on the findings and raise any areas that could be considered for future work of the JSNA reference group

1. REASONS FOR THE DECISIONS

1.1 N/A

2. ALTERNATIVE OPTIONS

2.1 N/A

3. DETAILS OF REPORT

3.1 The presentation, at a general level, highlights long standing issues of poorer health outcomes in the Borough compared to elsewhere relating to wider determinants of health (income, poverty, housing, employment), higher prevalence of risk factors for health (smoking, poor diet, low physical activity, problem drinking etc), higher levels of illness (eg heart disease, stroke, diabetes, lung disease, lung cancer) and poorer survival (eg cancer). It is a source of significant concern that Tower Hamlets has the lowest health life expectancy for women in the country and the fourth lowest for men.

The presentation also highlights the link between the JSNA findings and the Health and Wellbeing Strategy as well as emerging areas of focus for next year's work programme.

4. COMMENTS OF THE CHIEF FINANCE OFFICER

4.1. There are no financial implications arising from this report, as there are no decisions sought.

5. LEGALCOMMENTS

5.1. Section 192 of the Health and Social Care Act 2012 amended s116 of the Local Government and Public Involvement in Health Act 2007, which places a duty on the Health and Wellbeing Board to undertake a joint strategic needs assessment. The duty to prepare this plan falls on local authorities and the Clinical Commissioning Group, but must be discharged by the Health and Wellbeing Board.

5.2. In preparing this assessment, the Board must have regard to the Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies published on 26 March 2013, and can only depart from this with good reason.

5.3. The assessment must be prepared in accordance with the public sector equalities duty to eliminate unlawful conduct under the Equalities Act 2010, the need to advance equality of opportunity and the need to foster good

relations between persons who share a protected characteristic and those who do not.

6. ONE TOWER HAMLETS CONSIDERATIONS

6.1. Addresses health inequalities across the borough across all of the protected characteristics.

7. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

7.1 Includes the impact on greener spaces on the health and wellbeing of individuals in Tower Hamlets.

8. RISK MANAGEMENT IMPLICATIONS

8.1. There's a risk that identified needs in the JSNA aren't informing the Health and Wellbeing Strategy. However, these can be picked up in other Council work streams.

9. CRIME AND DISORDER REDUCTION IMPLICATIONS

9.1 N/A

10. EFFICIENCY STATEMENT

10.1 This presentation is not concerned with expenditure.

Appendices and Background Documents

Appendices

- None

Background Documents

- None

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Life and Health in Tower Hamlets

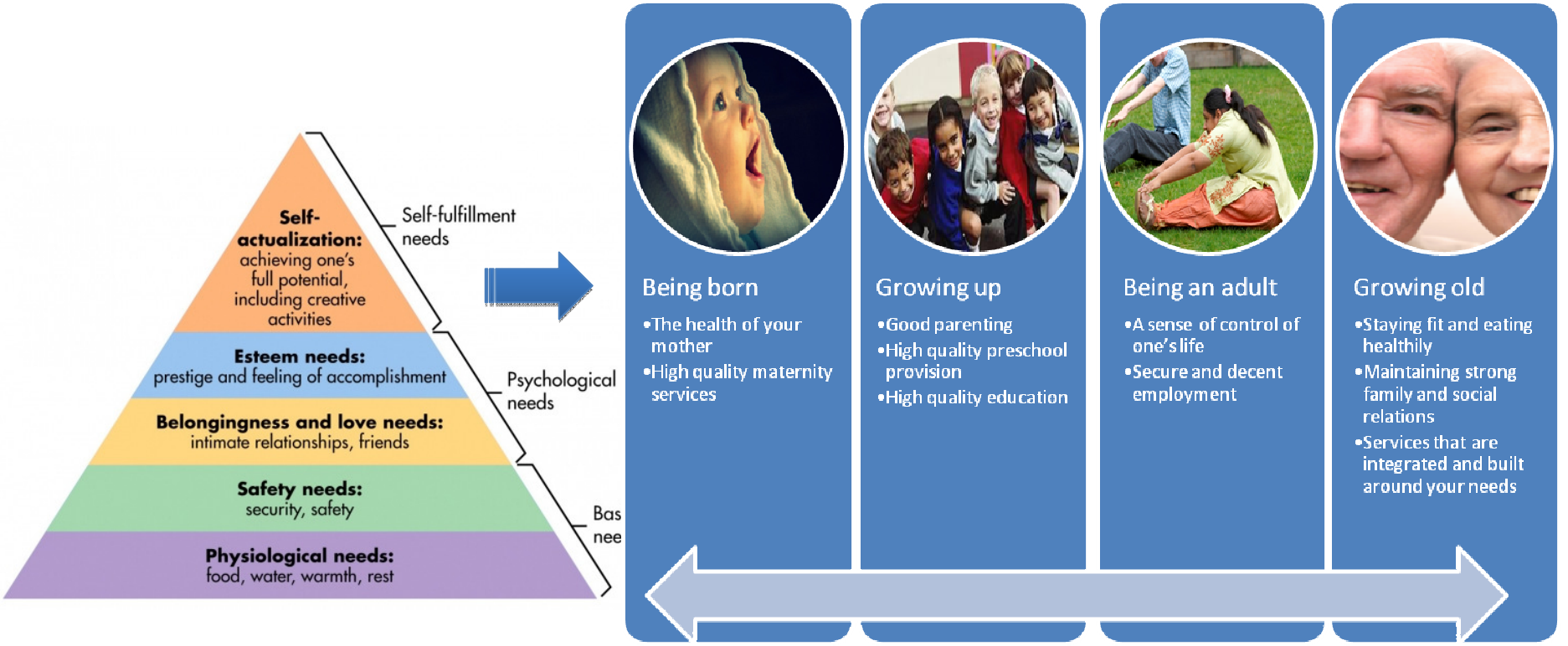
Key issues from the JSNA 2013

What is Health?

'Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity'

WHO Constitution, 1946

What makes for a healthy life?



Thanks
Nicky, Rafia, Simon, Cathy, Rakhee, Lisa, Anoushka

An income for healthy living, quality housing, an environment that supports health, strong social networks, a sense of community, living healthily, high quality services

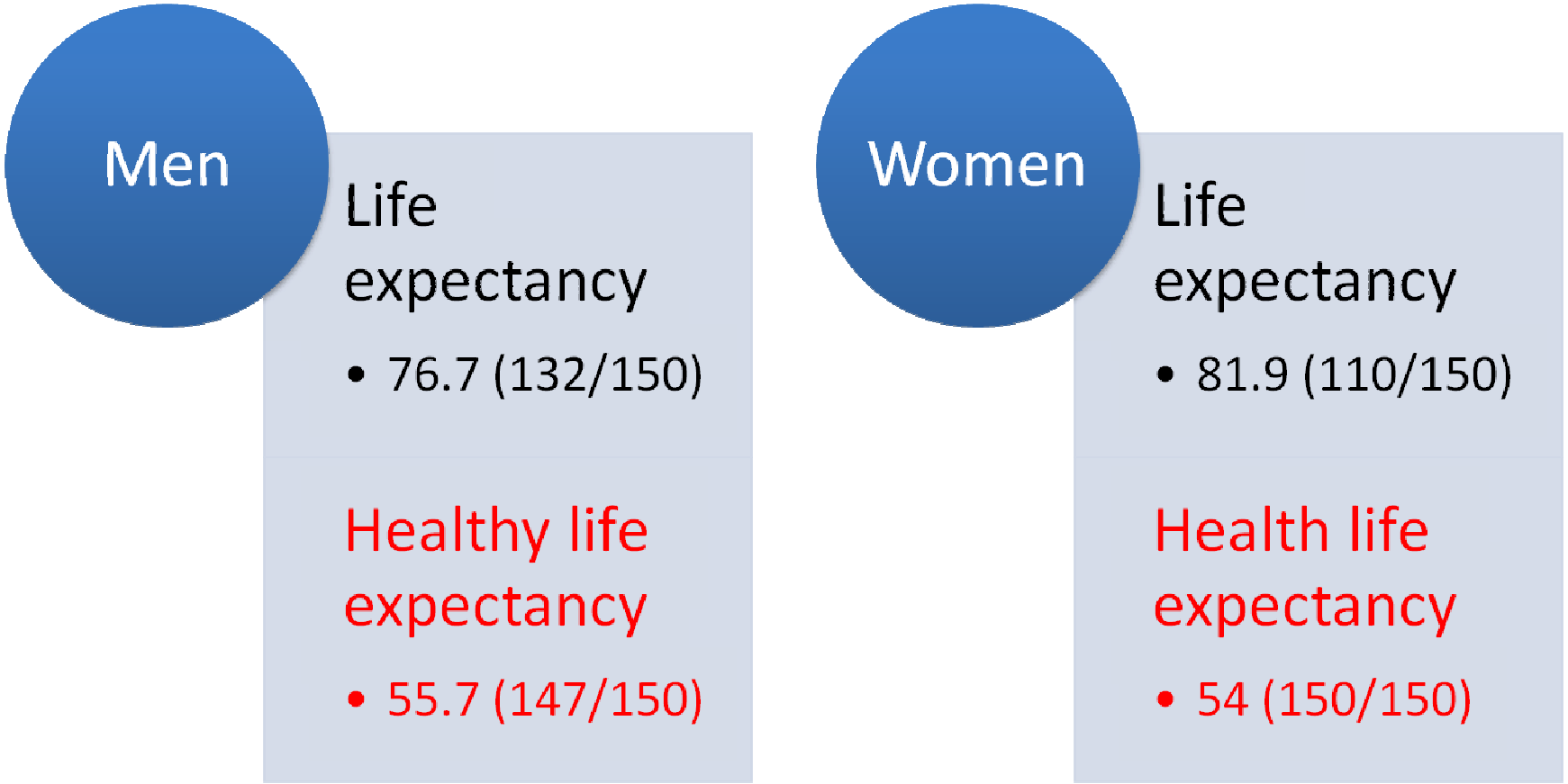
What will improve health?

- Giving every child the best possible start in life
- Enabling all to make the most of their capabilities and have control over their lives
- Creating fair employment and good work for all
- Ensuring a healthy standard of living for all
- Creating and developing healthy and sustainable places and communities
- Strengthen the role and impact of ill-health prevention

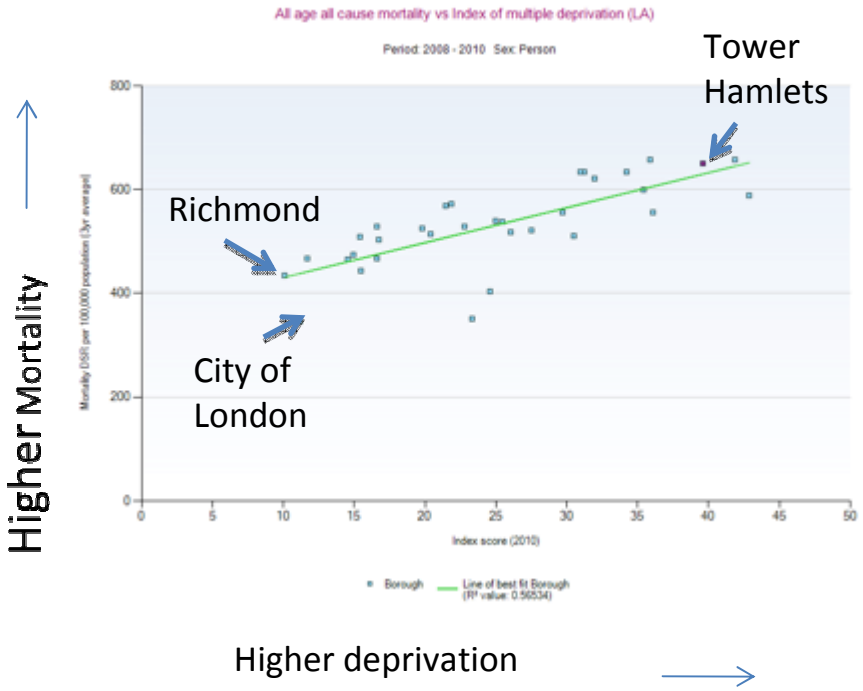
What is health like in Tower Hamlets?

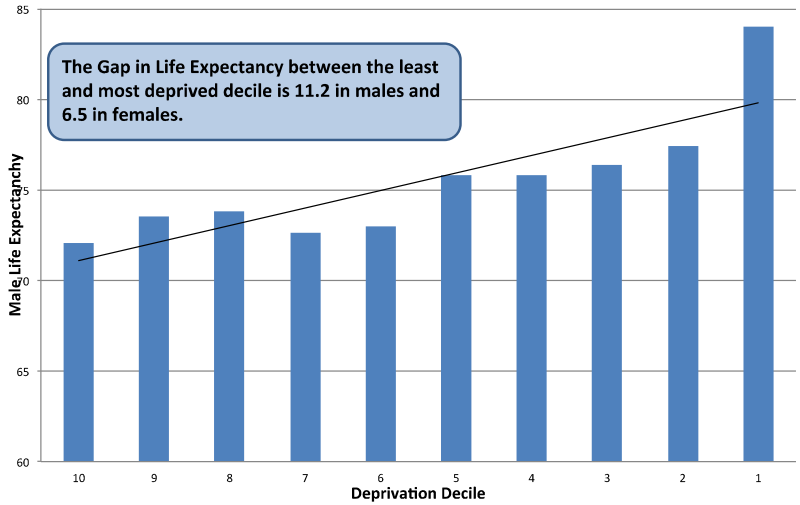
People, Place, Life

Health Headlines



Health inequalities
The accumulation of positive and negative impacts on health…….





Lower life expectancy than more affluent boroughs

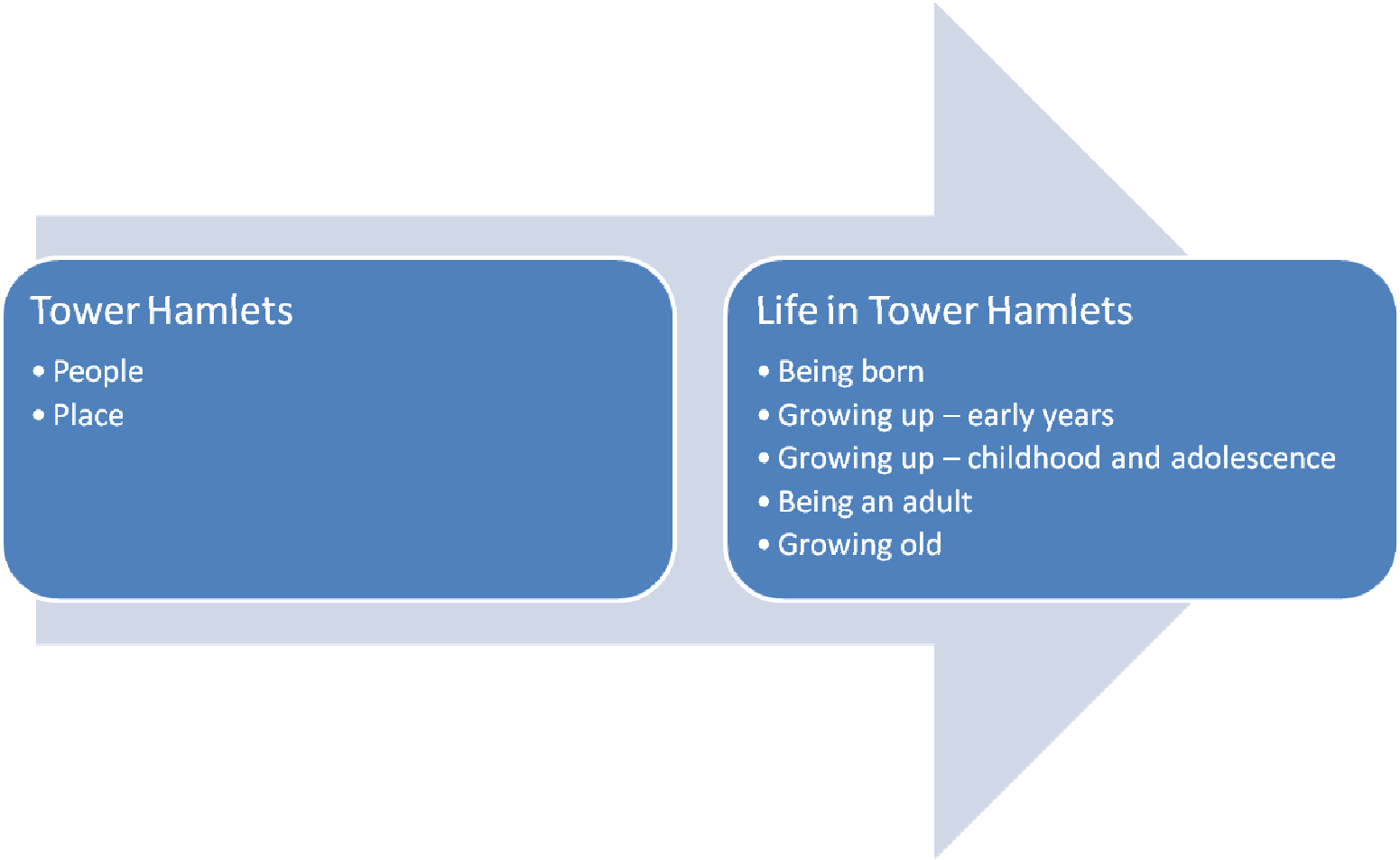
Lower life expectancy in people living in more deprived parts of the borough

Age and ethnicity breakdown
Bad health (self reported)

	Age 0 to 15	Age 16 to 49	Age 50 to 64	Age 65 +	Grand Total
Asian	**2.2**	**1.5**	**3.5**	**2.9**	**2.2**
Black	**2.0**	**1.5**	**1.6**	**1.8**	**1.6**
Mixed	**1.7**	**1.1**	**2.1**	**1.4**	**1.4**
Other Ethnic	**2.8**	**1.3**	**2.9**	**2.2**	**1.7**
White	**1.4**	**0.9**	**1.9**	**1.6**	**1.3**
Grand Total	***2.0***	***1.2***	***2.3***	***1.9***	***1.6***

This table shows how Tower Hamlets compares to England on the Census 2011 statistic of self reported 'bad or very bad health'. So, for example, the percentage of 50-64 years olds reporting bad or very bad health is 2.3x higher than England and for Asians in this age group it is 3.5x higher.

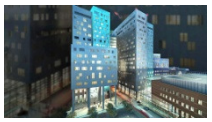
A framework for thinking about health and wellbeing…..

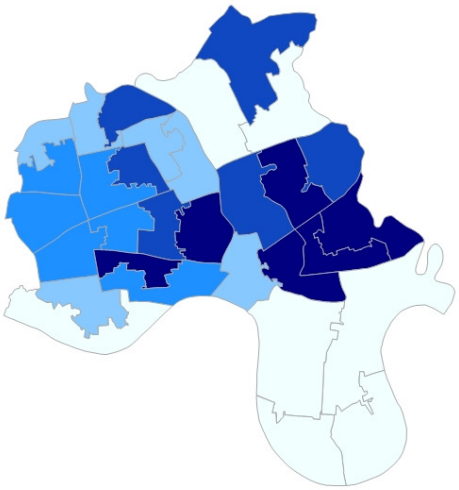


260,000 people

- Lower income, higher unemployment
  - Strong link to worse health
- Highly diverse
  - Diversity of attitudes to health
  - Disease patterns linked to ethnicity
- Population growth
  - Capacity to meet health needs

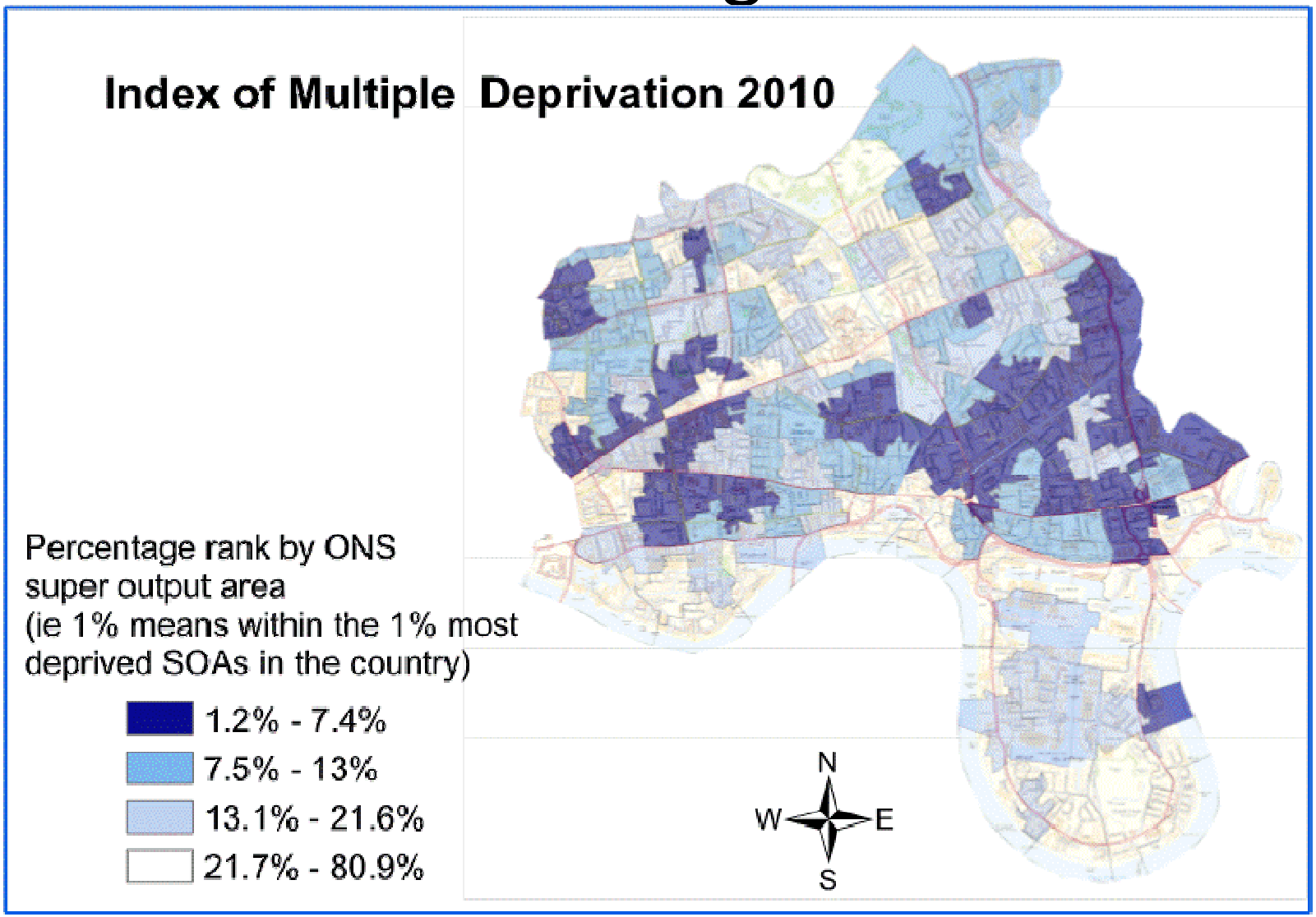
Place





- All but one of the wards most deprived nationally
  - Strong link to lower life expectancy
- Higher overcrowding
  - Child development
  - Physical and mental health impacts
- Limited green space
  - Impact on potential benefits to physical and mental health
- Limited healthy food options in parts of borough
  - Harder to maintain a healthy diet

The most deprived places in the borough



People living in the most deprived parts of the borough..

	Least deprived	Most deprived
% means tested benefits	13%	54%
% social tenure	11%	48%
% Bangladeshi	8%	44%
% 3+ children	7%	32%
% single parent households	6%	9%
% 3 generation	2%	9%
% over 65 living alone	1%	2%

Some older guys club together, do some gardening, get fitter, become friends

The Bow Geezers are a group of older men in Bow. The Geezers Gardening club, which has received a Can Do Community Grant to buy equipment and materials, has 20 members.

A group member described the benefits of the gardening club:

"It gives us the opportunity to get some healthy exercise out in the open. Gardening gives us a sense of achievement, seeing things grow that we have planted together. We share and sell the food we produce. This helps us to have affordable fruit and veg and also the money we make allows us to buy more seeds. It has brought out some hidden skills amongst our group and has given us a change to work as a team".

Being born
4500 Tower Hamlets babies a year

Jake, the first baby born in the Barkantine Birth Centre

- Mothers
  - 50% Bangladeshi
  - Teenage pregnancy now average
  - Overall less likely to be smoker at birth, but more likely if white (16%)
  - Issue of late booking much improved
- Babies
  - Higher proportion low birth weight (9% vs 7.5%)
  - Recent increase in infant mortality (under investigation)

A woman is helped to breastfeed and loves it…..

First time mother, J speaks about the support she received around breast feeding:
“My decision has always been to breastfeed my baby as I know that's the best start to life for a child. I have been exclusively breastfeeding my baby since he has been born and I still am 8 months on.

“As much as I enjoy breastfeeding and the wonderful bond it has created between me and my baby, it has not been an easy process and I have encountered many breastfeeding issues along the course. I encountered issues of latching on, breast side preference, engorgement and expressing. To help tackle my issues and continue with breastfeeding I sought help and support from the Tower Hamlets Breastfeeding Support Team.

“From the beginning, S has been my main source of support from home visits to telephone advice she has been there for me. I have also attended the breast feeding support groups which have been very helpful. I have found the support and advice from the team to be invaluable as without it, I would not be breastfeeding right now.”

Early Years
19,000 aged 0-5

Scene from John Smith's Childrens Centre in Stepney

- More likely to be born into socio economic circumstances that adversely impact on health
- By age 5
  - Less likely to have achieved good level cognitive development (50% vs 60% nationally)
  - More likely to be obese
  - More likely to have tooth decay (unexpectedly worsening)
  - More likely to be immunised

Mums (and dads) learn to feed their young families healthily…

Cook4Life (families with children 0-5yo)
The majority of participants find the course content was all useful and liked it all.

Examples of participant's comments about the course:

- *''The course I attended was great at informing us on how we can improve our health. This was a life saving course for me and my family. Now I understand what I should eat and feed my children.*

- *"I would like to do more healthy eating courses similar to this one''*

- *''I really did benefit from the course. It would be good to run more courses to involve more Mums as they are the ones who usually do the cooking for the family'' (comment from a Dad)*

- *''Really good course, I liked sitting down and discussing healthy eating. Good amount of practical and theory''*

- *''I'm offering healthier snacks and eating them in front of my daughter to set better example''*

- *''I have had a complete change. I have joined Weight Watchers, I cook everything from scratch and I am a vegetarian. For my child, I give him all homemade food and more fruit choices''*

Children and Young People
43,000 aged 5-19

- More likely to be facing socio-economic circumstances impacting on development
  - Poverty
  - Overcrowding
  - Domestic violence
- More likely to be obese (1 in 4)
- Less likely - 3hours PE/Sport?
- As elsewhere
  - Starting to smoke
  - Experimenting with alcohol and drugs
- 1 in 10 likely to have mental health disorder
- High levels of substance misuse issues for those in contact with criminal justice system (43%)
- More likely to admitted to hospital for injury

Young adulthood
131,000 aged 20-39

Tower Hamlets College
Graduation Class

- More likely to facing socioeconomic circumstances affecting health
  - Unemployment
  - Low income
  - Housing and homelessness
- More likely
  - To be at risk from or having sexually transmitted infection/HIV
  - For HIV to be undiagnosed if heterosexual transmission
  - To be facing problem drug use (and problem alcohol use in drinkers)
  - To be facing mental health problems (that may be hidden)
  - To have poor physical health if having mental health problems
  - To be accumulating risk
    - Smoking
    - Poor diet
    - Low physical activity
    - Alcohol
  - To be using emergency services (esp men aged 18-29)

A 30 year old lady finally gets out of the house, goes swimming and makes friends

Miss K, white British in her 30s, was referred to the Health Trainers by her GP. Following an accident a few years ago, she has been unable to get out of the house very much. This contributed to the onset of depression, accompanied by drinking more than she had previously and weight gain. As a consequence her confidence fell and she became reluctant with public contact.

After attending her first health trainer session Miss K felt motivated to 'do something' about her health. She took a big step by going swimming for the first time in many years with a Health Trainer and three other clients. After two months Miss K was 'full of joy' at her progress and was committed to going swimming on a regular basis with new friends from the Health Trainer group.

She said that with the help of the programme, she had lost a dress size, her clothes felt better on her, she was walking faster and further and that her confidence had improved significantly.

Middle age
53,000 aged 40-64

My Weigh programme class, Social Action for Health

- More likely to facing socioeconomic circumstances affecting health and more likely for health conditions to be affecting circumstances
- More likely to
  - Be a smoker (esp if Bangladeshi male)
  - Have lower levels of physical activity
  - Be eating a healthy diet
  - Be at risk of problem drinking
- More likely to at risk of or having a long term conditions
  - Diabetes (esp in South Asian population)
  - Cardiovascular disease
  - Long term lung disease
  - Liver disease
  - Tuberculosis (esp if Banglahdeshi)
  - Mental Health problems (and poorer physical health)
- More likely to developing lung cancer
- Less likely to be accessing cancer screening services
  - Breast
  - Cervical
- More likely to be receiving primary care services delivering effective control of risk factors for cardiovascular disease (best outcomes in the country)
- More likely to present late with disease

Older age
16,000 aged 65+

Scene from Linkage Plus Community Centre

- More likely to be facing socioeconomic circumstances affecting health
  - Social isolation
  - Housing
  - Low income
- Less likely to be disability free in old age
- Less likely to living a healthy life (although health benefits of stopping smoking, good diet and physical continue in later life)
- Likely to be living with more than one chronic condition
  - 40% of those with chronic condition have at least another two conditions
- More likely to be developing some of the diseases of older age
  - Stroke
  - Colorectal and stomach cancer
- More likely to die of cancer once diagnosed
  - Late diagnosis
  - Link with deprivation
- More likely than not that dementia is undiagnosed
- Likely to not die in one's place of choice

An older lady gets her flat fixed and finally feels safe, meets friends, has dinner and enjoys the odd game of bingo…..

As a result of the work done by the handyperson, Mrs B feels a lot more secure in her flat. She now gets out more than she did when she first moved into her flat, and she looks forward to going to the LinkAge Plus hub each week:

"Oh I really look forward to tomorrow [Friday when she goes to hub]… we have a lovely 3-course dinner there… being transported I've got to know these other women and we see the same ones each week. So we meet each other, like I say we have a lovely dinner. I can't praise them enough.

She does wonderful work, she really does [the outreach worker]... all of them. And then maybe one day we might play a bit of bingo, or they do exercises. Which I should do! I mainly sit down and do them... I try, yeah."

Link between HWBS priorities and JSNA

Some emerging areas of JSNA focus for 14/15 work programme

- Wider determinants
  - Health and housing
  - Welfare reforms and health (as part of existing welfare reforms work)
  - Mental health and employment
  - Isolation
- Healthy lives
  - Qualitative understanding of attitudes and barriers to healthy lives across life course
- Population groups
  - Carers
- Disease areas
  - Liver disease
  - Comorbidities

Thank You!

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Health and Wellbeing Board 6th February 2014	Tower Hamlets Health and Wellbeing Board
Report of the London Borough of Tower Hamlets	**Classification:** Unrestricted
Better Care Fund Planning Template	

Lead Officer	Robert McCulloch-Graham, Corporate Director Education, Social Care and Wellbeing
Contact Officers	Deborah Cohen, Service Head (Commissioning and Health), Education, Social Care and Wellbeing
Executive Key Decision?	No

Executive Summary

In the 2013 Spending Round, the Government announced a national £3.8 billion pooled budget for health and social care services, building on the current NHS transfer to social care services of £1 billion. The Spending Round stated that 'the Government will introduce a £3.8 billion pooled budget for health and social care services, shared between the NHS and local authorities, to deliver better outcomes and greater efficiencies through more integrated services for older and disabled people'.

Local Authorities and Clinical Commissioning Groups (CCGs) are required to Submit a jointly agreed DRAFT Better Care Fund Planning Template to the Local Government Association (LGA) and NHS England by 14 February 2014. This is an externally imposed deadline. The FINAL Better Care Fund Planning Template must be submitted by 4th April 2014. NHS England guidance states that both of these templates need to be agreed and authorised by Health and Wellbeing Boards.

This report is the DRAFT Better Care Fund Planning Template. Due to being a DRAFT there are a number of areas which are still in development. Key areas of the Template that are still being developed are:

- Finance: Finance sections will be developed during the interim period between 14th February 2014 and 4th April 2014 after wider consultation with Health and Wellbeing Board Members, Partners and wider stakeholders.

- Finance: The current finance data is provisional and will be finalised for the FINAL Better Care Fund Planning Template which will be agreed and authorised by the Health and Wellbeing Board at the Board meeting on 24th March 2014.

- Finance: Allocations to the Better Care Fund are composed of NHS Funding, Carers' Breaks funding, Reablement funding, Capital Funding and transfer funds

from health to social care (S256 monies). Further detail of allocations will be provided to the Health and Wellbeing Board at the Board meeting on 24th March 2014.

- Outcomes and Metrics: DRAFT Outcomes and Metrics have been included in the Template with FINAL baseline and performance data currently being developed.

- Documents: Supporting Documents will be supplied for the FINAL Better are Fund Planning Template.

Recommendations:

The Health and Wellbeing Board is recommended to:

1. AGREE: The DRAFT Better Care Fund Planning Template be submitted to the LGA and NHS England

1. REASONS FOR THE DECISIONS

1.1 The Department of Health require for all Health and Wellbeing Boards to Agree and Authorise a Draft Better Care Fund Planning Template by 14th February 2014 before submission to LGA and NHS England.

2. ALTERNATIVE OPTIONS

2.1 N/A

3. DETAILS OF REPORT

3.1 The attached report is the DRAFT Tower Hamlets Better Care Fund Planning Template which the Health and Wellbeing Board is required to approve and submit to NHS England / Local Government Association by 14th February 2014. The Better Care Fund allocation for 2014/2015 totals £18.681m and for 2015/16 totals £20.367m. The proposed allocation of the Fund is detailed in section 5 of the plan template 'Finance'.

3.2 This report is the DRAFT Better Care Fund Planning Template. Due to being a DRAFT there are a number of areas which are still in development. Key areas of the Template that are still being developed are:

- Finance: Finance sections will be developed during the interim period between 14th February 2014 and 4th April 2014 after wider consultation

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- Outcomes and Metrics: DRAFT Outcomes and Metrics have been included in the Template with FINAL baseline and performance data currently being developed.

3.3 In the 2013 Spending Round, the Government announced a national £3.8 billion pooled budget for health and social care services, building on thecurrent NHS transfer to social care services of £1 billion. The SpendingRound document stated that 'the Government will introduce a £3.8 billion pooled budget for health and social care services, shared between the NHSand local authorities, to deliver better outcomes and greater efficienciesthrough more integrated services for older and disabled people'.

3.4 Local Authorities and Clinical Commissioning Groups (CCGs) are required to Submit a jointly agreed DRAFTBetter Care Fund Planning Template to the Local Government Association (LGA) and NHSEngland by 14 February 2014. This is an externally imposed deadline. The FINAL Better Care Fund Planning Template must be submitted by 4th April 2014. NHS England guidance states that both of these templates need to be agreed and authorised by Health and Wellbeing Boards.

3.5 The Better Care Fund has been initiated by government to promote a greater level of cooperation, joint planning and integrated delivery of health and social care. The reconfiguration and redesign of health and social care services is central to the intentions inherent in the Health and Social Care Act and the Care Bill. Funding mechanisms are likely to become increasingly combined into pooled arrangements, underpinned by integrated working and focused on improving health and wellbeing, supporting more people in community based settings and services and reducing demand on acute care.

3.6 The Better Care Fund provides an opportunity to transform care so that people are provided with better integrated care and support. It encompasses a substantial level of funding and it will help deal with demographic pressures in the health and social care system. The Better Care Fund is an opportunity to take the integration agenda forward at scale and pace, building on the WELC integrated care programme, and successful bid to become a "Pioneer"

4. COMMENTS OF THE CHIEF FINANCE OFFICER

4.1. The Better Care Fund is worth £3.8 billion nationally. Tower Hamlets share of this has been confirmed as £18.681m for 2014/15 and £20.367m for 2015/16.

4.2. The attached report is the DRAFT Tower Hamlets Better Care Fund Planning Template which the Health and Wellbeing Board is required to approve and submit to NHS England / Local Government Association by 14th February 2014.

4.3. The proposed use of the Tower Hamlets share, as agreed by the Local Authority and the CCG, is detailed in section 5 of the plan template 'Finance'.However, this current finance data is provisional and will be finalised for the FINAL Better Care Fund Planning Template which will be agreed and authorised by the Health and Wellbeing Board at the Board meeting on 24th March 2014.

4.4. Approval of these draft plans by the Health and Wellbeing board are necessary to progress through the planning stages to secure the allocated funding via NHS England.

4.5. It is worth noting that this fund is derived from pooling a number of existing funding steams which are currently committed on a number of existing health and social care services. These draft plans take into consideration the future shape and commitment on those services within the parameters of the better care fund objectives.

5. LEGAL COMMENTS

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

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

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

5.4. The Better Care Fund is being developed as part of the integrated care strategy within the overarching framework of the Tower Hamlets Health and Wellbeing Strategy.

6. ONE TOWER HAMLETS CONSIDERATIONS

6.1. The development of the Better Care Fund is predicated on the findings of the Tower Hamlets Joint Strategic Needs Assessment. As such, the key objectives of the Better Care Fund are to address the issues of wider determinants of health, the high prevalence of risk factors for health locally, and poorer survival of long term conditions.

6.2. One of the key aims of the Better Care Fund is to improve health outcomes for the some of the most vulnerable patients and service users in Tower Hamlets. This is highlighted in the 'Risk Stratification' of patients/service users in the Planning Template.

7. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

7.1 N/A

8. RISK MANAGEMENT IMPLICATIONS

8.1. There are 6 important risk areas highlighted within this report and with a list of mitigation measures in place.

9. CRIME AND DISORDER REDUCTION IMPLICATIONS

9.1 N/A

10. EFFICIENCY STATEMENT

This submission document identifies effective use of the pooled income in the provision of social care services with health benefits.

Appendices and Background Documents

Appendices

NONE

Background Documents

NONE

Officer contact details for background documents:

NONE

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DRAFT Better Care Fund planningtemplate – Part 1

Please note, there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission.

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**London Borough of Tower Hamlets**
Clinical Commissioning Groups	**Tower Hamlets CCG**
Boundary Differences	**<Identify any differences between LA and CCG boundaries and how these have been addressed in the plan>**
Date agreed at Health and Well-Being Board:	**<dd/mm/yyyy>**
Date submitted:	**<dd/mm/yyyy>**
Minimum required value of ITF pooled budget: 2014/15 (	**£1.2m**
2015/16	**£20.367m**
Total agreed value of pooled budget: 2014/15	**£18.681m**
2015/16	**£20.367m**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	<Name of ccg>
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

<Insert extra rows for additional CCGs as required>

Signed on behalf of the Council	<Name of council>
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

<Insert extra rows for additional Councils as required>

Signed on behalf of the Health and Wellbeing Board	<Name of HWB>
By Chair of Health and Wellbeing Board	<Name of Signatory>
Date	<date>

<Insert extra rows for additional Health and Wellbeing Boards as required>

c) Service provider engagement
Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

The CCG and local authority are committed to engaging with all our providers, across the statutory and independent sectors. Both of our local Trusts and the Tower Hamlets Voluntary Community Sector (THCVS) are members of the Health and Wellbeing Board (HWB B) and are fully engaged in the business of the Board including the development of this plan.

All members of the Board are signed up to the Tower Hamlets Health and Wellbeing Strategy. This has four priority areas, which are to be delivered by a set of "enablers" – these are the ways of working and things we need to do to implement the Strategy. There are six enablers, three of which are relevant to this section of the BCF plan:

- **Community engagement and co-production** – a local "out in the community" approach to identifying priorities to improve health and wellbeing and to designing interventions;
- **Integrated care** – bringing different providers together to deliver joined up holistic packages of care; and
- **Commissioning with commitment** – developing a plurality of provision of health, social care, and wellbeing services through the development of local providers and services

The Health & Wellbeing Board has an Engagement & Co-production sub group (see section (d) below).

In addition to this subgroup, the CCG and Local Authority, the commissioners on the HWB Board, each have their own engagement mechanisms to work with both the statutory and the independent/ voluntary sectors. Both the CCG and Local Authority have contracts for a range of services with many third sector organisations and they contribute to the THCVS' Health & Wellbeing Forum where the plans for integrated care have been taken. There are also two representatives from THCVS who sit on the Integrated Care Board in Tower Hamlets.

The Local Authority "Local Account" of performance for adult social care is an annual publication that has tracked developments in how social care works with the Health

Service locally. This is circulated to all local providers. The Council holds regular forums for Adult Social Care providers where providers are informed about key issues and proposed changes. They are a forum for consultations and communication about integrated care plans. Key Council publications for current and potential providers are the Market Position Statement and the Commissioning Plan (current plan covers the period 2012 – 2015). These documents are part of a continuing dialogue with providers. Both of these documents are in the process of being updated and the next editions will reflect changes related to the Better Care Fund.

The Tower Hamlets 2013/16 Prospectus, published in May 2013, sets out the CCG's commitment to work with all providers of health and care based services locally – with specific reference to commissioning services that are arranged around individual people, with the flexibility to be personalised as much as possible. The prospectus highlights the aim of commissioning services that act together seamlessly through adopting an approach that involves a collaborative approach with different commissioners and providers through partnership working. We will build on past successes of integrated services for older people, which has required much closer working between commissioners and providers (CCG, Local Authority, GPs, community health services and social care) and has seen a significant improvement in management of long term conditions, most notably in diabetic care.

A key channel of communication and engagement for the CCG with primary care providers is through the 8 local primary care networks. In each locality, members of practices local to that area meet regularly and the agendas of these groups have started to include integrated care, considering the role of GPs, and the interface of primary care with the new community health teams. Primary care provider involvement in developing the integrated care system in Tower Hamlets includes:

- Briefings and workshops at Clinical Leads, Network, and Locality meetings about the design of integrated care interventions, ensuring primary care is a"co-producer" of service redesign. Organisational development activities, including an event with a speaker from the Nuffield Trust to talk about different primary care provider models.
- Facilitation of a borough wide Task & Finish Group of clinical and managerial primary care representatives from across the 8 local networks to determine the role of primary care in the strategic management of integrated care service provision.
- The development of a single body at borough level for clinical and managerial primary care representatives to represent and support primary care to play its part in the delivery model of integrated care.
- Facilitation of and support for primary care involvement in the senior provider group.

The Council has commissioned a local organisation, using s256 funding, to undertake a range of engagement and peer research activity (SUPeR Group) over the next 2 years. Areas they have been commissioned to work on include: the experience of the ***discharge process from hospital to home,*** identifying issues related to delays in the discharge process, an in depth piece of work on the experience of stroke patients, and ways of engaging people with dementia in residential and nursing care homes.

d) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

As stated above patient, service user and public engagement are built into the Health and Wellbeing Strategy. The compilation of the Strategy itself has been underpinned by significant engagement with the local community.

National Voices "work directly with some patients, service users, carers and their families", in order to improve care. They are committed to ensuring that there is a patient voice in the decisions made in health-care, and provide patient leadership training, amongst other programmes, as a way of achieving this. In 2013, they published work commissioned by NHS England to provide a narrative for person-centred coordinated care.

Engagement on our Strategy

The Tower Hamlets Health and Wellbeing Strategy has an Engagement & Co-production sub groupwhose remit is stakeholder communications and engagement. This group is led jointly by the local authority, CCG and Healthwatch. It aims to explore ways to deliver services in an "equal and reciprocal relationship between professionals, people using services, their families and their neighbours" (NEF & NESTA). In doing this, its ultimate aim is to engage patients fully at every stage of their care. This sub-group will be used to inform the development of the Better Care Fund. Part of this work will be to steer the engagement plan and to build on an initial public event held by the CCG in October on integrated care.

In addition, the Tower Hamlets 2013/16 Prospectus, referred to in the section above, sets out the plans for integrated care. Tower Hamlets CCG is also using its website and internet content to disseminate information about Integrated Care. The Tower Hamlets CCG website is easy to navigate, is interactive, and is starting to embrace the use of videos and YouTube. One such video, on Integrated Care is available at: http://www.youtube.com/watch?v=rqAz8x3m0lM. This kind of communication makes it easy for patients to engage with the CCG's plans.

The Local Authority undertakes annual Service User surveys that give insight over time into service users' experiences of social care services (see also Outcomes and Metrics). There are plans nationally to revise some of the questions to include health interface questions, but as an interim measure locally a question has been added into the 2014 survey to test how people experience joined up care and support. Furthermore, the next national Carers survey, which is completed every 2 years, is due in autumn 2014. Data from these surveys will help to provide the HWB Board with feedback on the changes being made in 2013-14 for building into service redesign plans. More widely, the Local Account captures all findings from the past year's adult social care engagement activity. This provides an analysis of performance in regards to service user satisfaction in comparison to previous years.

Engagement in the delivery of services (co-production)

Both the CCG and Council have identified funding for the delivery of discovery interviewing techniques and it is intended to use this to gather feedback and involve users and their carers, in the development of the integrated care services. The Council has a rewards and recognition policy under which it can make payments to service users where appropriate.

The Local Authority and CCG jointly fund the Tower Hamlets LinkAge plus network of services for older adults across the Borough. This provides a network of older people with whom the partnership can test out ideas and plans for integrated care.

Building on that work, the CCG has conducted a range of initiatives involving patients in developing Integrated Care in Tower Hamlets including Integrated Care "conversations" alongside voluntary sector patient groups. The first one to take place was run conjunction with the *Tower Project*, which works with children, young people and adults with disabilities. 10 participants, predominantly carers, provided feedback and engagement on plans to Integrate Care. Further similar conversations are due to take place with patients, service users, carers or other stakeholders involved with organisations including Toynbee Hall, which works with deprived communities to reduce poverty and disadvantage, and Age UK, which helps and supports the elderly.

We have recently recruited a local voluntary sector organisation Urban Inclusion, working in conjunction with HealthWatch to carry out "a patient and carer-based evaluation of our "Integrated Care" programme." The aim of this evaluation is to understand "the experiences of and feedback from users of the new service, evaluating their first six months of using it" including:

- Experiences of services before the changes
- Feedback about how easy the new services are to use, navigate and how the service feel to use e.g. did people feel they were treated as partners in their care, did they feel cared for.
- How peoples' health has changed since using the new services, and how their perceptions of their health and ability to manage their health has changed.
- Ideas for improvements and new designs to the Integrated Care programme.
- This user-based evaluation will be used to tailor and improve the Integrated Care programme to the needs of the people who use it.

Related documentation
Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
Tower Hamlets Health and Wellbeing Board Strategy 2013 - 16:	
Tower Hamlets Joint Strategic Needs Assessment	
Tower Hamlets CCG Patient and Public Involvement Strategy 2013/14:	
Action points from the December Integrated Care Board meeting – including discussion and actions for care coordination & rapid response:	
Care Co-ordination Workstream -on-going developments. From the December Integrated Care Board meeting:	
National Voices narrative slide-pack on 'coordinated care'	National Voices narrative slide-pack on 'coordinated care'
Feedback from the Tower Project patient user group engagement event:	
Websites for: The Tower Project, Toynbee Hall and Age UK.	The Tower Project - website Toynbee Hall - website Age UK - website
Write up of the 2013 Health Conversation – Patient and public engagement event, Whitechapel Idea Store, 19 October 2013:	
Tower Hamlets CCG 2013/16 Prospectus:	Tower Hamlets CCG 2013/16 Prospectus *See pp11 – 12 for Patient and public involvement, and pp30 – 33 for Integrated Care*
Integrated Care programme - patient and carer evaluation: Project specification:	
Understanding co-production	
See 3) National Conditions; a) Protecting social services	
See 3) National Conditions; c) Data sharing	

2) VISION AND SCHEMES

1. Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

The development of our integrated care strategy is within the overarching strategic framework in the Health and Wellbeing Strategy with the aims to

- Improve health and wellbeing throughout all stages of life
- Reduce health inequalities; and
- Promote independence, choice and control

Our Vision

Our vision for health and care services[1] is of an integrated care system that coordinates care around the patient and delivers care in the most appropriate setting. That services:

- Empower patients, users and their carers
- Provide more responsive, coordinated and proactive care, including data sharing information between providers to enhance the quality of care
- Ensure consistency and efficiency of care

Case for Change

The Tower Hamlets Joint Strategic Needs Assessment highlights long standing issues of poorer health outcomes in the Borough compared to elsewhere relating to wider determinants of health (income, poverty, housing, employment), higher prevalence of risk factors for health (smoking, poor diet, low physical activity, problem drinking etc), higher levels of illness (eg heart disease, stroke, diabetes, lung disease, lung cancer) and poorer survival (eg cancer). As a result of these population health characteristics a preventative approach is taken locally to reduce the prevalence of long term conditions in the population, and promote better management of long term conditions where they exist. As well as the burden of ill health, this also places additional pressure on the health and social care system, where too often, hospital care is the fall back position.

Our strategic objectives to achieve this vision over the next 5 years are set out below:

(a) Delivery of the Tower Hamlets Integrated Care Programme

The new model of Integrated Care will be targeted at the top 20% of patients in Tower Hamlets, who account for around 85% of total acute activity and 75% of acute spend

Interventions will be delivered via integrated multidisciplinary teams coordinated around GP practice networks and localities. This will build on the well established locality and

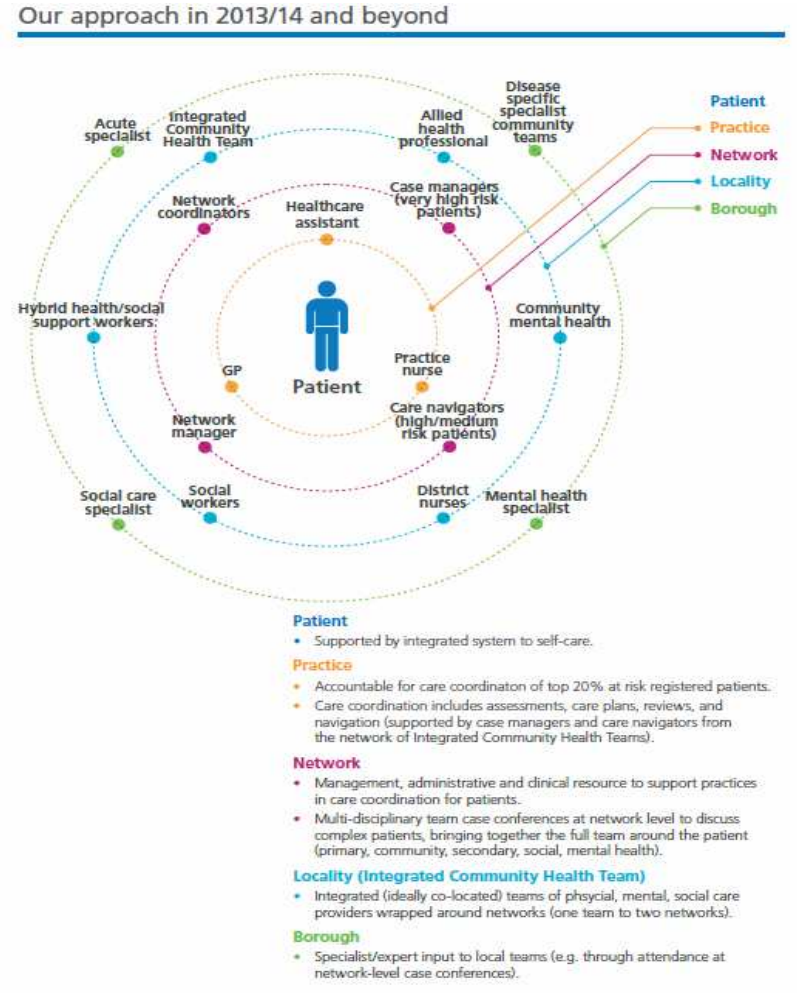
[1]Implementing Integrated Care across Tower Hamlets, East London and City April 2013

GP network that exists in Tower Hamlets.

The programme will have two dimensions:

- The redesign of the model of services and care pathways including the development of an "integrator function" that will hold the whole system of services together to operate in a joined up way; and
- The joint commissioning of services ensuring where appropriate the contestability of services. Services will be commissioned in such a way as to ensure that there is the flexibility for services to be personalised as much as possible. The "whole system" will be commissioned so that services can work together seamlessly.

For more information see 'description of planned changes'



(b) WELC Pioneer

The case for change has been developed across the three boroughs of Waltham Forest, Tower Hamlets and Newham who in October became the "WELC Integrated Care Pioneer". Each borough within the programme has its own integrated board reporting to the local HWB Board ensuring the inclusion of local factors within each borough's plans. However there are many benefits for working at scale in terms of development of enablers (for example information sharing and governance, workforce development programmes etc).

(c) Personalisation

It is a fundamental part of our vision that care and support are personalisedto patients' and service users' needs and preferences, and this wil be a core part of the work under the BCF. More specifically, 2014-15 will see the introduction of Personal Health Budgets for Continuing Care, and then for all Long Term Conditions from 2015. These will be built into the new models of care with detailed financial modelling being developed within phase 2 of the programme.

Commissioning Innovation

We recognise that we cannot deliver the changes and improvements we seek by doing things the way they have been done in the past. We see the providers of care for our population to be:

- Focused on outcomes, not inputs and outputs
- Put user involvement and experience at the heart of what they do
- Work together to coordinate their services around individuals needs
- Work together to share risk and reward, and break down traditional barriers between health, social care, and the voluntary sector.

In order to deliver this, we will be commissioning an 'Integration Function' in which all providers will be compelled to participate in order to be commissioned for Integrated Care. See 'description of planned changes' for more information.

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

Aims and objectives of the integrated system

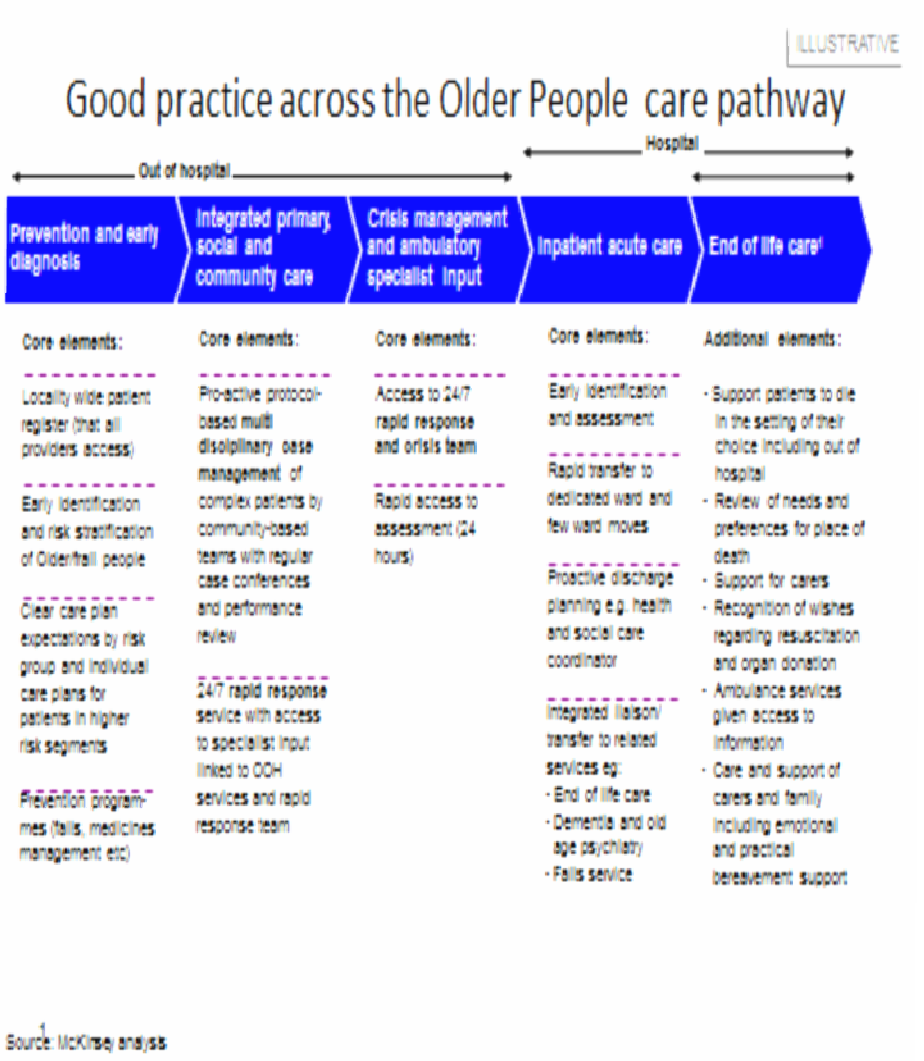
Our vision for the new system is based on three aims with a set of objectives/desired outcomes for the new system as follows:

1. **Empower patients, users and their carers**
   - Enable patients and service users to live independently and remain socially active
   - Establish education and self-care programmes for patients
   - Personalise care to patients' and service users' needs and preferences

2. **Provide more responsive, coordinated and proactive care**
   - Proactively manage patient's health and improve their outcomes
   - Enable high-quality care that responds to patient/service user needs rapidly in crisis situations
   - Provide more care in the community or at home
   - Prevent avoidable admissions
   - Leverage tools and technology to deliver timely and better quality of care

3. **Ensure consistency and efficiency of care**
   - Deliver the best possible care at minimum necessary costs
   - Avoid duplication of effort in situations where patient is seen by multiple health and social care providers
   - Ensure most effective possible use of clinical time and resources

The diagram below sets out pictorially the vision of how the pathway for Older People will work.



Measurement of aims and objectives

The new integrated service model will be composed of three tiers which will provide a structure to measure the system's aims and objectives:

Tier 1 – Commissioner Level: The Better Care Fund and Key Performance Indicators. The Metrics used by the BCF will be reported to the Health and Wellbeing Board (as commissioner of the BCF) on a regular basis.

Tier 2 – System Management: 'The Integration Function'. The Integration Function will have five key aspects/functions: Governance, Outcomes, Care Plans, Single point of access and communication and information sharing. The outcomes function will be comprised of a dashboard that describes the desired outcomes of individual integrated care services lines and will be used by both providers and commissioners. This will be used to measure the aims and objectives across the whole system.

Tier 3 – Service Delivery: . All Teams that come under the 'Integration Function' (such as Community Health Teams) will have built into their operational policies and team plans the objectives, activities and milestones. These will be fed up to Tier 2.

Measuring health gain of population

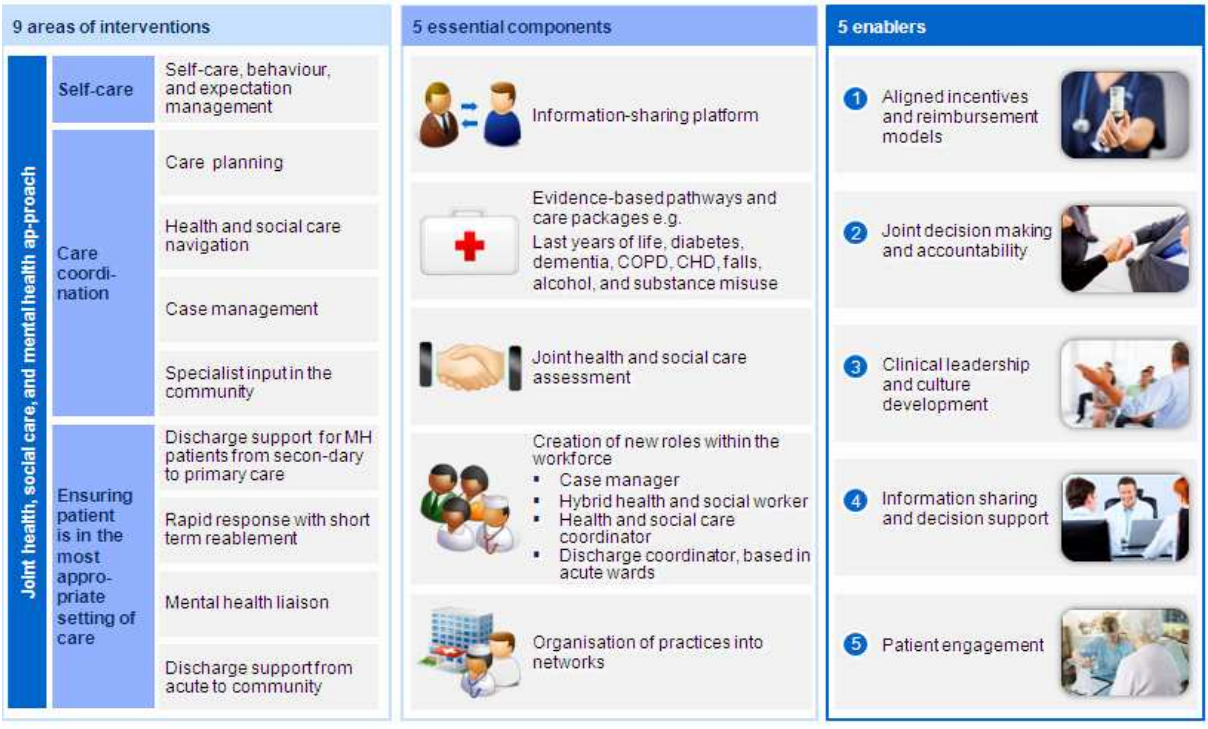
The Tower Hamlets Health and Wellbeing Strategy is composed of four priority areas, which in turn have four Action Plans. These Action Plans cover Maternity Early Years, Healthy Lives, Mental Health and Long Term Conditions and Cancer. Collectively with the outcomes in the three national outcomes frameworks, they provide the Health and Wellbeing Board with a comprehensive measurement of the health of the population over a four year period 2013 – 2016. See Tower Hamlets Health and Wellbeing Strategy in related documentation for further detail.

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

The Integrated Care Programme in Tower Hamlets is based on 9 key interventions, 5 essential components and 5 enablers as shown in the diagram below.



This model of care has been adapted from international best practice and evidence. The

result is a suite of standard interventions that broadly cover supported discharge, care planning and coordination, and mental health liaison and Rapid, Assessment, Interface and Discharge (RAID).

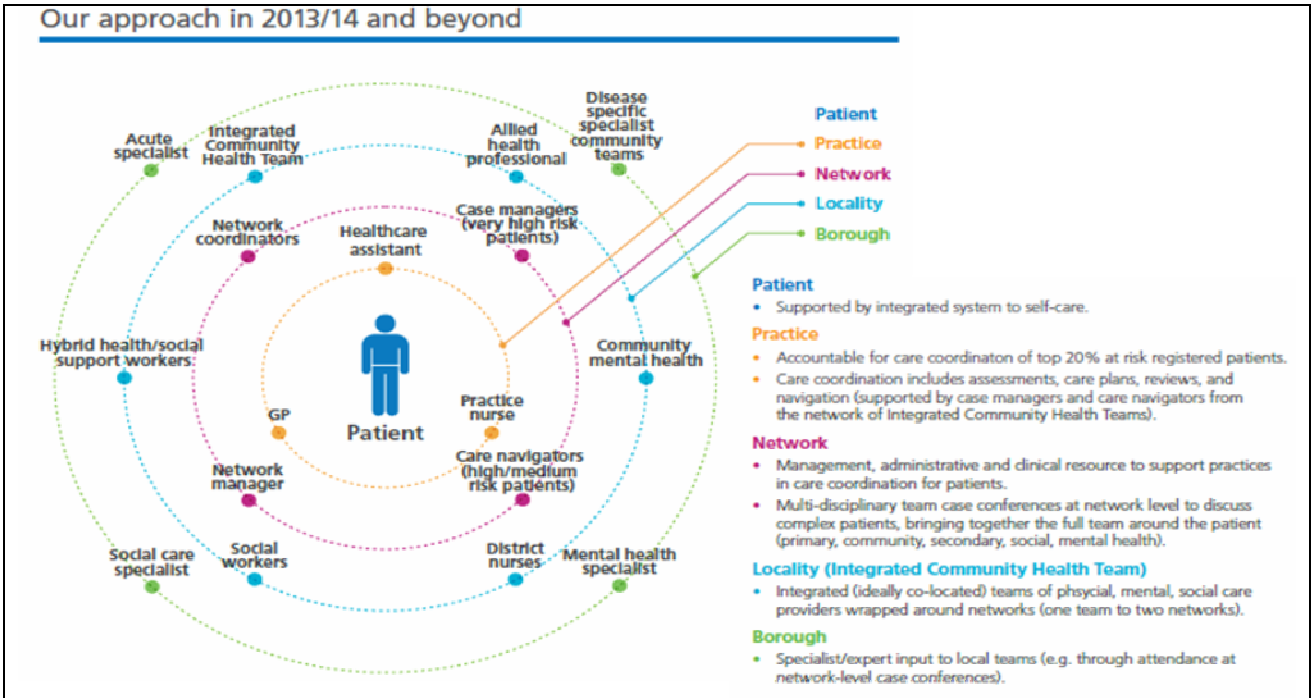
In the first two years, planned changes will revolve around the topics of risk stratification, care coordination, rapid response, discharge support, mental health liaison. In years 2 – 5 the focus will move to increasing input from the voluntary sector, self-management/ care, and assistive technology. Alongside these changes, will be the introduction of personal health budgets. The work to bring together different components of the health systems across primary, community and secondary services is already underway with the work to incorporate social care following during 14-15. It is expected that by the end of 15-16 there will be alignment of health and social care services for the target population for integrated care.

Risk Stratification

Some patients have a higher risk of requiring an emergency admission following a crisis than others, and certain characteristics can be indicative of that risk. Therefore we can stratify patients into categories of risk. Information used to identify this risk includes age, their previous acute admissions, and the existing long-term conditions. Because of the high and growing number of people in the borough with one or more long-term conditions, stratifying the risk of patients in order to focus on those with the highest risk of admission is increasingly important. Our risk stratification has identified the following split of our registered population into the following categories:

Risk factor	**National average - percentage**	**Total**
Very high risk	0.5%	1,662
High risk	4.5%	11,871
Moderate risk	15%	23,600
(Total TH population)	-	261,536
(Total TH population that are very high – moderate risk)	-	37,133

For 2014/15 and 2015/16 the model of care we will be introducing will focus on the Very High and High risk patients groups. The model of care is summarised in the diagram below



Self-care:

Using extensive evidence on the effectiveness of interventions for the self-management of long-term conditions, compiled predominantly at Queen Mary's University, both the CCG and the local authority will be looking to commission interventions that teach patients/ local residents how to manage their conditions. This could involve managing the symptoms to reduce their impact, or adjusting psychologically to life-style changes that living with the condition require. Some of the interventions also involve other people as well as the sufferer, including friends, family, and colleagues.

Where effective, these can have a range of different effects, from reducing the number of admissions and check-ups, to a greater degree of mental wellbeing for the patient. It should free-up both patients and services, and certainly links with the vision of integrated care making patients' care more smooth and reliable by putting control into their hands.

The evidence also presents cases where interventions have not proved successful, have shown some signs of success, or related issues that require more research. All of these could become helpful to implementing integrated care by influencing commissioning choices; either commissioning or decommissioning services or interventions, and by influencing further research.

The planned changes in self-care are also relevant to voluntary sector input, as in some cases; it is voluntary sector organisations that provide the interventions enabling patients to self-manage their conditions.

Care coordination: provided by general practice and an Integrated Community Health Teamthis comprises:

- **Care planning** - joint health and social care assessment.
- **Health and social care navigation** - Administrative support to ensure patients are receiving the correct services. Also provides a 'one stop shop' for questions about

their care plan..

- **Case management** - Deliver care and perform detailed review of a patient's case and condition by GPs, case manager, or MDTs.
- **Specialist input in the community**

Rapid response

The rapid response team will be responsible for providing community based urgent assistance predominantly in patient's own homes in response to acute episodes. The rapid response service will be available for patients, clinicians and care navigators to call on during extended working hours to provide advice and attend the patient as necessary to wherever possible remove the need to call on other emergency care provision, and work with primary and social care.

Discharge support: provided by the acute trust, community health services and social care, this includes

The development of clear discharge procedures, and to build on the opportunities brought by sharing of information between providers. Specifically will include:

- **Discharge support for mental health patients from secondary to primary care;**

ensuring that patients who no longer require specialist mental health care are transitioned to primary care and that GPs are empowered to care for them.

- **Discharge support from acute to community:**

Ensure discharge planning starts from day 1, that patients are assessed regularly during their stay, and that all required care packages are in place for when the patient returns home. This will also aim to ensure that post-acute care can happen at home as much as possible, e.g. rehabilitation, or within alternative housing options and that it can be put in place in time for a patient's discharge.

- **Discharge Coordinator** (Band 4+ hybrid health and social care worker (Allied Health Professionals)

- ***Discharge management***

The function aims to reduce the number of beds days used for each patient, ensure a smooth transition for the patient from hospital to home and improve the communication. They act as the interface between acute and community care.

- ***Mental Health Liaison***

The mental health liaison function operates in the acute setting in A&E and on the wards. It aims to ensure that patients are adequately diagnosed for mental health comorbidities and referred to the right setting of care so that patients with mental health issues who attend A & E can avoid admission, where possible, or if they are admitted, the length of their stay is reduced.

Planned Changes to the Commissioning of ServicesThe Integration Function

The aim of the integration function is to ensure that from a patient perspective the hand offs from one provider to another, one service line to another, one clinician to another are seamless and that patients feel health and social care needs are coordinated around them and with them. For the integrated care approach to be completely successful requires that providers work together to provide an integrated system with the patient at its centre. The integration function will be delivered by all core service providers working in concert to ensure that the benefits of integrated services are realised.

The integration function will need to operate across provider and physical boundaries with key staff being available as required for urgent escalations, but not necessarily face to face. It is envisaged that the provider will need to commit dedicated staff to the delivery of the integration function and will also draft in front line and management staff in a matrix form.

The integration function will operate in a way that supports the patient seamlessly across provider boundaries. Care must be taken to explain to the patient at each stage of their journey what will happen next and at the point of hand over a dialogue will be established with the receiving provider to ensure the patient's needs are understood by the receiver. The integrationfunction will monitor and work to keep to a minimum the number of different health and social care professionals a patient interacts with. Information sharing between providers will be critical to successful integration and providers should be working towards safe, secure and efficient mechanisms to share relevant data across organisational boundaries.

The core integrated care services must include the local authority to ensure that from a patient perspective a seamless health and social care service that centres on the patient is delivered. The core services must also be integrated with primary care providers to the same end.

The integration role will need to cover the providers that are directly involved in the provision of integrated services but will also need to cover the links with other provider groups including social services, LAS and the wider primary care network.

From 2015/16 onwards, part of the payment to the providers will be based on the successful delivery of the Integration Function.

Voluntary Sector Input:

Several voluntary organisations already provide health and social care to Tower Hamlets residents; however this is often not within the framework of any other care they receive. In other words, it is sometimes not linked up with their NHS care or social care from the Local Authority. This means that the services are not necessarily quality assured or accountable, and that there is no interaction between their official care providers and the providers of the care they receive through voluntary organisations.

We want to ensure that the huge value of the voluntary and community sector is realised through better integrated care. We have been working with the network of local voluntary organisations, CVS, to map the services that they offer, and are engaging in conversations with them over the coming months in order to involve them heavily in plans for integrated care, with a view to commissioning services from them.

Assistive technology:

The Local Authority has an established Assistive Technology (AT) project that was set up to implement a new approach to supporting people with Telecare/AT. Instead of AT being aimed mostly at people with low to medium level needs, it is now also offered to people with higher level needs, especially those with long term health conditions. People with dementia and patients on community virtual wards (CVWs) are of particular interest to the new provision. The variety of devices has been increased to cater for a wider range of people's circumstances and health conditions. Training has been provided to potential prescribers of AT, to make them familiar with the application of AT devices and solutions and to ensure they are aware of risks and ethical issues. The process for providing AT includes appropriate approvals for prescriptions as well as points at which reviews are done to check the suitability of prescribed devices. The current AT project is supported through existing S256 monies and the success of the existing AT projects will be developed on through the BCF. This will be achieved through linking the work with ongoing work streams of the health and Wellbeing Strategy.

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

Impact on Secondary Care

Operational and Cultural Impact

Moving health services to a personalised approach from one based on disease categories will require significant transformational change. The Integrated Care Board, and WELC pioneer group have been actively working with all providers on potential implications for OD and workforce. It is likely that providers will respond to these intentions by making changes to their team structures. This work has already started in Tower Hamlets, with a full redesign of an Integrated Community Health Team, and the development of a competency framework for care coordination and navigation.

Financial Impact

Investment

Our plans include some investment in enhanced services in secondary care namely:Investment in mental health liaison – the provision of a single multi-disciplinary mental health and drug and alcohol assessment service to provide expert advice, support and training to Royal London Hospital clinicians. The Service will be fully integrated into the acute trust sites in Tower Hamlets, and will maintain a very high profile.

Disinvestment

The Integrated Care Programme in Tower Hamlets aims to improve the health and wellbeing of those at highest risk of a hospital admission. As outlined previously, we will do this through a combination of patient centred care planning, information sharing, and redesigned services to better respond to patients' needs. Therefore we expect that as a result, there will be a reduction in income to secondary care as a result of:

- Reduced emergency admissions to hospital from patients within very high and high risk groups by around 25%-40%
- Reduction in emergency activity in A&E from patients within very high and high risk groups
- Potential reduction in "elective" procedures due to better managed conditions
- Reduction in drugs costs associated with very high and high risk groups

Risk of non-delivery

Through our provider appointment process providers have been instructed that the remuneration framework for their services will move from a purely activity based or block contract, to a mixed contract which includes incentive payments for the production of high quality outcomes for patients.

Improved provider efficiency

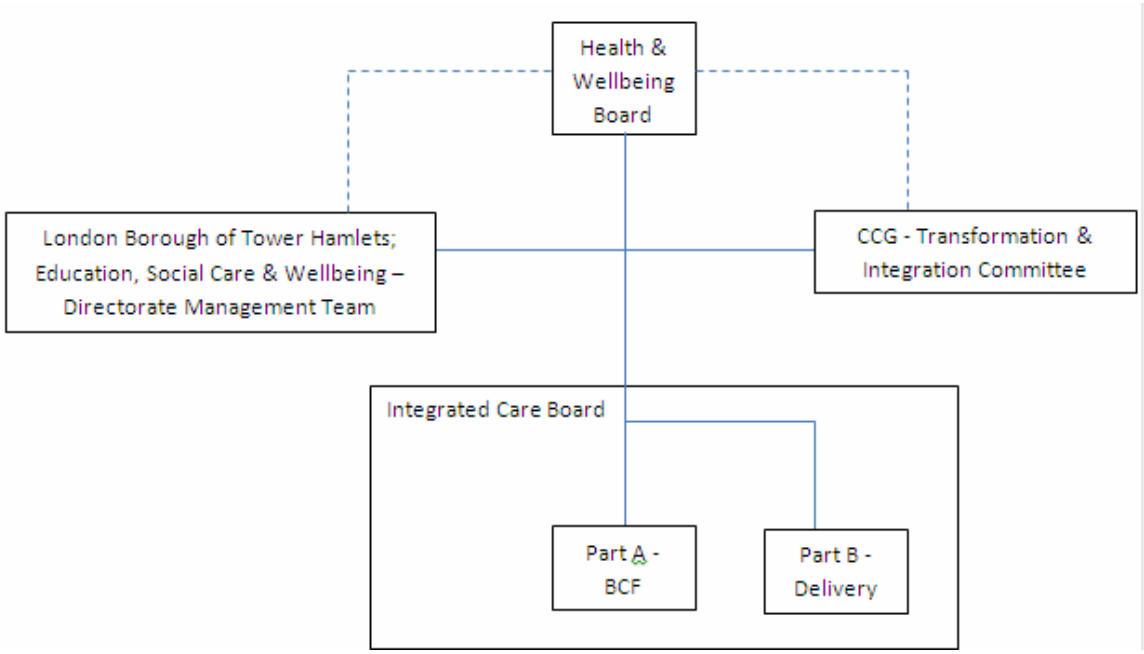
Through transformational change, adjustments to investments and disinvestments, and through innovations such as data sharing and hybrid roles, that providers will be able to release operational efficiencies. For example, our case for change assumes that we can avoid a significant number of emergency admissions and reduce length of stay. This will support provider organisations to be able to secure income and minimise costs

Integration Function
The integration function will require organisations delivering part of the patients' care, including hospital acute care, to work together much more closely than they ever have before and hold each other to accountfor delivery of seamless care across the system. Working together will need to be underpinned by robust shared management and governance arrangements, and it is proposed to put in place a pooled fund into which a proportion of the savings will be placed and used to mitigate the risks of additional costs resulting from service change and shifts in activity between providers.

In particular providers will be required to articulate:
- Collaborative vision for joined up care
- An agreed plan that describes how partners will share risk and deal with clinical governance issues for the collaborative.
- How any share of the savings pool created by integrating services will be used to further develop integrated services

e) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes



ICB governance

The Better Care Fund will be governed by the Integrated Care Board (ICB); which comprises members of the CCG and the Health & Wellbeing Board (HWB). Within each constituent organisation the, London Borough of Tower Hamlets' Education, Social Care & Wellbeing Directorate Management Team, and the CCG's Transformation & Integration Committee respectively hold important governance functions. Ultimately in this model it will be the role of the Health and Wellbeing Board to hold the whole system to account at a strategic level.

It is proposed that monthly ICB meetings will be split into two sections; Part A for commissioning only and Part B is for commissioners and providers. The use of the Better Care Fund will be dealt with under the commissioning section of the ICB.

In 2014-15, the first year of the BCF, there will be a Memorandum of Understanding between the Council and CCG. From the second year (2015/16) onwards, the allocation of funds will be governed by a Section 75 Partnership Agreement,

A programme management approach will be taken to overseeing the Better Care Fund in Tower Hamlets. A joint project plan with agreed milestones will be agreed between the CCG and the Borough, managing the transfer of funds, and the commissioning of services using those funds. This will involve regular meetings between both parties, regular monitoring of performance against outcomes and objectives, including ones expressed here, but also more detailed and time-specific ones that can be reviewed as we progress with implementing integrated care.

Outcomes and objectives monitoring will be underpinned by the development of a Better

Care Fund dashboard, in order to keep a clear and continuous record of outcomes against objectives. Using the programme management approach, escalation routes will be agreed so that problems can be identified early on, and there are agreed strategies for prioritising and dealing with them swiftly.

3) NATIONAL CONDITIONS

a) Protecting social care services
Please outline your agreed local definition of protecting adult social care services.

Yes the eligibility criteria will remain the same.

We will ensure that eligibility criteria for Tower Hamlets will remain the same that is providing care for those who met Critical and Substantial within the Fair Access to Care Services criteria. As stated above in section 2(d) the pooled budget will be used to mitigate any risks arising from significant shifts in activity.

Please explain how local social care services will be protected within your plans.

The redesign of how care is delivered locally, described in section 2c) above will change the way health works with social care and will move care out of hospital into the community. This is likely to change the distribution of costs and savings between the different parts of the health service and between acute and community care, and health and social care. The BCF will be utilised to enable progress to be made with integration and to ensure that shifts in costs and savings are not impediments to the integration of services by using a pooled budget (from 2015-16) to match resources to where they are needed.

The pooling of the health and social care budgets from 15-16 will reduce some of the risk associated with shifts in activity between providers. This will not only protect local social care services, it will strengthen them.

Recognising the potential changes to the distribution of costs and savings, the local authorities involved in the WELC programme have agreed to track the changes and model the costs and savings: a financial modelling exercise to identify and capture the financial implications of integrated care for social care services.To do this will require sharing of patient/service user level information. This is discussed further below.

b) 7 day services to support discharge
Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

This is already being done by NHS services, and there is a strategic agreement to enhance 7 day working across all services including social care services. Current winter plans provide 7 day working, covering evenings and weekends. This will provide a benchmark for the level of service to be provided long term, in line with Sir Bruce Keogh's initiative to drive seven day services across the NHS over the next three years, in response to concerns about the safety and accessibility of services, amongst other

things, at weekends.

A series workshops organised by NHS Improving Quality are being organised aimed to build “CCGs’ capability to lead transformational change in the care delivery system”. This will involve seven workshops, each approximately one month apart. Each cohort will bring three or four Alliance teams together, each of which will be tackling a specific “change challenge”. The cohort that Tower Hamlets CCG is enrolled on will tackle the topic of building the capability to do 7 day working across the system. The CCG will also invite other relevant partners – possibly from the local authority, third sector, the CSU, and/or the Area Team.

c) Data sharing

Background

Data sharing was identified early on as a key component and enabler of integrated care. As such, finding a way to introduce and implement a system that could deliver this became a priority. The Virtual Community Ward Pilot system (precursor to the integrated care programme) was designed to allow identified users to view patient data shared between clinical systems across designated organisations using a “clinical portal” into a data warehouse containing data for all organsiations within the integrationusing a system called the Orion Health Rhapsody Integration Engine.

Both the CCG and the Council are committed to introducing Orion as quickly as possible, and enabling it to be fully functioning soon (although they are working to different timetables). The system is already partially functioning, and enables access tosecure patient/ service user records across different systems and providers to communicate with their other records, remain up to date and will facilitate mobile working. This will enable cooperation and coordination between providers and transparency into the care that patients are receiving.

We would also like to be able to start implementing the Orion system in the voluntary organisations that we work with. As voluntary organisations become more involved with providing commissioned care/ services, they will have and require data that could influence patients’ care elsewhere in the integrated system. It is therefore extremely important to work towards being able to achieve this next step. Challenges involved include making the Orion system compatible with different types of organisations’ own IT systems, as well as data security.

As well as the sharing of patient data between providers, tracking integrated care changes and modelling the costs and savings (see *protecting social services*) requires sharing of patient level information. To overcome the barriers that these present on Information Governance, it is proposed over the next 6 months:

1. That a data sharing agreement be put in place to enable appropriate health and social care data to be linked for activity and costs to be tracked over the full care pathway and to support developing a full view of the full cost per patient. This will come back to DMT and the Council’s IG Group as required for sign off by the end of March 2014. The approach will be underpinned by the governing principle that wherever possible service user/patient consent to sharing information about them will be obtained.

2. That a time limited project be set up (under the Social Care Transformation Programme umbrella?) to address confidentiality and IG issues. WELC will be applying for s251 approval[2] from the Confidentiality Advisory Group (of the DH) but failing obtaining approval an alternative approach will be needed which will be overseen by this group.

3. That a three borough working group to set up the modelling and tracking process and to report from time to time on cost and savings shifts. To identify an SRO from this group to coordinate the work across the three boroughs.

To underpin the above there is a WELC Informatics Strategy in near final draft form that seeks to ensure we have a strategic approach to using patient data and technology to deliver integrated care.

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

CCG/ CSU: YES
LA: *No we do not currently use the NHS number but have plans to do so in the future*

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

CCG/ CSU: N/A
LA: *In place circa June 2015. Have begun to store the NHS Numbers of service clients in anticipation of using them as the primary identifier. At present, it has the NHS Numbers of:*

60% of clients of Learning Disabilities services
60% of clients of Mental Health services
43% of clients of physical disabilities/ frailty services
34% of clients from other vulnerable groups (usually drugs and/or alcohol related)

Given the number of people in the top 20% (at risk) being older people London Borough of Tower Hamlets has committed to getting increasing the levels for clients of physical disabilities/ frailty services and from other vulnerable groups, to at least the same level at learning disabilities services and mental health services (60%).

[2]Section 251 of the NHS Act 2006 (originally Section 60 of the Health and Social Care Act 2001) provides the statutory power to ensure that NHS patient identifiable information needed to support essential NHS activity can be used without the consent of patients. The power can be used only to support medical purposes that are in the interests of patients or the wider public, where consent is not a practicable alternative and where anonymised information will not suffice.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

CCG/ CSU: YES – message source between systems using open source HC7 standards
LA:: *Yes we are committed to ensuring we support open APIs and Open Standards*

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, and professional clinical practise and in particular requirements set out in Caldicott2.

CCG/ CSU: Systems hosted by NEL CSU; IG Toolkit Level 2;
ASHU (?) Accredited; Hosts DSCRO
LA: *We are committed to ensuring that all appropriate IG controls will be in place.*

d) Joint assessment and accountable lead professional
Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

The agreed accountable lead professional will be:
- The GP: for those aged over 75, and those identified as Very High Risk
- For other patients, the lead professional will be based on their primary health need. Therefore it could be a doctor, therapist, or secondary care clinician

The joint process for assessing risk, planning care and allocating a lead professional involves GP practices running a monthly risk stratification testto assess risk amongst their patients.

The proportion of the adult population identified as at very high risk, high risk and moderate risk of hospital admission in Tower Hamlets is:

Risk factor	**National average - percentage**	**Total**
Very high risk	0.5%	1,662
High risk	4.5%	11,871
Moderate risk	15%	23,600

(Total TH population that are very high – moderate risk)	-	37,133

We are currently recruiting stratified patients to care coordination and care planning. For some of these patients, this will build on and ultimately replace existing care plans for specific conditions, to create a comprehensive plan and assessment.

4) RISKS
Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

Risk	Risk rating	Mitigating Actions
Risk 1: Risk of transfer of activity and therefore care costs from NHS to Council (social care)		Use the Evaluation and Outcomes Group to monitor significant shifts in activity in social care To and develop a savings pool to ensure that resources move in line with activity.
Risk 2: There is a failure in one part of the integrated care system that places pressure on another part of the system.		The implementation of the integration function
Risk 3: Providers fail to commit to delivery of the integration function		To seek to procure a provider for the integration function
Risk 4: Baseline outcomes and metrics data is based on 2012/13 data, as 13/14 YTD data is not available, so we are basing our level of ambition on old data.		Keep monitoring 13/14 performance in order to start working towards targets and take action if necessary before 14/15/
Risk 5: that providers and commissioners are not able to share data and information		Seeking full signed consent as a matter of routine best practice from every patient/service user who is within the integrated care services. Currently applying for s251 approval and working with the Pioneer programme at the DH.
Risk 6: The local health and social care system currently performs well on the DTOC measure – most DTOCs are due to specialist services commissioned by		To focus on DTOCs caused by delays in social care To develop alternative measures to track reductions in lengths of stay

NHS England.		

Possible (risk mitigation) options include (as provided by THCCG):

- Pool risk based on the contributions of each partner
- Pool risk based on the lead or integrated commissioner model (this is the model being developed by the WELC Integrated Care Pioneer project) [3]
- Increase the pooled budget to include budgets that will be exposed to risk as a result of the programme, for example, the CCG's non elective budget, and LBTH's Adult Social Care Budget

[3] See DMT/CMT paper on Integration Sept/Oct 2013

FINANCE - Summary

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actu contributions to the Better Care Fund pooled budget in 2015/16.

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15	Minimum contribution (15/16)	Actual contribution (15/16)
Local Authority	N	£8.314m		
CCG	N	£10.367m		
CCG and Local Authority	TBD		£20.367m	£20.367m
Local Authority #2				
etc				
BCF Total		**£18.681m**	**£20.367m**	**£20.367m**

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

TBD

Contingency plan:		2015/16	Ongoing
Outcome 1	Planned savings (if targets fully achieved)	TBD	TBD
	Maximum support needed for other services (if targets not achieved)	TBD	TBD
Outcome 2	Planned savings (if targets fully achieved)	TBD	TBD
	Maximum support needed for other services (if targets not achieved)	TBD	TBD

Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please expand the table if necessary.

BCF Investment	Lead provider	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 benefits	
		Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent
Integration	Barts/Local Authority	£14.331m				£16.645m			
Reablement/Rehabilitation	Local Authority	£0.473m				£0.303m			
Carers	Local Authority	£0.150m				£0.150m			
Mental Health	ELFT	£0.447m				£0.290m			
Enablers	CCG	£1.11m				£1.11m			
Learning Disability	Local Authority	£0.04m				£0.040m			
Helping People live at Home	Local Authority	£2.130m				£1.829m			
Total		**£18.681m**				**£20.367m**			

OUTCOMES & METRICS

For each metric other than patient experience, please provide details of the expected outcomes and benefits of the scheme and how these will be measured.

REDUCED *Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population*–**figures derived from ASCOF.**
Reducing the number of admissions of older people to residential and nursing care homes means that more are receiving appropriate and effective care of their conditions. As a result, their health will deteriorate less, they have appropriate support, and they can maintain their independence, therefore do not need to be admitted permanently to residential and nursing care homes.

INCREASED *Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services* – **figures derived from ASCOF.**
Reablement/ rehabilitation services aim to provide patients with the tools and support to carry out their daily lives as independently as possible. These services can re-teach patients skills and daily tasks that in turn allow them to stay active, healthy and independent. Remaining at home, as opposed to being admitted to hospital or care, signifies independence and capability, so a higher proportion of older people who were still at home 91 days after discharge from hospital into reablement/ rehab services represents success.

REDUCED*Delayed transfers of care from hospital per 100,000 population (average per month)* – **figures derived from ASCOF.**
A delayed transfer of care means that a patient stays in hospital for longer than is needed, which increases the risk of infection, and indicates either that the hospital staff are too busy to discharge the patient, or, if the patient requires transferring to other hospital or social care services, that those services do not have the capacity to receive the patient, causing a delay in them receiving the care that is most appropriate for them. Reducing this number means that patients have reduced risk of infection and receive the right care faster.

REDUCED - *Avoidable emergency admissions (composite measure)* – **composite measure being developed by NHS England.**
Many emergency attendances are avoidable, as are many admissions to emergency services. This can cause over-crowding in emergency services and stretches staff, amongst other negative effects. Over-crowding and stretched staff can lead to long waiting times and can also lead to lower quality, sometimes unsafe care. It is also very costly for those services and for the wider economy. Reducing emergency admissions can increase safety in emergency department. It requires patients' Integrated Care to step in with rapid response services, and more appropriate ways of a) increasing their awareness of emergency and other services, helping them to choose the right care option, and b) reduce the need for emergency services through improved health outcomes as a result of improved care.

REDUCED - *Local measure – emergency admissions per 1000 eligible population* – **Source data is from North East London Commissioning Support Unit (NELCSU) Sandpit SUS extract.**
As opposed to avoidable admissions, reducing all emergency admissions suggests explicitly that, patients' health can be maintained or even improved, with the right care. Indeed this can reduce the need for all interventions, including emergency admissions (including all the avoidable admissions who could have gone elsewhere). Reducing all emergency admissions will have similar benefits to reducing avoidable emergency admissions; reducing waiting times, higher quality, more appropriate care, reduced costs, and much more. This measure is also an indication of the success of the integrated care that eligible patients receive. One of the main aims of integrated care is to reduce the number of admissions amongst those most at risk in the population.

REDUCED - Local measure - Readmissions of eligible population receiving integrated care – **Metric not developed yet. Will be measured once formal integrated care is underway.**
As explained above, one of the main aims of integrated care is to reduce the number of admissions amongst those most at risk in the population. Reducing the number of times that those most at risk are readmitted is a clear indication of the success of integrated care at maintaining and improving their health.

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015 payment. Please see the technical guidance for further detail. If you are using a local metric please provide details of the expected outcomes and benefits and how these will be measured, and include the relevant details in the table below

We are currently in the process of developing our own local patient experience metrics, and intend to use for this purpose

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans

For discussion at BCF board meeting

If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template both for each HWB and for the multiple-HWB combined

N/A

Submission guidance recommended using http://ccgtools.england.nhs.uk/opa/flash/atlas.html for figures but it didn't have any of the relevant information. Instead, most data came from http://ascof.hscic.gov.uk/Outcome/711/.

http://www.hsj.co.uk/Journals/2013/12/17/u/q/z/Planning-guidance.pdf

http://www.local.gov.uk/documents/10180/12193/Better+Care+Fund+-+Technical+Guidance.pdf/cf2b02a5-4b3e-47c2-9246-435103b884df

Metrics		Current Baseline (as at….)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*			
	Numerator			
	Denominator			
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*			
	Numerator			
	Denominator			
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*			
	Numerator			
	Denominator			
Avoidable emergency admissions (composite measure)	*Metric Value*			
	Numerator			
	Denominator			
Patient / service user experience [for local measure, please list actual measure to be used. This does not need to be completed if the national metric (under development) is to be used]				
*Local measure – **emergency admissions per 1000 eligible population TBD***	*Metric Value*			
	Numerator			
	Denominator			
*Local measure - **Readmissions of eligible populationreceiving integrated care TBD***	*Metric Value*			
	Numerator			
	Denominator			

Health and Wellbeing Board 6th February 2014	Tower Hamlets Health and Wellbeing Board
Report of the London Borough of Tower Hamlets	**Classification:** Unrestricted
AHWB -Section 256 Funding 2013-14	

Lead Officer	
Contact Officers	**Kate Bingham, Service Head ESCW Resources (x 4811)**

EXECUTIVE SUMMARY

1.1 The National Health Service (NHS) Operating Framework and the Local Authority (LA) Grant Settlements in 2011/12 and 2012/13 included funding transfers to be made from the NHS to LAs to support social care. Funding is generally made available under the three funding streams of Social Care, Reablement and Winter Pressures and is transferred from the NHS to LAs under Section 256 of the *National Health Service Act 2006*.

1.2 In previous years, the Department of Health (DH) transferred this funding to LA's through local Primary Care Trusts. The funding conditions require that it should be spent on agreed social care priorities that also result in health care benefits.

1.3 Earlier this year the Government announced the allocations for 2013/14 and it has been confirmed that Tower Hamlets will receive £5.243m through the social care element. Specific allocations for Reablement and Winter Pressures are in the process of being finalised.

1.4 New directions issues by DH state that this year the transfer of funding from the NHS to local authorities is the responsibility of NHS England and spending plans need to be agreed locally with Clinical Commissioning Groups (CCGs) and the area team of NHS England. Local Health and Well-Being Boards (HWB) are expected to approve local proposals for funding, which is a pre-condition to NHS England signing a funding agreement.

1.5 This report outlines the funding available to London Borough of Tower Hamlets (LBTH) in 2013/14 and the proposals that have been agreed with the local CCG on how this should be spent by the local authority to support local health outcomes.

RECOMMENDATIONs

The Health and Wellbeing Board is Recommended to:

2.1 Note the requirements of the transfer from NHS England to LBTH.

2.2 Approve spending plans for the 2013/14 allocation as agreed between Tower Hamlets CCG and London Borough of Tower Hamlets, as detailed in Appendix 1.

1. REASONS FOR THE DECISIONS

1.1 Spending plans will need to be submitted to NHS England and a 'Memorandum of Agreement' to secure drawdown of funding will need to be put in place.

1.2 The plans for 2013/14 have had to be progressed on the basis of agreements between the Authority and the CCG, so the Health and Wellbeing Board agreement formalises approval for the overall plan.

1.3 A formal plan allows a report monitoring progress to be produced for the Health and Wellbeing Board Quarterly.

2. ALTERNATIVE OPTIONS

2.1 Not to agree the plan and to ask for it to be resubmitted.

3. DETAILS OF REPORT

Introduction

3.1 The Governments Comprehensive Spending Review in 2010 announced a number of new funding streams which were designed to support social care activities which also have a health service benefit.

3.2 This report outlines the funding available to LBTH in 2013/14 and the proposals that have been agreed with the local CCG on how this should be spent by the local authority to support local health outcomes.

3.3 It is worth noting that up to now there has not been any restriction on unspent funds being carried forward from one financial year to the next. Therefore the spending plans include some lines that are badged as "three year programmes" on the basis that the total funding allocations have been packaged together from carried forward underspends from previous financial years and the 2013/14 allocation to commit to programmes over a three year period to maximise benefit for the health and social care economy over a longer period.

SECTION 256 ALLOCATIONS - 2013/14

Allocation

3.4 On 19 December 2012 the government announced total 2013/14 funding allocations for social care (£859m), winter pressures (£25m) and reablement (£300m). The winter pressures and reablement elements have now been incorporated into CCG base budgets and we are still awaiting confirmation from the CCG with regards how much LBTH is likely to receive. The social care element has been passed to NHS England, previously known as the NHS Commissioning Board, and LBTH has been allocated £5.243m from the national allocation.

Table 1: 2013/14 Allocations

	Social Care £M	Reablement £M	Winter Pressures £M	Total £M
Allocation 2013/14	5.243	TBC	TBC	5.243
Planned expenditure	**(5,243)**	**TBC**	**TBC**	**(5,243)**

Spending Plan Agreed

3.5 On the 17th June 2013, following discussions, a spending plan was agreed with the CCG and these are detailed in **Appendix 1**. It was agreed that a proportion of this new allocation would continue to fund commitments already made using previous funding received and these commitments include the support for effective learning disability transitions, the three year contract for the new autism service, additional funding to increase use of assistive technology, managing demand from demographic pressures and austerity as well as continued support for integration projects.

3.6 There are also a number of new projects agreed and these are mainly designed to increase social work capacity to speed up annual reviews and continue to ensure clients are receiving appropriate support, improve response times, maintain a high level service to a growing number of clients as well as ensure an effective brokerage service and support for clients receiving direct payments.

3.7 In the main, the funding is being used to fund short term projects designed to meet the conditions of the grant detailed below. This is inorder to minimise the impact on council budgets should the funding cease. However, at least £1.4m of the funding has been earmarked for 'managing growth and demand'. This effectively contributes towards the cost of care packages and should funding cease will create a growth pressure on council budgets that will need to be funded.

3.8 The process for governing the use of this funding is regulated through various Directions, Conditions and Guidance issued by NHS England and these are explained below.

Directions

3.9 The Directions governing the payment of section 256 funding (*Department of Health Guidance on Funding Transfer*) state that the payments must be made: (A) in respect of functions or activity which would have a beneficial effect on:

(i) the health of any individuals; or
(ii) the exercise of functions, or the provision of health services, as part of the health service in England.

(B) in order to support new or existing services or programmes to transform such services only if the services or programmes:
(i) are, or would be, of benefit to the wider health and care system in the area of the local authority;
(ii) provide, or would provide, beneficial outcomes for persons using the services in question; and
(iii) in the case of existing services or programmes, would be terminated or reduced as a result of financial considerations by the local authority, if the payment was not made.

3.10 In making payments in accordance with these Directions, the NHS England is to have regard to the commitment in the White Paper "*Caring for our Future; reforming care and support*" published July 2012 to the effect that payments under section 256 may be used to cover the revenue costs to local authorities in the relevant financial year of the commitments in that White Paper.

3.11 Beyond the directions, the DoH wants to allow flexibility for local areas to determine how this investment in adult social care services is best used. In line with their responsibilities under the *Health and Social Care Act 2012*, NHS England is required to ensure that LAs, NHS England, and the local CCG have regard to the Joint Strategic Needs Assessment (JSNA) for their local population, and existing commissioning plans for both health and social care, in how the funding is used.

3.12 Further, each LA must be able to demonstrate to the NHS England how the payments will improve services provided in the exercise of social care functions and the outcomes that are expected to be achieved for the users of those services.

3.13 Finally, for the purpose of ensuring that the conditions specified in the Directions are met, NHS England must make arrangements for each LA to provide it with information as to how the payments made in accordance with these Directions are being used by that LA.

<u>Conditions</u>

3.14 The grant conditions (*The NCB (Conditions Relating to Payments by NHS Bodies to LAs) Directions 2013*) state that before making a payment under section 256, NHS England or a CCG must be satisfied that the payment:
- is likely to secure a more effective use of public funds than the deployment of an equivalent amount on the direct provision of NHS services or the commissioning of certain health services by the local CCG (sections 3(1), 3A and 3B of the *NHS Act 2006*); and
- is used so as to secure the most efficient and effective use of the amount paid.

3.15 On the 19th June 2013 (**Appendix 2**) and 18th July 2013, NHS England (**Appendix 3**) issued further information regarding the arrangements for the section 256 funding transfer in London, in accordance with paragraph 5.6 above.

3.16 The letter states that:

- Plans for the use of the funding should have due regard to the findings of the local Joint Strategic Needs Assessment. The CCG's commissioning plans and the LAs plans for social care;
- Spending plans should be jointly agreed with the local CCG and discussed with other relevant partners at the local HWB, as part of their wider discussions on the use of the total health and care resources in the area.
- Local HWBs will be expected to approve local proposals for the use of funding. This is stated as a precondition to NHS England signing a funding agreement.
- NHS England must ensure that it has access to timely information via HWBs on how the funding is being used locally against the programme of adult social care expenditure and the local plan.

3.17 NHS England will require expenditure plans by local authority to be categorised into the following service areas as agreed with the Department of Health:

Service Areas- 'Purchase of social care'

- Community equipment and adaptations
- Telecare
- Integrated crisis and rapid response services
- Maintaining eligibility criteria
- Re-ablement services
- Bed-based intermediate care services
- Early supported hospital discharge schemes
- Mental health services
- Other preventative services
- Other social care (please specify)

4 COMMENTS OF THE CHIEF FINANCE OFFICER

4.1. This is a financial report identifying how £5.243m of Section 256 funding for 2013/14 is planned to be spent. These plans have been discussed in detail over recent months by the Authority and the CCG. Having agreed the spending plans, through this report, the Authority and the CCG are seeking formal endorsement of the plans to comply with NHS England requirements.

4.2. Spending has started on these projects and the framework for monitoring these projects and reporting on them regularly has been set up in Education Social Care and Wellbeing Directorate.

4.3. **Appendix 1** identifies, project by project, how the funding will be applied and it is expected that this will be spent over three financial years as per the table below.

Table 2: Profile of planned 2013/14 S256 allocation

Financial Year	Planned spend £'000

2013/14	2,367
2014/15	2,626
2015/16	250
Total	**5,243**

4.4. For completeness, the Memorandum of Agreement in **Appendix 4** includes the brought forward S256 funding from previous years of £4.493m (which includes Social Care, Reablement and Winter Pressures). Again, these projects are underway and are being managed through the same framework as the 2013/14 projects.

5. LEGAL COMMENTS

5.1. Under section 256 of the National Health Service Act 2006 the NHS Board or a clinical commissioning group may make payments to a local authority in connection with any of the authority's functions which have an effect on the health of any individuals or are connected with or affected by NHS functions.

5.2. A detailed process following directions from the Secretary of State has given the responsibility of transferring funding to NHS England with spending plans to be agreed locally with the clinical commissioning groups and the area team of NHS England. The Health & Well-being Board must approve funding proposals as a pre-condition to NHS England completing a funding agreement. This report seeks approval to the spending plan agree with the clinical commissioning group to enable the process to be finalised.

6. ONE TOWER HAMLETS CONSIDERATIONS

6.1. Section 256 funding is being used to provide the listed social care services which have been commissioned after taking into consideration the findings of the JSNA; which analyses the health and social care needs of the Tower Hamlets population across all of the protected characteristics as well socio-economic determinants.

7. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

7.1 N/A

8. RISK MANAGEMENT IMPLICATIONS

8.1 Appendix 1 includes a column setting out the risks/exit strategies attached to each project.

8.2 The biggest risk to Adult Social Care is the potential loss in the future of the additional £1,416k we have earmarked to fund the cost of care packages in 2013-14. S256 funds this on the basis that delays or blockages in the ability of local authorities to fund social care is key in avoiding adverse impact on the NHS (for example in being able to ensure timely discharging from hospital and prevention of admission to hospital). This funding is in the context of all local authorities facing overall significant reductions in funding and the demographic growth in the older population.

9. CRIME AND DISORDER REDUCTION IMPLICATIONS

9.1 N/A

10. EFFICIENCY STATEMENT

10.1 The section 256 funds are being used to provide Adult Social Care services in the most efficient and cost effective manner. This has been agreed between the Tower Hamlets CCG and the London Borough of Tower Hamlets.

Appendices and Background Documents

Appendices

- Appendix 1 – Spending Plans for 2013/14 Allocations
- Appendix 2 – NHS England Guidance on Funding Transfer (19th June 2013)
- Appendix 3 – NHS England Guidance on Funding Transfer (18th July 2013)
- Appendix 4 - Section 256 Memorandum of Agreement

Background Documents

None

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Appendix 1: Spending Plan for 2013/14 section 256 funding allocation

				Spend Profile			
Ref	Area	Description	Allocation £'000	2013/14 £'000	2014/15 £'000	2015/16 £'000	Risk if funding ceases
1	Stroke Pathway Social Worker	Specialist Social worker in the first response hospital team to support the stroke pathway	50	50			Risk Shared by LA/NHS. Post recruited to recurrently.
2	Learning Disability Transitions	Establishment of further posts in the transitions team to support the transitions pathway for clients at the age of 16 *(contributes to a 3 year programme)*	300		300		LA Risk. However, posts are fixed term contracts that could be terminated should funding cease.
3	Autism Strategy	Implementation of the autism strategy *(contributes to a 3 year programme)*	250			250	Shared Risk. Risk to be covered by review of CLDS over the three year life of this contract. Shared risk between LA and Health Commissioners (see Cabinet paper).
4	Quality of Support Planning/peer researchers	Improvements in support planning	50	50			No Risk. Commissioned service with no obligation to continue after end of contract.
5	Learning Disability Partnership Board Coordinator	Continue funding Learning Disabilities Partnership Board Coordinator	40	40			LA post permanently filled. LA risk.
6	MH Engagement Strategy	Rehab workers to support people to move out of supported accommodation to create capacity for clients in out-of-borough supported accommodation	20	20			No Risk. Time limited Project.

7	Community Virtual Ward	Supporting integration – cost of additional social workers pending service redesign	250		250		Time limited. Fixed term contracts to support integration. Contracts can be terminated should funding cease.
8	Assistive Technology	Improvement of services in line with the Adult Social Care Outcomes Framework (ASCOF) Links to the Informatics part of the Integrated Care Programme *(contributes to a 3 year programme but is subject to annual review)*	370	200	170		Pilot project. Temporary posts being reviewed annually.
9	Integration	Increased capacity in Strategy Policy and Performance to support Health & Wellbeing Board.	60	60			Time limited. No risk.
10	Re-commissioning of Care Homes/Residential Care for Dementia care	Supporting Joint Commissioning with the NHS *(contributes to a 3 year programme)*	250		250		Will be a three year contract of a core service jointly commissioned. Risk sits with both LA and NHS.
11	Adult Social Care - Carers Support	Carers Healthcare checks *(contributes to a 3 year programme*	100	100			To be rolled up in PH wider Healthchecks programme.
12	Effective Day Care Provision	Supporting small third sector providers to prepare for day opportunities review	40	40			One off. No risk
13	Mental Health Services	Additional staffing to support mental health commissioning team through reorganisation in 13-14	117	117			One off. No risk.
14	Mental Health Services	Recovery College pilot to help Increases service user independence and reduces use of health services	110	110			Seed corn funding. No ongoing risk.
15	Mental Health Strategy	Funding the Mental Health Resettlement Team	200	200			For one year only.

Ref	Area	Description	Allocation £'000	2013/14 £'000	2014/15 £'000	2015/16 £'000	
16	Mental Health Services	Alzheimer's Society Bangladeshi Development Worker and Dementia Café *(contributes to a 3 year programme)*	80		80		Will be a three year contract of a core service jointly commissioned. Risk sits with both LA and NHS.
17	Mental Health Services	Adult Psychological services to support parents and families *(contributes to a 3 year programme)*	100		100		Will be a three year contract of a core service jointly commissioned. Risk sits with both LA and NHS.
18	Adult Social Care	Additional Social work and OT support to help reduce waiting lists and improve response times to clients.	400	200	200		Time Limited. No longer term risk.
19	Adult Social Care - Carers Support	Fund project worker - Integrated approach to meeting carers needs, to enable informal carers to continue to provide care.	50	50			One Off. No risk. However, capacity will need to be reviewed in light of Care Bill and anticipated changes to carers services.
20	Adult Social Care	Safeguarding project officer to support multi agency work.	40	40			One off. No risk.
21	Adult Social Care	Social worker in Primary Care mental health - to case manage those people recently transferred from East London Foundation Trust (ELFT) to primary care (pilot to assess impact of the new model of care on social care)	50	50			Short term project. No risk.
22	Adult Social Care	Increase capacity to improve brokerage activity and reduce waiting times for packages/placements.	340	140	200		LA risk. Capacity will be subject to review in light of the Care Bill and the anticipated further additional

							demands on this service.
23	Adult Social Care	Increase capacity to improve support for clients in receipt of direct payments *(contributes to a 3 year programme)*	190	90	100		LA risk. Capacity will be subject to review in light of the Care Bill and the anticipated further additional demands on this service.
24	Learning Disability Clients	2 social workers to support the resettlement of people with learning disabilities.	120	60	60		Time limited. No risk.
25	Integrated Care	Programme management and other non-recurrent support for the NHS integration programme.	250		250		Time limited. No risk.
26	Managing Growth and Demand	Prevent deterioration in health that will result in admittance to hospital and residential care through support packages. Managing risk around efficiency opportunities.	1,416	750	666		LA risk. Potentially funding additional care packages as a result of increase in demand. Likely to create LA budget pressures should funding cease.
			5,243	**2,367**	**2,626**	**250**	

Appendix 2

Gateway Reference: 00186

Financial Strategy & Allocations
Finance Directorate
Quarry House
Leeds
LS2 7UE

Email address – england.finance@nhs.net
Telephone Number – 0113 82 50779

To:
Area Team Finance Directors
CCG Clinical Leads
CCG Accountable Officers

19 June 2013

Dear Colleagues

Re: Funding Transfer from NHS England to social care – 2013/14

1. With reference to the letter of 19 December 2012 from the Department of Health to Paul Baumann (DH Gateway Reference 18568), funding to support adult social care has been passed to NHS England as part of the 2013/14 Mandate.

2. This letter provides information on the transfer to local authorities, how it should be made, and the allocations due to each local authority under Section 256 (5A)(5B) of the 2006 NHS Act. It is noted that decisions may have already been made for the use of the funding and that this letter is formalising such arrangements.

Amount to be transferred
3. For the 2013/14 financial year, NHS England will transfer £859 million from the Mandate to local authorities. We have undertaken an exercise to map all local authorities to NHS England Area Teams, and the amounts to be paid to individual local authorities from the Area Teams are set out at Annex A.

Legal basis for the transfer
4. The payments are to be made via an agreement under Section 256 of the 2006 NHS Act. NHS England will enter into an agreement with each local authority and will

be administered by the NHS England Area Teams (and not Clinical Commissioning Groups). Funding from NHS England will only pass over to local authorities once the Section 256 agreement has been signed by both parties.

For reference, please find below the updated Directions, which set out the conditions, Memorandum of Agreement and Annual Vouchers for use:

https://www.gov.uk/government/publications/conditions-for-payments-between-the-nhs-and-local-authorities

https://www.gov.uk/government/publications/funding-transfer-from-the-nhs-to-social-care-2013-to-2014-directions

In summary, before each agreement is made, certain conditions must be satisfied as set out below:

Use of the funding
5. The funding must be used to support adult social care services in each local authority, which also has a health benefit. However, beyond this broad condition, NHS England wants to provide flexibility for local areas to determine how this investment in social care services is best used.

6. The joint local leadership of Clinical Commissioning Groups and local authorities, through the Health and Wellbeing Board, is at the heart of the new health and social care system.NHS England will ensure that the local authority agrees with its local health partners how the funding is best used within social care, and the outcomes expected from this investment. Health and Wellbeing Boards will be the forum for discussions between the Area Teams, CCGs and local authorities on how the funding should be spent.

7. In line with their responsibilities under the Health and Social Care Act, NHS England will make it a condition of the transfer that local authorities and CCGs have regard to the Joint Strategic Needs Assessment for their local population, and existing commissioning plans for both health and social care, in how the funding is used.

8. NHS England will also make it a condition of the transfer that local authorities demonstrate how the funding transfer will make a positive difference to social care services, and outcomes for service users, compared to service plans in the absence of the funding transfer.

9. The funding can be used to support existing services or transformation programmes, where such services or programmes are of benefit to the wider health and care system, provide good outcomes for service users, and would be reduced due to budget pressures in local authorities without this investment. The funding can also support new services or transformation programmes, again where joint benefit with the health system and positive outcomes for service users have been identified.

10. The *Caring for Our Future* White Paper also sets out that the transfer of funding can be used to cover the small revenue costs to local authorities of the White Paper commitments in 2013/14 (excluding the Guaranteed Income Payments disregard, which is being funded through a grant from the Department of Health).

Governance

11. The Area Teams will ensure that the CCG/s and local authority take a joint report to the Health and Wellbeing Board to agree what the funding will be used for, any measurable outcomes and the agreed monitoring arrangements in each local authority area.

12. The Health & Wellbeing Board then approves the report which has appended to it the agreed Section 256 agreement between the local authority and NHS England. The agreement is signed by both parties.

13. A copy of each signed agreement should be sent to NHS England Finance Allocations Team at england.finance@nhs.net so that a national review of the transfer can be undertaken.

14. Purchase Orders should then be set up by the Area Teams with each Local Authority that will confirm the precise financial arrangements.

Reporting

15. Area Teams will be supplied with specific budget codes to enable them to set up Purchase Orders, monitor the expenditure on this allocation and to drawdown the necessary cash required to pay local authorities on the agreed basis. Area Teams should use their specific cost centre (Annex B) and the local authority sub analysis 2 code (Annex C) to generate their purchase orders (using the non-catalogue request category 'XXX').

16. NHS England will require expenditure plans by local authority to be categorised into the following service areas (Table 1) as agreed with the Department of Health. This will also ensure that we can report on a consolidated NHS England position on adult social care expenditure.

Table 1:

Analysis of the adult social care funding in 2013-14 for transfer to local authorities

Service Areas- 'Purchase of social care'	***Subjective code***
Community equipment and adaptations	52131015
Telecare	52131016
Integrated crisis and rapid response services	52131017
Maintaining eligibility criteria	52131018
Re-ablement services	52131019
Bed-based intermediate care services	52131020
Early supported hospital discharge schemes	52131021
Mental health services	52131022
Other preventative services	52131023
Other social care (please specify)	52131024
Total	

Furthermore, as part of our agreement with local authorities, NHS England will ensure that it has access to timely information (via Health & Wellbeing Boards) on how the funding is being used locally against the overall programme of adult social

care expenditure and the overall outcomes against the plan, in order to assure itself that the conditions for each funding transfer are being met.

Further considerations

17. Area Teams to copy this letter to their local government colleagues.

18. NHS England will not place any other conditions on the funding transfers without the written agreement of the Department of Health.

If you require any further information, please contact Tim Heneghan, Senior Finance Lead, Financial Strategy & Allocation on 0113 82 50779 or email tim.heneghan@nhs.net

Yours sincerely

Sam Higginson
Director of Strategic Finance

NHS England
London Region
105 Victoria Street
London
SW1E 6QT

To:
LA Chief executives
LA Directors of Adult Social Care
CCG Clinical Leads
CCG Accountable Officers

18 July 2013

Dear Colleagues,

Arrangements for the section 256 funding transfer in London

I am writing to bring to your attention the letter of 19 June 2013, Funding transfer from NHS England to social care – 2013/14 (DH gateway reference: 00186) attached in annex 1. As you will be aware NHS England is now responsible for managing this funding, taking on the role previously undertaken by Primary Care Trusts.

This funding provides a significant opportunity for NHS and Local Authorities to work together to better meet the health and social care needs of our communities. I am keen we make the most of this opportunity and I wanted to share with you the arrangements for the section 256 funding transfer in London.

I know many local areas have already made commitments to improving the integration of services within your Urgent and Emergency Care Recovery and Improvement Plans. I hope that the formal announcement of this funding provides local areas with the opportunity to further develop these plans.

Conditions for the use of funds:

In line with the national directions for payment, the application and outcome monitoring of the use of funds must be agreed between NHS England, the local authorities and their local health partners.

The plans for the use of the funding should have due regard to the findings of the local Joint Strategic Needs Assessment, the CCG's commissioning plan and the Local Authority's plans for social care.

Agreement should be made following a submission of a Joint LA/CCG proposal

to your local Health and Well Being Board which will be the forum for the discussion and agreement of your local plans for the use of these funds.

Local plans will need to meet the conditions associated with use of the Section 256 funds which are detailed in the letter provided in Annex 1, and summarised below:

1. Funding must support adult social care services in each local authority in a way that also has a health benefit.
2. Local authorities must obtain agreement from their local health partners on how the funding is best used within social care and the anticipated outcomes from the investment.
3. Health and Wellbeing Boards will be expected to discuss and approve local proposals for use of the funding.
4. NHS England will make it a condition of the transfer that local authorities demonstrate how funding will make a positive difference to social care services and the benefits for service users, compared to service plans in the absence of the funding transfer.

The process for Payment:

Payments will be administered by the NHS England (London) Delivery Teams and the funds will pass over to local authorities once the Section 256 agreement has been signed by both parties.

As part of the formal process for the agreement of Section 256 funds, NHS England must ensure that it has access to timely information (via Health & Wellbeing Boards) on how the funding is being used locally against the overall programme of adult social care expenditure and the overall outcomes against the plan.

To support this assurance, funds will be applied in three equal payments in quarters 2, 3 and 4, contingent on the appropriate application of funds and the monitoring against the agreed outcomes in your plan.

I hope the information provided within this letter supports you to further development joint working across health and social cares services in your local area and to improve the health and social care outcomes for London.

If you have any questions regarding the application or processing of these funds please contact your Local Area Delivery Team in the first instance (please view contact details on the following page).

NCEL
Delivery director: paul.bennett8@nhs.net

Barnet CCG	Barking and Dagenham CCG	Camden CCG
City and Hackney CCG	Enfield CCG	Haringey CCG
Havering CCG	Islington CCG	Newham CCG
Redbridge CCG	Tower Hamlets CCG	Waltham Forest CCG

SL
Delivery director: jacqui.harvey2@nhs.net

Bexley CCG	Bromley CCG	Croydon CCG
Greenwich CCG	Kingston CCG	Lambeth CCG
Lewisham CCG	Merton CCG	Richmond CCG
Southwark CCG	Sutton CCG	Wandsworth CCG

NWL
Delivery director: AlexGordon@nhs.net

Brent CCG	Central London CCG
Ealing CCG	Hammersmith and Fulham CCG
Harrow CCG	Hillingdon CCG
Hounslow CCG	West London CCG

Yours sincerely,

Anne Rainsberry
Regional Director (London region)

cc: Simon Weldon, Director of Operations and Delivery (London Region)
David Slegg, Director of Finance (London Region)
Ian Boyle, Head of Financial Assurance, (London region)
Khadir Meer, Head of Rectification and CCG Support, (London region)

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Memorandum of Agreement
Section 256 Partnership Arrangements

Between Tower Hamlets Clinical Commissioning Group (THCC) and London Borough of Tower Hamlets (LBTH):

Non-recurrent NHS Support for Social Care

1. In 2013/14 Tower Hamlets is due to receive £5,243,000 from the Department of Health (DoH) to support adult social care spend. The DoH has passed this funding to NHS England and the 'funding transfer guidance' published by NHS England on 19th June 2013 details the new governance arrangements for these resources.

2. This new guidance requires that a section 256 agreement be put in place between Tower Hamlets and NHS England before funding can be released. Prior to this, it requires spending plans to be agreed between Tower Hamlets Clinical Commissioning Group (THCCG) and London Borough of Tower Hamlets (LBTH). Following which a joint report needs to be taken to the Health and Wellbeing Board where final agreement is to be reached.

3. This agreement confirms that THCCG and LBTH have met on the 17th June 2013 and have agreed the priorities detailed in Appendix 1 for the use of this non-recurrent funding allocation of £5,243,000.

4. Thus this memorandum of understanding is valid for the £5,243,000 to be transferred in 2013-14 (Appendix 1). For the sake of completeness there are also carry forwards of £4,493,000 from previous year allocations which have been committed to be spent in 2013/14 on the schemes detailed in Appendix 2. These have also been agreed between THCCG and LBTH.

Signed: John Warrell Date: 20.01.2014

Deputy Chief Office

Jane Milligan
Chief Officer
on behalf of Tower Hamlets Clinical Commissioning Group
2nd Floor, Alderney Building, Mile End Hospital, Bancroft Road,
London, E1 4DG

Signed: Date: 14/1/14

Robert McCulloch-Graham
Interim Corporate Director, Education Social Care and Wellbeing,
London Borough of Tower Hamlets
Mulberry Place, 2 Clove Crescent, East India Dock, London E14 1BY

Appendix 1: Allocation of funding 2013-14

Ref	Area	Description	2013/14
1	Stroke Pathway Social Worker	Specialist Social worker in the first response hospital team to support the stroke pathway	50
2	Learning Disability Transitions	Establishment of further posts in the transitions team to support the transitions pathway for clients at the age of 16 *(contributes to a 3 year programme)*	300
3	Autism Strategy	Implementation of the autism strategy *(contributes to a 3 year programme)*	250
4	Quality of Support Planning/peer researchers	Improvements in support planning	50
5	Learning Disability Partnership Board Coordinator	Continue funding Learning Disabilities Partnership Board Coordinator	40
6	MH Engagement Strategy	Rehab workers to support people to move out of supported accommodation to create capacity for clients in out-of-borough supported accommodation	20
7	Community Virtual Ward	Supporting integration – cost of additional social workers pending service redesign	250
8	Assistive Technology	Improvement of services in line with the ASCOF Links to the Informatics part of the Integrated Care Programme *(contributes to a 3 year programme but is subject to annual review)*	370
9	Integration	Increased capacity in Strategy Policy and Performance to support Health & Wellbeing Board.	60
10	Re-commissioning of Care Homes/Residential Care for Dementia care	Supporting Joint Commissioning with the NHS *(contributes to a 3 year programme)*	250
11	Adult Social Care - Carers Support	Carers Healthcare checks *(contributes to a 3 year programme)*	100
12	Effective Day Care Provision	Supporting small third sector providers to prepare for day opportunities review	40
13	Mental Health Services	Additional staffing to support mental health commissioning team through reorganisation in 13-14	117
14	Mental Health Services	Recovery College pilot to help Increases service user independence and reduces use of health services	110
15	Mental Health Strategy	Funding the Mental Health Resettlement Team	200
16	Mental Health Services	Alzheimer's Society Bangladeshi Development Worker and Dementia Café *(contributes to a 3 year programme)*	80
17	Mental Health Services	Adult Psychological services to support parents and families *(contributes to a 3 year programme)*	100

18	Adult Social Care	Additional Social work and OT support to help reduce waiting lists and improve response times to clients.	400
19	Adult Social Care - Carers Support	Fund project worker RM - Integrated approach to meeting carers needs, to enable informal carers to continue to provide care	50
20	Adult Social Care	Safeguarding project officer to support multi agency work.	40
21	Adult Social Care	Social worker in Primary Care mental health - to case manage those people recently transferred from ELFT to primary care (pilot to assess impact of the new model of care on social care)	50
22	Adult Social Care	Increase capacity to improve brokerage activity and reduce waiting times for packages/placements	340
23	Adult Social Care	Increase capacity to improve support for clients in receipt of direct payments *(contributes to a 3 year programme)*	190
24	Learning Disability Clients	CLDS 2 social workers to support the resettlement of people with learning disabilities.	120
25	Integrated Care	Programme management and other non recurrent support for the NHS integration programme	250
26	Managing Growth and Demand	Prevent deterioration in health that will result in admittance to hospital and residential care through support packages. Managing risk around efficiency opportunities.	1,416
			5,243

Appendix 2: 2011/12 and 2012/13 allocations carried forward into 2013/14

Funding Stream	Area	Description	Carry Forward £'000
Social Care	Learning Disability Transitions (SP2/3/4)	Establishment of further posts in the transitions team to support the transitions pathway for clients at the age of 16	700
Social Care	Autism Strategy (SP2/3/4)	Implementation of the autism strategy	826
Social Care	MH Accommodation Strategy (SP2/3)	Rehab workers to support people to move out of supported accommodation to create capacity for clients in out-of-borough supported accommodation	20
Social Care	Integrated Care (SP1/4)	Programme management and other non recurrent support	250
Social Care	Integrated Care (SP1/4)	Community Virtual Ward	245
Social Care	Mental Health	Mental Health Engagement Strategy	11
Social Care	Integrated Care (SP1/4)	Reablement/Care Homes	203
Social Care	Increased Demand/managing risk (SP3/4)	Prevent deterioration in health that will result in admittance to hospital and residential care through support packages. Managing risk around efficiency opportunities.	914
		TOTAL SOCIAL CARE	3,169
Reablement	Reablement Service	Occupational therapy	250
Reablement	Reablement Service	Community Nursing	100
Reablement	Reablement Service	Clinical Nurse/Advanced Nurse Practitioners/Case Managers	161
		TOTAL REABLEMENT	511
Winter Pressures	Adult Social Care	Domiciliary Care* (Bridging support)	47
Winter Pressures	Adult Social Care	Staffing for Christmas Period	44
Winter Pressures	Community Equipment	Community Equipment Services	300
Winter Pressures	Telecare	Greater use of Telecare to increase independence and reduce impact on health services from trips and falls	422
		TOTAL REABLEMENT	813
		TOTAL	**4,493**

Health and Wellbeing Board 6th February 2014	Tower Hamlets Health and Wellbeing Board
Report of the London Borough of Tower Hamlets	**Classification:** Unrestricted
Health and Wellbeing Board Sign-up to the Disabled Children's Charter	

Lead Officer	Robert McCulloch-Graham, Education Social Care and Wellbeing,LBTH
Contact Officers	Steve Liddicott, Interim Head of Children's Social Care, Education Social Care and Wellbeing, LBTH
Executive Key Decision?	No

Executive Summary

The Children's Trust, Tadworth, and Every Disabled Child Matters, have produced a charter for Health and Wellbeing Boards to sign up to, setting out their commitments in relation to understanding and meeting the needs of children with disabilities.

This paper sets out the current position in terms of meeting the commitments, and next steps for signing up to the Charter. In particular, the paper considers progress in developing a JSNA for children with disabilities. This paper follows on from the 25th November report to the Children and Families Partnership Board, where it was agreed that Tower Hamlets meets the commitments set out in the Charter and recommended that the Health and Wellbeing Board sign the Charter.

The paper explains how the Health and Wellbeing Board, through the Children and Families Partnership, meets the commitments set out in the charter. The draft Joint Strategic Needs Assessment, which is relevant for commitment 1, is attached as an appendix for discussion and feedback from the Board.

Recommendations:

The Health and Wellbeing Board is recommended to:

1. Consider the position statement in relation to each of the commitments in the Charter and agree to the Tower Hamlets Partnership signing up to the Charter;
2. Note the JSNA attached as an appendix

1. REASONS FOR THE DECISIONS

1.1 Disabled Children's Charter for Health and Wellbeing Board

The Children's Trust, Tadworth, and Every Disabled Child Matters have produced a charter for Health and Wellbeing Boards to sign up to, setting out their commitments in relation to understanding and meeting the needs of children with disabilities. All Health and Wellbeing Boards have been asked to sign up to the Charter as evidence of their commitment to disabled children. The council and its partners meets these commitments, and recommends that the Health and Wellbeing Board agrees to signing up to the charter.

2. ALTERNATIVE OPTIONS

2.1 The alternative option is to not sign up to the charter. This option is not recommended.

3. DETAILS OF REPORT

3.1 The Children's Trust, Tadworth, and Every Disabled Child Matters, have produced a charter for Health and Wellbeing Boards to sign up to, setting out their commitments in relation to understanding and meeting the needs of children with disabilities.

3.2 The council and our partners meets these commitments, and recommends that the Health and Wellbeing Board agrees to signing up to the charter.

3.3 Commitment 1: We have detailed and accurate information on the disabled children and young people living in our area, and provide public information on how we plan to meet their needs

3.4 The JSNA for children with disabilities includes detailed and accurate information on disabled children and young people living in Tower Hamlets, and subject to approval processes for the JSNA, will be finalised and made available on the Council website. The Health and Wellbeing Strategy and Children and Families Plan are both public documents which provide strategic-level information on how we plan to meet the needs of children with disabilities and the JSNA supplements these documents with further evidence and detail around children with disabilities, with reference to specific information about how we plan to continue meeting their needs. Our Short Break Statement is also a public document, available as part of our Directory of Services for Disabled Children and Families, which sets out how we are delivering on our short break duty for children with disabilities and their families.

3.5 Commitment 2: We engage directly with disabled children and young people and their participation is embedded in the work of our Health and Wellbeing Board

3.6 Children with disabilities are currently engaged and consulted with at annual consultation fun days, commissioned by the Children with Disabilities Team. Children with disabilities are represented on the Youth Council, and disabled children are also consulted as part of the commissioning process for short breaks. The Children with Disabilities Strategic Group has a role in continuing to develop our approach to engagement with disabled children and young people.

3.7 Commitment 3: We engage directly with parent carers of disabled children and young people and their participation is embedded in the work of our Health and Wellbeing Board

3.8 Parents and carers of disabled children are engaged and consulted via PACSEN (Parent and Carers for Children with Special Educational Needs). For example, PACSEN invited parents to consultation events on transition to adult services; direct payments and short breaks during 2013. Parents are included on panels for evaluating tenders, and on interview panels for relevant positions within the Integrated Service for Disabled Children. The Children with Disabilities Strategic Group is considering how to further engage parents and carers of disabled children in strategic decision making processes.

3.9 Commitment 4: We set clear strategic outcomes for our partners to meet in relation to disabled children, young people and their families, monitor progress towards achieving them and hold each other to account

3.10 Our strategic outcomes for children with disabilities are set out in our Children and Families Plan: Our vision is for all children and young people to be safe and healthy, achieve their full potential, be active and responsible citizens, and emotionally and economically resilient for their future.

3.11 The Children and Families Plan contains detailed priorities for achieving this vision for all children and young people at each life stage, from maternity and early years through to transitioning into adulthood. It sets out indicators for positive outcomes for all children and young people; if we are meeting all those indicators for children and young people with disabilities, this can be considered evidence that we are making a difference. There are some outcome indicators which we can focus on which specifically tell us how we're doing in relation to children and young people with disabilities – these outcomes are either specific to them, or are in relation to an issue which the evidence tells us may be more prevalent amongst the children with disabilities population. These outcomes are considered in the JSNA.

3.12 To help achieve our vision for children with disabilities, the London Borough of Tower Hamlets and Tower Hamlets NHS promote inclusion by ensuring services in universal settings can be accessed by children with disabilities and additional needs. Additional services will be targeted to the needs of those with more complex needs. Services will be timely, accessible, co-ordinated and responsive to the needs of children, young people and their carers. This approach is set out in the terms of reference for the Children with Disabilities Strategic Group.

3.13 Commitment 5: We promote early intervention and support for smooth transitions between children and adult services for disabled children and young people

3.14 Early intervention is an overarching theme in our Children and Families Plan. For children with disabilities, a key way in which we deliver on this agenda is via our comprehensive short breaks programme, as well as through inclusive universal services, including for children during the early years from birth to age 5.

3.15 Our approach to supporting transition into adult services is being developed through a Transitions Steering Group, chaired by the Service Head for Adult's Social Care. An action plan and a practitioner's guide on transition have been developed, for dissemination across relevant teams and under the overnight of the Transitions Strategy group during December 2013 and into 2014/15.

3.16 Commitment 6: We work with key partners to strengthen integration between health, social care and education services, and with services provided by wider partners

3.17 The Integrated Service for Disabled Children and Families includes practitioners from across health, social care and education services. Senior managers from across these service areas meet bimonthly on the Children with Disabilities Strategic Group, which reports into the Children and Families Partnership Board. We also have integrated panels where decisions are made on how we will meet the needs of children with disabilities.

3.18 Commitment 7: We provide cohesive governance and leadership across the disabled children and young people's agenda by linking effectively with key partners

3.19 The Children with Disabilities Strategic Group oversee the development of services for disabled children and their families in Tower Hamlets. The group oversees the integration of services across Council and health services (both directly provided and externally commissioned services) to meet the needs of disabled children and their families. The group takes responsibility for ensuring integrated local practice is aligned to national recommendations and research for best practice. The group is responsible for ensuring we deliver on our vision for children with disabilities, set out under commitment 4 above.

3.20 This group reports into the Children and Families Partnership which is responsible for the overarching plan to meet our vision for all children and families, set out in our Children and Families Plan 2012-15.

3.21 The Children and Families Partnership Board reports into the Health and Wellbeing Board, responsible for the delivery of our Health and Wellbeing Strategy.

4. COMMENTS OF THE CHIEF FINANCE OFFICER

4.1. This is not a financial report and there are no financial implications arising from the recommendations.

5. LEGALCOMMENTS

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

5.2. In preparing this strategy, the Board must have regard to whether these needscould better be met under s75 of the NHS Act 2006. Further, the Board must have regard to the Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies published on 26 March 2013, and can only depart from this with good reason. The guidance states that the HWB must consider the demographics of the population and how the needs of people of different ages may vary.

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

6. ONE TOWER HAMLETS CONSIDERATIONS

6.1. The disabled children's charter specifically addresses disability and seeks to improve outcomes for disabled children. Within the JSNA wider equalities considerations are outlined.

7. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

7.1 N/A

8. RISK MANAGEMENT IMPLICATIONS

8.1. There is a reputational risk to the Health and Wellbeing Board if it does no sign up the Disabled Children's Charter.

9. CRIME AND DISORDER REDUCTION IMPLICATIONS

9.1 A disabled child's quality of life is determined not solely by their impairments (and subsequent health and social care needs), but the other barriers that often result in them being excluded from family and community activities such as poverty, negative attitudes and a disabling environment, for example,

unequal access to education, healthcare, leisure activities, transport and housing.

10. EFFICIENCY STATEMENT

10.1 This report is not concerned with expenditure, and commitments outlined are being met using existing resources.

Appendices and Background Documents

Appendices
Disabled Children's JSNA

Background Documents
NONE

Children with disabilities factsheet

Tower Hamlets Joint Strategic Needs Assessment 2012-2013

UPDATED QUARTER

Executive Summary

This factsheet is concerned with the health and well-being of children with physical and learning disabilities. Separate fact sheets exist on Learning Disability (all ages), Diabetes (all ages), Epilepsy (all ages), Asthma (all ages), Autism and Consanguinity.

Measuring disability in childhood is difficult, because the notion of disability is multi-dimensional, dynamic and contested. Definitions vary across different settings. Most robust estimates and local data suggest that there are approximately 2,000 children and young people aged 0-19 with a disability in Tower Hamlets.

In 2013, 1,562 children who attended a school in Tower Hamlets had statements of SEN, equivalent to 3.6% of the school population. The number of pupils with a statement of SEN maintained by the Local Authority, but not included in that figure (i.e. with a statement of SEN but who attended a school out of borough), increased by 21.2% between 2009 and 2013. Statemented and non-statemented SEN levels are higher than both England and London.

The impact of disability upon a child and it's family are multiple:

1. Greater exposure to the social determinants of poor health, specifically poverty;
2. Health inequalities in access to services and outcomes;
3. Specific health impacts aside from the child's disability;
4. Multiple impairments;
5. Increased risk of harm through neglect and violence;
6. Social barriers and exclusion.

There are a number of factors affecting the presentation of children with disabilities that will have an impact on future service provision:

1. The *proportion* of children identified as having a disability has remained broadly constant – however the *number* of children identified as having a disability is increasing due to the increasing 0-19 population;
2. An increasing number of children with statements of SEN are staying in education beyond 16 years;
3. Children with disabilities are being identified by services earlier.

The Children and Families Bill (2013)represents a profoundly new approach to special educational needs and disability and is being implemented from 2014.

Recommendations

1. Review and learn from joint and single agency commissioning (and from what works well at Joint Commissioning Panel) to support the development of integrated services; includingwhere appropriate to local circumstances use of section 75s, pooled budgets and joint appointments to overcome some of the complexity of funding & providing Education, Health and Care Plans;
2. For commissioners to be cognisent of new statutory obligations (Children and families Bill & the NHS Mandate) to work collaboratively and jointly commission services for children – using the Health & wellbeing board as the mechanism/vehicle to facilitate this.

- Need to ensure sustainable provision of appropriately skilled nursing staff to support children's medical needs during their short breaks and develop a sustainable response to issues arising around care during transport;

3. Experience of transition still needs to be improved, in particular issues around preparing children and young people and their families for the reality that eligibility for adult services is more restricted – what might supporting families and CWD to build resilience and independence look like?
4. Need to review and address the challenges around meeting the accommodation needs of families and young people;
5. Family finding for Looked After Children with disabilities (approximately 26/year);
6. Review provision of services to meet mental health needs of adolescents with learning disabilities (prevalence of depression is higher in adolescents with learning disability than in than in their peers) in order to identify additional commissioning needs e.g. increasing counseling support for adolescents with disabilities, delivered by appropriately qualified practitioners.
7. Ensure that post diagnosis support (as delivered in Childrens' Centres and by Childrens' Society) is replicated and accessible at further key transition points during the parent/carer and child's journey.

1. What is disability in childhood?

The UN Convention on the Rights of Persons with Disabilities defines disabilities as "long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder [a person's] full and effective participation in society on an equal basis with others."[1]

Article 7 draws attention to the rising profile of childhood disability and the need "to ensure the full enjoyment by children with disabilities of all human rights and fundamental freedoms on an equal basis with other children."

This view of disability is consistent with UNICEF's focus on protection of children with disabilities against discrimination[2] and with the framework of the International Classification of Functioning, Disability and Health, in which disability is regarded as an "an umbrella term for impairments, activity limitations and participation restrictions…the interaction between individuals with a health condition (e.g. cerebral palsy, Down syndrome and depression) and personal and environmental factors (e.g. negative attitudes, inaccessible transportation and public buildings, and limited social supports)."[3]

The specific and unique aspects of disability in childhood require disability to be set in the context of delays, deviations, and variations in expected growth and development.[4]

In the UK, one study estimated that 7.3% of children aged under 18 years old were reported to be disabled as defined by the Disability Discrimination Act (DDA).[5]

The DDA is superseded by the Equality Act (2010), section 6 of which states that a person is disabled if they have a disability which is defined as:

- Physical or mental impairment;
- Impairment that has a substantial and long term adverse effect on their ability to carry out normal day-to-day

[1]UN enable. Frequently asked questions regarding the Convention on the Rights of Persons with Disabilities.http://www.un.org/disabilities/default.asp?id=151.(accessed July 30, 2013).
[2]UNICEF. Childinfo: monitoring the situation of children and women. http://www.childinfo.org/disability.html.(accessed July 17, 2013).
[3]World Health Organization (WHO) International Classification of Functioning, Disability and Health (2001)
[4]The International Classification of Functioning, Disability and Health for Children and Youth (ICF-CY)
[5]Blackburn CM et al. Prevalence of childhood disability and the characteristics and circumstances of disabled children in the UK: secondary analysis of the Family Resources Survey. BMC Pediatrics. Apr 2010.

activities;

A child with a progressive degenerative condition meets the criteria if their condition is likely to result in a 'substantial and long term adverse effect' in the future, even if it does not currently do so. It also includes those who would have such difficulties or problems if they did not take medication.

Local education services play a significant role in supporting children with a range of disabilities. Children are considered to have special educational needs (SEN) if they have a learning difficulty that calls for special educational provision to be made for them, with three levels of SEN:

- School Action – extra or different help is provided to the child;
- School Action Plus – extra or different help is provided to the child, plus the class teacher and school's Special Educational Needs Coordinator (SENCO) receive advice or support from outside specialists, e.g.,

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[6]Rosenbaum P; Cerebral palsy: what parents and doctors want to know.BMJ. 2003 May 3;326(7396):970-4.
[7]Defined as performance two or more standard deviations below the mean on age appropriate standardised norm-referenced testing.
[8]Baird G, Simonoff E, Pickles A, Chandler S, Loucas T, Meldrum D, Charman T. Prevalence of disorders of the autism spectrum in a population cohort of children in South Thames: the special needs and autism project (SNAP). Lancet2006;368:210-5.
[9]Blanchard LT, Gurka MJ, Blackman JA. Emotional, developmental, and behavioural health of American children and their families: a report from the 2003 national survey of children's health. Paediatrics2006;117:e1202-12.
[10]Horridge KA. Assessment and investigation of the child with disordered development. Arch Dis Child EducPract Ed2011;96:9-20.
[11] NICE CG72 Attention deficit hyperactivity disorder (ADHD)
[12]The child with general learning disability: for parents and teachers (Factsheet 10), Royal College of Psychiatrists, 2004
[13] Emerson E, Hatton C, Robertson J, Roberts H et al (2010) People with Learning Disabilities in England 2010
[14]Department for Education, Special Educational Needs in England 2013
[15] Emerson E (1997) 'Is there an increased prevalence of severe learning disabilities among British Asians?' Ethnicity and Health, 2:317–321.
[16]Mir, G., Nocon, A., Ahmad, W., et al (2001) Learning Difficulties and Ethnicity. London: Department of Health.
[17] Baxter C (1998) 'Learning difficulties', pp. 231–242 in: Rawaf S and Bahl V, (eds.) Assessing Health Needs of People from Minority Ethnic Groups, London: Royal College of Physicians/Faculty of Public Health Medicine.
[18] Emerson E (1997) *Ibid*
[19]Emerson, E., Baines, S., Allerton, & Welsh, V. (2011).Health Inequalities and People with Learning Disabilities in the UK: 2011. Durham: Improving Health & Lives: Learning Disability Observatory.
[20]*Ibid*
[21] Department of Health (2005) Vaccination services: reducing inequalities in uptake. London: Department of Health
[22]Peckham C, Bedford H, Seturia Y et al. (1989) The Peckham report – national immunization study: factors influencing immunisation uptake in childhood. London: Action Research for the Crippled Child
[23]Heslop P, Blair P, Fleming P, Hoghton M, Marriott A, Russ L. Confidential inquiry into premature deaths of people withlearning disabilities (CIPOLD): final report. Mar 2013. www.bris.ac.uk/cipold/fullfinalreport.pdf
[24] Emerson E, Baines S, Allerton L, Welch V (2011) *ibid*
[25]*ibid*
[26] The Mental Health of Children and Adolescents with Learning Disabilities in Britain (2007), Institute for Health Research, Lancaster University
[27] Emerson et al (2011) *ibid*
[28] Jones L, Bellis MA, Wood S, Hughes K et al. (2012) Prevalence and risk of violence against children with disabilities: a systematic review and meta-analysis of observational studies. The Lancet - 8 September 2012 (Vol. 380, Issue 9845, Pages 899-907) DOI: 10.1016/S0140-6736(12)60692-8. http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(12)60692-8/fulltext?_eventId=login
[29]Sheddena S, Taylora V, Pajaka R, Corredor-Lopez P 2013. Parenting children with disabilities is hard. Does parenting style contribute to experience of parental stress in parents of children with additional needs? LBTH Disabled Childrens' Outreach Service

an educational psychologist;
- Statement of SEN – the pupil has a statement of SEN, a legal document that specifies the child's needs and the extra help they should receive.

The categories "School Action" and "School Action Plus" will cease to exist once the Children and Families Bill is passed (2014).

Separate fact sheets exist on Learning Disability (all ages), Diabetes (all ages), Epilepsy (all ages), Asthma (all ages), Autism and Consanguinity.

Types of disability

There is a wide spectrum of disabilities that can affect children. These can broadly be categorised into physical and learning disabilities, although there is often an overlap between the two.

Physical disability

There are many physical disabilities that can affect children, such as delayed walking, deafness or visual impairment. Cerebral palsy (CP) is the most common physical disability in childhood.[6] Approximately 2 per 1,000 infants in developed countries are born with the condition, which provides an umbrella term for a broad group of non-progressive motor impairment conditions secondary to lesions or anomalies of the brain arising in the early stages of development.

There are other conditions that may not usually be considered as disabilities but are chronic in nature and therefore can have an impact on the child's development indirectly (e.g. through days lost at school, inability to partake fully in physical activities, need to take medication regularly). These include asthma or diabetes for example.

Global development delay

Clinically the term "global developmental delay" means a significant delay[7] in two or more of the four main developmental domains (gross and fine motor skills, speech and language, social and personal and activities of daily living, performance and cognition).
In the United Kingdom the term global developmental delay is usually reserved for younger children (under 5 years of age) while **learning disability** is usually applied to older children, when IQ testing is more valid and reliable (although formal testing of IQ is rarely performed in clinical practice and the child's assessment is based on functional abilities).
Global developmental delay affects 1-3% of children. About 1% (95% confidence interval 90-141/10□000) of children have an autism spectrum disorder,[8] 1-2% a mild learning disability, 0.3-0.5% a severe learning disability, and 5-10% have a specific learning disability in a single domain.[9,10](There is some disagreement about categories of severity, possibly stemming from international differences in definitions of learning disabilities, and international mixtures of research evidence in epidemiological studies.)

Again, there is a significant list of associated conditions, the most well-known being Down's syndrome. The effects may be far-reaching, with speech and communication problems which can result in (or be associated with) behavioural problems. Associated physical problems are common.

Autism

Autistic Spectrum Disorder (ASD) is a lifelong developmental disorder characterised by impairments in social interaction, social imagination and communication. The spectrum includes autism and Asperger's syndrome. People with ASD may have a range of very different needs; some people may be non-verbal or have a severe learning disability, whilst those with Asperger's syndrome often have an average or above average IQ. The National Autistic Society states that "estimates of the proportion of people with autism spectrum disorders

(ASD) who have a learning disability, (IQ less than 70) vary considerably, and it is not possible to give an accurate figure. Some very able people with ASD may never come to the attention of services as having special needs, because they have developed strategies to overcome any difficulties with communication and social interaction, and found fulfilling employment." See Tower Hamlets' Autism JSNA for further information.

ADHD

ADHD is a heterogeneous behavioural syndrome characterised by the core symptoms ofhyperactivity,impulsivity and inattention. While these symptoms tend to cluster together, somepeople are predominantly hyperactive and impulsive, while others are principally inattentive. Twomain diagnostic criteria are in current use – the International Classification of Mental andBehavioural Disorders 10th revision (ICD-10) and the Diagnostic and Statistical Manual of MentalDisorders 4th edition (DSM-IV). ICD-10 uses a narrower diagnostic category, which includespeople with more severe symptoms and impairment. DSM-IV has a broader, more inclusivedefinition, which includes a number of different ADHD subtypes.[11]

Sensory impairment

'Sensory impairment,' is a term used to encompass visual impairment (those who are sight impaired or severely sight impaired) and hearing impaired (those who are profoundly deaf, deafened or hard of hearing). Sensory impairments may be congenital or acquired at any age.

Risk factors

Global Development Delay/Learning Disabilities may be caused by genetic factors, infection prior to birth, brain injury at birth, brain infection, brain damage after birth or have an unknown cause.[12]

One report found that nationally SEN associated with learning disabilities is more common among boys, children from poorer families and among some minority ethnic groups. Moderate and severe learning difficulties are more common among Traveller and Gypsy/Romany children. Profound multiple learning difficulties are more common among Pakistani and Bangladeshi children (who account for 62.5% of the 0-17 year old population in Tower Hamlets).[13] However, for school aged pupils with statements of SEN across England as a whole in 2013, 2.5% were Asian (2.7% were Bangladeshi) compared to 3.1% White (3.2% White British)[14] (see Table 6 and Figure 1 in appendix).

In Tower Hamlets 45.9% of children under the age of 16 live in families inreceipt of out of work benefits or tax credits where theirreported income is less than 60% median income in 2010 (compared to 21.1% in England).There is a well-established link between socioeconomic deprivation and the prevalence of mild or moderate learning difficulties[15] reflected in lower income, poorer housing, higher unemployment and a greater reliance on welfare benefits. Some evidence of a link between severe learning difficulties and poverty has been reported.[16]

High levels of material and social deprivation have been found amongst South Asian people with learning disabilities and their families. It has been suggested that such deprivation may combine with other factors – such as inequalities in access to maternal health care, misclassification and higher rates of environmental or genetic risk factors – to produce the much higher prevalence rates.[17, 18]

Genetic risk factors may also play a role in influencing the prevalence of certain physical disabilities (those associated with autosomal recessive conditions for example), but it is important to note that how these factors play out locally to influence the prevalence of disability in Tower Hamlets is not straightforward.

What is the impact of disability in childhood?

Health inequalities

People with disabilities report seeking more health care than people without disabilities and have greater unmet

needs, and hence experience poorer health than the general population, differences which are to a large extent avoidable, and thus represent health inequalities.

Five key determinants of health inequalities for people with disabilities have been identified:[19]

1. Greater risk of exposure to social determinants of poorer health such as poverty, poor housing, unemployment and social disconnectedness.
2. Increased risk of health problems associated with specific genetic and biological causes of learning disabilities.
3. Communication difficulties and reduced health literacy.
4. Personal health risks and behaviours such as poor diet and lack of exercise.
5. Deficiencies relating to access to healthcare provision.

It is to be expected that children with learning disabilities would have poorer health, not because of their learning disability per se but because they are more likely than their non-disabled peers to be exposed to a range of 'social determinants' of poorer health. It has been estimated that increased exposure to low socio-economic position/poverty may account for:

- 20–50% of the increased risk for poorer physical and mental health among British children and adolescents with learning disabilities;
- 29-43% of the increased risk for conduct difficulties and 36-43% of the increased risk for peer problems among Australian children with learning disabilities or borderline learning functioning;
- a significant proportion of increased rates of self-reported antisocial behavior among adolescents with learning disabilities;
- 32% of the increased risk for conduct difficulties and 27% of the increased risk for peer problems among a nationally representative sample of 3 year old British children with developmental delay.[20]

Inequalities in access and outcomes

Health promotion and prevention activities often don't target people with disabilities[21, 22] and people with disabilities are particularly vulnerable to deficiencies in health care services.[23] Depending on the group and setting, people with disabilities may experience greater vulnerability to secondary conditions, co-morbidities, age-related conditions, engaging in health risk behaviors (such as smoking, poor diet and physical inactivity) and have higher rates of premature death.

Specific health impacts aside from the child's disability

The risk of children being reported by their main carer to have fair/poor general health is 2.5-4.5 times greater for children with learning disabilities when compared to their non-disabled peers.[24]

A number of syndromes associated with learning disabilities are also associated with specific health risks. Mental health problems and challenging behaviours are more prevalent among people with autistic spectrum disorders, obesity and sleep problems are more prevalent among people with Down's Syndrome; the prevalence of epilepsy rises from .5% - 1% in the general population to up to 35% among those with moderate learning disability and 30% among those with severe and profound disability.Studies suggest that the prevalence of depression is higher in adolescents with learning disability than in typically developing adolescents,[25] and children and young people with learning disabilities are 6 times more likely to have mental health conditions than other young people.[26]

Multiple impairments

Many people experience multiple types of impairment, for example:

- People with learning disabilities are 8-200 times more likely to have a visual impairment compared with the general population;
- Approximately 40% of people with learning disabilities are reported as having a hearing impairment;
- People with Down's syndrome are at particularly high risk of developing vision and hearing loss;

- It has been estimated that between 20-33% of people with learning disabilities also have an autistic spectrum disorder (ASD), and that 55% of children aged 10-14 with ASD also have learning disabilities.[27]

Increased risk of harm

Children with disabilities are three to four times more likely to be victims of violence: 3.7 times more likely for combined measures of violence, 3.6 times for physical violence and 2.9 times for sexual violence. Children with mental or intellectual disabilities were found to be 4.6 times more likely to be victims of sexual violence than peers without disabilities.[28]

Parenting a child with additional needs is associated with increased stress levels in parents, and local research suggests that this is the case in Tower Hamlets also.[29]

Social barriers and exclusion

A disabled child's quality of life is determined not solely by their impairments (and subsequent health and social care needs), but the other barriers that often result in them being excluded from family and community activities such as poverty, negative attitudes and a disabling environment, for example, unequal access to education, healthcare, leisure activities, transport and housing.

2. What is the Policy Context?

National policy

A number of UK statutes influence services for children and young people with disabilities, setting out the broad legal framework and establishing the rights of children with learning difficulties and disabilities, most notably:

Children Act 1989 - Children with disabilities are children 'in need' as defined by section 17(10(c)) of the Act and are entitled to a range of support services depending on their circumstances. Section 17(11) of the Act states '...a child is disabled if he is blind, deaf or dumb or suffers from mental disorder of any kind or is substantially and permanently handicapped by illness, injury or congenital deformity or such other disability as may be prescribed.'

This definition that also applies to children under the two following Acts:

- Disabled Persons (Services, Consultation and Representation) Act 1986 (section 16)
- Chronically Sick and Disabled Persons Act 1970 (section 28a)

Section 25 of the Children and Young Persons Act 2005 requires local authorities to provide Short Breaks for Disabled Children. From April 2011, a new legal duty came into force on local authorities to provide a range of Short Break services including:

- Overnight care in the homes of disabled children or elsewhere
- Day time care in the homes of disabled children or elsewhere
- Educational or leisure activities for disabled children outside their homes
- Services available to assist carers in the evenings, at weekends and during the schools holidays.

Health commissioners and provider NHS Trusts have statutory responsibilities defined in the Equality Act 2010, the Mental Capacity Act 2005 and the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, as well as the UN Convention on the Rights of Persons with Disabilities.
The Mandate from the Government to the NHS Commissioning Board (2012), requests that the NHS CB "support children and young people with special educational needs or disabilities, to ensure that these children and young people have access to the services identified in their agreed care plan and that, from April 2014, their parents

are able to ask for a personal budget based on a single assessment across health, social care and education" as part of its objectives.

Most, but not all, children with disabilities will be assessed as having Special Educational Needs (SEN). The provision for these children falls within Part IV of the Education Act 1996 as amended by more recent legislation such as the Special Educational Needs and Disability Act 2001. Provision for these pupils is guided by the SEN Code of Practice (2001).

The current UK Government published the Support and aspiration: A new approach to special educational needs and disability Green Paper in 2011 in order to address weaknesses that it perceived as being inherent in the current system of education provision for children with special needs, namely that children did not have a voice, teachers were given insufficient training and support, too many assessments were involved, appropriate support could be too difficult to access and that the appeals process was costly. Draft legislation was presented to Parliament in September 2012.

The Children and Families Bill (2013) takes forward the Coalition Government's commitments to improve services for vulnerable children and support strong families. It sets out to reform the systems for adoption, looked after children, family justice and special educational needs.It takes forward the reform programme set out in Support and aspiration: A new approach to special educational needs and disability.

Key measures relating to SEND are:

- Replacing SEN statements and Learning Difficulty Assessments (for 16 to 25 year-olds) with a single, simpler 0 to 25 assessment process and Education, Health and Care Plan from 2014. Statutory protections comparable to the Statement extended to 25 (if in further education).
- Revised Code of Practice
- Requiring local authorities to publish a local offer showing the support available to disabled children and young people and those with SEN, and their families. This must include information on the education, health and care services available locally.
- Giving parents or young people with Education, Health and Care Plans the right to a personal budget for their support
- Local Authorities and Clinical Commissioning Groups must make arrangements for joint commissioning

The Coalition Government introduced the Care and Support Billto Parliament on 10th May 2013 initiating the formal legislative process to implement principles from the draft Care and Support Bill, the Dilnot Commission into the future funding of social care, and the Law Commission for Adult Social Care.The Bill is split into three primary parts:

- The reform of care and support;
- The response to the Francis Inquiry (on failings at Mid Staffordshire Hospital);
- The establishment of Health Education England and the Health Research Authority.

Current national policy developments, including changes to social housing provision, the welfare reform programme, changes to education funding and reform of the health service, pose challenges and opportunities for the borough and are likely to impact in particular upon families with children with disabilities.

Local policy

Tower Hamlets Health and Well-Being Strategy

The strategic vision is "to improve health and wellbeing through all stages of life to reduce health inequalities and promote choice, control and independence".

Within the priority area 'Maternity and Early Years'the strategy prioritises 'early detection and treatment of

disability and illness' and that 'all parents and children achieve positive physical and emotional development milestones'. Within the 4th priority area - long term conditions and cancer which includes disabilities the strategy identifies 'increasing identification, diagnosis of learning disability', 'ensuring robust and integrated care and support, including a focus on improved housing options and support for young people' and 'improving engagement and understanding of carers by primary care services including improved recognition of specific needs of carers, increased use of carers' registers, and greater provision of health checks' as priorities.

The Tower Hamlets Children and Families Plan 2012-2015 sets out the vision all children and young people to be safe and healthy, achieve their full potential, be active and responsible citizens and emotionally and economically resilient for their future. To help us achieve this vision for children with disabilities, the London Borough of Tower Hamlets and Tower Hamlets NHS promote inclusion by ensuring services in universal settings can be accessed by children with disabilities and additional needs. Additional services are targeted to the needs of those with more complex needs and there is a commitment to services being timely, accessible, coordinated and responsive to the needs of children, young people and their carers.

3. What are the effective interventions?

Commissioning services for people with learning disabilities is a substantial test of working together in effective partnerships and, through this, securing better health and support for local people while safeguarding this most vulnerable group of the population. Commissioning services for people with learning disabilities is complex as many people have a wide range of needs that can be the responsibility of a number of services.[30]

The Children and Families Bill (2013) sets out the vision that:

- Children's SEN are picked up early and support is routinely put in place quickly – Early Support for complex needs and systems from the start
- Staff have the knowledge, understanding and skills to provide the right support for children and young people who have SEN or are disabled;
- Parents know what they can reasonably expect their local school, college, LA & local services to provide, without having to fight for it;
- Aspirations for children and young people are raised through an increased focus on life outcomes, including employment;
- For more complex needs, an integrated assessment and a single Education, Health and Care Plan are in place from birth to 25;
- There is greater control for parents and young people over the services they and their family use.

Health Inequalities and People with Learning Disabilities in the UK: 2011Learning Disabilities Public Health Observatory - translates the key messages from previous review into advice for commissioners. Sets out a number of key commissioning actions including:

- Ensuring that the health inequalities faced by people with learning disabilities are carefully documented in the Joint Strategic Needs Assessment (JSNA);
- Taking action to commission with all relevant partner agencies, services which address the determinants of health inequalities where these are linked to:
  - social factors such as poverty and poor housing
  - specific conditions
  - poor communication and understanding of health issues

[30] Royal College of General Practitioners (2012) Improving the Health and Wellbeing of People with Learning Disabilities: An Evidence-Based Commissioning Guide for Clinical Commissioning Groups (CCGs). http://www.rcgp.org.uk/ (accessed 02/09/2013)

  - individual lifestyles
  - the way healthcare is delivered.
- Improving the number and quality of annual health checks;
- Ensuring that requisite reasonable adjustments are implemented in all health care settings;
- Raising awareness of healthy lifestyles with people who have learning disabilities, their families and paid supporters;
- Measuring progress using tools such as the Performance and Self- Assessment Framework (Department of Health 2009).

The Government's Mandate to the NHS Commissioning Board (2012) says: "The NHS Commissioning Board's objective is to ensure that CCGs work with local authorities to ensure that vulnerable people, particularly those with learning disabilities and autism, receive safe, appropriate, high quality care. The presumption should always be that services are local and that people remain in their communities; we expect to see a substantial reduction in reliance on inpatient care for these groups of people." (para. 4.5)

The Joint Commissioning Panel for Mental Health has published good practice guidance on Commissioning mental health services for people with learning disabilities[31]. The full range of mental health services should be accessible to people with learning disabilities and mental health problems, and mental health and learning disability services should work together to ensure that there is a single point of access and robust local pathways for people with overlapping needs that are delivered in the least restrictive way possible. The JSNA should include information about the needs of people with learning disabilities and mental health problems, and Health and Wellbeing Boards should facilitate joint working.

Healthy Child Programme (0-19) + "Getting it right for children, young people and families"[32]is a new national framework for the school nursing service to be adapted to meet local health needs and circumstances.

The National Service Framework for Children, Young People and Maternity Services (2004)set standards in children's health and social care serviceshealth support for disabled children and their families. There are specific standards to address the requirements ofchildren and young people who are disabled and/or have complex healthneeds and their families (standard 8), andto address the needs of childrenand young people who are ill (standard 6). The mental health and psychological wellbeingof disabled children and young people, particularly those with learningdisability, are addressed in Standard 9. Standard 8 sets out that disabled children and young people need to receive co-ordinated, high quality child and family centred services based on assessed needs that help promote social inclusion and enable children and families to live ordinary lives whenever possible.

Aiming high for disabled children: better support for families (2007) set out what good services for children and young people with a disability and their families should look like, including:
- Improved provision of information and greater transparency in decision making;
- Putting families in control of the design and delivery of their care package and services;
- Supporting disabled children and young people and their families and carers to shape services;
- Ensuring that services are responsive and provide timely support;
- Ensuring early intervention through good prioritisation of needs;

[31]Joint Commissioning Panel for Mental Health (2013).Mental health services for people with learning disabilities
[32] Department of Health (March 2012). Getting it right for children, young people and families. Maximising the contribution of the school nursing team: Vision and Call to Action. London. Department of Health. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216464/dh_133352.pdf
[33]Mansell, J. (2007). Services for People with Learning Disabilities and Challenging Behaviour or Mental Health Needs. Report of a project group (revised edition).

- Provision of good joined-up care across services;
- Provision of high-quality vital services for disabled children and young people – e.g. short breaks, wheel chairs and equipment;
- Ensuring that children, families and carers have a consistent experience, independent of the service they are using.

The Children's Trust Tadworth and Every Disabled Child Matters have produced a charter for Health and Wellbeing Boards (2013) setting out the following commitments in relation to understanding and meeting the needs of children with disabilities:

- To have detailed and accurate information on the disabled children and young people living in our area, and provide public information on how we plan to meet their needs
- to engage directly with disabled children and young people and their participation is embedded in the work of our Health and Wellbeing Board
- toengage directly with parent carers of disabled children and young people and their participation is embedded in the work of our Health and Wellbeing Board
- to set clear strategic outcomes for our partners to meet in relation to disabled children, young people and their families, monitor progress towards achieving them and hold each other to account
- to promote early intervention and support for smooth transitions between children and adult services for disabled children and young people
- to work with key partners to strengthen integration between health, social care and education services, and with services provided by wider partners
- to provide cohesive governance and leadership across the disabled children and young people's agenda by linking effectively with key partners

"Services for people with learning disabilities and challenging behaviour or mental health needs" (2007)[33]This good practice guidance sets out the actions that should be taken in order to effectively meet the needs of people with challenging behaviour. The guidance contained in this document supports the agenda set out in 'Valuing People' (2001) and the focus on personalisation and prevention in social care.

NICE guidance

PH12: Social and emotional wellbeing in primary education (2008)
PH20: Social and emotional wellbeing in secondary education (2009)
PH21: Reducing differences in the uptake of immunisations (2009)
PH28: Looked-after children and young people (2010)
PH40: Social and emotional wellbeing: early years (2012)

CG72: Attention deficit hyperactivity disorder: Diagnosis and management of ADHD in children, young people and adults (2008, modified 2013)
CG145: Spasticity in children and young people with non-progressive brain disorders: Management of spasticity and co-existing motor disorders and their early musculoskeletal complications (2012)
CG158: Antisocial behaviour and conduct disorders in children and young people: recognition, intervention and management (2013)
CG170: Autism - management of autism in children and young people (2013)

4. What is the local picture?

Prevalence estimates vary considerably and although a range of UK administrative, population census and survey sources contain data, the availability of current reliable quantitative data to inform public health planning and the commissioning and provision of services at national and local level has been limited.[34,35,36,37, 38]

Prevalence of disability

Table 1 suggests that there is a confluence of estimates and local data from the more robust sources of between 1,600 and 2,000 children and young people with a disability in Tower Hamlets. The Secondary analysis of Family Resources Survey (2010) is nonetheless interesting as the analysis is of a large sample of children (16,000) and the overall estimate of prevalence might be expected to be fairly reliable.

Table 1: Summary of main sources of data relating to prevalence and numbers of children with disabilities

Data Source	Age Range Covered	Number of people in TowerHamlets with a disability	Prevalence (percentage of the population)
Census 2011	0-15	1,966	3.9%
DWP Disability Living Allowance (2013)	0-17	1,850	3.2% (based on total population 57,3000 GLA 2013 estimate)
Tower Hamlets Council Children with Disabilities Register (2012/13)	0-19	1,728	2.7% (based on total population of 62,500 GLA 2012/13 mid-year estimate)
Secondary analysis of 2004/05 Family Resources Survey (2010) (National estimate of prevalence applied to TH population)	0-18	4,770 (4509 – 5032)	7.3% (6.9 - 7.7)

Census 2011 "activity limiting health problems or disabilities"

The 2011 ONS Census analysis describes the health of the population of England and Wales in respect to activity limiting health problems or disabilities.[39] 2.1% (1,040) of children aged 0-15 in Tower Hamlets are reported as having an activity limiting health problem or disability that limits their day to day activities a little and 1.8% that limit day to day activities a lot (926). These are broadly similar responses as London and England.

Therefore 1,966 children aged 0-15 in Tower Hamlets report having a health problem or disability that limits their day to day activity at least a little.

National prevalence estimates

A number of surveys suggest a national prevalence ranging from 3.0% to 7.7% of children aged 0-18 with a disability. This would translate to between 1,729 and 4,439 of the 0-18 population in Tower Hamlets (see table 2 in Appendix 1).

One analysis[40] of national data (The Family Resources Survey) suggested a 7.3% (95% CI 6.9, 7.7) prevalence of children with a DDA-defined disability, 8.8% of boys and 5.8% of girls, with the lowest prevalence being in the 0-4 age group (3.7%) then increasing (8.2% in the 5-11 age group) to 9.5% between the 12-15 and falling off in the 16-18 age group to 8.5%.

The report found that the prevalence of DDA-defined disability among UK children appeared to increase across income quintiles, with the highest prevalence of childhood disability found among those in the poorest income quintile.[41]

In this national analysis the ethnicity of children with disability was 7.6% White UK/other, 9.5% Mixed,7.1% Black or Black British, 5.1% Pakistani and Bangladeshi, 4.4% other ethnic group and 2.7% Indian. The only result that is statistically significantly different to the White UK population is that of the Indian group. This is one of the few analyses that estimate ethnicity prevalence, however, while overall prevalence estimates from this study may be fairly reliable due to the large sample size, smaller BME sub-groups may have made further prevalence

estimates less robust. This finding is at odds with other work that suggests that levels of disability amongst South Asian children are higher than their White UK counterparts (for some types of disability).

One study for example suggests that the prevalence of learning difficulties in South Asians aged between 5 and 32 is up to three times higher than in other communities.[42]

Local data

Children in receipt of Disability Living Allowance (DLA)

Department of Work and Pensions Disability Living Allowance returns for Tower Hamlets (Feb 2013) indicate that 330 under 5's, 760 5-11's, 590 11-16's and 170 16-17's claim the allowance (a total for 0-17 of 1,850 children). Everyone in this group would meet the definition of disability in the Equality Act 2010, but these estimates do not reflect the total number of people covered by the Equality Act.

The Tower Hamlets Council Children with Disabilities Register (2012/13)

This holds information on 1,728 children and young people. The categories A-D are defined below.

Table 2: Number of children and young people on LBTH CWD Register (2012/13)

Category:	Number:	Category description:
A	511	Children and young people with ASD (who have severe learning difficulties or behaviour which is challenging) OR those children and young people whose challenging behaviour is associated with other impairments such as severe learning disabilities
B	395	Children and young people with complex health needs including those with physical and or/ learning disabilities, those who require nursing care and those with associated sensory impairments.
C	721	Children and young people with low-medium learning difficulties/ global delay but disability is not accompanied by a complex health need.
D	101	Children and young people with either hearing loss or visual loss.
Total	1,728	

Child Development Team (CDT) clinic data

Barts Health CDT clinic provides an assessment and co-ordination service for children with multiple disabilities and their families when 2 or more areas of developmental delay are identified in the child. 514 children were identified as having been seen for the first time in the CDT clinic between 01/01/08 and 14/03/13. 68.3% were male and 47.7% were identified as being of Bangladeshi ethnicity, while 53.2% were identified as speaking Bengali or Sylheti at home.Further analysis is being carried out on this dataset.

Prevalence of Special Educational Needs (including Learning Disabilities)

Three types of SEN, when combined are roughly equivalent to learning disabilities:[43]

- Moderate learning difficulty;
- Severe learning difficulty ;
- Profound Multiple Learning difficulty.

While there is a reasonable amount of information on children with SEN and the type of need that they have (as set out in the tables below) it is important to insert the caveat that not all of this data is linked to a readily replicable definition (referring in particular to tables 7 and 8).

Table 3: Summary of main sources of data relating to prevalence and numbers of children with SEN and Learning Disabilities

Data Source	Age Range Covered	Number of people in TowerHamlets with a disability	Prevalence
Special Educational Needs with Statement Department of Education 2013 (based on where child attends school)[44]	School aged children	1,562	3.6%
Special Educational Needs (without statement) Department of Education 2013(based on where child attends school)[45]	School aged children	7,067	16.2%
Learning Disabilities Observatory (2010) (National estimate of prevalence applied to TH population)	7-15	1,711	7.5%

The Learning Disabilities Observatory calculated (using 2010 school census) how many schoolchildren aged 7-15 may be expected to have learning disabilities in Tower Hamlets.[46] If Tower Hamlets' prevalence reflected the national prevalence then the numbers of children that would be expected to have learning disabilities in Tower Hamlets would be as in table 4.

Table 4: National prevalence of children with learning disabilities and numbers expected in Tower Hamlets

Category	Rate	Estimated number of children (**aged7-15**) in Tower Hamlets (2010 figures – total of 22,703 children)
Severe Learning Difficulties	37.9/10,000	86
Profound and Multiple Learning Difficulties	13.2/10,000	30
Moderate Learning Difficulties	647/10,000	1,469
Autistic Spectrum Disorder	55.5/10,000	126
Total	/	1,711

Number of children with Special Educational Needs

In 2013 1,562 children (all schools) who attended a school in Tower Hamlets had statements of SEN, 3.6% of pupils. 664 of state funded primary and 496 of state funded secondary school age children had statements of SEN. This is equivalent to 2.7% of the primary and 3.2% of the secondary school population. Both statemented and non-statemented SEN levels are higher than both England and London.

The percentage of pupils with statements of SEN is consistently higher for Tower Hamlets (3.6% in 2013) than for the neighboring boroughs of Newham (.8%) and Hackney (3.2%). See tables 4-5 in Appendix 1.

A further 183 pupils had a statement of SEN maintained by the London Borough of Tower Hamlets in 2013 (i.e. with a statement of SEN but who attended a school out of borough), an increase of 21.2% between 2009 and 2013. See table 6 in Appendix 1.

In practice, many children with SEN are also defined as having a disability under the Equality Act. However, not all disabled children have an SEN and not all children with SEN have a disability.

Tables5and 6 summarise the primary need of children referred into the Educational Psychology Service of under 5's, and the main presenting need of older children at the end of 2012.

Table 5: Primary need at referral under 5's, 2011-12 academic year (Sept 2011 – Aug 2012)

Primary need	Number	%
Global Development Delay	39	33%
Speech and Language need	25	21%
Autism	31	26%
Physical	8	7%
Hearing impairment	6	5%
Visual impairment	3	3%
Behavioural, Emotional and Social Development	1	1%
Insufficient information	6	5%
Total	**119**	**100%**

Table 6: Main presenting need at the conclusion of the statutory assessment process 2011/12 academic year (aged 5 - 18)

Primary need	**Number**	**%**
Speech, language and communication needs	480	29.3
Autistic Spectrum Disorder	267	16.3
Global Developmental Delay	265	16.2
Behavioural, Emotional and Social Development	211	12.9
Hearing Impairment	90	5.5
Physical Disability	80	4.9
Profound Multiple Learning Disability	70	4.3
Severe Learning Disability	68	4.1
Medical condition	53	3.2
Visual Impairment	36	2.2
Specific Learning Disability	19	1.2
Total	**1639**	100.0

Tables 6 and 7 summarise the type of need for those children who have a statement or 'School Action Plus' at primary and secondary school in Tower Hamlets.

Learning disabilities

There were 563 school-aged children identified as having a learning disability in Tower Hamlets in 2013.There are large differences between the numbers of children in some categories and those estimated as 'expected' (1,585) by the Learning Disability Observatory (table 4 above). Further analysis is needed to ascertain whether category definitions align closely, and if they do, why Tower Hamlets' actual numbers differ to such an extent for some categories.

A cross cultural study of Asian and white British families[47] found that Asian British families were significantly more likely to want care to be provided by a relative than the white British families, who were more likely to want care to be provided in a community home provided by statutory or voluntary services. The study also found that Asian Britishfamilies were significantly less likely to know the name of their child's condition (learning disability) and that over half did not know the cause oftheir child's learning disability. Such cultural factors are likely to influence levels of local identified need.

Physical disabilities

From tables 7 and 8 below it can be seen that there were 168 school-aged children identified as having a physical disability in Tower Hamlets in 2013.

Sensory Impairment

There were 177 school-aged children identified as having a hearing impairment, 61 identified as having a visual impairment and 3 identified as having a multi-sensory impairment in Tower Hamlets in 2013.

Table 7: Number and % of Primary school pupils with statement of SEN or School Action Plus by type of need (Jan 2013)[48]

	England	London	Tower Hamlets	
	%	%	No.	%
Speech, Language & Communication Need	30.6	37.6	1,102	46.1
Behaviour, Emotional & Social Difficulties	18.4	17.8	333	13.9
Moderate Learning Difficulty	20.3	14.2	235	9.8
Specific Learning Difficulty	9.1	8.0	187	7.8
Autistic Spectrum Disorder	7.8	9.2	147	6.1
Other Difficulty/Disability	4.2	4.2	111	4.6
Hearing Impairment	2.3	2.1	101	4.2
Physical Disability	4.0	3.7	84	3.5
Severe Learning Difficulty	1.3	1.3	44	1.8
Visual Impairment	1.3	1.1	29	1.2
Profound & Multiple Learning Difficulty	0.5	0.5	15	0.6
Multi-Sensory Impairment	0.2	0.2	3	0.1
Total	**100.0**	**100.0**	**2,390**	**100.0**

Table 8: Number and % of Secondary school pupils with statement of SEN or School Action Plus by type of need (Jan 2013)[49]

	England	London	Tower Hamlets	
	%	%	No.	%
Speech, Language & Communications Need	10.1	15.4	381	25.3
Behaviour, Emotional & Social Difficulties	27.7	30.3	378	25.1
Moderate Learning Difficulty	21.6	18.7	233	15.5
Specific Learning Difficulty	15.8	14.2	182	12.1
Physical Disability	3.9	3.1	84	5.6
Hearing Impairment	2.9	2.4	76	5.0
Autistic Spectrum Disorder	9.8	8.0	54	3.6
Other Difficulty/Disability	5.7	5.4	49	3.3
Visual Impairment	1.5	1.3	32	2.1
Severe Learning Difficulty	0.9	0.8	29	1.9
Profound & Multiple Learning Difficulty	0.1	0.2	7	0.5
Multi-Sensory Impairment	0.1	0.1	x	x
Total	**100.0**	**100.0**	**1,505**	**100.0**

Attention deficit hyperactivity disorder (ADHD)

Literature suggests that using the narrower criteria (of ICD-10, hyperkinetic disorder), 1–2% of children and young people might be expected to experience severe ADHD. This wouldrepresent between 375 and 750 5-17 year olds in Tower Hamlets. Using the broader criteria (DSM-IV, ADHD), 3–9% of school-age children and young

people (between 1,125 and 3,375 5-17 year olds in Tower Hamlets might be expected to experience ADHD. (This assumes a total Tower Hamlets school age (i.e. 5-17) population of 37,500).

Primary care and health co-morbidities

An analysis in 2011-12 of the Tower Hamlets primary care practice data (EMIS) showed the crude prevalence of certain conditions by age group/1000 of the registered practice population. In the tables below a red box indicates that a group or condition is higher than the registered population as a whole, while a green box indicates the reverse. Table 9 shows that the prevalence of learning disabilities is higher amongst 16-24 year olds registered with practices in Tower Hamlets than it is for the total registered population.

Table 9: Crude prevalence per 1000 population by age group in Tower Hamlets[50]

Condition/care group	Tot registered population	0-4	5-15	16-18	19-24
Learning Disabilities	2.8	-	-	4.7	4.2
Serious Mental Illness	8.3	-	-	0.8	3.8

-suggests that there are no cases on practice registers; further analysis needs to be undertaken to establish why this is the case.

The prevalence of the majority of chronic diseases is seen to be higher in those with learning disabilities, with serious mental illness and those that are deaf-affected and registered blind than in the population as a whole. For example, twice the rate of the practice registered population with a diagnosis of learning disability have a diagnosis of asthma than do the general registered population. As learning disabilities and serious mental illness are also prevalent among young and middle-aged people, the high prevalence of chronic disease is in these groups is unlikely to be fully accounted for by an association with older age.

Table 10: Crude disease prevalence per 1000 population by care group in Tower Hamlets[51]

Disease	All	Learning Disability	Serious Mental Illness	Deaf Affected	Profoundly Deaf	Registered Blind
Asthma	44.4	80.5	67.7	118.8	134.3	72.3
Cancer	11.2	28.6	20.1	59.4	-	96.4
Chronic Obstructive Pulmonary Disease	10.4	-	30.2	66.8	-	72.3
Coronary Heart Disease	17.0	-	23.8	99.0	-	138.6
Diabetes	44.4	80.5	153.3	148.5	119.4	325.3
Hypertension	75.9	76.4	151.9	358.9	194.0	512.0
Learning Disabilities	2.8	n/a	26.5	76.7	-	-
Obesity (BMI>30)	104.0	238.7	307.1	232.7	209.0	216.9
Morbid Obesity (BMI>40)	12.1	55.9	42.6	27.2	-	-
Serious Mental Illness	8.3	79.1	n/a	17.3	-	-
Smoking	201.4	169.2	471.4	151.0	194.0	162.7
Stroke	5.3	12.3	13.7	34.7	-	84.3

Trends in prevalence of disabilities in children

There are few robust comparable prevalence figures, but it is widely felt that the incidence of disability among children and adolescents has risen over a period of thirty years. This apparent rise may have several contributing factors:

- Partly due to medical and social advances enabling severely disabled infants to survive, as well as prolonging

life expectancy;

- A sustained trend for women to be older when having their first child;
- Increase in diagnosis rates for most of the conditions that cause childhood disability. For example, the autistic spectrum disorders (ASDs) are more widely recognised/ diagnosed, although it seems likely that their overall prevalence has not changed;[52]
- A likely increase in the reporting of disability due to improved knowledge among the general public and medical, teaching and social care professions;
- High levels of social deprivation are associated with increased prevalence of learning disability. Possible explanations include poor nutrition and low uptake of screening programmes and antenatal care;
- There is evidence to suggest that there is an increased prevalence of learning disabilities in the British Asian population,[53, 54,55, 56] but it is important to bear in mind that this effect is likely to be due to a confluence of factors impacting on well-being.

There are, conversely, a number of factors that serve to reduce the incidence of disability:

- Antenatal screening for Downs syndrome;
- Maternity care delivered in line with guidelines and good practice reducing disability with iatrogenic cause;
- Increased use of oral contraception by older women reduces the conception rate of this group.

Past trends

The 0-19 year old population of Tower Hamlets is estimated to have increased by 2.6% between 2011 and 2013. Nonetheless, the number of children identified within the LBTH children with disabilities register as a proportion of the 0-19 population has remained relatively constant between 2011 (2.5%) and 2013 (2.7%).

Similarly, the number of pupils attending school in Tower Hamlets with statements of special educational needs has increased year on year, by 15% (from 1,355 to 1,562) between 2009 and 2013, but the proportion of pupils that this represents has remained relatively constant (table 4 in Appendix). There has been a downward trend in the proportion of children with SEN without statements since 2009. There has been an increase of 21.2% between 2009 and 2013 in pupils with a statement of SEN *maintained* by the London Borough of Tower Hamlets (i.e. with a statement of SEN but who attended a school out of borough.

The Educational Psychology Service reports that there has been a significant increase in notifications over recent years and thatthose children are being referred at an earlier age, with the majority being under three. It is not clear whether this increase is due to an increase in the number of children with additional needs, better awareness amongst health professionals of SEN procedures for young children with additional needs or parents connecting with services whilst their child is at an earlier age.

Future trends

The 0-17 year old population in Tower Hamlets is projected to increase by approximately 8% between 2013 and 2018, from 60,000 to 65,200 0-17 year olds[57] and hence the numbers of children with disabilities may be expected to rise by a similar proportion.

However, data from the LBTH Short Breaks register indicates that the number of children identified as having a disability (falling under category A, B, C or D) was 1533 in 2011, 1660 in 2012 and 1728 in 2013, representing 2.6%, 2.8% and 2.8% of the 0-17 population respectively (not reflecting thepresumed rise in line with population size increases).

Thus there are a number of key factors feeding into the presentation of children with disabilities locally:

4. An increase in the population of 0-19 year olds in Tower Hamlets;
5. The proportion of children identified on key local databases has remained constant – i.e. the number of children identified as having a disability is increasing, but the rate as a proportion of the whole 0-19 year old population has remained constant;

6. An increasing number of children with statements of SEN are staying in education beyond 16 years;
7. Children with disabilities are being identified by services earlier.

5. What is being done locally to address this issue?

Services for disabled children in Tower Hamlets are provided by integrated teams across the LBTH Education, Social Care and Wellbeing Directorate, 'Health' and the Voluntary and Community Sector to meet the needs of disabledchildren with a timely and coordinated approach.

Tower Hamlets Integrated Service for Disabled Children and Families produces a directory of services and annual short breaks statement for disabled children and young people and their families.

Social care

Children with Disabilities Team

LBTH Children's Social Carehas a specialist disabled children's team. The service's main work is with children who have severe learning and/or physical disabilities, children within the autistic spectrum and children who are deaf. In 2013 a total of 142 referrals were made to the team (6.6% of all referrals to children's social care) and a total of 329 children were on the team's caseload. Approximately 5% of those children had a Child Protection Plan

- Social Workers – assessment and intervention, designated Child in Need if child has disability
- Disabled Children's Outreach Service (early and crisis intervention)
- Externally commissioned short breaks provision, plus some internal Council short break servicesincluding Inclusion Officer for access to universal services
- Personal care

Tower Hamlets Short breaks

Tower Hamlets' offer is that all disabled children and young people have access to one short break of their choice. This will either be a specialist short break (for children in either category A or B) or a short break in a universal setting. Access to more than one specialist short break requires a Social Care assessment.

Transition

Transitions Team in the Community Learning Disability Service (CLDS)
Transitions Workers in Children's Social Care attend SEN reviews for children with disabilities known to Children's Social Care from age 16 to support transition planning (aim is to build capacity and engage from 14 years of age).

Health

Tower Hamlets Clinical Commissioning Group

Commission a range of services for children and young people including; Children'sCommunity Nursing Team, Speech and Language Therapy, Physiotherapy, Occupational Therapy, Audiology,School Nursing for Children with Continuing Care needs, Richard House Children's Hospice, and acute inpatientand outpatient services. A specialist community continence services is being developed to review and treat children and young people with enuresis, constipation and long term continence problems. The national best practice tariff for children's diabetes will come into effect from 2013/14 which will result in an increase in funding to Barts Health for their children's diabetes service, based on them continuing their current best practice in this area.

Child Development Team (CDT)

The Child Development Teamwithin Bart's Health NHS Trust provides an assessment and co-ordination service for children with multiple disabilities and their families where there are 2 or more areas of developmental delay identified in the child. All children who meet the referral criteria should be referred to this single service. A

clinical decision is made on an individual basis of when to refer to the Clinical Genetics Service at Great Ormond Street Hospital and genetic tests and genetic counseling are carried out as deemed appropriate.

Autism Spectrum Disorder Assessment Service (ASDAS) multi-disciplinary service including specialist paediatricians, speech and language therapists, occupational therapists and social workers. The team's role is to complete diagnostic assessments of children when it is thought that the child may have an autism spectrum disorder (ASD) and signpost/advise families.

Child and Adolescent Mental Health Services
Tower Hamlets CAMHS provides mental health assessment andtreatment services to all children and youngpeople who are experiencing serious risks totheir emotional and psychological wellbeingand development. For children with difficultiessuch as Autistic Spectrum Disorder, brain injury or learning difficulties, where there is a concern about a significant mental health difficulty there is a dedicated Neuro-developmental CarePathway.
Children with a physical disability andsignificant mental health difficulties receive a service through the Emotional andBehavioural Care Pathway.

Primary care and General Practice
GPs play a key role in recognition of developmental problems in the young child (e.g. at the 6 week check), in referral on to specialist services (CAMHS and secondary care), in treatment (e.g. prescribing complex and multiple drug regimes) and coordination of care for children with disability (including a role of transition of care to adult services). The GP will also often provide referral, treatment and coordination of care for the parent or carer of the child with disabilities.

The childhood immunisation schedule below is delivered by community based nursing team and primary care:
2 months: 5-in-1 (DTaP/IPV/Hib) vaccine; Pneumococcal (PCV) vaccine; Rotavirus vaccine;
3 months: 5-in-1 (DTaP/IPV/Hib) vaccine, third dose; Pneumococcal (PCV) vaccine, second dose;
4 months: 5-in-1 (DTaP/IPV/Hib) vaccine, third dose, Pneumococcal (PCV) vaccine, second dose;
12-13 months: Hib/Men C booster, Measles, mumps and rubella (MMR) vaccine, Pneumococcal (PCV) vaccine, third dose;
2 and 3 years: Flu vaccine (annual);
3 years and 4 months: Measles, mumps and rubella (MMR) vaccine, second dose, 4-in-1 (DTaP/IPV) pre-school booster.

Maintaining high rates of immunisation coverage in childhood are a key prevention measure for disability. Health Visitors play a significant role in the early identification of children with disabilities through the Healthy Child Programme.

School Health
The school health team screens all children in Reception year classes (aged 4-5 years) for vision and hearing abnormalities. The childhood immunisation team provides HPV vaccine at 12-13 years, 3-in-1 (Td/IPV) teenage booster at 13-18 years and Meningitis C booster at 13-15 years.

The school health team currently provides targeted support to those children who require follow up after screening, and those children whose needs are brought to the attention of the Service through any other means, are offered additional targeted healthcare and support by the Service and referred on to other services as required. Children and young people with long term conditions receive:

- Care plans
- Access to information, support and advice

- Access to specialist services as required
- Support to improve self-care
- Effective transition plans.

Education

School based support – Primary and Secondary Advisory Teachers
Support for Learning Service
A team of Specialist Teachers and four instructors supporting schools to work with pupils with SEN and their parents (pre-school to 19). Following delegation of SEN resources to schools in 2000 SLS central funding is used to do advisory work to build school capacity for inclusion of pupils with SEN in mainstream settings. Teams are deaf and partially hearing (398 on locally; vision impaired; physically disabled or with serious medical condition; language and communication difficulties; specific learning difficulties (including dyslexia); behaviour difficulties.

Educational Psychology
Under 5 casework
Educational Psychology Service (EPS) responds to SEN notifications on behalf the Local Authority. EPS works with families, pre-schools settings and other professionals. They offer advice on assessment of the child's additional needs and any required interventions.

The service received 119 referrals in 2011/12. It received a higher number of notifications for under 5's than in previous years with an increasing number for children under two years of age. The majority of notifications come from CDT/ASDAS. The commonest category of SEN is speech, language and communication difficulties with many of these children having or undergoing assessment for Autism or ASD.

School aged casework
Every maintained school in Tower Hamlets has a link Educational Psychologist (EP) who provides psychological advice for all cases where there is reason to believe that a pupil may have significant SEN. The EPs also support schools in their planning and implementation of individual arrangements for some targeted pupils through 8 week planning meetings or Annual Reviews of statements of SEN.

Table 10: Educational Psychology school aged casework 2011/12

	Special		Mainstream		Out of borough		
	M	F	M	F	M	F	Total
Nursery	9	3	78	18	0	0	108
Primary	26	3	462	201	30	11	733
Secondary	39	6	146	30	42	21	284
Total	**74**	**12**	**686**	**249**	**72**	**32**	**1125**

Tower Hamlets has a number of in borough specialist schools for children and young people:
Cherry Trees School - for primary age boys (5 – 11 years)with behavioural, emotional and social difficulties (BESD);
Ian Mikardo High School - for young people aged 11 - 16 with severe and complex BESD and statements of special educational need;
Phoenix Primary and Secondary School – special school for children aged 5 – 16 years with severe language and communication difficulties whose needs lie within the autistic spectrum;
Stephen Hawking School - special school for approximately 75 pupils aged2- 11 years. The majority of the children at the school have profound and multiple learning difficulties. A significant number of children have additional sensory and physical impairments. Barts Health providenursing, physiotherapy, occupational therapy

and speech and language therapy input. Additional high level support from LBTH peripatetic teachers for the hearing and visually impaired.
Beatrice Tate School - school provides education for approximately 60 pupils aged 11-19, all of who have a Statement of Special Educational Need and whose needs cannot be met within mainstream schools. Educational Psychologist, Psychiatrists, Attendance and Welfare Advisor, Social Workers from the Specialist Disability Team, Physiotherapists, Occupational Therapists, Speech Therapists, Audiologist, Optometrist, School Dental Team and a full time School Nurse (paediatric nurse).
Bowden House – residential school for children aged 10-16 with severe and complex BESD and statements of special educational need;

Voluntary and Community Sector

Disability Advocacy Service (provided by Children's Society)Works with young disabled people aged 11 to 21 toprovide independent, personal and health advocacy.

Family Support for ASD (provided by National Autistic Society)Provides support to the parents or carers of children and young people (0-19) with an autism spectrum disorder (ASD) living in the borough.

Parents' Advice Centre (PAC): provides the parent partnership service for Tower Hamlets. Offers mediation, advocacy and telephone support for parents/carers of children and young people with Special Educational Needs (SEN) and supports parents of children with SEN through transition and the admission system. Currently works with children aged 0-19, from 2014 will work with 0-24 year olds and their brief will widen to include health, social care and education as well as young people (16 years +) themselves. Provide support to a number of support groups including PACSEN, Bengali and Somali Parent Support groups and the ADHD parenting programme (an 8 week training and support programme run by parents). They have also delivered an annual Independent Volunteer training programme in order to build local capacity, of which 3 have run, each has a 6 month 3 hour/week volunteering commitment.

6. What evidence is there that we are making a difference?

Quality Assurance

- LBTH's 2 overnight short break providers have been graded as outstanding by the Care Quality Commission;
- LBTH's 3 special schools have been graded outstanding by Ofsted;
- Tower Hamlets council is sector champion for the national short breaks programme.

Outcomes

The Tower Hamlets Children and Families Plan 2012-15 contains detailed priorities for achieving its vision for all children and young people at each life stage, from maternity and early years through to transitioning into adulthood.
It sets out indicators for positive outcomes for all children and young people; meeting all those indicators for children and young people with disabilities may be considered to be evidence of improvement.
There are specific indicators that willindicate progress in relation to children and young people with disabilities – these outcomes are either specific to them, or are in relation to an issue which the evidence indicates may be more prevalent amongst the children with disabilities population. These specific indicators are set out below for each life stage for children and young people. See below for specific outcomes.

Impact on indicators

Public Health Outcomes Framework

Those outcome indicators marked with '*' are shared with Tower Hamlets Children and Families Plan 2012-15.

1.1 Percentage of children in relative poverty (living in households where income is less than 60 per cent of median household income before housing costs)
1.2 School readiness

1.3 Pupil absence
1.4 First time entrants to the youth justice system
1.5 16-18 year olds not in education, employment or training*
2.7 Hospital admissions caused by unintentional and deliberate injuries in under 18s
2.8 Emotional well-being of looked after children
2.10 Self-harm*
2.21 Access to non-cancer screening programmes, sub-indicators 2.21i and 2.21ii - screening coverage or uptake for infectious diseases in pregnancy (including screening for HIV, hepatitis B, syphilis and rubella susceptibility)*
2.23 Self-reported well-being
3.3 Population vaccination coverage (sub-indicators 3.3i to 3.3xii relating to childhood immunisations)
4.2 Tooth decay in children aged 5

NHS Outcomes Framework

Domain 2 Enhancing quality of life for people with long-term conditions

Overarching indicator

2 Healthrelatedqualityoflifeforpeople withlongterm conditions(EQ5D)

Improvement areas

Ensuringpeoplefeelsupportedto managetheir condition

2.1 Proportion ofpeoplefeelingsupportedto managetheir condition

Improvingfunctionalabilityinpeople withlongterm conditions

2.2 Employmentofpeople withlongterm conditions

Reducingtime spentinhospitalbypeople withlongterm conditions

2.3.ii Unplannedhospitalisationfor asthma,diabetes andepilepsyin under19s*

Enhancingqualityoflifefor carers

2.4 Healthrelatedqualityoflifefor carers(EQ5D)

Enhancingqualityoflifeforpeople with mentalillness

2.5 Employmentofpeople with mentalillness

Other indicators

NI146 Increase in proportion of Adults with Learning Disabilities in Employment

Local indicators set out in Tower Hamlets Children and Families Plan 2012-15

Maternity and Early Years

- Early detection and treatment of disability and illness
- All parents and children achieve positive physical and emotional development milestones
- Improving levels of speech and language development amongst the most vulnerable children in the borough

Childhood

- Children with disabilities and their families are supported following diagnosis
- Good and improving key stage 2 attainment of level 4 English and maths and good levels of progression between key stage 1 and 2 in English and in Maths all pupils with SEN

Young people

- All young people with mental health needs have access to appropriate services
- Good and improving key stage 4 attainment (5 or more A*-C grade GCSEs including English and maths) for all pupils with SEN

Preparing for adulthood

- Increasing numbers of young people with disabilities are securing appropriate, safe housing
- Deliver financial literacy sessions and explore how financial literacy and welfare reform programmes can be tailored to vulnerable groups

- Tailor existing parenting programmes to parents/carers of children with a disability as they prepare for adulthood
- Ensure timely transition plans for young people with disabilities
- Provide effective support to meet the emotional needs of young people with a disability, learning difficulty and/or life threatening medical condition as they face the challenges of approaching adulthood

7. What is the perspective of the public on support available to them?

National

The Children and Young People's Health Outcomes Forum, Disability and Palliative Care Subgroup, stressed that many families highlighted difficulties in accessing services, fragmentation of services (particularly a lack of join-up between health, social service and education services) and sporadic good practice, such as the provision of a key worker approach to help with joining up care.

The VIPER project - a three-year Big Lottery Fund funded research project, which started in summer 2010, set out to explore the participation of disabled children and young people in decision-making about services.

Local

Tower Hamlets Integrated Services for Children with Disabilities hold an annual*Primary and Secondary (relating to schools/age) Children's Forum Consultation Fun Days* in 2011, giving young people the opportunity to try a range of sporting activities and using the opportunity to consult on a particular theme ('choices' in 2012, 'friendship' in 2013).

Tower Hamlets Local Voices[58] *consultation and engagement project* was conducted in 2013 to help understand the concerns, views and aspirations of local disabled people and to:

- Inform the review of the previous Disability Equality Scheme;
- Better understand disabled people's priorities for a forthcoming Single Equality Scheme;
- Develop an ongoing model for consulting with disabled people.

While the consultation involved adults rather than children, young people or their carers, the following overarching themes emerged and felt relevant to children and people and their carers:

- Negative attitudes towards disabled people;
- Inaccessible, poor information;
- Lack of participation and voice.

With priority scores ranging from 1-9 (with 7-9 being very high) the specific issues of welfare and benefits, social care and getting out and about were rated very high, crime, anti-social behaviour and safety rated 6, Health and healthcare and housing both rated 5 and jobs, volunteering and training rated 4.

Much concern expressed was with regard to the current political, social and particularly economic discourse on 'welfare' and also specifically disability, social care was the top area of concern for survey respondents, with many services valued highly but some issues were reported and a sense of inadequate levels of support were expressed. Similarly for health, the second highest area of concern, some positive experiences, but more concerns (poor experience of services, concerns about staff attitudes and awareness) from older people.

Part of the scope for the project was "developing a model to increase the representation and involvement of disabled people in decision making, service design and scrutiny" and the report makes recommendations as to how this could be approached.

PACSEN Parents' Workshop on Transitions (2013)

Parents and carers voiced concerns about:

- The stage at which the 'front door' into Adults Services is opened. Parents' and carers' experience is that this is not until the young person is aged 18, and it needs to be earlier;
- Young people in receipt of Children's Services not meeting the eligibility for Adults Services, particularly young people with ASD not being eligible for services if they don't have also have a learning disability;
- Service decisions being made without a professional who knows the child being present and occasionally poor communication of decisions;
- Insufficient mental health support for young people during the transition period;
- Access to appropriate housing and further education options.

The following quotes from children, young people and parents/carers were made about the specialist short breaks providers during 2012/13:

- "*John tried lots of new activities with Jo, things he wouldn't do normally because he's quite clear about what he likes and dislikes. He went to a Tibetan Festival with Jo, something he would never have tried by himself….John has really enjoyed spending time with his befriender, he's much more confident, social and I've notice that having a friendship with Jo has helped his self-esteem. He's much happier in himself. It's been good for him to have time away from us doing things he enjoys and getting that social contact which has been lacking in the last couple of years*."
- "*Maryam has found a way to calm herself when feeling anxious, she counts to 10 in her head when she feels frustration in her starting to rise and it helps her stay calm and not lose it.... It's really helping her. Maryam's confidence grows every time she sees Sarah [befriender]…*"
- "*Pleasant environment and helpful staff. My son straight away started activities, which enables me to go home and attend to other children*."
- "*Sonya always comes back with something that she has brought from her outdoor trips and is excitedly showing it off. It gives Sonya a chance to socialise and gives me a break because I have younger children to look after. I know she really enjoys coming to Discovery Home, I can see it from her expressions*."

8. What more do we need to know?

- Barts Health Children's Disability Team are further analysing CDT clinical data in order to be able to provide population level information on diagnosis, genetics referrals and the level of developmental delay experienced;
- Assurance as to whether relevant staff have the skills and knowledge to facilitate disabled children's participation, including skills associated with working within a social model of disability (e.g. addressing accessibility issues such as making information accessible or removing barriers faced by young people with communication needs);
- Analysis of potential cost savings and improved outcomes by having Occupational Therapy/dietetics support co-located;
- How to reduce number of hospital appointments for children with disabilities and building outreach/care within the community;
- Better understanding of the best ways of involving disabled young people in the services they use, and of how they would like to participate;
- The number and profile of Looked After Children with disabilities;
- ADHD: Clarity on the Tower Hamlets ADHD pathway, referral routes and multi-modal identification and intervention; further local research is required to establish local prevalence and the apparent discrepancy between national prevalence estimates and the local clinical picture;
- Rates of children and young people from Tower Hamlets in the Youth Justice System and whether these reflect national estimates that they are over-represented.[59]

9. What are the priorities for improvement?

1. Review and learn from joint and single agency commissioning (and from what works well at Joint

Commissioning Panel) to support the development of integrated services; including use of section 75s, pooled budgets and joint appointments to overcome some of the complexity of funding & providing Education, Health and Care Plans;

2. For commissioners to be cognisent of new statutory obligations (Children and families Bill & the NHS Mandate) to work collaboratively and jointly commission services for children – using the Health & wellbeing board as the mechanism/vehicle to facilitate this.
   - Need to ensure sustainable provision of appropriately skilled nursing staff to support children's medical needs during their short breaks and develop a sustainable response to issues arising around care during transport;
3. Experience of transition still needs to be improved, particular issues around preparing children and young people and their families for the reality that eligibility for adult services is more restricted – what might supporting families and CWD to build resilience and independence look like?
4. Need to review and address the challenges aroundmeeting the accommodation needs of families and young people;
5. Family finding for Looked After Children with disabilities (approximately 26/year);
6. Review provision of services to meet mental health needs of adolescents with learning disabilities (prevalence of depression is higher in adolescents with learning disability than in than in their peers) in order to identify additional commissioning needs e.g. increasing counseling support for adolescents with disabilities, delivered by appropriately qualified practitioners.
7. Ensure that post diagnosis support (as delivered in Childrens' Centres and by Childrens' Society) is replicated and accessible at further key transition points during the parent/carer and child's journey.

10.Contacts / Stakeholder Involvement

Contacts

	NAME	CONTACT DETAILS
AUTHORS	**Simon Twite**, LBTH Public Health **Harriet Potemkin**, LBTH Commissioning Manager, Children with Disabilities	Firstname.lastname@towerhamlets.gov.uk
UPDATED BY		
SIGNED OFF BY		

Stakeholders

Representatives from the Children with Disabilities Strategic Group, including the Service Manager, Integrated Service for Disabled Children and representatives from the Support for Learning Service, CAMHs, Youth Services, Parents Advice Centre, Children's Commissioning Team, Family Support Forum and Tower Hamlets CCG Children and Young People's Programme Board have been consulted in relation to the development of this JSNA.

Appendix 1

Table 1: Activity limiting health problems or disabilities for children aged 0-15

	Day-to-day activities not limited		Day-to-day activities limited a little		Day-to-day activities limited a lot		Total population (0-15)	
	No.	%	No.	%	No.	%	No.	%
England	/	96.3	/	2.2	/	1.5	/	100
London	/	96.6	/	1.9	/	1.5	/	100
Tower Hamlets	48,177	96.1	1,040	2.1	926	1.8	50,143	100

Source: ONS nomis

Table 2: Summary of main sources of population prevalence of disability in children with numbers for Tower Hamlets if national prevalence applied

Source	National or local	Age	Percentage/proportion/rate	Number
ONS 2011 Census	Local Census data	0-15	2.1% (limits activity a little) 1.8% (limits activity a lot)	
Analysis of 2004/05 Family Resources Survey (2010)[60]	National survey – prevalence applied to TH population	0-18	7.3% (95% CI 6.9, 7.7) with a DDA-defined disability. **Gender** Male: 8.8 (8.2 – 9.4) Female: 5.8 (5.3 – 6.3) **Age** 0-4: 3.7% (3.2 – 4.3) 5-11: 8.2 (7.6 – 8.9) 12-15: 9.5 (8.6 – 10.5) 16-18: 8.5 (7.2 - 10.0)	0-18: 4208 Male: Female: 0-4: 5-11: 12-15: 16-18:
Thomas Coram Research Unit (2008)[61]	National survey – prevalence applied to TH population	0-18	Between 3.0% and 5.4%based on the number of children with a SEN statement and the number of children in receipt of DLA	
Disability Living Allowance (DLA) payments[62]	Estimates based on a sample survey	0-17	An approximate claimant rate/10,000 of the 0-17 population can be calculated of 321. This is higher than Newham (238) and Hackney (260).[63]	<5: 330 5-11: 760 11-16: 590 16-17: 170 0-17: 1850

Table 3: Pupils with special educational needs (SEN) in ***state-funded schools*** (January 2013)[64]

	School/age	Pupils with statements		Pupils with SEN without statements (School Action + School Action Plus)		Pupils with SEN	
		Cases	%	Cases	%	Cases	%
England	Primary	/	1.4	/	16.0	/	17.4

	Secondary	/	1.9	/	17.0	/	19.0
London	Primary	/	1.6	/	16.5	/	18.1
	Secondary	/	2.1	/	18.9	/	21.0
Tower Hamlets	Primary	664	2.7	4,072	16.5	4,735	19.1
	Secondary	496	3.2	2,774	18.0	3,270	21.3

Table 4: Pupils with statements of special educational needs (SEN) (***all schools***)[65]

	2009		2010		2011		2012		2013	
	Cases	%	Cases	%	Cases	%	Cases	%	Cases	%
England	/	2.8	/	2.8	/	2.8	/	2.8	/	2.8
London	/	2.7	/	2.7	/	2.7	/	2.7	/	2.7
Tower Hamlets	1,355	3.4	1,363	3.3	1,401	3.4	1,477	3.5	1,562	3.6
Hackney	973	3.0	1,069	3.1	1,093	3.1	1,169	3.2	1,235	3.2
Newham	506	1.0	456	.9	444	.8	468	.8	468	.8

Table 5: Pupils with special educational needs (SEN) without statements (***all schools***)[66]

	2009		2010		2011		2012		2013	
	Cases	%	Cases	%	Cases	%	Cases	%	Cases	%
England	/	17.9	/	18.3	/	17.8	/	17.0	/	16.0
London	/	19.0	/	19.5	/	18.7	/	17.8	/	16.4
Tower Hamlets	8,123	20.4	8,618	21.1	8,089	19.4	7,424	17.6	7,067	16.2

Table 6: Pupils with special educational needs (SEN) with statements maintained by local authority (***all schools***)[67]

	2009	2010	2011	2012	2013
	Number	Number	Number	Number	Number
Tower Hamlets	1,440	1,480	1,560	1,625	1,745

Table 7: School aged pupils (Primary, Secondary and Special schools) with Statements of SEN by ethnicity

Ethnic group	**%**
White	**3.1**
White British	3.2
Irish	3.1
Traveller of Irish heritage	5.1
Gypsy / Roma	3.6
Any other White background	2.1
Mixed	**3.1**
White and Black Caribbean	3.6
White and Black African	3.0
White and Asian	2.4
Any other mixed background	3.2
Asian	**2.5**
Indian	1.8
Pakistani	3.0
Bangladeshi	2.7
Any other Asian background	2.3
Black	**3.5**
Black Caribbean	4.1
Black African	3.1

Any other Black background	4.0
Chinese	**2.0**
Any other ethnic group	**2.4**
Unclassified	**3.8**
All pupils	**3.1**

Figure 1: School aged pupils (Primary, Secondary and Special schools) with SEN by ethnicity (with and without statements)

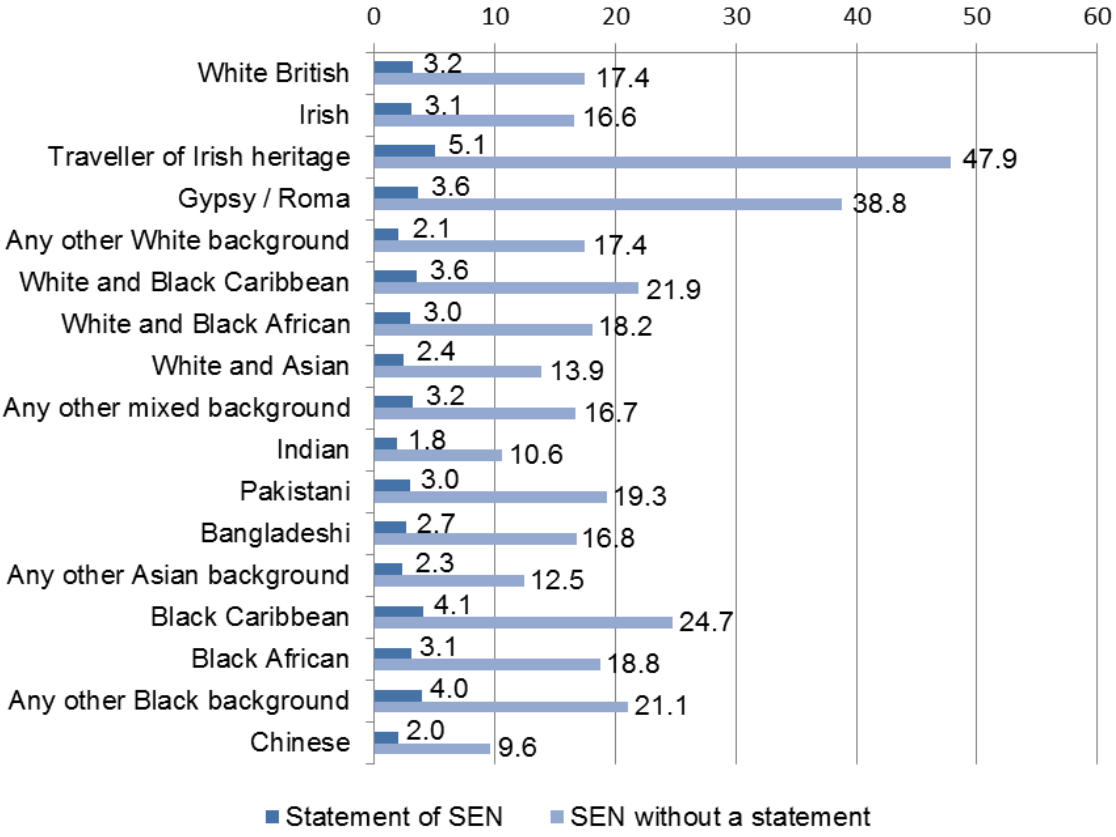

Table 8: Children with disabilities known to LBTH Children's Social Care: Referrals, caseload and characteristics

		Number (31/03/12)	%	Number (31/03/2013)	%	Notes
CWD referrals				142	6.6*	*% of all referrals
CWD caseload	0-4	44	14.1	32	9.7	
	5-9	95	30.4	112	34.0	
	10-14	110	35.1	117	35.6	
	15 - 16	41	13.1	51	15.5	
	17+	23	7.3	17	5.2	
	Total	313	100.0	329	100	
Gender	Female	127	40.6	120	36.5	
	Male	186	59.4	208	63.2	
Ethnicity White		44	14.1	43	12.8	

Mixed		11	3.5	16	4.8	
Asian or Asian British		228	72.8	207	61.6	
Black or Black British*		35	11.2	47	14.0	*inc. Somali – 13 (2012); 24 (2013)
Chinese/other ethnic group		4	1.3	13	3.9	
Not known		11	3.5	10	3.0	
Total		313	100.0	336	100.0	
Looked After Children with disability	0-4	3	12.5	2	8.0	
	5-9	6	25.0	4	16.0	
	10-14	11	45.8	10	40.0	
	15 - 16	2	8.3	9	36.0	
	17+	2	8.3	0	0.0	
	Total	24	100.0	25	100.0	
LAC CWD gender	Female	13	54.2	14	56.0	
	Male	11	45.8	11	44.0	

Health and Wellbeing Board 6th February 2014	Tower Hamlets Health and Wellbeing Board
Report of the London Borough of Tower Hamlets	**Classification:** [Unrestricted or Exempt]
Winterbourne Actions – Update report to HWBB	

Lead Officer	John Rutherford
Contact Officers	John Rutherford
Executive Key Decision?	No

Executive Summary

This is an update report on the actions taken to comply with the Winterbourne report.

Recommendations:

The Health and Wellbeing Board is recommended to:

1. Note the Tower Hamlets compliance with the Winterbourne actions and to receive annual updates on future review activity related to people in assessment and treatment centres and the longer term development of local housing and care support.

1. REASONS FOR THE DECISIONS

1.1 To note the report

2. ALTERNATIVE OPTIONS

2.1 N/A

3. DETAILS OF REPORT

3.1 This is an update report on the actions taken to comply with the Winterbourne report.

4. COMMENTS OF THE CHIEF FINANCE OFFICER

4.1 There are no financial implications from this report as it is for noting.

5. LEGALCOMMENTS

5.1 By taking note of the Winterbourne update, the HWB will be exercising it functions in accordance with the Health and Social Care Act 2012 and supplementary regulations and guidance. In particular:

- Encouraging 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 encourage those 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.

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.

6. ONE TOWER HAMLETS CONSIDERATIONS

6.1 The actions contained within this report enable people with a learning disability to receive safe and effective care in the least intrusive care setting.

7. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

7.1 N/A

8. RISK MANAGEMENT IMPLICATIONS

8.1 The actions contained within this report minimise the risk of people with learning disabilities receiving unsafe care

9. CRIME AND DISORDER REDUCTION IMPLICATIONS

9.1 N/A

10. EFFICIENCY STATEMENT

10.1 N/A

Appendices and Background Documents

Appendices

- NONE

Background Documents

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

- State NONE if none.

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Tower Hamlets Health & Wellbeing Board – 6th February 2014

Winterbourne Review Update

The Winterbourne Report made recommendations to prevent the type of serious and systematic physical, emotional and institutional abuse of vulnerable people with a learning disability,as portrayed in a BBC Panorama documentary.

The abuse happened due to a range of factors, such as little contact with their families and no advocacyto act on their behalf. The Winterbourne staff were not well managed and a culture of institutional abuse developed, which was normalised by the staff who worked there. The report also noted that abuse was not identified by health and social care staff undertaking reviews or through Care Quality Commission inspections. In summary, the report concluded that all agencies had failed the people placed at Winterbourne.

Winterbourne actions require agencies to put in place measures so that people with learning disabilities and challenging behaviour are not put at future risk.

It is recommended that Health & Wellbeing Boards (HWBB) lead on ensuring thattheir local agencies comply with Winterbourne actions. These include the following:-

- People with a learning disability and challenging behaviour receive safe care
- Any patterns of abuse identified in assessment and treatment centres are acted upon immediately by all agencies working together
- That Council's and the NHS develop local services through joint commissioning of accommodation and care, especially for those people with a learning disability and challenging behaviour

The report highlighted that assessment and treatment centres can be used inappropriately to contain people with challenging behaviour for long periods of time when their remit is to help people recover or in the case of forensic units to be legally detained.

Tower Hamlets has made limited use of assessment and treatment centres and only when no other option was available and for those people where it was appropriate. Currently Tower Hamlets have 3 people in such centres (one of the lowest rates in the country) andwere highlighted in Parliament as promoting good practice in limiting the use of assessment and treatment centres. However,our local review has identified a lack of local provision of high support /extra care housing in order that people can continue to live in Tower Hamlets and access to support, employment and training opportunities for people with complex learning disabilities.

The Winterbourne Report required local authorities, NHS commissioners, providers and stakeholders to review all people currently living in assessment and treatment centres (hospitals) in England and Wales to ensure:

- Reviews were within specified timescales
- People with a learning disability were listened to
- People were seen and receiving personalised support and care
- Independent advocates were provided for each person with a learning disability
- Families/carers were helped to visit the person with a learning disability including arranging and funding transport arrangements if they were unable to do so.
- To ensure that there was clear and strategic leadership in place
- Health and social care jointly commissioned community support options for people with challenging behaviour and complex needs.

Tower Hamlets Actions

Tower Hamlets reviewed all people placed in out of Borough placements within the six month timescale, as required by Winterbourne and applied the Winterbourne actions as good practice.

1. Currently Tower Hamlets has 3 people in assessment and treatment centres. These are defined as people who are in hospital placements and include two people who are currently in the medium secure unit in Hackney. There are specialist beds in the forensic unit for male patients witha learning disability, which is beneficial for our population, but this local facility does not exist for females.

2. Reviews were completed for the 3 service users in assessment and treatment centres. In addition all cases funded by the NHS have been reviewed and the details passed to the Tower Hamlets Clinical Commissioning Group (CCG). The deadline of June 2013 for all reviews to have been completed was met and annual reviews are in planned.

3. All peoplewho require such placements are placed out of the Borough as there is limitedlocal specialist provision for people with learning disabilities and challenging behaviour.There is a long term strategy to aim to provide local supported housing and care support.

4. There is a challenging behaviour work stream of the Learning Disability Partnership Board that is identifying the unmet needs of people with challenging behaviour and learning disabilities. One of its key functions is to highlight this unmet need with health and social care commissioners, so local provision can be provided.

5. There have been some early discussions with other councils across East London, following a London wide stocktake of provision. This identified common areas of unmet need that could be commissioned effectively on a sub-regional basis, if cross borough funding agreements and location of provision could be agreed.

	Action	*Outcome*	*Time scale*	*Named responsible person/team*
Complete outstanding Reviews on Out of Borough placement	Reviews allocated to each care programme and performance reviewed in supervision	Completed	Monthly	All care programmes Each Manager reviewing outcomes and sign off
Minimise risks for LD service user living in residential care	All cases reviewed to ensure that no service users in any of the residential /nursing homes flagged for concerns	Visits addressing standards around • Safeguarding • Documentation • Discharge arrangements • Customer evaluation • Environment • Medication • Keyworker sessions • Personalisation	On going Care programme managers to review monthly- that reviews are compliant and signed off by the manager	Care program managers Service manager to check compliance on 5 random cases each month.
Safeguarding	To review numbers of safeguarding alerts in residential and nursing care as a proportion of the cohort all safeguarding cases	To prepare quarterly safeguarding reports and extract this information as a proportion of the whole	Every 4 months	Care Programme Managers and Service Manager Report to go governance meeting every 3 months
Personalisation	All cases to be reviewed considering if the service user can return to the Borough or nearer to	Review the numbers of people with LD moving on from residential and nursing care. This is an ongoing exercise	On going	Review as part of performance report for the

	home Care manager to actively explore this option with the service user and carers			CLDS service
PCTs to develop registers of all people with learning disabilities or autism and who have mental health conditions or behaviour that challenges in NHS funded care	PCT commissioners to identify all people with a learning disability or autism who have challenging behaviour,	31st March 2013/ completed (however assumes all service users are registered with a GP		PCT commissioners/ CCG commissioners
Review all LD in patients in assessments and treatment centres	a. To visit all inpatients Continuing care / health and residential and nursing care b. Personalised care plan c. Evidence of engagement and agreement with families and carers d. A discharge plan (including estimated discharge date) e. A named care co-ordinator f. An identified lead CCG g. Date of a comprehensive physical health check h. Identified independent advocacy to support the move on.	June 2013	Completed Completed Completed d)When required this will be completed as part of the discharge planning agreements completed Richard Fradgley Date of	CCG commissioners to report CLDS to action

			health check included in the review Advocates identified with SU agreement and/or if family do not act as the advocate	
Position statement to NHS Commissioning	Statement to include the following : 1. The number of people within your registers currently in learning disability or autism inpatient beds; 2. The number of people in learning disability or autism inpatient beds who have received an appropriate review between 1 November 2012 and 28 February 2013; 3. The number of people in learning disability or autism inpatient units yet to be reviewed by 31 May 2013; 4. Confirmation that the capacity to complete outstanding	Currently tendering for an Autism community team, we currently have 3 people who are in inpatient beds as specified. All service users have received an appropriate review There are no outstanding reviews of people with LD in inpatient units		

	reviews by 31 May 2013 is in place	There are systems and processes in place to ensure reviews happen in a timely fashion		

In addition, there is an expectation that the local NHS has an updated list of learning disability patients. The council andCCG are working to rationalise these lists and ensure that the information is shared, through the development of data sharing protocols and ICT alignment.

In addition to the Winterbourne actions, the council and the local NHS are working together to focus such activity to all people living in residential and nursing homes.

Recommendation

The HWBB is asked to note that Tower Hamlets is compliant with the specific Winterbourne actions, but to receive annual updates on future activity related to reviews of people within assessment and treatment centres and the longer term development of local provision of housing and care support.

Health and Wellbeing Board 6th February 2014	Tower Hamlets Health and Wellbeing Board
Report of the London Borough of Tower Hamlets	**Classification:** Unrestricted
2013 Adult Autism Self-Assessment Framework (SAF)	

Lead Officer	Robert McCullock-Graham Corporate Director for Education, Social Care and Wellbeing (ESCW)
Contact Officers	Deborah Cohen Service Head Commissioning and Health (ESCW)
Executive Key Decision?	No

Executive Summary

As part of the implementation of the Government's 2010 National Autism Strategy (*Fulfilling and Rewarding Lives*), Local Authorities and CCGs nationally have been requested by the Department of Health (DoH) to self-evaluate their performance (via an on-line return) in meeting the five quality outcomes for improving the lives of people with autism. This includes reporting on progress in implementing adult autism diagnostic pathways; increasing awareness of autism to front line workers; improving access to services and involving people with Autism their families and carers in service planning

Following completion and submission of the SAF to the DoH on 7th October 2013, this report provides a summary of key findings from both organisations, with a brief description on next steps for on-going monitoring and reporting.

This report also:

- Updates on progress towards establishing a local diagnostic and intervention service for adults with autism.

- Highlights key areas of progress and where additional work is being advanced since the 2012 baseline survey.

Recommendations:

The Health and Wellbeing Board (HWB) is recommended to:

1. Note the content of the report and the final Autism Self-Evaluation document (provided as Appendix One).

2. To include the questions contained within Appendix Two into quarterly HWB performance reports. This will enable the HWB to track delivery and progress of both the Council and the CCG in implementing measures to improve outcomes for local people with autism.

1. REASONS FOR THE DECISIONS

1.1 No decisions are required for this report.

1.2 HWB requested to note the submitted SAF, which ensures compliance to DoH directive to submit the completed self-assessment to the HWB Board.

1.3 To also note reporting considerations set out in Section 8 to enable the HWB Board on-going oversight of the Council's and CCG's progress in implementing measures aligned to the 2010 National Strategy - *Fulfilling and Rewarding Lives*

2. ALTERNATIVE OPTIONS

2.1 N/A

3. DETAILS OF REPORT

The 2010 National Adult Autism Strategy

3.1 The National Adult Autism Strategy - *Fulfilling and Rewarding Lives* was published in 2010 and sets out the Government's long term vision for transforming the lives of and outcomes for adults with autism. The Department of Health (DoH) is the lead policy department for the Strategy, with delivery shared across a range of government departments and agencies, and local health and social care providers.

3.2 The Autism Strategy defines five areas for action aimed at improving the lives of adults with autism. These are:

- increasing awareness and understanding of autism;
- developing a clear, consistent pathway for diagnosis of autism;
- improving access for adults with autism to services and support;
- helping adults with autism into work; and
- enabling local partners to develop relevant services.

3.3 The Government considers the above outcomes as key in driving long term change in how services meet the needs of people with Autistic Spectrum Disorder (ASD). As such, local areas are encouraged to develop innovative approaches to ensure people with ASD are able to access services and

dedicated support in their area. This includes the delivery of clear and consistent adult diagnostic pathways and ensuring organisations make reasonable adjustments to enable people with autism to access services.

3.4 Local Health and Wellbeing boards are therefore tasked with overseeing delivery of local planning and ensuring alignment with the emerging priorities of Clinical Commissioning Groups (CCG).

4. Tower Hamlets Adult Autism Diagnostic and Intervention Service:

4.1. The Council is currently progressing a procurement process to secure a provider to deliver an adult autism diagnostic and intervention service for the borough. The service contract will be for three years and funded from already allocated S256 monies.

4.2. Key components of the service include:

- A core diagnostic team to provide assessment of adults with suspected ASD in Tower Hamlets based on Clinical Guidance 142
- A post diagnostic brief intervention programme to improve service user well-being, including building social relationships.
- Support to service user to access employment and training opportunities (delivered by subcontracted local Third Sector organisation)

4.3. A procurement route plan setting out intended delivery and associated timelines was agreed by Cabinet on 5th June 2013. Subsequent approval from the Completion Planning Forum (Tollgate 1) was also received on 5th August, 2013.

4.4. A standard (two stage) restricted tender process has been applied for this contract, whereby bidders were requested to complete and submit a pre-qualification questionnaire (PQQ), as part of the first stage, with tender documentation and method statement submitted for the second. Both phases have now ended, and evaluations of returns have been conducted panel consisting of representatives from Public Health, ESCW Commissioning, the CCG and Children Services.

4.5. Final shortlisting will be conducted via an interview and presentation (16th January 2014) with representation required from both the prime organisation and subcontracted partner. It is anticipated that contract mobilisation will commence on 1st April 2014.

5. 2013 Autism Self-Assessment Framework (SAF)

5.1. As part of the implementation of the Government's 2010 National Autism Strategy (*Fulfilling and Rewarding Lives*), Local Authorities (including the NHS) have been requested to self-evaluate their performance to date. This includes collecting data across specific themed criteria, including the establishment of

adult diagnostic services; data capture; increasing awareness; improving access to services and involving people with Autism their families and carers.

5.2. On 2nd August 2013, the Minister of State at the Department of Health (Norman Lamb) wrote to local authority leads to obtain assistance in taking forward the second self-assessment exercise via an on line return. The covering letter from the Minister of State was copied to Directors of Public Health, Directors of Children's Services, CCG leads and Health and Wellbeing Board Chairs.

5.3. This Adult Autism SAF (submitted on 7th October 2013) builds on the first self-assessment (submitted last year), which provided a base line survey on progress made since the launch of the National Strategy (2010). Although the Local Authority was tasked with the consolidation of the return (as the lead local body), the exercise also placed an obligation on Clinical Commissioning Groups (CCG) to highlight their progress, so that a multi-agency perspective was captured in each area.

5.4. The intention is to obtain a national overview of local area implementation of the National Strategy and identify where barriers exist and any examples of good practice that can be shared. Local Health & Wellbeing Boards are required to consider the outcomes of the self-assessment exercise prior to February 2014, as evidence for local planning and supporting local implementation work.

5.5. A copy of the completed return is provided as Appendix 1

6. Coordination of data capture

6.1. Officers within Education, Social Care and Well-being (ESCW) were responsible for coordinating the data and submitting the on-line return.

6.2. The 2013 SAF contained 37 questions across thematic areas concerning health and local authority provision. For some questions a RAG rating system with scoring criteria was applied, with respondents requested to provide further information on any issues preventing progress and/or where successes had been achieved.

6.3. A copy of the uncompleted on-line return was sent to CCG leads in order to capture data on areas relevant to health (i.e. GP register), whilst areas pertinent to the Council were captured via direct liaison with officers across Housing, Human Resources, Social Care and Community Safety.

6.4. Once all returns had been collated, a draft version was submitted to the Autism Project Board and the Autism Carers Group for comment prior to receiving approval from the Corporate Director of ESCW. The completed return was submitted to the Department of Health (prior to deadline) on 7th October, 2013.

7. Summary of key findings

7.1. Since the first DoH autism evaluation exercise, the Council and CCG have progressed a number of various work streams in order to meet statutory obligations as set out in the 2009 Autism Act and 2010 National Strategy, including:

- **Delivery of the LBTH Autism Awareness Training programme for LBTH frontline staff:** To date, 12 sessions delivered to accelerate learning on the condition and how to work with people with ASD. This training was also made open to NHS staff.

- **Delivery of the peer led Autism Carers Drop-in:** Established in 2013, the group provides support and advice to carers of people with autism. Recently recommended by the National Autistic Society as a model of good practice

- **Cabinet agreement (June 2013) to deliver a dedicated Adult Autism Diagnostic and Intervention Service:** Currently going through LBTH procurement processes (expected contract start date 1st, April, 2014), this new service will provide people with and suspected of having ASD a clear pathway towards diagnosis and support.

- **Delivery of Adult Autism consultation:** Completed in mid-2013, this exercise has enabled the Council to better understand residents' and stakeholder views regarding local plans, which have been used to inform development of the new adult autism service.

7.2. However, whilst the submission pinpoints areas in Tower Hamlets where progress is being made, it also highlights challenges that will need to be addressed in order to ensure the national outcomes are reached. For instance, the gathering of local data to identify the numbers of local people with Autism Spectrum Disorder (ASD) continues to be an area requiring further attention from both the Council and local NHS agencies.

7.3. The submission sets out planned measures to be implemented in order to ensure effective data capture across both health and social care services, including:

- Reconfiguring internal social care I.T systems (i.e. Frameworki) to enable effective data capture on those with ASD who may or may not be eligible for social care provision

- Development of a single NHS data platform (Orion) to provide a single data source for health and social care information across organisations

- Creation of a comprehensive borough-wide GP register of people with a diagnosis of autism

7.4. These changes are anticipated to be delivered by April 2014 and will enable the mandatory capture of information on, not only those receiving services, but also on those receiving a diagnosis of the condition – whether that is autism or

Aspergers syndrome (high functioning autism). It is expected that these changes will also reduce the need to conduct prevalence mapping in the future.

7.5. Furthermore, the requirement to raise awareness of autism across agencies (including primary care, criminal justice system and housing) continues to be a development area for both the Council and the CCG. Although the Council is progressing delivery of autism awareness training for its front line staff, engagement with criminal justice agencies is still to be advanced. In order to address this, a request has been submitted to the Community Safety lead (CLC), so that discussions around autism awareness and the National Strategy can be initiated via the Community Safety Partnership forum.

7.6. Additionally, to support the recent announcement (November 2013) by the Royal College of General Practitioners to make autism a clinical priority from 2014, the CCG have agreed to review its annual training programme via the lead GP for autism (Dr Shah Choudhury) to increase understanding of the condition amongst the primary care workforce (including GPs). This work will also be further complimented by liaison from clinical leads within the new autism service (specified in the contract) to ensure effective referral processes between agencies are implemented.

7.7. Of the 37 questions, 17 required a RAG rating to highlight progress in implementing specific work areas. A breakdown of the RAG ratings is provided in Table One

7.8. Table One: Breakdown of RAG status

Red	Amber	Green
0	15	2

7.9. Although not directly comparable to the previous submission format, there is an overall improvement in how services are meeting the needs of people with autism (e.g. previous submission contained one red rating, this submission has none).

7.10. A breakdown of the questions with RAG ratings is provided as Appendix Two.

8. Next steps:

8.1. As part of the next steps, the Department of Health are currently drafting a high level report using the information submitted nationally, to highlight national response rates and headline figures – although without local breakdowns. This report is expected to be circulated to local authorities later in the year.

8.2. The results of the exercise will also inform the DoH's formal review of the national Strategy. This process will provide the Government the opportunity to assess whether the set objectives of the Strategy are fundamentally the right ones, whilst providing assurance that progress by Local Authorities and the NHS is being achieved in meeting them. The investigative stage of the Review

will last until the end of October and the Strategy will be revised (as necessary) by March 2014.

8.3. As part of local monitoring of progress, it is also proposed to include the questions contained within Appendix Two into quarterly HWB performance reports. This will enable the HWB to track delivery and progress of both the Council and the CCG in implementing measures to improve outcomes for local people with autism. Background and main details of the report.

9. COMMENTS OF THE CHIEF FINANCE OFFICER

9.1. There are no financial implications arising from this report, as there are no decisions sought.

10. LEGALCOMMENTS

10.1 In noting the findings of the Adult Autism Self-Assessment Framework (SAF) HWBB will be exercising it functions in accordance with the Health and Social Care Act 2012 and supplementary regulations and guidance. In particular:

- Encouraging 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 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.

10.2 The HWBB will also have regard to the National Autism Strategy, which is issued by the Secretary of State pursuant to section 1 of the Autism Act 2009, together with “Fulfilling and Rewarding Lives’, the associated statutory guidance for local authorities and the NHS for the implementation of the autism strategy, published on 17 December 2010. This guidance is issued under s7 of the Local Government Social Services Act 1970, so must be followed unless there is good reason.

11. ONE TOWER HAMLETS CONSIDERATIONS

11.1. There are no equality or diversity implications associated with this report. The Tower Hamlets SAF does, however, highlight areas of positive achievements in meeting the needs of people with autism, their families and carers (e.g. delivery of the Autism Carers Drop-in).

12. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

12.1. N/A

13. RISK MANAGEMENT IMPLICATIONS

13.1. The self-assessment report was submitted on 7th October 2013 prior to deadline, which mitigated any reputational risk associated with not providing a return.

14. CRIME AND DISORDER REDUCTION IMPLICATIONS

14.1. As part of the Self-Assessment Framework, the Council were asked whether the Criminal Justice System were engaging in planning for adults with autism. An 'amber' rating was submitted due to contact being made to the Council's Community Safety lead, so that direct liaison with Criminal Justice agencies can be progressed via the Community Safety Partnership. The borough also intends to work closely with its CJS partners around autism once the new planned adult autism diagnostic service becomes operational (April 2014).

15. EFFICIENCY STATEMENT

15.1. There are no major expenditure or resources implications associated with this report. In accordance with EU procurement legislation, the Council is currently progressing a procurement exercise to secure an external provider to deliver the new Adult Autism Diagnostic Service. The service contract will run for three years and is funded via a S256 agreement. This will cover all service expenditure including staffing and providing clinical and support elements of the contract. .

Appendices and Background Documents

Appendices

- Appendix One: Full version of Tower Hamlets SAF submission
- Appendix Two: Summary of RAG ratings

Background Documents

- NONE.

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Autism Self Evaluation

Local authority area

1. How many Clinical Commissioning Groups do you need to work with to implement the Adult Autism Strategy in your local authority area?

1

Comment

2. Are you working with other local authorities to implement part or all of the priorities of the strategy?

◯ *Yes*
⊗ *No*

If yes, how are you doing this?

Planning

3. Do you have a named joint commissioner/senior manager of responsible for services for adults with autism?

⊗ *Yes*
◯ *No*

If yes, what are their responsibilities and who do they report to? Please provide their name and contact details.

Deborah Cohen, Service Head for Commissioning and Health and John Rutherford (interim) Service Head for Adult Social Care. Responsible for strategic commissioning and adult social care and both report to the Director of Education, Social Care and Well-being who is responsible adult and children's social care services. Contact details: deborah.cohen@towerhamlets.gov.uk Tel: 0207 364 0497 and john.rutherford@towerhamlets.gov.uk Tel: 0207 364 2127

4. Is Autism included in the local JSNA?

◯ *Red*
⊗ *Amber*
◯ *Green*

Comment

The Tower Hamlets Joint Strategic Needs Assessment will be refreshed over the next 12 months, which will include a specific section on autism. In Tower Hamlets, a standardised framework covering the local picture, evidence base, and current actions to address issue, progress, user perspectives, information gaps and priorities will be covered.

5. Have you started to collect data on people with a diagnosis of autism?

- ◯ Red
- ⊗ Amber
- ◯ Green

Comment

The Council collects data of children with a statement of SEN with a diagnosis of autism, and of adults with autism and a co-occurring condition (i.e.learning disability) receiving social care services. However, it is recognised that the Council and many other local statutory organisations still do not routinely (or sufficiently) collect data on the numbers of people with Autistic Spectrum Disorder (ASD) living in the borough, or receiving services.

Therefore, the Council is currently working with other key providers to ensure mechanisms are in place to capture information on those with a diagnosis of autism, which can be shared amongst partners delivering care. This includes working primary care providers to set up a comprehensive GP register of people with a diagnosis of autism, and amending existing electronic social care data systems to include those with a diagnosis of autism. This will ensure the authority captures information on people receiving a diagnosis, as well as those able to access social care services.

These changes will coincide with delivery of the new diagnostic service (April 2014) and will mean data will be gathered (mandatory) not only on those receiving services, but also on their condition - whether that is autism or Aspergers syndrome (high-functioning autism).It is expected that these changes will also reduce the need to conduct prevalence mapping in the future.

6. Do you collect data on the number of people with a diagnosis of autism meeting eligibility criteria for social care (irrespective of whether they receive any)?

- ⊗ Yes
- ◯ No

If yes, what is

the total number of people?

28

the number who are also identified as having a learning disability?

12

the number who are identified as also having mental health problems?

0

Comment

To date, figures to indicate the total number of people with ASD receiving care is 28. Of this total, 12 have been identified as also having a learning disability. There are no records of people with a diagnosis of autism and mental health in receipt of social care services. However, the Council recognises the need to amend existing data capture systems in order to ensure all those able to receive care are recorded appropriately. As mentioned, changes to data systems will coincide with delivery of the new diagnostic service (April 2014), which will collect data on all those receiving an automatic community care assessment with the diagnosis.

7. Does your commissioning plan reflect local data and needs of people with autism?

- ⊗ Yes
- ◯ No

If yes, how is this demonstrated?

The Council has in place a commissioning plan that sets out its intention to deliver a dedicated adult autism and intervention service by April 2014. The service will provide a deliver a clear and dedicated diagnostic pathway for adults with suspected ASD, which is also designed to facilitate local compliance with requirements of the Autism Act 2009.

Key components of the service are:

** A core diagnostic team to provide assessment of adults with suspected ASD in Tower Hamlets aligned with NICE Clinical Guidance 142 for care of adults with autism.*

** Post diagnostic brief intervention programme to adults with ASD (high functioning) utilising techniques to improve general well-being (i.e. Cognitive Behavioural Therapies) and social relationships.*

** Support to service users, including young people, to access the service via effective transitional arrangements that lead to independent living and access to employment*

The Council understands the analysis of local data is vital in identifying service gaps in order to deliver effective and 'in reach' services. In this light, the Council has utilised local data (e.g. JSNA), and feedback from a recently conducted adult autism consultation (2013), to ensure intentions reflect local need, and take account of views of adults with autism, their families and carers in the design of new services.

Key headline findings from the JSNA (2011) include:

** A high estimated prevalence of autism amongst the adult population when compared to other London boroughs. (1,910 adults with ASD in Tower Hamlets, with approximately 765 without an additional learning disability).*

** A likelihood that a substantial number of people who have ASD in the borough have not received a diagnosis, or that the diagnosis has not been recorded.*

** Special Educational Needs (SEN) data indicating a indicating disproportionate increase (69.8%) in the number of children (aged 18 and under) with ASD in Tower Hamlets, from 159 children in 2007 to 270 children in 2011*
**A need to implement locally a dedicated diagnostic pathway for adults with suspected autism*

The 2011 census also noted that the population in Tower Hamlets increased by 29.6%, which may impact further on the prevalence of individuals with autism in the borough. Recent GP data also indicates there are 76 people with a diagnosis of autism living in the borough. However, this is not considered to accurately reflect ASD prevalance in the borough.

Additionally, an adult and carers consultation exercise was conducted in 2013, as a way to ensure the new service addresses local aspirations and need. The exercise reflected the significant challenges that local people with autism and their carers experience when seeking support. The majority of responses broadly supported the proposals and that, subject to effective implementation, the plan had the potential to impact positively on the lives of people with autism and their carers.
.
The consultation found that the highest priorities for local people included:

** Support into employment,*

** Better information about autism,*

** Targeted support to assist adults with autism live independently,*

** Better training for support and other front line staff in understanding the prevalence and needs of people with autism.*

Accordingly, the intended service will seek to fill this gap and provide dedicated provision towards diagnosis and follow on support for high function adults with ASD in the borough. The service will also work across agencies and assist young people's transition, and facilitate service users to access local employment and training opportunities where a need has been identified.

8. What data collection sources do you use?

- ◯ *Red*
- ◯ *Red/Amber*
- ⊗ *Amber*
- ◯ *Amber/Green*
- ◯ *Green*

Comment

Internal electronic social care systems (Frameworki) and the GP data

9. Is your local Clinical Commissioning Group or Clinical Commissioning Groups (including the Support Service) engaged in the planning and implementation of the strategy in your local area?

- ◯ *Red*
- ⊗ *Amber*
- ◯ *Green*

Comment

The LBTH Autism Project Team was established in 2011 to oversee the development of local adult autism services. The Project Team is chaired by the Service Head for Adult Social Care and has membership from education, Public Health, local special school, carer and a representative from the Clinical Commissioning Group (Mental Health lead).

10. How have you and your partners engaged people with autism and their carers in planning?

- ◯ *Red*
- ◯ *Amber*
- ⊗ *Green*

Please give an example to demonstrate your score.

The Council conducted an Autism and Carers consultation exercise to find out whether or not stakeholders and the general public agreed with the Council's approach towards improving services for adults with autism in Tower Hamlets.

This consultation ran from April to June 2013. The consultation was widely publicised, with communications sent to all known contacts with a connection to autism in Tower Hamlets, including individuals, schools, colleges, service providers and local community and Third Sector organisations. A questionnaire via which people presented their views was made available on the Council's website in various community languages.

In all, 5 consultation events were held across Tower Hamlets where people could find out about the local plans and forward their views. 1 of these events was a focus groups, which the Council's Equality and Inclusion team members were pivotal in supporting.

Of the respondents, 49 people replied to the consultation:

* *6 people indicated that they were a person with autism*

* *40 were carers or parents of a person who has autism*

* *3 worked with people who have autism*

The consultation found that the highest priorities for local people included:

* *Support into employment and further education*

* *Better information about autism in terms of getting a diagnosis and also support around coping mechanisms for carers/family members*

* *Targeted support to assist adults with autism live independently,*

* *Better training for support and other front line staff in understanding the prevalence and needs of people with autism.*

11. Have reasonable adjustments been made to everyday services to improve access and support for people with autism?

- ◯ *Red*
- ⊗ *Amber*
- ◯ *Green*

Please give an example.

To date, the Council has implemented an Autism Awareness training programme, which is available to all front line staff (including health) following a review of the Council's E-Learning staff training modules. This has been developed using a tiered approach according to level of knowledge and required for roles. The Council is also considering the establishment of 'Autism Champions' within mainstream services, which will seek to embed autism awareness via service Champions with specialist knowledge. These Champions would receive a level of training and support that would enable them to advise their services on making them fully accessible to people with Autism. This continues to be a development area, which will be continually reviewed once the new service becomes operational.

12. Do you have a Transition process in place from Children's social services to Adult social services?

⊗ *Yes*
○ *No*

If yes, please give brief details of whether this is automatic or requires a parental request, the mechanism and any restrictions on who it applies to.

In Tower Hamlets, the transition phase starts at age 14 (Year 9) and continues for several years sometimes up to age 25. This is for children who have a statement of education need, or are known to the Children with Disabilities Team and during this time, children's service practitioners and their colleagues in adults' services work together with the family to understand the young person's needs and how those needs can be met by adult services when they reach the age of 18.

At present, the Transitions Team (situated with Community Learning Disability Service) conducts an assessment of the young person to ascertain if they meet the fair access to eligibility criteria for Adult Social Care. This will usually be carried out when the young person is 16 (Year 12), and ensures those who do not meet eligibility for continuing support are signposted and advised on other relevant services. All planning is undertaken with using a person centred approach, with family members involvement

The two sets of eligibility criteria are as follows:

(i) A person has a Learning Disability which includes the presence of: A significantly reduced ability to understand new or complex information and to learn new skills (impaired intelligence), with a reduced ability to cope independently (impaired social functioning); which both started before adulthood, with a lasting effect on development.

(ii) The person has to have a critical or substantial risk to independence as defined by the Council's "Fair Access to Care" criteria (i.e. how the person looks after themselves is causing extreme concern about their immediate safety).

If the planning process identifies that the young person doesn't meet the eligibility criteria for Adult Social Care once they are 18, information and support will be provided on accessing alternative universal services. Often this is the route for young people who have autism without a diagnosis of learning disability.

However, a key element of the new Autism Service (once implemented) will be to work with those young people not served by the transition process who do not meet the eligibility criteria for adult care services. This will include:

** Reviewing transitions planning process and assisting the young person to access into the new autism service (where required) and support elements.*

** Ensuring that young person & their carers are informed of their right to assessment as transition approaches*

** Delivering joint working, planning & robust communication between key services & agencies*

** Ensuring full & appropriate involvement of young person with autism & families in the transition process.*

13. Does your planning consider the particular needs of older people with Autism?

○ *Red*
⊗ *Amber*
○ *Green*

Comment

The Council is currently reviewing its existing universal older people's care contracts (Link Age Plus) in order to ensure the care needs of older people with autism are appropriately addressed. This includes ensuring staff members receive appropriate training; developing referral access routes towards the new Autism service, and configuring services to enable access for people with autism living in the borough.

In addition, once the new autism service is in place, anyone over the age of 18 will be able to access the service and receive a diagnosis and intervention once initial screening process has been completed. However, whilst the Council expects a large proportion of those with suspected ASD will access the service, it is likely that a number of these will be high functioning older people seeking only a diagnosis without the need for follow on support. Therefore, the new service will provide effective sign posting to ensure this cohort are provided information to address any issues affecting those in old age. This includes: social care, housing and health information with onward referrals to health practitioners should issues be identified that requires further attention (i.e. dementia/mental health).

Training

14. Have you got a multi-agency autism training plan?

- [x] *Yes*
- [ ] *No*

15. Is autism awareness training being/been made available to all staff working in health and social care?

- [ ] *Red*
- [x] *Amber*
- [ ] *Green*

Comment: Specify whether Self-Advocates with autism are included in the design of training and/or whether they have a role as trainers. If the latter specify whether face-to-face or on video/other recorded media.

The Council has developed a dedicated Autism Training programme to increase awareness of the condition amongst front line staff and accelerate learning on how best to deal with people with autism accessing services. To date, 12 sessions have been delivered, which has attracted staff from across the Council and external health services. The programme was also reviewed by attendees of the Autism Carers Drop-in (consisting of both people with autism and their carers) who advised on the course content. In addition, the Council has also developed links with the local special school (Phoenix) and NAS Tower Hamlets in order to ensure people with autism and their cares are able to access training to increase confidence and assist their aspirations on becoming self-advocates. Once a sufficent cohort are in place, the Council will seek to utilise their knowledge to deliver training across external agencies and partner organisations.

16. Is specific training being/been provided to staff that carry out statutory assessments on how to make adjustments in their approach and communication?

- [ ] *Red*
- [x] *Amber*
- [ ] *Green*

Comments

The Council is continuing to roll out its dedicated autism awareness training programme to frontline staff across Council services (i.e. social care and housing) and health services. This programme has been developed to enable staff to recognise autism, whilst providing guidance on how to respond appropriately when dealing with a person with the condition. This includes a specialist training programme for those delivering and assisting diagnostic assessments (i.e. DISCO). To date, 12 training sessions have been delivered (attracting over 200 staff) with further courses available (up to March 2014) to those requiring advanced knowledge and skills. The training has been a first vital step in delivering the local plan and is one of our key aims in increasing understaning across Council services. Further to this, the Council's adult social care service and human resource department has also developed an Autism awareness training pack for all staff and new starters, which provides basic information on the 2009 Act and how staff need to be aware of peeople with autism accessing services.

17. Have Clinical Commissioning Group(s) been involved in the development of workforce planning and are general practitioners and primary care practitioners engaged included in the training agenda?

◯ *Yes*
⊗ *No*

Please comment further on any developments and challenges.

Training & awareness for Primary Care workforce, including GPs, is an development area. Although the restructuring of the CCG means we do not yet have confirmation of how this will take place, we do have a lead GP for Autism within the CCG who will provide support in taking this forward. This work is expected to build on available best practice advice (such as the National Autistic Society guidelines for CCGs) and may be incorporated into the annual training programmes for GPs as part of their continuous professional development. This could take place in a number of ways, including the annual GP appraisal and revalidation scheme (a recommendation for NHS bodies).

18. Have local Criminal Justice services engaged in the training agenda?

◯ *Yes*
⊗ *No*

Please comment further on any developments and challenges.

The Council is currently engaging with local Criminal Justice agencies via the Community Safety Partnership, the borough's key statutory forum which includes all CJ agencies operating in the borough. A meeting to raise the profile of autism at the Partnership has been scheduled for November 2014. A key aim of this engagment will be to raise awareness of the 2009 Act and identify areas of joint need and working, including training and joint communications.

Diagnosis led by the local NHS Commissioner

19. Have you got an established local diagnostic pathway?

◯ *Red*
⊗ *Amber*
◯ *Green*

Please provide further comment.

There is an established diagnostic pathway for children and young people in Tower Hamlets. The Autistic Spectrum Disorder Assessment Service (commissioned by TH CCG) provides a service to children from 2 years up to the age of 19 years with suspected autistic spectrum disorder via medical and multidisciplinary assessments. Although autism diagnosis is avialable for adults with a learning disability (delivered via the Community Learning and Disability Service) there is (at present) no dedicated diagnostic pathway for adults with suspected autism (high functioning) as the primary condition.

For adults, persons presenting with suspected autism will be referred via a single entry point to Community Mental Health Teams (East London Foundation Trust). If a particularly complex need is identified that require specialist assessment and treatment that ELFT are not able to provide, ELFT will refer on to the specialist service at South London and Maudsley Foundation Trust (within 28 days).

However, LBTH is currently in the process of securing an external provider to deliver a dedicated Adult Autism Service in order to meet its statutory obligations as set out in the Autism Act 2009. The service will provide a high quality diagnostic and intervention service for high functioning adults (aged 18 years and over) with suspected Autism Spectrum Disorder (ASD) in Tower Hamlets. This includes delivery of a core diagnostic team to provide assessment of adults with potential ASD in Tower Hamlets, which uses best clinical practice and in line with NICE clinical guidelines for care of adults with autism. The service will also operate an open referral system, which will include an option for self referral, from a GP or social worker.

20. If you have got an established local diagnostic pathway, when was the pathway put in place?

Month (Numerical, e.g. January 01)

Year (Four figures, e.g. 2013)

Comment

New dedicated local diagnostic pathway for adults (high functioning) expected to operational by April 2014

21. How long is the average wait for referral to diagnostic services?

Please report the total number of weeks

Comment

A dedicated local diagnostic pathway will be implemented April 2014. However, using best practice, the new service will issue an appointment for diagnosis within 8 weeks from initial referral (whether by self referral or by GP/Social Worker)

22. How many people have completed the pathway in the last year?

Comment

New dedicated local diagnostic pathway for adults (high functioning) expected to operational by April 2014

23. Has the local Clinical Commissioning Group(s)/support services taken the lead in developing the pathway?

- ⊗ *Yes*
- ○ *No*

Comment

An LBTH Autism Project Team was established in 2011 to oversee the development of a dedicated local pathway for adults with suspected autism in Tower Hamlets. The Project Team is chaired by the Service Head for Adult Social Care and has membership from the Clinical Commissioning Group (CCG) education, Public Health, carer and social care commissioning representatives. This Group is also supported by a 'Clinical & Practitioner Reference Group' and has membership across social work, speech and language therapy, psychology and psychiatry and includes staff from the transition service. The group is specifically tasked with developing a clear and consistent pathway for diagnosis and ensuring that health and social care staff make reasonable adjustments to services to meet the needs of adults with autism.

24. How would you describe the local diagnostic pathway, ie Integrated with mainstream statutory services with a specialist awareness of autism for diagnosis or a specialist autism specific service?

- ○ *a. Integrated with mainstream statutory services with a specialist awareness of autism for diagnosis*
- ⊗ *b. Specialist autism specific service*

Please comment further

The new service will be a Specialist Autism Specific Service. However, the Council understands the requirement for improving the lives of adults with autism is wide-ranging and complex, which involves a multi-agency approach at every level. Therefore, the Council will ensure joined up and integrated approach is made across a range of partners in order to make comprehensive progress in meeting the needs of people with ASD, including Health, Social Care, Employment, Education, Criminal Justice and the local Third Sector.

25. In your local diagnostic path does a diagnosis of autism automatically trigger an offer of a Community Care Assessment?

◯ *Yes*
⊗ *No*

Please comment, i.e. if not who receives notification from diagnosticians when someone has received a diagnosis?

All Community Care Assessments are triggered by an identified need - rather than a diagnosis. However, people with a learning disability (and autism) receive an assessment, as do all young people in the transition process, which are conducted within the Community Leaning Disability Service. Any person receiving a diagnosis for autism will be notified along with their carer/parent, GP and social worker.

However, a dedicated local diagnostic pathway for adults will be implemented by April 2014. It is expected the core diagnostic team will include a social worker, nurse and phychology input to ensure Community Care assessments are carried out in-house and health needs are addressed. The team will be also required to provide written notification to the individual's GP/health worker that a diagnosis for autism has been carried out, with the results and any further intervention.

The team will offer specialist information, advice and support for people with Autism (both FACS eligible and non-FACs eligible) including GP Health Checks Programme for (1) young people in transition; and (2) for adults with Autism (also information advice and support to carers.) All individuals will also have their details entered on to the Council's electronic social care systems, which will be configured to ensure effective data capture of all those accessing the new service, which will be shared amongst both health and social care professionals.

26. What post-diagnostic support (in a wider personalisation perspective, not just assuming statutory services), is available to people diagnosed?

At present, FACS eligibility plays a huge part in the level of support an adult diagnosed with Autism receives. However, some reasonable adjustments to 'universal services' have been made to ensure people diagnosed with Autism are able to access services in the borough. This includes:

** Carers drop in: Peer led service providing support to people with autism and their carers. Participants of the group receive training and advice, whilst the service provides an important vehicle for engagement from external organisations.*

** Information, Advice and Advocacy Services: This service provides an advocacy and support to residents (including people with autism) requiring information and possible access into key services.*

In terms of those who are FACs eligible, support is also provided via the Community Learning Disability Service who provided post diagnostic intervention for those with a learning disability and autism. This includes psych-education for clients and families, family and marital work concerning understanding autism, psychological consultation to health services and social care support services, anxiety-management and anger-management interventions, art therapy and other psychotherapeutic approaches as appropriate. The Council also commissions a 'Jobs, Employment and Training' service, which assist service users (FACs eligible) to gain skills to enter the jobs market.

For children and young people with a diagnosis of autism, the following direct services are available:

** Early Years Service providing parental support (Portage) and pre-school home teaching*

** Short Breaks provision, which also assist in providing respite for those with a caring or parental responsibility*

** School out reach*

** Family Support (delivered by National Autistic Society)*

** Disabled Children's Outreach Service*

** Child and Adolescent Mental Health Service*

** Educational Psychology*

It should be noted, the Council is currently implementing its plan to deliver an adult Autism Diagnostic and Intervention service, which will provide post diagnostic support to both non and FACs eligible residents with a diagnosis of autism. This will include:

(i) A programme of post intervention support to adults with ASD (high functioning) and assistance with developing social relationships

(ii) Service user support to access employment and training programmes. This will be delivered via a local Third Sector organisation, which will ensure the service is 'in reach' to the borough's diverse communities and other hard to reach groups. Under this scheme, adults with ASD will be made aware of wider employment initiatives, training options and work placements. Lifelong learning and development are included, ensuring adult education learning opportunities are accessible to people with autism. This service will also link closely to local colleges and Job Centre Plus.

(iii) Sign posting and referral to other services should a primary condition be other than ASD (i.e. mental health) or a risk be identified (i.e. self harm or harm to others) that may require in-patient treatment

Care and support

27. Of those adults who were assessed as being eligible for adult social care services and are in receipt of a personal care budget, how many people have a diagnosis of Autism both with a co-occurring learning disability and without?

a. Number of adults assessed as being eligible for adult social care services and in receipt of a personal budget

2710

b. Number of those reported in 27a. who have a diagnosis of Autism but not learning disability

10

c. Number of those reported in 27a. who have both a diagnosis of Autism AND Learning Disability

8

Comment

The Council recognises there is a lack of information about the number of people with a diagnosis of autism in the community. Better diagnosis and a more consistent approach in capturing information will help improve the quality of data. Until these are in place (April 2014), the lack of information will be a limitation in understanding the level of need, how this need presents, and how well services are meeting those needs.

At present, none of the current data fields exclusively capture information on people with autism. Where those with autism are known, this is usually with a co-occurring condition (i.e. learning disability). In order to address this issue, a review of data systems is currently taking place. From 2014/15 health condition information will be routinely collected and reported for all those entering the new autism service.

Within the proposed list of conditions Autism and Aspergers will be specifically identified. With improved recording of autism it will become possible to specifically determine the outcomes for these clients within the Adult Social Services and beyond - particularly in relation to clients in paid employment, living in settled accommodation with any satisfaction levels reported

In addition, the NHS are also leading the development of a single data platform (Orion) to provide a single data source for health and social care needs in the borough. This system will extract data from a number of sources, leading to better data sharing across lead organisations.

28. Do you have a single identifiable contact point where people with autism whether or not in receipt of statutory services can get information signposting autism-friendly entry points for a wide range of local services?

⊗ *Yes*
○ *No*

If yes, please give details

The Council has in place a network of Information, Advice and Advocacy services, which are free to access for both non FACs eligible and eligible residents. Within this network, residents have access to single entry points across a diverse range of options in health, leisure, housing volunteering and welfare advice. The services are needs led and provide universal Information, Advice and Advocacy Services residents say are important to them. This includes provision to support people with autism, including 'autism friendly' access to sessions, which are delivered via drop-ins or surgeries, specific outreach support and within people's homes. The services operate an open access policy, or via referral from other organisations or service.

29. Do you have a recognised pathway for people with autism but without a learning disability to access a community care assessment and other support?

○ *Yes*
⊗ *No*

If yes, please give details

30. Do you have a programme in place to ensure that all advocates working with people with autism have training in their specific requirements?

- ◯ *Red*
- ⊗ *Amber*
- ◯ *Green*

Comment

The Council is continuing to roll out its dedicated autism awareness training programme to frontline staff across Council services and its external delivery partners delivering universal services including Information, Advice and Advocacy services to people with autism. This programme has been developed to enable staff to recognise autism, and deliver a response appropriately to their needs. At present, 12 sessions have been delivered, which has attracted over 200 staff members from across social care, health and community services including housing.

31. Do adults with autism who could not otherwise meaningfully participate in needs assessments, care and support planning, appeals, reviews, or safeguarding processes have access to an advocate?

- ◯ *Red*
- ◯ *Amber*
- ⊗ *Green*

Comment

Yes. In 2011, the Council commissioned an external organisation to coordinate a consortium of organisations to deliver a Information, Advice and Adocacy Service in Tower Hamlets.This service is aimed at people with support needs including those with sensory impairments, physical and learning disabilities, autism and living with HIV/AIDS. The Council understands that good information, advice and advocacy are essential for all adults and their carers who need support in order to know their rights and to live independently. Therefore, the
service offers support to people with Autism (and their carers) to make informed choices, enable them to take control and help service users and carers to maintain their abilities, skills and independence well into the future.

The following specialist services are delivered:

** Benefits and welfare information and advice*

** Housing advice and information*

** Legal advice for service users with disabilities*

** Welfare, money management and benefits information and advice*

** Volunteering information and advice*

** Crisis, one to one, group, citizen and self-advocacy*

32. Can people with autism access support if they are non Fair Access Criteria eligible or not eligible for statutory services?

- ⊗ *Yes*
- ◯ *No*

Provide an example of the type of support that is available in your area.

The following services are currently available to people with autism (non FACs eligible):

(1) Carers drop in: Peer led service providing support to people with autism and their carers. Established in 2013, the service has received recommendation from the National Autistic Society as a model of good practice. Participants of the group receive training and advice, whilst the service provides an important vehicle for engagement from external organisations.

(2) Information, Advice and Advocacy Services: This service provides a advocacy and support to residents (including people with autism) requiring information and possible access into key services. This includes:

** the provision of accurate, up-to-date and objective information about personal and lifestyle issues, learning and career opportunities, progression routes, choices, where to find help and advice, and how to access it*

** the provision of advice through activities that help residents of Tower Hamlets to gather, understand and interpret information and apply it to their own situation*

** the provision of impartial advocacy and specialist support to help residents understand their needs, confront barriers, resolve conflicts and develop solutions.*

The delivery of holistic universal Information, Advice and Advocacy Service targets support for residents of Tower Hamlets with additional needs. This includes ensuring residents and carers understand what services are available and how to access them.

Additional support is offered to those with learning difficulties (including autism) and disabilities by trained staff.

33. How would you assess the level of information about local support in your area being accessible to people with autism?

- ◯ *Red*
- ⊗ *Amber*
- ◯ *Green*

Comment

The Council has made some progress in raising the profile of existing support to people with autism (and their carers). For example, the Council has delivered an Autism Carers drop in, which provides a key mechanism for information flows between the Council and people with autism and their carers living in the borough. Recently established (2013) the group has informed plans for a dedicated autism service, and enabled better engagement between services (housing) and external agencies to increase awareness of available support. Due to its success, the National Autistic Society (NAS) has recently recommended the group as a model of good practice to other London boroughs. In addition, the Council has also set up an autism library, which provides up-to-date and easy to read literature on the condition and techniques to improve social interaction. This includes information in a number of community languages with supported awareness training available to those with English as a second language.

In terms of its future plans, the Council is also leading the development of a comprehensive multi-agency communications plan, which will dovetail with delivery of the new service. The purpose of the plan will be to raise the profile of the new service across agencies (and the wider public) and increase awareness of the condition amongst front line staff working including health, social care, criminal justice and schools.

Housing & Accommodation

34. Does your local housing strategy specifically identify Autism?

- ◯ *Red*
- ⊗ *Amber*
- ◯ *Green*

Comment

The Council recognises that support with housing is key to helping adults with autism live more independently. Housing staff have been provided information and training on the needs of adults with autism and how to communicate effectively with them. The Council's Housing Service are also currently developing an ASD action plan to improve services for adults with autism.

Employment

35. How have you promoted in your area the employment of people on the Autistic Spectrum?

◯ *Red*
⊗ *Amber*
◯ *Green*

Comment

A local provider has been commissioned by LBTH to deliver a Jobs, Enterprise and Training (JET) programme for people with a learning disability and autism in Tower Hamlets. This programme works with local employers to develop employment opportunities for people with autism, and leaning disabilities.

36. Do transition processes to adult services have an employment focus?

◯ *Red*
⊗ *Amber*
◯ *Green*

Comment

Support is provided at transition from school to employment or further education. Support is on an individual basis, providing tailor made support for each person. Support includes Transition, work preparation, support into further training/college, CV preparation, interview skills training, work experience placements, voluntary work, supported paid permitted work, in- work support.

Criminal Justice System (CJS)

37. Are the CJS engaging with you as a key partner in your planning for adults with autism?

◯ *Red*
⊗ *Amber*
◯ *Green*

Comment

The Council is currently engaging with Criminal Justice agencies (via the local Community Safety Partnership) to ascertain levels of ASD awareness amongst CJ organisations in the borough, and to raise awareness of the new autism service. The Council aims to initiate further joint working between agencies so that communication needs and behaviours of people with autism are better understood, which will reduce the likelihood of misinterpretation of behaviours and lead to better support within the criminal justice system.

Optional Self-advocate stories

Self-advocate stories.

Up to 5 stories may be added. These need to be less than 2000 characters. In the first box, indicate the Question Number(s) of the points they illustrate (may be more than one. In the comment box provide the story.

Self-advocate story one

Question number

Comment

Self-advocate story two

Question number

Comment

Self-advocate story three

Question number

Comment

Self-advocate story four

Question number

Comment

Self-advocate story five

Question number

Comment

This marks the end of principal data collection.

Can you confirm that the two requirements for the process to be complete have been met?

a. Have you inspected the pdf output to ensure that the answers recorded on the system match what you intended to enter?

☒ *Yes*

b. Has the response for your Local Authority area been agreed by the Autism Partnership Board or equivalent group, and the ratings validated by people who have autism, as requested in the ministerial letter of 5th August 2013?

☒ *Yes*

The data set used for report-writing purposes will be taken from the system on 30th September 2013.

The data fill will remain open after that for two reasons:

1. to allow entry of the dates on which Health and Well Being Boards discuss the submission and
2. to allow modifications arising from this discussion to be made to RAG rated or yes/no questions.

Please note modifications to comment text or additional stories entered after this point will not be used in the final report.

What was the date of the meeting of the Health and Well Being Board that this was discussed?

Please enter in the following format: 01/01/2014 for the 1st January 2014.

Day

19

Month

12

Year

2013

Appendix Two: Breakdown of RAG ratings

SAF Ref:	Question:	Red:	Amber:	Green:
4.	Is Autism included in the local JSNA?		X	
5.	Have you started to collect data on people with a diagnosis of autism?		X	
8.	What data collection sources do you use		X	
9.	Is your CCG engaged in the planning and implementation of the strategy in your local area?		X	
10.	How have you and partners engaged with people with autism and carers in planning?			X
11.	Have reasonable adjustments been made to everyday services to improve access and support for people with autism?		X	
13.	Does your planning consider the particular needs of older people with autism		X	
15.	Is autism awareness training being/been made available to all staff working in health and social care?		X	
16.	Is specific training being/been provided to staff that carry out statutory assessments on how to make adjustments in their approach and communication?		X	
19.	Have you got an established local diagnostic pathway?		X	

Appendix Two: Breakdown of RAG ratings

30.	Do you have a programme in place to ensure that all advocates working with people with autism have training in their specific requirements?		X	
31.	Do adults with autism who could otherwise meaningfully participate in needs assessments, care and support planning, appeals, reviews or safeguarding processes have access to an advocate?			X
33.	How would you assess the level of information about support in your local area being accessible to people with autism?		X	
34.	Does your local housing strategy specifically identify autism?		X	
35.	How have you promoted in your area the employment of people on the Autistic Spectrum?		X	
36.	Do transition processes to adult services have an employment focus?		X	
37.	Are the Criminal Justice System engaging with you as a key partner in your planning for adults with autism?		X	