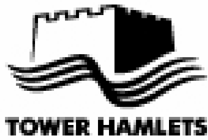

TOWER HAMLETS HEALTH AND WELLBEING BOARD

Tuesday, 8 July 2014 at 5.00 p.m. Committee Room MP701, 1st Floor, Town Hall, Mulberry Place, 5 Clove Crescent, London, E14 2BG

This meeting is open to the public to attend.

Members:

Chair: Mayor Lutfur Rahman	(Mayor)
Vice-Chair: Councillor Abdul Asad	(Cabinet Member for Adult Services)
Councillor Alibor Choudhury	(Cabinet Member for Resources)
Councillor Gulam Robbani	(Cabinet Member for Children's Services)
Vacancy	(Executive Advisor, Adults Social Care)
Councillor Denise Jones	(Non Executive Majority Group Councillor)
Robert McCulloch-Graham	(Corporate Director, Education Social Care and Wellbeing)
Dr Somen Banerjee	(Interim Director of Public Health, LBTH)
Dr Amjad Rahi	(Healthwatch Tower Hamlets Representative)
Dr Sam Everington	(Chair, Tower Hamlets Clinical Commissioning Group)
Jane Milligan	(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)
Steve Stride	(Chief Executive, Poplar HARCA)
John Wilkins	(Deputy Chief Executive, East London and the Foundation Trust)
Mahdi Alam	(Young Mayor)
Robert Rose	(Hospital Director for Royal London and Mile End)

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

Questions

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

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

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Role of the Tower Hamlets Health and Wellbeing Board.

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

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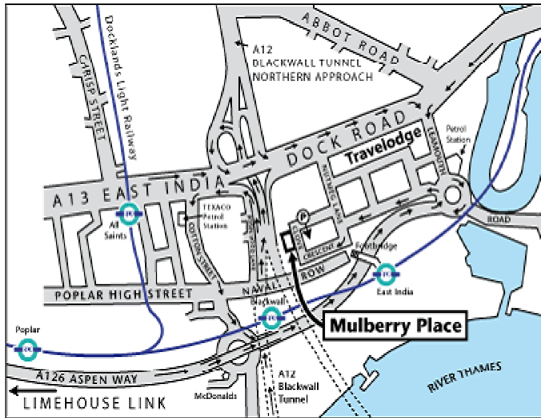

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		PAGE NUMBER(S)
1.	**STANDING ITEMS OF BUSINESS**	
1 .1	**Welcome, Introductions and Apologies for Absence** To receive apologies for absence and subsequently the Chair to welcome those present to the meeting and request introductions.	
1 .2	**Minutes of the Previous Meeting and Matters Arising** To confirm as a correct record the minutes of the meeting of the Tower Hamlets Health and Wellbeing Board held on the 24th March 2014. To consider matters arising including. Memorandum of Understanding - Deborah Cohen, Service Head, Commissioning and Strategy, Education, Social Care and Wellbeing, LBTH. Oral Health for children – Dr Somen Banerjee, Interim Director of Public Health, LBTH	**1 - 10**
1 .3	**Declarations of Disclosable Pecuniary Interests** To note any declarations of interest made by members of the Board. (See attached note of Monitoring Officer).	**11 - 14**
1 .4	**Terms of Reference, Quorum, Membership and Dates of Meetings.** Recommendations: To note the Tower Hamlets Health and Wellbeing Board (HWBB) Terms of Reference, Quorum, Membership as attached to this report and future meeting dates.	**15 - 18**
1 .5	**Forward Programme** To consider and comment on the Forward Programme. Lead for item: Deborah Cohen, Service Head, Commissioning and Strategy, Education, Social Care and Wellbeing, LBTH.	**19 - 22**
1 .6	**Healthwatch Update - Maternity Services Liaison Committee Patient Feedback** Verbal Update. Lead for item: Dianne Barham, Director of Healthwatch Tower Hamlets.	

2. HEALTH AND WELLBEING STRATEGY

2 .1 Maternal, Early Years and Child Health, update for the Health and Wellbeing Board **23 - 38**

Recommendation(s):

The Health and Wellbeing Board is asked to discuss

Partnership arrangements for taking forward work to improve maternal, early years and child health

Priorities for action to improve maternal, early years and child health

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

2 .2 Presentation on Maternity Service Quality at the Royal London Hospital **39 - 48**

Recommendation:

To note the work of Tower Hamlets CCG and Barts Health NHS Trust on the improvement of Maternity Services at the Royal London Hospital

Lead for Item: Dr Martha Leigh, Tower Hamlets CCG Governing Board's lead for maternity.

2 .3 Commissioning of Primary Care services **49 - 58**

Recommendation:

To note that this paper sets out the arrangements for commissioning of primary care services in the NHS post 1 April 2013.

Lead for Item: Vanessa Lodge, Director of Nursing, Central and North East London NHS England (London)

2 .4 Presentation on the Expression of Interest for the co-commissioning of Primary Care Services in Tower Hamlets **59 - 72**

Recommendation:

Note Tower Hamlets CCG's submission of an Expression Of Interest to NHS England on the Co-commissioning of primary care services.

Lead for Item: Jane Milligan, Tower Hamlets CCG

2 .5 Drug and Alcohol Action Team (DAAT) Commissioning Intentions **73 - 106**

Recommendation:

Note the intention to re-procure drug / alcohol treatment services in Tower

Hamlets

Note the preferred option of the DAAT Board (agreed by CLC / ESCW DMTs and CMT) and comment in advance of consideration at Cabinet.

Note the timescales provided

Lead for Item: Andy Bamber, Service Head, Community Service, LBTH

Rachael Sadegh, DAAT Co-ordinator, LBTH

3. BOARD OVERSIGHT

3 .1 Reform of Special Educational Needs (SEN): The Children and Families Bill 2013 & the Draft SEN Code of Practice **107 - 122**

Recommendation:

Support the work of the project board and the plans to ensure that the Local Offer is underpinned by local authority and clinical commissioning group agreeing on local provision in line with the priorities of this Health & Wellbeing Board.

Support the implementation of the SEN Reforms by promoting the greater responsibilities on non-education services to participate.

Support the Joint Commissioning Plans between the Council and the CCG to secure and review the wide range of provision made across all agencies to meet the needs of children and young people with SEN.

Lead for Item: Anne Canning, Service Head, Learning and Achievement, Education, Social Care and Wellbeing, LBTH.

David Carroll, Principal Educational Psychologist, SEN & Inclusion Lead, London Borough of Tower Hamlets.

4. ANY OTHER BUSINESS

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

Date of Next Meeting:
Tuesday, 9 September 2014 at 5.00 p.m. in Committee Room 1, 1st Floor, Town Hall, Mulberry Place, Town Hall, 5 Clove Crescent, London, E14 2BG

LONDON BOROUGH OF TOWER HAMLETS

MINUTES OF THE TOWER HAMLETS HEALTH AND WELLBEING BOARD

HELD AT 5.00 P.M. ON MONDAY, 24 MARCH 2014

COMMITTEE ROOM MP701, 7TH FLOOR, TOWN HALL, MULBERRY PLACE, 5 CLOVE CRESCENT, LONDON, E14 2B

Members Present:

Councillor Abdul Asad (Vice-Chair)	(Cabinet Member for Health and Wellbeing)
Robert McCulloch-Graham	(Corporate Director, Education Social Care and Wellbeing, LBTH)
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)
John Wardell (Substitute for Jane Milligan)	(Deputy Chief Officer, Tower Hamlets Clinical Commissioning Group)

Co-opted Members Present:

Sharon Hanooman	(Vice-Chair, Tower Hamlets Community Voluntary Sector)
Robert Rose(Substitute for Sue Lewis)	(Hospital Director for Royal London and Mile End)
Steve Stride	(Chief Executive, Poplar HARCA)
John Wilkins	(East London NHS Foundation Trust)

Others Present:

Dr Steve Ryan	(Medical Director, Barts Health NHS Trust)
Brian Parrott	(Independent Chair - Tower Hamlets Safeguarding Adults Board)
Daniel Heller	(Tower Hamlets, Clinical Commissioning Group)
Sarah Castro	(Poplar HARCA)
Mark Gravel	(Barts Health NHS Trust)
Ian Read	(Communications Advisor, Communications, Directorate of Law, Probity and Governance)

Officers in Attendance:

Deborah Cohen	(Service Head, Commissioning and Health, Education, Social Care and Wellbeing, LBTH)

David Galpin	(Service Head, Legal Services, Directorate Law Probity and Governance, LBTH)
Robert Driver	(Senior Strategy, Policy and Performance Officer, Education, Social Care and Wellbeing LBTH)
Leo Nicholas	(Strategy, Policy and Performance Officer, Education, Social Care and Wellbeing LBTH)
Nishaat Ismail	(Committee Officer, Democratic Services, Directorate Law Probity and Governance LBTH)
Zoe Folley	(Committee Officer, Directorate Law, Probity and Governance LBTH)

Apologies:
Councillors Oliur Rahman, Denise Jones

Jane Milligan, Alistair Camp and Sue Lewis

COUNCILLOR ABDUL ASAD (CHAIR)

The Chair announced that Items 2.3, Health & Housing workshop feedback and 3.3 Reform of Special Educational Needs (SEN) would be deferred for consideration at the next meeting of the Board in July 2014. It was also reported that Robert Rose, (Hospital Director for Royal London and Mile End) would be replacing Sue Lewis (Chief Operating Officer, Barts Health NHS Trust) as a co-opted Member of the Board.

Deborah Cohen (Service Head for Commissioning and Health, Education, Social Care and Wellbeing, LBTH) referred to the postponement of the item on the Commissioning of Primary Care services until the July 2014 meeting of the Board. Members noted the links between this and agenda item 2.2, Clinical Commissioning Group Operating Plan and Quality, Innovation, Productivity and Prevention. The Board should note this when considering item 2.2.

The Board were also advised of the recent submission of an application for a small amount of funding from the Local Government Association. If successful this would help shape the work of the HWB in the future.

1.1 Minutes of the Previous Meeting and Matters Arising

The minutes of the meeting held on 6th February 2014 were approved as a correct record of the proceedings.

1.2 Declarations of Disclosable Pecuniary Interests

No declarations of Disclosable Pecuniary Interest were made.

1.3 Forward Programme

The Board noted the Forward Plan.

2. HEALTH AND WELLBEING STRATEGY

2.1 The Care Quality Commission feedback on Barts Health Inspection and Action Plan

The Board welcomed to the meeting Dr Steve Ryan (Barts Health's Medical Director) to present the outcome of the Care Quality Commission (CQC) inspection of Barts Trust hospital sites in November 2013 and the Trust response to this.

Dr Ryan explained the nature of the inspection and the findings for each hospital site. He highlighted the positive findings regarding the quality of staff and particular services. The inspectorate identified specific area of service excellence. He also highlighted the areas identified for improvement around: complaint handling, staff engagement and morale, amongst other issues.

He explained the scope of the action plans, developed in response to the inspection. This included a single high level action plan and five site specific plans for the individual hospitals. The Trust wide actions included: ensuring staffing levels reflected patient needs in wards; ensuring equipment was readily available, providing 24/7 consultant cover, ensuring the risk registers were managed well; improving staff morale, engagement and visible leadership and learning from experience.

Work was underway to facilitate staff engagement through online surveys; to improve integrated care; to improve staff training; to enhance the visibility of and engagement with senior managers and to remedy the staff culture issues.

It was also reported that the Trust placed a lot of importance on the feedback from Heathwatch in monitoring and delivering services.

The Board asked questions about the reasons for the issues and the perceptions around staff culture, given the feedback.

Dr Ryan commented that certain issues were long term issues and were legacies from before the merger. Nevertheless this was now an opportunity to address these issues. Dr Ryan noted the issues around staff culture that, in his opinion, were mainly due to the pressures from the working environment. The Trust had carried out a lot of work to address such issues. However, it

was noted that more needed to be done. Such issues were prevalent across the NHS generally.

In response to further questions, Mr Ryan noted the need for a flow chart highlighting the complaints procedure. There was a great deal of work in progress with the Complaints Team to address complaints at an early stage to avoid going through the formal process that was very lengthy. Dr Ryan also clarified the meaning of a 'never event' and the measures to prevent such instances.

Dr Ryan confirmed that the Healthwatch feedback would be incorporated into the CQC inspection action plan.

Resolved:

That the contents of the report and Barts Health's response to the CQC inspection and Healthwatch feedback be noted.

2.2 Tower Hamlets Clinical Commissioning Group Operating Plan and Quality, Innovation, Productivity and Prevention

John Wardell (Deputy Chief Officer, Tower Hamlets Clinical Commissioning Group THCCG) presented the report. The report outlined the CCG's final Operating Plan due for submission to the NHS England on 4th April 2014, following consideration of the draft plan at HWB in February .The operating plan outlined the key actions and outcomes the CCG expected to achieve in relation to the NHS England's key prioritises.

Mr Wardell explained the main sections of the Operating Plan. He also drew attention to the summary of the CCG's improvement plans focusing on Quality, Innovation, Productivity and Prevention (QIPP) and the alignment of these plans to the Health and Wellbeing Strategy.

He also highlighted the summary of the CCG's planned expenditure over the next two years. The report also contained a summary of the draft Better Care Fund submission.

The Board sought clarity on some of the terminology in the report and the expected outcomes. In particular, the amount of patients experiencing poor experience of GP and community care. Mr Wardell advised that this figure was expected to decrease in the long term as shown in the committee report. He outlined the remit of the CCG in respect of GP performance. Whilst the CCG lacked any contractual measures to directly address this issue, it was working with relevant colleagues and took action within its remit to secure improvements.

Dr Sam Everington stressed the need for the feedback to be kept in perspective given the pressures on staff and budgets and that the results compared well to others. It was anticipated that the work on intergraded care should make a key difference.

Resolved:

That the report be noted.

2.3 Health and housing: workshop feedback- Item Deferred

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

Action: Leo Nicholas (Strategy and Performance Officer, LBTH) to add to the Board's Forward Plan.

2.4 Transforming services, changing lives in east London

Dr Sam Everington (Chair, Tower Hamlets Clinical Commissioning Group) presented the report regarding the East London CCG's plans to develop a new 'Hospital Care workstream'. Dr Everington considered that this was a really important area of work.

He explained the need for the initiative driven by developments in the local health economy. For example: population changes, the need to deliver integrated services; to utilise new technology and more effective ways of working to provide better outcomes for patients.

The Tower Hamlets CGG would be engaging with key stakeholders such as Local Authorities and HWBs to develop and test ideas. It was planned to establish a number of clinical working groups to take forward the programme. These would focus on: unplanned care/planned care, clinical support services, paediatrics, maternity and neonatal care. Once completed, the case for change would be subject to far reaching consultation.

The Board noted the proposed timescale for the initiative and the next steps in the process as detailed in the report.

In response, Dr Steve Ryan (Barts Health's Medical Director) welcomed the proposals. He advised that the plans had been taken to Healthwatch for feedback. There was much support for the use of new technologies such as "skype" consultations. He stressed the need for ongoing consultation with Healthwatch over these plans and with secondary care providers.

The Board also requested that representatives from the voluntary sector should be invited to the event on 4th April 2014.

Resolved:

1. That the date of the case for change stakeholder event (4 April 2014) be noted.

2. That the case for change be discussed at the 9th September 2014 meeting of the Health and Wellbeing Board

Action: Leo Nicholas to add to the Board's Forward Plan.

2.5 Memorandum of Understanding

Deborah Cohen (Service Head for Commissioning and Health, Education, Social Care and Wellbeing) presented an update on the Memorandum of Understanding (MOU) between Barts Health, Tower Hamlets Clinical Commissioning Group (CCG) and the Council. The Board noted the aim of the agreement to reduce health inequalities and improve the health of local people in respect of a number of health and social care factors. It also had a focus on providing employment opportunities for local people.

Ms Cohen welcomed the creation of the Barts Health Learning Hub (as detailed in Appendix 2 of the report). The parties should be congratulated on championing this work.

Ms Cohen also drew attention to the recommendations in the report. If agreed, it would be necessary to work with the Public Health at the Council and at Barts Health Trust

Sharon Hanoonman (Vice-Chair, Tower Hamlets, Community Voluntary Sector) urged that the MOU should be widely promoted so that organisations were aware of the agreement. John Wardell (Deputy Chief Officer, Tower Hamlets Clinical Commissioning Group THCCG) expressed support for the MOU targets to be broadened to include the aims in the Mental Health Strategy and relevant aspect of the CCG plans.

Resolved:

That the Board note:

- Progress made on the MOU (Appendix 2 and Appendix 3)
- The ongoing work between LBTH and Barts Health NHS Trust around employment
- The overlap between the MOU (especially paragraphs 7 and 8) and the work on the BCF and integration and that the MOU may be a duplication of this area of the Board's work. This will be reflected in the update referred to in the Committee Report
- That the MOU can be used as a way to maximise social value (in the sense of the Public Values (Social Value) Act 2012) and that officers will look at how to measure this more formally as a way of evaluating the success of the MOU.

That it be Agreed that:

- That the MOU be reviewed in early 2014-15 and an update be taken to the Health and Wellbeing Board not later than July 2014 that reflects the above comments.

Action:

Deborah Cohen and Leo Nicholas

3. REGULATORY OVERSIGHT

3.1 Oral Health of Children

Dr Somen Banerjee (Interim Director of Public Health, LBTH) gave an update on the oral health of children in the Borough. The findings were derived from the national survey of 5 year olds carried out in 2012 and access figures from 2013 published by the Health and Social Care Information Centre.

He drew attention to the proportion of 5 year old children with decay experience in TH that was above the London and national average. The survey also showed that the proportion of local children accessing dental services had increased due to the investment in dental services. Nevertheless, both figures were below the target.

The Council was implementing a number of programmes targeted at children including school fluoride programmes and teeth brushing advice. It had also taken the issues around capacity to the NHS.

In response, the Board expressed concern about the level of tooth decay in local children. The Board stressed the need to work closely with schools and families to improve dental care and address the underlying issues.

Concern was also expressed about the perceived links between tooth decay and a range of other health issues seen in young children such as obesity. It was considered that a holistic approach needed to be taken to these problems and that the lessons learnt from the adult integrated care services could be applied to the services for this age group.

One idea might be to undertake out reach work with families in addressing these problems or possibly to reintroduce mobile dental units to provide education on young children's oral health. There might also be opportunities to address these matters in the Child Health Review and through the changes in school nursing.

As a result, the Board **Agreed** to set up a working group to investigate the issues around dental decay in 0-5 year olds in TH and other linked health problems. It was agreed that the working group would report back to the Board in three months time.

Resolved:

1. That it be agreed to promote the Council's engagement with NHS England to increase the capacity within general dental practice including the resolution of issues delaying the opening of the new dental practice at the Harford Health Centre.

2. That the importance of oral health improvement programmes for children including the school fluoride varnish programme in addressing trends in dental decay be noted.

3. That it be agreed to explore the possibility of including figures from the dental school primary care service in monitoring the dental access indicator.

4. That a working group be set up to investigate the issues around dental decay in 0-5 year olds in Tower Hamlets and other linked health problems and report back to the Health and Wellbeing Board in three months time.

Action: Robert McCulloch-Graham (Corporate Director, Education Social Care and Wellbeing, LBTH), and Somen Banerjee, (Interim Director of Public Health).

3.2 Better Care Fund Planning Template

The report was printed separately from the main agenda pack but was circulated by the statutory deadline.

Deborah Cohen (Service Head for Commissioning and Health, Education, Social Care and Wellbeing) introduced the final draft of the Better Care Fund planning template following consideration of the draft template at the last Board meeting in February 2014.

Ms Cohen highlighted the changes to the template following that meeting. If approved the proposals would be submitted to the Council's Cabinet for agreement.

A question was asked about the process for patient access to the care path way. It was confirmed that access would be through GP referral.

John Wardell explained the nature of the consultation in developing the template with services providers, users and the public. This included the use of focus groups to gain feedback on services.

Resolved:

That the final version of the Better Care Fund Planning Template (Appendix 1) be agreed for final submission to NHS England on 4 April 2014

3.3 Reform of Special Educational Needs (SEN): The Children and Families Bill 2013 & the Draft SEN Code of Practice

Item deferred for consideration at the next meeting of the Board in July

Action: Leo Nicholas to add to the Board's Forward Plan.

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

Brian Parrott (Independent Chair of the Tower Hamlets Safeguarding Adults Board) presented the protocol following consideration of the draft proposals at the Shadow Health and Wellbeing Board in September 2013.

The protocol sets out the role and responsibilities of each Board and the interrelations between them in terms of safeguarding and the effective coordination of work.

It was intended that the relationship between the Boards should be reciprocal in nature in terms of reporting and accountability.

Resolved:

1. That the Protocol, attached to the Committee report, be agreed in support of the relationship between the Tower Hamlets Health and Wellbeing Board, the Tower Hamlets Local Safeguarding Children Board and the Tower Hamlets Local Safeguarding Adults Board

2. That the timescales for sharing for plans and priorities set out in the protocol and Committee report be noted.

Action: Louse Russell, Brian Parrott, and Sarah Baker, (Strategy - Partnerships and Performance, LBTH).

4. ANY OTHER BUSINESS

Dr Amjad Rahi (Healthwatch Tower Hamlets Representative) drew attention to a recent presentation by Dr Sam Everington on social prescribing. He asked whether this presentation should be given to the Board. Deborah Cohen agreed to look into this.

Action: Deborah Cohen.

The meeting ended at 6.30 p.m.

Vice Chair, Abdul Asad
Tower Hamlets Health and Wellbeing Board

DECLARATIONS OF INTERESTS - NOTE FROM THE MONITORING OFFICER

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

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

Interests and Disclosable Pecuniary Interests (DPIs)

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

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

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

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

Effect of a Disclosable Pecuniary Interest on participation at meetings

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

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

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

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

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

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

Further advice

For further advice please contact:-

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

APPENDIX A: Definition of a Disclosable Pecuniary Interest

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

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

Committee **Tower Hamlets Health and Wellbeing Board**	Date 8th July 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 It is traditional that following the Annual General Meeting of the Council at the start of the Municipal Year, at which various committees are established, that those committees note their Terms of Reference, Quorum and Membership for the forthcoming Municipal Year. These are set out in the Appendix to the report.

2.2 The Board's meetings for the year are set out below as agreed at the Council meetings on 26 March 2014 and 11 June 2014.Meetings are scheduled to take place at 5.00pm .

- Tuesday, 8th July, 2014
- Tuesday, 9th September, 2014
- Tuesday, 25th November, 2014
- Tuesday, 13th January, 2015
- Tuesday, 10th March, 2015

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 Council on 26 March 2014 and 11 June 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)
- That should the Mayor be unable to attend a meeting then the Cabinet Member for Health and Wellbeing would Chair the meeting in his place.

Elected Representatives of LBTH
- Cabinet Members for Adult Services (Health & Wellbeing) and Children's Services (2)
- Cabinet Member for Resources
- Executive Advisor on Adult Social Care (position to be confirmed)
- 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 Forward Plan

	Report Title	Lead Officer	Reason for submission	Time
Date: September 2014				
Public Questions	Public Questions			
Standing Items	Apologies & Substitutions Minutes & Matters Arising Forward Plan			
Health and Wellbeing Strategy	HWBS Year End Reporting	Louise Russell	Moved from July	
	Vision Strategy	Barbara Disney/Deborah Cohen	Moved from July	
	JSNA Priorities	Somen Banerjee		
	Introduction to PNA	Paul Iggulden		
	Community Plan Refresh	Louise Russell		
	Transforming Services, Changing Lives	Zoe Hooper		
	Health and Housing	Louise Russell		
	MOU	Deborah Cohen		
Board Oversight				
Date: November 2014				
	Report Title	**Lead Officer**	**Reason for submission**	**Time**
Public Questions	Public Questions			
Standing Items	Apologies & Substitutions Minutes & Matters Arising Forward Plan			
Health and Wellbeing Strategy	Migrant Health - UKBA paper	Fran Jones		
Board Oversight				

Health and Wellbeing Board Workshop Forward Plan

Date: Summer 2014, 15:00 - 17:00, Room TBC				
	Report Title	**Lead Officer**	**Reason for submission**	**Time**
Summer	**OD workshop**	Deborah Cohen/Leo Nicholas	OD workshop for HWBB members	
2014	**Care Act Workshop**	Karen Sugars		
2014	**BCF Workshop**	Deborah Cohen/Leo Nicholas		

Health and Wellbeing Board - Items to be scheduled

Board/Workshop/EOG	Suggested meeting date	Report Title	Lead Officer	Reason for submission	Time
Board	2014	Liver Disease	Somen Banerjee		
Board	After May 2014	Interface between schools and health	Robert McCulloch - Graham		
Board	TBC	Social Prescribing	CCG		

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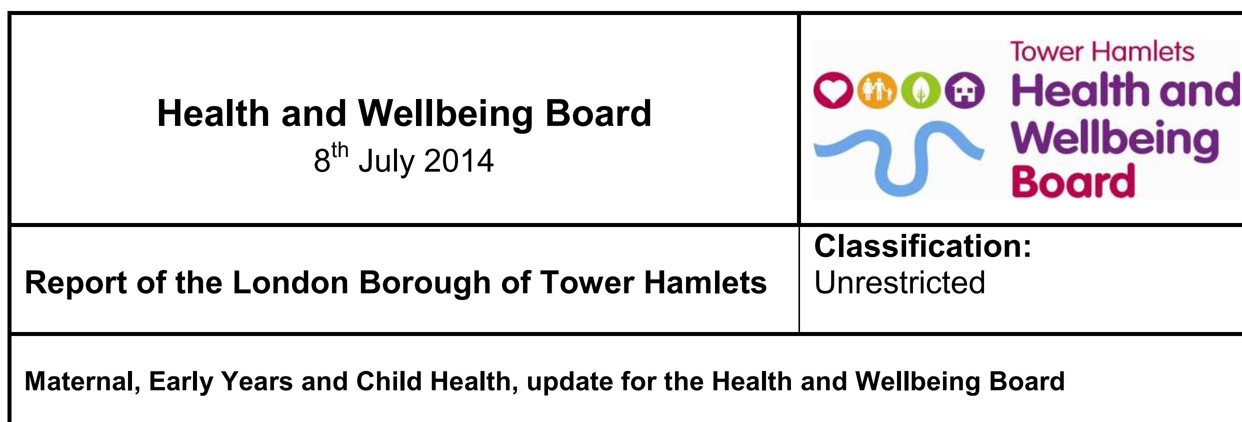

Health and Wellbeing Board 8th July 2014	Tower Hamlets Health and Wellbeing Board
Report of the London Borough of Tower Hamlets	**Classification:** Unrestricted
Maternal, Early Years and Child Health, update for the Health and Wellbeing Board	

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

Executive Summary

The purpose of this report is to provide an overview of maternal, early years and child health across Tower Hamlets. Local performance against relevant indicators from the Public Health Outcomes Framework is presented, and compared to data from London and England, to highlight areas of need and also local strengths and achievements.

Tower Hamlets has the highest level of child poverty in the country as well as high levels of statutory homelessness and low utilisation of outdoor space for exercise / health reasons. All of these significantly impact on maternal, early years and child health.

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

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

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

The report describes a variety of multi-agency groups that have responsibility for addressing maternal, early years and child health.

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

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

Recommendations:

The Health and Wellbeing Board is asked to discuss:

1. Partnership arrangementsfor taking forward work to improve maternal, early years and child health

2. Priorities for action to improve maternal, early years and child health

1. REASONS FOR THE DECISIONS

1.1 No decisions, paper for discussion

2. ALTERNATIVE OPTIONS

2.1 Not applicable

3. DETAILS OF REPORT

3.1 Report attached

4. COMMENTS OF THE CHIEF FINANCE OFFICER

4.1. This report provides an overview of maternal, early years and child health across Tower Hamlets with local performance compared with London authorities and nationally. There are no direct financial implications as a result of this report however any future partnering arrangements would need to consider resource implications and be managed within existing budgets.

5. LEGALCOMMENTS

5.1. Section 12 of the Health and Social Care Act 2012 (‘the 2012 Act’) inserts new section 2B into the NHS Act 2006 to give the Council a new duty to take such steps as it considers appropriate to improve the health of the people in

its area. Additionally, section 18 of the 2012 Act gives the Secretary of State the power to make regulations as to the exercise by local authorities of certain public health functions by inserting new section 6C into the NHS Act 2006. This means that the Secretary of State can require local authorities to carry out aspects of his health protection functions by taking certain prescribed steps. For example:

- Regulation 3 of the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013 places a duty on the Council to weigh and measure children at least once during reception and again during their last year of primary school.

- The Council has new duties under Regulation 17 of the NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012 to secure the provision of oral health promotion programmes and surveys.

5.2. Therecommendations for the HWB are consistent with the general policy, reflected in the 2012 Act, of giving HWBs responsibility for joint health and wellbeing strategies and the joint strategic needs assessment, and fall within the functions of the HWB as set out in its Terms of Reference.

5.3. In particular, therecommendation for the HWB to discuss partnership arrangements arising from the report of Maternity, Early Years and Child Health, falls within the HWB functions of encouraging integration and supporting partnerships under section 75 of the NHS Act 2006.

5.4. Therecommendation for the HWB to discuss priorities arising from the report of Maternity, Early Years and Child Health within the function to identify needs and priorities across Tower Hamlets.

5.5. When planning for integration of health and social care functions, the Council and its committees must have due regard to the need to eliminate unlawful conduct under the Equality Act 2010, the need to advance equality of opportunity and the need to foster good relations between persons who share a protected characteristic and those who don't. Some form of equality analysis will be required and officers will have to decide how extensive this should be.

6. ONE TOWER HAMLETS CONSIDERATIONS

6.1. The paper is to discuss how the HWBB can work together to address health inequalities in children

7. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

7.1 Not applicable

8. RISK MANAGEMENT IMPLICATIONS

8.1. Not applicable

9. CRIME AND DISORDER REDUCTION IMPLICATIONS

9.1 Not applicable

10. EFFICIENCY STATEMENT

10.1 Not applicable

Appendices and Background Documents

Appendices

Background Documents

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

- Esther Trenchard-Mabere, Associate Director Public Health (Esther.trenchard-mabere@towerhamlets.gov.uk)

Maternal, Early Years and Child Health
Update for the Health and Wellbeing Board, 8th July 2014

1. Introduction

The purpose of this report is to provide an overview of maternal, early years and child health across Tower Hamlets. Local performance against relevant indicators from the Public Health Outcomes Framework is presented, and compared to data from London and England, to highlight areas of need and also local strengths and achievements. The key multi-agency groups that have responsibility for addressing maternal, early years and child health are listed with a summary of their responsibilities and priorities.

2. Public Health Outcomes Framework

Early years and childhood, including 'pre-birth', is a critical period for the 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 and childhood 'cast a long shadow' over the subsequent social development, behaviour and health and wellbeing of the individual.

The following key indicators from the PHOF demonstrate the high level of need in Tower Hamlets, but also local strengths and achievements.

Key:

Diff TH E*	Difference between Tower Hamlets and England	↑↓	Recent trend
	Tower Hamlets significantly worse than England	↑	Increase / worse
	Tower Hamlets significantly better than England	↓	Decrease / worse
	Difference not significant	↑	Increase / better
	Significance not tested	↓	Decrease / better

2.1 Wider Determinants

Indicator	England %	London %	Tower Hamlets %	Diff TH E*	↑↓	Comments
Children under 16 years in Poverty, 2011	20.6	26.5	**43.6**		↓	While levels of child poverty have been decreasing there is a risk that the impact of welfare reform could reverse this trend and the level of child poverty in Tower Hamlets remains the

						highest in the country.
School readiness (Reception), 2012/13	51.7		**45.9**		↑	While the proportion of children achieving a good level of school readiness at the end of reception in Tower Hamlets is significantly worse than the national average, this reflects the high levels of child poverty. When the comparison is with children entitled to free school meals Tower Hamlets children do significantly better than average. Improving school readiness in Tower Hamlets remains a priority
School readiness, pupils entitled to free school meals (Reception) 2012/13	36.2		**42.6**		↑	
School readiness: phonics (Year 1), 2012/13	69.1		**70.6**		↑	By the end of year 1 the proportion of Tower Hamlets children achieving a good level of school readiness (phonics) is slightly better than average but the difference is not significant. Again comparing children entitled to free school meals Tower Hamlets children do significantly better than average.
School readiness: phonics, pupils entitled to free school meals (Year 1), 2012/13	37.2		**64.6**		↑	
Pupil Absence, 2011/12	5.11	4.82	**4.66**		↓	Levels of pupil absence in Tower Hamlets are significantly lower than average. Role of Health Visitors and School Nurses in the Health Education Action Partnership is being strengthened.
Statutory homelessness/ households in temporary accommodation, 2011/12	2.32	11.33	**19.31**		↓	Homelessness has a major impact on child health and development. While the level of homelessness in Tower Hamlets has been decreasing it remains significantly higher than average.
Utilisation of outdoor space for exercise / health reasons	15.33	10.5	**9.42**		↑	Utilisation of outdoor space for exercise / health reasons is significantly lower in Tower Hamlets than average. There is a range of work aiming to improve access to and perceived safety of outdoor space for children and families

2.2 Health Improvement

Indicator	England %	London %	Tower Hamlets %	Diff TH E*	↑↓	Comments
Under 18 conceptions, 2011	30.7	28.74	**28.5**		↑	Latest figures show a slight increase but longer term trend is of decreasing rates. Family Nurse Partnership provides intensive support for first time teenage parents that will significantly improve life chances of the children.
Smoking status at time of delivery, 2012/13	12.7	5.0	**3.0**		↓	Risk that smoking rates in pregnancy rates could increase as consequence of demographic changes.
Low birth weight of term babies, 2011	2.8	3.2	**4.1**		↓	Highest for Bangladeshi mothers and linked to small maternal body size. May increase risk of child obesity and diabetes and cardiovascular disease later in life.
Breastfeeding initiation, 2012/13	73.8		**86.8**		↑	Barts Health maternity service recently re-assessed for UNICEF BFI reaccreditation and had improved in a number of areas but decision still under review due to evidence that infant formula is sometimes given without valid medical grounds or evidence of informed maternal choice.
Breastfeeding at 6-8 weeks, 2011/12	47.2		**71.1**			Community services (Health Visitors and Children's Centres) successfully achieved BFI re-accreditation and the Breastfeeding Support service was commended**.** Despite high total breastfeeding rates we have low exclusive breastfeeding rates and recent local research has highlighted the role of the extended family: grandmothers and mothers in law in influencing infant feeding practices. The recommendations are being discussed with services.
Excess weight in 4-5 year olds, 2012/13 (Academic year)	22.2	23.3	**23.6**		↓	Levels of obesity have been decreasing since 2006/07 although for the last 3 years this seems to have plateaued.
Excess weight in 10-11 year olds, 2012/13 (Academic year)	33.3	37.5	**41.4**		↑	After a halt in the increase in rates of obesity in Tower Hamlets from 2008/09-2011/12

						there was a further increase in 2012/13 This is particularly marked in Bangladeshi and Somali boys which are the focus of a new community engagement /action research project.
Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years), 2012/13	103.8		**81.5**		↓	Prevention strategy will be developed as part of 'Healthy Lives' strategy.
Emotional wellbeing of looked after children, 2011/12	13.8	13.5	**13.2**		↓	The need to strengthen tier 1 and 2 mental health services has come up in several reviews. New specification for School Health includes a pilot of school nurses carrying out the annual reviews of LAC in their school and also strengthens their role in promoting and supporting emotional wellbeing for all children.

2.3 Health Protection

Indicator	England %	London %	Tower Hamlets %	Diff TH E*	↑↓	Comments
Fraction of mortality attributable to particulate air pollution, 2011	5.4		**8.1**			Higher than average in Tower Hamlets (significance not tested) Recent research in Tower Hamlets schools shows that exposure to particulate air pollution is having a measurable impact on lung development
Dtap/IPV/Hib (1 year old), 2012/13	94.7	91.3	**96.8**		↑	Coverage of the child immunisation programme remains high, it is important to maintain a focus on this programme to ensure that coverage does not drop.
MMR one dose (2 years old), 2012/13	92.3	86.1	**93.8**			
MMR two doses (5 years old), 2012/13	87.7	81.0	**93.4**		↑	
HPV (12-13 years), 2012/13	86.1		**72.0**		↓	Coverage of HPV dropped from 83.9% in 2011/12. This appears to be due to low uptake of the 3rd vaccination. This has been raised with the School Health service and NHSE, the new commissioners of the school vaccinations service.

2.4 *Healthcare and Premature Mortality*

Indicator	England %	London %	Tower Hamlets %	Diff TH E*	↑↓	Comments
Infant mortality (2009-11)	4.29	4.34	**4.98**		↑	Infant mortality in TH was previously lower than average for London and England. There has been a recent increase but small numbers mean that it is hard to interpret. This is being monitored to see if it is becoming a trend.
Children with dental decay (5 years), 2012	27.9	32.9	**27.9**		↑	Following improvements and a narrowing of the gap between Tower Hamlets and London & England from 2002-2008, there has been a deterioration in Tower Hamlets. More needs to be done both to improve children's access to dental care and also preventative work including raising awareness of impact of dietary sugar and oral hygiene. This will be linked to work on healthy weaning
Average number of teeth with decay, 2011/12	0.94	1.23	**1.78**			

3. Key Partnership Groups

There is no single partnership group with a strategic overview of the full range of work on maternal, early years and child health.

Key multi-agency groups[1] with responsibility for different aspects of maternal, early years and child health include:

- Maternity, Early Years and Childhood Commissioning and Delivery Group (of the Children and Families Partnership Board)
- CCG Children and Young People Programme Board
- Maternity and Early Years Health Improvement Group
- School Health and Wellbeing Forum
- UCL Partners child health research projects

3.1 Children and Family Partnership Board

This board has responsibility for the Tower Hamlets Children and Families Plan and is supported by two 'Commissioning and Delivery Groups' each responsible for two life course segments as follows:

- Maternity & Early Years and Childhood (MEYC), 0-11 years
- Young People and Preparing for Adulthood (YPPA), 12-19 years

[1] Not including groups convened to address specific issues e.g. CAMHS, Children with Disabilities, Safeguarding Children and other defined areas

The MEYC C&D group is also responsible for the Maternity and Early Years priority of the Health and Wellbeing Strategy.

The Child and Families Plan aims to support children to be:

- Safe
- Healthy
- Achieve their full potential
- Active and responsible citizens
- Emotionally and economically resilient for their future

There are a large number of outcomes and indicators in the plan for each of the above themes. In order to reduce duplication of work that is already in service work plans or is being taken forward by other operational partnership groups it was agreed to identify one or two priority areas per life course segment and theme.

Criteria for selecting these priority actions were that they should be strategic, with potential to impact on a number of the priority outcomes in the Children and Families Plan both within and across themes and there should be significant added value from wider partnership action.

The health priorities agreed by the MEYC C&D group are:

- Maternal (parent/carer) and infant emotional health and wellbeing
- Strengthening partnership working around the 2 year development review
- Child obesity (with a particular focus on 5-11 years)

See appendix for action plans.

The longer M&EY action plan, originally developed by this group has been delegated to the Maternity and Early Years Health Improvement Group (see below).

3.2 CCG Children and Young People Programme Board (CYPP Board)[2]

The main focus of this board is on specialist children's services commissioned by the CCG. During 2013/14 there was a stock take of CCG commissioned services and projects on the paediatric continence service, best practice tariff for diabetes, continuing care, gastroenterology, asthma, A&E attendances and transitions.

Partnership working includes integrated working with LBTH on speech and language therapy, disabilities and SEN reforms, follow up of recommendations from Child Death Overview Panel, links to the mental health strategy and coordination with public health on child public health services (e.g. child weight management and school health) and agreement of joint governance arrangements between the CCG, NHSE and LBTH (public health) for Health Visiting.

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[2] The CCG Maternity Quality Group is responsible overseeing the maternity service transformation programme to make services safer, higher quality and a good experience (see separate presentation to the Health and Wellbeing Board)

3.3 Maternity and Early Years Health Improvement Group

This multi-agency operational group brings together and coordinates work including: antenatal parenting support, smoking in pregnancy, maternal nutrition and obesity, promoting breastfeeding, healthy weaning, oral health promotion, obesity prevention, injury prevention, management of minor ailments

The more detailed Maternity & Early Years health action plan, originally developed by Maternity & Early Years and Childhood Commissioning and Delivery Group has been delegated to this group.

This group reports to the MEYC C&D group and also to the CCG CYPP Board and Maternity Quality Group, as appropriate.

3.4 School Health and Wellbeing Forum

This newly established operational group aims to promote and support the health and wellbeing of school aged children and young people in Tower Hamlets by strengthening and improving the coordination of health promotion and healthcare input to schools.

It has a wide membership of agencies from schools, NHS, local authority and voluntary sector. This group reports to both the MEYC and YPPA C&D groups.

3.5 UCL Partners/CLAHRC research projects on Child Health

The following research projects are being developed with a focus on Tower Hamlets:

- Pilot of a woman / community led intervention to improve early nutrition (6-24 months) in the Bangladeshi community. This will look at weaning practices, oral health, developments of overweight / obesity and also under nutrition. The pilot will form the basis for a bid for a larger RCT (that will be wider than Tower Hamlets)
- Development of quality outcome indicators for Health Visitors on maternal emotional health and wellbeing and maternal/infant attachment
- Also putting together a funding bid for a project on physical activity (barriers, perceptions and fears) for children and young people with long term conditions (epilepsy, asthma, diabetes).

Appendix

Action Plans for key priorities agreed by the Maternity, Early Years and Childhood Commissioning and Delivery Group of the Children and Families Partnership Board

Maternity & Early Years (pre-birth – 5 years)

Maternity and Early Years is one of the four strategic priorities of the Health and Wellbeing Strategy and it was agreed that this piece of work would be taken forward by the Maternity, Early Years and Childhood commissioning and delivery group of the Children and Families Partnership Board.

They key health outcomes in the Children and Families Plan for Maternity and Early Years are:

1. Good and improving maternal health (including mental and physical health)
2. Reduction in under 18 conceptions and support teenage parents
3. Early detection and treatment of disability and illness, and ensure that children achieve positive physical, emotional and cognitive developmental outcomes
4. Maintain low infant mortality rates and promote good health in infancy and early years
5. Decrease levels of overweight and obesity in 4-5 year olds and provide more opportunities for active play and healthy eating
6. Reduce dental decay in 5 year olds

The agreed priority areas for partnership action on Maternity and Early Years in the 'Health' theme are as follows:

Health Priority 1:

Maternal and infant mental health: develop partnerships across health, children's centres and community organisations to support maternal mental health and wellbeing and secure attachment with the baby during the first year of life

This priority contributes to health outcomes 1, 2, 3 and 4 above and also to outcomes under the 'achieving potential', 'emotional and economic resilience' and 'safe' themes.

Milestones	Progress	RAG
Map the ante and post natal depression pathway and identify gaps and opportunities by January 2014	Multi-agency steering group convened and has met twice (October 2013, March 2014) Mapping complete, using framework from 1001 Critical Days (Cross Party Manifesto, Wave Trust and NSPCC)	
Convene wider multi-agency meeting/workshop to scope work across children's centres, voluntary sector and health by March 2014	Multi-agency workshop held on 15th January 2014	

Develop proposal to strengthen 'Universal' elements of support for maternal and infant emotional health and wellbeing plus pilot support package for pregnant women and parents/carers of infants identified to be 'at risk' by May 2014	Outline proposal has been agreed (training for community organisations/volunteers and health professionals plus supervision and support networks).	
Secure funding / commission pilot intervention by June 2014	Funding for 2014/15 has been identified from the public health grant. Ongoing funding (initially for 2015-17) still to be confirmed. Exploring opportunities to bid for external / match funding	
Agree and implement action plan for strengthening 'Universal' elements of support for maternal and infant emotional health and wellbeing by June 2014	Action Plan agreed at steering group meeting 3rd June	
Hold second multiagency workshop to consult on commissioning proposals by July 2014		
Commission training and parent volunteer support network by September 2014		

Health Priority 2:

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

This priority contributes to health outcomes 3, 4 and 5 above and also contributes to outcomes for the 'achieving potential' theme, including improving the proportion of children achieving a good level of school readiness at the end of reception.

Milestones	Progress	RAG
Workshop reviewing current referral pathways and partnerships supporting the 2/2.5 year healthy child development review in December 2014	Workshop held December 2013	
Identify opportunities for wider join up to ensure that children at risk of impaired physical, social, emotional and cognitive development are identified and supported	Public health strategist now attending integrated 2 year review steering group (includes representatives from health, learning and achievement and children's centres. Next meeting 3rd June 2014	
Secure access to key health outcome data from 2/2.5 year healthy child development review.	MOU has been signed off between NHSE and THCCG that will give access to Health Visiting performance data. Request for new EMIS templates (child growth) has gone to Barts Health	

Childhood (5-11 years)

They key health outcomes in the Children and Families Plan for Childhood are:

1. Decreasing levels of obesity and overweight
2. Looked After Children receive their annual health assessment, are fully immunised and have had their appropriate screening checks e.g. vision and dentist within the previous 12 months
3. Looked After Children have good emotional wellbeing
4. Children with disabilities and their families are supported following diagnosis
5. Reduction in emergency admissions for children with asthma.

The agreed priority for partnership action on Childhood (5-11 years) in the 'Health' theme is as follows:

Health Priority 3

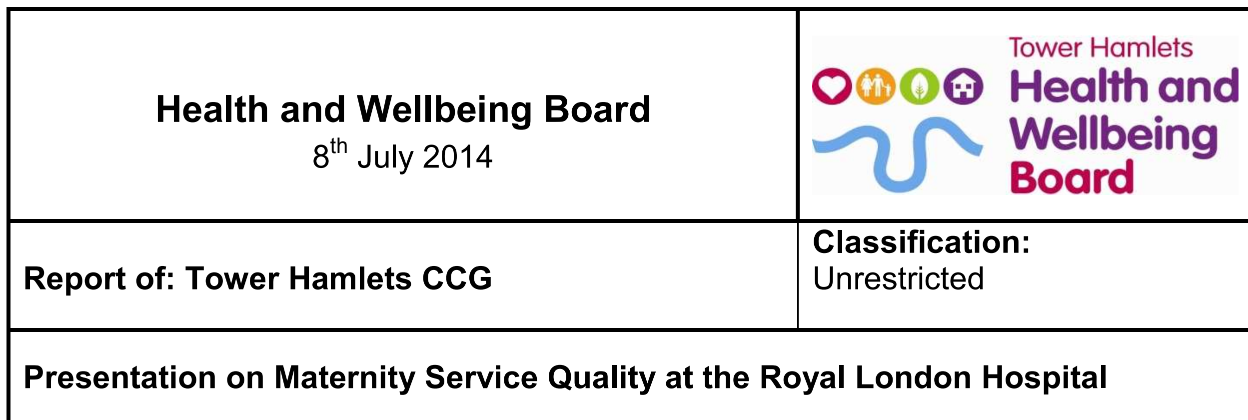
Child obesity: create wider opportunities for children to engage in physical activity and healthy eating in community, leisure, school, faith and home settings in order to reduce the prevalence of overweight and obesity in 10-11 year olds

This work is targeted at primary school aged children because of the ongoing increase in levels of overweight and obesity in 10-11 year olds. Ongoing prevention work targeting pre-school aged children is still underway and links to work on reducing sugar consumption / improving oral health.

Activity 1 Review and strengthen support for schools to create environments that support healthy eating and physical activity		
Milestones	**Progress**	**RAG**
Increase the number of schools achieving the Enhanced Healthy Schools Award and GLA 'Bronze' and 'Silver' awards September 2014, 3 new schools signed up for 'Enhanced' and 4 for 'GLA Silver'	20 schools have already achieved Enhanced Healthy Schools status (which includes targeted work on child obesity) 92% of school have achieved GLA 'Bronze' Award (highest in London) 4 schools have achieved GLA Sliver Award (highest in London)	Green
Introduction of school based family cookery clubs: - Training for new schools to run September / October 2014 - 5 new schools to have signed up to run family cookery clubs by December 2014	Pilot family cookery clubs (involving parents, carers and children and focus improving cooking skills and awareness of healthy eating and portion size) have run in 5 schools with very positive feedback from schools and parents	Green
Additional training and support from School Sports Foundation for schools meeting Enhanced Healthy Schools Status, *September 2014*	School Sports Foundation runs after school sports and physical activity sessions in majority of primary schools	Amber

	Negotiations underway to increase input	
Activity 2 Improve the uptake and quality of school meals in primary schools		
Milestones	**Progress**	**RAG**
Implement free school meals commitments - Review of uptake of first year of scheme August 2014 - Roll out of national scheme (reception, years 1 and 2) September 2014 - Roll out of free school meals for all primary school pupils September 2015	Free school meals have been made available for all reception year 1 pupils from September 2013 Commitment to makes free school meals available to all primary school pupils from September 2015 School meals meet the School Food Trust standards	
Identify and share examples of good practice in improving the dining environment - 5 case studies of best practice identified - August 2014 - Dissemination (e.g. school visits, healthy schools newsletter) Sept – Dec 2014	Local research shows that an important factor in low uptake of school meals is a poor quality dining environment. Roll out of good practice / improved dining experience is likely to lead to better uptake of school meals. 3 case studies of best practice have already been identified	
Submit application to be a London Flagship Food Borough, 2 May 2014	Application submitted but not successful. Consultation with Head Teachers produced useful ideas for improving quality / attractiveness of school meals through training Dinner Ladies and will be exploring how this could be funded	
Activity 3 Improve the effectiveness of targeted programmes to promote healthy weight in primary school aged children		
Milestones	**Progress**	**RAG**
Commission evaluation of Healthy Lives Champions (to Identify the impact of the Healthy Lives Champions on levels of obesity in year 6 and any learning on what increases their effectiveness) - *Specification agreed April 2014* - *Advertise contract May 2014* - *Contract starts June 2014*	Healthy Lives Champions are active in 13 primary Schools. In 2013 350 children (mainly year 5) participated with an average 37% reduction of BMI Contract for evaluation agreed and will be completed November 2014, interim report July 2014	
Re-commission Child and Family Weight Management and School Health services - New specifications agreed February 2014 - Advert March 2014 - New contracts1st October 2014	Procurement process completed to schedule and now awaiting sign off of recommendations. New specification strengthens the coordination and linkages across these services with respect to:	

	- identification of overweight and obese children (new funding for NCMP coordinator based ion School Health) - parental and family engagement	
Review and update child obesity care pathway (to improve identification and referral of children who would benefit from support in weight management, involving wider range of frontline services in identification of overweight and obesity children, brief advice and referral) - *Initial planning meetings May/June 2014* - *Roll out of new training programme from October 2014*	Initial discussions have been held with CCG Board lead for Children, GP Child Health lead and Consultant Paediatrician. Requirements for supporting new care pathway have been strengthened in new contract for Child and Family Weight Management	
Activity 4 Strengthen parent and community involvement and increase opportunities for children to be active and eat healthily in the wider community		
Milestones	**Progress**	**RAG**
Consult with community, parent and faith groups regarding issue of high obesity in Bangladeshi and Somali boys and agree community based interventions to address the issue Initial consultation – October 2014 Agree action plan – November 2014	Collating list of key groups to consult and preparing topic guides	
Strengthen role of the 'Healthy Family Parent Ambassadors' in prevention of child obesity	More fathers now involved in programme	
Improve the food offer in leisure centres and other food outlets used by children and their families	Proposal for pilot 'healthy vending machines' in the new Poplar Baths	
Pilot new approaches to improving nutritional quality of 'fast food' available to school children - Pilot mobile healthy street food schemes to commence from September 2014 - Fast food outlet to trial range of modifications to improve food offer (start date TBC)	Stepney Ward forum and St Pauls School have each has decided to fund a pilot mobile healthy street food project, but process no longer clear Specification for 12 month pilot Healthy Fast Food pilot in an existing outlet complete and awaiting sign off.	
Increase availability of and access to open spaces - Exploring feasibility of use of section 106 funding to create new open spaces - Project to improve accessibility for disabled children	- Evidence review completed and awaiting planning approval - Steering group established	



Health and Wellbeing Board 8th July 2014	Tower Hamlets Health and Wellbeing Board
Report of: Tower Hamlets CCG	**Classification:** Unrestricted
Presentation on Maternity Service Quality at the Royal London Hospital	

Contact for information	Catherine Platt, Tower Hamlets CCG

Executive Summary

A presentation on the work that Tower Hamlets CCG and Barts Health NHS trust have undertaken to improve maternity services at the Royal London Hospital following the CQC inspection in late 2013.

Recommendations:

The Health and Wellbeing Board is recommended to:

1. To note the work of Tower Hamlets CCG and Barts Health NHS Trust on the improvement of Maternity Services at the Royal London Hospital

1. DETAILS OF REPORT

1.1. Presentation attached.

NHS
Tower Hamlets
Clinical Commissioning Group

Maternity Service Quality

Dr Martha Leigh: CCG Board lead for maternity

CQC visit December 2013

NHS
Tower Hamlets
Clinical Commissioning Group

The RLH site was found to be providing safe effective and responsive care. Some issues were reported however:

IT and administrative support an issue / unable to access information

- Admin staff review and subsequent additional staffing arranged
- New 24/7 rota for the labour ward
- IT board set up to resolve data issues

Equipment not readily available on all sites (RL) CTG monitors sometimes had to be borrowed from other areas

- Equipment review now also completed
- Extra CTG purchased at end of 2013 and again in March 2014
- New check lists implemented

Across site audit to be introduced in 2014

- RL has full audit programme in-line with best practice standards

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Ensure new clinical safety briefing system in place

- Launch of *Hot Topics* Newsletter

Services are stretched at times; which can limit choice:

- Integrated teams have been launched across localities
- A new leaflet promoting choice has been designed and will be routinely given to women

Birth to midwife ratio too high (at time was 1:32 on RLH site)

- Extra nine staff have been recruited and more being recruited.

Some women had negative experience from a small number of staff on post natal wards who did not consistently treat women with consideration and respect

- Great expectations programme staff development programme underway. Band 7's have undertaken training already. Improvements in themes from complaints noted

New teams need to be embedded over the next year to reduce staff anxiety and offer support

- New teams in place and extra senior staff being recruited to specifically support newly qualified midwives
- Great Expectations programme

CQC visit December 2013

Integration and joint working was still fragmented in some areas / stronger leadership required in specialist services

- Review of specialist services to work across Barts is underway (education / screening / bereavement)

Appraisals completed but some concern about quality and content

- New teams reviewing and updating as required / new database started and appraisal plan

Multi-professional ownership required for complaints

- New complaints process implemented and no overdue complaints in maternity services

CCG priorities

NHS
Tower Hamlets
Clinical Commissioning Group

- Improve **patient experience** (lack of compassion, care and information)
- Improve **signposting and triage** (who to call or where to go, to access help and support)
- Update **antenatal and post-natal pathways** (due for review)
- Increase **community births** (low uptake)
- Improve **patient choice** (place of birth, type of birth)
- Ensure **community midwifery** services that are fit-for-purpose (continuity of care, good quality information, effective test/results process, effective referral process)
- Identification/signposting to **mental health services**
- Make better use of the **Maternity Mates Service** commissioned to support those who are particularly vulnerable within the borough during the maternity pathway

Maternity Transformation Programme 2014/15

NHS
Tower Hamlets
Clinical Commissioning Group

Low community birth rates

Increase community birth rates by 20% on 1314 rates; delivering choice for low risk mothers

Provide better continuity of care between mother and midwife

Reconfiguration of staffing and pathways to allow better continuity of care between mother and midwife

Improving patient information to empower mothers and increase confidence

Systematise and improve the quality, accuracy and range of maternity information given to mothers during the pregnancy pathway by MW's – verbally and written

MSLC Information Pilot

Inform deprived/disadvantaged mothers about health, access and choice at community-level, using trained community outreach workers

MSLC Engagement

Continual feedback captured by local mothers about local services – to inform commissioning intentions and inform new commissioning ideas

Maternity Transformation Programme 2014/15

NHS
Tower Hamlets
Clinical Commissioning Group

Alongside Unit

Work with Barts to launch the midwifery led along-side unit at RLH to increase capacity and ensure lower risk mums give birth in more appropriate care setting

Triage

Launch one dedicated triage / information desk at RLH to improve access to general support or in times of emergency

Review of antenatal and postnatal pathways

To bring us in-line with national best practise and inform any changes to pathways in 1516

Development of pan WELC commissioning intentions

Align strategy for 1516 for maternity services across the Barts footprint

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Tower Hamlets
Clinical Commissioning Group

Questions

Health and Wellbeing Board 8th July	
Report of: NHS England	**Classification:** Unrestricted
NHS England: Commissioning Primary Care Services	

Contact for information	Vanessa Lodge Director of Nursing, Central and North East London NHS England (London)

Executive Summary
This paper produced for the Tower Hamlets Health and Wellbeing Board, sets out the arrangements for commissioning of primary care services in the NHS post 1 April 2013.

Recommendations:

The Health and Wellbeing Board is recommended to:

1. To note that this paper sets out the arrangements for commissioning of primary care services in the NHS post 1 April 2013.

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1. DETAILS OF REPORT

Appendices
- None

Commissioning Primary Care Services

1 Introduction

1.1 This paper produced for the Tower Hamlets Health and Wellbeing Board, sets out the arrangements for commissioning of primary care services in the NHS post 1 April 2013.

2 Background

2.1 CCGs commission the majority of NHS services for their populations. CCGs also have a statutory responsibility to support NHS England to improve the quality of primary medical care. Even though they are responsible for local services, in the construct of the reconfigured NHS, CCGs were not granted the rights to commission primary care as this was considered to create a conflict of interests. This passed to NHS England.

2.2 Primary care commissioning is broad and complex. It has been a significant challenge to move from many different systems to a singenational operating model, while retaining vital local responsiveness and sensitivity. It is important that NHS England plans local primary care services in the context of CCGs' commissioning strategies, health and wellbeing strategies, the JSNA and the PNA. Some services, like sight tests from optometrists, will continue to be demand-led and not actively commissioned.

3 NHS England Primary Care Commissioning functions

3.1 NHS England is responsible for planning, securing and monitoring an agreed set of primary care services. These are set out in more detail in **Annex 1**. The following functions underpin this:

Planning the optimum services which meet national standards and local ambitions, ensuring that patients, carers and the public are involved in the process alongside other key stakeholders and the range of health professionals who contribute to patient care;

Securing services, using the contracting route that will deliver the best quality and outcomes and promote shared decision-making, patient choice and integration; and

Monitoring, assessing and, where necessary, challenging the quality of services; and using this intelligence to design and plan continuously improving services for the future.

4 Support functions

4.1 The following are also the responsibility of NHS England, discharged in local area teams, through the primary care commissioning arrangements:

- Local responsible officer functions(via Medical Director)
- Local management of the performer lists(via Medical Director)
- Market entry and exit for pharmaceutical services (in London this is managed by a London wide "Control of Entry") team
- Managing individual performance issues for dentists, community pharmacists, GPs and optical providers via Medical Director
- Commissioning occupational health services for primary care providers
- Helping to secure services for patients following a major incident such as fire, flood or similar emergency
- Supporting providers in difficulty to ensure that basic services continue
- Contracts for disposing of clinical waste, including medicines
- Distributing forms e.g. prescriptions, sight test forms.

4.2 NHS England manages the premises reimbursement budgets but delegatesGP IT functions to CCGs to aid integration with broader system development.

4.3 The following matters, carried out by some former PCTs, didnot transfer to NHS Englandand are the responsibility of providers themselves:

- Provision of locums and other temporary or support staff
- Bulk purchasing of equipment and services other than the disposal of clinical waste.

5 Payment and associated functions

5.1 At its most simple, this is payment for contract delivery. However, for many of the primary care payments there is a relationship between them and the resulting net income or pay of individual contractors. For GP payments, this is made more complex, by various sources of contractual income, including payments for weighted capitation ('global sum' for GMS contractors), and practice income from QOFand items like flu vaccinations, premises, etc.

5.2 Payment to GPs is inextricably linked to the patient registration system, which in turn is linked to the system supporting screening and immunisations. Those providing these payment services also process the NHS pension arrangements for some primary care contractors.

5.3 The responsibility for the vast majority of these services for all contractors transferred to NHS England and isdischarged through the primary care commissioning arrangements typically delivered through Family Health Services (FHS) agencies.

5.4 Local Authorities and CCGs are responsible for making arrangements for the payment for primary care services that they respectively commission.

6 Payment services

Dental, pharmaceutical and ophthalmic payments

6.1 The NHS Business Services Authority (BSA) continues to provide a pharmaceutical and dental payments service, as well as contract monitoring data, audit and fraud prevention work.

6.2 NHS Englandis developing a national specification for primary ophthalmic payments. Greater automation will mean efficiency savings for both NHS England as the commissioner and for many service providers. It will also improve post-payment verification and fraud detection.

GP services

6.3 Before reorganisation, there were three methods of GP practice payment and patient registration: directly by the commissioner; a shared service arrangement with other commissioners; or through an external contract.

6.4 GP practice payment, patient registration and other associated functions can be delivered more consistently and efficiently, even more so when paper-based medical records are eliminated. These are delivered through SBS (NE London) and the FHS service based at Stephenson House for the former NC London. A national review of these services is currently underway.

7 The role of clinical commissioning groups (CCGs)

7.1 CCGs have a critical role in providing clinical leadership to commission high quality, responsive and safe services for patients. CCGs are dependent on the unique role of general practice in connecting and acting as the intermediary for most of the care patients receives.

7.2 Practices are central to the new commissioning arrangements as well as providing primary medical services. As providers of care, GP practices take micro commissioning decisions daily with each referral and prescription. CCG member practices need to work together to ensure that these micro decisions are clinically appropriate and deliver best outcomes for patients. Whilst intelligence about these commissioning decisions is of primary concern to CCGs, it is also critical for NHS England to review the performance of individual practices.

7.3 CCGs are best placed to support quality improvement in primary medical care, where necessary in partnership and with the support of NHS England. CCGs are not responsible for contract compliance and should be able to focus on local priorities and supporting continuous development.

7.4 CCGs, working with NHS England, take a quality improvement approach based on:

- Evidence of engagement and involvement with patients and the public
- Benchmarking across member practices of healthcare needs indicators, interventions, and patient outcomes
- Commitments to openness about data and mechanisms to enable information sharing
- Clear approaches to peer review and discussions across member practices
- Self assessment of need, intentions and anticipated impact.

7.5 CCGs should drive greater integration between primary care and other services by commissioning 'wrap-around' community-based services for local populations, so that the services provided in individual practices form part of a broader network of integrated, community-based care for patients, with shared clinical leadership, clinical pathways/protocols, and clinical information systems.

7.6 These wider community-based services could include some services provided by GP practices themselves, subject to CCGs being able to demonstrate that they go beyond the 'core' services expected under the GP contract, that they provide good value for money, have followed an appropriate procurement route, and that they have appropriately managed conflicts of interest.

7.7 CCG commissioning plans, which are based on local joint health and wellbeing strategies, will inform local decisions about access to services and the development of new or replacement services. Some services, like the procurement of a new practice, arethe responsibility of NHS England. Others, like the development of additional community services not necessarily exclusive to GPs, are the responsibility of the CCG.

7,8 Since its inception, staff at NHS England have made efforts to engage with CCG teams about key primary care commissioning decisions (e.g. surrounding the replacement or dispersal of practices falling vacant through retirement, resignation, death of a contract holder, and large new premises infrastructure needs). The teams have worked closely in the development of new 5 year strategic plans.

7.9 Over the past few weeks, CCGs nationally have been invited to submit expressions of interest for new ways of co/joint commissioning of primary care. At the time of preparation of this paper, such a proposal was being worked up by the CCG in collaboration with others locally. The commissioning environment may therefore change again over the months ahead.

8 Specific issues arising from last meeting

i Information on the new Dental Practice on Ocean Estate - NHS England will be meeting with the Provider on 24th June 2014, where we will be able to provide more comprehensive details on the service. The current mobilisation position is that the lease has been agreed with and by the Provider and the commissioning team are finalising the specific contractual and service element of the contract. If there is no further clarification from both parties, then service commencement is likely to be agreed for 1st September 2014.

ii View around seven day working and opening hours - The national GMS contract is vague around definition of opening hours. It requires practices to deliver services to meet the reasonable need of their patients. It also describes "in hours" as 8.00 a.m. to 6.30 p.m. Monday to Friday excluding public holidays. There is a general intent to improve access across GP services and any widening of the narrow definition is likely to require practices to work together in networks or federations in order to deliver this. NHS England in London is at a forming stage (i.e. prior to consultation and engagement of setting a new range of standards for primary care which at this early stage, include proposals for guaranteed same day access to a GP for "in hours" and generally, 8 to 8 access seven days a week. This will be developed over the summer.

iii New data on access – Jane – anything locally?

iv Confirmation on who commissions Walk-in Centres – Walk in centres are commissioned by CCGs and generally are part of their urgent care strategies. In some place, walk in activity is still locked in NHS England contracts with GP Led Health Centre providers that were inherited from the former PCTs. Dependent upon the date of expiry of those contracts, the activity and contracts are being separated but only after discussion with the CCG and the provider. It then falls to the CCG to determine future arrangements.

9 Conclusion

9.1 The commissioning of primary care is complex as has been described above and requires close working relationships between all the various agencies and Healthwatch for NHS England to deliver its commissioning responsibilities. Some of those new relationships continue to be developed.

Neil Roberts
Head of Primary Care
NHS England, London Region (North, East & Central London)
June 2014

ANNEX 1

Scope

The Health and Social Care Act 2012 sets out NHS England's responsibility to commission primary care services for the population of England, including many of the services provided by GPs, primary care dentists, community pharmacists, appliance contractors and optical providers. It allows NHS England to delegate some of its medical and ophthalmic commissioning functions to clinical commissioning groups (CCGs) and places a duty on CCGs to support improvements in the quality of primary medical care. Local authorities also have responsibilities to commission health improvement services and they may wish to commission some of these from primary care providers.

NHS England is also responsible for commissioning community, secondary and urgent dental services.

1. Primary Medical Services Commissioning

Since April 2004, three contracting routes have been available to enable commissioning of primary medical services. The routes are

- General Medical Services (GMS)
- Personal Medical Services (PMS) which includes Specialist PMS (SPMS), and
- Alternative Provider Medical Services (APMS).

General Medical Services (GMS)

This contracting route is provided for by the NHS Act 2006 Section 83, and the NHS (General Medical Services Contracts) Regulations 2004, as amended. It is underpinned by a nationally agreed GMS contract. About 53% of primary medical services nationally are provided under GMS contracts. These contracts are negotiated nationally and their terms are not open for local re-negotiation because the financial impact of any change would eventually impact the income of all GMS contract holders nationally

Personal Medical Services (PMS)

This contracting route is provided for by the NHS Act 2006 Section 92 and the NHS (Personal Medical Services Agreements) Regulations 2004, as amended. PMS contracts are negotiated locally but are underpinned by national regulations. Around 44% of primary medical services nationally are currently provided through PMS contracts. This rate is higher in many parts of London.

Specialist PMS is an additional, local flexibility to help to address unmet needs amongst client groups that traditionally have experienced primary medical services as being more difficult to access, for example, homeless people, prisoners, drug users. There are none of these contract types in London.

Alternative Provider Medical Services (APMS)

APMS contracts are provided under Directions of the Secretary of State for Health. They are time limited contracts. APMS contracts can be used to commission primary medical services from traditional GP practices as well as others such as:

- Commercial providers
- Not-for-profit organisations
- Voluntary and community sector organisations
- NHS Trusts
- NHS Foundation Trusts.

Primary medical services comprise:

Essential services
Every GMS practice is required to provide essential services (or, in PMS, their equivalent) to their registered patients and temporary residents. Essential services cover the:

- Management of patients who are ill or believe themselves to be ill, with conditions from which recovery is generally to be expected, for the duration of that condition, including relevant health promotion advice and referral as appropriate, reflecting patient choice wherever practicable
- General management of patients who are terminally ill
- Management of chronic disease in the manner determined by the practice, in discussion with the patient.

Additional services
All GMS and PMS practices have a preferential right to provide additional services (e.g. maternity services). Practices can, however, temporarily or permanently, opt out of providing additional services in accordance with fixed rules. Where opt-outs occur, NHS England is required to commission the services from a different provider.

Out of hours services
Since April 2004 all GMS and PMS practices have had the opportunity to opt out of their responsibilities for securing out-of-hours services for their registered patients. Where that responsibility remains retained by GMS and PMS practices NHS England will be the commissioner as the duty to secure out-of-hours is an integral part of the GMS and PMS contract. Around 10% of GMS and PMS practices retained their out-of-hours responsibilities.

NHS England is responsible for ensuring that all other opted out GP out-of-hours services are commissioned as part of Clinical Commissioning Groups' responsibilities for developing 24/7 urgent care services. Clinical commissioning groups will be responsible for monitoring all NHS commissioned GP-out-of-hours services and assuring the quality of these to consistent standards.

NHS England has delegated authority to CCGs to commission all GP out of hours services.

Enhanced services
Enhanced services are generally understood and defined as

(a) Medical services other than essential services, additional service or out of hours services; or
(b) Essential services, additional services or out of hours services or an element of such a service that a contractor agrees under the contract to provide in accordance with specifications set out in a plan, which requires of the contractor an enhanced level of service provision compared to that which it needs generally to provide in relation to that service or element of service.

The contract regulations (GMS, PMS and APMS) work to allow medical services to be of any type, in any setting, and to extend beyond the scope of primary medical services. NHS England commissions some enhanced services nationally using single specifications. These nationally commissioned enhanced services replaced the arrangements that placed Primary Care Trusts under a duty through legal directions to commission prescribed enhanced services to meet the needs of the population (services known and commissioned as 'Directed Enhanced Services').

NHS England also has the flexibility to commission enhanced services locally to meet the differing primary care needs of local populations. These commissioned services are more tightly defined and managed than those currently commissioned as 'Local Enhanced Services.' Local commissioning reflects the fact that CCGs are largely responsible for the resources attached to current Local Enhanced Service schemes (excluding those supporting defined public health services where responsibility passed to local authorities).

2. Primary Dental Services Commissioning

Since April 2006, the following contracting routes have been available to enable commissioning of primary dental services. The routes are

- General Dental Services contracts (GDS)
- Personal Dental Service agreements (PDS) which includes non mandatory services such as orthodontics and sedation.

GDS contracts and PDS agreements

The GDS and PDS contracting routes are provided for by the NHS (General Dental Services Contracts) Regulations and Personal Dental Services Regulations 2005 (as amended).

Both GDS contracts and PDS agreements are negotiated locally but are underpinned by national regulations. The main differences between GDS and PDS are that GDS contracts are not time limited (PDS agreements are) and that PDS can apply to non mandatoryservices (e.g. orthodontic only) practices.

Community or Salaried Dental Services used to be solely provided by PCTs or NHS Trusts (although increasingly are now provided through Social Enterprise organisations) and are directly commissioned using the PDS contract framework and generally provide services for hard to reach groups.

Primary dental services comprise:

Essential services

Every GDS practice is required to provide a full range of general dental services (mandatory services) plus any agreed non mandatory services. PDS may also includemandatory services and a mix of additional locally negotiated services, but can alsobe agreed for solely non-mandatory services (i.e. with no general dental services). Community or Salaried Dental Services are as defined locally.

All GDS providers and PDS contractors with a mandatory service agreement are expected to provide a full range of primary care dental services to all their NHS patients based on clinical need (limited only by their ability to clinically provide the intervention).

Additional services

All GDS and PDS practices can contract or agree to provide additional services with the commissioner, but they have no right to do so.

NHS England also commissions**secondary care based dental services.**

3. Pharmaceutical services

Arrangements for pharmaceutical services are provided for by virtue of Sections 126 and 127 of the NHS Act 2006 (as amended). Schedule 1 of the National Health Service (Pharmaceutical Services) Regulations 2005 provides for **Essential services**: which must be provided by all community pharmacies and include dispensing, repeat dispensing, health promotion, signposting, support for self-care and disposal of unwanted medicines. Schedule 2 provides for the dispensing services which dispensing doctors are required to provide. Other services which match pharmaceutical services and which are provided by dispensing

doctors would be provided under primary medical services arrangements. Schedule 3 provides for those services which appliance contractors are required to provide. NB There are no dispensing doctors in London.

The Pharmaceutical Services (Advanced and Enhanced Services) (England) Directions 2011 provides for **Advanced services**: which require both the pharmacist and the pharmacy premises to be accredited e.g. medicines use reviews, the New Medicine Service, appliance use reviews and stoma customisation and **Enhanced services**.

Local Pharmaceutical Services
Section 144 of the NHS Act 2006 and the NHS (Local Pharmaceutical Services etc.) Regulations 2006 enable the provision of pharmaceutical services through direct contracting arrangements.

Enhanced services
NHS England also has the flexibility to commission enhanced services locally to meet the differing primarycare needs of local populations.

It is only NHS England which can commission **pharmaceutical** enhanced services. These services will be more tightly defined and will use nationalservices specifications.

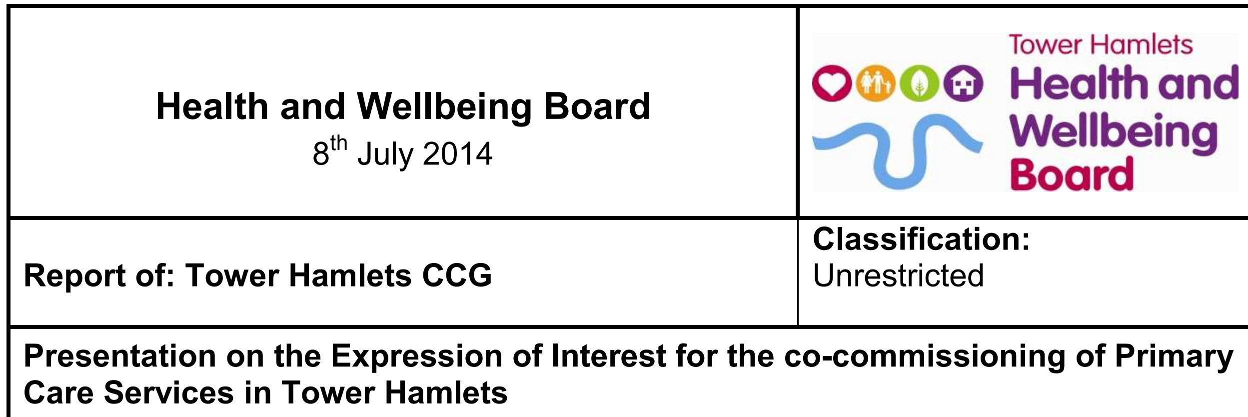
However, clinical commissioning groups and local authorities are able to commissionservices direct from community pharmacy providers but cannot call these enhanced services. These arrangements would beoutside the community pharmacy contractual framework and service specifications andremuneration would need to be negotiated by the commissioner and the provider. PublicHealth England may decide to develop standard specifications and tariffs to support thecommissioning of public health services. However, legal provision has also been madefor local authorities to make arrangements with NHS England.

4. Ophthalmic services
Primary ophthalmic services are provided under section 115 of the NHS Act 2006. Under the Act, NHS England must arrange for ‘essential’ services, i.e. NHS sight tests for those who are eligible. Any suitable provider is able to have a contract to provide NHS sight tests and there are no restrictions on the number of contracts that may be awarded or the number of sight tests they may carry out.

Contractors work to a national contract and the sight test is governed by national regulations. The Act also provides for ‘additional’ services, which NHS England must arrange. Currently the only additional service is domiciliary sight testing. Contractors providing essential services can apply for a contract to provide the service. The service can also be commissioned from other providers (who do not provide essential services) under a separate contract.

Clinical commissioning groups can commission services from community optometrists for the provision of community ophthalmic services. These arrangements are outside the GOS contract and the service specifications and remuneration would need to be negotiated by the commissioner and provider.

NHS England may also commission enhanced services nationally or locally to meet the needs of the population. These enhanced services would be commissioned using single specifications.



Health and Wellbeing Board 8th July 2014	
Report of: Tower Hamlets CCG	**Classification:** Unrestricted
Presentation on the Expression of Interest for the co-commissioning of Primary Care Services in Tower Hamlets	

Contact for information	Jane Milligan, Tower Hamlets CCG

Executive Summary

This presentation describes the Expression of Interest Document submitted to NHSE on Primary Care Co-commissioning proposals and suggested next steps for their further development and mobilisation.

Recommendations:

The Health and Wellbeing Board is recommended to:

1. Note Tower Hamlets CCG's submission of an Expression Of Interest to NHS England on the Co-commissioning of primary care services.

1. DETAILS OF REPORT

1.1. Presentation attached.

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NHS
Tower Hamlets
Clinical Commissioning Group

Co-commissioning of Primary Care

Expression of Interest

Submitted to NHSE on 20th June 2014

6/26/2014

Context

- NHSE wrote to all CCGs inviting expressions of interest (EOI) from CCGs to work more closely with NHSE and other CCGs in commissioning general practice.
- TH CCG submitted a formal EOI in collaboration with City and Hackney, Waltham Forest and Newham CCGs on 20th June with the aim of some implementation during 14/15 and more complete co-commissioning for 15/16
- WELC CCGs have agreed to work together to develop a model for co-commissioning activities with NHSE (both shared and independent), this development is integral to achievement of local CCG / Borough priorities and shared wider objectives such as 5 year strategic plans, Transforming Services Together (TST) and Integrated Care.
- TH has a number of initiatives in place that support co-commissioning but formal arrangements with partner commissioners will enable the full benefits of these developments to be realised – e.g.
  - NIS outcome based contract circa 7m through networks
  - TH multiagency estates group
  - Achieving Excellence in Primary Care Programme Board
  - Common IT platform

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Aims

- The aims of the WELC Co-commissioning EOI are:-
  - Improve the quality and outcomes of primary medical services
  - Provide strategic leadership to the development of primary care
  - Work in partnership with other NHS organisations to improve and modernise the primary care infrastructure

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EOI Outline

- The joint EOI from the 4 WELC CCG covers the following: -
  - Areas of strategic co-commissioning that the 4 CCGs wish to do together with NHSE
  - Proposed detailed collaborative arrangements for Newham ,Tower Hamlets and Waltham Forest that align to 5 year plan, TST and Integrated Care
  - City and Hackney CCG has submitted an additional EOI of proposed activities at Borough level
  - The current EOI describes a focus on general practice but in future inclusion of other contractors (pharmacy, dental and optometry) may be explored as collaborative models of delivery develop against the 3 priority areas of co-ordinated, proactive and accessible care

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Guiding Principles for Inclusion in Co-commissioning EOI

- There needs to be sufficient scale to justify the shift in commissioning
- There needs to clarity on governance to ensure there are no conflicts of interest between parties
- The need to ensure consistency across London in the way Area Teams work with CCGs to design their expressions of interest
- The co-commissioning should be locally led, based on patient flows
- The approach should deliver benefits not achievable within the current operating framework
- The approach should maximise the opportunities to deliver the London Quality Standards

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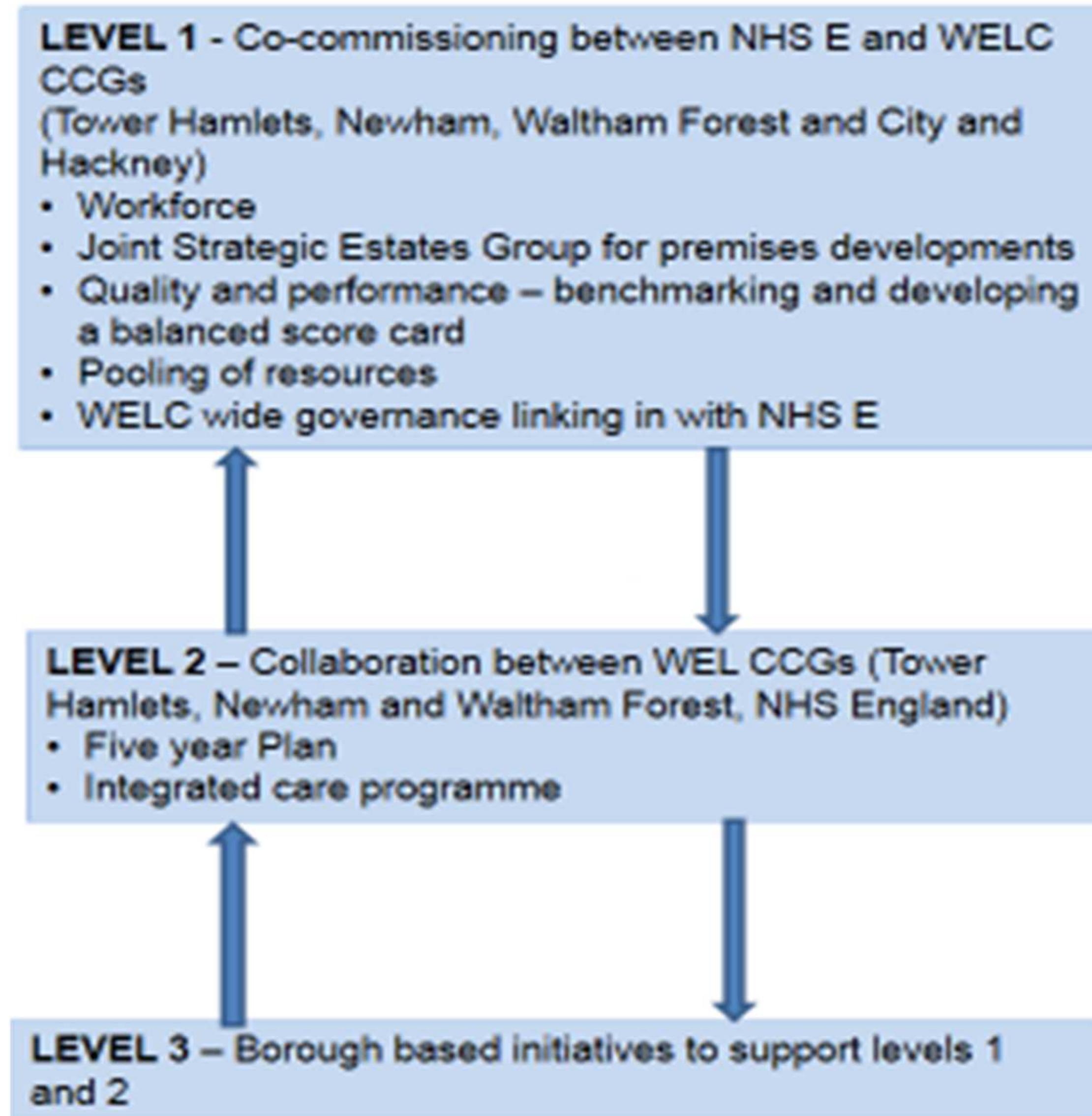
Proposed Collaborative Arrangements



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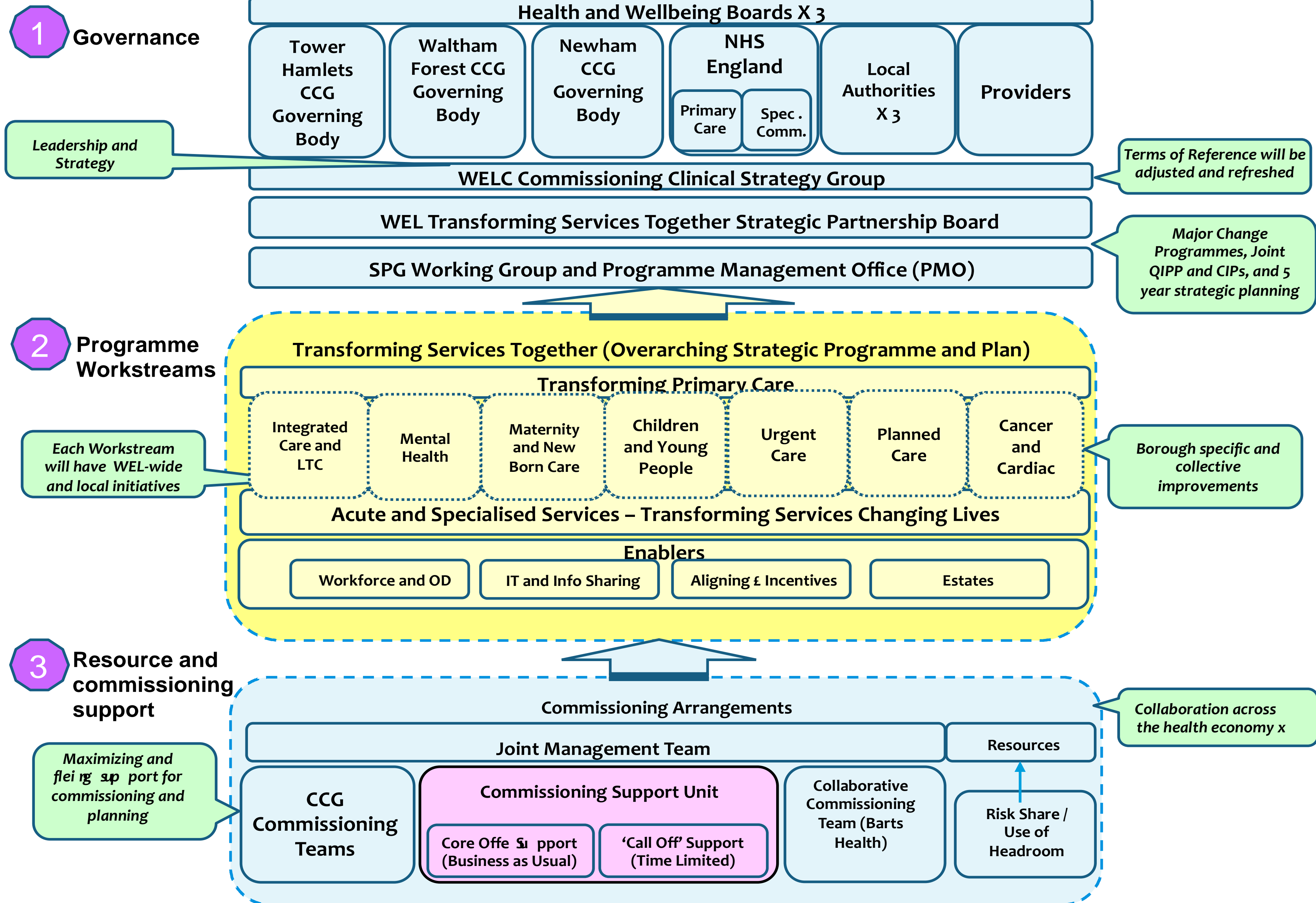
Joint Decision Making and Accountability

WEL CCGs Collaborative Governance Overview – *TO BE FINALISED*



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Intended Benefits

	WELC CCGs Five Year Plan Objectives
1	Improving additional years of life from conditions amenable to health care (PYLL per 100,000) by 3.2%
2	Improving the health related quality of life of those with 1+ long-term conditions by 0.37%
3	2.38% reduction in emergency admissions
4	Improving patient experience of hospital based care by 3%
5	Improving patient experience of general practice and GP out of hours services by 1% in 2014/15 increasing to 5% by 2017/18
6	Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside hospital by 11%

- Improving the quality of services for patients
- Improving access and variability
- Strategic oversight of Primary Pare
- Primary Care Infrastructure Transition

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Phasing 1

Joint Commissioning of Primary Care, CCGs and NHS England November 2014
Strategic oversight of Primary Care and a lead role in investments and decision making
Joint Strategic Estates Development
Quality improvement through a benchmarking and audit approach
Workforce development and education

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Phasing 2

Phase 2 - Joint Commissioning of Primary Care, CCGs and NHS England April 2015 (subject to gateway process and CCG Governing Body approval)
Pharmacy
Public Health Commissioning with Public Health England including vaccinations and screening and medicines use review.
Specific Primary care contracting functions

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Next Steps

- Pause pending feedback from NHSE
- Convene a WELC primary care committee
- Convene a WELC Estate Development Group
- Development of a co-commissioning work programme
- Continue stakeholder engagement as co-commissioning plans develop
- Agree how staff will work together across the organisations
- Put in place monitoring and evaluation arrangements

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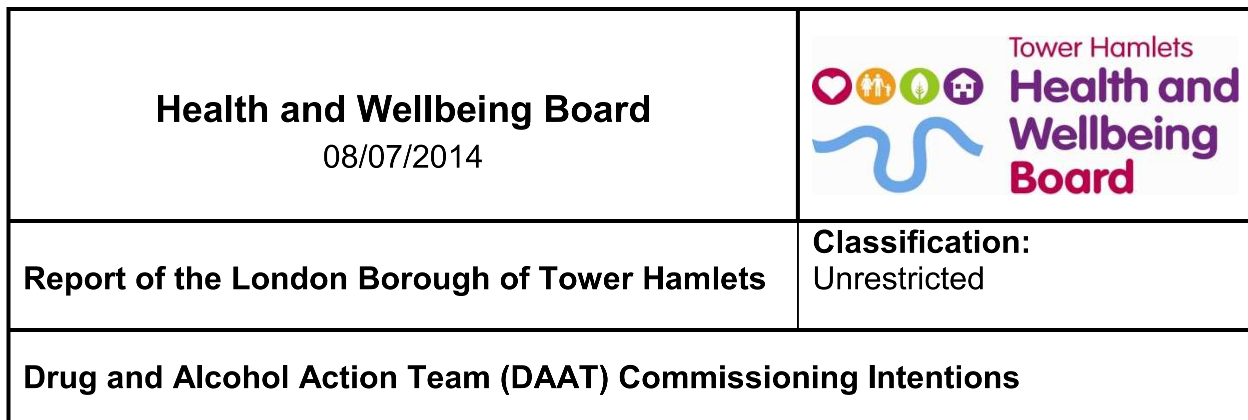

Health and Wellbeing Board 08/07/2014	Tower Hamlets Health and Wellbeing Board
Report of the London Borough of Tower Hamlets	**Classification:** Unrestricted
Drug and Alcohol Action Team (DAAT) Commissioning Intentions	

Lead Officer	Stephen Halsey, Director CLC / Head of Paid Service
Contact Officers	Andy Bamber / Rachael Sadegh
Executive Key Decision?	Yes

Executive Summary

The Drug and Alcohol Action Team (DAAT), within CLC, currently commissions drug / alcohol treatment interventions via 23 individual contracts with statutory and third sector providers. There is now an urgent need to re-procure this provision for three reasons:

i) Most services have not been subject to a competitive tender for a number of years.
ii) Current performance is declining across many providers
iii) There is now a request from ESCW to reduce the amount of Public Health Grant allocated to drug / alcohol services by £1.06m (from £8.8m to £7.74m, including £865k for in-house Drug Intervention Programme provision).

The need to re-procure drug/alcohol treatment services presents an opportunity to procure a more recovery-orientated service delivering improved performance and better value for money. Options for re-procurement have been developed, including a standstill option, and have been reviewed by the DAAT Board, ESCW and CLC DMTs and CMT. It should be noted that this report is only concerned with contracts commissioned via the DAAT.

Recommendations:

The Health and Wellbeing Board is recommended to:

1. Note the intention to re-procure drug / alcohol treatment services in Tower Hamlets
2. Note the preferred option of the DAAT Board (agreed by CLC / ESCW DMTs and CMT) and comment in advance of consideration at Cabinet.
3. Note the timescales provided

1. REASONS FOR THE DECISIONS

No decisions are required. The report is for noting.

The Treatment system must be re-procured for three reasons:

1.1 Most services have not been subject to a competitive tender for a number of years.

1.2 Current performance is declining across many providers

1.3 There is a request to reduce the amount of Public Health Grant allocated to drug / alcohol services by £1.06m

2. ALTERNATIVE OPTIONS

2.1 Current recommendations from DAAT Board, CLC / ESCW DMTs and CMT suggest option 3 is the preferred option of the four options presented.

3. DETAILS OF REPORT

3.1 Prior to the implementation of the Health and Social Care Act 2012, most drug / alcohol contracts were funded via NHS held monies. Funding was provided directly to services or via Section 256 agreements specifying the services to be contracted by LBTH. In 2012, a project was initiated to redesign the treatment system to ensure fitness for purpose and better value for money. Unfortunately this was delayed due to the impending implementation of the Health and Social Care Act and transfer of Public Health responsibilities to Local Authorities. On 1 April 2013 Public Health responsibilities were transferred and since that date, LBTH have been responsible for delivering a number of public health interventions which include drug / alcohol interventions.

3.2 The health contracts were legally transferred from the NHS to the DAAT under a statutory instrument and were time limited to 31 March 2013 (following Cabinet agreement to extend them for a year). As previously reported the existing Council contracts expired some time ago (with these services operating longer than the original contract term). As such, TH Legal Services advised that all DAAT contracts should not be extended any further and be re-commissioned to be legally compliant.

3.3 However, due to the legal and technical complexity of the process, and the lack of national guidance until quite late in the process, numerous delays materialised. This resulted in the original re-procurement deadline being unachievable. As a consequence, the DAAT sought Mayoral Executive Approval (January 2014) to extend the contract renewal timeline to January 2015 to enable resources to focus on the re-commissioning process. This opportunity to re-procure all drug / alcohol treatment services presents an opportunity to align service configuration to local need.

3.4 The extension of current provision was approved on the basis that a robust DAAT procurement plan be developed to:

- Mitigate the risk due to possible legal challenge
- Enhance performance
- Improve value for money
- Ensure better service alignment to need
- Improve the capability of partnership and providers
- Facilitate a review of resource across the whole system and deliver local economic benefits

3.5 Procurement plans began immediately but a proportion of the activity could not take place during the pre-election period due to the decisions required, hence the current timetable.

3.6 Current contractual arrangements have been extended until the end of December 2014 as there is a commitment within the Mayor's Decision paper to agreeing mobilisation dates for new contracts by that date. There is now an immediate need to begin procuring/re-procuring drug/alcohol treatment services.

Need for Re-procurement

3.7 There has been a corporate request for 10% savings to be generated from the Public Health Grant in 2015/16. Public health have specified that £1m of these savings should come from the adult drug/alcohol commissioning budget and £60k from DAAT salaries and savings proposals will be presented to the Mayor. It would not be possible to re-procure the current model of provision with such a budget reduction.

3.8 This presents an opportunity to examine what is currently procured and procure an integrated treatment system which will deliver improved outcomes. The case for changing the provision currently procured is outlined below.

Future service options

3.9 The need to re-procure all adult substance misuse provision is now unavoidable. However the decision regarding exactly what to procure has yet to be made.

3.10 Following Mayoral Approval, key workstreams were initiated to serve as the evidence base for the future treatment system – these included:

- A Needs Assessment to identify local needs (Appendix 1)
- An independent Service Review (to assess the extent to which the borough treatment system currently addresses need and identify any gaps)

This work identified a number of pressing priorities for the Tower Hamlets treatment system which have largely stemmed from an organic growth of the treatment system over many years – resulting in a highly complex arrangement. As such, the borough system has evolved, rather than being

holistically planned, and is a treatment system that is focused on Opiate substitution therapy and addressing presentation through the Criminal Justice System. The key priorities highlighted through the needs assessment and the service reviews were to:

- Maintain Opiate priorities within the system
- Expand non-Opiate and alcohol provision
- Integrate drugs and alcohol services
- Rationalise and reduce the number of service contracts
- Regularly review and scrutinise substitute prescribing
- Increase psychosocial interventions
- Build stronger recovery capital of clients
- Reduce client key worker ratios and support the role of key workers
- Increase 1-1 and group counselling/work
- Increase client readiness for structured treatment and maximise the outcomes from inpatient detox (drugs and alcohol) and residential rehabilitation
- Review information management systems to better understand how best they serve strategic and service level needs
- Maintain a client focused services fit for purpose that encompasses strong client involvement and peer led recovery outcomes

A previous attempt to reconfigure the treatment system and address the same issues was started in 2011 but this work was terminated due to the announcement that all substance misuse services and the associated funding streams would transfer to the Council in April 2013.

3.11 The Home Office Drugs Strategy 2010 moved the focus of treatment towards long term goals of recovery and reintegration for drug users, whilst maintaining provision that minimises harm to both the individual and the community. This is now measured within the Public Health Outcomes Framework (PHOF2.15) as the number of drug users who successfully leave treatment and do not re-present to services within 6 months. Whilst the treatment system in Tower Hamlets has been successful in engaging large numbers of clients in effective treatment, successful completions of treatment are low and decreasing, and re-presentations are increasing. There have been numerous strategies for improving this performance over recent years and a new action plan will be implemented for 2014/15. However, significant improvements within the same treatment system structure are unlikely.

3.12 An Options Appraisal has been developed to establish which potential future service arrangements could best meet the identified local needs. In total, four structural options have been considered reflecting the key points in the treatment journey from treatment entry, through various treatment interventions and ultimately successfully exiting treatment (a structural diagram of each option is presented in Appendix 2). The four potential options developed are as follows:

Option**One**: Standstill (23 contracts) (leave the treatment system largely as it is) but with a single point of system entry, triage and comprehensive assessment with onward referral to provider services.

Option **Two**: Main treatment provider for Tier 3 treatment (all drugs and alcohol) with separate recovery/support contracts (10-15 contracts). Therefore combine the main treatment provision for tier 3 treatment (opiate, non-opiate and alcohol) into one contract including treatment entry, assessment, pharmacological and psychosocial interventions. This would work with targeted access points into treatment and additional recovery providers offering the full menu of recovery support.

Option**Three**:Two drug + alcohol treatment contracts; one for treatment and one for recovery (2 contracts). Single drug treatment provider for all Tiers 2-3 treatment, this option should coexist with a separate commissioned recovery agency, targeting their work solely on recovery activity.

Option **Four**: Single integrated drugs and alcohol service contract. (1contract).

Alongside all of these options would be a referral/outreach contract to focus on engaging targeted groups into treatment and re-engaging individuals who have dropped out of treatment. There is also an ongoing need for an element of (re-specified) shared care provision and a service at Health E1 (homeless GP practice).

3.13 On 8th April 2014 these options were presented to the DAAT Board who unanimously recommended Option 3 as the most appropriate borough service arrangement to take forward – given it addressed the key concerns and requirements highlighted in both the Needs Assessment and Service Review while also offering the potential to deliver improved performance efficiencies.

Procurement plan

3.14 It is intended that all borough substance misuse services will be re-procured and be fully mobilised in April 2015.

3.15 The procurement approach will be guided by the seven imperatives outlined by LBTH and will incorporate these imperatives within the tender process and the final service specifications. In particular we will be keen to deliverbudget efficiencies, value for money and local employment and training opportunities within the context of a highly specialised service.

3.16 To mitigate the risk of a successful procurement challenge a robust project plan has been developed (see appendix 3). The plan highlights the timeline for the various phases of re-procurement process including contract initiation,

planning, re-procurement and mobilisation to replace all the DAAT contracts over the next 8 months or so. Key dates are listed below:

- Consultation (June)
- EQIA (June)
- Spec and tender material development (Apr-June)
- Decisions prior to tender (July-Sep)
- Tendering and Evaluation (July-Nov)
- Decision ratification (Oct-Dec/Jan)
- Contract sign off and mobilisation dates set (Jan/Feb)

3.17 There has been extensive consultation undertaken regarding treatment provision in Tower Hamlets with commissioners, providers, service users and other stakeholders. This has been in conjunction with previous plans for remodelling as well as the recent needs assessment and service review. When a proposed model for procurement is agreed, there will be further consultation as well as an equality assessment.

4. COMMENTS OF THE CHIEF FINANCE OFFICER

4.1 There is currently budget provision of £8.8m from the Public Health allocation. This currently commissions £7.9m drug and alcohol treatment interventions (DAAT) including salaries. The balance of the provision supports the £865k in-house Drugs Intervention Programme (DIP).

4.2 A savings reduction of 10% has been specified from the Public Health grant for 2015/16. A savings target of £1.06m has been requested from the DAAT budget. There is the expectation that £1m of the savings target will be delivered from the drug /alcohol commissioning budget of £7.4m reducing the commissioning provision to £6.4m. The remaining savings of £60k is to come from a reduction in the staffing budget of £566k reducing to £506k.

4.3 The report provides four options for consideration. Option 1 provides a standstill position and does not relinquish any savings. The other three options all provide an element of restructuring and consolidation, Option 2 (10-15 contracts), Option 3 (2 Contracts) and Option 4 a single contract. The recommendation of the DAAT board is that Option 3 be considered as the most appropriate borough service arrangement. The reduction in the Public Health allocation suggest that Option 3 and 4 are the most likely options that would deliver the £1.06m reduction and provide for sufficient resources to commission contracts.

4.4 The procurement strategy detailed within this paper is aimed at the Option agreed being fully mobilised April 2015. It is likely that an extension would be required to the current contracts post January 2015. There is sufficient provision within the existing budget envelopeto manage any contracts extension.

5. LEGALCOMMENTS

Council's Duties

5.1 In January 2012, the Council adopted its Substance Misuse Strategy 2012 – 2015, consistent with its obligation under section 6 of the Crime and Disorder Act 1998 to formulate and implement strategies in conjunction with other specified responsible authorities for: reduction of crime and disorder; combating the misuse of drugs, alcohol and other substances; and reduction of re-offending. The Council is obliged when carrying out its functions to have due regard to the likely effect of the strategy on, and the need to do all that it reasonably can to prevent, crime and disorder, misuse of drugs and alcohol and re-offending in Tower Hamlets. The proposed contracts are connected with the delivery of that strategy.

5.2 The proposed contracts may also help deliver the Council's other statutory duties, which include the following –

- The Council is required under the National Health Service Act 2006 to take such steps as it consider appropriate for improving the health of the people of Tower Hamlets
- Under section 11 of the Children Act 2004, the Council is required in the discharge of its functions to have regard to the need to safeguard and promote the welfare of children.

5.3 The Council has power under section 1 of the Localism Act 2011 to do anything that individuals generally may do, subject to specified restrictions and limitations imposed by other statutes. The provision of drug and alcohol treatment interventions is something that an individual could do, if so minded, so this may also be a source of power to support entry into the contracts. There may be good reasons for exercising the power in this way, given the alignment of the interventions to the Substance Misuse Strategy.

5.4 The Council has an obligation as a best value authority under section 3 of the Local Government Act 1999 to "make arrangements to secure continuous improvement in the way in which its functions are exercised, having regard to a combination of economy, efficiency and effectiveness". This obligation extends to the purchase of all goods works and services.

5.5 The Council may comply with its best value duty by subjecting the proposed purchase of services to the appropriate level of competition. Whichever of the options are chosen the final contracts must be tendered in order to meet this obligation. The Council must award tenders to the bidder who has made the most economically advantageous tender to the Council. For this purpose the Council must set award criteria which have regard to both quality and price and award the contracts to the bidders whose offers most closely reflect the evaluation criteria. Further, the Council must comply with European law in respect of requirements for the procurement process.

5.6 When considering its approach to procuring these services, the Council must have due regard to the need to eliminate unlawful conduct under the Equality Act 2010, the need to advance equality of opportunity and the need to foster good relations between persons who share a protected characteristic and those who don't. If services have been significantly redesigned then consultation prior to implementation must occur with the service users, their families and any other relevant stakeholders. An initial equality analysis has been carried out which identifies that further and more detailed equality analysis will be required, once a general approach to procurement has been chosen.

Role of the Health and Wellbeing Board

5.7 The HWB is asked to note the intention to re-procure drug / alcohol treatment services and note and comment on the preferred option of the DAAT Board at its meeting on 8 July 2014. This is consistent with the general policy, reflected in the Health and Social Care Act 2012, of giving HWBs responsibility for joint health and wellbeing strategies and the joint strategic needs assessment, and falls within the functions of the HWB set out in its Terms of Reference agreed by the Mayor in Cabinet on 4 December 2013, in particular the following function –

- 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 of integration across outcomes spanning health care, social care and public health. Areas of focus to be agreed by the Board from time to time by members of the Board as part of work planning for the Board.

5.8 Due to the significant financial implications of these proposals, this will be a key decision which requires Executive approval. The recommended approach was presented to the Mayor's Advisory Board on 10 June 2014 for endorsement. The HWB is asked to provide comment in respect of the proposals in advance of presentation to Cabinet on 23 July 2014.

6. ONE TOWER HAMLETS CONSIDERATIONS

6.1. The current treatment system within Tower Hamlets has been successful in attracting a wide range of individuals into treatment across the equality strands. Within the large number of services commissioned there are specialist services for BME clients (with a focus on Bangladeshi and Somali individuals), female clients, pregnant clients and clients with mental health issues. Commissioning a simplified structure would mean fewer specialist provisions. However, within the procurement process there will be requirements for providers to determine how best they will incorporate the needs of such populations. Providers will be encouraged to form consortia or sub-contract with other providers and provide services in a flexible manner from a wide range of venues to ensure specialism is incorporated into their

service offer. Once contracts are awarded there will be performance targets for engaging targeted populations based upon the equality strand data that has been collected over the last three years.

6.2. Whilst the current treatment system has been successful in engaging known populations of drug / alcohol users, there are still a number of groups not engaging in treatment. For example, it is well documented that problematic drug / alcohol use is more prevalent within populations such as homosexual men, Chinese, Eastern Europeans, students / young adults, high earning individuals, than the demand presented to our current services. In the current financial situation, it will not be possible to initiate specialist services for each new population that demonstrates a demand for treatment services and therefore a more flexible approach should be developed to target emerging population needs.

6.3. A full equality analysis is underway now that the election is over and we may full engage stakeholders in consultation.

7. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

7.1 There are no major environmental implications within this proposal but bidders for services will be requested to demonstrate their commitment to contributing to a sustainable environment.

8. RISK MANAGEMENT IMPLICATIONS

8.1. As mentioned earlier in the report, there is now an urgent need to re-procure to avoid legal challenge with regards to current contracts. Hence the procurement project necessary to mitigate that risk.

8.2. If option 1 is pursued and the treatment system remains broadly the same as its current configuration, there are risks to future affordability and performance. An element of payment by results would be implemented as an additional contract management tool but this would not greatly change the client experience. This option would not realise any savings for this year or future years and required savings would need to be met fromelsewhere.

8.3. Options 2-4 would involve an element of restructure. A large scale restructure of any system will bring a risk of destabilisation. Potential ramifications within the treatment system are a temporary drop in numbers of individuals accessing treatment and potential risks to effective ongoing management of individual clients. In order to mitigate against this risk, a comprehensive implementation plan will be developed to ensure handovers between services are as smooth as possible, including data, premises, client handover, communications, records transfer etc. It is highly likely that a number of staff currently engaged in services will continue to be part of the treatment system via TUPE arrangements and as many of the leases for premises are held by

LBTH, many of the current service premises will be available for use in a new system.

8.4. There is a significant risk that the re-procurement of treatment services across the borough may not be completed prior to the end of December 2014. A timetable has been developed to complete the tender process and make recommendations for contract award by the first week in October, allowing presentation to Cabinet in December (subject to meeting schedule). However, this tight schedule requires a smooth process with no meeting cancellations and is not sufficiently robust to withstand any unforeseen issues that may delay the process. Therefore, it is highly likely that the delivery timeline will extend beyond 1st January 2015 – requiring a further extension in the later part of the re-procurement process. Legal have advised this approach would be defensible against challenge on the basis that the procurement process was being undertaken.

9. CRIME AND DISORDER REDUCTION IMPLICATIONS

9.1 Problematic drug / alcohol use within the borough contributes significantly to crime and anti-social behaviour across the borough. Treatment interventions are funded on the basis that they prevent further health harm and costs associated with crime. In Tower Hamlets, it is estimated that every £1 spent on drug treatment saves £2.82 in health and crime costs. This is based upon current performance of the treatment system and a more effective system with improved outcomes would increase this cost benefit. Latest data shows that 23% of referrals into the treatment system are via criminal justice agencies (police, probation, prison).

10. EFFICIENCY STATEMENT

10.1 The current treatment system configuration does not offer good value for money. Options for re-procurement have been developed and all four options presented have currently been developed within the same commissioning budget envelope (£7.4m) to allow direct comparison of spend and maintain the integrity of the treatment system. If spend is retained and merely distributed differently, options 2,3 and 4 would facilitate progressively lower management / admin costs which may be re-invested in frontline staff and recovery focussed services resulting in lower case loads and facilitating improved performance.

10.2 Options 2-4 have also been developed to demonstrate the effects of budget reductions of between 5% and 20%. Whilst this modelling gives an idea of the budgets available for individual elements of the service, there is further work to be completed on the frontline staffing impact within individual services.

10.3 The DAAT team is currently carrying a number of vacant posts. A restructure of the team will be carried out once the model of treatment provision to be procured is determined. A team can then be built around the requirements of

the service and will generate savings of at least 10% against current establishment costs.

Appendices and Background Documents

Appendices

- Appendix 1: Needs assessment executive summary
- Appendix 2: Treatment System Options
- Appendix 3: Project timeline
- Appendix 4: Equalities Analysis Quality Assurance Checklist

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.

- Options Appraisal

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

- Rachael Sadegh, Rachael.sadegh@towerhamlets.gov.uk, 0207 364 0395

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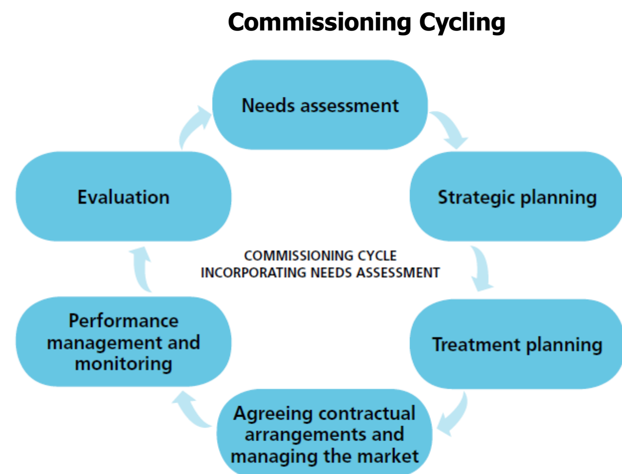
London Borough of Tower Hamlets Substance Misuse Needs Assessment 2013/14

Executive Summary
February 2014

Introduction

1. Conducting a Substance Misuse Needs Assessment is essential to treatment planning and commissioning (see below, commissioning cycle) as it reviews service demand, offers comparison to relevant regional and national baselines and assesses local partnership performance over time. This needs assessment has reviewed the needs of the Tower Hamlets' substance misusing population to support the Drug and Alcohol Action Team (DAAT) and its wider partnership to respond to future treatment demand.

Commissioning Cycling



2. The Tower Hamlet's Substance Misuse treatment system has developed over time and is now one of the largest treatment systems in London. Its performance has historically been strong although in recent years there has been a decline in outcomes. Presentations to borough treatment services are heavily opiate and crack focused, with much of the resources targeted to a complex and high need client group which needs to be managed through the treatment care pathway to effective recovery.

Approach

3. This needs assessment has been based on a range of desk research and data analysis, primary and secondary research and an assessment of service provision across the borough. The core data used to support the needs assessment was derived from the National Drug Treatment Monitoring System (NDTMS), which is critical to assessing both service need and performance and supports an understanding of treatment demand to inform substance misuse intervention priorities for local partnerships.

4. Additional operational data was available through Mi-Case and directly provided by services across the DAAT. Partnership data was also gathered and analysed that has supported the findings of this assessment.

5. Primary quantitative and qualitative research included:

   - 200 Service Users surveys
   - 45 interviews with practitioners and stakeholders
   - 4 focus groups with 36 participants
   - 64 stakeholders engaged in workshops and presentations

6. All emerging findings were also scrutinised by an independent steering group with representatives from the project team, Public Health England (PHE), Home Office (HO) and a DAAT Coordinator from an external authority.

Resources

7. In 2012/13 Tower Hamlets spent £9.5m on community based substance misuse treatment in the borough. All borough substance misuse services are commissioned and/or delivered by LBTH via the DAAT, the Drug Interventions Programme (DIP) and Children's Commissioning with annual funds for the DAAT (and DIP) in the region of £9.5m for 2013/14 which is derived from the PH Grant (£8.8m) and the Mayor's Office for Policing and Crime (£613k for DIP). This funding commissions 25 services to address the treatment needs of local drug users.

Impact of commissioned services

8. There are a range of performance highlights which have emerged from the borough's treatment system. The key impacts of commissioned services are:

Drugs

- The Borough's treatment penetration rate for opiate and/or crack users (OCU) is 34% (down 3% on the previous year). This is set

against an estimated OCU population of 3,027. The 2012/13 penetration rates are set out in the table below.

OCU Penetration Rates 2012/13

Tower Hamlets Glasgow Estimates	Tower Hamlets	London	National
2010/11 Estimated OCU Population	3,027	52,623	298,752
Number of OCUs in Treatment 2012/13	1,037	16,276	119,763
Penetration Rate 2012/13	34%	31%	40%

- Women are under-represented in treatment in the community (at 20%) and are below the London and national rates of presentation.
- In 2012/13 there were 833 new entries into treatment, 2,154 people in treatment and 611 people exiting the treatment system
- Treatment providers with the highest volume of clients were Lifeline CDT with 857 (40%) clients, Tower Hamlets Specialist Addictions Unit (SAU) 339 (16%), Health E1 with 257 (12%) and NAFAS 149 (7%).
- Just over a third, 217 (36%) left treatment in a planned way, successfully completing treatment (accounting for 20% of the drug treatment budget) and 233 (38%) left in an unplanned way, majority of which dropped out of treatment.
- As a percentage of the numbers in treatment 9.3% opiate clients successfully completed treatment (compared to 9.8% London and 8.7% national average). However, in September 2013 this dropped to 5.1% (compared to cluster top quartile performance range, 8% to 10%).
- Thirty-four percent of non-opiate clients successfully completed treatment (compared to cluster top quartile performance range, 49% to 63%). In September 2012/13 this dropped further to 29.5%.
- Tower Hamlets has a prevalence rate of 17 per 1,000 aged between 18 and 64 OCUs, 15 for opiate users, 16 for crack users and 4 for injecting drug users (opiate use is twice as prevalent compared to London and national averages, whilst crack use is more than three times the national rate).
- OCUs in effective treatment make up almost the entire treatment population in Tower Hamlets which has ranged between 96% and 93% since 2008/09.
- North West Health Observatory figures indicate 30,810 at risk drinkers, with 9,168 consuming alcohol at higher risk and 16,382 binge drinkers.

Alcohol

- Alcohol admissions to the treatment system are growing in Tower Hamlets (with 470 alcohol referrals, 738 in treatment amongst providers and 432 treatment exits).
- Tower Hamlets is hitting a 50% successful completion rate for alcohol users with around half (46%) reporting unplanned exits.
- Alcohol related hospital admissions have risen from 986 in 2002/03 to 2,577 in 2012/13 almost tripling over this period.
- Alcohol is an increasing concern locally and one which the treatment system needs to address.

The Performance of the Partnership

9. In Tower Hamlets one in four clients in treatment (opiate and non-opiate) have very high complex needs (442), this is almost twice as many very high complex need clients compared to the national average.

10. Tower Hamlets opiate treatment population falls into cluster E and non-opiate treatment population into cluster D. Clusters range from A to E, with A representing the least complex treatment populations and E the most complex. Therefore the borough's cluster comparators are the most complex opiate and the second most complex non-opiate Local Authority areas.

Opiate Clients

11. In September 2013 Tower Hamlets had 1,456 opiate clients in treatment, which is below cluster average placing Tower Hamlets mid-table for the size of its opiate treatment population. There has been a significant reduction in the number of opiate clients successfully completing treatment since October 2012, this means Tower Hamlets is ranked 6th lowest for the number of opiate successful from

a position of 14th highest at the 2012/13 baseline.

12. In 2012/13 one in four opiate clients had a drug using career length that spanned over 21 years, similar to cluster average. However a high proportion (43%), have been in treatment for less than one year, higher compared to cluster average of 22% and the proportion of opiate clients that have had more than four previous treatment journeys is equal to 24% (higher compared to 19% cluster and national average) which has increased from one in five in the previous year.

13. Whilst completion rates are broadly consistent with cluster average, this suggests a significant number of opiate clients are engaging and disengaging in treatment and as the number of previous attempts at treatment increase they are less likely to complete the next time they are in treatment.

14. The outcomes data suggests, in the past six months, there have been 46% less clients successfully completing treatment (138, 2012/13 baseline and 74, September 2013). The proportion of opiate clients re-presenting to treatment has fluctuated between 37% and 19% since 2010/11, with September 2013 showing 34% re-presentations.

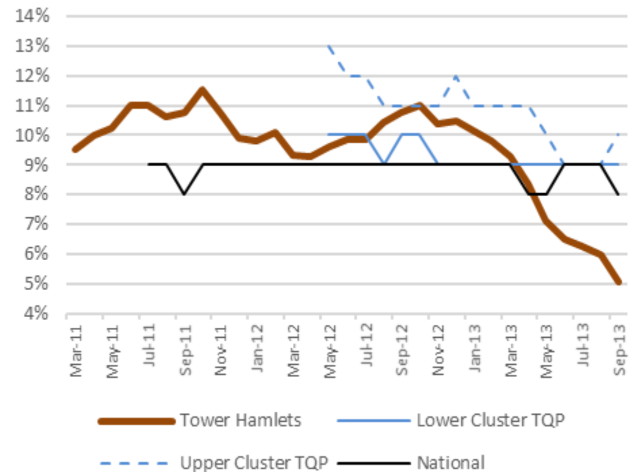
Non-Opiate Clients

15. In September 2013 Tower Hamlets had 224 non-opiate clients in treatment, which is below cluster average and ranks Tower Hamlets 8th lowest for the size of its non-opiate treatment population. Non-opiate clients account for 13% of the total treatment population. In the past 6 months, 6% less non-opiate clients successfully completed treatment (70, 2012/13 baseline and 66, September 2013). In the latest reporting period there have been no re-presentations to treatment.

16. The distribution of non-opiate clients in treatment is broadly similar to cluster and national average, with the majority (59%) in treatment with no previous treatment journeys, however completion rates are much lower at 37%, compared to 47% cluster and 43% national average.

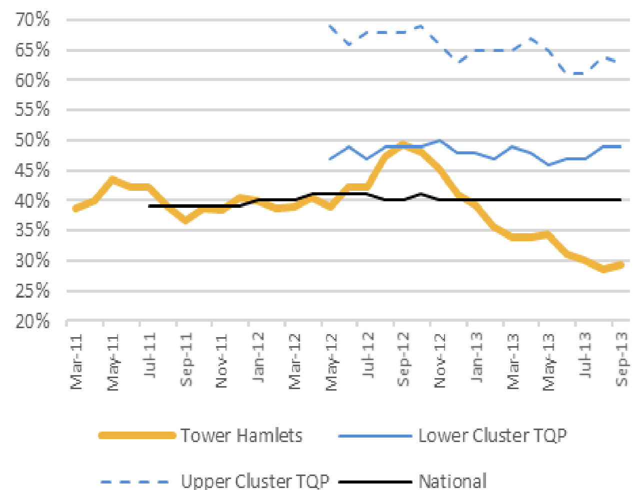
17. As a proportion of the numbers in treatment 5.1% opiate clients successfully completed treatment in September 2013, the chart below maps this trend from 2010/11 baseline against cluster and national performance.

Partnership: Opiate % Successful Completions, Cluster and National Comparators



18. For the non-opiate clients, 29.5% successfully completing treatment in September 2013.

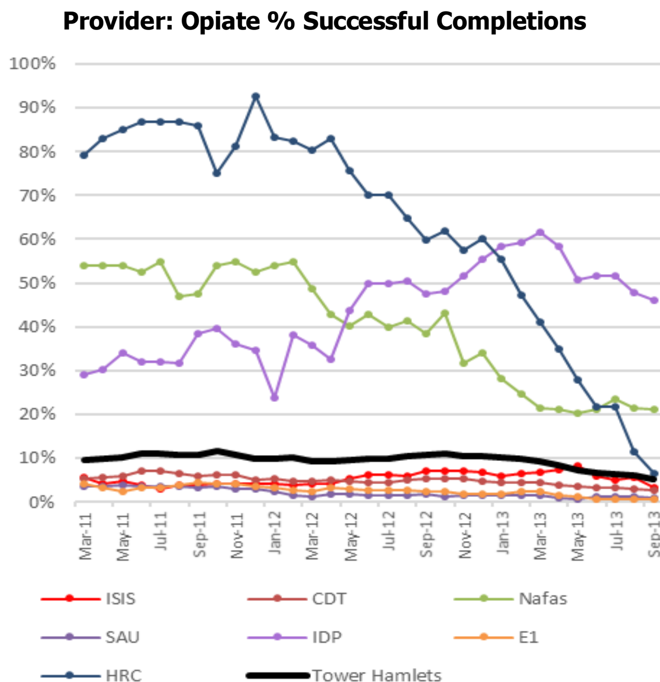
Partnership: Non-opiate % Successful Completions, Cluster and National Comparators



The Performance of substance misuse treatment providers

19. Tower Hamlets has numerous providers reporting into NDTMS, however the bulk of opiate clients are distributed amongst seven main treatment providers and non-opiate clients amongst five.

20. In September 2013 the number of opiate clients in treatment across the main providers ranged from 745 to 63, Lifeline CDT having the highest number of opiate clients in treatment and RAPT Day Programme the least. Compared to 2012/13 baseline the number of opiate clients in treatment has fallen with the majority of providers. Fewer opiate clients have been successfully completing treatment at each baseline period for all providers. The reduction in the number of opiate clients in treatment was proportionately less than the reduction in the numbers successfully completing, as a result successful completions as a proportion of the numbers in treatment show a stark decline in performance, as set out in the chart below,.



21. In addition a high proportion of clients re-presented to treatment, one third of completions resulted in client re-presentations for Lifeline CDT and NAFAS and 28% for the Harbour Recovery Centre.

22. In the first 6 months of 2012/13 treatment exit outcomes show opiate clients dropping out of treatment far outweigh those successfully completing treatment. Collectively 11% left treatment in a planned way (successfully completing treatment). For all providers, with the exception of NAFAS, this ranged from 0% to 18%. NAFAS however achieved 72% planned exits. The proportion of unplanned exits resulted in almost 50% opiate clients dropping out of treatment; this is equal to 111 clients collectively.

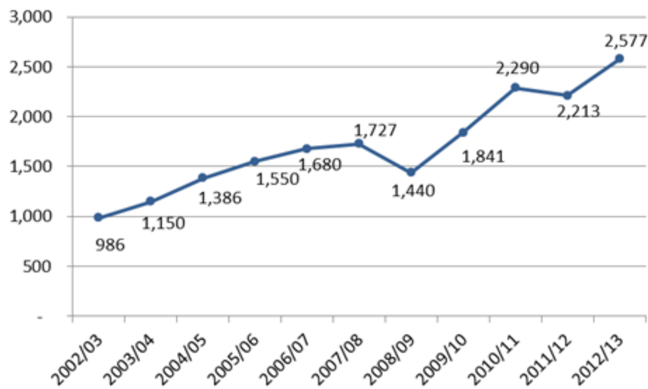
23. Non-opiate clients ranged from 54 to 19, NAFAS having the highest and SAU the least. The number of non-opiate clients in treatment has increased slightly or remained the same across most providers. There were no re-presentations to treatment.

24. The treatment exit outcomes for non-opiate clients show higher proportion of planned exits with some providers, whilst equal for others in comparison to the proportions that dropped out of treatment. Overall the treatment outcomes for non-opiate clients are better compared with opiate clients with almost half leaving treatment having successfully completed.

The Impact of Drugs and Alcohol in the Community

25. A wider review of partnership data shows that drugs and alcohol has a significant impact on the borough in terms of health, crime, community safety. The borough has seen increasing levels of drugs and alcohol callouts made by the London Ambulance Service, the borough has also seen increasing levels for Alcohol related admissions to hospital 986 in 2002/03 rising to 2,577 in 2012/13 and almost tripling over this period, this trend can be seen below.

Hospital Admissions for Alcohol Related Harm (NI39) 2002 to 2013



26. There was an average of 256 drug offences per month in the borough, with peaks in the summer of 2012, there was a hugh spike of possession cases that resulted in convictions in June 2012, (associated with preparations for the Olympics). The numbers of drug trafficking offences (dealing) is lower and there has been a broadly consistent level of offences throughout this period with a spike in October 2012. The Borough Police have targeted a dealer a day as part of a local campaign and during this period there was an average of 16 arrests a month.

27. Tower Hamlets has a higher rate of recorded crime attributable to alcohol, greater than London and England; although this is falling it did see a rise in the estimate in 2009/10. With respect to violent crime Tower Hamlets also has a higher rate than London and England and once again this figure is declining broadly in line with the London and England profiles. The rate for sexual crime attributed to alcohol is however growing compared to London and England which are declining albeit very slowly. This is a concern but is likely to be affected by the club based night time economy emerging in the borough.

28. The impact and cost of drugs and alcohol on the borough is great and it is important to engage these people in treatment and to work particularly with the 'frequent flyers' of these services to ensure that treatment can be used to mitigate repeat episodes.

Primary Research Findings

29. A range of primary research was completed in developing this needs assessment. This included stakeholder interviews and workshops, a service user questionnaire completed by 200 respondents, four focus groups targeting opiate users, non-opiate users, women and alcohol treatment clients. The headline findings of these are set out below.

Stakeholder interviews

30. Interviews and workshops engaged over 50 practitioners and stakeholders in the borough. There were many themes which came out of these interviews however the main focus was:

- The treatment system lacks holistic planning and has evolved with additional services being added over time
- Heavy operational focus on opiates, low level of non-opiate engagement, but high complexity clients in deprived and challenging environment
- Volume of providers creates a situation where clients are held onto and transferred haphazardly, leading to duplication of provision, lack of mutual value and some interagency miss-trust
- Critical need to address the 'disjointedness' of treatment provision and to consolidate a clear understanding of what everyone is doing.
- Clients are often not treatment ready particularly with respect to detox and rehab
- Low levels of treatment value from clients
- Low levels of recovery focus but a priority aim of the treatment system, pockets of good practice although these are often not shared
- An overwhelming positive commitment to improve the treatment system but a clear realisation amongst providers and stakeholders that whilst this will be opportunistic for the treatment system it is likely to be a threat to them

Service User Questionnaire

31. Throughout the survey and its findings there was a loyal sense of support for the way the treatment system works from the majority of

the 200 respondents who took the time to complete the survey:

- 96.0% think their substance misuse negatively impacts on their life
- 78% feel optimistic about their ability to reduce dependency
- 85.8% have a good relationship with their treatment providers
- 85.8% key worker skills and abilities in interpreting their needs are good
- 71.8% felt their treatment provider was good at meeting their needs
- 74.9% have a care/recovery plan and
- 80.6% of these worked on care/recovery plan with their key worker
- Going forward they prioritised:
    - After care
    - 'After/out of hours' services
    - Better service access across the borough
    - More and better counselling, psychosocial therapies, alternative therapies
    - More access to housing, detox, rehab and aftercare
    - Better information and communication about what's available

Service User Focus Groups

32. Four Focus groups were completed as part of this needs assessment. There were a range of key findings that are set out in the main body of this report and in a separate focus group report. The main themes that emerged are set out below:

- Clients felt that there is a branding issue in local treatment as many have pre-conceived perceptions of services which stigmatise provision
- Their consistent view was that Drugs and Alcohol are a common part of life for many in the borough
- Focus groups felt there was an absence of commitment and operational structures to support client recovery
- Many felt that services are incoherent and need better integration, particularly with respect to drugs and alcohol
- Most clients experience unstable housing, poor public services access and more support for ETE
- Focus Group participants do not see GPs are being part of their care team and there is concern about the quality of care received from GPs
- Clients feel there is a desperate need for more effective aftercare and recovery support
- Treatment clients felt that services need to be more patient centred
- There were also strong arguments for more Peer involvement to support recovery

Conclusions [Key issues emerging from the assessment]

33. There are some clear issues for the treatment system to contend with, in particular:

- Reduction of successful completions achieved by the partnership
- Slowing down of new treatment entries across most providers
- Several bottlenecks in the system, in particular the borough's CDT
- General low levels of client readiness for the recovery journey
- Low levels of treatment compliance by clients (drop outs)
- Low levels of recovery capital in clients
- High levels of complexity and diversity within the system
- Some poor inter agency procedures and protocols to enable effective treatment transfers
- Specific operational issues within the DIP
- Clients in Shared Care arrangements in the borough tend to be stabilised but not benefiting from a strong recovery focus to their treatment

34. The role of shared care in the borough's treatment is strong with over 800 clients receiving their treatment in this way. Capacity to effectively support and treat clients in this shared approach suggests the need for a strong revamp. Particularly as this is affecting the capability of the Partnership to meet its successful completion targets set in the Public Health Outcomes Framework.

35. The difficulty in engaging clients and their lack of recovery capital prevents successful completions from emerging and fails to support clients to be treatment ready and to enable the associated benefits of recovery being realised. In short, treatment needs to actually be provided and clients and practitioners need to better distinguish between the role of substitute prescription as a method of stabilisation/maintenance and structured treatment as a support to reducing and eventually stopping their drug use.

36. Diversity and the cultural needs of different clients are also key considerations for the borough. It is vital that prospective clients from all communities are at ease with entering the treatment systems either to stabilise their substance misuse and or to begin a journey through to recovery. In Tower Hamlets there seems to be a far greater proportion of the former and far fewer of the latter.

Value for Money

37. Addressing Value for Money (VFM) and cost effectiveness is a relatively inaccurate science nonetheless the NDTMS have provided tools that can support a better understanding. The VFM tool estimates that if there were no provision for drug treatment this would have a cost to Tower Hamlets of £23.7m. However based on a budget of £4.2m over the spending review period there is a net benefit of £16.9m and a cost benefit ratio of 1: £2.82.

38. The large variation in subsidy per head of providers suggests varying cost in provision, varying numbers of clients in effective treatment and potential to rationalise some of these costs against need.

Recommendations

39. This needs assessment has identified a number of key priorities for the Tower Hamlets Treatment System, these are set out and addressed below:

    - Develop a treatment system that meets the needs of the local community
    - Develop a clear annual treatment plan
    - Support the transition to an integrated drugs and alcohol service
    - Better alignment of services and treatment activity
    - Deliver more outcome focused treatment
    - Improve the recovery capital of clients
    - Develop more client facing services
    - Rationalise the commissioning function and performance management of contracts
    - Support the ongoing workforce development of treatment staff and stakeholders
    - Use the procurement process to better clarify the roles and responsibilities and operational relationships between providers
    - Better clarify the distinctions between shared care and structured treatment roles in the treatment system
    - Utilise the procurement process to rebrand services

40. Aims of the Drug and Alcohol Treatment Service should be:

    - To offer personalised opportunities for those using drugs and/or alcohol to move towards total cessation.
    - To reduce the harm caused by substance misuse on the local community including contributing to a reduction in crime and anti-social behaviour
    - To ensure that the principles of harm minimisation underpin the delivery of all interventions in order to improve the health and well-being of service users
    - To deliver a non-judgemental and inclusive service which treats service users with

dignity, respecting gender, sexual orientation, age, ethnicity, physical or mental health ability, religion, culture, social background and lifestyle choice
- To deliver services which are accessible, responsive and offer greater service user choice
- To improve the outcomes for children of service users by reducing the impact of drug and alcohol related harm on family life and to promote positive family involvement in treatment
- To facilitate a co-ordinated and holistic approach to recovery which emphasises the inclusion, or re-entry into society of service users by working with a range of local partner agencies
- To reduce the impact of drug and alcohol misuse on the wider public sector economy by promoting effective treatment and harm reduction responses in a range of settings including primary and community health care, mental health and criminal justice services
- To identify and safeguard vulnerable adults and children of adults who use the services

41. A key recommendation to the DAAT Board is that they needs to review a set of options going forward as to how the treatment system should be re-procured.

42. Options are emerging from this needs assessment and service review, it is recommended that the DAAT undertake an options appraisal of these treatment/ procurement options and debate this issue early in 2014.

43. The borough's partnership between its providers and other statutory agencies has been well established but there is a current opportunity to improve these relationships and to build a stronger set of local commitments to drugs and alcohol. It is on this basis that the following recommendations and treatment plan priorities are made:

44. Strategic Recommendations:

- Maintain the management of drugs and alcohol treatment planning, commissioning and performance management through the DAAT team within the Council
- Establish evidence based commissioning and treatment planning by using this needs assessment and set appropriate targets and performance management tools for the borough's drugs and alcohol treatment system
- Maintain the priority of drugs and alcohol treatment services through current and future changes to funding streams in Tower Hamlets
- Develop and maintain annual treatment plans which fit into the Public Health commissioning priorities to tackle addictions in the community
- The Tower Hamlets DAAT needs to maintain up to date data and to review performance against the 2014/15 treatment plan

45. Key Treatment Plan Priorities:

- Tower Hamlets has seen a slow decrease in opiate presentations over the last three years. However this does not address the wider treatment naive population. Opiate users should always be a priority group within substance misuse treatment provision
- Services will need to be maintained and strengthened for non-opiate and other problematic substance misuse
- There is a clear need to plan for and target the increasing emergence of alcohol.
- Increase the numbers of those entering the treatment system to maintain a steady client flow through
- Undertake a more dynamic approach to sourcing new clients and or targeting ex-clients who may now be treatment naive
- Maximise the number of clients in effective treatment, this is currently falling and may affect future service success and impact
- Develop programmes to increase the Recovery capital available to clients
- Work to address the recovery agenda and drive forward the increase in Successful Completions for the borough

- Establish a focus on addressing the long term clients i.e. clients who have been in the treatment system for over 6 years.

46. Operational Priorities:

- Set targets for the treatment provision secured through the re-procurement exercise
- Define service scope and capacity to expand the community focus of the work and to provide beyond the traditional 9-5 operational model, extending to more evening and or weekend provision where feasible
- Redefine the Borough's Shared Care system to take account of the treatment/recovery needs of clients in particular those receiving their substitute prescribing from their GP
- Review and support aftercare and consider effective options to extend aftercare services
- Support providers to work with the 'assertive' outreach services within the DIP to support re-engagement and to engage new clients
- Target non-opiate and alcohol treatment provision with associated treatment options in particular psychosocial analysis, behavioural treatment and motivational interviewing.
- Review the role and provision of community detox
- Support clients readiness for treatment
- Enhance the key worker capabilities in the borough
- Implement a comprehensive and frequent review of client treatment and care plans both from a clinical and treatment perspective.
- Improved contract management, setting recovery focused delivery targets for each provider, in part this is already in the performance management of the providers but may need revisiting and reinvigorating.
- Clear fiscal controls with all providers in contract to support treatment system benefits and to guide/influence decision making
- Contracts to be set to secure a controlled and where possible reducing subsidy level and increasing cost benefit ratio regarding costs of crime as nominal targets.
- Review those parts of the treatment service where there are high levels of expenditure but which do not contribute to performance targets or indicator
- Develop Annual workforce development plan
- Work with partners to secure effective up to date data exchange on; A&E admissions, drugs and alcohol Hospital admissions, Ambulance service call outs and maintain a working review of Policing, drug and alcohol crime and Integrated Offender management (IOM) and Probation client data.

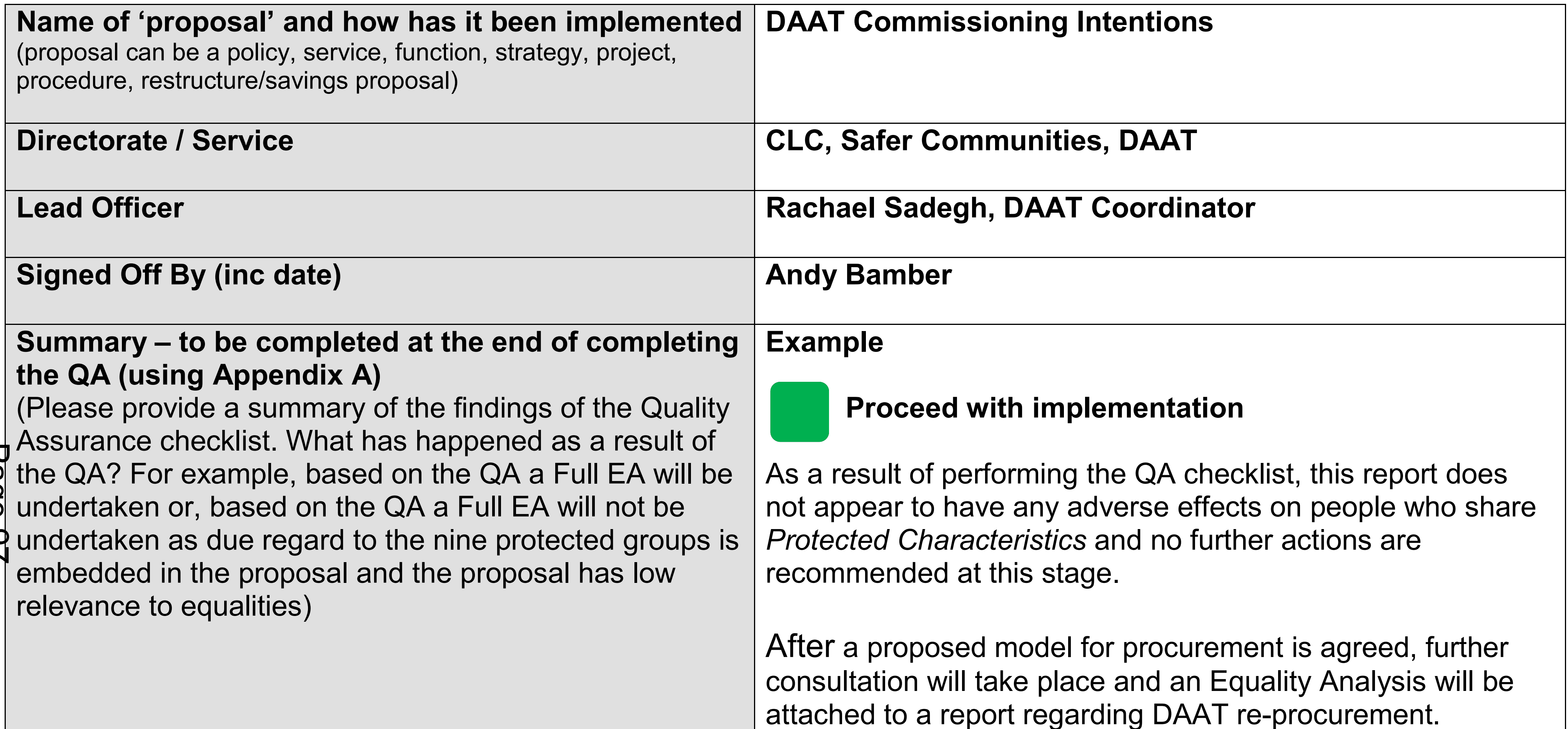
Acknowledgements
In compiling this Needs Assessment we would like to thanks those who have supported us in this work and in particular we would like to acknowledge the support from:

Andy Bamber, Rachael Sadegh, Mark Edmunds, Sarah Khalifeh, Noormuz Zaman, Cliff Askey, Anna Hemmings, Dayo Agunbiade, Alex Verner, Tarlok Boyton-Singh, Gabriella Ndenecho, Nuno Albuquerque, Monica Geraghty, James Parker, Tohel Ahmed, Harun Miah, Paula McGranaghan, Gill Burns, Anna Livingston, Richard Fragley, Chris Lovitt, Elizabeth Hamer, Diane Monk, Abdul Azad, Somen Banerjee, Peter Buchman, Phil Greenwood, George Gallagher, Mandie Wilkinson, Bianca Horn, Amanda Troughton, Penny Louch, Rebecca Pritchard, Peter Bentley, Deborah Moonsammy, Georgina Gilmartin.

We would also like to thank those service users who completed surveys and service provider teams that supported our research. We also would like to thank services users for their involvement in focus groups and staff teams from CDT and SAU for their involvement in PHE Recovery Workshops.

For further information about Drugs and Alcohol Services, please contact the Drugs and Alcohol Action Team (DAAT) on 020 7364 3176

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)	**DAAT Commissioning Intentions**
Directorate / Service	**CLC, Safer Communities, DAAT**
Lead Officer	**Rachael Sadegh, DAAT Coordinator**
Signed Off By (inc date)	**Andy Bamber**
Summary – to be completed at the end of completing the QA (using Appendix A) (Please provide a summary of the findings of the Quality Assurance checklist. What has happened as a result of the QA? For example, based on the QA a Full EA will be undertaken or, based on the QA a Full EA will not be undertaken as due regard to the nine protected groups is embedded in the proposal and the proposal has low relevance to equalities)	**Example** **Proceed with implementation** As a result of performing the QA checklist, this report does not appear to have any adverse effects on people who share *Protected Characteristics* and no further actions are recommended at this stage. After a proposed model for procurement is agreed, further consultation will take place and an Equality Analysis will be attached to a report regarding DAAT re-procurement.

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 report seeks the approval of MAB to endorse the approach set out regarding the re-procurement of all substance misuse treatment provision. The report asks for MAB to consider the recommendation made by the DAAT Board regarding Option 3 and indicate a MAB preferred option.
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 of those affected?	Yes	The report asks for MAB to consider the recommendation made by the DAAT Board regarding Option 3 and indicate a MAB preferred option. The indication of a preferred option will inform the re-procurement process, which will include stakeholder consultation. Further equalities consideration will take place during the development of the re-procurement process.
2	Monitoring / Collecting Evidence / Data and Consultation		
a	Is there reliable qualitative and quantitative data to support claims made about impacts?	N/A	The report asks for MAB to consider the recommendation made by the DAAT Board regarding Option 3 and indicate a MAB preferred option. Further equalities consideration will take place during the development of the re-procurement process.
	Is there sufficient evidence of local/regional/national research that can inform the analysis?	Yes	The service has data on the current service users' equalities data (all 9 protected characteristics). The planned consultation will provide further equalities data of stakeholders.
b	Has a reasonable attempt been made to ensure relevant knowledge and expertise (people, teams and partners) have been involved in the analysis?	Yes	There has been extensive consultation undertaken regarding treatment provision in the Borough with commissioners, providers, service users and other stakeholders. When a proposed model for procurement is agreed, there will be further consultation and equality assessment.
c	Is there clear evidence of consultation with stakeholders and users from groups affected by the proposal?	Yes	When a proposed model for procurement is agreed, there will be further consultation and equality assessment.
3	Assessing Impact and Analysis		
a	Are there clear links between the sources of evidence (information, data etc) and the interpretation of impact	N/A	When a proposed model for procurement is agreed, there will be further consultation and equality assessment.

	amongst the nine protected characteristics?		
b	Is there a clear understanding of the way in which proposals applied in the same way can have unequal impact on different groups?	Yes	The service is aware that a number of groups require the service, in addition to the groups that have been successfully engaged. A more flexible approach, which may be achieved by re-procurement, may respond to the needs of the emerging groups.
4	Mitigation and Improvement Action Plan		
a	Is there an agreed action plan?	N/A	A procurement project timetable is attached to the report (Appendix 2). MAB is requested to note the timescale.
b	Have alternative options been explored	Yes	The report includes 4 options. Option 3 was unanimously recommended by the DAAT Board.
5	Quality Assurance and Monitoring		
a	Are there arrangements in place to review or audit the implementation of the proposal?	Yes	After a proposed model for procurement is agreed, re-procurement will be overseen by competition Board and the DAAT Board. The procurement project timetable (Appendix 2) identifies the re-procurement process.
b	Is it clear how the progress will be monitored to track impact across the protected characteristics??	Yes	A procurement project timetable is attached to the report (Appendix 2).
6	Reporting Outcomes and Action Plan		
a	Does the executive summary contain sufficient information on the key findings arising from the assessment?	N/A	

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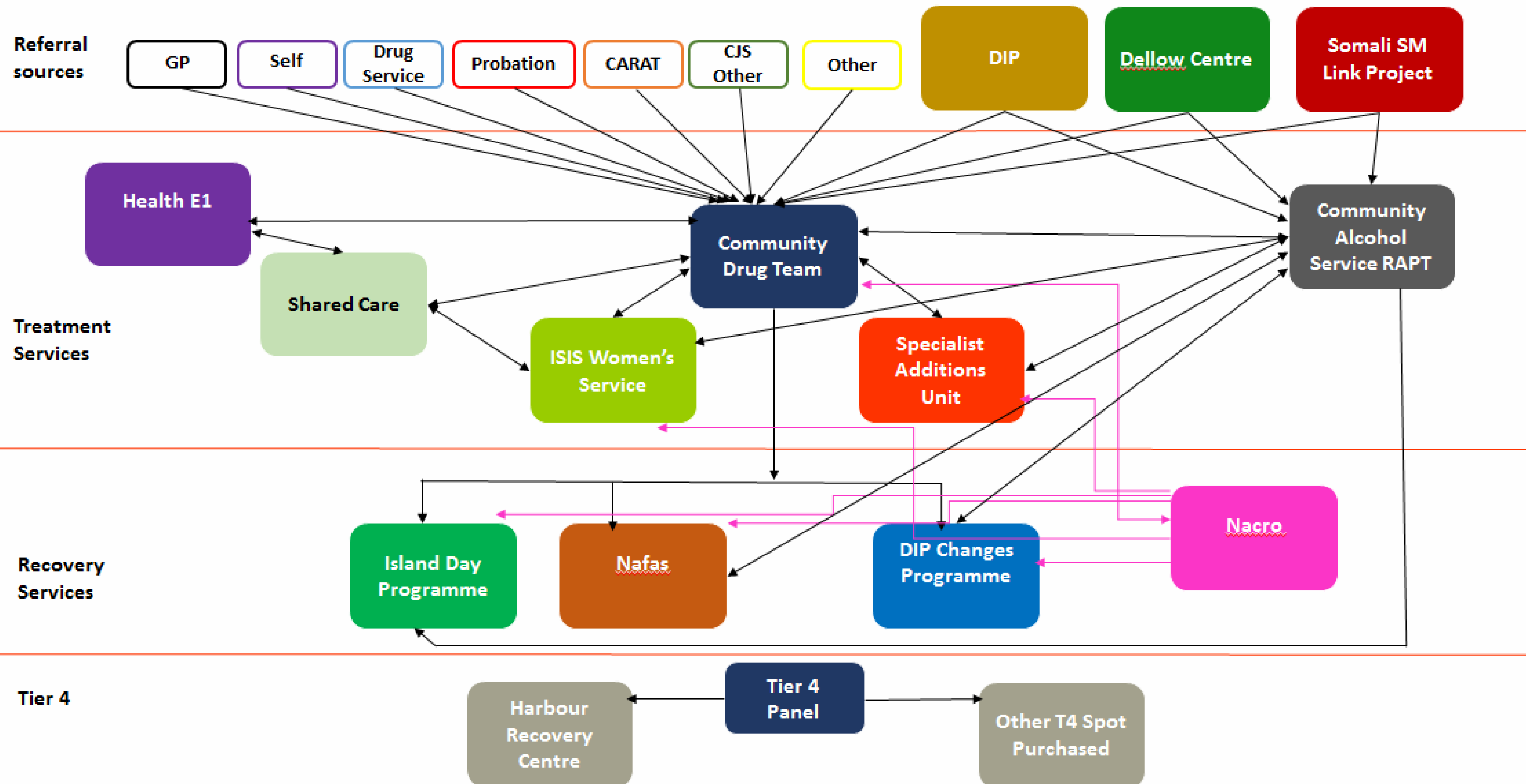
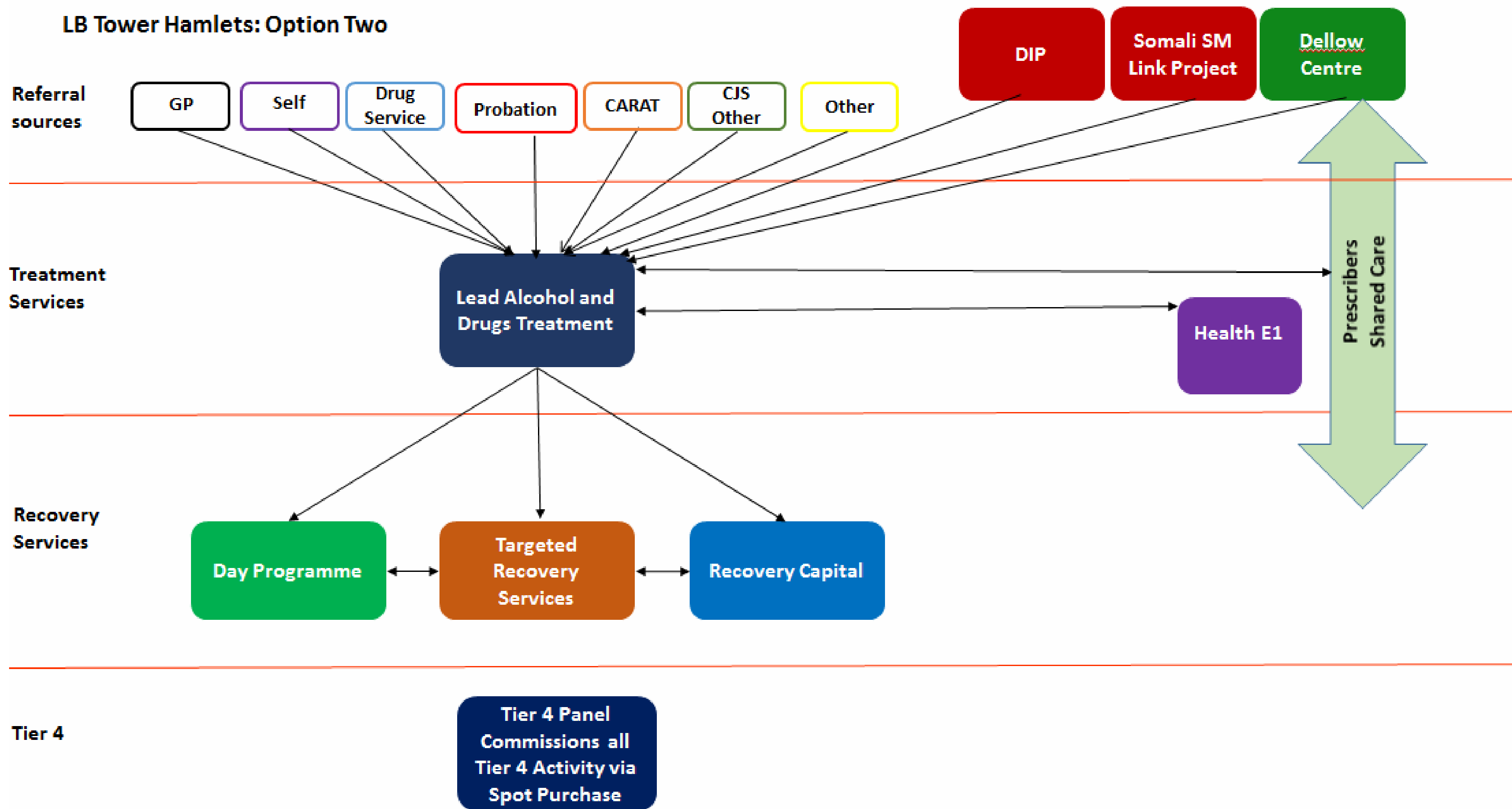
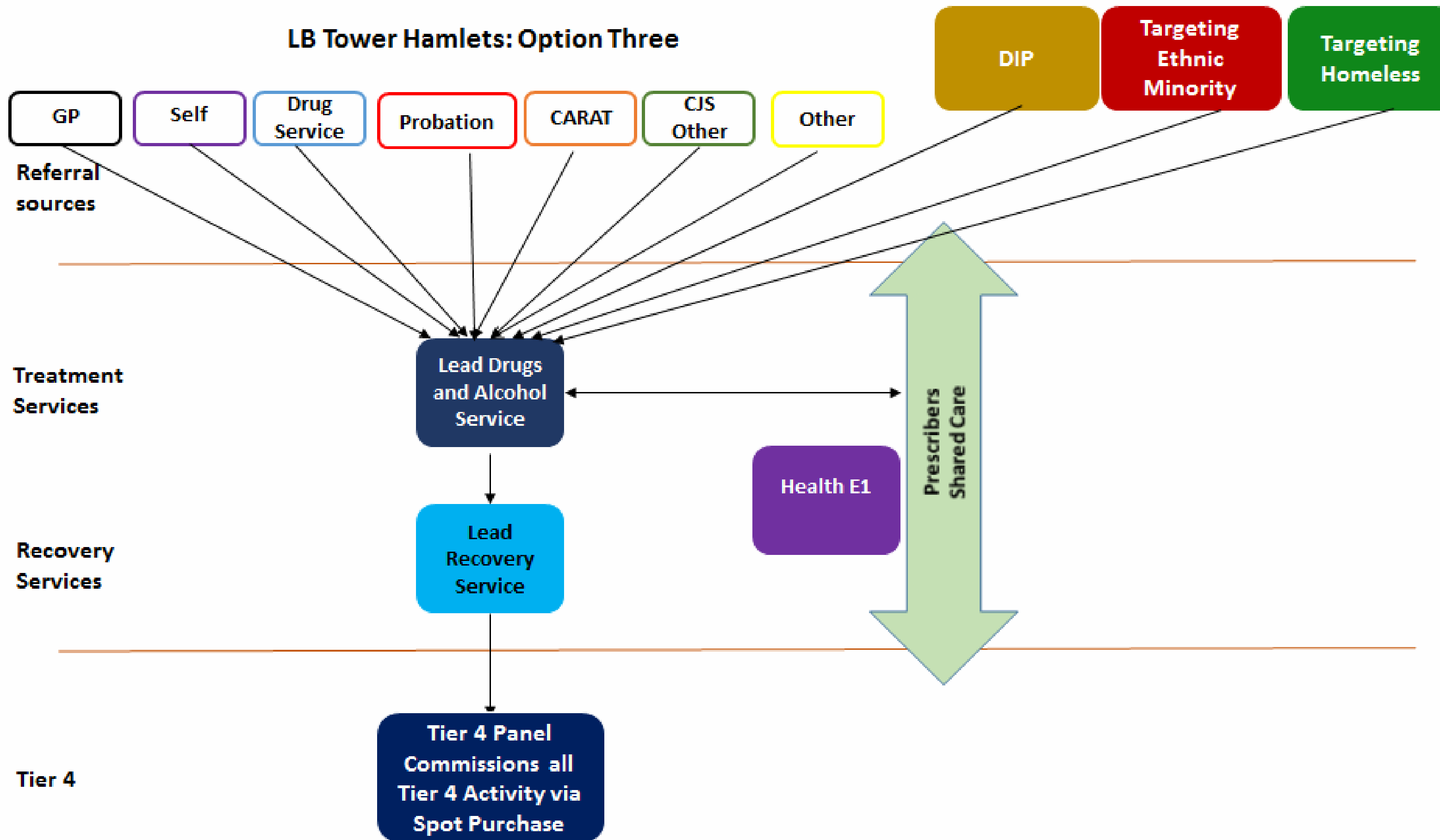
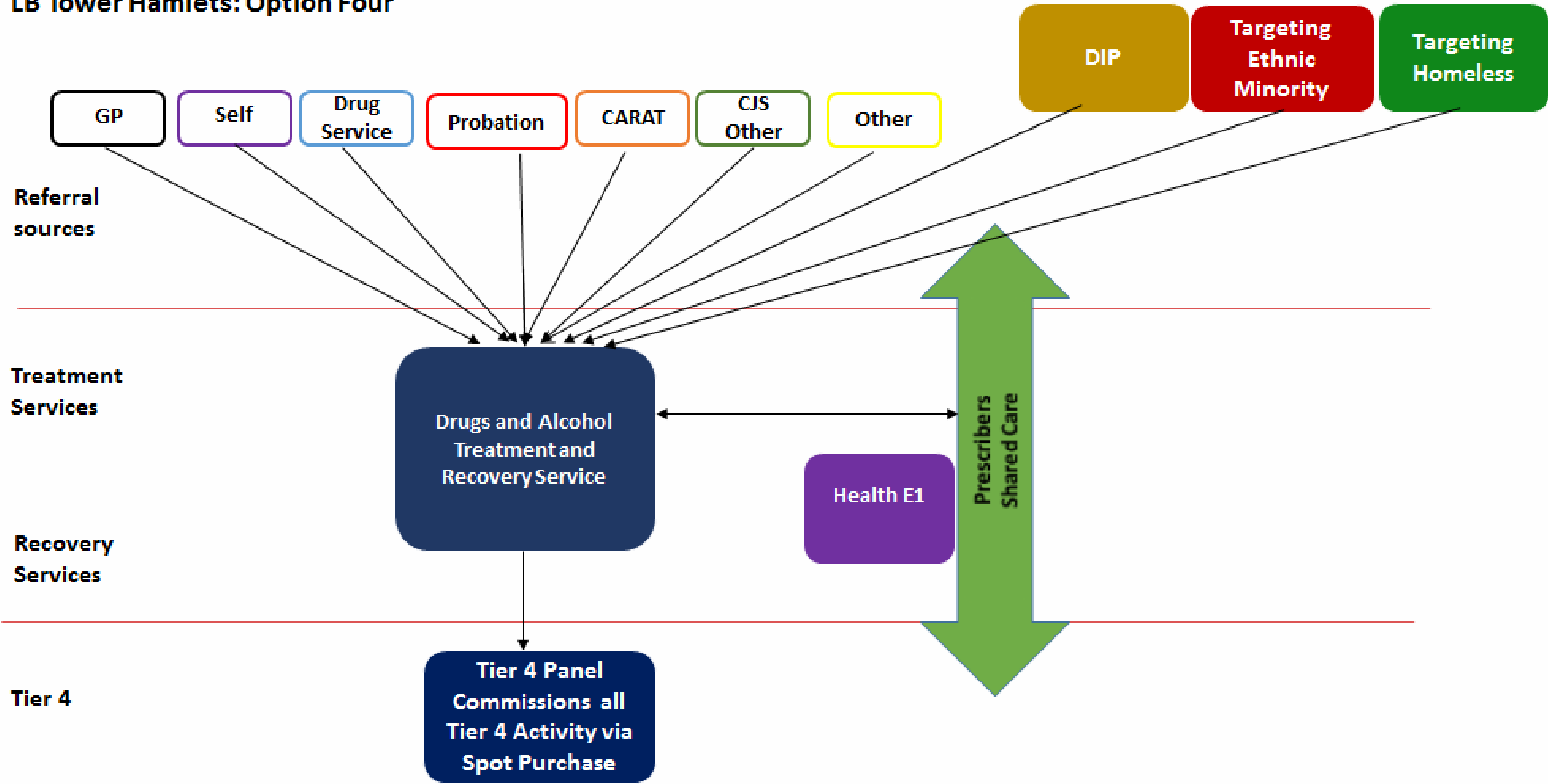
Appendix 2: LBTH DAAT Treatment Service Options (1 to 4)




LB Tower Hamlets: Option Two
Referral sources
GP
Self
Drug Service
Probation
CARAT
CJS Other
Other
DIP
Somali SM Link Project
Dellow Centre
Treatment Services
Lead Alcohol and Drugs Treatment
Health E1
Prescribers Shared Care
Recovery Services
Day Programme
Targeted Recovery Services
Recovery Capital
Tier 4
Tier 4 Panel Commissions all Tier 4 Activity via Spot Purchase


LB Tower Hamlets: Option Three
GP
Self
Drug Service
Probation
CARAT
CJS Other
Other
DIP
Targeting Ethnic Minority
Targeting Homeless
Referral sources
Treatment Services
Lead Drugs and Alcohol Service
Prescribers Shared Care
Health E1
Recovery Services
Lead Recovery Service
Tier 4
Tier 4 Panel Commissions all Tier 4 Activity via Spot Purchase


LB Tower Hamlets: Option Four
GP
Self
Drug Service
Probation
CARAT
CJS Other
Other
DIP
Targeting Ethnic Minority
Targeting Homeless
Referral sources
Treatment Services
Drugs and Alcohol Treatment and Recovery Service
Health E1
Prescribers Shared Care
Recovery Services
Tier 4
Tier 4 Panel Commissions all Tier 4 Activity via Spot Purchase

DAAT Contract Procurement Timetable

Target dates week commencing

KEY MEETING
COMPLETE

Phase task unique identifier	Phase 1:	Work Stream [Theme]	Responsibility	Critical Dates/Decisions	Status	Activity	Lead Officer	20-Jan	27-Jan	03-Feb	10-Feb	17-Feb	24-Feb	03-Mar	10-Mar	17-Mar	24-Mar	31-Mar
1.1	Phase 1: Project initiation	Project Preparation	DAAT/OSM		Complete	**Finalise Needs Assessment**												
1.2	Phase 1: Project initiation	Project Preparation	OSM		Complete	Prepare short presentation (4 slides)												
1.3	Phase 1: Project initiation	Project Preparation	AB/BPH/RS		Complete	Present Needs Assessment to S.Halsey			28/01/2014				25/02/2014					
1.4	Phase 1: Project initiation	Project Preparation	OSM		Complete	Finalise Service Review												
1.5	Phase 1: Project initiation	Project Preparation	OSM/DAAT		Complete	Finalise Options paper section of the service review												
1.6	Phase 1: Project initiation	Project Preparation	DAAT		Complete	**Emergency DAAT Board**												
1.7	Phase 1: Project initiation	Project Preparation	DAAT/OSM		Complete	Options defined												
1.8	Phase 1: Project initiation	Project Preparation	DAAT/OSM		Complete	Cost impact of options												
1.9	Phase 1: Project initiation	Project Preparation	AB/BPH/RS		Complete	Present Needs Assessment to Lead Members												
1.10	Phase 1: Project initiation	Project Preparation	DAAT		Complete	Disseminate Needs Assessment												
1.11	Phase 1: Project initiation	Project Preparation	OSM/DAAT		Complete	Options Appraisal										Draft 1		
1.12		Project Preparation	OSM/DAAT		Complete	Outline re-procured treatment structures												

	Phase	Work Stream [Theme]	Responsibility	Critical Dates/Decisions	Status	Activity	Lead Officer	07-Apr	14-Apr	21-Apr	28-Apr	05-May	12-May	19-May	26-May
1.13	Phase 1: Project initiation	Project Administration	DAAT			**Emergency DAAT Board**		**08.04.14**							
1.14	Phase 1: Project initiation	Project Administration				Establish Project Board and Project Working Groups									
1.15	Phase 1: Project initiation	Project Administration				Agree Project Delivery Team									
1.16	Phase 1: Project initiation	Project Administration				Establish Meeting dates for Relevant Boards and Team Meetings									
2.1	Phase 2: Project planning	Procurement	OSM/DAAT			Outline service procurement priorities									
2.2	Phase 2: Project planning	Project Consultation				Develop Engagement Plan	NZ								
2.3	Phase 2: Project planning	Project Consultation	DAAT			Provider & Service user Consultation on preferred model	NZ								
2.4	Phase 2: Project planning	Service Premises				Review Treatment Services' Premises Contracts to establish premises strategy & termination notice period required, if necessary & identification of new Service locations									
2.5	Phase 2: Project planning & development	Service Premises				Identify other premises if required									
2.6	Phase 2: Project planning & development	IT				Agree suitable local Service data system and reporting requirements									
2.7	Phase 2: Project planning & development	Contract Development				Agree Contract and specification content requirements									
2.8	Phase 2: Project planning & development	Contract Development	DAAT			Develop Financial Frameworks within agreed budget									
2.9	Phase 2: Project planning & development	Project Administration				Establish project delivery budget & identify financial risks									
2.10	Phase 2: Project planning & development	Contract Development	DAAT			Finalise procurement packages									
2.11	Phase 2: Project planning & development	Contract Development				> Finalise Treatment Option Packages									
2.12	Phase 2: Project planning & development	Contract Development				> Finalise Tier 4 Arrangements									
2.13	Phase 2: Project planning & development	Contract Development				> Finalise Share Care Model									
2.14	Phase 2: Project planning & development	Contract Development	Legal/DAAT			Legal Tests									
2.15	Phase 2: Project planning & development	Contract Development	Pro/DAAT			Procurement Tests									
2.16	Phase 2: Project planning & development														
2.17	Phase 2: Project planning & development	n/a				Purdah									Election
2.18	Phase 2: Project planning & development														
2.19	Phase 2: Project planning & development	Contract Development	DAAT/OSM			Draft Specifications									
2.20	Phase 2: Project planning & development	Contract Development				Develop Method Statements									
2.21	Phase 2: Project planning & development	Contract Development				Develop Performance Monitoring & Reporting Requirements									
2.22	Phase 2: Project planning & development	Contract Development	DAAT/L/P			Verify Specifications and Draft T&C with Legal and Procurement									
2.23	Phase 2: Project planning & development	Project Reporting	DAAT			> Draft report to CMT/DMT/MAB/PAP/Cabinet									
2.24	Phase 2: Project planning & development	Project Reporting				> Draft EqIA for attachment									
2.25	Phase 2: Project planning & development	Project Reporting				>Report to Andy for Clearance						07.05.14			
2.26	Phase 2: Project planning & development	Project Reporting				> Report to DMT Clerk [Publication]							12.05.14		
2.27	Phase 2: Project planning & development	Project Reporting	DAAT			**DMT: DAAT Commissioning Intentions**							**15.05.14 M**		
2.28	Phase 2: Project planning & development	Project Reporting				> Report to Robin							15.05.14		
2.29	Phase 2: Project planning & development	Project Reporting				> Report to HoPS [Publication]							n/a		
2.30	Phase 2: Project planning & development	Project Reporting	DAAT			**CMT: DAAT Commissioning Intentions**									**27.05.14 M**

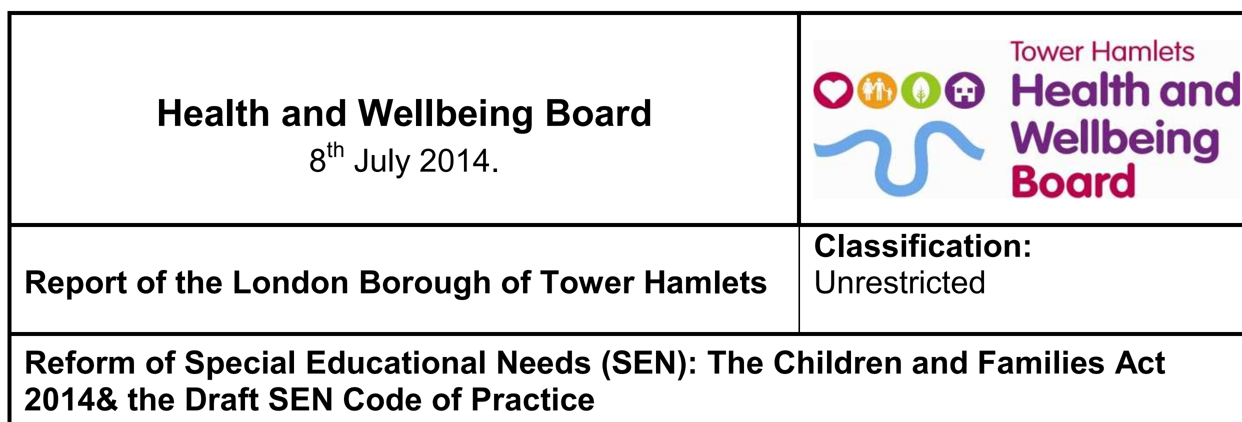
	Phase	Work Stream [Theme]	Responsibility	Critical Dates/Decisions	Status	Activity	Lead Officer	02-Jun	09-Jun	16-Jun	23-Jun	30-Jun	07-Jul	14-Jul	21-Jul	
2.31	Phase 2: Project planning & development	Project Consultation				> Consultation Published										
2.32	Phase 2: Project planning & development	Project Consultation				> Formal Consultation Period [21 Days]										
2.33	Phase 2: Project planning & development	Project Consultation				> Draft Results										
2.34	Phase 2: Project planning & development	Contract Development				Revisions to Model following formal consultation										
2.35	Phase 2: Project planning & development	Project Consultation	DAAT/OSM			Consultation on Model Complete										
2.36	Phase 2: Project planning & development	Project Procurement				Proceed to Procurement Phase										
2.37	Phase 2: Project planning & development	Project Reporting				**Competition Board [Runs alongside Cabinet approval process]**										
2.38	Phase 2: Project planning & development	Project Procurement	DAAT			Tender Advert and Paperwork Drafted										
2.39	Phase 2: Project planning & development	Project Reporting	DAAT			Papers prepared for Competitions Planning Forum and Board				16.06.14						
2.40	Phase 2: Project planning & development	Project Reporting				Complete tollage 1 form for sign off by Competition Board										
2.41	Phase 2: Project planning & development	Project Procurement				Tender & PQQ Panels Established										
2.42	Phase 2: Project planning & development	Project Procurement				Develop Evaluation Criteria & Scoring Matrix for PQQ										
2.43	Phase 2: Project planning & development	Project Procurement				Advertise Intention to Tender with relevant Materials & PQQ										
2.44	Phase 2: Project planning & development	Project Procurement				Develop Consortium Guidelines										
2.45	Phase 2: Project planning & development	Project Reporting	DAAT			**Competition Planning Forum (TG1)**					23.06.14					?
2.46	Phase 2: Project planning & development	Project Reporting	DAAT			**Strategic Competition Board (TG1) - INDEPENDENT DATE FROM CABINET**							**07.07.14**			
2.47	Phase 2: Project planning & development	Project Reporting	DAAT			**Cabinet Approval Process**										
2.48	Phase 2: Project planning & development	Project Reporting	DAAT			>Report to Andy/Robin/Steve Adams		[22.05.14]								
2.49	Phase 2: Project planning & development	Project Reporting	DAAT			>Report Deadline to CFO & Legal		02.06.14								
2.50	Phase 2: Project planning & development	Project Reporting	DAAT			>Report Deadline to HoPS										
2.51	Phase 2: Project planning & development	Project Reporting	DAAT			>Report Deadline for Publication			12-13.06.14							
2.52	Phase 2: Project planning & development	Project Reporting	DAAT			**MAB: Commissioning Intentions**				**18.06.14 M**						
2.53	Phase 2: Project planning & development	Project Reporting	DAAT			>Report to Andy/Robin/Steve Adams		05.06.14								
2.54	Phase 2: Project planning & development	Project Reporting	DAAT			>Report Deadline to CFO & Legal				16.06.14						
2.55	Phase 2: Project planning & development	Project Reporting	DAAT			>Report Deadline to HoPS				19-20.06.14						
2.56	Phase 2: Project planning & development	Project Reporting	DAAT			>Report Deadline for Publication					26-27.06.14					
2.57	Phase 2: Project planning & development	Project Reporting	DAAT			**PAP MEETING 2 July 14**						**02.07.14**				
2.58	Phase 2: Project planning & development	Project Reporting	DAAT			**Health & Wellbeing Board: 8 July 14: Commissioning Intentions**							**08.07.14**			
2.59	Phase 2: Project planning & development	Project Reporting	DAAT			**Cabinet: Commissioning Intentions**							10.07.14 [Deadline: Report]		**23.07.14**	CRITICAL DATE [To allow post activities to

	Phase	Work Stream [Theme]	Responsibility	Critical Dates/Decisions	Status	Activity	Lead Officer	28-Jul	04-Aug	11-Aug	18-Aug	25-Aug	01-Sep	08-Sep	15-Sep	22-Sep	29-Sep	06-Oct
3.1	Phase 3: Tender & procurement Process	Project Procurement	DAAT			Advert Placed (all packages)	DAAT											
3.2	Phase 3: Tender & procurement Process	Project Procurement	DAAT			Tendering period (P1 PQQ)	DAAT											
3.3	Phase 3: Tender & procurement Process	Project Procurement	DAAT			Tendering period (P2 Full tender)	DAAT											
3.4	Phase 3: Tender & procurement Process	Project Procurement	DAAT/L/P			Tender evaluation	DAAT/L/P											
3.5	Phase 3: Tender & procurement Process	Project Procurement				Panel Tender Approval & Contract Award Recommendation												
3.6	Phase 3: Tender & procurement Process	Project Reporting	DAAT			Draft Tollgate 2 form in preparation for Competition Planning Board												
3.7	Phase 3: Tender & procurement Process	Project Consultation	DAAT/L/P			Interviews/contract assessment meetings/Inc service user engagement	DAAT/L/P											
3.8	Phase 3: Tender & procurement Process	Project Procurement	DAAT/L/P			Negotiation	DAAT/L/P											

	Phase	Work Stream [Theme]	Responsibility	Critical Dates/Decisions	Status	Activity	Lead Officer	20-Oct	27-Oct	03-Nov	10-Nov	17-Nov	24-Nov	01-Dec	08-Dec	15-Dec	22-Dec	29-Dec	19-Jan	
4.1	Phase 4: Contract Award & Mobilisation	Project Reporting	DAAT			Mayor and lead member updated	DAAT													
4.2	Phase 4: Contract Award & Mobilisation	Project Reporting	DAAT			**Competition Planning Forum (TG2)**	DAAT		27/10/2014											
4.3	Phase 4: Contract Award & Mobilisation	Project Reporting	DAAT			**Strategic Competition Board (TG2)**	DAAT				10/11/2014									
4.4	Phase 4: Contract Award & Mobilisation	Project Reporting	DAAT			**DMT: Decision Report: approval to move forward**	DAAT	16.10.14	30.10.14											
4.5	Phase 4: Contract Award & Mobilisation	Project Reporting	DAAT			**CMT: Decision Report: approval to move forward**	DAAT		28.10.14	11.11.14										
4.6	Phase 4: Contract Award & Mobilisation	Project Reporting	DAAT			**MAB: Decision Report: approval to move forward**						19.11.2014								
4.7	Phase 4: Contract Award & Mobilisation	Project Reporting	DAAT			**Cabinet: Decision Report: approval to move forward**												07/01/2015		
4.8	Phase 4: Contract Award & Mobilisation	Project Procurement				Stand Still / Call in														
4.9	Phase 4: Contract Award & Mobilisation	Project Procurement	DAAT/L/P			Contract Award	DAAT/L/P													
4.10	Phase 4: Contract Award & Mobilisation	Project Procurement	Providers			Mobilisation date set	Providers													Feb
4.11	Phase 4: Contract Award & Mobilisation	Project Procurement	DAAT/Providers			Contract commencement	DAAT/Providers													April

Other associated activities

	Work stream IT	Phase 5	Responsibility	Critical Dates/Decisions	Status	Activity	Lead Officer
5.1						Agree Service Data Requirement & Systems	
5.2						Ensure premises is IT Ready	
5.3						Service Data Transfer	
	Work stream HR	**Phase 6**	**Responsibility**	**Critical Dates/Decisions**	**Status**	**Activity**	**Lead Officer**
6.1						TUPE Process Initiated	
6.2						TUPE Arrangements Finalised	
	Work stream Communication & Marketing	**Phase 7**	**Responsibility**	**Critical Dates/Decisions**	**Status**	**Activity**	**Lead Officer**
7.1						Develop Communication Strategy	
7.2						Agree Treatment Service Branding	
7.3						Develop Launch Strategy	



Health and Wellbeing Board 8th July 2014.	Tower Hamlets Health and Wellbeing Board
Report of the London Borough of Tower Hamlets	**Classification:** Unrestricted
Reform of Special Educational Needs (SEN): The Children and Families Act 2014& the Draft SEN Code of Practice	

Lead Officer	Robert.McCulloch-Graham ESCW Corporate Director
Contact Officers	David Carroll SEN & Inclusion Lead Principal Educational Psychologist
Executive Key Decision?	No

Executive Summary

This report outlines the changes required in practice and development of new systems because of the reform to Special Educational Needs legislation. The project board overseeing the change programme is consulting with key stakeholders from health education social care the voluntary sector and in particular parents at each stage of development.

There are three distinctive area of development that LA parent representatives and its partners are undertaking.

1. Agreeing Joint Commissioning Arrangements with the CCG through a work plan that looks at integrated commissioning.

2. Defining designing and promoting the Local Offer in partnership in particular with parent representatives

3. Transforming the way services are delivered so that parents' experiences are qualitatively different and specialist teams across all agencies and schools deliver assessments and interventions through the SEN system which is person centred and outcomes focussed.

Recommendations:

The Health and Wellbeing Board is recommended to:

1. Support the work of the project board and the plans to ensure that the Local Offer is underpinned by local authority and clinical commissioning group agreeing on local provision in line with the priorities of this Health & Wellbeing

Board.

2. Support the implementation of the SEN Reforms by promoting the greater responsibilities on non-education services to participate.

3. Support the Joint Commissioning Plans between the Council and the CCG to secure and review the wide range of provision made across all agencies to meet the needs of children and young people with SEN.

1. REASONS FOR THE DECISIONS

1.1 The new statutory SEN framework which come into force in September 2014 includes a duty on local Health and Well Being Boards to have oversight of arrangements to implement changes.

2. ALTERNATIVE OPTIONS

2.1 The HWBB board may decide that another approach to implementing the SEN reforms is needed.

3. DETAILS OF REPORT

3.1 The scope of the Act
The Act covers a wide range of areas listed below; however the vast majority of the Act's clauses refer to SEN changes and developments:

- Adoption
- Family Justice
- SEN
- Childminder Agencies
- Children's Commissioner
- Statutory Rights to Leave & Pay
- Time off Work
- Rights to request Flexible Working

3.2 This paper sets out to provide the board with:

- An outline of the key SEN changes to be introduced by the Children and Families Act, the new SEN code of Practice and the timescales for introducing phased changes
- A broad outline of key areas for development that the LA is making in partnership with other stakeholders
- An assessment of what might be the implications for the LA as it implements changes
- A set of recommendations showing how the stage of developments might be taken forward

3.3 What's different to the present SEN system?
The approach; the child or young person is at the centre of the assessment of need and the Single Plan. All professionals working together carry out their role in a way which reflects the learning and culture of person planning approaches. Parents and carers have an active partnership role in identifying, developing and evaluating the support plan. Parents can have an increased choice through access to a personal budget. There is transparency and openness in regard to all parts of the process. Plans are outcome focussed with clear and accountable resource allocations.

3.4 To implement this different way of working and relating to children young people (CYP) and their families it will require a change in culture and behaviour of staff both within the Local Authority and amongst key partners especially in health. They will need to relate differently to services users, sharing power and information with them. Staff will need to develop and use new skills to engage with families so that the Single Plan is owned by the service user.

3.5 The Transformation Journey
In March 2011 the Government published its Green Paper Support and Aspiration - A new approach to special educational needs and disability which set out a vision for children with SEN.The principles outlined in the Green Paper have been reiterated with every subsequent publication.

3.6 In September 2011, 31 LAs combined with their local PCTs to work together on 20 SEN Pathfinder projects funded by the DFE. There common objectiveshave been to deliver a new system that adheres to the Green Paper's vision.

3.7 These projects were originally expected to finish in April 2013 and provide direction for future legislation. All projects have been extended until August 2014 with 10 selected as Champions to support developments with other LAs. The SEN Champions programme will now extend into 2015.

3.8 September 2012 draft legislation on reform of provision for children and young people with SEN was published. It confirmed the intention for changes in seven key areas;

- Streamlined assessment process, which integrates education, health and care services, and involves children and young people and their parents.

- New 0-25 Education, Health and Care Plan, replacing Statements and Learning Difficulty Assessments, which reflects the child or young person's aspirations for the future, as well as current needs.

- New requirement for LA, health and care services to commission services jointly re meeting the needs of CYP with SEN & disabilities.

- LAs to publish a clear, transparent 'local offer' of services for all CYP with additional needs, so parents can understand what is available.

- New statutory protections for young people aged 16-25 in FE and a stronger focus on preparing for adulthood.

- Offer of a personal budget for families and young people with a Plan, extending choice and control over their support.

- Academies, Free Schools, Further Education and Sixth Form colleges to have the same SEN duties as maintained schools

3.9 December 2012 Education Select Committee published its report 'Education Committee - Sixth Report Pre-legislative scrutiny: Special Educational Needs.' Most prominent of the committees conclusions were that the forthcoming regulations commit Health providers to specific timetables when conducting SEN assessments and that responsibilities for Health and Local Authorities in providing certain therapy services are substantially clarified. They also called for all current protections afforded by a Statement of SEN to be maintained in the new legislation and for a more coherent means of appeal/redress for parents dealing with a variety of agencies in Health and Education.

3.10 Early 2013 the revised Bill was introduced into Parliament. In October the DFE published its consultation documents on a draft for the new 0 to 25 SEN Code of Practice which will become statutory guidance from September 2014. They also consulted on associated draft regulations. The consultation closed 9th December 2013. The Act received Royal Assent this Spring(and subject to Parliamentary process) the new SEN Code of Practice will also be in use from September 2014 when the reforms go live.

3.11 The main elements of the draft SEN Code of Practice
The draft Code has seven chapters some of which build upon the present arrangements and practice albeit with the expectation of changes in how the process is delivered and experienced by families and introducing new responsibilities and requirements. The definitions are clear this will be a statutory process including Education/Health/Care assessments but child must be shown to firstly have Special Educational Needs. The definition of SEN remains exactly as in the current Code of Practice. It defines disability as when a child or person has a physical or mental impairment which has a substantial and long term adverse effect on their ability to carry out normal day to day activities. So a child may be disabled and not have SEN, a child may have SEN and not be disabled and a child with significant care needs (requiring high levels of intervention) may or may not have SEN.

3.12 The new system
The Code sets out how the new systems must have children & young people to be at the heart of the system. There must be close co-operation between all of the services that support children & families. The system must be built on the early identification of children and young people with SEN. It must be clear & easy to understand and include Local Offers of education, health & social care services. For the most complex needs, a co-ordinated assessment and 0-25 EHC Plan will be necessary. The EHC Plan must have a clear focus on outcomes anticipating the support the child or young person may need for a clear pathway through education to adulthood, paid employment and independent living. The system must increase choice, opportunity & control

for parents and young people and the offer of a personal budget for those with an EHC plan.

3.13 Parental Involvement

The Code expects parents children and young people to be more actively engaged in both the system and how assessments and decisions take place that affect them. Local Authorities will be given some additional duties and expected to redesign if necessary their systems so that parental engagement is at the heart of how SEN delivers services.

3.14 Some of the specific ways in which Local Authorities must ensure parental involvements have already been identified these include:

- Planning and reviewing the Local Offer
- Reviewing special educational and social care provision
- Drawing up individual EHC plans, in reviews and reassessments
- Person centred approaches adopted universally
- Tailoring support and personal budgets around the person's plan

3.15 The Local Offer

The Children and Families Act and SEN Code introduce a new concept of the Local Offer. Local authorities must publish, in one place, information about provision they expect to be available in their area for children and young people from 0-25 who have SEN. The Local Offer must be underpinned by local authorities and clinical commissioning groups agreeing on local provision & the priorities of the local Health & Wellbeing boards. Children, young people & families should be involved by local authorities in:

- Planning the content
- Deciding how to publish the local offer
- Providing feedback on services in the local offer

The Local Offer should have 2 key purposes:

1. To provide clear, comprehensive information about support and opportunities available

2. To make provision more responsive to local needs and aspirations by directly involving children & YP with SEN and parents & carers in its development

The Local Offer should be constructed so that it is engaging, accessible, transparent and comprehensive. It must include:

- Education, health and care provision for children & YP with SEN,
- Arrangements for identifying and assessing children & YP with SEN.
- Other education provision (outside schools & colleges)
- Training provision including apprenticeships
- Arrangements for travel to and from schools, post 16 provision and early years providers

- Support for children and young people moving between phases
- Supported preparation for adulthood including preparation for employment, independent living & community participation
- Information, advice & support from the LA about support for families with children with SEN
- Information about making complaints and being supported in conflict resolution

3.16 Settings Early Years/Schools/Colleges
This Code builds on recent changes especially in relation to the Ofsted inspection framework for schools and the new funding arrangements for schools which were implemented in April 2013. Improving outcomes for all and setting high expectations for children and young people with SEN and all teachers are teachers of children with SEN are two cornerstones upon which good practice is based in schools. This section reiterates that the majority of children with SEN should have the choice of being included in mainstream education and the majority will be seen as having Additional Educational Needs (AEN) and be supported from within the school's own delegated resources. As is the case now a minority will have a specialist assessment and be provided through an Education Health & Care Plan.

3.17 Assessments that lead to Education Health & Care Plans
Statutory assessments of education, health and care needs will take place for those few children and young people with complex SEN. Most (but not all) will then lead to an Education, Health & Care Plan (EHC). Timescales for the whole process will be reduced to a maximum of 20 working weeks (currently it is 26 weeks). There are time scales for elements throughout the process. There are no requirements for national reporting on separate aspects but if not met parents and carers have the right to complain. Therefore our systems must be able to track progress in the same manner that operates for the present SEN IT work flow.

3.18 The Code proposes giving the right to professionals from outside of education in partnership with parents to request an assessment. It also intends to allow young adultswho are competent to make such requests themselves too. However the criteria the LA must consider when deciding whether an assessment is necessary is similar to the present Code with the addition of considering the circumstances for a young person of 18 years + and whether staying in education would help them make a successful transition into adult life.

3.19 The Code proposes that LA must seek advice for an EHC assessment from the same range of services as currently however it puts greater responsibilities on non-education services to participate.

3.20 For young people aged 16-25 the Code states that they may request an assessment. It acknowledges that some may not need this as it is not in their interest to continue their education. It also makes clear that some young adults with complex needs which are primarily health or social care may not

need an EHC assessment and are best provided by continuing Adult Health or Social Care provision.

3.21 Reference is also made to transport and personal budgets. Transport should only be included in the EHC plan in those exceptional cases where the child has specific transport needs as LAs will have transport polices applying to all children with SEN and should not be used to limit parental choice of school. Transport costs may be provided as part of a personalised budget.

3.22 A personal budget is the amount of money identified by each commissioner to deliver all or some of the provisions set out in the EHC plan covering health, care and educational provision. Parents & YP can request a personal budget once an EHC plan is established. Personal budgets may include funding from health, social care and education sources either pooled generally or case specific.

3.23 A personal social care budget:
This refers to the budget that will be made available if it is clear that a young person or child is assessed as needing additional and individual support at home and when out and about in the local and wider community.

3.24 A personal health budget:
This refers to the budget that will be made available should a young person or child have complex, long-term and/or a life-limiting condition/s. A personal health budget may also be made available to help with equipment costs or other health services. Children, who are supported through 'Continuing Care' funding, will have the right to request a personal health budget from April 2014. From August 2013, the NHS has the legal power to give direct payments.

3.25 A personal SEN budget:
This is a sum of money made available by a local authority because it is clear that without this additional (*top-up*) funding it will not be possible to meet the child's learning support needs. The school/college involved will already have funding for learning support across the school; only pupils or students with more complex learning support needs are likely to need a personal SEN budget. In some circumstances the head teacher/principal and school or college/learning provider may choose to offer some funding towards a personal SEN budget; this will always be the decision of the head teacher.Personal budgets must not be used to fund a school place.

3.26 Resolving Disputes
The emphasis is on early resolution. The LA & CCG are expected to work together to resolve disputes. At the moment when this fails parents or young people can appeal to SEND Tribunals. In future there is a possibility that CYP or their families could appeal against **health offers or provisions to SEND Tribunals**. It will also be mandatory for the LA to make an offer of independent mediation which it must commission from Disagreement resolution services (DRS). The LA must make sure the service and the way it

works available to parents, operatives are suitably qualified and aware of the SEN process.

3.24 At present the national frameworks mean Health Education and Social Care appeals systems are separate. Where they relate to SEN they are likely to be aligned so that wherever possible they are simpler and clearer for families.

3.26 Joint Commissioning
Local governance arrangements **must** be established which ensure clear ownership and accountability across SEN commissioning. They **must** be robust enough to ensure that all partners are clear about who is responsible for delivering what, who the decision makers are in education, health and social care, and how partners will hold each other to account in the event of a dispute. It is important for elected members and chief executives across education, health and social care to demonstrate leadership for integrated working. Arrangements for children and young people with SEN should be specifically accountable to councillors and senior commissioners. It should be clear who can make decisions both operationally (e.g. deciding what provision should be put in an EHC plan) and strategically (e.g. what provision will be commissioned locally, exercising statutory duties).

3.27 While the details of which services should be commissioned should be agreed locally, the local authority and its partner CCGs **must** make arrangements for agreeing key issues outline above. These include;

The range of provision reasonably required by local children and young people with SEN;

- How provision will be secured and by whom; what advice and information is to be provided about provision and by whom and to whom it is to be provided;
- How complaints about education, health and social care provision can be made and are dealt with; and
- Procedures for ensuring that disputes between local authorities and CCGs are resolved as quickly as possible.
- Partners should also consider how they will respond to children and young people who need to access services swiftly.

3.28 Joint commissioning arrangements **must** include all education, health and care provision which has been assessed as being needed to support children and young people with SEN in the area. The services covered will include specialist support and therapies, such as clinical treatments and delivery of medications, speech and language therapy, occupational therapy, physiotherapy, a range of nursing support, specialist equipment, wheelchairs and continence supplies. They could include highly specialist services needed by only a small number of children which are commissioned centrally by NHS England (for example augmentative and alternative communication systems, or provision for young offenders in the secure estate). They can also include provision delivered by the private or voluntary sectors: voluntary organisations

often offer services which are more responsive and locally acceptable to the people who use them. CCGs must work with their local authority partners to ensure that the right services are in place locally to meet the needs of the population. These services will be included in the local offer.

3.29 For social care, services will include any support assessed as being reasonably required by the learning difficulties and disabilities which result in the child or young person having special educational needs. This can include any services assessed under an early help assessment and/ or under section 17 or section 47 of the Children Act 1989 or assessments under adult care provisions. It can also include services for parents and carers which will support the child's outcomes such as mental health support.

4. COMMENTS OF THE CHIEF FINANCE OFFICER

4.1 The SEN Reforms will have resource implications, much of which will involve reprioritising available resources. The Department for Education has, however, acknowledged that there will be implementation costs and to assist with those costs, they have provided a one-off grant in 2014/14 of £0.579m, which can be used to recognise the programmes of change underway in SEN or to best meet local need.

4.2 The project board will identify any on-going implications of reforms. Most of the direct costs of providing support for pupils with Special Educational Needs are funded from the Schools Budget (Dedicated Schools Grant). The new ways of working would be factored into budget and service planning cycles for the Schools Budget and Authority's General Fund budget (i.e. as part of the Medium Term Financial Plan) for future years.

5. LEGALCOMMENTS

5.1 The Children and Families Act 2014 replaces the existing SEN legislation. A new SEN Code of Practice together with a number of statutory Regulations will also be introduced to support the legislative changes. The report outlines the changes required in practice and development of new systems in order to implement the changes, including joint commissioning. Though it should be noted that many of the provisions replicate the current system implementation of the proposed changes will commence from September 2014 with a transitional programme of implementation dates. As the Children and Families Bill was scrutinisedthere may be some changes to the numbering of sections referred to below.

5.2 Part 3 of the Bill introduces a new single system from birth to 25 for all children and young people with SEN and their families. The new arrangements combine the current separate arrangements for children in schools and young people in post-16 institutions and training up to the age of 25 and provides for an integrated Education, Health and Care (EHC) Plan to replace the statement of Special Educational Needs (SEN). The Bill also

removes the separate treatment of local authority maintained schools and academies under SEN legislation.

5.3 The Bill retains the central role of the local authority in identifying, assessing, and securing the educational provision for children and young people with SEN. Under section 19 the local authority must follow four guiding principles.

These are that the local authority must:

- Listen to the views, wishes and feelings of children, young people and parents;
- Ensure children, young people and parents participate in decision-making;
- Provide the necessary information and support to help children, young people and their parents participate in those decisions; and
- Support children, young people and parents to help children and young people can achieve the best possible educational and other outcomes preparing them effectively for adulthood.

5.4 The Bill introduces a new requirement for local authorities and health services to commission education, health and social care services jointly. This includes arrangements for considering and agreeing what advice and information is to be provided about education, health and care provision, and by whom, to whom and how such advice and information is to be provided.Clinical Commissioning Groups (CCGs) must comply with the health service requirements in EHC plans.

5.5 The current definitions of SEN and special educational provision are broadly retained and extended to include young persons in education or training under the age of 25 (s.20). A child or young person has special educational needs if he or she has a learning difficulty or disability which calls for special educational provision to be made for him or her. Under what is currently section 21 of the Bill health and social care provision which educates or trains a child or young person is to be treated as special educational provision. Children with disabilities are not included automatically in the definition of special educational needs although they may also have SEN (see s.37).

5.6 A local authority must exercise its functions with a view to securing that it identifies all children and young people in its area who have or may have SEN or a disability (s.22), and is “responsible” for them when the authority has identified them or they have been brought to the authority’s attention by a health service body if below compulsory school age (s.23). A local authority is responsible for all children or young person who it has identified as having SEN, or have been brought to the local authority’s attention as may be having special educational needs (s.24).

5.7 The local authority must work with health and social care services to ensure 'the integration of educational provision and training provision' where this promotes the well-being of children with SEN or a disability and improves the quality of special educational provision for them (s.25). The local authority and its partner commissioning bodies (the local CCGs and where relevant the NHS Commissioning Board) must make joint commissioning arrangements about education, health and care provision to be secured for children and young people with special educational needs and those who have a disability (s.26).

5.8 Joint Commissioning Arrangements 'must include arrangements for considering and agreeing' (although there is no duty to agree) EHC provision 'reasonably required' by the learning difficulties and disabilities of children and young people having SEN. Joint Commissioning Arrangements must include the EHC provision for children and young people with disabilities in the local authority area who do not have special educational needs. The arrangements must include what, and by whom, EHC provision is to be secured, what advice and information is to be provided and by whom, how complaints are to be dealt with, and how disputes between the commissioning partners are to be resolved. The parties to the commissioning arrangements must have regard to the arrangements and keep the arrangements under review. The local authority and NHS commissioning bodies must have regard to the Joint Strategic Needs Analysis prepared by the local authority and the Health and Wellbeing Strategy agreed by the Health and Wellbeing Board.

5.9 A local authority must keep under review the local special educational provision and consider the extent that it is meeting the needs of the children and young people for whom it is responsible (s.27). The local authority must work with schools and other education providers to keep this provision under review. In carrying out these and other functions, the local authority must co-operate with a range of local partners including maintained schools and academies, further education bodies, shire districts (for County Councils), and CCGs, and in turn, they must co-operate with the local authority in the exercise of the local authority's functions (s.28). Local authorities must ensure their officers co-operate with each other (including those who work in children's social care). Similarly, each educational institution must cooperate with the local authority in the exercise of the educational institution's functions (s.29).

5.10 A local authority must publish a "local offer" of services it expects to be available for children and young people with special educational needs (s.30). The details of what must be included as part of the local offer is explained in the body of the report. The new provisions require greater co-operation between local authorities and a wide range of partners, including schools, Academies, colleges, other local authorities and services responsible for providing health and social care.

5.11 The Bill requires local authorities to involve parents, children and young people in reviewing and developing provision for those with SEN; and introduces a more streamlined assessment process for those with more

severe and complex needs, integrating education, health and care services and involving children, young people and their parents.

5.12 The provisions on EHC plansare based on the current legislation for statements of special educational needs (s.33) including the assumption that a child with a Plan is educated in a mainstream school. If following an EHC assessment (s.36), the local authority decides to secure EHC provision using a plan (s.37 onwards) then the local authority must secure provision in a mainstream institution 'unless it is incompatible with (a) the wishes of the children's parent or the young person, or (b) the provision of efficient education for others'. In determining whether mainstream education for a child with an EHC Plan is 'incompatible' with the provision of efficient education, the local authority will need to demonstrate that 'no reasonable steps' can be taken 'to prevent the incompatibility'.An EHC needs assessment may be requested by a child's parents, a young person or an educational institution (s.36). The local authority may carry out an EHC needs assessment when it is responsible for a child who has, or may have, SEN under s.24. Details of the specific requirements are set out in the report. If required by the EHC needs assessment, the LA must secure that an EHC Plan is prepared and subsequently maintained (s.37). As under the current provisions, a claim for judicial review will lie if this duty in not complied with.

5.13 Section 49 sets out the provisions on personal budgets and direct payments. The local authority must prepare a 'personal budget' if requested by a child's parents or young person. The personal budget is the amount specified or proposed to be specified in the EHC plan with the money being paid to the parents or young person.Provision is made for 'direct payments' where the local authority pays any fees etc. with the consent of the parents or young person. Details of how personal budgets will operate will be set out in Regulations.

5.14 The new provisions promote mediation to resolve disagreements. As under the current regime, parents may appeal to the First-tier Tribunal against certain matters including decision not to do an EHC needs assessment, a decision not to secure an EHC plan following an assessment, and once a plan is finalised about the content of the plan, re-assessment, amendment and ceasing (s.51). Regulations may set out other grounds of appeal to the Tribunal. It is a criminal offence not to comply with a decision of the Tribunal. A right to mediation is provided in s.52. Although, participation in mediation will not be a requirement of appealing to the Tribunal, the local authority must inform the parent or young person of their right to mediation, and there are different routes for health care mediation (s.53) and educational and social care mediation (s.54). If mediation is sought on health care issues, the local authority must be informed about the health care provision the parent wishes to see in the plan. The rules about how mediation operates are found in s.56 and the mediation will be conducted by a mediation adviser (s.55).

5.15 The local authority must put in place arrangements for avoiding or resolving disputes between the local authority or school or other educational institution

and a child's parents or young person with an EHC plan (s.57). An independent person must be appointed to resolve the dispute.Health service bodies are included inthe dispute resolution procedure.

5.16 Details of the new SEN Code of Practice (currently in draft) are set out in the report. In carrying out its functions under the new Act the Local Authority must have regard to the Code.

6. ONE TOWER HAMLETS CONSIDERATIONS

6.1. By implementing fully the SEN framework the Council will be ensuring that a particular vulnerable group of children and young adultshave their needs identified and addressed.

7. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

7.1 The report has no direct impact on environmental factors. However the Council's policy of providing a range of appropriate provision locally to meet the complex needs of children with SEN means few young people transported regularly out of the borough.

8. RISK MANAGEMENT IMPLICATIONS

8.1. The project board overseeing the implementation of the SEN reforms has identified risks and the actions needed to ensure that they are addressed.

9. CRIME AND DISORDER REDUCTION IMPLICATIONS

9.1 The proposals in the report do not contribute to the reduction of crime and disorder. However the widening of the duties under the new SEN framework mean that the Council will be responsible for monitoring the delivery of appropriate education health and care provision of those in custody or secure accommodation if they have EHC Plans.

10. EFFICIENCY STATEMENT

10.1 See section 3.22 – 3.25 of the main report, which outlines the efficient use of personal budgets for service users.

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.

- None