TOWER HAMLETS HEALTH AND WELLBEING BOARD

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

This meeting is open to the public to attend.

Members:	**Representing**
Chair: Mayor Lutfur Rahman	(Mayor)
Vice-Chair: Councillor Abdul Asad	(Cabinet Member for Health and Adult Services)
Councillor Alibor Choudhury	(Cabinet Member for Resources)
Councillor Gulam Robbani	(Cabinet Member for Education and Children's Services)
Councillor Mahbub Alam	(Executive Advisor on Adult Social Care)
Councillor Denise Jones	
Robert McCulloch-Graham	(Corporate Director, Education Social Care and Wellbeing)
Dr Somen Banerjee	(Interim Director of Public Health, LBTH)
Dr Amjad Rahi	(Healthwatch Tower Hamlets Representative)
Dr Sam Everington	(Chair, Tower Hamlets Clinical Commissioning Group)
Jane Milligan	(Chief Officer, Tower Hamlets Clinical Commissioning Group)
Co-opted Members	
Alastair Camp	(Non-Executive Director, Barts Health and Chair of the Integrated Care Board)
Sharon Hanooman	(Vice-Chair, Tower Hamlets Community Voluntary Sector)
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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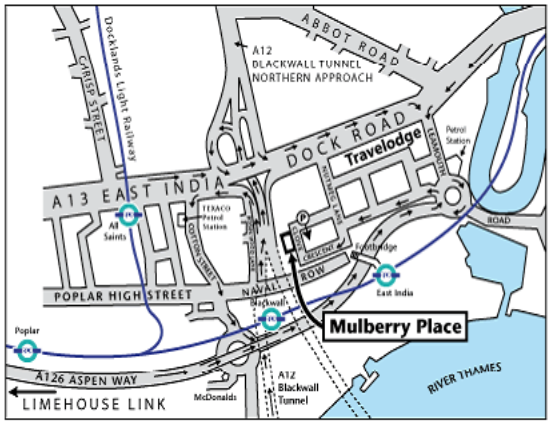

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PAGE NUMBER(S)

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

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

1 .3 Minutes of the Previous Meeting and Matters Arising **5 - 14**

To confirm as a correct record the minutes of the meeting of the Tower Hamlets Health and Wellbeing Board held on 8th July 2014 and to consider matters arising.

1 .4 Forward Programme **15 - 20**

To consider and comment on the Forward Programme.

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

1 .5 Healthwatch Update

Verbal Update.

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

2. HEALTH AND WELLBEING STRATEGY

2 .1 Health and Wellbeing Strategy 2013/14 Year End Monitoring Report **21 - 84**

Recommendations:

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

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

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

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

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

2 .2 Tower Hamlets Plan for Eye Care **85 - 142**

Recommendation:

Note the contents of the report and support the implementation of plan

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

2 .3 Integrated Care Update **143 - 150**

Recommendation:

To note the progress outlined in this report.

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

2 .4 Resubmission of the Better Care Fund Planning Template - To Follow

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

2 .5 Liver Disease in Tower Hamlets - What are the issues, why does it need to be a priority and what are we doing? **151 - 170**

Recommendation:

The Health and Wellbeing Board is asked to comment on the approach, priorities and how members would like to involved in raising the profile of liver disease in their organisations and the community. It is proposed to bring an update on progress to the Board in 9 months.

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

3. REGULATORY OVERSIGHT

3 .1 Transforming Services, Changing Lives **171 - 176**

Recommendations:

Provide comment and feedback to the programme team based on their review of the Interim Case for Change. This will be used in the development of the final case for change, which is due to be published in October.

Consider and confirm requirements and timings for future updates and presentations about the final Case for Change and any future work programmes.

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

3 .2 Memorandum of Understanding **177 - 190**

Recommendations:

To note:

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

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

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

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

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

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

3 .3 Community Plan Refresh - Presentation **191 - 212**

Recommendations:

Comment on the proposed approach and issues for the refreshing the Community Plan

Explore the key questions related to health and social care and the wider determinants of health and wellbeing.

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

4. ANY OTHER BUSINESS

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

4 .1 Care Act Workshop 22nd September 3pm - 5pm, Jack Dash House, Council Chambers **213 - 214**

Date of Next Meeting:
Tuesday, 25 November 2014 at 5.00 p.m. in Committee Room 1, 1st Floor, Town Hall, Mulberry Place, 5 Clove Crescent, London E14 2BG

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DECLARATIONS OF INTERESTS - NOTE FROM THE MONITORING OFFICER

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

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

Interests and Disclosable Pecuniary Interests (DPIs)

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

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

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

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

Effect of a Disclosable Pecuniary Interest on participation at meetings

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

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

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

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

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

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

Further advice

For further advice please contact:-

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

APPENDIX A: Definition of a Disclosable Pecuniary Interest

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

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

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LONDON BOROUGH OF TOWER HAMLETS

MINUTES OF THE TOWER HAMLETS HEALTH AND WELLBEING BOARD

HELD AT 5.15 P.M. ON TUESDAY, 8 JULY 2014

COMMITTEE ROOM MP701, 1ST FLOOR, TOWN HALL, MULBERRY PLACE, 5 CLOVE CRESCENT, LONDON, E14 2BG

Members Present:

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

Co-opted Members Present:

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

Others Present:

Vanessa Lodge	(Director of Nursing, Central and North East London NHS England (London))
Esther Trenchard-Mabere	(Associate Director of Public Health, Commissioning & Strategy)
Dianne Barham	(Director of Healthwatch Tower Hamlets)
Dr Martha Leigh	(Tower Hamlets Clinical Commissioning Group Governing Board's Lead for Maternity)
Sarah Baker	(Tower Hamlets Independent Local Safeguarding Children's Board Chair)

Officers in Attendance:

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

	Wellbeing, LBTH)
Graham White	(Interim Head of Legal Operations LBTH)
Leo Nicholas	(Strategy, Policy and Performance Officer, Education, Social Care and Wellbeing LBTH)
Zoe Folley	(Committee Officer, Directorate Law, Probity and Governance LBTH)

Apologies:
Councillor Gulam Robbani ,Dr Amjad Rahi, Alastair Camp and Brian Parrott

1. STANDING ITEMS OF BUSINESS

1.1 Welcome, Introductions and Apologies for Absence

COUNCILLOR ABDUL ASAD (CHAIR)

Councillor Asad welcomed everyone to this first meeting of the Board for this municipal year 2014/15. He advised that, due to the focus of this meeting on maternity services, the feedback on the Health and Housing workshop would now be considered at the September 2014 meeting of the Board.

It was also reported that the Health providers represented on the Board at the meeting (Deputy Chief Executive, East London and the Foundation Trust) (Vice-Chair, Tower Hamlets Community Voluntary Sector and Non-Executive Director, Barts Health and Chair of the Integrated Care Board) would be invited to leave the meeting for item 5.5 (Drug and Alcohol Action Team (DAAT) Commissioning intentions). This was because the item concerned the consideration of procurement options and, under the Board's procedural rules, Health providers represented must be excluded from meetings in the event of the Board making procurement decisions and/or recommendations.

As a result, it was agreed that item 5.6 (Reform of Special Educational Needs (SEN) The Children and Families Bill 2013 & the Draft SEN Code of Practice). would be considered before 5.5

It was also agreed that item 2.2 (Presentation on Maternity Service Quality at the Royal London Hospital) would be considered after item 1.4 (Healthwatch Update - Maternity Services Liaison Committee Patient Feedback)

However, for ease of reference the order of the minutes follow the agenda order.

1.2 Declarations of Disclosable Pecuniary Interests

No interests were declared.

1.3 Minutes of the Previous Meeting and Matters Arising

The minutes of the meeting held on 24th March 2014 were approved as a correct record of the proceedings.

Deborah Cohen (Service Head, Commissioning and Strategy, Education, Social Care and Wellbeing, LBTH) updated the meeting on the Memorandum of Understanding. It was noted that the health actions of the understanding have been superseded by the Better Care Fund Initiative, with the board receiving regular reports. It was proposed that the employment aspects would be taken forward by Development and Renewals Employment and Development Service. It was anticipated that a comprehensive update on the MOU would be reported back to the September board meeting.

Dr Somen Banerjee (Interim Director of Public Health, LBTH) gave an update on Oral Health for children. He reported on the establishment of a senior professional group, comprising representatives from the Council, Bart's Health and local CCG's to address the issues around dental access. Dr Banerjee would keep the Board updated on this work.

1.4 Terms of Reference, Quorum, Membership and Dates of Meetings.

Deborah Cohen introduced the report.

Resolved:

That the Tower Hamlets Health and Wellbeing Board (HWBB) Terms of Reference, Quorum, Membership as attached to the Committee report and future meeting dates be noted subject to the following amendment to the terms of reference regarding a Board Members role.

That the following wording

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

Should replace:

Chief Operating Officer - NHS Tower Hamlets CCG

1.5 Forward Programme

The Board noted the Forward Plan.

1.6 Healthwatch Update - Maternity Services Liaison Committee Patient Feedback

Dianne Barham (Director of Healthwatch Tower Hamlets) introduced the item.

Ms Barham welcomed to the meeting representatives from Social Action for Health to talk about their work in setting up the Maternity Service Liaison Committee (MSLC) project with local CCGs, Barts Heath and local mothers to improve maternity services.

Carly Bond (Social Action for Health) reported on the development and the role of the MSLC. The MSLC now comprised 146 active mothers. They would listen to the feedback from mothers about maternity services and report back to the health care providers and commissioners involved in the initiative. This was a reciprocal process with mutual dialogue between both sides. She highlighted examples of how the Committee had helped its members develop transferable skills and build up confidence.

The Board also heard from Nurun Nessa and Sultana Uddin who were members of MSLC. They explained the MSLC's current priorities, based on the feedback from mothers. This included: to improve patient experience with post natal services and midwives and arranging for spot checks on maternity wards. Other key aims of the group related to breast feeding in a secure and safe environment and the need for clear information on help and support. These priorities and issues had been feedback to Barts Health for their response (see item 5.2).

Questions were then asked about progress with these issues as some were longstanding.

In response, Dr Martha Leigh (Tower Hamlets CCG Governing Board Member and lead for maternity) explained the work to improve services, as highlighted by the Head of Maternity Services presentation at a recent Care Quality Board meeting. There had been a review of the appraisal system for midwives to improve performance. Work was also underway to create a one stop service and to ensure all the options available for mothers were clearly set out. Further details on the improvements were reported under item 5.2. (Presentation on Maternity Service Quality at the Royal London Hospital).

The Board thanked the representatives from Social Action and the Maternal Services Liaison Committee for their presentation.

2. HEALTH AND WELLBEING STRATEGY

2.1 Maternal, Early Years and Child Health, update for the Health and Wellbeing Board

Esther Trenchard-Mabere (Associate Director of Public Health, LBTH) presented the overview of maternal, early years and child health across Tower Hamlets. The evidence was based on performance against indicators from the Public Health Outcomes Framework. She highlighted the areas where Tower Hamlets were performing worse than London and England

subject to red indicators. This included: the highest levels of child poverty in the country, low use of outdoor play space, low birth weights of term babies that could increase risk of childhood obesity, dental decay in 5 year olds, increasing rates of obesity in 10 -11 year olds. It appeared that Bangladeshi and Somalia boys had the highest levels of obesity in the 10 -11 age group. There were also lower than average levels of HPV vaccination.

She referred to the variety of partnership groups with responsibility for these issues and their priorities. This included community engagement work to address childhood obesity in 10-11 years with a detailed action plan. The Tower Hamlets Immunization Group would be re - established to improve rates of HPV vaccination. Focus would be placed on improving lifestyles when addressing dental decay in children as well as access to service.

A full list of the findings and proposed solutions were set out in the report.

In response to questions about low birth rates and childhood obesity, it was intended to gain better data to identify the nature of this relation and the causes of childhood obesity. The Schools Health Services were in the process of being re-commissioned with new performance indicators. The Board considered that there might be some merit in sharing the performance information across schools. This could also include free schools and independent schools if possible. A schools Health and Wellbeing body had been established that would meet three times a year. This body would report to the Board where necessary.

Action: Esther Trenchard-Mabere.

The Board noted the role of schools in administering the HPV vaccine as it was considered that they were better place to do so. There had been some discussion about the need for an agreement between the commissioners and schools for accountability purposes.

Resolved:

1. That the Partnership arrangements for taking forward work to improve maternal, early years and child health be noted.

2. That the priorities for action to improve maternal, early years and child health be noted.

2.2 Presentation on Maternity Service Quality at the Royal London Hospital

Dr Martha Leigh (Tower Hamlets CCG Governing Board Member and lead for maternity) gave a presentation on the work of the Tower Hamlets CCG and Barts Health NHS Trust in improving maternity services at the Royal London Hospital following the CQC inspection in late 2013.

The sites were found to be providing a safe and responsive case. Some issues were however identified and these were currently being addressed.

The solutions included: improved IT and administrative support, a new IT board to bring together performance information, the 'Great Expectations staffing programme' to improve patient experience, better staff to patient ratios, a new leaflet promoting choice in services for women and a new mentoring scheme for new midwives.

Other improvements included: a new complaints process, a new administration post to improve screening and the introduction of a one stop service to streamline services.

The services would be working closely with the mental health services to provide the best possible support for vulnerable patients. The services were involved in the Transforming Services, Changing Lives- Interim Case for Change programme.

In response to questions about the clinical indicators and the rates for caesrium treatments, it was reported that performance in these areas was broadly similar to the national average.

In relation to the transferal of patients to other hospitals, it was anticipated that such cases should lessen in the future, due to better use of existing facilities and the possibility of an increased number of staff in recognition of the complexity of cases.

It was commented that it was important to bear in mind the safeguarding issues when transferring patients between hospitals and the danger of children falling out of sight of services

The CCG would monitor the services and improvements and would report back to the Board in due course.

Resolved:

That the work of Tower Hamlets CCG and Barts Health NHS Trust on the improvement of Maternity Services at the Royal London Hospital be noted.

2.3 Commissioning of Primary Care services

Vanessa Lodge (Director of Nursing, Central and North East London NHS England (London)) presented the report that sets out the arrangements for commissioning primary care services in the NHS post 1 April 2013.

Ms Lodge explained the role of NHS England in commissioning primary care services in the context of CCG strategies including the payment services. She also explained the role of the CCG in supporting NHS England in providing such services and its approach to quality improvement.

Ms Lodge also gave an update on the new Dental Practice on the Ocean Estate. The lease had been agreed and the contract for the service was being finalised. The service should start on 1st September 2014.

NHS England were also exploring the option of seven day working and opening hours for GP Practices. The proposals would be developed over the summer.

The Chair reported on his attendance of a campaign meeting on Saturday 5th July about the closure of GP's practices locally. The Chair requested that representatives leading the campaign be invited to the next meeting of the Board.

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

A Board Member also stressed the need for dentists and hygienists to interact more in treating patients to improve oral health.

Resolved:

That the arrangements for commissioning of primary care services in the NHS post 1 April 2013 be noted.

2.4 Presentation on the Expression of Interest for the co-commissioning of Primary Care Services in Tower Hamlets

Jane Milligan (Chief Officer, Tower Hamlets CCG) gave a presentation on the Expression of Interest (EOI) Document submitted to NHSE on the Co-Commissioning of Primary Care Services by the Tower Hamlets CCG and other local CCGs on 20th June 2014.

The aims of the EOI were to: develop a model for co-commissioning activities for both shared and independent services; provide strategic leadership and improve the quality of primary care services and to work in partnership with other NHS organisations to improve and modernise primary care infrastructure. The current EOI had a focus on general practice but in future other services may be included as the initiative develops. The initiative would be central to the achievement of strategic plans.

In response, the Board stressed the need to consult and include patients in the decision making process. Ms Milligan confirmed that the CCG would look to engage with patients as part of the next stage.

The Board expressed concern about the formula for calculating the Minimum Practice Income Guarantee (MPIG) and the impact from the phasing out of the funding. It was considered that the formula did not give due weight to the impact of local issues on the cost of GP services – such as deprivation, language issues. Therefore, Tower Hamlets and Hackney were at a disadvantage. The Board cited examples of where local practices were at risk and noted that practices were working together to minimise the impact.

Members considered that the Board should write to the Secretary of State to raise these concerns about the MPIG and the impact on local GP practices. It was agreed that the Board Members and Officers would meet separately outside the meeting to discuss and agree the content of the letter.

Action: Robert McCulloch-Graham (Corporate Director, Education Social Care and Wellbeing, LBTH),

Dr Somen Banerjee undertook to contact the Hackney Health and Wellbeing Board about this issue. Sarah Baker (Tower Hamlets Independent Local Safeguarding Children's Board Chair) offered to lobby the London safeguarding Board on this issue.

Resolved:

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

2.5 Drug and Alcohol Action Team (DAAT) Commissioning Intentions

John Wilkins (Deputy Chief Executive, East London and the Foundation Trust) and Sharon Hanooman (Vice-Chair, Tower Hamlets Community Voluntary Sector) left the meeting for this item (and the remaining items of business) due their interest in this item as set out in the opening remarks.

Rachael Sadegh (Drug and Alcohol Action Team Co-ordinator DAAT, LBTH) presented the report regarding the re-procurement of drug and alcohol services in Tower Hamlets.

It was considered necessary to re-procurement the services to achieve better value for money, increase performance and deliver better services reflecting local needs.

Four options for re-procurement had been developed and reviewed by the DAAT and the Council's Senior Management Groups.

The Board noted the four options including the recommended option three to be submitted to the Cabinet in July for approval. Under this option, there would be:

- Two drug plus alcohol treatment contracts; one for treatment and one for recovery (2 contracts). There would be a 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.

Reassurances were sought regarding the merits of this option. Ms Sadegh confirmed that that there should be a consortium approach to the provision of services including outreach work. GPs would still be a part of the support.

The Board felt it important to integrate the drug and alcohol services with other services such as for sexual health. It was reported that the DAAT were looking at a number of options to better link the services. This could include expanding additional services to achieve this and more outreach work.

In response to further questions, it was reported that mothers with drug and alcohol problems were referred to specialist midwives at hospitals supported, supported by a clinic for such patients.

Resolved:

1. That the intention to re-procure drug / alcohol treatment services in Tower Hamlets be noted.

2. That the preferred option of the DAAT Board be noted in advance of consideration at Cabinet.

3. That the timescales provided be noted.

3. BOARD OVERSIGHT

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

David Carroll (Principal Educational Psychologist, Special Educational Need (SEN) & Inclusion Lead, LBTH) outlined the actions required following the reform of the SEN legislation.

The new system required a close cooperation between all SEN services, with streamlined assessments involving parents, children and young people. It also required clear and assessable Local Offers of services and introduced a new 0-25 Care Plan with clear outcomes. There were also provisions for personal budgets and a new requirement for the Local Authority, health and care services to commission services jointly.

In response to questions, it was confirmed the plans for each child would have a number of measurable outcomes through education to adulthood. The Chair of the Children's Safeguarding Board suggested that that Board could also monitor these performance indicators. Appropriate safeguards would be put in place regarding direct payments.

The Chair requested that the Joint Commissioning Plans between the Council and the CCG to secure and review the SEN services across all agencies be brought back to a future meeting of the Board for input and oversight.

Action: David Carroll (Principal Educational Psychologist, Special Educational Need (SEN) & Inclusion Lead, LBTH

Resolved:

That the Board support:

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

3. 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.

4. ANY OTHER BUSINESS

- Transforming Services, Changing Lives- Interim Case for Change.

Jane Milligan gave an update on the above. The programme would engage with a wide range of stakeholders – public, staff, patients, local authorities asking for feedback on the interim case for change. This would be published during w/c 7th July 2014 with a dedicated website and supporting material.

A presentation on the initiative and consultation would be circulated to the Board.

- Tower Hamlets, Health Profile 2014 – Public Health England.

Dr Somen Banerjee drew attention to the Profile for Tower Hamlets dated 8th July 2014. This leaflet would also be circulated to the Board

Action: Leo Nicholas (Strategy, Policy and Performance Officer, Education, Social Care and Wellbeing) to circulate information.

The meeting ended at 7.20 p.m.

Vice Chair, Councillor Abdul Asad
Tower Hamlets Health and Wellbeing Board

Draft HWBB Annual Agenda Plan 14 -15

HWBB Meeting		Sept'14	Nov'14	Jan'15	Mar'15
HWB Strategy	Maternity and Early Years				
	Mental Health & Wellbeing		Time to Change Update		Update
			Mental Health Strategy update		
	Long Term Conditions and Cancer	Vision Strategy	Cancer Update		
		Liver Strategy		Update	
				Winterbourne View update	
	Enablers	Better Care Fund: Sign off revised plan		Integrated Care Update	
		Integrated Care Update			
	Others	JSNA Priorities	Migrant Health	Pharmaceutical Needs Assessment Sign Off	
		Community Plan Refresh	Health and Housing		
		Introduction to Pharmaceutical Needs Assessment			
Board Oversight		Local Safeguarding Children's Board Annual Report	Safeguarding Adults Board Annual Report		
		Transforming Services Changing Lives	Transforming Services Changing Lives	Transforming Services Changing Lives	Transforming Services Changing Lives
				HWBS 6 month monitoring	
		HWBS year end monitoring for 13-14		Local Account	

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Health and Wellbeing Board Forward Plan

	Report Title	Lead Officer	Reason for submission	Time
Date: November 2014				
Public Questions	Public Questions			
Standing Items	Apologies & Substitutions Minutes & Matters Arising Forward Plan			
	Healthwatch Update	Dianne Barham		
Health and Wellbeing Strategy	Migrant Health - UKBA paper (TBC)	Fran Jones		
	Time to change update	Deborah Cohen		
	Cancer update	CCG, Public Health, Barts Health, LBTH (Partner Update)		
	Health and Housing update	Louise Russell		
Board Oversight	SAB annual report	Brian Parrott		
	LSCB annual report	Sarah Baker		
Date: January 2015				
	Report Title	**Lead Officer**	**Reason for submission**	**Time**
Public Questions	Public Questions			
Standing Items	Apologies & Substitutions Minutes & Matters Arising Forward Plan			
	Healthwatch Update	Dianne Barham		
Health and Wellbeing Strategy	HWBS Monitoring (6 month monitoring) 14/15	Louise Russell		
	Winterbourne View update	Bozena Allen		
Board Oversight	The Local Account 2013/14	RMC/Layla Richards		
Date: March 2015				
	Report Title	**Lead Officer**	**Reason for submission**	**Time**
Public Questions	Public Questions			
Standing Items	Apologies & Substitutions Minutes & Matters Arising Forward Plan			
	Healthwatch Update	Dianne Barham		
Health and Wellbeing Strategy				
Board Oversight				

Health and Wellbeing Board Workshop Forward Plan

Date: Summer 2014, 15:00 - 17:00, Room TBC				
	Report Title	**Lead Officer**	**Reason for submission**	**Time**
Sep-14	**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 9 September 2014	Tower Hamlets Health and Wellbeing Board
Report of the London Borough of Tower Hamlets	**Classification:** [Unrestricted]
Health and Wellbeing Strategy 2013/14 Year End Monitoring Report	

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

Executive Summary

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

Recommendations:

The Health and Wellbeing Board is recommended to:

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

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

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

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

1. REASONS FOR THE DECISIONS

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

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

2. ALTERNATIVE OPTIONS

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

3. DETAILS OF REPORT

3.1 The Health and Wellbeing Strategy, agreed by the Board at its first full meeting in February 2014, drives the collective actions of the NHS and local government, both commissioners and providers, and engages communities in the improvement of their own health and wellbeing.

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

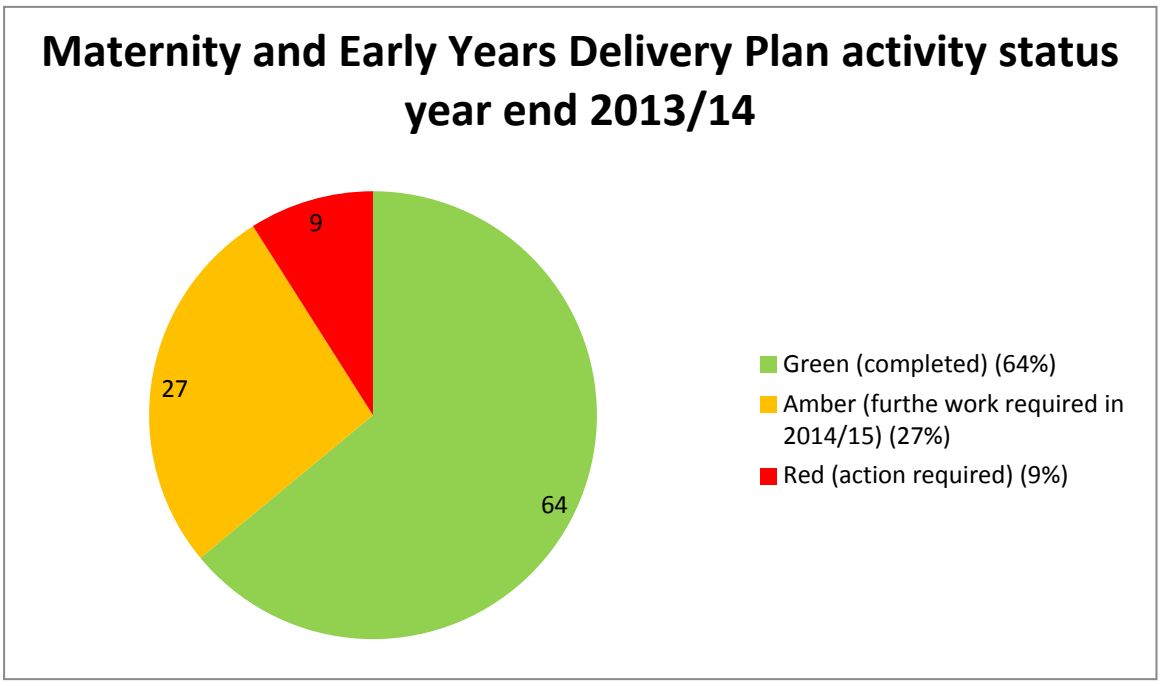
3.3 There are current delivery plans for all four priorities:

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

Maternity and Early Years

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

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



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

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

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

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

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

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

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

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

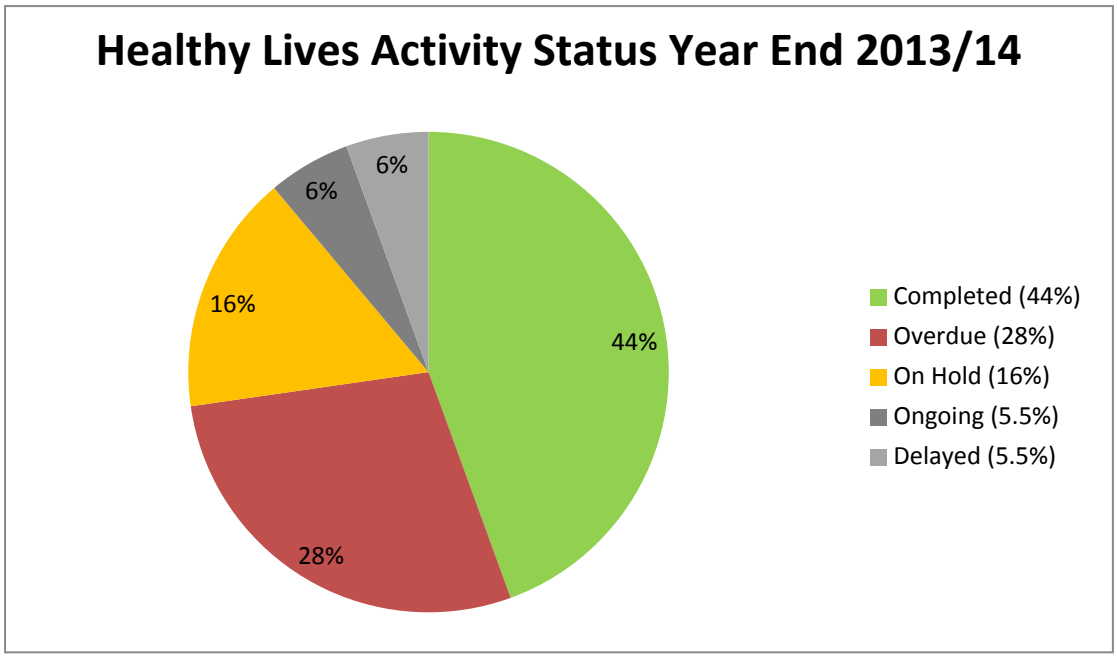
<u>Healthy lives</u>

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

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

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

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



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

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

3.14 In addition to the above, at year end:

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

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

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

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

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

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

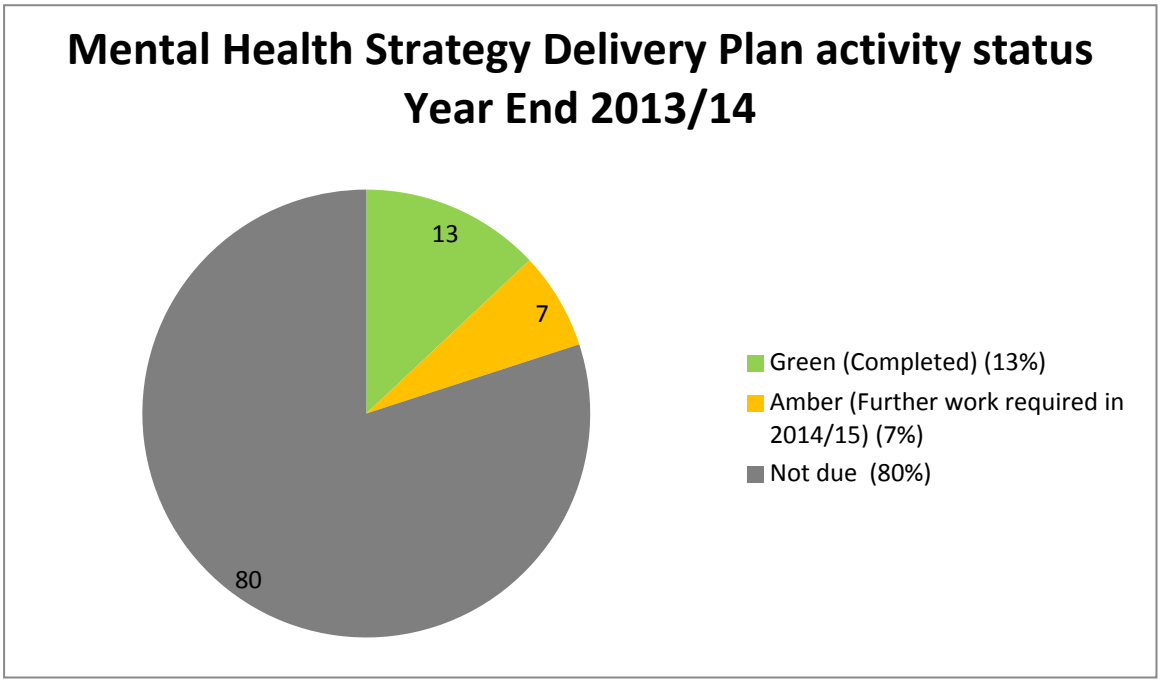
This is due to the workstreams needing to be integrated into the wider Healthy Lives Strategy, which is due to be launched in November 2014.

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

Mental Health

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

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



3.20 Some good progress has been made as follows:

- A review of talking therapy pathways is underway.
- A review of rehabilitation pathways is underway.
- A review of demand, capacity and quality in residential, nursing and continuing care for people with dementia is underway, and will report in August
- Suppliers have been selected to develop a new information portal on mental health for the borough
- Work is about to commence to refresh the service model for Tier 2 and Tier 3 CAMHS
- The school nursing service has been re-specified with a much greater emphasis on their role in supporting mental health and wellbeing.
- The reprocurement of tobacco cessation services specified the need for access for people with mental health conditions.
- Two additional dementia cafes have been commissioned, bringing the total to 4, operating once a month for people with dementia and their carers.
- The Police and London Ambulance Service attended a concordat event and an action plan will be presented to the Health and Wellbeing Board in the Autumn to ensure to ensure there is a strategic overview of mental health crises in the Borough.
- GP training has been delivered on dementia, the Mental Capacity Act and learning disability.

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

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

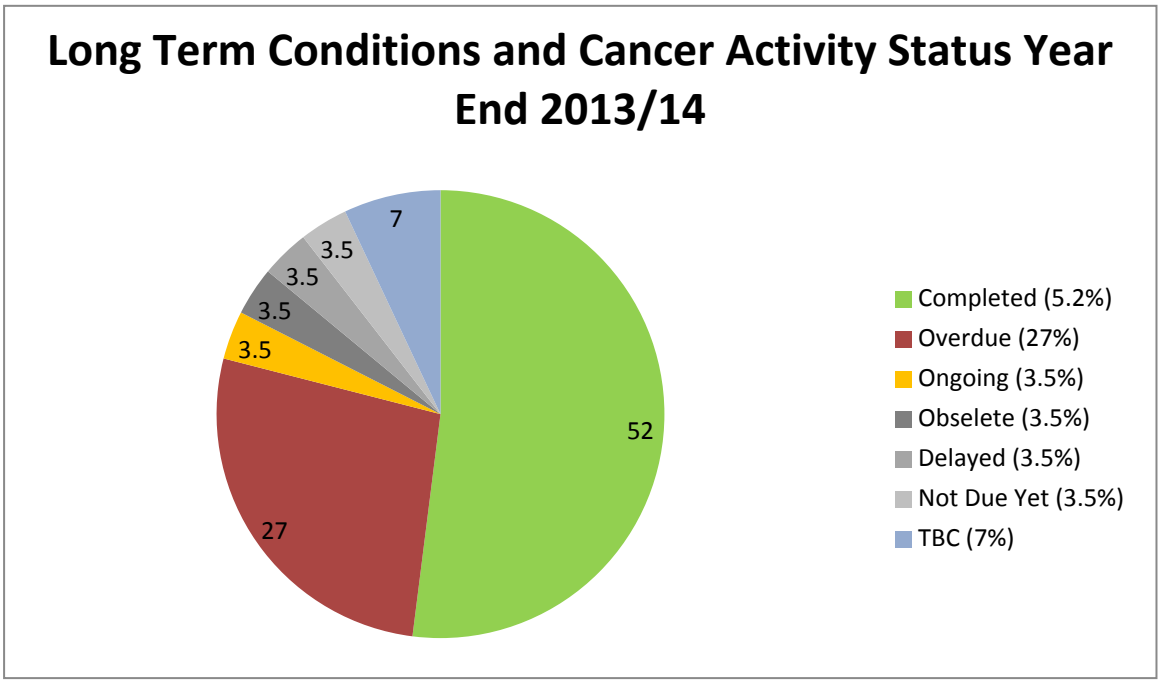
Long Term Conditions and Cancer

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

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

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

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



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

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

3.25 In addition to the above, at year end

- NHS Health Checks are being carried out to detect onset of cardiovascular diseases to appropriately refer onto care packages.
- Diabetes care planning is being reviewed on an ongoing basis as part of a continuous commissioning cycle.
- The Integrated Community Health Team went live in November 2013 and there has been an improvement in the coordination and consistency between reablement and rehabilitation; greater integration of social workers into the locality based clinics; and the development of robust community based Geriatric provision.
- A plan for autism services and improvement has been developed and implemented, with a diagnostic and Intervention Team in place.
- "Small c campaign" performing well. More people with early stage lung cancer had life-saving surgery at the Royal London Hospital, and there has been a reduction in the proportion of women in Tower Hamlets with late stage breast cancer.

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

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

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

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

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

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

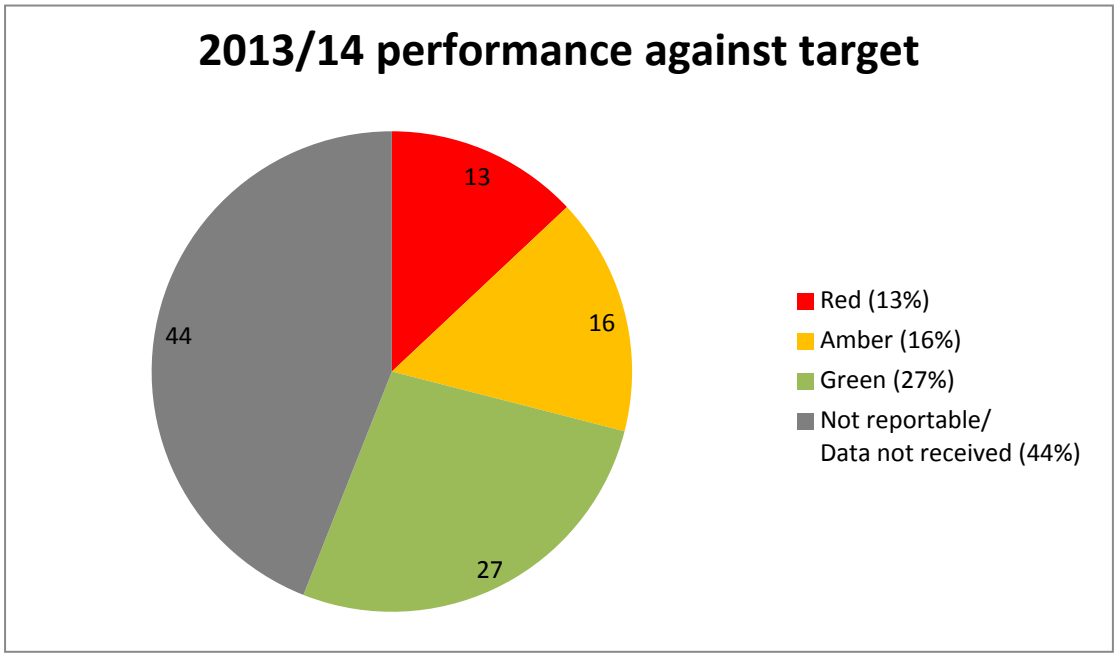
3.29 One activity is now **obsolete** (shaded grey in the appendix). The activities marked as obsolete relate to the establishment of a forum, jointly chaired with health and social care, to **develop an integrated approach to**

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

Measures

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

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



A summary of the key points is as follows.

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

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

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

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

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

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

4. COMMENTS OF THE CHIEF FINANCE OFFICER

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

5. LEGAL COMMENTS

5.1. This report provides an update on the progress against the Health and Wellbeing Strategy delivery plans for the six months to 31st March 2014. There are no immediate legal implications arising from this report. The recommendations for the HWB are consistent with the general policy, reflected in the Health and Social Care Act 2012, of giving HWBs responsibility for joint health and wellbeing strategies and the joint strategic needs assessment, and fall within the functions of the HWB as set out in its Terms of Reference.

6. ONE TOWER HAMLETS CONSIDERATIONS

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

7. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

7.1 There are no specific environmental implications.

8. RISK MANAGEMENT IMPLICATIONS

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

9. CRIME AND DISORDER REDUCTION IMPLICATIONS

9.1 There are no specific crime and disorder implications.

Appendices and Background Documents

Appendices

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

Background Documents

- NONE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Healthy Lives

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

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

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

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

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

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

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

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

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

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Tower Hamlets Mental Health Strategy Delivery Plan 2014-16

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Long Term Conditions and Cancer

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

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

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

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

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

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

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

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

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

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

Health and Wellbeing Board 9 September 2014	Tower Hamlets Health and Wellbeing Board
Report of the London Borough of Tower Hamlets	**Classification:** Unrestricted
Tower Hamlets Plan for Eye Care	

Lead Officer	Robert McCulloch-Graham
Contact Officers	Barbara Disney
Executive Key Decision?	No

Executive Summary

The report outlines the development and implementation of the Tower Hamlets Eye Care Plan. The development of the plan was supported by the London Visual Impairment Forum and the Thomas Pocklington Trust, which has also funded this project.

The vision of the Eye Care Plan aims to ensure that the broad outcomes of the UK Vision Strategy are being met at a local level and with a joined up, integrated eye care pathway that places the person at the centre of their journey. It aims to achieve the outcomes prioritised by people living with sight loss, their families and carers in Tower Hamlets and to eliminate preventable sight loss and promote inclusion.

Recommendations:

The Health and Wellbeing Board is recommended to:

1. Note the contents of the report and support the implementation of plan

1. REASONS FOR THE DECISIONS

1.1 This paper is presented to the Health and Wellbeing Board for information and support.

2. ALTERNATIVE OPTIONS

2.1 N/A

3. DETAILS OF REPORT

3.1 Background of Report

3.1.1 The Tower Hamlets Eye Care Plan has to be understood in the context of the UK Vision Strategy 2013 to 2018. This Strategy sets out a framework for change and the development of excellent services to build a society in which avoidable sight loss is eliminated and full inclusion becomes accepted practice. It continues to respond to shortfalls in the UK's eye health, eye care and sight loss services that have been identified through consultation across all four UK countries.

3.1.2 Since the summer of 2013, the Tower Hamlets (TH) Vision Strategy group has been meeting to develop the Tower Hamlets Eye Care Plan with support from the Thomas Pocklington Trust. The group was chaired by Sharon Schaffer, Development and Vision Strategy Manager with the London Visual Impairment Forum (LVIF) and the East London Vision (ELVis). This project is part of a wider national, programme – the UK Vision Strategy Implementation Programme – funded by the Thomas Pocklington Trust and with further support from the London Visual Impairment Forum. The LVIF which aims to implement an Eye Care Plan in each of the 32 London Boroughs with a benchmark of standard services to avoid a 'postcode lottery'.

3.1.3 Representation of the TH Vision Strategy group has been developed over the past few months to include Strategic Commissioning, the Sight and Hearing Service, Children's Services, the Voluntary Sector such as, BlindAid, DeafBlind and user led groups such as Dekhtay Chai, Beyond Barriers. Members also include representatives from Moorfield's Eye Hospital.

3.1.4 The vision of the Eye Care Plan is to ensure that the broad outcomes of the UK Vision Strategy are being met at a local level and with a joined up, integrated eye care pathway that places the person at the centre of their journey. It aims to achieve the outcomes prioritised by people living with sight loss, their families and carers in each local area and in the context of 'Seeing it My Way' the nationally recognised framework that has defined these outcomes:

- Inclusion of eye care in JSNA (NB. eye health is a public health indicator)
- A joined up pathway

- Key stakeholders round the same table
- Communication exchange
- The implementation of an action plan

3.1.4 The support provided by the Thomas Pocklington Trust has facilitated and directly work towards

- **a local eye care plan**, built on model documents and populated with local information
- **engagement with key local stakeholders**
- a clear description or **map of local services** that are important to people with sight loss with some indication of their recognised quality or value to people with sight loss
- an **indication of gaps in services** vis á vis the universal framework indicated by 'Seeing it My Way'
- effective **consultations** with local stakeholders and people with sight loss living in the Borough and those working with or caring for them
- **refinement and extension of the local eye care plan** in ways that reflect consultation and local priorities for service development
- **establishment of a local eye care plan working group and action plan** to implement the local vision plan.

3.1 Key Issues

3.2.1 Themain challenges facing Tower Hamlets in its provision of eye health and visual impairment support services are:

- The population of visually impaired people, who are affected in their day-to-day life in Tower Hamlets, is expected to increase from 3,340 to 3,950 by 2020 [1]
- In 2010/11, £9.34 million was spent by Tower Hamlets Primary Health Care Trust on 'Problems of Vision'. With the expected increase in visual impairment by 2020, this could rise significantly over the next seven years[2].
- It is estimated that 50% of visual impairment and associated expenditure, is avoidable. Greater awareness of eye health, improved sight loss pathways, more timely detection of eye disease and changes to individuals' lifestyles are some of the factors that can reduce this.

3.2.1 Reducing unnecessary sight loss can help to maintain good health, wellbeing and independence for individuals and along with modification of lifestyle and increased awareness of visual impairment can potentially lead to cost savings within local areas.

3.2.2 While there is some good work happening to support those with a visual impairment in Tower Hamlets there are also some critical gaps and recommendations.

1 RNIB Sight Loss Data Tool (Nov 2013)
22010-11 Programme Budgeting Benchmarking Tool Version 1.1 27.01.12

- **Health and Wellbeing**: Embed the Eye Care Plan into the Health and Wellbeing framework, and achieve a user led partnership approach to the planning, delivery and evaluation of eye health and sight loss support services
- **Prevention**: Maximise the uptake of eye examinations and raise awareness of eye health to ensure that avoidable sight loss is prevented wherever possible
- **Joined up data:** Ensure that comprehensive cross sector data on sight loss and local demographics is collected and shared to inform resource allocation across Public Health, NHS, Optometry, Social Care and Voluntary organisations
- **Joined up services:** Ensure that an effective and efficient service provision is available, resulting in a clear pathway for people experiencing sight loss from diagnosis through to independent living. This will include optometrists, GPs, eye clinics, social care teams and voluntary services
- **Social inclusion and independence**: Ensure that people with sight loss have good access to key local services - information, transport, leisure, employment, education and welfare rights to obtain and maintain independence and not experience social exclusion, inequality or isolation
- **Children's services**: Develop and embed into the main eye care plan considerations for children and young people, including evidence of current and future need, sight loss pathway, arrangements for transition to adult services and an action plan to address gaps and need
- **Visually Impaired people with complex needs:** Ensure that the needs of people with visual impairment as a secondary presenting condition are recognised. Visual impairment is often overlooked in those with, for instance, Dementia, Parkinson's, Learning Disabilities, etc.

3.3 Current and Future Needs

3.3.1 There are 1,225 residents registered with a visual impairment in Tower Hamlets**;** 615 are registered as Severely Sight Impaired (blind) and 610 as Sight Impaired (partially sighted). Of these 105 are under 16 years of age.[3] However, for a number of reasons, not everyone with a visual impairment affecting their day-to-day life is registered as sight impaired or severely sight impaired.[4]Therefore, a much more accurate estimate would be about 3,340blind or partially sighted people living in Tower Hamlets[5].

3.3.2 In 2011, £9.34 million was spent by Tower Hamlets Primary Health Care Trust on 'problems of vision'[6].This refers to the cost of low vision services such as hospital admission for cataract surgery or glaucoma treatment. This does not include the associated costs to the NHS for accidents that arise from visual

[3]RNIB Sight Loss Data Tool (Nov 2013)
[4]This is based on the fact the while 360,000 are registered as blind and partially sighted it is estimated that2,000,000 people in the UK live with sight loss that affects their day-to-day lives. See http://www.rnib.org.uk/aboutus/research/statistics/Pages/statistics.aspx for more information.
[5]RNIB Sight Loss Data Tool (Nov 2013)
6NHS programme budgeting PCT
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_132501.zip

impairment. It is estimated that there are 3,340 people currently living in Tower Hamlets with a visual impairment. The three major causes of preventable sight loss are: glaucoma, age-related macular degeneration and diabetic retinopathy. This is projected to increase to 3,950 by the year 2020. This would be an extra 610 people living in the community with visual impairment that impinges on their day-to-day life.[7]

3.3.3 The main reasons for this increase are related to an aging population, ethnic background, living in a deprived area and certain lifestyle factors such as alcohol, smoking and associated conditions such as obesity, high blood pressure, strokes and diabetes that place people at increased risk of visual impairment which in turn can lead to depression and social isolation.

3.3.4 For example, Tower Hamlets is a deprived borough ranked 3rd out of 32 for levels of deprivation in London and 7th out of 346 in England. Research has shown that three out of four people with visual impairment live in, or on the margins of, poverty.[8]This means that those living with a visual impairment are also more likely to include some of the most economically vulnerable people in the Tower Hamlets. Those with a low life expectancy are also more likely to develop a visual impairment later on in life, due to poorer health indicators throughout their lives.

3.3.5 Ethnicity can also affects one's chances of developing a visual impairment:

- Glaucoma - is more common in people of African, African-Caribbean, South- East Asian, or Chinese origins.
- Cataracts – are more common in people of Asian origin.
- Diabetic Retinopathy – is more common in people of African, African-Caribbean, or Asian origins.

3.3.6 Furthermore, one in ten people with a learning disability have some form of visual impairment.[9] This means that out of the 1,000 adults in Tower Hamlets with learning disabilities, roughly 100 will also be experiencing some form of visual impairment[10]. In addition, visual impairment is most likely to develop in older people. Therefore, it often accompanies other medical conditions that are more prevalent later in life - such as dementia. Research by the Thomas Pocklington Trust conservatively estimated that 2% of the population aged 75+ are visually impaired and suffer from dementia. This equates to 148 people in Tower Hamlets**.**

3.3.7 Blindness and visual impairments are also linked to a higher risk of falls which can be both physically and psychologically damaging. Physically, blind and partially sighted people are 1.7 times more likely to fall and 1.9 times more

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[7]RNIB Sight Loss Data Tool (Nov 2013)
8Unseen: neglect, isolation and household poverty amongst older people with sight loss, RNIB, March,
2004,
9http://www.seeability.org/our_services/knowledge_base/eye_2_eye_campaign.aspx
10Learning Disabilities Tower Hamlets JSNA 2010-11 http://www.towerhamlets.gov.uk/lgsl/701-750/732_jsna.aspx

likely to have multiple falls leading to injury, such as fractured hips. The cost of falls to the NHS in Tower Hamlets in 2010-11 was estimated to be £1,146,000.[11] 21% of this total is estimated to have been spent on those with a visual impairment, this equates to £240,660**.**

3.4 Next Steps

3.4.1 Once the Vision Strategy group was established representing a range of stakeholders from the NHS, LBTH and the voluntary sector, wider consultations took place. A consultation questionnaire was developed and sent out to a diverse range of stakeholders including service users to identify any gaps and priorities in service provision and improve prevention and addressing 'at risk' groups. In addition, a stakeholder event took place earlier in 2014 to identify priorities and begin the development of an implementation plan that will be taken forward by an action planning subgroup.

3.4.2By the end of March 2014, the support through the Thomas Pocklington Trust and the London Vision Forum came to an end. While there will be still attendance by the London Vision Forum as one of the stakeholders, the Vision Strategy group is now chaired by a service user of the Beyond Barrier service user group. The Vision Strategy group will meet quarterly with the action planning group twice yearly. The Vision Strategy group will own the Tower Hamlets Eye Care Plan and oversee its implementation while the action planning subgroup will complete and update the action plan and ensure that the agreed actions are followed up.

3.5 Recommendation

The Tower Hamlets Eye Care Plan supports directly the Public Health Indicator:

- healthcare public health and preventing premature mortality – preventable sight loss

It also would support the indicators

- healthcare public health and preventing premature mortality –health related quality of life for older people
- healthcare public health and preventing premature mortality - hip fractures in over 65s
- health improvement – self reported wellbeing
- Health improvement - falls & fall injuries in the over 65s

Supporting the implementation of the Tower Hamlets Eye Care Plan therefore would contribute to the Public Health indicators as part of the Health and Wellbeing Board performance and monitored by the Board.

4. COMMENTS OF THE CHIEF FINANCE OFFICER

4.1. This report is for information so there are no direct financial implications arising from it. The £9.340m spend by the health service relates to the direct

[11]Falls in Tower Hamlets 2011 http://www.towerhamlets.gov.uk/lgsl/701-750/732_jsna.aspx

costs of delivering the initiatives described in the strategy. The strategy will, however, contribute to public health outcomes which could indirectly assist in lessening the social care needs of some residents.

5. LEGALCOMMENTS

5.1. Section 29 of the National Assistance Act 1948 currently places a duty on the Council to provide services to promote the welfare of blind people in its area. Additionally, there is an existing requirement to maintain a register of blind and partially sighted people, under the 1948 Act. This is intended to ensure that the Council can properly plan service provision.

5.2. Please note that the current legislation will be replaced when the relevant sections of the Care Act 2014 come into effect in April 2015 and April 2016. Section 2 of the Care Act 2014 places a duty on the Council to provide or arrange resources, which will contribute towards preventing or delaying the development by adults in its area of needs for care and support or reduce the needs for care of adults in its area. Section 3 requires local authorities to integrate its care and support provision with health provision.

5.3. Section 77(1) of the Care Act 2014 replicates and replaces the existing duty on the Council to establish and maintain a register of sight-impaired and severely sight-impaired adults who are ordinarily resident in its area.

5.4. The recommendation that the HWB should note and support to contents of the Plan for Eye Care and Inclusion 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. As the HWB has statutory status, due regard should be given to its decision making authority within its terms of reference.

5.5. These recommendations are within the terms of reference of the HWB agreed by the Mayor in Cabinet on 4 December 2013, in particular:

- 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.

5.6. When considering its approach to planning how to meet the needs of residents in respect of sight and eye care, 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 do not.

6. ONE TOWER HAMLETS CONSIDERATIONS

6.1 The Tower Hamlets Eye Care Plan will improve the pathways to eye care and contribute to improved access to treatment and early interventions and awareness raising to reduce preventable visual impairment and sight loss. There is an emphasis on reaching vulnerable and other at risks groups such as older people, those living with dementia and a learning disability; there is also a focus on residents of BAME background where they fall within identified risk groups. One important element of the TH Eye care Plan is its emphasis on inclusion of people with visual impairments and sight loss. The themes of the Tower Hamlets Community Plan that the Tower Hamlets Eye Care Plan addresses are

- A healthy and supportive community - objective 2: helping people to live healthier lives and objective 3: enabling people to live independently, particularly those with mental health problems
- a great place to live - objective 5: providing effective local services and facilities

7. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

7.1 There are no immediate sustainability or environmental issues to consider. All commissioned and internally provided services would be required to comply with all national and local legislation regarding energy conservation, recycling etc.

8. RISK MANAGEMENT IMPLICATIONS

8.1. Currently LBTH does not have an eye care plan. This plan would support closer working relationships between different services which share the responsibility of eye care. [Authors should identify how the proposals in the report mitigate any risk to the Council and/or any risks arising from the proposals themselves and the action taken to address these.]

9. CRIME AND DISORDER REDUCTION IMPLICATIONS

There are no immediate crimes and disorder reduction implications.

10. EFFICIENCY STATEMENT

10.1 The Tower Hamlets Eye Care Plan would implement a more effective pathway to treatment along with early interventions and awareness raising on how to prevent preventable visual impairment and sight loss. It would thereby contribute to maximising independence and avoid costly and more intensive care.

Appendices and Background Documents

Appendices

- Tower Hamlets Eye Care Plan

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

Officer contact details for background documents:

-

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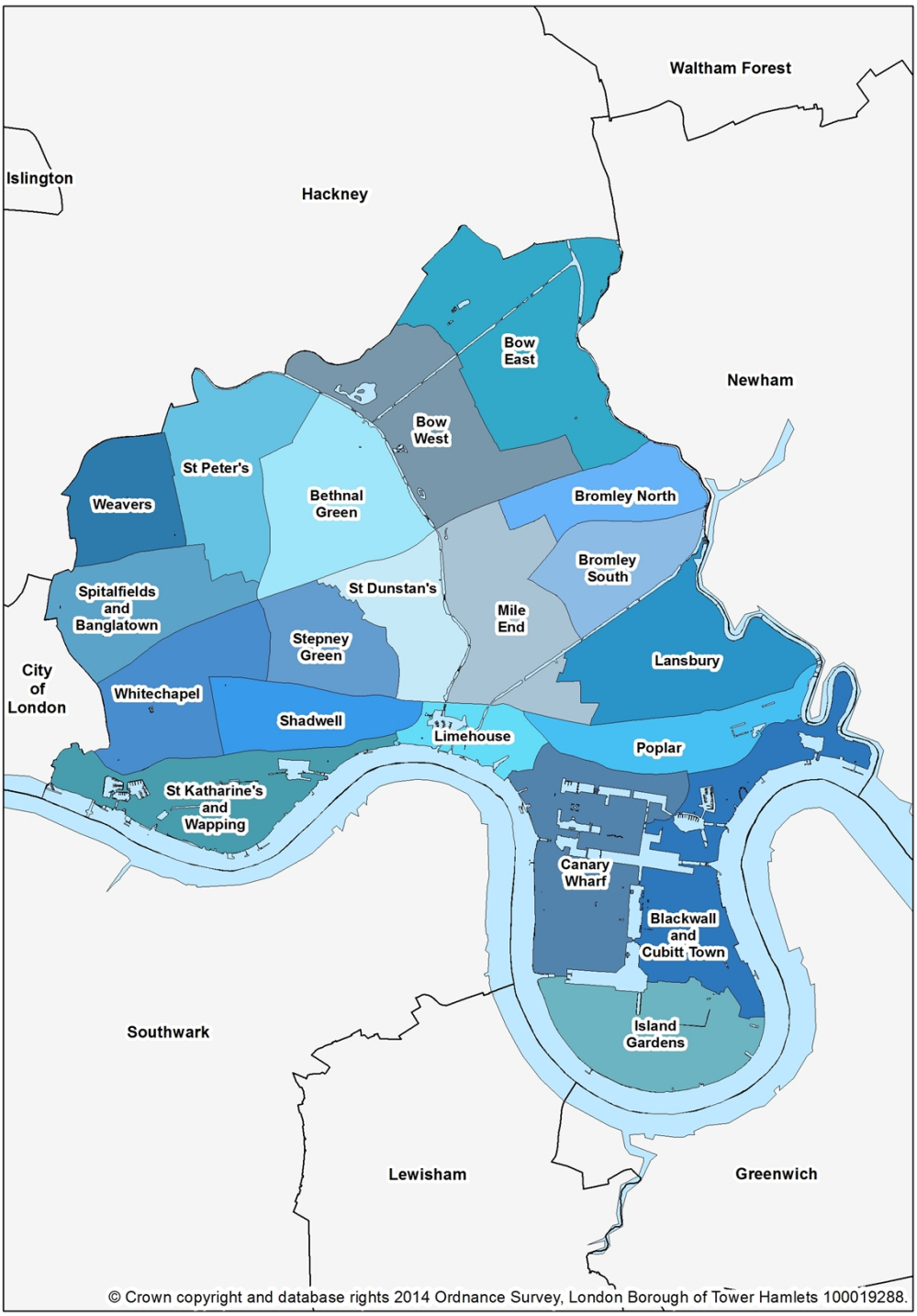
Vision for Tower Hamlets:

A Plan for Eye Care & Inclusion

2013 – 2016



Contents

Executive Summary

Tower Hamlets Vision Plan sets out the current landscape for eye health and visual impairment support provision in the Tower Hamlets identifies service and delivery considerations and sets out recommendations for current and future service provision.

The Plan brings together professionals across hospitals, health agencies, the council, voluntary sector, patients and service users to evidence current and future service requirements, resulting in a cross sector plan of action that supports the implementation of Outcome Frameworks for the NHS, Public Health and Adult Social Care.

The main challenges facing Tower Hamlets in its provision of eye health and visual impairment support services are:

- The population of visually impaired people in Tower Hamlets is expected to increase from 3,340 to 3,950 by 2020 [1]
- In 2010/11£9.34 million was spent by Tower Hamlets Primary Health Care Trust on 'Problems of Vision'. With an expected increase in visual impairment by 2020, this could rise significantly over the next 7 years[2].
- 50% of visual impairment, and expenditure, is avoidable. Greater awareness of eye health, improved sight loss pathways, more timely detection of eye disease and changes to individuals' lifestyles are some of the factors that can reduce this.

Reducing unnecessary sight loss can potentially lead to cost savings within local areas as well as helping to maintain good health, wellbeing and independence for individuals through the modification of lifestyle and increased awareness of visual impairment.

While there is some great work happening to support those with a visual impairment in Tower Hamlets there are also some critical gaps. The most critical main gaps in the provision of vision services are:

- **Health and Wellbeing**: Embed the Vision Plan into the Health and Wellbeing framework, and achieve a user led partnership approach to the planning, delivery and evaluation of eye health and sight loss support services (Action Plan 1)
- **Prevention**: Maximise the uptake of eye examinations and raise awareness of eye health to ensure that avoidable sight loss is prevented wherever possible (Action Plan 2)
- **Joined up data:** Ensure that comprehensive cross sector data on sight loss and local demographics is collected and shared to inform resource allocation across

1 RNIB Sight Loss Data Tool (Nov 2013)
2 2010-11 Programme Budgeting Benchmarking Tool Version 1.1 27.01.12

Public Health, NHS, Optometry, Social Care and Voluntary organisations (Action Plan 3)

- **Joined up services:** Ensure that an effective and efficient service provision is available, resulting in a clear pathway for people experiencing sight loss from diagnosis through to independent living. This will include optometrists, GPs, eye clinics, social care teams and voluntary services (Action Plan 4)
- **Social inclusion and independence**: Ensure that people with sight loss have good access to key local services - information, transport, leisure, employment, education and welfare rights to obtain and maintain independence and not experience social exclusion, inequality or isolation (Action Plan 5)
- **Children's services**: Develop and embed into the main Vision Plan considerations for children and young people, including evidence of current and future need, sight loss pathway, arrangements for transition to adult services and an action plan to address gaps and need (Action Plan 6)
- **Visually Impaired people with complex needs:** Ensure that the needs of people with visual impairment as a secondary presenting condition are recognised. Visual impairment is often overlooked in those with, for instance, Dementia, Parkinson's, Learning Disabilities, etc. (Action Plan 7)

The immediate priorities, identified through consultation with visually impaired people in Tower Hamlets are:

- **Health and Wellbeing**:
    - Embed the Vision Plan and Eye Health JSNA (2009) into the Health and Wellbeing framework and Commissioning Plan,
    - Ensure links with Tobacco Control, Healthy Weight, Healthy Lives (Obesity), Diabetes, Falls strategies are in place.

- **Prevention:** Maximise the uptake of eye examinations and raise awareness of eye health, through targeted campaigns, to ensure that avoidable sight loss is prevented wherever possible.

- **Joined up data:** Implement method of identifying agreed accurate cross-sector figures for the number of local people with sight loss or low vision.

- **Joined Up Services: Improved guidance on existing services:**
    - **Referral Systems**: Ensure referral systems between the sectors (Health, Social Services (Adults and Children) and Voluntary) are in place and being used effectively.
    - **Community Optometry:** Re-address and re-commission the Learning Disability Service, Low Vision Service and Direct Cataract Referral Scheme
    1. **Eye Clinic Liaison Officers**: Provide an Early Intervention/Advice and Information Service at all Eye/Low Vision Clinics

2. **Ongoing Support:** Maximise the opportunities for both those with sudden sight loss and long-term degenerative conditions to access on-going rehab and emotional support services at any and multiple points in their life.

- **Social inclusion and independence:**
  - **Accessible formats:** Increase availability of information on services, social activities and appointments (GP and hospital) in accessible formats
  - **Visual Awareness Training:** Increase visual awareness training for staff who provide public services (esp. with regard to transport, employment services, life-long learning, leisure services)
  - **Navigation:** Address street furniture, uneven pavements, barriers and bleepers at road crossings, to enable Visually Impaired people to travel safely

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1. Introduction

The Tower Hamlets Vision Plan aims to provide a single portal for the planning, commissioning, delivery and evaluation of services for eye health and visual impairment support in the Tower Hamlets. It also aims to ensure that Tower Hamlets is able to implement national outcomes linked to eye health and visual impairment set out in the Government's outcomes frameworks for the NHS[3], Public Health[4] and Adult Social Care[5]. References to the relevant outcomes are made throughout the document.

The Plan sets the stage for the development of seamless, cost effective and joined up prevention initiatives and service provision in Tower Hamlets that puts patients and service users at the heart of their delivery. The Plan and its accompanying Action Plan is clear opportunity to respond to the Public Health Outcome Framework aim of having a comprehensive agreed inter agency plans for responding to public health incidents (3.7). An accompanying action plan will ensure that the recommendations are owned and implemented across all key sectors.

The Plan and action plan have been developed by a cross sector planning group, whose members includes patients and service users, clinicians, professionals, senior managers and advisory agencies representing the Local Authority, Health and the Voluntary Sector.

The implementation of the recommendations contained in this document and its accompanying Action Plan will be regularly reviewed by the Tower Hamlets Vision Strategy Group and revised as local policy, strategy, priorities or service considerations in the Tower Hamlets change.

The Tower Hamlets Vision Plan implements the UK Vision Strategy[6]; the UK Vision Strategy's three outcomes are:

- Everyone in the UK looks after their eyes and their sight.
- Everyone with an eye condition receives timely treatment and, if permanent sight loss occurs, early and appropriate services of support is available and accessible to all.
- A society in which people with sight loss can fully participate.

Visual impairment impacts our community on many different levels; on a personal level it can be a deeply traumatic life event. On an economic level, it is estimated that in 2008 visual impairment cost the UK £22 billion. Yet, the number of visually

3 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131723.pdf

4 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_132559.pdf

5 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_133335.pdf

6 http://www.vision2020uk.org.uk/ukvisionstrategy/page.asp?section=32&sectionTitle=About+the+Strategy

impaired people living in the UK is set to double from 2 to 4 million by 2050. Therefore, the issues that surround the support and prevention of visual impairment need to be urgently tackled.

"I could not believe it. It was like somebody had ripped the rug from underneath my feet. I was in no man's land." [7]

The development of a visual impairment can be an upsetting and disrupting experience. It can lead to the loss of one's employment, hobbies and leisure activities, routines need to be adapted, and everyday tasks become harder to achieve without outside help. Depression is also a common consequence of visual impairment in later life. However, these consequences can be eased with the right kind of rehabilitation, support, and enablement. The right support at this time can be crucial in helping individuals regain independence and to re-engage in a social and economic context. In essence, with the appropriate rehabilitation, the costs associated with visual impairment can be eased on a personal, social and economic level.

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Evidence Base

2. Costs, Trends, and Prevalence of Visual Impairment

There are 1,225 registered with a visual impairment in Tower Hamlets; 615 are registered as Severely Sight Impaired (blind) and 610 as Sight Impaired (partially sighted). Of these 105 are under 16 years old.[8]

However, for a number of reasons, not everyone with a visual impairment affecting their day-to-day life is registered as sight impaired or severely sight impaired.[9] Therefore, a much more accurate estimate would be about 3,340 blind or partially sighted people living in Tower Hamlets[10].

Clearly, a more comprehensive registration process would help service providers plan their services more effectively, it would also help empower people living with a

7 Blind female aged 30, 'Executive Report for the Thomas Pocklington Trust: Emotional Support to People with Sight Loss', 30th June 2010, p322.

8 RNIB Sight Loss Data Tool (Nov 2013)

9 This is based on the fact the while 360,000 are registered as blind and partially sighted it is estimated that 2,000,000 people in the UK live with sight loss that affects their day-to-day lives. See http://www.rnib.org.uk/aboutus/research/statistics/Pages/statistics.aspx for more information.

10 RNIB Sight Loss Data Tool (Nov 2013)

visual impairment to push for better low vision services by illustrating their widespread need in Tower Hamlets.

In 2011 £9.34 million was spent by Tower Hamlets Primary Health Care Trust on 'problems of vision'[11].

NB: this refers to the cost of low vision services such as hospital admission for cataract surgery or glaucoma treatment. This does not include the associated costs to the NHS for accidents that arise from visual impairment.

There are 254,100 people living in Tower Hamlets,

- 18,700 are age 0-4
- 43,300 are aged 5-19
- 125,500 are aged 20-39
- 50,900 are ages 40 - 64
- 15,500 are aged 65+. [12]

The ratio of men to women in the Tower Hamlets is 49.6:50.4**.**
51.2% are from black or ethnic minority backgrounds.
The 3 largest migrant groups are from:
Bangladesh 20.1%
India 2.7 %
China 1.9 %[13]

2.1 Future trends in visual impairment and predicted costs

Figure **1** - Predictions of the number of people who will be living in the Tower Hamlets broken down by eye-condition type.

Source: Sight Loss Data Tool (Nov 2013)

Condition	**Current Prevalence**
Age Related Macular Degeneration (AMD)	930
Cataracts	1,250
Diabetic Retinopathy	2,950
Glaucoma	1,690

11 NHS programme budgeting PCT
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_132501.zip

12 2011 Census Population Figures

13 GLA Intelligence: London Borough Profiles 2011/12

It is estimated that there are 3,340 people currently living in Tower Hamlets with a visual impairment. This is projected to increase to 3,950 by the year 2020. This would be an extra 610 people living in the community with visual impairment that impinges on their day-to-day life.[14]

The reasons for this increase will be discussed in detail below but the main reasons for this increase are; an aging population, ethnicity and certain lifestyle factors that place people at increased risk of visual impairment.

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[14] RNIB Sight Loss Data Tool (Nov 2013)

3. Main Diagnoses of Visual Impairment

Public Health Indicator for Eye Health

The first ever Public Health Indicator for eye health came into force on April 1st, 2013.

As part of the new Public Health Outcomes Framework, the Indicator will track changes in the numbers of people who are certified as blind or partially sighted and have lost their sight from one of the three major causes of preventable sight loss: glaucoma, wet age-related macular degeneration and diabetic retinopathy.

The Public Health Framework Date Tool, detailing prevalence in each region can be accessed here:
http://www.phoutcomes.info/search/eye%20health#gid/1/par/E12000007/ati/102/page/0

3.1 Age Related Macular Degeneration – this is the most common form of sight-loss in the UK and mainly affects people aged 50 and over.

Estimates suggest that there are roughly 930 people in Tower Hamlets living with Age Related Macular Degeneration.

3.2 Glaucoma - this is caused by optic nerve damage, although early diagnosis and regular treatment can halt its progression.

Estimates suggest that there are roughly 1,690 people in Tower Hamlets living with Glaucoma.

3.3 Diabetic Retinopathy - is a complication of diabetes, and is also the leading cause of blindness in people under the age of 65. Estimates suggest that there are roughly 11,859 people in Tower Hamlets who suffer from diabetes (with 2,950 currently experiencing background Diabetic Retinopathy) and 80% of people living with diabetes for longer than 10 years will develop some degree of diabetic retinopathy. Consequently, without even accounting for an increase in the number of diabetics, within 10 years there is likely to be a further increase in people living with impaired vision in Tower Hamlets.

3.4 Cataracts – are also common in older people, but can be treated through surgery.

Estimates suggest that there are roughly 1,250 people in Tower Hamlets living with Cataracts.

3.5 Accidents - changes in vision can also result from optic nerve damage caused by brain injuries. The most common cause of brain injuries is a blow to the head during car and motorcycle accidents. Research from the US has also suggested that visual impairment tends to be higher amongst veterans given the higher likelihood of bodily injury, this phenomenon has become known as 'blast trauma'.[15]

3.6 Cancer - there are several cancers that can cause problems with vision. The most direct cause is eye-cancer, which can necessitate the removal of one or both eyes. Regular eye check-ups can help spot the problem early and prevent the need for major surgery. Nasal and sinus cancers may also cause problems with vision, as can cancer of the nasopharynx (the tube that connects the nose to the back of the mouth) and brain tumours.[16]

3.7 Neurological Conditions - There are also several neurological conditions that are closely associated with visual impairment, the most common of which is Multiple Sclerosis (M.S.). This is a condition where the immune system attacks the brain, spine and optic nerves. One of the first symptoms of M.S. can be the loss or blurring of vision, therefore it is important that eye-health professionals are able to recognise symptoms and refer patients is necessary.

3.8 Strokes – are similarly a risk factor in the development of visual impairment. Around 60% of stroke survivors have some form of visual impairment, such as loss of visual field, blurred vision, double vision and 'tunnel' vision.[17]

There were 2044 strokes in 2012 in Tower Hamlets**.** The 2006/7 incidence of Stroke emergencies was 151.8, which in 2008/9 increased to 153.5.[18]

3.9 Genetic Eye Conditions - In addition to the above sight loss condition there are a diverse range of eye disorders which can result in blindness; (eg Retinitis Pigmentosa – RP) these conditions can have a genetic origin, in many cases the deterioration is a gradual erosion of sight, taking decades and may remain undiagnosed until a significant impact on an individuals sight is experienced. These conditions are rarely treatable, making the need for direct access to consistent levels of support and rehabilitation services essential throughout a person's life as adaptation to the loss of vision takes place.

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15 http://www.aao.org/publications/eyenet/200811/woundsofwar.cfm

16 For more information on sight loss and cancer consult: http://www.cancerresearchuk.org/home/

17 For more information see http://www.rnib.org.uk/eyehealth/eyeconditions/eyeconditionsoz/pages/stroke.aspx.

18 Tower Hamelets Stroke: factsheet : https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=7&cad=rja&ved=0CFYQFjAG&url=http%3A%2F%2Fwww.towerhamlets.gov.uk%2Fidoc.ashx%3Fdocid%3D2fd81f12-8ee3-45d7-9b83-c7754d61bae2%26version%3D-1&ei=OBSnUYmDM8S_Oe3dgMgB&usg=AFQjCNE1zo7gj0r5cK_Zyj5YYde3SdSdDg&bvm=bv.47244034,d.ZWU

4. Socio-Economic Factors

4.1 Deprivation - Tower Hamlets is a deprived borough. It is ranked 3rd out of 32 for levels of deprivation in London, and 7th out of 346 in England.

Research has shown that three out of four people with visual impairment live in, or on the margins of, poverty.[19] This means that those living with a visual impairment are also more likely to be the some of the most economically vulnerable in the Tower Hamlets. Those with a low life expectancy are also more likely to develop a visual impairment later on in life, due to poorer health indicators throughout their lives.

4.2 Ethnicity - also affects one's chances of developing a visual impairment.

Glaucoma - is more common in people of African, African-Caribbean, South-East Asian, or Chinese origins.
Cataracts – are more common in people of Asian origin.
Diabetic Retinopathy – is more common in people of African, African-Caribbean, or Asian origins.

Tower Hamlets has a black and ethnic minority (BAME) population of 51.2%
The three largest groups are:
Bangladeshi 20.1%
Indian 2.7%
Chinese 1.9%20

Research by Sight Loss UK has suggested that information campaigns targeting black and ethnic minority populations can be highly cost effective in prevention campaigns.[21]

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19 Unseen: neglect, isolation and household poverty amongst older people with sight loss, RNIB, March, 2004,

20 London Borough Profiles 2012

21 Darwin Minassian and Angela Reidy Future, Sight Loss UK 2: An epidemiological and economic model for sight loss in the decade 2010-2020, Epivision and RNIB, 2009.

5. Life and Lifestyle Factors

Lifestyle factors have a significant bearing on the prevalence of visual impairment in a local area. The main factors are listed below with an indication of how we might expect their relevant importance to increase (or decrease) in the next few years.

5.1 Aging – on a positive note, improved public health, nutrition, and lifestyle means people in the UK are living longer. This is no exception in Tower Hamlets, where the number of people aged 60 + is estimated to increase from 15,570 to 19,293 by 2015.

Unfortunately, 80% of those who are blind or partially sighted are aged 60+. As a consequence, the number of people who suffer from visual impairment will increase by 15,434 within the next 2 years. Aging increases the likelihood, of Macular Degeneration, Cataracts, and Glaucoma.

This will represent a significant challenge for providers of low vision services in the immediate future; an increase in older people in the community will not only increase the number of people seeking help from services, but also alter the needs of those seeking help. Rehabilitation for visual impairment in older people may well need to be done in with reference to other age related health problems, such as poor mobility or dementia.

There is a specific Public Health Outcome indicator for preventable sight loss (4.12). However, there are additional Public Health, NHS and Adult Social Care Public Indicators that can be addressed as part of this Vision Plan

The Adult Social Care Indicators for aging include the proportion of older people (65+) who are at home 91 days after discharge from hospital into re-enablement/rehabilitation services (2B)

5.2 Smoking - the link between smoking and macular degeneration is well documented. Not only are smokers 50% more likely to develop macular degeneration, but they are also likely to develop it at an earlier age. On the other hand, the cessation of smoking (for a period of 20 years) has also been shown to reverse the damage caused by smoking.[22] Tower Hamlets smoking prevalence rates stands at 27%, compared to a national prevalence of 21% in 2011.[23]

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22 'Further Observation on the Association Between Smoking and the Long-term Incidence and Progression of Age-related Macular Degeneration: The Beaver Dam Eye Study', Ronald Klein, Michael D. Knudtson, Karen J. Cruickshanks, Barbara E. K. Klein, Archive of Ophthalmology. 2008, vol. 126, no. 1, pp.115-121.

23 Statistics on Smoking: England, 2011, Health and Social Care Information Centre, Lifestyle Statistics, 2011.

5.3 Obesity - has been shown to be a risk factor for all four major eye-diseases, macular degeneration, Glaucoma, Diabetic Retinopathy and Cataracts.[24]

Given recent trends in obesity, this is a particular point of concern. It is estimated that 20-30% of the adult population in Tower Hamlets is clinically obese indicating that obesity related eye problems will increasingly become a major eye-health issue. [25] In regards to childhood obesity nearly 1 in 7 children aged 4-5, and over 1 in 4 children aged 10-11 are obese in the borough. The obesity rates are the fifth highest proportion of obesity aged 10-11 in London and the sixth highest in the country. [26]

5.4 Alcohol - there is clear association between excessive consumption of alcohol over a sustained period of time and the development of all four main eye-diseases, although, the reason for this is not currently clear. In addition, alcohol consumption by women during pregnancy has also been linked to ocular abnormalities in children.[27]

Tower Hamlets JSNA shows that use of alcohol within the community is moderate, with 63% consuming alcohol in the borough.

Binge drinking in Tower Hamlets has been shown to be increasing. Again, it is likely that this trend will lead to increased pressure on low vision services in the area. Also, accidents resulting in visual impairment are often linked to intoxication.

Recent research on alcohol use amongst older people also suggests that alcohol use amongst older people tends to be higher despite a lower tolerance to its effects. Many health conditions and hospital admissions are also related to alcohol use, which may in turn reflect social isolation, bereavement and loss of status in older age.[28]

5.5 High Blood Pressure - the restriction of blood to the eye can cause damage to the retina and result in the deterioration of eye health. Heart health and good circulation is therefore essential to maintaining good eye health.

In Tower Hamlets, instances of high blood pressure have reached 15,000 people of the borough's population. Again, it is likely that this will strain of the provision of local visual impairment services.

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24 'Obesity and Eye Disease', Cheung and Wong, Survey of Ophthalmology, vol.52, issue. 2, pp. 180-195.

25 NHS Tower Hamlets Adult Obesity http://www.towerhamlets.nhs.uk/about-us/public-health/our-priorities/adult-obesity/

26 NHS Tower Hamlets Childhood Obesity http://www.towerhamlets.nhs.uk/about-us/public-health/our-priorities/childhood-obesity/

27 'Alcohol and Eye-Disease: A Review of Epidemiologic Studies', Hiratsuka and Li, Journal of Studies on Alcohol and Drugs, 2001, May, Vol.62, issue 3.

28 http://www.ias.org.uk/resources/factsheets/elderly.pdf

5.6 Strokes – As previously referred to in the 'Main Diagnosis of Visual Impairment' section, strokes are similarly a risk factor in the development of visual impairment, and will have an impact on the provision of local visual impairment services.

There are approximately 2000 people living in Tower Hamlets who have had a stroke and each year there are approximately 350 incidences of stroke admissions to secondary care each year.[29]

5.7 Diabetes - Diabetes is the leading cause of blindness in working age people. As such, it could be considered one of the most economically damaging factors leading to visual impairment.

There are currently 11,859 of people in Tower Hamlets living with diabetes[30]. National trends have suggested that the number of people living with diabetes has increased by 25% since 2006, and if trends were to continue (given that 80% of diabetics develop retinopathy within ten years[31]) diabetic related visual impairment will become a major pressure on local low vision and rehabilitation services.

Aside from the strong associations between obesity and type 2 diabetes, there are also some important demographic links; people of South Asian origin are six times more likely than white people to develop type 2 diabetes, and those of African-Caribbean origin three times more likely. Members of ethnic minorities are also more likely to develop complications of diabetes at an earlier stage. It is particularly important, therefore, for people within ethnic minorities to be aware of the potential effect of diabetes on their sight.

National guidelines suggest children will not get screened for Diabetic Retinopathy until they are at 12 years old. Therefore it is important that children and their parents are made aware of the impact of diet, lifestyle and condition management before they reach the age of screening to avoid the early onset of Diabetic Retinopathy.

Tower Hamlet's eye screening programme takes place in the diabetes centre in Mile End Hospital. The service provided offers a wide range of services from screening and testing to support and education. One of the services available is HAMLET (Hands-on Approach to Motivation and Lifelong Empowerment Training) is a structured diabetes education for people with type 2 diabetes, which is designed to help people manage their diabetes on a day-to-day basis. DIANA (Daily Insulin dose Adjustment to Nutrition and Activities) is another service that provides an educational course for people with type 2 diabetes, teaching people how to used the tools needed to accurately adjust their insulin to match their carbohydrate.[32]

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29 Stroke JSNA Factsheet 2010-11

30 Diabetes Fact Sheet Tower Hamlets JSNA 2010-2011 http://www.towerhamlets.gov.uk/lgsl/701-750/732_jsna.aspx

31 Klein BE. Overview of epidemiologic studies of diabetic retinopathy. Ophthalmic Epidemiology. 2007 Jul-Aug, vol. 14, no. 4, 179-83.

There are clear indications that the number of people experiencing visual impairment will strain local resources in the coming years as the projected health demographics of Tower Hamlets develop. Therefore, measures that tackle the above factors, such as improved sight loss pathways, better public awareness and increased eye screening could reduce future eye care costs, help to eliminate avoidable visual impairment, and could also improve the overall health and wellbeing of the local community.

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[32] Tower Hamlets NHS http://www.towerhamlets.nhs.uk/your-services/diabetes-service/

6. Other Conditions Linked to Visual Impairment

Delivering a smooth, joined-up and holistic service for those with a visual impairment requires a consideration of additional health and wellbeing factors that are most common in people with visual impairment.

6.1 Learning Disabilities – 1 in 10 people with a learning disability have some form of visual impairment.[33] This means that out of the 1,000 adults in Tower Hamlets with learning disabilities, roughly 100 will also be experiencing some form of visual impairment[34].

Diagnosis of visual impairment in people with severe learning disabilities presents several problems for the health care professional. People with learning disabilities can struggle to use the traditional sight tests, which are based on reading and letter recognition. Those with learning disabilities may also be less able to express to others that they feel that their eye-sight is deteriorating.

Yet, research conducted by the Centre for Disabilities Research in 2008 suggested that only half of people with learning disabilities had received an eye test in the past twelve months. It also showed that the proportion relieving regular eye examinations declined as the severity of the disability increased.[35]

6.2 Dementia - visual impairment is most likely to develop in older people. Therefore, it often accompanies other medical conditions that are more prevalent later in life - such as dementia. Research by the Thomas Pocklington Trust conservatively estimated that 2% of the population aged 75+ are visually impaired and suffer from dementia. This equates to 148 people in Tower Hamlets.

The relationship between dementia and visual impairment is particularly problematic as patients may struggle to remember how their vision has deteriorated over time.

Some forms of dementia have a direct impact on vision, and may cause the loss of functional vision even when a person's eyes are healthy. Recent research has also suggested that some forms of dementia and visual impairment share a common causal pathway. Although this research is still in its infancy, the higher rate of visual impairment in those with dementia certainly suggests a strong link between the two.[36]

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33 http://www.seeability.org/our_services/knowledge_base/eye_2_eye_campaign.aspx

34 Learning Disabilities Tower Hamlets JSNA 2010-11 http://www.towerhamlets.gov.uk/lgsl/701-750/732_jsna.aspx

35 Hemmerson & Hatton, People with Learning Disabilities in England, Centre for Disabilities Research Report, May, 2008, p.14.

36 Pham T, Kifley A, Mitchell P, Wang JJ (2006) Relation of age-related macular degeneration and cognitive impairment in an older population, Gerontology 52, 353-358; Uhlmann RF, Larson EB, Koepsell TD, Rees EB, Duckert LG (1991) Visual

6.3 Deaf blindness – dual sensory loss requires specialist care to enable both communication and mobility. However, despite the need for highly specialised support, Sense UK has suggested that the deaf blind population are significantly underestimated. In January 2014 there were 86 people in Tower Hamlets living with deaf blindness on the Sight and Hearing Service's databace. The Centre for Disability Research has estimated that the population for deaf blindness will increase by 60% in the next 18 years.[37]

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impairment and cognitive dysfunction in Alzheimer's disease, Journal of General Internal Medicine 6, 126-132.

37 http://www.sense.org.uk/Resources/Sense/Publications/Documents/Sense%20of%20Urgency.pdf

7. Health, Wellbeing and Visual Impairment

7.1 Depression – there is a well established link between depression and visual impairment, as discussed earlier. This can result in a reluctance to actively seek help, or respond to help when offered; it has also been shown that those who are depressed have poorer health outcomes from rehabilitation. This is particularly true of older people with visual impairment who are three times more likely to suffer from depression than their peers without visual impairment.[38]

7.2 Social Isolation – Research by the Thomas Pocklington Trust has shown that visual impairment can lead to social isolation because, as mobility becomes harder, one's opportunity to socialise outside the home decreases. It also highlighted that an inability to pick up on important visual cues in social settings makes communication with others difficult thereby increasing social isolation. Finally, visual impairment increases one's dependence on friends and family, this can in turn result in social relationships becoming tense as family members and friends feel the strain of looking after loved ones.[39]

7.3 Falls – can be both physically and psychologically damaging. Physically, blind and partially sighted people are 1.7 times more likely to fall and 1.9 times more likely to have multiple falls leading to injury, such as fractured hips.

The cost of falls to the NHS in Tower Hamlets in 2010-11 was estimated to be £1,146,000. [40]21% of this total is estimated to have been spent on those with a visual impairment, this equates to £240,660.

There is no falls strategy for Tower Hamlets available online. Tower Hamlets does have a Falls Prevention Team that consists of a physiotherapist, occupational therapist, a nurse and rehabilitation support workers. They offer a one to one therapy to improve strength, balance, mobility, confidence and overall function. There is also a twelve week balance and strength training programmes at various centres within Tower Hamlets including a group at Mile End Hospital. [41]

Better planning of public space, transport, and rehabilitation could help prevent the need for resources being spent further down the line on treatment for the physical injuries, as well as improving the psychological wellbeing, of those with visual

38 Burmedi, Becker, Heyl, Wahl and Himmelsback, "Emtional and Social Consequences of Age-Related Low Vision: a narrative view", Partial Sight and Blindness Research, Vol. 4, No. 1, pp. 47-71.

39 'Emotional Support to People with Sight Loss: Research Findings', September 2009, no.26.

40 Falls in Tower Hamlets 2011 http://www.towerhamlets.gov.uk/lgsl/701-750/732_jsna.aspx

41 Community Health Services Tower Hamlets http://www.towerhamlets.gov.uk/lgsl/701-750/734_community_catalogue/staying_healthy/community_health_services.aspx#Falls

impairment. Psychologically, a severe fall causing physical injury can lead to fear of leaving known environments, thereby increasing social isolation.

The additional factors, out lined above, underlines the diverse and varied ways that visual impairment can impact upon the everyday life of visually impaired people. It also highlights the need to consider how visual impairment may be part of the wider needs of the individual. It is a strategic aim of Tower Hamlets that the care and treatment provided for individuals is considered in this holistic manner.

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8. Patients, Service Users and Carers

8.1 Patients and Service Users - In 2012 a national consultation of thousands of service users across the UK was undertaken as part of an initiative called 'Seeing it My Way[42]. The consultation identified 10 key expectations of patients and service users with visual impairment:

1. That I have someone to talk to
2. That I understand my eye condition and the registration process
3. That I can access information
4. That I have help to move around the house and to travel outside
5. That I can look after myself, my health, my home and my family
6. That I can make the best use of the sight I have
7. That I am able to communicate and to develop skills for reading and writing
8. That I have equal access to education and life long learning
9. That I can work and volunteer
10. That I can access and receive support when I need it

8.2 Carers

Tower Hamlets has two carers strategy the 'Carers Plan 2012 – 2015' and the 'Young Carers Strategy'. These plans do not specifically outline the strategy for carers of those with visual impairments.

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Mapping The Sector

9. Introducing the Vision Pathway

The chart below illustrates the ideal path that a service user should experience during the initial process of diagnosis and rehabilitation. It is hoped that this will highlight how service gaps can interrupt the process of rehabilitation, prolonging, or even impeding progress towards an active, independent, and fulfilling life.

Stage 1

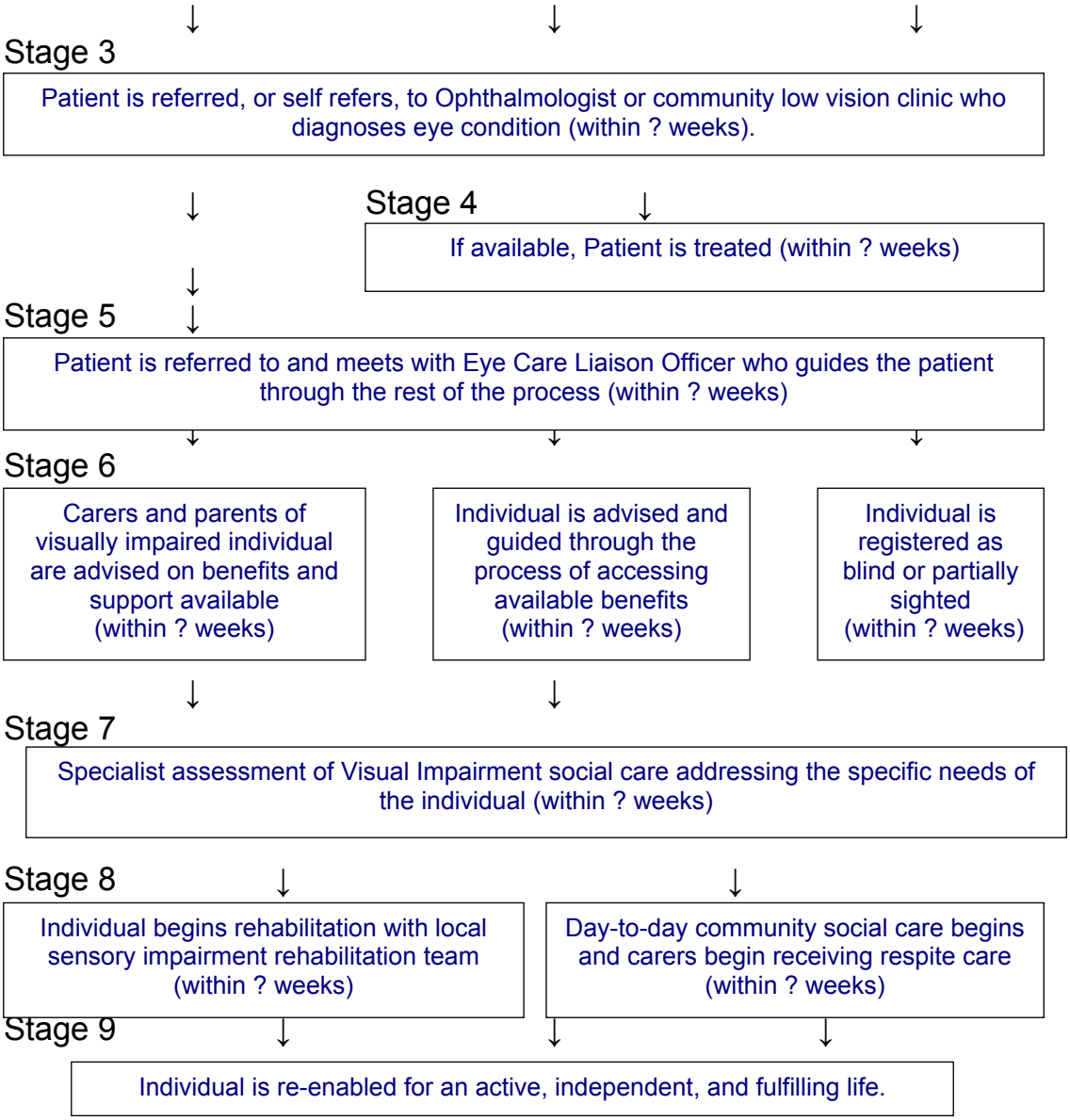
Local eye-health campaigns promote eye-health awareness amongst GPs and encourage individuals to visit their local Optician.

↓ ↓ ↓

Stage 2

Individual, family member or carer refers patient.	Optometrist notes abnormality during regular eye test	GP suspects loss of vision

42 http://www.actionforblindpeople.org.uk/get-involved/campaigns/seeing-it-my-way/



(Total ? weeks)

[N.B. in the ideal pathway a patient can withdraw at any time and re-enter the pathway when they are ready to complete the process

The steps below describe the ideal path that a service user should experience during the initial stages of prevention, diagnosis, treatment and rehabilitation. It is hoped that this will highlight how service gaps can interrupt, prolonging, or even impede early diagnosis, treatment or progress towards an active, independent, and fulfilling life.

Stage 1: Promoting Eye Health

- Implementation of the Public Health Outcome Indicator for sight loss
- Cross sector eye-health and lifestyle campaigns to promote eye-health awareness and the impact of lifestyle on vision with the general public
- Activities to increase knowledge and awareness of local service provision and referral mechanisms across service providers and professionals

Stage 2: Spotting the Problem

- Individual, family member, carer or professional refers patient to Optometrist, GP or Hospital
- Optometrist notes abnormality during regular eye test.
- GP suspects loss of vision

Stage 3: Diagnosis

- Patient is referred, to Primary Eyecare Acute Referral Scheme (PEARS) service (if available)
- GP, Optometrist or PEARS service refers to an Ophthalmologist. Eye condition is diagnosed
- GP, Optometrist, Ophthalmologist or PEARS service refers to a community low vision clinic, who assesses patient (within **8** weeks)

Stage 4: Treatment

- Ophthalmologist treats patient (within maximum of 18 weeks), who advises whether sight is recoverable, will further deteriorate or is untreatable. Patient advised whether eligible for Certificate of Visual Impairment (CVI) and if so this is issued within 5 days of patient's agreement.
- Community Low Vision Clinic provides support with visual aids and adaptations

Stage 5: Introduction to Support

- Where available, patient is referred to and meets with Eye Clinic Liaison Officer (ECLO) or equivalent
- Patient receives information on emotional and psychological support options available
- Individual is signposted to voluntary sector organisations options for information and support

Stage 6: Emotional and Practical Support

- ECLO/equivalent advises and supports the patient, their carer or parents to access benefits and support (within **1** week)
- Individual is registered as blind or partially sighted (within **1** week)
- Individual begins emotional and practical support options via formal or informal counselling, and support from Voluntary Sector organisations
- Local Authority or contracted agency contacts to begin social care assessment

Stage 7: Assessment and Rehabilitation

- Specialist assessment of individual by social care or contracted agency to address the specific needs (within **5** weeks)
- Individual begins rehabilitation with local sensory impairment rehabilitation team or contracted agents (within **16** weeks)
- Day-to-day community social care begins and carers begin receiving respite care

Stage 8: The Road to Independence

- Individual's health and social care needs are reassessed at regular intervals and programme of care is adjusted accordingly
- Individual is advised of the level of care to be provided by the sensory team and purchase of services (within **1** week)
- Individual accesses Voluntary Sector support, activities, events, training and other services
- Individual is supported to undertake independence activities (accessing transport, leisure, education, employment)

Stage 9: Independence

- Individual is able to live an active, independent, and fulfilling life.

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10. Services on the Visual Impairment Pathway in Tower Hamlets

This section has been organised to follow the ideal path that a person might experience in relation to prevention, or on identifying eye health problems or visual impairment might follow

10.1 Stage 1 – Promoting eye-health

Local public health campaigns that promote the eye-health of the local community, especially those that target 'at risk' groups, are an essential in sparking the process of diagnosis and rehabilitation.

There is currently no public awareness campaign focusing on eye-health in Tower Hamlets.

It is important that practitioners and professionals across the eye health and sight loss support pathway are aware of services that may complement or overlap their own service provision, which will improve the seamlessness of services (which also has the potential to reduce costs).

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10.2 Stage 2 - Spotting the Problem

The agencies described below are crucial in Tower Hamlets eye-care system; it is through visits to a local high street Optometrist, or to the GP, that early signs of eye-sight deterioration will be picked up. This means that these agencies tend to be the

first point of contact that individuals losing their sight will have with eye-care professionals.

Local Optometrists - Optometrists play a vital role in the maintenance of eye-health, whether they are based on the high street or in local hospitals. Therefore, it is important that members of the community are able to access local Optometrists. There are 19] high street optometrists in Tower Hamlets**,** who serve a population of 254,096 - this equates to one optometrist per 13,373 of the population.

Research by RNIB has shown a tendency for people to visit their local high street optometrist only when they sense a problem with their sight. This lessens the ability of local optometrists to act as an early warning system for potential eye-disease, by finding and noting abnormalities before they become a problem. This is important in conditions such as glaucoma where the deterioration is not reversible but can be halted by the right treatment at the right time.[43] It is also suggested that both ease of transport to a high street optometrists and their optometrist's perceived independence from the need to sell spectacles both influenced the likelihood of individuals attending eye tests. [44]

With numerous competing companies, and patients not limited to a specific locality to access an eye-test, service provision is somewhat fragmented. Therefore, it is not possible to provide statistics for the number of people who had an eye-test within the last year.

Eye tests for users with specific needs
Optometrists who offer low vision assessments or enhanced eye tests for people with a learning disability:
G Bleetman
347 Bethnal Green Road, E2 6LZ
Tel: 020 7739 2356

Eye Society Opticians
94 Whitehorse Lane, E1 4LR
Tel: 020 7702 8253

Gore Opticians
130 Roman Road, E2 ORN
Tel: 020 8980 3872

L A Sackwild Opticians

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43 The barriers and enablers that affect access to primary and secondary eyecare services across England, Wales, Scotland and Northern Ireland: A Report to RNIB by Shared Intelligence, Carol Hayden, RNIB Community Engagement Projects, January, 2012.

44 The barriers and enablers that affect access to primary and secondary eyecare services across England, Wales, Scotland and Northern Ireland: A Report to RNIB by Shared Intelligence, Carol Hayden, RNIB Community Engagement Projects, January, 2012.

237 Whitechapel Road, E1 1DB
Tel: 020 7247 4442

Watney Eyecare
Watney Market, E1 2PP
Tel: 020 7702 8256

Local GP Services - It is also possible that problems with a patient's eyesight might be picked up by their GP. However, the most common role for the GP is to refer patients to their local eye hospital for further testing and diagnosis. This can often be a slow and frustrating experience for patients concerned about deterioration of their vision.

There is currently no information on any GP's with a special interest in Optometry or Ophthalmology in Tower Hamlets.

There is currently no information on any actions that are being taken to ensure Doctors Surgeries are accessible.

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10.3 Stages 3-4 – Diagnosis and Treatment

The NHS Framework identifies several outcomes that relate to the diagnosis and treatment of long term conditions. These include Ensuring that people feel supported to manage their condition (2.1), Improving people's experience of outpatient care (4.1) and improving people's experience of accident and emergency services (4.3).

The Adult Social Services outcome Indicator relating to diagnosis and treatment states that 'earlier diagnosis, intervention and re-enablement mean that people and their carers are less dependent on intensive services' (2A). Note: Indicator (2A) also relates to health and wellbeing indicator referred to at stage seven in the pathway.

Services available in Tower Hamlets include the following:

PEARS - Many areas are now operating a Primary Eyecare Acute Referral Scheme (PEARS), where accredited optometrists are able to carry out further tests themselves without the need to refer to doctors or local eye hospitals. This saves the NHS the costs of treating individuals in secondary care settings and the patient time and anxiety while they wait for further tests.

Community Low Vision Service – Tower Hamlets does have a community low vision service that picks up on individuals who have a visual impairment that does not require hospital treatment, and those who have completed a course of treatment

by an Ophthalmologist, but do not need further hospital treatment. Low vision services are an important method of early detection of new eye conditions, in discharged patients and the early onset of eye conditions in patients who have not yet been referred to an Ophthalmologist.

The Community low vision service is held on the first Monday of the month at LBTH Sight and Hearing Service, Albert Jacob House, 62 Roman Road, London E2 0PG. For more information contact Mary Ellis or Carol Excell on 020 7364 6953

Orthoptists - Orthoptists specialises in defects in binocular vision and eye movement abnormalities. Although Orthoptists work with patients of all ages, because of their profession tends to specialise in areas such as lazy eye or squints, many have a specific role of preventative screening and treatment of children, in addition to the work they undertake in hospitals and local communities.

Ophthalmology Provision – The main hospital with specialist Ophthalmology departments serving Tower Hamlets is Moorfields and The Royal London Hospital.

In The Royal London Optometry department there are facilities to treat Glaucoma, Diabetic Retinopathy and Cataracts. They do not offer treatment for ARMD, for which patients would need to travel to Moorfields to receive treatment.

For those living furthest away from The Royal London Hospital in Tower Hamlets, travelling to the hospital (via public transport) takes, on average, 35 minutes.

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10.4 Stages 5-6 – Emotional and Practical Support

Eye Clinic Liaison Officer (ECLO) - The role of an ECLO (is to provide practical support for newly diagnosed patients. For instance, an ECLO should be able to signpost social services and local voluntary organisations that can provide additional support or information on benefit entitlement and other forms of support.

ECLO's can also provide initial emotional support for patients coming to terms with their diagnosis, which has been indentified as a service not always offered by time-pressed Ophthalmologists. Ideally, an ECLO will remain with a patient throughout their journey towards re-establishing independence life.[45] Research by City London University suggests that a majority of professionals (90% of clinical staff and 63% rehabilitation officers) believe that ECLO's significantly improve patient experience.

Eye Clinic Liaison Officers may also be known by other job titles, but will be providing similar role in support and signposting of the newly diagnosed and those undergoing treatment for eye conditions.

Most people are referred to Moorfields Eye Hospital and The Royal London Hospital. Moorfields has an ECLO. The Royal London Hospital used to have an ECLO service, but does not currently.
The role is key to ensuring that early registration takes place, that the newly diagnosed are provided with and signposted to early support and that there are accurate figures to inform the Public Health Outcome Indicator.

Ensuring Early CVI Registration – it is important that all those who are eligible to be CVI registered are identified at the earliest opportunity. The role of the ECLO or the voluntary sector is one key aspect that enables this to happen. However, Optometrists, Ophthalmologists, Social Care and the Voluntary sector need to work together more closely to share information and statistics, and develop cross sector working practices that will ensure the early identification of all those who are eligible for registration, even if they are not currently at any stages of the vision pathway. (Action Plan Action 3).

Psychological, Emotional and Practical Support – the ECLO and/or local voluntary organisation is able to signpost to or provide initial support at the time of diagnosis or need. In addition to this support, other emotional and psychological support includes:

45 http://www.rnib.org.uk/aboutus/research/reports/2011/eclo_role_report.doc Cost implications for the ECLO role - The average price of the ECLO training course is £760.00 based on information collected from the ECLO survey. The average annual cost of employing an ECLO is £38,170 pro rata. This includes salary costs, employer national insurance and superannuation contributions, overheads such as telephone, heating and stationary, capital overheads such as building and fittings costs and one time training and set up costs. The cost of an ECLO per patient per contact is £17.95 assuming an average of 9 patients are seen per day, in a 42 week year. The costs involved are likely to rise every year in line with inflation and this must also be borne in mind. Costs are also likely to be 15%-20% higher in London.

Tower Hamlets Improving Access to Psychological Therapies (IAPT) service and is known as Community and Primary Care Psychology Counselling Service. Within service is the Disability Counselling Service (DCS) that provides a specialist clinical counselling service to newly disabled people or people with acquired disabilities their families and carers. The service offers counselling in a variety of languages: English, Sylheti, Bengali, Hindi, Urdu and British Sign Language. [46]

There are also a variety of voluntary sector organisations that offer information about the emotional and practical support. See 10.5.3 below

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10.5 Stage 7 – Assessment and Rehabilitation

There are several Adult Social Care Outcome Indicators that relate to the assessment and rehabilitation stages of the pathway. These include:

- Everyone has the opportunity to have the best health and wellbeing throughout their life, and can access support and information to help them manage their care needs (2A) Note: This indicator also refers to the earlier diagnosis indicator at stage 5 in the pathway
- People know what choices are available to them locally, what they are entitled to and who to contact when they need help (3C)
- People, including those involved in making decisions on social care, respect the dignity of the individual and ensure support is sensitive to the circumstances of each individual (3D)
- The proportion of people who feel safe (from harm, injury, abuse and able to manage risk (4A)
- The proportion of people who use services who say those services have made them feel safe and secure (4B)

10.5.1 Sensory Loss Teams – The Sight and Hearing Service in Tower Hamlets deal with people who are aged 18 and over with either visual or hearing impairment, as well as people with dual sensory loss. It is unclear what number of people in the sensory loss team who specialise in visual impairment. The main tasks and responsibilities of the sensory loss team are to provide:

- Social work support
- Information, support and advice
- An assessment o needs with regard to sight loss, hearing loss and dual sensory loss.
- Support services to meet eligible needs following assessment, this mat include home help and specialist equipment.
- Rehabilitation training and equipment to encourage independent living skills.

[46] http://www.towerhamlets.nhs.uk/your-services/mental-health-services/online-directory-of-services/?entryid101=39251&p=11

- Mobility training
- Classes in Braille and advice on IT equipment
- Communicator guides, BSL interpreters, a BSL video link and interpreters in community languages
- Links with local community groups and the NHS who work with adults that have sensory loss.

The Sight and Hearing Service is located at:
Albert Jacob House,
62 Roman Road
E2 0PG
Tel: 02073646953
Email: sensory@towerhamlets.gov.uk

The referral of patients to the Sight and Hearing Service is done via self-referral, GP, hospital the average waiting time for patients to begin rehabilitation is **40** working days.

10.5.2 Children's Sensory Loss and Rehabilitation Services

Tower Hamlets Vision Impairment Service forms part of the Sensory Support Team, alongside the Service for Deaf and Partially Hearing. These teams lie within the Borough's Support for Learning Service.

It works with visually impaired children, young people and their families from the age of diagnosis until 19 years of age (depending on educational setting). It is a team of 6 qualified teachers of the visually impaired (adding to 5.1 full time posts) and 2 full time specialist V.I. instructors. The main focus is raising educational attainment. It also prioritises wider and long term issues such as independence, mobility, family engagement, social and emotional wellbeing. One of the team is bilingual to aid our liaison with families.

The Early Years teachers provide a service for pre-school babies and youngsters with a vision loss. They support in the home, introducing families to the Developmental Journal, which tracks the child's progress. They run a weekly group called DOVES, a parent and child drop-in session. This allows families to meet and teachers to model good practice with V.I. children during play and light stimulation.

For pupils educated within the Borough at mainstream and special schools, they have a core offer and provide interventions at a low, moderate and high level depending on pupil need. The support pathway generally begins with a hospital referral to the service. The team has strong working relationships with the Royal London Hospital, Moorfields and GOSH. Schools and other professionals can refer to Tower Hamlets Vision Impairment Service via CAF if there is a visual diagnosis.

A team member will then carry out a functional vision assessment and a SERSEN Needs Analysis to determine the level of intervention needed for that child.

Tower Hamlets Vision Impairment Service supports and monitors over 200 youngsters with vision impairment in Tower Hamlets across homes, nurseries, schools and during transition to college. Tower Hamlets is an inclusive borough, so parents of a V.I. child can be assured of support in any school. However, there are currently a number of visually impaired pupils educated at Morpeth secondary school where resources and staff specialisms have been built up to enable curriculum modification, adaptation of materials and Braille Teaching. Mulberry Secondary School for Girls also has a number of V.I. Pupils and a breadth of experience in this area.

The team writes reports and advice sheets which schools find invaluable. These help explain eye conditions and their implications, give information on the periodic eye tests they have carried out and advise on issues such as lighting, print size, position in class, modification, resources and access technology. Team members attend annual reviews and help set targets. They liaise regularly with pupils so that they can represent their views and help with social and emotional difficulties.

In special schools, the team's focus is to create small step increase in the child's use of vision. They encourage classroom staff to join them in assessments, set workable targets and stimulate the child's residual vision. Light work in optimum dark room conditions can spark the first realization that looking brings rewards and information.

Youngsters who are resident in Tower Hamlets, but educated out of borough are monitored by Tower Hamlets Vision Impairment Service service at annual reviews.

They buy in the services of a senior MSI consultant to provide specialist assessment and advice for dual sensory (deaf/blind) pupils. They also provide mobility and habilitation training for pupils to increase their independence and self-help skills.

The service set up a weekly Braille class to train teaching assistants in the borough as qualified and nationally accredited Braillists. Parents are also welcome at this class.

Where necessary, they support families at their specialist eye clinic appointments.

They have formed the Children's Sensory Team with Social Care colleagues to find solutions for visually impaired pupils and their families using joint professional expertise. They also attend multi agency meetings on a child's behalf and take part in cross agency groups with the intention of promoting VI issues in the borough.

Vision Impairment Service
Team Leaders: Philippa Moody and Lorna Paterson

020 7364 6321

10.5.3 Third Sector Organisations – Blind Society/Voluntary Sector Organisation can offer additional support for sensory loss and rehabilitation which includes:

Beyond Barriers

Chairperson: Ashrafia Choudhury Mobile Number: 07956510008 Email: ashrafia1@btinternet.com
Secretary : Mahendra Rastogi Mobile Number: 07850000095 Email mahendrarastogi@gmail.com

User led peer support group, which runs a monthly programme of meetings and outings/activities.
The overall purpose of Beyond Barriers is to assist visually impaired people, living or working in Tower Hamlets and surrounding boroughs, combat social isolation, increase self dependence and enhance the quality of their lives. Beyond Barriers aims to enable visually impaired people to live a valued life and participate fully in society socially, economically and politically.

BlindAid

020 7403 6184
enquires@blindaid.org.uk
Home visiting service, telephone befriending and annual events for people with a visual impairment in the 13 inner London boroughs, including Tower Hamlets.

Deafblind UK

Tel/Textphone: 01733 358 100
Email: info@deafblind.org.uk
Address: Deafblind UK Head Office, National Centre for Deafblindness, John & Lucille van Geest Place, Cygnet Road, Hampton, Peterborough, PE7 8FD
Deafblind UK - Our overarching goals

To work towards a more equal society by raising awareness and understanding of deafblindness by engaging with people who have a sight and hearing loss, the Government and other organisations, individuals and communities.
To enable people with both a sight and hearing loss to remain in their own homes and participate in their local communities.
To provide relevant, high quality **Peer Support**, **Befriending** and **Information and Advice** services to people with a dual sensory loss, helping them to; live independently, interact with others, understand their rights and access their entitlements

Deafblind Tower Hamlets group meets monthly

Mobility Support Services
5 Clove Crescent
E14 1BY
Tel: 02073645003
Email: mobility@towerhamlets.gov.uk
Provides a wide range of concessionary travel and parking schemes to give residents with disabilities greater opportunities for independent travel.

RLSB (Royal London Society for Blind People)
Telephone: 02078086170
Email: enquiries:rlsb.org.uk
Address: London office, Royal London Society for Blind People (RLSB), Victoria Charity Centre, 11 Belgrave Road, London, SW1V 1RB
RLSB - focuses particularly on supporting the education and skill development of blind and partially sighted young people in London.
They run a peer support group in Tower Hamlets for young people up to the age of 25.

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10.6 Stage 8 - Independence and Accessibility

To help inform services that facilitate independence, Tower Hamlets has surveyed [number] local venues for accessibility, which is available on the Tower Hamlets pages of the Disabled GO website. The aim of the site is to identify local businesses and services that are disabled accessible.

(Note: To find out information in your Tower Hamlets click on link below)
http://www.disabledgo.com/en/search

10.6.1 Transport

Tower Hamlets has a Transport Planning Strategy 2011-2032 is available on the Tower Hamlets website at: http://www.towerhamlets.gov.uk/lgsl/451-500/493_planning_policies_for_tran.aspx The strategy does now specifically outline the plan for those with a visual impairment.

Buses – There are 28 bus routes and 10 night bus routes running through Tower Hamlets**.** The area does have talking buses however does not have talking bus stops.

(**Note** – specific Tower Hamlets information on buses can be sourced via http://www.tfl.gov.uk/tfl/businessandpartners/buses/Tower Hamletsreports/)

Dial a Ride – Dial a Ride is a Transport for London initiative specifically for people with a disability who cannot use public transport to go shopping, visiting and access leisure activities.

TaxiCard – The Tower Hamlets TaxiCard scheme is for people who have serious mobility and sight impairment resulting in difficulty in using public transport. The service is subsidised by Tower Hamlets. For each trip taken the user must pay the first £1.50, the council will then pay a maximum of £10.30 per trip.
Tower Hamlets has a banding system for taxicard usage which is determined by the LBTH criteria.

Band 1 gives up to 4 journeys a month
Band 2 gives up to 8 journey a month
Band 3 gives up to 12 journeys a month
Band 4 gives up to 16 journeys a month.

Any unused journeys can be carried forward for use in subsequent months. Users are allowed to swipe their card twice during one journey, allowing two trips and two subsidies to be used to cover one long journey.

Taxis and Mini Cabs – Black taxis in the borough mainly operate in accessible locations across the borough.

The Disabled Go website does not explore whether the staff of mini cab companies have undertaken specific visual impairment training (as opposed to being equalities aware). This could be an additional barrier to independence, as service users have cited examples of mini cab drivers sitting in their car tooting the horn despite being advised that the passenger has a visual impairment, rather than escorting an individual from their door to the taxi, and dropping them at the entrance of their destination.

Trains, Trams and Underground – Tower Hamlets has 31 train stations providing links to major destinations across London**.** Trains are operated by 3 providers, and platform staff have undertaken training to support people with a visual impairment and can provide support with travel and escort whilst in the train station for people with a disability on request.

Public Riverboat Services – There are 2 waterway services in offering public transport in Tower Hamlets, Canary Wharf pier and Masthouse Terrace Pier.

10.6.2 Streets and Street Furniture

Tower Hamlets has a highway assets management plan (HAMP) setting out the vision for managing Tower Hamlets 'assets': streets, lighting, road surfaces, markings, structures (such as bridges), street signs, trees, hedges and planted areas. The plan feeds into the London Transport Strategy and is an important part of Tower Hamlets local implementation plan. There is no information available on Tower Hamlets HAMP online.

10.6.3 Leisure and Shopping

There are **[number]** leisure centres all of which can accommodate an assistance dog, and 2 of which provide information in Braille and large print.

There are 4 theatres in Tower Hamlets that can accommodate an assistance dog and 1 provides information in Braille/large print.

In terms of Libraries, there are 6 libraries in the Tower Hamlets which can accommodate an assistance dog and 6 of these provide information in large print, and provide audio books and large print books.[47]

Of the 70 supermarkets in Tower Hamlets**,** 17 are on the disabled go website stating that they can accommodate an assistance dog.

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47 Disabled GO http://www.disabledgo.com/en/org-results/tower-hamlets-council

[Insert any issues about barriers to shopping and leisure in the Tower Hamlets through consultation or local forums]

10.6.4 Employment

Evidence shows that 66% of people with a visual impairment of working age are not in employment, and that Government schemes fail to place blind and partially sighted people in work and that training and employment opportunities for those furthest from the labour market are dwindling.[48] Providers of support into employment in Tower Hamlets including the following:

Job Centre plus, is one of the main sources of employment in the Tower Hamlets. They provide support into work, access to benefits and provide specialist support for those who are disabled.

Job Enterprise and Training (JET) is a specialist service for people with a disability or long term health condition in Tower Hamlets. It provides information, advice and guidance on finding work, keeping a job, developing skills and making adjustments for work. JET is located at: Tower Project Job, Enterprise and Training Service Candy Wharf, Unit 2, 22-23 Copperfield Road, E3 4RL. The can also be contacted via telephone on: 02089803500

Disability Information training Opportunities (DITO) provides IT training, one to one support with finding/applying for jobs and benefits advice. They are located at The resource Centre,40-50 Southern Grove E3 4PX or contacted via email: infor@ditoth.org

Action for Blind People is an organisation that supports people with a visual impairment with job retention (but not support in seeking work), self employment work experience opportunities and provides careers guidance across the UK. They also provide advice on support for travelling to work and support available in the workplace. However, they can be contracted to provide tailored support into employment for people with a visual impairment.

It is unclear how many other voluntary sector organisations are providing support into employment in Tower Hamlets, or how many are able to support people with a visual impairment to obtain work opportunities. It is also not clear how many of these are Department of Work and Pension primary or secondary contractors.

[Insert any issues relating to barriers to employment in the Tower Hamlets through consultation or local forums]

[48] http://www.rnib.org.uk/aboutus/research/reports/employment/Pages/employment.aspx

10.6.5 Education

Children's Education – Tower Hamlets has a visual impairment teaching service. The policy of the local authority is to have children with a visual impairment taught in mainstream schools and specialist centres.

Tower Hamlet's has a vision impairment special needs support for the ages of 0-19 years old. The service provides support for hearing impaired and visually impaired pupils in both mainstream and special schools. For children below school age, support is provided in the home and in nurseries. They can be contacted via telephone on: 02073646468[49]

There are 3 mainstream schools in Tower Hamlets that have experience and support skills for pupils with a visual impairment.
Harbinger Primary School, that is located in the Isle of Dogs where they have a resource room where Braille can be produced electronically and used for other pupils in the borough. They can be contacted via Telephone: 02073871924.

Bangabandhu Primary School in Bethnal Green is a mainstream school that provides high quality learning opportunities for all children whatever they need. They have a variety of facilities and learning materials as well employing a large number of teaching assistants who are there to support pupils needs. The school can be contacted via telephone on: 020980 0580.[50]

Halley Primary School is located in Stepney. They have a large and experienced 'inclusion team' who are dedicated to giving everyone the same opportunities and educational support. They can be contacted via telephone on:02072658061.[51]

Stephen Hawking School in Tower Hamlets is small school with 75 students aged 2-11 years old. The school works with pupils that generally have profound and multiple learning difficulties with a significant number of children who have additional sensory impairments.[52]

Further Education – Tower Hamlets has 1 main centre for further education, Tower Hamlets College.
[Add description, accessibility information and equalities impact assessment].

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[49] Tower Hamlets Family Services Directory https://fisonline.tribalhosted.co.uk/TowerHamlets/EarlyYears/PublicEnquiry/Search.aspx?providerID=1371
[50] Bangabandhu Primary School http://www.bangabandhu.towerhamlets.sch.uk/Contact-Us/
[51] Halley Primary School http://www.halley.towerhamlets.sch.uk/contact.htm
[52] Stephen Hawking School http://www.stephenhawking.towerhamlets.sch.uk/welcome_to_our_school.html

Higher Education – Higher education in Tower Hamlets is offered by London Metropolitan University and Queen Mary University. London Metropolitan has a variety of assistive-technologies available as well as teaching support if needed. Queen Mary University provides learning support in the form of scanning text or reading books onto tape, taking notes in lectures and tutorial support if it's wanted.

Adult Education/Lifelong Learning – Idea Store offers a diverse range of vocational and practical courses for adult learners in Tower Hamlets. The Idea Store is located in various places across Tower Hamlets, Bethnal Green, Whitechapel, Shadwell, Bow and Canary Wharf. No courses are tailored towards people with a visual impairment but there are a variety of learning resources and support available.

10.6.6 Welfare Rights

Understanding the entitlement to welfare rights and benefits and access to benefit entitlement is an important way of ensuring independence for people with a visual impairment.

[Insert text on voluntary sector providers operating in Tower Hamlets and any cross referral or co delivery of services]

10.6.7 Accessibility

A recurring theme that runs through the all stages of the pathway is the need to ensure that information is produced in an accessible format and imparted to patients and service users in a timely and accessible way. Examples of this include when accessing the GP, receiving information about appointments, understanding eye conditions, accessing benefits/seeking advice, dealing with household bills, etc.

Therefore, work needs to be undertaken to ensure that as many statutory, voluntary and commercial organisations in Tower Hamlets are providing both accessible information and accessible services.

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11. Wider Avenues of Support

There are numerous national bodies that also provide support to people living with sight loss in Newham. Many of these charities provide practical information and community spaces where people can seek advice or support from other people living with sight loss.

ACTION for Blind People:
Telephone: 020 7635 4800
Or RNIB helpline: on 0303 123 9999
Email: helpline@rnib.org.uk
Address: Action for Blind People, 53 Sandgate Street, London, SE15 1LE
Action for Blind People - provides practical information for people with visual impairment, as well as information and the contact details for local groups and services. It is part of the RNIB Group.

Blind Veterans UK
Telephone: 020 7723 5021
Email: enquiries@blindveterans.org.uk
Address: Blind Veterans UK, 12-14 Harcourt Street, London, W1H 4HD
Blind Veterans UK - a specialist charity that provides physical and emotional support for ex service men and women to enable them to live as independently as possible.

BlindAid
020 7403 6184
enquires@blindaid.org.uk
Home visiting service, telephone befriending and annual events for people with a visual impairment in the 13 inner London boroughs.

Deafblind UK
Tel/Textphone: 01733 358 100
Email: info@deafblind.org.uk
Address: Deafblind UK Head Office, National Centre for Deafblindness, John & Lucille van Geest Place, Cygnet Road, Hampton, Peterborough, PE7 8FD
Deafblind UK - Our overarching goals
To work towards a more equal society by raising awareness and understanding of deafblindness by engaging with people who have a sight and hearing loss, the Government and other organisations, individuals and communities.
To enable people with both a sight and hearing loss to remain in their own homes and participate in their local communities.
To provide relevant, high quality **Peer Support**, **Befriending** and **Information and Advice** services to people with a dual sensory loss, helping them to; live independently, interact with others, understand their rights and access their entitlements

Guide Dogs
Telephone: 0118 983 5555
Email: guidedogs@guidedogs.org.uk
Address: The Guide Dogs for the Blind Association, Burghfield Common, Reading, RG7 3YG
Guide Dogs - organises and trains dogs for the visual impaired, as a charity their primary interest lies in enabling the mobility of the visually impaired.

London Visual Impairment Forum (LVIF)
Telephone: 07875 541133
Email: sharon.schaffer@lvif.co.uk
Website: www.lvif.co.uk
Links organisations for the blind and partially sighted in London.

Macular Society
Telephone: 01264 350 551
Email: info@macularsociety.org
Address: Macular Society, PO Box 1870, Andover, Hampshire, SP10 9AD
Macular Society – offers support and information on macular disease and central vision loss, and has branches throughout UK

The Partially Sighted Society
Telephone: 0844 477 4966
Email: info@partsight.org.uk
Address: The Partially Sighted Society, 7/9 Bennetthorpe, Doncaster, DN2 6AA
The Partially Sighted Society - provides equipment (such as magnifiers) and information (on matters such as lighting) for individuals to make the most of their remaining sight.

RNIB:
Telephone: 0303 123 9999
Email: helpline@rnib.org.uk
Address: RNIB Headquarters, 105 Judd Street ,London ,WC1H 9NE
RNIB - offer a telephone counselling service for those having difficulties coming to come to terms with their sight loss, as well as a wealth of practical information for parents, carers and the visually impaired.

RLSB
Telephone: 02078086170
Email: enquiries:rlsb.org.uk
Address: London office, Royal London Society for Blind People (RLSB), Victoria Charity Centre, 11 Belgrave Road, London, SW1V 1RB
RLSB - focuses particularly on supporting the education and skill development of blind and partially sighted young people in London.
They run a peer support group in Tower Hamlets.

SeeAbility
Telephone: 01372 755 000
Email: enquiries@seeability.org
Address: SeeAbility House, 1a Hook Road, Epsom, Surrey, KT19 8SQ
SeeAbility is a national charity that provides support for people who are visually impaired but also have other disabilities, such as mental health problems, mobility impairment or learning disabilities.

Thomas Pocklington Trust
Telephone: 020 8995 0880
Email: info@pocklington-trust.org.uk
Address: Pier House, 90 Strand on the Green, Kew, London w4 3NN
Housing and support for people with sight loss, including Research & Befriending (Tele, Email & Buddy Befriending schemes)

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In Conclusion

12. Conclusion

There is some very positive work being done in Tower Hamlets to help those who are blind or experiencing a visual impairment. These, identified through consultation with local service users, include:

- The Eye Health JSNA 2009 and legacy of the Low Vision Committee
- A well resourced Sight & Hearing Service, that delivers excellent support services
- Recently commissioned peer led support group, Beyond Barriers
- Barts Charity funding for Information & Advice Officer at Royal London Hospital, Children's Eye Clinic
- A good sense of community

Nonetheless, in Tower Hamlets the number of older people is growing, as is the number of people with obesity, heart disease, and diabetes. As a consequence, by 2020 there will be 22% more visually impaired people in need of support and care from the community.

However, as 50% of visual impairment is thought to be avoidable, prevention will need to become a central part of the Tower Hamlets Vision Plan. In particular attention will need to be focused on accessing 'at risk groups'. Successful targeting of these key audiences could significantly reduce the pressure on low vision services in the future.

There are also some important gaps in the provision of services for people already experiencing visual impairment; these gaps are focused on the following key themes:

- Embed the Vision Plan into the Health and Wellbeing framework and achieve a user led partnership approach to planning, delivery and evaluation of eye health and visual impairment support services

- Prevention: Maximise the uptake of eye examinations and raise awareness of eye health and lifestyle to ensure that avoidable visual impairment is prevented wherever possible

- Ensure that comprehensive cross sector data on visual impairment is collected and disseminated

- Ensure that comprehensive service provision is available, resulting in a clear pathway for people experiencing a visual impairment

- Ensure that people with a visual impairment have good access to information, transport, the environment, leisure, education, employment and welfare rights, and so do not experience social exclusion, inequality or isolation

- Develop and embed into the main Vision Plan considerations for children and young people, including evidence of current and future need, sight loss pathway, arrangements for transition to adult services and an action plan to address gaps and need

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13. Service Development Priorities

Based on the above gaps in service provision in Tower Hamlets the following service priorities have been identified. These service priorities have been arranged into the categories of prevention, services and inclusion, to reflect the objectives of the UK Vision Strategy with a note of the desired outcome.

13.1 Health and Wellbeing (Action One of the Action Plan)

Outcome: Ensuring that the Vision Plan and Action Plan are an integral part of local planning and service delivery

Indicators:

- Health and Well Being Board (either directly or via another forum to be agreed) is signed up to this Vision Plan and it is informing the implementation of its Action Plan
- Engagement of other decision making structures so that they are part of the implementation of the strategy and can help shape the future direction of the action plan, in particular:
  - -HealthWatch
  - -Clinical Commissioning Groups
  - -Council Social Care and Commissioning Teams
- Opportunities for cross sector learning, information sharing and/or joint working are developed between relevant health sector, social care and voluntary sector agencies

13.2 Prevention (Action Two of the Action Plan)

Outcome: a reduction in avoidable sight loss.
Indicators:

- Cross sector Public Health campaigns, which include the impact of priority health conditions such as diet, lifestyle and health conditions on eyesight and vision
- Activities to engage locally identified or hard to reach groups in the area is undertaken
- Cross sector activities are implemented and evaluated to increase the number of Eye Examinations (general or targeted group)

13.3 Joined Up Data (Action Three of the Action Plan)

Outcome: comprehensive cross sector data on sight loss and local demographics is collected and shared to inform resource allocation across Public Health, NHS, Optometry, Social Care and Voluntary organisations.

Indicators
- A method of collecting and collating data on eye health and sight loss support services is developed, implemented and evaluated, and can inform current and future needs
- Accurate information can inform the Public Health Outcome Indicator
- A cross sector system is implemented and evaluated to detect early changes in vision in those who already have sight conditions or low vision to enable treatment and early registration
- CVI information is accurate, processed effectively and is of use to all relevant parties

13.4 Joined up Services (Action Four of the Action Plan)

Outcome: individuals are empowered so that they can access the type of support and information they require at the time of need to maximise their independence.

Indicators:
- An evaluation of the ECLO post is carried out and a cross sector business case for continuation of the post is undertaken
- Health sector organisations and services are mapped, recommendations for change are made if appropriate and an effective communication system is created
- Statutory rehabilitation resources are increased to ensure relevant support is available on an ongoing basis
- Voluntary sector services are mapped, rationalised if appropriate and funding is made available to sustain high quality and effective delivery

13.5 Social inclusion and independence (Action Five of the Action Plan)

Outcome: individuals with visual impairment are able to lead active and independent lives, where they are able to fully engage in social, economic and educational opportunities

Indicators:

- Access (physical access and accessible information) is developed to enable people with sight loss to excel in education and undertake leisure activities
- Employment support and back to work agencies have developed and implemented policies to support people with sight loss into employment and training
- People experiencing sight loss are clear about, and supported in their rights and options in relation to their health, social care and independence needs
- Activity to ensure that information in accessible formats in the commercial, statutory and voluntary sectors results in service users being noticeably more satisfied in this area
- Action to explore how access can be improved via public transport links between all parts of the borough and Hospital, to ensure that people are able to access treatment and are not at risk of avoidable sight loss

13.6 Children's Services (Action Six of the Action Plan)

Outcome: Tower Hamlets Vision Plan identifies and addresses considerations relating to children and young people

Indicators

- Children's considerations are firmly embedded into the main Vision Plan and Action Plan to ensure that service providers are joined up and service considerations are identified, addressed and monitored for impact
- Evidence that diet and lifestyle prevention awareness has been undertaken with young diabetics and their parents/carers, and that they are adequately prepared for annual Diabetic Retinopathy screening when it begins at age 12 to prevent the early onset of Diabetic Retinopathy
- A clear transition pathway from children to adult services (both clinical and social care) is developed and communicated to partners, children and their parents/carers
- The process of children's registration is investigated and, if required, amended, or good communication ensures that the process is understood by all

13.7 Visually Impaired people with complex needs (Action Seven of the Action Plan)

Outcome: People whose primary condition is not related to their vision will have their eye health and sight loss support needs addressed

Indicators:

- Cross sector commissioning protocols are developed to address conditions where sight loss is a known factor (Diabetes, Strokes, Learning Disability, Elderly, Deaf-Blindness)

- Cross sector service provision is developed to address the treatment and rehabilitation needs of both the primary and secondary conditions
- Training is developed and delivered to ensure that carers (temporary and respite carers) including those in care homes are sight loss aware and are equipped to support those in their care

13.8 Involve local People in Sight Loss Priorities (Action Eight of the Action Plan)

Outcome: Local People are actively engaged in defining local priorities and providing local feedback on eye health and sight loss support services

Indicators

- Active engagement by patients and service users who have input and own the Vision Plan and the accompanying action plan, and active engagement at the implementation and evaluation stages
- Consultation on service provision and its impact has been undertaken
- An active forum is in place to look at eye health and sight loss support needs from a local perspective, which is able to feed into Healthwatch, local campaigning and local decision making processes

Tower Hamlets Vision Action Plan

An action plan has been developed to accompany the Vision Plan, giving further details of the areas outlined in the Outcome Indicators. This will enable the delivery of the Tower Hamlets Vision Plan to be monitored and its impact assessed over time.

It will be necessary to periodically revisit the Vision Plan and action plan to reflect the changes resulting from its delivery and the ongoing needs of blind and partially sighted people living in Tower Hamlets.

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Acknowledgements

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Helen Corbett, Thomas Pocklington Trust
Celia Watson, Thomas Pocklington Trust


LVIF
London Visual Impairment Forum


UK Vision
Strategy


TOWER HAMLETS


Thomas Pocklington Trust
Housing and support for
people with sight loss

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Health and Wellbeing Board 9 September 2014	Tower Hamlets Health and Wellbeing Board
Report of: Jane Milligan, Chief Officer, Tower Hamlets Clinical Commissioning Group.	**Classification:** [Unrestricted or Exempt]
Tower Hamlets Integrated Care Programme	

Contact for information	**Jane Milligan, Chief Officer, Tower Hamlets Clinical Commissioning Group.**

Executive Summary

Waltham Forest, East London and the City face an unprecedented challenge over the coming years in their health and social care system. The boroughs of Newham, Tower Hamlets and Waltham Forest have come together to address these challenges over the next 3 to 5 years

- Demand for health and social care is rising, driven by deprivation, population change and disease prevalence
- We already face challenges in outcomes and the system is currently not meeting patients' expectations of integrated care – coordination, transparency and a focus on experience and relationships
- Clinicians also find the current system challenging in how they provide care to their patients and work with their colleagues

It is recognised that 21% of patients drive 80% of costs acorss health and social care. Integrated care can help address these challenges, by empowering patients and service users, by improving outcomes and by providing the best quality of care at the minimum possible cost

Commissioners, providers and Local Authority came together to develop a localised vision for Integrated Care in Tower Hamlets. This vision focuses on **patient centred care,** with primary care, network resources and activities (e.g. MDT case conferences), Integrated Community Health Teams and borough-level specialist support **wrapping around patients**. Primary care, being closest to the patient, holds the final accountability for the patient's care, but is supported by network and CHS resources to coordinate and provide care as required.

Recommendations:

The Health and Wellbeing Board is recommended to:

1. To note the progress outlined in this report and endorse the approach

2. To note that the model described in this report underpins our submission for the Better Care Fund (with certain slight amendments for local factors).

1. DETAILS OF REPORT

The Waltham Forest, East London and City (WELC) Integrated Care Programme has the opportunity to revolutionise care for a population of almost one million people in an area facing significant health and social challenges. The footprint of the UK's largest trust, Barts Health NHS Trust, provides us with the unique ability to leverage the existing local examples of excellence in integrated care and deliver them at scale and pace across east London.

Local patients and carers have told us that it needs to be clearer who they should speak to and when, with a single point of contact and consistent information. They don't want to have to repeatedly provide their details and they expect that we will share that information with others who need it to provide their care. They want all the professionals they come into contact with to act as a team.

Staff have told us that there are many things they could do differently with the right enablers in place, knowledge about who else is involved in the care of a person, and access to a joint care plan at the right time.
How we deliver integrated care in each of the boroughs is evolving but the programme partners have agreed a common set of principles:

- Systematic, regular risk stratification of the whole population to support case finding for those most at risk of hospitalisation.
- Care that is centred on an individual's needs to enable individuals to live independently and remain socially active.
- Care that is evidence based and cost-effective.
- Preventing admission to hospital wherever possible by supporting care at home or in the community.
- Avoiding duplicated effort in situations where a patient has many people involved in their care.
- Actively developing local providers and supporting collaboration in the way we contract.
- Evaluating what we do as we do it and revising our approach as we learn about what we are achieving.
- Learning from each other, learning from national and international integration programmes and sharing our learning outside the programme.

- Health and local government partners in east London have come together to build a model of integrated care that looks at the whole person – their physical health, mental health and social care needs.

Tower Hamlets is amongst some of the most deprived in London, with significant health needs and inequalities. There is a rising need for care across the country as society gets older and we see more people with chronic illnesses. Care needs to be personalised so people stay healthy for longer and can live independently reducing reliance on hospital services.

We recognise we need to address these needs while tackling significant financial pressures on health and local government budgets. We know we need to create whole system change at scale and pace and build an integrated care system across health and social care to have a chance at meeting the needs of patients and staff and addressing these pressures. By joining up health and social services to provide more care in the community, we hope to reduce non-elective spend by 24-40%[1] over the next five years.

Empower people and their carers

- Enable people to live independently and remain socially active.
- Establish education and self-care programmes for people
- Personalise care to people's needs and preferences

Provide more responsive, coordinated and proactive care

- Proactively manage people's health and improve their outcomes
- Enable high-quality care that can respond to people's needs rapidly in crisis situations
- Provide more care in the community or at home
- Prevent avoidable admissions and minimise residential care
- Leverage tools and technology to deliver timely and better quality of care

Ensure consistency and efficiency of care

- Deliver the best possible care at minimum necessary costs
- Avoid duplication of effort in situations where people are seen by multiple health and social care providers
- Ensure most effective possible use of clinical time and resources

Headline health indicators show significant health inequalities between Tower Hamlets and the rest of the country. Both male and female life expectancy is lower than national averages (male - 75.3 years, female - 80.4 years). Tower Hamlets has the highest or second highest mortality in London for the three major killers: cardiovascular disease, cancer and chronic respiratory disease (COPD). There are an increasing number of patients with co-morbidities, particularly in the 65 years and over age group, and the distribution of these patients varies across the borough. The highest numbers of patients with multiple co-morbidities are found in LAPs 1, 6 and 7. Within this there are variances in prevalence of long term conditions across different ethnicities, age groups and genders in Tower Hamlets. Hypertension, depression and asthma are the most common conditions affecting the white

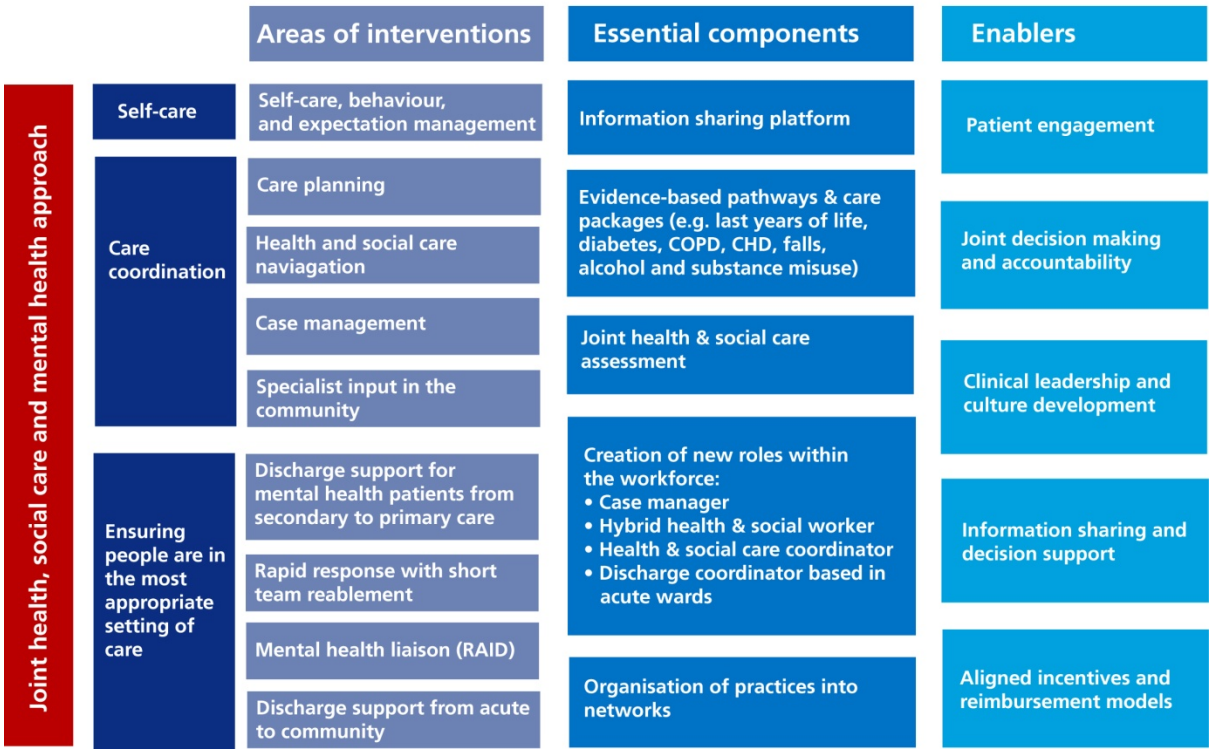
[1] This range reflects an estimate of variability between practices across the boroughs, a comparison of WELC performance against ONS top performers and a review of the international evidence base for integrated care.

population, whereas asthma, diabetes and hypertension are most commonly seen in the Bangladeshi population.

Around 1,140 Tower Hamlets residents will die per year of which around 870 will need some form of last-years-of-life care. The majority of these people will be aged over 65. Tower Hamlets has a higher hospital death rate at 68% than the national average and a significantly lower home death rate at 17%.

Our model of care has been adapted from international best practice and evidence[3-34]. The result is a suite of standard interventions that broadly cover supported discharge, care planning and coordination, and mental health liaison and Rapid, Assessment, Interface and Discharge (RAID). These interventions will be supported by system changes like routine information sharing and primary care networks, and enablers like patient systematic engagement, clinical leadership.

WELC will provide nine key interventions for its population underpinned by five components and enablers



Care Planning and Case Management

The case managers are an essential link between acute and community settings and with social care services. They work as part of the locality community health teams and focus on

- case managing patients at high risk of admission (previously community virtual ward patients)
- reducing non-essential use of A&E, to prevent hospital admissions and attendance at emergency services
- reducing inappropriate use of services (acute and primary care) by ensuring that the care planning and case management are effective

- complementing existing services by bridging service gaps
- promoting multiagency working, assisting in preventing the breakdown of service provision
- linking closely with local social workers and social care providers
- case finding frequent attenders at hospital and working with them to reduce hospital use
- care navigator role

Rapid Response
The rapid response team will be responsible for providing community based urgent assistance predominantly in patient's own homes in response to acute episodes. The rapid response service will be available for patients, clinicians and care navigators to call on during extended working hours to provide advice and attend the patient as necessary to wherever possible remove the need to call on other emergency care provision, and work with primary and social care.

Discharge management
The function aims to reduce the number of beds days used for each patient, ensure a smooth transition for the patient from hospital to home and improve the communication. They act as the interface between acute and community care.

The function includes:
- Attendance of acute MDT discharge planning meetings and liaising with the Locality Community Health Teams to facilitate discharge in a timely manner;
- Ensuring the appropriate equipment is ordered and provided for specific patients prior to discharge;
- Advising and supporting services to carry out CHC assessments to facilitate discharge;
- Working closely with the Locality Community Health Teams and continuing health care team to facilitate continuing care reviews;
- Continuing to develop discharge pathways to facilitate discharges from in-patient facilities
- Proactive case finding to facilitate discharge

Mental Health Liaison
The mental health liaison function operates in the acute setting in A&E and on the wards. The function is designed to attend patients with mental health issues swiftly on attendance in A&E to avoid admission where possible, and to provide support to

patients with physical and mental health needs that have been admitted to reduce their length of stay.

2. FINANCE COMMENTS

2.1. N/A

3. LEGAL COMMENTS

3.1. N/A

4. IMPLICATIONS TO CONSIDER

4.1 N/A

Appendices

Appendices

- None.

Integrated Care Update for Health & Well Being Board

August 2014

Care Co-ordination and rapid response workstream

- Integrated Community Health Teams (ICHT) co-located with community nursing, 4 social worker, 2 x wte CPN and community psychogeriatirician to provide support, 4 x Palliative Specialist Nurse and community Geriatrician
- Community health service single point of access established to deliver 24/7 working and co-located with the GP Out of Hours Service at the Royal London site.
- Ongoing recruitment programme with Barts health to fully establish their teams.
- There are 16 care co-ordination roles within the team. The 8 existing roles are supplemented by 8 Care Navigator posts hosted by Barts.

Discharge Support Workstream

- Community nurse attached to the ICHT present in A+E and participating in the daily ward meetings to support early discharge, where appropriate from hospital and organise support in the community interfacing with the ICHT.

Rapid, Assessment, Interface and Discharge (RAID) and mental health liaison

- RAID Discharge service launched and formerly opened by Jim Fitzpatrick MP, 3rd July 2014. The Service is co-located on the site of the Royal London Hospital and situated near to the Emergency Department.
- Team fully established.
- An agreement has been made with the Royal London Hospital for the RAID service to provide mental health training in existing development pathways for acute hospital staff

Self-Management Workstream

A new workstream established to oversee the delivery of the following :

- CCG self-management proposals
- PAM pilot
- HENCEL funded Self-Management UK pilot
- Social prescribing pilot
- Any Innovation Bursary projects that have a self-management component
- Links with primary are innovations projects commissioned by the Excellence in General Practice programme.

This workstream reports to the Integrated Care Board for strategic oversight. This approach will enable alignment of work undertaken within the Long Term Conditions and Integrated Care programmes around self-management and reduce duplication of effort.

ENABLERS

Information

- **Orion** – Tower Hamlets Integrated Community Record in pilot Laps 3 & 4. Information streaming from primary care, GP out of hours and Barts Cerner clinical systems for patients who have consented to share information.
- Community health, mental health and social care flagging consented patients from the target population onto their clinical systems
- Next phase to connect mental health RiO and social work frameworki to the portal. Health and social care professionals identified fields to view. Orion developing specification for technical connectivity to the portal.
- Shared care planning template being built as part of the next phase.

Organisational Development

- Genesis has been commissioned by WELC Partners (Waltham Forest, Newham and Tower Hamlets) to develop a shared OD framework to support delivery of integrated care. Workshops have been held with three groups Leadership, Middle Managers and frontline staff from health and social care as well as commissioners. A questionnaire has also been developed to tap into the knowledge from a small group. A draft of the framework is due end of September.

Health and Wellbeing Board 9 September 2014	Tower Hamlets Health and Wellbeing Board
Report of the London Borough of Tower Hamlets	**Classification:** Unrestricted
Liver Disease in Tower Hamlets – What are the issues, why does it need to be a priority and what are we doing?	

Lead Officer	Robert McCulloch-Graham
Contact Officers	Somen Banerjee
Executive Key Decision?	No

Executive Summary

Tower Hamlets has amongst the highest levels of premature death from liver disease in England. Nationally liver disease has only recently become an areas of focus following its inclusion in the Public Health Outcomes Framework. Causes of liver disease can be divided into four categories: non alcoholic fatty liver disease, alcohol related liver disease, hepatitis B and hepatitis C. All of these are significant issues for Tower Hamlets.

The paper summarises the findings from a needs assessment on liver disease in Tower Hamlets and a service mapping. These findings were discussed in depth at a Liver Disease stakeholder event involving leads from the Health and Wellbeing Board, Public Health, the CCG, general practice, Barts Health and drugs and alcohol services. This was the first time that stakeholders had come together around this issue and the discussion was wide ranging. The opportunity to do this was highly welcomed and considered well overdue.

Following the meeting a working group has been established across Public Health and the CCG and the following 6 month priorities have been identified:

1. Increase awareness of liver disease through a communication and engagement plan clarifying key messages to the population and engaging with high risk group
2. Review the local immunisation policy for Hep B and consider the case for universal immunisation for Hep B in childhood
3. Review how case finding of Hepatitis can be improved through screening of high risk groups
4. Developing local guidelines in primary care to improve early identification and referral for liver disease
5. Educating primary care staff around liver disease and their role in increasing awareness, early identification and treatment
6. Reducing the cost of liver function tests to screen for liver disease through

'unbundling LFTs'

7. Ensuring that drugs and alcohol services are linked into liver disease treatment pathways as part of the specification of the new services
8. Review implication for CCG commissioning of the treatment pathway including the impact of new drugs and NICE guidelines

Recommendations:

The Health and Wellbeing Board is asked to comment on the approach, priorities and how members would like to involved in raising the profile of liver disease in their organisations and the community. It is proposed to bring an update on progress to the Board in 9 months.

1. REASONS FOR THE DECISIONS

1.1 Improving prevention and treatment of liver disease in Tower Hamlets

2. ALTERNATIVE OPTIONS

2.1 Board may consider other options for priority

3. DETAILS OF REPORT

3.1 The paper sets out the findings of a needs assessment on liver disease, service mapping. It then goes onto to identify the priorities for action following a partnership stakeholder event on liver disease. It is proposed that these priorities will inform the refresh of action plans for the Health and Wellbeing Strategy. It is possible that they will inform future commissioning priorities for the CCG and Public Health in the Council but it is too early to say at this point.

4. COMMENTS OF THE CHIEF FINANCE OFFICER

4.1 The priorities for action identified within this report will be met from existing NHS and Public Health grant resources, refocusing existing activity to incorporate prevention of liver disease.

5. LEGAL COMMENTS

5.1. The recommendation that the HWB should comment on the approach, priorities and how members would like to be involved in raising the profile of liver disease, 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. As the HWB has statutory status, due regard should be given to its decision making authority within its terms of reference.

5.2. These recommendations are within the terms of reference of the HWB agreed by the Mayor in Cabinet on 4 December 2013, in particular:

- 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.

5.3. When considering its approach to planning how to meet the needs of residents in respect of liver disease, 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 do not.

6. ONE TOWER HAMLETS CONSIDERATIONS

6.1. Liver disease and the risk of disease will be more prevalent in specific groups within the population and these are highlighted in the report. Equality dimensions specifically relevant will be ethnicity, gender and sexual orientation. Interventions will also need to be targeted at the most vulnerable groups (particularly in relation to hepatitis and alcohol related liver disease).

7. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

7.1 N/A

8. RISK MANAGEMENT IMPLICATIONS

8.1. The proposals mitigate risks in relation to future expenditure on health and social care through prevention and early identification of liver disease. This will require partnership working across the council, NHS and voluntary sector.

8.2. They also mitigate risks in not meeting the duty of the council through the Health and Social Care Act 2012 to take steps to improve the health of population as liver disease has been identified as a particular health issue for the borough.

9. CRIME AND DISORDER REDUCTION IMPLICATIONS

9.1 N/A

10. EFFICIENCY STATEMENT

10.1 The report does not propose additional expenditure and the focus is improving existing services to improve quality and targeting. It does propose that liver

disease and its importance should be incorporated into refreshed action plans of the Health and Wellbeing Strategy.

Appendices and Background Documents

Appendices

This is added to the main paper and provides more detailed overview of needs assessment

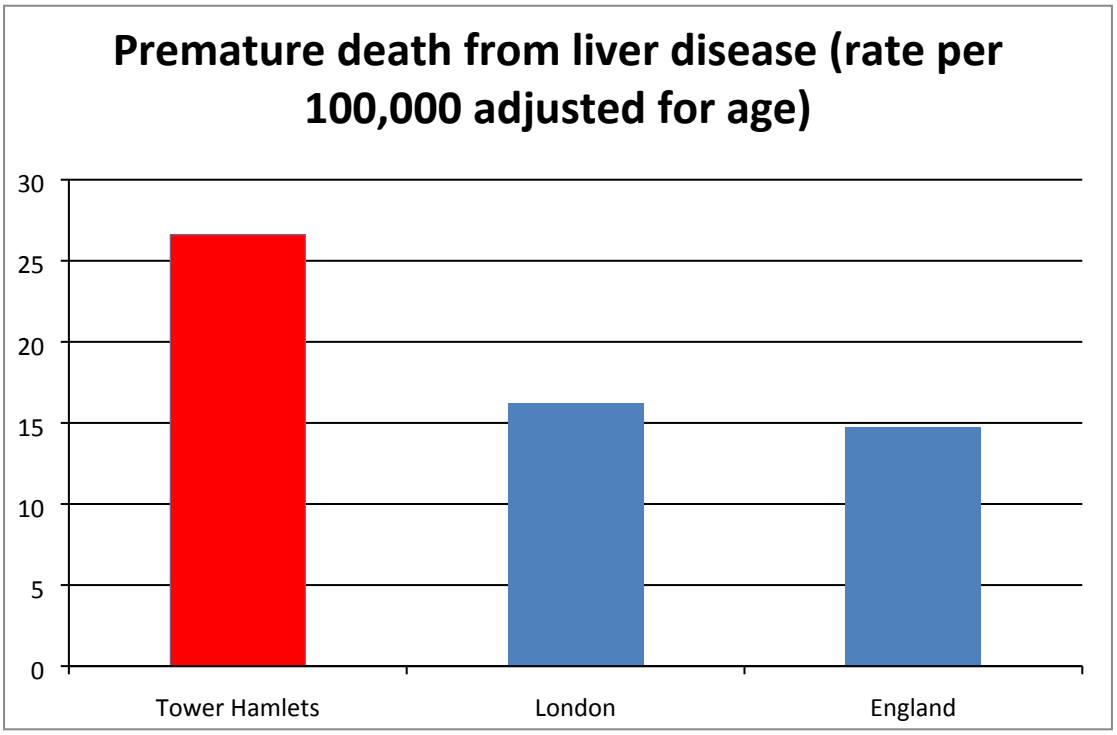
Background Documents

- NONE

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

1. Why is liver disease an important public health issue in Tower Hamlets?

The Joint Strategic Needs Assessment 2013/14 has highlighted the high levels of premature death from liver disease compared to elsewhere:



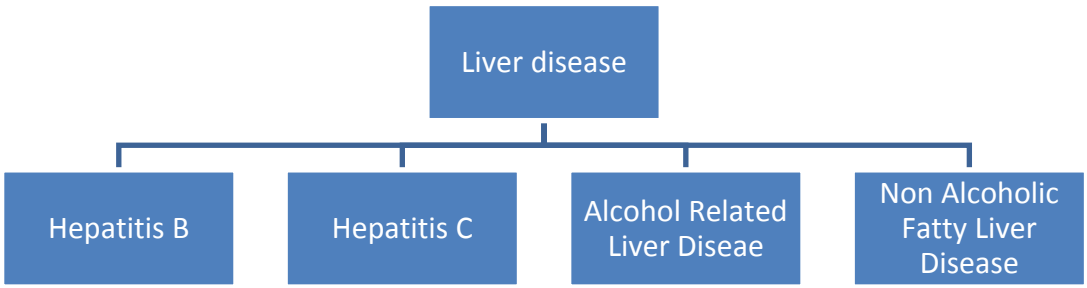
Premature liver disease is an indicator that was added to the national Public Health Outcomes Framework as it has not been previously been an area of national focus. The finding prompted a more in depth needs assessment on liver disease in the borough which brought together a set of worrying statistics:

Indicator	Tower Hamlets
Liver disease mortality (<75yo)	Amongst highest in England
Rate of admission for cirrhosis	Highest in England
Rate of primary liver cancer mortality (<75yo)	Highest in England
Incidence of acute hepatitis B	Fifth highest in England
Hospital admissions chronic hepatitis B	Highest in London
Chronic hepatitis C prevalence rate	Fourth highest in England
Trend in hospital admissions for alcoholic liver	Increasing

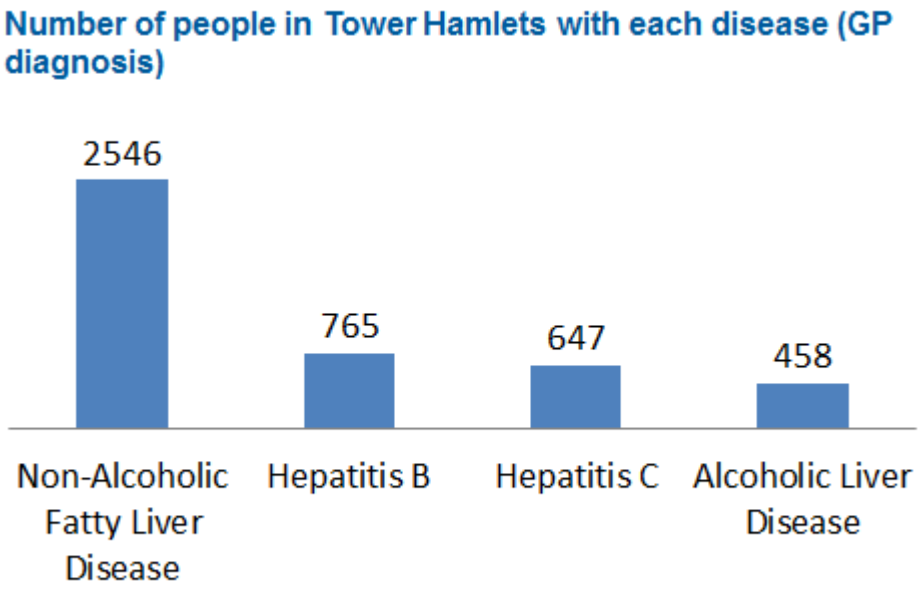
The detailed findings of the needs assessment are set out in Appendix A.

2. Why is liver disease complex, what are the numbers and what should we be doing?

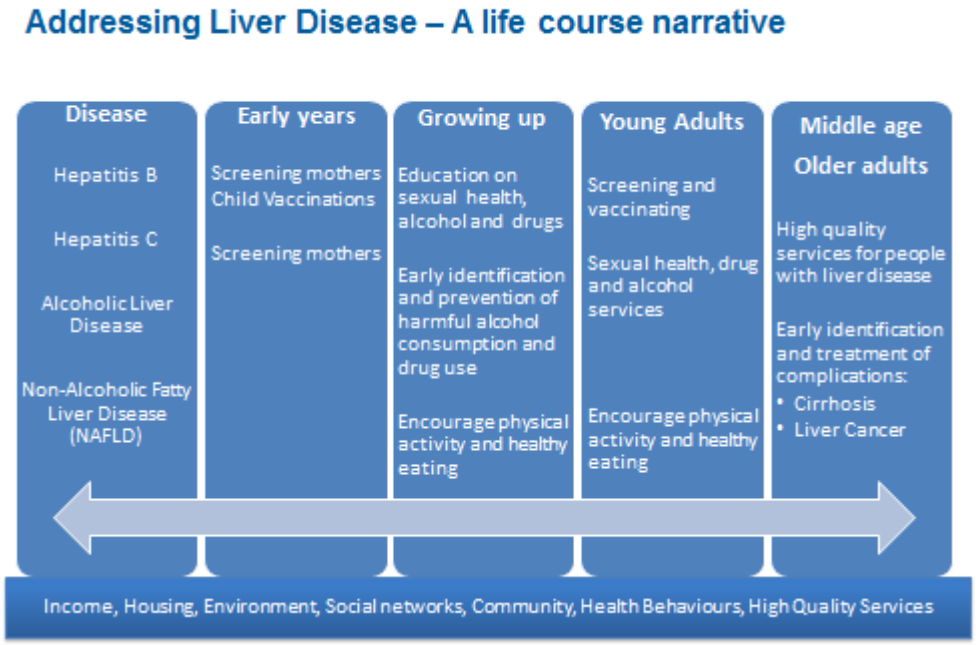
Liver disease is a particularly complex area to assess as there a number of different pathways leading to the condition:



Of these conditions, the numbers of people with Non Alcoholic Fatty Liver Disease (NAFLD) constitutes the highest proportion of those with liver disease:



In thinking through the important interventions to address liver disease, it has been helpful to take a life course approach:



3. What are the causes of liver disease and what are the local issues?

Non alcoholic fatty liver disease

This is caused by fat depositions in the liver which lead to cirrhosis of the liver. Risk factors are obesity and diabetes. In Tower Hamlets, the Bangladeshi population is a high risk group. Prevention and treatment is essentially weight loss and exercise.

Issues identified in service mapping related to lack of guidelines around identification and management of the condition, lack of referral criteria to secondary care and NAFLD not being specific criteria for weight management services.

Hepatitis B

This is caused by viral infection of the liver. The routes of spread are from mother to child (known as vertical transmission), sexual transmission and sharing needles. If untreated, it can lead to cirrhosis or primary liver cancer.

New infections in Tower Hamlets are typically in people who change sexual partners frequently or inject drugs or recently travelled to an area of high prevalence. Long term cases (chronic) seen in Tower Hamlets are typically

aged 25-44, male, and who have acquired the condition in a country of relatively high prevalence (eg Bangladesh). The Royal London sees the highest number of people with chronic Hep B of any London hospital. Tower Hamlets has the fifth highest number of new cases of Hep B in London

Issues identified in service mapping related to the need to vaccinate children born to Hep B mothers, vaccination of high risk groups (primary care, sexual health services, blood born virus team) , offering vaccination in travel clinics (charging may be a barrier) and identifying undiagnosed cases.

Hepatitis C

This is caused by viral infection of the liver. It is primarily passed between adults through sexual transmission and sharing needles. If is untreated it can lead to cirrhosis of primary liver cancer. In Tower Hamlets, cases are mainly male adults and predominantly of white ethnicity. Risk groups are infecting drug users, people who change sexual partners frequently and men who have sex with men. There are 647 diagnosed cases but it is estimated that there there around 1800 case in the borough so it is likely that there are over a thousand people with undiagnosed Hep C. Admission are increasing which may be a result of increasing numbers but also better detection. There is no vaccination.

Issues identified in the service mapping focussed on identifying undiagnosed cases, getting them into treatment pathways, contact tracing around the index case and increasing awareness of the condition (how to prevent and identify if you are at risk)

Alcoholic related liver disease

Alcohol related liver disease has three stages. Drinking large amounts of alcohol leads to build up of fat in the liver. This does not usually cause symptoms but is a warning sign of harmful drinking. Prolonged misuse results in inflammation of the liver which if severe can be life threatening. The final stage is cirrhosis. Stopping at this stage can reduce progress but the damage is typically irreversible.

It is estimated that there are around 9000 high risk drinkers in Tower Hamlets. These are predominantly of white ethnicity. It is also estimated that 68% of migrants drink harmfully. Admissions for alcoholic liver disease are rising and the majority occur in the white population.

Issues identified in the service mapping included an absence of universal alcohol screening in A and E, a need to improve awareness of referral pathways to community alcohol services, and a need for referral criteria into secondary care.

4. What are we doing about it?

Stakeholder event

The issues identified in the needs assessment and review of pathways were discussed at a Liver Disease Stakeholder event on the 11th June involving leads from the Health and Wellbeing Board, Public Health, the CCG, general practice, Barts Health and drugs and alcohol services. This was the first time that stakeholders had come together around this issue and the discussion was wide ranging. The opportunity to do this was highly welcomed and considered well overdue. The write up of the event is available on request.

Liver disease working group

Following the stakeholder event a joint working group between Public Health and the CCG has been established. Given the complexity and range of issues discussed at the stakeholder meeting, it was agreed that it was important to take forward a small number of feasible high priority actions over the next six months to develop the workstream and also to inform updates of the action plans of the Health and Wellbeing Strategy.

Priorities over next 6 months

These are the following:

1. Increase awareness of liver disease through a communication and engagement plan clarifying key messages to the population and engaging with high risk group
2. Review the local immunisation policy for Hep B and consider the case for universal immunisation for Hep B in childhood
3. Review how case finding of Hepatitis can be improved through screening of high risk groups
4. Developing local guidelines in primary care to improve early identification and referral for liver disease
5. Educating primary care staff around liver disease and their role in increasing awareness, early identification and treatment
6. Reducing the cost of liver function tests to screen for liver disease through ‘unbundling LFTs’
7. Ensuring that drugs and alcohol services are linked into liver disease treatment pathways as part of the specification of the new services
8. Review implication for CCG commissioning of the treatment pathway including the impact of new drugs and NICE guidelines

Each of these workstreams are being taken forward by CCG or Public Health leads. In terms of governance, it is expected that they will inform the refresh of the action plan of the Health and Wellbeing Strategy and also report through the governance processes of the CCG.

5. How can the Health and Wellbeing Board be involved on this agenda?

Questions for HWBB

1. Do these priorities sound right?
2. What more would Board member like to know?
3. Would Board members like to be involved eg raising profile in organisation, engaging community?

Proposed next steps

1. Integrated priorities into HWB Strategy action plan refresh
2. Bring update to Board in 9 months

Dr Somen Banerjee
Director of Public Health (interim)
August 2014

Appendix
Liver Disease in Tower Hamlets Needs Assessment: Summary of Findings and Recommendations

Executive Summary

This report summarises the findings of a liver disease needs assessment that was prompted by 2012 PHOF data showing that Tower Hamlets has a very high liver disease mortality rate.

The main causes of liver disease are hepatitis B and C, non-alcoholic fatty liver disease and alcoholic liver disease. Tower Hamlets hospital admissions data from 2007-2012 shows that most liver disease-related admissions were for alcoholic liver disease (273) followed by hepatitis C (108), non-alcoholic liver disease (81 admissions) and hepatitis B (80 admissions). Key findings from the needs assessment are summarised in the table below:

Area	Tower Hamlets Performance
Liver disease mortality in under 75 year olds	**One of highest in England**
Rate of admission for cirrhosis	**Highest in England**
Rate of primary liver cancer mortality in under 75 year olds	**Highest in England**
Incidence of acute hepatitis B	**Fifth highest in England**
Hospital admissions with chronic hepatitis B	**Highest in London**
Chronic hepatitis C prevalence rate	**Fourth highest in England**
Trend in hepatitis C hospital admissions rate over past 5 years	**Increasing**
Trend in hospital admissions for liver disease attributable to alcohol over past 5 years	**Increasing**

Local factors are likely to contribute to these high rates in Tower Hamlets – including high levels of deprivation; a large Bangladeshi community who are more susceptible to NAFLD and will travel to and from areas of higher hepatitis prevalence; high levels of risky drinking in its white population; and an established MSM and commercial sex worker community. Limited information about service provision (in particular activity data) and stakeholder engagement was available for inclusion in this needs assessment.

Key recommendations include increasing hepatitis B vaccination uptake amongst higher risk groups, improved hepatitis B and C screening, increasing awareness about risky drinking, set up of a Liver Disease Working Group to review current pathways and service provision and addressing risk factor associated with liver disease.

1 Introduction

- The Tower Hamlets Liver Disease (THLD) Needs Assessment was undertaken between June 2013 and March 2014 by Tower Hamlets Public Health in response to a finding in the 2012 Public Health Outcomes Framework showing a very high mortality rate of liver disease in Tower Hamlets. This report summarises the findings from the THLD needs assessment and sets out recommendations for next steps.

2 Liver Disease in Tower Hamlets

- Liver disease is a significant problem in Tower Hamlets and nationally. **Tower Hamlets has one of the highest mortality rates from liver disease nationally in people aged under 75, per 100,000 population (Tower Hamlets 26.6 per 100,000, England average 14.7 per 100,000)**.
- The main causes of liver disease are hepatitis B, hepatitis C, non-alcoholic fatty liver disease (NAFLD) and alcoholic liver disease (ALD); this report focuses on these causes. Prolonged damage to the liver due to the liver disease can cause cirrhosis (irreversible scarring of the liver), liver failure or liver cancer.
- **Premature death from chronic liver disease is rising in England, largely as a result of lifestyle issues such as alcohol abuse, drug-taking and obesity with an 88% increase in age-standardised mortality rate from chronic liver disease between 1993 and 2010**. However, there is widespread variation across the country in terms of risk factors, services, expenditure and outcomes for patients and the wider population.
- **Deprivation** is a key factor in the significant variation in premature loss of life due to liver disease between areas.
- **Tower Hamlets also has the highest rate of admission for cirrhosis nationally (207.9) per 100,000 population**.
- **Tower Hamlets has the highest rate of primary liver cancer mortality in under 75 year olds nationally (5.3) per 100,000 population**.
- The data on the causes of liver disease within the Tower Hamlets population is limited.
- Analysis of the 2007-2012 hospital admission data for liver disease of the Tower Hamlets population showed that alcoholic liver disease was most common (273 admissions), followed by hepatitis C (108 admissions), non-alcoholic liver disease (81 admissions) and hepatitis B (80 admissions).
- Local causes that can help explain the high rates of liver disease include
    - **Hepatitis B** is spread by bodily fluids and by vertical transmission
        - Tower Hamlets has a large Bangladeshi community. It is likely that the high levels of **immigration** from and travel

to/from South Asia which has a higher rate of hepatitis B (2-8%) than the UK baseline (0.3%) contributes to this.
        - Additionally, **high birth rates** to Bangladeshi population (45%), potentially at increased risk of vertical transmission of viral hepatitis
    - **Hepatitis C** is spread mainly by bodily fluids.
        - Tower Hamlets has **high rates of sexually transmitted infection** (8th highest rate of STI per 100,000 nationally) and **IV drug misuse**
        - Established commercial **sex worker population**
        - Significant numbers of **men who have sex with men** (MSM).
    - **Non-alcoholic fatty liver disease** is caused by obesity and diabetes.
        - Tower Hamlets has a significant **Bangladeshi community** who are noted to have an **increased morbidity for a given obesity level**. Therefore local obesity findings are likely to be under representative of the scale of the problem in the borough.
        - **High prevalence of diabetes**
    - **Alcoholic liver disease** is caused by dangerous levels of drinking.
        - Tower Hamlets has a significant white migrant community who are known to have increased levels of hazardous drinking compared to the baseline population.
- Activity levels for liver disease services and stakeholder engagement was not available for inclusion in the needs assessment.
- The following sections examine the main types of liver disease.

3 Types of Liver Disease in Tower Hamlets

1.1 Hepatitis B

- **Tower Hamlets has the fifth highest incidence of acute hepatitis B in the country at 2.2 / 100,000**. This compares with a national incidence of 1.13 / 100,000 and London incidence of 2.06 / 100,000. The majority of cases of hepatitis B occur in Asians with only 21% of cases occurring in the white population. This high rate locally is likely due to a high rate of immigration and travel to/from Bangladesh which has a high incidence of hepatitis B.
- There is a high local burden of chronic hepatitis B, with the **Royal London Hospital reporting the highest number of cases of any hospital in London in 2011** (n=1069, though not all will be Tower Hamlets residents). Two-thirds of the chronic cases occur in men aged between 25 and 44, which may be due to the young population in Tower Hamlets: having the lowest median age nationally (29). 95% of new chronic hepatitis B infections occur in migrant populations, having been acquired perinatally in the country of birth.

- Hepatitis B can be transmitted by sexual intercourse. **Tower Hamlets has a high (8th highest in England) and rising incidence of sexually transmitted infections**. Tower Hamlets is also known to have an established sex worker population, which increases the risk of sexually transmitted infection. This problem with sexually transmitted disease may play a role in the high rates of hepatitis B in Tower Hamlets.
- **Tower Hamlets had an estimated 3849 problematic drug users in 2008-2009, and 85% identifying heroin as their first drug.** Poor hygiene with injecting drug use can contribute to the spread of hepatitis B.
- The UK policy is to recommend vaccination of people at high risk of hepatitis B. **NICE guidance includes** raising awareness of the condition, testing for hepatitis B in a variety of settings and **commissioning locally appropriate integrated services**.
- Services available for hepatitis B include:
    - Offering screening for hepatitis B to pregnant mothers
    - Neonatal vaccination for babies of hepatitis B positive mothers.
    - Screening of hepatitis B is performed at GP practices and GUM clinics.
    - Care of hepatitis patients is by the blood borne virus team.

1.2 Hepatitis C

- **Tower Hamlets has the fourth highest diagnosed chronic hepatitis C prevalence rate in the country**. However, it is estimated that this represents no more than 20% of hepatitis C cases in Tower Hamlets, with a resultant 10% referred and therefore only 5% treated.
- For the Tower Hamlets Drug Action Team **it was estimated that the total infected population was 2677, with 1766 cases of mild to moderate liver disease and 84 cases with cirrhosis or end stage liver disease**. This report estimated the estimated annual additional number requiring treatment as 28 with an estimated annual cost of treating these additional cases of £264,980.
    - It is estimated that there is an **undiagnosed population of 10,708 hepatitis C sufferers in Tower Hamlets**.
- **Local hepatitis C hospital admissions have been increasing** over the five year period, increasing from 12.7 to 19.3 per 100,000 between 2007 and 2012.
- This shows that the **majority of cases of hepatitis C occur in white males, but a quarter of cases occur in females and a quarter in the Asian population**. Possible cause of this local variation: hepatitis C is transmitted by contaminated bodily fluids. This is most commonly by sexual transmission or by injecting drug use.
- In a similar fashion to hepatitis B, **the high local STI and drug use in Tower Hamlets are likely to contribute to this high disease burden of hepatitis C** in the borough.

- **NICE guidance includes** raising awareness of the condition, testing for hepatitis C in a variety of settings and **commissioning locally appropriate integrated services**.
- Services available for hepatitis C include
    - Screening at GP practices and GUM clinics.
    - Care of hepatitis patients is by the blood borne virus team.

1.3 Non-Alcoholic Fatty Liver Disease (NAFLD)

- Non-alcoholic fatty liver disease represents a spectrum of liver disease with fatty infiltration in the absence of excessive alcohol. **Obesity and diabetes are significant risk factors** for this condition and can be used as proxy measures for disease. Unlike the infective causes of hepatitis (e.g. hepatitis B and C) it is often harder to detect in the early stages and therefore focus on its prevention is needed.
- Tower Hamlets falls in the **second highest quintile for child obesity in 4-5 year olds in the country**. Local surveys indicate that 3 in 10 adults in the borough are overweight and 3 in 10 are obese.
- Tower Hamlets has a significant Bangladeshi population. People of Bangladeshi ethnicity are more affected by obesity, with worse morbidity for the same obesity level. They are more susceptible to NAFLD particularly in the presence of diabetes.
- In March 2010, there were 11,859 diagnosed cases of diabetes in Tower Hamlets (6.1% of the population). **Diabetes prevalence is higher in Tower Hamlets than the national** (5.4%) and London averages (5.3%). **Prevalence is also increasing at a faster rate in Tower Hamlets than the national average.** Diabetes prevalence in Tower Hamlets is predicted to reach 10.1% by 2030.
- Research from the Royal London Hospital shows **significantly more NAFLD diagnoses in patients with Bangladeshi ethnicity** compared to the overall borough population. The **mean age of Bangladeshi NAFLD patients is significantly lower** than Caucasians (hospital: 43 vs 57 years; TH community: 46 vs 55 years). However **half of admissions due to NAFLD were shown to be due to white females**.
- Services available for NAFLD include:
    - The Weight Management Service.
    - The Diabetes LES suggests tailored treatments for patients, and GPs are financially incentivised to ensure that patients are well managed and have received recommended tests.

1.4 Alcoholic Liver Disease (ALD)

- Alcoholic liver disease is caused by dangerous levels of drinking. **Tower Hamlets has a higher rate of hospital admissions relating to alcohol than the London and England averages** (DSR of hospital admissions attributable to alcohol was 2213 in TH: higher than the London (1911.7) and England averages (1,895)).

- **Admissions to hospital attributable to alcohol per 100,000 population have been increasing** between 2006 and 2011 in males (from 1435 to 1859) and females (from 672 to 916.
- **Hospital admissions for liver disease attributable to alcohol in Tower Hamlets have been increasing over the past five years** from 2007-2012 (from 31.6 to 54.6 per 100,000 population).
- The ethnicity of admissions for liver disease caused by alcohol in Tower Hamlets over the period from 2007 – 2012 shows that the **majority of admissions due to alcoholic liver disease occur in the white population** with only 6% occurring in Asian males and no recorded cases in Asian females.
- Alcohol consumption across Tower Hamlets shows high levels of risky drinking across all socioeconomic groups (even when taking ethnicity into account). There is a large abstinent population in Tower Hamlets (1 in 2 of adults had not had an alcoholic drink in the previous year), so the problem of alcohol misuse is worse than implied by the data. High risk drinking in the population who do drink is common – of those who do drink**, 43% have harmful or hazardous drinking patterns**. **In the white ethnic group 40% are classified harmful drinkers or at risk of harm compared to 20% nationally**. This high level of dangerous drinking is likely to be responsible for the levels of alcoholic liver disease.
- **NICE** recommend a wide range of **interventions aimed at individuals and the whole population**. These include strategy interventions (restricted advertising, education, alcohol pricing) and prevention (advice, screening of people at risk, services for alcohol misuse). The **Government Alcohol strategy highlights** the importance of a local joint health and wellbeing strategy, highlighting **identification and brief advice and alcohol liaison nurses in A&E**.
- **Patients diagnosed with liver disease are screened for alcohol misuse**. If alcohol is the likely cause of liver disease, patients are **referred to the Community Alcohol Team for detox**.

4 Key Recommendations for Addressing Liver Disease in Tower Hamlets

- Targeted work with higher risk populations in Tower Hamlets to increase hepatitis B vaccination uptake
- Improve screening of hepatitis B and C, particularly amongst hard to reach and high risk populations.
- Targeted work with higher risk populations to increase awareness of risky drinking patterns, early diagnosis and early intervention for this group.
- Recommendations for obesity, diabetes, sexual health and drug use will be detailed in the Healthy Lives Strategy
- Set up Liver Disease Working Group to:
    - Review existing pathways

- Ensure optimal provision and uptake of liver disease services in Tower Hamlets
- Identify gaps/areas for further improvement and ways to address this to maximally benefit the local population

Detailed recommendations are attached in the appendix.

Detailed Recommendations for Addressing Liver Disease in Tower Hamlets based on needs assessment findings

Viral Hepatitis (Hepatitis B and C)

Sexual Health

- Review the screening of hepatitis C in sexual health
- Audit proportion of patients accessing GUM services offered hepatitis B testing and vaccination (vaccination recommended for people who change sexual partners frequently (Green Book and NICE PH43))
- Clarify the treatment and testing pathways for hepatitis C in patients attending HIV clinics
- Review uptake of hepatitis B vaccine as part of sexual health NIS against Green book recommendations

Drug use

- Review extent of hepatitis B testing and vaccination for patients accessing drug services and compare against guidance from Green Book and NICE PH43.
- Review percentage of people accessing drug services who are offered and accept hepatitis C testing and compare against guidance in NICE PH43
- Review staff update and induction training to ensure hepatitis C protocols are embedded into drug services.
- Agree and implement strategies to improve hepatitis C testing uptake and access to treatment
- Review uptake of hepatitis C treatment amongst drugs users
- Review effectiveness of local drug treatment services in achieving recovery and identify scope for improvement in local drug treatment services and systems

Vaccination

- Review and set targets for uptake of testing for hepatitis B in pregnant mothers and compare against national guidelines from Department of Health *Screening of pregnant women for hepatitis B and immunisation of babies at risk* (1998).
- Annually audit and set targets for uptake of hepatitis B booster in children born to hepatitis B positive mothers and compare with guidelines in the Green Book and NICE PH43.
- Prepare an options paper considering the benefits of locally adopting a universal hepatitis B childhood vaccination programme.

Migration/Port Health

- Prepare a cost-benefit analysis for offering free travel clinics for hepatitis B vaccination for people travelling to or from areas of high hepatitis B prevalence (vaccination recommended for travellers to

areas of high or intermediate prevalence who place themselves at risk (Green Book)).

Testing and diagnosis

- Audit the testing for hepatitis B in GP new patient sexual health and substance misuse checks and compare with the guidance in NICE PH43.
- Review the evidence for testing for hepatitis B in mid-life patient checks.
- Review the arrangements for contact tracing for patients who test positive hepatitis B or C and communicate these current pathways to primary care and other relevant professionals.
- Follow national guidance on ways to promote and offer testing to people at an increased risk of hepatitis C infection and compare with the guidance in NICE PH43

Treatment

- Review barriers to treatment for hepatitis C patients and how to tackle these

Other

- Review locally available services for hepatitis B and C testing and treatment and develop and commission a fully integrated care pathway involving primary and secondary care (as recommended in NICE PH43 guideline).
- Quantify extent of local discrepancy between number of people who need to be treated and the resources necessary to provide treatment
- Review treatment outcomes of people testing positive for hepatitis C locally to identify barriers to successful treatment outcome and how to address barriers
- Review strategies for prevention and case-identification locally and their success in reducing risk of hepatitis C
- Review degree of contact with patients with viral hepatitis

Non-Alcoholic Fatty Liver Disease

- Recommendations for the prevention of obesity and diabetes will be covered by the Healthy Lives Strategy, which will address the underlying cause of non-alcoholic fatty liver disease.

Alcoholic Liver Disease

- Review provision of Identification and Brief Advice (IBA)
- Review coverage and availability of alcohol liaison nurses in A&E
- Review integrated services available for young people at risk of alcohol misuse (NTA Substance Misuse guidance)
- Explore opportunities for early detection of alcoholic liver disease in the health service
- Review current patterns of acute service provision and ascertain whether alternatives to admission are possible

- Provide psychological interventions for alcohol use disorders (e.g. CBT) as per NICE guidance CG115
- Improve effectiveness and capacity of specialist alcohol treatment
- Ensure targeted interventions for alcohol are directed at vulnerable groups
- Conduct rigorous monitoring and evaluation of alcohol interventions
- Review trends in diagnosis of alcohol misuse from prescribing trends of acamprosate and disulfiram
- Update action plan in drugs and alcohol strategy

Prevention, early diagnosis and effective management

- Develop strategies that focus on risk assessment, prevention, early diagnosis and early treatment to prevent the development of advanced liver disease
- Stakeholder engagement: Thorough mapping of use of available services and pathways currently available
    - Map available services to maximise collaborative working and optimal care outcomes
- Development of clinical network and integrated care pathway for liver disease across primary and secondary care
    - Agree pathways for investigation and management of liver disease at local level
    - Agree mechanisms for interpreting tests
    - Agree pathways for abnormal test results
    - Agree protocols for tests to avoid inappropriate duplication
    - Develop local protocols between primary and secondary care to ensure clear pathways for medical and social needs are in place
- Ensure that patients receive appropriate and early intervention with effective combination therapy, to reduce progression to ESLD (secondary prevention)
- Make available specialised services for patients with ESLD to reduce mortality – ensure access to expert care
- Review current pathway for people presenting to hospital with cirrhosis to identify improvements
- Review configuration of services and management of primary liver cancer to identify improvements and opportunities for improving early diagnosis

Health and Wellbeing Board 9th September 2014	Tower Hamlets Health and Wellbeing Board
Report of: Transforming Services, Changing Lives programme team	**Classification:** Unrestricted
Transforming Services, Changing Lives	

Contact for information	**Zoe Hooper, TSCL Communications Manager**

Executive Summary

The Local Clinical Commissioning Groups (CCGs) of Tower Hamlets, Waltham Forest, Newham, Barking and Dagenham, and Redbridge; plus NHS England, Bart's Health and other local providers, have established a clinical transformation programme called Transforming Services, Changing Lives (TSCL). It which will consider how services need to change to provide the best possible health and health care for local residents. **It does not, at this stage, outline any recommendations for change.**

A key element of the programme is to consider how best to ensure safe, effective and sustainable hospital services at Bart's Health hospitals, set in the context of local plans to further develop and improve primary, community and integrated care services.

The work of the programme, which was launched in February 2014, and is expected to run until autumn 2014, will develop a baseline assessment of the drivers for change in the local health economy and support further discussions about the scope, scale and pace of change needed.

Key milestones:

- **9 July:** Interim Case for Change published. Engagement commences to gather feedback to help to inform the final Case for Change and help us determine priorities for the future. This includes events for all Barts Health staff, attendance at public events and a series of patient focus groups.
- **Autumn:** Publication of final Case for Change.
- **After publication of Case for Change:** Explore and agree joint priorities to improve local services. If we think change is required we will work with the public and clinicians to consider a range of potential options to help improve healthcare services.

Recommendations:

The Health and Wellbeing Board is recommended to:

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

1. DETAILS OF REPORT

1.1 Background and Introduction

Local clinicians have been asked to use their own knowledge of national and international best practice to review the quality and performance of East London health services, highlight areas of good practice that should be maintained and developed, and set out if, why, and in what specialties they think there may be a case for change to ensure the very best care for local residents. They are not, at this stage, setting out any recommendations for change.

Their work has been published as an 'Interim Case for Change', which is available to view at www.transformingservices.org.uk.

Key milestones:

- **9 July:** Interim Case for Change published. Engagement commences to gather feedback to help to inform the final Case for Change and help us determine priorities for the future. This includes events for all Barts Health staff, attendance at public events and a series of patient focus groups.
- **Autumn:** Publication of final Case for Change.
- **After publication of Case for Change:** Explore and agree joint priorities to improve local services. If we think change is required we will work with the public and clinicians to consider a range of potential options to help improve healthcare services.

1.2 Governance

The governance arrangements for the programme have been established as follows:

- Programme Board – tasked with providing the strategic oversight for the Programme. To reflect the external decision making requirements, the Programme Board reports to the relevant statutory bodies of CCGs, providers and the NHS England. CCGs ensure a clear link through to HWBBs. Deborah Cohen, London Borough of Tower Hamlets Service Head Commissioning and Strategy, is a member of the programme board and has been asked to nominate a replacement representative upon her departure.

- Clinical Reference Group and Clinical Working Groups – these reflect the key clinical leadership role in exploring and shaping a Case for Change. CCGs,

Barts Health, Homerton Hospital, community and mental health service providers and the London Ambulance service have nominated clinicians and other front-line staff to join clinical working groups. Links are also being established with academic partners. The clinical working groups focus on:

- unplanned care (urgent and emergency care, acute medicine, non-elective surgery)
- long-term conditions
- elective surgery
- maternity and newborn care
- children and young people, and;
- clinical support services

- A Public and Patient Reference Group – this group meets on a regular basis to provide ideas and feedback to clinicians leading the TSCL programme and support and advise on public engagement activities. Representatives have been invited from three broad groups:
  - local branches of Healthwatch
  - patient representatives from the CCGs involved in the programme.
  - patient representatives from the providers involved in the programme.

Tower Hamlets Representation:

Programme Board
Jane Milligan, Tower Hamlets CCG Chief Officer
Sam Everington, Tower Hamlets CCG Chair
Deborah Cohen, LBTH Service Head: Commissioning & Health

Programme Executive
Jane Milligan, Tower Hamlets CCG Chief Officer
John Wardell, Tower Hamlets CCG Deputy Chief Officer
Sam Everington, Tower Hamlets CCG Chair

Clinical Reference Group
Sam Everington, Tower Hamlets CCG Chair
Katherine Gerrans, Tower Hamlets CCG

Clinical Working Groups
Sam Everington, Tower Hamlets CCG Chair
Katherine Gerrans, Tower Hamlets CCG
Victoria Tzortiou-Brown, Tower Hamlets CCG
Mike Fitchett, Tower Hamlets CCG
Neil Douglas, Tower Hamlets CCG
Martha Leigh, Tower Hamlets CCG

1.3 Engagement

Since the programme was launched in February 2014, extensive engagement has taken place with stakeholders across Tower Hamlets, Newham, Waltham Forest, Redbridge and Barking and Dagenham.
Tower Hamlets specific engagement activity includes, but is not limited to:

- Information about the launch of the programme sent in February to the CCG, key contacts at London Borough of Tower Hamlets, including the Chief Executive, Lead Member of Health and Adult Services Select Committee, Health and Wellbeing Board Chair, Council Leader, Corporate Director of Adult and Community Services and Corporate Director of Social Services, Healthwatch, local MPs and London Assembly Members
- Regular meetings of and updates to the TSCL Public and Patient Reference Group. Tower Hamlets members include David Burbidge (Healthwatch Tower Hamlets Co-Chair) and Andrew Wood (Royal London Hospital Patient Panel Chair)
- A series of large engagement events for Barts Health staff
- Key stakeholders from the Tower Hamlets community invited to attend large events about the programme which took place on 4 April and 6 June at Stratford Town Hall. Invitations issued to key contacts at London Borough of Tower Hamlets, Healthwatch, local MPs and Assembly Members.
- Informal briefing to the Inner North East London Joint Overview and Scrutiny Committee
- Press release about the interim case for change sent to wider senior ELFT staff, Council for Voluntary Services, Tower Hamlets Health Overview and Scrutiny Committee and Health and Wellbeing Board, Tower Hamlets College, Docklands and East London Advertiser, East End Life and East End Homes
- Presentation at the Tower Hamlets CCG Governing Body meeting, as well as a follow up discussion at a Governing Body seminar session
- Presentation and attendance at Tower Hamlets Healthwatch Community Event
- Presentation at the Tower Hamlets Locality Chairs Board

Further engagement across the area is planned in order to gather local people's feedback on the interim Case for Change.

- 9th September – Tower Hamlets Health and Wellbeing Board
- 11th September – Inner North East London Joint Overview and Scrutiny Committee
- 16th September – Health Scrutiny Committee
- Mid-September - a series of patient focus groups

1.4 Why have we taken this step?

The five CCGs have a duty to promote a comprehensive health service for their population of around 1.3 million people.

Today, local NHS services face the very real challenge of providing care for a rapidly growing local population, whilst continuing to meet the health needs of some of the most deprived areas seen anywhere in the UK.

The health economy is never static. Change is happening all around the system. In the last year, since the establishment of CCGs, we have seen the introduction of NHS 111, the development of integrated care and soon the launch of personal health budgets. We need to respond to these changes to ensure that benefits are realised and unintended consequences are avoided.

However, we also know that some services simply need to improve to meet local needs. We need to address the areas where we are not so good. We know that the quality of care we provide is inconsistent. We need to work better with providers and with social care to address the challenges we face and decide how we can introduce new and different ways of providing care.

Collectively commissioners have agreed with providers to look at the challenges we face, to ensure we can continue to provide the care our patients need, at the best possible place for them. Organisation boundaries must not and cannot impede the commitment to deliver improvements at scale across the partnership.

We also need to make sure that any changes in the future happen safely and effectively.

In developing their case for change, clinicians will be guided by the principles of the Francis Report to ensure delivering first class care for patients and local populations is the driver for change.

3. CONTACTS

For further information please contact:

Neil Kennett-Brown	Programme Director	Neil.Kennett-Brown@nelcsu.nhs.uk	020 3688 1222
Zoe Hooper	Communications Manager	Zoe.hooper@nelcsu.nhs.uk	020 3688 1678

4. APPENDICES

- NONE

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Health and Wellbeing Board 8 July 2014	Tower Hamlets Health and Wellbeing Board
Report of the London Borough of Tower Hamlets	**Classification:** Unrestricted
Memorandum of Understanding	

Lead Officer	Robert.McCulloch-Graham ESCW Corporate Director
Contact Officers	Deborah Cohen
Executive Key Decision?	No

Executive Summary

1. Prior to the formation of Barts Health NHS Trust, the London Borough of Tower Hamlets (LBTH), NHS East London and The City (subsequently Tower Hamlets Clinical Commissioning Group) and Barts Health, which was formed in April 2012 as a result of a merger, entered into a memorandum of understanding (MOU) with respect to a number of health and social care factors to reduce health inequalities and improve the health of local people. The MOU also had a focus on providing employment opportunities for Tower Hamlets residents. Due to changes in health and social care, including the PCT ceasing operation the MOU is out of date.

2. The MOU was a non-legally binding agreement and is expressed in terms of joint aspirations rather than as a detailed list of performance indicators or outcomes, and was compiled before the Health & Wellbeing Strategy and Performance Framework was put into place

3. This paper provides an update to the Health and Wellbeing Board on the actions undertaken to implement the MOU. A considerable amount of the MOU has been superseded by the Better Care Fund (BCF) and Public Health's move into the Council; however, there is still a need for a focus on employment, enterprise and young people's careers. This paper proposes that this work is better carried forward by the Economic Taskforce partnership under the wider umbrella of One Tower Hamlets and the Prosperous Community theme.

4. A copy of the full MOU is attached as Appendix 1.

Recommendations:

The Health and Wellbeing Board is recommended to NOTE:

- Progress made on the MOU, contained within the table within this report.
- The need for ongoing working between the Council and Barts Health on employment which exists in a number of different parts of the One Tower Hamlets Partnership but specifically lead by the One Tower Hamlets Prosperous Community theme which drives the work on employment and skills.
- That the majority of the MOU's actions are being carried forward by existing work programmes connected to the HWBB such as the Better Care Fund, Public Health's Healthy Lives work programme and HWBB's subgroups.
- The recommendations laid out in the table outlining the original MOU actions.
- That the work on employment, enterprise and young people's careers be better carried out through the work of the Economic Task Force and that the decision to put in place a new MOU between the Council and Barts Health on skills development and local employment is facilitated by the Councils Economic Development Team.

1. REASONS FOR THE DECISIONS

1.1 The original MOU predated the Care Act, BCF and integration which means that a significant part of the MOU is carried forward elsewhere but still with the remit of the Health & Wellbeing Board. However a focus on the employment aspect of the MOU is still required and it is proposed that this move to Economic Development Team within D&R.

1.2 This paper provides a final status update and recommendations for carrying the MOU's principles forward either by Health and Wellbeing Board or handed over to Economic Development Team within D&R

2. ALTERNATIVE OPTIONS

2.1 The board may decide a new MOU is needed or to expand the scope of the existing MOU.

3. DETAILS OF REPORT

3.1 The following table outlines the agreements as laid out in the MOU, the status and recommendations, where applicable, for continuation of the piece of work. Points 1 – 6 focus on all parties working together.

MOU	Status	Action Required
1. Improve the health and healthcare of people who live, visit or work in the borough and in particular to reduce health inequalities.	Key role of Public Health who since the MOU have moved into the local authority. In addition there has been the appointment by BH of a director of public health and development of a range of activity. This is a key responsibility of the HWBB; the board formally approved the Borough's 3 year Joint Health and Wellbeing Strategy in February 2014, which outlines the HWBB's approach to improving the Borough's health and wellbeing. The Health and Wellbeing Strategy Subgroup continues to monitor the HWBB partnership's progress against the Health and Wellbeing Strategy delivery plan and provide regular updates to the HWBB.	No further action required
2. Improve local access to services and information to local people about facilities so that they can choose and use the right facilities for them.	On going work programme of the HWBB Engagement subgroup which is now well established between all parties of the MOU..	No action further action required.
3. Agree a programme of health promotion work to be delivered through schools to reach all	The Council's Public Heath team has commissioned the Healthy lives team in the ESCW directorate. At present 89% of the Borough's schools have	Robert McCulloch-Graham to nominate a lead officer from the Education Social Care and Wellbeing directorate to explore a programme working in

	pupils, their families and the wider community and to work with schools to promote careers in the local NHS	achieved the Healthy Schools Award; which is recognition of a school work to improve and maintain their provision around certain health based criteria, including healthy eating, sex and relationships eduaction and physical activity. A programme focusing on Mental Health resillience for schools is currently being commissioned. This is partly achieved but work on the promotion of careers in schools I need. .	partnership with Barts Health Public Health and local higher education providers to promote careers in the local NHS to School Children. In addition the Apprenticeship taskgroup through the work of the Economic Development Team to ensure that apprenticeships and other training and experience opportunities are promoted to young people.
4.	Work closely with our local university, Queen Mary, University of London to develop new opportunities for students within Tower Hamlets to enter in to medical training	Not progressed at this point.	See action required for 3.
5.	Agree a mechanism that ensures efforts regarding economic development are aligned and encourage a) big businesses to relocate to the area b) small businesses to start up and develop in the borough	Ongoing meetings between key senior staff in BH and the Council are taking place.	This is a key responsibility of the Council's Development and Renewal Directorate and handed over to Economic Development within D&R.

6. Agree and implement a programme to encourage and assist at least 1,000 residents of Tower Hamlets over the next two years to apply for and obtain employment in the new Trust.	There are numerous projects in place between the Council's Employment service and Bart's Health trust including: An agreement in place for the Council to be informed of the Trusts Apprenticeship requirements in advance giving Skillsmatch the time to prepare local young people and give them the chance to compete for the positions from an advantage point.	This is a key responsibility of the Council's Development and Renewal Directorate and handed over to the Economic Development team within D&R.
7. Work with the Council to actively encourage local people to make their voice heard and ensure patient and public involvement is at the heart of every aspect of the new Trust.	Reports from Healthwatch are received at each HWBB meeting and the Board has an Engagement subgroup.	No further action required.
8. Develop robust mechanisms to report to the Council on performance with particular respect to community health services and hospital discharge pathways.	The role of the HWBB in this area is set out in the Better Care Fund plan and there will be a separate set of metrics that will be monitored. The BCF can be seen to supersede this part of the MOU. Performance metrics include reducing DTOCs; reducing avoidable emergency admissions and increased reablement of older people after discharge.	Deborah Cohen, Service Head for Commissioning and Health and Jane Milligan, CE Tower Hamlets CCG, to bring reports on performance against the BCF metrics will be reported to the HWBB.
9. Provide opportunities for	Delivery of this commitment (in para 9) is tied to BH	No further action required.

council representation in the trust governance structure.	becoming a foundation trust. The appointment of a Council advisor to BH has not been progressed in the context of the establishment of the HWB Board. However BH have met with the Council leadership many times over the last year and have put structures in place to engage local authority members in addition to working with Health Scrutiny (a statutory requirement), and sitting as co-opted members on the Health and Wellbeing Board.	
10. Ensure that the Council is engaged in the development of high quality health services and provided with every opportunity to influence healthcare provision locally.	This is part of the HWBB's role as a statutory committee of the Council, as outlined in the terms of reference, with performance monitored by the HWBB's Health and Wellbeing Strategy Subgroup	No further action required
11. Actively review the working arrangments and the success of collaborative working – in particular a programme of regular meetings between the Mayor and the Chief Executive of the Council, commissioners, and the Chair	As above - BH have met with the Council leadership many times over the last year and have put structures in place to engage local authority members in addition to working with Health Scrutiny (a statutory requirement), and sitting as co-opted members on the Health and Wellbeing Board. To note that the Council has no Chief Executive in place.	No further action required within the MOU. However periodic meetings to continue.

and the Chief Executive of the new trust.		

4. COMMENTS OF THE CHIEF FINANCE OFFICER

4.1 This report provides an update to the Health and Wellbeing Board on the actions undertaken to implement the MOU and to agree which existing work programmes will take forward the aspirations which were contained within the original agreement. It is proposed that some of the themes will be carried forward by the Economic Taskforce partnership which is led by the D&R directorate.

4.2 There are no direct financial implications as a result of these proposals, all the themes within the original MOU will be carried forward within existing work programmes and budgets.

5. LEGAL COMMENTS

5.1. The recommendations are consistent with the general policy, reflected in the Health and Social Care Act 2012, of giving HWBs responsibility for joint health and wellbeing strategies. As the HWB has statutory status, due regard should be given to its decision making authority within its terms of reference.

5.2. These recommendations are within the terms of reference of the HWB agreed by the Mayor in Cabinet on 4 December 2013, in particular 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.

6. ONE TOWER HAMLETS CONSIDERATIONS

N/A

7. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

7.1 N/A

8. RISK MANAGEMENT IMPLICATIONS

8.1. The MOU is a non-legally binding agreement and nothing in the MOU is intended to require the Council to act contrary to its legal duties.

8.2. Any new MOU should take account of legally binding existing agreements for example the Royal London Section 106 agreement in place.

9. CRIME AND DISORDER REDUCTION IMPLICATIONS

9.1 N/A

10. EFFICIENCY STATEMENT

10.1 N/A

Appendices and Background Documents

Appendices

- Appendix 1 - Memorandum of Understanding

- Appendix 2 - Barts Health Employment Breakdown (Tower Hamlets Data)

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

Memorandum of Understanding between:

London Borough of Tower Hamlets; and

NHS North East London and the City; and

Barts Health NHS Trust, the new trust formed by the merger of Barts and The London NHS Trust, Whipps Cross University Hospital NHS Trust and Newham University Hospital NHS Trust

The parties agree to work collaboratively and proactively to:

1. improve the health and healthcare of people who live, visit or work in the borough, and in particular to reduce health inequalities;
2. improve local access to services and information to local people about facilities so that they can choose and use the right services for them;
3. agree a programme of health promotion work to be delivered through schools to reach all pupils, their families and the wider community; and to work with schools to promote careers in the local NHS;
4. work closely with our local university, Queen Mary, University of London to develop new opportunities for students within Tower Hamlets to enter into medical training;
5. agree a mechanism that ensures efforts regarding economic development are aligned and encourage:
    a. big businesses to relocate to the area
    b. small businesses to start up and to develop in the borough; and
6. agree and implement a programme, to our best endeavours, to encourage and assist at least 1,000 residents of Tower Hamlets over the next two years to apply for and obtain employment in the new Trust, for instance by:
    a. helping the long-term unemployed into training or jobs
    b. focusing on working with children and young people to develop their career opportunities
    c. helping talented local people to become graduates
    d. the trust seeking to use its influence with local training providers to make medical training more accessible to local people
    e. providing local people access to jobs
    f. notifying the Council Employment and Enterprise Team of all job opportunities arising with the Trust; and
    g. participating in the Council Employment and Enterprise initiatives

The NHS Trust will:

7. work with the Council to actively encourage local people to make their voice heard and ensure patient and public involvement is at the heart of every aspect of the new trust;
8. develop robust mechanisms to report to the Council on performance with particular respect to community health services and hospital discharge pathways. This may be incorporated into the NHS contracts from 2012/13 onwards and the new Trust will negotiate this with commissioners; and
9. provide opportunities for council representation in the trust governance structure including (subject to approval by Monitor) a nomination of at least one Governor to

the board of governors when the trust becomes a Foundation Trust and, in the meantime, the Council to propose an advisor to the Barts Health NHS Trust Board.

10. ensure that the Council is engaged in the development of high-quality health services and provided with every opportunity to influence healthcare provision for local people.

The parties agree to:

11. actively review the working arrangements and the success of collaborative working - in particular a programme of regular meetings between the Mayor and Chief Executive of the Council, commissioners, and the Chair and Chief Executive of the new trust.

This Memorandum sets out a statement of some of the intended benefits and deliverables to be derived from the joint working between the parties. The parties enter into this Memorandum in good faith.

The parties acknowledge that this is a non-legally binding agreement and nothing in this Memorandum is intended to require the parties to act contrary to their legal duties and obligations, nor to act contrary to the instructions of the Secretary of State for Health or Monitor. It is not intended to, and shall not be deemed to, establish any legal partnership between the parties, constitute either party as the agent of the other, nor authorise either of the parties to make or enter into any commitments for or on behalf of the other party.

The agreement shall remain valid until the time at which responsibility for commissioning services transfers from NHS North East London and the City to new Clinical Commissioning Groups.

To be signed and take effect from 1 April 2012.

Aman Dalvi

Chief Executive London Borough of Tower Hamlets

Peter Morris

Chief Executive Barts Health

Andrew Ridley

Managing Director NHS East London and City

Barts Health Tower Hamlets Residents and their Protected

Staff in Post 31 March 2014

	Permanent				Fixed Term Temp			
Age Group	**Bands 1-4**	**Bands 5+**	**Medical/Other**	**Total**	**Bands 1-4**	**Bands 5+**	**Medical/Other**	**Total**
Under 25	61	29		**90**	10	3	16	**29**
25 - 34	257	242	4	**503**	19	22	107	**148**
35 - 44	136	225	23	**384**	6	15	44	**65**
45 - 54	120	175	36	**331**	1	5	7	**13**
55 - 64	71	65	7	**143**	2	1	1	**4**
65 and over	16	2	1	**19**	1		1	**2**
Grand Total	**661**	**738**	**71**	**1470**	**39**	**46**	**176**	**261**

	Permanent				Fixed Term Temp			
Disability	**Bands 1-4**	**Bands 5+**	**Medical/Other**	**Total**	**Bands 1-4**	**Bands 5+**	**Medical/Other**	**Total**
No	404	486	36	**926**	32	41	143	**216**
Not Declared	243	241	34	**518**	5	5	31	**41**
Undefined	1			**1**				
Yes	13	11	1	**25**	2		2	**4**
Grand Total	**661**	**738**	**71**	**1470**	**39**	**46**	**176**	**261**

	Permanent				Fixed Term Temp			
Ethnicity	**Bands 1-4**	**Bands 5+**	**Medical/Other**	**Total**	**Bands 1-4**	**Bands 5+**	**Medical/Other**	**Total**
Asian	301	159	16	**476**	20	7	32	**59**
Black	93	135	2	**230**	6	10	4	**20**
Mixed	16	16		**32**	1	1	5	**7**
Not Stated/Undefined	24	13	2	**39**	3	1	42	**46**
Other	21	88	1	**110**	1	9	5	**15**
White	206	327	50	**583**	8	18	88	**114**
Grand Total	**661**	**738**	**71**	**1470**	**39**	**46**	**176**	**261**

	Permanent				Fixed Term Temp			
Gender	**Bands 1-4**	**Bands 5+**	**Medical/Other**		**Bands 1-4**	**Bands 5+**	**Medical/Other**	
Female	509	574	40	**1123**	24	41	97	**162**
Male	152	164	31	**347**	15	5	79	**99**
Grand Total	**661**	**738**	**71**	**1470**	**39**	**46**	**176**	**261**

	Permanent				Fixed Term Temp			
Religion	**Bands 1-4**	**Bands 5+**	**Medical/Other**		**Bands 1-4**	**Bands 5+**	**Medical/Other**	
Atheism	11	50	2	**63**	2	2	17	**21**
Buddhism	2	6		**8**				
Christianity	133	219	11	**363**	12	29	30	**71**
Hinduism	3	8	2	**13**	1		7	**8**
Not disclosed	64	92	11	**167**	5	5	72	**82**
Islam	203	99	4	**306**	16	3	14	**33**
Other	9	29		**38**	2	2	8	**12**
Undefined	236	235	41	**512**	1	5	28	**34**
Grand Total	**661**	**738**	**71**	**1470**	**39**	**46**	**176**	**261**

	Permanent				Fixed Term Temp			
Sexual Orientation	**Bands 1-4**	**Bands 5+**	**Medical/Other**		**Bands 1-4**	**Bands 5+**	**Medical/Other**	
Bisexual	4	2		**6**				
Gay	8	13	1	**22**		2	1	**3**
Heterosexual	339	371	18	**728**	33	36	86	**155**
Not disclosed	77	112	11	**200**	5	3	62	**70**
Lesbian		3		**3**				
Undefined	233	237	41	**511**	1	5	27	**33**
Grand Total	**661**	**738**	**71**	**1470**	**39**	**46**	**176**	**261**

Characteristics

Bank/Locum				
Bands 1-4	Bands 5+	Medical/Other	Total	Grand Total
		43	43	162
	2	118	120	771
		67	67	516
		40	40	384
1		13	14	161
		5	5	26
1	2	286	289	2020

Bank/Locum				
Bands 1-4	Bands 5+	Medical/Other	Total	Grand Total
	2	260	262	1404
1		24	25	584
				1
		2	2	31
1	2	286	289	2020

Bank/Locum				
Bands 1-4	Bands 5+	Medical/Other	Total	Grand Total
		93	93	628
		47	47	297
		3	3	42
		46	46	131
		11	11	136
1	2	86	89	786
1	2	286	289	2020

Bank/Locum				
Bands 1-4	Bands 5+	Medical/Other		Grand Total
1	2	192	195	1480
		94	94	540
1	2	286	289	2020

Bank/Locum				
Bands 1-4	Bands 5+	Medical/Other		Grand Total
	2	8	10	94
		3	3	11
		50	50	484
		4	4	25
		95	95	344
		59	59	398
		11	11	61
1		56	57	603
1	2	286	289	2020

Bank/Locum				
Bands 1-4	Bands 5+	Medical/Other		Grand Total
		1	**1**	**7**
		5	**5**	**30**
	2	143	**145**	**1028**
		77	**77**	**347**
		2	**2**	**5**
1		58	**59**	**603**
1	**2**	**286**	**289**	**2020**

Health and Wellbeing Board 9 September 2014.	Tower Hamlets Health and Wellbeing Board
Report of the London Borough of Tower Hamlets	**Classification:** [Unrestricted]
Review of the Community Plan	

Lead Officer	Louise Russell, Service Head, Corporate Strategy and Equality
Contact Officers	Shanara Matin, Service Manager, Corporate Research Unit

Executive Summary

1.1 This presentation outlines the approach to developing the new Community Plan. The Plan was last refreshed in 2011 since when there have been significant legislative, financial and organisational changes within local government, health, and other partners. At the same time we have the start of a new Mayoral term with a re-elected Mayor and a borough wide mandate.

1.4 This presentation sets out the process for consultation across the Partnership and the plans for public engagement. It includes key questions for the Health and Wellbeing Board to comment on.

Recommendations:

The Health and Wellbeing Board is recommended to:

- Comment on the proposed approach and issues for the refreshing the Community Plan
- Explore the key questions related to health and social care and the wider determinants of health and wellbeing.

1. REASONS FOR THE DECISIONS

N/A

2. ALTERNATIVE OPTIONS

N/A

3. DETAILS OF REPORT

3.1 This presentation outlines the approach to developing the new Community Plan. The Plan was last refreshed in 2011 since when there have been significant legislative, financial and organisational changes within local government, health, and other partners. At the same time we have the start of a new Mayoral term with a re-elected Mayor and a borough wide mandate. This presentation sets out the process for consultation across the Partnership and the plans for public engagement. It includes key questions for the Health and Wellbeing Board to comment on.

4. COMMENTS OF THE CHIEF FINANCE OFFICER

4.1 The Community Plan will take into consideration legislative, financial and organisational changes during its lifecycle, inevitably these changes will have a significant impact on resources. The impact of these changes will be factored into budget and service planning cycles (i.e. as part of the Medium Term Financial Plan) for future years.

5. LEGAL COMMENTS

5.1. The review of the Community Plan will need to address the legislative changes which have already come into effect under the Health and Social Care Act 2012, together with the upcoming impact of the new Care Act 2014 and associated regulations and Guidance. The recommendation that the HWB comments on the approach to be taken when reviewing the Plan 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.

6. ONE TOWER HAMLETS CONSIDERATIONS

6.1. N/A

7. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

7.1 N/A

8. RISK MANAGEMENT IMPLICATIONS

8.1. N/A

9. CRIME AND DISORDER REDUCTION IMPLICATIONS

9.1 N/A

10. EFFICIENCY STATEMENT

10.1 N/A

Appendices and Background Documents

Appendices

This is added to the main paper and provides more detailed overview of needs assessment

Background Documents

- NONE

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Community Plan – 2014 Refresh

Health and Wellbeing Board

Shanara Matin
Service Manager, Corporate Research Unit
LBTH

Improving today, shaping tomorrow

Sustainable Community Strategy….Community Plan

- Typically 3 key elements:
  - A (long-term) vision for an area
  - A (shorter-term) action plan
  - A performance framework

- Sets out a shared vision and provides the strategic framework for the Partnership and partner agencies
- Usually more about 'what' and less about 'how'

Who is it for?

- Strategic direction for key partners e.g. NHS, Police and Voluntary and Community Sector
- Resident participation in developing priorities
- Inclusion and engagement of wider partners e.g. Universities, Businesses

Improving today, shaping tomorrow

Reasons for the refresh…….. why now?

- Last Community Plan refresh was in 2011. Three to four year cycle
- Significant legislative, financial and organisational changes e.g. new duties (Health and Social Care Act), cuts to local government funding, public health transition
- New Executive Mayoral term – borough wide mandate

Improving today, shaping tomorrow

Reasons for the refresh…….. why now?

- Review within TH Partnership: desire to retain collaborative working and important to continue to work together in the context of fewer resources
- Some of the most significant funding cuts yet to come – identifying priorities in the context of reduced funding

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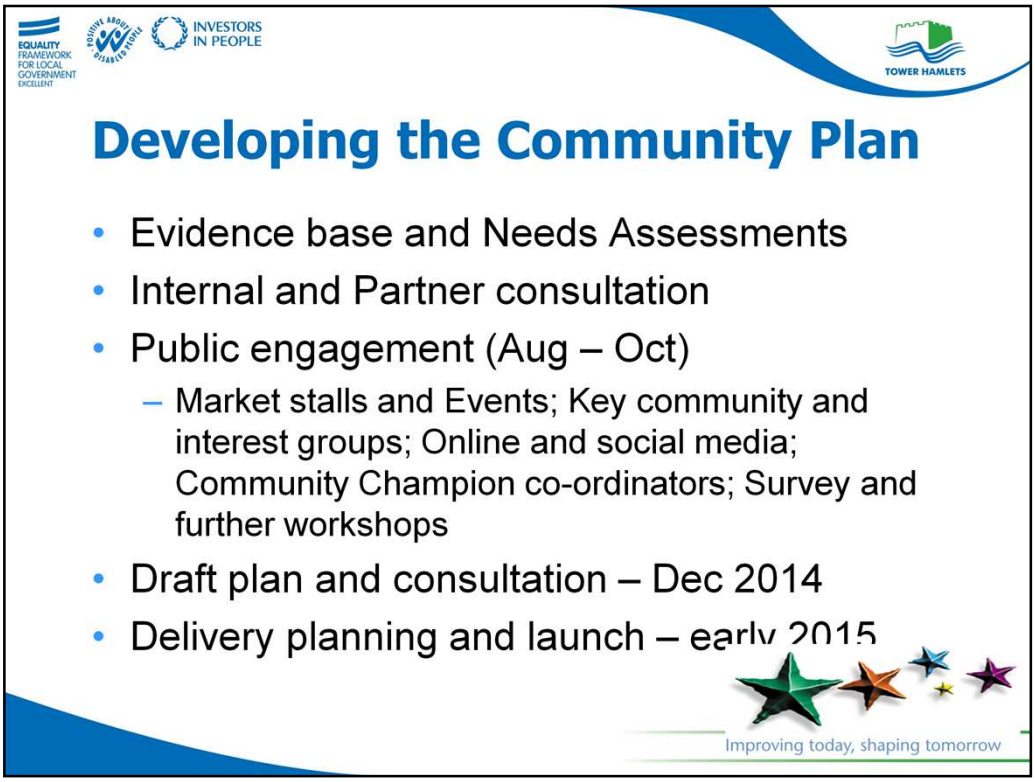

Review demographics, existing needs analyses, performance to date –

Partner/CPDG engagement – Jul - Sept

Public engagement – Jul – Sept

Emerging options and ideas – report back to Executive in Oct

Draft plan and consultation – to Dec 2014

Delivery planning and launch – early 2015

Public engagement

- Combine with considering big issues around funding and Council budgets
- Variety of methods
  - CPDGs
  - Key community and interest groups
  - Community Champion co-ordinators
  - Online and social media
  - Independent survey and deliberative workshops

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Achievements

- Fast changing borough and greater prosperity
  - Borough with highest number of affordable homes built since 2011
  - More people in employment and reducing levels of child poverty
  - Population expected to increase by a fifth by 2024
  - People are satisfied with where they live and local services
  - People from different backgrounds get on well together

Improving today, shaping tomorrow

Achievements in Health & Social care

- Increase in the number of self directed support care users
- Surveys show social care related quality of life is improving
- Time between a child entering care and moving in with an adoptive family is comparatively low
- Significant reduction in teenage pregnancy rates – the current rate is lower (better) than the London average
- Historic very strong performance in terms of smoking cessation over the period

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Some current challenges

- Male and Female mortality rates remain amongst the worst in London – these are long-term measures
- Demographic changes such as population increase and an ageing population impacts particularly on health and social care
- In terms of wider determinants many still face difficulties in finding jobs and affordable housing
- **And** the most significant public funding cuts are yet to be implemented….Increasing demand across Council services which need to be met with fewer resources.

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External challenges

- Future funding scenarios for health and social care are of continuing financial austerity and real uncertainty after 2015/16
- Care Act – additional cost pressure not fully picked up by Government
- Children and Families Act focused on vulnerable children
- Integration agenda e.g. Better Care Fund

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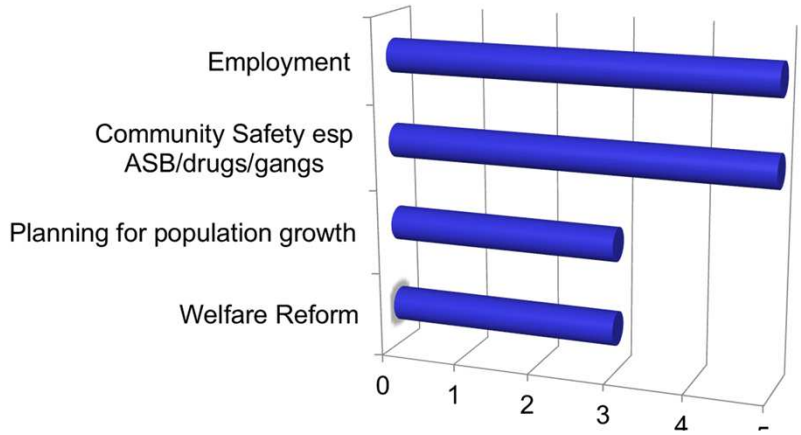
Priorities from Partnership review



For 2014-17 Emerging themes

- Managing Growth/Making Growth work for everyone
- Fairness – avoiding communities being left behind by gentrification
- Collaboration – health and social care; other public sector; with private sector
- New contract with residents – 'rights and responsibilities'
- Employment as a key enabler of improved outcomes

Key Questions

What can the Council do to support people to help themselves:

- live more healthily?
- gain skills for employment?
- manage difficult lives and circumstances?

Could the Council make better use of technology e.g. provide services online?

What can we do to ensure the impact of an ageing population is a source of economic growth and wellbeing and not an increasing burden on the wider population and services?

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Trends and future need

(Source: Kings Fund - Future Trends Analysis).

Figures are for the UK as a whole unless otherwise stated

- **Health is determined by a complex interaction between individual characteristics, lifestyle and the physical, social and economic environment**
- **Growing population and increasing diversity.** TH expected to reach 350,000 by 2032
- **More people are living alone**. 40 per cent of all households by 2032. Over 85 and living on their own is expected to grow from 573, 000 to 1.4 million.
- **Ageing population and increased life expectancy**
  Over 85 will grow by 106 per cent in next 20 years (baby boomers)

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Trends and future need

- **Significant health inequalities are likely to persist** – higher rates of disease and multiple diseases, seven year difference in life expectancy
- **Diet, smoking and alcohol consumption (lifestyles) present a serious threat to health,** particularly for disadvantaged groups
- **More than 60 per cent of the population have a negative or fatalistic attitude** towards their own health
- **Some improving trends in behaviour of young people**, but many (80% of children) continue to have a poor diet

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Trends and future need

- **The number of people with more than one long-term condition is growing rapidly**. Will grow by a third in just three years to 2018 (1mn to 2.9mn)
- By 2030 the number of older **people with care needs is predicted to rise by 61 per cent**
- **Sources of informal care are shrinking**
  Unpredictable impact of new technologies on models of care and skill-mix requirements in workforce in the future

Improving today, shaping tomorrow

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22nd September 3pm - 5pm

Jack Dash House
Council Chambers

2 Lawn House Close

Isle of Dogs

E14 9YQ

careandhealthreform@towerhamlets.gov.uk

Care Act Workshop

Understanding the changes

The government is transforming the health and social care system provided to those that need support by the council. The Care Act became law on May 14, 2014, and makes changes to the way that the social care system in England wi work in the future. These changes will affect anyone who has care needs.

Come along to this workshop especially designed by Tower Hamlets council for Health and Wellbeing Board.

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