# TOWER HAMLETS HEALTH AND WELLBEING BOARD

**Tuesday, 7 July 2015 at 5.00 p.m. Committee Room MP701 7th Floor, Mulberry Place, 5 Clove Crescent, London E14 2BG**

**This meeting is open to the public to attend.**

| **Members:** | **Representing** |
|---|---|
| **Chair:** Mayor John Biggs | Mayor |
| **Vice-Chair:** | |
| Councillor Rachael Saunders | |
| Councillor Amy Whitelock Gibbs | |
| Councillor Denise Jones | (Non - Executive Group Councillor) |
| Councillor David Edgar | |
| Robert McCulloch-Graham | (Corporate Director, Education Social Care and Wellbeing) |
| Dr Somen Banerjee | (Interim Director of Public Health, LBTH) |
| Dr Amjad Rahi | (Local Healthwatch Tower Hamlets Representative) |
| Dr Sam Everington | (Chair, NHS Tower Hamlets Clinical Commissioning Group) |
| Jane Milligan | (Chief Officer, NHS Tower Hamlets Clinical Commissioning Group) |
| Dr Ian Basnett | (Public Health Director, Barts Health NHS Trust) |
| **Co-opted Members** | |
| Steve Stride | (Chief Executive, Poplar HARCA) |
| Dr Navina Evans, | (Deputy Chief Executive and Director of Operations) |
| James Ross | (Hospital Director at Newham Hospital) |
| Suzanne Firth | (Tower Hamlets Community Voluntary Sector) |
| 1 Vacancy | |

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:
Elizabeth Dowuona, Democratic Services

Scan this code for the electronic

1st Floor, Mulberry Place, Town Hall, 5 Clove Crescent, E14 2BG
Tel: 02073644207
E:mail: elizabeth.dowuona@towerhamlets.gov.uk
Web: http://www.towerhamlets.gov.uk/committee

agenda

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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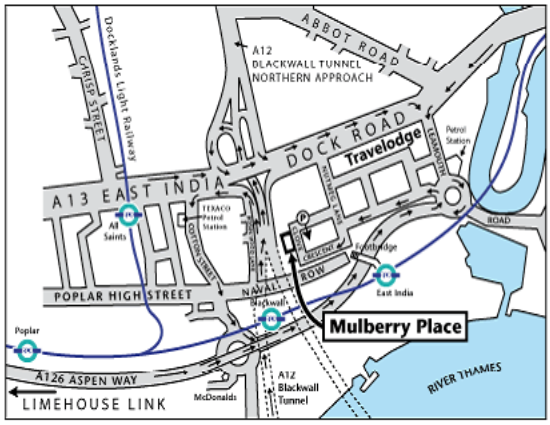


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PAGE NUMBER(S)

## 1. STANDING ITEMS OF BUSINESS

### 1 .1 Chair's Opening Remarks

The Chair to welcome those present at the meeting and request introductions.

### 1 .2 Apologies for Absence

### 1 .3 Public Questions

To receive questions from members of the general public.

### 1 .4 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).

## 2. MINUTES OF THE PREVIOUS MEETING 5 - 18

To confirm the minutes of the meeting of the Tower Hamlets Health and Wellbeing Board held on 10 March 2015 as a correct record.

## 3. TERMS OF REFERENCE, QUORUM, MEMBERSHIP, AND DATES OF FUTURE MEETINGS 19 - 28

To note the Terms of Reference, Quorum, Membership and Dates of Meetings of the Tower Hamlets Health and Wellbeing Board.

## 4. FORWARD PROGRAMME

Lead Officer Somen Banerjee

To plan a work programme for the 2015/16 municipal year.

## 5. COMMUNITY INTELLIGENCE - HEALTHWATCH PERSPECTIVE 29 - 30

Lead Officer : Dianne Barham

The report provides a dashboard highlighting key themes and issues from local resident feedback on health and social care services in

Tower Hamlets and a brief on the community intelligence currently being collected through 17 community groups on the needs and wants of local residents to feed into the Health and Wellbeing Strategy refresh and the commissioning process.

Recommendation: To note the report.

## 6. HEALTH AND WELLBEING STORY - HEALTHY HOMES PROJECT 31 - 34

Lead Officer: Jonathan Arnold/Tim Madelin

The report presents the healthy homes project which seeks to increase the number of properties with vulnerable tenants that have their conditions improved through environmental health intervention.

Recommendation :

1. To note the case study of an intervention as part of the Healthy Homes project.

2. Reflect on the role housing plays in Health and Wellbeing.

**ITEMS OF BUSINESS FOR CONSIDERATION**

## 7. CARE QUALITY COMMISSION REPORT 35 - 38

Lead Officer: Somen Banerjee/Karen Breen

The report provides the Board with a briefing on the outcomes of the CQC report on Barts Health, the response of the trust and implications for the Board.

Recommendation:

To note the report

## 8. EARLY YEARS: HEALTH VISITING SERVICE - FINDINGS FROM STAKEHOLDER ENGAGEMENT 39 - 90

Lead Officer: Esther Trenchard-Mabere

The report sets out the engagement process that has been carried out on the emerging integrated locality model for the health visiting service.

Recommendation

To note the report

## 9. MENTAL HEALTH: CRISIS CARE CONCORDAT 91 - 108

Lead Officer: Carrie Kilpatrick

The report provides a progress update on the local action plan that has been developed in response to the Government's inter-agency Mental Health Crisis Care Concordat.

Recommendation:

To note the report

## 10. HEALTH AND WELLBEING STRATEGY: REFRESH AND FINAL MONITORING 2013-2014 109 - 178

Lead Officer: Louise Russell/ Somen Banerjee

The report provides a final update of the 2013/14 delivery plans which were rolled forward to 2014/15.

Recommendations:

3. To note the update on performance set out in part 3 of the report and detailed in Appendices 1- 5;
4. Note the timescales of the refresh of the Health and Wellbeing Strategy.

## 11. UPDATE ON PREVIOUS AGENDA ITEMS

### 11 .1 Update on Liver Disease 179 - 182

Lead Officer: Somen Banerjee

The report sets out the progress since the position set out at the September 2014 Board.

Recommendations:

To note the report.

### 11 .2 Update on Breast Cancer Screening 183 - 186

Lead Officer: Somen Banerjee

The report sets out the improvement plan and progress since the position set out at the January 2015 Board.

Recommendations:

To note the report.

## 12. ACTION UNDER DELEGATED AUTHOURITY

**187 - 194**

Lead Officer: Somen Banerjee/Jane Milligan

This item reports on action taken under delegated authority by the Director of Public Health and approved by the Chair since the last meeting of the Wellbeing Board.

Recommendation

To note the approval of the CCG Quality Premium on 8th June 2015.

## 13. ANY OTHER BUSINESS

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

## 14. DATE OF NEXT MEETING

**Date of Next Meeting:**
Tuesday, 8 September 2015 at 5.00 p.m. in Committee Room MP701, 7th Floor, 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.<br>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—<br>(a) under which goods or services are to be provided or works are to be executed; and<br>(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)—<br>(a) the landlord is the relevant authority; and<br>(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—<br>(a) that body (to the Member's knowledge) has a place of business or land in the area of the relevant authority; and<br>(b) either—<br><br>(i) the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body; or<br><br>(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. |

**LONDON BOROUGH OF TOWER HAMLETS**

**MINUTES OF THE TOWER HAMLETS HEALTH AND WELLBEING BOARD HELD AT 5.00 P.M. ON TUESDAY, 10 MARCH 2015 COMMITTEE ROOM MP701, 7TH FLOOR, TOWN HALL, MULBERRY PLACE, 5 CLOVE CRESCENT, LONDON E14 2BG**

**Members Present:**

| | | |
|---|---|---|
| Councillor Abdul Asad | – | (Vice-Chair) (In the chair) |
| Councillor Denise Jones (Member) | – | Non-executive Majority Political Group Councillor Nominated by Council |
| Robert McCulloch-Graham (Member) | – | (Corporate Director, Education Social Care and Wellbeing) |
| 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:**

| | | |
|---|---|---|
| Dr Ian Basnett | – | Bart's Health |
| Dianne Barham | – | Healthwatch Tower Hamlets |

**Apologies:**

| | | |
|---|---|---|
| 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) |
| Dr Amjad Rahi | – | (Healthwatch Tower Hamlets Representative) |
| Steve Stride | – | (Chief Executive, Poplar HARCA) |

**Others Present:**

| | | |
|---|---|---|
| Sarah Castro | - | Poplar HARCA |
| Chris Lovitt | - | Associate Director of Public Health, LBTH |
| Abigail Knight | - | Acting Associate Director of Public Health |
| Wesley Hedger | - | Senior Strategy Policy & Performance Officer |
| Karen Sugars | - | Care and Health Reform Programme Manager |

**Officers in Attendance:**

| | | |
|---|---|---|
| Jamal Uddin | – | Strategy, Policy and Performance Officer, LBTH) |
| Elizabeth Dowuona | – | (Senior Committee Services Officer) |

## 1. STANDING ITEMS OF BUSINESS

### 1.1 Welcome

The Chair welcomed everybody to the Health and Wellbeing Board. He reported that the meeting would largely focus on the Council's responsibility to approve the Health and Wellbeing Strategy Delivery Plans in addition to statutory duties such as signing off the Better Care Fund Section 75 Agreement.

### 1.2 Apologies for Absence and Substitutions

Apologies for absence were received from Councillor Alibor Choudhury (Cabinet Member, Resources), Councillor Mahbub Alam (Executive Advisor on Adult Social Care), Dr Amjad Rahi (Healthwatch Tower Hamlets Representative) and Dr Navina Evans, Co-opted Member.

### 1.3 Minutes of the Meeting on 13 January 2015

**RESOLVED**:

The minutes of the meeting held on 13 January 2015 be approved as a correct record subject to the inclusion of Dr Ian Basnett on the list of Co-opted Members' Present.

### 1.4 Public Questions

The Board noted that no questions had been received from members of the public.

## 2. DECLARATIONS OF DISCLOSABLE PECUNIARY INTERESTS

There were no declarations of interest.

It was noted that advice of the Legal Adviser to the Board, regarding the query raised at the Board meeting on 9 December 2015 on the declaration interests already declared in the Members Register of Interests, was outstanding.

It was agreed that the advice be reported to the next meeting of the Board.

**Action By:** Sarah Williams (Legal Services)

## 3. FORWARD PROGRAMME

The Board noted the Forward Plan.

## 4. INTEGRATION : HEALTHWATCH PERSPECTIVE

### 4.1 Evaluation: Tower Hamlets Coordinated Care Programme - Summary

Dianne Barham, Director, Healthwatch Tower Hamlets introduced the report, which was taken together with Agenda Item 3.2 Integrated Care Programme Update were taken together.

A short video was played, which showed services users experiences of the integrated care programme.

Dianne Barham outlined the Integrated Care programme as a major piece of health and social care transformational work. The purpose of the evaluation of the programme was to understand the experiences of and obtain feedback from both providers and the users of the new service over a period of time so that the programme could be both improved upon and tailored to their needs.

A second video was played. The video highlighted communication/ interaction between the social care providers arrangements in respect of scheduling of appointments, patient transportation and patient care including rapid response.

Members discussed the system of integrated care and underlined the need for healthcare providers and commissioners to enable better integration of care so that services were less fragmented and easier for patients to access.

It was noted that Tower Hamlets in collaboration with Waltham Forest, Newham and City and Hackney (WELC) had been chosen as a pioneer in the new models of care, supporting self-management to promote and enhance the quality of life for people with long term conditions. This had attracted £2million funding and support from Central Government.

Robert McCulloch-Graham, Corporate Director, Education Social Care and Wellbeing) pointed to the need for a press release in the local media as a good news story to which the Board agreed.

**RESOLVED –**

1. That the report be noted.
2. That a briefing would be provided to the Board in September 2015 with an update on the progress of the programme.

### 4.2 Integrated Care Programme Update

This item was discussed conjunction with Item 4.1 – Evaluation: Tower Hamlets Integrated Care Programme Summary.

**RESOLVED –**

That the report be noted.

### 4.3 Better Care Fund S75 Agreement

Robert McCulloch-Graham, Corporate Director, Education Social Care and Wellbeing) introduced the report.

He outlined the establishment of the £5.3bn Better Care Fund (formerly the Integration Transformation Fund). It was noted that the Fund was a Government initiative to ensure a transformation in integrated health and social care. The Better Care Fund (BCF) is one of the most ambitious ever programmes across the NHS and Local Government. It created a local single pooled budget to incentivise the NHS and local government to work more closely together around people, placing their well-being as the focus of health and care services.

The Tower Hamlets Better Care Fund plan was submitted to the Department of Health in April 2014, a revised version was submitted in September 2014 and approval of the plan was confirmed by NHS England on 7 January 2015 (see Appendix 1). The plan has effect from 1 April 2015. The planned expenditure covered by the Better Care Fund plan is £21.577 million in 2015/16.

In order to provide a governance framework for the commissioning and delivery of the Better Care Fund and the management of the budget and expenditure, an agreement made under Section 75 of the National Health Services Act 2006 was required. This agreement included the following core components:

- Commissioning arrangements, including confirmation of which agency would act as Lead Commissioner for each element of the fund;
- Governance arrangements, including arrangements for reporting progress in delivering the plan to the Health and Wellbeing Board;
- Arrangements for management of the pooled funds;
- Arrangements for managing risk across the partners to the agreement;
- Information about each of the individual schemes which together made up the Better Care programme; and
- A standard range of terms and conditions covering issues such as dispute resolution and information sharing.

In response to questions, the Board heard that the Lead Commissioner was ultimately accountable to the Health and Wellbeing Board for the delivery of the Better Care Fund plan. It was recommended that the Health and Wellbeing Board devolved responsibility for overseeing delivery of the Better Care Fund plan to the Integrated Care Board, a sub-group of the Board. It was further recommended that the Integrated Care Board provide an annual report on performance against the plan, to include any recommendations for

change. It was noted that the Integrated Care Board, would report to the Health and Wellbeing Board as required.

It was noted that if the recommendation to devolve oversight to the Integrated Care Board was agreed, the Terms of Reference for the Integrated Care Board would be amended to reflect the additional requirements relating to overseeing plan delivery about the proposal for monthly meetings of all parties.

Members also noted the proposed timescale as April 2015.

Following discussion, it was

**RESOLVED:**

That Subject to Mayoral approval, the Health and Wellbeing Board:

1. Note that the terms of the Tower Hamlets Better Care Fund Section 75 Agreement between NHS Tower Hamlets Clinical Commissioning Group (the CCG) and the London Borough of Tower Hamlets (the Council) as attached at Appendix 2 to this report were consistent with the Better Care Fund Plan approved by HWB on 9 September 2014 and recommend approval of the agreement to the CCG and the Council;

2. Note the lead commissioning arrangements for managing the delivery of the Tower Hamlets Better Care Fund;

3. Delegate authority for overseeing delivery of the Better Care Fund Plan to the Tower Hamlets Integrated Care Board and to note the arrangements for reporting of progress back to the Health and Wellbeing Board.

4. Strengthen patient and voluntary sector representation on the Integrated Care Board.

## 5. HEALTH AND WELLBEING STRATEGY - DELIVERY PLAN

Dr Somen Banerjee, Interim Director, Public Health introduced the report and outlined the revisions to the Health and Wellbeing Strategy's current delivery plans to ensure delivery against the current strategy's objectives continued in 2015-16.

Dr Banerjee referred to the details of the action plan and drew attention to the priorities namely: Early years and Maternity, Mental Health, Healthy Adults Lives and Healthy Environments, Long Term Conditions.

The Board discussed item following the presentation of the priorities under the following items:

Item 5.1 – Early Years
Item 5.2 – Healthy Lives
Item 5.3 – Integrated Long Term conditions and Cancer

The Board asked a number of questions and made comments on the report. The following points were noted:

- That leisure activity had been omitted in the Plan;
- That a meeting had been planned for the Overview and Scrutiny Committee on 6th March 2015 to consider the scrutiny review report on the impact of health communications of literacy and numeracy levels on outcomes for children and their families;
- That it was important to target support in schools in order to improve education achievement;
- There was a need to close gaps in outcomes of healthcare interventions, particularly in conditions such as diabetes; and
- To re-enforce the issue of prevention and use every opportunity to involve young people.

It was noted that the current Health and Wellbeing Strategy was in the process of being refreshed with a view to a new strategy commencing from April 2016. In the meantime the current, delivery plans were being revised to ensure that delivery against the current strategy's objectives continued in 2015-16.

**RESOLVED –**

1. That the delivery plans, proposed outcome measures and targets which would be the measures used to track progress on the plan and on which performance would be reported to the Health and Wellbeing Board be agreed.
2. That the delivery and performance monitoring arrangements set out in section 3 of the report below be agreed.
3. That the Health and Wellbeing Strategy Sub-Group be requested to monitor and adapt the delivery plan targets on behalf of the Health and Wellbeing Board and provide 6 monthly updates.

## 5.1 Early Years

The Health and Wellbeing Board noted the priorities, targets and objectives of the Early Years (0-5 year olds) to ensure that more children were given the opportunity of a healthy start in life by the following action plans:

- Supported by parents and carers with good physical and mental health before, during and after pregnancy
- With secure emotional attachment and good cognitive development
- Being breastfed and establishing healthy eating habits
- With strong foundations for excellent oral health
- Developing physically and socially through play

- Living in environments free from the health harms of alcohol, tobacco and drugs
- Fully immunised

**5.2 Healthy Lives**

The Wellbeing Board noted the action plans for the Healthy Lives Priority of the Health and Wellbeing Strategy for 2015/16.

It was underlined that tackling health inequalities required a holistic approach, recognising the importance of factors determining health (eg income, employment, education), healthy environments, (eg housing, physical environment), strong communities and integrated services promoting prevention and early intervention. This approach also recognised that health behaviours impacting on health such as diet, physical activity, smoking were strongly influenced by the environments the people lived in.

The action plan was a basis of changes in lifestyles improve health and wellbeing and reduce health inequalities in the borough.

The action plans covered the following areas:

1. More people living healthy fulfilling lives (cross cutting actions around developing new HWBS Strategy in 16/17)

2. Healthy People (supporting mental wellbeing, physical health, healthy habits and protecting them from health harms)
    a. Healthy families, children and adolescents
    b. Healthy adults

3. Healthy place
    a. Healthy environments
    b. Healthy communities
    c. High quality integrated services supporting prevention and early intervention

**5.3 Long Term Conditions and Cancer**

Jane Milligan outlined the action plan relating to Integrated Long Term Conditions, Cancer and Integrated Care System. She described the partnerships vision of an integrated care system, as one in which care is coordinated around the individual and was delivered in the most appropriate setting for that individual.

The main aim was to ensure that:

- More patients, users and their carers' were empowered;
- More patients were receiving responsive, coordinated and proactive care through shared data between providers across the NHS, Council and other provider organisations;

- More patients were receiving quality of care that was consistent and cost effective

It was noted that the Care Act, the Better Care Fund were significant levers for driving integrated care and Transforming Services Together Programme, a five year strategic plan commissioned by Newham, Tower Hamlets and Waltham Forest.

**RESOLVED**

That the report be noted.

## 6. CCG COMMISSIONING UPDATE

Jane Milligan, Chief Officer, Tower Hamlets Clinical Commissioning Group presented the report which provided a full and comprehensive Update on primary care commissioning. The Board noted Tower Hamlets CCG was one of 64 CCGs across the country that had been approved by NHS England to take on greater 'delegated' commissioning responsibility for GP services from April 2015. This would give patients, communities and clinicians more scope in deciding how local services were developed.

The latest move follows the plan set out in the Next steps towards primary care co-commissioning document developed by the joint CCG and NHS England primary care co-commissioning programme oversight group in partnership with NHS Clinical Commissioners, and is another step towards delivering the wider strategic agenda set out in the Five Year Forward View.

Jane Milligan reported that the Tower Hamlets GP Care Group put in a bid for the Prime Minister's Challenge Fund, to improve primary care access of Tower Hamlets residents to face to face primary care services from 8am to 8pm 7 days a week, for provision of routine and urgent care. The fund would also be used to improve working in partnership with community pharmacies to offer an enhanced Minor Ailments Service with increased formulary and upskilling of pharmacists as independent prescribers as well as working closely with voluntary groups in the borough to complement enhanced primary care provision to address the cycle of demand.

The GP Care Group was awaiting the outcome of the bid, would be known by early March 2015.

Jane Milligan also reported on a recent review by the King's Fund celebrated the scale and ambition of the WELC Integrated Care Programme, recognising the significant progress made over the recent years. The King's Fund Review took place in December 2014 and January 2015, and involved stakeholder interviews along with a literature review. The King's Fund noted a clear vision for integrated care across WELC and the successful implementation of a number of new services and interventions to support integration. The emerging challenges highlighted the demanding plan for capitated budgets

and the requirement to change behaviours and cultures throughout local organisations to facilitate integrated working.

It was noted that the Tower Hamlets and City and Hackney Clinical Commissioning Groups in partnership with East London NHS Foundation Trust (ELFT) were conducting a 13 week consultation on proposed changes to inpatient services for older people with mental health problems aged 65 and over, who lived in City and Hackney and Tower Hamlets.
It was noted that the consultation would end on 16 March 2015.

**RESOLVED**

That the submitted report be noted.

## 7. LOCAL ACCOUNT 2013/14

Robert McCulloch-Graham (Corporate Director, Education Social Care and Wellbeing, LBTH) presented the report. The report outlined the introduction of the publication of a single set of data for local authorities which replaced the requirement for local authorities to produce an Annual Performance Assessment within a format prescribed by Care Quality Commission, abolished in 2011.

In response to questions, the purpose of the Local Account were noted as follows:

- That Local Accounts was a means of ensuring that the care and support provided locally by the local authorities was open and transparent;

- That the publication of Local Accounts would make the people of Tower Hamlets aware of the work undertaken by the Department during 2013-14, in relation to both social care and safeguarding.

- To publicise the range and scale of services provided by the Authority.

- That Local Accounts uses a combination of performance information, survey results and case studies to demonstrate how Tower Hamlets Council has enhanced the quality of life for people using care and support services.

It was noted that the Local Account would be published as a Council-wide document and made available to the public through the Tower Hamlets Council website. It is proposed to use the Local Account as part of a wider set of mechanisms for obtaining customer views and feedback and informing residents, users and carers about progress made in delivering services and the Authority's priorities for the future.

Robert McCulloch-Graham highlighted the key messages in the Local Account, and drew particular attention to the following:

- The impact of the significant cuts in funding provided by Central Government to Local Government, leading to difficult decisions across the public sector, changes to welfare benefits;

- The introduction of the 2014 Care Act. The Act brings together more than 40 separate pieces of legislation and puts people's needs, goals and aspirations at the centre of care and support, supporting people to make their own decision, realise their potential and pursue life opportunities. Significantly the Act set out new rights for carers, emphasised the need to prevent and reduce care and support needs, and introduces a national eligibility threshold for care and support. Additionally it introduced a cap on the costs that people would have to pay for care and set out a universal deferred payment scheme so that people would not have to sell their home in their lifetime to pay for residential care. It was noted that the Care Act would be implemented in two phases in April 2015 and April 2016. In preparation for these changes a Care and Health Reform Programme to the Care Act had been set up by the Authority.

- As a consequence of supporting people in the community for longer our residents generally tend to access residential and nursing care at an older age than other boroughs at a point where they are too frail to be supported in the community.

- The Local Account includes a section on the financial position of the relevant divisions of the ESCW directorate. This includes financial outturn and performance data for 2013/2014 which is consistent with publications and reports that are already within the public domain. In particular, the Council's annual accounts and reports submitted to Cabinet and Full Council in April 215.

**RESOLVED –**

The Health and Wellbeing Board

1. That the content and format of The Tower Hamlets Local Account for 2013/14 be noted;

2. That the Tower Hamlets Local Account for 2013/14 be approved for publication;

3. That the Tower Hamlets Local Account for 2013/14 be submitted to CABINET for consideration.

## 8. LOCAL GOVERNMENT DECLARATION ON TOBACCO CONTROL

The Health and Wellbeing Board received a presentation on the Local Government Declaration on Tobacco Control.

It was noted that the aim of the Declaration was to ensure that there was clear local leadership on reducing smoking rates and that tobacco control is part of mainstream public health work. The Declaration included a number of specific commitments for individual boroughs to sign up to:

- Reduce smoking prevalence and health inequalities
- Develop plans with partners and local communities
- Participate in local and regional networks
- Support government action at national level
- Protect tobacco control work from the commercial and vested interests of the tobacco industry
- Monitor the progress of our plans
- Join the Smoke free Action Coalition

The Board was reminded about previous and ongoing work by Tower Hamlets in relation to the use of tobacco in the borough and the concerns of the impact on both the individual and the wider community - the main cause of premature death and poor health in local residents.

It was noted that the Borough had since 2007 implemented a comprehensive tobacco control strategy, working in collaboration with health, social care, education and the voluntary sector to reduce tobacco use and subsequent harm. This partnership work had led to some of the most successful outcomes of any London borough in terms of cessation and tobacco control. The Tower Hamlets Tobacco Control Alliance continues to support and implement this strategy.

Members in discussion expressed strong support for the Declaration which they considered would enhance the Authority's work on tobacco control. They noted that the NHS who were their partners in this regard had also been invited to sign the National NHS statement of support which was had been launched on 23 February 2015.

Officers considered that a press launch to show case the work already done in Tower Hamlets would be most appropriate.

**RESOLVED –**

The Health and Wellbeing Board

1. Note the good progress that had been made in reducing the harm associated with tobacco use in Tower Hamlets.

2. To ask the Mayor, as the Chair of the Health and Wellbeing Board to sign the Local Government Declaration on Tobacco Control.

3. Consider communication and publication opportunities where partners could demonstrate their commitment to the declaration.

## 9. PHARMACEUTICAL NEEDS ASSESSMENT

The Health and Wellbeing Board considered the report on the statutory requirement on every local authority to produce, a Pharmaceutical Needs Assessment (PNA) by March 2015 under the Health and Social Care Act 2012. The Pharmaceutical Needs Assessment was to examine health needs in the Borough, services currently provided, public views of local pharmacy services provided and how those services could be improved in future.

The report provided the findings of the consultation responses and how the responses would inform the NHS planning of local pharmacy services. Specifically, for the NHS England in informing decisions on applications for new pharmacies, changes in premises for existing pharmacies, and changing services of existing pharmacies.

It was noted that the Pharmaceutical Needs Assessment consultation document was published on 30th January 2015 and the consultation would conclude at the end of March 2015.

It was noted that the overall conclusions were that overall, there was sufficient capacity of community pharmacy provision to meet need and no significant gaps were identified. However, the assessment was that population growth would increase the need for services. This increase could be met to an extent through increasing staff within existing provision and increasing automated services.

Following discussion, the emerging view was the need to include Pharmaceutical Needs Assessment in the system of integrated services.

**RESOLVED**-

1. That the views of the Health and Wellbeing Board be noted.

2. That the Health and Wellbeing Board note that an amended version of the consultation document would be distributed electronically to the Health and Wellbeing Board members on the 23rd of March 2015 for final comments.

## 10. ANY OTHER BUSINESS

**Proposed Dates of Future Meetings - 2015/2016 Municipal Year**

It was noted that future meetings of the Health and Wellbeing Board would continue to be held on **Tuesdays at 5.00pm**

The proposed dates were noted as follows:

7 July 2015

8 September 2015
8 December 2015
12 January 2016
15 March 2016

The meeting ended at 6.45 p.m.

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

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| Non-Executive Report of the:<br><br>**TOWER HAMLETS HEALTH AND WELLBEING BOARD**<br><br>7 JULY 2015 | TOWER HAMLETS |
|---|---|
| **Report of:** John S. Williams, Service Head, Democratic Services | **Classification:**<br>Unrestricted |
| **TOWER HAMLETS HEALTH AND WELLBEING BOARD TERMS OF REFERENCE, QUORUM, MEMBERSHIP AND DATES OF MEETINGS** | |

| | |
|---|---|
| **Originating Officer(s)** | Elizabeth Dowuona, Democratic Services |
| **Wards affected** | All wards |

## 1. SUMMARY

1.1 This report sets out the Terms of Reference, Quorum, Membership and Dates of meetings of the Tower Hamlets Health and Wellbeing Board for the Municipal Year 2015/16 for the information of members of the Board.

## 2. RECOMMENDATIONS

2.1 That the Tower Hamlets Health and Wellbeing Board note its Terms of Reference, Quorum, Membership and Dates of future meetings as set out in Appendices 1, 2 and 3 to this report.

## 3. DETAILS OF REPORT

3.1 At the reconvened Annual General Meeting of the full Council held on 24 June 2015, the Authority approved the review of proportionality, establishment of the Committees and Panels of the Council and appointment of Members thereto.

3.2 It is traditional that following the Annual General Meeting of the Council at the start of the Municipal Year, at which various committees are established, that those committees note their Terms of Reference, Quorum and Membership for the forthcoming Municipal Year. These are set out in Appendix 1 and 2 to the report respectively.

3.3 The Board's meetings for the remainder of the year, as agreed at the meeting of the Council on 24 June 2015, are as set out in Appendix 3 to this report.

3.4 In accordance with the agreed calendar, meetings of the Tower Hamlets Health and Wellbeing Board are scheduled to take place at 5.00pm.

3.5 The membership of the Tower Hamlets Health and Wellbeing Board is set out at Appendix 2 of the report, in line with Paragraph 3, Section 3.3.21 in Part 3 of the Council's Constitution.

## 4. COMMENTS OF THE CHIEF FINANCE OFFICER

4.1 Matters brought before the Committee under its terms of reference during the year will include comments on the financial implications of decisions provided by the Chief Finance Officer. There are no specific comments arising from the recommendations in this report.

## 5. LEGAL COMMENTS

5.1 The information provided for the Committee to note is in line with Paragraph 3, Section 3.3.21 in Part 3 of the Council's Constitution.

## 6. ONE TOWER HAMLETS CONSIDERATIONS

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

## 7. BEST VALUE (BV) IMPLICATIONS

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

## 8. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

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

## 9. RISK MANAGEMENT IMPLICATIONS

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

## 10. CRIME AND DISORDER REDUCTION IMPLICATIONS

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

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**Linked Reports, Appendices and Background Documents**

**Linked Report**

- None

## 11. APPENDICES

Appendix 1 – General Purposes Committee Terms of Reference
Appendix 2 – Appointments to Committee
Appendix 3 – Dates of Meeting

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

- None

**Officer contact details for documents:**

- N/A

## APPENDIX 1

## Tower Hamlets Health and Wellbeing Board – Terms of Reference 2015/2016 Municipal Year

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

The Health and Wellbeing Board has the following functions:

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

**APPENDIX 2**

**Tower Hamlets Health and Wellbeing Board – Quorum and Membership 2015/2016 Municipal Year**

**Quorum**

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

**Membership**

Chair

- Mayor of London Borough of Tower Hamlets (LBTH)
- That should the Mayor be unable to attend a meeting then the Cabinet Member for Health and Wellbeing would Chair the meeting in his place.

Elected Representatives of LBTH

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

Local Authority Officers- LBTH

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

Local HealthWatch

- Chair of local Healthwatch

NHS (Commissioners)

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

Co-opted Members (Non-Voting)

- Health Providers
- Chief Operating Officer - Barts Health
- Chair of Tower Hamlets - Council for Voluntary Services
- Deputy Chief Executive - East London and the Foundation Trust
- Representative from the Housing Forum.
- Chair of the Integrated Care Board

- The Young Mayor

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

- Representative of NHS England
- Chairs of Tower Hamlets Safeguarding Boards (Adults and Childrens).
- Chair of the LBTH Health Scrutiny Panel
- Local Liaison Officer for National Commissioning Group.

## APPENDIX 3

## SCHEDULE OF DATES 2015/16

## TOWER HAMLETS HEALTH AND WELLBEING BOARD

Tuesday, 7 July 2015 - 5.00pm

Tuesday, 8 September 2015 - 5.00pm

Tuesday, 8 December 2015 - 5.00pm

Tuesday, 12 January 2016 - 5.00pm

Tuesday, 15 March 2016 - 5.00pm

Note – the above dates are subject to agreement at the reconvened Council Annual General Meeting on 24 June 2015. Any alterations will be tabled at the Health and Wellbeing Board meeting on 1 July 2015.

It may be necessary to convene additional meetings of the Board should urgent business arise. Officers will keep the position under review and consult with the Chair and other Members as appropriate.

| Health and Wellbeing Board<br>Tuesday 7 July 2015 | Tower Hamlets Health and Wellbeing Board |
|---|---|
| **Report of:** Healthwatch Tower Hamlets | **Classification:**<br>[Unrestricted] |
| Community Intelligence – Healthwatch perspective | |

| **Contact for information** | Dianne Barham<br>Healthwatch Tower Hamlets<br>dianne.barham@urbaninclusion.co.uk |
|---|---|


**Executive Summary**

Healthwatch Tower Hamlets to provide:

1. A dashboard highlighting key themes and issues from local resident feedback on health and social care services in Tower Hamlets
2. A brief on the community intelligence currently being collected through 17 community groups on the needs and wants of local residents to feed into the Health and Wellbeing Strategy refresh and the commissioning process.


**Recommendations:**

The Health and Wellbeing Board is recommended:

To note the report and hold the **8th of September 9:30 to 1 pm** to attend the 'Health Conversation' event. This a chance for attendees to:

- review intelligence gathered and issues identified by the 17 local community groups under key themes;
- give your own views on how we might tackle these issues; and
- come up with recommendations to feedback to the Health and Wellbeing Board.

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**Appendices**

- NONE

| Health and Wellbeing Board<br>Tuesday 7 July 2015 | Tower Hamlets Health and Wellbeing Board |
|---|---|
| **Report of the London Borough of Tower Hamlets** | **Classification:**<br>[Unrestricted] |
| **Health and Wellbeing Story: Healthy Homes project case study** | |

| | |
|---|---|
| **Lead Officer** | Somen Banerjee, Director of Public Health |
| **Contact Officers** | Tim Madelin, Senior Public Health Strategist |
| **Executive Key Decision?** | No |

## Executive Summary

Many health & social care professionals have contact with some of most vulnerable people in the community, but there is a gap in their knowledge in how to identify and refer poor housing conditions that they may either seen directly or that they observe the effect of in terms of exasperated long term conditions or slower recover from illness.

The healthy homes project has developed a referral system to environmental health particularly around vulnerable tenants and to increase awareness in both professionals and tenants about what can be done to tackle poor hosing conditions in private sector housing. The case study illustrates the type of intervention and outcomes that can be achieved by the project.

## Recommendations:

The Health and Wellbeing Board is recommended to:

1. Note the case study of an intervention as part of the Healthy Homes project.
2. Reflect on the role housing plays in Health and Wellbeing.

## 1. REASONS FOR THE DECISIONS

1.1 Presentation is for information, no decision required.

## 2. ALTERNATIVE OPTIONS

2.1 Presentation is for information, no decision required.

## 3. DETAILS OF REPORT

3.1 Many of the poorest housing conditions in Tower Hamlets are found within the private rented sector with over 16 % of dwellings having a serious hazard present (category 1 hazard as defined by Housing Health and Safety Rating System, BRE report 2013). Whilst the effect of these can be extremely detrimental to the tenants the cost of these hazards to wider society is estimate to be nearly £3 million.

3.2 Many health & social care professionals have contact with some of most vulnerable people in the community, but there is a knowledge gap in how to identify and refer poor housing conditions; that they may either have seen directly or have observed the effects of in terms of exasperated long term conditions or slower recovery from illness.

3.3 The aim of the project is to increase the number of properties with vulnerable tenants that have their conditions improved through environmental health intervention.

3.4 This will be achieved by a multi-faceted approach namely:

- Establishing referral mechanisms with the primary health care sector particularly with groups that visit people in their homes.
- Increasing health professionals' knowledge, confidence and skills about private sector housing conditions and how poor conditions can be addressed.
- Developing a mobile reporting tool
- Establishing a fund to enable small scale works which have a highly detrimental effect on tenants to be carried out expeditiously.
- Embedding the evaluation of the wider cost benefits of the improvements in conditions achieved using appropriate tools such as the Housing Health Cost Calculator

3.5 The presentation to board illustrates the type of intervention and outcomes that can be achieved by the project by way of a case study. It also highlights of the poor housing conditions that can be found in the private rented sector often occupied by vulnerable tenants and the impact on health and wellbeing they can have.

## 4. COMMENTS OF THE CHIEF FINANCE OFFICER

4.1. Not Applicable -presentation is for information

## 5. LEGAL COMMENTS

5.1. Not Applicable -presentation is for information

## 6. ONE TOWER HAMLETS CONSIDERATIONS

6.1. Not Applicable -presentation is for information.

## 7. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

7.1 Not Applicable -presentation is for information.

## 8. RISK MANAGEMENT IMPLICATIONS

8.1. Not Applicable -presentation is for information.

## 9. CRIME AND DISORDER REDUCTION IMPLICATIONS

9.1 Not Applicable -presentation is for information

## 10. EFFICIENCY STATEMENT

10.1 Not Applicable -presentation is for information

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**Appendices and Background Documents**

**Appendices**

- None

**Background Documents**

- None

| Health and Wellbeing Board<br>Tuesday 7th July, 2015 | Tower Hamlets Health and Wellbeing Board |
|---|---|
| **Report of the London Borough of Tower Hamlets** | **Classification:**<br>[Unrestricted or Exempt] |
| **CARE QUALITY COMMISSION REPORT** | |

| | |
|---|---|
| **Lead Officer** | Somen Banerjee, Director of Public Health |
| **Contact Officers** | Somen Banerjee, Director of Public Health |
| **Executive Key Decision?** | No |

**Executive Summary**

This paper provides the Board with a briefing on the outcomes of the CQC report on Barts Health, the response of the trust and implications for the Board

**Recommendations:**

The Health and Wellbeing Board is recommended to:

1. to note the report and discuss how it would seek to be updated on progress against the improvement plan and its role in supporting its delivery

## 1. REASONS FOR THE DECISIONS

1.1 This is a briefing for discussion

## 2. ALTERNATIVE OPTIONS

2.1 N/A

## 3. DETAILS OF REPORT

3.1 Attached

## 4. COMMENTS OF THE CHIEF FINANCE OFFICER

4.1. There are no direct financial implications for the Council as a result of the recommendations in this report.

## 5. LEGALCOMMENTS

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

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

5.3. Additionally, under the Care Act 2014 ("the 2014 Act") the Council has a number of general duties in ss.1-7 including a duty to co-operate with NHS bodies in the area and further to promote the integration of care support with health services.

5.4. The Council's general duties meet with the goal of aiming for higher quality health, care and support to individuals in order to have a positive impact on their wellbeing.

5.5. In ensuring the Council meets with its general duty it is important that consideration is given to how co-operation and integration between services can be embedded into any response to the CQC report.

5.6. However, s.22 of the 2014 Act retains the boundary between the legal responsibilities of the NHS and the Council so this distinction must be maintained.

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

## 6. ONE TOWER HAMLETS CONSIDERATIONS

6.1. The report relates to how people living and working in the borough get the best possible healthcare care services

## 7. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

7.1 N/A (not within scope of the CQC report)

## 8. RISK MANAGEMENT IMPLICATIONS

8.1. The report does not make any proposals so there are no specific risk implications. Excellent care provided by Barts Health involves working with council services in an integrated way to provide the best outcomes

## 9. CRIME AND DISORDER REDUCTION IMPLICATIONS

9.1 N/A

## 10. EFFICIENCY STATEMENT

10.1 The report does not propose expenditure

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**Appendices and Background Documents**

**Appendices**

- APPENDIX 1 - Briefing paper on CQC report attached

**Background Documents**

- NONE

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| Health and Wellbeing Board<br>Tuesday 7th July 2015 | Tower Hamlets Health and Wellbeing Board |
|---|---|
| **Report of the London Borough of Tower Hamlets** | **Classification:**<br>Unrestricted |
| **Health visiting service – findings of the stakeholder engagement** | |

| | |
|---|---|
| **Lead Officer** | Robert McCulloch-Graham, Corporate Director, ESCW |
| **Contact Officers** | Somen Banerjee, Director of Public Health and<br>Esther Trenchard-Mabere, Associate Director of Public Health |
| **Executive Key Decision?** | No |


**Executive Summary**

Commissioning responsibility for 0-5 public health services (Health visiting service and Family Nurse Partnership) transfers to the local authority on 1st October 2015. The current 2015/16 NHS contract will be novated to the local authority and a re-procurement process initiated to have a new local authority contract in place by 1st April 2016. Public Health commissioned Prederi Ltd to facilitate and write up a stakeholder engagement process (January – April 2015) to inform the localisation of the national service specification for the Health Visiting service. A multi-agency steering group was established and met monthly to oversee the engagement process.

The engagement process included consultation in three phases with the following groups:

***Phase 1***

- 126 parents and carers (44 in 8 focus groups plus 82 via supported on-line survey)
- 56 members of the health visiting service

***Phase 2***

- 23 attendees at early years professionals workshop
- 23 attendees at key health professionals and commissioners workshop
- 13 attendees at social care professionals workshop
- 3 organisations at third sector focus group
- 36 GPs via on-line survey

***Phase 3***

- Total of 55 attendees (most of whom had attended phase 1 or 2 workshops) at one of two multi-disciplinary workshops

Key themes that emerged from phases 1 and 2 of this engagement process were:

***Capacity:*** including ensuring good skill mix, extending the role of support workers, increasing administrative capacity, strengthening leadership, making better use of IT and improving recruitment and retention.

***Access:*** including flexible opening hours, increasing number and type of locations

for service delivery, drop-in and booked appointments, telephone advice line, named or single point of contact for service users and professionals, on-line services and translation services.
***Continuity of care:*** named HV for service users during the first year of babies life.
***Links with other health and early years services:*** shared vision with early years services, locality working, co-delivery/integration, improved data sharing supported by interoperable IT systems.
***Quality and consistency of care:*** training, preceptorship and clinical supervision, development of specialist roles (e.g. mental health, healthy weight), agreement on and use of clinical standards.
***Promote understanding of the service:*** information about appropriate and timely use of the service.

Phase 3 provided more in depth feedback and suggestions on strengthening the following priority areas:

- The role of HVs in community engagement and development
- Implementing the new antenatal contact
- Integration of the HV service with both children's centres and primary care
- Capabilities, capacity and competencies
- More intensive offer for high need families.

The views and recommendations from this engagement process will be used to 'localise' the national service specification for health visiting which is built around four tiers as follows:

- ***Community:*** Building community capacity with partners, health promotion in the community and tackling inequalities
- ***Universal:*** Mandatory health and development reviews, health promotion, screening, immunisation
- ***Universal Plus:*** early identification of need, responsive care and signposting/onward referral if indicated
- ***Universal Partnership Plus:*** identification of vulnerable children and children with complex needs, working with other agencies for children and families requiring intensive support, safeguarding.

The Tower Hamlets service model will include requirements for a stronger locality focus including four locality clinical leads who will become members of the children's centres` locality teams and named HVs for each children's centre and GP practice. We are developing a model where clusters of GP practices are linked to each children's centre.

**Timescales:**

- Draft service specification reviewed at final Stakeholder Engagement Steering Group, ***28th May 2015***
- Approval of re-procurement by Competition Board, ***8th June 2015***
- Advertise PQQ on portal, ***July 2015 (TBC)***
- Service specification finalised, ***30th June 2015***
- Invitation to tender, ***10th August 2015 (TBC)***
- Novation of NHS England contract to local authority, ***1st October 2015***
- New local authority contract (based on new service specification), ***1st April 2016***

**Recommendations:**

The Health and Wellbeing Board is recommended to:

1. Note the engagement process that has been carried out
2. Comment on the emerging integrated locality model for the health visiting service

## 1. REASONS FOR THE DECISIONS

1.1 Report is for information and comment only

## 2. ALTERNATIVE OPTIONS

2.1 Report is for information and comment only.

## 3. DETAILS OF REPORT

3.1 See Executive Summary above and appended report by Prederi Ltd.

## 4. COMMENTS OF THE CHIEF FINANCE OFFICER

4.1. There are no direct financial implications as a result of the recommendations in this report.

## 5. LEGAL COMMENTS

5.1. Best Value Duty

5.2. The Council has a duty to make arrangements to secure continuous improvement in the way in which its functions are exercised, having regard to a combination of economy, efficiency and effectiveness by virtue of section 3 of the Local Government Act 1999. This is known as its Best Value Duty.

5.3. It is usual for the Council to subject its purchases and engagements with contractors to competition in order to ensure that it achieves best value in respect of the purchases it makes. However, this is not initially possible in this instance. The Council is to become responsible for the services outlined in this report due to legislation implemented by the Secretary Of State for Health and this requires the Council to take over the existing contract for these services that was originally entered into between NHS England and Barts Health. However, this agreement will expire on 31 March 2016 and the Council must use this time to procure a procurement law compliant tenderer to take over the provision of the services on expiry.

5.4. Section 72 of the Public Contracts Regulations 2015 allows a novation of an existing contractor where there is the natural succession of a contractor. However, it is intended to refer to a change in the supplier contractor rather than the purchaser. However, it is notable that the Council is forced to take on this novation agreement as a result in the change in law and therefore, it is likely that it would be determined that until the contract expires it is impossible to achieve competition in any event which lowers the risk of a successful challenge significantly.

5.5. The Council is required to consult for the purposes of deciding how to fulfil its best value duty. This obligation was the subject of consideration in the case of R (Nash) v Barnet LBC. Some guidance was given in the High Court to the

effect that it is not every time an authority makes a particular operational decision, by way of outsourcing or otherwise, that it is required by section 3 to consult about that decision. The High Court thought that consultation about "the way in which" it performs its functions connotes high-level issues concerning the approach to the performance of an authority's functions.

5.6. The statutory provisions relating to Health Visitors are contained in the Nursing and Midwifery Order 2001, SI2002/253. The commissioning of these services is currently the duty of NHS England.

5.7. Section 22 of the Health and Social Care Act 2012 inserts a clause in section 7A of the NHS Act 2006 that creates a new power which enables the Secretary of State, by agreement, to delegate the funding and commissioning of public health services to NHS England.

5.8. The Secretary of State and NHS England have agreed that children's public health services from pregnancy to age 5 will be commissioned by NHS England until 30 September when the commissioning responsibility for this programme are transferred to local government from 1 October 2015.

5.9. The transfer of 0-5 commissioning will join-up public health services for children and young people aged 5-19 that are already delivered by Local Authorities (and up to age 25 for young people with SEND).

5.10. NHS England requires that some elements of the 0–5 children's public health services to be delivered in the context of a national, standard format to ensure consistent delivery. The key elements are: antenatal health visits, the new baby review, 6-8 week assessments, the one year assessment and the 2 to 2.5 year review. It is important that the Council takes note of these elements and ensures these are delivered.

5.11. Equalities Duty

5.12. The Council has an Equality Duty under section 149 of the Equality Act 2010 to ensure that it eliminates discrimination between people who have a protected characteristic (as defined under the Act) and those who do not; and to promote equality and fair treatment between people who have a protected characteristic and those who do not. It is unlikely that the Best Value Action plan itself will give rise to any significant equality impacts, but further consideration should be given to the impacts of each action before they are implemented.

5.13. The Council also has a duty to ensure that organisations are not discriminated against by the Council's processes. For example, ensuring that the procurement criteria are fair and do not either favour nor disfavour any group, company or individual.

## 6. ONE TOWER HAMLETS CONSIDERATIONS

6.1 To ensure that equalities considerations are fully addressed it will be important to ensure that the service specification covers:

- Ensuring the service is well publicised with flexible access to ensure that families with different needs are able to access the service
- Ensuring that there is a clear model for identification of and providing support for families with additional needs
- Guidance on caseloads to ensure capacity to provide both the universal and more intensive service

Health visiting is a universal service and provides an important opportunity to ensure that contact is made with all families with young children so that needs are adequately assessed.

## 7. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

7.1 No implications.

## 8. RISK MANAGEMENT IMPLICATIONS

8.1 No risks are identified from the recommendations report.

## 9. CRIME AND DISORDER REDUCTION IMPLICATIONS

9.1 Department of Health research shows that investment in healthy early years pays dividends in improved educational outcomes and reduced criminal justice costs.

## 10. EFFICIENCY STATEMENT

10.1 The Council will seek efficiencies through a recommissioning process for the transferred services by April 2016.

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**Appendices and Background Documents**

**Appendices**

- Tower Hamlets - Health Visiting Stakeholder Engagement Report. Dr Anita Jolly and Tom Butler, Prederi LTD, 23rd April 2015

**Background Documents** .

- NONE

# Tower Hamlets -
# Health Visiting Stakeholder Engagement Report

Dr Anita Jolly, Tom Butler

23rd April 2015

Acknowledgements

We would like to thank all the following for their contribution and hard work in helping us with this Stakeholder Engagement project. In particular the LBTH Public Health team: Dr Esther Trenchard-Mabere, Dr Anna Seale, Selina Heer, Kamrul R. Islam and Simon Twite. And to all members of the Steering Group as well as our colleague Dr Judith Stanton.

And most importantly many thanks to all the participants who gave up their time to attend workshops or fill in the on-line survey.

Introduction ..... 4
Local Context ..... 4
Section 1 ..... 6
Stakeholder Engagement Process ..... 6
Phase 1 and 2: Stakeholder Engagement Findings ..... 8
Needs ..... 9
Competency, skills and capabilities ..... 10
Access to services ..... 15
Communication between services ..... 19
Partnership ..... 22
Health promotion ..... 26
Early intervention ..... 27
Information and guidance ..... 27
Training ..... 29
Information technology ..... 29
Resource ..... 30
Management ..... 30
Safeguarding ..... 31
The 4 tiers of service ..... 33
Conclusion ..... 36
Section 2 ..... 38
Phase 3: Summary Report ..... 38
Introduction ..... 38
Engagement Process ..... 38
How do we strengthen the role of the Health Visitor in community engagement and development? ..... 38
What do we need to do to fully implement the antenatal contact? ..... 40
How do we strengthen the integration of the Health Visitor Service with Primary Care and Children's Centres? ..... 41
How do we improve the capabilities, competencies and capacity of the Health Visiting service? ..... 42
What do we need to do to offer a more intensive service for high needs families that do not meet the threshold for statutory services? ..... 43

# Health visiting services in the London Borough of Tower Hamlets

## Introduction

The health and wellbeing of children and young people matters and health visitors are key professionals in supporting families, babies, infants and young children in the developing years 0-5 to have the best possible health and development outcomes. Health visitors are specialist community public health nurses who provide expert advice, support and interventions to families with babies and young children. They help empower parents to make decisions that affect their family's future health and wellbeing. Health visitors are supported by a skill mix team. From 1st October 2015 Local Authorities will be responsible for commissioning early years (0-5 years) public health services, including the health visiting service.

In January 2015 Prederi were commissioned by the London Borough of Tower Hamlets (LBTH) Public Health Department to develop and deliver a stakeholder engagement project to inform the future commissioning of health visiting services.

The project was carried out in 3 phases. Phases 1 and 2 were discovery phases to explore stakeholder views on LBTH health visiting services, in particular to find out what was valued about the service and what was not working well and could be improved upon, including ideas for future services. Stakeholders included members of the health visiting service, parents and carers and a range of professionals from health, early years, social care and third sector services.

The purpose of Phase 3 was to reflect findings from the previous 2 phases back to engagement participants. Information on national recommendations for service developments and innovative practice occurring in other areas was also presented. Participants were asked to make suggestions for how local services could be developed.

This report consists of 2 sections. Section 1 is the full report on Phases 1 and 2 describing the stakeholder engagement findings. Section 2 is a summary from the Phase 3 discussions regarding future service developments.

### Local Context

The transfer of 0-5 public health commissioning to the local authority, along with the significant expansion of the health visitor workforce, provides an important opportunity to strengthen health visiting services in the London Borough of Tower Hamlets (LBTH). This includes strengthening the public health role of health visitors in prevention and early detection, improving integration with other local authority children's services and improving continuity for children and their families. It is important to do this whilst maintaining and strengthening links with primary care and other NHS and voluntary sector services.

Public health commissioners in LBTH recognise that when commissioning future services the health visiting service specification should include requirements mandated in the national health visitor service specification[1] but also be tailored to reflect local circumstances.

Prederi were commissioned by LBTH to manage and run a stakeholder engagement process to enable the Public Health Department in LBTH ensure the best possible provision of the health visiting service through identifying current strengths, challenges and priorities, and the changes required locally to ensure a high quality, innovative service that is responsive to local needs and priorities.

[1] http://www.england.nhs.uk/wp-content/uploads/2014/03/health visitor-serv-spec.pdf.

# Section 1

## Stakeholder Engagement Process

Phase 1 was designed to hear and collect the views and suggestions of health visitors and parents and carers of children who are currently 5 and under. We engaged with members of the health visiting service in a single workshop. Participants included established health visitors, newly qualified health visitors, clinical leads, wider members of the health visitor skill mix team[2] and student health visitors. The views of parents and carers were sought in 8 focus groups (FGs) held at Children's Centres and through an online survey.

In Phase 2 we engaged with general practitioners (GPs), early years professionals (EYPs)[3], children's social care (SC) professionals, commissioners of services for children and child health professionals, including speech and language professionals (SALT), midwives, family nurse practitioners (FNPs) and mental health professionals.

Engagement took place in three parallel workshops:

1. Early Years Professionals (EYP) workshop
2. Key Professionals (KP) workshop
3. Social Care Professionals (SC) workshop

The views of GPs were gained through an online survey. An additional focus group was held with representatives from the third sector and a member of the project team also attend a LBTH Safeguarding Meeting and fed back issues relevant to this project.

(Phase 3 focussed on drawing out themes from Phases 1 and 2 and discussing these with all stakeholders. It is documented in Section 2 of this report.)

All the workshop engagement consisted of a set of open questions which were along the lines of "*Tell us:*

- *about health visitor in LBTH*
- *what is going well*
- *what needs to be developed or improved*
- *and how?"*

All information was anonymous and this approach created open discussions giving participants the opportunity to tell us what they thought of the current service (positive and negative) and discuss their ideas about what to change or improve and how.

The online surveys asked far more detailed questions supplying more specific data. They also gave the project a far wider reach and enabled us to access those who could not attend a workshop. Surveys included both closed and open-ended questions (free text responses).

Details of the engagement sessions are given below.

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[2] These include several roles such as community nursery nurses and community nurses and in this document are referred to as support workers.

[3] These included Children's Centre workers and members of the wider early years workforce.

| Table 1: Stakeholder Engagement Session – locations and number of attendees. |
|---|
| Phase 1- Parents and Carers and Health visitors |
| 8 parent and carer focus groups at Children's Centres:<br>• Ocean<br>• Isle of Dogs<br>• Overland<br>• Meath Gardens<br>• APCC (Poplar)<br>• Crisp St<br>• Marner<br>• Wapping<br>In total 44 parents and carers attended. |
| Parent and carer on-line survey:<br>• 82 parent/carer survey respondents |
| 1 Health visitor workshop:<br>• 56 members of the health visiting service attended |
| Phase 2 - Practitioners, Professionals and Clinical staff |
| The following workshops were held:<br>• Early Years Professionals workshop - 23 attendees<br>• Key Professionals workshop – 23 attendees<br>• Social Care Professionals – 13 attendees<br>• 1 third sector focus group – 3 organisations |
| GP on-line survey<br>• 36 respondents |

Below are the Objectives, which were discussed within each workshop.

| Table 2: Workshop Objectives |
|---|
| Phase 1: Health visiting service (HV) workshop |
| 1. To gain an understanding of the needs of parents/carers and their young children from the perspective of HEALTH VISITOR service practitioners<br><br>2. To gain an understanding of how current practice meets these needs, including what is valued most about the health visitor service that shouldn't be changed and anything that could be done differently<br><br>3. To elicit and explore new and innovative ways of working that can be realistically achieved and will further meet the needs of parents/carers and their families. |
| Phase 2: Early Years Professionals workshop |
| 1 a) What is your understanding of what the Health visitor Service currently does?<br><br>1 b) What do you most value about the Health visitor Service and what would you want to improve and how? |

| |
|---|
| 2 a) What impact could an improved Health visitor Service have on you and your job and are there opportunities to better work together?<br><br>2 b) And what would your proposed changes mean for babies/children parents and carers in Tower Hamlets? |
| Phase 2: Key Professionals workshop |
| 1. What do you value about the health visitor service?<br><br>2. What would you improve about the health visitor service?<br><br>3. What are the Opportunities for Joint Working, Barriers and Enablers? |
| Phase 2: Social Care Professionals workshop |
| 1. What do you value about the health visitor service?<br><br>2. What would you improve about the health visitor service?<br><br>3. What are the Opportunities for Joint Working, Barriers and Enablers? |

Notes were taken by an observer during focus groups. Workshop attendees were asked to record all their comments on paper. These were subsequently collated into master transcripts for each workshop.

### Phase 1 and 2: Stakeholder Engagement Findings

A thematic analysis was carried out on all focus group notes and workshop transcripts and survey free text responses. The following themes were identified:

- Needs
- Competency, skills and capabilities
- Access to services
- Partnership
- Health promotion
- Early intervention
- Information and guidance
- Training
- Information technology
- Resource
- Management
- Safeguarding

The majority of themes were cross cutting across all stakeholder groups, including parents and carers. Training, information technology, resource and management are less visible to service users and these issues were largely confined to members of the health visitor service and other professional groups.

Participants valued many aspects of the current health visiting service and these are described first for many of the themes identified, followed by perceived limitations and ideas for service improvements.

### Needs

This was explored in all stakeholder events. In some events participants were asked directly about needs, in others these were explored through other objectives.

Participants in the HV workshop were asked to describe what they believed the needs of parents/carers and their babies/young children to be. Their answers are shown in the Table 3 below.

**Table 3. Needs in LBTH as told by members of the health visiting service**

| | |
|---|---|
| **Needs of Parents/Carers:**<br>Preparation for parenthood<br>Emotional support/wellbeing<br>Mental health issues<br>Postnatal depression<br>Anxiety<br>Attachment/bonding<br>Breastfeeding<br>Couple counselling<br>Domestic abuse | **Support for Vulnerable Groups:**<br>Homeless<br>Asylum seekers<br>Refugees<br>Travellers<br>Hard to reach families<br>Young carers |
| **Needs of Babies/Young Children:**<br>*Prevention needs:*<br>Home safety<br>Cot death prevention<br>Immunization<br>Screening<br>Audiology assessment<br>*General needs*<br>Oral health<br>Behavior management<br>Sleep management<br>Toilet training<br>Weaning<br>Infant feeding<br>Obesity Minor ailments<br>Diagnosis and onward referral<br>Skin conditions<br>Infant Mental Health issues<br>Learning Needs<br>Autism<br>Speech and language delays | **Specialist support for Babies/Young Children:**<br>Support to babies in special care baby units<br>Disabled children<br>Physical, emotional, sexual abuse/neglect |

Whilst discussing this objective, health visiting service participants frequently highlighted the role of needs assessment and onward referral in both identifying and addressing need.

The following needs were articulated by other stakeholder groups:
Parents/Carers called for more support for:

- Emotional wellbeing
- Postnatal depression
- Identification of concerns in the home
- Breastfeeding
- Sleep issues
- Help on how to cope immediately after birth
- Support for mothers following Caesarian sections
- Support for babies/infants with minor illnesses
- Weaning advice
- Healthy eating advice
- Support for minor illnesses when *"it is silly to go to the doctors".*
- Speech and language delay

Key professionals called for more support for:

- New mums on postnatal wards
- Parental mental health
- Infant/child mental health

Social care workshop participants identified the following as local support needs:

- Domestic abuse
- Postnatal depression

Early years professionals highlighted the following:

- Speech and language concerns
- Developmental delay

### *General Practitioners*

Survey respondents were asked what they considered the top 5 extra support needs of parents/carers were that LBTH health visiting service could help with. Twenty-eight GPs responded to this question. Support with parenting, family support and support with domestic violence were rated the most frequently as the top support needs. Support with postnatal depression was also ranked by many although as a lower priority, as was support for other issues, which are commonly, addressed by health visitor services e.g. advice on immunisations.

### *First most important extra support needs*

| Breastfeeding | Weaning/infant feeding support | Managing minor illnesses | Post-natal depression support | Family support | Support with parenting issues | Support with domestic violence |
|---|---|---|---|---|---|---|
| 2 | 3 | 1 | 1 | 5 | 12 | 4 |

## Competency, skills and capabilities

All stakeholders highlighted aspects of practice which related to the underlying competency, skills and capabilities of practitioners. This included a subjective assessment of practitioner knowledge and skills as well as views regarding their approach to care giving.

Table 4 below gives a description of the health visitor role as described by members of the health visiting service within the HV workshop. A summary description was given by one participant as:

*To provide professional support, advice and guidance on child care issues, maternal health and social issues* (HV workshop)

| Table 4. Description of Practice | | |
|---|---|---|
| **Scope** | **Knowledge & skills** | **Approach** |
| Babies<br>Young Children<br>Pregnant mothers<br>Families<br>Prevention to treatment/referral<br>Universal<br>Contextual to home environment | Physical Health<br>Child development<br>Mental health<br>Emotional wellbeing<br>Parenting<br>Attachment<br>Needs assessment<br>Health navigator<br>Advocacy | Holistic<br>Relationship building<br>Trusted<br>Non-judgemental*<br>Caring*<br>Reassurance*<br>Objective*<br>Patience*<br>Tolerance*<br>*"Service with a smile"**<br>Consistent<br>Pro-active<br>Peer support to colleagues<br>Timely and responsive |

* *Frequently raised by the HV support workers.*

### *From a Service Users perspective*

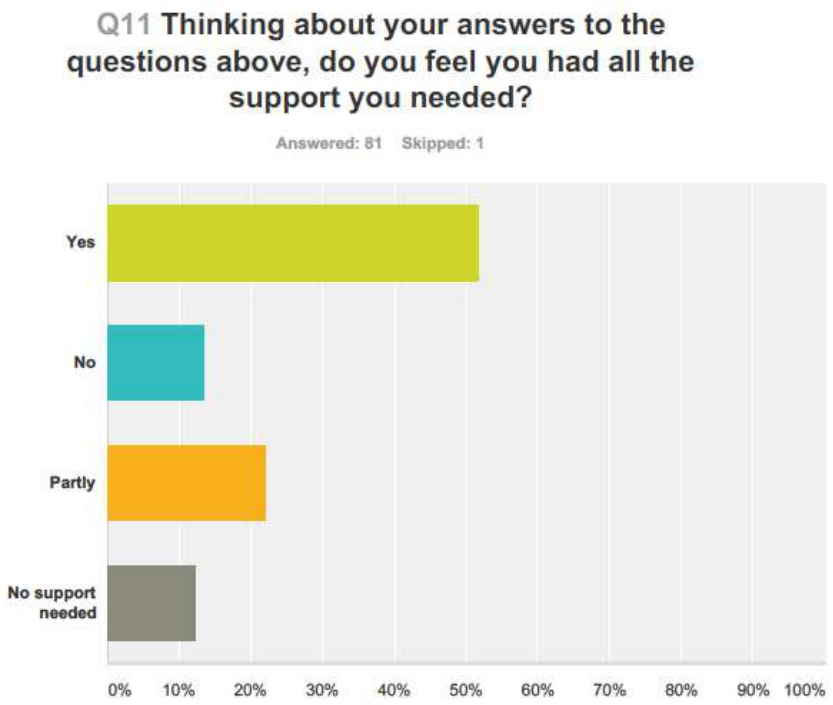
Parents/carers were asked what they valued about the current health visiting service. With respect to competency, skills and capabilities, health visitors were valued for:

- providing reassurance (this was a frequent theme)
  *"If your mum is not there, the health visitor plays a crucial part in reassuring, supporting, and informing you"* (Parents FG)
- advice on small problems
- providing written and verbal information
- support with specific issues e.g. breastfeeding

Survey respondents were asked if they had received support for specific concerns from the health visiting service and if so, to rate it. Table 5 shows the percentage of respondents who rated that support as 'Very Good or Good'.

| Table 5: Parent and Carer survey – quality of support received. | | | |
|---|---|---|---|
| | Total number who received support | Number rating support: Very Good/ Good | Percentage rating support: Very Good/ Good |
| Breastfeeding | 42 | 25 | 60 |
| Weaning/infant feeding support | 22 | 14 | 64 |
| Sleep management | 16 | 8 | 50 |
| Infant crying | 13 | 7 | 54 |
| Advice on toilet training | 11 | 6 | 55 |
| Advice on immunisations | 23 | 17 | 74 |
| Managing minor illnesses | 15 | 10 | 67 |
| Child accident prevention advice | 8 | 7 | 88 |
| Support with development concerns | 7 | 5 | 71 |
| Speech and language concerns | 9 | 7 | 78 |
| Postnatal depression support | 9 | 5 | 56 |
| Contraceptive advice | 8 | 7 | 88 |
| Family support | 6 | 4 | 67 |
| Support with parenting issues | 6 | 5 | 83 |

Respondents were also asked if they had received all the support they needed. The results are shown in the graph below. Just over 50% of parents had received all the support they needed.



Survey respondents were also asked to say what was 'good' about the LBTH health visiting service. With respect to competency, skills and capabilities many reported that they were pleased with the advice they had been given which they found up-to-date and reliable. Health visitors were seen as knowledgeable practitioners who provided a wealth of advice to families when needed.

> *"They'd give advice, even when I didn't ask. They knew what I needed"*

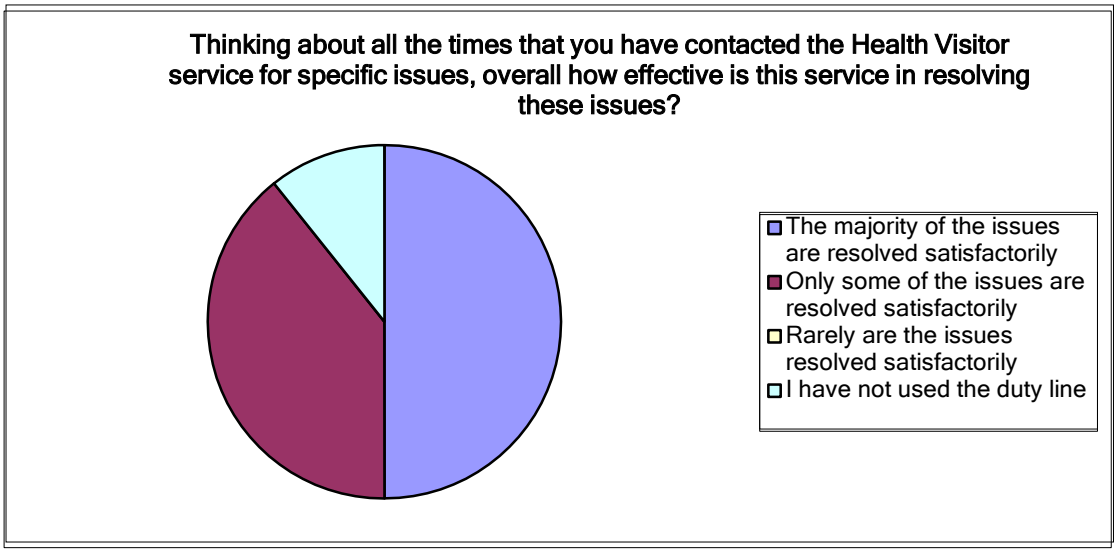
> *"Advice and reassurance from very knowledgeable Health visitors"*

Overall there were 15 respondents that commented positively on the amount of and quality of advice/information they received from the health visiting service and 12 respondents commented on how helpful and supportive members of the health visitor team were.

From a professional perspective
Other professionals also valued health visiting service practitioners for:

- the reassurance given to parents
- as trusted professionals
- relationship building with families
- their public health role
- good support to vulnerable mums
- family focussed care
- health expertise
- acting in a lead professional role
- acting as an independent practitioner
- their local expertise
  *"the longer in practice the more experienced plus better knowledge of local area"* (KP workshop)
- skills in managing postnatal depression and providing emotional support

GP survey respondents were asked about the extent to which the health visiting service was able to resolve issues that they referred to them. Fifty percent said that the majority of issues were resolved satisfactorily.




Survey respondents were also asked to rate how well parents and carers extra support needs were being met by the health visiting service. Fifty percent of all responses indicated that needs were being met to a HIGH standard, although this support was not necessarily viewed as being available to all.

### *Limitations*

Free text comments were made in the parent/carer survey which related to the competency, skills and capabilities of health visitor practitioners. Some respondents felt they did not receive enough or appropriate support for the following:

- toilet training (2 respondents)
- postnatal depression (3 respondents)
- infant colic (1 respondent)
- sleep management (1 respondent)
- breastfeeding (1 respondent)

Some parents/carers highlighted inconsistency in practice between health visitors. One talked about how the quality of care varied according to which health visitor was seen, describing it as a *"hit and miss"* experience. Newly qualified health visitors within the HV workshop also highlighted that consistency of advice and information was needed by parents/carers. This theme was also raised amongst EYP workshop attendees.

A few parents/carers were also critical of the advice they received, describing it as standardised and not tailored to individual needs.

> *"From personal experiences the group felt most of the health services were to 'tick boxes' ……They are not computers the job is to be human beings"* (Parents FG)

In a few focus groups parents and carers highlighted that they felt that too much emphasis was put on weighing their babies at the expense of discussing other issues that were of concern.

## Access to services

This was a theme that came through strongly from all stakeholder groups.

Access to health visiting services was discussed both in terms of service user accessibility and also communication between professionals. Each is discussed in turn.

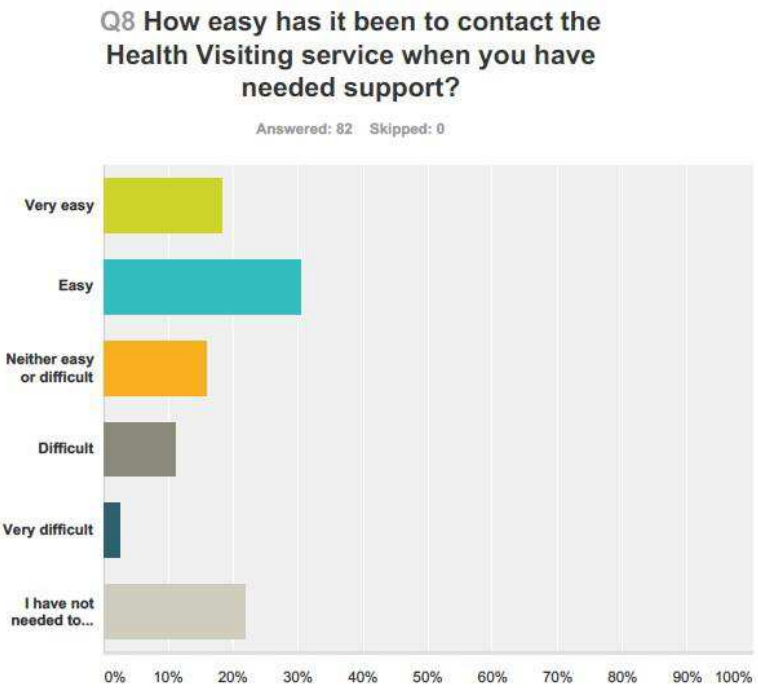
### *Service User Accessibility*

### *From a service user perspective*

Parents and carers expressed both satisfaction and dissatisfaction with their access to the health visiting service.

#### *What went well:*

- Eighty two percent (67 out of 82) of parent/carer survey respondents stated that they knew how to contact the health visiting service.
- Respondents were also asked how easy it was to contact the health visitor service when they needed support. Approximately one half replied very easy or easy.




- The majority of survey respondents thought the service was very flexible
- Parents and carers liked the new birth visit at home and expressed anxiety about it being replaced by a clinic visit as they claimed is the practice in a neighbouring borough
- There was a general feeling that experience of the health visiting service was positive if parents and carers saw the same health visitor at all appointments and they had the time to talk to them

- Parents and carers who were interviewed at Children's Centres stated that they liked going there because it gave them the opportunity to meet other parents and their children could play in play sessions whilst they were waiting to see the health visitor.
- Some parents and carers expressed satisfaction with how the developmental reviews were run.

### *Limitations*

- Parent/carer survey respondents were asked what could be done to make the service better. There were 48 free text replies and many of these were concerned with better access including a desire for more locations for the health visitor to operate from, more ways to contact the service and more flexible appointment times and service hours.
- Thirteen percent of parent/carer survey respondents stated that they found it difficult/very difficult to contact the service when needed. A number of Focus Group parents and carers also stated they did not know how to contact the health visiting service, although others stated that they did.

  *"The number is in the Red Book but this wasn't explained and no one explains the Red Book."* (Parent FG)

- Many parents and carers highlighted long clinic waiting times which were often coupled with short appointment times. The quote below reflects the experience of many parents and carers that attended the focus groups.

  *"In the clinic there were long waits 2 hours, then about 5 minutes with the health visitor, not much time, I did ask for something extra, for them to measure the height of my baby, and I was told that there we people waiting outside, but I had waited 2 hours*." (Parent FG)

- There was a common perception amongst parents and carers that health visitors were *"rushed off their feet"*.
- Long queues for drop-in clinics were cited as being problematic for working parents.
- A few parents and carers believed that the service was not available to older children (after babyhood and infancy) and they had commented that they had not seen a health visitor after their child was two.
  *"At two years the health visitor finishes. The health visitor needs to be longer." (Parent FG)*

### *Crossover between services*

Parents/carers described the crossover in use between different services:

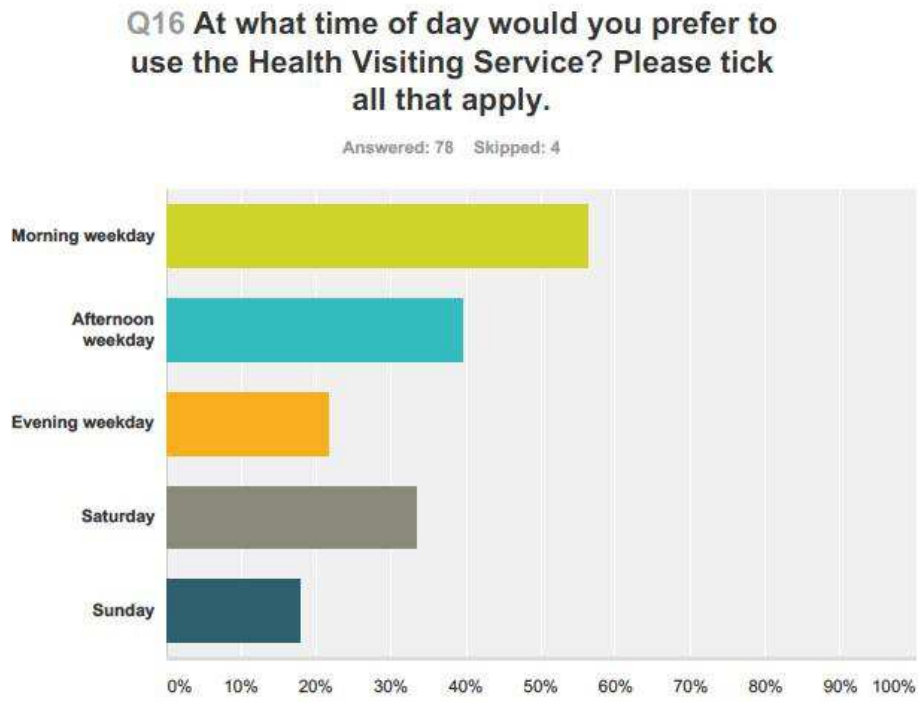
*"A lot of parents said that when GP appointments were not available, they relied on HEALTH VISITORs to offer advice"* (Parents FG)

*"Parents get more help from children centres than health visitors"* (Parents FG)

### *Suggestions for improving accessibility:*

Parents and carers made the following suggestions for improving accessibility to health visiting services:

- More open access clinics at Children's Centres
- More clinics to be held in community settings such as libraries, schools and play groups
- More home visits
- Instigate an appointment based system as well as having drop-in clinics
- Instigate evening and weekend provision - although 19% (15 out of 78) of parent/carer survey respondents found the service to be very flexible with respect to the time of day they could access the service and a further 56% (44 out of 78) found this to be ok, both focus group participants and survey respondents asked for more flexible provision. The chart below shows the survey responses to the question *'At what time of day would you prefer to use the health visiting service?'*




- Consider setting up a telephone help line. As one survey respondent put it: *"I wish there was a way I could telephone health visitors for advice. The clinic set up means that you have to call on the day and it is pot luck whether you will get an appointment. It cannot be booked in advance and is not a drop in but rather last minute appointments. Does not suit me as a working mother as I cannot risk a day off and not get an appointment. It is too rigid. A phone service would be helpful and follow up booked appointment if necessary".* (Parent/carer survey respondent)

*From a professional perspective*

Accessibility to services can be sub-classified into the following themes[4]:

- Acceptability – this refers to the characteristics of the service which the user perceives as desirable and which facilitate use
- Accommodation – this is the relationship between the manner in which resources are organised to accept users and the users ability to accommodate them
- Availability – this is the relationship of the volume and type of existing services and resources to person's volume and type of need. It refers to the adequacy of the supply of health care providers and facilities
- Accessibility – this is the relationship between the location of supply and the location of the potential user, taking account of transportation resources.

The table below describes how professionals currently view health visiting services in terms of their accessibility to service users alongside suggestions for service improvements using the above framework. Viewpoints arising from the HV workshop are shown in bold.

| Currently Valued | Ideas for Service Improvements |
|---|---|
| Acceptability | |
| **Continuity of care**<br>**Consistency in care**<br>**Approachable staff**<br>**Baby friendly setting with toys in Children's Centres**<br>**Tailored to family needs**<br>**Translation services**<br>Culturally appropriate | **More translation services**<br>**Written material in many languages**<br>**More Bangladeshi health visitors and support workers**<br>**One stop shop for all health and social care needs**<br>**Named Health visitor per family for antenatal care until 1 year** (this was also a strong theme amongst EYP, SC and KP workshops)<br>More baby friendly settings<br>Improve organizational knowledge regarding cultural beliefs of families |
| Accommodation | |
| **Flexibility of appointments/ability to see at short notice**<br>**Drop-in clinics**<br>**Home visitor**<br>**Phone advice** | **Increase methods of contact – telephone, text, social media**<br>**Online information in many languages**<br>**Flexible working – evening and weekend clinics to accommodate working mothers and fathers**<br>**Out of Hours service**<br>Single point of contact for all parents/carers<br>More home visitor |
| Availability | |
| **Universal services** (appreciated by all stakeholders)<br>**Targeted according to need**<br>**Regular clinics both in location and timing** | **Increase numbers of skill mix staff and extend their role**<br>**Mobile working**<br>More Health visitors (EYP)<br>Limit caseload size to 250 max (KP) |

[4] Penchansky R, Thomas JW. The concept of access. Medical Care 1981;**XIX**(2):127-40

| | |
|---|---|
| **Full time service**<br>**Responsive service** | *"Health visitors in Tower Hamlets have too many clients, and can only tackle the clients on the enhanced service, but those that are borderline get missed. Then you don't get seen until two years. The eight month check is a bit hit and miss."* (EYP workshop) |
| Accessibility | |
| **Home visits**<br>**Convenience of GP and CC clinics** | **Locality focused**<br>Health visitors in community settings e.g. schools, PVI settings (EYP)<br>More clinics in Children's Centres (EYP) |

### *Results from GP survey*

Twenty-five out of 28 GP respondents thought that the workload of the health visiting service had increased and 18 out of 25 (72%) cited a reduced workforce as a reason for this. Additionally 23 out of 28 (82%) of respondents thought that lack of capacity to cover workload was the most significant challenge facing the health visitor workforce.

> *"They are doing the best they can, capably, going beyond the call of duty, extra unpaid hours. Problem is lack of capacity and also consequent lack of continuity with families and with fellow professionals."* (GP survey)

> *"would have rated excellent in my network as the team work very hard and are great in communicating etc. but focus tends to be on the high risk patients and less time on universal needs due to capacity/ work needs"* (GP survey)

## Communication between services

### *From a Service User perspective*

Parents and carers discussed how communication could be improved between services.

> *"There is a communications issue between the midwives, health visitors and GP. The problems between the midwives and health visitors should really be worked on."* (Parents FG)

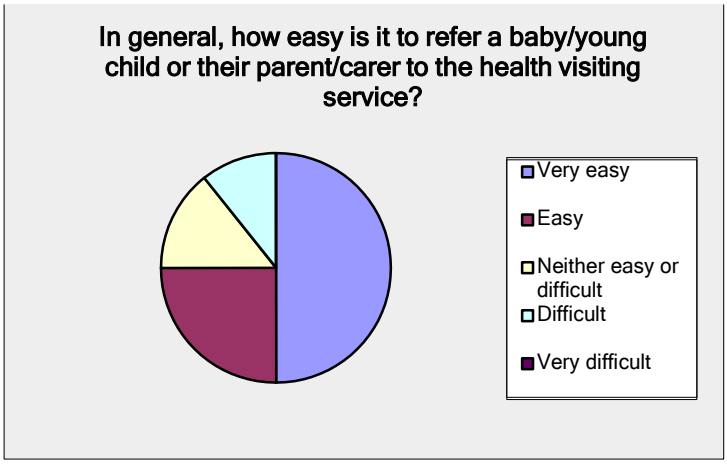
Other service users also raised the issue of poor communication between midwifery and health visitor:

> *One parent asked if there is a relationship with health visitor and midwifes? Is it a blaming relationship, Do they feel united and can support each other? The parent discussed how this is not apparent and the two services could be more united to allow parents to feel more supported*. (Parents FG)

### *From a professional perspective*

Many stakeholders raised communication between services as an issue. In general informal communication between health visitors and other professionals occurred when services were co-located and this was viewed positively.

When asked how easy it was to refer into the service 75% of GP survey respondents replied very easy or easy and 22 out of 28 (79%) of respondents said they were very likely or likely to get a timely response if they contacted the service for families with URGENT support needs.




### *Limitations*

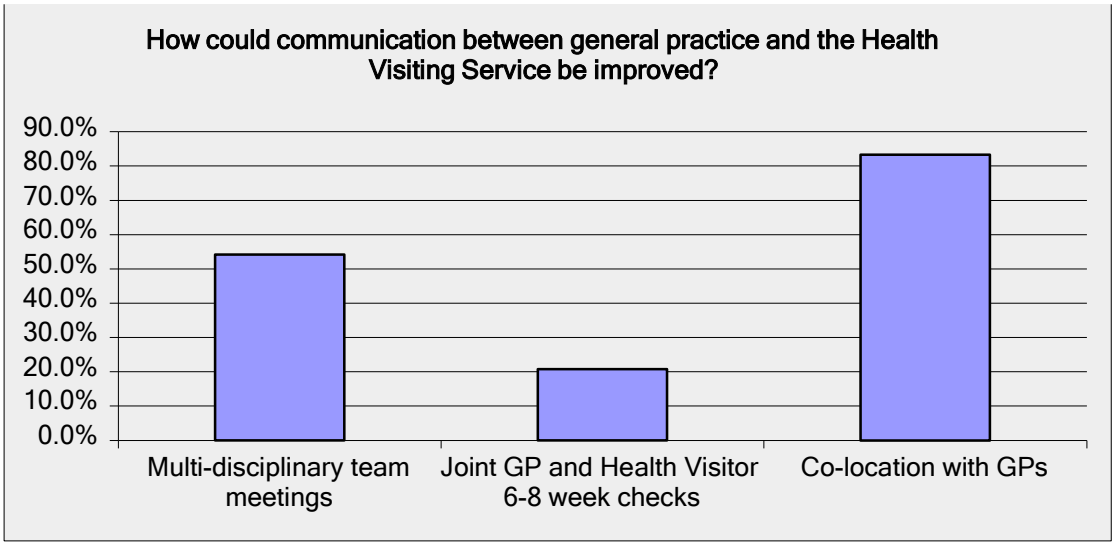
Many professionals described difficulties in contacting the health visiting service, explaining that this could be very time consuming.

> *Missed opportunity when health visitor telephones and social workers away from desk, as a lot of work will have gone into trying to talk* (SC workshop)

> *Email is the most effective way to get hold of the Health visitor, they are hard to access i.e. you have to call between 8 and 8.30 in the morning*. (NGO FG)

### *Suggestions for improving communication between professionals*

GPs survey respondents were asked how communication between general practice and the health visitor service could be improved. The results are shown in the figure below.



Further suggestions came from other professionals:

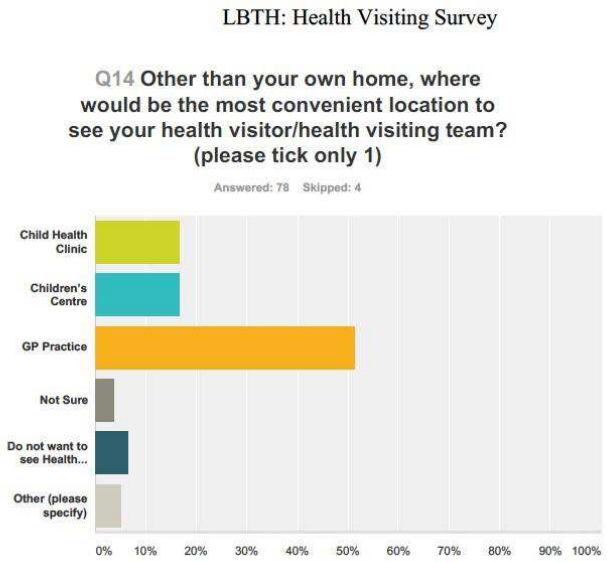
- Identify a named health visitor as a contact
- Centralised contact number
- Establish secure email between health visiting and non-health services.

### *Location of services*

A range of views were expressed about where Health visitor services should be located.

### *From a service user perspective*

All the parents and carers focus groups took place in Children's Centres and when asked where they would like to see their health visitor many respondents chose Children's Centres. However, 50% of parent/carer survey respondents replied that their GP practice would be the most convenient place to see their health visitor.




Participants in the focus groups cited the following as reasons for preferring to see their health visitor in a Children's Centre:

- They meet other families
- Children can attend play sessions whilst they wait
- They are child friendly locations

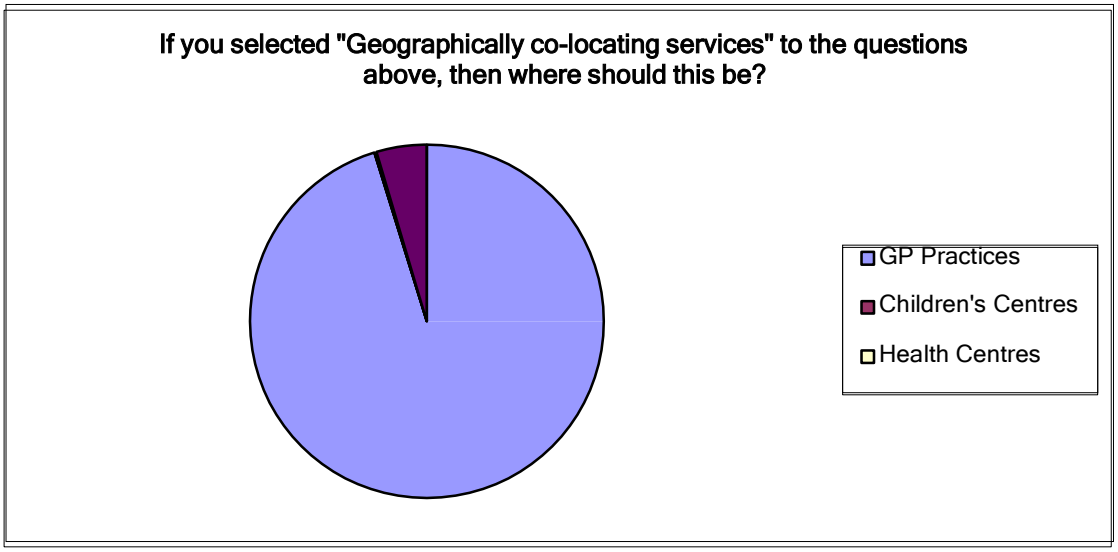
However it was also acknowledged that it was convenient to attend GP surgeries and that it was useful to be able to see a GP at the same time if necessary.

### *From the perspective of the Health visiting service*

Established and newly qualified health visitors and support workers valued practicing from GP surgeries and their links with GPs were highly regarded. Practitioners did not want to lose this close working. Clinical leads wanted more locality working including more alignment with Children's Centres. They recognised the challenges of doing so within the current service configuration.

### *From the perspective of GPs*

The GP survey asked GPs where they would like health visiting services to be co-located. Twenty-one responded and of these 20 (95%) stated GP practices. One respondent wanted services to be co-located in Children's Centres.




### *From the perspective of other professionals*

Participants in the EYP workshop really valued a health visitor presence in Children's Centres:

> "*Love 2 year reviews in Children's Centre buildings!"* (EYP workshop)

There was a call for health visitors to work in other settings:

> *"We would like a health visitor monthly or two weekly, to hold surgery at our school"* (EYP workshop)

Participants in the EYP and SC workshops thought co-location of their services with health visiting services would improve communication and SC professionals spoke of how it would reduce the time spent "*trying to get hold of*" health visitors.

## Partnership

### *From a professional perspective*

It was an aim of all workshops and the NGO focus group to explore how well services currently work together and to generate ideas for more joined up working. Many issues arose and there was much commonality between stakeholder groups as well as some differences. Findings have been tabulated to show the provenance of topics as well as the frequency with which they arose.

| Table 6. Valued aspects of partnership working | |
|---|---|
| **Topic** | **Provenance (Frequency)** |
| **Links with other services**<br>A large number of stakeholders stated they valued the links that | |

| | |
|---|---|
| the health visiting service has with other services. In these instances the nature of the link was not elaborated on although services were cited as: | |
| Gateway midwives | KP (1) |
| Children's Centres | HV (3) EYP (5) KP (2) |
| Voluntary sector | HV (2) KP (1) |
| Other services | KP (1) |
| Social care: *"We rely on health visitors an awful lot despite knowing there are only a few and they see many families"* (SC workshop) | SC (1) |
| 25/28 (63%) of GP survey respondents valued the liaison between health visiting services and social services | GP survey |
| **Signposting and referral to other services**<br>This was a very common topic and health visitors were highly regarded with respect to it. Many professionals highlighted this as a top priority when asked what they valued about the health visiting service. Health visitors were explicitly valued for the referrals they made to speech and language therapy (SALT), audiology, breastfeeding and Children's Centre services such as playgroups. Health visitors and support staff recognised the good liaison they had between services. | HV (1)<br>EYP (5)<br>KP (3)<br>SC (2) |
| **Information sharing with and support from other health services**<br>Health visitors and other health professionals valued the support between Health visiting service and the following: | |
| GPs | HV (4) KP (2) |
| SALT | HV (2) |
| Psychological services/CAMHS | HV (1) |
| Data sharing with health was also acknowledged as a service strength | HV (3) KP (1) |
| **Informal data sharing**<br>This was valued by EYPs when health visitor teams operate out of Children's Centres. | EYP (1) |
| **Interpersonal relationships between professionals**<br>This was acknowledged in the safeguarding meeting as an important enabler of joint working which should continue to receive support. Children's Centre staff also liked forming relationships with health visitors who worked from Children's Centres. | SG (1)<br>EYP (2) |
| **Joint working with the CAF**<br>Social care professionals highlighted the importance of health visitor involvement in the CAF and stated they were key members of the Team around the Child/core group. | SC (3)<br>EYP (1) |
| **Health visitors as expert advisors**<br>Early years professionals appreciate health related advice given by health visitors to other services. | EYP (1) |
| **Joint home visits** | |

| | |
|---|---|
| Participants described how health visitors carried out joint home visits with EYPs and social care professionals and these were both useful and highly thought of. | EYP (2)<br>KP (1) |
| **Registration at Children's Centres** | EYP (2) |
| **Transition from Health visitor to School Nursing** | HV (3) |

### *Areas for improvement*

The following emerged as areas where joined up working could be strengthened.

| **Table 7. Partnership working – areas for improvement.** | |
|---|---|
| **Topic** | **Provenance (Frequency)** |
| **Handover between midwifery and health visitor services**<br>Participants called for this to be improved (with the exception of handover from gateway services) | HV (4) SG (1) |
| **Better links (unspecified) between health visitor and other services**<br>Although many professionals valued the links between services, others called for them to be improved: | |
| Midwifery | HV (2) KP (3) |
| Social care | HV (3) |
| Children's Centres | HV (3) |
| Community paediatrics | KP (1) |
| PVI settings | EYP (1) |
| Housing (one health visitor commented on how they were unable to influence housing decisions even though there was local need was great) | HV (1) KP (1) |
| Third sector | NGO (1) |
| **Better data sharing with non-health services**<br>This included sharing more data | EYP (4) HV (3) SC (1) |
| AND<br>Sharing better quality data consistently including information on sub-threshold families with additional needs.<br>Health visitors highlighted that this also applies to information shared from other services into the health visiting service. | EYP (4) SC (1) NGO (1) |
| **More joined up working for families with additional needs**<br>Including: | |
| Health visitors to attend more multi-disciplinary team meetings | SC (1) |
| Health visitors to initiate and complete more CAFs | SC (1) EYP (2) |
| Health visitors to take on the lead professional role more frequently | EYP (1) |

### *Suggestions for service improvements*

These came from all professional groups as indicated.

#### *Organizational level*

- Health visiting and Early Years services should share a service vision including shared outcome targets (EYP, KP). Participants in the KP workshop called for service managers to be given the time and resources to be able to do this.

#### *Integration between health visiting and early years services*

- Many EYP participants called for joint assessments to be carried out by EYPs and health visiting team members, in particular highlighting the opportunity of an integrated 2 year review. Health visitors wanted a *"multiagency approach to the 2 year review"* (HV workshop).
- There was a call to link Health visitor caseloads to Children's Centres to *"lighten the load"* (EYP workshop)

#### *Co-delivery between services*

The following were identified across professional groups as facilitating co-delivery:

- Shared language between health, early years and social care professionals
- *"harmonise assessment tools"* (EYP workshop)
- One stop health and early years shop
- Shared training sessions across professional groups (EYP, KP) and upskill EYPs in health
- Joint clinics held between midwives and health visitors (HV workshop) and health visiting and SALT and occupational therapy (KP)
- More joint home visits

#### *More joined up services*

The following was suggested as promoting more seamless services:

- Joint care pathways for midwives, health visitors and EYP and condition specific pathways between health visiting and other health services (KP)
- Midwifery services operating from Children's Centre (HV workshop)
- Each social care team to have a named health visitor (SC workshop)
- When asked what would help create a seamless service for families 100% responded 'having a named health visitor' (GP survey).

#### *New services*

- Practical parenting support delivered by health visiting team skill mix (HV workshop)

#### *Greater understanding between services*

- New health visitors to attend Children's Centre groups as part of their induction programme (EYP workshop)
- Health visitors in other settings e.g. nurseries and ideas stores (EYP workshop)

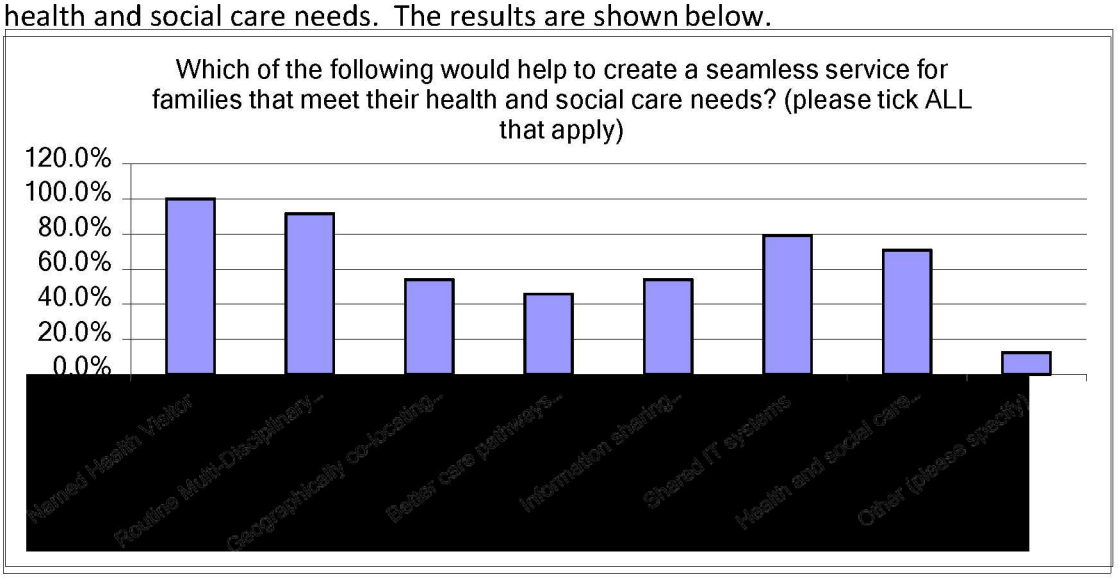
#### *Improved data and information sharing*

- Refresh LBTH data sharing agreement and promote widely to all professionals (HV workshop)

#### *More joined up working for families with additional needs*

- Simplify CAF (HV, SC workshops - top priority)
- Multidisciplinary CAF panels (HV and EYP workshops)
- Promote awareness amongst GPs of guidelines regarding what to do with families who 'do not attend'
- Senior health visitors to attend MDT meetings (SC).

GPs were asked what would help to create a seamless survey for families that met all their health and social care needs. The results are shown below.




When asked what is their top pick of the above, the results are shown below.

| Named Health Visitor | Routine Multi-disciplinary team meetings | Geographically co-locating services | Better care pathways between all health and local authority services | Information sharing protocols between health and local authority services | Shared IT systems | Health and social care teams serving a shared geographical locality and sharing caseloads where applicable |
|---|---|---|---|---|---|---|
| 12 | 4 | 4 | 0 | 0 | 1 | 3 |

## Health promotion (primary prevention)

This was a theme that arose in all engagement events with the exception of the Social Care workshop and Safeguarding meeting. It arose fairly frequently and participants in the Health visitor, Early Years Professionals and Key Professionals workshops identified health promotion/education as an important issue. Both health visitors and EYPs highlighted it as a top priority. Health visitors and support workers described what they were already doing:

*Health promotion and advice e.g. dental care and immunisations*
*Healthy advice: Educating and information: housing issue, good hygiene, weaning, Home safety and parents to have facilities for their children's development*

Participants in the key professionals workshop wanted health visitors to do more Health Promotion/Health Education and this was also listed as a top priority amongst HV workshop participants, with ring-fenced funding for Health Promotion also being identified as a top priority.

### *Ideas for Service Improvements:*

- Public Health workshops delivered by health visitors in nurseries (EYP)
- More Health Promotion group based work; more community based HP work (NGOs)

- Once a month drop-in clinics giving advice on normal child development and parental health (parent focus group)

### Early intervention (secondary prevention)

All professional stakeholder groups emphasized the importance of early intervention and it was listed as a top priority is all workshops and the NGO focus group. Many comments were written about this theme:

*Health visitor workshop:*

*"Early intervention-Heads off problems-builds therapeutic relationships"*
*"nested within a universal service"*

*Social care workshop:*

"*risk identification…..an outcome of contact and relationship building with families"*

*NGO focus group*

*"The fact that they can see in the home and mums that are not "presenting" in another setting, this gives a valuable power for early intervention*
*Seeing in the home is critical*." (NGO focus group)

*Early Years Professionals workshop*

*"Because they see everyone they might pick up on issues and they signpost."*

*Key professionals workshop*

*"Frontline professionals with mother/baby at a critical time who can pick up problems before they escalate."*

All stakeholder groups valued health visitors with respect to early intervention, but there was recognition both within the service and from other professionals that more needed to be done. Home visits were seen as particularly important to this. Participants in the SC workshop wanted earlier intervention for cases of postnatal depression and domestic abuse.

Overall participants believed that an improved health visiting service would do more early intervention.

*Ideas for service improvements*

- Increase capacity and role of skill mix to allow them to focus more on early intervention (HV workshop)

### Information and guidance

A call for more information about LBTH health visiting services was a consistent theme across all stakeholder groups.

*Parents and Carers*

Many parents and carers were unclear about the services on offer and there was a lack of clarity regarding the health visitor's role:

> *"No one knows what a health visitor does"* (Parent FG)

Parents and carers highlighted how they were often confused about the roles and remit of different professionals particularly between midwives and health visitors. One mother described how she was not sure whether it was a midwife or health visitor visit her. Other

parents and carers stated how they would like more support in knowing when to go to the health visitor and when to the GP. One parent suggested having a sheet to say when to go to the GP and when not to and possibly some guidance to stop going to the GP unnecessarily.

Very many parents and carers agreed that the service should be promoted to first time parents with clarity about what health visitors do and how and when to access them:

> *"A call from the HEALTH VISITOR would be helpful with an introduction of themselves, and advice of what will happen next"* (Parent FG)

### *Professionals*

Many participants within the workshops and focus groups called for a greater awareness of the health visiting service, both amongst themselves and also for parents and carers. As one stated:

> *'There are such a huge amount of early years professionals and we don't know who they are and what they all do*." (KP workshop)

This was recognised by members of the health visitor service who wanted to see their profile raised and highlighted this as a priority for improving services. This included managing expectations by informing service users and other professionals of what the service *"can and cannot do"* (HV workshop).

Professionals wanted a greater understanding of the knowledge and skills of the health visitor workforce as this would support closer working and enhance the interface between services. Some participants in the EYP workshop did not know that there was a skill mix within the service. Professionals also recognised the need to manage expectations:

> *"Promote health visitor service more widely so parents learn what they can expect from it"* (KP workshop)

### *Ideas for service improvements*

From the health visiting service:

- Relaunch the health visiting service to increase profile and recognition e.g. Start for life, ad on TV, mention far more info etc.

From Parents and Carers

- Antenatal contact with a health visitor
- Awareness sessions for parents and carers about health visitor services
- Parents given a schedule of visits and what to expect from health visiting services. This could be included in the red book, which should be given to parents/carers before birth.

### Training

Members of the health visitor service explicitly valued the training they received and this was also recognised by KP workshop participants who highlighted the support that newly qualified health visitors receive during their preceptorship period. However there was also a call for more training from all professional groups and for this to be up-to-date, varied and contextually relevant to local needs. In particular SG meeting participants recognised that newly qualified health visitors needed support in dealing with vulnerable families. Key professional workshop participants called for better training for health visitors on breastfeeding.

### *Ideas for service improvements*

*From the HEALTH VISITOR service*

- More regular training sessions including an increase in access for support workers. Allow practitioners to access teaching sessions across the borough and in neighbouring boroughs where appropriate.
- Develop specialist roles and enable specialists to support and train generalist health visitors
- Standardise some aspects of practice e.g. new birth visit in order to achieve a quality threshold.
- Link in-house training with a local University to ensure that students are being taught consistent practice

*From other professionals*

- Co- training on data sharing between health visitors, early years professionals and social care (EYP workshop)
- Training in utilising multi agency setting (SC workshop)

### Information technology

Information technology was viewed by professionals as both a barrier and an enabler of efficient and joined-up working. This theme came through most strongly from participants in the Health visitor workshop. It was also frequently cited as a service improvement in the Key Professionals workshop.

Members of the Health visitor service and other health professionals (KP workshop) valued sharing information amongst healthcare staff (particularly community midwives) using the EMIS system, which is also used by GPs. However it was noted that this system did not always work well and could be slow.

### *Limitations*

*From the perspective of the health visiting service:*

Health visitors described how the current IT arrangements impacted on workflow and caused inefficiencies. One group described them as *"not fit for purpose"* (HV workshop). Health visitors do not have mobile phones or laptops and are not able to input or retrieve data remotely although the majority of their work is conducted away from their base. When asked about service improvements one comment was:

> *"appropriate tech to be able to do our jobs"* (HV workshop)

### *From the perspective of other professionals*

Other professionals recognised the limitations of the current IT system especially the lack of interoperability between systems used by different agencies. They highlighted that this:

- Adversely affected the number of common assessment frameworks (CAFs) that were either initiated or completed by members of health visitor teams. Participants in the EYP workshop thought that this was in part due to health visitors having to enter data into 2 systems which is very time consuming.
  *"Transfer of data is problematic and health visitor assessments in EMIS, which are CAF compliant, could, but are not currently able to be transferred electronically."* (Safeguarding meeting)
- Inhibited information sharing between agencies, although it was also recognised that professionals needed explicit guidance as to what data could and could not be shared and when.

Professionals also stated that it was difficult to share real time information with health visitors as they did not have access to the same secure email system.

### *Suggestions for service improvements*

Nearly all groups within the HV workshop proposed IT solutions as ideas for service improvements with many earmarking them as top priorities. The following suggestions originate from the HV workshop unless otherwise indicated.

- Robust commissioning around IT and investment in the Child Health Information System and EMIS
- Laptops or tablets and mobile phones to support mobile working
- Interoperability between health and local authority IT systems
- IT to support routine transfer of CAF data between agencies (SG meeting)
- Secure email between health and other agencies (SC, EYP, KP)
- Access to EMIS support

## Resource

Service funding was not frequently raised as an issue in itself, but many references were made both by parents/carers and all professionals about a lack of availability of and a need for more health visitors and support workers (see Accessibility section). Some participants highlighted that a lack of staff resulted in the service only having the capacity to deal with the most needy families leaving a gap at the universal plus tier (NGO FG). Members of the health visiting service also called for more resource to be put into estates, IT, facilities and administrative support.

## Management

Participants from all workshops and the NGO focus group identified management issues.

### *Comments on current management practice:*

These mainly came from health visiting service practitioners:

- Health visiting service practitioners valued their clinical supervision and the role of practice educators and mentors
- Frontline practitioners highlighted the following management issues:

- Staff feel disconnected from management and would like more transparency and communication between management and front-line staff. This includes more information about the service e.g. current establishment.
- Staff feel disempowered to lead and there is a suggestion that team leaders and band 7s were not given enough authority
- All professionals identified that there was a high turnover of staff
- When asked to comment on what could be done to make the Health visitor service better, 5 GP survey respondents highlighted that management appeared "distant" to front-line staff and there was a perception that they were not adequately supported.
  *Understaffed and staff poorly supported by their management so massive and demanding workload cannot be managed as well as they would like.* (GP survey)

### *Service Improvements*

The following were mainly identified within the HV workshop unless indicated otherwise:

- Clear vision and leadership (all)
- Health visitor roles and responsibilities including skill mix explicitly defined (all)
  "*not jack-of-all-trades"* (HV participant)
- Shared vision and outcomes between services
  - Link with family wellbeing model (social care and safeguarding)
- Outcome based service (KP, EYP and HV)
  - Outcomes to be qualitative as well as quantitative
  - Evidence based
- Frontline staff represented at management level (HV workshop)
- Increased capacity at management level to support and implement change

Participants in the HV workshop identified the following as supporting delivery of care:

- Caseload management which adjusts caseload size according to underlying need and case complexity
- Skill mix – increase capacity and role of support workers
- Development of specialist roles
- Increase in workforce
- Better recruitment and retention of staff (also discussed in the KP workshop)
- Empower staff to be professionally autonomous (SC workshop)
- Increase time for training/mentorship and reduce caseload of specialist practice teachers and mentors

### Safeguarding

Safeguarding was discussed within all the workshops and the NGO focus group. Additional information about this topic has also been gathered from a LBTH safeguarding meeting. The word safeguarding was a commonly used term amongst all stakeholders.

The role played by health visitors in safeguarding was valued highly by all professionals, in particular the benefit to safeguarding that home visitor brings.

Comments on the existing service and areas that were valued were as follows:

- Health visitors have a key role in safeguarding as they are recognised as being non-threatening to families, which facilitates access to the home environment.
  *If a statutory authority needs to come into the home, parents can be defensive and on their guard; and they can disguise themselves*.
- This was reiterated by members of the health visiting service:
  *Safeguarding is non-threatening and more likely to disclose to health visitors. Open and honest relationships in safeguarding, health visitors are consistent after family crisis times, clients value health visitors in these times*. (HV workshop)
- Health visitors were recognised for their *contribution* towards child protection plans, working closely with social workers
- The role of health visitors in early identification of problems through comprehensive needs assessment was discussed in several workshops. The impact this has on safeguarding was widely recognised both through helping to address problems before they escalate and also by ensuring the timely involvement of multi-agency services.
- There was a desire to keep the Child Protection hotline

### *Limitations*

- There is a strong pull from Social Services for further Child Protection involvement, wanting a 'stronger' role for health visitors in Child Protection and health visitor home visits being recognised as 'formal' Child Protection visits. Participants in the Social Care workshop wanted health visitors to carry out the role of the core group. They also called for health visitors to feel more confident in holding 'high risk' cases.
- The Safeguarding meeting discussed risk assessment tools in some depth, CAF and Signs of Safety (SOS). The level of need required may not reflect a safeguarding issue. There is interest in using SOS and it is in the early stages of being rolled out in GP practices. It is unclear, however, if this is being used systematically or ad-hoc. If this system were to be used then there would be a need to think about other details needed, and when to use a CAF. However it was suggested that until SOS was used by the local authority as a local intervention model, it would be difficult to progress further. It was indicated that this was about levels of need and identifying risk; in any new system it would need to be clear when it was more appropriate to do mapping and SOS, and when to use the CAF.
- Some members of the HV workshop found the CAF time consuming to complete. There was a general call to make safeguarding less "*time consuming"* overall.
- Participants in the Social Care workshop called for health visitors to be given more safeguarding training, in particular for physical abuse and also more support for newly qualified health visitors in their preceptorship period.
- It was suggested that although health visitors are notified of emergency department attendances there is not a structured process for risk assessment from these notifications.
- There was a suggestion that safeguarding could be improved by sharing data in nursery schools.

## The 4 tiers of service

Information gathered during the stakeholder engagement exercise built a picture of current services, which are described in Table 8. This is not an objective evaluation of service provision, rather a high level description of each service tier based on stakeholder findings. It highlights issues that commissioners may want to consider when commissioning future health visiting services.

| Service Tier | Stakeholder findings on current services | Considerations for future commissioning |
|---|---|---|
| Community Offer<br>i. Building community capacity with local partners to support families support the health and wellbeing of their children aged 0-5.<br>ii. Champion health promotion and support reduction in health inequalities | • Stakeholders reported that the community offer is currently limited within LBTH<br>• Health visitors have built good links with GPs and CCs | • There was recognition that more could be done to champion health promotion at the community level and in general health visitor practitioners welcomed this<br>• Findings suggested that the HV service could build more links with community services |
| Universal<br>iii. Health and development reviews<br>iv. Advising on best practice in health promotion in the early years of childhood<br>v. Screening<br>vi. Immunisation (advice)<br>vii. Promotion of social and emotional development<br>viii. Support for parenting<br>ix. Reducing hospital attendance and admission<br>x. UNICEF community Baby Friendly accreditation | • New birth visit, 6-8 week check, 1 and 2.5 year development reviews offered and delivered. The service is considering how to implement a universal antenatal contact.<br>• Health promotion delivered as part of routine contact with families.<br>• Screening and immunisation advice identified as a service delivery by members of the HV service.<br>• Members of the HV service highlighted the work they do in promoting social and emotional development and providing parenting support. This was valued by parents/carers and professionals.<br>• UNICEF Baby Friendly status achieved | • Parent and carer participants highlighted that clinics can have long waiting times and be very busy. Other stakeholders highlighted heavy health visitor workloads.<br>• Better links with midwifery are needed to support the implementation of the antenatal contact and avoid duplication<br>• All stakeholder groups identified the importance of health promotion and called for more. Suggestions were made for standalone health promotion sessions.<br>• Greater integration of health visiting and early years services may support the delivery of developmental reviews. |
| Universal Plus<br>xi. Responsive care at time of need<br>xii. Early identification of developmental and health needs | • Stakeholder findings suggest that provision at the universal plus tier is lacking due to capacity shortage and a need to concentrate resources on | • A lack of continuity of care was considered to be detrimental to clients with additional needs<br>• Stakeholders called for a different use of |

| | | |
|---|---|---|
| and signposting/onward referral if indicated<br>xiii. Parenting support | families with the highest needs.<br>• All stakeholders recognised the contribution of health visitors in early identification and referral.<br>• Health visitors and support workers offer parenting support on an individual client basis. Parenting/family support was identified as a local need by stakeholders as was emotional health and postnatal depression. These could be supported at the Universal plus level. | skill mix within the service to free up health visitors time for families with additional needs.<br>• Better links between services, including better data sharing, is likely to further support Universal Plus families<br>• Development of specialist roles was welcomed by the Health Visitor service and could support UP needs. |
| Universal Partnership Plus<br>xiv. Identifying vulnerable and complex children<br>xv. Establishing appropriate safeguards and interventions to decrease risk to the child and improve future health and wellbeing<br>xvi. Working with other Agencies for children/families requiring intensive support<br>xvii. Comply with statutory duty to share information and communicate with other agencies and health professionals when there are safeguarding concerns. | • Established links with gateway midwifery services to identify and support vulnerable pregnant women<br>• Health visitors work as members of multi-agency teams for families who reach safeguarding thresholds<br>• Home visiting was recognised as particularly valuable to safeguarding | • Although the role health visitors play in safeguarding is highly valued there is a call for them to do more<br>• Newly qualified health visitors need additional support with safeguarding issues<br>• There is a need to streamline safeguarding including use of risk assessment tools |

## Conclusion

Phases 1 and 2 of this stakeholder engagement project have generated great insight into health visitor services in LBTH. Health visitors and members of the wider skill mix team are highly valued and recognised for the unique and vital role they play in supporting families with young children in the borough. The health visiting service is regarded by stakeholders as essential to supporting the physical, emotional, developmental and wellbeing needs of children aged 0-5 and is at the centre of health, local authority and voluntary sector services that serve the early years population.

This project was commissioned to inform the future commissioning of LBTH health visiting services. The findings from Phases 1 and 2 have identified several priority areas for future service development.

### *Capacity*

The findings suggested there is a need to increase frontline and managerial capacity to support delivery across all 4 tiers of service. Areas to consider include[5]:

- A change in skill mix to include an increase in support workers
- Extending the role of support workers
- Resourcing and implementing technologies to support mobile working
- Improving current IT infrastructure
- Increasing administrative support

### *Access*

In general there was a call for health visiting services to be more accessible to service users and other professionals. Suggested initiatives to improve access could include:

- Flexible opening hours including evenings and weekends
- Increasing the number and type of locations for services without losing current links with general practice.
- Availability of drop-in and booked appointments
- Telephone advice line
- Named or single point of contact for service users and professionals
- Online services
- More use of translation services

### *Continuity of care*

There was agreement amongst many stakeholders that service users would benefit from continuity of care, ideally seeing the same health visitor each time at least for the first year of life.

### *Links with other health and early years services*

Findings suggested that links between services could be strengthened. Suggestions for improvements include:

- Developing a shared vision between health visitor and early years services

[5] The expansion of the health visitor workforce under A Call to Action trajectories is not considered here as this is not within the scope of this project.

- Locality working
- Co-delivery/integration of health and early years services
- Joint working between different services such as midwifery and health visitor
- Improved data sharing between services supported by interoperable IT systems

### *Support for quality and consistency of care*

Participants told us that areas to consider include:

- Building on current training, preceptorship support and clinical supervision opportunities
- Development of specialist roles
- Agreement on and use of clinical standards

### *Promote understanding of Health visitor services*

This will benefit service users who told us that they did not know enough about the health visitor service and help support the appropriate and timely use of services.

The above issues impact across all 4 tiers of service provision. Findings also identified tier-specific issues that are of relevance to future commissioning.

### *Community*

This appears to be lean with not much current activity

### *Universal*

High caseloads and a lack of capacity are resulting in busy clinics with long waiting times. The service is looking to implement a universal antenatal contact.

### *Universal Plus*

There is a suggestion that families with additional needs would benefit from more input from the health visitor service.

### *Universal Partnership Plus*

Stakeholders highlighted a need to strengthen the role of Health visitors in safeguarding and streamline processes.

Stakeholder findings from Phases 1 and 2 were used to identify priority areas for discussion in Phase 3. A summary of these discussions is given in the next section.

# Section 2

## Phase 3: Summary Report

### Introduction

The purpose of Phase 3 was to feedback Phase 1 and 2 findings to stakeholders who took part in any of the engagement events and other key stakeholders who were unable to attend these initial events. After discussion with LBTH Public Health commissioners it was also decided to use Phase 3 as an opportunity to progress ideas for service developments generated from the discovery phase findings.

### Engagement Process

All attendees of Phases 1 and 2, and some key stakeholders who had been invited but were unable to attend, were invited to the Phase 3 workshops. Overall 55 people attended one of 2 workshops. The workshops comprised of:

- A presentation on the new National Health visitor Service Specification
- A high level report back of Phase 1 and 2 stakeholder engagement findings
- A presentation on future service design and configuration including models of innovative practice occurring elsewhere e.g. the Brighton commissioning model.

Attendees were asked a series of set questions on topics that were identified as priority areas by public health commissioners based on stakeholder findings.

1. How do we strengthen the role of the health visitor in community engagement and development?

2. What do we need to do to fully implement the antenatal contact?

3. How do we strengthen the integration of the health visiting service with primary care and children's centres?

4. How do we improve the capabilities, capacity and competencies of the health visiting service?

5. What do we need to do to offer a more intensive service for high needs families?

A summary of the discussions generated on each topic is presented below.

### How do we strengthen the role of the Health Visitor in community engagement and development?

Currently there is only limited community engagement carried out by the HV service within LBTH. The majority of Phase 3 participants welcomed the idea of doing more although a few voices called for a greater understanding of why this was necessary.

Participants discussed the form that future community engagement and development could take and many ideas were generated that ranged from a strategic approach:

*"It's not about being in the community but working with community agencies."*

to a more service delivery orientated approach such as health visiting teams carrying out health events.

How to do community engagement and development emerged as an iterative process:

### *Embedding*

Many participants believed that geographical (locality) working would strengthen links with other early years and community services. This would support HV practitioners to develop local community networks. There were suggestions that HVs should work in joint teams with other services e.g. Children's Centre teams to strengthen their presence in the community. However, participants were also clear that clarification was needed around the roles and agendas of the health visiting service and other services to support dovetailing and avoid duplication.

### *Community profiling*

*"Health visitors need to get back to being out on the ground – profile the community to identify local public health issues to address"*

Many participants highlighted the role of health visitors in helping to build a picture of local needs that could be used to help strategically plan services and support the development of community assets.

### *Emerging community role*

There were many suggestions about how the Health Visiting service could 'do' community engagement and development.

*Settings* – there was a call for health visitors to provide services in community settings such as ideas stores, nursery schools and supermarkets to increase their community presence. Several local markets were cited as community assets where health visitors could practice from if suitable facilities were available e.g. within a healthcare setting in Crisp Street Market.

*Participating in local community events* – several participants thought health visiting teams could attend local community events to promote their services and deliver public health messages to the community.

*Partnership working* – suggestions were made for health visitors to co-deliver services with community groups e.g. HVs to attend community play sessions to offer ad hoc support to parents.

*Advocacy* – health visitors should advocate for families with wider needs e.g. housing and help harness community assets to meet these needs.

### *Enablers*

It was widely recognised that enablers were needed to support health visitors fulfill a community role:

*Capacity* – there was recognition that practitioners would need time to carry out community engagement. This could be challenging within current service capacity.

*Shared vision* – between services to promote community working.

*Widespread dissemination of information* – to families to tell them what services are available to meet different support needs and help them navigate through services.

### What do we need to do to fully implement the antenatal contact?

Participants discussed the format the contact should take, what should happen within this contact, access, links with midwifery and the logistics of delivering an additional universal contact.

#### *Format*

Many suggestions were made as to what format the antenatal contact should take and no single preferred option emerged. Some participants preferred face-to-face contacts whilst others suggested telephone consultations. Another suggested method was a virtual contact (Skype). When discussing face-to-face contacts, many participants thought this should be a home visit as it presented an opportunity for risk assessment and early intervention if appropriate. A home visit could be confined to first time mothers only and other forms of contact used in subsequent pregnancies. It was noted that HVs currently see women antenatally if they are deemed vulnerable, but a universal antenatal contact will help identify 'borderline' mothers.

When asked when the antenatal contact should take place, participants suggested it should be later on in pregnancy (26 to 32 weeks).

#### *Content*

Discussions were focused around what should take place in the antenatal contact. Ideas for content included:

- Information about health visiting services; although many participants thought this could be given out in leaflets or online
- Public health messages
- Advice on bonding and attachment

It was also acknowledged that some families might need more intensive support and referral onto other services.

Participants also discussed the usefulness of standardized tools and guidelines in the antenatal visit.

#### *Access*

Discussion took place regarding how to make the antenatal contact as accessible as possible, including to fathers. Apart from home visits participants thought face-to-face contacts could take place in antenatal clinics and parenting classes. There was wide

agreement that a different approach would be needed for hard to reach families who do not present in routine settings but this was not elaborated on.

There was acknowledgement that the service had to be flexible to support working mothers and fathers (evening and weekend availability). There was also a wish for there to be continuity of health visitor from this initial contact onwards.

### *Links with midwifery*

These need to be strengthened to include better data sharing, more joined-up working/co-delivery between midwifery and health visiting and for a greater mutual understanding to be developed between these services. Participants were clear that there is a risk of duplication and were keen for this not to happen.

Logistics

Questions raised included:

- How to alert the HV service about pregnant mums?
- How to increase capacity in the HV service to deliver the antenatal contact?
- Who will have overall responsibility for joint midwife/HV working?

No clear answers emerged to these questions.

### How do we strengthen the integration of the Health Visitor Service with Primary Care and Children's Centres?

The discussion is often about the most appropriate setting i.e. immunisations in a surgery and two year reviewing children's centres and different settings have pros and cons.

The clear definition of the health visitor role within the various setting maximises the best use of their skills and even more so alongside fellow colleagues. Clear pathways also benefit the HV role.

Location issues can be overcome by linking a health visitor to a location and with joint GP/HV meetings and models of working such as Team Around the Child and Multidisciplinary Team meetings, bring professionals together and promote integration into both GP surgeries and Children's Centres.

2 -year checks at children's centres are good practice to build on and further joint clinics can work in community settings or children's centres. However it is more challenging to integrate with a children's centre than a GP surgery.

There are examples of successful health visiting in children's centres and this can be copied elsewhere. Bromley-by-Bow was cited as a model of good practice where all relevant services are in one location. However GP premises can also be a barrier to co-location.

There needs to be strong leadership, a shared vision and borough-wide planning to address fragmentation.

The new service specification and commissioning could include the combined use of facilities.

As ever the effective sharing of information and IT are critical to success.

### *How do we improve the capabilities, competencies and capacity of the Health Visiting service?*

#### *Capabilities and competencies*

Three areas to focus on came through strongly – leadership, increasing knowledge and skills, and supporting high quality practice.

*Leadership*

- There was a call for health visitor representation at senior levels of management to ensure that the service remains visible to senior decision makers
- Desirable for health visitor service leaders to retain a clinical role as they will be more aware of 'on the ground' competency issues and be able to detect gaps in competencies in frontline workers
- Service leaders to be further supported in their management training needs
- Support leaders to act as role models
- Establish a new leadership post dedicated to training

*Increasing knowledge and skills*

- Conduct skills and learning needs audit in order to focus training on learning needs
- Soft skills e.g. communication skills need to be developed as well as increasing knowledge
- Regular training to be accessible to all
- Protect time for learning
- Specialists to teach generalists
- Regular appraisal and practitioners to have professional development plans
- Build on current supervision and mentoring
- Develop HV specific learning and competency frameworks that practitioners can work to
- Practitioners asked to demonstrate achievement/competency following training events

*Supporting high quality practice*

- Consider developing minimum standards and standardize some clinical processes
- Support innovation to happen from the 'bottom-up' and allow time for change to bed in. Support a no blame culture to allow practitioners to take risks
- Minimize practicing in isolation through bolstering team working. This will help practitioners learn from others and also help build reliance.

#### *Capacity*

Participants discussed how the service capacity could increase by changing the profile of health visiting teams. There was general agreement that more support workers (community nurses and nursery nurses) were needed as well as more qualified Health Visitors. Suggestions were made to increase administrative support to managers and frontline practitioners, as this will free up their time. There was a call to increase the number of

service leads to at least 4 locality leads. Streamlining services with other early years services may reduce duplication and free up capacity.

*Recruitment*
There was an acknowledgement that the service needed to recruit more staff by headhunting early in Universities for newly qualified Health Visitors and by developing support workers to become Health Visitors.

*Retention*
Many participants cited this an issue. However they also recognised the unique appeal of LBTH and many suggestions were made as to how these could be capitalized on to both recruit and retain staff. In particular reference was made to the appeal of LBTH as a diverse community which was well served by services and hence offered opportunities for interesting and innovative working. There was recognition of a need for more structured career progression. The chance to develop specialisms and undertake secondments in other workplaces were highlighted as attractive propositions which were thought would promote staff retention.

Heavy workload and lower pay in comparison to other boroughs were given as reasons as to why staff left the service in LBTH.

**What do we need to do to offer a more intensive service for high needs families that do not meet the threshold for statutory services?**
An over-riding summary of what to offer could be

*"A more robust universal service from antenatal and focused on the first year = better engagement for vulnerable families. Offer standard review appointments at children's centre play sessions. "*

Initially the service must identify needs. The service should find a better way of identifying 'high need' or 'borderline' families and to be clear about who the vulnerable groups are and the social care thresholds. The service should also include mental health competencies, it could also benefit from specialist knowledge around attachment and Speech and Language. This argument could extend to specialist roles.

There are common tools and methods to support these families, which should be further exploited: TAC/lead professional, SOS, CAF, MDT, Family Wellbeing Model and the Meach Parenting Programme. As well as structured methods there should be joint appointments, stronger networks of professionals and core locality based teams. And a stronger relationship with social care.

Regarding working near the social care threshold there should be clear guidance from statutory services regarding further concerns and the health visitor should have the competence, experience, confidence and rigour to question, challenge and confirm. There are unrealistic recommendations from social care for some families who do not meet thresholds for statutory services. And therefore all professionals need to have a very clear understanding of thresholds and who is responsible for what. For higher need families,

responsibilities should be clearly defined with an explicit framework about who is doing what? And who is the key person?

There are risks within the workforce that the majority of current health visiting recruits have limited experience and therefore in the short term there are too few experienced health visitors to deliver more intensive programmes of support for higher needs families. There should be more training for junior health visitors.

The role of the health visitor

- The health visitor should understand the context in which the child/mother live- within family relationships, within community e.g. couple issues. And be able to recognise isolated mothers
- The health visitor is the lead, who pulls together all 'views' of child/family and identifies concerns and makes referrals and is identifiable to all of 'us'

It was stressed that the service must have two more Clinical Leads, giving LBTH four in total, one to cover each locality.

| Health and Wellbeing Board<br>Tuesday 7 July 2015 | Tower Hamlets Health and Wellbeing Board |
|---|---|
| **Report of:** Mental Health and Joint Commissioning Team | **Classification:**<br>[Unrestricted] |
| Mental Health Crisis Care Concordat | |

| | |
|---|---|
| **Contact for information** | Martin Bould, Senior Joint Commissioner<br>Mental Health and Joint Commissioning Team<br>020 3688 2572<br>Martin.bould@towerhamletsccg.nhs.uk |

## Executive Summary

A local action plan has been developed in response to the government's inter-agency Mental Health Crisis Care Concordat, and is signed by local statutory partners and supported by local third sector organisations. The Health and Wellbeing Board has been identified as the forum to support and ensure the necessary partnership working.

Tower Hamlets already has many strengths in its local crisis pathway and services. However, partners wish to continue to make improvements. They have identified the first areas to consider as the patient experience of crisis services, and the functioning of crisis pathways at the Emergency Department. The full plan includes the creation of a local dashboard to scrutinise performance, consideration of the needs of vulnerable groups, and engagement of service users and carers, as well as reducing inappropriate call-outs to emergency services.

## Recommendations:

The Health and Wellbeing Board is recommended to:

1. To note the report.

## 1. DETAILS OF REPORT

### 1.1 Background to the Mental Health Crisis Care Concordat

In February 2014 the government published the Mental Health Crisis Care Concordat, which is a joint statement, written and agreed by its signatories, that describes what people experiencing a mental health crisis should be able to expect of the public services that respond to their needs. The expectation in this document, reinforced by Norman Lamb, then Minister for Care and Support at the Department of Health, was that all local areas would commit to agreeing the national principles, making their own local declaration, and setting an action plan. A London declaration was made in October 2014 by a wide range of partners including the London Office of CCGs and London ADSS and Directors of Public Health.

Improving crisis care is seen as a significant step towards achieving 'parity of esteem' (the government's commitment to value mental and physical health equally).

The government's aim is an effective local system that anticipates - and where possible prevents – crisis. Locally, it states that this is first and foremost a commissioning responsibility.

### 1.2 Issues for Tower Hamlets Health and Wellbeing Board

The Mental Health Care Crisis Concordat document expects that local Health and Wellbeing Boards (HWB) will bring together health and social care commissioners, the local community and wider partners, and support the crisis care concordat through their Joint Health and Wellbeing Strategies (JHWS). Joint working should include people experiencing mental health crisis.

The document sets out certain requirements, including governance for action plans, and key areas to address (care pathways, resources, transient populations, drug and alcohol services and children young people). However, the key requirement is for HWBs to meet local circumstances and needs highlighted in the JSNA.

Local health and social care commissioners are expected to develop their own commissioning plans in line with any relevant JSNA or JHWS, and must be able to justify any parts of their plans which are not consistent with these.

Local partnership working and oversight of the strategic direction of mental health crisis care are therefore the key issues for Tower Hamlets Health and Wellbeing Board.

To date, the Health and Wellbeing Board has adopted a Joint Mental Health Strategy, which, as part of its commitment to high quality services, has prioritised crisis resolution and a review of crisis pathways. This has laid a strong foundation for future partnership work.

The Tower Hamlets Mental Health Crisis Care Concordat action plan (Appendix 2) was agreed in March 2015 by the CCG, the Council, East London Foundation Trust (ELFT), Barts Health, the London Ambulance Service and The Metropolitan Police, and supported by eight local third sector organisations.

### 1.3 Key principles of the Mental Health Crisis Care Concordat

The Concordat is arranged around four outcomes:

- Access to support before crisis point
- Urgent and emergency access to crisis care
- The right quality of treatment and care when in crisis
- Recovery and staying well, and preventing future crises

The core principles that apply to these outcomes are summarised in Appendix 1. Overall, the aspiration of the Mental Health Crisis Care Concordat is transformational: its scope and impacts cover many parts of primary care, mental health, and accident and emergency services in the NHS, and in turn seeks to affect their interfaces with a wide range of other partners.

### 1.4 Developing a local action plan in Tower Hamlets: overview

The process of developing the action plan is summarised in the action plan itself. It reflects:

- A strong starting point in Tower Hamlets – there are many positive features of the crisis pathway
- Dialogue with local partners, including service users
- Agreement to focus on urgent and emergency access to crisis care, and the right quality of treatment and care when in crisis, as delivered through the Emergency department at the Royal London Hospital.

### 1.5 Current strengths in Tower Hamlets

Nationally, the Mental Health Crisis Care Concordat seeks to address some deficits such as:

- Inadequate liaison psychiatry services in Emergency Departments
- Insufficient 24 hour mental health care provision
- Inadequate number of inpatient psychiatric beds
- People in crisis being detained by police officers and taken to police stations for assessment
- Young people being placed in inpatient units far from home

Tower Hamlets does not have these problems. On the contrary, its services have several positive achievements, developed over the years by local mental health organisations working with partners in crisis care:

- Our local crisis pathway offers an alternative to admission (the 'crisis house')
- Access standards in the Emergency Department (A&E) at the Royal London Hospital are a priority focus for all agencies. In December 2014, 96% of A&E patients referred to the Rapid Assessment Interface and Discharge (RAID) service were seen in under an hour by RAID, and the overall A&E four hours wait target was met for 91%. (RAID is a widely-adopted model for multidisciplinary mental health services in acute general hospitals. The formal title of the service in Tower Hamlets is the Department for Psychological Medicine.)
- The local service system continues to offer good access to available mental health beds, with monthly occupancy of between 75% and 83% throughout 2014/15 (against a norm of 85% suggested by the Royal College of Psychiatrists, but often exceeded in other areas)
- The local standard of Approved Mental Health Professionals (AMPH) attendance within an hour of call-out is met
- The designated place of safety for people detained under section 136 of the Mental Health Act is a hospital not a police station (and has been for some years)
- Very few mental health assessments take place at police stations
- Local services include police station diversion and court diversion by mental health professionals
- Local police are actively involved in multi-agency forums and aftercare, where appropriate.

Partners are committed to maintaining these achievements.

### 1.6 Dialogue undertaken with local partners, including service users

The Mental Health Partnership Group meets every two months and brings together CCG and Council Commissioners, Public Health, third sector providers, partner organisations and service user and carer representatives. It has developed local principles and priorities for the Mental Health Crisis Care Concordat through the following process:

- Special meeting of the Mental Health Partnership Group (the local multiagency forum) held in June 2014 with invited police and ambulance service senior managers
- Focus groups of service users and carers (held separately) in August and September 2014
- Meeting with Tower Hamlets Council and ELFT borough manager in November 2014
- The regular service user engagement event 'Your Say Your Day' ( December 2014)
- Mental health summit to discuss the progress of the Joint Mental Health Strategy, also in December 2014
- Mental Health Partnership Group to sign off the action plan, February 2015

The focus groups developed a local set of expectations that mental health service users and carers have when they seek crisis care.

Following this process, the action plan was agreed by local signatories and uploaded by the CCG in March 2015 to the national crisis care concordat website, as required by NHS England.

### 1.7 Focus on urgent and emergency access to crisis care

As well as ensuring delivery of crisis services, this focus includes the right pathways, and quality of treatment when in crisis. In Tower Hamlets, a lot of mental health activity from several different organisations takes place at the Emergency Department ('A&E') at the Royal London Hospital, so the focus naturally settles there:

- People are directed to A&E out of hours by services, or attend in an emergency
- The RAID liaison psychiatry service covers the Emergency Department and sees people in mental health crisis
- Members of the public can be taken to A&E by the police as a place of safety, pending a mental health assessment under section 136 of the Mental Health Act
- Ambulances take patients there, and are used to transfer patients to mental health inpatient beds
- People with mental health problems present there for physical health emergencies, e.g. self-harm
- The service operates 24 hours a day seven days a week
- Partner organisations highlighted the emergency department as a place where the practicalities of handovers could be improved by interagency working
- Service users reported concerns about their experience as patients at A&E

This area of service therefore appeared to partners to be the most sensible place to begin to make improvements. However, partners are equally aware of the long term challenges posed by the Mental Health Crisis Care Concordat as a whole, and the need to reduce police and ambulance call outs to situations which should be addressed by mental health crisis services.

### 1.8 Briefing for longer term issues

There are a number of specific pathways where detailed information and stakeholder consensus are required in the coming months.

- Children and adolescents
- People who misuse drugs and alcohol
- Homeless people
- People with dementia

- Black African and Black Caribbean service users who are currently disproportionately represented amongst users of section 136 and those admitted into hospital under other sections of the Mental Health Act.
- Older adults

Further information is being gathered on these subjects by the CCG and partners for report to the Mental Health Partnership Group.

### 1.9 Action plan for 2015

The following actions are listed in the action plan (which is attached as Appendix 2) and will be developed into specific project plans:

- Improve service user and carer experience of mental health crises at the Royal London Hospital Emergency Department
- Obtain feedback from service users and carers with experience of local crisis services, and review options for improvement (with reference to the principle that *People in crisis, and the carers of people in crisis, should be treated with dignity and respect and their expertise listened to)*
- Develop improved on-line access to information and services through *the In the Know* on-line information service (on the Idea Store
- Audit crisis plans and CPA plans (including for older adults) and reduce variability in quality
- Reduce proportion of mental health crises where police are first to attend
- Continue to ensure good response times and high quality services from LAS for Mental Health Act call-outs, and work to reduce inappropriate emergency ambulance crisis call-outs
- Develop a mental health urgent care and crisis care dashboard, including monitoring ethnicity and age
- Engage service users and carers in monitoring the delivery of services according to expectations

In line with wider NHS England priorities, the CCG has also been able to invest additional resources into the Early Intervention Service, which will increase the speed of response and offer NICE compliant interventions to people with their first experience of psychotic illness.

The NHS London Strategic Clinical Networks have drawn up commissioning standards and recommendations which will be considered when developing specific service proposals.

### 1.10 Governance and implementation

A senior partners group is being set up from the named signatories or their nominees to draw up detailed plans to improve support police and ambulance response, and to propose improvements at the Royal London Hospital Emergency Department.

This group will also oversee timelines and progress on the other actions, such as the dashboard and the audit of crisis plans.

The Mental Health and Joint Commissioning Team has already engaged with service users to plan focus groups and surveys on service user experience, and to develop the content of an on-line information resource.

Progress is due to be reported to the inter-agency Mental Health Partnership Board in October 2015.

## 2. FINANCE COMMENTS

**2.1.** Any costs associated with implementing the action plan will be met from within existing resources.

## 3. LEGAL COMMENTS

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

**3.2.** This duty is reflected in the Council's constitutional arrangements for the HWB which states one of the functions of the HWB as "To encourage integrated working between persons who arrange for the provision of any health or social services in Tower Hamlets for the advancement of the health and wellbeing of the people in Tower Hamlets."

**3.3.** Additionally, under the Care Act 2014 ("the 2014 Act") the Council has a general duty to promote the integration of care and support with health provision and health related provision.

**3.4.** The Council is committed to a number of ambitions as set out in its Community Plan strategy. Part of this strategy relates to the importance of promoting good mental health and wellbeing which is supported by the aims of the approach to integration.

**3.5.** In agreeing the local priorities, consideration should have been given to the public sector equalities duty to eliminate unlawful conduct set out at Section 149 of the Equality Act 2010. It requires the Council, when exercising its functions, to have 'due regard' to the need to eliminate discrimination (both direct and indirect discrimination), harassment and victimization and other conduct prohibited under the Act, and to advance equality of opportunity and foster good relations between those who share a 'protected characteristic' and those who do not share that protected characteristic.

## 4. IMPLICATIONS TO CONSIDER

**4.1** Improved joint working by partner organisations on mental health crisis has the potential to benefit the residents of Tower Hamlets, and to assist organisations to make best use of their resources.

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**Appendices**

- Appendix 1: Core principles and outcomes (extracted from the Mental Health Crisis Care Concordat, section 5)
- Appendix 2:Tower Hamlets Mental Health Crisis Care Concordat Action Plan

**Appendix 1**

**Extract from section 5 of Mental Health Crisis Care Concordat (HM Government, 2014)**

# Core principles and outcomes

## A. Access to support before crisis point

A1 Early intervention – protecting people whose circumstances make them vulnerable

## B. Urgent and emergency access to crisis care

B1 People in crisis are vulnerable and must be kept safe, have their needs met appropriately and be helped to achieve recovery

B2. Equal access

B3 Access and new models of working for children and young people

B4 All staff should have the right skills and training to respond to mental health crises appropriately

B5 People in crisis should expect an appropriate response and support when they need it

B6 People in crisis in the community where police officers are the first point of contact should expect them to provide appropriate help. But the police must be supported by health services, including mental health services, ambulance services, and Emergency Departments

B7 When people in crisis appear (to health or social care professionals or to the police) to need urgent assessment, the process should be prompt, efficiently organised, and carried out with respect

B8 People in crisis should expect that statutory services share essential 'need to know' information about their needs

B9 People in crisis who need to be supported in a health based place of safety will not be excluded

B10 People in crisis who present in Emergency Departments should expect a safe place for their immediate care and effective liaison with mental health services to ensure they get the right ongoing support

B11 People in crisis who access the NHS via the 999 system can expect their need to be met appropriately

B12 People in crisis who need routine transport between NHS facilities, or from the community to an NHS facility, will be conveyed in a safe, appropriate and timely way

B13 People in crisis who are detained under section 136 powers can expect that they will be conveyed by emergency transport from the community to a health based place of safety in a safe, timely and appropriate way

## C. Quality of treatment and care when in crisis

C1 People in crisis should expect local mental health services to meet their needs appropriately at all times

C2 People in crisis should expect that the services and quality of care they receive are subject to systematic review, regulation and reporting

C3. When restraint has to be used in health and care services it is appropriate.

C4. Quality and treatment and care for children and young people in crisis

## D. Recovery and staying well / preventing future crises

Following a crisis, NICE recommends that people using mental health services who may be at risk are offered a crisis plan.

**Appendix 2**

Tower Hamlets action plan: follows on next page

# LONDON BOROUGH OF TOWER HAMLETS

## 1 Introduction

The Mental Health Crisis Care Concordat was published by the government in February 2014. It is a commitment by 22 national bodies to work together to improve the system of care and support.

Every local area in England made a local declaration for the same purpose by the end of 2014. Tower Hamlets was covered by the London Declaration last October. Local action plans must be uploaded to the Crisis Care Concordat website by the end of March 2015. This is Tower Hamlets' action plan.

## 2 Local declaration

We, as partner organisations in Tower Hamlets, support the 2014 London Declaration on improving outcomes for people experiencing mental health crisis.

We will work together locally to put in place the principles of the national concordat and all the joint agreements in the London Declaration. We will work together within Tower Hamlets, across Waltham Forest, East London and the City (WELC) and across London to improve the system of care and support, so that people in crisis because of a mental health condition are kept safe. We will help them to find the help they need – whatever the circumstances – from whichever of our services they turn to first.

*sIGNATORIES*

Tower Hamlets CCG
London Borough of Tower Hamlets
East London NHS Foundation Trust
Barts Health NHS Trust
Metropolitan Police
London Ambulance Service

ALSO SUPPORTED BY

Bangladeshi Mental Health Forum
Beside
Bowhaven
Hestia
Mind in Tower Hamlets and Newham
Rethink Mental Illness
Vietnamese Mental Health Services
Working Well Trust

Contents


1. Introduction
2. Local declaration
3. The expectations of people in crisis, and the carers of people in crisis
4. Key principles for our Local Action Plan in Tower Hamlets
5. Current crisis services
6. Action plan for improvement
7. Planning the next cycle of improvement

METROPOLITAN POLICE TOTAL POLICING

Barts Health NHS NHS Trust

# 3 The expectations of people in crisis, and the carers of people in crisis

*(based on local focus groups, September 2014)*

### SERVICE USER EXPECTATIONS: GP AND COMMUNITY SERVICES

- Receptionists and GPs to have an understanding attitude towards individuals when they are talking about mental distress
- Space for a private explanation of the reason for GP visits
- GPs to have access to the crisis plan
- CMHT care coordinators to tell people their rights clearly
- CMHT users to have a crisis plan, updated to show use of crisis services

### SERVICE USER EXPECTATIONS: AT TIME OF CRISIS

- A reasonable physical environment
- Not to feel alone, but to have some contact with friendly staff whilst waiting at A&E, and some connection with the team at A&E providing patient care, giving information about what's going on, in order to help us reduce our anxiety
- Respectful relationships and language in the general milieu of the Emergency Department (A&E)
- Staff to remember that people are still listening and aware even when in crisis – their views are not to be dismissed

### SERVICE USER EXPECTATIONS: AFTER THE CRISIS

- Tapering down of intensive support in a planned way after a crisis
- Good information about ongoing sources of support in the community
- Active introduction and linking in with community services available, as well as information
- Staff to have a professional, reassuring manner and explain what is happening at each stage
- Reassuring first contact
- A named nurse who understands me and is available.

### CARERS' EXPECTATIONS

- GPs and their teams to have respect and understanding for carers
- GPs to give more priority to mental health
- Phones to be answered in a crisis, or at worst an answering machine with another contact number to ring where someone will answer
- The care coordinator will have a good relationship with them, even if the people that carers are caring for do not want contact
- To be told if the key worker of the person they care for will not be around for a period, such as leave, changed responsibilities, or an extended course.
- Help when their own situation gets serious, as well as help when the situation of the person they care for gets serious

These expectations will be used as the basis for monitoring of service user and carer experience.

# 4 Key principles for our local action plan in Tower Hamlets

- People in crisis, and the carers of people in crisis, should be treated with dignity and respect and their expertise listened to
- We will work together to:
    - Improve patient and care out of hours response
    - Put service users at the centre of their crisis care planning
    - Obtain feedback from carers
    - Meet service user and carer expectations in the Royal London Hospital Emergency Department
    - Support our partners in emergency response , the London Ambulance Service, the Metropolitan Police and the British Transport Police
- We will improve the monitoring and scrutiny of our performance, and work to engage service users and carers in those processes

# 5 Current crisis services

East London Foundation NHS Trust, the local NHS provider of secondary care mental health services, has self assessed its services against the requirements of the publication 'Mental Health Care Crisis Concordat' (February 2014), and reports the following positive achievements working with partners in crisis care:

- Our local crisis pathway offers an alternative to admission (the 'crisis house')
- Access standards in the Emergency Department (A&E) at the Royal London Hospital are a priority focus for all agencies. In December 2014, 96% of A&E patients referred to the RAID team were seen in under an hour by RAID, and the overall A&E four hours wait target was met for 91%.
- The local service system continues to offer good access to available mental health beds
- The local standard of Approved Mental Health Professionals (AMPH) attendance within an hour of call-out is met
- The designated place of safety for people detained under section 136 of the Mental health Act is a hospital not a police station (and has been for some years)
- Very few mental health assessments take place at police stations
- Local services include police station diversion and court diversion by mental health professionals
- Local police are actively involved in multi-agency forums and aftercare, where appropriate.

As partners, we are committed to maintaining these achievements.

# 6 Action plan for improvement

The following plan is proposed. Actions (in terms of the expectations above) focus initially on 'the time of crisis'.

| Principle | Action | Lead |
|---|---|---|
| **People in crisis and the carers of people in crisis, should be treated with dignity and respect and their expertise listened to** | Improve service user and carer experience of mental health crises at the Royal London Hospital Emergency Department | All signatories |
| | Obtain feedback from service users and carers with experience of local crisis services | Mental Health Partnership Group |
| **Improve patient and carer out of hours response** | Review options for improvement with partners | Tower Hamlets CCG |
| | Develop improved on-line access to information and services | Partner agencies via *In the Know* on-line information resource |
| **Put service users at the centre of their crisis care planning** | Audit crisis plans and CPA plans (including for older adults) and reduce variability in quality | ELFT |
| **Support our partners in emergency response , the London Ambulance Service and the Metropolitan Police and British Transport Police** | Reduce proportion of mental health crises where police are first to attend<br><br>Continue to ensure good response times and high quality services from LAS for Mental Health Act call-outs, and work to reduce inappropriate emergency ambulance crisis call-outs | All signatories |
| **Scrutiny of performance including service user and carers** | Improve reporting of crisis activity and develop a mental urgent care and crisis care dashboard, including monitoring ethnicity and age | CCG |
| | Engage service users and carers in monitoring the delivery of services according to expectations | Mental Health Partnership Group |

*Notes:*

*The Mental Health Partnership Group is an interagency forum convened by Tower Hamlets CCG.*
In the Know *is the on-line information resource developed with Tower Hamlets Idea Store*

It is envisaged that improvements in these areas can be made within available resources.

**Detailed implementation plans with milestones, leads and timelines** will be developed by task and finish groups convened through the Mental Health Partnership Group, or as part of existing contract management arrangements.

Consideration of the London Mental Health Crisis Commissioning Standards will be included in these task and finish groups.

# 7 Planning the next cycle of improvement

As part of our longer term planning, we will consider whether mental health services should move to hours of operation which match those envisaged for the future of primary care.

We will also work with other CCGs and the London Ambulance Service to consider ways of improving ambulance response times to mental health crises.

There are a number of specific pathways where more information and stakeholder consensus is required. Information about crisis pathways in Tower Hamlets for the following groups will be gathered by the CCG, in partnership with other agencies:

- Children and adolescents
- People who misuse drugs and alcohol
- Homeless people
- People with dementia
- Black African and Black Caribbean service users who are currently disproportionately represented amongst users of section 136 and those admitted into hospital under other sections of the Mental Health Act.
- Older adults

Information and proposals will be presented to the Mental Health Partnership Group meeting in May 2015.

# 8 Timeline

**How the Tower Hamlets response has been developed to date (March 2015)**

- Special session of the Mental Health Partnership Group (the local multiagency forum) -June 2014
- Focus groups of service users and carers (separately) -August and September 2014
- Meeting with Tower Hamlets Council and ELFT borough manager -November 2014
- The regular service user engagement event 'Your Say Your Day' - December 2014

- Mental health summit on joint strategy - December 2014
- Mental Health Partnership Group, February 2015
- Submission to NHS England, March 2015

**Proposed implementation milestones**

- Full list of local signatories – March 2015
- Task and finish groups identified – April 2015
- Report on areas where more information is required - May 2015
- Report on work of task and finish groups -October 2015
- Review of Crisis Concordat and Action Plan – December 2015

# 9 Signatories

Confirmed signatories for Tower Hamlets Mental Health Crisis Care Concordat action plan

| Organisation | Signatory |
|---|---|
| **Tower Hamlets CCG** | Jane Milligan, Chief Officer |
| **Tower Hamlets Council** | Robert McCulloch Graham, Corporate Director, Education Social Care and Wellbeing |
| **East London NHS Foundation Trust** | Dr Robert Dolan, Chief Executive; Paul James, Deputy Director of Operations and Borough Director for Tower Hamlets |
| **Barts Health NHS Trust** | Peter Morris, OBE, Chief Executive; Professor Alistair Chesser, Group Director (Emergency and Acute Medicine) |
| **London Ambulance Service NHS Trust** | Natasha Wills, T/Assistant Director Operations, East Central Sector |
| **Metropolitan Police** | Wendy Morgan, Det Superintendent, Tower Hamlets BOCU |

# 10 Supporters

**Other local organisations declaring their support by 30 March 2015**

| Organisation | Signatory | |
|---|---|---|
| **Bangladeshi Mental Health Forum** | Shamsur Rahman Choudhury Secretary | bmhf Bangladeshi Mental Health Forum |
| **Beside** | Richard O'Brien Director | beside |
| **Bowhaven** | Rita Dove Chair of Trustees | BowHaven User Run Mental Health Centre |
| **Hestia** | Thomas Neumark Director of Performance & Development | Hestia |
| **Mind in Tower Hamlets and Newham** | Michelle Kabia Chief Executive Officer | Mind in Tower Hamlets and Newham mind For better mental health |
| **Rethink Mental Illness** | Mark Winstanley Chief Executive | Rethink Mental Illness. |
| **Vietnamese Mental Health Service** | Jack Shieh, OBE | Vietnamese Mental Health Services Serving the mental health needs & promoting wellbeing of people from Vietnam Hội Tâm Thần Việt Nam 越南心理保健服務 |
| **Working Well Trust** | Helen Forster Trust Director | workingwell trust |

| Health and Wellbeing Board – (7th July 2015) | |
|---|---|
| **Report of the London Borough of Tower Hamlets** | **Classification:** [Unrestricted] |
| **Health and Wellbeing Strategy Final Monitoring Report of 2013/14 Delivery Plans** | |

| | |
|---|---|
| **Lead Officer** | Louise Russell, Service Head Corporate Strategy and Equality |
| **Contact Officers** | Vicky Allen, 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 a final update of the 2013/14 delivery plans which were rolled forward to 2014/15. 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, which we can revise for future reports;

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

4. Consider the merit of adopting a standardised approach to performance monitoring set out below; and

5. Note that six monthly monitoring of the new Delivery Plans 2015/16 will be provided to the Health and Wellbeing Board in the Autumn.

## 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 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 The Health and Wellbeing Strategy is split into four Delivery Plans areas:

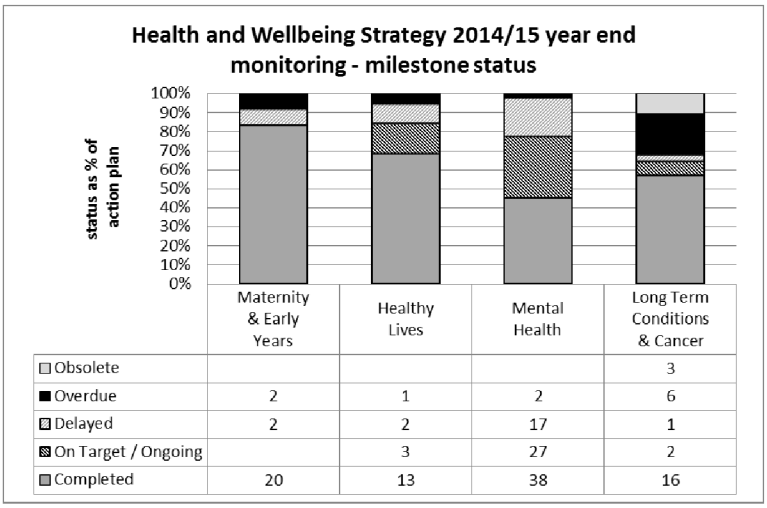
- Maternity and Early Years
- Healthy lives
- Mental Health
- Long term conditions and cancer

*Delivery Plan monitoring*

3.3 During the course of 2014/15, the Delivery Plans were refreshed to be operational in the 2015/16 financial year and beyond. The refreshed Delivery Plans will be monitored for the first time at the six monthly stage (September). The monitoring provided below is an update on progress made against the 2013/14 Delivery Plans, rolled forward to 2014/15, to date.

3.4 The majority of actions/milestones across the four Health and Wellbeing Action Plans have either been completed or are ongoing/on target. Whilst the Mental Health action plan has less than half of its actions/milestones complete, the plan also includes actions relating to the current financial year.

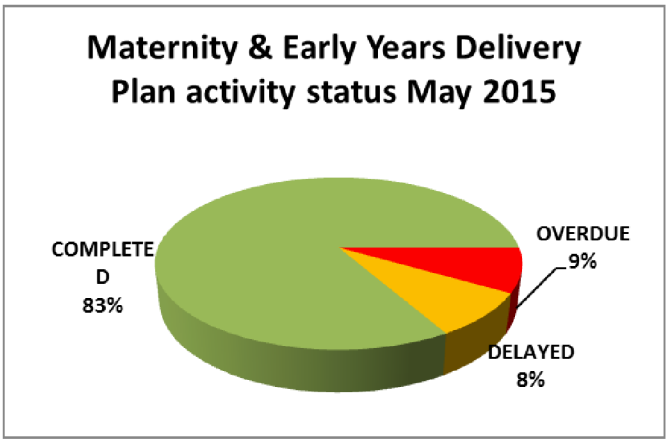
Delayed, ongoing and overdue actions from the four 2013/14 Delivery Plans have been incorporated in to the 15/16 Delivery Plan refresh where they are still deemed to be a priority. An overview of action/milestone status over the four Delivery Plans is provided below:




3.5 Where possible, managers have provided comments for all delayed and overdue activities to explain why the deadline was missed; what is being done to rectify the situation; and when the activity will be completed.

*Maternity and Early Years*

3.6 The 2013/14 Delivery Plan is attached at Appendix 1 and the key points are summarised below. There are 24 milestones in the 2013/14 delivery plan. Of those, 20 milestones are completed, 2 milestones delayed, and 2 milestones are described as overdue. The delayed and overdue milestones have been included in this year's action plan and will also be incorporated into the refreshed HWB Strategy.




3.7 Two milestones are marked as **Delayed:**

Health priority two: Two year development review

- **Secure access to key health outcome data from 2/2.5 year healthy child development review –** A memorandum of understanding has been signed off between NHSE and THCCG that will give access to health visiting performance data. A request for new EMIS templates (for child growth) has gone to Barts Health.

  We are now receiving health visiting performance data. First report received October 2014, following some delays we have recently received the first of what will be monthly reports. This will be picked up under the new service specification for health visiting (in the H&WB strategy 2015/16 delivery plan – MEY section) and subsequent performance management. Child growth data still not available, but will be incorporated into performance management of health visiting service in 2016 (It's unlikely to be available prior to this date).

Health priority three: Child obesity

- Strengthen the parent and community involvement and increase opportunities for children: **Improve the food offer in leisure centres and other food outlets used by children and their families –** Proposals for a pilot 'healthy vending machines' in the new Poplar Baths has been discussed but has not yet been implemented.

  This specific milestone is obsolete – contractual arrangements make this site not suitable for an early pilot. However, work is underway to progress the (delayed) healthy food standards that will provide a framework for taking forward this type of work in the future. This has been included in the Community Plan action plan and could be added to the H&WBS delivery plan – under H&WB strategy 2015/16 delivery plan (Healthy Lives Delivery Plan – under Healthy Place (To enhance partnership work on the food environment in the borough - increasing access to affordable and healthy food)).

3.8 Two milestones are **Overdue** relating to the child obesity health priority:

- Improve the effectiveness of targeted programmes to promote healthy weight in primary school aged children: **Review and update child obesity care pathways –** This work has been delayed due to a five month delay in the award for the Child and Family Weight Management and School Health Services contract. An initial planning meeting was held in April 2015 and the roll out of new training programme will commence from October 2015.

  This milestone is now subsumed under 'Mobilisation of new child and family weight management programme' in the H&WB strategy 2015/16 delivery plan (Healthy Lives Delivery Plan – under 'More children who are healthy and have the foundations for lifelong health').

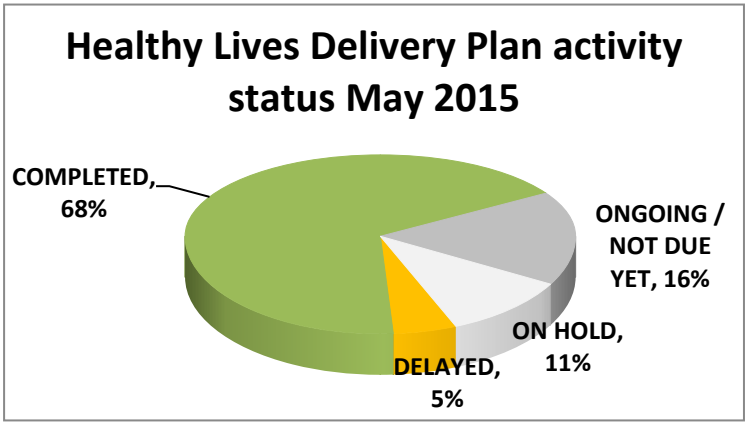
- Strengthen parent and community involvement and increase opportunities for children: **Pilot new approaches to improving nutritional quality of 'fast food' available to school children –** The specification for a 12 month pilot for Healthy Fast Food has been agreed and is about to be advertised. The element of this milestone which is overdue relates to the piloting of mobile healthy street food schemes; Stepney Ward Forum and St Paul's School did propose funding for the pilot but in the end this was not taken forward.

  This milestone is included the H&WB strategy 2015/16 delivery plan (Healthy Lives Delivery Plan – under Healthy Place (To enhance partnership work on the food environment in the borough - increasing access to affordable and healthy food)) and it is also in the Community Plan Action Plan.

Healthy lives

3.9 All activities within the Healthy Lives delivery plan have been monitored and are included in Appendix 2 with the exception of one milestone relating to the Local Development Framework.

3.10 There are 18 activities in the Healthy Lives delivery plan. 3 activities are in progress/ongoing; 1 activity is 'delayed' and one is 'on hold'. Thirteen activities have been fully completed; one activity is complete bar one milestone which is 'ongoing'. All delayed, on hold and in progress/ongoing activities will be included in the refreshed Health and Wellbeing Strategy.




3.11 Three whole activities and one milestone are marked as '**in progress / ongoing'**:

- **Build on and extend community engagement in the development and implementation of the new (Healthy Lives) strategy** – work undertaken to date have informed actions for the 2015/16 Health and Wellbeing Plan.

- **The monitoring of the Local Development Framework and impact –** Milestones relating to local food growing, urban agriculture, and restrictions on new hot food takeaways near schools and leisure centre have been completed. 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.

- **Embed screening and brief intervention around drugs and alcohol into front-line services (beyond A&E)** – Already embedded for GPs, NIS, A&E and Barts, going forward there are plans to embed sign up to screening more widely (eg. inpatient services, CHS, and the voluntary sector).

- **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 staff** – Whilst the Lifecourse promotion and access plan has been developed and adopted, the monitoring of the uptake of the plan is an ongoing process.

3.12 One activity is marked as '**delayed'**:

- **Agree and implement evidence based health food standards across partner agencies as exemplars of good practice** – standards have been drafted and discussions with GLL and CLC regarding the Poplar Baths programme and implementation of health vending machines and healthy options for the Community Café. The Poplar Baths leisure facilities are not due to be completed until June 2016.

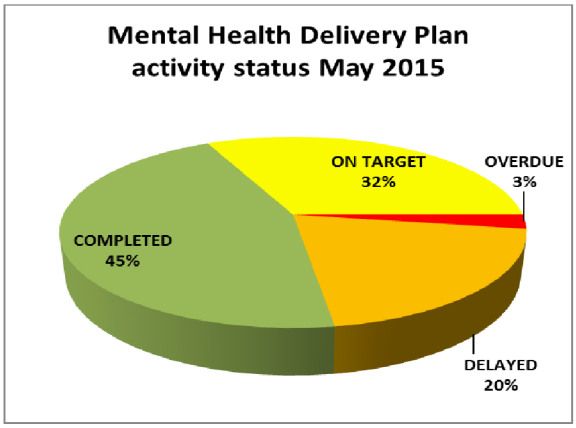
3.13 One milestone has been placed **'on hold'**, (shaded grey in the appendix).

- Relating to stakeholder engagement and reporting within the '**Refresh of the Healthy Weight, Healthy Lives strategy to becoming the Healthy Food, Active Lives Strategy activity'**. The workstream will now be incorporated into the 2015/16 Health and Wellbeing Strategy Action Plan and future actions will be integrated into the new Health and Wellbeing Strategy from 2016/17.

*Mental Health*

3.14 There are 84 'commitments' in the delivery plan. 38 are **'Completed'**, 28 are **'On Target'**, 2 are **'Overdue'**, and 16 are **'Delayed'**. Year-end monitoring for

this action plan is included as Appendix 3. The On target, overdue and delayed commitments are being carried forward into the refreshed Health and Wellbeing Strategy.




3.15 The mental health delivery plan runs until March 2016. The activities within are also incorporated into the Tower Hamlets joint Mental Health Strategy (Council and CCG) which runs until 2019. A number of commitments are not yet due for completion and they include the following:

- Working with the reducing re-offending workstream of the Community Safety Partnership to ensure that mental health support is included within plans for Integrated Offender Management;
- Implementing the Hostels Strategy;
- Configuration of adult community mental health services in light of work to develop CAMHS services and review of older adult's mental health services;
- Preparatory work for payment by results and monitoring them by protected characteristics to inform future commissioning;
- Reviewing perinatal service and dual diagnosis service model;
- Reviewing extent to which recovery service users feel they have control over care planning processes;
- Personal health budgets in mental health pilots;
- Reviewing the older adults CMHT;
- Developing refreshed commissioning plan for people with a learning disability and mental health problem.

3.16 The high number of delayed and overdue actions in the Mental Health Delivery Plan can be explained by two factors. There has been a recent lack of capacity in the service; however this has now been resolved. In addition, in some instances there has been a miss-alignment of activity deadlines between the Mental Health Delivery Plan and the Mental Health Strategy (all actions in the Mental Health Delivery Plan are also incorporated into the Mental Health Strategy).

3.17 11 objectives under the leadership of the Mental Health and Joint Commissioning Team and other parts of LBTH Commissioning and Health have slipped and are either overdue or delayed. With regard to the major strategic priority; 'the re-commissioning of recovery and wellbeing services', it is now anticipated that this will go to the July Cabinet for decision. The remaining slippages have occurred as a result of commissioners responding to new developments since the publication of the strategy, leading to changed priorities and/or timescales, or a lower priority has been allocated than was envisaged at the time of the strategy's original development.

3.18 There are seventeen commitments which have been flagged as delayed, and the HWB are asked to approve deadline extensions to them. All the overdue and delayed activities are being carried forward into the final year of the Mental Health Delivery Plan:

- Building resilience: mental health and wellbeing for all:
    - **Develop an anti-stigma campaign specific to children and young people** – work will be commissioned by July 2015 and run as a pilot over 3-4 months. Request for deadline date to be extended to July 2016. Going forward, the service are procuring a mental health wellbeing intervention, tackling mental ill-health stigma in four disproportionately affected populations: young people, BME, LGBT, men. These will be delivered by March 2016, with an evaluation to inform longer term commissioning programmes.
    - **Work with Ideas Stores to capitalise on opportunities for improving access to self-help support and bibliotherapy –** this will be addressed through the mental health and wellbeing project being commissioned through Public Health, additionally the set of Health and Wellbeing Outreach workers are in the process of being recruited, a request is made to amend the deadline to March 2016.
    - **Review the Forensic Mental Health Practitioner and Link Worker scheme** – Public Health currently working on needs assessment to scope service needs and gaps, following changes to probation services from April 2015. This will determine whether an FMHP or other service is needed in the borough on an ongoing basis. Request for deadline change to March 2016. The JSNA has now been completed and is due to be considered by the Mental Health Programme Board on Tuesday 16th June.
    - **Prospective audit of people who are admitted to hospital who were recorded as not previously known to mental health services in the borough** – This will be undertaken by the end of March 2016.

- High quality treatment and support

- **Consider the case for developing a primary care depression service, including support for employment** - Initial report showed Tower Hamlets rate is high compared to London but low compared to national; further work to be decided.

- Living well with a mental health problem:
  - **Purchase the ImROC support pack to self-assess our recovery orientation across the partnership** – Initial discussions took place to ascertain the suitability of using the IMROC support pack and consultancy. It was determined that alternative approaches would be better suited to recovery orientation across the partnership. This has not delayed progress in areas of transformation relating to recovery orientation, i.e. Primary Mental Health Service
  - **Improving mental health and dementia awareness in home care and day care** – procurement of domiciliary care delayed. Request for deadline to be moved to March 2016.
  - **Develop a range of respite options appropriate for people with dementia, for carers to choose from** – The Tower Hamlets Plan for Carers 2015/16 includes a commitment to review access to residential respite by June 2015, with the aim of improving the availability of residential respite places in Tower Hamlets and the surrounding area, including to people with dementia.
  - **Develop a refreshed commissioning plan for people with a learning disability and mental health problem** – MH and LD is within the scope of the redesign/tender of Community Learning Disability Services. Revised deadline for this is now April 2016.
  - **Develop an outcomes dashboard to track the delivery of the Strategy which will be published on the CCG website** – This will be delivered by December 2015, as part of the Mental Health Strategy Summit
  - **Develop a public mental health and well-being programme to tackle stigma and discrimination in mental health** – local statutory organisations have signed Time to Change Pledge and developed action plans, and will consider steps to become mindful employers. Going forward, the service is procuring a mental wellbeing intervention, as highlighted in the anti-stigma campaign activity above. In addition a second stage Time to Change pledge programme is being developed within ESCW. There will be a request for the Time to Change Pledge to be adopted by other employers in the borough to be taken forward by the relevant Partnership Board.
  - **Work with housing providers to improve mental health awareness with staff who work in and around housing** – A bid has been submitted to Health Education North Central and East London Locality-Based Workforce Development funding scheme 2015/16 for

mental health first aid training. This includes a bid for funding of a 3 hour training course for 100 people. This bid has been coordinated by Tower Hamlets Community Education Provider Networks (CEPN). If successful, we will offer places on the programme to housing providers and, following the evaluation and learning from this, will look to role this programme out to more housing providers in 2016/17 via further partnership arrangements and capitalising on other funding opportunities.

- **Target health promotion interventions at all ages in the public mental health programme –** A stocktake of services to improve physical health for people with SMI due for consideration by Mental Health Programme Board in May 2015. The service provided the following update: the Public Health component of this was discussed at the May Board, a working group is being convened to take forward actions. Health Care component will be discussed at the July Board.
- **Use the Time to change pledge to encourage our suppliers to adopt an Emotional First Aid programme for their employees –** implementation currently being discussed between Public Health and ESCW. Service update as above.
- **Develop a specific plan for young carers of parents with a mental health problem** – We have an existing work programme for young carers which are delivered through the Young Carers Strategy Group. The Council and CCG also commission services to support young carers including services that work specifically with children and young people affected by parental mental illness.
- We will be developing our plan for young carers over the coming year to ensure that we continue to meet the needs of this group of children and young people..
- **Develop a methodology to understand prescribing activity and undertake a review** – New national documents have provided increased understanding in this area, including the NICE Guideline on Schizophrenia and Nuffield Trust, which will be incorporated into our work on this in 2015/16.

3.18 Two commitments are ragged as **Red/Overdue**:

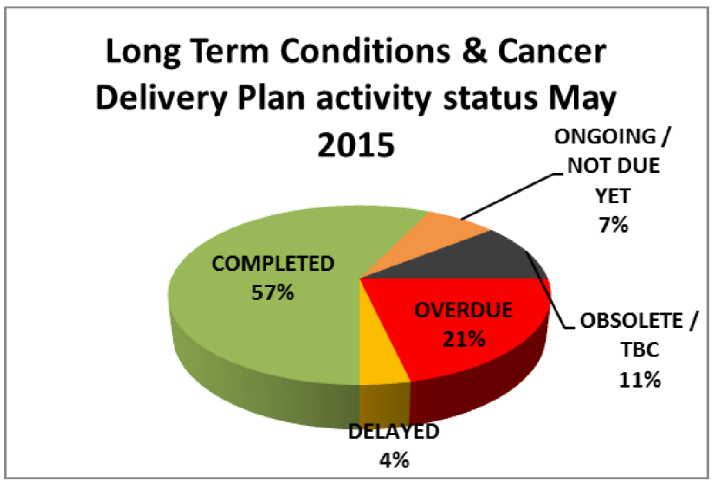
- Building resilience: mental health and wellbeing for all:
  - **Develop a refreshed model for the delivery of day opportunity and support services, with an accompanying procurement plan** – Pending Cabinet decision, strategy remains to procure the new service delivery model pooling LBTH and CCG voluntary sector funding. If a decision is not forthcoming an alternative strategy may be implemented.
  - **Develop a referral and diagnostic pathway for people with ASD who are not eligible for mental health services, with clear**

**thresholds for where people may require mental health services** – This is currently being addressed by the CCG and the Council.

Long Term Conditions and Cancer

3.19 All activities within the Long Term Conditions and Cancer delivery plan have been monitored and are included in Appendix 4 with the exception of two activities: '**Improve availability and access to information on healthy dying by embedding in single health and social care information resource system for professionals and residents'** and **'Lead a cultural change programme for professionals and staff about self-care'**.

3.20 There are 29 activities in the delivery plan. 16 activities have been marked as 'completed'; 1 activity is 'ongoing'; 6 activities are overdue; 1 activity is 'delayed'; 1 is 'obsolete'; 1 is not due yet. One activity which is marked as complete has one milestone marked as overdue. 2 activities are 'TBC' as they are still to be set by the Health and Wellbeing Strategy Sub-Group and therefore no information is available.




3.21 There are six activities which have been assessed as being **Overdue**:

- 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)** – Concept built into CHS specification currently in live procurement process. NHS 111 re-procurement decision across WELC will also need to be taken into account
    - **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.

- **Develop and provide continence service in care homes (0% complete)** - no proposals have been put 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.
- **Engender a cultural shift that "normalises" death in the community and supports advanced care planning (20% complete)** – To be reviewed by the CCG.
- **Improve support given to those dying and their carers** – a checklist which is triggered when a GP issues DS1500 to patients has not been implemented.
- **Review current programmes that support preferred place of death and produce analysis of what works and what doesn't work (75% 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.

3.22 One activity is marked as '**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 next year.

3.23 One activity is marked as '**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.

3.24 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*

3.25 The outcome measures for the 2013/14 Health and Wellbeing Strategy Action Plans were drawn from national outcome frameworks and have been used to monitor progress and report on an annual basis. The current position is

attached at Appendix 5. A refreshed set of performance measures have been chosen for the 2015/16 Action Plans going forward.

3.26 Performance against target is measured as either 'Red', Amber, or 'Green' (RAG). Performance which has fallen more than 10% below the 2013/14 target is marked as Red. Performance which is less than 10% of the 2013/14 target is marked as Amber. Performance which has exceeded the 2013/14 target is marked as Green. Direction of travel has been provided where possible. London comparisons are also provided where available.

*Next Steps*

3.27 Each of the four Delivery Plans have been monitored in a slightly different way. Not all of the Delivery Plans have a percentage complete column. The status of activities, actions, commitments and milestones (RAG) do not appear to use standardised terminology, nor is the definition for the status standardised.

3.28 The Health and Wellbeing Board should consider the merit of adopting a more standardised approach to monitoring the refreshed Delivery Plans. This might include a percentage completed column and an agreed approach to RAG status e.g.

- **Completed** – the activity and all related milestones are completed
- **Delayed** – the activity is completed with the exception of one milestone which does not contribute significantly to the success of the overall activity, and/or all but one milestone is overdue but almost completed (90% or more), and/or the overdue milestone is due to be completed by the end of the following quarter.
- **Overdue** – one or more milestones contributing to the activity is has not been completed by 90% or more, and/or is not due to be completed by the end of the following quarter.
- **On Target** – where activities and milestones are due to complete by the deadline provided.

In addition, where an activity is off target, delayed or overdue; comments should be provided on progress, which include the following:

- why the target was missed;
- what action is being taken to address this; and
- when the action will be completed.

## 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 2015, there are no direct financial implications as a result of this report.

## 5. LEGAL COMMENTS

5.1. It is a function of the HWB to have oversight of the quality, safety, and performance mechanisms operated by its member organisations, and the use of relevant public sector resources across a wide spectrum of services and interventions, with greater focus on integration across outcomes spanning health care, social care and public health.

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

## 6. ONE TOWER HAMLETS CONSIDERATIONS

6.1. The 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

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
Appendix 6 – Refresh of the Joint Health and Wellbeing Strategy

## Background Documents

- NONE

APPENDIX 1

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

**Key Health Outcomes in the Children and Families Plan for Maternity and Early Years:**
1. Good and improving maternal health (including mental and physical health)
2. Reduction in under 18 conceptions and support teenage parents
3. Early detection and treatment of disability and illness, and ensure that children achieve positive physical, emotional and cognitive developmental outcomes
4. Maintain low infant mortality rates and promote good health in infancy and early years

| Priority Area for the Health Theme | Lead Officer | Deadline | Status | % Comp | Comments |
|---|---|---|---|---|---|
| **Health Priority 1: Maternal and infant mental health: develop partnerships across health, children's centres and community organisations to support maternal mental health and wellbeing and secure attachment with the baby during the first year of life** | **Esther Trenchard-Mabere** | | | | |
| **Milestone** | **Lead Officer** | **Deadline** | **Status** | **%** | **Comments** |
| Map the ante and post natal depression pathway and identify gaps and opportunities by January 2014 | | 31/01/2014 | Completed | 100% | Multi-agency steering group convened and met in October 2013, January and March 2014 and then monthly up to July 2014<br>Mapping complete, using framework from 1001 Critical Days (Cross Party Manifesto, Wave Trust and NSPCC) |
| Convene wider multi-agency meeting/workshop to scope work across children's centres, voluntary sector and health by March 2014. | | 31/03/2014 | Completed | 100% | Multi-agency workshop held on 15th January 2014 to review and comment on mapping of services and options for strengthening support across the system |
| 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 as 'at risk' by May 2014. | | 31/05/2014 | Completed | 100% | Outline proposal agreed (training for commnuity organisations/volunteers and health profesionals plus supervision and support networks with locality coordinators) |
| Secure funding / commission pilot intervention by June 2014 | | 30/06/2014 | Completed | 100% | Funding for 2015 - 2017 agreed from the Public Health grant. |
| Agree and implement action plan for strengthening 'Universal' elements of support for maternal and infant emotional health and wellbeing by June 2014. | | 30/06/2014 | Completed | 100% | Action Plan agreed at steering group meeting on 3rd June. |
| Hold second multi agency workshop to consult on commissioning proposals by July 2014 | | 31/07/2014 | Completed | 100% | 2nd multi-agency workshop held on 22nd July 2014 to consult on commissionong proposals / model for pilot project |
| Commission training and parent volunteer support network by September 2014. | | 30/09/2014 | Completed | 100% | Specification for Parent and Infant Wellbeing programme (volunteer support network and training programme) advertised on 25th November 2014 and contracts awarded to three voluntary sector organisations on 9th February 2015 |

| **Key Health Outcomes in the Children and Families Plan for Maternity and Early Years:**<br>**3. Early detection and treatment of disability and illness, and ensure that children achieve positive physical, emotional and cognitive developmental outcomes**<br>**4. Maintain low infant mortality rates and promote good health in infancy and early years**<br>**5. Decrease levels of overweight and obesity in 4-5 year olds and provide more opportunities for active play and healthy eating** | | | | | |
|---|---|---|---|---|---|
| **Priority Area for the Health Theme** | **Lead Officer** | **Deadline** | **Status** | **% Comp** | **Comments** |
| **Health Priority 2:**<br>**Two year development review: building on the 2/2.5 year child development review (health visiting) develop and strengthen partnerships across health, children centres, nurseries and community organisations to promote children's physical, social, emotional and cognitive development.** | **Monica Forty** | | | | |
| **Milestone** | **Lead Officer** | **Deadline** | **Status** | **%** | **Comments** |
| Workshop reviewing current referral pathways and partnerships supporting the 2/2.5 year healthy child development review in December 2014. | | 31/12/2014 | **Completed** | | Workshop held December 2013 |
| Identify opportunities for wider join up to ensure that children at risk of impaired physical, social, emotional and cognitive development are identified and supported. | | | **Completed** | | Public Health strategist now attending integrated 2 year review steering group (includes representatives from health, learning and achievement and children's centres. Next meeting 3rd June 2014. |
| Secure access to key health outcome data from 2/2.5 year healthy child development review. | | | Delayed | | MOU has been signed off between NHSE and THCCG that will give access to Health Visiting performance data. Request for new EMIS templates (child growth) has gone to Barts Health. |

**Key Health Outcomes in the Children and Families Plan for Childhood (5-11 years):**
**1. Decreasing levels of obesity and overweight**
**2. Looked After Children receive their annual health assessment, are fully immunised and have had their appropriate screening checks e.g. vision and dentist within the previous 12 months**
**3. Looked After Children have good emotional wellbeing**
**4. Children with disabilities and their families are supported following diagnosis**
**5. Reduction in emergency admissions for children with asthma**

| Priority Area for the Health Theme | Lead Officer | Deadline | Status | % Comp | Comments |
|---|---|---|---|---|---|
| **Health Priority 3: Child obesity: create wider opportunities for children to engage in physical activity and healthy eating in community, leisure, school, faith and home settings in order to reduce the prevalence of overweight and obesity in 10-11 year olds** | **Esther Trenchard-Mabere** | | | | |
| **Activity 1: Review and strengthen support for schools to create environments that support healthy eating and physical activity** | | | | | |
| **Milestone** | **Lead Officer** | **Deadline** | **Status** | **%** | **Comments** |
| Increase the number of schools achieving the Enhanced Healthy Schools Award and GLA 'Bronze' and 'Silver' awards<br>September 2014, 3 new schools signed up for 'Enhanced' and 4 for 'GLA Silver' | | | Completed | 100% | 20 schools have already achieved Enhanced Healthy Schools status (which includes targeted work on child obesity)<br><br>74 schools (92%) chieved GLA 'Bronze' Award, 21 schools achieved GLA Silver Award and 4 schools achieved GLA Gold Award (highest in London at all three levels) |
| Introduction of school based family cookery clubs:<br>- Training for new schools to run September / October 2014<br>- 5 new schools to have signed up to run family cookery clubs by December 2014 | | 31/10/2014<br>31/12/2014 | Completed | 100% | Pilot family cookery clubs (involving parents, carers and children and focus improving cooking skills and awareness of healthy eating and portion size) have run in 5 schools with very positive feedback from schools and parents |
| Additional training and support from School Sports Foundation for schools meeting Enhanced Healthy School Status, September 2014 | | 30/09/2014 | Completed | | School Sports Foundation runs after school sports and physical activity sesions in majority of primary schools |

| Activity 2: Improve the uptake and quality of school meals in primary schools | | | | | |
|---|---|---|---|---|---|
| **Milestone** | **Lead Officer** | **Deadline** | **Status** | **%** | **Comments** |
| Implement free school meals commitments<br>- Review of update of first year of scheme August 2014<br>- Roll out of national scheme (reception, years 1 and 2) September 2014<br>- Roll out of free school meals for all primary school pupils September 2015 | | 31/08/2014<br>30/09/2014<br><br>30/09/2015 | Completed | | Free school meals have been made available for all reception year 1 pupils from September 2014<br><br>Commitment to make free school available to all primary school pupils from September 2015<br><br>School meals meet the School Food Trust standards |
| Identify and share examples of good practice in improving the dining environment<br>- 5 case studies of best practice identified - August 2014<br>- Dissemination (e.g. school visits, healthy schools newsletter) Sept - Dec 2014 | | 31/08/2014<br><br>31/12/2014 | Completed | | Local research shows that an important factor in low update of school meals is a poor quality dining experience is likely to lead to better update of school meals.<br><br>3 case studies of best practice have already been identified. |
| Submit application to be a London Flagship Food Borough | | 02/05/2014 | Completed | | Application submitted but not successful. Consultation with Head Teachers produced useful ideas for improving quality / attractiveness of school meals through training Dinner Ladies and will be exploring how this could be funded. |

| Activity 3: Improve the effectiveness of targeted programmes to promote healthy weight in primary school aged children | | | | | |
|---|---|---|---|---|---|
| **Milestone** | **Lead Officer** | **Deadline** | **Status** | **%** | **Comments** |
| Commission evaluation of Healthy Lives Champions (to identify the impact of the Healthy Lives Champions on levels of obesity in year 6 and any learning on what increases their effectiveness)<br>- Specification agreed April 2014<br>- Advertise contract May 2014<br>- Contract starts June 2014 | | 30/04/2014<br>31/05/2015<br>30/06/2014 | **Completed** | | Healthy Lives Champions are active in 13 primary schools. In 2013, 350 children (mainly year 5) participated with a reported average 37% reduction of BMI.<br><br>Contract for evaluation agreed and will be completed in November 2014, interim report in July 2014.<br>Final evaluation report submitted October 2014 and showed that the project was valued by schools and parents anbd made recommendations on how to improve monitoring and consisteny of messages |
| Re-commission Child and Family Weight Management and School Health Services<br>- New specifications agreed February 2014<br>- Advert March 2014<br>- New contracts 1st October 2014 | | 28/02/2014<br>31/03/2014<br>31/10/2014 | Completed | | Procurement process completed to schedule but contract award delayed due to delay in sign off of procurement recommendations.<br>Contract with new provider started from 1st March 2015<br>New specification strengthens the coordination of linkages across these services with respect to:<br>- identification of overweight and obese children (new funding for NCMP coordinator based in School Health)<br>- parental and family engagement |
| Review and update child obesity care pathways (to improve identification and referral of children who would benefit from support in weight management, involving wider range of frontline services in identification of overweight and obese children, brief advice and referral)<br>- Initial planning meetings May/June 2014<br>- Roll out of new training programme from October 2014 | | 30/06/2014<br>31/10/2014 | Overdue | | This work was delayed due to 5 month delay in the award of the above contract. Initial planning meeting has now been held (April 2015) and roll out of new training programme will commence from October 2015 |

| Activity 4: Strengthen parent and community involvement and increase opportunities for children | | | | | |
|---|---|---|---|---|---|
| **Milestone** | **Lead Officer** | **Deadline** | **Status** | **%** | **Comments** |
| Consult with community, parent and faith groups regarding issue of high obesity in Bangladeshi and Somali boys and agree community based interventions to address the issue<br>Initial consultation - October 2014<br>Agree action plan - November 2014 | | 31/10/2014<br>30/11/2014 | Completed | 100% | 8 focus groups have been held involving 76 parents and grandparents and eight Year 6 pupils plus one focus group with parental school engagement officers. One to one interviews were also held with an assistant head teacher, a local GP, a nursery nurse, a school nurse and 2 imams. Based on the findings a proposal for 2 or 3 locality pilots has been agreed to strengthen coordination of services at a very local level based around a primary school with links to the local GP practice and led by parental engagement officers and Healthy Family Parent Ambassadors |
| Strengthen role of the 'Healthy Family Parent Ambassadors' in prevention of child obesity | | | Completed | | More fathers now involved in programme and linkages to child and family weight management service are being strengthened. Healthy Family Parent Ambassadors will play a key role in the above locality pilots |
| Improve the food offer in leisure centres and other food outlets used by children and their families | | | Delayed | | Proposal for pilot 'healthy vending machines' in the new Poplar Baths has been discussed but has not yet been implemented |
| Pilot new approaches to improving nutritional quality of 'fast food' available to school children<br>- Pilot mobile healthy street food schemes to commence from September 2014 | | 30/09/2014 | Overdue | | Stepney Ward forum and St Pauls School did propose funding for a pilot mobile healthy street food project, but in the end this was not taken forward |
| - Fast food outlet to trial range of modifications to improve food offer (start date tbc) | | tbc | Completed | | Specification for 12 month pilot Healthy Fast Food pilot has been agreed and is about to be advertised |
| Increase availability of and access to open spaces<br>- Exploring feasibility of use of section 106 funding to create new open spaces | | | Completed | | Evidence Review completed and was submitted but still awaiting planning approval. Alternative sources of funding have been used to develop 'pocket parks' |
| - Project to improve accessibility for disabled children | | | Completed | | Steering Group established and funding secured |

# 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 | Completed | 100% | The plan for this activity has changed - the element of this strategy are incorporated into the 15/16 Health and Wellbeing Strategy Action Plan and future actions will be integrated into the new Health and Wellbeing Strategy from 16/17 |
| **Milestone** | **Lead Officer** | **Deadline** | **Status** | **%** | **Comments** |
| Finalise plan | Public Health (Esther Trenchard-Mabere) | 30/06/2013 | Completed | | As above |
| Present to H&WB board for agreement | Public Health (Esther Trenchard-Mabere) | TBC | Completed | | As above (HWBS action plan agreed at HWBB) |
| Identify Board level champion and leads across partner agencies and local authority directorates | Public Health (Esther Trenchard-Mabere) | TBC | Completed | | As above |
| Involve Healthwatch/Vol Sector in planning Stakeholder Conference | Public Health (Esther Trenchard-Mabere) | 30/09/2013 | On Hold | | This is in the 15/16 action plan |
| Report to H&WB Board on implementation | Public Health (Esther Trenchard-Mabere) | 31/03/2014 | On Hold | | This will be incorporated into feedback on the HWBS coming to the board |
| 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% | This has been recommissoned |
| **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)<br>Healthwatch (Diane Barham)<br>VCS H&WB forum (TBC) | 30/04/2013 | In process | | The actions set out in the HWBS action for 15/16 have been informed by community engagement and extending it - it is planned to extend further in 15/16 to inform the new Health and Wellbeing Strategy |
| **Milestone** | **Lead Officer** | **Deadline** | **Status** | **%** | **Comments** |
| Make links between strategy objectives and wider community development work | Public Health (Esther Trenchard-Mabere)<br>Healthwatch (Diane Barham)<br>VCS H&WB forum (TBC) | 30/04/2013 | In process | | As above |
| Present to H&WB Board | Public Health (Esther Trenchard-Mabere)<br>Healthwatch (Diane Barham)<br>VCS H&WB forum (TBC) | 30/04/2013 | Ongoing | | As above |

APPENDIX 2

| 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)<br>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)<br>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)<br>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)<br>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)<br>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)<br>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)<br>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)<br>LBTH, D&R (Michael Bell) | On-going | Completed | | Community gardeners programme commissioned |
| Restrictions on new hot food takeaways near schools and leisure centres | Public Health (Tim Madelin)<br>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)<br>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 | Completed | 100% | The plan for this activity has changed - the element of this strategy are incorporated into the 15/16 Health and Wellbeing Strategy Action Plan and future actions will be integrated into the new Health and Wellbeing Strategy from 16/17 |
| **Milestone** | **Lead Officer** | **Deadline** | **Status** | **%** | **Comments** |
| Finalise plan | Public Health (Chris Lovitt) | 03/02/2014 | Completed | 100% | As above |

| | | | | | |
|---|---|---|---|---|---|
| Present to H&WB board for agreement | Public Health (Chris Lovitt) | 01/03/2014 | Completed | 100% | As above (HWBS action plan agreed at HWBB) |
| **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 | Completed | 100% | Services recommissioned |
| **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 | Completed | 100% | |
| Review commissioning process and re-commission ASSIST if effective | Public Health (Chris Lovitt) | 31/03/2014 | Completed | 100% | Service continued |
| **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)<br>LBTH, CLC (Dave Tolley) | 30/10/2013 | Completed | 100% | Completed |
| **Milestone** | **Lead Officer** | **Deadline** | **Status** | **%** | **Comments** |
| Incorporate into refreshed plan | Public Health (Chris Lovitt)<br>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)<br>LBTH, CLC (Dave Tolley) | Quarterly | Completed | 100% | Completed |
| Support and pan London /national campaigns and initiatives | Public Health (Chris Lovitt)<br>LBTH, CLC (Dave Tolley) | 30/10/2013 | Completed | 100% | Tower Hamlets DPH is confirmed as the lead for London on Tobacco control |

APPENDIX 2

| 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)<br>CCG (Jane Milligan)<br>Barts Health (Ian Basnett)<br>Education, Social Care and Wellbeing (Anne Canning) | 03/03/2014 | Completed | 100% | Programme objectives achieved - training programmes for health and social care staff delivered, engagement with NHS on alignment of approaches (further actions are set out in 15/16 plans) |
| **Milestone** | **Lead Officer** | **Deadline** | **Status** | **%** | |
| Develop joint action plan with Barts Health (working with public health director) | Public Health (Paul Iggulden)<br>CCG (Jane Milligan)<br>Barts Health (Ian Basnett)<br>Education, Social Care and Wellbeing (Anne Canning) | 30/06/2013 | Completed | 100% | Tobacco was the focus for 13/14 and 14/15. Alcohol is a particular focus for 15/16 including KPIs in the Barts Health Contrack |
| Primary care – implement healthy lives locally enhanced services and revise spec for 14/15 | Public Health (Paul Iggulden)<br>CCG (Jane Milligan)<br>Barts Health (Ian Basnett)<br>Education, Social Care and Wellbeing (Anne Canning) | Ongoing | Completed | 100% | Completed |
| Community pharmacy – develop healthy lives plan with community pharmacists | Public Health (Paul Iggulden)<br>CCG (Jane Milligan)<br>Barts Health (Ian Basnett)<br>Education, Social Care and Wellbeing (Anne Canning) | 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)<br>CCG (Jane Milligan)<br>Barts Health (Ian Basnett)<br>Education, Social Care and Wellbeing (Anne Canning) | 30/09/2013 | Completed | 100% | Training programme delivered for social care teams |
| **Activity** | **Lead Officer** | **Deadline** | **Status** | **% Comp** | **Comments** |
| Reduce the use of smokeless tobacco | Public Health (Chris Lovitt)<br>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)<br>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)<br>LBTH, CLC (Dave Tolley) | 30/06/2013 | Completed | 100% | Completed |

| **Outcome Objective 3: Reduced levels of harmful or hazardous drinking (PH framework)**<br>**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)<br>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)<br>Public Health (Chris Lovitt) | 31/07/2013 | Completed | 100% | |
| Agree priorities and review timescales for action plan delivery | DAAT Coordinator (Mark Edmunds)<br>Public Health (Chris Lovitt) | 30/09/2013 | Completed | 100% | |
| Update HWB (via DAAT Board) on substance misuse action plan | DAAT Coordinator (Mark Edmunds)<br>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)<br>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)<br>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)<br>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)<br>Public Health (Chris Lovitt) | 30/09/13 - 31/12/13 | Completed | 100% | As above |

APPENDIX 2

| 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)<br>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)<br>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)<br>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)<br>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)<br>Public Health (Chris Lovitt) | 30/06/2013 | | 80% | Screening and briefing embedded into GP NIS and A and E. KPIs on screening in Barts Health contract. Making Every Contact Count training incorporates drugs and alcohol. 15/16 plans aim to embed more widely |
| **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)<br>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)<br>Public Health (Chris Lovitt) | 31/05/2013 | | 70% | Sign up from GP and A and E. However, there remain benefits from extending screening to other groups (eg inpatient services, CHS, voluntary sector) |
| Develop a package for training and implementation for front-line staff, including evaluation | DAAT Coordinator (Mark Edmunds)<br>Public Health (Chris Lovitt) | 30/06/2013 | Completed | 100% | |

APPENDIX 2

| 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 |

APPENDIX 2

| 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 | Completed | 100% | Completed and updated on ongoing basis (data for vulnerable group limited - but will become available through recommissioned services) |
| **Milestone** | **Lead Officer** | **Deadline** | **Status** | **%** | **Comments** |
| Needs assessment undertaken across care pathways | Public Health (Chris Lovitt) | 01/02/2014 | Completed | 100% | 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)<br>Health Lives Team (Kate Smith)<br>Options Team (Liat Sarner) | 31/10/2013 | Completed | 100% | Plans are in place |
| **Milestone** | **Lead Officer** | **Deadline** | **Status** | **%** | **Comments** |
| Lifecourse Promotion and Access Plan developed and adopted | Public Health (Chris Lovitt)<br>Health Lives Team (Kate Smith)<br>Options Team (Liat Sarner) | 31/05/2013 | Completed | 100% | |
| Monitoring of uptake of plan | Public Health (Chris Lovitt)<br>Health Lives Team (Kate Smith)<br>Options Team (Liat Sarner) | 31/10/2013 | Ongoing | | t. |

# Tower Hamlets Mental Health Strategy Delivery Plan 2014-16

| Pillar | Commitment | Action | Lead Officer | Timescale | RAG Status | Comments |
|---|---|---|---|---|---|---|
| **BEING BORN AND GROWING UP IN TOWER HAMLETS** | | | | | | |
| Buidling 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 o supportt during the pregnancy and in the first year of life to promote paren/infact attachment, parent and infant communication and emotional regulation in order to promote lifelong resilience and mental helath 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 Chidren's Centres, primary care and by voluntary and community organisations) (CYP) | Esther Trenchard-Mabere, Public Health Consultant, LBTH | March 2014 complete mapping and prioritisation.<br><br>June 2014 proposal for training programme to support universal tier of service plus recommendations for strengthening targeted | COMPLETED | Mapping completed, two multi agency workshops held first to inform mapping process and second to inform proposals to strengthen the universal tier of the sevice. Currently developing service specifications with the intention to go out ot procurement September/October. |
| 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 | Abigail Knight, Public Health Consultant, LBTH | September 2014 for plan. **Request change to July 2015.** | DELAYED | As part of our mental health and wellbeing project we are commissioning a specific strand of this work related to young people with the aim of supporting a reduction in stigma. This will be procured by July 2015 and run as a pilot over 3-4 months. We anticipate this will give us information to inform future commissioning plans |
| 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 | Dec-15 | ON TARGET | |

| Pillar | Commitment | Action | Lead Officer | Timescale | RAG Status | Comments |
|---|---|---|---|---|---|---|
| Building resilience: mental health and wellbeing for all | In our review of the School Health Service, we will ensure that promotion of emotional health and well-being health is considered as a central component of future commissioned services. We wil in 2015 and beyond consider the role of health visitors in promoting emotional health and wellbeing (CYP). | We will ensure that the roles of school nurses in relation to emotional health and well-being are clearly articulated in specifications for the reprocurement of the School Health service. | Esther Trenchard-Mabere, Public Health Consultant, LBTH | Dec-14 | COMPLETED | The new specification for the School Health service, developed by public health, clearly highlights the important role that school nurses can play in supporting the emotional health and wellbeing of children and young people. Following a procurement process the contract has been awarded to a new provider, Compass Wellbeing. The strength of their bid in relation to the role of school nurses in promoting emotional health and wellbeing was one of the reasons that they won the tender. Additional funding has also been obtained from the Burdett Trust for a training programme 'Young Minds' for the school nurses.<br><br>A stakeholder review of the health visiting service has just been completed by public health and the new specification will also highlight the importance of promoting secure attachment and emotional health and wellbeing in early childhood.<br><br>A new voluntary sector based parent and infant wellbeing programme, that involves training peer supporters to support maternal emotional health and wellbeing, parenting skills and secure attachment during pregnancy and the first year of life has just been commissioned by public health. |
| 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 specifications delivered by March 2015 | COMPLETED | Project plan in place; advisory group in place. So far work has undertaken extensive consultation with children and young people, relatives and professionals to identify the outcomes that matter most for children and young people and is developing metrics to measure these outcomes. Next stage will include further development of the service model and service specification ready for procurement in April 2016. |
| 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) | | | | COMPLETED | |
| 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) | | | | COMPLETED | |

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| 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) | | | | COMPLETED | |
| 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) | | | | COMPLETED | |

| BEING AN ADULT IN TOWER HAMLETS | | | | | | |
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| 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. **Second stage work - March 2016** | ON TARGET | Preliminary review undertaken, with funding arrangements in place for 14/15 for Resettlement Team. Second stage work planned to remodel services by end of year - additional deadline set for this of March 2016.. |
| 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 | COMPLETED | Extensive work undertaken to strengthen the Enhanced Primary Care Service, with funding agreed by CCG for 2015/16. To achieve this, service model was co-designed and agreed by ELFT and primary care representatives (building on the previous SMI NIS arrangements). The model includes both "step-down" and "step-up" components, and uses a recovery approach with peer support built into the model. This service will be mobilising in the course of 2015/16. |
| 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) | | | | COMPLETED | |
| High Quality Treatment & Support | With East London NHS Foundation Trust, we will further develop opportunities for practice based clinics (AWA) | | | | COMPLETED | |

| Pillar | Commitment | Action | Lead Officer | Timescale | RAG Status | Comments |
|---|---|---|---|---|---|---|
| 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 | Jun-14 | COMPLETED | The following was specified in the procurement exercise and in the contract as service specification:-<br>• Those living with severe or enduring mental illness within the community<br>• Those who may be smoking tobacco along with the use of illegal substances such as cannabis<br><br>Services have now been recomissioned and we are mobilising new contracts.<br><br>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.<br><br>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 | Jun-14 | COMPLETED | CCG contracted East London FT to work with local providers to develop during 14/15. Further development of Recovery College has now been included in Recovery and Wellbeing Services procurement exercise. |
| 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 | OVERDUE | Consultation and design process undertaken with service users and voluntary sector, however revised service model has not been implemented because of delays in sign off by the Council. Currently for scheduled for review by June Cabinet. Marked as red, as still to determine when this will be delivered, although it is hoped this will be in 2015/16 financial year. |

| Pillar | Commitment | Action | Lead Officer | Timescale | RAG Status | Comments |
|---|---|---|---|---|---|---|
| Building resilience: mental health and wellbeing for all | We will work with the Ideas Stores to capitalize on opportunities for improving access to self help support and bibliotherapy (AWA, OP) | We will develop a public mental health and well-being programme which will include 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 | Abigail Knight, Public Health Consultant, LBTH | June 2014 for plan; commitment commissioned by end March 2015. **Request change to March 2016.** | DELAYED | This will be addressed through the mental health and wellbeing project being commissioned through Public Health also the set of the Health and Wellbeing Outreach workers who are in the process of being recruited |
| 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. **Request change to March 2016.** | DELAYED | Review of Linkworker service undertaken by Supporting People, with service being respecified and reprocured on this basis. Public Health currently working on needs assessment to scope service needs and gaps, following changes to Probation services from 1st April 2015. This will determine whether an FMHP or other service is needed in the borough on an ongoing basis. |
| 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 | Mar-16 | ON TARGET | |
| 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 | Mar-16 | ON TARGET | |

| Pillar | Commitment | Action | Lead Officer | Timescale | RAG Status | Comments |
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| 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 Abigail Knight, Public Healh Consultant, | Audit complete by June 2015. **Request change to September 2015.** | DELAYED | Unlikely to complete by June 2015. Suggested revised date of September 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 require mental health services (AWA) | We will review and evaluate the new commissioned service mid way through the contract (at 18 months) | Barbara Disney, Service Manager, Strategic Commissioning, LBTH | Referral pathway developed by March 2015 | OVERDUE | Not delivered. Responsibility for ASD currently under review. |
| 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 | ON TARGET | Thorough evaluation process established, being undertaken by UCL |
| 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 | COMPLETED | Review led to procurement of counselling services in three lots, including bilingual (Sylheti/English) FROM Compass WB. Mind proposal includes joint working with Age UK. |
| 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) | | | | DELAYED | Initial report showed Tower Hamlets rate is high compared to London but low compared to national; further work to be decided. |

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| 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 | Mar-16 | COMPLETED | Children and Young people's outcome-based commissioning report completed with options to be decided in June 2015 - has included 18-25 services in scope |

| Pillar | Commitment | Action | Lead Officer | Timescale | RAG Status | Comments |
|---|---|---|---|---|---|---|
| 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 | 01/03/2015 **to be revised to March 2016** | ON TARGET | National work has shifted deadline to March 2016, as 2015/16 confirmed as an additional shadow year to provide more time for development and preparation, led by CSU. Continued work to prepare for Payment by Results has been underway throughout 2014/15. |
| 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 | ON TARGET | |
| 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 | ON TARGET | |
| 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 | Jun-16 | COMPLETED | Crisis House reprocured, effective from 1st April 2015. |
| 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) | | | | COMPLETED | |

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| 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 | 01/03/2015 . **Request change to March 2016.** | DELAYED | Considerable work to implement Recovery approach, in terms of development of Recovery and Wellbeing service model, support of Recovery College and development of Enhanced Primary Care, to enable a more Recovery-based approach, encouraging people to be care for in primary care whenever possible. A formal self-assessment has not yet been undertaken however, and is scheduled for 2015/16. |
| **Pillar** | **Commitment** | **Action** | **Lead Officer** | **Timescale** | **RAG Status** | **Comments** |
| 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 | ON TARGET | This was considered in the strategic work on voluntary sector services, although the procurement exercise has been delayed, so marked as amber. Currently for scheduled for review by June Cabinet (see line 26 above) |
| 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) | | | | COMPLETED | Peer support workers included in contract agreement with ELFT for new Primary Care Mental Health Service, to be phased in during 2015/16 |
| Living well with a mental health problem | We will work across the Consortium to consider opportunities for developing, and commissioning, the shared decision making approach in practice (AWA, OP) | As part of self-assessing our recovery orientation across the partnership, we will review the extent to which service users feel they have control over care planning processes. | Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG | Mar-16 | ON TARGET | |
| 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 | Mar-16 | ON TARGET | |

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| 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 | ON TARGET | This was considered in the strategic work on voluntary sector services, although the procurement exercise has been delayed, so marked as amber. Currently scheduled for review by June Cabinet (see line 26 above). The CCG is also taking part in an East London Social Impact Bond scheme in 2015/16 |
| 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 | ON TARGET | |
| **Pillar** | **Commitment** | **Action** | **Lead Officer** | **Timescale** | **RAG Status** | **Comments** |
| **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 | Apr-14 | COMPLETED | Two 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 carers. The Alzheimer's Society won the tender to deliver these services, and the current contract will run until 31st March 2017 |
| High 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 | COMPLETED | Extensive work undertaken to strengthen the Enhanced Primary Care Service, with funding agreed by CCG for 2015/16. Older people will have access to this service and age of service users will be monitored moving forwards. |
| 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 | Abigail Knight, Public Healh Consultant, LBTH | June 2014 for plan; commitment commissioned by end December 2014 | COMPLETED | Considerable awareness raising activity undertaken, including the following: Dementia Awareness Week sessions and stalls in May 2014 and May 2015, sessions for schools, business, primary care, voluntary sector organisations, housing associations, Extra Care Sheltered Housing, etc. |

| | | | | | | |
|---|---|---|---|---|---|---|
| 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) | deliver this, alongside other public mental health commitments over 2014/16 | Abigail Knight, Public Healh Consultant, LBTH | June 2014 for plan; commitment commissioned by end December 2014. **Request change to March 2016.** | DELAYED | Reprocurement of domiciliary care providers delayed progress in this area. Now this process is concluded, full plan to be developed for awareness raising in MH and dementia in these settings. |
| 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) | | Abigail Knight, Public Healh Consultant, LBTH | June 2014 for plan; commitment commissioned by end December 2014 | COMPLETED | Loneliness Factsheet completed with plans in development to tackle loneliness, particularly focusing on older people. |

| Pillar | Commitment | Action | Lead Officer | Timescale | RAG Status | Comments |
|---|---|---|---|---|---|---|
| High Quality Treatment & Support | We will review current community pathways for older adults with a functional mental health problem, in the context of our developing plans for integrated care in the borough in the context of the development of our integrated care model (OP) | We will review the older adults CMHT. | Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG | Review complete by June 2015 - **to be revised to September 2016** | ON TARGET | Deadline to be revised, as system needs to be more stable before reorganisation of functional older adult community teams is undertaken, particularly in terms of: 1. Integrated care structures are still forming, 2. Community Health Services recommissioning, 3. functional older adult inpatient redesign will be implemented in 2015/16. Revised deadline for review to be undertaken - September 2016. |
| 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 | COMPLETED | Audit completed |
| High 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 | COMPLETED | Review completed. |
| High 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 | COMPLETED | Inpatient service review undertaken with proposals for centralisation of wards across Tower Hamlets and City and Hackney taken through public consultation. |
| High 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 | COMPLETED | Specification in place, with 4 FTE band 7 and 1 care home OT recruited. In 2015/16 CCG agreed to support pilot of specialist older adult MH consultant support to the model. |

| Pillar | Commitment | Action | Lead Officer | Timescale | RAG Status | Comments |
|---|---|---|---|---|---|---|
| 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 | 01/03/2015 . **Request change to March 2016.** | DELAYED | Council's thorough review of the carers strategy has been delayed, however we have gathered further evidence of the need for respite options for people with dementia and the Council has included this as a priority in the Interim Carers Plan for 2015/16. |
| 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 and Joint Commissioning, THCCG | Service model developed by March 2015 | COMPLETED | Review completed. Council and CCG have considered the conclusions and recommendations and have commited to making care homes one of their joint high priorities to take forwards. |
| **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 | Jun-14 | COMPLETED | Complete; crisis concordat event held with Police & LAS present and Concordat action plan to be presented to HWBB Autumn 2014 |
| Building Resilience: mental health and wellbeing for all | We will develop a rolling programme of training for GP's and other primary care staff on specific aspects of mental health (G) | We will develop a rolling programme of training for GP's and other primary care staff | Dr. Ashrafi Jabin, Clinical Lead for Mental Health, THCCG | In place by June 2014 | COMPLETED | In 201415 training delivered on a range of topics, including dementia, mental capacity act, learning disability. Strategic approach to training primary care has been developed through the Enhanced Primary Care model for 2015/16 |
| 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 | COMPLETED | Completed as part of Enhanced Primary Care model. |
| 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 | COMPLETED | Complete, signed by partners and uploaded onto National Crisis Concordat website. ; Concordat action plan to be presented to HWBB May 2015 |

| Pillar | Commitment | Action | Lead Officer | Timescale | RAG Status | Comments |
|---|---|---|---|---|---|---|
| Building Resilience: mental health and wellbeing for all | We will develop a refreshed commissioning plan for people with a learning disability and mental health problem (G) | We will develop a refreshed commissioning plan. | Barbara Disney, Service Head, Stratrgic Commissioning, LBTH | Plan in place by June 2014. **New deadline April 2016.** | DELAYED | This work has been subsumed into the re-specification of Learning Disability Services. Revised deadline - new service model by April 2016. |
| 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 | COMPLETED | Summit was held to report on progress on strategy. |
| 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 Abigail Knight, Public Health Consultant, LBTH | Outcomes dashboard in place by December 2014 | DELAYED | No separate dashboard has been developed but this spreadsheet is currently reported in the public HWBB papers. |
| 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 | ON TARGET | |
| 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 | ON TARGET | |

| Pillar | Commitment | Action | Lead Officer | Timescale | RAG Status | Comments |
|---|---|---|---|---|---|---|
| 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 | ON TARGET | |
| 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 | ON TARGET | |
| 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 Abigail Knight, Public Health Consultant, LBTH | Mar-15 | COMPLETED | Local statutory organisation have signed Time to Change Pledge and developed action plans. |
| 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 | Abigail Knight, Public Healh Consultant, LBTH | September 2014 for plan | COMPLETED | Local statutory organisations have signed Time to Change Pledge and developed action plans. Public Health have developed a programme for commissioning public mental health initiatives, currently subject to Council procedures |

| Pillar | Commitment | Action | Lead Officer | Timescale | RAG Status | Comments |
|---|---|---|---|---|---|---|
| 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 Abigail Knight, Public Health Consultant, LBTH and Abigail Knight, Public Healh Consultant, LBTH | September 2014 for plan | ON TARGET | Local statutory organisations have signed Time to Change Pledge and developed action plans, and will consider steps to become mindful employers. We will continue to pick this up in our partnership work with them. |
| 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) | | Abigail Knight, Public Healh Consultant, LBTH | June 2014 for plan; commitment commissioned by end December 2014 | COMPLETED | Public mental health programmes include focus on BME. Bilingual counselling specification includes mental health awareness work with Bangladeshi partner organisatio0ns |
| 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 | COMPLETED | Co-production work undertaken with service users and In the Know interface is now live, drawing the Ideas Store directory but with distinctive branding for MH services. |
| 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) | | | | COMPLETED | Partnership established with Ideas Store to develop digital buddies for *In the Know* as part of wider Idea Store offer |

| Pillar | Commitment | Action | Lead Officer | Timescale | RAG Status | Comments |
|---|---|---|---|---|---|---|
| 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 | Abigail Knight, Public Healh Consultant, LBTH | June 2014 for plan; commitment commissioned by end December 2014 | DELAYED | Local statutory organisations have signed Time to Change Pledge and developed action plans, and will consider steps to become mindful employers. |
| 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) | | Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG and Carrie Kilpatrick, Service Manager, Accommodation, LBTH | In place by March 2015. | DELAYED | Not undertaken, as there may be opportunities to address this as part of Integrated Care, so waiting for IC structures to be more established. Priority for 2015/16 |
| Building Resilience: mental health and wellbeing for all | In our public mental health programme we will target health promotion interventions at all ages. We will seek to make them culturally relevant to our diverse population. We will ensure that commissioning focuses on improving the linkage between physical and mental health and contribute to the achievement of parity of esteem (G) | | Abigail Knight, Public Health Consultant, LBTH | June 2014 for plan; commitment commissioned by end December 2014. | DELAYED | Public Health have developed a programme for commissioning public mental health initiatives, currently subject to Council. Stocktake of services to improve physical health for people with SMI due for consideration by Mental health Programme Board in May 2015 |
| 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) | | Abigail Knight, Public Health Consultant, LBTH | June 2014 for plan; commitment commissioned by end December 2014. | DELAYED | The TTC workplan (phase 2) is in the process of being dicussed for implementation by the ESCW corporate team |

| Pillar | Commitment | Action | Lead Officer | Timescale | RAG Status | Comments |
|---|---|---|---|---|---|---|
| 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 | 01/03/2015 . **Request change to March 2016.** | DELAYED | We are reviewing support for all young carers currently and will pay particular attention to young people living with parental mental illness. |
| 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 | ON TARGET | |
| 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 | Abigail Knight, Public Healh Consultant, LBTH | Mar-15 | COMPLETED | Factsheet completed and recommendations going to June Mental Health Board |
| 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 | ON TARGET | |
| Building Resilience: mental health and wellbeing for all | We will work with providers to improve recording of sexual orientation as part of equalities monitoring requirements to inform future commissioning (G) | We will monitor activity by protected characteristic to inform future commissioning, and publish specific reports on our website. | Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, THCCG | Complete by March 2015 | ON TARGET | Monitoring by protected characteristics in place but providers report that most service users choose not to answer question on sexual orientation. We will continue to discuss this with them. Marked as amber, as more improvement to be achieved int his area. |

| Pillar | Commitment | Action | Lead Officer | Timescale | RAG Status | Comments |
|---|---|---|---|---|---|---|
| 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 - **Request change to March 2016** | DELAYED | Initial scoping work undertaken showing that TH is high in London but low nationally for antipsychotic prescribing. Further work to be done to deliver full commitment by March 2016, however change ideas already being implemented to deliver improvement, including collaborative draft CQUIN 2015/16 for ELFT, which includes extensive work on physical health of people on antipsychotics and Enhanced Primary Care service for people with MH problems, which includes strong focus on physical health. |
| 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 | 01/03/2015 - **Change to March 2016** | ON TARGET | Deadline to be revised, as per above - as Payment by Results shadow year extended to March 2016. |
| 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 | ON TARGET | |
| 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 | Mar-16 | ON TARGET | Waiting times monitored closely throughout 2014/15, with business cases approved to support provides to reduce waiting times in key services by March 2016. Dashboard to be developed in 2015/16. |
| 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 | Abigail Knight, Public Health Consultant LBTH, and Esther Trenchard Mabere, Public Health | Dec-14 | COMPLETED | Delivered. Further work on stocktake on physical health of people with SMI due for review in May 2015 |

| Pillar | Commitment | Action | Lead Officer | Timescale | RAG Status | Comments |
|---|---|---|---|---|---|---|
| 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 | | ON TARGET | Ongoing work on track. |
| 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 | We will award 2 year grants for user led groups for 2014-16, and consider opportunities for pooled | Richard Fradgley, Deputy Director of Mental Health | April 2014 for 2 year ULG contract | COMPLETED | Two year User Led Grants issued |
| 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 | We will consider opportunities for commissioning peer support as part of existing | Richard Fradgley, Deputy Director of Mental Health | 2016 | ON TARGET | |

APPENDIX 4

# 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<br>30/09/13<br>31/12/13<br>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 |

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|---|---|---|---|---|---|
| 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 | Completed | 100% | Post in place |
| **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% | Will be built in 2015 contract round |

APPENDIX 4

| **Cancer** | | | | | |
|---|---|---|---|---|---|
| **Activity** | **Lead Officer** | **Deadline** | **Status** | **% Comp** | **Comments** |
| Early Identification through:<br>• increasing the uptake of breast, bowel and cervical screening using targeted outreach, primary care endorsement, improved practice systems<br>• increasing public awareness of cancer and the need to report symptoms without delay through the small c campaign | Public Health | 31/03/2014 | Completed | 100% | The small c campaign continuing, four contracts in place to deliver messages with local communities (14/15). 15/16 plans agreed through GP NIS |
| **Milestone** | **Lead Officer** | **Deadline** | **Status** | **%** | **Comments** |
| Link with Public Health England to<br>• agree screening targets | Public Health | 31/07/2013 | Completed | 100% | Screening programmes reviewed. PHE attended HWBB |
| • agree assurance process | Public Health | 31/07/2013 | Completed | 100% | Process for DPH assurance of data in place and reporting to HWBB where there are issues of concern |
| 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<br><br>Update: concept built into CHS specification currently in live procurement process. NHS 111 reprocurement decision across WELC will also need to be taken into account. |
| **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% | |

APPENDIX 4

| 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.<br><br>Update: WELC integrated care programme developing common care plan method. All partners involved |
| **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% | |

APPENDIX 4

| 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% | See comment on joint care planning action |
| Collecting data and qualitative feedback to develop a baseline position to inform developments of advance care planning | TH CCG | 30/04/2014 | Overdue | 20% | See comment on joint care planning action |
| **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 | 75% | 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 Outturn | 2013/14 Target | 2014/15 (latest) Local Outturn | RAG (against 2013/14 target) | DOT (compared to previous outturn) | 2014/15 (latest) London Average (National Average*) | Comments |
|---|---|---|---|---|---|---|---|
| **HEALTHY LIVES MEASURES** | | | | | | | |
| ~~(Proportion of children in Year 6 who are obese)~~ Excess weight in 10-11 year olds (PHOF2.06ii) | 26.50% | 25.10% | **42.30%** | - | - | 37.20% | New measure is excess weight |
| Proportion of adults (18+) who smoke | 19.30% | 21% | **19.30%** | GREEN | Same ⇨ | 17.30% | Latest data relates to 2013. Datasource GLA London Datastore. |
| Rate of admissions to hospital that are alcohol- related per 100,000 population (PHOF2.18) | 2577 | 2424.3 | **634** | GREEN | Better ⇧ | 561.2 | |
| Proportion of all in treatment, who successfully completed treatment and did not re-present within 6 months (opiates) (PHOF2.15) | 9% | 11% | **4.20%** | RED | Worse⇩ | 9.50% | |
| Successful completions of treatment for children and young people | - | 74.50% | **-** | - | - | - | Data not available |
| Successful completion of alcohol treatment | 33% | 55% | **-** | - | - | - | Data not available |
| People arrested and identified as having substance misuse issues who are previously not known to the Drug Intervention Programme | 57 | 20/month | **-** | - | - | - | Data not available |
| Number of binge drinking callouts (Incidents where London Ambulance Service have attended someone suffering from an alcohol related illness) | 293 | 1273 | **-** | - | - | - | Data not available |
| Numbers of screenings completed in primary care | - | 25000 | **-** | - | - | - | Data not available |
| Rate of people aged 15-24 testing positive for chlamydia (PHOf3.02) | 1479 | 1800 | **1451** | GREEN | Better ⇧ | 2109 | |
| Proportion of HIV infections diagnosed late (PHOF3.04) | 32% | 33% | **29.90%** | GREEN | Better ⇧ | 42.60% | |
| **HEALTHY LIVES & MATERNITY AND EARLY YEARS MEASURES** | | | | | | | |
| Smoking status at time of delivery (PHOF 20.3) | 3.00% | 3.50% | **3.20%** | GREEN | Worse⇩ | 5.10% | |
| ~~(Proportion of children in Reception who are overweight)~~ Excess weight measure (PHOF2.06i) | 10.90% | 10.80% | **23.70%** | - | - | 22.90% | New measure is excess weight |
| ~~Proportion of children in Reception who are obese~~ | 12.70% | 13.10% | | | | | |
| ~~(Proportion of children under 5 with tooth decay)~~ *Tooth decay in children aged 5 (PHOF2.06ii) | 27.90% | 30.00% | ***1.78%** | - | - | *1.16% | |
| Proportion of children accessing dental services | | 62.9% | | | | | Data not available |
| Teenage pregnancy rate | 24.30% | 27.50% | **18.70%** | GREEN | Better ⇧ | 21.30% | Datasource: GLA London datastore. Latest data is 2013. |
| **MATERNITY AND EARLY YEARS MEASURES** | | | | | | | |
| Proportion of women who are obese during pregnancy (BMI > 30) | - | 12% | **-** | - | - | - | Data not available |
| Proportion of pregnant women who have an antenatal screening for HIV | - | Data Quality | **-** | - | - | *98.9% | Data not available |
| Proportion of pregnant women who have an antenatal screening for Downs Syndrome (Completion of lab request forms) | - | 97% | **-** | - | - | - | Data not available |
| Proportion of pregnant women who have antenatal screenings for sickle cell and thalassemia | - | Data Quality | **-** | - | - | *98.9% | Data not available |

| Indicator | 2013/14 Outturn | 2013/14 Target | 2014/15 (latest) Local Outturn | RAG (against 2013/14 target) | DOT (compared to previous outturn) | 2014/15 (latest) London Average (National Average*) | Comments |
|---|---|---|---|---|---|---|---|
| Proportion of new born babies given a blood spot screening | - | 95% | **-** | - | - | - | Data not available |
| Proportion of new born babies given a hearing screening (PHOF 2.21v) | - | 95% | **98.40%** | GREEN | - | 98.20% | |
| Child development at 2-2.5 years | - | TBC | **-** | - | - | - | Data not available |
| Rate of infant mortality (children who die before reaching their first birthday) (PHOF4.01) | 5.3 | 5 | **5.0** | GREEN | Better ⇧ | 3.6 | |
| Proportion of babies born with low birth weight (<2.5kg) (PHOF2.01) | 4.1% | 9% | **5%** | GREEN | Worse⇩ | 3.80% | |
| Proportion of mothers who breastfeed at birth (PHOF 2.02i) | 86.80% | 88.50% | **-** | - | - | *73.9% | Data not available |
| Proportion of mothers who are breastfeeding at 6-8 weeks | 71.10% | 71.50% | **-** | - | - | - | Data not available |
| Proportion of babies who receive the BCG vaccination when they are a year old | - | 95% | **-** | - | - | - | Data not available |
| Proportion of babies who receive the DTap/IPV/Hib vaccination when they are a year old (PHOF3.03iii) | 96.8% | 95% | **97.30%** | GREEN | Better ⇧ | 89.60% | Values estimated. |
| Proportion of babies who receive the MMR vaccination when they are two years old (PHOF3.03viii) | 93.8% | 95% | **93.80%** | AMBER | Same ⇨ | 87.30% | Values estimated. |
| Proportion of babies who receive the DTap/IPV/Hib vaccination when they are five years old | - | 95% | **-** | - | - | - | Data not available |
| Proportion of babies who receive two doses of the MMR vaccination when they are five years old (PHOF 3.03ix) | 93.4% | 95% | **93%** | AMBER | Better ⇧ | 86.60% | Values estimated. |
| **LONG TERM CONDITIONS AND CANCER MEASURES** | | | | | | | |
| Mortality rate from causes considered preventable (PHOF 4.03) | - | - | **241.7** | - | - | 174.8 | Data not available |
| Rate of deaths from causes considered preventable of persons under 75 (PHOF4.04ii) | - | 107.4 | **71.30%** | - | - | 51.20% | Data not available |
| Rate of deaths from all cardiovascular diseases of persons under 75 (PHOF4.05ii) | 107.5 | 81.4 | **108.6** | RED | Worse⇩ | 81.5 | |
| Rate of deaths from cancer of persons under 75 (PHOF4.05i) | 150.2 | 124 | **165.4** | RED | Worse⇩ | 138.6 | |
| Rate of deaths from respiratory disease of persons under 75 (PHOF4.05i) | 40.6 | 32.2 | **33.0** | AMBER | Better ⇧ | 18.1 | |
| Percentage of people who are eligible for cancer screening who are screened:<br>⇨ Cancer screening (PHOF2.20i)<br>⇨ Cervical (PHOF2.20ii) | - | TBC with Public Health England | **61.5%**<br>**69%** | - | - | 68.2%<br>70.2% | |
| Proportion of people who are eligible, who take up the NHS Health Check Programme (PHOF2.22ii) | 15% | +12% | **17.20%** | GREEN | Better ⇧ | 21.50% | |
| Proportion of people feeling supported to manage their condition | 70% | 91% | **-** | - | - | - | Data not available |
| Proportion of people who use services and carers who find it easy to find information about services | - | 75% | **-** | - | - | - | Data not available |
| Overall satisfaction of people who use services with their care and support | - | 66% | **-** | - | - | - | Data not available |
| Overall satisfaction of people with learning disabilities who use services with their care and support | - | 93% | **-** | - | - | - | Data not available |

| Indicator | 2013/14 Outturn | 2013/14 Target | 2014/15 (latest) Local Outturn | RAG (against 2013/14 target) | DOT (compared to previous outturn) | 2014/15 (latest) London Average (National Average*) | Comments |
|---|---|---|---|---|---|---|---|
| Proportion of adults with learning disabilities in paid employment | - | 9% | - | - | - | - | Data not available |
| Proportion of adults with learning disabilities who live in their own home or with their family | - | 65% | - | - | - | - | Data not available |
| Quality of life as reported by carers | - | TBC | - | - | - | - | Data not available |
| Proportion of carers who report that they have been included or consulted in discussions about the person they care for | - | 30% | - | - | - | - | Data not available |
| Health-related quality of life for carers | 75% | 45% | - | - | - | - | Data not available |

# Refresh of the Joint Health and Wellbeing Strategy

## 1. Introduction

1.1 The Health and Wellbeing Strategy 2013-16 and its associated delivery plans are due a refresh. This paper, discussed at the last meeting of the Health and Wellbeing Board Strategy sub-group outlines the broad process and timeline for refreshing the strategy.

## 2. Context

2.1 The Health and Wellbeing Strategy remains a statutory plan under the Health and Social Care Act. Moreover there have been recent legislative and policy changes such as the Care Act, Better Care Fund and Children and Families Act, are contributing to changes in the delivery of health and social care. The newly elected Conservative government has pledged to create an integrated health and social care service, 7 day a week GP services and a greater priority on Mental Health; all of which will have an impact on Tower Hamlets.

2.2 Locally, the Community Plan is in the process of being refreshed as well as the Children and Families Plan; this provides an opportunity to align the Health and Wellbeing Strategy with these key documents.

## 3. Approach

3.1 The Health and Wellbeing Strategy will be built on a firm evidence base; with the JSNA at the centre of this. Data from the Community Plan/MTFP consultation will also be utilised. Healthwatch will be engaged with the process to input resident views and feedback. There are plans for a healthy lifestyle survey later on this year, with the results feeding into the development of the Health and Wellbeing Strategy baseline.

3.2 The development of the Health and Wellbeing Strategy will start with evidence collation and one to one discussions and forward looking workshops with key stakeholder organisations and HWB members. These workshops will be overseen by the HWBS sub-group, facilitated by the Corporate Strategy and Equality team, the LGA and the King's Fund.

3.3 There will be a need for constant dialogue with both the Board, stakeholders and Council committees. It is suggested that the Health and Wellbeing Strategy subgroup should act as the project board for the refreshing of the Health and Wellbeing Strategy

3.4 Communication will play a significant role during this exercise as stakeholders will need to be made aware of the process, their required engagement and any actions that may arise.

## 4. Timeline

| Activity | Leads | Dates |
|---|---|---|
| Workshop 1 scenario planning<br><br>Focus:<br>• Future health and social care landscape in Tower Hamlets;<br>• Is Tower Hamlets well equipped to meet future health needs? | Facilitated by the King's Fund with support from LBTH's Corporate Strategy and Equality team (CSE) and Public Health<br><br>Attendees: Lead officers from the HWB member organisations. | July |
| Baseline and evidence collation<br><br>Focus:<br>JSNA summary data<br>HWBS end year monitoring<br>Residents' views<br>Scenario modelling from above<br>Review of HWB member priorities and existing strategies<br><br>Early consultation with key stakeholders | JSNA Reference Group<br>LBTH CSE<br>HWBS Sub-Group members<br>Healthwatch<br><br>LBTH Mayor, CCG Exec, other HWB Board members | June - September |
| Workshop 2 Evaluation of existing Health and Wellbeing Strategy<br><br>Focus:<br>• Review of the 2013-16 Health and Wellbeing Strategy Framework<br>• What has worked well, what needs to change?<br>• Given existing work in train, what should be the key priorities for the Strategy from | Facilitated by LBTH's CSE and Public Health<br><br>Attendees: Lead officers from the HWB member organisations | August / September |

| | | |
|---|---|---|
| 2016<br>• Consider arrangements for the delivery of the Health and Wellbeing Strategy | | |
| Workshop 3 Board OD<br><br>Focus:<br>• LGA mediated session with board members<br>• Supporting board members to develop thinking/priorities for the Health and Wellbeing Strategy<br>• The refreshed HWS will reference key stakeholder strategies and will be an overarching strategy focussing on areas for collaboration. (Similar to the Community Plan) | Facilitated by LGA and CSE<br><br>Attendees: HWB members | September |
| Consultation with key stakeholders | CSE facilitated<br><br>Stakeholders: CCG; CVS; local forums, Health Scrutiny, CPDGs, Barts Health, ELFT<br><br>Other Community Plan Delivery Groups<br><br>Key interest groups and forums – eg Third Sector, and equality group forums | Sept - October |

| | | |
|---|---|---|
| Development of a Health and Wellbeing Strategy framework and priorities, and draft Strategy, for the Health and Wellbeing Strategy subgroup's approval<br><br>Develop outcome measures<br><br>Draft Equality Analyses | CSE | September – October |
| Draft Health and Wellbeing Strategy including framework, priorities and outcome measures presented to the HWB | CSE | November |
| Draft HWBS published for public consultation | CSE | Nov - January |
| Health and Wellbeing Strategy revised to respond to feedback and priorities and outcome measures developed and presented to Health and Wellbeing Strategy subgroup and HWB for sign off<br><br>Partnership organisations to take through internal decision making processes as required<br><br>Updated equality analysis | CSE | January – April |
| Develop and finalise Health and Wellbeing Strategy delivery plans | Identified priority leads. (e.g. Adult social care; Public Health, CCG, Children social care, CFPB) | April - May |
| Review of delivery plans by the Health and Wellbeing Strategy | CSE | June |

| | | |
|---|---|---|
| subgroup | | |
| Approval of the delivery plans by HWB and organisation's internal processes | CSE | June – August |

## 5. Health and Wellbeing Strategy Sub-Group

The HWBS subgroup reviewed and agreed this timeline and agreed that the subgroup act as the project board for the refreshing of the Health and Wellbeing Strategy and meets six weekly in order to monitor progress.

| Health and Wellbeing Board<br>07/07/15 | Tower Hamlets Health and Wellbeing Board |
|---|---|
| **Report of the London Borough of Tower Hamlets** | **Classification:**<br>[Unrestricted] |
| **Liver disease programme - update** | |

| | |
|---|---|
| **Lead Officer** | Dr Somen Banerjee, Director of Public Health |
| **Contact Officers** | Dr Somen Banerjee |
| **Executive Key Decision?** | No |

## 1. INTRODUCTION/SUMMARY

On 9 September 2014 a briefing paper was presented to the Tower Hamlets HWBB setting out the findings of a liver disease needs assessment for Tower Hamlets. The 2014 Public Health Outcomes Framework (PHOF) had found Tower Hamlets to have amongst the highest levels of premature deaths form liver disease in England. 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 Health and Wellbeing Board had requested an update to the Board in nine months.

## 2. RECOMMENDATIONS

The Health and Wellbeing Board is asked to note progress since the position set out at the September 2014 Board.

## 3. PROGRESS

The 2015 PHOF found that deaths from liver disease that are considered preventable in Tower Hamlets have decreased and are now similar to the average levels for England. These figures relate to the period 2011-13 and represent a positive trend for the borough.

In July 2014 a stakeholder workshop was held to agree priorities for the work programme. In April 2015 a learning event for primary care professionals was conducted to consolidate progress against the workplan.

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| *WORKSTREAM 1: Developing Guidelines for the treatment of Liver Disease* | • Guidelines created as a collaboration between CCG Clinical Lead and CEG<br>• Primary care templates created<br>• Communicated to primary care professionals |
| *WORKSTREAM 2: Unbundling of Liver Function Tests* | • Agreement reached with Barts laboratory about unbundling liver function tests, enabling specific tests to be requested and reducing unnecessary costs<br>• Communicated to primary care professionals |
| *WORKSTREAM 3: Educational Work Stream* | • Protected Learning Time (PLT) event for primary care professionals held in April 2015. |
| *WORKSTREAM 4: Awareness Raising/ Public Engagement* | • Love your Liver event held in May 2015 |
| *WORKSTREAM 5: Consider alcoholic liver disease and other drugs that have a negative impact on the liver* | • Incorporated into alcohol and drugs workstream |
| *WORKSTREAM 6: Local immunisation/ prevention strategy needs to be reviewed* | • Universal immunisation programme for hepatitis B planned for 2 years time |
| *WORKSTREAM 7: Treatment Pathway* | • Liver disease pathway mapped |
| *WORKSTREAM 8: Case Finding* | • Audit underway to understand delivery against NICE guidelines, 'Hepatitis B and C: ways to promote and offer testing to people at increased risk of infection' |

## 4. REASONS FOR THE DECISIONS

4.1 The HWB has requested a progress update for information.

## 5. ALTERNATIVE OPTIONS

5.1 None

## 6. COMMENTS OF THE CHIEF FINANCE OFFICER

6.1 There are no direct financial implications as a result of the recommendations in this report.

## 7. LEGAL COMMENTS

7.1 It is a function of the HWB to have oversight of the quality, safety, and performance mechanisms operated by its member organisations, and the use of relevant public sector resources across a wide spectrum of services and interventions, with greater focus on integration across outcomes spanning health care, social care and public health.

7.2 Further, it is a function of the HWB to identify the needs and priorities across Tower Hamlets and publish and refresh the Tower Hamlets Joint Strategic Needs Assessment (JSNA) so that future commissioning/policy decisions are based on evidence.

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

## 8. ONE TOWER HAMLETS CONSIDERATIONS

8.1 Premature mortality from liver disease is a significant health and health inequalities issue for the borough

## 9. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

9.1 Not applicable

## 10. RISK MANAGEMENT IMPLICATIONS

10.1 None

## 11. CRIME AND DISORDER REDUCTION IMPLICATIONS

11.1 Not relevant

## 12. EFFICIENCY STATEMENT

12.1 There is no council expenditure involved

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**Appendices**

- None

| Health and Wellbeing Board<br>07/07/15 | Tower Hamlets Health and Wellbeing Board |
|---|---|
| **Report of the London Borough of Tower Hamlets** | **Classification:**<br>[Unrestricted or Exempt] |
| **Breast Cancer Screening - update** | |

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| **Lead Officer** | Dr Somen Banerjee, Director of Public Health |
| **Contact Officers** | Dr Somen Banerjee |
| **Executive Key Decision?** | No |

## 1. INTRODUCTION/SUMMARY

A briefing paper presented to the Tower Hamlets HWBB on 13 January 2015 highlighted serious concerns about the decline in coverage of the NHS breast cancer screening programme in Tower Hamlets since April 2013. NHS England (London) was invited to respond to concerns and was represented at the meeting by Jo Murfitt, Head of Public Health Commissioning and Adrian Brown, Principal Public Health Screening Advisor.

In April 2013 commissioning of NHS screening programmes was transferred from the former Tower Hamlets PCT to NHS England (NHSE). However, Local Authority Public Health maintains an assurance role to monitor trends and to highlight concerns, in order to ensure adequate delivery of the service to the local population. A review of current trends around cancer screening programmes (breast, cervical and bowel) highlighted a particular area of concern around breast cancer screening where there has been a decline of almost 6.5% in breast cancer screening coverage over one year from 67.8% to 61.5%.

## 2. RECOMMENDATIONS

The Health and Wellbeing Board is asked to note the improvement plan and progress since the position set out at the January 2015 Board.

## 3. BACKGROUND

The Health and Wellbeing Board recommended that assurance was sought from NHS England (London) that it was taking the necessary measures to reverse the decline in uptake of breast cancer screening. It further recommended that the Health and Wellbeing Board Executive Officers Group continues to monitor progress on breast cancer screening uptake.

NHSE committed to an improvement plan to increase breast cancer screening coverage in Tower Hamlets. The plan included reintroduction of a targeted telephone outreach service to support women to access screening. This was to be based on a service successfully commissioned by Tower Hamlets PCT between 2007 and 2013 resulting in an increase in coverage from 53% to 67.8%.

Initially this would be by extending NHSE's existing contract with Community Links (a community organisation based in Newham) to work with Tower Hamlets GP practices. NHSE will subsequently tender for a provider to deliver this service in Tower Hamlets on a longer term basis.

## 4. PROGRESS

The calling service in Tower Hamlets has not yet commenced.

Community Links is ready to begin service delivery, depending on certain challenges being overcome.

(i) The next active screening round in Tower Hamlets will begin in February 2016. The current service is therefore limited to contacting women invited during the last screening round between September 2014 and March 2015 who did not attend 2 appointments (1,500 women). Contact details held by the breast screening service may be missing or inaccurate for these women.

(ii) Central and East London Breast Screening Service (CELBSS) propose that only one appointment date/time is offered to each of this group of women. CELBSS is under pressure to improve performance by offering earlier invitations in the 5 other CCGs for which it provides a service, all of which have active screening rounds this year.

Community Links has commenced delivery of a phone calling service for breast screening in Camden (which currently has a screening round in progress) and continues to deliver the same service in Newham.

NHSE is seeking increased flexibility of appointments by CELBSS, in order to avoid widening inequalities in coverage between Tower Hamlets and other CCGs.

## 5. ASSURANCE STATEMENT

Public Health and Tower Hamlets CCG are working with NHSE to address potential barriers to service delivery and increasing breast screening coverage. It is too early to provide assurance that the drop in breast cancer coverage has been addressed.

## 6. REASONS FOR THE DECISIONS

6.1 The HWB has requested a progress update for information.

## 7. ALTERNATIVE OPTIONS

7.1 None

## 8. COMMENTS OF THE CHIEF FINANCE OFFICER

8.1 There are no direct financial implications as a result of the recommendations in this report.

## 9. LEGAL COMMENTS

9.1 It is a function of the HWB to have oversight of the quality, safety, and performance mechanisms operated by its member organisations, and the use of relevant public sector resources across a wide spectrum of services and interventions, with greater focus on integration across outcomes spanning health care, social care and public health.

9.2 Further, it is a function of the HWB to identify the 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.

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

## 10. ONE TOWER HAMLETS CONSIDERATIONS

10.1 Uptake of the breast cancer screening service will impact on health and health inequalities in the borough

## 11. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

11.1 Not applicable

## 12. RISK MANAGEMENT IMPLICATIONS

12.1 An improvement plan has been agreed with NHS England to mitigate risks. A risk remains of CELBSS not providing flexibility of appointment times.

## 13. CRIME AND DISORDER REDUCTION IMPLICATIONS

13.1 Not relevant

## 14. EFFICIENCY STATEMENT

14.1 There is no council expenditure involved

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**Appendices**

- None

| Health and Wellbeing Board<br>Thursday 28 May 2015 | Tower Hamlets Health and Wellbeing Board |
|---|---|
| **Report of the London Borough of Tower Hamlets** | **Classification:**<br>[Unrestricted] |
| **CCG Quality Premium – chairs action approved on 8 June 2015** *(paper for information)* | |

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|---|---|
| **Lead Officer** | Dr Somen Banerjee, Director of Public Health |
| **Contact Officers** | Dr Somen Banerjee |
| **Executive Key Decision?** | No |

## 1. INTRODUCTION/SUMMARY

This paper summarises the decisions taken by the Clinical Commissioning Group (CCG), in consultation with Local Authority public health colleagues, about which metrics will be included in their quality premium for 2015/16.

NHS England guidance on quality premium metrics recommends that the Health and Wellbeing Board approves the decision on the two local measures, but this is not a policy requirement.

## 2. RECOMMENDATIONS

The Chair is requested to note the recommended metrics for the CCG's quality premium in 2015/16, on behalf of the Health and Wellbeing Board.

These metrics were submitted to NHS England on 15th May 2015 as part of the CCG's Operating Plan, and as such Health and Wellbeing Board sign off is overdue. For this reason the a Chair's action is sought in advance of the next Health and Wellbeing Board on 7th July for discussion.

## 3. BACKGROUND

The quality premium is intended to reward clinical commissioning groups (CCGs) for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reducing inequalities. NHS England is responsible for the management of the reward. The maximum financial reward equates to £5 per head of population.

Some of the metrics against which this payment will be made are fixed, and others can be determined locally. These metrics have been selected from a pre-determined list compiled by NHS England. These choices are set out in appendix A with rationale for decision making.

These metrics have been arrived at in consultation with the public health department, and have been discussed and agreed at the CCG's Senior Management Team 11th May 2015. These were reviewed with reference to the JSNA, the priorities set out in the Health and Wellbeing Strategy, and health inequalities.

## 4. RECOMMENDATIONS AND NEXT STEPS

We request a Chair's action to note the following list of metrics to constitute the CCG's quality premium in 2015/16:

- Reduction in potential years of life lost through the causes considered amenable to healthcare
- Reduction in delayed transfers of care which are an NHS responsibility
- Reduction in the number of people with severe mental illness who are currently smokers
- Improvements to antibiotic prescribing in primary and secondary care
- Increase in the number of people who are still at home 91 days after discharge from hospital into rehabilitation/reablement services
- Increase in the number of people who are streamed to urgent care or primary care from A&E

As part of developing implementation plans in relation to each of these metrics, it is recommended that the CCG pay due consideration to equalities dimensions and health inequalities.

## 5. REASONS FOR THE DECISIONS

5.1 The HWB is required to encourage integration between health and social care partners and be involved in any CCG commissioning plan. The levels of improvement needed to trigger the reward for the two local priorities should be agreed between the CCG, the HWB and the local NHS England team.

## 6. ALTERNATIVE OPTIONS

6.1 None

## 7. COMMENTS OF THE CHIEF FINANCE OFFICER

7.1 There are no direct financial implications to the Council as a result of the recommendations in this report.

## 8. LEGAL COMMENTS

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

8.2 This duty is reflected in the Council's constitutional arrangements for the HWB which states one of the functions of the HWB as "to be involved in the development of any CCG Commissioning Plan that applies to Tower Hamlets and to give its opinion to the CCG on any such proposed plan."

8.3 Additionally, under the Care Act 2014 ("the 2014 Act") the Council has a general duty to co-operate with the CCG and also to promote the integration of care support with health services.

8.4 The Council's general duty meets with the aim of aiming for higher quality health, care and support to individuals in order to have a positive impact on their wellbeing.

8.5 In ensuring the Council meets with its general duty it is important that consideration is given to how the metrics sought to be included by the CCG commissioning criteria impact on the wellbeing of individuals. Similarly, the impact of the metrics on the integration aims of the 2014 Act should be taken into account.

8.6 The Council, HWB and CCG must take into account the Joint Strategic Needs Assessment for consideration of the two local measures allowed for by NHS Enlgand.

8.7 S.22 of the 2014 Act retains the boundary between the legal responsibilities of the NHS, including the CCG, and the Council.

8.8 In light of the above, there is no decision making function of the HWB in relation to the choice of local measures by the CCG but rather its role is to encourage integration and be involved in decision making.

8.9 In relation to the two local quality measures NHS England Guidance states:

*These should reflect local priorities identified in joint health and wellbeing strategies. They should be based on indicators from the CCG Outcomes Indicator Set unless the CCG and the relevant Health and Wellbeing Board and local NHS England team mutually agree that no indicators on this list are appropriate for measuring improvement in the identified local priorities. The levels of improvement needed to trigger the reward should be agreed between the CCG, the Health and Wellbeing Board and the local NHS England team.* Para 11, Quality Premium: 2015/16 guidance for CCGs; April 2015.

8.10 The proposed measures in Annex A appear to lack sufficient detail to be specific and measurable. Further, the details of the proposed metrics appear to not reflect the level of detail recommended in the NHS England guidance, Quality Premium: 2015/16 guidance for CCGs; April 2015. It is acknowledged that this information has been submitted to NHS England prior to the preparation of this report.

8.11 The NHS England Guidance stipulates that when considering the two local quality premiums the level of improvement needed to trigger the reward should be agreed between the CCG, the HWB and the local NHS England team. Any failure to fully demonstrate this has occurred to NHS England risks the CCG failing to receive any payments under this scheme, regulation 4(1)(h) of the National Health Service (Clinical Commissioning Groups-Payments in Respect of Quality) Regulations 2013 (S.I. 2013/474).

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

8.13 The 2015 NHS England guidance recommends that as part of developing its local improvement plan for each Quality Premium measure, CCGs would benefit from completing an equality and health inequalities analysis. There is no evidence that this analysis has been undertaken and shared with the HWB or Council.

## 9. ONE TOWER HAMLETS CONSIDERATIONS

9.1 These metrics will impact on health and health inequalities in the borough

## 10. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

10.1 Not applicable

## 11. RISK MANAGEMENT IMPLICATIONS

11.1 The risks of this proposal relate to the CCG and not the local authority

## 12. CRIME AND DISORDER REDUCTION IMPLICATIONS

12.1 Not relevant

## 13. EFFICIENCY STATEMENT

13.1 There is no council expenditure involved

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**Appendices**

- **Proposed measures for THCCG Quality Premium 2015/16 (Appendix A)**

**Appendix A: Proposed measures for THCCG Quality Premium 2015/16**

| Theme | Options for metrics | Proposed metric | Rationale | Weight |
|---|---|---|---|---|
| Potential Years of Life Lost | Fixed measure:<br>Reduction in potential years of life lost through causes considered amenable to healthcare | Reduction in potential years of life lost through causes considered amenable to healthcare | Required measure | 10% |
| Urgent and Emergency Care | Can decide on one or several of the following:<br>• Avoidable emergency admissions<br>• Delayed transfers of care which are an NHS responsibility<br>• Increase in the number of patients admitted for non-elective reasons, who are discharged at weekends or bank holidays | Reduction in delayed transfers of care which are an NHS responsibility | • Reducing delayed transfers of care is a significant challenge and a national priority<br>• Reduction in numbers will support patient flow<br>• Improve referral to treatment times<br>• Support system wide collaborative working and resilience<br>• Can be used to offset the Better Care Fund metric on all delayed transfers of care (both within and without NHS responsibility) | 30% |
| Mental Health | Can decide on one or several of the following:<br>• Reduction in the number of patients attending an A&E department for mental health-related needs who wait more | Reduction in the number of people with severe mental illness who are currently smokers | • This is a considerable health inequality faced by this population group<br>• Public health supportive of this measure<br>• Evidence that smoking | 30% |

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| | than four hours to be treated and discharged, or admitted<br>• Reduction in the number of people with severe mental illness who are currently smokers<br>• Increase in the proportion of adults in contact with secondary mental health services who are in paid employment.<br>• Improvement in the health related quality of life for people with a long term mental health condition | | cessation should be part of clinical pathways<br>• Supports priorities within the Health and Wellbeing Strategy<br>• Part of the NHS 5 year forward view | |
| Prescribing | Fixed measure:<br>Improvements to antibiotic prescribing in primary and secondary care | Improvements to antibiotic prescribing in primary and secondary care | Required measure | 10% |
| 2 local measures | Locally determined metrics which should be based on local priorities such as those identified in the Health and Wellbeing Strategy | Increase in the number of people who are still at home 91 days after discharge from hospital into rehabilitation / reablement services | • Links to outcome measures for Better Care Fund, and improvement to integrated care<br>• Prevents admissions to hospital<br>• Addressing inequalities by focusing on the most vulnerable<br>• Improved partnership working | 10% |

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|---|---|---|---|---|
| | | | | |
| | | Increase in the number of people who are streamed to urgent care or primary care from A&E | • This is part of a 2 year programme that aims to prevent hospital admission via A&E.<br>• Reduce pressure on A&E<br>• Improving flow through hospital<br>• Reduced waiting times in A&E<br>• Encourages correct use of health services<br>• Better educated population<br>• Improved access to appropriate services, which will help address access inequalities | 10% |