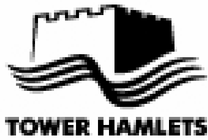

TOWER HAMLETS HEALTH AND WELLBEING BOARD

Tuesday, 15 March 2016 at 5.00 p.m. Committee Room MP702, 7th Floor, Mulberry Place, 5 Clove Crescent, London E14 2BG

This meeting is open to the public to attend.

Members:	**Representing**
Chair: Mayor John Biggs	Mayor
Vice-Chair: Councillor Amy Whitelock Gibbs	Cabinet Member for Health & Adult Services
Councillor Rachael Saunders	Cabinet Member for Education & Children's Services
Councillor David Edgar	Cabinet Member for Resources
Debbie Jones	Director of Children's Services
Dr Somen Banerjee	Director of Public Health
Luke Addams	Interim Director of Adults Services
Dr Amjad Rahi	Chair of Healthwatch Tower Hamlets
Dr Sam Everington	Chair, NHS Tower Hamlets Clinical Commissioning Group
Jane Milligan	Chief Officer, Tower Hamlets Clinical Commissioning Group

Co-opted Members

Dr Ian Basnett	Public Health Director, Barts Health NHS Trust
DengYan San	Young Mayor, Tower Hamlets
Dr Navina Evans	Deputy Chief Executive and Director of Operations, East London Foundation Trust
Suzanne Firth	Chair of Tower Hamlets Community Voluntary Sector
Jackie Sullivan	Hospital Manager, Barts Health
Phil Langworthy	Acting Borough Commander, Metropolitan Police
Jane Ball	Tower Hamlets Housing Forum Representative

The **quorum** 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
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

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Role of the Tower Hamlets Health and Wellbeing Board.

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

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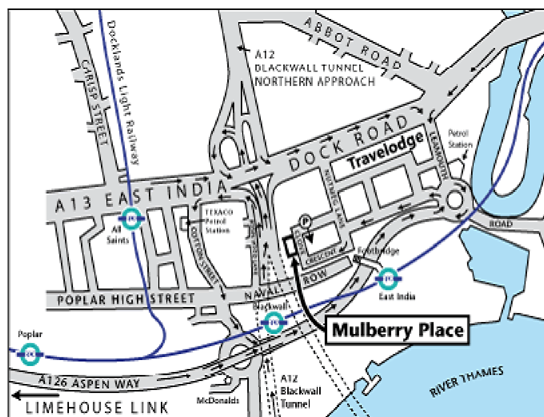

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PAGE NUMBER(S)

1. STANDING ITEMS OF BUSINESS

1 .1 Welcome, Introductions and Apologies for Absence

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

1 .2 Declarations of Disclosable Pecuniary Interests — 1 - 4

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

1 .3 Minutes of the Previous Meeting and Matters Arising — 5 - 10

To confirm as a correct record the minutes of the meeting of the Tower Hamlets Health and Wellbeing Board held on 12 January 2016. Also to consider matters arising.

2. ACTIONS UNDER DELEGATED AUTHORITY

To note any actions by the Director of Public Health Under Delegated Authority since the last meeting of the Board on 12 January 2016.

3. FORWARD PROGRAMME

To consider and comment on the Forward Programme.

Lead for item: Somen Banerjee, Director of Public Health, LBTH.

4. ITEMS FOR CONSIDERATION

4 .1 The Better Care Fund In Tower Hamlets: Review Of Progress To Date And Summary Of Changes For 2016-17 — 11 - 110

The report outlines progress with the Better Care Fund (BCF) programme in 2015-16 and seeks the endorsement of the Health and Well-Being Board for the proposed Better Care Fund programme for 2016-17. It covers a more detailed report presented to, and endorsed by, the Integrated Care Board on 18 January 2016.

Recommendations

1. Note progress with the Better Care Fund (BCF) programme in 2015-16, as set out in the report attached as Appendix 1, which was considered by the Integrated Care Board on 18 February 2016.
2. Endorse the proposed BCF programme for 2016-17, as summarised in
3. Appendix 1, and the draft agreement under section 75 agreement under of the NHS Act 2006 (Appendix 2).

4. Note that technical guidance concerning Better Care Fund planning for 2016-17 was published on 23 February 2016, which implies that final agreement of BCF plans by NHS England will not happen until early summer.
5. Note that the Mayor, on behalf of the council, and the CCG will be invited formally to adopt the programme, and this will be reflected in a legal agreement under section 75 of the NHS Act 2006.
6. Agree that any final amendments should be delegated to relevant Chief
7. Officers within the council and the CCG, subject to consultation with the Mayor and the Chair of the Health and Wellbeing Board.
8. Agree that day-to-day governance of the BCF programme in 2016-17 should be delegated to the CCG's Complex Adults Programme Board, on which the Council will be represented.
9. Note that a comprehensive review of the BCF programme will take place in 2016-17, as part of wider reviews of joint working between the Council and the CCG.

Lead Officers: Josh Potter, Deputy Director of Commissioning and Transformation, NHS Tower Hamlets CCG and Steve Tennison, Senior Strategy, Policy and Performance Officer – Integration Lead, LBTH

4 .2 Tower Hamlets Health And Wellbeing Strategy 2016-20: Developing A Strategy That Will Make A Difference - Next Steps **111 - 156**

The report sets out the key issues emerging out of the two Health and Wellbeing Strategy development workshops and discuss the implications for the Strategy.

Recommendations:

The Health & Wellbeing Board is recommended to:

Review the paper and reflect on the questions set out at the end:

1. Do the definitions of 'health' and 'wellbeing' (and the concept of health as one of a numbers of resources for wellbeing) feel ok as working definitions for the strategy?
2. Does the 'health community' description feel like a good description of what we would like Tower Hamlets to look like if it is a place that supports health as a resource for wellbeing?
3. Does the description of the interdependencies of the Health and Wellbeing Strategy with other strategies sound right?
4. Does the approach to the strategy sound right?
5. Do the transformational areas feel about right? Is there anything important missing?
6. Do the next steps of involving Board members and getting them to identify a s mall number of metrics and actions for the strategy to track feel right?
7. Anything else?

Lead Officer: Somen Banerjee, Director of Public Health

4 .3 Transforming Services Together Programme Strategy and Investment Case **157 - 208**

The report sets out the Transforming Services Together (a partnership programme of work between Newham, Tower Hamlets and Waltham Forest CCGs and Barts Health Trust).

Recommendations:

The Health and Wellbeing Board is recommended to:

1. Note the publication of the strategy and engagement plan;
2. Provide initial views; and
3. Take part in the engagement period both by making a formal response to the engagement and encouraging others to make their views known.

Lead Officer : Neil Kennett Brown, Transformation Manager, NEL CSU

4 .4 Impact of Air Quality on Health in Tower Hamlets **209 - 214**

The report sets out the significant negative impact air pollution has on health with effects ranging from worsening respiratory symptoms and poorer quality of life, to premature deaths, from cardiovascular and respiratory diseases. The report also reports on a recent report and suggests links between air quality and diabetes, obesity, and changes linked to dementia.

Recommendations

The Health & Wellbeing Board is recommended to:

1. Note the outcome of the research presented and the general impact on health and wellbeing from poor air quality.
2. Review and prioritise the following actions that could be undertaken at a local level to reduce the impact of poor air quality on health.

Lead Officers : Esther Trenchard-Mabere, Associate Director of Public Health, LBTH and Professor Chris Griffiths, QMUL

4 .5 Adult Social Care Local Account 2014-15 **215 - 226**

The report provides the Health and Wellbeing Board with a summary of achievements and priorities as set out in the Local Account of Adult Social Care.

Recommendations

1. The Health and Wellbeing Board are asked to note content of the attached Local Account

2. The Health and Wellbeing Board are asked to consider if the scope of the next Local Account should be extended to take into account the integration agenda and widen the remit to public health and align it more closely to the work of the Health and Wellbeing Board.

Lead Officer: Luke Addams, Interim Director of Adult Services, LBTH

4 .6 Update On Dental Care Access For Children **227 - 238**

The briefing paper gives an update on dental care access for children in Tower Hamlets.

The paper summarises the dental services available to children, and provides information on current access figures, trends and comparisons. The paper identifies national and local action to improve access to dental services and suggests further action that will be taken in 2016/17 to increase dental service uptake.

Recommendations

That the Tower Hamlets Health and Wellbeing Board note the actions that are being taken to improve access to dental services to increase access by 5% in 16/17 (from 50.4%).

Lead Officers: Desmond Wright Consultant in Dental Public Health, Public Health London and Somen Banerjee, Director, Public Health

4 .7 Review of Healthwatch Tower Hamlets **239 - 246**

The report provides an update on the council's current review of Healthwatch Tower Hamlets (HWTH) and some of the emerging findings. The aim of the review is to develop a model for HWTH which builds on existing strengths, identifies areas of improvement and incorporates good practice from other local Healthwatch organisations. The review findings will help to set out a refreshed vision for Healthwatch Tower Hamlets and inform the retender of the Healthwatch contract.

The existing contract for HWTH expires on 31st March 2017 and the Council is required to have a new contract in place by 1st April 2017. The paper outlines the methodology for the review and timetable for reporting on the findings and commissioning of the new Healthwatch contract.

Recommendations:

The Health & Wellbeing Board is recommended to:

Note the report and provide any comments on the future model for Healthwatch Tower Hamlets.

5. ANY OTHER BUSINESS

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

6. DATE OF NEXT MEETING

To note the date of the next meeting

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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:-

Melanie Clay, Director of Law, Probity & Governance & Monitoring Officer, Telephone Number: 020 7364 4801

APPENDIX A: Definition of a Disclosable Pecuniary Interest

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

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

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LONDON BOROUGH OF TOWER HAMLETS

MINUTES OF THE TOWER HAMLETS HEALTH AND WELLBEING BOARD HELD AT 5.00 P.M. ON TUESDAY, 12 JANUARY 2016 COMMITTEE ROOM MP702, 7TH FLOOR, MULBERRY PLACE, 5 CLOVE CRESCENT, LONDON E14 2BG

Members Present:

Councillor Amy Whitelock Gibbs (Vice-Chair, in the Chair)	–	Cabinet Member for Health & Adult Services
Councillor Rachael Saunders (Member)	–	Deputy Mayor and Cabinet Member for Education & Children's Services
Councillor David Edgar (Member)	–	Cabinet Member for Resources
Dr Somen Banerjee (Member)	–	Director of Public Health, LBTH
Dr Amjad Rahi (Member)	–	Chair of Healthwatch Tower Hamlets
Jane Milligan (Member)	–	Chief Officer, Tower Hamlets Clinical Commissioning Group

Co-opted Members Present:

Dr Ian Basnett	–	Public Health Director, Barts Health NHS Trust
Dr Karl Marlowe	–	Attending on behalf of Navina Evans, Deputy Chief Executive and Director of Operations, ELFT

Others Councillors Present:

Councillor Denise Jones
Councillor Andrew Wood

Apologies:

Debbie Jones	–	Interim Corporate Director, Children's Services
Luke Addams	–	Interim Director of Adult's Services
Dr Sam Everington	–	Chair, Tower Hamlets Clinical Commissioning Group
Steve Stride	–	Chief Executive, Poplar HARCA
Dr Navina Evans,	–	(Deputy Chief Executive and Director of Operations)
Karen Breen	–	Director of Hospitals, Barts NHS Trust
Suzanne Firth	–	Chair of Tower Hamlets Community Voluntary Sector
DengYan San	–	Young Mayor

Others Present:

Dianne Barham	–	Chief Executive Officer, Healthwatch
Abigail Knight	–	Acting Associate Director OF Public Health LBTH
Josh Potter	–	Deputy Director of Commissioning and Transformation, CCG Tower Hamlets
Isabel Hodkinson	–	CCG, Tower Hamlets
Esther Trenchard-Mabere	–	Associate Director of Public Health, LBTH
Chris Lovitt	–	Associate Director of Public Health, LBTH
Andy Ewing	–	Chief Superintendent, Metropolitan Police

Officers in Attendance:

Tim Madelin	–	Senior Public Health Strategist, LBTH
Luise Dawson	–	Senior Public Health Strategist, LBTH
Simon Twite	–	Senior Public Health Strategist, LBTH
Alicia Thorton	–	Senior Public Health Strategist, LBTH
Ellie Kuper Thomas	–	Planning Officer, Strategic Planning, LBTH
Shazia Hussain	–	Service Head, Culture, Learning and Leisure, LBTH
John Gillespie	–	Health and Wellbeing Representative Tower Hamlets Community Voluntary Sector
Kevin Kewin	–	Interim Service Head Corporate Strategy & Equality
Sarah Williams	–	Senior Lawyer, Legal Services, LBTH
Keith Burns	–	Programme Director, Commissioning Health, LBTH
Nasima Patel	–	Service Head, Children's Services
Sarah Vallelly	–	Corporate Strategy & Equality, LBTH
Jane Ball	–	Vice Chair of Tower Hamlets Housing Forum/Chair of Health, Housing and Social Care Sub Group & Director of Residential Services Gateway Housing
Bruce Rowling	–	External Facilitator
Elizabeth Dowuona	–	Senior Committee Services Officer

NOTE – AGENDA ORDER

During the meeting the Board agreed to vary the order of business. To aid clarity, the minutes are presented in the order that the items originally appeared on the agenda.

COUNCILLOR AMY WHITELOCK-GIBBS (VICE-CHAIR IN THE CHAIR)

1. WELCOME, INTRODUCTIONS AND APOLOGIES FOR ABSENCE

1.1 Chair's Opening Remarks

Councillor Whitelock-Gibbs welcomed everyone to the meeting. Following introductions, she advised that the focus of the meeting was on a workshop to focus on the development on priorities around the Health and Wellbeing Strategy 2016-2020.

1.2 APOLOGIES FOR ABSENCE

Apologies for absence were received from Mayor John Biggs (Chair), Dr Sam Everington (NHS Tower Hamlets Clinical Commissioning Group), Luke Addams (Interim Director of Adults Services), Debbie Jones (Director of Childrens' Services), Dr Navina Evans (Deputy Chief Executive of East London and Foundation Trust) and Steve Stride (Chief Executive, Poplar HARCA).

1.3 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 disclosable pecuniary interests.

3. MINUTES OF THE MEETING HELD ON 17 NOVEMBER 2015

The minutes of the meeting held on 17th November 2015 is to be agreed as a correct record subject to the inclusion of Councillor Edgar and Dr Amjad Rahi on the list of those present.

4. ACTIONS UNDER DELEGATED AUTHORITY

None.

5. FORWARD PROGRAMME

The Board noted the Forward Plan. It was agreed at the next meeting in March there would be a reflection on the Health and Wellbeing Strategy workshop (12 Jan) to help establish priorities for the Health and Wellbeing Strategy 2016-20.

It was envisaged that the board meeting in March would need to be extended by half an hour to complete the business on the agenda.

6. ITEMS FOR CONSIDERATION

6.1 Health and Wellbeing Strategy 2016-2020 - Vision and Focus Workshop

As set out in the chairs opening remarks (section 1.1) the majority of this meeting will be devoted to workshops to focus on the development on priorities around the Health and Wellbeing Strategy 2016-2020.

The Board noted that the new Health and Wellbeing Strategy for 2016 to 2020 was currently being developed. This was a key partnership strategy setting out a shared vision of health and wellbeing in the Borough and in order to focus on to improve and transform betters outcomes in Tower Hamlets.

In view of the importance of the strategy and the critical role of the Health and Wellbeing Board in developing, overseeing and owning it, the Board meeting participated in an interactive workshop facilitated by Bruce Rowling. The workshops were designed to explore the collective aspirations for 2020 and the areas of focus needed to make progress towards these aspirations.

It was agreed that a workshop summary will be submitted to the next board meeting in March 2016.

ACTION – Somen Banerjee, Director of Public Health
Jamal Uddin, Strategy, Policy & Performance Officer
Elizabeth Dowuona, Democratic Services Officer

6.2 Spatial Planning and Health - Refreshing the Local Plan for Tower Hamlets

The report was presented by Ellie Kuper Thomas (Planning Officer, Strategic Planning LBTH) and Tim Madelin (Senior Public Health Strategist, LBTH).

The report summarised the new Local Plan which set out the vision, strategic priorities and a planning policy framework to guide and manage development in the Borough for the next ten to fifteen years. This is in line with the planning policy requirements set out by national and regional government.

The Board noted that it was important for the Borough to have an up to date plan in place with a clear vision, objectives and planning policies to guide

development decisions. Together with the London Plan, the Local Plan is a critical tool to plan proactively and positively for development. This presents the opportunity to focus on community needs and opportunities in relation to places, housing, economy, infrastructure, local services and other areas. It can also seek to safeguard the environment, adapt to climate change and enhance the natural and historic environment.

Officers at the meeting noted that the current Local Plan had strengthened the health and wellbeing dimension as a key cross cutting objective. Officers considered that this should be retained and reiterated in the new plan.

Specific issues for consideration in the new Local Plan in relation to health and wellbeing were noted as follows:

- Open and Green Space:
- High Streets which promote wellbeing
- Healthcare Infrastructure
- Housing Design
- Active travel and air quality

Members asked a number of questions and made various comments in relation to the report. The following points were noted:

- That although secondary schools had a good amount of open spaces and playing fields, primary schools lacked such spaces.
- The HWBB noted the rapid health impact assessment that has been undertaken on the previous Local Plan to help inform the new Local Plan. As a result, the board is keen to work with the council to ensure further assessments of the health impacts are undertaken as the Plan progresses. The board is also keen to see how the health impact assessment principles can be incorporated, without unsustainable resource implications, into the development process so they are applied as a matter of routine.

Somen Banerjee agreed to provide a formal response on behalf of the Health and Wellbeing Board to the 'Our Borough, Our Plan: A new Local Plan first step' consultation document.

ACTION – Somen Banerjee, director of Public Health

The Chair thanked all Members and partners of the Health and Wellbeing Board for attendance and contributions and commitment to the next stage of the refreshing of the Local Plan.

RESOLVED

1. That the scope, process and timescales for the new Local Plan be noted.

2. That the impact of the wider physical and socio-economic environment on health be noted.
3. That the key health issues identified in the discussion of the report that should be addressed in the new Local Plan be noted.

7. ANY OTHER BUSINESS

None.

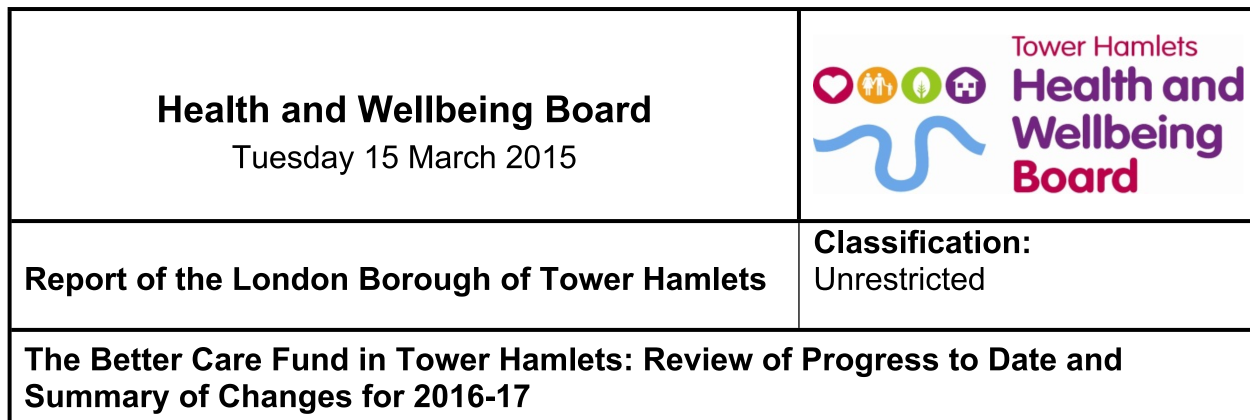
8. DATE OF NEXT MEETING

It was noted that the next meeting of the Health and Wellbeing Board was scheduled to take place at 5.00pm on 15 March 2016.

The meeting ended at 8.00 p.m.

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

Agenda Item 4.1



Health and Wellbeing Board Tuesday 15 March 2015	Tower Hamlets Health and Wellbeing Board
Report of the London Borough of Tower Hamlets	**Classification:** Unrestricted
The Better Care Fund in Tower Hamlets: Review of Progress to Date and Summary of Changes for 2016-17	

Lead Officer	Luke Addams, Director of Adult Services, LBTH Jane Milligan. Chief Officer, Tower Hamlets CCG
Contact Officers	Josh Potter, Deputy Director of Commissioning and Transformation, NHS Tower Hamlets CCG Steve Tennison, Senior Strategy, Policy and Performance Officer – Integration Lead, Tower Hamlets Council
Executive Key Decision?	No

Summary

This report outlines progress with the Better Care Fund (BCF) programme in 2015-16 and seeks the endorsement of the Health and Well-Being Board for the proposed Better Care Fund programme for 2016-17. It covers a more detailed report presented to, and endorsed by, the Integrated Care Board on 18 January 2016.

Following the Health and Well-Being Board's consideration of the proposed BCF programme at the present meeting, the Mayor, on behalf of the council, and the CCG will be invited formally to adopt the programme, and this will be reflected in a legal agreement under section 75 of the NHS Act 2006 (draft enclosed).

Recommendations:

The Health & Wellbeing Board is recommended to:

1. note progress with the Better Care Fund (BCF) programme in 2015-16, as set out in the report attached as Appendix 1, which was considered by the Integrated Care Board on 18 February 2016.
2. endorse the proposed BCF programme for 2016-17, as summarised in Appendix 1, and the draft agreement under section 75 agreement under of the NHS Act 2006 (Appendix 2).
3. note that technical guidance concerning Better Care Fund planning for 2016-17 was published on 23 February 2016, which implies that final agreement of BCF plans by NHS England will not happen until early summer.
4. note that the Mayor, on behalf of the council, and the CCG will be invited formally to adopt the programme, and this will be reflected in a legal agreement under section 75 of the NHS Act 2006.
5. agree that any final amendments should be delegated to relevant Chief Officers within

the council and the CCG, subject to consultation with the Mayor and the Chair of the Health and Wellbeing Board.

6. agree that day-to-day governance of the BCF programme in 2016-17 should be delegated to the CCG's Complex Adults Programme Board, on which the council will be represented.
7. Note that a comprehensive review of the BCF programme will take place in 2016-17, as part of wider reviews of joint working between the council and the CCG.

1. REASONS FOR THE DECISIONS

1.1 There is a need to review and update the Better Care Fund programme and associated section 75 agreement that was agreed in 2015-16. There is also a need to report on progress with the programme during 2015-16.

1.2 The government's BCF policy framework makes BCF available to Health and Well-Being Boards to be spent in accordance with the local Better Care Fund plan. However, as the HWBB is not legally able to commit resources, its decisions need to be ratified by the council and the CCG. The recommendations in the present report reflect this situation.

2. ALTERNATIVE OPTIONS

2.1 All of the 2015-16 schemes were scrutinised when developing the present proposed programme. As many are new initiatives that only commenced in 2015, while others are ongoing activity experiencing a high level of demand, there is a large amount of continuity in the programme proposed for 2016-17.
.

2.2 To ensure the future effectiveness and value for money of the programme it is proposed that a comprehensive review of BCF should take place in 2016-17. This will dovetail with other service reviews and the joint review of commissioning by the council and the CCG.

3. DETAILS OF REPORT

3.1 The aim of the Better Care Fund (BCF) is to deliver better outcomes and secure greater efficiency in health and social care services through better integration of provision. The BCF programme needs to be agreed jointly by the council and Tower Hamlets CCG. The jointly agreed programme is then incorporated in a formal agreement under Section 75 of the NHS Act 2006.

3.2 The BCF programme was overseen in 2015-16, on behalf of the Health and Well-being Board, by the Integrated Care Board (ICB), which is comprised of representatives from the CCG, the council and health provider organisations. The ICB endorsed the proposed programme for 2016-17 at its meeting on 18 February 2016.

3.3 The report to the ICB has also been submitted to the council's Mayor's Advisory Board for information and comment.

3.4 On 23 February 2016, NHS England and the Local Government Association issued Technical Guidance on the Better Care Fund in 2016-17. In developing BCF plans for 2016-17, local partners are required to develop, and agree, through their relevant Health and Wellbeing Board (HWB):

- a short, jointly agreed narrative plan, including details of how they are addressing the national conditions for the Better Care Fund;
- confirmed funding contributions from each partner organisation including arrangements in relation to funding within the BCF for specific purposes;

- a scheme level spending plan demonstrating how the fund will be spent;
- quarterly plan figures for the BCF national metrics.

3.5 The timetable associated with the Technical Guidance is as follows:

- **2 March:** Local areas to submit a BCF Planning Return template to NHS England detailing the technical elements of the Plan (This is a first 'checkpoint' to submit key information in draft format and an opportunity to flag any concerns or issues.).
- **21 March:** First submission of full narrative plans for Better Care, alongside a second submission of the BCF Planning Return template.
- **25 April:** Final submission, once formally signed off by the Health and Wellbeing Board.
- **?? May/June:** Likely formal agreement of BCF plan by NHS England.

3.6 This information was not available at the time the report to Integrated Care Board was produced, and there is a need to take into account its implications more fully. It is not anticipated that the technical guidance will require substantial changes to the BCF programme proposed to the Integrated Care Board. However, there is always the potential for NHS England to require changes to the borough's proposals. On the other hand, there is a pressing need for continuation funding to be agreed for schemes being rolled forward into the new financial year from 2015-16. Therefore it is proposed to continue the programme as planned, whilst completing the returns in line with the NHS England timetable, and to make any necessary amendments in the light of feedback from NHS England.

3.7 Following the Health and Well-Being Board discussion, the Mayor and the CCG will be asked formally to sign off the BCF programme for 2016-17 and the associated section 75 agreement (draft enclosed as Appendix 2). It will be proposed that any final amendments should be delegated to relevant Chief Officers within the council and the CCG, subject to consultation with the Mayor and the Health and Wellbeing Board.

3.8 When considering the proposed programme, the Board is asked to refer to Section 3 of the report to the 18 February meeting of the Integrated Care Board for a review of progress of approved schemes in 2015-16. Section 4 of the ICB report summarises the proposed BCF programme for 2016-17 and proposes a change to the governance arrangements for the BCF, whereby the CCG's Complex Adults Programme Board will replace the Integrated Care Board as the body with responsibility for oversight of the programme. The Health and Well-Being Board is asked to agree this change.

3.9 Prior to the 2016-17 BCF funding announcement, there were two capital grants included in the BCF: Social Care Capital Grant and the Disabled Facilities Grant. These have now been integrated into one grant, the Disabled Facilities Grant. The full implications of this change needs to be reviewed by the council, in particular whether there are ongoing schemes, previously funded by SCCG, which may require funding in 2016-17 and the legal

constraints on the uses of the pooled grant within the BCF. In the present report and the draft Section 75 agreement, the full £1,572,542 is shown.

3.10 There is one further proposed amendment to the overall programme set out in the paper to the Integrated Care Board, which arises from the technical guidance published on 23rd February. This allows for the performance pool from 2015-16 to be used as a local risk share. Given that the local incentive scheme within the BCF fulfils this function, there is no additional requirement for further CCG funds for community services to be included in the pooled budget. Consequently, the overall programme has been reduced by £1,135,628, leaving an overall programme of £21,434,989.

4. COMMENTS OF THE CHIEF FINANCE OFFICER

4.1 Better Care Fund (BCF) is a combination of central government funding streams that used to flow to LBTH and the NHS. The aim of the BCF is to facilitate an integrated approach to service procurement and delivery but as well ensure the social care budget is protected in terms of vital services to the community. The 2016-17 BCF guidance has placed a stronger emphasis on the protection of social care services which is being reflected in the proposed 2016-17 BCF allocation. The majority of the project funding is proposed to be spent on the services that interface with health and particularly on joint assessment and review teams.

4.2 During the 2015-16 the integration agenda has been pursued more on the joint assessment and reviews. The rest of the funding was spent on covering costs of social care services interfacing and impacting health services. The council and the CCG are currently undertaking a joint commissioning review to assess the areas and level of integration, including the budgetary implications.

4.3 There is a need to address the partners' BCF risk sharing in detail and review it regularly. The current 2016-17 proposed allocation tries to address any potential shift of demand but going forward the risk share should be reviewed regularly and reflected in the allocation. Failure to review the risk may lead to extra base budget pressures for the council.

5. LEGAL COMMENTS

Better Care Fund

5.1 The Care Act 2014 places a duty on the Council to exercise its functions by ensuring the integration of care and support provision with health provision, promote the well-being of adults in its area with needs for care and support and contribute to the prevention or delay of the development by adults in its area of needs for care and support. The 2014 Act also amended the National Health Service Act 2006 to provide the legislative basis for the Better Care Fund. It allows for the NHS Mandate to include specific requirements relating to the establishment and use of an integration fund.

5.2 The Government provides funding to local authorities under the Better Care Fund to integrate local services. The funding is through a pooled budget which is made available upon the Council entering into an agreement with a relevant NHS body under section 75 of the NHS Act 2006. Such agreements may be entered into where arrangements are proposed which are likely to lead to improvement in the way that prescribed NHS functions and prescribed health-related functions of the Council are exercised.

5.3 In order to receive the Better Care funding, the Government requires the Council to set out its plans for the application of those monies. The Government published a policy framework for the 2016/17 Better Care Fund programme in January 2016 which indicated that plans should be agreed by the Council's Health and Wellbeing Board ("**HWB**"), then signed off by the Council and CCG. This is consistent with the general policy, reflected in the Health and Social Care Act 2012, of giving HWBs responsibility for joint health and wellbeing strategies and the joint strategic needs assessment. The 2016/17 policy framework sets out the requirements for the plan to demonstrate how the area will meet certain national conditions, for example the delivery of 7-day services.

Contracting

5.4 Pursuant to section 75 of the National Health Service Act 2006, the NHS Bodies and Local Authorities Partnerships Arrangements Regulations 2000, the s75 Agreement provides for the establishment of funds made up of contributions from the Council and NHS CCG out of which payments may be made towards expenditure incurred in the exercise of their functions; for the exercise by NHS CCG of the Council's functions and for the exercise by the Council of the NHS CCG's functions in writing. In addition, the s75 Agreement covers specific objectives in relation (including but not limited) to:

5.4.1 agreed aims and outcomes of the partnership including the Council and NHS CCG's respective legal and regulatory responsibilities, and the client groups for whom the services will be delivered under the arrangement

5.4.2 operational arrangements for managing the partnership including performance and governance structures encompassing the resolution of disputes, conditions for renewal and termination of the partnership, provision and mechanisms for annual review, the treatment of VAT, legal issues, complaints and risk sharing

5.4.3 the respective financial contributions and other resources provided in support of the partnership including arrangements for financial monitoring, reporting and management of pooled, delegated and aligned budgets

5.4.4 linking in with existing governance arrangements including the role and function of the Integrated Care Board

5.4.5 achieving best value from Service Providers and principles in connection with the management of staff; and

5.4.6 flexibilities for the Council and NHS CCG in being permitted to add relevant service provisions and deciding future budgets for existing services within the remit of the s75 Agreement.

5.5 The s75 Agreement must be consistent with the 2016/17 Better Care Fund Plan approved by HWB and entering into it formalises the arrangements agreed by the Council and NHS CCG in accordance with the statutory, regulatory and guidance frameworks.

Wellbeing Principle and Equalities Duties

5.6 The Care Act 2014 places a general duty on the Council to promote an individual's wellbeing when exercising a function under that Act. Wellbeing is defined as including physical and mental health and emotional wellbeing and in exercising a function under the Act, the Council must have regard to the importance of preventing or delaying the development of needs for care and support or needs for support and the importance of reducing needs of either kind that already exist. The wellbeing principle should therefore inform the delivery of universal services which are provided to all people in the local population, including services provided through the Better Care Fund.

5.7 The Equality Act 2010 requires the council in the exercise of its functions to have due regard to the need to avoid discrimination and other unlawful conduct under the Act, the need to promote equality of opportunity and the need to foster good relations between people who share a protected characteristic (including age, disability, maternity and pregnancy) and those who do not.

6. ONE TOWER HAMLETS CONSIDERATIONS

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

7. BEST VALUE (BV) IMPLICATIONS

7.1 The Better Care Fund is concerned with achieving best value in the health and social care economy, by ensuring that services are provided most appropriately across the system and that the allocation of resources supports efficiency improvements, as well as better outcomes for service users. It also seeks to reduce the historic problem of financial savings in one sector being achieved at the expense of additional costs in the other, through better joint planning and shared priorities.

8. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

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

9. RISK MANAGEMENT IMPLICATIONS

9.1 As in 2015-16, the section 75 agreement will specify pooled funds within the BCF, commissioning arrangements and the arrangements for risk share, including how overspends and underspends will be dealt with for each pooled fund.

10. CRIME AND DISORDER REDUCTION IMPLICATIONS

10.1 The Better Care Fund has no direct implications for crime and disorder reduction.

11. CONCLUSIONS

11.1 The Health and Well-Being Board is invited to comment on the progress of the 2015-16 BCF programme and to endorse the proposed Better Care Fund programme for 2016-17. In addition, the HWBB is asked to note that, subject to the views expressed by the Board, the Executive Mayor and the CCG will be invited to sign off the BCF programme for 2016-17 by the end of March 2016.

Linked Reports, Appendices and Background Documents

Linked Report

- Report to Integrated Care Board, 18 February 2016 - The Better Care Fund in Tower Hamlets: Review of Progress to Date and Summary of Changes for 2016-17 (see Appendix to present report)

Appendices

- Report to Integrated Care Board, 18 February 2016 - The Better Care Fund in Tower Hamlets: Review of Progress to Date and Summary of Changes for 2016-17
- Draft section 75 agreement between London Borough of Tower Hamlets and NHS Tower Hamlets Clinical Commissioning Group

Local Government Act, 1972 Section 100D (As amended)
List of “Background Papers” used in the preparation of this report
None

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NHS
Tower Hamlets
Clinical Commissioning Group

Appendix 1

Integrated Care Board							Enclosure
Date of meeting	18 February 2016						
Agenda item							
Title of report:	**The Better Care Fund in Tower Hamlets: Review of Progress to Date, and Summary of Changes for 2016 – 17**						
Author(s):	Josh Potter, Deputy Director of Commissioning and Transformation, NHS Tower Hamlets CCG Steve Tennison, Senior Strategy, Policy and Performance Officer – Integration Lead, Tower Hamlets Council						
Presented by: **Sponsor (if different):**	NA						
Executive summary	• Updates the Board on progress with agreed BCF initiatives in 2015-16 • Outlines the proposed BCF programme for 2016-17.						
Recommendation (place an ' X' in one only)							
Information	☐	**Approval**	☒	**To note**	☐	**Decision**	☐
Key issues	There is a requirement to undertake an annual review of the BCF programme. There is also a need to agree a programme for 2016-17.						
Report history	The report is a standing item on the agenda.						
Patient and Public involvement	The Integrated Care Strategy has been developed and delivered with significant PPI activity. The BCF is a pooled budget to facilitate this ongoing delivery						
Risk implications	The CCG and LBTH require a Section 75 to be in place to govern pooled funds. An agreed BCF assists with compliance with the Operating Framework standards						
Impact on Equality and Diversity	N/A The Integrated Care Strategy was subject to an EQIA in 2014/15						
Resource requirements	N/A						
Next steps	A similar report will be presented to the Mayor's Advisory Board on 8 March 2016, the Health and Well-Being Board on 15 March, prior to sign off by the Executive Mayor and the CCG.						

APPENDIX 1

1. **Introduction**

1.1 This report is to seek the approval from the Integrated Care Board, CCG Governing Body, and Mayor's Advisory Board of the proposed 2016-17 Better Care Fund (BCF) programme, prior to its consideration at the Health and Well-Being Board on 15 March 2016 and its anticipated sign-off by the Mayor. The report also briefly summarises progress to date on the BCF programme in 2015-16 for information and comment.

1.2 The Board is asked to:

(i) note progress with the BCF programme in 2015-16;
(ii) approve the proposed BCF programme for 2016-17, and
(iii) note that the proposed 2016-17 programme will be considered at the 15 March 2016 meeting of the Health and Well-Being Board, prior to its anticipated formal sign-off by the CCG and by Individual Mayoral Decision in the council.

2. Background

2.1 The Better Care Fund was introduced in the 2013 Spending Round. The Government announced a national £3.8 billion pooled budget for health and social care services, building on the existing NHS transfer to social care services of £1 billion (usually referred to as S256 funding). The aim of the BCF is to deliver better outcomes and greater efficiencies in health and social care through more integrated health and social care services.

2.2 In 2014, the London Borough of Tower Hamlets, and Tower Hamlets Clinical Commissioning Group (CCG) submitted a jointly agreed Better Care Fund application to NHS England and Local Government Association. This was approved without conditions on 07 January 2015 by NHS England and came into effect on 1 April 2015. The total value of the fund in 2015-16 for Tower Hamlets was £21.577m.

2.3 The BCF programme is governed by a formal agreement between the council and the Tower Hamlets CCG under Section 75 of the NHS Act 2006. In recent weeks, the CCG and the council have been developing a proposed BCF programme for 2016-17. This will be reported to the Health and Well-Being Board (HWBB) on 15 March. The Health and Well-Being Board (HWBB) terms of reference state that it should 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'. However, it is not empowered formally to commit the resources of the CCG or the Council.

2.4 The Section 75 agreement governing the BCF, therefore, requires separate formal decisions to be made by both organisations. It is anticipated that the CCG and the Mayor will formally 'sign off' the programme shortly after the meeting of the HWBB.

3. Review of 2015/16 Better Care Fund Schemes

(i) Integrated Care Network Improved Service (ICNIS)

What is the purpose of the scheme?

3.1 The introduction of the IC NIS aims to incentivise an integrated care approach for patients in the top risk levels in Tower Hamlets.

3.2 Two levels of integrated care packages were introduced:

- **"level 1"** package of integrated care will include many of the desirable features of the Avoidable Unplanned Admissions Direct Enhanced Service (AUA DES) (such as crisis plan and named clinician) – currently, given the undertaking by the CCG to make no changes to the disease specific NISs a person under for example, the diabetes care package, can also be in receipt of level 1
- **"level 2"** package of integrated care will deliver the remainder of the specification of the previous Co-ordinated Care NIS (including personalised care planning and where appropriate anticipatory care planning). Patients under the level 2 package will exit from disease specific care packages for the purpose of payment (i.e. their data will not contribute to payment outcome measures). However, practices will still be expected to provide the components of care as specified in these packages for as long as is clinically appropriate.

Have any changes been made to the scheme since the original proposal was made?

3.3 For 2016/17 the CCG has undergone a review of the Network Improved Services within Tower Hamlets. The review has resulted in a new structure to this incentive scheme, within the same overall cost:

- The scheme now focuses on clinical stratification (rather than using the risk of admission score). Therefore the population is divided into: complex (i.e. people with complex needs such as palliative), LTCs and a 'healthy' cohort (i.e. the remaining of our patients).
- Based on the above, the IC NIS will be divided into IC1 which will include the complex group and IC2 which will include people with LTCs who were previously under care packages (Diabetes, CVD, Hypertension, COPD and cancer).
- The AUA DES, if it is still funded by NHSE, will be replaced by the IC1 Admission Avoidance component of the NIS which will incentivise a comprehensive review within 3 weeks of the day of discharge of patients who are admitted due to MI/stroke/HF or patients over 65 years admitted with hypoglycaemia, falls and fractures or gastrointestinal bleeding/ COPD/vascular ulceration/gangrene.

What has the scheme achieved?

3.4 The ICNIS contributes towards the delivery of the Integrated Care Strategy as a whole. Please see "Integrated Community Health Team" for a description of achievements to date

3.5 In terms of process indicators, performance at January 2016 is:

	Entry Level Consent	Crisis Plan	Account GP	1st PAM	2nd PAM	Patient Centred Care Plan
Borough	1636	2435	1192	390	22	1847
The One Network	92	318	60	40	0	177
East End Health Network	236	449	263	0	0	312
Stepney and Whitechapel Network	283	166	83	35	0	131
The Highway Network	162	251	166	23	0	220
Bow Health Network	212	298	146	159	12	234
Mile End East and Bromley By Bow Network	326	329	155	131	10	274

Poplar and Limehouse Network	320	467	253	2	0	317
Healthy Island Network	5	157	66	0	0	182

(ii) Rapid Assessment Interface and Discharge (RAID)

What is the purpose of the scheme?

3..5 Rapid Assessment Interface and Discharge (RAID) is a service open to all patients with mental health and drug and alcohol problems over the age of 16 presenting at the Royal London Hospital and all associated Barts Health sites in Tower Hamlets.

3.6 The service offers a comprehensive range of mental health specialities within one multi-disciplinary team. The role of this team is to provide clinical support and supervision in mental health interventions, alongside formal and informal training for general acute hospital staff.

3.7 The model emphasises rapid response, with a target time of one hour within which to assess referred patients who present to A&E and 24 hours for seeing referred patients on inpatient wards. This focus on prompt assessment and intervention is intended to improve patient experience and outcomes, support diversion and discharge from A&E and facilitate early discharge from inpatient wards. The RAID service is available 24 hours a day.

Have any changes been made to the scheme since the original proposal was made?

3.8 No, and we would like to continue with the service in its current form.

What has the scheme achieved?

- Since its launch in April 2014, there has been a 40% increase in patients seen by RAID in A&E and a 62% increase in patients seen by RAID in inpatient wards.
- As of August 2015, the service reported seeing 93% of patients in A&E within 1 hour of referral and 94% of patients within inpatient wards within 24 hours of referral.
- Over 1,200 staff have been trained face to face by the RAID team.
- An interim evaluation of the four RAID services across East London (including Tower Hamlets) by UCLP partners indicated that, when outliers were excluded, the combined overall impact of RAID across all hospitals was as follows:
    - There is evidence of an overall decrease in length of stay for patients with mental health and drug and alcohol problems since the introduction of RAID. This is largely driven by a reduction in bed usage for non-elective patients, especially for those with dementia, substance misuse and severe mental illness. It is estimated that this reduction has in total saved approximately 2833 bed days in the 2014/15 financial year
    - According to the data available, the introduction of RAID does not appear to have had any impact on excess bed days for patients with mental health or drug and alcohol problems. It also appears that the percentage of readmissions for mental health and drug and alcohol patients has increased since the introduction of RAID.

(iii) Integrated Community Health Team

What is the purpose of the scheme?

APPENDIX 1

3.9 The integrated community health team provides health and social care input to all patients over the age of 18 graded as being at very high risk, high risk or medium risk of admission of a hospital admission. The service offers a comprehensive range of specialities within one multi-disciplinary team, including nursing, therapies, social care, mental health and case management. There is also specialist input from a community geriatrician and palliative care nurse. The teams are divided into 4 localities across the borough. The focus of the service is primarily related to preventing the highest risk groups from requiring health interventions, particularly acute and secondary health services, and providing personalised, co-ordinated care in the community. The emphasis is upon improving patient experience and outcomes, supporting self-care, preventing A&E attendances and hospital admissions and facilitating timely discharge from inpatient wards. The service is available 24 hours a day (between 8pm-8am, this is comprised of nursing provision only).

Have any changes been made to the scheme since the original proposal was made?

3.10 No, and we would like to continue with the service in its current form. It should be noted that as a key part of a service subject to recommissioning, the mobilisation of any new Community Health Services contract may result in amendments being made to the day to day operations of the Community Health Teams

What has the scheme achieved?

- In March 2015, the integrated community health teams had over 1000 people from the integrated care pathway on their caseload.
- On average, across the four locality teams in March 2015, the service reported:
  - Responding to 98% of rapid response referrals within 2 hours
  - Providing input/putting in place packages of care for 97% of urgent referrals within 24 hours
  - Providing input/putting in place packages of care for 96% of routine referrals within 5 days
- Following a number of recruitment drives, the vacancy rate has significantly reduced and is expected to reach 95% posts filled over the next few months.
- The service, together with other key players across the integrated care pathway, has played a central part in reducing A&E attendances and emergency admissions:

Description	Annual Target Savings	Risk Band	YTD Actual Achieved £	FOT Savings Achieved £	FOT Variance (Savings Achieved) £
Inpatient	£1,183,031	**Very high**	£649,259	£3,105,369	**£1,922,338**
		High	£1,119,190		
		Moderate	£560,578		
Outpatient	£276,198	**Very high**	£64,816	£473,549	**£197,351**
		High	£185,052		
		Moderate	£105,294		

A & E	£95,089	**Very high**	£43,744	£72,487	**-£22,602**
		High	£7,146		
		Moderate	£3,475		
	£1,554,318		**£2,738,554**	**£3,651,405**	**£2,097,087**

(iv) Community Health Team (Social Care) (CHT SC)

What is the purpose of the scheme?

3.11 This scheme seeks to improve the experience and outcomes for those with long term conditions, at the highest risk of hospital admission or readmission. The service works with those who are in the Integrated Care Pathway (ICP) target cohort; their families and Carers. The overall aim is to decrease the risk of hospital admission, reduce or postpone the need for long term care and prevent Carer breakdown.

Have any changes been made to the scheme since the original proposal was made?

3.12 It was evident that to deliver on the overall BCF CHT SC integrated operational and strategic aims, that a more robust management structure was needed. The staffing structure was reconfigured to address this issue and the team is now almost fully recruited to and operational.

What has the scheme achieved?

3.13 CHT SC Managers are working on specific operational and strategic areas in partnership with Health colleagues. These include planning and implementing procedures, WELC - Care Planning, Vanguard - Single Point of Access, THIPP and TST End of Life work. They are Continuing Health Care (CHC) Panel and Joint Funding meeting members and are proactive in improving CHC processes. They are responsible for the management of the team including operating a Duty/Safeguarding service for those in the target cohort.

3.14 Senior Practitioners each have a responsibility for 2 Localities and 4 Primary Networks; they attend Locality Board meetings in a liaison role. They act as a resource for CHT colleagues, around social care issues, legislation and safeguarding. A Senior Practitioner post is embedded in the Assessment and Intervention team leading on integrated working in the Adults service.There are now 10 Social Work posts in the team. Each has a responsibility for either a Primary Network or Central CHT Neuro rehabilitation work. They attend MDT meetings for their designated area. They carry out joint visits with health colleagues. This involves supporting the individual to self- assess; carrying out Carers' and joint assessments. They use a person-centred model in doing so, and also respond to crises to prevent a person being admitted to hospital or Carer breakdown. Each worker is allocated to approximately 24 people at any one time, plus others on a duty basis. Full co-location has not been possible due to ICT and telephone issues. However a successful bid to Vanguard was made for IT systems, equipment and mobile devices will be made available and this will support co-location becoming a reality. (There is a target of mid-2016.)

3.15 Outcomes include:

- Over the period June 2015 to January 2016, the number of clients at highest risk of hospital admission that are on the ICP list and receiving long term care service has risen from 891 to 1326.

- The proportion of clients who are assessed as being at high risk has fallen from 28% to 24% in the same period.
- Joint intervention highlights where the client requires rehabilitation and/or an equipment solution, to reduce risk.

Measure	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan
Number ICP clients receiving long term social care services			891			1179	1254	1274	1307	1326
Number/% ICP cohort assigned to a social care team						747 (63.4%)	871 (69.4%)	881 (69.12%)	900 (68.85%)	949 (71.6%)
Number/% ICP clients allocated to CHT			422			464	500	484	475	525
			47.40%			39.40%	39.90%	38.00%	36.40%	39.60%
Social Care Episodes Completed for ICP Cohort	*534*	*524*	*742*	*685*	*555*	*726*	753	*634*	*243*	*696*
ASCOF 1C - % of cohort receiving self-directed support			70.9			68.5	68.8	59.8	60.3	61.1
ASCOF 2A - permanent admissions of cohort to residential and nursing care 65+ (in last 12 months)			11			15	19	16	13	16
% clients in community care setting			779 (87.4%)			%	1107 (88.3%)	1132 (88.85%)	1164 (89.06%)	1178 (88.8%)

(v) <u>Seven Day Hospital Discharge/ Avoidance</u>

What is the purpose of the scheme?

3.16 Unnecessary delays in discharging patients can lead to delays in admissions, transfers and cancellation of operations. An acute bed is estimated to cost the approximately NHS £500 per night. The goal is for timely, effective and appropriate discharges, which maximise the outcomes for individuals and support families and carers.

3.17 It is not in a patient's best interest to remain in an acute hospital bed longer than necessary; the risks include exposure to hospital-acquired infections, loss of functional independence and depression.

3.18 The BCF scheme supports the extension on the role of social workers to 7 days per week within Bart's Health NHS Trust, with particular attention to the Royal London Hospital, the Trust's trauma centre. The scheme expands the operating hours that social workers assess and discharge patients deemed medically fit for discharge. The area of the hospital covered initially was A&E and wards 11E and 11F.

Have any changes been made to the scheme since the original proposal was made?

3.19 The scheme has progressed due to its success in creating vacant beds at the Royal London Hospital. It now covers the entire hospital, apart from children's wards. We have introduced two designated social workers to be based in A&E and 11E/F the

area known as AAU – Acute Assessment Unit. A development for 2016-17 is to seek a move for social workers to be ward-based, as part of our integration program. This will lead to efficiencies in assessment turnaround times and improved multi-disciplinary working. We are continuing to develop our work with the Home from Hospital scheme in AAU regarding admission avoidance work. We also work closely with CHT – Community Health Team – in identifying people who are frequent visitors to hospital, via the ICP – Integrated Care Pathway list.

What has the scheme achieved?

3.20 There is a quick turnaround of cases, and good working relationships have been developed with health colleagues. Since the introduction of the Patient Flow Coordinators, there has been an increase in the number of referrals but also added pressure on social work staff. For the 7-day service, we are now able to both receive and assess patients on the acute wards who are deemed medically fit at weekends and bank holidays, and reduce the throughput of assessment time, thereby facilitating earlier discharges from acute beds.

Measure	**April**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Total**
Number of referrals to Out of hours	65	88	87	59	81	82	83	81	115	88	829
Number of referrals From Acute and Assessment Unit to Out of hours to prevent Hospital Admission	21	17	34	16	30	20	32	21	35	26	252
Total Number of discharges completed to reduce hospital length of stay	31	47	43	26	34	41	33	38	45	35	373
Total Number of discharges completed to prevent hospital Admission	9	10	17	9	17	12	16	15	26	19	150
Accelerated discharges completed to prevent hospital admission as a % of all referrals	42.9%	58.8%	51.5%	56.3%	56.7%	60.0%	50.0%	71.4%	74.3%	73.1%	
Accelerated discharges completed to reduce hospital length of stay as a % of all referrals	47.6%	53.4%	49.4%	44.1%	42.0%	50.0%	39.8%	46.9%	56.20%	56.40%	
Assessments undertaken and services needed identified	53	65	79	36	68	56	54	59	95	65	630

(vi) <u>Reablement Team</u>

APPENDIX 1

What is the purpose of the scheme?

3.21 Reablement services aim to help people with illness or disability cope better by learning or re-learning skills necessary for daily living. These skills may have been lost through deterioration in health and/or increased support needs. The focus is on helping people do as much for themselves as possible, rather than resolving health issues as such.

3.22 Reablement Services are generally provided for a period of up to six weeks. Some people meet their goals in a far shorter period of time, while others, such as stroke survivors, may need a much longer reablement and rehabilitation period. Typically, people receiving reablement services have suffered an acute illness/event (e.g. a fall), have a long-term condition, and/or are growing frail. The service is large, with approximately 60 employees, including its own dedicated Out of Hours Service.

3.23 *Joint working with Community Health Team Therapies*: Reablement and CHT joint working agreements were set up by Lead Reablement OT and Lead CHT Physiotherapist to streamline service users journey through intermediate care services, promote integration and partnership working across health and social care, maximise functional outcomes for service users, target resources to services users likely to benefit most and prevent duplication. Initially, three target user groups were identified and pilot joint working agreements were set up for each target group.

Have any changes been made to the scheme since the original proposal was made?

3.24 Functional disorder joint working cases with CHT has been stopped due to the complex nature of the user group and negative functional responses by this user group to therapeutic input.

What has the scheme achieved?

3.25 The following relates to mainstream Reablement activity.

- Referrals for 2015-16 are on average 55 per month, with 54% of these referrals coming from the Hospital Social Work Team.
- The waiting list for an allocated worker in Reablement is at present 43 people, with the longest wait for an 'assessment' being 42 days. The average wait for an 'assessment' in Reablement is approximately 25 days.
- All urgent support packages within Reablement are started within 24-48 hours (for example, for hospital discharges or urgent request from Assessment and Intervention (A&I) Social Care Team).
- There have been 41 Community Physiotherapy cases to date since July 2015 and this joint working stream is going well, Physiotherapists are working with Reablement Officers to implement exercise programmes, practice outdoor mobility and progress independence in mobility aid (e.g. walking frame to stick).
- *Discharge to Assess/Home Assessment Pathway* – This is a new scheme running from November 2015 to March 2016. Its primary focus is safely to discharge medically stable patients, who are in the Royal London Hospital and aged over 65 years, either to an extra care sheltered flat, or home. The Reablement Service will be offering the option for this service to access Reablement Officer support to help support the therapy staff in the team to meet agreed treatment goals for this user group during the 28 day 'rehabilitation' period. There will be an option for these users to access the Reablement pathway following this period, where appropriate. As of the end of January 2016 the service has supported 26 users within this pathway, with 12 being referred in January 2016.

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Measure	April	May	June	July	Aug	Sept	Oct	Nov
Number of referrals to reablement	41	47	49	45	57	39	64	56
Number of referrals from hospital team	23	28	22	30	32	25	37	20
Number of referrals from community teams	18	19	27	15	25	14	27	27
Number of independence plans completed	31	46	43	36	24	36	36	
Number completed reablement episodes	36	33	45	44	45	30	36	19
Average length of time in service (referral to conclusion) weeks	10	12.7	13.6					

(vii) Independent Living (Assistive Technology Project)

What is the purpose of the scheme?

3.26 The objective of the Assistive Technology (AT) Project is to integrate the use of assistive technology into mainstream health and social care provision, to enable residents to live independently in their own homes. It uses a range of training and communication methods to raise staff awareness, giving them the knowledge, confidence and support to prescribe appropriate assistive technology equipment for their service users.

3.27 The project also included the evaluation and development of an Independent Living Service (ILS) to look at the integration of a number of teams to rationalise processes and improve service provision.

Have any changes been made to the scheme since the original proposal was made?

3.28 The development of the ILS now forms part of a larger review of Adult Services, which is now underway.

What has the scheme achieved?

- Since April, operational staff across a wide range of health and social care teams have continued to receive training in the use of AT to support independent living. AT Implementation Officers have provided further support by having a presence in 18 operational teams across nine separate locations. They deliver awareness sessions, hold surgeries at area offices, and attend team meetings. The total number of training sessions delivered so far this year is 15 and has involved 104 staff, 37 from health and 67 from social care.
- Systems have been put in place to enable health and social care staff to prescribe appropriate items of assistive technology equipment and 1:1 support is provided to assist them, where appropriate. For April 2015 to January 2016, the number of requests for AT was 434, and installations was 472. Requests for AT were received from 14 different teams, 5 of which are hospital or community based teams. This illustrates that awareness has been raised across a range of social care and health professionals in various locations.
- Between April and December there were avoided costs of £235,230, in 21 cases, as a result of assistive technology. This does not include continuing avoided costs validated from previous periods. For the 21 cases, the projected annual avoided costs are £289,513. The avoided costs for cases identified in January cannot be validated yet and so no figures for this period have been included.

Measure	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Jan	Total
Number of requests for AT equipment made per month	30	52	43	40	54	36	39	42	51	47	434
Number of installations of AT equipment	46	48	51	33	55	49	44	44	57	45	472
Number of health and social care staff trained	16	7	19	8	3	12	0	8	5	26	104

(viii) Better Care Fund Enablers

What is the purpose of the scheme?

3.29 This scheme involves four additional officers within the council's Children and Adult Services', Policy, Programmes and Community Insight service, to perform the following functions:

- Programme managing and monitoring BCF schemes
- Co-ordinating the council's involvement in a range of programmes and processes concerned with the integration of health and social care
- Improvement of joint information management systems to facilitate more effective service delivery involving health and social care providers.

Have any changes been made to the scheme since the original proposal was made?

3.30 The scheme was formally added to the BCF programme by the Integrated Care Board in December 2015.

What has the scheme achieved?

3.31 The Team:

- provides a programme management office for all of the council's work to integrate social care and NHS services.
- leads on the development of a strategic vision for the council's approach to integration, including the engagement of council members.
- has developed Service Level Agreements for all approved BCF schemes for which the council is the lead commissioner
- has established and maintains performance management and monitoring systems for BCF-funded initiatives within the council
- has strengthened the council's involvement in a range of partnership bodies concerned with the integration of health and social care, including the Tower Hamlets Integrated Provider Partnership (THIPP), the Vanguard New Care Model, the WELC Pioneer and Transforming Services Together (TST)
- has contributed to the development of data sharing arrangements between the council and Health sector organisations.

(ix) Capital Schemes - Disabled Facilities Grant/ Social Care Capital Grant

What is the purpose of the scheme?

3.32 The Council has a statutory duty to provide Disabled Facilities Grants (DFGs) to eligible disabled residents for the adaptation of their home environment, to enable

them to continue to live as independently and safely as possible. DFGs are mandatory for necessary adaptations to provide better movement in and around the home and access to essential facilities. Social Care Capital Grant is used for the same purposes as DFG. Types of work eligible for grant funding are:

- to make it easier to get into and out of the dwelling - for example, by widening doors and installing ramps;
- ensuring the safety of the disabled person and other occupants - for example, via improved lighting to ensure better visibility;
- to make access to the living room easier;
- improving access to the bedroom, and kitchen, toilet, washbasin and bath (and/or shower) facilities - for example, by installing a stair lift or providing showering facilities;
- to improve or provide a suitable heating system in the home;
- to adapt heating or lighting controls to make them easier to use;
- to improve mobility around the home to enable the disabled person to care for another person who lives in the property, such as a spouse, child or another person for whom the disabled person cares;
- to improve access to and from the garden of the home, where feasible.

Have any changes been made to the scheme since the original proposal was made?

3.33 No. The Grant will continue in 2016-17. The funding allocation is still awaited.

What has the scheme achieved?

3.34 The main outcomes are summarised in the table, below.

Adaptation	No of Approvals (1.4.15 – 31.1.16)	No of Completions (1.4.15 – 31.1.16)
Wet floor shower	100	123
Stairlifts	29	29
Ramps	8	18
Ceiling track hoists	12	17
Steplifts	5	5
Other (incl. Through-floor lifts, over-bath showers, door widening, door openers etc.)	8	9
Total	**162**	**201**

(x) <u>Care Act Duties</u>

What is the purpose of the scheme?

3.35 The 2014 Care Act placed a number of new duties on the local authority, including a requirement to assess and meet the needs of carers on a similar basis to people cared for.

3.36 This scheme covers funding of two main areas: 2014 Care Act Implementation and new duties in relation to Carers. The aim of the scheme is to set the needed infrastructure in place and deal with the extra demand arising from the new duties of the Care Act.

3.37 The council has created additional capacity within social care services to support and put carers on a par with users for assessment, review and provide carer services and packages (for carers and social care clients). In addition, the council is working on

improving services such as Safeguarding Adults Board, advocacy and legal literacy training as well as investing into much needed IT systems.

3.38 The Carers Hub provides a range of personalised services and support to carers, and in so doing seeks to prevent, reduce or delay the requirement of more intensive, publicly-funded care services. The Carers Centre also supports the wellbeing of the carer, enabling them to continue in their caring role. The services support the main adult carer, who is a Tower Hamlets resident or who is caring without payment for someone who lives in Tower Hamlets.

3.39 The service offers a range of person-centred information, advice and advocacy, including statutory independent advocacy, as defined by the Care Act 2014. It also provides supported carer's assessments and referrals for statutory assessments and supporting services, as appropriate.

3.40 The key services provided are:

- signposting to other available universal services in the borough
- specialist information, advice and independent advocacy, including statutory advocacy, as defined for carers by the Care Act 2014
- where appropriate, support a referral to the council for a full, statutory carer's assessment, which may lead to a Carer's One Off Direct Payment (CDP) or carers' breaks
- information and advice and access to other services, as appropriate, that support carers to prevent, delay or reduce social care needs
- support for carers on hospital admission/ discharge, and forming links with primary care and Public Health to support carers of those with long term conditions, including carers of people with mental ill health and of end of life care needs
- information and support for carers to manage their own health and wellbeing needs
- services and activities to alleviate and manage stress and provide a break from caring
- representing and supporting carers' views in local authority and CCG planning, and acting as the voice of carers and building partnerships with other organisations
- outreach and support for hidden carers
- the development and delivery of a range of carers' training and awareness programmes and production of a quarterly newsletter aimed at carers, with news and updates on available services, policy or legislative changes.

Have any changes been made to the scheme since the original proposal was made?

3.41 Yes, the Carers' Hub contract was varied to better fit with the Care Act 2014 and we would like to continue with the service in its current form.

What has the scheme achieved? *(Quarters 1 to 3, 2015-16)*

- Over 1,000 carers accessed specialist information and advice; 137 accessed non-statutory advocacy and 29 accessed statutory independent advocacy; as defined by the Care Act 2014.
- 260 carers (target 300) were supported through carers' assessments and/or referred to the council for a full statutory carer's assessment
- 206 carers were referred to other services to support them to prevent, delay or reduce social care needs.
- Services and activities to alleviate and manage stress and/or provide a break from caring: 315 carers attended a relaxation therapy (target 225), 303 attended

a Relaxation Day, 141 attended an Eid celebration, 93 attended a Carers' Christmas Party, 502 accessed emotional support, and 27 took part in a Carers' Week coach trip.
- The Carers Centre enabled 41 carers to participate in Local Authority and CCG planning/consultation events. The service works with a wide range of agencies, building partnerships facilitate the meeting carer's needs.
- Outreach and support for hidden carers: the service reached 437 new carers who have not received the service previously or in the last two years.
- The Carers Centre enabled 81 carers to access training on manual handling, managing stress and managing challenging behavior.

(xi) Dementia Cafes

What is the purpose of the scheme?

3.42 BCF funding enables the Dementia Café Service to support people with Dementia and their carers to stay well for longer in the community. The Alzheimer's Society delivers four cafes per month in two community venues. Two cafes are inclusive and two are aimed specifically at the Bangladeshi community. The service aims to reduce social isolation, increase knowledge of the dementia pathway and increase take-up of other services.

Have any changes been made to the scheme since the original proposal was made?

3.43 No, and we would like to continue with the service in its current form.

What has the scheme achieved?

3.44 The success of the scheme can be seen from the performance data from the first three quarters of the year. The cafes were attended by 265 individual people with Dementia and 249 individual carers. The cafes are structured into information sharing and activities that are beneficial for the health of people with Dementia. For example, the past quarter saw the inclusive cafe deliver information sessions led by Safer Transport Team, Healthwatch, Talking Point, Stay Well this Winter campaign and the promotion of the Dementia-friendly swimming sessions. Activities at the inclusive café in quarter 3 included Singing for the Brain, the Connaught Opera, Strictly Come Dancing, Smell Reminiscence and an arts session led by the Geffrye Museum.

3.45 The following represents the number of individual people who attend any of the cafes during the quarter:

Unique users & carers	**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**	
	user	**carer**	**user**	**carer**	**user**	**carer**	**user**	**carer**
Target Inclusive Café 1	18	17	18	17	18	17	18	17
ACTUAL	25	22	25	21	36	32		
Target Inclusive Café 2	18	17	18	17	18	17	18	17
ACTUAL	23	17	25	19	30	27		
Target Bangladeshi Café 1	15	15	15	15	15	15	15	15
ACTUAL	14	14	17	21	18	22		
Target Bangladeshi Café 2	15	15	15	15	15	15	15	15
ACTUAL	17	16	18	20	17	18		

3.46 The impact of the service can be measured in part through its outcome monitoring. Quarter 3 of 2015/16 saw 96.8% of people from the inclusive café and 95.83% of people from the Bangladeshi Café indicate positive social engagement. Social isolation is especially damaging to the health of people with dementia. This service enables them to continue to access the community and activities targeted at making them feel included. A side effect of the cafes is that carers also feel supported and are able to network and share experiences with other carers. Keeping carers healthy is essential to keeping people well supported at home and not in hospital.

3.47 90.6% and 83.33% of people from the inclusive café and Bangladeshi cafe espectively reported a higher take up of local services. Often older people within the Bangladeshi community dislike accessing mainstream health services. The Alzheimer's Society manages this through bringing services into the café. A Quarter 3 case study details how the services work together. The Dementia Inclusion Service found an older Bangladeshi woman in the community with worries about her memory. Through their support she was able to get a formal diagnosis at the Memory Clinic and attend the café. At one of the café's health visiting sessions the optician was able to correctly attribute her deteriorating vision not to her vascular dementia but to her eye sight. Glasses thus restored her sight making the risk of falls much lower.

3.48 Finally, 90.6% and 87.5% of people from the inclusive café and Bangladeshi cafe respectively indicate better understanding of dementia and dementia care pathway. A better understanding of the services available to support someone with Dementia is necessary for diverting people away from emergency services to community based options.

3.49 Future plans for the scheme include ensuring that the services have maximum geographical reach. If the research suggests that there are people from areas of Tower Hamlets who do not access the service, there is an option of adding further venues if necessary. We are also exploring how to use assets in the community to instigate social support and networks between the formal café sessions and to use the current client base to facilitate this.

(xii) BME Dementia Inclusion Service

What is the purpose of the scheme?

3.50 The BCF funding enables the BME Dementia Inclusion Service to increase the proportion of people from Bangladeshi and other BME backgrounds with dementia who receive a formal diagnosis. The Alzheimer's Society delivers this service through case finding in the community, casework with individuals and their families, working with GPs, making referrals to diagnostic/support services and awareness-raising to communities which have little knowledge of Dementia.

3.51 Tower Hamlets has the fifth highest BME population in London and the largest Bangladeshi population in the UK. The proportion of older people from these groups is steadily increasing. The borough's population is set to grow by over 25% by 2026, with the 50-65 age groups increasing by 67% and 65+ by 38% (GLA). It is predicted that the number of people with dementia from BME groups will continue to rise. 6.1% of all people with dementia among BME groups being young onset, compared with only 2.2% for the UK population as a whole. Some BME groups may also have much higher incidences of vascular dementia which, has been linked to lifestyle and diet.

Have any changes been made to the scheme since the original proposal was made?

3.52 No, and we would like to continue with the service in its current form.

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What has the scheme achieved?

3.53 By increasing diagnosis, the scheme is achieving BCF objectives and reducing unplanned admissions as follows:

- By helping to explain problems people are experiencing crisis access of the health service is reduced
- There are other causes, such as depression, which exhibit similar symptoms that it is important to diagnose and treat, which prevents escalation of other health issues
- Advice on dementia prevention lifestyle changes helps keep people well and out of health services for longer.
- It allows access to medication which can maintain independence for longer.
- Post-diagnosis management of cardiovascular risk factors can help delay progression.
- After diagnosis people and their carers and families can access information and carer/ peer support through services such as Dementia Advisor, social care and Cafes making them more likely to understand pathways and less likely to access services in crisis.
- We can advise people on future planning which again prevents crisis accessing of costly services, such as accident and emergency.

3.54 The successes of the scheme can be seen in the performance monitoring data. Quarter 3 saw the BME Inclusion service meet the SLA targets. The Alzheimer's Society found 39 people from the BME community with possible dementia, who they are now supporting into diagnostic services; undertook casework with 40 people from the BME communities including the Bangladeshi community; and organised 8 awareness raising events.

SECTION A: Activity Description: Bangladeshi	**Target**	**Q1**	**Q2**	**Q3**	**Q4**
(a) Case Finding *Definition: identifying and making contact with individuals/carers with memory problems*	28	27	25	29	
For commissioner's info only: (b) New clients referred for case work to BME Inclusion service DSW *Can be from case finding as part of this service, DA, etc.*	N/A For info only	4	**5**	4	
(c) Casework *Definition: one-to-one support – open cases. Carers can be reported as a separate number if dedicated individual support is being provided to them separate from the PWD to support them in their caring role*	25	27	29	29	
(d) Awareness Raising events held	4	4	4	5	

SECTION B: Activity Description: Other BME communities	**Target**	**Q1**	**Q2**	**Q3**	**Q4**
(a) Case Finding *Definition: identifying and making contact with individuals/ carers with memory problems*	10	8	9	10	
For commissioner's info:	N/A For	2	**3**	2	

(b) New clients referred for case work to BME Inclusion service DSW *Can be from case finding as part of this service, DA, etc.*	info only				
(c) Casework *(one-to-one support – open cases)*	8	8	11	11	
(d) Awareness raising events held	3	0	3	3	

3.55 Services such as this which increase dementia diagnosis have had a huge impact on our national performance. The dementia diagnosis rate has increased in Tower Hamlets from below the national target of 2/3 to over 80% of people with dementia receiving a formal diagnosis. Tower Hamlets now has the 4th best diagnosis rate in London.

3.56 Future plans for the scheme include a targeted focus on ensuring other communities, in addition to the Bangladeshi community, are robustly supported by the service.

(xiii) Adult Autism Diagnostic and Intervention Service

What is the purpose of the scheme?

3.57 The Adult Autism Diagnostic and Intervention Scheme is designed to support the council and the NHS to meet specific statutory duties under the Autism Act and the Care Act. The Autism Act Statutory Guidance published those duties in March 2015:

Local Authorities and NHS bodies should jointly: Ensure the provision of an autism diagnostic pathway for adults including those who do not have a learning disability and ensuring the existence of a clear trigger from diagnostic to local authority adult services to notify individuals of their entitlement to an assessment of needs. NICE guidance and NICE Quality Standard on autism represent best practice when developing diagnostic services and related services.

3.58 The Adult Autism Diagnostic and Intervention service (ASD service) provides a service for high functioning adults (aged 18 years and over) with suspected Autism Spectrum Disorder (ASD) in Tower Hamlets. It also raises awareness within other agencies, including other parts of the Council and NHS. It sub-contracts a local Third Sector provider (JET) to provide employment support options for people diagnosed with ASD and facilitates appropriate referral and signposting to other services, where needed.

3.59 The service includes the following:

- A core diagnostic team to provide assessment of adults with potential ASD in Tower Hamlets, in line with NICE clinical guidelines for care of adults with autism
- Sign posting and referral to other services should a primary condition be other than ASD (e.g. mental health) or a risk be identified (e.g. self-harm or harm to others) that may require in-patient treatment
- Post-intervention support to adults with ASD (high functioning) including Cognitive Behavioural Therapies and assistance with developing social relationships
- Locally-based sub-contracted support service which enables user access to employment, training and advocacy.

3.60 The service is founded on the principles of a person-centred approach, with an emphasis on helping individuals to develop (or rediscover) their own unique skills through active engagement and participation. This includes a proactive approach in

utilising resources that are available within the service and the community to meet individuals' needs and aspirations.

Have any changes been made to the scheme since the original proposal was made?

3.61 No, we would like to continue with the service.

What has the scheme achieved?

3.62 The outcome of the 2014 Autism Self-Assessment Framework received in January 2016, confirmed that Tower Hamlets only received two Green ratings: one for the Autism JSNA produced by Public Health and one for the diagnostic pathway.

Service Outcome:	***Indicator:***	***Total***
Referrals	Total number of referrals (including self-referrals)	186
	Total number of people receiving a screening.	100%
	% of service users reporting they are satisfied/very satisfied with the diagnostic process. Bi- Annually Reporting	100%
Assessment and information on possible support options	Total number of people receiving a screening assessment assessed for coexisting physical health and mental health problems	69
	Total number of people approved for diagnostic assessment	51%
	Total number of people signposted to other services	25%
	Total number of basic health checks delivered	51%
	Total number of direct referrals to Mental Health Services	0.40%
	Total number of direct referrals to Community Learning Disability Services	0.10%
Case management	% of service users who are satisfied with the objectives set out in their care plan have been achieved	100%
Transitional support and planning	Total number of young people assessed as eligible to access the service. 18-25years	29
Employment, training and volunteering	Number of service users referred into Tower Project Employment Service to support into access employment and training	20
Awareness raising sessions	Number of ASD awareness raising sessions delivered to external agencies	32
Autism Carer Drop-in	Number of carers attending Autism Carers Drop in	29
	Number of Autism Carers Drop-in sessions delivered per annum	30
Service user surveys	Number of complaints	0
	Number of focus groups held	4

(xiv) <u>Social Worker input into Memory Clinic</u>

What is the purpose of the scheme?

3.63 A social worker working as an integral member of the Diagnostic Memory Clinic Team offers community assessments under the Care Act 2014, carers' assessments, organises packages of care, and provides signposting, advice and information and support. The inclusion of social care in the Diagnostic Memory Clinic (DMC) provides an integrated model of care throughout the dementia pathway in Tower Hamlets.

Access to social care in the Diagnostic Memory clinic helps improve service users' journeys at a vulnerable and anxiety-provoking time in their lives.

3.64 The scheme aims to achieve:

- An earlier assessment of service users in need of social care support, and earlier signposting of those not in need of social care input, without referring service users onto another team/ service.
- A more seamless service, greater efficiencies and a reduction in 'hand-offs' and changes of key team/worker for service users.

Have any changes been made to the scheme since the original proposal was made?

3.65 There have been no significant changes to the scheme since it was first proposed. Some small changes were made following a Pilot scheme in 2014-15, but the scheme has run the same way for the past year, with the social worker being fully embedded in the team, and, therefore, able to give advice to team members and input into the Multi-disciplinary Team discussion at an earlier stage in the diagnostic process.

What has the scheme achieved?

3.66 The Pilot scheme had already shown greater service user satisfaction. The aim in 2015-16 has been to build on this and consolidate this improved level of service user satisfaction. The scheme is on track to meet the majority of its targets (see table, below).

Service Outcome:	***Activity:***	***Indicator:***	***Annual Target: Please insert figures and not % unless relevant***
Social Work Input into the Diagnostic Memory Clinic	Assessment of the social care needs of service users of the Diagnostic Memory Clinic	Number of referrals to the Memory Clinic	Target: 400 Actual : 290 to 15/01/16
		Number of those referred to Social Worker (SW) in the Memory Clinic	Target: 150 Actual : 133 to 15/01/16
		Number assessed for Social Care needs	Target: 120 Actual: 98 to 15/01/16
	Carers Assessments offered to carers of those seen by Diagnostic Memory Clinic	Carers advised of their entitlement to a Carers Assessment	Target: 95% of those referred to SW Of those with known carers: 100% offered
		Carers Assessments completed by Social Worker in the Memory Clinic	Target: 30 Actual: 12 to 15/01/2016
	Timely response (within 28 days) for social care assessment whilst under the Memory Clinic *difficulty in capturing this information from electronic system	Contact made with service user to arrange an assessment within 7 days of referral to Social Worker	80 % of those referred to the social worker Actual: 100% from small desktop audit
		Assessment contact completed within 28 days of referral to Social Worker	90% of those referred to the social worker who consent to assessment Actual: 60% from small desktop audit
	Gather Service	Satisfaction survey given	Target:25% response

	user and Carer satisfaction surveys	to all those service users and carers in contact with Memory Clinic Social Worker for an assessment.	rate; 80% positive response rate Actual: 20.4 % response rate to 15/01/16 (20 responses) Nearly 97.5% positive - satisfied or above.

(xv) Strategic Development Schemes: 2015/16

Personalisation

3.67 The Personalisation Programme supports greater person-centred care as part of Tower Hamlets' agenda on delivering Integrated Care. The Programme Board overseeing this work, reports to the CCG's Integrated Care Board. The work streams within the Personalisation Programme have been developed in response to the direction set within NHS Five Year Forward View and Forward View into action: Planning for 2015/16 and enables the delivery of the CCG's new strategic priority on person-centred care.

3.68 The work streams with the programme are as follows:
- Widening the offer of Personal Health Budgets (PHB) beyond Continuing Health Care (CHC)
- Delivering Integrated Personal Commissioning (IPC) in Tower Hamlets and contributing to the national evaluation of this. NHS England has Commissioned RAND Europe to undertake this evaluation.
- Piloting the use of Patient Activation Measure (PAM) in Tower Hamlets
- Self-management, including oversight of the self-management pilots, their evaluation and recommendations on future commissioning plans.

3.69 From October 2014, CCGs were required to offer personal health budgets (PHB) to people with continuing health care needs (CHC/CH). The Forward View into action: Planning for 2015/16 outlines the requirement for CCGs to expand this offer

"To give patients more direct control, we expect CCGs to lead a major expansion in 2015/16 in the offer and delivery of personal health budgets to people, where evidence indicates they could benefit. As part of this, by April 2016, we expect that personal health budgets or integrated personal budgets across health and social care should be an option for people with learning difficulties, in line with the Sir Stephen Bubb's review."

3.70 In addition, the NHS Mandate, 2015, sets the objective that:

- Everyone with long-term conditions, including people with mental health problems, should be offered a personalised care plan that reflects their preferences and agreed decisions;
- Patients who could benefit should have the option to hold their own personal health budget as a way to have even more control over their care.

3.71 As such, the expansion of Personal Health Budgets is a "must do" for CCGs with an ambition for 0.1% - 0.2% of CCG population to have a PHB in the next 3- 5 years. This is equivalent to 300 – 600 PHBs in Tower Hamlets the next 3- 5 years (based on GLA population projections). Tower Hamlets CCG has decided to provide this as part of an integrated personal budget for health and social care, required as part of the Integrated Personal Commissioning (IPC) programme.

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Tower Hamlets Integrated Personal Commissioning (IPC)

3.72 Tower Hamlets is a national demonstrator site for Integrated Personal Commissioning (IPC), which is a three-year programme from April 2015 – March 2018. In Tower Hamlets, it is intended that the expansion of PHB will be introduced as part of integrated personal budgets for people with existing social care packages and complex health needs.

3.73 The goals of IPC are as follows:

- People with complex needs and their carers have better quality of life and can achieve the outcomes that are important to them
- Prevention of crises in people's lives that lead to unplanned hospital and institutional care
- Better integration and quality of care.

3.74 These align closely with the objectives of Tower Hamlets Integrated Care, in particular in its focus on person-centred care planning and moving away from "what's the matter with you" to "what matters to you".

3.75 The IPC financial model also aligns with the capitation model being developed for integrated care. It attempts to shift incentives towards prevention and coordination of care, by testing an integrated capitated payment approach and incentivising providers to proactively understand who is at risk, and take early action to prevent deterioration and coordinate services, which, to be effective, involves working in partnership with people and their carers.

3.76 The four groups of people we will be focusing on are:

- Children with SEND
- Adults with severe and enduring mental health needs
- Adults with learning disabilities
- Adults with multiple LTCs including COPD and on level 2 of Integrated care NIS.

3.77 Early analysis shows approximately 900 adults fall into this cohort. Our original target for 16/17 were 1,275 care plans and 165 budgets. However, based on learning from year one of the programme we will be reviewing these targets. The costing in this business case is based on 100 care packages in 16/17.

3.78 In order to enable this to be delivered the following infrastructure needs to be developed including:

- processes and policies for agreeing and signing off and reviewing care plans and budgets
- determining the services which opened up as part of PHB and the contractual changes needed to enable the funding to be released from these budgets
- agreement around risk management
- set up of brokerage and finance services
- set up advise and support for people undergoing this process

APPENDIX 1

4. Proposed BCF Programme for 2016-17

4.1 The following table summarises the proposed funding allocations for 2016-17. It can be seen that, to a considerable extent, it is being recommended that the schemes funded in 2015-16 should continue to receive funding in the coming financial year. This is because a number of the schemes presently funded via BCF only commenced in 2015-16, while others are ongoing activity experiencing a high level of demand. In addition, the joint commissioning review between the CCG and LBTH may make recommendations that exceed the scope of current partnership arrangements, and so it is proposed that BCF changes in the interim be minimal, in order to reduce any duplication or additional administrative burden, following the joint commissioning review's report.

	Scheme	15/16 BCF	Changes for 2016/17?	16/17 Allocation
Integrated Teams	Integrated Community Health Team	£7,336,499	Possible changes following mobilisation of CHS contract but not for 1617	£7,336,499
	Primary Care Integrated Care Incentive Scheme	£1,020,746	No material changes, additional CCG contribution to reflect full budget for the NIS	£1,200,000
	Reablement and Rehabilitation Joint Working Pilot	£2,350,000	Potentially based on reablement review. Assume steady state	£2,413,871
	Integrated Health and Social Care CHC	£866,000	Increase due to NI changes	£895,500
	7 day working at the social work team RLH	£1,200,000	Increase due to NI changes	£1,230,800
Mental Health	RAID	£2,106,420	Not in 1617. Evaluation expected soon, maybe changes in 1718	£2,106,420
	Recovery College	£110,000		£110,000
Independence	Independent Living	£646,000	Reduction in line with underspend projection	£649,000
Other	Contribution to PMO	£50,000	No longer required due to TST programme	£0
	Peer researcher	£25,000	No longer required	£0
	Community Geriatrician	£150,000	Incorporated into Integrated Community Health Team	£0

APPENDIX 1

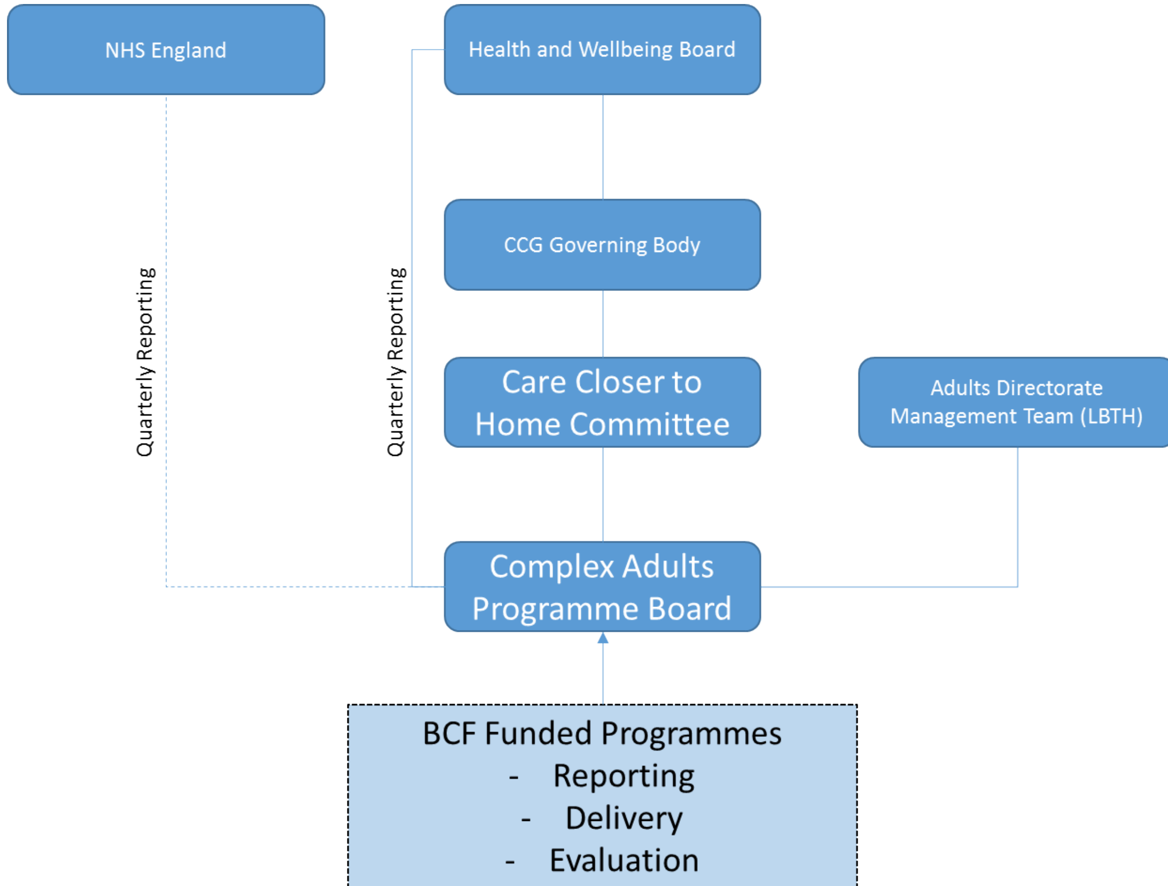
Mandated	DFG and Capital	£1,629,000		£1,572,542
	Care Act	£733,000		£733,000
	Carers	£697,000		£697,000
	Performance Pool	£1,091,313	Preserve for local incentive scheme of £1m	£1,000,000
New schemes	Autism Service	£330,000	Following LBTH request in December 2015 and new guidance	£330,000
	BME Dementia	£55,000		£55,000
	Dementia Café	£25,000		£25,000
	LBTH Enablers	£176,000		£208,000
	Additional NHS Community Services	£0	Following new guidance	£1,091,000
	Community Equipment Service	£0	7 Day CES Team	£154,985
Other			Additional Tower Hamlets BCF Allocation from DH	£67,000
Total		£20,596,978		£21,875,617

NON RECURRENT	Strategic Development	£852,000	Refreshed following CCG BC process: Personalisation Falls Prevention Mental Health in Primary Care Community Geriatrician	£695,000
Grand Total		£21,448,978		£22,570,617

Governance

4.2 The government makes Better Care Fund resources available to Health and Wellbeing Boards to be spent in accordance with a local Better Care Fund plan. It is proposed that the governance for the BCF remains with the CCG Committee that oversees the delivery of Integrated Care in Tower Hamlets. In 2015/16 this has been the Integrated Care Board. In 2016/17, in line with the refreshed programme structure of the CCG, this will transfer to the Complex Adults Programme Board. ToR and membership will be reviewed in order to accommodate this change

APPENDIX 1



Appendices:

Appendix 1: LBTH paper to the Integrated Care Board requesting re-profiling of schemes

Appendix 2: Proposal for 7 day ICES services

Appendix 2

Dated 2016

LONDON BOROUGH OF TOWER HAMLETS

and

NHS TOWER HAMLETS CLINICAL COMMISSIONING GROUP

FRAMEWORK PARTNERSHIP AGREEMENT RELATING TO THE COMMISSIONING OF HEALTH AND SOCIAL CARE SERVICES TO DELIVER THE TOWER HAMLETS BETTER CARE FUND PLAN

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THIS AGREEMENT is made on the day of 2016

PARTIES

(1) **LONDON BOROUGH OF TOWER HAMLETS** of the Town Hall, Mulberry Place, 5 Clove Crescent, London E14 2BG (the **"Council"**)

(2) **NHS TOWER HAMLETS CLINICAL COMMISSIONING GROUP** of 2nd Floor Alderney Building, Mile End Hospital, Bancroft Road, London, E1 4DG (the "**CCG"**)

BACKGROUND

(A) The Council has responsibility for commissioning and/or providing social care services on behalf of the population of the borough of Tower Hamlets.

(B) The CCG has the responsibility for commissioning health services pursuant to the 2006 Act in the borough of Tower Hamlets.

(C) The Better Care Fund has been established by the Government to provide funds to local areas to support the integration of health and social care and to seek to achieve the National Conditions and Local Objectives. It is a requirement of the Better Care Fund that the CCG and the Council establish a pooled fund for this purpose. The Partners wish to extend the use of Pooled Fund to include funding streams from outside of the Better Care Fund.

(D) Section 75 of the 2006 Act gives powers to local authorities and clinical commissioning groups to establish and maintain pooled funds out of which payment may be made towards expenditure incurred in the exercise of prescribed local authority functions and prescribed NHS functions.

(E) The purpose of this Agreement is to set out the terms on which the Partners have agreed to collaborate and to establish a framework through which the Partners can secure the future position of health and social care services through lead or joint commissioning arrangements. It is also the means through which the Partners will pool funds and align budgets as agreed between the Partners.

(F) The aims and benefits of the Partners in entering in to this Agreement are to:

a) improve the quality and efficiency of the Services;

b) meet the National Conditions and Local Objectives;

c) make more effective use of resources through the establishment and maintenance of a pooled fund for revenue expenditure on the Services; and

d) support the achievement of the vision for integrated care in the borough for a health and social care Services system that:

i. coordinates care around the patient and delivers care in the most appropriate setting;

ii. empowers patients, users and their carers;

iii. provides more responsive, coordinated and proactive care, including data sharing information between providers to enhance the quality of care; and

iv. ensures consistency and efficiency of care.

(G) The Partners have jointly carried out consultations on the proposals for this Agreement with all those persons likely to be affected by the arrangements. Additional consultations will be undertaken as

necessary, and in line with each Partners obligations regarding consultation with affected parties, in respect of any future proposals to vary the plan or individual schemes.

(H) The Partners are entering into this Agreement in exercise of the powers referred to in Section 75 of the 2006 Act and/or Section 13Z(2) and 14Z(3) of the 2006 Act as applicable, to the extent that exercise of these powers is required for this Agreement.

1 DEFINED TERMS AND INTERPRETATION

1.1 In this Agreement, save where the context requires otherwise, the following words, terms and expressions shall have the following meanings:

1998 Act means the Data Protection Act 1998.

2000 Act means the Freedom of Information Act 2000.

2004 Regulations means the Environmental Information Regulations 2004.

2006 Act means the National Health Service Act 2006.

Affected Partner means, in the context of Clause 24, the Partner whose obligations under the Agreement have been affected by the occurrence of a Force Majeure Event

Agreement means this agreement including its Schedules and Appendices.

Approved Expenditure means any additional expenditure approved by the Partners in relation to an Individual Service above any Contract Price and Performance Payments.

Authorised Officers means an officer of each Partner appointed to be that Partner's representative for the purpose of this Agreement.

Better Care Fund means the Better Care Fund as described in NHS England Publications Gateway Ref. No.00314 and NHS England Publications Gateway Ref. No.00535 as relevant to the Partners.

Better Care Fund Plan means the plan attached at Schedule 6 setting out the Partners plan for the use of the Better Care Fund.

CCG Statutory Duties means the Duties of the CCG pursuant to Sections 14P to 14Z2 of the 2006 Act

CQUIN means the Commissioning for Quality and Innovation payments framework which encourages care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare.

Change in Law means the coming into effect or repeal (without re-enactment or consolidation) in England of any Law, or any amendment or variation to any Law, or any judgment of a relevant court of law which changes binding precedent in England after the date of this Agreement

Commencement Date means 00:01 hrs on 01 April 2016.

Confidential Information means information, data and/or material of any nature which any Partner may receive or obtain in connection with the operation of this Agreement and the Services and:

(a) which comprises Personal Data or Sensitive Personal Data or which relates to any patient or his treatment or medical history;

(b) the release of which is likely to prejudice the commercial interests of a Partner or the interests of a Service User respectively; or

(c) which is a trade secret.

Contract Price means any sum payable to a Provider under a Service Contract as consideration for the provision of Services and which, for the avoidance of doubt, does not include any Default Liability or Performance Payment.

Default Liability means any sum which is agreed or determined by Law or in accordance with the terms of a Services Contract to be payable by any Partner(s) to a Provider as a consequence of (i) breach of the Partner's obligation(s) in whole or in part under a relevant Services Contract or (ii) any act or omission of a third party for which the Partner is, under the terms of a relevant Services Contract, liable to a Provider.

Financial Contributions means the financial contributions made by each Partner to a Pooled Fund in any Financial Year.

Financial Contributions Proposal means a proposal made by each Partner to a Pooled Fund or Non-Pooled Fund in respect of each Partner's financial contribution for each Individual Scheme subsequent to the first Financial Year's Financial Contributions.

Financial Year means each financial year running from 1 April in any year to 31 March in the following calendar year.

Force Majeure Event means one or more of the following:

(a) war, civil war (whether declared or undeclared), riot or armed conflict;

(b) acts of terrorism;

(c) acts of God;

(d) fire or flood;

(e) industrial action;

(f) prevention from or hindrance in obtaining raw materials, energy or other supplies;

(g) any form of contamination or virus outbreak; and
(h) any other event,

in each case where such event is beyond the reasonable control of the Partner claiming relief.

Functions means the NHS Functions and the Health Related Functions

Health Related Functions means those of the health related functions of the Council, specified in Regulation 6 of the Regulations as relevant to the commissioning of the Services and which may be further described in the relevant Scheme Specification.

Host Partner means for each Pooled Fund the Partner that will host the Pooled Fund [and for each Aligned Fund the Partner that will host the Aligned Fund]

Health and Wellbeing Board means the Health and Wellbeing Board established by the Council pursuant to Section 194 of the Health and Social Care Act 2012.

Indirect Losses means loss of profits, loss of use, loss of production, increased operating costs, loss of business, loss of business opportunity, loss of reputation or goodwill or any other consequential or indirect loss of any nature, whether arising in tort or on any other basis.

Individual Scheme means one of the schemes which is agreed by the Partners to be included within this Agreement using the powers under Section 75 as documented in a Scheme Specification.

Integrated Commissioning means arrangements by which both Partners commission Services in relation to an individual Scheme on behalf of each other in exercise of both the NHS Functions and Council Functions through integrated structures.

Joint (Aligned) Commissioning means a mechanism by which the Partners jointly commission a Service. For the avoidance of doubt, a joint (aligned) commissioning arrangement does not involve the delegation of any functions pursuant to Section 75.

Law means:

(a) any statute or proclamation or any delegated or subordinate legislation;

(b) any enforceable community right within the meaning of Section 2(1) European Communities Act 1972;

(c) any guidance, direction or determination with which the Partner(s) or relevant third party (as applicable) are bound to comply to the extent that the same are published and publicly available or the existence or contents of them have been notified to the Partner(s) or relevant third party (as applicable); and

(d) any judgment of a relevant court of law which is a binding precedent in England.

Lead Commissioning Arrangements means the arrangements by which one Partner commissions Services in relation to an Individual Scheme on behalf of the other Partner in exercise of both the NHS Functions and the Council Functions.

Lead Commissioner means the Partner responsible for commissioning an Individual Service under a Scheme Specification.

Local Incentive Scheme means the single incentive scheme payable to providers of Integrated Care services in Tower Hamlets which includes an element of CQUIN incentive monies (in the case of Acute, CHS and Mental Health), and a top slice incentive amount (in the case of Primary Care).

London Living Wage means the hourly rate of pay set by the Mayor of London for residents working in London (as amended from time to time).

Losses means all damage, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional services), proceedings, demands and charges whether arising under statute, contract or at common law but excluding Indirect Losses and "Loss" shall be interpreted accordingly.

Month means a calendar month.

National Conditions mean the national conditions as set out in the NHS England Planning Guidance as are amended or replaced from time to time.

NHS Functions means those of the NHS functions listed in Regulation 5 of the Regulations as are exercisable by the CCG as are relevant to the commissioning of the Services and which may be further described in each Service Schedule

Non Pooled Fund means the budget detailing the financial contributions of the Partners which are not included in a Pooled Fund in respect of a particular Service as set out in the relevant Scheme Specification

Non-Recurrent Payments means funding provided by a Partner to a Pooled Fund in addition to the Financial Contributions pursuant to arrangements agreed in accordance with Clause 10.5.

Overspend means any expenditure from a Pooled Fund in a Financial Year which exceeds the Financial Contributions for that Financial Year.

Partner means each of the CCG and the Council, and references to "**Partners**" shall be construed accordingly.

Partnership Board means the partnership board responsible for review of performance and oversight of this Agreement as set out in Schedule 2 (for the avoidance of doubt, in Tower Hamlets this is the Complex Adults Programme Board.

Permitted Budget means in relation to a Service where the Council is the Provider, the budget that the Partners have set in relation to the particular Service.

Permitted Expenditure has the meaning given in Clause 7.3.

Personal Data means Personal Data as defined by the 1998 Act.

Pooled Fund means any pooled fund established and maintained by the Partners as a pooled fund in accordance with the Regulations

Pooled Fund Manager means such officer of the Host Partner which includes a Section 113 Officer for the relevant Pooled Fund established under an Individual Scheme as is nominated by the Host Partner from time to time to manage the Pooled Fund in accordance with Clause 8.

Provider means a provider of any Services commissioned under the arrangements set out in this Agreement.

Public Health England means the SOSH trading as Public Health England.

Quarter means each of the following periods in a Financial Year:

1 April to 30 June

1 July to 30 September

1 October to 31 December

1 January to 31 March

and "**Quarterly**" shall be interpreted accordingly.

Regulations means the means the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 No 617 (as amended).

Scheme Specification means a specification setting out the arrangements for an Individual Scheme agreed by the Partners to be commissioned under this Agreement.

Sensitive Personal Data means Sensitive Personal Data as defined in the 1998 Act.

Services means such health and social care services as agreed from time to time by the Partners as commissioned under the arrangements set out in this Agreement and more specifically defined in each Scheme Specification.

Services Contract means an agreement for the provision of Services entered into with a Provider by one or more of the Partners in accordance with the relevant Individual Scheme.

Service Users means those individual for whom the Partners have a responsibility to commission the Services.

Standing Orders and Standing Financial Instructions (or equivalent) means the Partners' internal constitutional and corporate governance rules detailing the Partners' respective powers and delegations amongst other things.

SOSH means the Secretary of State for Health.

Third Party Costs means all such third party costs (including but not limited to legal, accounting and auditing costs) in respect of each Individual Scheme as a Partner reasonably and properly incurs in the proper performance of its obligations under this Agreement and as agreed by the Partnership Board.

Working Day means 8.00am to 6.00pm on any day except Saturday, Sunday, Christmas Day, Good Friday or a day which is a bank holiday (in England) under the Banking & Financial Dealings Act 1971.

1.2 In this Agreement, all references to any statute or statutory provision shall be deemed to include references to any statute or statutory provision which amends, extends, consolidates or replaces the same and shall include any orders, regulations, codes of practice, instruments or other subordinate legislation made thereunder and any conditions attaching thereto. Where relevant, references to English statutes and statutory provisions shall be construed as references also to equivalent statutes, statutory provisions and rules of law in other jurisdictions.

1.3 Any headings to Clauses, together with the front cover and the index are for convenience only and shall not affect the meaning of this Agreement. Unless the contrary is stated, references to Clauses and Schedules shall mean the clauses and schedules of this Agreement.

1.4 Any reference to the Partners shall include their respective statutory successors, employees and agents.

1.5 In the event of a conflict, the conditions set out in the Clauses to this Agreement shall take priority over the Schedules.

1.6 Where a term of this Agreement provides for a list of items following the word "including" or "includes", then such list is not to be interpreted as being an exhaustive list.

1.7 In this Agreement, words importing any particular gender include all other genders, and the term "person" includes any individual, partnership, firm, trust, body corporate, government, governmental body, trust, agency, unincorporated body of persons or association and a reference to a person includes a reference to that person's successors and permitted assigns.

1.8 In this Agreement, words importing the singular only shall include the plural and vice versa.

1.9 In this Agreement, "staff" and "employees" shall have the same meaning and shall include reference to any full or part time employee or officer, director, manager and agent.

1.10 Subject to the contrary being stated expressly or implied from the context in these terms and conditions, all communication between the Partners shall be in writing.

1.11 Unless expressly stated otherwise, all monetary amounts are expressed in pounds sterling but in the event that pounds sterling is replaced as legal tender in the United Kingdom by a different currency then all monetary amounts shall be converted into such other currency at the rate prevailing on the date such other currency first became legal tender in the United Kingdom.

1.12 All references to the Agreement include (subject to all relevant approvals) a reference to the Agreement as amended, supplemented, substituted, novated or assigned from time to time.

2 TERM

2.1 This Agreement shall come into force on the Commencement Date.

2.2 This Agreement shall continue until it is terminated in accordance with Clause 22.

2.3 The duration of the arrangements for each Individual Scheme shall be as set out in the relevant Scheme Specification.

3 GENERAL PRINCIPLES

3.1 Nothing in this Agreement shall affect:

3.1.1 the liabilities of the Partners to each other or to any third parties for the exercise of their respective functions and obligations (including the Functions); or

3.1.2 any power or duty to recover charges for the provision of any services (including the Services) in the exercise of any local authority function.

3.2 The Partners agree to:

3.2.1 treat each other with respect and an equality of esteem;

3.2.2 be open with information about the performance and financial status of each; and

3.2.3 provide early information and notice about relevant problems.

3.3 For the avoidance of doubt, the aims and outcomes relating to an Individual Scheme may be set out in the relevant Scheme specification.

4 PARTNERSHIP FLEXIBILITIES

4.1 This Agreement sets out the mechanism through which the Partners will work together to establish one or more of the following:

4.1.1 Lead Commissioning Arrangements; and

4.1.2 the establishment of one or more Pooled Fund.

in relation to Individual Schemes (the "**Flexibilities**")

4.2 The Council delegates to the CCG and the CCG agrees to exercise, on the Council's behalf, the Health Related Functions to the extent necessary for the purpose of performing its obligations under this Agreement in conjunction with the NHS Functions.

4.3 The CCG delegates to the Council and the Council agrees to exercise on the CCG's behalf the NHS Functions to the extent necessary for the purpose of performing its obligations under this Agreement in conjunction with the Health Related Functions.

4.4 Where the powers of a Partner to delegate any of its statutory powers or functions are restricted, such limitations will automatically be deemed to apply to the relevant Scheme Specification and the Partners shall agree arrangements designed to achieve the greatest degree of delegation to the other Partner necessary for the purposes of this Agreement which is consistent with the statutory constraints.

5 FUNCTIONS

5.1 The purpose of this Agreement is to establish a framework through which the Partners can secure the provision of health and social care services in accordance with the terms of this Agreement.

5.2 This Agreement shall include such functions as shall be agreed from time to time by the Partners.

5.3 On the Commencement Date of this Agreement the following Individual Schemes will be included in the scope of this Agreement:

5.3.1 Individual Schemes funded from the Better Care Fund:

Mandatory CCG contribution (recurrent schemes)

- Integrated Community Health Team
- Primary Care Integrated Care Incentive Scheme
- RAID
- Reablement Team
- Community Health Team (Social Care)
- 7 Day Hospital Social Work Team
- 7 Day Community Equipment Provision Team
- Assistive Technology Team
- Assistive Technology additional demand
- Dementia Café
- Community Outreach Service
- Adult Autism Diagnostic Intervention Service
- Carers
- Local Incentive Scheme
- Enablers
- Mental Health Recovery College

Additional CCG contribution (non-recurrent scheme)

- Falls Prevention
- Community Geriatrician Team
- Personalisation
- Mental Health Primary Care

LBTH contribution

- Disabled Facilities Grant

5.4 Where the Partners add a new Individual Scheme to this Agreement a Scheme Specification for each Individual Scheme shall be in the form set out in Schedule 1 and shall be completed and agreed between the Partners. The initial Scheme Specification is set out in Schedule 1 part 2 (which may be varied from time to time by the Partners in accordance with the terms of this Agreement).

5.5 The Partners shall not enter into a Scheme Specification in respect of an Individual Scheme unless they are satisfied that the Individual Scheme in question will improve health and well-being in accordance with this Agreement.

5.6 The introduction of any Individual Scheme will be subject to:

5.6.1 a business case (on the respective template of the Partner wishing to propose the same or as otherwise agreed between the Partners); and

5.6.2 approval by the Partnership Board.

6 COMMISSIONING ARRANGEMENTS

Integrated Commissioning

6.1 Where there are Integrated Commissioning arrangements in respect of an Individual Scheme, both Partners shall work in cooperation and shall endeavour to ensure that the NHS Functions and Health Related Functions are commissioned with all due skill, care and attention.

6.2 Both Partners shall be responsible for compliance with and making payments of all sums due to a Provider pursuant to the terms of each Service Contract.

6.3 Both Partners shall work in cooperation and endeavour to ensure that the relevant Services as set out in each Scheme Specification are commissioned within each Partner's Financial Contribution in respect of that particular Service in each Financial Year.

6.4 The Partners shall comply with the arrangements in respect of the Joint (Aligned) Commissioning as set out in the relevant Scheme Specification.

6.5 Each Partner shall keep the other Partners and the Partnership Board regularly informed of the effectiveness of the arrangements including the Better Care Fund and any Overspend or Underspend in a Pooled Fund or Non Pooled Fund.

6.6 The Partnership Board will report back to the Health and Wellbeing Board as required by its Terms of Reference.

Appointment of a Lead Commissioner

6.7 Where there are Lead Commissioning Arrangements in respect of an Individual Scheme the Lead Commissioner shall:

6.7.1 exercise the NHS Functions in conjunction with the Health Related Functions as identified in the relevant Scheme Specification;

6.7.2 endeavour to ensure that the NHS Functions and the Health Related Functions are funded within the parameters of the Financial Contributions of each Partner in relation to each particular Service in each Financial Year.

6.7.3 commission Services for individuals who meet the eligibility criteria set out in the relevant Scheme Specification;

6.7.4 contract with Provider(s) for the provision of the Services on terms agreed with the other Partners;

6.7.5 comply with all relevant legal duties (including any Change in Law) and guidance (as amended from time to time) of both Partners in relation to the Services being commissioned;

6.7.6 where Services are commissioned using the NHS Standard Form Contract, perform the obligations of the "Commissioner" and "Co-ordinating Commissioner" with all due skill, care and attention and where Services are commissioned using any other form of contract to perform its obligations with all due skill and attention;

6.7.7 undertake performance management and contract monitoring of all Service Contracts and ensure that effective and timely action to remediate any non-performance is taken;

6.7.8 make payment of all sums due to a Provider pursuant to the terms of any Services Contract.

6.7.9 keep the other Partner and the Partnership Board regularly informed of the effectiveness of the arrangements including the Better Care Fund and any Overspend or Underspend in a Pooled Fund or Non Pooled Fund.

Responsibilities of the other Partner

6.8 The other Partner, insofar as they are a provider of services under Individual Schemes, shall undertake to provide all necessary performance and financial data necessary to enabling the Lead Commissioner to fulfil the responsibilities at 6.7.

7 ESTABLISHMENT OF A POOLED FUND

7.1 In exercise of their respective powers under Section 75 of the 2006 Act, the Partners have agreed to establish and maintain such pooled funds for revenue expenditure as set out in the Scheme Specifications.

7.2 Each Pooled Fund shall be managed and maintained in accordance with the terms of this Agreement.

7.3 It is agreed that the monies held in a Pooled Fund may only be expended on the following:

7.3.1 the Contract Price*;*

7.3.2 where the Council is to be the Provider, the Permitted Budget;

7.3.3 Performance Payments;

7.3.4 Third Party Costs;

7.3.5 Approved Expenditure;

7.3.6 any other explicit allowances stipulated in this Agreement; and

7.3.7 subject to Clause 7.4.

("**Permitted Expenditure**")

7.4 The Partners may only depart from the definition of Permitted Expenditure to include or exclude other revenue expenditure with the express written agreement of each Partner and the Partnership Board.

7.5 For the avoidance of doubt, monies held in the Pooled Fund may not be expended on Default Liabilities unless this is agreed by all Partners.

7.6 Pursuant to this Agreement, the Partners agree to appoint a Host Partner for each of the Pooled Funds set out in the Scheme Specifications. The Host Partner shall be the Partner responsible for:

7.6.1 holding all monies contributed to the Pooled Fund on behalf of itself and the other Partners;

7.6.2 providing the financial administrative systems for the Pooled Fund; and

7.6.3 appointing the Pooled Fund Manager;

7.6.4 ensuring that the Pooled Fund Manager complies with its obligations under this Agreement.

7.7 At the Commencement Date of this Agreement there shall be three (3) Pooled Funds:

Pooled Fund	BCF Scheme	Lead Commissioner	Provider	BCF Allocation (£)
Mandatory CCG contribution (recurrent schemes)	Integrated Community Health Team	CCG	CCG	7,358,871
	Primary Care Integrated Care Incentive Scheme	CCG	CCG	1,200,000
	RAID	CCG	CCG	2,106,420
	Mental Health Recovery College	CCG	CCG	110,000
	Reablement Team	CCG	Council	2,413,871

	Community Health Team (Social Care)	CCG	Council	895,500
	7 Day Hospital Social Work Team	CCG	Council	1,230,800
	7 Day Community Equipment Provision team	CCG	Council	154,985
	Assistive Technology team	CCG	Council	287,000
	Assistive Technology additional demand	CCG	Council	362,000
	Dementia café	CCG	Council	55,000
	Community outreach service	CCG	Council	25,000
	Adult autism diagnostic intervention service	CCG	Council	330,000
	Carers	Council	Council	1,430,000
	Local incentive scheme	CCG	CCG	1,000,000
	Enablers	CCG	Council	208,000
	Total			19,167,447
Additional CCG contribution (non-recurrent schemes)	Falls prevention	CCG	CCG	68,000
	Community Geriatrician Team	CCG	CCG	115,000
	Personalisation	CCG	CCG	212,000
	Mental Health Personal Commissioning	CCG	CCG	300,000
	Total			695,000
Council contribution	Disabled Facilities Grant	Council	Council	1,572,542
	Total			1,572,542
	BCF total			**21,434,989**

8 POOLED FUND MANAGEMENT

8.1 When introducing a Pooled Fund in respect of an Individual Scheme, the Partners shall agree:

8.1.1 which of the Partners shall act as Host Partner for the purposes of Regulations 7(4) and 7(5) and shall provide the financial administrative systems for the Pooled Fund;

8.1.2 which officer of the Host Partner shall act as the Pooled Fund Manager for the purposes of Regulation 7(4) of the Regulations.

8.2 The Pooled Fund Manager in respect of each Individual Service where there is a Pooled Fund shall have the following duties and responsibilities:

8.2.1 the day to day operation and management of the Pooled Fund;

8.2.2 ensuring that all expenditure from the Pooled Fund is in accordance with the provisions of this Agreement and the relevant Scheme Specification;

8.2.3 maintaining an overview of all joint financial issues affecting the Partners in relation to the Services and the Pooled Fund;

8.2.4 ensuring that full and proper records for accounting purposes are kept in respect of the Pooled Fund and liaising with internal and external auditors as necessary;

8.2.5 reporting to the Partnership Board as required by the Partnership Board and the relevant Scheme Specification;

8.2.6 ensuring action is taken to manage any projected under or overspends relating to the Pooled Fund in accordance with this Agreement;

8.2.7 preparing and submitting to the Partnership Board Quarterly reports (or more frequent reports if required by the Partnership Board) and an annual return about the income and expenditure from the Pooled Fund together with such other information as may be required by the Partners and the Partnership Board to monitor the effectiveness of the Pooled Fund and to enable the Partners to complete their own financial accounts and returns. The Partners agree to provide all necessary information to the Pooled Fund Manager in time for the reporting requirements to be met.

8.2.8 preparing and submitting reports to the Health and Wellbeing Board as required by it.

8.3 In carrying out their responsibilities as provided under Clause 8.2 the Pooled Fund Manager shall have regard to the recommendations of the Partnership Board and shall be accountable to the Partners.

8.4 The Partnership Board may agree to the viring of funds between Pooled Funds subject always to the Law and the Partners' Standing Orders and Standing Financial Instructions.

8.5 The Partnership Board may agree to the secondment of employees between Partners for the purposes of managing Pooled Funds or management and delivery of Individual Schemes subject always to the Law, Partners' Standing Orders and Standing Financial Instructions, and the Partners' Human Resource and Managing Organisational Change policies and procedures.

9 NON POOLED FUNDS

9.1 Any Financial Contributions agreed to be held within a Non Pooled Fund will be notionally held in a fund established for the purpose of commissioning that Service as set out in the relevant Scheme Specification. For the avoidance of doubt, a Non Pooled Fund does not constitute a pooled fund for the purposes of Regulation 7 of the Regulations.

9.2 When introducing a Non Pooled Fund in respect of an Individual Scheme, the Partners shall agree:

9.2.1 which Partner if any shall host the Non-Pooled Fund; and

9.2.2 how and when Financial Contributions shall be made to the Non-Pooled Fund.

9.3 The Host Partner will be responsible for establishing the financial and administrative support necessary to enable the effective and efficient management of the Non-Pooled Fund, meeting all required accounting and auditing obligations.

9.4 Both Partners shall ensure that Services commissioned using a Non Pooled Fund are commissioned solely in accordance with the relevant Scheme Specification.

9.5 Where there are Joint (Aligned) Commissioning arrangements, both Partners shall work in cooperation and shall endeavour to ensure that:

9.5.1 the NHS Functions funded from a Non-Pooled Fund are carried out within the CCG Financial Contribution to the Non- Pooled Fund for the relevant Service in each Financial Year; and

9.5.2 the Health Related Functions funded from a Non-Pooled Fund are carried out within the Council's Financial Contribution to the Non-Pooled Fund for the relevant Service in each Financial Year.

10 FINANCIAL CONTRIBUTIONS

10.1 The Financial Contribution of the CCG and the Council to any Pooled Fund or Non-Pooled Fund for the first Financial Year of operation of each Individual Scheme shall be as set out in the relevant Scheme Specification.

10.2 Each Partner shall submit a Financial Contributions Proposal to the Partnership Board not less than 60 Working Days prior to the end of each Financial Year based on a review of the performance of each Individual Scheme from their respective commencement dates.

10.3 The Partnership Board shall submit any Financial Contributions Proposal made by the Partners pursuant to Clause 10.2 to the Health and Wellbeing Board which shall determine the Financial Contribution of each Partner to any Pooled Fund or Non-Pooled Fund for subsequent Financial Year(s) of operation of each Individual Scheme.

10.4 Financial Contributions will be paid as set out in the each Scheme Specification.

10.5 With the exception of Clause 13, no provision of this Agreement shall preclude the Partners from making additional contributions of Non-Recurrent Payments to the Pooled Fund from time to time by mutual agreement. Any such additional contributions of Non-Recurrent Payments shall be explicitly recorded in Partnership Board minutes and recorded in the budget statement as a separate item.

11 NON FINANCIAL CONTRIBUTIONS

11.1 The Scheme Specification shall set out non-financial contributions of each Partner including staff (including the Pooled Fund Manager), premises, IT support and other non-financial resources necessary to perform its obligations pursuant to this Agreement (including, but not limited to, management of Service Contracts and the Pooled Fund).

12 RISK SHARE ARRANGMENTS, OVERSPENDS AND UNDERSPENDS

Risk share arrangements

12.1 The Partners have agreed risk share arrangements as set out in Schedule 3, which provide for financial risks arising within the commissioning of Services from the pooled funds and the financial risk to the pool arising from the payment for performance element of the Better Care Fund.

Local incentive scheme

12.2 An incentive scheme will be developed by the CCG and the council to encourage and reward joint working that achieves the aims of the Tower Hamlets Integrated Provider Partnership and the Better Care Fund.

Overspends in Pooled Fund

12.3 Subject to Clause 12.3, the Host Partner for the relevant Pooled Fund shall manage expenditure from a Pooled Fund within the Financial Contributions and shall ensure that the expenditure is limited to Permitted Expenditure.

12.4 The Host Partner shall not be in breach of its obligations under this Agreement if an Overspend occurs PROVIDED THAT the only expenditure from a Pooled Fund has been in accordance with Permitted Expenditure and it has informed the Partnership Board in accordance with Clause 12.4.

12.5 Where the Pooled Fund Manager identifies an actual or projected Overspend and notifies the Partnership Board in accordance with Clause 8.9 the provisions of Clause 12.5, 12.6 and Schedule 3 shall apply.

12.6 Subject to Clause 12.6, for twelve (12) months from the Commencement Date of this Agreement the Partners agree that any Overspends occurring in respect of Individual Schemes however such Overspends arise, shall be the responsibility of the Scheme Provider to manage. For the absence of doubt this includes schemes for which the Council is the Service Provider.

12.7 The Partnership Board may agree, in circumstances where an Overspend arises and for which there is a causal relationship to the operation of other Better Care Fund Schemes, to contribute to the mitigation of said Overspend by authorising the virement of funds from elsewhere within the Pooled Fund subject always to there being sufficient capacity within the Pooled Fund to avoid the creation of a consequential Overspend elsewhere.

Overspends in Non Pooled Funds

12.8 Where in Joint (Aligned) Commissioning Arrangements either Partner forecasts an Overspend in relation to a Partner's Financial Contribution to a Non-Pooled Fund or Aligned Fund that Partner shall as soon as reasonably practicable inform the other Partner and the Partnership Board.

12.9 Where there is a Lead Commissioning Arrangement the Lead Commissioner is responsible for the management of the Non-Pooled Fund and Aligned Fund and shall discharge this responsibility in a manner consistent with the responsibilities assigned to the Host Partner by clauses 12.2 to 12.6. The Lead Commissioner shall as soon as reasonably practicable inform the other Partner and the Partnership Board.

Underspend

12.10 In the event that expenditure from any Pooled Fund or Non Pooled Fund in any Financial Year is less than the aggregate value of the Financial Contributions made for that Financial Year the Partners shall agree how the surplus monies shall be spent, carried forward and/or returned to the Partners. Such arrangements shall be subject to the Law and the Standing Orders and Standing Financial Instructions (or equivalent) of the Partners.

13 CAPITAL EXPENDITURE

13.1 With the exception of Pooled Funds covered by clause 13.2, neither Pooled Funds nor Non Pooled Funds shall normally be applied towards any one-off expenditure on goods and/or services, which will provide continuing benefit and would historically have been funded from the capital budgets of one of the Partners. If a need for capital expenditure is identified this must be agreed by the Partners.

13.2 The elements of the Pooled Funds which relate to Disabled Facilities Grant shall be treated as capital funds and all expenditure against these funds shall be subject to the Law and the Standing Orders and Standing Financial Instructions (or equivalent) of the Partners.

13.3 Any arrangements for the sharing of capital expenditure shall be made separately and in accordance with Section 256 (or Section 76) of the NHS Act 2006 and directions thereunder.

14 VAT

The Partners shall agree the treatment of the Pooled Fund for VAT purposes in accordance with any relevant guidance from HM Customs and Excise.

15 AUDIT AND RIGHT OF ACCESS

15.1 All Partners shall promote a culture of probity and sound financial discipline and control. The Host Partner shall arrange for the audit of the accounts of the relevant Pooled Fund and shall require the Audit Commission to make arrangements to certify an annual return of those accounts under Sections 20 and 21 (whichever is applicable to the relevant Host Partner of the relevant Pooled Fund) of the Local Audit and Accountability Act 2014.

15.2 All internal and external auditors and all other persons authorised by the Partners will be given the right of access by them to any document, information or explanation they require from any employee, member of the Partner in order to carry out their duties. This right is not limited to financial information or accounting records and applies equally to premises or equipment used in connection with this Agreement. Access may be at any time without notice, provided there is good cause for access without notice.

16 LIABILITIES AND INSURANCE AND INDEMNITY

16.1 Subject to Clause 16.2, and 16.3, if a Partner ("**First Partner**") incurs a Loss arising out of or in connection with this Agreement or the Services Contract as a consequence of any act or omission of another Partner ("**Other Partner**") which constitutes negligence, fraud or a breach of contract in relation to this Agreement or the Services Contract then the Other Partner shall be liable to the First Partner for that Loss and shall indemnify the First Partner accordingly.

16.2 Clause 16.1 shall only apply to the extent that the acts or omissions of the Other Partner contributed to the relevant Loss. Furthermore, it shall not apply if such act or omission occurred as a consequence of the Other Partner acting in accordance with the instructions or requests of the First Partner or the Partnership Board.

16.3 If any third party makes a claim or intimates an intention to make a claim against either Partner, which may reasonably be considered as likely to give rise to liability under this Clause 16. the Partner that may claim against the other indemnifying Partner will:

16.3.1 as soon as reasonably practicable give written notice of that matter to the Other Partner specifying in reasonable detail the nature of the relevant claim;

16.3.2 not make any admission of liability, agreement or compromise in relation to the relevant claim without the prior written consent of the Other Partner (such consent not to be unreasonably conditioned, withheld or delayed);

16.3.3 give the Other Partner and its professional advisers reasonable access to its premises and personnel and to any relevant assets, accounts, documents and records within its power or control so as to enable the indemnifying Partner and its professional advisers to examine such premises, assets, accounts, documents and records and to take copies at their own expense for the purpose of assessing the merits of, and if necessary defending, the relevant claim.

16.4 Subject to Clause 16.2 and 16.3, if any third party makes a claim against either Partner which gives rise to liability under this Clause 16. and such claim arises from unrecoverable non-performance by a Service Provider which for the avoidance of doubt includes but is not limited to:

16.4.1 a breach of the Provider's obligations under the Services Contract;

16.4.2 a termination event (as defined under the Services Contract) which entitles a third party to terminate the Provider's Services Contract

and all reasonable steps have been taken by the relevant Partner to recover such liabilities, the liability shall be met from the Pooled Funds.

16.5 For the purposes of Clause 16.4, where such action creates an Overspend such expenditure shall be deemed to be Permitted Expenditure under Clause 12.3.

16.6 Each Partner shall ensure that they maintain policies of insurance (or equivalent arrangements through schemes operated by the National Health Service Litigation Authority) in respect of all potential liabilities arising from this Agreement.

16.7 Each Partner shall at all times take all reasonable steps to minimise and mitigate any loss for which one party is entitled to bring a claim against the other pursuant to this Agreement.

17 STANDARDS OF CONDUCT AND SERVICE

17.1 The Partners will at all times comply with the Law and ensure good corporate governance in respect of each Partner (including the Partners' respective Standing Orders and Standing Financial Instructions).

17.2 The Council is subject to the duty of Best Value under the Local Government Act 1999. This Agreement and the operation of the Pooled Fund is therefore subject to the Council's obligations for Best Value and the other Partner will co-operate with all reasonable requests from the Council which the Council considers necessary in order to fulfil its Best Value obligations.

17.3 The CCG is subject to the CCG Statutory Duties and these incorporate a duty of clinical governance, which is a framework through which they are accountable for continuously improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. This Agreement and the operation of the Pooled Funds are therefore subject to ensuring compliance with the CCG Statutory Duties and clinical governance obligations.

17.4 The Partners acknowledge their respective duties under equality legislation to eliminate unlawful discrimination, harassment and victimisation, and to advance quality of opportunity and foster good relations between different groups and their respective policies. The Partners will maintain and develop these policies as applied to the Services, with the aim of developing a joint strategy for all elements of the Services.

17.5 The Partners acknowledge their respective commitments to the London Living Wage in this Agreement. Where applicable, the Partners shall use their reasonable endeavours to procure that Service Providers commissioned in respect of any Individual Schemes for which the Partners are responsible, accept and agree to the London Living Wage in their Services Contracts.

18 CONFLICTS OF INTEREST

18.1 The Partners shall comply with the agreed policy for identifying and managing conflicts of interest as set out in Schedule 7.

19 GOVERNANCE

19.1 Overall strategic oversight of partnership working between the Partners is vested in the Health and Well Being Board, which for these purposes shall make recommendations to the Partners as to any action it considers necessary.

19.2 The Partners have established a Partnership Board to oversee:

19.2.1 Delivery of commissioned Integrated Care Services provided by the Tower Hamlets Integrated Provider Partnership; and

19.2.2 Development of Integrated Care strategy, including the Better Care Fund.

19.3 The Partnership Board is based on a joint working group structure. Each member of the Partnership Board shall be an officer of one of the Partners and will have individual delegated responsibility from the Partner employing them to make decisions which enable the Partnership Board to carry out its objects, roles, duties and functions as set out in this Clause 19 and Schedule 2.

19.4 The terms of reference of the Partnership Board shall be as set out in Schedule 2.

19.5 Each Partner has secured internal reporting arrangements to ensure the standards of accountability and probity required by each Partner's own statutory duties and organisation are complied with.

19.6 The Health and Wellbeing Board shall be responsible for the overall approval of the Individual Scheme, ensuring compliance with the Better Care Fund Plan and the strategic direction of the Better Care Fund.

19.7 Each Scheme Specification shall confirm the governance arrangements in respect of the Individual Scheme and how that Individual Scheme is reported to the Partnership Board and Health and Wellbeing Board.

19.8 Each Scheme Specification shall confirm the governance arrangements in respect of the Services and how the Services are reported to the Partnership Board and Health and Wellbeing Board.

20 REVIEW

20.1 Save where the Partnership Board agree alternative arrangements (including alternative frequencies) the Partners shall undertake an annual review ("**Annual Review**") of the operation of this Agreement, any Pooled Fund and the provision of the Services within 3 Months of the end of each Financial Year.

20.2 Subject to any variations to this process required by the Partnership Board, Annual Reviews shall be conducted in good faith and, where applicable, in accordance with the governance arrangements set out in Schedule 2.

20.3 The Partners shall within 20 Working Days of the Annual Review prepare a joint annual report documenting the matters referred to in this Clause 20. A copy of this report shall be provided to the Partnership Board, and subsequently to the Health and Wellbeing Board. Each Partner has secured internal reporting arrangements to ensure the standards of accountability and probity required by each Partner's own statutory duties and organisation are complied with.

20.4 In the event that the Partners fail to meet the requirements of the Better Care Fund Plan and NHS England the Partners shall provide full co-operation with NHS England to agree a recovery plan. The Lead Commissioner will act as the lead Partner in any such engagement with NHS England.

21 COMPLAINTS

21.1 The Partners' own complaints procedures shall apply to this Agreement. The Partners agree to assist one another in the management of complaints arising from this Agreement or the provision of the Services and shall keep records of all complaints and provide the same for review by the Partnership Board every Quarter of this Agreement (or as otherwise agreed between the Partners).

22 TERMINATION & DEFAULT

22.1 This Agreement may be terminated by any Partner giving not less than 3 Months' notice in writing to terminate this Agreement provided that such termination shall not take effect prior to the termination or expiry of all Individual Schemes.

22.2 Each Individual Scheme may be terminated in accordance with the terms set out in the relevant Scheme Specification provided that the Partners ensure that the Better Care Fund requirements continue to be met.

22.3 If any Partner ("Relevant Partner") fails to meet any of its obligations under this Agreement, the other Partner may by notice require the Relevant Partner to take such reasonable action within a reasonable timescale as the other Partner may specify to rectify such failure. Should the Relevant Partner fail to rectify such failure within such reasonable timescale, the matter shall be referred for resolution in accordance with Clause 23.

22.4 Termination of this Agreement (whether by effluxion of time or otherwise) shall be without prejudice to the Partners' rights in respect of any antecedent breach and the provisions of Clauses 15 (Audit and Right of Access) 16 (Liabilities and Insurance and Indemnity) 22 (Termination & Default) 25 (Confidentiality) 26 (Freedom of Information and Environmental Protection Regulations) and 28 (Information Sharing).

22.5 In the event of termination of this Agreement, the Partners agree to cooperate to ensure an orderly wind down of their joint activities and to use their best endeavours to minimise disruption to the health and social care which is provided to the Service Users.

22.6 Upon termination of this Agreement for any reason whatsoever the following shall apply:

22.6.1 the Partners agree that they will work together and co-operate to ensure that the winding down and disaggregation of the integrated and joint activities to the separate responsibilities of the Partners is carried out smoothly and with as little disruption as possible to service users, employees, the Partners and third parties, so as to minimise costs and liabilities of each Partner in doing so;

22.6.2 where either Partner has entered into a Service Contract which continues after the termination of this Agreement, both Partners shall continue to contribute to the Contract Price in accordance with the agreed contribution for that Service prior to termination and will enter into all appropriate legal documentation required in respect of this;

22.6.3 the Lead Commissioner shall make reasonable endeavours to amend or terminate a Service Contract (which shall for the avoidance of doubt not include any act or omission that would place the Lead Commissioner in breach of the Service Contract) where the other Partner requests the same in writing Provided that the Lead Commissioner shall not be required to make any payments to the Provider for such amendment or termination unless the Partners shall have agreed in advance who shall be responsible for any such payment.

22.6.4 where a Service Contract held by a Lead Commissioner relates all or partially to services which relate to the other Partner's Functions then provided that the Service Contract allows the other Partner may request that the Lead Commissioner assigns the Service Contract in whole or part upon the same terms mutatis mutandis as the original contract.

22.6.5 the Partnership Board shall continue to operate for the purposes of functions associated with this Agreement for the remainder of any contracts and commitments relating to this Agreement; and

22.6.6 Termination of this Agreement shall have no effect on the liability of any rights or remedies of either Partner already accrued, prior to the date upon which such termination takes effect.

22.7 In the event of termination in relation to an Individual Scheme the provisions of Clause 22.6 shall apply mutatis mutandis in relation to the Individual Scheme (as though references as to this Agreement were to that Individual Scheme).

23 DISPUTE RESOLUTION

23.1 In the event of a dispute between the Partners arising out of this Agreement, either Partner may serve written notice of the dispute on the other Partner, setting out full details of the dispute.

23.2 The Authorised Officers shall meet in good faith as soon as possible and in any event within seven (7) days of notice of the dispute being served pursuant to Clause 23.1, at a meeting convened for the purpose of resolving the dispute.

23.3 If the dispute remains after the meeting detailed in Clause 23.2 has taken place, the Council's Director of Adult Services and the CCG's Chief Officer or their nominees shall meet in good faith as soon as possible after the relevant meeting and in any event with fourteen (14) days of the date of the meeting, for the purpose of resolving the dispute.

23.4 If the dispute remains after the meeting detailed in Clause 23.3 has taken place, then the Partners will jointly refer the matter to either (whichever is the sooner):

23.4.1 the next scheduled meeting of the Health and Wellbeing Board for settlement; or

23.4.2 the Partnership Board if the Chair of the Health and Wellbeing Board has agreed to devolve responsibility for settling the dispute to the Partnership Board.

23.5 If the dispute remains after the meeting detailed in Clause 23.4 has taken place, then the Partners will attempt to settle such dispute by mediation in accordance with the CEDR Model Mediation Procedure or any other model mediation procedure as agreed by the Partners. To initiate a mediation, either Partner may give notice in writing (a **"Mediation Notice"**) to the other requesting mediation of the dispute and shall send a copy thereof to CEDR or an equivalent mediation organisation as agreed by the Partners asking them to nominate a mediator. The mediation shall commence within twenty (20) Working Days of the Mediation Notice being served. Neither Partner will terminate such mediation until each of them has made its opening presentation and the mediator has met each of them separately for at least one (1) hour. Thereafter, paragraph 14 of the Model Mediation Procedure will apply (or the equivalent paragraph of any other model mediation procedure agreed by the Partners). The Partners will co-operate with any person appointed as mediator, providing him with such information and other assistance as he shall require and will pay his costs as he shall determine or in the absence of such determination such costs will be shared equally.

23.6 Nothing in the procedure set out in this Clause 23 shall in any way affect either Partner's right to terminate this Agreement in accordance with any of its terms or take immediate legal action.

24 FORCE MAJEURE

24.1 Neither Partner shall be entitled to bring a claim for a breach of obligations under this Agreement by the other Partner or incur any liability to the other Partner for any losses or damages incurred by that Partner to the extent that a Force Majeure Event occurs and it is prevented from carrying out its obligations by that Force Majeure Event.

24.2 On the occurrence of a Force Majeure Event, the Affected Partner shall notify the other Partner as soon as practicable. Such notification shall include details of the Force Majeure Event, including evidence of its effect on the obligations of the Affected Partner and any action proposed to mitigate its effect.

24.3 As soon as practicable, following notification as detailed in Clause 24.2, the Partners shall consult with each other in good faith and use all best endeavours to agree appropriate terms to mitigate the effects of the Force Majeure Event and, subject to Clause 24.4, facilitate the continued performance of the Agreement.

24.4 If the Force Majeure Event continues for a period of more than sixty (60) days, either Partner shall have the right to terminate the Agreement by giving fourteen (14) days written notice of termination to the other Partner. For the avoidance of doubt, no compensation shall be payable by either Partner as a direct consequence of this Agreement being terminated in accordance with this Clause.

25 CONFIDENTIALITY

25.1 In respect of any Confidential Information a Partner receives from another Partner (the "**Discloser**") and subject always to the remainder of this Clause 25, each Partner (the "**Recipient**") undertakes to keep secret and strictly confidential and shall not disclose any such Confidential Information to any third party, without the Discloser's prior written consent provided that:

25.1.1 the Recipient shall not be prevented from using any general knowledge, experience or skills which were in its possession prior to the Commencement Date; and

25.1.2 the provisions of this Clause 25 shall not apply to any Confidential Information which:

(a) is in or enters the public domain other than by breach of the Agreement or other act or omission of the Recipient; or

(b) is obtained by a third party who is lawfully authorised to disclose such information.

25.2 Nothing in this Clause 25 shall prevent the Recipient from disclosing Confidential Information where it is required to do so in fulfilment of statutory obligations or by judicial, administrative, governmental or regulatory process in connection with any action, suit, proceedings or claim or otherwise by applicable Law.

25.3 Each Partner:

25.3.1 may only disclose Confidential Information to its employees and professional advisors to the extent strictly necessary for such employees to carry out their duties under the Agreement; and

25.3.2 will ensure that, where Confidential Information is disclosed in accordance with Clause 25.3.1, the recipient(s) of that information is made subject to a duty of confidentiality equivalent to that contained in this Clause 25;

25.3.3 shall not use Confidential Information other than strictly for the performance of its obligations under this Agreement.

26 FREEDOM OF INFORMATION AND ENVIRONMENTAL PROTECTION REGULATIONS

26.1 The Partners agree that they will each cooperate with each other to enable any Partner receiving a request for information under the 2000 Act or the 2004 Act to respond to a request promptly and within the statutory timescales. This cooperation shall include but not be limited to finding, retrieving and supplying information held, directing requests to other Partners as appropriate and responding to any requests by the Partner receiving a request for comments or other assistance.

26.2 Any and all agreements between the Partners as to confidentiality shall be subject to their duties under the 2000 Act and 2004 Act. No Partner shall be in breach of Clause 26 if it makes disclosures of information in accordance with the 2000 Act and/or 2004 Act.

27 OMBUDSMEN AND PROHIBITED ACTS

27.1 The Partners will co-operate with any investigation undertaken by the Health Service Commissioner for England or the Local Government Commissioner for England (or both of them) in connection with this Agreement.

27.2 Neither Partner shall do any of the following:

a) offer, give, or agree to give the other Partner (or any of its officers, employees or agents) any gift or consideration of any kind as an inducement or reward for doing or not doing or for having done or not having done any act in relation to the obtaining of performance of this Agreement or any other contract with the other Partner, or for showing or not showing favour or disfavour to any person in relation to this Agreement or any other contract with the other Partner; and

b) in connection with this Agreement, pay or agree to pay any commission, other than a payment, particulars of which (including the terms and conditions of the agreement for its payment) have been disclosed in writing to the other Partner,

(together "**Prohibited Acts**" for the purposes of Clauses 27.2 to 27.6).

27.3 If either Partner or its employees or agents (or anyone acting on its or their behalf) commits any Prohibited Act or commits any offence under the Bribery Act 2010 with or without the knowledge of the other Partner in relation to this Agreement, the non-defaulting Partner shall be entitled:

a) to exercise its right to terminate under clause 22 and to recover from the defaulting Partner the amount of any loss resulting from the termination; and

b) to recover from the defaulting Partner the amount or value of any gift, consideration or commission concerned; and

c) to recover from the defaulting Partner any loss or expense sustained in consequence of the carrying out of the Prohibited Act or the commission of the offence.

27.4 Each Partner must provide the other Partner upon written request with all reasonable assistance to enable that Partner to perform any activity required for the purposes of complying with the Bribery Act 2010. Should either Partner request such assistance the Partner requesting assistance must pay the reasonable expenses of the other Partner arising as a result of such request.

27.5 The Partners must have in place an anti-bribery policy for the purposes of preventing any of their staff from committing a prohibited act under the Bribery Act 2010. If either Partner requests the other Partner's policies to be disclosed then the Partners shall endeavour to do so within a reasonable timescale and in any event within 20 Working Days.

27.6 Should the Partners become aware of or suspect any breach of Clauses 27.2 to 27.6, it will notify the other Partner immediately. Following such notification, the Partner must respond promptly and fully to any enquiries of the other Partner, co-operate with any investigation undertaken by the Partner and allow the Partner to audit any books, records and other relevant documentation.

28 INFORMATION SHARING

28.1 The Partners will follow the Information Governance Protocol set out in schedule 8, and in so doing will ensure that the operation this Agreement complies comply with the Law, in particular the 1998 Act**.**

29 NOTICES AND PUBLICITY

29.1 Any notice to be given under this Agreement shall either be delivered personally or sent by first class post or electronic mail. The address for service of each Partner shall be as set out in Clause 29.3 or such other address as each Partner may previously have notified to the other Partner in writing. A notice shall be deemed to have been served if:

29.1.1 personally delivered, at the time of delivery;

29.1.2 posted, at the expiration of forty eight (48) hours after the envelope containing the same was delivered into the custody of the postal authorities; and

29.1.3 if sent by electronic mail, at the time of transmission and a telephone call must be made to the recipient warning the recipient that an electronic mail message has been sent to him (as evidenced by a contemporaneous note of the Partner sending the notice) and a hard copy of such notice is also sent by first class recorded delivery post (airmail if overseas) within one (1) Working Day as that on which the electronic mail is sent.

29.2 In proving such service, it shall be sufficient to prove that personal delivery was made, or that the envelope containing such notice was properly addressed and delivered into the custody of the postal

authority as prepaid first class or airmail letter (as appropriate), or that the electronic mail was properly addressed and no message was received informing the sender that it had not been received by the recipient (as the case may be).

29.3 The address for service of notices as referred to in Clause 29.1 shall be as follows unless otherwise notified to the other Partner in writing:

29.3.1 if to the Council, addressed to the: Service Head: Commissioning and Health, Adults' Services, London Borough of Tower Hamlets, 4th Floor, Mulberry Place, 5 Clove Crescent, London E14 2BG;

Tel: 020 7364 0497
E.Mail: karen.sugars@towerhamlets.gov.uk

and

29.3.2 if to the CCG, addressed to: Deputy Director of Commissioning and Transformation, NHS Tower Hamlets Clinical Commissioning Group, 2nd Floor Alderney Building, Mile End Hospital, Bancroft Road, London, E1 4DG;

Tel: 020 3688 2518
E.Mail: josh.potter@towerhamletsccg.nhs.uk

29.4 Without prejudice to Clause 26, except with the written consent of the other Partner, (such consent not to be unreasonably withheld or delayed), the Partners must not make any press announcements in relation to this Agreement in any way.

29.5 The Partners must take all reasonable steps to ensure the observance of the provisions of Clause 29.4 by their staff, servants, agents, consultants and sub-contractors.

30 VARIATION

30.1 No variations to this Agreement will be valid unless they are recorded in writing and signed for and on behalf of each of the Partners subject to the Law and the Partners' Standing Orders and Standing Financial Instructions.

31 CHANGE IN LAW

31.1 The Partners shall ascertain, observe, perform and comply with all relevant Laws, and shall do and execute or cause to be done and executed all acts required to be done under or by virtue of any Laws.

31.2 On the occurrence of any Change in Law, the Partners shall agree in good faith any amendment required to this Agreement as a result of the Change in Law subject to the Partners using all reasonable endeavours to mitigate the adverse effects of such Change in Law and taking all reasonable steps to minimise any increase in costs arising from such Change in Law.

31.3 In the event of failure by the Partners to agree the relevant amendments to the Agreement (as appropriate), the Clause 23 (Dispute Resolution) shall apply.

32 WAIVER

32.1 No failure or delay by any Partner to exercise any right, power or remedy will operate as a waiver of it nor will any partial exercise preclude any further exercise of the same or of some other right to remedy.

33 SEVERANCE

33.1 If any provision of this Agreement, not being of a fundamental nature, shall be held to be illegal or unenforceable, the enforceability of the remainder of this Agreement shall not thereby be affected.

34 ASSIGNMENT AND SUB CONTRACTING

34.1 The Partners shall not sub contract, assign or transfer the whole or any part of this Agreement, without the prior written consent of the other Partners, which shall not be unreasonably withheld or delayed. This shall not apply to any assignment to a statutory successor of all or part of a Partner's statutory functions.

35 EXCLUSION OF PARTNERSHIP AND AGENCY

35.1 Nothing in this Agreement shall create or be deemed to create a partnership under the Partnership Act 1890 or the Limited Partnership Act 1907, a joint venture or the relationship of employer and employee between the Partners or render either Partner directly liable to any third party for the debts, liabilities or obligations of the other.

35.2 Except as expressly provided otherwise in this Agreement or where the context or any statutory provision otherwise necessarily requires, neither Partner will have authority to, or hold itself out as having authority to:

35.2.1 act as an agent of the other;

35.2.2 make any representations or give any warranties to third parties on behalf of or in respect of the other; or

35.2.3 bind the other in any way.

36 THIRD PARTY RIGHTS

36.1 Unless the right of enforcement is expressly provided, no third party shall have the right to pursue any right under this Contract pursuant to the Contracts (Rights of Third Parties) Act 1999 or otherwise.

37 ENTIRE AGREEMENT

37.1 The terms herein contained together with the contents of the Schedules constitute the complete agreement between the Partners with respect to the subject matter hereof and supersede all previous communications representations understandings and agreement and any representation promise or condition not incorporated herein shall not be binding on any Partner.

37.2 No agreement or understanding varying or extending or pursuant to any of the terms or provisions hereof shall be binding upon any Partner unless in writing and signed by a duly authorised officer or representative of the parties.

38 COUNTERPARTS

38.1 This Agreement may be executed in one or more counterparts. Any single counterpart or a set of counterparts executed, in either case, by all Partners shall constitute a full original of this Agreement for all purposes.

39 GOVERNING LAW AND JURISDICTION

39.1 This Agreement and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the laws of England and Wales.

39.2 Subject to Clause 23 (Dispute Resolution), the Partners irrevocably agree that the courts of England and Wales shall have exclusive jurisdiction to hear and settle any action, suit, proceedings, dispute

or claim, which may arises out of, or in connection with, this Agreement, its subject matter or formation (including non-contractual disputes or claims).

IN WITNESS WHEREOF this Agreement has been executed AS A DEED by the Partners on the date of this Agreement

THE CORPORATE SEAL of)
THE LONDON BOROUGH OF)
TOWER HAMLETS)
was hereunto affixed in the presence of:)

Signed for on behalf of **NHS TOWER HAMLETS CLINICAL COMMISSIONING GROUP**

____

Authorised Signatory

SCHEDULE 1– SCHEME SPECIFICATION

Part 1– Template Services Schedule

TEMPLATE SERVICE SCHEDULE

Unless the context otherwise requires, the defined terms used in this Scheme Specification shall have the meanings set out in the Agreement.

40 OVERVIEW OF SERVICES

40.1 Context and background information

Local Context

Tower Hamlets has a resident population of 284,000 people with an unusually young age profile. Only 6% (17,000) of the population is over 65. The population is expected to rise to 353,000 by 2033, an increase of around 20%.

31% of the population is classified as White British and 32% Bangladeshi, though this distribution varies substantially across different age groups. The White British, White Irish and Black Caribbean populations in the borough have older age profiles compared to other groups, while residents from mixed ethnic groups, the Other Black group and the Bangladeshi group are all characterised by younger age profiles, with higher proportions of children. Over one third of the Bangladeshi population is children aged under 16, compared with only 9 per cent of White British residents. Conversely, only 5 per cent of Bangladeshi residents are aged 60 or over, compared with 16 per cent of White British residents. Given the contrasting age profiles of the two largest populations, the ethnic makeup of the population varies significantly by age. The proportion of residents that are White British rises with age: 15 per cent of the borough's children (aged under 16) are White British compared with almost two thirds (63 per cent) of the population aged 75 and over. More than half of the borough's children are Bangladeshi.

Headline health indicators indicate significant health inequalities between Tower Hamlets and the rest of the country. Both male and female life expectancy is shorter than the national averages (male life expectancy is 76.7 years and female life expectancy is 81.9). Compared to London, Tower Hamlets has the second highest premature death rate from circulatory disease (87 per 100,000), the second highest premature death rate from cancer (128.5 per 1000) and the second highest premature death rate (36.9 per 100,000) from respiratory disease. (These conditions typically constitute 75% of all premature deaths.) Death rates vary across the borough and in general are higher in areas of higher deprivation.

Tower Hamlets has a higher rate for deaths that occur in a hospital (57.5%) (as opposed to other locations) compared to the national rate (48.3%). Our aim is that care should focus on reversing/ stabilising or effectively managing deterioration in functional or health status with palliative care as an integral component in line with our shift of focus on palliative care to a wider Last Years of Life perspective.

Integrated Care

The Tower Hamlets integrated care programme is part of the Integration Pioneer WELC integrated care programme. The programme requires that a holistic approach is taken to the management and care of patients. The component services within the programme will be delivered by a range of staff types and grades across a number of providers in a wide number of locations including patients' own homes.

The target population for Integrated Care over the next 3-5 years is the same for all providers and is identified as patients who have very high risk, high risk or moderate risk of a hospital admission in the next 12 months and have consented to participate in the programme. Across the borough this makes up the top 20% of the population who is at risk of admission.

40.2 **Pooled Funds:**

At the Commencement Date of this Agreement there shall be three (3) Pooled Funds:

Pooled Fund	BCF Scheme	Lead Commissioner	Provider	BCF Allocation (£)
Mandatory CCG contribution (recurrent schemes)	Integrated Community Health Team	CCG	CCG	7,358,871
	Primary Care Integrated Care Incentive Scheme	CCG	CCG	1,200,000
	RAID	CCG	CCG	2,106,420
	Mental Health Recovery College	CCG	CCG	110,000
	Reablement Team	CCG	Council	2,413,871
	Community Health Team (Social Care)	CCG	Council	895,500
	7 Day Hospital Social Work Team	CCG	Council	1,230,800
	7 Day Community Equipment Provision team	CCG	Council	154,985
	Assistive Technology team	CCG	Council	287,000
	Assistive Technology additional demand	CCG	Council	362,000
	Dementia café	CCG	Council	55,000
	Community outreach service	CCG	Council	25,000
	Adult autism diagnostic intervention service	CCG	Council	330,000
	Carers	CCG	Council	1,430,000
	Local incentive scheme	CCG	CCG	1,000,000
	Enablers	CCG	Council	208,000
Total				19,167,447
Additional CCG contributi on (non-	Falls prevention	CCG	CCG	68,000

recurrent scheme s)	Community Geriatrician Team	CCG	CCG	115,000
	Personalisation	CCG	CCG	212,000
	Mental Health Personal Commissioning	CCG	CCG	300,000
Total				695,000
Council contribution	Disabled Facilities Grant	Council	Council	1,572,542
Total				1,572,542
BCF total				**21,434,989**

40.3 **Strategic Objectives**

The strategic objectives for each individual scheme are as follows:

40.3.1 **Integrated Community Health Teams**

The Locality based Community Health Teams will provide an integrated team approach to the care of patients in the community and incorporate the function of the following services:

- Community virtual ward and case managers
- Community rehabilitation and support team (CReST) including the falls team
- Last years of life centre (facilitators and coordinators, service development and MCNS service)
- Adult community nursing (including IV therapy, community liaison, last years of life facilitators, district nursing, continence service and out of hour nursing)

40.3.2 **Reablement Team**

Referral routes are generally via the two main social care access points: Assessment and Intervention Team (community-based users), and the Hospital Social Work Team (users in inpatient units/A&E). In addition, the Community Health Teams can refer direct, as can the social care Personalisation and Review services (both social work and Occupational Therapy teams). Once the user is within the Reablement pathway they will receive:

- Maximising independence assessment and development of individual support programmes
- Programme co-ordination
- Review of Independence plan
- Eligibility decision and resource allocation
- Other assessments

- *For the user/patient:*

- Improving their quality of life
- Keeping and regaining skills, especially those enabling people to live independently
- Regaining or improving confidence (e.g., for someone who has had a fall)
- Increasing people’s choice, autonomy, and resilience
- Enabling people to be able to continue living at home

- *For the service:*

- Safe transfer of patients between acute care, community health and social care services and support return to independent living
- Prevention of unnecessary hospital admissions and to facilitate supported discharge
- Provide information and onward referral for services so that users/patients and their carers can make choices about care needs
- Prevent premature admissions to residential and nursing homes by maximizing independence and choice

- *For the organisation:*

- Reduction in admissions and readmissions in 91 day measures
- Financial benefits
- Sustainable reduction in support packages in the longer term, 6-12 months post reablement

  - *For the informal carer:*

- Provide information, training, and support to enable informal carers to maintain their roles with the user and within the community in which they live

40.3.3 **7 Day Hospital Social Work Team**

The 7-day service provides timely multidisciplinary assessments, which avoid unnecessary admissions to acute wards, and manages/facilitates speedier discharges in a seamless fashion, by commissioning community services that permit patients to return home.

The scheme operates 7 days per week (from 9am to 8pm, Monday to Friday, and 10am to 8pm on Saturdays and Sundays). The service aims to respond to referrals from the Royal London Hospital within 3 hours. If people present at A&E and are residents of Tower Hamlets, then the team addresses social care issues at that point. This can involve restarting social care services and preventing unnecessary admission. If people present at A&E and are from other council areas, they are signposted and the team notifies the responsible authorities to avoid social care admissions, following information from medical staff that there is no health reason for admission. The key strategic objective for the 7-day service is centred around prevention of unnecessary hospital admission, whereby community-based health and social care services can be quickly accessed by the referring social work team based at the hospital.

Those people requiring elective or emergency admission to the Royal London Hospital will have a planned discharge from the social work team based at the hospital by having a Care Act-required assessment of need carried out and services as necessary under the Act. Safeguarding adults investigations, as outlined in the Care Act 2014, are carried out following an alert from the community, hospital staff, residents or London Ambulance Service.

40.3.4 **Community Health Team (Social Care)**

The scheme seeks to improve the experience and outcomes for patients with complex health and social care needs, and the highest risk of hospital admission, by maximising independence, choice and control. Achieving this goal will result in improved overall health and wellbeing for the residents of Tower Hamlets.

The ongoing development and integration of the CHT (SC) will continue to strengthen links and partnership working between social care, health and other stakeholders. Activities being undertaken will build on the joint working already taking place across the 8 locality networks.

This includes:

- Working in partnership with health and other adults' teams systematically to identify adults who are most vulnerable and at risk of hospitalisation.
- Providing assessment and support using a coordinated, person centred and MDT approach.
- Promoting wellbeing and independence for those living with long term conditions.

- Assessing and supporting Carers if of people with long term conditions in alignment with the Care Act 2014
- Contributing to the reduction of unplanned admissions and readmissions to hospital.
- Maintaining patients in the community for longer and delaying admission to long term care.
- To develop and move towards integrated Continuing Healthcare assessments and joint planning for target cohort

40.3.5 **Mental Health Liaison (RAID)**

The Royal London Hospital Liaison Psychiatry Service is being commissioned to provide a single multi-disciplinary mental health and drug and alcohol assessment service to provide expert advice, support and training to Royal London Hospital clinicians. The Service will be fully integrated into the Royal London Hospital and associated Barts Health sites in Tower Hamlets, and will maintain a very high profile within the hospital.

40.3.6 **Recovery College**

The Recovery College model complements health and social care specialist assessment and treatment, by helping people with mental health problems and/or other long term conditions to understand their problems and to learn how to manage these better in pursuit of their aspirations. It will promote:

- The delivery of a planned, co-produced and co-delivered learning programme covering a range of mental health and physical health-related topics that provide education as a route to recovery, and foster increased resilience and self-management.
- Collaboration and co-production between people with personal and professional experience of mental health challenges; and provide an educational approach operating on college principles. It will use strengths-based and person-centred approaches that are inclusive, aimed at people with mental health and physical health challenges, their relatives and carers and staff; and focused on mental health recovery and helping people reach their own goals.

40.3.7 **Independent Living**

Assistive Technology Team

The scheme enables vulnerable people who require support to remain living independently in their own homes, by utilising assistive technology, including Telecare and Telehealth solutions. The Assistive Technology (AT) Team provides training and support to social care and health professionals, as well as piloting and implementing new initiatives and projects. The specific objectives of the project are to:

- Expand the range of AT equipment.
- Raise awareness among social care and health professionals.
- Increase take-up.
- Demonstrate avoided costs.

The scheme also aims to embed the use of Assistive Technology into mainstream provision, to help vulnerable residents of Tower Hamlets to live independently in their own homes.

40.3.8 **Integrated Care Incentive Scheme**

For 2016-17 the CCG has reviewed the Network Improved Services (NIS) within Tower Hamlets. The review has resulted in a new structure to this incentive scheme, within the same overall cost:

- The scheme now focuses on clinical stratification (rather than using the risk of admission score). Therefore the population is divided into: complex (i.e. people with complex needs, such as palliative), LTCs and a 'healthy' cohort (i.e. the remaining of our patients).
- Based on the above, the IC NIS will be divided into IC1, which will include the complex group, and IC2, which will include people with LTCs who were previously under care packages (Diabetes, Cardio Vascular Disease, Hypertension, chronic obstructive pulmonary disease (COPD) and cancer).

- The AUA DES, if it is still funded by NHS England, will be replaced by the IC1 Admission Avoidance component of the NIS which will incentivise a comprehensive review within 3 weeks of the day of discharge of patients who are admitted due to myocardial infarction (MI)/stroke/HF or patients over 65 years admitted with hypoglycaemia, falls and fractures or gastrointestinal bleeding/ COPD/ vascular ulceration/gangrene.

40.3.9 **Adult Autism Diagnostic and Intervention Service**

The Adult Autism Diagnostic and Intervention service (ASD service) is intended to align autism services in Tower Hamlets with the aims of the National Autism Strategy, which include:

- Increasing awareness and understanding of autism;
- Developing a clear and consistent pathway for diagnosis;
- Improving access to the services and support people need to live independently within the community;
- Delivering on Employment Opportunities; and Enabling local partners to develop relevant services to meet identified needs and priorities

The service provides a high quality diagnostic and intervention service for high functioning adults (aged 18 years and over) with suspected Autism Spectrum Disorder (ASD) in Tower Hamlets. It also sub contracts a local Third Sector provider (JET) to provide a range of support options for people diagnosed with Autism Spectrum Disorder, and facilitate appropriate referral and signposting to other services where needed.

The service includes the following:

- A core diagnostic team to provide assessment of adults with potential ASD in Tower Hamlets, which uses best clinical practice and in line with NICE clinical guidelines for care of adults with autism
- Sign posting and referral to other services should a primary condition be other than ASD (i.e. mental health) or a risk be identified (i.e. self-harm or harm to others) that may require in-patient treatment
- Post intervention support to adults with ASD (high functioning) including Cognitive Behavioural Therapies and assistance with developing social relationships
- locally based sub-contracted support service which enables user access to employment, training and advocacy

The service is founded on the principles of a person centred approach with an emphasis on helping individuals to develop (or rediscover) their own unique skills through active engagement and participation. This includes a proactive approach in utilising resources that are available within the service and the community to meet individual's needs and aspirations.

40.3.10 **Dementia Café**

The Alzheimer's Society provides a fortnightly, inclusive Dementia Café, run in English, for people with dementia and their carers in Tower Hamlets, including people from the black and ethnic communities and, a fortnightly Bangladeshi (Sylheti language) Dementia Café, for Bangladeshi carers and people with dementia.

The peer support group sessions within the café provide social and emotional support, encourage social engagement and shared experiences as well as information giving for both Sylheti speakers from the Bangladeshi community and the wider community.

The objective of the Dementia Café service is to help people with dementia to live well following diagnosis. The provision of dementia cafes in English and in Sylheti in Tower Hamlets are an important means by which the Council supports people with mild to moderate dementia and their carers. Intervention at an early stage helps to delay decline, by keeping people active, informed and connected to peers and linked to key services within the community and out of hospital. A survey undertaken for 2015-16 Q2 monitoring found that service users experienced positive social engagement, reported higher take up of other local services and said they had a better understanding of dementia.

40.3.11 **Community Outreach Service**

The BME Inclusion service provides community-specific input to BME communities in order to support people to understand dementia, break down stigma and access services. It does this by undertaking awareness raising at culturally-specific community networks; case finding and building relationships with people with dementia who may be hard to reach; case management through one to one support prioritised to those with the highest needs, and working with GP practices with high patient numbers from Bangladeshi and other BAME communities where there is a lower than expected dementia diagnosis rate.

The objective of this service is to address the particular issues preventing people with dementia from BME communities from accessing services. Getting a diagnosis of dementia enables people to access services and plan for the future, thereby avoiding admissions in crises to both health and social care services. However, there are significant barriers to people from BME communities getting a diagnosis, as there are strong stigmas associated with dementia, with it being perceived as ‘madness’, and often hidden by families until the point of breakdown.

40.3.12 **Carers & Care Act**

The strategic objective of the scheme is to help carers to care effectively and safely – both for themselves and the person they are supporting. It will include timely interventions or advice on matters such as moving and handling people safely, avoiding falls in the home and training for carers to feel confident performing basic care tasks.

The Carers Hub provides the following support to carers:

- specialist information, advice and independent advocacy including statutory advocacy for carers, as specified by the Care Act 2014.
- supported carers’ assessments and referral to the council for a full statutory carers’ assessment
- information, advice and access to other services, where appropriate, that support carers to prevent, delay or reduce social care needs
- support for carers on hospital admission/discharge
- services and activities to alleviate and manage stress and provide a break from caring
- representing carers’ views in local authority and CCG planning; acting as the voice of carers and building partnerships with other organisations.
- outreach and support for hidden carers
- development and delivery of a range of training and awareness programmes for carers.

40.3.13 **7-Day Community Equipment Provision Team**

This scheme will permit community equipment services to be provided to people able to leave hospital for longer hours on a 7 days a week basis. Community Equipment Service personnel will be available to receive requisitions for simple aids to living and complex pieces of equipment, such as hoists, special beds, pressure care, hand rails and so on via dedicated secure electronic faxes, telephone calls and secure emailing.

For the service user/patient, the service will:

- offer choice and flexibility for patients to be discharged from hospitals over a longer time span during weekdays and weekends.
- give patients, service users and carers confidence that equipment items have been delivered and installed prior to returning home.
- avoid unnecessary admissions and trips to A&E, by providing emergency deliveries, repair and replacement of hoisting, special beds and mattresses and other essential toileting and mobility equipment over extended hours.

It will also:

- support hospital teams to carry out safer discharges by providing an out of hours service
- minimise and prevent readmissions and Delayed Transfer of Care (DTOC).

- support Community Health and Social Care Teams to provide more complex care and support in users' own homes through CES being more accessible and flexible with delivery and installation times.
- facilitate safe, integrated and seamless transfer of patients between hospital, community health and social care services.
- prevent unnecessary hospital admissions, by providing timely delivery of equipment over 7 days to make the home environment safer and accessible.

For organisations, the extended hours service will:

- reduce length of stay in acute beds.
- enable discharge co-ordinators and bed managers to plan for discharges of people needing essential pieces of equipment for a safe discharge over a 7 day period.
- generate cost savings by reducing in-patient episodes and prevent and delay need for care home placements and high cost support packages.

For families and informal carers it will:

- enable family members and informal carers to be better prepared for their relatives to return home at times that are flexible over 7 days, convenient and fit in with their other commitments, such as child care and employment.

40.3.14 **Enablers**

Four officers are employed within the council to ensure:

- high level management support for strategic decision making on health and social care integration.
- that the council is represented at partnership bodies and other groups concerned with integration.
- coordination of input to partnership arrangements, such as Health and Wellbeing Board, the Complex Adults Programme Board, THIPP, Tower Hamlets Vanguard, WELC/ Care Closer to Home and Transforming Services Together (TST).
- manage health and social care partnership governance and planning arrangements within the council.
- prepare dashboards and monthly monitoring of performance measures for internal and external teams and partnerships.
- provide advice and guidance to scheme managers to strengthen integration work with health.
- programme management and monitoring of BCF schemes managed by the council
- co-ordinating the council's involvement in a range of programmes and processes concerned with the integration of health and social care, including the Tower Hamlets Integrated Provider Partnership (THIPP), the Vanguard New Care Model, the WELC Integrated Care Pioneer and Transforming Services Together (TST)
- the development and implementation of new models of working within Adult Social Care
- the improvement of joint information management systems to facilitate more effective service delivery involving health and social care providers.
- the provision of operational and performance information to support the development of integrated services and internal/external monitoring.

40.3.15 **Disabled Facilities Grant**

The council has a statutory duty to provide Disabled Facilities Grants (DFGs) to eligible disabled residents for the adaptation of their home environment to enable them to continue to live as independently and safely as possible. DFGs are mandatory for necessary adaptations to provide better movement in and around the home and access to essential facilities. The Housing Grants, Construction and Regeneration Act 1996, requires that the Housing Authority must approve a DFG to meet the assessed needs of an eligible disabled resident.

40.3.16 **Falls Prevention**

The proposal is to implement an education programme which will provide skills and confidence to care home and domiciliary staff and provide:

- education sessions to care home and domiciliary staff.
- regular meetings with care home staff to discuss residents who have fallen and who are at risk of falls
- initial falls assessment of those at risk and take appropriate action (e.g. involvement of CHT multidisciplinary professionals, primary care and external agencies, such as care home staff.
- advice regarding equipment needed (e.g. cot sides, hoists, slings and chairs of appropriate height and support).
- falls prevention education sessions.

40.3.17 **Personalisation**

The Personalisation Programme supports greater person-centred care, as part of Tower Hamlets' agenda on delivering Integrated Care. The Programme Board overseeing this work reports to the CCG's Complex Adults Programme Board. The work streams within the Personalisation Programme have been developed in response to the direction set within the NHS Five Year Forward View and Forward View Into Action: Planning for 2015/16, and enables the delivery of the CCG's new strategic priority on person-centred care.

40.3.18 **Mental Health in Primary Care**

This initiative aims to increase the capacity of the Barts Health, Health Psychology Team, by employing 2 additional psychologists that will be based in primary care and focus on the management of patients with LTCs and depression and anxiety. The current Community Health Service Health Psychology Service uses a model that is similar to collaborative care, by having health psychologists embedded into physical health teams including diabetes, heart disease, respiratory, and stroke. This model enables patients to receive emotional support across the whole pathway, with particular benefit to patients who are not open to 1:1 counselling.

40.3.19 **Community Geriatrician Team**

Funding is planned to increase the capacity of the existing community geriatrician team (part of the Integrated Community Health Team) to enable additional caseload and more effective Multi Disciplinary Team working.

40.3.19 **Local Incentive Scheme**

The incentive scheme is intended to encourage and reward joint working that achieves the aims of the Tower Hamlets Integrated Provider Partnership, namely to deliver an integrated model of care for patients with complex needs; an emerging system model for patients in the last years of life (LYOL); new models of delivery for long term conditions (LTC); new models of community health services (CHS); targeted health and social care initiatives and a public health prevention-orientated system that underpins the entire system. We have structured this single incentive scheme to be based on the achievement of outcomes, measured by:

- integrated care metrics (incl. mental health)
- Better Care Fund metrics
- Patient Experience metric development
- Population Health metrics

41 AIMS AND OUTCOMES

41.1 Integrated Community Health Teams

- Provide integrated nursing and therapy care services across the locality, ranging from a 2-hour response service to avoid admission to complex case management and promoting self-care
- Systematically identify adults in Tower Hamlets who are most vulnerable/at risk of hospitalisation and provide support and care to these patients which is coordinated and multidisciplinary in approach
- Reduce non-essential use of A&E and unplanned admissions
- Reduce readmission rates within 30 days of discharge from any acute setting

- Assess and support people with long term conditions in the community, promoting self-management and enabling patients to regain or maintain functional independence and restore confidence within a set timeframe
- Involve patients/service users and carers in planning and providing care;
- Facilitate carer assessment (either by completing the assessment or by referring to other agencies to carry out carer assessment);
- Ensure continuing health care assessment and reviews are completed in line with defined timescales
- Seek to improve health outcomes for the population through strong clinical leadership and governance and ensure productivity, innovation and efficiency are core service deliverables

41.2 **Reablement and Rehabilitation Joint Working Pilot**

The service will work with 700-750 users during 2016-17; with approximately 70% of these users being over the age of 65. Of this cohort of users the aim is that:

- 45% will result in no ongoing social care support needs
- 20% will result in a reduction of their previous long term social care support needs
- 10% will result in no change to their long term social care support needs
- 90% of over 65s receiving Reablement will still be living at home 91 days post discharge from an acute hospital stay

- 90% of users will receive a Reablement assessment within 5 days of referral
- The average ‘length of stay’ in Reablement will be 4-5 weeks
- All Reablement users with urgent support needs will have this in place for discharge from hospital, or within 24 hours if already in the community
- Pre- and post-Reablement support package demonstrates a £1.5m saving per annum for 2016-17 cohort of users, as a result of Reablement intervention
- User satisfaction levels will be 80%, showing a general satisfaction with their experiences within Reablement.
- Increased information sharing, joint assessments, and joint working opportunities with Community Health Teams for users within Rehabilitative pathways
- Joint working protocols with health colleagues to improve access to Reablement for users in the community with both health and social care needs; enabling access to Reablement support for users with long term health needs
- Timely facilitation of discharge from hospital for Reablement users to reduce incidence of DTOC

41.3 **Social work team 7 day working at Royal London Hospital**

The key aim is to keep a positive bed flow, so that people do not wait in the Acute Admissions Unit (AAU) for acute beds or have to be taken to other hospital for admission.

The social work team works within Department of Health rules around 4-hour turnaround times when presenting to A&E. The social workers covering this area of the hospital are integrated sufficiently with medical colleagues to support the discharge from A&E within this time. Their aim is to commission new services or restart existing services by liaising directly with Tower Hamlets’ brokerage team or independent care agencies.

A further aim is for the social work team to help prevent further, unplanned attendances at hospital. The team commissions or restarts services and then transfers case management to our community colleagues who then review services or set up support plans to help maintain people in their own homes. The scheme will:

- demonstrate how a change in working practise in the hospital social work service can deliver better outcomes to patients being discharged from the Royal London hospital.
- identify potential efficiency savings
- facilitate and work with any additional Consultants in supporting patients in a timely fashion, who are medically fit for discharge.
- help reduce any bottlenecks occurring over weekends on acute wards, thereby improving patient flow through AAU and A&E.

41.4 **Community Health Team (Social Care)**

The aims of this council-based service are:

- improved partnership working and joint decision making, with earlier referral to and intervention by social services
- joint and coordinated multi-disciplinary assessments and person-centred planning, involving clients and their families from the outset.
- early support and information provision for clients and their families to enable them to make informed decisions about care options in the community with the intention of delaying/preventing long term care provision.
- greater continuity and standardisation of community assessment and integrated interventions.
- earlier identification and support to carers thereby preventing carer breakdown and need for crisis response.
- Improved communication and enhanced quality, choice and control for the person, their families, carers and advocates
- Better, faster decision making by setting a standard for CHT social care of ensuring completion of DSTs in less than 28 days

41.5 **Mental Health Liaison (RAID)**

This scheme aims to:

- improve health outcomes for patients with a mental health or drug or alcohol problem who have been admitted to wards at the Royal London Hospital
- reduce length of stay for patients with a mental health or drug or alcohol problem who are admitted to wards at the Royal London Hospital
- reduce readmissions for patients with a mental health or drug or alcohol problem who have been discharged.

41.6 **Recovery College**

The aims of this scheme are to make a positive impact in the following areas:

- mental health
- social relationships
- volunteering
- learning and skills
- agency (self-esteem, autonomy, feeling valued, etc)

41.7 **Independent Living Service**

The aims of this scheme are to:

- help to facilitate timely discharge from hospital or reduce preventable hospital admissions.
- delay and avoid dependency on statutory and other long term services.
- support carers with their caring duties.
- train health and social care staff on the effective use of at.
- increase the number of at installations.
- demonstrate the benefits in terms of avoided costs.

41.8 **Integrated Care Incentive Scheme**

This scheme aims to achieve:

- Fewer avoidable emergency admissions to hospital [Non elective admissions]

- Shorter admissions and safer discharges with lower readmission rates [Non elective bed days, Non elective readmission within 28 and 90 days, Delayed transfer, Discharge from hospital to residential home]
- Improvement in people dying in the place of their choice
- Impacts on other service utilisation- prescribing costs, planned secondary care, continuing care
- Impact on disease specific care package payment metric performance- we will report metrics for the care packages without frail or complex for payment purposes AND the overall population performance to allow comparison with previous years.
- For those within the integrated care programme who make contact with urgent or emergency care providers/ LAS who have an anticipatory care plan (ACP) the % of people where the ACP is accessed
- People getting the right joined up care at the right time in the right place [SEAs on deaths, audits of unplanned admissions (mandatory for AUA DES target group only)]
- Proportion of local authority spend on nursing and residential care in over 65 yrs
- Quality reviews of care planning outputs.

41.9 **Adult Autism Diagnostic and Intervention Service**

This scheme aims to:

- deliver a diagnostic service for adults (18+) who may have ASD (including Asperger's Syndrome) for whom no care pathway currently exists
- deliver a timely diagnosis to those who may present with ASD behavioural conditions and symptoms
- deliver a locally managed service that incorporates the best clinical practice with regard to adults with ASD
- provide clear pathways to post diagnosis support for adults with ASD
- provide a community focused model that promotes greater opportunity for support within the community for people with ASD
- provide effective transitional pathways to assist young people's (with ASD) transfer from children's to adult services
- provide a model of care that actively supports principles of non-discriminatory practice and service delivery and avoids unnecessary and disruptive transitions across a range of providers.
- ensure recognition of the role of those with caring and parental responsibilities and (with permission of the person with ASD) to ensure their participation in discussions and decisions whenever possible.
- achieve the above we have increased the KPI's to include the number of users being referred for further education, training and employment opportunities, as well as strengthening the links with the Criminal Justice Service (CJS), including Probation, Courts, and the Police.

41.10 **Dementia Café**

The aim of the Dementia Cafes is to provide an inclusive peer support service for people at different stages of dementia and their carers, including people from the BAME communities in Tower Hamlets. The cafes aim to deliver a structured programme of activities and speakers to promote social engagement, understanding of dementia and help people to connect to other services and sources of support. They aim to complement formal care and information services as part of a wider range of psychosocial treatment, care and support for people with dementia. The identified outcomes of the service are:

- Reduction of social isolation
- Increasing access to services
- Access to information

41.11 **Community Outreach Service**

The Community Outreach Service aims to:

- Increase the numbers of people from Bangladeshi and other BAME communities receiving diagnosis and mainstream services available on the dementia pathway.
- Raise awareness of dementia, increase knowledge and reduce stigma within the Bangladeshi and other BAME communities.

- Identify unmet needs through case finding, and identify, connect and support individuals and carers to access appropriate services at the earliest opportunity.
- Reduce isolation and the number of people with dementia who are have not received a diagnosis and do not access services until crisis point has been reached.
- Provide one to one casework to people with dementia and their carers to ensure people can access the appropriate services at the right time.
- GP Practices – provide an expert resource/point of contact for practices wishing to refer patients for one to one community based support available through the proposed service

41.12 **Carers**

The aim is that Carers feel mentally and physically well, treated with dignity and that:

- they report feeling supported in their caring role
- there is accessible and relevant support for Carers
- they feel better informed about accessing support services
- both Carers and the cared for persons health and emotional wellbeing are maintained
- Carers from hard to reach groups know where to go for information.

Carers are recognised and supported as an expert partner

- More carers sustained in caring role
- Carers are supported to feel confident in their caring role through training to care
- Partner organisations help identify carers and know where to signpost carers for advice and support.

Carers are not financially disadvantaged:

- Carers know where to go for information and advice about benefits and the welfare reform changes
- Carers able to take part in educational, training or work opportunities

Carers enjoy a life outside caring:

- Carers are able to participate their local communities, including social and leisure activities
- Carers can balance their caring role and maintain a quality of life
- Carers have a voice in service development

41.13 **Disabled Facilities Grant**

Disabled Facilities Grant will be used to:

- decrease hospital admissions as a result of slips, trips and falls in the home. (The adaptations enable qualifying residents to remain safe in their homes.)
- increase in general well-being – The adaptations provided allow people to be more independent in their homes.
- ensure disabled residents have safe access in and around their homes and access to facilities.

41.14 **Falls prevention**

This initiative aims to:

- reduce the number of avoidable falls and London Ambulance Service (LAS) callouts to care home settings and the risk of secondary falls
- provide care home and domiciliary agency staff with the skills and confidence to support people who are at risk of falls and prevent falls
- reduce the number of avoidable falls in all Tower Hamlets care homes and prevent injury to residents

- reduce the number of LAS call outs and subsequent transport, non-elective admission and follow-up outpatient appointment.
- facilitate appropriate referrals to the Community Health Teams.

41.14 **Personalisation**

This initiative has the following aims:

- widening the offer of Personal Health Budgets (PHB) beyond Continuing Health Care (CHC)
- delivering Integrated Personal Commissioning (IPC) in Tower Hamlets and contributing to the national evaluation of this. NHS England has Commissioned RAND Europe to undertake this evaluation.
- piloting the use of Patient Activation Measure (PAM) in Tower Hamlets
- self-management, including oversight of the self-management pilots, their evaluation and recommendations on future commissioning plans.

41.15 **Mental Health in Primary Care**

The aims of this scheme are to:

- Provide support to primary care clinicians to recognise, screen and manage for psychological distress, anxiety and depression
- deliver information/ provide support for those providing annual reviews, etc.
- provide training for motivational interviewing (management of MH + LTC for primary care clinicians)
- MDTs
- deliver reflective practice sessions
- provide group work for patients who are first diagnosed and training for primary care clinicians to deliver this training
- increase the number of patients attending existing self-management courses that are provided by CHS and CVS organisations.
- embed psychological interventions into all self-management programmes where this element missing.

41.16 **Community Geriatrician Team**

To follow

41.17 Enablers

The team will provide the following support to BCF projects managers, senior officers and members:

- develop Service Level Agreements for all approved BCF schemes for which the council is the lead commissioner
- implement performance management and monitoring systems for BCF-funded initiatives within the council, including the production of reports to the Complex Adults Programme Board and the council's Adult Services DMT
- coordinate the council's involvement in a range of joint bodies concerned with the integration of health and social care, including the Health and Well-Being Board, Complex Adults Programme Board, Tower Hamlets Integrated Provider Partnership (THIPP), the Vanguard New Care Model, the WELC Pioneer and Transforming Services Together (TST)
- contribute to the development of data sharing arrangements between the council and Health sector organisations, in order to improve service outcomes through more effective joint working.
- provide management and guidance for strategic decision making within the council with an overview of policy, performance, finance and ICT relating to integration.

41.18 **Local Incentive Scheme**

An incentive scheme will be developed by the CCG and the council to encourage and reward joint working that achieves the aims of the Tower Hamlets Integrated Provider Partnership and the Better Care Fund.

42 **SERVICES**

Scheme	*Services*	*Beneficiaries*	*Contracts in place*
Integrated Community Health Teams	Community virtual ward and case managers Community rehabilitation and support team (CReST) including the falls team Last years of life centre (facilitators and coordinators, service development and MCNS service) Adult community nursing (including Intranvenous therapy, community liaison, last years of life facilitators, district nursing, continence service and out of hours nursing).	To follow	Yes
Reablement Team	- Barts Community Health Team - Tower Hamlets Reablement Service	The beneficiaries of the service will be: • adults who are ordinarily resident in Tower Hamlets • adults presenting with a health and/or social care need for support • adults who are experiencing difficulties managing activities of daily living due to illness or disability, whether temporary or permanent • in the case of carers, support will be provided if the cared-for person or people are ordinarily resident in Tower Hamlets • users who meet the criteria for input from a restorative (Reablement Service) service: • users who are discharged from hospital following a recent admission episode and are recovering from an acute illness or	Yes

		injury • users referred from the community who are experiencing increased difficulties in managing activities of daily living due to a chronic long term condition (LTC), or exacerbation of a LTC.	
7 Day Hospital Social Work Team	Social Work Team	Patients at the Royal London Hospital who are deemed medically fit at the weekend but require social services support before they can be discharged. The beneficiaries of this service are those who are ordinarily resident in the London Borough of Tower Hamlets and are deemed medically fit for discharge but require social services before they can be discharged.	Yes
Community Health Team (Social Care)		The scheme will focus on the joint assessment and support planning of the top 20% hospital attendance 'frequent flyers' over the age of 18 years. This client group often represent one of the highest proportions of care costs. All beneficiaries of these services will be: • A Tower Hamlets resident • Over the age of 18 years old • Graded as being high/very high risk of hospital admission using the Q-admissions rating scale implemented by GPs • CHT (SC) plan to screen and potentially work with those scoring 60% or more on the ICP during 2016. This	Yes

		will involve approximately 170 more people. • Patient is likely to have at least one long term condition • Patients receiving active neuro-rehabilitation, including those Tower Hamlets residents who are in-patients in regional hospitals and may or may not be on ICP. • Patient has consented to inclusion on the ICP.	
Mental Health Liaison (RAID)	- Royal London Hospital Liaison Psychiatry Service	People with a diagnosed mental health condition who present at/ are admitted to Barts Health sites. Barts Health Clinical Staff	Yes
Recovery College		Stage 1: (Pilot) Mental health service users who have used ELFT (Tower Hamlets) services in the previous 12 months, including those who have been discharged. Stage 2: (Roll Out) Supporters (carers, family, friends) of people using mental health services in Tower Hamlets. ELFT, local authority and voluntary sector staff working within mental health services. Complex co-morbidity – mental health issue and other long term physical condition Groups at risk of emergency hospital admission where effective self-care within a professional/peer supported environment	No

		(i.e. recovery college) may reduce preventable admissions.	
Assistive Technology Team	- Assistive Technology	• Social Care and Health professionals who require training, support and advice on the effective use of assistive technology. This constitutes 18 teams across 9 site locations. • Vulnerable service users will be indirect recipients of the service, which will contribute towards their being able to remain living independently in their own homes. This will include the provision of equipment and a service that facilitates discharge from hospital or a reduction of preventable hospital admissions. • Carers of vulnerable service users will be indirect recipients of the service, which will provide them with support and reassurance so that they can continue to care.	Yes
Assistive Technology Additional Demand		To follow	

Integrated Care Incentive Scheme	- Integrated Care Incentive Scheme	All patients who are in the top 4% risk of admission (borough level risk) who are eligible for Level 1. All patients in the four mandatory groups: palliative, heart failure, dementia and nursing home-irrespective of Q Admissions risk. These patients will be eligible for both Level 1 and Level 2. All discretionary patients under the previous CC NIS who were identified in the CEG August 2013 baseline search and who were consented into the CC NIS by 31/3/14, Irrespective of Q Admissions risk. These patients will be eligible for both Level 1 and Level 2. [No further discretionary patients can enter the programme currently]	Yes
Adult Autism Diagnostic and Intervention Service		The service is primarily for people with suspected ASD in Tower Hamlets, who do not have a Learning Disability and who are not eligible for services through the Community Learning Disability Team. Families and carers are also provided with information about local support groups and services specifically for carers, and advised on how to access these. They are advised of their right to a formal Carer's Assessment for their own physical and mental health needs and their capacity to continue in their caring role in line with the council's Carers' Strategy	*Yes*
Dementia Café		The population covered is people with dementia	*Yes*

		and their carers in Tower Hamlets, including people from the black and ethnic communities and Bangladeshi communities	
Community Outreach Service		The population covered will be people with dementia and their Carers, both within the Bangladeshi population and within the wider BAME community.	*Yes*
Disabled Facilities Grant		Eligible disabled adults Disabled children Carers	Yes
Carers		The services are to support the main adult carers, aged 18 and over, who are Tower Hamlets residents or who are caring for someone who lives in Tower Hamlets. This includes unpaid carers who live in another borough but care for a resident of Tower Hamlets.	Yes
Falls prevention		Residents of domiciliary care homes	Yes
Community geriatrician team		Over 65s in the caseload of the Integrated Community Health Team	Yes
Mental health personal commissioning		with LTCs and depression or anxiety	Yes
Personalisation		People with enduring mental health needs; people with multiple LTCs (respiratory plus additional LTCs); children with special educational needs; people with learning disabilities	
Enablers		BCF programme management and coordination	Yes
Local incentive scheme		The incentive scheme will be open to all THIPP organisations and payment will be based on. achievement of outcomes, measured by: • Integrated Care Metrics (incl. Mental	No

		Health) • Better Care Fund Metrics • Patient Experience Metric development • Population Health Metrics	

43 COMMISSIONING, CONTRACTING, ACCESS

Commissioning Arrangements

43.1 Commissioning arrangements for each of the schemes are consistent with those set out in the main body of the agreement at, but not limited to, Clause 4: Partnership Flexibilities and Clause 6: Commissioning, Contracting and Access.

43.2 Service Level Agreements will be developed for each of Council's directly provided services that are included in the Individual Schemes.

44 FINANCIAL CONTRIBUTIONS

Contributor	2016/17 (£000s)
LBTH	1572.542
CCG Mandated	18805.193
CCG Additional (recurrent)	362.254
CCG additional (non recurrent)	695
Total	21434.989

Deployment of contributions:

Scheme	2015/16 (£000s)
Raid	2106.42
Mental health recovery college	110
Adult Autism and diagnostic intervention service	330
Social worker input into memory clinic	50
Dementia café and community outreach service	80
Integrated care incentive scheme	1200
Integrated community health team	7358.871
Community Health Team (Social Care)	895.5
Out of hours 7 day hospital team	1230.8
Reablement	2413.871
Independent living	649
ENABLERS (see section 7)	208
7 Day Community Equipment Team	154.985
DFG and CAPITAL	1572.542
Care act implementation	733
Support for carers	697
Local incentive scheme	1000
Strategic development	695
Total	21,434.989

45 FINANCIAL GOVERNANCE ARRANGEMENTS

Management of the Pooled Fund	
Are any amendments required to the Agreement in relation to the management of Pooled Fund	**No**
Have the levels of contributions been agreed? How will changes to the levels of contributions be implemented?	**Yes. See S75 for rules on changes**
Have eligibility criteria been established?	**Yes, see scheme descriptors**
What are the rules about access to the pooled budget?	**See S75**
Does the pooled fund manager require training?	**No**
Have the pooled fund managers delegated powers been determined?	**Yes, in line with current SFIs**
Is there a protocol for disputes?	**Yes, see S75**
Audit Arrangements	
What Audit arrangements are needed?	**The current audit arrangements will apply**
Has an internal auditor been appointed?	
Who will liaise with/manage the auditors?	
Whose external audit regime will apply?	
Financial Management	
Which financial systems will be used?	**Existing financial systems in each partner org**
What monitoring arrangements are in place?	**Monthly budget reports** **Monthly provider performance reports**
Who will produce monitoring reports?	**Lead commissioner of that scheme**
Has the scale of contributions to the pool been agreed?	**Yes**
What is the frequency of monitoring reports?	**Monthly**
What are the rules for managing overspends?	**See S75**
Do budget managers have delegated powers to overspend?	**No, see S75**
Will delegated powers allow underspends recurring or non-recurring, to be transferred between budgets?	**See S75**
How will overspends and underspends be treated at year end?	**See S75**

Will there be a facility to carry forward funds?	**See S75**
How will pay and non pay inflation be financed?	**Annual review of budgets in accordance with S75 agreement**
Will a contingency reserve be maintained, and if so by whom?	**Performance pool. See S75**
How will efficiency savings be managed?	**See S75**
How will revenue and capital investment be managed?	**See S75**
Who is responsible for means testing?	**LBTH**
Who will own capital assets?	**NA**
How will capital investments be financed?	**NA**
What management costs can legitimately be charged to pool?	**Enablers scheme includes management costs**
What re the arrangement for overheads?	**None, the pool does not currently include commissioning overheads**
What will happen to the existing capital programme?	**NA**
What will happen on transfer where if resources exceed current liability (i.e. commitments exceed budget) immediate overspend secure?	**See S75**

46 VAT

VAT arrangements will be in accordance with normal arrangements for the Lead Commissioner

47 GOVERNANCE ARRANGEMENTS FOR THE PARTNERSHIP

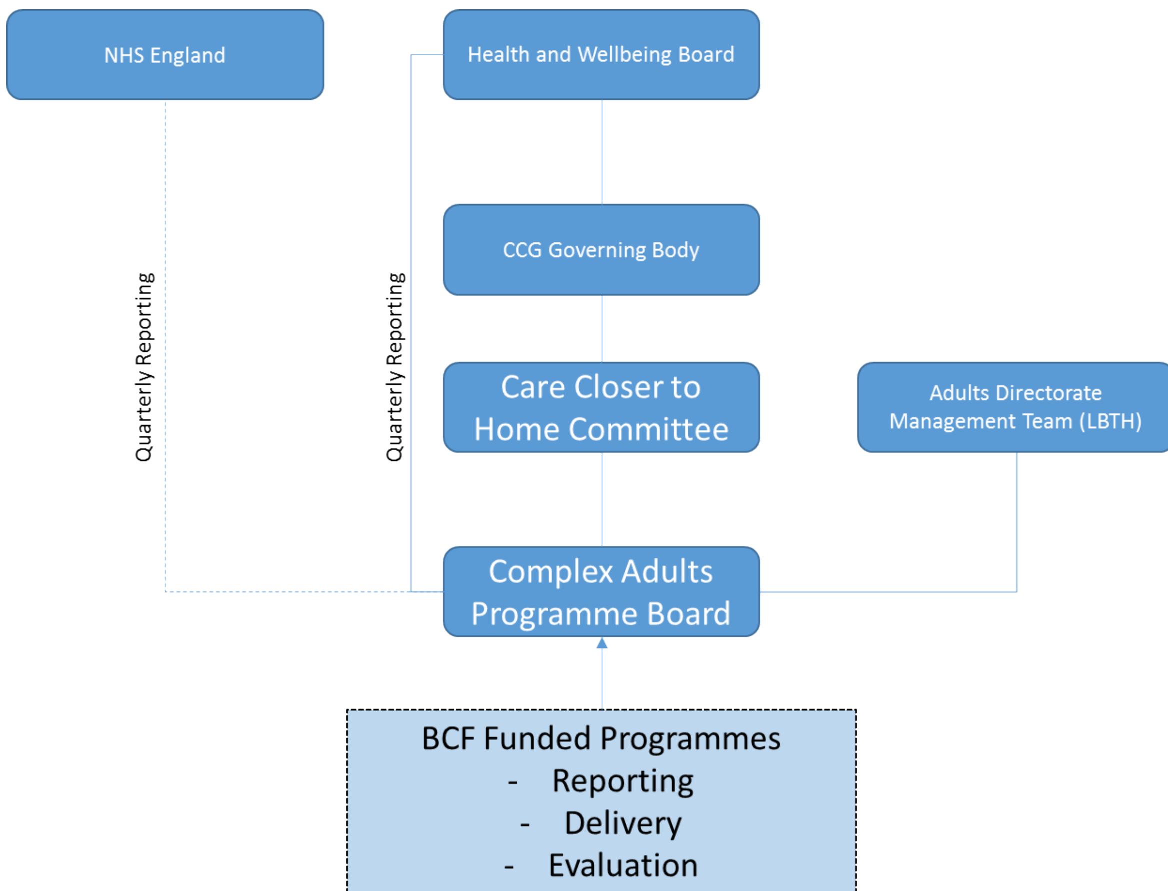
47.1 Integrated Care in Tower Hamlets is overseen and driven by a joint Complex Adults Programme Board (CAPB). The CAPB includes representatives from:
- CCG and LA commissioners
- Provider colleagues from social care, acute, community, mental health and primary care
- Voluntary sector
- Chaired by a provider non Executive director

47.2 The CAPB is a formal sub-committee of the Health and Wellbeing Board, as well as being a Tower Hamlets CCG programme board. The Chair of the Complex Adults Programme Board sits on the Health and Wellbeing Board, and Integration is a key strategic priority under the Tower Hamlets Health and Wellbeing Strategy.

47.3 The Complex Adults Programme Board oversees:

- Delivery of commissioned Integrated Care services, provided by the Tower Hamlets Integrated Provider Partnership

- Development of Integrated Care strategy, including the Better Care Fund



48 NON FINANCIAL RESOURCES

Council contribution

	Details	Charging arrangements	Comments
Premises	NA	NA	NA
Assets and equipment	NA	NA	NA
Contracts	NA	NA	NA
Central support services	NA	NA	NA

CCG Contribution

	Details	Charging arrangements	Comments
Premises	NA	NA	NA
Assets and equipment	NA	NA	NA
Contracts	NA	NA	NA
Central support services	NA	NA	NA

49 STAFF

To be agreed following further discussion at the Partnership Board

50 ASSURANCE AND MONITORING

See Better Care Fund application excel submission

Outcome	Metric	Source	Timeliness
BCF Metrics	See Part 2	See Part 2	Monthly
Emergency admissions for target group	Emergency admissions for target group	Integrated Care Dashboard	Monthly
Readmissions for target group	Readmissions for target group	Integrated Care Dashboard	Monthly
Average length of stay	Average length of stay	Integrated Care Dashboard	Monthly
Total bed days	Total bed days	Integrated Care Dashboard	Monthly
Bed days per 1000 eligible population	Bed days per 1000 eligible population	Integrated Care Dashboard	Monthly
Non-elective admission rate per 1000 eligible population	Non-elective admission rate per 1000 eligible population	Integrated Care Dashboard	Monthly
Number of attendances at A&E	Number of attendances at A&E	Integrated Care Dashboard	Monthly
Proportion of patients readmitted to acute hospital within 30 days of discharge	Proportion of patients readmitted to acute hospital within 30 days of discharge	Integrated Care Dashboard	Monthly
Proportion of patients readmitted to acute hospital within 91 days of discharge	Proportion of patients readmitted to acute hospital within 91 days of discharge	Integrated Care Dashboard	Monthly
Average acute cost per patient	Average acute cost per patient	Integrated Care Dashboard	Monthly
Avoidable emergency admissions	Avoidable emergency admissions	Integrated Care Dashboard	Monthly

51 LEAD OFFICERS

Partner	Name of Lead Officer	Address	Telephone Number	Email Address
Council	Karen Sugars	London Borough of Tower Hamlets, 4th Floor, Mulberry Place, 5 Clove Crescent, London, E14	020 7364 0497	karen.sugars@towerhamlets.gov.uk

Partner	Name of Lead Officer	Address	Telephone Number	Email Address
		2BG		
CCG	Josh Potter	NHS Tower Hamlets Clinical Commissioning Group, 2nd Floor Alderney Building, Mile End Hospital, Bancroft Road, London, E1 4DG	020 3688 2518	josh.potter@towerhamletsccg.nhs.uk

52 REGULATORY REQUIREMENTS

See individual service specifications

SCHEDULE 2 – GOVERNANCE

1 Partnership Board

1.1 The Tower Hamlets Complex Adults Programme Board will act as the Partnership Board defined by this agreement and its Terms of Reference will be amended to encompass the governance arrangements set out in the remainder of this Schedule and elsewhere in this agreement including, but not limited to, Clauses 5, 6 and 19.

1.2 The membership of the Partnership Board will be as follows:

Name	Role	CAPB Responsibility
Chair		
Victoria Tzortziou Brown	Tower Hamlets CCG Board member and Lead on Integrated Care and Research	Chair
Tower Hamlets CCG		
Isabel Hodkinson	Tower Hamlets CCG Board member and Lead on Informatics	Link to TST Informatics Work stream
CCG Clinical Leads TBC	Clinical Leads	As required depending on agenda item
Josh Potter	Deputy Director of Commissioning and Transformation	CCG BCF Lead and member of WELC Contracting and Reimbursement Steering Group
Julie Dublin	Transformation Manager	Crisis response
Angela Fernandez	Transformation Manager	Living with LTCs
Zakia Khatun	Programme Manager: Personalisation	Programme Manager for Personalisation
Folake Abayomi-Lee	Transformation Manager	Complex Care
Carrie Kilpatrick	Deputy Director of Mental Health and Joint Commissioning	CCG Mental Health Lead
Daniela Levarda	WELC PMO	
Dr Laura Eyre	Research Associate UCL-WELC Integrated Care Programme	
London Borough of Tower Hamlets		
Karen Sugars	Interim Service Head: Commission & Health Education, Social Care and Wellbeing	Pooled Fund Partner
Steve Tennison	Senior Strategy, Policy and Performance Officer – Integration Lead	
Abigail Knight	Acting Associate Director of Public Health	Public Health Input
Community and Voluntary Sector		
Myra Garrett	Health and Wellbeing Forum Lead: Tower Hamlets CVS	CVS Representative

2 Role of Partnership Board

The Partnership Board shall:

2.1.1 Provide strategic direction on the Individual Schemes

2.1.2 receive the financial and activity information;

2.1.3 review the operation of this Agreement and performance manage the Services;

2.1.4 agree such variations to this Agreement from time to time as it thinks fit;

2.1.5 review and agree annually a risk assessment and a Performance Payment protocol;

2.1.6 review and agree annually revised Schedules as necessary;

2.1.7 provide, at least annually, a report on progress in delivering the Better Care Fund plan to the Health and Wellbeing Board and to the CCG Board. The Partnership Board will report to the same two bodies more frequently by exception in respect of remedial action to address non-performance that it is beyond the delegated authorities of the Partnership Board to resolve.

2.1.8 request such protocols and guidance as it may consider necessary in order to enable teach Pooled Fund Manager to approve expenditure from a Pooled Fund;

3 Partnership Board Support

The Partnership Board will be supported by officers from the Partners from time to time.

4 Meetings

4.1 The Partnership Board will meet Quarterly at a time to be agreed within fourteen (14) days following receipt of each Quarterly report of the Pooled Fund Manager.

4.2 The quorum for meetings of the Partnership Board shall be a minimum of one representative (CCG Senior Management Team / LBTH Adult's Directorate Management Team) from each of the Partner organisations.

4.3 Decisions of the Partnership Board shall be made unanimously. Where unanimity is not reached then the item in question will in the first instance be referred to the next meeting of the Partnership Board. If no unanimity is reached on the second occasion it is discussed then the matter shall be dealt with in accordance with the dispute resolution procedure set out in the Agreement at Clause 23.

4.4 Where a Partner is not present and has not given prior written notification of its intended position on a matter to be discussed, then those present may not make or record commitments on behalf of that Partner in any way.

4.5 Minutes of all decisions shall be kept and copied to the Pooled Fund Managers within seven (7) days of every meeting.

5 Delegated Authority

5.1 The Partnership Board is authorised within the limited of delegated authority for its members (which is received through their respective organisation's own financial scheme of delegation) to:

5.1.1 authorise commitments which exceed or are reasonably likely to lead to exceeding the contributions of the Partners to the aggregate contributions of the Partners to any Pooled Fund; and

5.1.2 authorise a Lead Commissioner to enter into any contract for services necessary for the provision of Services under an Individual Scheme

6 Information and Reports

7.1 Each Pooled Fund Manager shall supply to the Partnership Board on a Quarterly basis the financial and activity information as required under the Agreement.

7 Post-termination

8.1 The Partnership Board shall continue to operate in accordance with this Schedule following any termination of this Agreement but shall endeavour to ensure that the benefits of any contracts are received by the Partners in the same proportions as their respective contributions at that time.

SCHEDULE 3 – RISK SHARE AND OVERSPENDS

1. To the extent that the pay for performance element of the Better Care fund is not available to the Pooled fund as a result of a failure to fully meet the target for reducing unplanned emergency activity the partners have agreed that the CCG will utilise the withheld Performance Funding as a risk pool to mitigate the direct impact of additional costs incurred in the health system as a result of this failure.

2 The CCG also agrees to give proper consideration to any submission by the Council to the effect that the failure to meet the target for reducing unplanned emergency activity has had a direct and demonstrable impact on the Council's social care budgets by, for example, leading to an increase in permanent admissions to residential care. Where the CCG is satisfied that such an impact is demonstrated the CCG undertakes to give consideration to allocating a suitable proportion of the risk pool to mitigate this impact.

3. The Partners agree that Overspends shall be apportioned in accordance with this Schedule 3.

Pooled Fund Management

4. The Pooled Fund Manager for each scheme within the Better Care Fund Plan will be responsible for quarterly reporting of income and expenditure for each scheme. Clause 8.2.7 of this Agreement defines this responsibility. The income and expenditure reports for each scheme will be incorporated into the Quarterly Performance Report submitted to the Partnership Board.

Overspend

5. Where potential or actual Overspends are reported in respect of any individual scheme the Board shall give consideration to the following options for remediating, subject always to Clause 12.5 of this Agreement:

   - agreeing an action plan to reduce expenditure in the relevant scheme or schemes;
   - identifying Underspends that can be vired from any other Fund maintained under this agreement or outside of this agreement;
   - agreeing additional investment by the respective Partners (in so far as the delegated authorities to Board representatives allow for this);
   - if no suitable investment or reduction in expenditure can be identified, agreeing a plan of action, which may include decommissioning all or any part of the Individual Service to which the Fund relates.

6. The Partnership Board shall act reasonably having taken into consideration all relevant factors including, where appropriate the Better Care Fund Plan and any agreed outcomes and any other budgetary constraints in agreeing appropriate action in relation to Overspends.

7. The Partners agree to co-operate fully in order to establish an agreed position in relation to any Overspends for which it is not possible or reasonable to identify mitigating action.

8. Subject to any continuing obligations under any Service Contract entered into by either Partner, either Partner may give notice to terminate a Service or Individual Scheme where the Scheme Specification provides and where the Service does not form part of the Better Care Fund Plan.

SCHEDULE 4– JOINT WORKING OBLIGATIONS

Part 1 – LEAD COMMISSIONER OBLIGATIONS

Terminology used in this Schedule shall have the meaning attributed to it in the NHS Standard Form Contract save where this Agreement or the context requires otherwise.

1 The Lead Commissioner shall notify the other Partners if it receives or serves:

1.1 a Change in Control Notice;

1.2 a Notice of an Event of Force Majeure;

1.3 a Contract Query;

1.4 Exception Reports

and provide copies of the same.

2 The Lead Commissioner shall provide the other Partners with copies of any and all:

2.1 CQUIN Performance Reports;

2.2 Monthly Activity Reports;

2.3 Review Records; and

2.4 Remedial Action Plans;

2.5 Joint Investigation Reports;

2.6 Service Quality Performance Report;

3 The Lead Commissioner shall consult with the other Partners before attending:

3.1 an Activity Management Meeting;

3.2 Contract Management Meeting;

3.3 Review Meeting;

and, to the extent the Service Contract permits, raise issues reasonably requested by a Partner at those meetings.

4 The Lead Commissioner shall not:

4.1 permanently or temporarily withhold or retain monies pursuant to the Withholding and Retaining of Payment Provisions;

4.2 vary any Provider Plans (excluding Remedial Action Plans);

4.3 agree (or vary) the terms of a Joint Investigation or a Joint Action Plan;

4.4 give any approvals under the Service Contract;

4.5 agree to or propose any variation to the Service Contract (including any Schedule or Appendices);

4.6 suspend all or part of the Services;

4.7 serve any notice to terminate the Service Contract (in whole or in part);

4.8 serve any notice;

4.9 agree (or vary) the terms of a Succession Plan;

without the prior approval of the other Partners acting through the Partnership Board. Such approval not to be unreasonably withheld or delayed.

5 The Lead Commissioner shall advise the other Partners of any matter which has been referred for dispute and agree what (if any) matters will require the prior approval of one or more of the other Partners as part of that process.

6 The Lead Commissioner shall notify the other Partners of the outcome of any Dispute that is agreed or determined by Dispute Resolution

7 The Lead Commissioner shall share copies of any reports submitted by the Service Provider to the Lead Commissioner pursuant to the Service Contract (including audit reports)

Part 2 – OBLIGATIONS OF THE OTHER PARTNER

Terminology used in this Schedule shall have the meaning attributed to it in the NHS Standard Form Contract save where this Agreement or the context requires otherwise.

1 Each Partner shall (at its own cost) provide such cooperation, assistance and support to the Lead Commissioner (including the provision of data and other information) as is reasonably necessary to enable the Lead Commissioner to:

1.1 resolve disputes pursuant to a Service Contract;

1.2 comply with its obligations pursuant to a Service Contract and this Agreement;

1.3 ensure continuity and a smooth transfer of any Services that have been suspended, expired or terminated pursuant to the terms of the relevant Service Contract;

2 No Partner shall unreasonably withhold or delay consent requested by the Lead Commissioner.

3 Each Partner (other than the Lead Commissioner) shall:

3.1 comply with the requirements imposed on the Lead Commissioner pursuant to the relevant Service Contract in relation to any information disclosed to the other Partners;

3.2 notify the Lead Commissioner of any matters that might prevent the Lead Commissioner from giving any of the warranties set out in a Services Contract or which might cause the Lead Commissioner to be in breach of warranty.

SCHEDULE 5 – PERFORMANCE ARRANGMENTS

1. The Partners have agreed that the achievement of the benefits it is intended be realised through the successful delivery of the Better Care Fund plan will be measured using three key methods:

   - Bi-monthly activity and progress reporting by Providers to the Partnership Board;
   - Quarterly reporting of the Integrated Care Dashboard, which includes all metrics relevant to Better Care Fund plan delivery, to the Partnership Board; and
   - Use of a Patient Experience Metric being developed for 2015/16 as part of the WELC Integrated Care Pioneer Programme. Quarterly reporting against this metric will be incorporated into the Integrated Care Dashboard for reporting to the Partnership Board.

2. The Partnership Board will use the bi-monthly activity and progress reports for each scheme submitted by Providers as a means of providing early warning of potential non-performance in respect of individual schemes. The Board will be proactive in discussing and implementing remedial actions designed to deal with identified non-performance. A lead Partner or Provider will be identified as being responsible for implementing the necessary remedial actions.

3. Progress in implementing any remedial actions will continue to be reported, by the Lead Partner or Provider, to subsequent meetings of the Partnership Board until such time as the Board is satisfied that the non-performance has been properly addressed and rectified.

4. In circumstances where authority to implement the necessary remedial actions is beyond the delegated powers of the Board or individual Partner or Provider representatives the following escalation procedures shall apply:

4.1 Where the Board as a whole does not have sufficient delegated authority the Chair of the Board will be responsible for escalating to the next meeting of the Health and Wellbeing Board for resolution. In circumstances where this is not practicable, for example because of time constraints, the Authorised Officers for each Partner will seek the necessary authority from their respective organisations.

4.2 Where the issue relates to the delegated authority of an individual Partner or Provider representative, said representative will be responsible for escalating the agreed remedial actions for approval within their own organisation.

5. The Lead Commissioner shall be responsible for presenting the Integrated Care Dashboard, with an accompanying narrative providing an overview of performance against the plan, to the Partnership Board on a quarterly basis. The Board shall use this report to take a more considered and strategic view of progress against the plan as a whole and to consider whether any adjustments across and between individual schemes, additional investment or disinvestment, or other interventions are necessary to maintain the desired level of progress in delivering against the plan.

6. The quarterly report prepared by the Lead Commissioner shall also include the income and expenditure report required by Clause 8.2.7 of this Agreement.

7. Where the wider quarterly review undertaken by the Board identifies potential or actual non-performance against the plan, the process for implementing remedial actions shall be as set out in Clauses 2 to 4 of this Schedule above.

8. The Lead Commissioner shall be responsible for the preparation of the Annual Performance Report to meet the requirements set out in Clause 20 of this Agreement and for presenting it to the Health and Wellbeing Board within the prescribed timescale.

9. As and when directed by the Partnership Board as per Schedule 2, Clause 3.1.8, the Lead Commissioner shall be responsible for preparing exception reports to the Health and Wellbeing Board.

10. The Partners acknowledge that as the WELC Integrated Care Pioneer Programme develops it is likely that the metrics and performance reporting arrangements underpinning the wider Programme

will continue to be refined and developed. The Partners therefore agree to keep the performance arrangements set out in this Schedule and elsewhere in this Agreement under review and to develop them as necessary to maintain continuity with the performance arrangements for the wider Programme.

SCHEDULE 6 – BETTER CARE FUND PLAN

1. The Tower Hamlets Better Care Fund plan 16/17 is working to the following timetable:

2 March: Local areas to submit only the completed BCF Planning Return template to your local DCO team (england.londonsubmissions@nhs.net) copied to the Better Care Support Team (england.bettercaresupport@nhs.net), detailing the technical elements of the planning requirements, including funding contributions, a scheme level spending plan, national metric plans, and any local risk sharing agreement.

21 March: First submission of full narrative plans for Better Care alongside a second submission of the BCF Planning Return template.

25 April: Final submission, once formally signed off by the Health and Wellbeing Board

Once approved the final Better Care Fund Plan will be appended to this agreement.

SCHEDULE 7– POLICY FOR THE MANAGEMENT OF CONFLICTS OF INTEREST

1. The Council and the CCG jointly recognise that each operates in a complex practice, policy and political environment and that from time to time this complexity could give rise to situations where the wider interests of one Partner may create an actual or perceived conflict of interest in respect of delivery of the Better Care Fund plan.

2. Both Partners also recognise that the complexity of the environment in which each operates means that it is incumbent on each Partner to ensure that in planning any investment or disinvestment decisions and/or policy or practice changes any potential impact on Better Care Fund plan delivery is considered and appropriate mitigation sought during the planning of change. In so doing, the Partners wish to reduce the likelihood of conflicts of interest arising inadvertently.

3. The Partners undertake to use best endeavours to minimise the risk of any such conflicts arising, and to minimise the adverse impact should such conflicts (actual or perceived) arise. At all times when addressing any actual or perceived conflicts the Partners will have due regard to the terms of this agreement, and the partnership approach underpinning it, and in particular to the General Principles set out in Clause 3.2 of the Agreement.

4. The Authorised Officers will, in the first instance, seek to resolve any actual or perceived conflict of interest that arises during the term of this Agreement through discussion. While this can be managed informally, a record of the actual or perceived conflict, and of the agreed means of resolving, should be kept by the Authorised Officers and reported to the next available Partnership Board meeting for noting.

5. In circumstances the Authorised Officers are unable to resolve the conflict of interest through informal discussion the Dispute Resolution procedure set out at Clause 23 of the Agreement shall be followed.

6. The Council recognises that its role as both Commissioner and Provider of services means that it is necessary to put additional safeguards in place to ensure transparency of decision making and to assure the CCG that the best interests of the Partnership are the primary consideration with regards to Better Care Fund plan delivery. In order to provide this assurance the Council will:

6.1 Ensure that at all times it is represented on the Partnership Board by at least one senior officer whose job functions are primarily Commissioning based, and who has no line management responsibility (or line management accountability to senior officers) for the delivery of Provider functions;

6.2 Ensure at all times that Commissioning intentions or decisions agreed by the Partners, or made under delegated authority by the Pooled Fund Manager, are not communicated to Provider functions within the Council in advance of their formal communication to the relevant Provider or Providers by the Partnership.

SCHEDULE 8 – INFORMATION GOVERNANCE PROTOCOL

1. Information Governance, including assurance of compliance with relevant Laws and the requirements of the Caldicott Guardians for each Partner, is a key component of the WELC Integrated Care Pioneer Programme. Arrangements for ensuring that individually identifiable data is managed securely and in full compliance with all relevant legislative requirements have been or are being put in place via this programme in order to ensure that the sharing of information necessary for delivering properly integrated arrangements can be facilitated. Details of the Information Governance protocols in place to support the Integrated Care Pioneer Programme can be obtained from the WELC Programme Office, currently hosted by NHS Tower Hamlets CCG.

2. The Partners to this Agreement have resolved, therefore, that the Information Governance arrangements to support the delivery of the Better Care Fund plan will be those established for the WELC Integrated Care Pioneer Programme. In particular, NHS numbers will be used as the common identifier for individual recipients of services, and the Council reconfirms its commitment to ensuring that all individual records held pursuant to discharge of its Community Care responsibilities include the individual's NHS number. For the purposes of Better Care Fund plan delivery this commitment extends to individuals aged eighteen (18) and over whose services are being provided under the Children and Families Act 2014 and related legislation and regulation.

3. Each Partner remains at all times responsible, through their own Information Governance arrangements, for assuring themselves that all data sharing and other agreements put in place to facilitate the sharing or transfer of individually identifiable data are compliant with the legislation relevant to that partner and to any internal protocols in place pursuant to ensuring that compliance.

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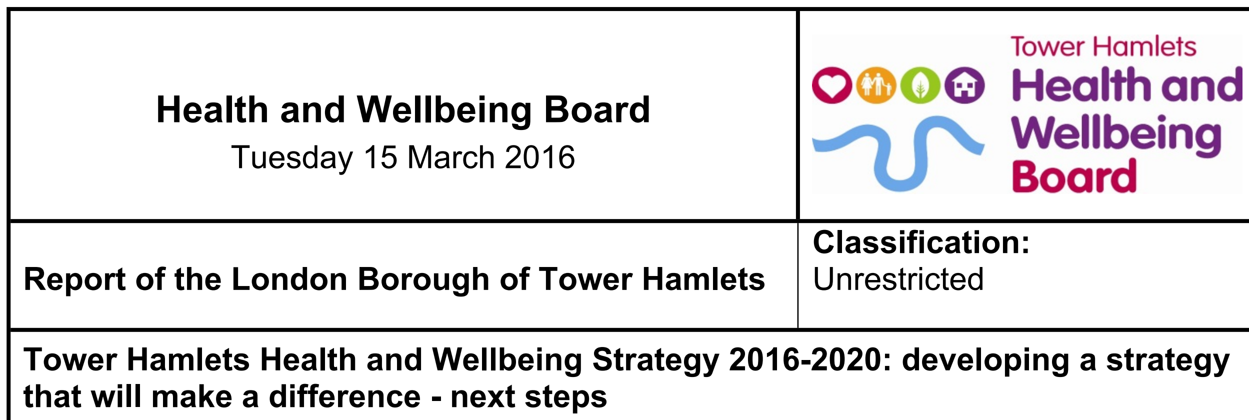

Health and Wellbeing Board
Tuesday 15 March 2016

Report of the London Borough of Tower Hamlets	Classification: Unrestricted

Tower Hamlets Health and Wellbeing Strategy 2016-2020: developing a strategy that will make a difference - next steps

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

Summary
The purpose of this paper is to set out the key issues emerging out of the two Health and Wellbeing Strategy development workshops and discuss the implications for the strategy.

It addresses the following questions
- Why do we want a Health and Wellbeing Strategy?
- What do we mean by Health and Wellbeing Strategy and what is the scope?
- What approach do we want to take?
- What do we want the Strategy to focus on?
- What could the transformational areas be?
- What are the next steps?

Recommendations:
The Health & Wellbeing Board is recommended to:

Review the paper and reflect on the questions set out at the end:
1. Do the definitions of 'health' and 'wellbeing' (and the concept of health as one of a numbers of resources for wellbeing) feel ok as working definitions for the strategy?
2. Does the 'health community' description feel like a good description of what we would like Tower Hamlets to look like if it is a place that supports health as a resource for wellbeing?
3. Does the description of the interdependencies of the Health and Wellbeing Strategy with other strategies sound right?
4. Does the approach to the strategy sound right?
5. Do the transformational areas feel about right? Is there anything important missing?
6. Do the next steps of involving Board members and getting them to identify a small number of metrics and actions for the strategy to track feel right?
7. Anything else?

The responses will inform the first draft of the strategy.

1. REASONS FOR THE DECISIONS

1.1 The reasons for the decision are to gather the Boards views on the approach to the strategy and develop ownership

2. ALTERNATIVE OPTIONS

2.1 If the Board were not fully involved in key decisions around the shape and approach of the strategy it would fail

3. DETAILS OF REPORT

3.1 See attached report

4. COMMENTS OF THE CHIEF FINANCE OFFICER

4.1 There are no direct financial implications as a result of the recommendations in this report. The Health and Wellbeing Strategy would need to factor in the financial resources which are available during the period covered by the strategy in accordance with the Council's Medium Term Financial Plan.

5. LEGAL COMMENTS

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

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

5.3 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.

5.4 The review of the strategy provides the opportunity to refresh and update the focus of the HWB to reflect current and future needs within the borough. This review programme provides the basis for the HWB to collate the perspectives of all relevant and interested parties before agreeing any final strategy and plan.

5.5 When considering the recommendation above, and during the review itself, regard must be given to the public sector equalities duty to eliminate unlawful conduct under the Equality Act 2010. The duty is set out at Section 149 of the 2010 Act. It requires the Council, when exercising its functions, to have 'due regard' to the need to eliminate discrimination (both direct and indirect discrimination), harassment and victimisation 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 strategy is about how health can be improved for the borough as a whole but with a particular priority on how those in greatest need can be targeted.

7. BEST VALUE (BV) IMPLICATIONS

7.1 Although this is only a strategy discussion report, one of the drivers shaping the strategy are the cost pressures on the health and care economy

8. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

8.1 The paper does refer to the health impacts of the environment and this is in line with developing sustainable action for a greener environment

9. RISK MANAGEMENT IMPLICATIONS

9.1 The proposals in the paper are draft currently and address a risk that the strategy focus does not engage the board and reflect the priorities and approach that will work for the board in years to come

10. CRIME AND DISORDER REDUCTION IMPLICATIONS

10.1 There is a reference in the paper to the interdependencies between strategies such as those relating to crime and disorder and the health and wellbeing strategy

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Linked Reports, Appendices and Background Documents

Linked Report

- NONE

Appendices

- Report on Health and Wellbeing Strategy workshop, January 2016
- Report on Kings Fund Strategy workshop, October 2015

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:

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

Tower Hamlets Health and Wellbeing Strategy 2016-2020
Developing a strategy that will make a difference – next steps

1. Purpose of this paper

1.1 The purpose of this paper is to set out the key issues emerging out of the two Health and Wellbeing Strategy development workshops and discuss the implications for the strategy.

1.2 To recap:

- The Kings Fund session explored the purpose of the strategy, the role of the Health and Wellbeing board and the elements of an exemplar strategy (Appendix A)

- The Pinpoint session at the extended Health and Wellbeing Board in aimed to identify potential priorities for the strategy (Appendix B)

2. Why do we want a health and wellbeing strategy?

2.1 There was some discussion through the workshops that without a Health and Wellbeing strategy there is much that would happen in any case around improving health and wellbeing in the borough. This raised a challenge around added value of a strategy.

2.2 However, there was a strong consensus that the current environmental, political, economic, social, technological contexts provide a complex set of threats and opportunities and that the need for strong focussed system leadership is greater than ever.

2.3 Having a health and wellbeing strategy that is jointly owned by key partners, that clearly articulates a shared set of aspirations and is a focus for collective action on the most important health and wellbeing issues facing local people, will be vital in what will undoubtedly be challenging years ahead for all of us.

3. What do we mean by a health and wellbeing strategy and what is the scope?

What do we mean by health and wellbeing?

3.1 It was evident from the workshop discussions that there are differences in how the terms 'health' and 'wellbeing' are understood within and between organisations.

3.2 Whilst this is inevitable as 'health' and 'wellbeing' are terms that are used differently across society and cultures, it is important that there is some consensus around the meaning of the core concepts around which the strategy is based and that partners can refer back to.

3.3 Based on discussion at the Pinpoint session as well as reference to wider literature, it is clear that health and wellbeing are not interchangeable terms. People may be healthy but have low levels of wellbeing and vice versa.

3.4 For example, in the last years of life, an individual's health (ie level of mental and physical functioning) may be poor but that person's sense of wellbeing may be high (eg due to having a good living conditions, a sense of control and connection to loved ones).

3.5 However, whilst not interchangeable, health and wellbeing are self-evidently linked. One way of thinking about this is to see health as a resource for wellbeing. Two particularly helpful definitions that could inform the strategy in making this clear are the following:

3.6 **Health** is more than the absence of disease; it is a resource that allows people to realize their aspirations, satisfy their needs and to cope with the environment in order to live a long, productive, and fruitful life. In this sense, health enables social, economic and personal development fundamental to well-being[1].

3.7 **Wellbeing** is a subjective evaluation of how we feel and experience our lives[2].

3.8 This concept of 'health as resource' and 'wellbeing as the outcome' has potentially profound implications for how services should be shaped

How does this inform the scope and interdependencies of the strategy?

3.9 Based on the above discussion, the high level purpose of the strategy can be framed as <u>a strategy that aims to develop health as a resource to improve people's wellbeing.</u>

3.10 The following is a helpful expression of the factors that help develop this resource:

'A healthy community is one where all sectors contribute to create social and physical environments that foster health. In practice, such a community meets basic needs: access to affordable, healthy foods; affordable housing and transportation; and essential services such as medical care and education. It offers a sustainable, healthful environment with clean air and

[1] http://www.cdc.gov/hrqol/wellbeing.htm
[2] http://www.local.gov.uk/health/-/journal_content/56/10180/3510475/ARTICLE

water, open space and parks, low levels of toxic exposures and low emissions, and affordable, sustainable energy. Equally important, it has a constructive economic and social environment with adequate job opportunities, educational opportunities for advancement, and social equity. Last but not least, it offers robust civic and social engagement with safe, supportive families, relationships, homes, and neighbourhoods for all parts of society.'[3]

3.11 This framework of thinking about a 'healthy community' highlights the breadth of factors that impact on the extent to which health is a resource for wellbeing. It also highlights the importance of being clear about the interdependencies of the Health and Wellbeing Strategy with other strategies.

3.12 For example, an employment strategy would aim to improve wellbeing through employment. Employment, in itself a determinant of wellbeing, impacts on a range of other factors linked to wellbeing, one of which is health. However, for some people, building health as a resource enables them to benefit from employment as a driver of wellbeing.

3.13 The relationship between the Employment Strategy[4] and the Health and Wellbeing strategy relates to how health barriers can be addressed to help people find employment and also potentially how the strategy can promote employment of people in the health and care sector where there are shortfalls.

3.14 Similar linkages could apply to a range of other strategies eg housing, environmental health, housing, transport, education, crime.

3.14 Looking at it from the other way, if health and care services support developing health as a resource but are also focused on wellbeing as the outcome, they have a role in helping people access services that enable them to access other resources promoting wellbeing such as good employment, housing, income and education.

3.15 Identifying and developing the shared aspirations between other strategies and the health and wellbeing strategy will therefore need to be a critical element of the strategy.

4. What approach do we want to take to the strategy?

4.1 The conclusion of the King's Fund workshop was a consensus that the requirement is <u>'a strategy with a small number of core, widely owned, accountable objectives, but that is adaptive and responds to feedback'.</u>

[3] *Public Health Reviews, Vol 32, No 1, 174-189*

[4] If there is a Health and Wellbeing Strategy would the Employment Strategy be better referred to as the Employment and Wellbeing Strategy?

4.2 The thinking behind this conclusion was that the purpose of the Health and Wellbeing Board, through its strategy is to provide collective systems leadership across the health and care economy. This is potentially a hugely powerful resource if it is focussed skilfully.

4.3 However, this power is dissipated if the strategy seeks to cover everything and the Board would set itself up to fail if it tried to track the breadth of activity impacting on health and wellbeing (much of which would continue without issue regardless of the Strategy or Board).

4.4 The approach to development of the strategy is therefore to identify those issues where collective systems leadership will significantly add value and unlock the potential for transformational change.

4.5 Another element of the thinking is the nature of this leadership. In the Kings Fund session it was recognised that the Strategy was about trying to drive change in a complex system. This means moving away from mechanistic action plans but recognising that trying to drive such change is iterative.

4.6 Whilst it is essential to have a clear end point, the journey there will require ongoing learning, evaluation, flexibility and adaptation rather than a rigid action plan. This will require a different and more dynamic way of framing the monitoring and oversight of the strategy.

5. What do we want the strategy to focus on?

5.1 One of the key themes of the King's Fund session was the importance of the Health and Wellbeing Board and stakeholders having a sense of ownership of the strategy and its priorities.

5.2 The purpose of the subsequent Pinpoint session was to surface those issues that the Board considers to be high priority in improving health as resource for wellbeing and to which it can add value through its systems leadership role.

5.3 The initial reflection was that whilst the Board functions well its added value remains unclear. However, the refresh of the strategy and the planned review of how the Board functions provides the opportunity to 'push the last 20%' and may require it to make controversial decisions.

5.4 This highlighted again the importance of the strategy focussing on a small number of transformational areas that are distinct from the wide range of 'business as usual' areas impacting on health as a resource for wellbeing across the council, NHS and non-statutory sectors.

5.5 In this context, participants identified and explored those areas that they thought would be important for the strategy to address having reflected on local health need and what they would like people to be saying about the achievement of the Board in 2020.

5.6 The areas were identified collectively and the following questions were explored further (pictures of the boards are in Appendix B):

How (by 2020) could the Board have an impact on…

- developing a shared understanding of health and wellbeing?
- improving outcomes through shared ways of working and shared goals?
- addressing the health consequences of deprivation?
- unlocking community capacity to improve health and wellbeing?
- reducing childhood obesity?
- improving health through housing?

Other areas identified but not explored were the health impacts of the environment (eg air quality, active travel) and mental health in early years.

5.7 Subsequent to the workshop, officers from public health, corporate strategy and policy and the CCG met to review the outputs of the meeting with an aim to assessing how these could inform identifying and articulating potential transformational areas for the Board. There was further discussion at the Health and Wellbeing Board Executive Officers Group.

5.8 Discussion around what constitutes a 'transformational area' identified the following criteria:

1. Transformation will have significant positive impact
    a. The area is considered to be an important health and wellbeing issue with regard to the size of the problem, inequalities issues and/or cost
    b. There is good evidence for intervention (or credible potential to build evidence)
2. The area matters to Tower Hamlets citizens
3. System change is feasible
4. There is collective will to achieve the change

5.9 The five transformational areas in the next session below are an interpretation of the outcomes of the workshops, discussion and reflection on the criteria and are set out for comment and discussion.

6. What could the transformational areas be?

6.1 To lead a transformation in how we address the health impacts of deprivation

What this might look like in 2020

- High level strategic commitment to levering all resources across the partnership to address the health impacts of poverty
- Step change in understanding and targeting of those with greatest health need linked to deprivation
- Joined up, targeted approaches involving integrated working between key partners eg health, housing, employment, welfare, education, community safety, voluntary sector and business

6.2 To lead a transformation in how communities lead change to improve health

What this might look like in 2020

- High level commitment to cultural change around the role of communities in shaping services
- Shared framework across the partnership around community engagement and mobilisation
- Supportive environment to encourage community led action around health and wellbeing

6.3 To lead a transformation in integrating health into planning

What this might look like in 2020

- High level strategic commitment to ensuring that considerations around health and wellbeing are built into planning
- Involvement of the Health and Wellbeing Board in planning decisions that will significantly impact on health and wellbeing
- Shared accountability of the Local Plan with the Health and Wellbeing Board

6.4 To lead a transformation in addressing childhood obesity in the borough

What this might look like in 2020

- High level strategic commitment across all key partners
- Willingness to make big, potentially sensitive decisions
- Strong engagement of communities and other partners to enable local solutions
- Dialogue across communities and other partners to ensure there is learning across the system
- High profile communications

6.5 To lead a transformation in developing a truly integrated health and care system

What this might look like in 2020

- High level strategic commitment to
    - Shared definition of health and wellbeing
    - Shared outcomes
    - Shared intelligence to inform planning
    - Shared, joined up commissioning plans
    - Shared workforce plans
    - Shared approaches to delivery across provider organisations

7. What are the next steps?

7.1 In summary, it is proposed that there are five areas for transformational change

- Addressing the health impacts of deprivation
- Helping communities lead change around health
- Integrating health into planning
- Tackling childhood obesity
- Developing a truly integrated system to support health

7.2 As discussed previously, the objective is 'a strategy with a small number of core, widely owned, accountable objectives, but that is adaptive and responds to feedback'

7.3 One way forward would be to assign a board member to each of these areas and (with the support of officers) to give them responsibility to:

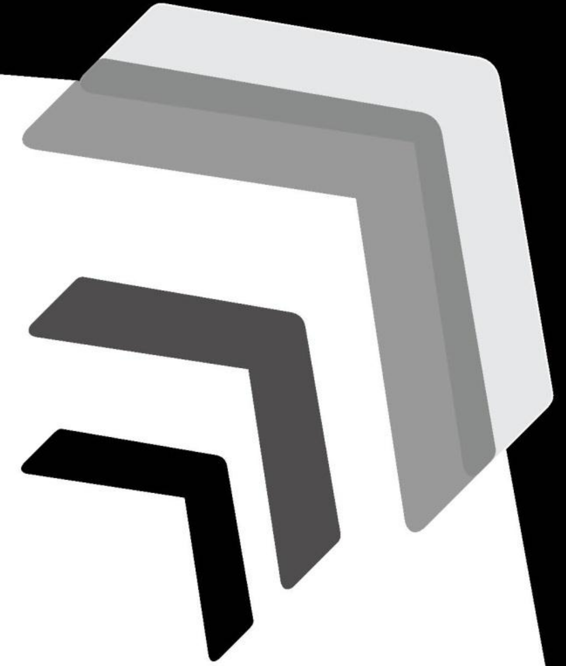
- Understand what is currently going on in the area
- Identify 1 or 2 high level metrics linked to the area that would be important for the Board to track
- Identify 1 or 2 areas of system transformation that are already happening or need to happen where the oversight of the Board could add value
- Identify whether there are any potential risks around 'business as usual' where the Board could add value

7.4 This would complete by the end of April to enable drafting of the strategy by the Board meeting in June

8. Questions for the Board

1. **Do the definitions of 'health' and 'wellbeing' (and the concept of health as one of a numbers of resources for wellbeing) feel ok as working definitions for the strategy?**

2. **Does the 'health community' description feel like a good description of what we would like Tower Hamlets to look like if it is a place that supports health as a resource for wellbeing?**
3. **Does the description of the interdependencies of the Health and Wellbeing Strategy with other strategies sound right?**
4. **Does the approach to the strategy sound right?**
5. **Do the transformational areas feel about right? Is there anything important missing?**
6. **Do the next steps of involving Board members and getting them to identify a small number of metrics and actions for the strategy to track feel right?**
7. **Anything else?**



Tower Hamlets HWB strategy session

Key points of 26th October 2015 discussion at the King's Fund

The King's Fund› Ideas that change health care

Agenda

1.	Introduction and context	13.30 – 13.45
2.	What changes are we facing over the next five to ten years? What are the implications for our strategy?	13.45 – 15.00
3.	What do we want our new strategy to achieve?	15.00 – 15.45
4.	Break	15.45 – 16.00
5.	What kind of strategy would help us achieve our aspirations?	16.00 – 16.50
6.	What are the next steps?	16.50 – 17.00

The King's Fund Ideas that change health care

1. Introduction, our future strategy

Putting health and wellbeing at the heart of everything we do in Tower Hamlets

The new Tower Hamlets Health and Wellbeing Strategy

Workshop 1:

What is the aspiration? What kind of strategy do we need?

1. Discussion points

- Current strategy
  - Process of development as important as outcome
  - HWB strategy “a critical pillar”, articulates story, connected to other strategies
  - Success not so much a story of the Board itself and its actions, but the relationships built around the table today
  - Hard pushed to find anyone who knows it “at the coalface”
- Future strategy
  - Move on from ticking boxes to impact. From processes delivered on time to actual outcomes delivered. Did it make a difference? Needs to be flexible and adaptive
  - A greater role for housing
  - Need to understand return on investment, together we have £250mn of resources

2. How should the strategy adapt to future trends?

- To change in the health and wider systems…
  - Supply side
    - Money
    - Workforce
    - Communities as assets
  - Demand side
    - Population ageing
    - Expectations

- To change in society…
  - Role of public services
    - Delivery? Enabling? Localism?
  - Medical and consumer technology
  - Networks
  - Housing and other wider determinants

- **Are these national trends that might affect how you revise your health and wellbeing strategy?**
- **If not, what is missing or not relevant to Tower Hamlets?**
- **What are the 3-5 key national factors that your strategy needs to reflect, or adapt to, locally?**

2. Discussion points

- National vs TH trends
  - Beware correlation ≠ causation e.g. evidence of intervention on housing vs housing problems association with poor health
  - TH, younger and more families, a potential strength
  - 1,700+ community organisations, are we making enough of this?

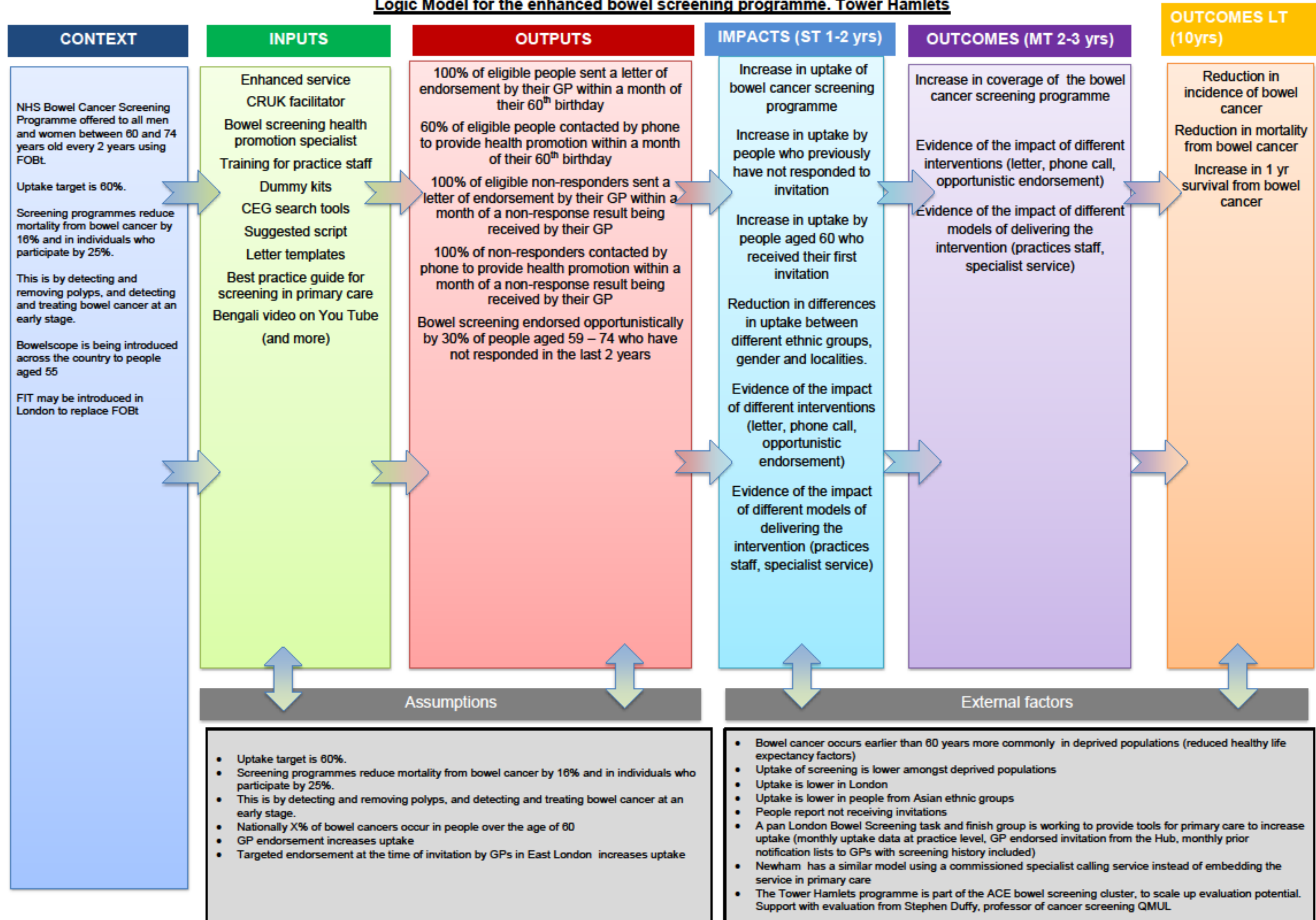
- What's missing?
  - Early years
  - Population churn and implications, very stable and very mobile populations require different approaches
  - Massive Lea Valley development, health in planning opportunity
  - Mental health
  - Radicalisation
  - But… "too many things, focus on narrow set and get them right"

Aspiration – expressed simply

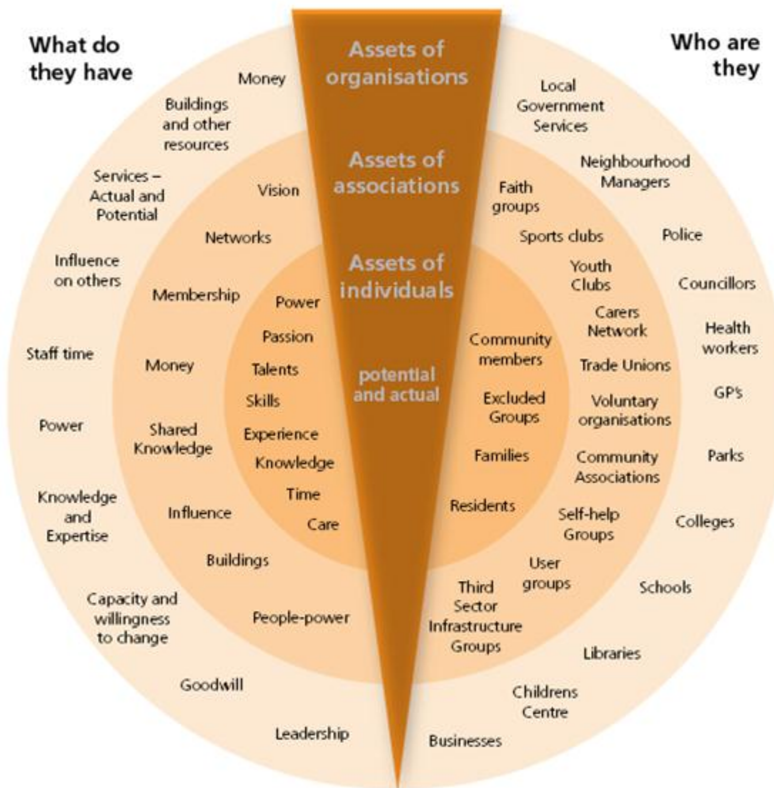
More people in the Borough leading healthier lives

- **A place that supports health**
  - Healthy environments
  - Healthy communities
  - Health promoting services
- **More people**
  - Valuing health
  - With foundations for healthy lives
  - Protected from health harms

Logic – relating inputs to outcomes



Assets that support health and wellbeing that we can influence



- Excellent joined up services
  - Statutory sector
  - Non statutory
- Wider determinants
  - Local economy
  - Employment
  - Income
  - Housing
  - Education
- Physical environment
  - Green spaces
  - Clean air
  - Active travel
  - Communal spaces
- Cohesion
  - Connecting people
  - Partnerships, enterprise

3. Key respondents

- Jane
  - A strong partnership that can deliver a focussed set of priorities (less rather than more)
  - Opportunity with new leadership at Bart's, the vanguard, through our staff and using our resources collectively
  - Need to manage demand through enabling health, and a social movement
- Luke
  - Need to improve outcomes for carers and on shared outcomes (e.g. housing and health)
  - The strategy needs to have a strong focus on prevention
- Diane
  - Move from a strategy between statutory sector to one between that sector and the public
  - An investment in improving health literacy, helping community plan for illness and response
  - Need to use schools and other settings for health
- Debbie
  - Need to avoid strategy losing its impact over time and as it cascades down; therefore needs to be bottom up
  - Innovation yes, but needs to be sustainable and breed resilience
  - Children and school readiness, vulnerable and complex needs

3. Discussion points

- Reach and focus
  - To spread aspiration (place and people) across the system at multiple levels (inc coalface and community)
  - Build and support assets and strengths, not conditions in isolation
  - Need to target long-term residents (IMD figures misleading)
  - A mixed approach. i) High impact, few objectives, ii) wider partnerships and accountability iii) be clear what can't do (don't overpromise)

- What's missing?
  - "Health heavy", need to focus on wellbeing to connect with community and key partners (otherwise "easy to step away")
  - Renewed map of community assets (not just physical)
  - Delivery needs to look very different in different parts of the borough
  - Staff have to be on board, or won't happen

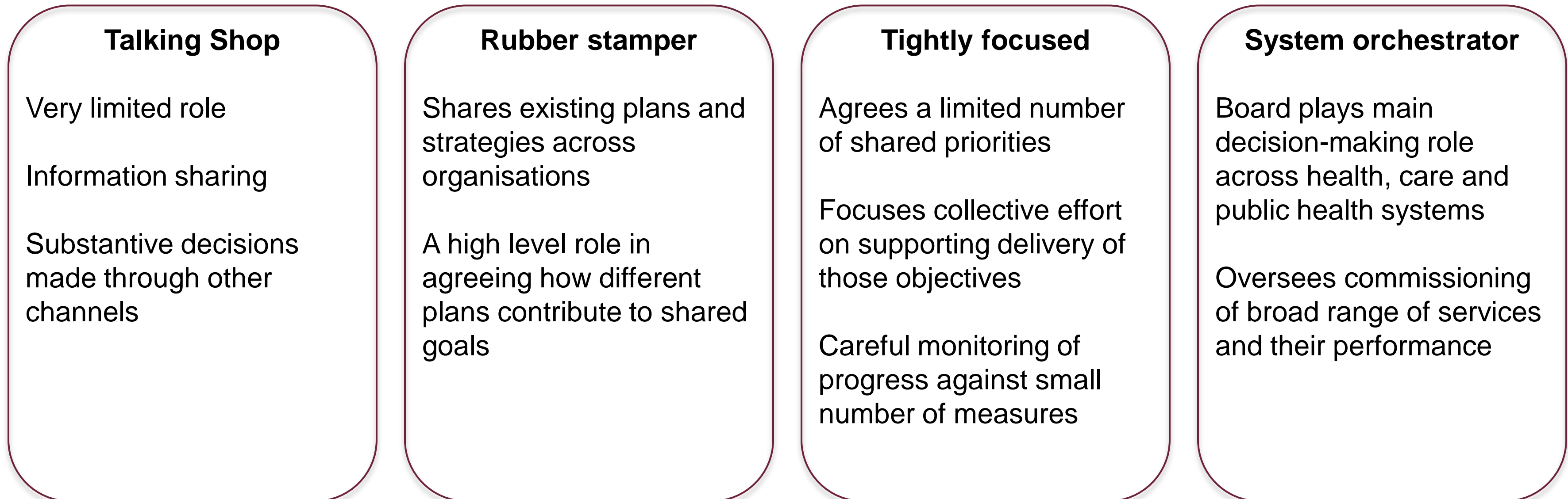
- Has it worked?
  - "Can feel the benefits, even if we don't know what's written on the paper"
  - Build in feedback, "a boat on a stormy sea", clear on destination but flexible and adaptive on route to get there

5. What kind of strategy/board is required?

What do we want from our strategy?...

- How well does the group believe it understand what the community wants to support their health and well-being?
- Are we able to formulate this in the most useful way – i.e. getting the underlying needs (and assets) rather than pointing to symptoms?
- Do we have a clear sense of our role and our resources and capabilities, which might inform where we focus our effort?
- Do we want a focused strategy aiming to drive forward a limited number of priorities or something more expansive?

What sort of board is realistic and best for our communities?...



5. Discussion points

- Strategy
  - We have a good sense of what the community needs
  - Or doe we? A focus on aspiration, wants, expectations, what the community can do for itself?
  - Should the focus be on key principles including ensuring feedback into systems, so that we can react and navigate to our destination?
  - Overall, focus on a few core objectives

- What’s missing?
  - “Health heavy”, need to focus on wellbeing to connect with community and key partners (otherwise “easy to step away”)
  - Health literacy, better patient experience and sense of “respect”

- The Board
  - Needs to be held to account for using information it receives and making a real difference to outcomes
  - Continuous learning and improvement in strategy over time
  - Enabling and decision-making, an “unlocker” on tricky issues
  - Form follows function, ensure objectives first then governance through the Board

Conclusion – King's Fund reflections

- Goodwill and engagement
  - There is a lot of goodwill and understanding amongst your partners
  - Most people were highly engaged in the conversation
  - There was not full consensus (and not to be expected at this stage) but in fact a high degree of common ground on direction of travel
- Direction of travel
  - Has to make a real difference, not tick-boxes, "*We can feel the benefits, even if we don't know what's written on the paper*"
  - The strategy needs to have a small number of core objectives; these can be a combination of principles, and of specific deliverables
  - The strategy needs to move away from specific conditions and pathways of care towards a holistic focus, enabling and engaging communities and their assets, as well as providing services in response to needs
  - The strategy therefore should pay as much attention (if not more) to wellbeing as health to ensure wide understanding and ownership by partners to it, and communities they serve
  - The strategy needs collective ownership and call upon collective resources, including finance and staff commitment

...a strategy with a small number of core, commonly and widely owned, accountable objectives; but that is adaptive and responds to feedback...

"PHEW! THAT'S A NASTY LEAK. THANK GOODNESS IT'S NOT AT OUR END OF THE BOAT."

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Tower Hamlets NHS

Health & Wellbeing Board Strategy Workshop

12 January 2016

Session Photographs & Digest

Tower Hamlets NHS

Health & Wellbeing Strategy 2020

Session Objectives:

to allow the board to reflect on its objectives and identify some high impact initiatives which all stakeholders can support.

Programme:

Focus exercise to identify progress to date

Future Search to highlight Board aspirations

Identify where the H & W B could have an impact

Contents:

Focus board ‘Where are we now?’

2020 Headlines!

Key themes from Future Search discussions

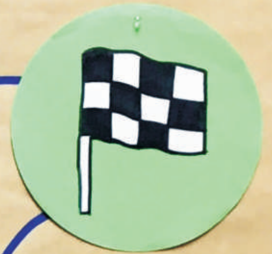
Board Impact syndicate discussions - 6 topics

How far has the Tower Hamlets Health & Wellbeing Board travelled towards its (strategic) goals?

The last 'bit' could be controversial & we stop - need to push the last 20%.

Well, Board functions, but we receive a lot of info but what does the board add?

Not on board, not seen a lot coming out yet.



Challenges for how we engage with community & mainstream services

Risk if we don't focus - risk of doing too much. Need to get the focus right - talk more about agencies & communities

Not made any controversial decisions yet.

How far Have We travelled?

A snapshot of how the Board feels it is doing. Many positive comments reflecting the ability of the Board members to work together, but a recognition that it has yet to take, and publicise, any controversial decisions.

A recognition that engagement and visible 'added value' are important.

Future Search - What We'd Like to Hear in 2020

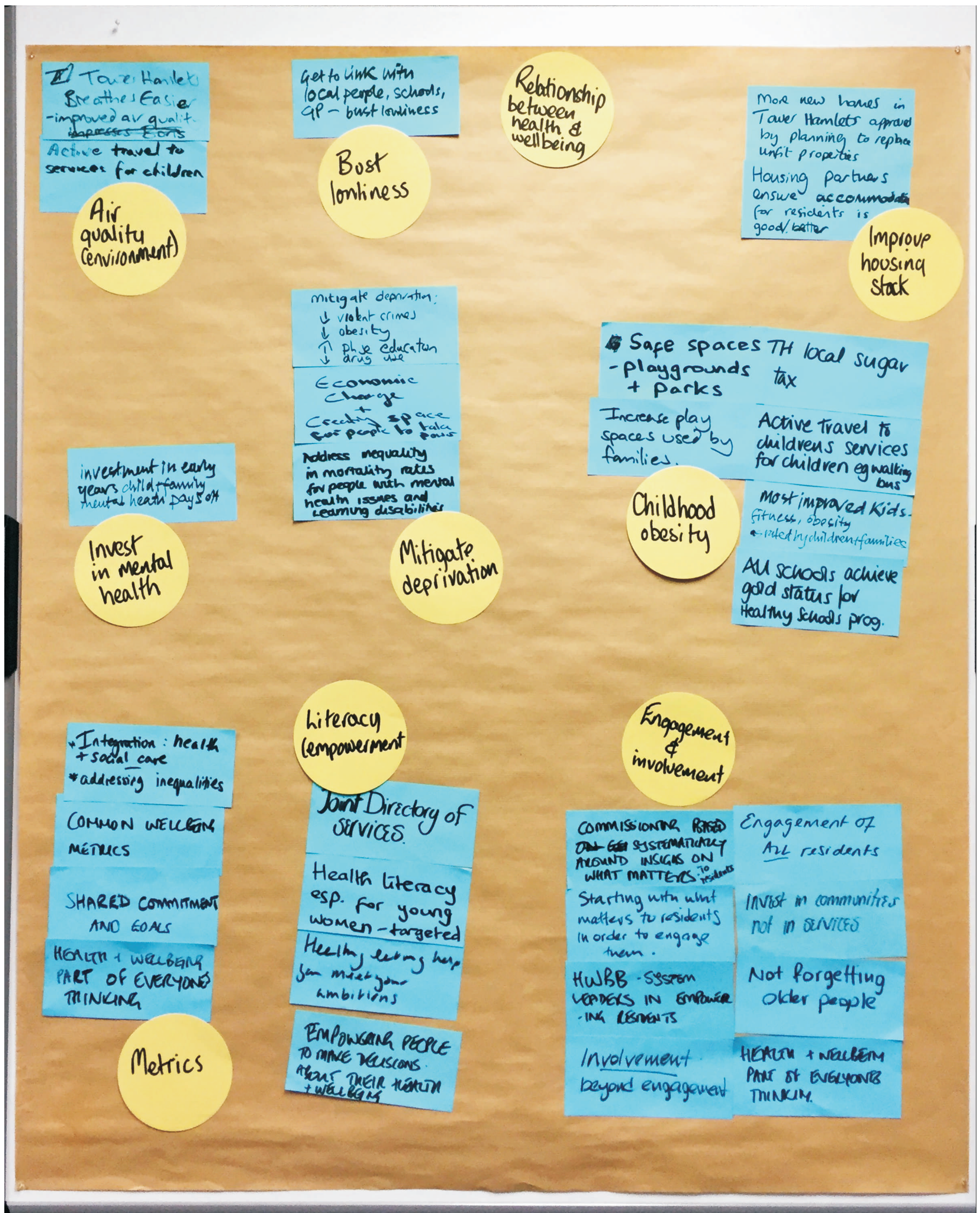
'changing the face of commissioning'

'tackling childhood obesity'

'the healthiest & happiest Borough'

'closing the equality gaps'

'closing the last chicken shop'



Key Themes from the Future Search Discussions

- air quality (the environment
- tackling lonliness
- articulating the link between health & wellbeing
- improving the housing stock
- investment in mental health
- mitigating deprivation
- addressing childhood obesity
- shared & common metrics
- literacy, especially health literacy
- engagement & involvement

Syndicate Discussions

The following pages contain photographs of the boards prepared by sub groups who talked about the following themes:

- ❑ developing a shared understanding of health & wellbeing
- ❑ the consequences of deprivation
- ❑ the quality of housing
- ❑ childhood obesity
- ❑ outcomes by agreeing shared ways of working and goals
- ❑ unlocking community capacity to improve HOW

Rather than simply re-type the comments, you are invited to explore these pages by looking at the cards and considering the comments in the original script.

A blank page has been inserted after each photograph for your comments.

How could the Health & Wellbeing Board have an impact on ....

DEVELOPING A SHARED UNDERSTANDING of HEALTH + WELLBEING ....by 2020?

Please think about IMPACT, partnership (where possible) and evidence base

Could we build on anything that's already being done?

WHO DEFINITION

WHAT MATTERS TO ME?

SOLUTION FOCUSED ASSET BASED APPROACH

Recovery Model learning

BHUTAN + GROSS NATIONAL HAPPINESS.

PERSON CENTRED COORDINATED CARE + SUPPORT PLANNING!

SOCIAL PRESCRIBING (but don't like name)

BUILDING ON NATIONAL METRICS OF WELLBEING

BIOMEDICAL + PSYCHOSOCIAL.

What's missing?

IS HEALTH ACTUALLY WELLBEING?

HEALTH + WELLBEING OF SOCIAL NETWORK

CAPTURING HOW YOU ARE FEELING?

SOCIAL NETWORKS + WELLBEING.

HOW TO CAPTURE SOCIAL NETWORKS

WHAT MATTERS TO YOU VS WHAT IS THE MATTER

HOW DO WE MEASURE WELLBEING AT INDIVIDUAL LEVEL?

IS EVERYTHING WELLBEING?

SOCIAL ISOLATION REGISTERS eg GPs.

Who might need to be involved?

THE COMMUNITY

PHE - WORK ON WELLBEING

"EXPERTS".

VANGUARD.

Suggestions for next steps?

FIND OUT WHAT IS GOING ON ELSEWHERE?

ENGAGEMENT WITH COMMUNITY

BE PREPARED TO CHANGE + TRANSFORM.

Mental Illness prevention = Are there other strategies in England/UK/world?

Develop some simple routine data capture methods re wellbeing + self-defined health status

Council/Area/CCG reports to include 'Impact on wellbeing' section

Engage with rest of council + partners initially around wellbeing rather than health.

Notes:

How could the Health & Wellbeing Board have an impact on .... the ~~negative~~ consequences of Deprivation ......by 2020?

Please think about IMPACT, partnership (where possible) and evidence base

Could we build on anything that's already being done?

Fairness commission

Marmot report

CVS >3,000 organisations

More power to HWBs

JSNA
HWB strategy

Mitigation against Welfare Reform

MENTAL HEALTH STRATEGY

LLW

What's missing?

A local plan to tackle deprivation

Good evidence base about what makes a difference

Shared vision and shared goals locally

Good communication - information accessible + understood.

CHILDREN NEEDS ASSESSMENT

Affordable homes (rent + buy)

Accessible + targeted health literature (joint directory)

Who might need to be involved?

Schools + Educational Establishments

Families, young people, communities

Business organisations + their workforce

GLA + Mayor of London

Job Centre Plus

Partners (HWBB plus others)

MP + HWB link.

OPPORTUNITIES FOR 16 - 25 YEAR OLDS

Suggestions for next steps?

Analysis of the Link between relative + absolute deprivation

Harnessing business power to foster change (CSR)

Build on the initiatives we have in place (that have a +ve impact)

Focus on children living in deprivation.

Actually engage children on what they want

Focus on mitigating the impact on the children in the here + now

Utilising local homeless + asylum seeker / refugee organisations

Notes:

How could the Health & Wellbeing Board have an impact on ....

quality of housing

........by 2020?

Please think about IMPACT, partnership (where possible) and evidence base

Could we build on anything that's already being done?

- Env. Health & housing work together
- Local plan consultation phase
- Damp & condensation + impact on health → asthma, dialysis, chronic lung disease
- supply of housing insufficient for population
- Design of housing - issues of towers - light, access/open spaces/loneliness
- absenteeism from home/investment opportunity in buying homes
- overcrowding issue & impact on mental health

What's missing?

- design mitigation on airflow systems for polluted airways
- research globally into what works elsewhere eg China/Hong Kong/Northern council?
- Flexible accom. for older people - flexible services reach out to carers/people
- Inter-gen. housing + support
- walkways to school, part of new housing plans

Who might need to be involved?

- Planners + housing team (strategic) + THHF
- Experts who have already done this
- Contractors, architects, planning consultants
- Mayor, Cabinet, Housing leads

Suggestions for next steps?

- Health impact assessment on new schemes - criteria on + hsg & health impacts
- Highlighting positive practice on "good" housing schemes
- Systems leadership to advocate for 'healthy' housing stock

Notes:

How could the Health & Wellbeing Board have an impact on ....

Childhood Obesity

.......by 2020?

Please think about IMPACT, partnership (where possible) and evidence base

Could we build on anything that's already being done?

- Healthy borough programme. Lapsed 2-3 yrs ago
- Open spaces review
- Existing commissioned services
- Neighbourhood/school pilots.
- Scale up interventions such as improvement of healthy content of FFO meals

What's missing?

- Strategic focus. High level commitment
- High profile
- Willingness to take big, potentially sensitive decisions
- Resources allocated by partners. - move toward joint commissioning, resourcing in kind.

Who might need to be involved?

- Commitment from/by all partners as to the role they can play.
- Planning. (physical environment planning)
- Map out/define role of range of partners. eg. police/fire services
- Schools + higher education + Academic Health Science bodies (UCLP etc)
- Corporate funding, business sponsorship.
- Community mobilisation, 'call to action', social movement.

Suggestions for next steps?

- Build credible case for change, building on narrative of 'why' TH, need for 'systems change' perspective
- Campaign. engagement, high profile something that 'speaks to' all HWBB members
- Developing common language, branding. 'family health' angle that resonates with families.

Notes:

How could the Health & Wellbeing Board have an impact on ....
Outcomes by agreeing shared goals & ways of working & goals & outcomes
.......by 2020?

Please think about IMPACT, partnership (where possible) and evidence base

Could we build on anything that's already being done?

Commitment, energy & partnership. eg. TST.

What's missing?

- Common approach
- unified measures
- unified meaning.

agreement on priorities + shared measures

Key partners eg. Business

A set of shared goals around core areas with shared measures

Who might need to be involved?

Business, Fire Service, LAS .....

Suggestions for next steps?

Shared & agreed community engagement strategy across partners

Notes:

How could the Health & Wellbeing Board have an impact on ....

Unlocking community capacity to improve H&W ......by 2020?

Please think about IMPACT, partnership (where possible) and evidence base

Could we build on anything that's already being done?

Looking at pockets of G' practice. Specific "Places" → spreading

Learning from past → joining up lessons & building on them.

Has to be neighbourhood / network / place basis.

→ duplicate here.

What's missing?

Change in partners culture to be able to support communities to lead change & improvement. Trainy staff as enablers.

Trust within senior stakeholders → letting go control. See it through Even when it's complicated

Coherence - Feeling that residents have control/responsibility - Empowering residents to feel they have a role in their neighbourhood.

Politics & patronage - corrupted view of r'lop between citizens & the state.

Look outwards. Bolton, Birmingham etc. comparable

Good communication tools - more than 1 -

Who might need to be involved?

not just staff with health system being trained

citizens & residents are the most important HWB workers

Equal partnership between professionals & community

Sell fact its more sustainable.

Suggestions for next steps?

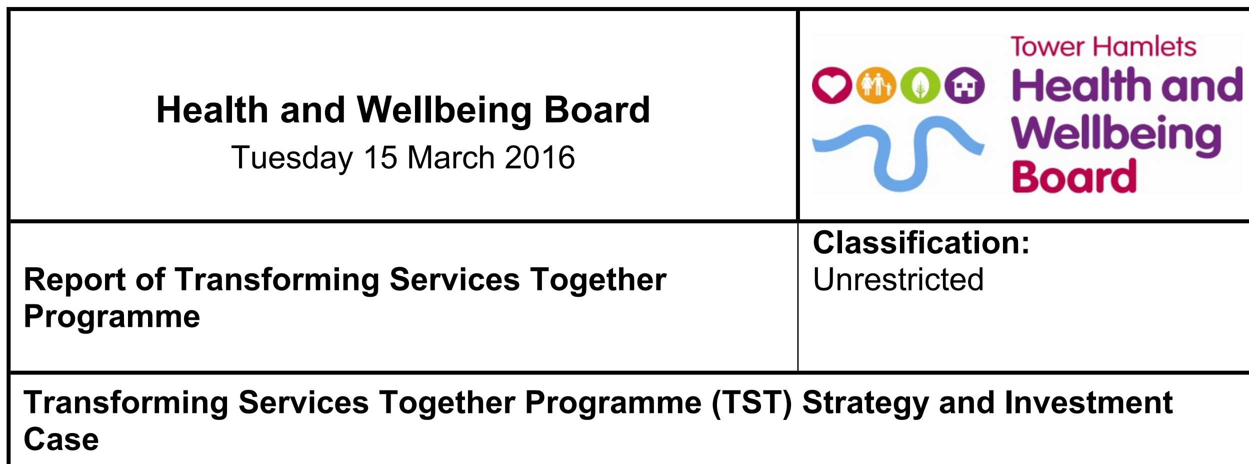
Review lessons from past & existing good projects & what made it work for each partner organisation. Then look at good external best practice thematically.

Being honest about budgets

Communities having trust

Culture change within organs & with citizens.

Notes:



Health and Wellbeing Board Tuesday 15 March 2016	Tower Hamlets Health and Wellbeing Board
Report of Transforming Services Together Programme	**Classification:** Unrestricted
Transforming Services Together Programme (TST) Strategy and Investment Case	

Contact for information	Neil Kennett-Brown Transformation Manager, NEL CSU Neil.kennett-brown@nelcsu.nhs.uk

Executive Summary

Transforming Services Together (a partnership programme of work between Newham, Tower Hamlets and Waltham Forest CCGs and Barts Health Trust) has now published its Strategy and Investment Case. A period of public engagement will run from 29 Feb to 22 May 2016.

Recommendations:

The Health and Wellbeing Board is recommended to:

1. Note the publication of the strategy and engagement plan
2. Provide initial views
3. Take part in the engagement period both by making a formal response to the engagement and encouraging others to make their views known.

1. DETAILS OF REPORT

The TST Strategy and Investment Case has been developed by over 1,000 clinicians, managers, staff and public and patients, and has been approved by the three CCG governing bodies and Barts Health board. It is a response to the agreed Case for Change[1] published in December 2014.

The case for change

If we don't change, due to population growth, the health economy will need an additional 550 inpatient beds by 2025 – the equivalent of a new hospital. The cost of building this capacity would be about £450 million; the cost of running these additional beds would be about £250 million a year. We wouldn't have

[1] www.transformingservices.org.uk

(or be able to recruit) the workforce to support this, and we know that hospital is not the right place for many people

If we don't change, the health economy finances will deteriorate further, patient experience will decline and patient safety will be put at risk. People will need to wait longer for operations or travel outside of east London for some routine elective care. People with a mental health illness will continue to be poorly treated compared with patients with a physical illness; too many people will continue to die in hospital rather than in a homely surrounding. Patients and staff will have to cope with poor environments.

The strategy

Our strategy: makes it easier for organisations to work together with common objectives and shared ideas; aims to shift activity into fit-for-purpose settings of care, often closer to home; will enable better prevention of ill health; helps people to stay healthier and manage illnesses; will improve access to high quality, appropriate care; focuses some specialisms in fewer locations to improve patient outcomes and experiences; reduces bureaucracy; and helps set our finances on a path of sustainability in an increasingly challenging environment.

Over the next five years we will focused attention on 13 carefully considered, costed and tested high-impact proposals. We will:

1. join up health and social care services to provide services that meet people's needs – usually closer to their home.
2. improve access to urgent primary care, joining a variety of different services together
3. improve primary care, for instance offering longer appointments for people with long term conditions, providing Skype and other online tools. Smaller GP practices will increasingly work together so they can offer more services – supporting people to manage their health and wellbeing and reducing costs
4. identify the need for end of life care earlier, have the difficult conversations and by doing so, support people make better choices about the end of their life

We recognise the need to strengthen existing A&Es and maternity services in our three main hospitals. We will:

5. create centres of excellence on each site to improve surgery
6. bring together all the expertise needed at the front door of hospitals to see and treat people quickly. We know that patients are keen to avoid spending time in hospital (and in fact for many (particularly older) people it is not good for them). These 'acute hubs' will reduce the number of people

unnecessarily admitted to hospital and reduce the time patients spend in hospital.

7. give women more choice of having a baby in a midwifery-led centre or at home. For most women these options place them at a lower risk of interventions and operations, are safer and better.

We will also work together to tackle bureaucracy and inefficiency in the NHS and improve patient experiences through:

8. transforming patient pathways. We know that far too often the patient journey is long, convoluted, frustrating and wasteful. We would like to see patients deciding when they need a follow up outpatient appointment, not simply book them into one in six months, whether they need it or not.
9. stopping unnecessary testing which is wasteful and subjects patients to inconvenience and worry.
10. sharing care records, to stop having to ask people for their history and stop the need to repeat tests
11. developing new roles, such as physician associates who can better meet the needs of patients, meaning that GPs can focus their attention on those patients who need their particular expertise
12. and 13. developing services and facilities at Whipps Cross and Mile End.

These services will need to benefit the whole community, reduce health inequalities and address mental health issues, as well as physical health problems.

The engagement

So far, more than 1,000 people have been involved in developing the plans e.g. the TST Patient and Public Reference Group; clinical workshops and GP groups; local organisations e.g. NELFT, ELFT, Homerton, Redbridge CCG, local authorities, overview and scrutiny committees; existing meetings e.g. Maternity Services Liaison Committee; and specific patient/public meetings e.g. diabetes workshop; mental health workshop; care records workshop.

Now we are providing a wider opportunity to discuss the proposals with the public, staff and stakeholders from 29 February to 22 May 2016.

We intend to inform people and enable them to have their say generally using a mail/email shot, advertisements, press releases, posters, drop in sessions in the community and hospitals etc. However we will primarily be organising local workshops on particular elements of the programme. The engagement strategy is attached.

2. <u>FINANCE COMMENTS</u>

2.1. Significant investment is required if we are to ‘invest to save’ so we have developed detailed analysis of the savings that could be achieved, with appropriate sensitivity analysis.

Our assessment is that the programme could save between £104 million and £165 million revenue costs over a five year period, with annual savings thereafter of £48 million.

Assessment of the capital requirements show that without TST (and therefore the need to build an extra 550 beds), the partners (and external resources e.g. national funds) would need to invest £352 million over five years and £1.1 billion over 10 years. However if the TST objectives are achieved the investment reduces to £173 million over five years and £636 million over 10 years. Both sets of figures include a cost of around £450 million over 10 years to rebuild Whipps Cross hospital.

3. LEGAL COMMENTS

3.1. The recommendations to:

- note the publication of the strategy and engagement plan;
- provide initial views; and
- take part in the engagement period both by making a formal response to the engagement and encouraging others to make their views known,

are consistent with the general policy, reflected in the Health and Social Care Act 2012, of giving HWBs responsibility for joint health and wellbeing strategies. As the HWB has statutory status, due regard should be given to its decision making authority within its terms of reference. These recommendations are within the terms of reference of the HWB agreed by the Mayor in Cabinet on 4 December 2013.

4. IMPLICATIONS TO CONSIDER

4.1.1 The outcomes of the engagement will be used to develop both the strategy and the local input into the STP

Appendices and background documents

Appendices

- There are three parts of the report and an engagement strategy. Part one of the report and the engagement strategy are attached. Part two and part three are also available and can be downloaded here: http://www.transformingservices.org.uk/strategy-and-investment-case.htm

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

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Transforming Services Together

Strategy and Investment Case

Part 1: Summary

About Transforming Services Together

The Transforming Services Together programme, established by Newham, Tower Hamlets and Waltham Forest Clinical Commissioning Groups (CCGs) proposes working in partnership to deliver high-quality, safe and sustainable services for local people.

The CCGs have developed these plans with patients, the public and their representatives and over 300 health and social care staff (for instance surgeons, pharmacists, midwives, nurses, GPs, practice managers, healthcare assistants and managers) in Barts Health NHS Trust; neighbouring CCGs – in particular, City and Hackney CCG, Barking and Dagenham CCG, Havering CCG and Redbridge CCG; Homerton University Hospital NHS Trust; East London NHS Foundation Trust; North East London NHS Foundation Trust; local authorities (including public health teams) – in particular the London Boroughs of Newham; Tower Hamlets; Waltham Forest; and Redbridge; NEL Commissioning Support Unit; NHS England – responsible for specialised commissioning; and the Trust Development Authority.

We will be testing our ideas with staff, local communities, partners and patient representatives, through meetings, workshops and other methods of engagement.

To make your views known please contact us:

Phone: 020 3688 1540
Email: TransformingServicesTogether@nelcsu.nhs.uk
Website: www.transformingservices.org.uk

or fill in the questionnaire at the back of this document. Whilst we will continue to discuss these proposals throughout their development, we will be finalising this Strategy and Investment Case early in the summer of 2016, so if you would like to contribute to this, we need your comments back by **22 May 2016** at the latest.

To view the full document please take a look at our website or contact us for a copy.

This document is intended to stimulate debate. We look forward to hearing from you.

Note:
East London is the term we use for the boroughs of Newham, Tower Hamlets and Waltham Forest. This is the focus of this strategy.

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Proposed Foreword

Transforming Services Together was established to improve the local health and social care economy in Newham, Tower Hamlets and Waltham Forest – very much in line with the challenges of the NHS *Five Year Forward View*[1]*,* local and regional plans and guidance[2].

Celebrating success

Whilst this document focuses on where we need to improve, it is worth recognising some of the huge achievements of the NHS over the past 20 years and appreciate the efforts made by everyone working in health and social care. We have one of the best trauma centres (at the Royal London) not just in the country, but in the world. We have improved the quality and accessibility of primary care services; our services for Tuberculosis, mental health, carers, our websites and management have been recognised nationally. Stroke care is second to none and mortality ratios at our hospitals (a key measure of how safe services are) are some of the best in the country. By working together we are ensuring local people are far more likely to survive diseases such as heart disease than people in many other parts of the country[3].

A partnership approach

But, we also recognise the complex challenges: a rising population; financial and workforce pressures; and in some cases poor patient care, estates and infrastructure.

Where we live, our environment and socio-economic situation is critical for wellbeing. We recognise the responsibility that local authorities have for the health and wellbeing of their populations and the potential this has to reduce the burden on the health service. Together we have developed proposals to respond to some of the challenges and take advantage of the opportunities we face. Clinicians have led the discussions, in partnership with key stakeholders and members of the public. We welcome the honesty that everyone has shown in reflecting on what is wrong with the existing system and their dedication in developing new ideas on how to make the changes that are clearly necessary.

We are encouraged by the enthusiasm for change, the willingness of all partners to work together and the strong belief that solutions can be found. Thank you to everyone who has taken part so far (over 1,000 of you). We want to develop a new partnership with local people. It is your NHS, and we know it is a much valued and respected institution. The health service, staff, partners, patients and residents need to work very differently with each other and everyone has a part to play.

Our plan

This document outlines the key health and social care changes and investments needed in East London. We have set out a credible plan to transform the services that almost one million people (and rising) rely on. We must ensure that we provide the patient experience that our populations expect, and the services that keep them well and safe. Most importantly these changes would set the system onto a path towards financial sustainability. We look forward to hearing from you.

Signatures

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[1] NHS England www.england.nhs.uk/ourwork/futurenhs/
[2] London Health Commission www.londonhealthcommission.org.uk/better-health-for-london/
[3] Health and Social Care Information Centre. January 2015 www.hscic.gov.uk/pubs/shmijul13jun14

1. The challenges we face

The future challenge means the NHS and social care has to change

- **Our population is projected to grow considerably.** Over the next 15 years, the population of Newham, Tower Hamlets and Waltham Forest will probably grow by 270,000 – the size of a new London borough. We anticipate thousands more births each year and, as people live longer, so their health and social care needs will also increase.

  But we are approaching the capacity of our buildings if we continue with the current configuration and ways of working. Our hospitals face unprecedented demand for services and population growth will require a further 550 beds over the next 10 years if we don't change the way we work. Extra funding from the population increase will not cover this cost, and in any case it would be misplaced. We need to redesign services to keep people out of hospital in the first place.

- **There are changes underway that will impact how our services operate.** King George Hospital's emergency department is expected to close, which will mean an increase in demand at Whipps Cross and Newham hospitals. We need to develop new partnerships; new forms of finance and payments that encourage innovation and efficiency; and new organisations to integrate care.

Existing challenges

On their own, these future issues would require considerable focus and attention to address, however the NHS in our area is already facing a number of major challenges.

- **Health and social care budgets are being squeezed.** The spending freeze to NHS budgets, and spending cuts to local authority budgets will place a greater financial strain on services – in particular in areas of care where integration between health and social care is so important. Whilst CCG finances are currently in balance, they are predicted to deteriorate rapidly over the next five years and Barts Health already has the largest expected deficit in the NHS at about £135 million.

- **We need to improve the quality of care and patient experience.** There are issues in access to, and experience of, primary care and other services in the community. Around 40% of respondents to the GP National Patient Survey reported that they could not see a GP of their choice and over 30% found it difficult getting through on the phone. Some of our health services are world class, but too many are not. Barts Health is struggling to meet the London Quality Standards. In June 2015 the Care Quality Commission assessed patient outcomes at Barts Health as being at, or better than, the national average across most medical and surgical at the hospital, but it also highlighted a significant number of areas where improvements are required and rated the trust 'inadequate'[4]. In response, the trust published *Safe and Compassionate*[5] which describes how, by working with staff, patients and partners, the trust will deliver lasting improvements.

- **Our workforce is stretched.** We are struggling to recruit and retain the number of staff we need. For example there is an existing shortfall of more than 730 nurses (around 13% of the total) in East London providers and there is a higher than

[4] www.cqc.org.uk/provider/R1H
[5] www.bartshealth.nhs.uk/media/286492/150915%20BH_Improvement_Plan_FINAL.pdf

average turnover of staff[6] (around 2,800 staff leave our hospitals each year – around 15% of the total). There are significant staff shortages in some critical specialist roles – such as in emergency medicine and paediatrics. There is a shortfall in primary and community care too – over 40% of male GPs in Newham and Waltham Forest are approaching retirement age; we already spend too much on agency staff to plug the gaps.

We need to address the high costs of living, low staff morale in some places and a lack of clear development and training routes.

- **We need to change the social culture of over-reliance on medical (and often emergency) services.** Life expectancy is worse than the rest of England – environmental factors and deprivation are of critical importance and need to be tackled. Supporting people to look after themselves, and better prevention of illness, would make the most significant difference to people's health – and yet we do not prioritise this area of health. We recognise that influencing this change is particularly difficult given the diversity and transient nature of the population.
- **Our facilities and IT systems are not always set up to deliver high quality or efficient care.** We have some of the most modern and high-tech facilities in the country – such as the new Royal London Hospital and the Sir Ludwig Guttmann Centre in Newham. However, many of our community facilities are under-used or inappropriately fitted out, too small, or in the wrong place for the services we need to deliver. We also have many old buildings that require significant investment just to maintain them (Whipps Cross requires over £80m of investment in its buildings).

  Our IT systems are not fit for purpose. Poor equipment and a lack of interconnectivity inhibits delivery of efficiencies and improved services.

If we allow things to continue as they are…

- we will need an extra 550 inpatient beds by 2025 (costing around £450 million to build and £250 million a year to run). Overall our organisations will be in deficit by almost £400 million by 2021/22. We wouldn't be able to recruit the workforce to staff these beds, and we know that hospital is not the right place for many people[7].
- patient experience will decline and patient safety will be put at risk. People will face a confusing health system, and will need to wait longer for operations or travel outside of the area for some planned care. People with a mental health illness will continue to be poorly treated compared with patients with a physical illness. Too many people will continue to die in hospital rather than in a homely surrounding. Patients and staff will have to cope with poor environments. We won't be able to bring care closer to home; we won't take advantage of the opportunities to transform the morale of our workforce and our finances will deteriorate[8].

[6] Compared with the Health Education North Central and East London area. HSCIC workforce statistics July 2015 www.hscic.gov.uk
[7] Audits show that up to 40% of beds are occupied by people who do not need hospital care.
[8] *The Review of Operational Efficiency in NHS Providers* (June 2015) suggested that the NHS overall could save £5 billion a year by making efficiencies in workforce and productivity; and improved medicines, estates and procurement management.

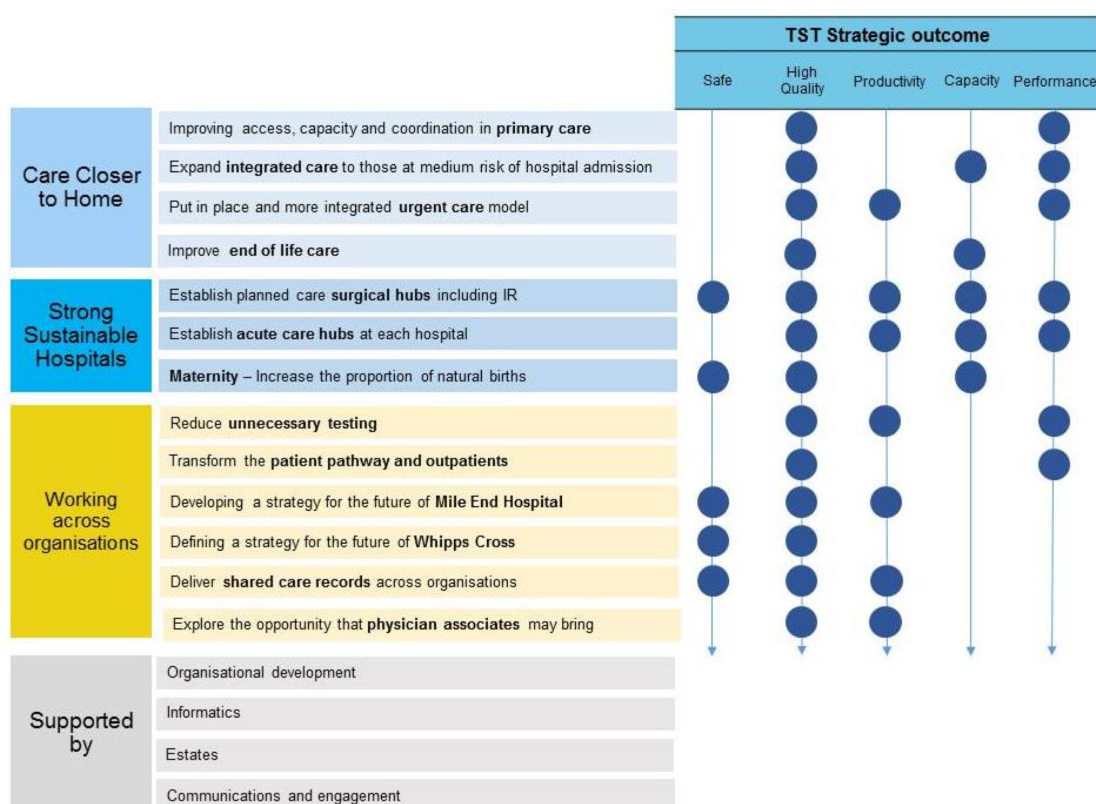
2. How we could create high quality, safe and sustainable services

Our strategy

Our strategy aims to:

- support the **health and wellbeing** strategies of our boroughs, helping people to stay healthier and manage illness; and to access high-quality, appropriate care, earlier and more easily
- **change the culture** of how we commission and deliver care
- **increase involvement of patients and carers** in co-production and shared decision-making
- **maximise the use of the assets** in our communities and voluntary sector
- commission activity to be in **fit-for-purpose settings of care, often closer to home**
- **focus some surgery in fewer locations** to improve patient outcomes and experiences and drive up efficiencies
- acknowledge the importance of supporting people's **mental health** and well-being
- **ensure the system is flexible** enough to respond to changing demands
- help set our **finances on a path of sustainability** in a challenging environment.

To ensure we will meet these aims, we have established three 'clusters' – which are responsible for the overall delivery of the programme. Each of these clusters has developed specific initiatives to address key priorities for change.



Three important themes are integrated throughout the clusters and initiatives. These are:

- Helping people manage their health better
- Mental health
- Children and young people

The expected outcomes

The impact of these initiatives, if they are delivered through a coordinated, integrated plan over the next five years, alongside productivity improvements, will be:

- a fairer service, treating the needs of everyone in society
- a healthier population and patients who experience better care
- significantly more care being delivered closer to home, in more efficient care settings
- a workforce that is more suited to deliver efficient and effective modern healthcare; staff who better understand their role, who feel supported and who are enthused about their job, healthcare and the NHS
- that hospitals are able to relieve the existing pressure on beds; can cope with the increase in population and long term conditions; and can reduce waiting times, or create opportunities for new income streams
- improvements in clinical quality. We expect these proposals to directly support the *Safe and Compassionate* improvement programme and the transition of Barts Health out of special measures
- net savings from the TST programme of between £104 million and £165 million over five years. By year five the annual saving is £48 million. The most likely position if we deliver the changes described in this document; internal cost improvement programmes (CIPs); and quality, innovation, productivity and prevention (QIPP) programmes, is one of overall balance with some organisations being in surplus and some in deficit.
- A significant reduction in the capital requirement. The TST programme proposes a budget for buildings and infrastructure of £72 million by 2021 (excluding essential estates and IT works), but the requirement if TST is not put into action is £250 million.

3. Getting the basics right

Patients have told us that getting the basics right improves clinical care as well as the patient experience. Patients want to be seen in well maintained buildings; they don't want to have to tell their story to every member of staff that they meet because our IT is not joined up; they want staff to talk to each other and coordinate care, be caring as well as competent, to understand that little things make a real difference, and above all to recognise that every person is different.

The estate

Our aim is for a flexible and fit-for-purpose estate. It will be actively managed and well used, with opportunities taken to share space with other services benefitting the public.

Primary and community care

GP practices are of varying quality and suitability in each borough; the traditional model of small GP surgeries is no longer suitable. We need fewer smaller practices and larger 'hubs', where a greater range of primary and community care services can be delivered in an efficient and modern setting. GP practices should cater for 10-15,000 patients or be working as part of a network, or collocated with other practices. Larger facilities of over 30,000 patients should host on-site minor surgery units, sexual health clinics, enhanced test facilities and community learning environments with access to nutritionists, health coaches and community groups.

Newham: The Vicarage Lane site in the north west of the borough would be a good location for a primary care hub. A second hub could be at the Sir Ludwig Guttmann Health Centre in Stratford. Centre Manor Park could be a good location for a third hub with two further hubs in Royal Docks ward and Canning Town.

Tower Hamlets: The hubs could be at: St. Andrew's Health Centre; Barkantine Centre; East One Health Centre; Blithehale Health Centre with an additional hub in Whitechapel.

Waltham Forest: Wood Street and Comely Bank could provide a good location for a primary care hub. A second hub could be at St James Health Centre; a third at Highams Hill. A fourth hub could be located around the adjoining Ainslie Therapy/Rehabilitation and Highams Court sites; a fifth hub could be at Thorpe Combe Hospital.

Acute care

The Barts Health estate includes some of the most modern and efficient facilities in London, but includes some of the worst. There are opportunities to improve many facilities, and to consolidate and dispose of parts of the estate that are inefficient or in locations where they hold considerable value to a residential or commercial market.

St Bartholomew's Hospital: Complete the phased redevelopment of parts of the site; consider disposing poorly used or unsuitable parts of the site; develop and preserve elements of the historic, heritage aspects.

Royal London Hospital: Increase the density (and therefore efficiency) and improve the clinical co-location of services on the site; progress the sale and transfer of the old Royal London hospital to the London Borough of Tower Hamlets; progress plans to develop two further plots of land into a life sciences specialist centre, in collaboration with local education partners.

Mile End Hospital: There is an opportunity to consider greater integration of acute[9], community, mental health and primary care services. A system-wide strategy is required to define the most appropriate use of the site.

Newham University Hospital: Develop the Gateway surgical centre to allow greater activity, in particular orthopaedic surgery.

Whipps Cross University Hospital: There is a continuing (and growing) demand for acute and emergency services on the site. Working with local partners, a system-wide long-term strategy is needed for the site.

IT and informatics

The NHS collects vast amounts of data and we can use this much more intelligently, systematically and transparently. Developing joined-up information systems will support more effective, integrated healthcare.

We want people to experience services that are truly seamless, with effective signposting, co-ordination of care and exchange of information supporting every patient's journey. All clinicians should have access to key patient data to make decisions and reduce the risk of gaps and duplications in care. We will focus on ensuring:

1. the infrastructure (computers, cables, services) is up to the job of supporting reliable, fast access to systems
2. wherever a patient is seen or a decision made in the health and care system, the appropriate data from every responsible health and care organisation is available safely in a real-time easy-to-use way
3. we can combine data from every organisation to inform and prompt changes to treatments and care pathways
4. patients get access to their record so they can take control of their own health.

Our workforce

There is a limited labour supply in East London, made worse by high turnover and retirement rates. We struggle to recruit to key roles, such as nurses, social workers, allied health professionals and emergency consultants. Rising costs are making living locally impossible for many nurses and support staff, with few key worker incentives offered, such as affordable housing.

We will address some of these challenges through the introduction of new roles, new ways of working and initiatives such as encouraging:

- recruitment. We will work with universities and other education providers to offer academic courses for new roles (e.g. physician associates and advanced nurse practitioners). We will encourage young people to work in the NHS by working with local schools and education establishments and develop apprenticeships and internships. We will market the attractiveness of working in the NHS in East London.

[9] Acute care is the name we use for care that is normally provided in a hospital for serious conditions needing 24/7 nursing under the direction of a consultant.

- retention of staff through training and development opportunities, flexible working options and financial incentives. These could include ‘golden hellos or handcuffs’, support with the high costs of London living and transport, key worker housing, bursaries or student loans to incentivise hard-to-fill vacancies. We will also look at removing perverse incentives such as high pay for bank and agency staff.

Multidisciplinary teams

Delivering care in multidisciplinary teams is central to a number of initiatives including improving surgery, urgent care and primary care:

- The services available at the front of our emergency departments need to be broadened by bringing together a wider range of staff and facilities. By doing so we will be able to care for a much greater proportion of patients and conditions without having to impact on the emergency department.
- Collaborative working is also needed in the community, with GPs, pharmacies, dental, community health and social care services (all connected by IT systems) working together to provide an integrated urgent care response, closer to where people live.

4. Our proposals in detail

Prevention

People in East London have some of the shortest life (and healthy life) expectancy in the country. We aim to change the existing culture of over reliance on medical/hospital services to one where prevention of ill health is given greater priority, and people take more responsibility for their own health. However this cannot be fixed by health services alone. The NHS must work with all organisations, including social care and the voluntary sector to:

- support people to live healthier lives
- make our schools and workplaces healthier
- identify physical ill health earlier – for instance through screening programmes.

Achieving this would mean a healthier population, with improved quality of life, a reduction in emergency department attendances and admissions to hospital, more supportive patient care, and healthier staff.

Delivering care closer to home

GPs with a registered list of patients need to remain as the foundation of NHS care. Over the next five years the NHS will invest more in primary care. The number of GPs in training needs to be increased as fast as possible, with new ways to encourage retention.

We need to integrate emergency and ambulance departments, GP out-of-hours services, urgent care centres and NHS 111 so people can get the right care at the right place at the right time.

Too many people go into hospital or stay in hospital longer than is necessary. Co-ordinated support early on, focused on a person's wellbeing as well as their health and social care needs, can reduce their dependency on services in the long run and ensure that admission to hospital only happens when it is really needed. Transformation will require new partnerships with local authorities, communities and employers, with decisive steps being taken to break down the barriers between GPs and hospitals, physical and mental health, health and social care.

New integrated providers will enable the NHS to take a more rounded view of patient care. We are also committed to developing local payment schemes and supporting leaders creating innovative solutions to local challenges.

Delivering these changes could deliver significant beneficial health outcomes, reduced health inequalities, radically improve patients' experience of interacting with the NHS, improve efficiencies and enable the NHS to manage the expected increase in attendances:

- Some activity in GP surgeries can be delivered in pharmacies and by supporting self-care
- Around 180,000 outpatient appointments, can be provided in alternative ways that are more convenient to patients
- 92,000 extra attendances expected at Barts Health emergency departments a year (by 2020) can be accommodated by shifting activity to primary care and improving pathways and system efficiencies.

To deliver care closer to home, we have prioritised a number of key initiatives:

Initiatives and the case for change	*Proposals*	*What we will deliver in five years*
Integrated care Too many people go into hospital or stay there longer than necessary.	Integrated care provides co-ordinated health and social care in patients' own home or in the community to help them stay well or manage their illness. We want to improve our services and extend integrated care to those at moderate risk of hospitalisation (it is currently only available to those at high risk of hospitalisation).	People with moderate risk of hospitalisation will manage their health better, stay well, be able to live in their own home or the community (rather than have long spells in hospital) and reduce their reliance on urgent care services.
Urgent care People find it difficult and confusing to access urgent care – so they often end up going to emergency departments or calling an ambulance, which diverts attention away from people with more serious and life-threatening issues.	Simplify and integrate urgent care by: - developing a simple online directory of services - integrating NHS 111 with the urgent care system so there is a single place where people can get advice, book urgent appointments at a primary care hub (see below), their GP or other providers - replacing standalone walk-in centres with primary care hubs which will provide a greater range of services. Provide more urgent care appointments in the community (including in the evenings and at weekends). Provide a more comprehensive service in urgent care centres at the front door of emergency departments.	Patients would get the care they need in a timely, easily understood and convenient fashion, helping them get back to health without the need to visit an emergency department. Around one in four patients attending an emergency department will be treated in an urgent care setting, meaning emergency departments are able to provide the best possible care to those most in need.
End of life care One in three people admitted as emergencies to a hospital are receiving end of life care. However most people would like to die in their usual place of residence.	Earlier identification of the need for end of life care, supported conversations and recording and sharing preferences and: - better sharing of care plans - more community and end of life services - better partnership working across the health, social care and voluntary sector – including making more use of community facilities such as hospices.	People will be able to make better choices about their end of life care and their experience of end of life will improve. A 30% reduction in bed days during the last year of life. Half the number of emergency hospital admissions.

Primary care There is an increasing (and ageing) population and a rising burden of disease; a shortage of GPs; and patients find access and quality of care unsatisfactory. The population has some of the poorest public health outcomes in the country (for example survival of cancers and cardiovascular disease and life expectancy).	Improve *access* to general practice, pharmacies, dentists and optometrists, for instance by providing supportive online tools or Skype appointments. Establish *proactive care*, by empowering patients to take more control of their health and by offering wellbeing inductions for new patients. *Coordinating* care. We will make sure 20% of appointments are longer, to suit the needs of patients with complex conditions; we will continue to connect our IT systems. We believe this type of care can only be delivered in: - primary care practices serving over 10,000 patients - smaller practices working together in networks, or in collocated facilities at primary care hubs by a broader range of professionals (for example by creating physician associate roles or by having pharmacists working alongside GPs).	The whole population will be healthier. People will find appointments are more convenient, so minor ill health can be resolved quickly and easily. More services will be available in the community, often in the same building so patients will have less need to go to hospital. We will have more primary care staff and patients will be more able to choose a female or male GP. We will reduce patient complaints by 50%.

Strong sustainable hospitals

Even though our focus is to help people stay fit and healthy and to provide care closer to home, we need to make sure that when people do fall seriously ill or need emergency care, there are strong, safe and sustainable services in local hospitals.

We know that there needs to be a continuous focus on quality and safety. Some of our proposals are small and will cost nothing to implement, others require organisations, staff and the public to work together to deliver improvements.

We need to change the way we work if we are to cope with the extra activity expected. The existing emergency departments and maternity units will need to be retained to deliver high quality local care but we need to change the way they work:

- **Improved local care with specialisation where this improves outcomes and delivers safer care**

  In order to effectively provide care for the growing populations we need to make sure that Newham and Whipps Cross are able to deliver high quality care for the vast majority of conditions in their local population. We also need the Royal London to function effectively to serve its local community and a wider population in its role as a specialist centre. This doesn't really happen at the moment as the site is often too busy treating emergency and very unwell patients to cater for the day-to-day needs of local people. This results in large amounts of planned surgery being cancelled and patients staying in hospital longer than they should, affecting local people and patients who have been transferred from further away.

- **More integration with community and social care**

  Our hospitals need to be better integrated with the community as well as forming stronger partnerships with charitable and voluntary organisations. We need to work to make sure that local services run as effectively as possible alongside other clinical teams both on and off the hospital sites to deliver the best care.

- **Working in networks across our sites and more widely**

  We need to be far better at organising and simplifying the acute and emergency care system and network arrangements. Our proposals will achieve both of these, standardising and improving the system and the standards of care.

  The three main acute sites do not consistently meet London quality standards. For example, we know that no site other than the Royal London offers access to emergency interventional radiology in under an hour. Our approach outlines where we need to look across sites and in some cases change configurations to improve arrangements for life- or limb-saving specialist services.

We have prioritised a number of key initiatives to develop strong, sustainable hospitals:

Initiative and the case for change	*Proposals*	*What we will deliver in five years*
Acute care hubs Too many people are admitted to a hospital ward as this is the only way to access rapid medical specialist opinion and tests. This means that patients who do not need 24/7 nursing care sometimes stay in hospital unnecessarily.	Bring together the clinical areas of the hospital that focus on initial assessment, rapid treatment and recovery at each site to work as 'acute care hubs'. This would mean that the majority of patients would be treated without needing to be admitted. Only patients needing 24/7 nursing/medical care would be admitted to a specialist ward.	Fewer patients would need a hospital bed – avoiding unnecessary stays in hospital. More emergency consultant cover and quicker treatment. Improved care for adults, young people and children with physical or mental health problems.
Maternity (increase the proportion of natural births) Over the next 10 years the number of births will increase **–** thousands more births every year. Women report some of the worst experiences of care in London. Too many women don't have real choice of where they have their baby – often giving birth in an obstetric-led ward which place women at higher risk of interventions and operations compared with planned midwife-led births.	Introduce new ways of working that provide more informed choice and promote more natural delivery. We want to ensure women have real continuity of care so they are supported throughout their pregnancy and can have a more natural birth in midwife-led settings.	Women will feel better supported through their pregnancies with an improved experience of care. Better, safer care and a reduction in unnecessary interventions. A third of women choosing to have a midwifery-led birth rather than an obstetric-led birth. The ability to care for women and their babies without having to build additional hospital capacity.
Surgical hubs The quality of surgery could be improved. Too many people stay longer in hospital than necessary. A lack of coordination means that planned surgery sometimes impacts on emergency surgery and vice versa.	Create surgery centres of excellence (hubs). Newham, Royal London and Whipps Cross would each specialise in a number of specialties. This would: - reduce waiting times and the number of patients having to go outside of the area to have surgery - improve emergency and planned surgery	Improved quality of care. Better use of specialist equipment and staff; shorter waiting times for patients; and fewer cancelled operations. Better patient experience, for example a 10% reduction in length of stay for planned admissions.

Many patients are waiting far too long for operations.	- reduce the number of cancelled operations. New pre-operative pathways will deliver care as locally as possible and focus on recovery and long term health improvement.	Better efficiency, for instance theatre utilisation improved by around 12%. Emergency and maternity services, and less complex surgery at each of the three hospitals would be properly supported.

Case study – surgical hubs

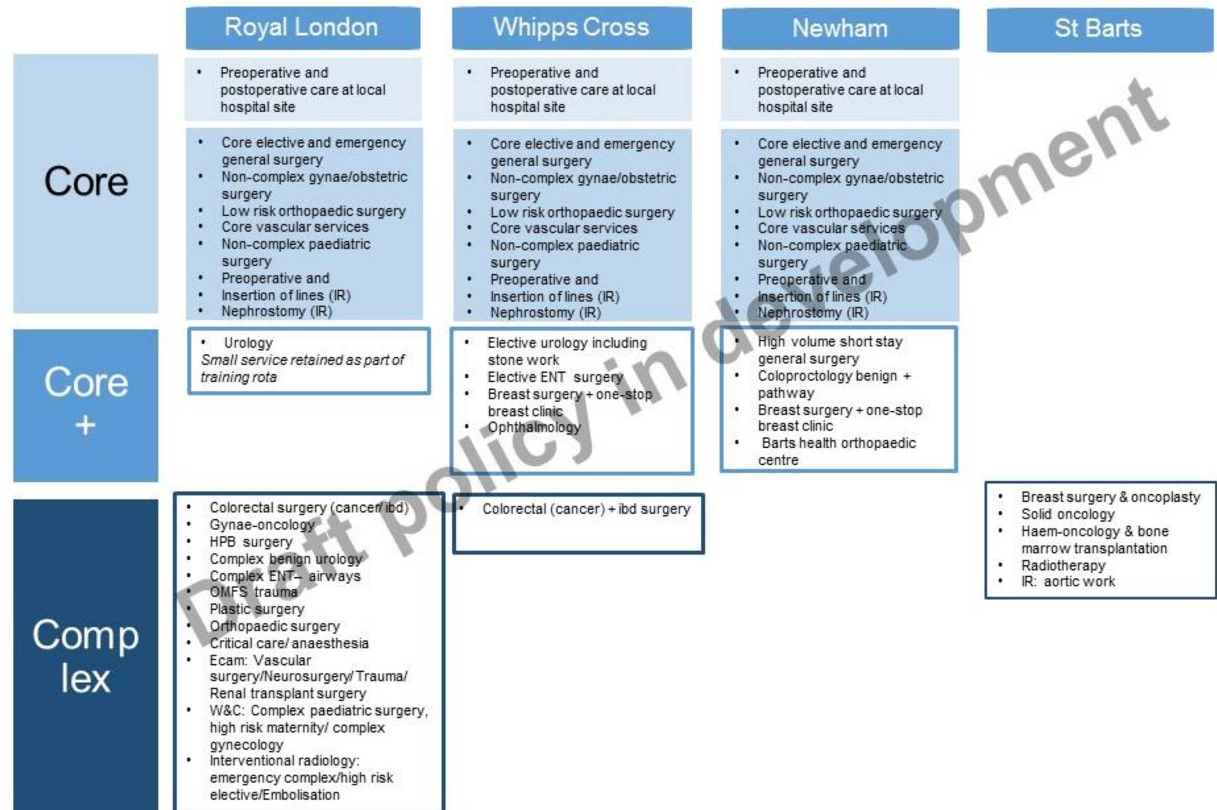
Describing ***surgica****l* services as 'core', 'core plus', and 'complex' provides a way of describing how they could be provided across East London.

'Core' services support emergency, medical and maternity care and should be available on all sites.

'Core plus' services require a degree of specialisation and/or resources. They require a concentration of the specialist workforce and dedicated capacity in order for care to be delivered safely and sustainably.

'Complex' services are required to support the treatment of complex cases, such as complex cancer or trauma. Clinical interdependencies and the input of multiple specialities are crucial to optimise safety and patient outcomes.

Each site would host core services and different combinations of core plus functions. A potential view of what surgical services might look like in East London is shown to the right.



Over the next six months we will test and enhanced this proposal (and other options) through appropriate engagement with the public, staff and local stakeholder groups.

Working across organisations to continually improve care

Many of the initiatives we are taking forward will require organisations to work together more closely than ever before. For example, clinicians from primary, community and secondary care organisations need to work together to agree pathways that speed up patients' diagnosis and treatment. We also need to work together to increase the number of physician associates, and to define strategies for the future of Mile End Hospital and Whipps Cross Hospital.

Two themes are threaded through all our initiatives:

Mental health

- A quarter of the population will suffer from a mental health problem in their life.
- Three quarters of people with mental health problems never receive treatment.
- People with a serious mental health illness die, on average, 20 years earlier than people without mental health problems.

We will prioritise improving services for expectant mothers and their partners; children and adolescents; people in crisis; and people with dementia, whilst we review the whole mental health system and develop a five year strategy.

Children and young people

We recognise that an investment in the health of our children is an investment in the future. A good, healthy start in life is essential if we are to increase life expectancy and the number of healthy years people live. We need to get better at:

- co-ordinating services and joint working. Young people needing healthcare are getting passed between too many people and organisations
- identifying when a child or young person's conditions could be better and more quickly treated in a community setting. There are too many referrals to hospitals
- supporting children and their parents/carers to self-care and access services when necessary.

We will involve children and young people in the design and commissioning of services; we will work with schools, children's centres and youth services which are vital settings for improving health; and we will improve the way young people transition into adult services.

We will redesign children's mental health services to make them less fragmented and work with schools to make sure mental health problems are identified earlier so that young people get the support they need more quickly.

We have prioritised a number of key initiatives to improve the East London health economy:

Initiative and case for change	*Proposals*	*What we will deliver in five years*
Transform the patient pathway and outpatients We are struggling to manage the number of outpatient appointments. However: - up to 20% of referrals to hospitals are not needed - up to 20% of patients do not attend their appointments - the referral process is complicated - the way follow up appointments are arranged can be ineffective – there are often better ways for patients to access specialist advice - we don't always help patients to manage their own conditions.	Redesign the patient pathways for some of the most common: • long-term conditions (for example cardiovascular disease, respiratory disease and type 2 diabetes) • planned care services (for example musculo-skeletal and dermatology). Make better use of technology. Develop new processes for outpatient treatment and follow up, to improve the quality of referrals.	There will be a 20% reduction in hospital-based outpatient appointments as unnecessary ones are not made and alternative ways of meeting patient needs are developed, for example by using phone, email and Skype clinics. Patients will find the system easier to navigate and be better cared for closer to their home.
Reduce unnecessary testing Around a quarter of tests carried out on patients are unnecessary. Some GPs in East London order over 50% more high-cost tests than other GPs. This is wasteful of resources, delays diagnosis and treatment of patients who need tests, and subjects patients to the inconvenience and worry of unnecessary tests.	Standardise processes and reduce unnecessary testing in the community and in hospitals. Consider enabling GPs to refer straight to tests in hospitals (rather than having to wait to see a hospital specialist first). Improve IT to share tests between GPs and hospitals (rather than have the tests repeated).	Patients will not have to attend (and be subjected to) unnecessary tests and appointments. There will be 20% reduction in spend on the top 20 most costly GP-generated tests by 2020/21.
Shared care records There has been significant progress in sharing patient records but there is still:	Better understand what needs to be shared and how it can be made accessible, secure and useful to staff who need it and to patients.	Our shared care record infrastructure will be in place. There will be quicker, more coordinated care.

- a lack of connectivity between all care providers - a need for a more comprehensive system, for example being able to book services through the system, and everyone being able to add information (not just 'read only') - a need to make access intuitive and simple, and to make records up to date and accurate, otherwise health and social care staff will not use them.	Increase the use of shared records. Increase the amount of information available. Increase the number of staff in health and social care organisations who can access shared records. Work with patients to gain their support and consent to view their records.	Patients will not have to keep repeating their 'story' and will be better able to self-care or receive care in their own home. Staff will be able to provide better care as they will have a better understanding of the patient history. We will improve efficiency as we remove our reliance on paper.
Physician associates The area needs an extra 125 GPs in five years and almost 200 in ten years – but there is already a national shortage of GPs. Physician associates can perform a large proportion of a doctor's tasks at a reduced cost – meaning doctors can focus on the patients and illnesses that require their skills.	As well as developing different ways of working and effective ways of recruiting and retaining staff we will introduce more physician associates.	We will have developed the role of physician associate. GPs and other clinicians can spend their time providing high quality healthcare and staff skills will be better aligned with patient needs. This will breathe new life into the workforce, improving staff satisfaction and motivation. Patients will get faster, more effective services.
Mile End hospital The Mile End site offers a range of services from different providers. Barts Health has two acute inpatient wards, but these are separate from the rest of the Royal London site and this makes them difficult to manage and provide high-quality care for patients.	We will continue to provide acute mental health services at Mile End but will seek to change other inpatient services. This would enable Barts and the local health economy to develop a longer term strategy for the site which could include more step-up/step-down facilities, mental health or community service facilities or	A health economy strategy to define the long-term future for the site. Improved efficiencies (for instance reduced clinician travel times and better sharing of facilities). Improved outcomes and patient satisfaction, as clinicians have better

	even sale of underused parts of the site for educational or residential use.	sight of patients, and are able to discharge patients in a timely manner.
Whipps Cross hospital - The buildings are old and require around £80 million just to keep them safe and meeting minimum requirements. - The buildings are not designed to deliver modern healthcare and have been developed in a piecemeal fashion over many years. For instance the maternity unit is not connected to the main site, so emergencies require an ambulance to transport mothers and babies. - Whipps Cross has one of the largest sites in London but is used very inefficiently. It is a wasted resource.	We will work with partners across health and social care to develop a robust strategy for the long-term future for the site.	We will have set out a clear strategy, defining the long term future for the site; determined how the transformation will be delivered; and be underway in delivering the changes we need.

5. Finance

The range of expected net savings and costs for each of the 13 initiatives is shown below.

	5-year net savings	
	Upper	Lower
	£m	£m
Care Closer to Home		
Primary Care	34.5	30.7
Urgent Care	5.8	2.5
Integrated Care	6.6	4.2
End of Life Care	3.4	1.6
	50.3	39.0
Strong Sustainable Hospitals		
Acute Care Hubs	35.7	22.6
Surgical Hubs, incl. IR	4.3	0.0
Normalising births	(13.8)	(14.1)
	26.3	8.6
Cross cutting themes		
Pathway redesign	82.4	64.9
Reduce unnecessary testing	25.5	20.7
Shared Care Records	(11.1)	(12.3)
Physician Associates	(3.2)	(11.5)
Mile End Hospital	-	-
Whipps Cross Hospital	(5.1)	(5.1)
	88.4	56.8
Net TST programme impact	**164.9**	**104.4**

By year five the annual saving is £48 million.

6. The health economy

Whilst TST initiatives will go a long way towards solving the big strategic challenges we face, there are a number of other initiatives that need to be delivered in partnership if we are to transform the health of our population and the health and social care system. For instance:

- better prevention of illness – with local authorities and Public Health England
- delivery of other savings. Even if the health and social care economy can achieve the improvements and efficiencies detailed here by 2021 there will still be an historic deficit which will require external investment, as will any rebuilding of Whipps Cross
- delivering changes to other health and social care services, for example specialist services.

7. Next steps

Success in these initiatives will be dependent on the continuation of the strong working relationships we have developed over the past year with all key partners.

Our greatest challenge is in how we develop the enthusiasm, collective responsibility, and clear, achievable plans to implement the solutions that we know people need. From February to May 2016 we will:

- engage with staff, stakeholders, patients and the public to test these proposals
- further develop our ideas and collate any further data that is required
- develop implementation plans with a phased and prioritised programme of change. This will include working on: the interdependencies of the Care Quality Commission improvement plan at Barts Health; the interdependencies between the different workstreams, including IT, estates and workforce; and funding mechanisms/incentives
- assess the impact of our proposals on travel, the environment and equalities
- strengthen the leadership and capability to support the next phase of the programme
- agree how we can measure, monitor and support progress towards the objectives.

We recognise that the content of some of our proposals may have to change, or that external pressures and circumstances will require a refresh of our thinking. It is certain that not every proposal will be able to be developed in the way we describe. The strategy will need to be continually monitored and reviewed as challenges and opportunities present themselves. However we are clear that not taking action now would be catastrophic for the health economy. We believe that the strategy sets the health economy on a path to deliver the changes that are needed to achieve clinical and financial sustainability.

Questionnaire

Questions

We welcome your comments on any aspect of our proposals. However you may wish to think particularly about:

1. **Overall strategy and scope.** Do you think the overall strategy is right? Do the strategy and initiatives focus on where there is most need? Is there anything missing? Are there are proposals you think are not necessary?

2. **The specifics.** Do you agree or disagree with the proposals?

3. **General comments about these proposals**

4. **Comments about the NHS in general**

About you

We would find it useful if you could answer the questions below so we can see what sorts of people are responding and whether they think differently from other groups. We also want to know if any groups are not represented in the responses to this survey.

Name:
You don't have to give us your name if you don't want to and we will still take your views.

Would you like to be kept up to date with information about this engagement?
Yes / No

If yes, please give us your email or postal address (please note that your email and / or postal address will only be used to keep you up to date on this engagement exercise and will not be used for any other purposes)

Gender:
Male / Female / Other / Prefer not to say

How old are you?
Under 16 / 16-25 / 26-40 / 41-65 / 66-74 /75 or over / prefer not to say

Do you consider yourself to have a disability?
Yes/ No / Prefer not to say

Do you identify as:
Heterosexual / homosexual / other / prefer not to say

What is your ethnic background?
White: White British/White Irish/Any other white background Mixed: White and Black African/White and Black Caribbean/White and Asian/Any other mixed background
Asian: Asian British/Indian/Bangladeshi/Pakistani/Chinese/Any other Asian background
Black: Black British/ Black African/Black Caribbean/Any other Black background
Any other ethnic group: Prefer not to say

Which belief or religion, if any, do you most identify with?
Agnosticism / Atheism / Buddhism / Christianity / Hinduism / Islam / Judaism / Sikhism / Other /
Prefer not to say

Thank you for your time

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TST overarching communications and engagement strategy and plan

(Approved at TST, CCG and Barts Health Boards in Jan/Feb 2016)

January to May 2016

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1. Aims and objectives

This communications and engagement plan sets out how Newham, Tower Hamlets, Waltham Forest and neighbouring CCGs, supported by NEL CSU and working with Barts Health NHS Trust, other providers, local authorities and NHS England aim to engage and communicate effectively with patients, the public and relevant stakeholders about transforming healthcare services in east London. Engagement activities will involve local people and stakeholders, particularly those likely to have an interest in these services so that:

- Staff, patients, the public and stakeholders:
  - have the opportunity to make their views known
  - are clear about any proposed changes
  - are positive about the changes
  - are not unnecessarily worried about the changes
  - can ‘sign up to’ engaging in the future
- The CCGs meet their legal/statutory obligations.

We want meaningful engagement with local people and other stakeholders. We will know that we have achieved this if people:

- feel informed and listened to
- have given their views
- provide feedback that improves the development of the service
- support the changes.

All communications and engagement will be planned, clear and informative so that stakeholders are reassured and their needs are managed.

2. Statutory responsibilities

Newham, Tower Hamlets and Waltham Forest CCGs (the CCGs) have been responsible for engaging with stakeholders to ensure their views help shape any changes.

The CCGs are also responsible for ensuring that public involvement is carried out properly (as outlined in section 14Z2 of The NHS Act 2006, as amended). NHS England's guidance: *Planning and delivering service changes for patients* (December 2013) is also relevant.

The CCGs will be supported by NEL CSU to plan and deliver:

- **Phase one:** Communications and engagement activities in the period following the publication of the Strategy and Investment Case (SIC) including analysis of feedback from engagement
- **Phase two:** Any required consultation(s) on significant changes arising from the SIC. This will potentially be based on proposals for significant surgery changes, Whipps Cross and Mile End hospitals later in 2016 or in 2017.

The CCGs' governing bodies are responsible for decision-making regarding the engagement.

3. Challenges and opportunities

The key communications challenges, opportunities and risks include:

Challenge / opportunity / risk	Proposed plan
• **Engage staff** in this transformational change – some may see this as another reorganisation, when many of them are already de-motivated (see CQC report).	• Clear internal communication and engagement of leaders and change leaders. • Work with the OD programme and Barts Health. Aim for similar integration and alignment in primary care, integrated care etc.
• Ensure the engagement provides the partners with the **legal authority** to make changes when consultation is not required.	• Develop a clear communications action plan, agree with key partners; ensure communications is seen as central and critical to the success of the programme and aligned with workstreams. • Discuss with the inner north east London Joint Overview and Scrutiny Committee (JOSC) and the outer north east London JOSC so there is a unified scrutiny arrangement and/or a unified view.
• **Ensure changes are not viewed as downgrading by managing public perceptions but are seen as positively taking the NHS forward.**	• Ensure proposals are discussed and agreed by staff (who have considerable influence on public opinion) and Boards

	• Build trust in the NHS; putting clinicians (especially) and managers in front of the public to explain the proposals • Build on the relationships we have in place with our local NHS (members of the Transforming Services Together programme meet regularly with CCG, Barts Health and other colleagues). • Develop lines to describe the benefits for each hospital (and the group of hospitals). Whilst this is a strategic plan, we cannot ignore the fact that the public are interested in *their* local hospital.
• **Positively engage with the section of public and stakeholders** who are negatively predisposed as they have: o seen reconfigurations (Fit for the Future, Health for NEL) leading to consultation fatigue and lack of belief that things will change o seen criticism of existing NHS services (e.g. CQC reports – so they lack trust in the NHS to make good decisions/changes) o fixed views on finances, PFI, privatisation etc (e.g. 38 degrees, Save our NHS).	• Build leadership and change leaders. • Make it clear how change is (and must be) continuous and that proposals build on previous (successful) work. • Explain that TST is part of the solution to the problems. • Recognise failings where they are clear but correct inaccurate criticism. • Brief stakeholders and ensure we understand their aims / objectives. How do we give them what they want? • Recognise that some critics will not change their mind. But we should not distance them from the programme, rather we need to listen to the issues to take them into consideration, amend our plans if necessary, and build a community of supporters around them.
• Manage the **political sensitivities.** E.g. ensure that any proposals are not used as a political football – particularly given the London elections in May.	• It is essential that we engage on the issues and options that are possible. Including all stakeholders in the planning process.

4. Key messages – case for change

We want to make a difference in east London and:

- address inequalities. Many of our residents receive excellent care, but the quality and availability of some of our services could be improved. The health of some of our residents is poor, with life expectancy in some parts of east London significantly lower than the England average.
- help patients to be in control of their own health and lead longer, healthier lives.

We have a huge challenge in east London and must plan ahead to address it.

- Our population is growing and in 15 years it is estimated we will have an additional 270,000 residents – equivalent to another London borough or a city the size of Southampton. If we carry on as we are, the East London organisations will be around £400 million in debt and would need a further 550 hospital beds – the equivalent to another hospital. This would be unaffordable to build and run.
- When we published our Case for Change in July 2014, we said that emergency and maternity services would be retained on each of the three main Barts Health sites. Since that time we have established that we face the opposite challenge. We need to maintain these services on each site, and cope with the anticipated increase in healthcare needs – but without having to build a new hospital.
- Health and social care budgets are being squeezed.
- We are struggling to recruit and retain the numbers of staff we need while many staff, particularly in primary care are nearing or past retirement age.
- Some of our buildings and IT are not fit for purpose – Whipps Cross needs more than £80 million of capital investment as a minimum. Much of the primary care estate is also unsuitable for the safe delivery of healthcare.
- CCG finances are currently in balance, but Barts has the largest deficit in the NHS.

This is not the start of the process; there is lots of work already underway to improve healthcare services

- Improvements put in place at Barts Health mean it has one of the lowest mortality rates in the UK (4th lowest). For example, performance in stroke and major trauma care are exceptional - these changes are saving lives.
- Over the past three years, £21 million has been invested in the Whipps Cross estate and we have some of the most modern and high-tech facilities e.g. the Sir Ludwig Guttmann Health & Wellbeing Centre or The Centre (Manor Park) in Newham.
- Integrated care is being provided to thousands of residents across east London, putting them more in control of their health and reducing admissions to hospital
- Our IT systems are getting better and more connected. For example, more hospital clinicians in Barts Health are able to see primary health records, and vice versa, resulting in a quicker and more streamlined service for patients.

5. Key messages – our proposals

The TST programme offers the opportunity to develop solutions:

- locally where necessary (but sharing learning and resources)
- in partnership with different organisations
- once across the three boroughs, where it is efficient and effective to do so.

Taken together, the changes would transform health and care in East London. In particular we need to focus on changing the social culture of over-reliance on medical services.

Care closer to home

- More **integrated care** for more people at risk of going into hospital, so that they can be cared for at home and stay out of hospital.
- A simplified and integrated **urgent care** system, so that people don't always turn up to emergency departments. We need to integrate NHS 111 with the urgent care system so patients can get advice, get a prescription, book an urgent or planned appointment with their GP – a one stop shop.
- Earlier identification of the need for **end of life care**, supported conversations and recording and sharing preferences. To enable this there needs to be shared care plans and enhanced community and palliative services delivered by better partnership working across the health, social care and voluntary sector.
- Making **primary care** more accessible; more proactive – helping people to take control of their own health and to be healthier; and more coordinated (with joined up IT systems so that care givers can provide better, quicker advice and services often in the same building). To do this we need fewer smaller GP practices. GP practices in the future should have list sizes over 10,000, or if they are smaller, work together in integrated provider networks, or on the same site as other practices.

Strong sustainable hospitals

We need three strong and sustainable hospitals providing emergency and acute care for our growing populations. Each needs a well-functioning emergency department and in the future, they will need to work more closely together and provide different services. We need to address the belief that having all services at a local hospital is a necessary 'security blanket'.

- Develop **surgery centres of excellence (surgical hubs)** at each of Newham hospital, Whipps Cross hospital and The Royal London. This would a) support the viability of these hospitals b) release capacity at Royal London, which is over-capacity c) provide a better patient experience (and outcomes), reducing cancellations and waiting times. Pre-operative and post-operative care would be at the patient's local hospital.
- Develop **acute care hubs** at each hospital site (Newham, Whipps Cross and The Royal London), bringing together more specialists and test facilities to the front door of hospitals so that patients can be diagnosed and treated more quickly and fewer patients will need to be admitted to a hospital ward.

- Provide more choice and continuity of care to **increase the proportion of natural births** (for instance in midwife-led settings). This will help us to cope with the expected 5,000 more births a year across north east London in the next 10 years.

Working across organisations

- Reduce the number of hospital-based **outpatient appointments** by improving the quality of referrals and improving Skype, telephone and other access.
- **Reduce unnecessary testing and sharing care records.** Consider GPs being able to directly refer patients for hospital tests (rather than to a hospital consultant who then does the referral) and at the same time, investigate why some GPs refer far more people for high-cost tests than other GPs.
- Develop new roles, different ways of working and effective ways of recruiting and retaining staff. For example, we will **introduce more physician associates**, health coaches and other roles who will be able to take on much of the day to day work of a GP. This will free up GPs (who are in short supply) to concentrate their expertise where it is needed most.
- Develop a strategy for making better use of **Mile End Hospital**. This could include more step-up/step-down facilities, mental health or community service facilities or even sale of underused parts of the site for educational or residential use
- Develop a strategy with partners, for the long-term future of **Whipps Cross.**
- We must improve the health, life expectancy and **care of people with mental health difficulties**, particularly focusing on rapid treatment early in life when the majority of symptoms first appear.
- We will work with schools, children's centres and youth services which are vital settings for improving the **health of young people**; and we will improve the way young people transition into adult services. We will redesign children's mental health services to make them less fragmented and work with schools to make sure mental health problems are identified earlier, leading to young people getting the support they need more quickly.

The expected outcomes

The combined impact of these initiatives, if they are all delivered through a coordinated, integrated delivery plan over the next five years, alongside productivity improvements, will be:

- a significant increase in activity being delivered closer to home, in more efficient care settings
- a healthier population, and patients who experience better care
- a workforce that is more appropriate for delivery of efficient and effective modern healthcare; staff who better understand their role, who feel supported and who are enthused about their job, healthcare and the NHS
- that hospitals are able to relieve the existing pressure on beds; can cope with the increase in population and long term conditions; and help to reduce waiting times, or create opportunities for new income streams
- improvements in the clinical quality of services and the physical and mental health of the whole population. We expect these proposals to directly support the Safe and

Compassionate improvement programme and the transition of Barts Health out of special measures

- net savings from the TST programme of between £104 million and £165 million over five years to 2020/21. The expected annual recurrent net saving by 2020/21 is £48 million. The most likely position if we deliver the changes described in this document; internal cost improvement programmes (CIPs); and quality, innovation, productivity and prevention (QIPP) programmes, is one of overall health economy balance with some organisations being in surplus and some in deficit.
- a significant reduction in the capital spend required. The TST programme proposes a budget for buildings and infrastructure of £72 million by 2021 (excluding essential estates and IT works), but the requirement if TST is not put into action is £250 million.

TST key messages on a page

Transforming Services Together is a joint agreement between Clinical Commissioning Groups (CCGs) in Newham, Tower Hamlets and Waltham Forest and our main local hospital trust Barts Health, to invest over £100 million in new health services and buildings over the next five years

1. We need to help people take responsibility for their own health, managing their health and illnesses better and to use health services appropriately
2. We are expecting 270,000 more people in our three boroughs. People will live longer. Drugs and treatments will get more expensive. We already struggle to recruit staff.
3. We need to strengthen our three main hospitals (Royal London, Whipps Cross and Newham). For instance, centres of excellence on each site will improve surgery. Acute hubs will reduce the number of people unnecessarily admitted to hospital and reduce the time patients are in hospital. Both these initiatives will strengthen the existing A&Es and maternity units
4. We will develop joined up services closer to people's homes. For instance, we will improve our sharing of records between different parts of the NHS, integrate care between different organisations and reduce unnecessary testing. There will be fewer small GP practices or they will work in networks or on sites with other practices so that they can offer better access, more services to help people manage their health better and to reduce costs.
5. We will work together to: develop services and plans for developing Whipps Cross and Mile End hospitals; develop new roles to meet the workforce challenges together (e.g. physician associates); and develop our IT
6. Our plan aims to save around £300 million over five years and around £800 million over ten years

These services will need to benefit the whole community, reduce health inequalities and address mental health, as well as physical health problems.

Our strategy

Our strategy aims to:

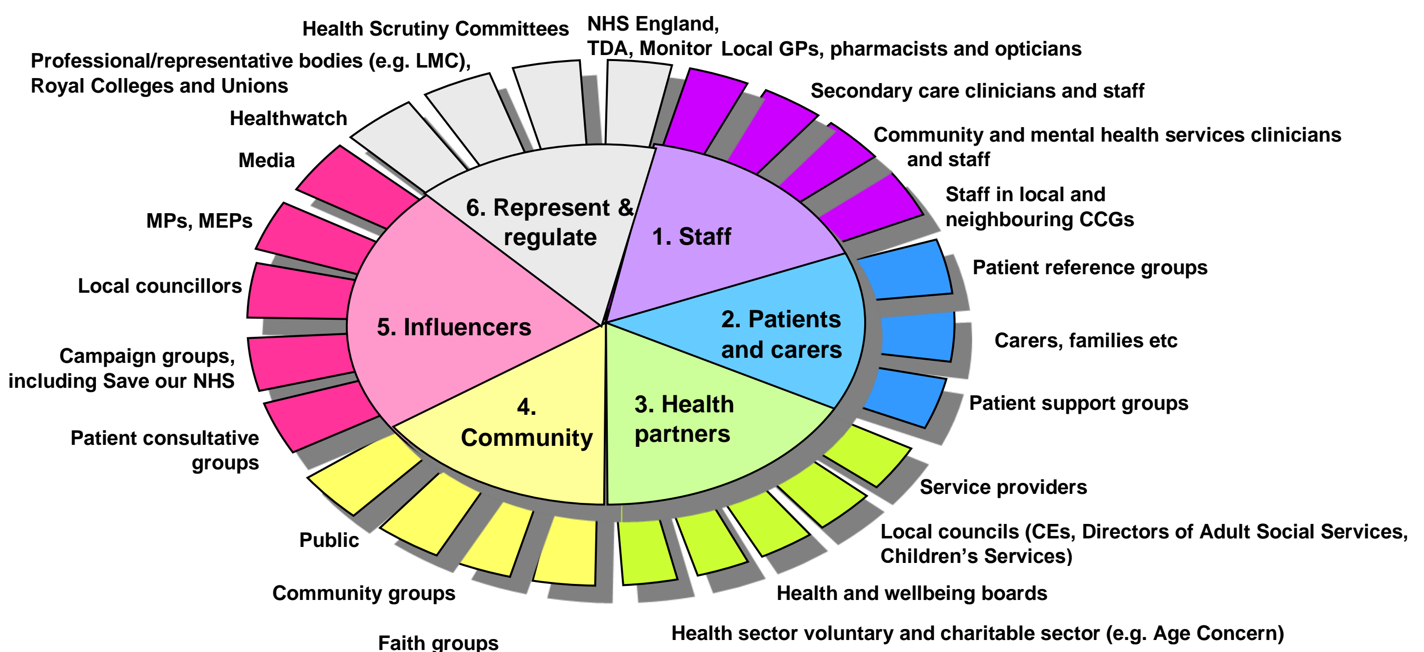
- embrace and support the health and wellbeing strategies of each borough;
- promote health and well-being by developing the knowledge, skills and confidence to self-manage through collaborative care and support planning
- change the culture of how we commission and deliver care and support a learning healthcare system
- increase involvement of patients and carers in co-production and decision-making
- maximise the use of the significant assets in our communities and voluntary sectors
- commission services in fit-for-purpose settings of care, often closer to home

- help people to stay healthier and manage illnesses; to access high quality, appropriate care earlier and more easily
- focus some specialisms in fewer locations to improve patient outcomes and experiences and drive up efficiencies
- value the importance of continuity and therapeutic relationships, acknowledging the importance of supporting people's mental health and well-being needs
- ensure the system can respond to the changing demands on our services that we have predicted as part of our *Case for Change*
- help set our finances on a path of sustainability in a challenging environment.

6. Stakeholders

There are a number of people and organisations who/which are involved, or interested in proposed changes to healthcare services in east London. They key external and internal audiences include:

- NHS England
- Neighbouring CCGs - in particular, City and Hackney, Barking and Dagenham, Havering, Redbridge and where appropriate, north central London CCGs
- NEL Commissioning Support Unit
- Homerton University Hospital NHS Trust
- East London NHS Foundation Trust
- North East London NHS Foundation Trust
- Third sector organisations
- Local authorities and public health teams; City of London; London boroughs of Hackney; Newham; Tower Hamlets; Waltham Forest; Redbridge; Barking and Dagenham; and Havering.



7. Our engagement strategy

- We are not consulting, we are engaging
- We are not asking permission to implement these programmes of work (except where the proposals is so new as to be a change in service), we are testing them, and asking for views on implementation. We should also be asking people to get involved in future work
- The breadth of TST means that there is a very limited number of people who will be interested in all aspects of the programme. Therefore **the majority of engagement will be at a local level about specific proposals** (initiatives) about what is important to local communities.

Responsibilities

TST programme communications

- Overarching key messages and collateral to introduce TST
- Establishment of communications framework (e.g. this strategy and plan)
- Coordination of three borough stakeholder meetings (e.g. JOSCs) and where a coordinated approach would add consistency and economy e.g. LMCs
- Establishment and coordination of methods of collation
- Facilitation of PPRG

TST programme (clusters and workstreams)

- Develop an engagement plan
- Develop cluster/workstream collateral to explain concepts and gain appropriate engagement
- Work with key stakeholders, staff, members of the public and patients to test and develop the proposals. This could be through focus groups, workshops or established groups

CCG communications teams

- Develop local collateral to explain how TST fits in with local plans
- Work with TST programme project managers to develop a locally appropriate engagement plan that dovetails with existing local engagement and meetings

Barts Health communications team

- Work with any/all of the above, to develop and deliver an engagement plan to staff
- Work with any/all of the above to assist in providing clinicians to speak at various forums

8. Alignment with other strategies / policies / issues

a) This communications and engagement strategy will need to align closely with the **organisational development and clinical leadership strategy**, to ensure the impact of both strategies is maximised

   An example of how this could work in practice is that the organisational development and clinical leadership strategy will need to take ownership of the programme to ensure it is delivered and implemented effectively. This will help to meet the aim of engaging CCG and Barts Health staff in the programme.

b) This implementation of this strategy will need to align with the **communications and engagement strategies of Newham, Tower Hamlets and Waltham Forest CCGs**.

c) All three CCGs (Newham, Tower Hamlets and Waltham Forest) have been approved to take on **fully delegated commissioning of local GP services**. The three CCGs have agreed to work together and will be developing a joint advisory board to oversee commissioning decisions. This should provide opportunities to better integrate care across the whole east London population – but will need to be explained.

d) **CQC inspections of Barts Health**. The trust is in special measures. The essential focus on these immediate issues may detract and/or complicate the focus on TST. The messaging has been (and continues to be) that TST addresses some of the underlying problems in the system and therefore has to be seen as part of the long term solution. It will also be important to highlight the positive aspects of Barts' care e.g. low mortality rates; some of the best stroke and major trauma care in the world; the Barts Heart Centre. Maintaining staff morale will be critical to the success of the trust and to the programme as a whole.

9. Our engagement plan

- The Strategy and Investment Case (SIC) was approved at the CCG governing body meetings in Tower Hamlets (26 January), Waltham Forest (27 January) and Newham (10 February); and at the Barts Health board on 3 February.
- The engagement will run for 12 weeks (29 February to midnight 22 May 2016).
- There are three documents:
  - Part 1: a summary to be tested with the Patient and Public Reference Group
  - Part 2: the main report
  - Part 3: the detail of the proposed high impact initiatives

We have already received feedback as the document has been drafted. Once the full document is publically available we will continue to invite comments from interested parties.

By engaging with stakeholders, we will be able to ensure commissioning decisions take into account public, patient and clinical views to ensure a safe service and excellent patient experience.

All engagement will build on links and relationships developed during previous engagement programmes (in particular Transforming Services, Changing Lives Case for Change (2014)).

Activity

The engagement plan includes:

- Drop-in sessions in each hospital
- A range of meetings / workshops and focus groups in each borough with staff, community and patient groups and representatives, and public to ask for their views.
- Media releases and adverts to be placed in the local press
- Offer of attending Overview and Scrutiny Committee meetings in each borough
- Offer to meet with Healthwatch, LMC and other stakeholders in each borough
- Monthly meetings with the Patient and Public Reference Group (PPRG)
- Production of a newsletter providing monthly updates on the programme
- Mail outs to interested parties asking for their views and the offer of a meeting (and requesting organisations mail out to their stakeholders e.g. council databases)

Collateral

A number of materials will be available throughout the engagement process to inform the public about the programme. These will include this engagement plan and:

- The Strategy and Investment Case
  - Part 1 – the summary
  - Part 2 – the main document
  - Part 3 – detail of the high impact initiatives
- Core presentation
- Advertisements and media releases
- Website and newsletters
- Questionnaire (on website and in the summary version to encourage feedback)
- Posters/banners for patient/public areas.

10. The high-level questions

We welcome your comments on any aspect of our proposals. However you may wish to think particularly about:

1. **Our strategy**	Prompts: Have we correctly set out the challenges? Is our overall strategy right? Are there issues we have not addressed well enough or at all?
2. Our investment case	Prompts: We plan to spend about £140 million over the next five years. We think this will help us meet the challenge of population growth and growing demand, make significant improvements and save the NHS around £300 million. Is this the right level of investment? Should we be more or less ambitious? Are our proposals achievable? Are any of them unnecessary?
3. The 13 high-impact initiatives	Prompts: Will these initiatives focus on the biggest challenges or on where they will make the biggest improvements? What issues should we bear in mind if we take them forward in their current format?
4. Do you have any other comments?	

Group	Engagement	Objectives	Responsibilities	Timescale
1. Staff	CCG engagement: • The CCGs and the three chief officers will lead on the engagement in each borough. This will include updates at staff meetings and briefings in staff newsletters and other internal communication channels.	To hear staff views Ensure a sense of ownership in each CCG about the TST programme so the proposals can be taken forward	CCG/TST/Comms	Ongoing
	• Ensure any engagement that is already happening locally in the CCGs is aligned to the TST strategy. This will be achieved through regular contact with the communications and other staff at the CCGs.	Ensure staff feel they have been involved in the programme and that TST is not just 'another thing'	CCG/Comms	Ongoing
	• Some of the changes will increase activity in primary care (e.g. moving some hospital appointments for patients with long-term conditions into primary care, where appropriate and where it will benefit the patient). The changes will occur at a time when primary care staff are already feeling overworked and demoralised. We will attend LMC meetings in each CCG area to engage with GPs	Develop NHS staff as potential ambassadors and drivers for change Help staff understand the impact of the proposals and allay fears they may have fears about the their jobs and understand the benefits for their future careers	GPs/TST/Comms	Ongoing
	Barts Health engagement: • Communicating with Barts Health staff is the responsibility of the trust; however the TST programme needs to work closely with communications and other staff at	Ensure a sense of ownership within the Trust about the TST programme so the	BH/TST/Comms	Ongoing

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	Barts Health to ensure their staff are informed about the programme and have the opportunity to engage. This will include providing materials and information for use within their internal channels, and working with them to arrange events and briefings. • Drop-in sessions will be held at each hospital site to inform staff, patients and carers about the programme	proposals can be taken forward Ensure staff feel they have been involved in the programme and that TST is not just 'another thing' Allay fears staff may have about the their jobs and understand the benefits for their future careers Align key message with BH's safe and compassionate plan	BH/TST/Comms	During engagement process
2. Patients and carers	• Regular meetings of the TST patient and public reference group (PPRG) • Drop- in sessions at each hospital site to inform patients and carers about the programme • Drop-in sessions in each borough. These will be hosted by staff and clinicians involved in the TST programme and will be an opportunity for the public to have their questions	Hear the views of patients and carers Emphasise the message that this is not another NHS case of 'change for change's sake' Allay fears over potential extra travel to different sites for treatment Provide reassurance of the NHS commitment to clinical quality and patient care Help prevent ill health and improve the health of residents	TST/Comms BH/TST/Comms CCG/TST/Comms	Every month During engagement process During engagement process

3. Health Partners (local authorities, health and wellbeing board, charity and voluntary sectors)	• Regular updates through meetings and other communication channels • Attendance at key events	Ensure any impact on health partners are fully explored Utilise specialist knowledge of issues and opportunities Ensure synergy with partners' developments and announcements	Comms/TST Comms/TST	Ongoing Throughout engagement process
4. Community	• Drop-in sessions for the public. These will be hosted by staff and clinicians involved in the TST programme and will be an opportunity for the public to have their questions answered. One session will be held in each of the three boroughs and at each Barts Health site	Encourage members of the public to attend events to understand their needs Build trust in the NHS as effective caretakers of the health of the local population	TST/Comms	Throughout engagement process
	• Workstreams and additional events and workshops as necessary which will be focused on particular areas of the programme	Help the public understand how the NHS works and the different services on offer	TST/Comms	Throughout engagement process
	• Newsletter – several editions of a newsletter have been produced which provides updates on the TST programme. This will continue throughout the engagement process	Understand the needs of the residents	Comms	Monthly
	• Take out adverts in local papers • Website – the website http://www.transformingservices.org.uk/	Ensure their views are listened to	Comms	Start and end of engagement process

	will be updated and continue to be a source of information for anyone with an interest in the TST programme • Literature and posters to be mailed out to Healthwatch and other stakeholders asking them to distribute and advertise in public areas • Media release to inform members of the public • Provide updates to CCG meetings with the public		Comms Comms Comms CCG/Comms	29 February Start and throughout Throughout (see below) Ongoing
5. Influencers (media, Mayor's office and London Assembly members, borough councillors)	• Adverts will be taken out in local papers • A reactive statement will be agreed to respond to any questions on publication of the SIC on 20 January 2016 • A further, proactive release will be prepared which will outline the programme and the engagement in more detail • Another proactive release (half way through the engagement) will encourage people to get involved • A final media release will be issued immediately following the closure of the	Ensure their views are listened to Facilitate them into providing reliable information to their readers/constituents	Comms Comms Comms Comms Comms	29 February 20 January 2016 29 February Half way through engagement process End of engagement process

	engagement period • Documents will be emailed to MPs and we will offer to meet with them to discuss further • Meetings with campaign groups such as Save our NHS • Details of the programme will be emailed to voluntary organisations and charities and we will offer to meet with them		Comms TST/Comms TST/Comms	29 May Throughout engagement process Throughout engagement process
6. Represent and regulate	• Attend meetings with the LMCs, NHS England, Royal Colleges, scrutiny committees and Healthwatch	Provide information as required under the NHS Act (OSCs) Receive independent endorsement for proposals and provide reassurance for relevant audiences Receive critical challenge and objective examination	TST/Comms	Throughout engagement process

11. FAQs

Q: Is this about closing hospitals?

A: No. Closing hospitals can save money and improve the quality of services but in East London, because of the expected extra 270,000 people, this would not be appropriate. Nor would opening a new hospital. We need to live within our means and reduce our reliance on hospital-based care.

Q: Will the Transforming Services Together programme solve the funding gap in this area?

A: Not completely – but it would play an important part in restoring balance.

Q: Will people have to travel further if you are proposing to consolidate some surgery?

A: Some people may have to travel further for their operation. However pre and post-operative assessments would mainly be done at the patient's local hospital. The proposals would reduce the number of cancelled operations and bring many services (such as outpatient) closer to home. So for most patients there will be a reduction in the need to travel. Patients would also benefit from shorter waiting times for surgery and improved outcomes.

12. Timeline

The engagement process will begin on the 29th February and last for 12 weeks. Analysis of the engagement period will then be incorporated into an engagement report for 17th June.

13. Risks and mitigations

Risk	Mitigation
1. Any proposed service moves from one hospital to another will be seen as 'downgrading'	• Lines to take will be developed to make it clear that all moves strengthen the offer at each site
2. Not all decision-makers fully understand the requirements for engagement and consultation, so services are changed prior to approval	• NEL CSU communications team attend programme meetings to advise decision-makers and others (as appropriate) on legislation, guidance and best practice in relation to service change
3. Everything focuses on small contentious changes when most of the programme is about being more efficient; making small-scale changes to streamline services and improve patient care	• Develop narrative around the smaller scale changes (such as new protocols) and the benefits they will bring, and emphasise in all communications to stakeholders

4. Impact of Barts Health being put into special measures, following publication of the CQC report on Whipps Cross Hospital. The need to address immediate issues may detract from the longer-term vision	• Continue to emphasise that action to address the immediate issues is crucial, but so is developing the longer term strategy, as this will address some of the root causes of the current challenges.
5. That ONEL/INEL JOSC do not support the proposals	• Send the documentation and plans to the JOSCs prior to engagement asking for comment; offer to meet with chairs and/or committees in advance; offer to meet with committees during the engagement
6. Risk of loss of momentum	• Ensure ownership of programme through engagement and getting staff members to present/discuss at every opportunity

As phase two of this programme may involve consultation on service changes, it is important to be mindful of the reasons why proposals for health service change in England are contested. The Independent Reconfiguration Panel advises that one of the most common reasons why proposals are referred is:

8. Health agencies caught on the back foot about the three issues most likely to excite local opinion – money, transport and emergency care	• The financial implications will be clearly laid out • The clinical workstreams are asked to consider implications for travel in their impact analysis • There is an urgent and emergency care coordination workstream in place. There is clear consensus within this group that emergency care needs to be retained on all sites.

14. Evaluation

The success of the formal engagement will be measured by:

- Meeting milestones and adherence to action plan
- Key stakeholders (including patients) are aware and understand the issues
- Respondents' views on quality of proposals and of the process
- Relevance of views expressed and the improvements made on the proposals
- Processes are sound and do not allow successful legal/quasi-legal challenge.

These align with the aims and objectives outlined in part 2 of the Strategy and Investment Case.

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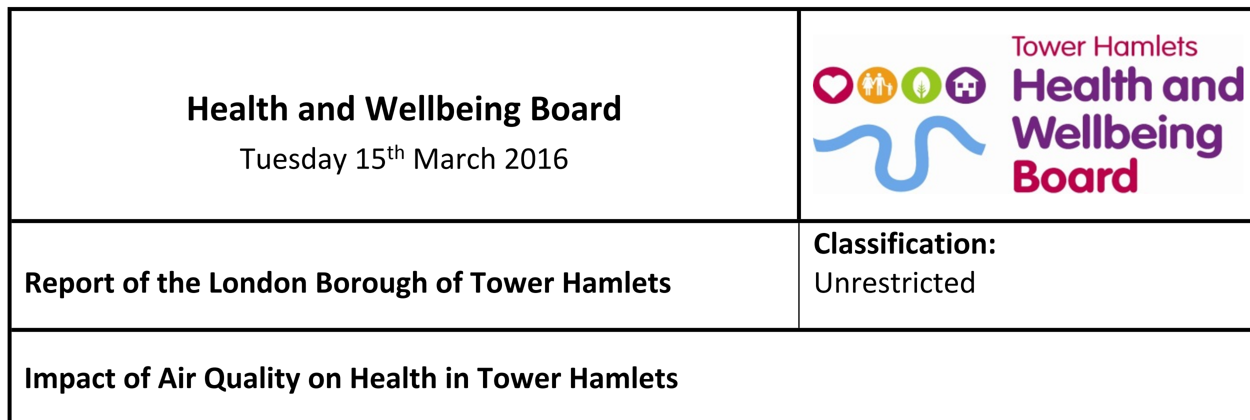

Health and Wellbeing Board Tuesday 15th March 2016	
Report of the London Borough of Tower Hamlets	**Classification:** Unrestricted
Impact of Air Quality on Health in Tower Hamlets	

Lead Officer	Somen Banerjee, Director of Public Health
Contact Officers	Tim Madelin, Senior Public Health Strategist, Healthy Environments and Communities Esther Trenchard-Mabere, Associate Director of Public Health
Executive Key Decision?	Yes

Summary

Air pollution has a significant negative impact on health with effects ranging from worsening respiratory symptoms and poorer quality of life, to premature deaths, from cardiovascular and respiratory diseases.[i] A recent report also suggests links between air quality and diabetes, obesity, and changes linked to dementia[ii]. In Tower Hamlets 7.4% of all deaths in people over 30 are attributable to particulate air pollution.[iii] Air pollution contributes to widening health inequalities as levels of particulate matter and NO2 are higher on the most heavily trafficked roads which are used more by disadvantaged people as places where they live, work and shop.

Professor Chris Griffiths, Centre for Primary Care and Public Health, Queen Mary University of London (QMUL) and colleagues will give a presentation at the Board meeting on the findings from a long term study of children in East London (including Tower Hamlets) which shows evidence of reduced lung volume in school children related to long term exposure to traffic pollutants consistent with impaired lung growth.

Tower Hamlets is currently implementing a range of measures arising from the borough's Air Quality Action Plan (AQAP) to demonstrate compliance with the UK Air Quality Strategy 2010. Tower Hamlets is exceeding the limit values contained within the European Union's Ambient Air Quality Directive (2008/50/EC) and therefore is required to implement measures to reduce air pollution. These measures consist of a range of consultation processes, monitoring, enforcement and projects including;

- BARTS Health Project
- Zero Emissions Network Project; and
- Tower Bridge Anti-Idling Project
- Neighbourhood Pathfinder project based around Marner Primary School

However the evidence of the impact or poor air quality on the health of our local population warrants greater priority being given to measures to improve air quality and mitigate the

impacts on health and wellbeing.

Recommendations

The Health & Wellbeing Board is recommended to:

1. Note the outcome of the research presented and the general impact on health and wellbeing from poor air quality.
2. Review and prioritise the following actions that could be undertaken at a local level to reduce the impact of poor air quality on health
   - Move towards replacement of LBTH fleet with electric vehicles
   - Put in requirements when procuring new contracts for suppliers to purchase electric vehicles when replacing or purchasing vehicles
   - Extend No Parking Zones around schools – could be piloted with schools where the Head Teacher is willing to support
   - Expand safe routes to school initiative to include air quality considerations
   - Agree criteria for requiring more new developments to be car free
   - Agree planning standards e.g. ventilation requirements for developments proposed to be build adjacent to main roads
   - Promote Electric Car Club and increase the number of electric charging points
   - Measures to promote cycling and walking and decrease car use
   - Improve the enforcement of the low emission zone standards
   - Lobby / negotiate with TFL to reduce through traffic, potentially to close roads during severe poor air quality episodes (60% of emissions due to through traffic)

1. REASONS FOR THE DECISIONS

1.1 To improve air quality so that effect on infant and children's lung growth is reduced and the excess mortality and morbidity rates associated with the current levels of air pollution are reduced. This will help meet the community plan priorities of 'A great place to live' and 'A healthy supportive community.' Air Quality has also been proposed as a priority for the refreshed Health and Wellbeing Strategy.

2. ALTERNATIVE OPTIONS

2.1 Do nothing additional, but continue to meet legal requirements of the UK Air Quality Strategy 2010.

3. DETAILS OF REPORT

3.1 This report is concerned with outdoor air pollution only. Indoor air quality is not covered although the council does have a number of activities such as the decent homes programme and the smoke free initiatives which will improve indoor air quality.

3.2 Tower Hamlets is currently implementing a range of measures contained within the borough's Air Quality Action Plan (AQAP) to demonstrate compliance with the UK Air Quality Strategy 2010. Tower Hamlets is exceeding the limit values contained within the European Union's Ambient Air Quality Directive (2008/50/EC) and therefore is required to implement measures to reduce air pollution. These measures consist of a range of consultation processes, monitoring, enforcement and projects including;

- BARTS Health Project
- Zero Emissions Network Project; and
- Tower Bridge Anti-Idling Project
- Neighbourhood Pathfinder projects based around primary schools

3.3 Air pollution has a significant negative impact on health with effects ranging from worsening respiratory symptoms and poorer quality of life, to premature deaths, from cardiovascular and respiratory diseases.[iv] In Tower Hamlets 7.4% of all deaths in people over 30 are attributable to particulate air pollution.[v] Air pollution contributes to widening health inequalities as levels of particulate matter and NO2 are higher on the most heavily trafficked roads which are used more by disadvantaged people as places where they live, work and shop. There is also evidence that these same people are more susceptible to the adverse health impacts of air pollution[vi].

3.4 There have a been a number of recent reports which re-iterate and highlight the serious impact on health of air pollution including the TFL report 'Understanding the Health Impacts of Air Pollution in London'[vii] and the report of the Royal Colleges of Physicians and Paediatric Child Health (RCP/RCPCH) 'Every breath we take: the lifelong impact of air pollution'[viii] which reviewed the impact of exposure to air pollution across the course of a lifetime and highlights that each year in the UK,

around 40,000 deaths are attributable to exposure to outdoor air pollution and that it has been linked to cancer, asthma, stroke and heart disease, diabetes, obesity, and changes linked to dementia. The health problems resulting from exposure to air pollution have a high cost to people who suffer from illness and premature death, to our health services and to business. In the UK, these costs add up to more than £20 billion every year.

3.5 Key recommendations from the RCP/RCHP report include:

- **Put the onus on polluters.** Polluters must be required to take responsibility for harming our health. Political leaders at a local, national and EU level must introduce tougher regulations, including reliable emissions testing for cars.
- **Local authorities need to act to protect public health when air pollution levels are high.** When these limits are exceeded, local authorities **must** have the power to close or divert roads to reduce the volume of traffic, especially near schools.
- **Monitor air pollution effectively.** Air pollution monitoring by central and local government must track exposure to harmful pollutants in major urban areas and near schools. These results should then be communicated proactively to the public in a clear way that everyone can understand.
- **Quantify the relationship between indoor air pollution and health**. We must strengthen our understanding of the key risk factors and effects of poor our quality in our homes, schools and workplaces. A coordinated effort is required to develop and apply any necessary policy changes.
- **Define the economic impact of air pollution.** Air pollution damages not only our physical health, but also our economic wellbeing. We need further research into the economic benefits of well-designed policies to tackle it.
- **Lead by example within the NHS.** The health service must no longer be a major polluter; it must lead by example and set the benchmark for clean air and safe workplaces.

3.6 The main presentation from Professor Chris Griffiths, QMUL will outline the results of a six year study, (currently awaiting publication) which observes evidence of reduced lung volume in school children related to long term exposure to traffic pollutants consistent with impaired lung growth[ix].

3.7 There will also be a short presentation on a community led project addressing the issue of air pollution in the neighbourhood around Marner Primary School.

4. COMMENTS OF THE CHIEF FINANCE OFFICER

4.1 The recommendations in this report cover a number of areas across the Council with resourcing considerations if the priorities were to be implemented. Each recommendation would need to be assessed individually for cost and other implications and would likely require further approval through the Council's relevant decision making processes.

5. LEGAL COMMENTS

5.1 The Council has statutory obligations to fulfil the requirements of the Local Air Quality Management (LAQM) process as set out in Part IV of the Environment Act 1995. The LAQM process places an obligation on all local authorities to regularly review and assess air quality in their areas and to determine whether or not the air quality objectives are likely to be achieved.

5.2 The air quality objectives application to LAQM in England is set out in the UK Air Quality Strategy. The objectives are shown in units of microgrammes per cubic metre and specify the number of exceedances in each year which are permitted.

5.3 Where exceedances are considered likely the local authority must declare an Air Quality Management Action Plan and prepare an Air Quality Action Plan, setting out the measures it intends to put in place in pursuit of the objectives.

5.4 As detailed in the report, air quality in Tower Hamlets exceeds the limit values contained within the European Union's Ambiant Air Quality Directive and therefore the Council is required to implement measures to reduce air pollution. The measures recommend in the report will assist the Council in reducing the impact on health of poor air quality and will contribute to the achievement of the statutory obligations.

6. ONE TOWER HAMLETS CONSIDERATIONS

6.1 Air pollution contributes to widening health inequalities as levels of particulate matter and NO2 are higher on the most heavily trafficked roads which are used more by disadvantaged people as places where they live, work and shop. There is also evidence that these same people are more susceptible to the adverse health impacts of air pollution[x].

6.2 The main presentation outlines research which shows that poor air quality causes a reduction in lung development that is permanent so is an important consideration if the councils wants to meet the 'give every child the best start in life' priority.

7. BEST VALUE (BV) IMPLICATIONS

7.1 Not applicable.

8. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

8.1 Much of the air pollution arises from use of both petrol and particular diesel internal combustion engines and action to reduce these emissions are likely to have a beneficial effect on both people and the environment including a reduction in the burning of fossil fuels.

9. RISK MANAGEMENT IMPLICATIONS

9.1 Not applicable.

10. CRIME AND DISORDER REDUCTION IMPLICATIONS

10.1 Not applicable.

Linked Reports, Appendices and Background Documents

Linked Report

- NONE

Appendices

- NONE

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:

- Esther Trenchard-Mabere, Associate Director of Public Health, LBTH
  Esther.Trenchard-Mabere@towerhamlets.gov.uk

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[ii] Royal Colleges of Physicians and Paediatric Child Health, 2016, Every breath we take: the lifelong impact of air pollution https://www.rcplondon.ac.uk/file/2912/download?token=EAp84pJk

[iii] Public Health Outcomes Framework, data on indicator 3.01 Fraction of mortality attributable to particulate air pollution for 2012for those aged 30+ http://www.phoutcomes.info/

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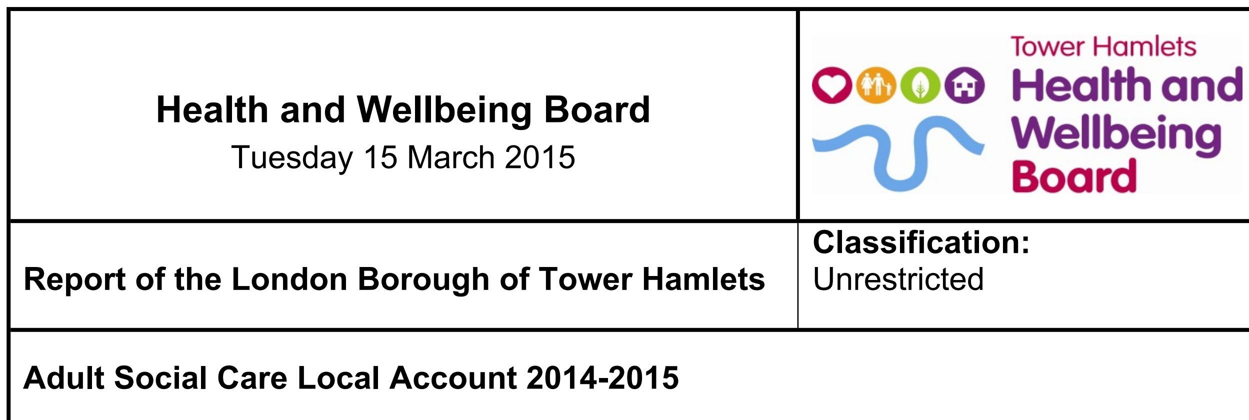

Health and Wellbeing Board Tuesday 15 March 2015	Tower Hamlets Health and Wellbeing Board
Report of the London Borough of Tower Hamlets	**Classification:** Unrestricted
Adult Social Care Local Account 2014-2015	

Lead Officer	Luke Adams, Interim Director of Adult Services
Contact Officers	Jack Kerr, Strategy Policy & Performance, LBTH
Executive Key Decision?	No

1. INTRODUCTION/SUMMARY

1.1 This report provides the Health and Wellbeing Board with a summary of achievements and priorities as set out in the Local Account of Adult Social Care.

1.2 The aim of the Local Account is to provide transparency for local people to better understand how social care is being delivered in Tower Hamlets, leading to greater involvement and challenge. This Local Account covers the period of 2014-2015 and also sets out priorities for 2015/16.

2. FOR HEALTH AND WELLBEING BOARD TO CONSIDER

2.1 The Health and Wellbeing Board are asked to note content of the attached Local Account

2.2 The Health and Wellbeing Board are asked to consider if the scope of the next Local Account should be extended to take into account the integration agenda and widen the remit to public health and align it more closely to the work of the Health and Wellbeing Board.

3. BACKGROUND

3.1 The Association of Directors of Adult Social Services (ADASS) have previously recommended that all councils with social care responsibilities produce a 'Local Account' as a means of reporting back to people on the quality of services and performance in adult social care. Local Accounts were described in the Department of Health's 'Transparency in outcomes: a framework for adult social care' consultation paper (November 2010, section 4) as a way of being more open and transparent about the care and support that is provided locally by the Council.

3.2 The purpose of the Local Account is to make residents of Tower Hamlets aware of the work undertaken by Adult Social Care during 2014-15. It uses a

combination of performance information, survey results, and examples of latest work to demonstrate how Tower Hamlets Council has enhanced the quality of life for people using care and support services**.** The Local Account also helps to publicise the range and scale of services we provide. The Local Account will be published as a council wide document and made available to the public through the Tower Hamlets Council website and published as a magazine.

3.3 This year's Local Account primarily focuses on how Tower Hamlets Council has responded to the changes made by the Care Act.

4. BODY OF REPORT

4.1 This report will not serve to replicate the extensive narrative within the Local Account, but will summarise key messages. The Local Account is attached to this report as Appendix A.

4.2 The introduction of the 2014 Care 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 sets out new rights for carers, emphasises the need to prevent and reduce care and support needs, and introduces a national eligibility threshold for care and support. In order to deliver these changes we set up a Care and Health Reform Programme. Much of the information in this Local Account and our plans for the future relate to the Care Act.

4.3 The number of people in England who have health problems requiring both health and social care is increasing. In the next 20 years, the percentage of people over 85 will double. This means there are likely to be more people with 'complex health needs', meaning more people with more than one health problem, requiring a combination of health and social care services. But these services often don't work together as well as they should. For example, people can be sent to hospital, or stay in hospital too long, when it would be better for them to get care at home. Sometimes people have to go through the same information a number of times, to both the NHS and social care organisations, or an important part of their care is missing. Consequently the government has announced that the Health and Social Care system will be fully integrated by 2018. Work to make this a reality in Tower Hamlets has been a priority for Adult Services last year and remains a key priority going forward. The strategy for Integration in Tower Hamlets is part of a shared 5 year plan, 'Transforming Services Together', across Tower Hamlets, Newham and Waltham Forest. Tower Hamlets' Health and Wellbeing Board oversees the delivery of this work through the Integrated Care Board and services are now being coordinated through Tower Hamlets Integration Provider Partnership (THIPP). This partnership group includes representatives from Tower Hamlets Council, Barts Health NHS Trust, East London NHS foundation Trust and Tower Hamlets CCG. This work is still in the early stages of development but the focus so far has been on ensuring a positive patient experience and, as such, patients can expect an improved experience

of care across all health and social care services in the local community. This work has been boosted by being recognised as one of the government's 50 vanguard sites which means we will be able to draw on extra government funding to specifically help us improve integrated care services in Tower Hamlets through THIPP. Lastly, a number of schemes have begun to be implemented using resources made available through the Better Care Fund. This will remain an important resource in helping to move forward our ambitions to join up health and social care services.

4.4 Key Priorities

- Demand for adult social care is likely to rise in future. At the same time, the amount of funding we get from the government has gone down. One of the main ways we want to address this is by continuing to focus on "prevention" to help people stay as well as possible for as long as possible. For example, this will include working with partners to explore the use of Assistive Technology to combat loneliness and isolation for people with dementia.

- We will continue with the things we know work well. This ranges from setting up more work placements for adults with a learning disability to further developing the support provided to people with dementia.

- We will offer people more choice. More people will be offered personal budgets and more people will have a choice over any equipment they need to stay safe at home.

- We understand that people would like the option of choosing the type of services they receive. In response to this, we will be carrying out a review of the services we currently provide to see which services people use the most. This will help us to commission more of services that you like to use. In addition to this, we are now recording social care needs that cannot be adequately met by products and services currently available for people to choose from. We will feed these needs back to the organisations we commission on a regular basis so that required products and services are provided on the market for people to choose from.

- People have been telling us for a long time that it can be a very disjointed and disorienting experience when they have to move between different services. For example, people who need social care and health care have to meet with at least two sets of professionals, sometimes more, all asking similar questions for assessments, but working completely separately. This doesn't make sense; it's frustrating for those involved and wasteful of resources too. It's much better to join things up so people who use different services are treated as 'whole people' and have an altogether smoother, more seamless, less fragmented experience. Moving forward, integration remains a key priority for us. We will continue using the Better Care Fund to deliver more integrated and coordinated health and social care services. To take this work forward the council works in several formal partnerships with NHS and voluntary sector bodies. These include

the Health and Wellbeing Board, the Integrated Care Board and the Tower Hamlets Integrated Provider Partnership (THIPP). In 2015, THIPP was named by the government as one of 50 national 'Vanguard' sites by NHS England, which are piloting new ways of working in health and social care. The borough is currently developing plans for integrated care that could be adopted nationally and is receiving additional support from NHS England to develop the programme. We will continue to develop this area of work.

- We currently have a one year Carers plan. This plan sets out how adult social care will support carers between 2015 and 2016 in partnership with Tower Hamlets Clinical Commissioning Group, third sector providers and others. It follows on from the Tower Hamlets Plan for Carers 2012-15. It is an interim position for adult social care pending the development of a more detailed 2016-19 Plan for Carers. We are currently working on the new Carers Plan and launch this in 2016. The 2016-19 Plan for Carers will have a wider scope than the current one year plan, and will have a greater focus on partners such as the Tower Hamlets Clinical Commissioning Group as well as young carers.

5. COMMENTS OF THE CHIEF FINANCE OFFICER

5.1 The cost of producing the Local Account will be met through existing budgets, there are no other direct financial implications arising from the publication of the local account.

6. LEGAL COMMENTS

6.1 The report informs members about the publication of a Tower Hamlets Local Account. The local account is intended to be a source of information, developed locally, which may include quality and outcome priorities and how these have been progressed; a description of partnership working; and data relating to quality and performance. Local information and local outcome measures should be contained in a local account, supplementary to national outcomes measures so as to promote quality, transparency and accountability in adult social care.

6.2 The delivery by the Council of its statutory functions in respect of adult social care in a way that is high quality, transparent and accountable is consistent with good administration. There is thus adequate power to support development of a local account inherent within the statutory functions which will be the subject of the local account narrative. Were it necessary, an additional source of power may be found in the general power of competence in section 1 of the Localism Act 2011. The general power enables the Council to do anything that individuals generally may do, subject to such restrictions and limitations as are imposed by other statutes.

6.3 The local account is a report and summary that ranges across the Council's adult social care functions. To the extent that the local account sets out priorities or actions, these are a reflection of the content of a number of Council plans and strategies. The delivery of these may give rise to legal issues that will need to be addressed. The Council will continue to have act within its statutory functions, including by complying with its many duties in respect of adult social care and its best value duty under section 3 of the Local Government Act 1999.

6.4 In developing the local account, the Council will need to have due regard to the need to eliminate discrimination, harassment, victimisation and any other conduct prohibited under the Equality Act 2010, the need to advance equality of opportunity and the need to foster good relations between persons who share a protected characteristic and those who don't.

7. ONE TOWER HAMLETS CONSIDERATIONS

7.1 The report informs Cabinet that the Local Account is a requirement under *Transparency in Outcomes: A framework for adult social care* (ASCOF). The Local Account development process seeks to identify areas of inequality for local people. The report highlights areas where further work will be carried out in the coming year to better understand and address potential issues.

7.2 The report addresses provision of care and support for vulnerable people, particularly safeguarding, in conjunction with partners. The report is therefore very relevant to the aims of One Tower Hamlets and has a direct impact on the following Strategic Objectives:

- **A Safe and Supportive Community** – bringing together support for the most vulnerable residents with community safety issues
- **A Healthy Community** – including public health, access to primary care and mental health

7.3 The Local Account is intended to be a mechanism for local challenge. The format of this year's Local Account, a magazine summarising key information will increase this involvement further and encourage more people to get involved in the development of social care for vulnerable adults.

8. BEST VALUE (BV) IMPLICATIONS

8.1 The Local Account is published annually as a paper copy in a magazine format. This incurs design and printing costs. However, this is a necessity as 65% of our Adult Social Care clients have told us they do no use the internet.

9. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

Not applicable

10. RISK MANAGEMENT IMPLICATIONS

10.1 The Association of Directors of Adult Social Services recommended that all councils with social care responsibilities produce a 'Local Account' as a means of reporting back to people on the quality of services and performance in adult social care. This is recommended as best practice however it is not a statutory responsibility to do so.

11. CRIME AND DISORDER REDUCTION IMPLICATIONS

Not applicable

12. SAFEGUARDING IMPLICATIONS

12.1 The Local Account makes reference to safeguarding practices in adult social care and latest progress made in this area. The final draft of the Local Account will be amended to include contact details for people who want to report abuse or contact the safeguarding board/team

13 EQUALITES CONSIDERATIONS

13.1 The text for the Local account has been written in plain English and has been designed so that it is as accessible as possible for services users and carers to read and understand. We will also be producing an 'easy read' version for adults with a learning disability.

14 CONCLUSION

14.1 The Local Account is being presented to HWBB for discussion so that they can note its content and have an oversight of the work that has taken place in Adult Social Care. HWBB are being asked to consider if future Local Accounts should take into account the work of Public Health and align more closely to the Health and Wellbeing Board agenda.

15. APPENDICES

Appendix 1 Adult Social Care Local Account 2014-15

Adult Social Care: How are we doing?

The "Local Account" of Adult Social Care in Tower Hamlets

Adult social care in Tower Hamlets helps and supports people who are disabled, ill, frail, elderly or vulnerable for another reason.

This report tells you about adult social care over the last year and our plans for the future.

Adult Social Care Services
live life your way

TOWER HAMLETS

What We Do

Our aim is to help vulnerable, frail, elderly, disabled and socially isolated people remain independent, active and safe. Our care can be provided in someone's home, in a community setting or in a care home.

We support those who have physical disabilities, learning disabilities, people with mental health problems, as well as carers.

Our services include:

- Information and advice;
- Day activities, such as day centres;
- Short breaks and short-term help to maintain people's independence
- Home care (also known as 'home help')
- Employment, training and work experience opportunities;
- Care homes and care funding advice;
- Equipment to help with daily living.

Did you know in 2014/15?

- **4476** people received long-term support from adult social care. Many more people also got other types of help, ranging from short-term sheltered housing to support to find work.
- **1542** Carers who care for friends or family received support from adult social care in their own right, an increase of 23% on the previous year.
- **2438** people received home care to help them to stay in their home.
- **792** people were supported to live in a residential or nursing care home.
- **772** people used day care services
- **2000** people received a Personal Budget from the council to manage their own health and social care needs.
- **340** Carers also received a Personal Budget.

What we Spent in 2014/15

- The budget for adult social care was approximately £96 million in 2014/15, 3 per cent less than the previous year as a result of government funding cuts.
- The table below shows a breakdown of how we spent our money in 2014/15

Residential Care and Nursing Care – including non-permanent care such as respite	£30m
Assessments – staff costs for carrying out community care assessments, support plans and reviews	£15m
Domiciliary Care – care services provided to people in their own homes	£19m
Supported Accommodation – housing that enables people to live independently but with support	£2m
Direct Payments – money which is passed directly to the people so they can purchase and manage services to meet their eligible needs	£7m
Day Care – support access during the day	£7m
Voluntary Organisations – contributions preventative services	£5
Management, Commissioning & Operational costs	£1m
Enablement – intensive short term support which encourages people to be independent as possible	£3
Occupational Therapy, Equipment & Client aids to daily living – e.g. Hoists, Stair lifts, Pressure relieving cushions and mattresses.	£2
Transport – e.g Help to take people to a Day centre	£3
Extra Care Housing Accommodation with varying on site support	£2

- We spend the most of our money on care homes - £30 million.
- Around 95 per cent of the care and support from the council is provided by other organisations on our behalf.

What we did in 2014/15

With less money available, but demand for services going up, our adult social care system faces ongoing challenges.

To meet demand, we know that we have to arrange services differently, joining up social care and health care, so that it is easier for people to use our services and that we become more efficient at delivering them.

We have been busy implementing the new Care Act of 2014. This replaces most current law regarding carers and people being cared for. It outlines new obligations on us for how we should look after carers, the way in which we should carry out carer's assessments and needs assessments; how we should determine who is eligible for support; and how we should provide this support.

The next section explains some of the key elements the Care Act has introduced and how we have addressed them.

Wellbeing

The Care Act says that we have to look after an individual's 'wellbeing'. This means that we should always keep in mind things like effects on mental or physical health when making decisions about people or planning services for them. This includes protecting them from abuse and supporting them to manage daily life.

We have delivered a successful training programme to help our staff consider wellbeing when planning care for people. This could mean that they look at anything from helping them to take part in work opportunities, or education, to making sure they have suitable living accommodation.

The council also wants to be sure that staff working in the organisations we fund stick to wellbeing principles, so we have built this requirement into their contracts.

Information and Advice

Over the year, we have worked to improve our information and advice for residents; how to get help with social care needs, how to live healthier lifestyles, and how to access financial advice.

Where to go for help depends on what is needed:

- If you have a general question about getting help or if you are not sure where to start, please contact Local Link on 020 7001 2175 or the Carer Centre (for carers) on 020 7790 1765. These local organisations can explain more about adult social care and can help you to find support and activities near to where you live.

  For more information on social care, please contact Local Link
  by phone call 020 7001 2175
  by text on 079 0037 6781
  by email at local-link@real.org.uk
  by visiting their website at www.local-link.org.uk

  Carers can contact the Carers Centre
  by phone call 020 7790 1765
  by email at enquiries@carerscentretowerhamlets.org.uk
  by visiting their website on www.carerscentretowerhamlets.org.uk

- If you require a mental health service or think you have a mental health condition please contact your GP in the first instance.
- If the situation is serious or urgent, or you are worried about adult abuse you can contact adult social care at the council on 020 7364 5005. Staff can speak to you about the things you need help with and see if you need an "assessment" from adult social care. In any emergency situation, always call 999 to speak to emergency services

We have also updated our website.

The online 'community catalogue', lists products and services for social care. People can use it to search for specific types of services and the catalogue includes listings on accommodation, carers services day time activities, independent living support, education, employment and training opportunities.

The Tower Hamlets Community Catalogue is part of a quality assurance scheme, along with five other east London boroughs which checks that the services listed are safe and reliable.

The community catalogue can be accessed at:
http://communitycatalogue.towerhamlets.gov.uk/

Prevention

The Care Act says that we need to provide more prevention services for people and their carers. These are services that help to delay or reduce the need for care and support for as long as possible.

We have a range of services for people in Tower Hamlets to try and help people stay independent for longer. This includes lunch clubs, befriending schemes, health projects and exercise sessions. We have also trained staff on how to help residents live healthier lives through a programme called Making Every Contact Count.

Eligibility criteria

There is a new national eligibility criteria for both carers and the person being cared for. This introduces a minimum threshold and, if a carer, or the person being cared for, meets this threshold, they will have eligible needs.

We know people are often confused about what care they can expect from their local authority and this sets out the basic minimum entitlements to services so that everyone can be reassured there is some level of support they can expect.

Following a financial assessment, we have to agree with the person assessed which of their eligible needs we will meet, and how we will meet them. We will create a support plan that might include things like visiting day centres, home help or direct payments, so you can buy your own support. If we can't help you because you are not eligible for our help, we will always tell you about other organisations that can help you.

We have also changed the way we carry out assessments to make sure that your views and needs are at the centre of the process.

Our work is now built around you and what you want to achieve

We also provide self-assessment forms available from:

Email: adultcare@towerhamlets.gov.uk
Postal Address: Assessment and Intervention Team
Education, Social Care and Wellbeing
London Borough of Tower Hamlets
2nd Floor, John Onslow House
1 Ewart Place
London E3 5EQ

If you complete a self-assessment, we will:

- Consider if your plan works for you, and how it can be made better;
- Decide what can be funded, taking into account the national eligibility criteria;
- Offer a support plan, if suitable
- Review the plan to check it is working; and
- Carry out annual reviews to keep up to date with your changing needs.

Advocacy: Help to speak out

Anyone who finds it very hard to understand the assessment process or needs help to put across their views should have an independent advocate, if there is no friend or family member to provide this support. The advocate should be there to help them throughout the process so they can be reassured their needs and decisions are taken into account.

We have increased the number of advocates available for adults as well as young people who are preparing for adulthood, and trained social care staff so they know when an advocate might be needed.

Personal Budgets

Everybody receiving adult social care should be given a personal budget.

A personal budget is money given to you by the council so that, if you want, you can manage your own care, once your needs have been assessed.

A personal budget can be overseen by the council, or paid to an individual as a direct payment. We already provide direct payments to 565 people who want to arrange their own support.

An updated policy on personal budgets and direct payments is being developed; and will come into operation by April 2016.

Friends and family who care for others

In Tower Hamlets we have approximately 19,000 carers - people who provide unpaid care or support to an adult family member or friend, either in their own home or somewhere else.

Carers now have the right to a separate assessment and support. They may need practical support, such as a short break or information about local support groups. In 2014/15, 1308 carers received an assessment or review of their social care needs.

Our Carers Plan for 2015/16 sets out how we want to build on this and improve services for carers, including:

- Providing temporary support to people who are cared for in emergency situations.

- Early identification of Carers in need , e.g. though GP's, so we can help signpost them to the right services

The Carers' Centre is also available to help carers with any questions:

Telephone: 020 7790 1765
Email: enquiries@carerscentretowerhamlets.org.uk
Address: The Carers Centre
21 Brayford Square
London E1 0SG

Keeping adults safe from abuse

Our Adult Safeguarding Board brings together senior people from the council, NHS, police and other organisations and services in the borough to protect vulnerable adults and prevent abuse. As a council, we have to investigate when we think someone is 'at risk of harm'. In 2014/15 579 adult safeguarding cases were investigated and concluded significant increase when compared to the figure of 396 for 2013-14

The 2014 Annual Report shows that there has been good progress in a number of areas, with generally positive responses from people using adult social care services about how this support helps them to feel safe. Also, to improve our practice around this, social care staff received a comprehensive training programme equipping staff from all partner agencies with skills and confidence.

Working with others

We are working hard to join up health and social care services across the borough to provide seamless, integrated care for those people that need our help.

Services often don't work together as well as they should. For example, people can be sent to hospital, or stay in hospital too long, when it would be better for them to get care at home.

We are joining up services through a shared 5 year plan, 'Transforming Services Together', across Tower Hamlets, Newham and Waltham Forest. In tower Hamlets the work is being coordinated by our Health and Wellbeing Board and through the coordinated through Tower Hamlets Integration Provider Partnership (THIPP). This partnership group includes representatives from Tower Hamlets Council, Barts Health NHS Trust, East London NHS foundation Trust and Tower Hamlets CCG.

We are also part of a pilot project so we will be able to receive extra funding to improve joined up care in Tower Hamlets, as well as additional money from the Government's "Better Care Fund", to help develop our integrated health and social care services.

These schemes are:

Integrated Community Health Teams

The Integrated Community Health Team provides care, support and advice to people over the age of 18 to provide assessments that look at all aspects of their care including health and social care, case management and co-ordination of patient care.

The service also works with families and carers to ensure they receive help and support.

7-day hospital discharge

Social care workers are on hospital wards at the Royal London Hospital seven days a week, meaning that people can be discharged even at the weekend.

Reablement and Rehabilitation

Providing a coordinated service for people who need health rehabilitation services (for example after suffering a stroke), and short term social care reablement services to help them get back their independence, following an emergency.

Supporting independent living

Using technology to help people stay in their own homes for longer. For example this includes using alarms that send a signal to the council's 24 hour monitoring centre, when a person has a fall, or 'talking' units that can remind people to take their medication.

Our plans if organisations close

We would put in place temporary management measures to protect people who rely on care services in the event of the failure of a residential or nursing care home.

For homecare, people's care packages would be transferred to other organisations. Previous experience shows other local organisations would be able to fill the gap and deliver services for us on a temporary basis.

If a day service fails, the council would either put temporary arrangements in place or individuals would be introduced to new services, elsewhere in the borough.

Checking the quality of services

We have a specialist team that checks the health and care services we provide to make sure that we are providing our residents with a quality led service that delivers the right care. They also visit people who have gone to care homes outside of Tower Hamlets to check their conditions, as well as carrying out spots checks on services. The team gathers clear evidence so we know which are the right services to continue to buy and use in the future.

What we did in 2014/15

View of service users and carers.

The information on this page sets out what people told us in 2014/15 alongside other key facts and figures:

- In a survey, 90 per cent of adult social care users said they were satisfied with their care and support services[1]. 4 per cent were dissatisfied. This year's results show he highest levels of satisfaction, and lowest levels of dissatisfaction since the service user survey began in Tower Hamlets five years ago.

- 93 per cent of adult social care users said support helps them to have a better quality of life. 87 per cent said it helps them to have control over their daily life. 87 per cent said it helps them to feel safe.
- We work hard to put things right if things go wrong. In 2014/15, 52 complaints were made to the local authority relating to Adult Services. This compares with 57 for the year before. The biggest single reasons for making a complaint in 2014/15 were "challenge assessment decision" (15 complaints compared to 24 the previous year) and "conduct/competence" (15 compared to 15 the previous year).
- The table below sets out our performance in other important areas:

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[1] The 2014-15 Service User Survey was sent to 3479 people in receipt of Tower Hamlets-funded "FACS eligible" adult social care. 837 service users completed this survey in February 2015. Please note there is a -/+ 5% margin of error when looking at the results.

	Tower Hamlets 2014/15	London 2014/15
Service users who say they have control over their daily lives[2]	78%	72%
Care and support should help people have more control over their daily lives. We are pleased that people living in Tower Hamlets report a positive experience in this area than the London average		
Service users who say they have as much social contact as I want with people I like	40%	41%
This measures how lonely or socially isolated people getting social care feel. We are now planning a range of initiatives over the next year to tackle this.		
Percentage of service users receiving a direct payment	18%	27%
Direct payments are an amount of money from the Council to purchase care and support. These enable people to have more flexibility and choice over the support they receive. We will be working over the next year to ensure people know about their option to receive a direct payment and the benefits of this.		
Percentage of adults with a learning disability in employment	5%	8%
This measures how many adults with a learning disability who receive support from social care are in work. We are planning to increase this figure over the next year – for example, by offering people more work placements at the Council.		
Percentage of adults with a mental health issue in employment	5%	6%
This measures how many adults with a mental health problem who receive support from social care are in work. We are planning to increase this figure over the next year – for example, by offering employment advice and support.		
Percentage of adults with a learning disability living in their own homes or with their family	67%	69%
This measures how many adults with a learning disability are living at home (as opposed to living in a care home). We have an "accommodation plan" in place to enable those living in care homes outside the borough to return if this is right for them.		

[2] This is based on the results of a questionnaire sent to all adult social care users in February 2015. Over 800 responses were received.

	Tower Hamlets 2014/15	London 2014/15
Percentage of adults with a mental health issue who are living independently	2%	4%
This measures how many adults with a mental health problem are living at home (as opposed to living in a care home). We are pleased that more people live independently in Tower Hamlets when compared to the London average.		
Percentage of older people discharged from hospital who receive rehabilitation or reablement services	90%	85%
This measures how many older people receive short-term help to get back on their feet after a period in hospital. We will be working with health to try and offer this support to more people over the coming year.		
Percentage of older people discharged from hospital who are still living independently after 91 days	5%	8%
This measures how many older people are living at home (as opposed to being readmitted to hospital or a care home) after a period in hospital. We are pleased that our performance is above the average figure for London.		

In addition:

- For every 100,000 people aged 18 to 64 in Tower Hamlets, 9 people moved into a care home. The result for London is 11. As we know that most people want to live independently at home, we are pleased that our performance is above the London average.
- For every 100,000 people aged 65 and over in Tower Hamlets, 591 people moved into a care home. The result for London is 492. The result in Tower Hamlets is better than the previous year, and we will continue to work on this. 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.
- For every 100,000 adults in Tower Hamlets, 6 experienced a delay in being discharged from hospital. 2 experienced a delay due to adult social care. The results for London are 7 and 2 respectively. We are pleased that our performance is above the London average.

Our plans for the next year

- We will have a strong focus on "prevention" to help people stay as well as possible for as long as possible.
- We will offer people more choice. More people will be offered personal budgets and more people will have a choice over any equipment they need to stay safe at home.
- We will carry out a review of the services we provide to see which services people use the most. This will help us to buy more of services that you like to use.
- Where you tell us that more varied services are needed, or a wider range of products should be available, we will feed that back to the organisations we commission, so that they can be provided.
- We will continue to work hard on our integration agenda, so that we can provide seamless, joined up services for residents that deliver the right care, at the right time.
- We are currently working on the new Carers Plan and will launch this in 2016. The Plan will look further ahead and will also have a new focus on young carers.

To request more information on any of the issues raised in this report, or to give feedback on the report:

Email us at **qualityandperformance@towerhamlets.gov.uk** or write to:

Freepost RTBJ-UYTJ-SBCK
Quality and Involvement Team
5th Floor
Mulberry Place
5 Clove Crescent
London, E14 2BG

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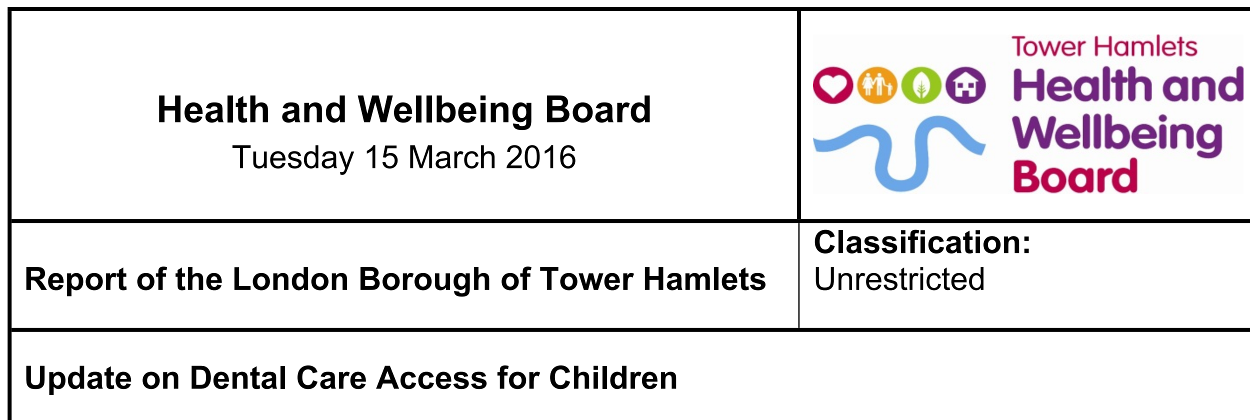

Health and Wellbeing Board Tuesday 15 March 2016	
Report of the London Borough of Tower Hamlets	**Classification:** Unrestricted
Update on Dental Care Access for Children	

Lead Officer	Luke Addams, Interim Director of Adult Services, LBTH
Contact Officers	Somen Banerjee, Director of Public Health, LBTH
Executive Key Decision?	No

Summary
This briefing paper gives an update on dental care access for children in Tower Hamlets.

The paper summarises the dental services available to children, and provides information on current access figures, trends and comparisons. The paper identifies national and local action to improve access to dental services and suggests further action that will be taken in 2016/17 to increase dental service uptake.

Recommendations:

The Health & Wellbeing Board is recommended to:

Note the following actions that are being taken to improve access to dental services to increase access by 5% in 16/17 (from 50.4%)

1. Council services for children and young people will have oral health and dental service uptake embedded at a strategic and operational level. The CYP team will ensure that performance reviews for commissioned services include a focus on oral health
2. Council PH team will work with NHS England, Health Education England and the Dental Institute of Queen Mary to identify training needs of dental teams to enable them to provide services for very young children in Tower Hamlets. A plan of action has been agreed
3. The Public Health team will work with the communications team to ensure that the local population are made aware of the new dental practice at Harford Street
4. The Council will support the implementation of the Paediatric Dentistry Commissioning Guide (when published)
5. The Council will collaborate with Queen Mary University to identify/ undertake research to identify strategies to increase access to dental services in multi-

cultural deprived communities

6. The Public Health team will continue to make the case to NHS England to identify additional resources for dental services for children
7. The impacts of these measures will be monitored on an ongoing basis and evaluated at the end of 16/17 by the Public Health team to assess effectiveness and value for money.

1. REASONS FOR THE DECISIONS

1.1 Improving access to dental services in children is outlined in the Health and Wellbeing Strategy under the Maternity and Early Years priority workstream.

2. ALTERNATIVE OPTIONS

2.1 To not take action would result in Tower Hamlets children continuing to have lower access to dental services than elsewhere.

3. DETAILS OF REPORT

3.1 A briefing paper giving an update on dental access for children in Tower Hamlets. It provides information on the latest access figures, trends and comparison. It summaries current action to improve dental access.

4. COMMENTS OF THE CHIEF FINANCE OFFICER

4.1 The Council currently has a budget of £168k for Children's Dental Health services through the Public Health Grant. Any additional resources required in order to implement the recommendations contained within this report would need to be contained within the Public Health Grant.

5. LEGAL COMMENTS

5.1 This report is pursuant to the Council's duties under Regulation 17 of the NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012 to secure the provision of oral health promotion programmes and surveys.

5.2 The recommendations are also consistent with the general policy, reflected in the Health and Social Care Act 2012, of giving HWBBs responsibility for joint health and wellbeing strategies and the joint strategic needs assessment, and fall within the functions of the HWB set out in its Terms of Reference.

5.3 The recommendation for the Council to engage with NHS England and Queen Mary University falls within the HWBB functions of encouraging integration and supporting partnerships under section 75 of the NHS Act 2006.

5.4 When planning for integration of health and social care functions, the Council and its committees must have due regard to the need to eliminate unlawful conduct under the Equality Act 2010, the need to advance equality of opportunity and the need to foster good relations between persons who share a protected characteristic and those who don't.

6. ONE TOWER HAMLETS CONSIDERATIONS

6.1 Poor dental outcomes and inequalities in dental access are key issues linked to deprivation. This paper is particularly focussed on addressing how to engage with ensure equitable access for the sections of the population with greatest oral health need.

7. BEST VALUE (BV) IMPLICATIONS

7.1 The BV implications are minimal as there are no specific commissioning proposal or the council

8. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

8.1 No specific impacts

9. RISK MANAGEMENT IMPLICATIONS

9.1 The proposals mitigate the continued risk of poor dental health in children in Tower Hamlets and the reputational risk of failing to take action

10. CRIME AND DISORDER REDUCTION IMPLICATIONS

10.1 No specific impacts

Linked Reports, Appendices and Background Documents

Linked Report

- NONE

Appendices

- Update on dental access for children for the HWBB.

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

Contact officer for the report

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

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TOWER HAMLETS

Update on dental access for children for the HWBB

1 Introduction

1.1 This briefing paper gives an overview of dental access for children in Tower Hamlets. It summarises the available dental services, current data on dental service uptake and provides a background and basis for the targets in the Health and Wellbeing Strategy.

1.2 Local Authorities have statutory responsibilities (Statutory Instrument 2012 No. 3094 Section 4) specifically relating to oral health.

1.3 The responsibilities include assessing the oral health needs of their population, developing oral health strategies, commissioning appropriate population-based oral health improvement programmes to meet those needs and commissioning oral health surveys as part of the national dental epidemiology programme or other local surveys.

1.4 Local Authorities are also responsible for delivering the Public Health Outcomes Framework Indicator 4.2 '*Tooth decay in children aged 5*'. The national dental epidemiology programme will provide the data for monitoring this indicator.

1.5 All clinical dental services for Tower Hamlets are commissioned by NHS England.

2. Summary of dental services

2.1 Dental services available to children in Tower Hamlets are summarised below:

- 30 general dental practices
- 2 practices providing specialist orthodontic services
- Out of hours dental services for evenings, weekends and bank holidays via NHS 111 (From April 2016)
- Community dental services for children with special care needs (including children with physical and learning disabilities and looked after children) provided by Barts Health
- Hospital dental services for specialist paediatric dental care provided by Barts Health

In addition to the services above, a number of children access primary care dental services at the Dental Institute of Queen Mary University as part of the undergraduate and postgraduate teaching programmes.

3. Dental Access

3.1 The percentage of children accessing dental services has increased from a baseline of 46.9% in 2006 when the current dental contact was introduced to the current figure of 50.4% (2015). This compares to 62.8% for London and 69.4% for England. Figure 1 summarises the trends in dental access for children from 2006 to 2015.

3.2 The steady increase in child dental access from 2006 to 2009 was associated with a significant investment in dental services. However much of this was non-recurrent funding.

3.3 Fewer children in Tower Hamlets are accessing dental services compared to London and England. This is thought to be due to a combination of socio-economic, cultural, religious and educational factors.

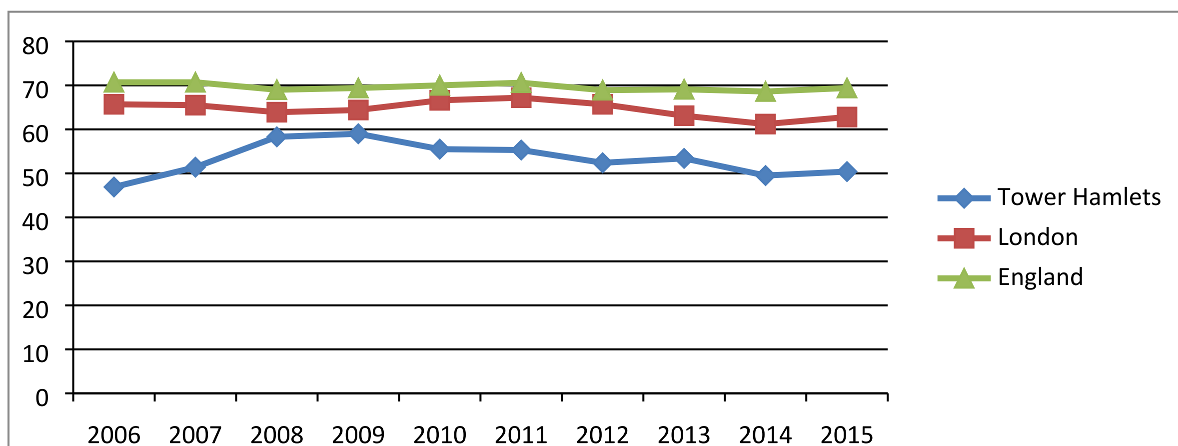
3.4 Whilst the percentage of children accessing dental services in England has remained the same over the years the percentage accessing dental services in Tower Hamlets has steadily fallen.

3.5 When very young children attend a dental practice families are often turned away and advised to come back when the child is 3 years old. This is often too late as many have established dental disease by 3 years and children would benefit from attendance before 1 year of age to access appropriate preventive dental care.

3.6 Dental extraction is the highest cause of non-emergency hospital admissions for children in London. In 2014, the number of children living in Tower Hamlets admitted to hospital for dental extractions was 469. This represented 0.7% of the child population, similar to London.

3.7 A number of children access primary care dental services at the Dental Institute of Queen Mary University. These figures are not included in the national data. The percentage of children accessing dental services in Tower Hamlets is therefore thought to be much higher than the current figure of 50.4%. Several attempts have been made to quantify the number of number of children accessing services at the Dental Institute but because the general and hospital dental services use different systems this has been difficult to resolve. Discussions are on-going.

Figure 1. Percentage of children accessing dental services 2006 - 2015



4 National and Regional Action

4.1 A National Steering Group led by NHS England is finalising a Paediatric Dentistry Commissioning Guide. This guide is expected to ensure that there is a consistent and coherent approach to improving oral health, reducing oral health inequalities and ensuring good and equitable access to dental services for children that would reflect the need and complexity of care.

4.2 A new national dental contract has been piloted and prototypes are being tested. The contract is expected to be introduced in 2018.

4.3 NHS England London Region is in the process of re-commissioning specialist paediatric services and service for children with special care needs across London. This includes children with physical and learning disabilities. The new service should improve access for these children.

5. Local Action

5.1 A new dental practice will open at The Harford Street Health centre, near the Ocean Estate on the 1st April 2016. This practice will provide services for 4,500 new patients.

5.2 NHS England has provided additional funding for a small number of general dental practices.

5.3 The Council is implementing a number of programmes targeted at children. These include the Smiling Start, Brushing for Life and School Fluoride Varnish Programmes.

5.4 The school fluoride varnish programme commissioned by the Council is expected to prevent tooth decay but also identify children with tooth decay and direct them to treatment services thus improving uptake.

5.5 The Tower Hamlets oral health promotion team plays a major role in working with families through schools and Children's Centres to encourage them to access dental services.

5.6 The Council is working with the CCG to develop and implement a dental care pathway for looked after children.

6. Access trajectory for 2016/17

The current dental access figure of 50.4% is way below the London average of 62.8%. We would expect to see an increase in the trajectory of 5%.

7. Key priorities for 2016/17

7.1 The following actions are being taken to improve access to dental services:

- Council services for children and young people will have oral health and dental service uptake embedded at a strategic and operational level. The CYP team will ensure that performance reviews for commissioned services include a focus on oral health
- Council PH team will work with NHS England, Health Education England and the Dental Institute of Queen Mary to identify training needs of dental teams to enable them to provide services for very young children in Tower Hamlets. A plan of action has been agreed
- The Public Health team will work with the communications team to ensure that the local population are made aware of the new dental practice at Harford Street
- The Council will support the implementation of the Paediatric Dentistry Commissioning Guide (when published)
- The Council will collaborate with Queen Mary University to identify/ undertake research to identify strategies to increase access to dental services in multi-cultural deprived communities
- The Public Health team will continue to make the case to NHS England to identify additional resources for dental services for children
- The impacts of these measures will be monitored on an ongoing basis and evaluated at the end of 16/17 by the Public Health team to assess effectiveness and value for money.

Desmond Wright
Consultant in Dental Public Health

March 2016

REFERENCES

1. **Health and Social Care Information Centre, NHS Dental Statistics for England 2015** http://www.hscic.gov.uk/searchcatalogue?topics=1%2fPrimary+care+services%2fDental+services&sort=Relevance&size=10&page=1#top
2. **Public Health England. Dental extractions data 2014** http://www.nwph.net/dentalhealth/

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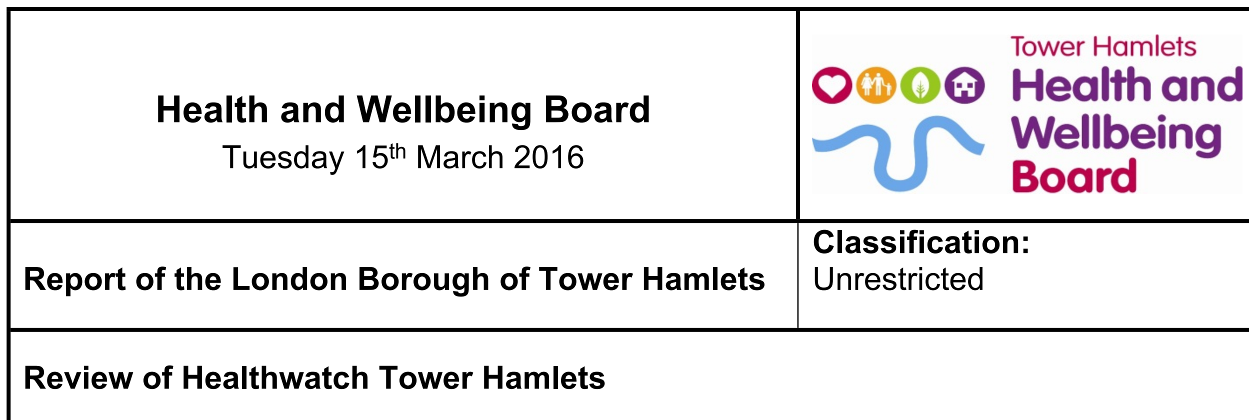

Health and Wellbeing Board
Tuesday 15th March 2016

Report of the London Borough of Tower Hamlets

Classification:
Unrestricted

Review of Healthwatch Tower Hamlets

Lead Officer	Melanie Clay, Director of Law, Probity and Governance
Contact Officers	Kevin Kewin, Service Head Corporate Strategy & Equality / Afazul Hoque, Senior Strategy, Policy & Performance Officer
Executive Key Decision?	No

1. Summary

This report provides an update on the council's current review of Healthwatch Tower Hamlets (HWTH) and some of the emerging findings. The aim of the review is to develop a model for HWTH which builds on existing strengths, identifies areas of improvement and incorporates good practice from other local Healthwatch organisations. The review findings will help to set out a refreshed vision for Healthwatch Tower Hamlets and inform the retender of the Healthwatch contract.

The existing contract for HWTH expires on 31st March 2017 and the Council is required to have a new contract in place by 1st April 2017. The paper outlines the methodology for the review and timetable for reporting on the findings and commissioning of the new Healthwatch contract.

2. Recommendations:

The Health & Wellbeing Board is recommended to:

1. Note the report and provide any comments on the future model for Healthwatch Tower Hamlets.

3. DETAILS OF REPORT

BACKGROUND

3.1. Healthwatch Tower Hamlets was established as part of the Health and Social Care Act 2012 and is the local consumer champion for patients, service users and the public, covering health and social care. Altogether there are 152 Local Healthwatch across the country and a national body called Healthwatch England which provides oversight and supports the development of the local Healthwatch network.

3.2 Healthwatch Tower Hamlets undertakes the following key activities:

- Provides information, sign-posting and advice to the public about accessing health and social care services and choice in relation to aspects of those services;
- Obtains the views of people about their needs for and experience of local care services and make those views known to those involved in the commissioning, provision and scrutiny of care services;
- Promotes and supports the involvement of people in the monitoring, commissioning and provision of local care services;
- Influence the commissioning and provision of services through producing evidence-based reports and recommendations about how those services could or should be improved. Local Healthwatch have a statutory seat on the local Health and Wellbeing Board to help them to do this effectively;
- Makes the views and experiences of people known to Healthwatch England helping it to carry out its role as national champion;
- Makes recommendations to Healthwatch England to advise the Care Quality Commission to carry out special reviews or investigations into areas of concern;

3.3 The Council went through a formal tendering process and awarded the contract for establishing HWTH to Urban Inclusion in March 2013. HWTH was set up as a Charitable Company made up of 12 Board Members, most of whom are local residents with some third sector representatives. The Board is responsible for oversight of the business and performance of the organisation. HWTH currently has a staff team of four. Additionally there is a large pool of volunteers (250+) drawn from across the area who receive training to support the delivery of the Healthwatch Tower Hamlets work programme, for example by doing outreach sessions in the community and carrying out “Enter and View” visits. Under the statutory regulations, local Healthwatch organisations have the power to Enter and View health and social care providers so that authorised representatives can observe matters relating to health and social care services and get insight from patients / service users.

3.4 Given HWTH has now been in operation for almost three years – and the contract is due to be re-tendered – the Cabinet Member for Health and Adult Services and council officers agreed it was timely to conduct a full review of its operation to date, to influence the development of the Healthwatch model

for the new contract. Engagement with stakeholders, including the Health and Wellbeing Board, on the performance of HWTH, is a critical part of the review.

4. METHODOLOGY

4.1 The review has been undertaken during January 2016 - February 2016 and comprised the following components:

I. Desk research: performance and contract monitoring information to date, review of broader literature on the development of local Healthwatch and national evaluations of local Healthwatch;

II. Stakeholder engagement:

a. Meetings and semi-structured interviews with key stakeholders in the health and social care system including LBTH (Adults Services, Children's Services, Public Health & Community Engagement leads), the Tower Hamlets Clinical Commissioning Group (CCG), Bart's Health Trust, East London Foundation Trust, Healthwatch England, HWTH staff and board members and HW commissioners in other areas.

b. Discussion groups with Healthwatch volunteers, community groups including the Health & Wellbeing forum, Voluntary and Community Sector representatives and equality forums.

c. Visits to two other London boroughs Healthwatch organisations that were selected on the advice of Healthwatch England as good practice examples.

III. Review of existing research on how local people wants to be engaged and involved including engagement undertake to develop the council's Community Engagement Strategy.

4.2 These are the key questions being addressed in the review**:-**

- To what extent is HWTH inclusive and representative of the diverse local community that it serves?
- What can be done to raise the profile of Healthwatch Tower Hamlets amongst local people of all ages and backgrounds and local community organisations?
- How can local people be more engaged in setting the priorities for HWTH and being involved in delivering its work programmes?
- How can HWTH effectively influence services and harness the views of the public to make positive changes?
- How can Healthwatch become more effective in quantifying its evidence and demonstrating how it has contributed to practical changes as a result of its work? How can it maximise strategic influence over the local health economy?
- How can Healthwatch improve its ability and reach in signposting local people to services and providing information and advice? What can be done to help HWTH improve the quality of its analysis and reporting?

5. EMERGING FINDINGS

5.1 The outcome from the review and commissioning proposals will be presented to the Council's Cabinet in June 2016 and inform the new model for Healthwatch going forward. The emerging findings indicate that HWTH is recognised as a key partner across the governance structures in the health and care system. They have good links with a range of voluntary and community organisations across the borough and are valued for bringing the 'patient voice' to a range of forums and meetings. However, more work needs to be done in terms of HWTH developing effective relationships with social care, the relationships with the health sector are more established.

5.2 Senior stakeholders who were consulted as part of this review cited several examples where HWTH had made a difference through their work for example through enter and view visits in Community Mental Health Team (CMHT) settings. Also senior NHS staff stated that HWTH influence is implicit in that it obliges them to be thorough in thinking about patient involvement, for example in consultations around service change. Many examples were provided of how HWTH bring the patient voice to meetings and discussions. The consensus was that in the next phase of its evolution, HWTH needs to move its focus from bringing patient concerns and complaints to give more emphasis to working with the system at a strategic level to identify solutions that are patient-centred. This is a key component of the organisation's 'critical friend' role.

5.3 HWTH have an excellent pool of volunteers who are an effective resource for the organisation in delivering outreach work, conducting enter and view visits as well as collecting patient feedback and carrying out research. HWTH manages its voluntary workforce well, and has a good balance of skills on the board. Having recruited some new board members in 2015, HWTH is exploring ways to harness the skills and experience of board members more in the work of the organisation.

5.4 Whilst many local people who were consulted as part of various community groups and had not heard of Healthwatch, those that had were generally very positive about their experience of the organisation, saying that staff 'really listen' to people's concerns and give local people a voice. This shows a clear need to raise awareness of HWTH, particularly its consumer champion role.

5.5 Many stakeholders across community groups and within the health and care system along with some HWTH volunteers thought that the current office base for the organisation at the Mile End hospital was not in the best location for visibility to the local community and accessibility. However, this has to be balanced with affordability as rents for premises in prime locations are high. The current location has enabled HWTH to forge a good working relationship with the East London Foundation Trust and other health colleagues.

5.6 The Community Intelligence Bursary (CIB) was cited by a number of senior stakeholders in the health and care system as well as community groups as an excellent example of good practice in engaging the local community in research in health and care issues. However, people also were keen to know what the impact of this work has been so far, and what actions are planned in future. This highlights the importance of HWTH communicating regular feedback of the work they are doing and the changes that they have contributed to.

5.7 Many stakeholders expressed a willingness to develop more partnership work with HWTH and acknowledged that they had not always been proactive in pursuing this, and it has to be balanced against finite resources, limited capacity and competing priorities across the health and care system and local community organisations. The council, the CCG and NHS organisations have all offered to help raise the profile of HWTH locally and set out examples of how they can support their activities.

5.8 Going forward HWTH needs to invest in building the quality and depth of its information repository which should serve as a tool for developing HWTH's strategic priorities, identifying issues from patients that need further investigation and providing a good evidence base for presenting constructive challenge to the health and care system and producing credible, evidence based reports. Staff and board members consulted as part of this review felt that this was an area that needs more attention. Some stakeholders found the reports they get from HWTH very useful but others felt that the format and presentation of evidence could be improved and others questioned the methodologies used. There is a need for HWTH to maximize its use of evidence strategically, to determine focused priorities and achieve influence.

5.9 HWTH is required to provide information, advice and signposting as one of its core statutory functions. This is a key aspect of the organisation's performance that needs to improve. It is also an area where there is potential for duplication. Very few stakeholders or local residents who took part in this review were aware of this service. Progress has been hampered as the Healthwatch hub; a portacabin outside the Royal London hospital was closed due to unforeseen circumstances, shortly after opening in September. Considerable energy and effort went into setting up the hub, which was designed as a place for people to visit, find out about Healthwatch, give feedback and get information and advice. The visit to other local Healthwatch highlighted good systems for capturing data around information and signposting activities, and using it to inform other work, such as their strategic priorities and workplace, as well as a high public presence and physical visibility in their community. They also demonstrated a strategic approach to linking the information and signposting function to targeted outreach activities.

5.10 The current contract specification for HWTH contains performance indicators based predominantly on outputs and quantitative targets. The new specification, whilst necessarily including some required outputs, needs to be framed in terms of evidencing outcomes.

6. FUTURE SERVICE MODEL

The Council is using the evidence collated from the review, HWTH's progress to date, learning from other local Healthwatch and the insight from the various consultations and workshops to develop a revised vision and service model for Healthwatch and will base the specification for the new contract on this.

7. DISSEMINATION & FUTURE COMMISSIONING PLAN: The table below outlines the timeframe for this review and the commissioning of the new service which will start from April 2017.

Activity	Timeframe
HWTH Service Review	Jan 2016 – Mar 2016
Report to CMT	March 2016
Stakeholder engagement	*April – June 2016*
Report to MAB	April 2016
Report to Cabinet	June 2016
Procurement	July – Dec 2016
Decision Making	Jan-Mar 2017
Contract mobilisation	**Apr 2017**

8. COMMENTS OF THE CHIEF FINANCE OFFICER

8.1 This report provides an update on the current status of the Healthwatch service in Tower Hamlets. There are no financial implications arising from the contents of this report.

9. LEGAL COMMENTS

9.1 The Health and Social Care Act 2012 (“the 2012 Act”) amends the Local Government and Public Involvement in Health Act 2007 (“the 2007 Act”) to make provisions about local Healthwatch as the consumer champion for health and social care services. The legislation stipulates that there must be arrangements for a local Healthwatch in each local authority area.

9.2 The body contracted to be the local Healthwatch must be a ‘body corporate’ (i.e. a legal entity), which is a social enterprise. ‘Social enterprise’ does not have a single legal definition (rather, it is a collective description of social-purpose organisations) and there are several legal forms for it. However, a general description would be 'businesses with primarily social objectives whose surpluses are principally reinvested for that purpose in the business or in the community'.

9.3 Section 221(2) of the Local Government and Public Involvement in Health Act 2007 sets out the activities that Tower Hamlets Healthwatch must undertake pursuant to the contractual arrangements made with the Council. Section 227 of 2007 Act Requires the Healthwatch to prepare an annual report into its activities.

9.4 Local Healthwatch have a statutory seat on the Health and Wellbeing Board to help them to effectively influence the commissioning and provision of services through producing evidence-based reports and recommendations about how those services could or should be improved.

9.5 When the retendering process is initiated for Healthwatch services, the Council’s Legal Services will advise to ensure that relevant statutory and constitutional provisions are complied with in particular the Public Procurement Regulations 2015, the Council’s Procurement Procedures and the duty to obtain best value as required by section 3 of the Local Government Act 1999.

10. ONE TOWER HAMLETS CONSIDERATIONS

The review specifically explores the extent to which HWTH is inclusive and representative of the diverse local population of Tower Hamlets. Recommendations arising from the review will suggest ways that HWTH can reach people of all ages and backgrounds across the borough. The review also seeks to maximise the opportunity for local people in Tower Hamlets including those whose voices are seldom heard to become more engaged in

setting the priorities for HWTH and delivering its work programmes throughout the borough.

11. BEST VALUE (BV) IMPLICATIONS

11.2 The Council is using the evidence from the review to inform the contract specification for the retender of HWTH and will ensure that the future model of local Healthwatch is sustainable, fit for purpose, cost effective and demonstrably adds value to the local community.

12. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

12.1 There is no direct sustainable action for a greener environment arising from this report.

13. RISK MANAGEMENT IMPLICATIONS

13.1 The Council is legal required to establish a local healthwatch to champion the voice of local people in health and social care. The review and commissioning timetable has sufficient leeway built into to ensure there are no gaps in provision.

14. CRIME AND DISORDER REDUCTION IMPLICATIONS

14.1 There is no direct crime and disorder reduction implications arising from this report.

Linked Reports, Appendices and Background Documents

Linked Report

- NONE

Appendices

- NONE

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

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