AGENDA REPORTS PACK

Wednesday, 8th March, 2017 at 6.00 pm

The Tomlinson Centre, Queensbridge Road, E8 3ND

Contact: Peter Gray
Governance Services Officer
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Tim Shields
Chief Executive

The press and public are welcome to attend this meeting

Health & Wellbeing Board

Board Membership and Additional Attendees

Board Members	
Cllr Jonathan McShane Cabinet Member, Health, Social care and Culture (Chair)	**Dr Clare Highton** Chair, City and Hackney Clinical Commissioning Group
Dr Penny Bevan Director of Public Health Hackney Council	**Paul Fleming** Chair, Hackney Healthwatch
Dr Navina Evans Chief Executive, East London Foundation Trust	**Tracey Fletcher** Chief Executive, Homerton University Hospital NHS Foundation Trust
Alistair Wallace Health and Social Care Forum	**Cllr Anntoinette Bramble** Cabinet Member, Children's Services
Anne Canning Group Director, Children, Adult Services and Community Health, Hackney Council	**Kim Wright** Group Director, Neighbourhoods and Housing, Hackney Council
Paul Haigh Chief Officer, City and Hackney Clinical Commissioning Group	**Laura Sharpe** GP Confederation
Raj Radia Chair, Local Pharmaceutical Committee	

NHS England Representative	
Neil Roberts Head of Primary Care NHS England London central, North and East	

Independent Advisers	
Jim Gamble Chair, City and Hackney Safeguarding Children Board	**Adi Cooper** Chair, City and Hackney Safeguarding Adult Board

Additional Attendees	
Moira Griffiths Group Care and Support Director, Family Mosaic Better Homes Partnership	**Jackie Brett** Health and Social Care Forum
Sonia Davis Chief Inspector, Metropolitan Police	**Ida Scoullos** Community Empowerment Network
Peter Gray Governance Services Officer Hackney Council	

Health & Wellbeing Board

AGENDA
Wednesday, 8th March, 2017

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Health & Wellbeing Board

ADVICE TO MEMBERS ON DECLARING INTERESTS

Hackney Council's Code of Conduct applies to **all** Members of the Council, the Mayor and co-opted Members.

This note is intended to provide general guidance for Members on declaring interests. However, you may need to obtain specific advice on whether you have an interest in a particular matter. If you need advice, you can contact:

- The Corporate Director of Legal, HR and Regulatory Services;
- The Legal Adviser to the committee; or
- Governance Services.

If at all possible, you should try to identify any potential interest you may have before the meeting so that you and the person you ask for advice can fully consider all the circumstances before reaching a conclusion on what action you should take.

1. Do you have a disclosable pecuniary interest in any matter on the agenda or which is being considered at the meeting?

You will have a disclosable pecuniary interest in a matter if it:

i. relates to an interest that you have already registered in Parts A and C of the Register of Pecuniary Interests of you or your spouse/civil partner, or anyone living with you as if they were your spouse/civil partner;

ii. relates to an interest that should be registered in Parts A and C of the Register of Pecuniary Interests of your spouse/civil partner, or anyone living with you as if they were your spouse/civil partner, but you have not yet done so; or

iii. affects your well-being or financial position or that of your spouse/civil partner, or anyone living with you as if they were your spouse/civil partner.

2. If you have a disclosable pecuniary interest in an item on the agenda you must:

i. Declare the existence and nature of the interest (in relation to the relevant agenda item) as soon as it becomes apparent to you (subject to the rules regarding sensitive interests).

ii. You must leave the room when the item in which you have an interest is being discussed. You cannot stay in the meeting room or public gallery whilst discussion of the item takes place and you cannot vote on the matter. In addition, you must not seek to improperly influence the decision.

iii. If you have, however, obtained dispensation from the Monitoring Officer or Standards Committee you may remain in the room and participate in the meeting. If dispensation has been granted it will stipulate the extent of your involvement, such as whether you can only be present to make representations, provide evidence or whether you are able to fully participate and vote on the matter in which you have a pecuniary interest.

3. Do you have any other non-pecuniary interest on any matter on the agenda which is being considered at the meeting?

You will have 'other non-pecuniary interest' in a matter if:

i. It relates to an external body that you have been appointed to as a Member or in another capacity; or

ii. It relates to an organisation or individual which you have actively engaged in supporting.

4. If you have other non-pecuniary interest in an item on the agenda you must:

i. Declare the existence and nature of the interest (in relation to the relevant agenda item) as soon as it becomes apparent to you.

ii. You may remain in the room, participate in any discussion or vote provided that contractual, financial, consent, permission or licence matters are not under consideration relating to the item in which you have an interest.

iii. If you have an interest in a contractual, financial, consent, permission or licence matter under consideration, you must leave the room unless you have obtained a dispensation from the Monitoring Officer or Standards Committee. You cannot stay in the room or public gallery whilst discussion of the item takes place and you cannot vote on the matter. In addition, you must not seek to improperly influence the decision. Where members of the public are allowed to make representations, or to give evidence or answer questions about the matter you may, with the permission of the meeting, speak on a matter then leave the room. Once you have finished making your representation, you must leave the room whilst the matter is being discussed.

iv. If you have been granted dispensation, in accordance with the Council's dispensation procedure you may remain in the room. If dispensation has been granted it will stipulate the extent of your involvement, such as whether you can only be present to make representations, provide evidence or whether you are able to fully participate and vote on the matter in which you have a non pecuniary interest.

Further Information

Advice can be obtained from Gifty Edila, Corporate Director of Legal, HR and Regulatory Services, on 020 8356 3265 or email Gifty.Edila@hackney.gov.uk

Rights of Press and Public to Report on Meetings

Where a meeting of the Council and its committees are open to the public, the press and public are welcome to report on meetings of the Council and its committees, through any audio, visual or written methods and may use digital and social media providing they do not disturb the conduct of the meeting and providing that the person reporting or providing the commentary is present at the meeting.

Those wishing to film, photograph or audio record a meeting are asked to notify the Council's Monitoring Officer by noon on the day of the meeting, if possible, or any time prior to the start of the meeting or notify the Chair at the start of the meeting.

The Monitoring Officer, or the Chair of the meeting, may designate a set area from which all recording must take place at a meeting.

The Council will endeavour to provide reasonable space and seating to view, hear and record the meeting. If those intending to record a meeting require any other reasonable facilities, notice should be given to the Monitoring Officer in advance of the meeting and will only be provided if practicable to do so.

The Chair shall have discretion to regulate the behaviour of all those present recording a meeting in the interests of the efficient conduct of the meeting. Anyone acting in a disruptive manner may be required by the Chair to cease recording or may be excluded from the meeting. Disruptive behaviour may include: moving from any designated recording area; causing excessive noise; intrusive lighting; interrupting the meeting; or filming members of the public who have asked not to be filmed.

All those visually recording a meeting are requested to only focus on recording councillors, officers and the public who are directly involved in the conduct of the meeting. The Chair of the meeting will ask any members of the public present if they have objections to being visually recorded. Those visually recording a meeting are asked to respect the wishes of those who do not wish to be filmed or photographed. Failure by someone recording a meeting to respect the wishes of those who do not wish to be filmed and photographed may result in the Chair instructing them to cease recording or in their exclusion from the meeting.

If a meeting passes a motion to exclude the press and public then in order to consider confidential or exempt information, all recording must cease and all recording equipment must be removed from the meeting room. The press and public are not permitted to use any means which might enable them to see or hear the proceedings whilst they are excluded from a meeting and confidential or exempt information is under consideration.

Providing oral commentary during a meeting is not permitted.

FS 566728

MINUTES OF A MEETING OF THE HEALTH AND WELLBEING BOARD

WEDNESDAY, 11TH JANUARY, 2017

Board Members Present:	**Cllr Jonathan McShane in the Chair**
	Deputy Mayor Bramble, Dr Penny Bevan, Dr Navina Evans, Paul Fleming, Tracey Fletcher, Paul Haigh, Dr Clare Highton (Vice-Chair), Raj Radia, Alastair Wallace, Kim Wright
Officers in Attendance:	**Jack Gooding (Public Health), Andrew lee (Education), Toni Dawodu (Education), Richard Bull (Hackney and City Clinical Commissioning Group), Katie Ellis (GLL), Ian Tompkins (NEL STP) Peter Gray (Governance Services)**

1. Welcome and Introductions

1.1 The chair welcomed all those present and introductions were made.

1 Declarations of Interest

2.1 There were no declarations of interests.

3. Minutes of Previous Meeting

3.1 The minutes of the previous meeting were agreed as a correct record subject to the removal of Paul Fleming from the list of attendees.

4. Community Voice - Verbal

4.4 There was no presentation under this item.

4.5 Jon Williams reported to the Board that he had recently sought Carers views on their experience in this role in the Borough of Hackney. They had responded that Hackney was a busy Borough to work in. The traffic lights could be confusing for people with disabilities and there was a need for appropriate signage and signposting. Further, Carers felt at risk, feeling that they could be falsely accused by those they were caring for. They required support and a network to have respite and to be assured that they were not alone in the caring process.

5. Hackney Dementia Action Alliance

5.1 Sandra Cater presented to the Board on an overview of work of the Hackney Dementia Action Alliance over the past 12 months and the next steps to be taken. She stressed the need for people with disabilities to live well and feel involved. The Alliance was creating a social movement by engaging cross-sectors' statutory third,

and business to radically improve the lives of people with dementia, their carers and families.

5.2 The Chair told the Board that he visited Havering to observe the travel arrangements that were in place in that area. He told the Board that TFL Dial a Ride would not now take persons with disabilities unless accompanied by a carer. Kim Wright would investigate this concern.

5.3 Kim Wright told the Board that the aim was to have liveable neighbourhoods that were appropriate to the needs of people with disabilities. A programme for street improvement was currently underway in the Borough. As part of the Dementia friendly initiative audits had been carried out in the Borough's Leisure Centres. People with disabilities would be consulted on the extent to which current initiatives were sufficient to meet their needs.

RESOLVED:

To support the continuation of the HDAA and to continue to explore registering for the recognition process to be a dementia-friendly community and Hackney a dementia – friendly Borough.

6. Dementia Friendly Swimming

6.1 Katie Ellis, National Community Engagement Manager, reported to the Board on the work of the Dementia Friendly Swimming programme, funded through the Amateur Swimming Association with funding from the Department of Health. Kings Hall Leisure had been involved in the national pilot which aimed to support people living with dementia to take part in swimming and had carried out training. Katie told the Board that many people with dementia accessed the Leisure Centre to be involved in the social aspects on offer. Funding had been made available for non-slip shoes and coffee and cake were available. These sessions at the Leisure Centre had received positive feedback. It was hoped to expand Dementia Friendly Swimming to all Leisure Centres in the Borough and link into the older people's programme.

6.2 Kim Wright told the Board that the GLL initiative had gone beyond what was provided through the national scheme with 31 participants and that this was now to be extended beyond swimming.

6.3 In response to a question from Tracey Fletcher, Katie Ellis told the Board that this was a dedicated outreach service advertised through leaflets and newsletters. Raj Radia asked that details of the service be sent to him.

6.4 Bill Gibbins, Alzheimer's Society, expressed the hope that funding for the service should continue and that the Health and Wellbeing Board would support this. The Chair confirmed that an update on funding would be submitted to the next meeting of the Board.

6.5 Work would continue to upskill staff to undertake dementia awareness training and to continue to develop links with older people's organisations to support more people living with dementia to attend Leisure Centres.

7. City and Hackney Safeguarding Adults Board (CHSAB) Annual Report 2015/16

7.1 Adi Cooper introduced the annual report that captured the work undertaken by the CHSAB in delivering its vision and supporting people. Work was ongoing raising awareness of safeguarding. The report provided the Board with an outline and assessment of the CHSAB and the developments in local multi-agency adult safeguarding systems in 2015/16, along with a statistical overview of key adult safeguarding activity in Hackney and the City of London. The Board noted key achievements for 2015/16 and priorities for 2016/17. Adi Cooper told the Board of improvements in partnership working and delivery through the high risk panel set up as part of the work on self -neglect; and closer working regarding domestic abuse.

RESOLVED:

That the contents of the report and annual report be noted.

8. Children and Special Educational Needs or Disability Partnership Board

8.1 Andrew Lee and Toni Dawodu, Education Services, introduced the report.
The Board expressed concerns around the proposal that the Board should have oversight of the governance of the SEND Partnership Board and agreed to the receipt of yearly updates on its work.

RESOLVED:

To note the remit of the SEND Partnership Board and development of the SEND strategy and receive regular updates on the SEND Partnership activities.

9. Young Black Men Work Programme

9.1 This item was deferred to the next meeting.

10. North East London Sustainability and Transformation Plan (NEL STP) - Update

10.1 Ian Tompkins introduced the report providing a further update to the Board on the development of the North East London Sustainability and Transformation Plan. He told the Board that it was a priority to improve communication and engagement. A workshop of all NHS and Local Authority communications and engagement leads, as well as those for policy and strategy and public health was being held on 26th January 2017. Further events would be arranged on engagement. A draft memorandum of understanding had been circulated. Ian Tompkins would ensure that this was circulated to members of the Board. Ian Tomkins stressed the importance of having a simple narrative and transparency. Jon Williams told the Board of Healthwatch Hackney's input into the STP.

10.2 Shirley (Member of the Public) asked a number of questions and made a number of comments, including that:

- The need for a list of voluntary organisations;

- Who was involved in the workshop on 26th January?
- The need for engagement and involvement at the design stage together with transparency

10.3 Ian Tompkins told the Board that he would produce a list of voluntary organisations. He confirmed that the event on 26th January would include all relevant local groups. He emphasised the importance of engagement and involvement and confirmed that as many people as possible would be involved in the process.

RESOLVED:

To note the report.

11. CCG - Delegated Commissioning of Core Primary Services from NHS England from April 2017

11.1 Paul Haigh introduced the report on Health and Social Care devolution. He told the Board that there was now more experience in managing risk. Dr Clare Highton confirmed that delegated commissioning would lead to increased local control.

RESOLVED:

(1) To note the potential benefits of moving to level three delegated primary care commissioning.

(2) To note that taking on delegated primary care commissioning is subject to a due diligence process.

(3) To note the proposed changes to the terms of reference of the Local GP Provider.

12. Health and Social Care Devolution - Update - Verbal

12.1 Paul Haigh introduced the report. It was noted that as the three organisations developed the model to start on 1 April a set of principles to guide how the arrangements were set up had been agreed. He told the Board that there had been much work carried out on preparing the terms of reference and a report would be made to the next meeting with more detailed proposals. In response to a member question he confirmed that the PPG had been consulted on the initiative.

RESOLVED:

To note the report.

13. Establishing Integrated Commissioning

13.1 Paul Haigh introduced the report outlining proposals to establish an integrated commissioning model by 1 April 2017. More concrete proposal would be submitted to the next meeting of the Board. He confirmed to the Board that this had been discussed with the PPI group.

RESOLVED:

To note the report.

14. Update on Hackney's Autism Alliance Board

14.1 The Board noted the update on Hackney’s Autism Alliance Board.

15. Dates of Future Meetings

15.1 The date of the next meeting of the Board was noted as 8th March 2017.

Duration of the meeting: 6 – 7:50pm

Report to Hackney Health and Wellbeing Board

Item No:	**NA**	**Date:**	**08 March 2017**
Subject:		**Report update on improving the health of children and young people, in particular tackling childhood obesity and working with pregnant mothers and children aged under five years old**	
Report From:		Nadia Sica and Kate Heneghan Public Health, London Borough of Hackney	
Summary:		• This progress report provides an update and action plan for Strategic priority 1 in Hackney's Joint Health and Wellbeing (HWB) Strategy: Improving the health of children and young people, in particular tackling childhood obesity and working with pregnant mothers and children under five years old • Hackney and the City have the 4th highest obesity rate in reception children and the 5th highest obesity rate in year 6 children in London. Based on NCMP 2015/16 data alone, this is an improvement from the highest rate in 2013/14 • A new Obesity Strategic Partnership (OSP) was formed 2016. The OSP sets the strategic direction for tackling obesity in Hackney. It supports a whole system approach to address the complex and wide-ranging drivers of obesity, promoting a shared understanding of the 'problem' and how to address it • Public Health are currently reviewing local childhood obesity and physical activity services and pathways. The review will inform the development of future services and commissioning intentions, with new services due to go live in April 2018 • The new 0-5 Health Visiting Service has been designed, re-commissioned and awarded to Homerton University Hospital Foundation Trust (HUFT). The new service went live on 01 July 2016 • Following on from the Welcome Hackney Babies pilot in summer 2015, the Hackney Baby Box initiative will be implemented in summer/autumn 2017 in partnership with the Baby Box Co.	
Recommendations		Members of the Board are requested to:	

	• note the content of the attached briefing and agree or amend the future priorities in this paper regarding the focus on improving the health of children and young people, in particular tackling childhood obesity and working with pregnant mothers and children aged under five years old • consider and discuss how their representative organisations can continue to support local action on improving the health of children and young people (e.g. through healthy eating provision)
Contacts:	Nadia Sica, Public Health Service Manager (Children and Young People) nadia.sica@hackney.gov.uk Kate Heneghan, Public Health Strategist kate.heneghan@hackney.gov.uk

1. Background and Context: Childhood obesity rates in Hackney (and the City of London)

1.1 The National Child Measurement Programme (NCMP) is one of the council's statutory Public Health deliverables, and measures children's height and weight in all maintained schools at reception year (age 4-5) and year 6 (age 10-11). It has been running since 2007/08, and is delivered by local authority commissioned school nurses (Homerton University Hospital Foundation Trust). Data for City and Hackney is combined.

1.2 In the 2015/16 National Child Measurement Programme (NCMP), 12.1% of reception year children were recorded as overweight and 12.5% of reception children were recorded as obese in City and Hackney. This places City and Hackney as the fourth highest area in London for obesity in reception year, and fifth highest for overweight and obese combined. The overall rates of overweight and obese reception age children in 2015/16 are not significantly different to previous years and remain stable.

1.3 In the same year, 15.5% of year 6 children were recorded as overweight, and 27% were recorded as obese. This places City and Hackney as the 5th highest area in London for obesity in year 6, and 5th highest for overweight and obesity combined. The distribution across weight categories in year 6 has remained largely stable since 2007/08, with some year-on-year variation (see Table 1 below).

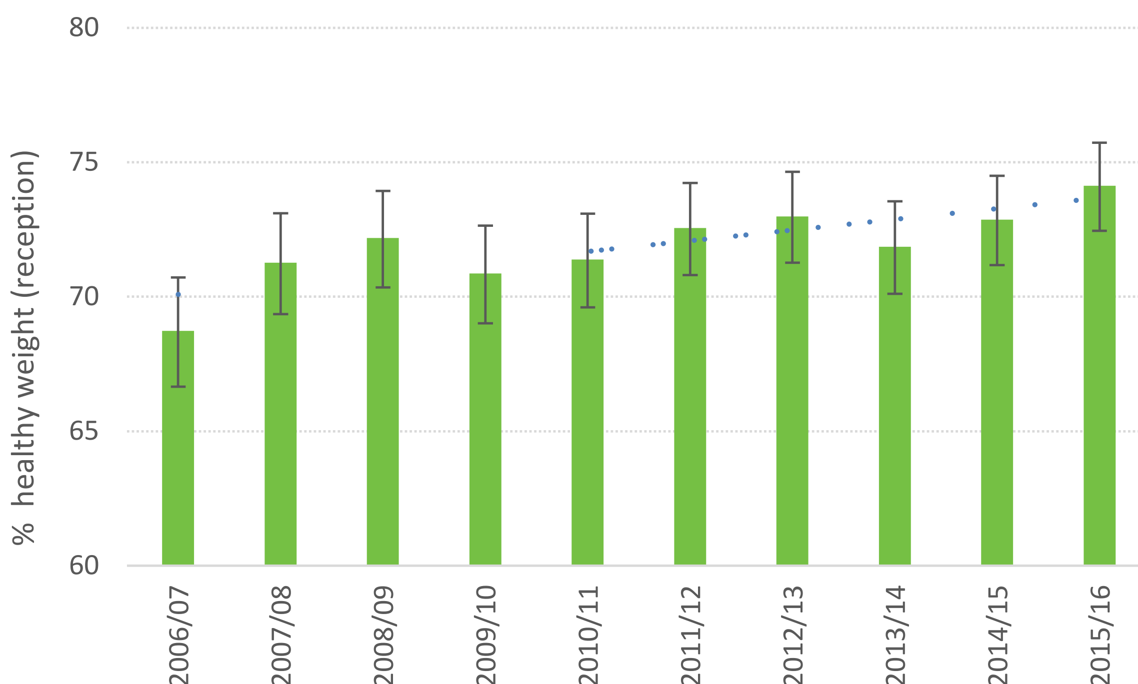
1.4 *Table 1: Distribution of children's weight (Year R and Year 6), Hackney and the City 2007/08 to 2015/16*

	Year R				Year 6			
	Underweight	Healthy weight	Over-weight	Obese	Underweight	Healthy weight	Over-weight	Obese
2007/08	1.2%	70.3%	14.4 %	14.0 %	1.7%	59.6%	15.1 %	23.6 %
2008/09	1.3%	71.8%	13.6 %	13.3 %	1.4%	59.0%	15.6 %	24.0 %
2009/10	1.7%	71.2%	12.7 %	14.4 %	1.3%	58.3%	14.9 %	25.5 %
2010/11	0.9%	71.1%	13.5 %	14.6 %	1.7%	57.3%	15.9 %	25.0 %
2011/12	1.1%	71.6%	13.9 %	13.4 %	1.6%	55.6%	15.6 %	27.1 %
2012/13	0.9%	72.8%	13.1 %	13.2 %	1.4%	57.4%	16.0 %	25.2 %
2013/14	1.3%	71.5%	12.8 %	14.4 %	1.5%	58.2%	14.3 %	26.1 %
2014/15	1.5%	72.6%	14.0 %	12.0 %	1.4%	57.5%	15.5 %	25.6 %
2015/16	1.3%	74.1%	12.1 %	12.5 %	1.0%	56.5%	15.5 %	27.0 %

Source: NCMP 2007/08 – 2015/16

1.5 The 2015/16 NCMP data show the highest percentage of reception year children in Hackney and the City recorded as having a healthy weight since the inception of the programme (see Figure 1 below). This is statistically significant when compared with 2006/7 (but similar to subsequent years), and in line both with national trends and when compared to Hackney's 'statistical neighbours' (i.e. areas with similar population demographics).

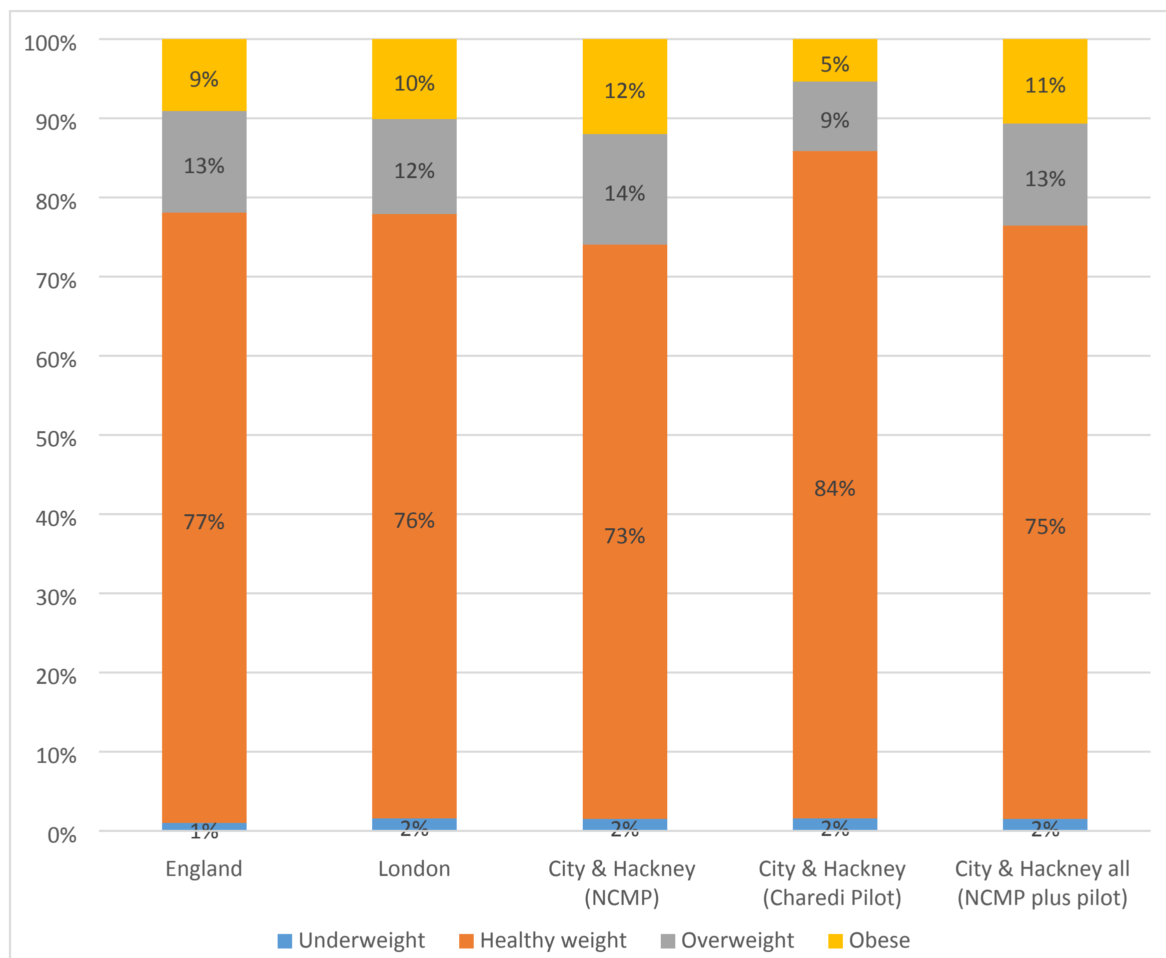
1.6 *Figure 1: percentage of reception age children recorded as having a healthy weight in Hackney and the City over time*



Source: NCMP 2007/08 – 2015/16

1.7 The NCMP only covers children attending state maintained schools and, therefore, misses a significant proportion of our child population (22% of children attend non-state maintained schools in Hackney, with a high concentration in the Orthodox Jewish community). Therefore, in 2014/15 we measured Hackney children in the Orthodox Jewish population through a new integrated health check at reception (also incorporating/ hearing and vision screening), in order to better ascertain actual local levels of/ childhood obesity. Including this group for 2014/15 reduces obesity prevalence in reception year to 13%. This would have ranked as the 27th highest nationally in 2014/15, but still statistically significantly higher than the national average (see 1.8). In 2016/17 the measurement programme of children in the Orthodox Jewish population has been extended to include year 6 children, who are also offered a dental health education session.

1.8 *Figure 2: NCMP 2014/15 comparison - national, regional, Hackney and the City, plus Charedi pilot*



1.9 Public Health have undertaken two health needs assessments for children and young people living in Hackney and the City of London in 2015-16, the first for 0-5 year olds, and the second for 5-19 year olds. The key findings from both needs assessments have been highlighted in the children and young people's chapter of the JSNA in 2016.

2. Integrated Local Obesity Delivery **2.1** Tackling childhood obesity remains one of the key priorities in the Board's Joint Health and Wellbeing strategy. Get Hackney Healthy is the local programme that coordinates the work, and aims to improve child and family health outcome, specifically aimed at reducing obesity in under 5's and their families. An update on the Get Hackney Healthy programme can be found in Appendix 1 of this report.

2.2 A new Obesity Strategic Partnership (OSP) was formed in February 2016, chaired by the Chief Executive of the London Borough of Hackney. The OSP sets the strategic

direction for tackling obesity in Hackney. It supports a whole system approach to address the complex and wide-ranging drivers of obesity, promoting a shared understanding of the ‘problem’ and how to address it. It is cross cutting partnership with representatives from transport, planning, communications, housing, public realm, parks and leisure, children and adult social care, public health, schools, and the CCG. The Terms of Reference for the OSP can be found in Appendix 2 of this report.

2.3 The Partnership agreed on the following five key deliverables for 2016/17:

- a borough-wide campaign to increase walking
- implementation of the Daily Mile in Hackney primary schools
- piloting of a community-designed affordable recipe pack in Haggerston
- roll-out of the Healthier Catering Commitment scheme across the borough (to improve the food offer in hot food takeaways) and piloting of a ‘healthy retail’ model to encourage healthier purchases in local convenience stores
- improve the identification of overweight/obese social care clients and access to appropriate weight management advice and support.

Appendix 3 provides more detail on progress and next steps for each of these priority actions.

This work is new, but complements and dovetails with the actions outlined in priority one of Hackney’s Joint Health and Wellbeing strategy, and the recommendations from the 2012/13 scrutiny review of child obesity.

2.4 London Councils, in partnership with Sustain, have launched the Local Government Declaration on Sugar Reduction and Healthier Food. The Declaration supports councils to publicly commit to reduce sugar and promote healthier food. The OSP will discuss whether Hackney Council will commit to signing the declaration in April 2017.

3. Children and Young People’s Healthy Weight and Physical Activity Services

3.1 In December 2015 Hackney Council’s Public Health team coordinated a cross council Child Obesity Self-Assessment review as part of the Association of Directors of Public Health (ADPH) London Sector Led Improvement work programme. The review fed into a series of peer-review workshops with neighbouring local authorities, to share best practice and highlight areas for improvement in tackling childhood obesity (appendix 4).

3.2 Following on from a review in 2014, Public Health are currently reviewing local childhood obesity and physical activity pathways. The review is evaluating services against national and international guidance, identifying best practice and evidence for targeted programmes, engaging local residents and stakeholders, and utilising the findings and recommendations from the 2015 review and ADPH self-assessment. Discussions have started to take place with the CCG about the potential to jointly commission some services in future, in line with the integrated commissioning/devolution plans.

3.3 The Great Weight Debate (GWD), which is overseen by the London Prevention Board, is a conversation aiming to fully engage and involve Londoners in the future

health of their children. The GWD aims to galvanise wider social action and steer the strategic direction to tackle childhood obesity. An online GWD survey was published and promoted in autumn 2016 and data from Hackney resident responses will be included in the review of local childhood obesity services.

4. 0-5 Health Visiting Service

4.1 The new 0-5 Health Visiting Service has been designed, re-commissioned and awarded to Homerton University Hospital Foundation Trust (HUHFT) following transfer of responsibility to Public Health from NHS England in October 2015. The service went live on 01 July 2016 and has been bedding in well, with key milestones around service transformation and implementation of additional health checks in place. The new service is being overseen by a newly formed 0-5's Health Oversight Group.

4.2 Within the new service Health Visitors work from Children's Centres across the borough and there is a named Health Visitor for each GP practice, allowing for increased opportunities for better integrated working. Health Visitors are also utilising mobile working through the use of laptops and tablets, which is particularly beneficial in accessing the RIO database in home visits and also creates time efficiencies through writing and saving electronic notes out of the office.

4.3 There are five mandated assessments that all families receive under the universal level of service which are listed below. The assessments are designed to regularly review family health and wellbeing, identify early signs of developmental and health needs and to tailor support or intervention to meet the needs of individual families.

- Antenatal
- New baby
- 6 – 8 weeks
- 9 – 12 months
- 2 – 2 ½ years

4.4 Two additional assessments are offered in the home to vulnerable families with a focus on maternal mental health, maintaining infant health, promoting development and keeping safe. The targeted families include first time parents and families identified as having needs at the Universal Plus/ Partnership Plus levels. Assessments are offered at the following points:

- 1 month
- 3 - 4 months

4.5 There are six High Impact Health Visitors (HIHV) who lead on the local high impact areas including maternal and infant mental health, healthy weight, transition to parenthood, substance misuse, children with disabilities and breastfeeding. The HIHV have started to work to develop the pathways across the Health Visiting service in these key areas. Another new role is the lead nurse for quality and development who is focused on improving the professional development of the team and the quality of the service delivered.

5. Future work to improve the health of pregnant women and children in Hackney

5.1 Following on from the Welcome Hackney Babies pilot in summer 2015, the Hackney Baby Box initiative will be implemented in summer/autumn 2017 in partnership with the Baby Box Co. The Hackney Baby Box initiative will provide expectant and new Hackney parents with the opportunity to complete an online education course delivered by local experts on key health priorities. Families will then be offered a free Baby Box that the baby can sleep in. The Baby Box will include a firm mattress, waterproof cover, 100% cotton sheet, nappies, wipes, onesie and breast pads.

5.2 A task and finish group with key stakeholders has been established to oversee the Baby Box initiative implementation, members include public health, CCG, midwifery, health visiting and Hackney Learning Trust.

Area of work	**Future Priorities**
Integrated Local Obesity Delivery	The next OSP meeting will take the format of an interactive workshop, which will aim to: • review the achievements of the OSP over the first 12 months and what we have learned so far • review the membership and terms of reference of the OSP, and consider how we can involve wider stakeholders (including service providers, residents, businesses and members) to activate whole systems change • discuss the Local Government Declaration on Sugar Reduction and Healthier Food initiative and decide whether Hackney Council will commit to signing the declaration (appendix 5). • agree future priorities for the OSP, potentially: o Applying behaviour change principles to tackling obesity across Universal and targeted services o Enhancing green infrastructure and adopting a Healthy Streets approach to our public realm • Longer term, the OSP will coordinate the update of the current Healthy Weight Strategy, Achieving a healthy weight for all in Hackney and the City which expires in 2018
Children and Young People's Healthy Weight and Physical Activity Services	• Complete the childhood obesity and physical activity review to inform the redesign of future services, including the Get Hackney Healthy work programme. • Commission new childhood obesity and physical activity services, to go live in April 2018
0-5 Health Visiting Service	• Continue to work with the Health Visiting service to develop pathways and appropriate support in the high impact areas of the service • Ensure the five mandated health assessments are offered to all families in Hackney and the City in a timely

	manner
Future work to improve the health of pregnant women and children in Hackney	• Implement the Hackney Baby Box initiative with an appropriate and sustainable local pathway, developed in partnership with key stakeholders • Oversight of the Hackney Baby Box initiative will be taken on by the 0-5 Health Oversight Group, to ensure the programme is embedded and promoted by relevant local services.

6. Priorities for 2017/18 and beyond

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Appendix 1: Hackney Joint Health and Wellbeing Strategy 2015-2018 action plan update
Priority 1: Improving the health of children and young people, in particular tackling childhood obesity and working with pregnant mothers and children aged under five years old
March 2017

Priority Action	Owner	Progress	Next steps
1.1 Develop a borough wide framework for reducing obesity and promoting healthy weight and healthy lifestyles including:			
Enhancing practitioner effectiveness: i) to recognise children at risk of obesity early ii) providing training on how to help parents make lifestyle changes iii) encouraging practitioners to model healthy lifestyles	Amy Wilkinson (Head of Service Public Health (CYP), LBH) Angela Scattergood (Head of Early Years, HLT, LBH)	Two healthy weight guidance documents have been produced and distributed widely to professionals who work with children, young people, and families. The 'Healthy Weight, Healthy Lives for Children and Young People: Hackney Child Obesity Framework 0-5years' (appendix 6) and the 'Early Years Setting and Children's Centre Healthy Weight Guidance 2016' (appendix 7). A rolling training programme is delivered to Early Years professionals on healthy lifestyle topics (e.g. 20 childminders and 55 early year's staff attended a training workshop on Healthy Eating in September 2016). HLT continue to work with Early Years settings to implement Eat Better Start Better guidelines. To date 97 EY settings have signed up and accessed training from a dietician and early years consultant to implement the guidelines	Healthy weight behaviour change training for professionals is being considered as part of the current review of Public Health child obesity commissioned services. The final service specification is scheduled for June 2017.

		(amounting to 84% of the total EYFS settings). Taking into account current involvement, this programme has the potential to affect the diets of approximately 4809 children (0-5 year olds) in Hackney. A local Eat Better Start Better website with useful templates and other resources has been developed.	
1.2 Incorporating and strengthening healthy lifestyles within existing services:			
i) Implementation of a local education and health check at 27 months ii) Implementation of a school-based nursing model	Angela Scattergood Amy Wilkinson	Integrated 27 month reviews between health and education have been implemented in the borough, and are embedded within the service specification of the 0-5s Early Years Health Visiting service. The new school-based health model is well established. A survey of schools views on the model and service delivery was conducted in December 2016, results are yet to be analysed. An updated ‘Get Healthy Stay Healthy’ leaflet (appendix 8) was produced in October 2016, this is sent with the NCMP feedback letter to parents of participating year 6 pupils. The leaflet lists healthy activities available to children, young people and families (e.g. One You community projects), and information on weight management and dietetic services for children who are overweight or obese.	Healthy weight is one of the high impact areas in the new 0-5s Early Years Health Visiting service, and there is a specific Health Visitor Lead for Healthy Weight.

1.3 Develop a comprehensive health improvement communications campaign			
Raise awareness of how to improve the health of children and young people across the borough.	Public Health, LBH Communications team, LBH Family Information Service, HLT, LBH	Hackney residents took part in the regional 'Great Weight Debate' which was promoted locally through various media channels, and supported by Cllr McShane. Public Health continue to attend estate fun days promoting Change4Life national family campaigns based on eating well and moving more. Public Health managed the delivery of the 'sugar swap' healthy lifestyle session to approximately 2000 year 6 children in partnership with TfL's Junior Citizenship programme at Hackney Museum. A number of primary schools resources have been produced to support schools in delivering healthy lifestyle lessons. These were adapted for local use from the national Change4Life materials. The Hackney Active Kids Guide was distributed to every primary school age child in the borough, and to community settings (GPs, children's centres etc.).	A more concerted campaign on walking located in Dalston around the A10 is planned through Hackney's Obesity Strategic Partnership (OSP). The campaign will encourage families to walk for ten minutes a day, alongside changes to the physical environment to improve the walkability around the A10 corridor. The campaign will start in March 2017.
1.4 Assessment and subsequent roll out where successful of current pilot interventions, including:			
The Randal Cremer whole school intervention pilot, 'Health	David Toombs (Children's Health	13 schools have participated in Health Heroes projects since September 2012. A number of	An expansion of Health Heroes to develop the

Heroes'	and Wellbeing Leader, LBH)	interventions have been piloted to see what works to increase physical activity levels, and improve access to and knowledge of healthy food in schools. In July 2016, the Health Heroes funding grant was launched and match funds projects up to the value of £10,000 (£5,000 from LBH, £5,000 from the school). The grant application has a menu of options for interventions that have been piloted and successful in previous years. School food catering and physical activity reviews are mandatory as these have proven to have the biggest impact and most sustainable outcomes once the projects have finished. Five schools were successful in their grant applications for the 2016/17 academic year, and are currently being project managed by the Public Health team.	support provided to schools to create healthy weight environments (especially around school food catering), is currently being considered as part of the child obesity services review being conducted by Public Health. The final service specification is scheduled for June 2017.
Play Streets	Nick Jackson (Play Development Manager, LBH)	There have been 50 Play Streets since the start of the project four years ago; 38 are currently active. A new 'How To' leaflet is being developed to support residents to setup Play Streets. The Hackney Play Street model was presented at the 'Child in the City' annual conference in Belgium in November 2016.	Options are being considered on how to support establishing Play Streets in housing estates, where it may be most needed, but where there may not be the required volunteer infrastructure.

HENRY (Health, Exercise, Nutrition for the Really Young)	Susie Longford (Clinical Service Manager, LEAP, Homerton University Hospital NHS Foundation Trust)	HENRY groups continue to run at various children's centres across the borough (12 per year). A training programme of HENRY facilitators continues (11 new facilitators were trained in the most recent quarter). A HENRY group took place at Lubavitch Centre for the *Charedi* Orthodox Jewish communities. This was a specific tailored session led by a trained HENRY facilitator from the community. The first HENRY group session in a school took place at Randal Cremer Primary School.	A HENRY group session with Speech and Language Therapists is planned, alongside the regular HENRY programme and additional community specific sessions (e.g. to the Orthodox Jewish and Turkish/Kurdish communities).

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Appendix 2:

Terms of Reference for Hackney Obesity Strategic Partnership

February 2016

"Working together for a place where everyone can achieve a healthy weight"

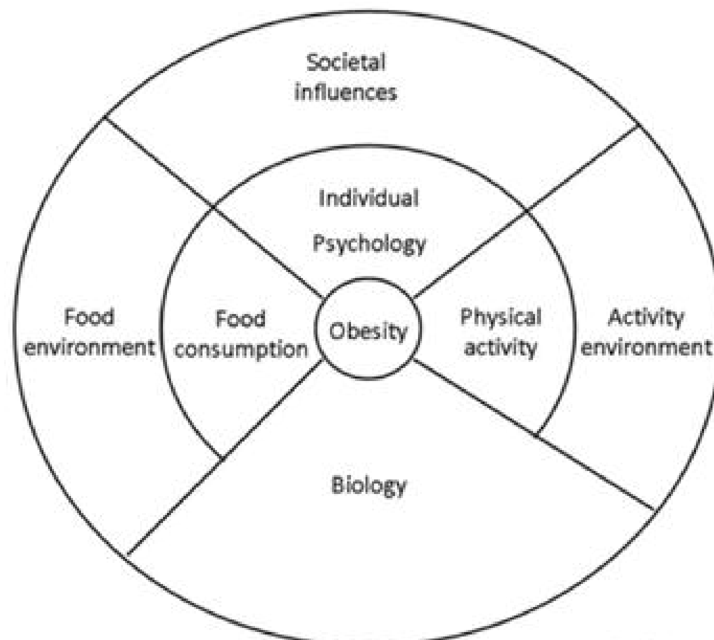
Purpose

The purpose of the Obesity Strategic Partnership (OSP) is to:

- set the strategic direction for reducing obesity and associated health inequalities;
- support the implementation of a 'whole systems' approach to obesity (taking into account the role of the food environment, physical activity environment, social influences, as well as individual psychology, physical activity and food consumption);
- promote a shared understanding of how to address obesity and develop evidence-based approaches for collaborative action.

Context

Obesity is influenced by a wide range of factors, as summarised in the simplified diagram below (based on the Foresight report from 2007). Preventing and tackling obesity effectively requires the development of a sustained 'whole systems' approach, working across individual, environmental and societal levels, and requires the participation of a broad partnership of stakeholders.



Role
The Hackney OSP will:

- lead the review and implementation of the local obesity strategy and subsequent action plans;
- ensure a cohesive approach to commissioning of healthy weight, physical activity and weight management services across the borough, including making recommendations to commissioners as appropriate;
- maintain an overview of any emerging trends and key issues arising around obesity;
- share learning from current research and best practice to inform interventions;
- steer and support research and evaluations relating to obesity as appropriate;
- contribute to the design of an evaluation framework for the local obesity pathways;
- provide an opportunity for colleagues working to reduce obesity to co-ordinate local developments, build networks and identify opportunities for collaboration;
- share best practice and identify opportunities to work with neighbouring London Boroughs were appropriate (e.g. through London's Growth Boroughs network and the London Obesity Network).

Format of meetings
1) Focus topic/learning set (ideally with external expert input)
2) Practical planning or review session (ideally linked to focus topic)

Frequency of meetings
The OSP meets quarterly. This will be reviewed after 12 months (i.e. in early 2017).

Accountability
The OSP is accountable to:

- Hackney Health and Wellbeing Board

The OSP will also feed into a range of health and wider determinants partnerships, including the Children's Health and Wellbeing Partnership.

Review
The Terms of Reference will be reviewed annually.

Guiding documents
National

- Healthy Lives, Healthy People: Our strategy for public health in England
- Everybody Active, Every Day: An evidence-based approach to physical activity
- Fair Society, Healthy Lives: The Marmot Review
- Foresight: Tackling Obesities: Future Choices – Project Report

Regional

- Better Health for London

Local

- Achieving a Healthy Weight for all in Hackney and City, 2010-2018 (and subsequent action plans)

- Hackney's Joint Health and Wellbeing Strategy
- City of London Joint Health and Wellbeing Strategy
- London Borough of Hackney Childhood Obesity Scrutiny Review report 2012/13

Membership
The OSP will be a strategic group comprised of leaders from across the obesity system. This will include a representative for/on behalf of the City of London.

Task and finish groups will be established to support implementation of specific emerging projects, as required. This will be drawn from a larger operational group, and include providers. This will include a City-focused group to implement/coordinate City-specific initiatives.

Membership will be by role rather than by name, to ensure that the TOR for the OSP remains current if staff change. Each role should have an alternate representative, so that at least one of the two attend each OSP meeting. Members (and their representatives) will have a strategic, decision-making role in their organisation so that they are able to take back and implement actions agreed by the OSP.

The OSP will be chaired by the Chief Executive of Hackney Council. Administration will be the responsibility of a designated officer in the Public Health team, who will also maintain an updated list of the individuals (and their alternate representatives) who will participate in the OSP. There will be representatives from both the adult and children's divisions within the Public Health team at every meeting.

The OSP strategic group membership will include:
- NHS commissioners (including City & Hackney CCG and NHS England)
- education authority partners
- children and young people's service commissioners
- adult social care commissioners
- strategic partners from across the Council, including:
  - spatial planning
  - housing policy
  - communications and consultation
  - transport planners and active travel team
  - environmental health
  - parks and public realm
  - leisure and sports team
  - libraries and cultural services
  - public health

Other stakeholders will constitute a wider operational group, and will be invited to attend OSP meetings for relevant agenda items, and to participate in task and finish groups and/or provider forum meetings, as appropriate:
- providers of our newly commissioned obesity services (to be confirmed in 2016)
- other NHS providers (including pharmacists, GPs, health visitors, dieticians)
- local providers of catering services (including Council premises)

- local employers, including the Council and Homerton Hospital
- retailers and food outlets
- schools and early years settings (including school nurses)
- Family Information Service (as a communications route to families)
- social landlords
- voluntary and community sector providers, including successful bidders as part of our public health grants programme to test out ideas on tackling the wider causes of obesity (starting in April 2016)
- residents' groups
- Healthwatch
- academic partner (tbc)

Appendix 3: Hackney Obesity Strategic Partnership (OSP) 2016/17 action plan update March 2017			
Priority Action	**Implementation group**	**Progress**	**Next steps**
Walking A borough-wide campaign that aims to increase physical activity. Walking will be the focus, using insight gained from the walking potential study commissioned by the sustainable transport team. Subsequent work by TfL on key local "walking corridors" with greatest potential, and insight from last year's health and wellbeing resident survey.	Maryann Allen, Group Engineer, Sustainable Transport, LBH Damani Goldstein, Senior Public Health Strategist, LBH Andrew Woollard, Communications Officer, LBH Natalie Broughton, Strategic Policy Manager, Planning, LBH	Regular meetings between LBH Transport, Leisure, Public Health and Communications have taken place to plan the campaign. A communications plan has been completed. The campaign will run for four to six weeks and encourage residents to take a ten minute brisk walk, which was chosen as an achievable target for most residents. The campaign will run through a number of channels: Hackney Today, leaflets distributed in public spaces (libraries, GP surgeries etc.), and targeted advertising on Facebook.	Pilot the campaign for four weeks in Dalston in March 2017. Evaluate and look to roll-out across the borough.
Running around Implementation of the Daily Mile in ten Hackney Primary Schools by July 2017.	Jack Gooding, Public Health Practitioner, LBH David Toombs, Children's Health and	11 Hackney Primary Schools have participated in the Hackney Daily Mile since September 2016, (approximately 2,000 primary	By 2018 aim to get 25-30 Hackney Primary Schools doing the Daily Mile.

Pupils run, jog, walk, for fifteen minutes a day (from desk to desk) as part of the school day.	Wellbeing Leader, LBH Andrew Woollard, Communications Officer, LBH	school children). Schools have been offered support to help implement the Daily Mile, including meeting with parents, school staff, assemblies, 'How To' events; and developing campaign resources, (e.g. risk assessments, FAQ sheets, and engagement letters).	
Cooking Pilot a community designed affordable recipe kit, distributed at community settings. A new social enterprise will distribute the packs based in Haggerston Ward, with potential to scale-up across the borough.	Gareth Wall, Head of Service, Public Health, LBH Henry Muss, Public Health Officer, Community & Partnerships, LBH	Residents have been involved in the design of the recipe packs, have tested recipes, and have given feedback on design, product and branding, through focus groups and live demos. The Social Enterprise, Makeit, successfully reached their crowd funding target, and alongside match funding from Healthy London Partnership will distribute the packs for free to families of two to four people to pilot the approach.	An independent evaluation has been commissioned with Healthy London Partnership, due to be begin in March 2017.
Shopping and eating out – offer to	Gareth Wall, Head of Service, Public		

businesses Healthier Catering Commitment The Hackney Healthier Commitment project will work with food businesses to become healthier through a tiered award scheme based on the Chartered Institute of Environmental Health scheme. Retail offer A healthy retail pilot, working with local convenience stores to encourage healthier shopping choices. London Healthy Workplace Charter	Health, LBH Damani Goldstein, Senior Public Health Strategist Aleyne Fontanelle, Head of Projects and Regulatory Services, LBH Thom Dunn, Senior Public Health Practitioner, LBH	Healthier Catering Commitment Recruitment for the Healthier Catering Commitment project role has been completed, due to start in March 2017. Retail offer A feasibility study has been completed of changes that could be made in corner shops, as well as a nutritional analysis of popular drinks, crisps, confectionary and chocolate to identify potential product swaps that could be promoted, how they could be promoted, and how changes in customer purchasing could be measured. London Healthy Workplace Charter	Healthier Catering Commitment To work with and award a total of 380 businesses in the borough over a three year period. Retail offer A pilot phase which will involve testing out the changes to stores (e.g. healthier till points, and displays) to try to ‘nudge’ customers into making healthier choices, March 2017. London Healthy Workplace Charter

The charter is a framework to guide investment in staff health and wellbeing, for organisations of all sizes across all sectors. Two of the eight Charter standards are healthy eating and physical activity; there are also core standards around corporate support and leadership. Accreditation means that the council can support local businesses to work towards Charter status and become healthier workplaces		The London Borough of Hackney was awarded the London Healthy Workplace Charter in November 2016. Homerton University Hospital NHS Foundation Trust is also Healthy Workplace Charter accredited.	To provide ongoing support to businesses to become healthy workplaces.
Caring – supporting overweight and obese social care clients Obesity has a direct negative impact on social care costs. This action will amend the initial assessment with clients to understand the extent to which weight and related health conditions affect mobility or risks exacerbating the problem if not addressed.	Simon Galczynski, Director, Adult Services, LBH Jayne Taylor, Public Health Consultant, LBH Damani Goldstein, Senior Public Health Strategist, LBH	An initial scoping document has been produced and a working group has been formed.	Social workers and frontline staff will be trained to provide support and referrals into local weight management services. Public health intelligence will work with adult commissioning to provide a robust economic measure for the impact.

Appendix 4: ADPH Childhood Obesity Self-Assessment Framework

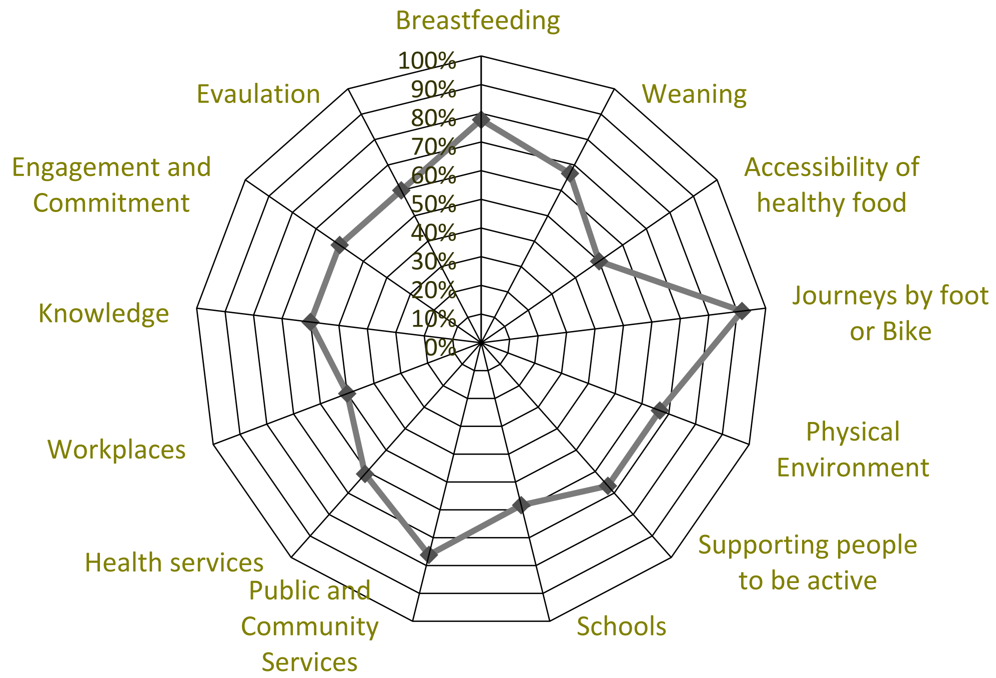
Summary table of priorities

Your scores from each theme are ranked in the table below. The themes that achieve the highest percentage score reveal areas where your borough is doing well. Those areas with lower percentage scores highlight area where greater focus should be applied. This ranking is also illustrated in the radar graph.

Your Strategy and Priorities score is summarised separately in the table below.

1	Journeys by foot or Bike	92%
2	Breastfeeding	78%
3	Public and Community Services	76%
4	Weaning	67%
5	Physical Environment	67%
6	Supporting people to be active	67%
7	Health services	61%
8	Knowledge	60%
9	Engagement and Commitment	60%
10	Evaluation	60%
11	Schools	58%
12	Accessibility of healthy food	50%
13	Workplaces	50%

Strategy and Priorities 94%


Summary table of priorities
Breastfeeding
Weaning
Accessibility of healthy food
Journeys by foot or Bike
Physical Environment
Supporting people to be active
Schools
Public and Community Services
Health services
Workplaces
Knowledge
Engagement and Commitment
Evaulation
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%

Local Government Declaration on Sugar Reduction and Healthier Food

Support pack

sustain
the alliance for better food and farming

Sustain: The alliance for better food and farming, advocates food and agriculture policies and practices that enhance the health and welfare of people and animals, improve the living and working environment, enrich society and culture, and promote equity. It represents around 100 national public interest organisations working at international, national, regional and local level.

Part of Sustain, London Food Link is an independent network of individuals, businesses and organisations working for better food in the capital. We run and partner on policy initiatives, campaigns and practical projects that improve the food system including Urban Food Fortnight, the Urban Food Awards, the Capital Growth network, The Jellied Eel magazine, London Food Poverty Campaign, the Good Food for London report, Cage Free Capital, as well as running good food training and networking events.

More information and resources

Available at www.sustainweb.org/londonfoodlink/declaration

Contact: sofia@sustainweb.org

sustain
the alliance for better food and farming

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change
4 life
Eat well
Move more
Live longer
OXFORD

Introduction

The aim of the Local Government Declaration on Sugar Reduction and Healthier Food is to achieve a public commitment to improve the availability of healthier food and drinks and to reduce the availability and promotion of unhealthy options. It should be endorsed by the elected leaders of London boroughs and relevant senior officers such as directors of public health.

The declaration is open to all local authorities in London and beyond. To sign the declaration the local authority has to commit to take at least six different actions across six different key areas. In addition, the local authority commits to report on progress annually.

Action can include continuing support to existing initiatives as long as there is a commitment to new initiatives as well.

This support pack includes a menu of initiatives under each key area of action for local authorities to choose from. Local authorities can adapt the wording of the initiatives based on local conditions, as long as commitments cover all six areas and some of them are new.

From 2017 the declaration will feature as a measure in the Good Food for London report, encouraging local authorities to sign up and implement an annual evaluation programme.

The Buywell Food for Health project supports market traders to increase their fruit and veg sales. Courtesy of Tower Hamlets Council

What is the problem?

Diet related conditions, including obesity, diabetes and heart disease, are some of the greatest health problems facing the UK today. More is spent on the direct medical costs of diabetes and obesity-related conditions than on fire and police services combined. And the total societal cost of obesity, including lost productivity, is second only to smoking.

The problems are even worse in London, where one in three children are overweight or obese by the time they start secondary school.[1] If left unchanged, this situation will lead to serious health complications later in life, such as diabetes, heart disease and cancers. In total more than 3.8 million Londoners are overweight or obese.[2]

Overconsumption of foods high in sugar, fat and salt, and sugary drinks is a major contributor to the health crisis. Unfortunately unhealthy foods are available at every corner, at every time of the day and night and strategically located near schools, in our high streets and in areas of higher deprivation where few healthy alternatives are available. Consumption of unhealthy food is also actively promoted through advertising, sponsorship deals and price promotions.

Urgent action is needed at all levels to promoter healthy eating and sugar reduction. Local authorities have an important role to play. They control planning, public and environmental health, leisure and recreation. They control or at the very least influence food and drink in schools, nurseries, civic centres, leisure centres and others.

In order to help local people to achieve healthier diets, local authorities need to integrate and co-ordinate their policies. This is a vital part of taking a whole-systems approach to achieving healthier diets.

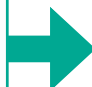
A Local Government Declaration on Sugar Reduction and Healthier Food is a whole-systems approach which will help to address these problems through targeted action under six key areas of commitment by local authorities across the Capital.

1 National Child Measurement Programme - England, 2014-15, available online at http://content.digital.nhs.uk/catalogue/PUB19109
2 London Health Commission (2014), Better Health for London, available online at http://www.london-healthcommission.org.uk/wp-content/uploads/London-Health-Commission_Better-Health-for-London.pdf

The steps to sign the declaration

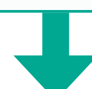
Step 1: Identify the priorities in your borough and define the scope of the declaration

Make a compelling case for why action is needed in your borough. You may have already identified priorities (e.g. in your Health and Wellbeing Strategy or Obesity Strategy). Choose at least six actions, one under each of the six key areas from the menu or propose your own as long as they include SMART goals. What are the outcomes you would like to see in terms of meal quality, increase in water points, vending, money raised through a voluntary sugary drinks' duty, etc.? Start with the easy wins. Your borough may already be taking action but this is an opportunity to galvanize support and do more.



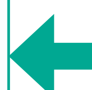
Step 2: Take the proposal to your champion(s)

Take the proposal to the elected member responsible for public health and director of public health. Ideally they will champion the declaration through the democratic process. They need to be well briefed to make their case to other members and the media.



Step 3: Internal consultation

Ideally your champion will facilitate consultation with other departments such as Children's Services (school meals, nurseries), Adult Services (meals on wheels, care homes), Leisure (leisure centres), Environment and/ or Parks (water points in parks), Finance, Corporate Management Team, etc. What are the priorities for the whole of the council? What are the difficulties envisaged? At the end of this process you should have a declaration that the whole of the council will support.



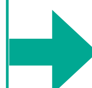
Step 4: Identify the route the council will take to sign up

Ideally the declaration should be discussed and agreed in full council and/or cabinet. This will signal strong political ownership and support and may protect the actions under the declaration from future budget cuts.

Step 5: Sign up and celebrate

Send the commitments you chose to work on and expected impact to Sustain and…

Congratulations! You have become a signatory. Take photos, share it with the local media and think about holding an event to celebrate. Send photos to Sustain so we can publicise it on our website and news too.



Step 6: Don't let the declaration gather dust…

Review local policies and practise and embed the declaration's commitments into local plans and activity.

Monitor the progress of the plan against commitments and publicise the results annually.

Work in partnership with other boroughs in London to exploit opportunities to collectively shift our food culture and environment across borough boundaries.

Support the government in taking action at national level to help local authorities reduce obesity prevalence and heath inequalities in our communities.

The journey to a Local Authority Declaration on Healthy Weight in Blackpool

Obesity is a problem in Blackpool, as it is across the country. Billed as Britain's favourite seaside resort, the town has a high density of fast food outlets. Fish and chips, and sweet 'treats' like ice-cream and sticks of rock have become synonymous with a trip to the seaside.

Following support from Food Active, the council team first presented the idea for a local declaration to the portfolio holder for public health in September 2015 alongside a review of the local healthy weight strategy. They discussed the complex challenges driving obesity levels, and the particularly worrying rates in children. The declaration moved forward and a paper to the authority's Corporate Leadership Team followed soon after. A process of consultation with the Healthy Weight Steering Group and senior managers from across all directorates of the authority was set up to determine the local areas for action. The wide range of discussions revealed a number of perspectives ranging from the practicalities of advertising restrictions, income from corporate sponsorship of council-led events and initiatives, the strength of the council's position to lead by example and influence the local environment.

This process was taking place at a time when child obesity was featuring frequently in the media and this greatly influenced the local declaration going forward in the council. The House of Commons Health Select Committee was working on child obesity and celebrity chef Jamie Oliver was campaigning for a sugary drinks tax. There was local interest too around the #GULPchallenge, Blackpool's campaign encouraging teens to 'give up loving pop'.

In the end the journey has been quicker and smoother than originally anticipated. In January 2016, only five months after the first discussions the Local Authority Declaration on Healthy Weight was formally presented and signed in a Full Council meeting. Although there were some anxieties about potential impacts on the economy and revenues, there was a clear acceptance that supporting healthier weight was the right thing to do. The council has since then been working with procurement and revising vending arrangements to reduce the amount of sugary drinks available, linking to other Strategies. Other work underway include the relaunch of the council's healthier catering award, a healthier packed lunch project with schools, a re-run of the GULP campaign and a Health and Wellbeing Board summit for partner organisation to commit to similar declarations.

Contact

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The six key areas of action – menu of actions

The declaration is open to all local authorities in London and beyond. To sign the declaration the local authority has to commit to take at least six different actions covering all the six key areas.

The menu of options below is not an exhaustive list. The local authority can choose more from amongst these actions or commit to different actions as long as they have SMART (specific, measurable, attainable, realistic, timely) goals so we can quantify impact locally and cumulatively across all those who have signed the declaration. Action can include initiatives under council control as well as those influenced by the council.

Action can include support to existing initiatives as long as there is a commitment to new initiatives on some of the six areas.

In addition, the local authority should set up a timetable outlining when they expect to reach the outcomes and implement an annual evaluation programme.

Area 1 – Tackle advertising and sponsorship

Actions under council control:

1.1 Develop coherent policy on future corporate partnerships or sponsorships that welcomes opportunities for investment in the borough and joint working, whilst avoiding those that promote unhealthy foods and drinks and undermine breastfeeding (total number of corporate partnerships affected by the policy)

1.2 Develop coherent policy on future marketing/advertising that welcomes opportunities for investment in the borough and joint working, whilst avoiding those that promote unhealthy foods and drinks and undermine breastfeeding (total number of advertising boards covered by the policy)

Actions under council influence:

1.3 Ensure all food and beverage advertising in publications, events, billboards, bus stops and others under the control of the council includes nutrition information e.g. traffic light labels (number of adverts affected by this policy)

Hackney corporate sponsorship policy on sugar-sweetened fizzy drinks

Hackney Council has previously refused sponsorship offers from fizzy drinks companies, but did not have a formal policy to ensure that the health implications of sponsorship opportunities are considered in a consistent way. This changed when Hackney launched a new Obesity Strategic Partnership (OSP) in February 2016.

The OSP is chaired by Hackney Council's Chief Executive, and brings together stakeholders from across the system to work together for a place where everyone can achieve a healthy weight. The OSP members discussed opportunities to use corporate levers to make healthier food and drink choices easier for local residents.

Following agreement at an OSP meeting, the Public Health team provided input into the review of the Corporate Sponsorship Policy in June 2016. The policy states that the Council will not put itself in a position where entering into an agreement could, or could be thought to, have aligned the Council with any organisation that conducted itself in a manner that conflicted with the Council's aims and objectives. The Council will, therefore, make a case-by-case decision on sponsorship from sugar-sweetened fizzy drinks companies and sponsorship from these companies will not be accepted for events targeting children. The Council will not accept direct sponsorship for promotions of products that the Council feels may adversely affect the well-being of its residents, or be in conflict with the organisation's values or policies (including its new responsibilities to protect and improve the public's health).

Contact

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St Helens Borough Council experience

St Helens is a metropolitan borough of Merseyside, in North West England. Over the years it has undertaken various approaches to try and increase the prevalence of healthy weight and halt the increase in unhealthy weight. Currently, adult obesity stands at almost 30 per cent. Obesity in children, as captured in the NCMP (National Child Measurement Programme), currently stands at ten per cent in reception age and increases to 20 per cent amongst year six pupils, demonstrating a linear increase in unhealthy weight through generations.

In 2014 a Healthy Weight Strategy was launched which highlighted three priority areas to address – people, places and policy. Action since then has included:

People reframing weight management services to include more universal preventive programmes and recommissioning of specialist weight management services.

Policy building on the successful supplementary planning guidance, working with local takeaways on a chip fryer award, healthier takeaways.

Places introducing the workplace wellbeing charter with local businesses; healthy eating awards in early years settings and schools, introducing a range of outdoor gyms across the borough and promotion of active travel.

When Food Active developed the Healthy Weight Declaration this presented an ideal resource for the council to put their own spin on. The council has adopted the declaration in September 2016. Key to ensure uptake included:

- Availability of local data highlighting the issue, particularly amongst children (via NCMP).
- National Childhood Obesity Strategy coverage within the media generating the interest of local press, the local population and members.
- Proactive and passionate cabinet member for Public Health who took on a personal approach to highlighting the need for such a declaration convincing peers to adopt.
- Being the first council in Merseyside to adopt the declaration.

The declaration highlighted the work that was already underway and provided an opportunity for the council to commit to a whole system approach. It raised the profile of the work on healthy weight and provided cross council support for a number of initiatives that are being taken forward.

Contact

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Area 2 – Improve the food controlled or influenced by the council and support the public and voluntary sectors to improve their food offer

Actions under council control:

2.1 Improve catering by working towards the Government Buying Standards, for example by running accreditation programmes such as Food for Life Catering Mark, Sustainable Restaurant Association, Healthier Catering Commitment and build these standards into contracts as they come up for re-tender (number of meals served by caterers making commitments)

2.2 Remove foods high in sugar, fat and salt from tills and queuing areas e.g. register action at Check junk off the checkouts (number of checkouts committed)

2.3 Discontinue promotions including 'meal deals' on foods high in sugar, fat and salt and replace with promotions on healthier food e.g. fruit and vegetables (number of points of retail affected)

2.4 Remove vending offering food and drinks high in sugar, fat and salt from council run premises or commissioned services e.g. leisure centres (number of vending machines affected)

2.5 Tackle portion size by working towards 'nutrition best practise' in the Government Buying Standards (number of points of retail affected)

Actions under council influence:

2.6 Work with public and voluntary sector partners e.g. schools, early years, after school clubs, youth clubs, to improve food and restrict access to foods high in sugar, fat and salt with initiatives such as a closed gate policy, vans on site, awareness days, etc. (number of settings affected)

Central Bedfordshire vending requirements in leisure centres

When the Council re-tendered the management of leisure centres in 2014, staff from different departments were engaged to identify ways in which the centres could contribute to wider objectives. Discussion with Public Health resulted in the inclusion of a section for 'Promoting health and reducing health inequalities'. Contracts now have a requirement that:

- At least 25 per cent of options in vending machines should be 'healthy eating'
- Cafes need to achieve Heart Beat Award

Leisure centres need to report monthly as part of an outcomes scorecard. The results from the vending machines vary from month to month but most of the time the 25 per cent target is being (or close to being) reached. The 'healthy eating' options includes a reduction in the number of sugar sweetened fizzy drinks and availability of bottled water.

Two leisure centres achieved the Heart Beat Award so far and the Council is working with the remaining four.

The Heart Beat Award is a local award to caterers who can demonstrate that they offer healthy, nutritious and wholesome food to customers. Central Bedfordshire works with dietitians at Bedford Hospital to ensure updates are correctly implemented into the scheme. Criteria is currently being revised but so far includes: at least one-third of the dishes on the menu are 'healthy choices'; at least 30 per cent of food handling staff had received training on hygiene; healthy options were applied in the preparation of food for sale in canteens and workplaces; placement of products for sale.

Contact

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Area 3 – Reduce prominence of sugary drinks and actively promote free drinking water

Actions under council control:

3.1 Put in drinking fountains, or become a water refill point. List your venue on tapwater.org (number of drinking fountains installed/ registered)

3.2 Make sure that bottled water is most prominent in vending and retail, ban promotions on sugary drinks, or make sure health warning information on sugary drinks is displayed (number of points of retail affected)

3.3 Put in place voluntary sugary drinks levy and raise funds for children's health promotion e.g. sign up to the Children's Health Fund (amount of money raised/amount of drinks affected)

Actions under council influence:

3.4 Promote voluntary 'sugary-drinks duty' to local businesses, such as convenience stores, cafes and restaurants, to help dissuade people from drinking high-sugar drinks and raise vital funds for children's health promotion e.g. Children's Health Fund (amount of money raised/ amount of drinks affected)

London's City Hall becomes first Government building to introduce sugar tax

In January 2016 the City Hall café, operated by OCS, introduced a 10 pence charge on all added-sugar soft drinks sold in its café. By doing so they joined 130 others around the UK, including all Jamie Oliver restaurants, Leon, Abokado and Tortilla who had already introduced a levy on added-sugar drinks.

The money raised by the levy goes to the Children's Health Fund, launched by celebrity chef Jamie Oliver and food charity Sustain to support schemes that improve children's health. To date, the Fund has awarded £50,000 to 26 projects from 11 regions in the UK to provide water fountains within it's Water Fountain Fund and £40,000 to strategic projects working on children's food.

Contact

Gloria Davies-Coates,
Children's Health Fund Manager, gloria@sustainweb.org

Lisa Bennett, Principal Policy Officer, GLA Food Team,
Lisa.Bennett@london.gov.uk

Brighton influences outlets to go Sugar Smart

In October 2015, Brighton launched its campaign to became the first Sugar Smart City. The campaign is led by Brighton and Hove City Council in conjunction with other partners. As the leading partner in the campaign, the council is using its influence to ask caterers, cafes, restaurants and takeaways to be sugar smart.

Caterers have already begun making pledges including those working in NHS Trusts, universities, workplaces, leisure centres and major venues. The University of Brighton is leading the way by being the first university in the country to consider introducing a sugar levy across their campuses with any funds raised supporting cookery sessions and food education for their students. The council's primary school caterer, Eden Foodservice, has reduced sugar in their desserts by 40 per cent by changing recipes and removing drizzles and icings. Lusso Catering, for employer Legal & General, has committed to reducing unhealthy snacks available in the staff restaurant. The i360 (catered by Heritage Portfolio) is committing to serving a selection of low/sugar-free cakes are served in their tearoom.

Sussex County Cricket Club is one of the latest major players in the city to go Sugar Smart. The club has introduced a 20p levy on sugary drinks. The club has posters prominently displayed to explain the changes. The cricket ground is also introducing healthy kids lunch boxes and new meal deals. The club has achieved a Healthy Choice Award in recognition of making these, and other, commitments.

Contact

www.brighton-hove.gov.uk/sugarsmart

Area 4 – Support businesses and organisations to improve their food offer

Actions under council control

4.1 Restrict the proliferation of businesses selling foods high in sugar, fat and salt by adopting planning laws to stop new outlets opening, or use licensing to encourage them to improve the standard of food sold (number of outlets affected by the policy)

4.2 Consider supplementary guidance for hot food takeaways, specifically in areas around schools, parks and where access to healthier alternatives is limited (number of outlets affected by the policy)

4.3 Put in place weighted/financial support or favourable treatment in planning or access to land and premises for healthier affordable retail e.g. greengrocers, co-operatives, street markets, etc., especially in deprived areas (number of outlets affected by the policy)

4.4 Work towards adopting a Breastfeeding Friendly/Welcome scheme which encourages and supports businesses to welcome breastfeeding mothers (number of services and businesses accredited)

4.5 Ensure that Public Health is consulted on planning applications, including at pre-application stage (number of planning applications reviewed by Public Health)

4.6 Work with vending suppliers to ensure only healthy produce is sold (number of vending machines affected)

Actions under council influence:

4.7 Work with takeaway businesses, public facing establishments, iconic businesses e.g. museums, park cafes, and the food industry to make food healthier by working towards the Government Buying Standards for example by running accreditation programmes such as Food for Life Catering Mark, Sustainable Restaurant Association, Healthier Catering Commitment (number of outlets and meals affected)

4.8 Encourage local fruit and vegetable businesses to accept Healthy Start Vouchers and/or Rose Vouchers (number of outlets accepting vouchers and total number of vouchers)

4.9 Encourage local businesses and public sector employers to run their own sugar campaigns e.g. Sugar Smart campaign (number of businesses taking action)

4.10 Encourage local food retailers, public facing establishments, iconic businesses (e.g. museums, park cafes) to remove foods high in sugar, fat and salt from tills and queuing areas e.g. register action at Check junk off the checkouts (number of checkouts committed)

4.11 Work with local employers to remove vending offering food and drinks high in sugar, fat and salt from their premises or encourage them to work with vending suppliers to ensure only healthy produce is sold (number of vending machines affected)

4.12 Encourage local businesses and employers to tackle portion size by working towards 'nutrition best practise' in the Government Buying Standards (number of points of retail affected)

Gateshead's Supplementary Planning Document to limit hot food takeaways

The Gateshead and Newcastle core strategy and urban core plan (2015) set out to improve access to healthier food and control the location of unhealthy outlets following concern of Council members with high levels of child obesity. The Gateshead Approach to Healthy Weight (2014) emphasised a number of levers to influence the local environment and set out a target to lower obesity amongst Year 6 children to less than 10% in every ward. This measure was chosen because it can be monitored using the National Child Measurement Programme (NCMP) ward level data.

The SPD developed states that planning permission to new hot food takeaways (A5) will not be granted in locations where:

- Children and young people congregate
- Levels of child obesity above 10 per cent (using NCMP data)
- Over proliferation of hot food takeaways
- Clustering of hot food takeaways will have a negative impact on the vitality of the local area

All future hot food takeaways would need to be accompanied by a Health Impact Assessment.

To make a robust case for determining planning permission for new A5 outlets the Council collected and tested 374 food samples from 187 takeaways for nutritional quality and portion size. This proved the poor nutritional quality of takeaway food. Furthermore, the Council has checked the concentration of takeaways in each ward using data from the Local Food Premises Register and made a review of academic evidence linking obesity to exposure to takeaways.

The conditions set out in SPD mean there are currently no locations where opening a new hot food takeaway would be possible (all wards have child obesity levels above 10 per cent). The numbers of applications and successful appeals have dropped, resulting in no new permissions granted since the SPD was implemented.

The resources deployed were staff time (to review academic evidence, undertake research and draft the policy), costs of collecting samples and laboratory analysis (£90 per sample).

Contact

LDF@gateshead.gov.uk

Islington targeted approach to takeaways near secondary schools and in planning

The Healthier Catering Commitment was initially promoted in Islington through Hearty Lives Islington, a British Heart Foundation grant-funded project, and is now funded by Islington Council. The cost is approximately £125 per outlet plus the associated administration, monitoring and evaluation costs.

There are currently over 240 businesses signed up (16 per cent of all catering outlets), serving approximately 26,600 meals a day.

In 2013 Islington ran a pilot targeting takeaways within 500 metres of secondary schools and of the 25 initially targeted 16 signed up. In 2014 the secondary schools project was rolled out across the whole borough. In total 90 hot food takeaways within 500 metres of 11 secondary schools are now aware of the Healthier Catering Commitment and around 70 have signed up and meet the required criteria. Businesses include pizza premises, fish and chip shops, kebab shops and sandwich bars.

The work is promoted to young people through the Youth Health Forum and to schools via Junior Citizens for primary school age children and through secondary school food technology teachers.

In parallel, the new Supplementary Planning Document approved in April 2016 restricts the opening of new hot food takeaways within 200 metres of schools and will only grant planning/change of use permission to outlets that have a minimum three star Food Hygiene Rating and gain the Healthier Catering Commitment award within six months.

The council is using its procurement powers to promote further take up of the Healthier Catering Commitment. Children's centres with cafes are contractually required to have the award and adventure playgrounds and greenspace concessions are expected to work towards it.

Contact

Michelle Webb, Environmental Health Manager, London Borough of Islington, Michelle.Webb@islington.gov.uk

Tower Hamlets Buywell Food for Health markets project

The Food for Health Award and Buywell were launched in Tower Hamlets in 2009 as part of the Healthy Borough Programme, a whole systems approach to tackling the environmental causes of obesity. The award scheme recognises restaurants, cafes and market traders for making small, healthy changes to the food they sell and recognising them through a three-tiered award system -standard, silver or gold. Buywell supports convenience stores to increase purchase of fruit and vegetables by improving availability, positioning and promotion.

The Buywell Food for Health markets project builds on these schemes and supports market traders to increase their fruit and veg sales by providing them with the help of a retail and marketing expert who works with them to help grow their business and boost their sales. By improving the quality, range and freshness of their produce, displays, pricing and promotions, sales have increased by nearly £1.5M a year through the Buywell Food for Health project.

Traders can then be assessed for a Food for Health Award. In order to qualify for a standard award, fruit and veg stalls must increase by 40% compared to sales before joining the scheme, for silver they must develop a partnership with the local community where appropriate (for example by supplying the local school tuck shop) and gold winners have to demonstrate innovation.

A pilot started in 2015 to help low income families buy more fresh fruit and vegetables from their local market by supporting traders to accept the government's Healthy Start Vouchers. This scheme provides £3.10 or £6.20 a week to families which can be spent on healthier produce. The pilot project focused on two gold Food for Health fruit and vegetable stall traders in Chrisp Street Market. This is one of four Buywell markets across the borough located in a deprived area, who had been struggling to survive financially.

The pilot was funded by the Mayor of London's High Street Fund. The £3,440 budget covered retail advice to traders, support with setting them up in terms of systems and processes, banners and posters. It also provided support to, and gained support from, parent volunteers from the local children's centre who undertook targeted outreach to spread the word to families and friends and encourage them to spend their vouchers in the market.

After the six month pilot, the project continues to grow and has proved its sustainability. The scheme offers great quality affordable and easily accessible fruit and veg to identified low income families. Traders are benefiting from a marketing campaign that brings them new customers, estimated to be worth £20,000 per annum.

Contact

Buywell Fruit and Vegetable Scheme, stephanie@ricemarketing.co.uk

Food for Health Award, foodsafety@towerhamlets.gov.uk

Area 5 – Public events

Actions under council control:

5.1 Ensure that the majority of food and drink provided at public events organised by the council are healthy choices, supporting food retailers to deliver this offer (number of events affected by the policy)

Actions under council influence:

5.2 Ensure that the majority of food and drink provided at public events on council premises and property are healthy choices, supporting food retailers to deliver this offer (number of events affected by the policy)

5.3 Ensure that mothers are aware that breastfeeding is welcome at public events, and space to breastfeed is provided (number of events affected)

5.4 Influence other event organisers to provide healthy choices (number of events affected)

Area 6 – Raise public awareness

Actions under council control:

6.1 Develop a network of local champions from various backgrounds e.g. elected members of the council, schools, public health, children's centres, nursing, primary care, education, health visiting, catering and retail to advocate the healthier food and sugar reduction agenda (number of champions recruited)

6.2 Run staff development and training programmes e.g. sign up to the GLA's Healthy Workplace Charter or similar workplace led initiatives (number of council staff affected)

6.3 Use the council's publicity team to help promote simple steps individuals can take to reduce the amount of excess sugar, fat and salt they consume through national campaigns such as Change4Life, One You or more locally sensitive campaigns set around the Eatwell Guide (number of people engaged)

6.4 Support mothers to start and maintain breastfeeding by promoting the health and wellbeing benefits of breastfeeding along with creating a supportive environment for women to breastfeed in. Ensure maternity and health visiting services are working towards achieving UNICEF Baby Friendly accreditation (number of beneficiaries)

6.5 Develop healthy eating programmes targeting residents in areas of high deprivation and those at risk of diabetes and cardiovascular disease (number of beneficiaries)

6.6 Support and influence the London Mayor and national government in taking action at London-wide and national level to help local authorities reduce obesity prevalence and heath inequalities in our communities e.g. by taking part in national consultations (number of consultations)

6.7 Support and promote local voluntary and community food partnerships and projects that encourage a healthy food culture e.g. sign up as a member of Sustainable Food Cities (number of beneficiaries of projects)

StreetBase and Splash healthy living reward scheme in Barking and Dagenham

The StreetBase and Splash card scheme is unique to Barking & Dagenham and consists of reward cards to encourage young people to lead healthier and more active lives.

Every young person between the age of 11 and 19 who lives and studies in the borough is given a StreetBase card free of charge and the parents/ guardians of every child aged five to 11 are given a Splash card. Each time a young person uses this to buy healthy food items at their school or take part in positive activities such as using a local library, leisure centre or attending a youth club, they earn points. The activities rewarded through the StreetBase and Splash scheme are wide ranging and include visits to Trewern Outdoor Activity Centre in Wales, cycling proficiency training and attending the theatre or gym. The points earned can be exchanged for prizes such as free swims, art sets or sports equipment. In 2015/16, 2,500 young people claimed rewards.

The scheme has seen an increase in the number of healthy items of food and drink consumed in the borough's schools by 500,000 last year.

Contact

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Hackney Community Kitchens

One You Community Classes are Hackney's Council programme of fitness and cook and eat courses taking place in community centres, churches and libraries across Hackney. They run alongside the national Public Health England One You campaign to encourage residents to get fitter, eat healthier and feel better.

Within this programme, residents can learn how to cook healthy and nutritious meals on a budget at the community kitchens the council run on estates across Hackney. There are lunchtime and after-school cooking courses for families with children, and adults' courses on week nights delivered by local providers including Made in Hackney, Shoreditch Trust and Helping Hackney Health.

The programme, now in phase four, is making a positive impact on long-term healthy choices of participants. Evaluations are carried out at the end of every phase of the programme and adjustments are made based on the outcomes. For example:

Daily fruit and vegetables consumption increased from three portions (pre-course) to four portions six months after the course (evaluation by Helping Hackney Health, Family Cook and Taste Courses delivered April to July 2014 in the New Kingshold Community Centre)

Confidence in preparing new foods and recipes at home increased from 18 to 90 per cent six months after the course (evaluation by Made in Hackney, courses delivered during the summer of 2014 at the Redmond Community Centre)

The programme started in May 2014 and is funded until April 2017. To date 1,700 residents took part and approximately half of those are families. Annual funding is dependent on the number of courses and locations. The approximate spend for three years of the programme is £220,000 – equivalent to around £130 per beneficiary – for a six week course / 12 hours course time.

Contact

Henry Muss, Public Health Officer, London Borough of Hackney, henry.muss@hackney.gov.uk

FAQs

Obesity is a complex problem. Will a local authority declaration make a difference?

Everyone agrees that encouraging lifelong good food habits is going to take many different interventions and policies. Public Health England conducted an analysis of the evidence for action on sugar reduction and suggests that a successful programme should include action at many levels including the environment around us that influences our food choices; our food supply and changes that could be made to this; knowledge and training; and local action.[1]

Local authorities have an important role to play. They control planning, public and environmental health, leisure and recreation and regeneration and this declaration is a vehicle to take the sort of whole-systems approach needed to tackle this complex issue. By seeking a public commitment endorsed by the elected leaders of London boroughs, the declaration can have an impact across local authority departments, making sure the council works as one to achieve maximum impact, and ideally will by working with other local partners have an impact far beyond council controlled areas.

Why the focus on these six areas of action and not others?

During consultation with stakeholders from local authorities, GLA (Greater London Authority), health sector and campaigning organisations these six areas were identified as the ones where local authority action will have the maximum impact.

Many local authorities in London are currently taking action to improve school meals, restrict hot food takeaways, working with businesses to improve their food and running local eating programmes. While we think it is important to recognise what is already being done, we invite local authorities to go beyond and look at the crucial areas of advertising and sponsorship policies and public events where there hasn't been so much action.

How the idea for a local declaration came about?

It arose out of the East London 'Growth Boroughs' 'Healthier Children Healthier Place' programme. The latter was established to share learning and good practise on developing a whole systems approach to tackling child obesity, including what can be done differently to improve local food and the local food environment. The inspiration for a local declaration came from the Local Declaration on Tobacco Control and the work of Food Active in the North West that culminated in the Blackpool Local Government Declaration on Healthy Weight. The councils then commissioned Sustain as an independent organisation to run the project, from consulting with key stakeholders on the content of the declaration to promoting it to the majority of London councils.

Can we change the wording or add to the declaration?

Absolutely! The acknowledgments section can be tailored to the local authority and contain local data (e.g. NCMP child obesity data). The commitments (at least six, covering all six areas of action) can be chosen from the menu of actions or include new ones not included in the menu as long as the action goals are relevant and SMART (specific, measurable, attainable, realistic, timely).

The Government has adopted a national Sugary Drinks Industry Levy. Why are you advocating local voluntary action on sugary drinks?

We are thrilled that the Government has now committed to doing this, with the national Soft Drinks Industry Levy to be introduced in 2018. However the nature of how the levy will be introduced is still up for debate, and there is a likelihood that none of the levy will be passed on by the industry to make the most sugary drinks more expensive, therefore missing out on one of the key components of, for example, those participating in the Children's Health Fund where customers pay more for the those drinks with added sugar.

Also, two years is a long time in politics and a lot could change before the national levy is implemented. Action is needed now to improve the health of our diet. This is why we are encouraging local authorities to influence local restaurants to implement a sugary drinks levy for the foreseeable future, and re-distribute this money to causes that help healthier food and food education.

1 Public Health England (2015), Sugar Reduction: The evidence for action. Available online at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/470179/Sugar_reduction_The_evidence_for_action.pdf

Sugary drinks levies have been introduced successfully in France and Mexico in recent years. They have worked – for example, in Mexico there was a decrease of approximately 6 per cent in sales of sugary drinks in the year since January 2014 when they imposed the levy. The effect has been even greater in lower-income households, which are often the most affected by diet-related ill-health.

France, Finland, Hungary, and Berkeley and Philadelphia in the USA have also successfully introduced extra taxes on sugary drinks.[1] Studies suggest that people who swap to lower or no-sugar alternatives don't tend to add on the extra sugar and calories elsewhere in their diets.

What do you mean by healthier products in vending?

Healthier products are low in sugar, fat and salt. The Irish Health Service Executive has standards in place concerning vending that the declaration signatories should look to for best practise. It differentiates between 'Better Choice Items' and 'Other Choice Items' and lays out that the ratio of 'Better Choice' to 'Other Choice' in vending machines should be 60:40. This classification of products is useful but there is no reason why local authorities should not go beyond the 60:40 target and aim for 100 per cent better choice.

	Better Choice Items	**Other Choice Items**
Energy	≤150kcals per packet	≤250 kcals per packet
Total fat	≤20g/ 100g	Not restricted
Saturated fat	≤5g / 100g	Not restricted
Sugar	≤15g/ 100g	Not restricted
Salt/ sodium	≤1.5g/0.6g /100g	Not restricted

Furthermore:

- No soft drinks, energy drinks, sports drinks and fruit/vegetable drinks with added sugars (or sugar products) can be included in the 'Better Choice' selection.
- Milk and water will be the only drinks that can be included in the "Better Choice" items.
- Packets of unprocessed nuts and dried fruit are exempt from sugar and fat criteria. Items containing nuts and dried fruit as an ingredient must meet sugar and fat criteria.

What about the economic impact of the declaration?

The role of the local authority is to work for the wellbeing of the population and the situation we are in now is one were we can't afford inaction. Sugary drinks and unhealthy food are posing a heavy burden on our NHS, social care services and society as a whole.

The local authority and other public sector bodies need to balance the long term costs to the health and care services against the short term costs of turning down sponsorship or vending deals. Sponsorship and advertising, vending or others may be a source of income locally and for the local authority but supporting healthier food is the right thing to do.

1 http://foodresearch.org.uk/wp-content/uploads/2015/06/Food-and-beverages-taxes-final-amended.pdf

Template press release

XXX becomes the first council in London to sign a charter on sugar reduction and healthier food

Councillors voted in favour of a Local Authority Declaration on Sugar Reduction and Healthier food at the Full Council/ Cabinet meeting held XXX.

The Council's declaration leads the way amongst other local authorities in London by it becoming the first to sign this new initiative conceived by local authorities in East London and now promoted by Sustain, a charity working for better food and farming and with a strong presence in London.

Council leader XXX, along with Public Health Director XXX, met with representatives from Sustain to put the Council's commitment down in writing by signing a declaration that will be proudly placed in the Council building.

Cllr XXX, Cabinet Member for XXX, said: "Obesity is a huge problem for us in XXX. XX% of children in the borough are overweight or obese by the time they start secondary school (complete using National Child Measurement Programme borough level data).

"I'm really pleased that this council is working with other councils in London and Sustain to lead the way on tackling sugary drinks and making food under council control or influence healthier.

"Our work will focus on … (complete with actions the council is committing to under the declaration)

Sofia Parente, coordinator of this initiative on behalf of Sustain, said: "Congratulations to XXX Council for taking this stand.

"We all know how difficult it is to make the right choices when we are surrounded by unhealthy food, the wrong advertising messages and when sugary drinks are cheaper than water. I am delighted that XXX Council is doing everything they can to help their residents, workers and pupils eat healthier.

"I hope other councils in London will now follow XXX's example".

For more details on the Local Authority Declaration on Sugar Reduction and Healthier Food initiative visit: www. sustainweb.org/londonfoodlink

Local Government Declaration on Sugar Reduction and Healthier Food
Support pack

A Sustain publication
November 2016

Sustain: The alliance for better food and farming, advocates food and agriculture policies and practices that enhance the health and welfare of people and animals, improve the living and working environment, enrich society and culture, and promote equity. It represents around 100 national public interest organisations working at international, national, regional and local level.

sustain
the alliance for better food and farming

Sustain: The alliance for better food and farming
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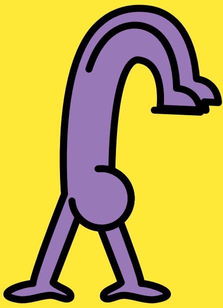
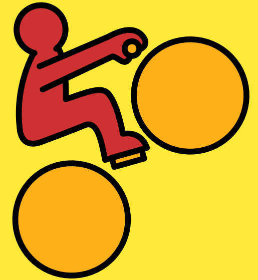
020 7065 0902

Part of Sustain, London Food Link is an independent network of individuals, businesses and organisations working for better food in the capital.

We run and partner on policy initiatives, campaigns and practical projects that improve the food system including Urban Food Fortnight, the Urban Food Awards, the Capital Growth network, The Jellied Eel magazine, London Food Poverty Campaign, the Good Food for London report, Cage Free Capital, as well as running good food training and networking events.

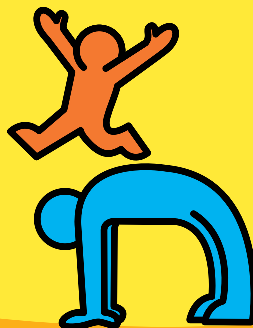
Sustain is a Registered Charity No. 1018643





Healthy Weight, Healthy Lives for Children and Young People

Hackney Childhood Obesity Framework: 0-5 years



change 4 life
Eat well Move more Live longer

Hackney

1.0 Introduction

The framework aims to provide guidance to reduce the risks of obesity for babies, toddlers and pre-school children. It is a framework for universal practitioners who work with parents, carers and families of these children, and provides a basis for guiding public health strategy.

Vision: To work together to reduce the proportion of overweight and obese children and young people in Hackney by supporting them and their families to lead healthy lifestyle

This vision will be achieved by:

- Taking the whole needs of the child into consideration
- Recognising that children and parents are crucial to achieving the vision
- Working in partnership
- Prioritising prevention at an early age and early intervention
- Focusing on healthy food, physical activity and the family

2.0 Purpose

Many agencies are already involved in excellent work within Hackney, supporting the prevention and treatment of childhood obesity, and the promotion of healthier lifestyles to children, young people and their families (see Appendix).

The purpose of this framework is to:

- Bring together and further develop existing good practice in tackling childhood obesity in a way that is accessible for parents and practitioners
- Ensure an integrated and coordinated approach of partners working towards key priorities
- Inform the commissioning of services and provision around childhood obesity reduction

3.0 Background

3.1 Childhood Obesity

The 1990 UK national BMI (Body Mass Index) charts are most commonly used to report on obesity. BMI is calculated by dividing the individual's weight in kilograms by the square of their height in metres, with some adjustment for children. > 85% BMI means overweight and > 95% means obese.

Overweight and obese children are more likely to become obese adults, and have a higher risk of morbidity, disability and premature mortality in adulthood.

Research has shown that obesity in children can lead to the following early markers of more serious disease:

- Raised blood pressure
- Fatty changes to the arterial linings
- Hormonal and chemical changes (such as raised cholesterol and metabolic syndrome)

Other health risks of childhood obesity include:

- Type 2 diabetes (which has increased in overweight children)
- Early puberty
- Eating disorders such as anorexia and bulimia
- Skin infections
- Asthma and other respiratory problems
- Some musculoskeletal disorders
- Disturbed sleep and fatigue

The emotional impacts of childhood obesity can also include discrimination and teasing by peers, low self-esteem and anxiety and depression. Severely obese children and young people have rated their quality of life as low as children and young people with cancer on chemotherapy[1].

Evidenced through the National Child Measurement Programme, Hackney currently still has some of the highest childhood obesity rates in the country, despite a recent fall.

Trends for the past eight years are shown at the top of page 4.

[1] Information sourced from the National Obesity Observatory website (part of Public Health England). Available at: http://www.noo.org.uk/LA/impact/health (accessed 16.03.16)

	Year R				Year 6			
	Under weight	Healthy weight	Over weight	Obese	Under weight	Healthy weight	Over weight	Obese
2007/08	1.2%	70.3%	14.4%	14.0%	1.7%	59.6%	15.1%	23.6%
2008/09	1.3%	71.8%	13.6%	13.3%	1.4%	59.0%	15.6%	24.0%
2009/10	1.7%	71.2%	12.7%	14.4%	1.3%	58.3%	14.9%	25.5%
2010/11	0.9%	71.1%	13.5%	14.6%	1.7%	57.3%	15.9%	25.0%
2011/12	1.1%	71.6%	13.9%	13.4%	1.6%	55.6%	15.6%	27.1%
2012/13	0.9%	72.8%	13.1%	13.2%	1.4%	57.4%	16.0%	25.2%
2013/14	1.3%	71.5%	12.8%	14.4%	1.5%	58.2%	14.3%	26.1%
2014/15	1.5%	72.6%	14.0%	12.0%	1.4%	57.5%	15.5%	25.6%

Source: NCMP 2014/15

3.2 National and Local Context

The Get Hackney Healthy programme (funded by Hackney's Health and Wellbeing Board) aims to tackle some of the key challenges pertaining to child overweight and obesity. It is based on evidence from Sir Michael Marmot's 2010 review outlining the influence of wider social determinants on health, and the need to engage with these to prevent the intergenerational cycle of health inequalities. His work stresses the importance of investment in the early years, which yields considerably higher returns than in adolescence [2].

Recent emerging evidence also suggests work in the pre-natal period and with 0 - 2 year olds and their mothers is effective in reducing obesity[3] and emphasises the importance of establishing healthy eating and lifestyle patterns early on.

If levels of overweight and obese school age children continue to escalate this would not only have a detrimental impact on the lives of Hackney's children and young people, but would create further strain on local health services due to the illnesses and associated health risks with overweight and obesity; these are currently estimated by the Department of Health to cost the NHS £5 billion every year nationally[4].

[2]Post 2010 Strategic Review of Health Inequalities: Sir Michael Marmot: February 2010

[3]Effectiveness of home based early intervention on children's BMI at age 2: randomised controlled trial. Li Ming Wen, Louise A Baur, Judy M Simpson, Karen Wardle, Victoria M Flood. BMJ 2012;344:e3732 doi: 10.1136/bmj.e3732 (Published 26 June 2012)

[4]Reducing obesity and improving diet, DH: 2013, https://www.gov.uk/government/policies/reducing-obesity-and-improving-diet (accessed 02.08.13)

Locally, work on overweight and obesity links into a number of strategic strands. A report on Childhood Obesity by the Hackney Children and Young People Scrutiny Commission, agreed by Cabinet on 22nd April 2013, made a number of recommendations to help reduce overweight and obesity levels of children and young people in Hackney; many of the recommendations have been taken on by the Health and Wellbeing board.

A new Obesity Strategic Partnership (OSP) was launched in February 2016 and is chaired by the Chief Executive of London Borough of Hackney. The OSP will set the strategic direction for reducing obesity and associated health inequalities across the borough, and support the implementation of a 'whole systems' approach to obesity, taking into account the role of the food environment, physical activity environment, social influences, as well as individual psychology, physical activity and food consumption.

The work also links into the 2008-2018 Sustainable Community Strategy priority 3, to promote health and wellbeing for all, and support independent living. Priority 1 of the 2013/14 – 2014/15 Corporate Plan: helping and protecting those residents who most need support, and working with them to improve their lives and capacity for independence, identifies a number of priority areas of work. One of the priority areas is to strive to improve the health of children and young people, in particular tackling childhood obesity and working with pregnant mothers and children aged under five years old.

Nationally, the work on obesity in Hackney ties into the two high level outcomes developed by the Department of Health (DH) in The Public Health Outcomes Framework for England, 2013-2016; namely, increased healthy life expectancy and reduced differences in the life expectancy between communities. The National Institute for Health and Care Excellence (NICE) public health guidance 42, Obesity: working with local communities provides a framework for Hackney's work[5].

4.0 Risk Factors for Obesity

The causes of obesity are complex and multifaceted, and are still being explored. Although there are many reasons why an individual may become obese, it is now generally accepted that the current prevalence of obesity in the UK population is primarily caused by people's latent biological susceptibility interacting with a changing environment that includes more sedentary lifestyles and increased dietary abundance[6].

[5]Public Health Guidance 42, Obesity: working with local communities, NICE: 2013, http://www.nice.org.uk/guidance/ph42 (accessed 13.05.14)

[6]Foresight (2007), Tackling Obesities: Future Choices - Project Report, [Online], Government Office for Science. Available at:
Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/287937/07-1184x-tackling-obesities-future-choices-report.pdf (accessed 10.09.15)

Source: Public Health England, 2015

However, there are certain factors that have been linked to childhood obesity that professionals working with children and families should be aware of [7]:

- **Family and social factors**
  - Parental obesity – the risk of developing obesity increases when parents are obese, particularly when both parents are affected
  - Family history of heart disease or diabetes
  - Poverty – there is a clear link between deprivation and obesity
  - Race and ethnicity – e.g. nationally Black children are more likely to be obese
  - Sedentary behaviours

- **Pregnancy**
  - Maternal obesity
  - Excess weight gain in pregnancy
  - Gestational diabetes
  - Smoking

[7] Rudolf, M. (2009), Tackling Obesity Through the Healthy Child Programme: A Framework For Action, Leeds, University of Leeds. Available at: http://www.noo.org.uk/uploads/doc/vid_4865_rudolf_TacklingObesity1_210110.pdf (accessed 10.09.15)

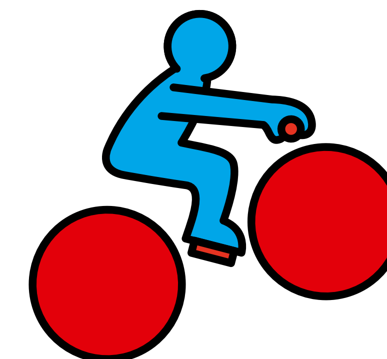
- **Infancy**
  - Birth weight - babies who are born large for gestational age have an increased risk for obesity, with alterations in glucose metabolism already evident in the early months. At the other end of the spectrum babies born small for gestational age are also at increased risk for both obesity and type 2 diabetes, especially when rapid catch up growth occurs.
  - Rapid weight gain - some low-birth-weight babies may be especially susceptible to catch-up growth, while others experience this as a direct consequence of their diet. Obese babies have ten times the risk of later obesity, and babies who gain weight rapidly (even if they are not obese) have six times the risk.
  - Bottle feeding - breastfed babies show slower growth rates than formula-fed babies and this may contribute to the reduced risk of obesity later in life shown by breastfed babies
  - Early weaning

5.0 Reducing Levels of Obesity

The prevention of childhood obesity requires a broad based health promotion programme and interventions at home and community level which need to be matched by changes in the social and cultural context so that changes can be sustained and enhanced. Strategies to prevent obesity in a child population e.g. healthy eating and physical activity and the promotion of emotional health and wellbeing will benefit all children irrespective of whether they are at risk of being overweight or obese. It is clear, therefore, that a coordinated approach is vital to achieve this 'industrial' scale change.

Where children present as obese, evidence shows that treatment is more successful where the needs of the child are addressed in the context of their family and their environment.

The framework therefore uses a multi-faceted approach covering universal provision, targeted interventions, and treatment options.



6.0 Preventing Obesity

Healthy Weight, Healthy Lives[8] summarises evidence-based methods of promoting healthy weight in children:

- Breastfeeding
- Reduced HFSS (high fat sugar and salt) advertising to children
- Children's centres (including activity and nutrition)
- Community interventions all ages
- Reduced consumption of HFSS foods e.g. through reformation and clear labelling
- Targeted support for at risk families

Healthy Lives, Healthy People: A call to action on obesity in England[9], local government is urged to:

- Promote active travel e.g. walking and cycling
- Ensure the widest possible access to opportunities to be physically active e.g. parks and linking with local leisure and sport services
- Make the most of the potential for the planning system to create a healthier built environment
- Work with local businesses and partners to increase access to healthy food choices
- Link activities on healthy weight to initiatives relating to the environment and sustainability e.g. allotments and food growing projects
- Lead by example e.g. ensure healthier catering in settings and services they run
- Make the most of key opportunities to engage with communities and promote behaviour change e.g. through libraries and youth services

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7.0 Action Plan

Hackney has a Children and Young People's Healthy Weight Action Plan which contains five strands: establishing definitions of healthy weight; the environment; support; physical activity; healthy food. The action plan is derived from the Hackney ten year Healthy Weight Strategy, and delivery is monitored by a range of partners through the Hackney Obesity Strategic Partnership.

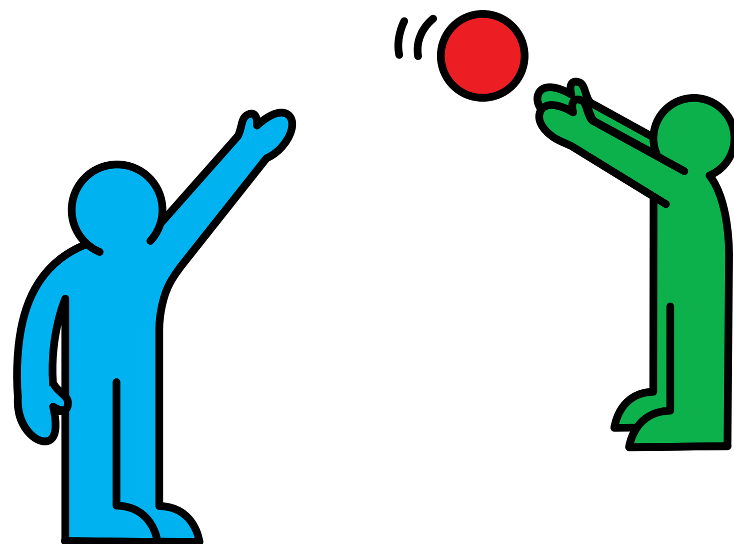
[8] Healthy Weight, Healthy Lives, DH: 2008 http://webarchive.nationalarchives.gov.uk/20100407220245/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_084024.pdf (accessed 13.05.14)

[9] Healthy Lives, Healthy People: A call to action on obesity in England, DH: 2011 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213720/dh_130487.pdf (accessed 13.05.14)

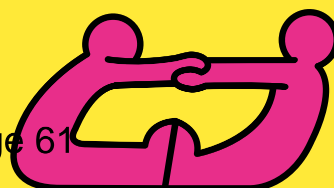
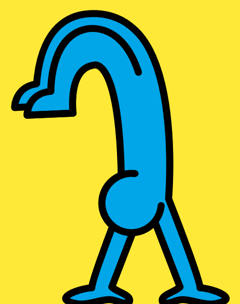
Appendix: Preventative and Obesity Reduction Services for 0-5s

Tier	Services, training and education
Universal (Tier 1)	**Health Visitors** – information and advice to parents on breastfeeding, weaning, physical activity, screen time. If there is evidence of rapid weight gain the HV will communicate the risk of obesity and may suggest regular clinic attendance for weight check and ensure access to advice about infant nutrition and physical activity. **Children's centres** Children's centres provide a variety of universal healthy weight activities including: • Dietetics input • HENRY (spans tier 1 and 2 – see detail in tier 2 below) • Health awareness sessions • Fitness classes for parents • Healthy cooking courses • Gardening sessions • Fruit and veg stalls • Antenatal groups • Baby's First Foods weaning programme • Breastfeeding support groups • Stay and play including tasting sessions • Occasional oral health practitioner activities (e.g. awareness of sugary drinks) • Family walks • Toy libraries • Music and movement • Messy play • Baby massage • Tummy time • PEEP (home learning initiative including opportunities for active play) • Food Matters pilot on healthy food choices **Schools and early years/childcare setting** • Eat Better Start Better works with early years settings to support the implementation of the Children's Food Trust Eat Better Start Better voluntary food and drink guidelines by providing training and support from an early years nutritional expert. Self-assessment packs are completed by early years settings and childminders. Feedback is then provided and settings submit a good practice portfolio. HLT provide this service in partnership with Dietetics. • Settings support children's healthy physical development, as required within EYFS: promoting physical activity; outdoor play; teaching healthy lifestyles through appropriate curriculum; supporting physical development within home learning • Settings ensure that ongoing assessment and 2 year old integrated review have a focus on physical development, sharing any concerns with parents and making timely referrals, where necessary • Settings support families to access available universal services and activities

Tier	Services, training and education
Universal (Tier 1) cont...	**Dietetics** • Weaning education sessions • Breastfeeding advice • Nursery fruit scheme sessions on fruit portions • Team has received post-graduate behavioural change training (BCT) **Child health clinics** **Paediatricians** – trained to provide advice and direct parents at an early stage including at the Ark, Homerton and in the community **GPs** – trained to provide advice and direct parents at an early stage **Training** • LEAP conducts childhood obesity training for practitioners working with children aged 1-18, training on useful resources to support practitioners to provide first line advice on healthy eating and raising the issue of weight and other ad hoc training on request • HENRY conducts training on raising the issue of weight using the HENRY approach for practitioners working with 0-5 year olds, training on useful resources to support Health Visitors to raise the issue of weight and to provide first line support, HENRY core and facilitator training and HENRY refresher training



Tier	Services, training and education
Targeted (Tier 2)	**Parenting programmes** • HENRY (Health, Exercise and Nutrition for the Really Young) Healthy Families Right from the Start is an eight week evidence based group programme for all parents and carers of children under 5 years, giving families the tools and skills to gain confidence around healthy eating, parenting and physical activity to support a healthier lifestyle. The programme has been awarded the CANparent Quality Mark. • Strengthening Families Strengthening Communities covers healthy lifestyles and parents are signposted to exercise and health awareness sessions at children's centres. Parents also referred to HENRY and Dietetics if needed. • Solihull programme provides advice on recognising when babies' distress is due to needs other than hunger and developing tactics other than feeding to calm the baby **First Steps** – provide a range of family interventions including parenting support **Dietetics** • One to one clinical sessions, including during antenatal period • One O' Clock Wednesday Club at Homerton for pregnant women with a BMI>30 **Dietetics and CAMHS** – fussy eating groups **Speech and Language Therapy (SLT)** – provide advice on responsive feeding practice and provide one to one support where needed **Paediatricians** – provide individual advice on responsive feeding, particularly for children with complex difficulties and in conjunction with SLT and Dietetics **FNP** – intensive home visiting service for first time mothers under the age of 19, including health messages on eating and weight. Referral to obesity services where there is an identified need.
Specialist (Tier 3)	**LEAP** – targeted tier 3 multi-disciplinary weight management service for children and young people with moderate to severe obesity, delivered by HUHFT. LEAP offers individual and group appointments focusing on behaviour change. The multi-disciplinary team includes a dietitian, clinical psychologist, physiotherapist, registered nutritionist and paediatrician.
Highly Specialist (Tier 4)	**Royal London** – Tertiary Paediatric Metabolic Obesity Service.

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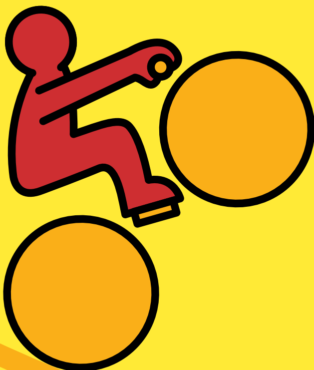
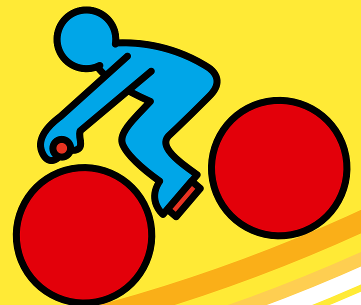
Early Years Settings and Children's Centre Healthy Weight Guidance 2016





change 4 life
Eat well Move more Live longer

Hackney

1. Introduction

This guidance is intended to support managers of City and Hackney's children's centres and other early years settings to understand key messages for families around healthy weight, and to aid their commissioning of services for this purpose.

The guidance incorporates:

- Key elements in promoting healthy weight
- How to raise the issue of overweight and obesity
- Data on overweight and obesity
- Commissioned services
- Evaluation
- Appendices on: risk factors for obesity; impact of obesity; common misconceptions around obesity
- References

2. Key elements in promoting healthy weight

2.1 Breastfeeding

The National Childbirth Trust (NCT) have created a resource for children's centres around breastfeeding[1]. This includes a frequently asked questions section which can be used to help with "myth busting" around breastfeeding and some tips for how children's centres can encourage breastfeeding:

- Normalising breastfeeding through creating a space where mothers feel comfortable and presenting it as the natural and healthy way to feed babies.
- Creating a private space for individuals (including staff) if requested and providing facilities for expressing and storing milk.
- Providing easily accessible information, such as leaflets about breastfeeding (e.g. the Off to the Best Start leaflet as contained in the references).
- Providing publicity to encourage breastfeeding and taking part in World Breastfeeding Week.
- Ensuring all staff are aware of the centre's breastfeeding policy and support women's right to breastfeed (even if a complaint is made).
- Ensuring that breastfeeding is presented as normal to fathers, discussed in relevant groups and leaflets are available.

[1] NCT (2009) 'Breastfeeding pack for children's centres', [Online], NCT.
Available at: **https://www.nct.org.uk/sites/default/files/related_documents/Breastfeeding%20pack%20for%20Children's%20Centres-1.pdf** (accessed 10.09.15)

- Providing or signposting to local breastfeeding support groups, ideally where a crèche is available.
- Signposting specialist breastfeeding help.
- Ensuring children's books in the centre represent breastfeeding as the norm.
- Aiming for breastfeeding mothers to be involved in any talks with children about caring for a baby.
- Ensuring the centre has no equipment with infant formula logos and referring any representatives of infant formula companies who may ring up to the maternity unit or the breastfeeding coordinator.

Start4Life have produced a guide to breastfeeding called 'Off to the Best Start'[2] which provides information on breastfeeding, expressing milk and a father's role. The key points about breastfeeding in the leaflet are:

- Mother's milk has many health and other benefits for mother and baby that infant feeding formula does not contain. For example, babies who are not breastfed are at increased risk of: diarrhoea and vomiting; chest infections; ear infections; constipation; obesity (increased risk of developing type 2 diabetes in later life); developing eczema; being fussy about new foods. For mothers, it lowers the risk of getting ovarian or breast cancer, uses up about an extra 500 calories a day (meaning breastfeeding mothers may find it easier to lose weight post-pregnancy) and it saves money.
- The mother holding the baby next to her skin straight after birth helps calm the baby and is a great time to breastfeed (the baby will want feeding in the first hour after birth).
- Tips for breastfeeding are: ensuring the baby's head and body are in a straight line to aid swallowing; ensuring the baby is held close to the mother, with the mother supporting their neck, shoulders and back (the baby should be able to tilt their head back easily and shouldn't have to reach out to feed); it's best if the mother gets comfortable before starting breastfeeding, although it's OK to change position slightly; the baby's nose should be opposite the nipple so that they can attach properly and can get a big mouthful of breast from underneath the nipple.
- The following are signs that the baby is feeding well: the baby has a large mouthful of breast; the baby's chin is firmly touching the breast; it doesn't hurt when the baby feeds (although the first few sucks may feel strong); if the mother can see the dark skin around her nipple, she should see more dark skin above the baby's top lip than below the baby's bottom lip; the baby's cheeks stay rounded during sucking; the baby rhythmically takes long sucks and swallows (it is normal for the baby to pause from time to time); the baby finishes the feed and comes off the breast on their own.

[2] NHS Start for Life (2014) 'Off to the best start: Important information about feeding your baby', [Online], Public Health England. Available at: **www.gov.uk/government/uploads/system/uploads/attachment_data/file/216327/dh_125827.pdf** (accessed 10.09.15)

- It is recommended that babies do not have a dummy before breastfeeding is established (normally around one month) as it can be more difficult for the baby to attach to the mother's breast and they might not take in as much milk.

Unicef have produced guidance for children's centres on reaching the Baby Friendly Initiative standards around breastfeeding[3], which we would recommend working towards.

2.2 Weaning

Weaning can be defined as the introduction of solid foods to babies as they become less dependent on milk and coincides with a period of rapid growth and development, so a good diet during this period is crucial. The following information comes from the Caroline Walker Trust Guidelines[4].

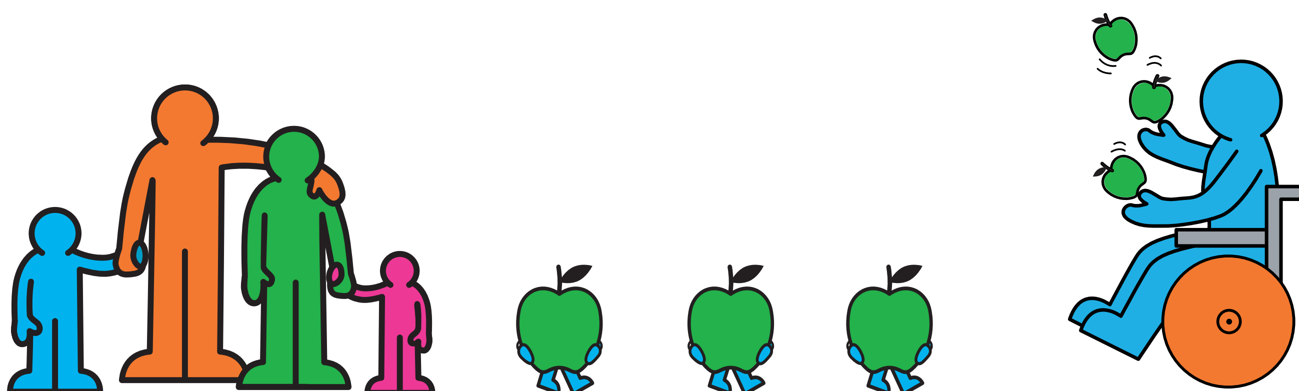
- The Department of Health recommends that babies should not be given any solid foods until they are six months but some health professionals suggest that babies can be weaned from four months (weaning before this is never recommended).
- Many health professionals prefer to advise parents to wean when their children show developmental cues such as being able to sit up with some support, having some trunk control, showing an active interest in food and having the ability to pick food up and put it to their mouth, rather than by age alone.
- From about six months, the majority of infants are able to take food from a spoon, chew and use the tongue. They will also at this stage be curious about other tastes and textures and develop their hand-to-eye coordination. By about six months an infant can also have finger foods. There is no evidence that waiting until six months to wean will affect a baby's ability to chew. When the baby seems ready to experiment, small spoons of baby rice and puréed vegetables such as carrots or peas or mashed potato can be offered. Some babies will take time to learn to take food from a spoon, so it is important to go at the baby's pace and smile encouragement as they learn.
- Babies weaned at about six months usually accept a greater variety of foods and changes in food textures more quickly than those weaned earlier. All babies should have started on solid foods by around six months since at this stage babies need more iron and other nutrients than can be provided by milk alone. Parents of babies who were born prematurely need individual advice about when to start solid food.
- Certain foods can cause an allergic reaction in some babies. It is therefore recommended that babies should not be given certain foods before six months. Further details can be found in the Caroline Walker Trust document.

[3] Unicef (2016) 'Guidance for children's centres on implementing the Baby Friendly Initiative standards', [Online], Unicef. Available at: **www.unicef.org.uk/Documents/Baby_Friendly/Guidance/guidance_childrens_centres.pdf** (accessed 17.03.16)

[4] Crawley, H. (2006), Eating well for under-5s in child care: Practical and nutritional guidelines, London, Caroline Walker Trust. Available at: **www.cwt.org.uk/wp-content/uploads/2014/07/Under5s.pdf** (accessed 10.09.15). Hereafter referred to as *Eating well for under-5s in child care*.

- Rice or oat cereals are acceptable and should be given from the spoon. Foods should not be added to bottles of milk as this does not allow the infant to learn how food feels in the mouth or how to chew, and it may cause choking. Manufactured weaning foods can be chosen according to the baby's age. It is important to offer a good variety of tastes so that infants get used to different flavours.
- One particularly important nutrient for babies is iron, as by six months the body stores of iron that an infant is born with have been used up, and the baby needs to obtain iron from the diet. Good sources of iron which can be given as purées or mash are: meat; fish such as tuna or sardines; pulses such as peas, beans and lentils; and green vegetables. The iron from meat and some fish is easily absorbed into the body and a daily helping of these foods is a valuable way of providing iron in the weaning diet.
- Texture is also important. First foods should be of a puréed consistency but as soon as babies are used to taking food from a spoon, chewing and swallowing, they can be given soft lumps or food which is mashed rather than puréed. As eating and chewing skills increase, minced or finely chopped foods and finger foods should be given and different textures of food should be introduced.
- By about 12 months, children should be getting a good mixed diet with three meals and, depending on their sleeping patterns and appetite, one or two healthy snacks each day.
- It is recommended that infants and young children should be given vitamin drops containing vitamins A, C, and D. Due to high levels of vitamin D insufficiency/ deficiency in Hackney and the City of London, Healthy Start vitamins are provided free to all women who are pregnant or have given birth in the last year, and to all children from four weeks old up to their fourth birthday. Although all infants are eligible from four weeks of age, those who are fed infant formula will not need these vitamins until they have less than 500ml of infant formula a day, as these products are fortified with vitamin D. More information on this is contained in the 'Commissioned Services' section below.

For more information, the Infant and Toddler Forum[5] has a number of evidence based leaflets on weaning both for parents and health professionals.

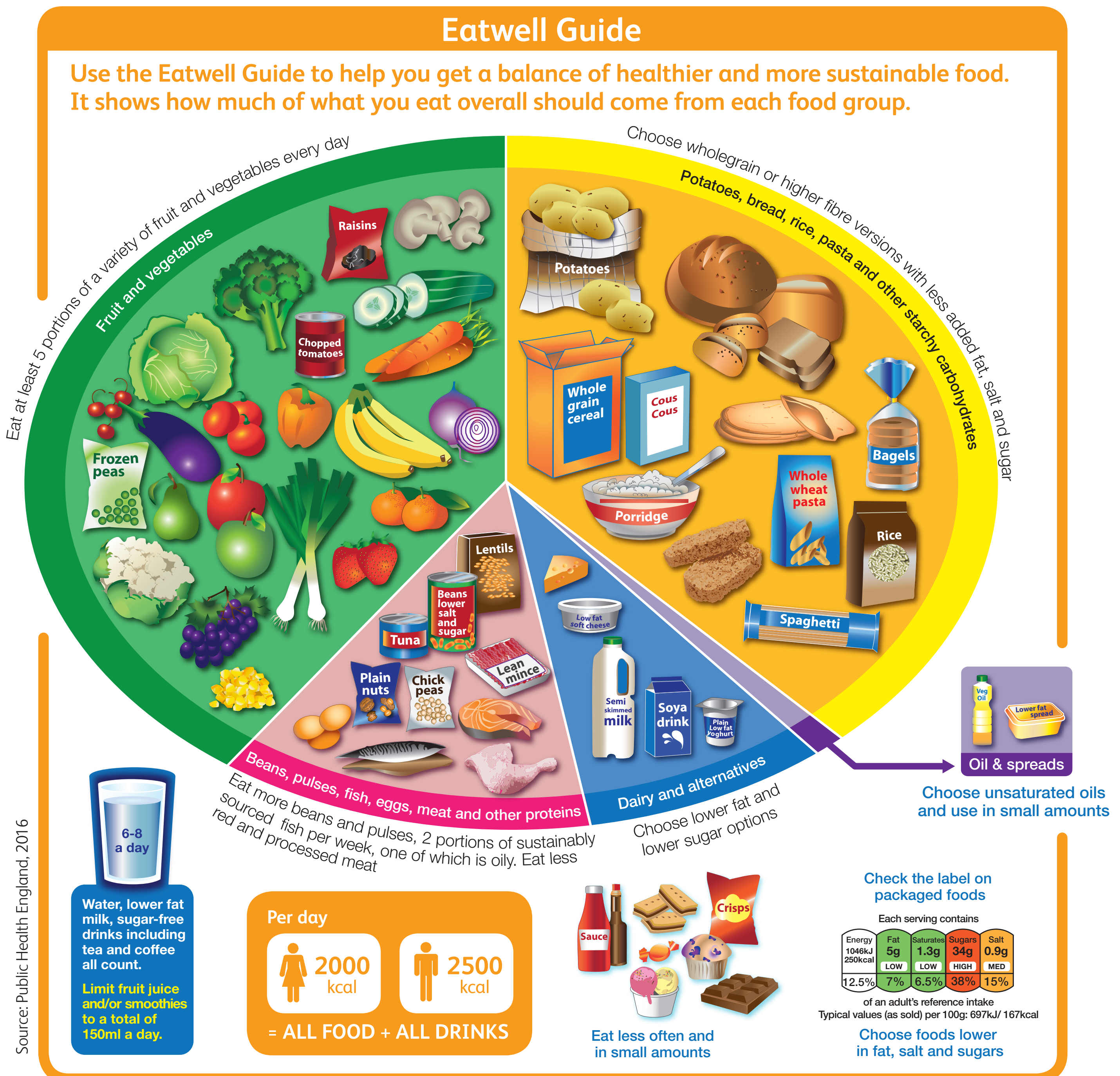


[5] All materials available at: **www.infantandtoddlerforum.org** (accessed 02.03.16).

2.3 One to four year olds

Change4Life have produced an early years local supporters guide which provides information on ways to engage with parents of 1 – 4 year olds around healthy eating, based on research they've undertaken[6]. They suggest six simple messages:

- **Sugar swaps** – swapping high sugar snacks to low or natural sugar alternatives e.g. fruit instead of biscuits and chocolate, and swapping high sugar drinks to water or milk (ideally semi-skimmed but under 2s should drink full fat and under 5s should not drink skimmed milk) between meals and watered down 100% fruit juice with meals if at all. It is also recommended for children to avoid artificial sweeteners and low sugar versions of drinks to prevent developing a "sweet tooth".



[6] NHS Change4Life 'Early years guide for local supporters: How to help toddlers and pre-school children get the best start in life', [Online], DCSF. Available at: **www.nhs.uk/Change4Life/supporter-resources/downloads/EY_LocalSupportersGuide_acc.pdf** (accessed 10.09.15). Hereafter referred to as 'Change4Life Early years guide for local supporters'.

- **Me size meals** – serving smaller portions to children. This includes pre-packaged food (which is often adult-sized) – it is recommended that a small amount is taken out for a child or that children share. The "eatwell" plate below shows the proportions of different food groups that should be eaten every day to ensure a healthy and well-balanced diet from the age of two upwards. Please note that the calories guide is for adults and not children.
- **Meal time** – ensuring regular, healthy meals and snacks are eaten each day. It is recommended that young children eat three child-size healthy meals and two to three healthy snacks per day. Being a part of family meal times helps children to observe and learn more about healthy food. Young children should not have any sugar or salt added to their meal either during cooking or at the table.
- **Snack check** – ensuring that children get healthy snacks to keep them topped up with nutrients they need. Giving children a healthier option at a young age means they will be less likely to want unhealthier options as they grow up. The amount of healthy snacks required will depend on the child and they also need to be kept hydrated throughout the day. Young children should not be fed low-calorie snacks designed for adults or low-fat dairy products (apart from milk where over 2s can drink semi-skimmed) as these are full of the nutrients needed to grow and develop properly. Note that small children should not eat nuts as there is a risk of choking, and that dried fruit is not recommended as it's naturally very high in sugar.
- **5 a day** – eating five portions of fruit and vegetables per day (a portion is about the size of a child's fist). Fruit and vegetables are packed with essential vitamins, minerals and fibre which may help reduce the risk of illnesses in later life. Giving children a variety of flavours and tastes helps them to get used to different fruit and vegetables. If children are picky there are different ways for them to get their five a day; adding them to meals, making them into a drink and serving them with a dip are recommendations. Canned and frozen fruit and vegetables count although it is important that canned fruit is in juice, not sugary syrup, and that canned vegetables are in water, not brine. Cutting fruit and veg into small, easy to hold, bite-sized portions helps but it is important that children are never left alone when eating.
- **Up and about** – ensuring children have chance for active play to burn off energy, learn skills, use their imagination and develop strong, healthy bodies. Active play doesn't just mean organised exercise, it can be exercise easily incorporated into everyday life – running around in the park, walking to the shops. Short bursts of energy and activity are healthy for young children, including in the home. It is recommended that time being sedentary is limited – this includes time in the buggy or car seat and sitting in front of the TV. Children who can walk on their own should be physically active every day for at least 180 minutes (3 hours)[7]. The British Heart Foundation have some useful materials about how to encourage babies and children to be active, as well as a briefing on the evidence behind physical activity[8].

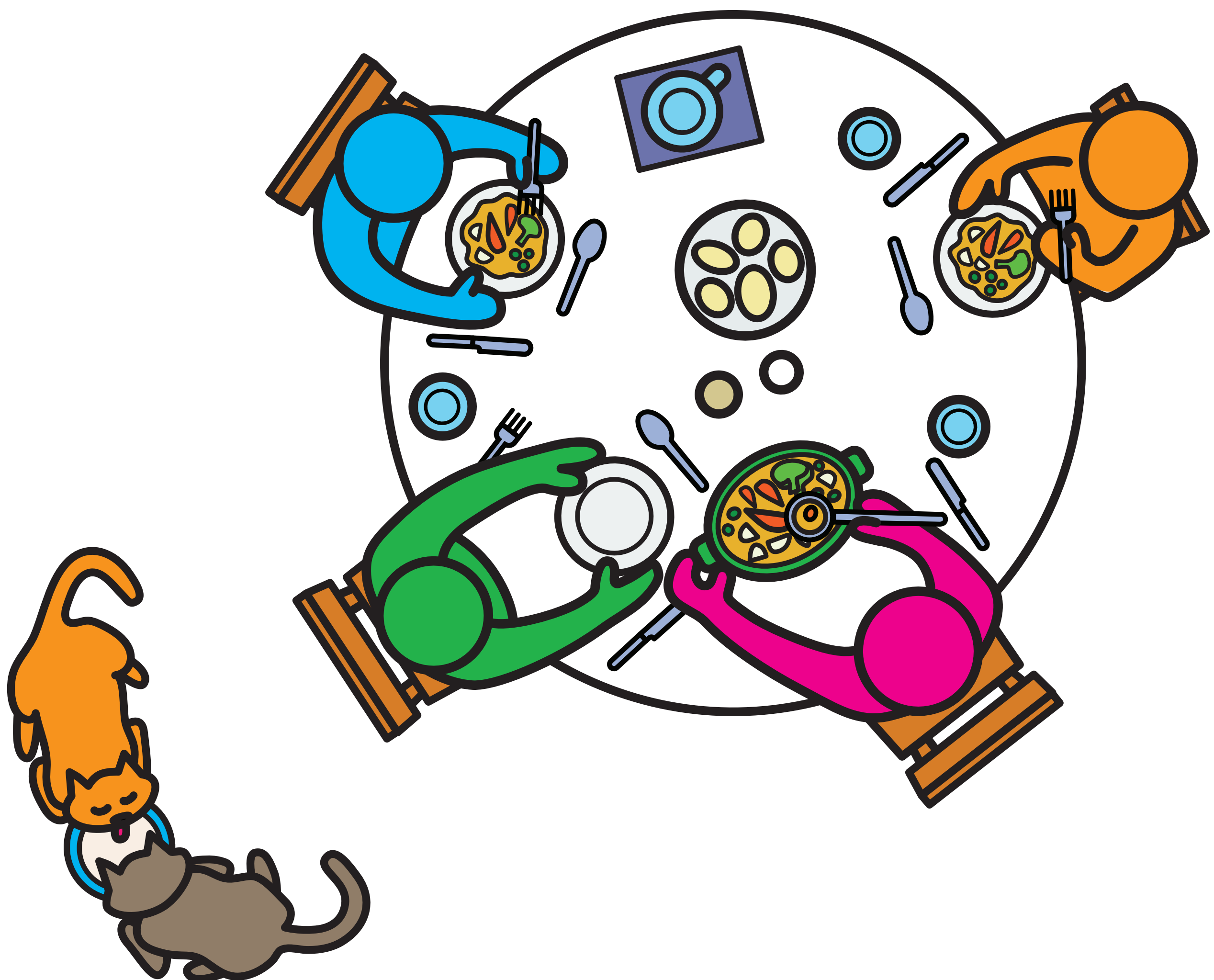
[7] DH (2011), 'Physical activity guidelines for early years (under 5s) – for children who are capable of walking', [Online], DH. Available at: **www.nhs.uk/Livewell/fitness/Documents/children-under-5-walking.pdf** (accessed 10.09.15)

[8] All materials available at: **www.bhfactive.org.uk/earlyyearsguidelines/index.html** (accessed 10.09.15)

The Caroline Walker Trust has produced comprehensive guidelines for child care settings on nutrition in the under 5s. The guidelines not only provide very detailed information on the role of different nutrients in ensuring good health for children, but they have practical recommendations about dealing with food refusal, working with parents and developing a nutrition policy, amongst many other useful things[9].

The Infant and Toddler Forum have a number of evidence based fact sheets on healthy eating for toddlers to pre-school age children covering topics such as fussy eating, portion sizes and other common nutritional problems[10].

The East London Infant and Toddler Feeding Guidelines, which provide practical and evidence based information and advice on nutrition for children under five, are currently being updated and will be circulated once completed. For more information, email the Dietetics Service at Homerton University Hospital NHS Foundation Trust at **nutritionanddietetics@homerton.nhs.uk**



[9] Eating well for under-5s in child care.

[10] All materials available at: **www.infantandtoddlerforum.org** (accessed 02.03.16)

3. How to raise the issue

Weight is often a sensitive topic and raising concerns about a child's weight with their parent or carer can be difficult. However, there are some ways the issue can be addressed which can support health professionals to have this conversation. It is recognised that some health professionals are avoiding raising the subject of weight, which could have an impact on families accessing weight management services and interventions. To give health professionals confidence and skills in raising this conversation with parents it is recommended that practice-based training is provided to all front line staff. Some key guidance includes:

- The way the conversation is framed should be tailored to the particular circumstance of the family
- Communication of long term risks to health are taken seriously by most parents
- Ask permission before giving advice or information
- Never use words that blame, shame or stigmatise
- Avoid using the term "obese" and use "overweight" with caution

The LEAP Service at Homerton University Hospital NHS Foundation Trust can advise about the latest training on raising the issue of weight. They can be contacted at **huh-tr.LEAP@nhs.net**

Change4Life conducted research around marketing healthy weight behaviours to parents and found the following[11]:

- Parents aren't motivated by the word "obesity" – it can be seen as an insult and more about the way someone looks than health risks.
- Parents are motivated by future danger to their children – once parents understand that high levels of fat in the body can lead to serious health conditions such as type 2 diabetes, heart disease and cancer, they are much more willing to consider changing their behaviour.
- Parents often don't recognise their own unhealthy behaviours – parents tend to underestimate the amount their family eats and overestimate the amount of physical activity undertaken and sometimes find it easier to prioritise their child's happiness now than their long term health (e.g. giving in to demands for unhealthy snacks).
- No one likes to be thought of as a bad parent – messaging shouldn't blame parents and should recognise that modern life makes it harder to make healthy choices but should encourage parents to try and make healthier choices as role models to their children.
- Parents are fed up with being told what to do – however it is important to understand what and why changes are necessary so Change4Life aims to provide simple suggestions and ideas.
- Parents on tight budgets often think that healthy living takes too much time or money – Change4Life aims to provide free or cheap suggestions for physical activity and healthy eating e.g. buying frozen/tinned or in season fruit and veg.

[11] 'Change4Life Early years guide for local supporters'.

4. Local data on overweight and obesity

The National Child Measurement Programme (NCMP) measures children's Body Mass Index (BMI) at reception and year six in maintained schools and categorises these into underweight, healthy weight, overweight and obese. BMI is calculated by dividing the individual's weight in kilograms by the square of their height in metres, with some adjustment for children.

According to the NCMP Hackney and the City of London currently still have some of the highest childhood obesity rates in the country, despite a recent fall.

Trends for the past seven years are shown in table 1 below.

Table 1: Distribution of children's weight (Year R and Year 6), City and Hackney 2007/08 to 2013/14

	YR				Y6			
	Under weight	Healthy weight	Over weight	Obese	Under weight	Healthy weight	Over weight	Obese
2007/08	1 %	70 %	14 %	14 %	2 %	60 %	15 %	24 %
2008/09	1 %	72 %	14 %	13 %	1 %	59 %	16 %	24 %
2009/10	2 %	71 %	13 %	14 %	1 %	58 %	15 %	25 %
2010/11	1 %	71 %	13 %	15 %	2 %	57 %	16 %	25 %
2011/12	1 %	72 %	14 %	13 %	2 %	56 %	16 %	27 %
2012/13	1 %	73 %	13 %	13 %	1 %	57 %	16 %	25 %
2013/14	1 %	71 %	13 %	14 %	1 %	58 %	14 %	26 %
2014/15	1 %	73 %	14 %	12 %	1 %	57 %	16 %	26 %

Over a quarter (26 %) of City and Hackney's children are starting school overweight or obese. Recent research has outlined the importance of the early years in setting patterns of healthy behaviour. Sir Michael Marmot's 2010 review on health inequalities stresses the importance of investment in the early years, which yields considerably higher returns than in adolescence[12]. Recent emerging evidence also suggests work in the pre-natal period and with 0 - 2 year olds and their mothers is effective in reducing obesity and emphasises the importance of establishing healthy eating and lifestyle patterns early on[13]. Therefore children's centres have an important role to play in their everyday interactions with families.

[12] Marmot Review (2010), 'Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England Post 2010', London, Marmot Review. Available at: **www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review** (accessed 10.09.15)

[13] Wen, L. M., et al. (2012), 'Effectiveness of home based early intervention on children's BMI at age 2: randomised controlled trial', BMJ, 344 (e3732) pp. 1-11. Available at: **www.bmj.com/content/344/bmj.e3732** (accessed 10.09.15)

4.1 Inequalities in weight in young children

This section will look at the latest broken down data available (2013/14) from the reception year children (YR) to look at groups which have higher rates of overweight and obesity. This information can be used to target groups when undertaking work in children's centres.

4.1.1 Gender

At the local level, there does not appear to be a consistent difference in obesity by gender in YR. In contrast, at the national level there is a statistically significant trend for YR boys to have higher rates of obesity than YR girls.

4.1.2 Ethnicity

Ethnicity is self-reported using pre-defined census categories. At the national level, obesity prevalence rates in YR Black children are significantly higher than all other ethnic categories. Within City and Hackney, at YR, Black children are more likely to be obese than both White and Asian children.

Up until 2012/13, City and Hackney's NCMP analysis captured variations among sub-classifications of ethnicities. However, coding of ethnicity changed from the Department of Education coding to the Department of Health coding for the 2013/14 data, meaning that the latest data is not available. Figure 1 below presents pooled data from the 2006/07 NCMP up until the 2012/13 NCMP. However, please note there are limitations in Figure 1; as very small numbers of children are included in each group it is difficult to ascertain genuine, statistically significant differences between each sub-classification. Any group with a total population of less than 20 has not been included.

When analysed by broad ethnic categories (as stated above), the Black child population appears to be the group with the highest rates of obesity. However, as observed in the chart below, by highlighting the variation within this and other ethnic groups, a more nuanced picture emerges.

In YR, the Irish Traveller, Black Congolese, Black Ghanaian, Turkish, and Kurdish populations are the groups with the highest recorded rates of obesity (Figure 1).

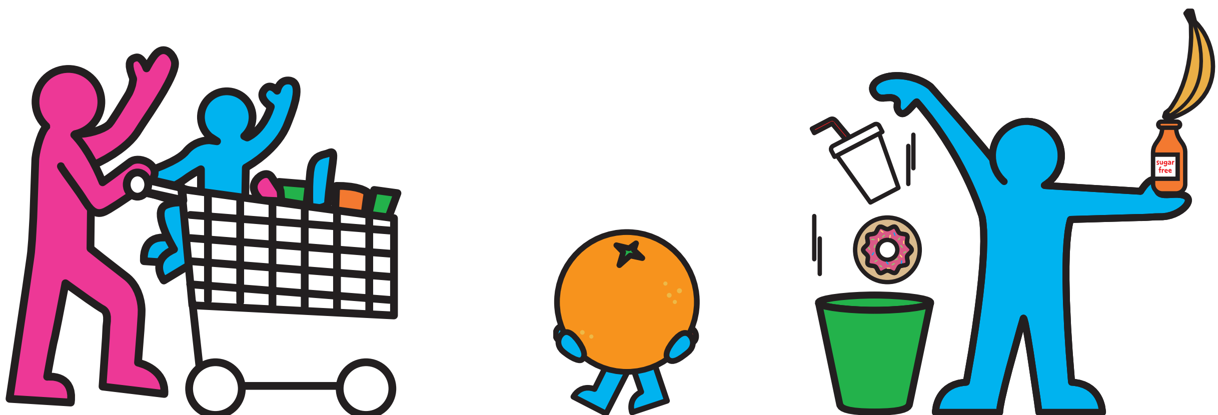
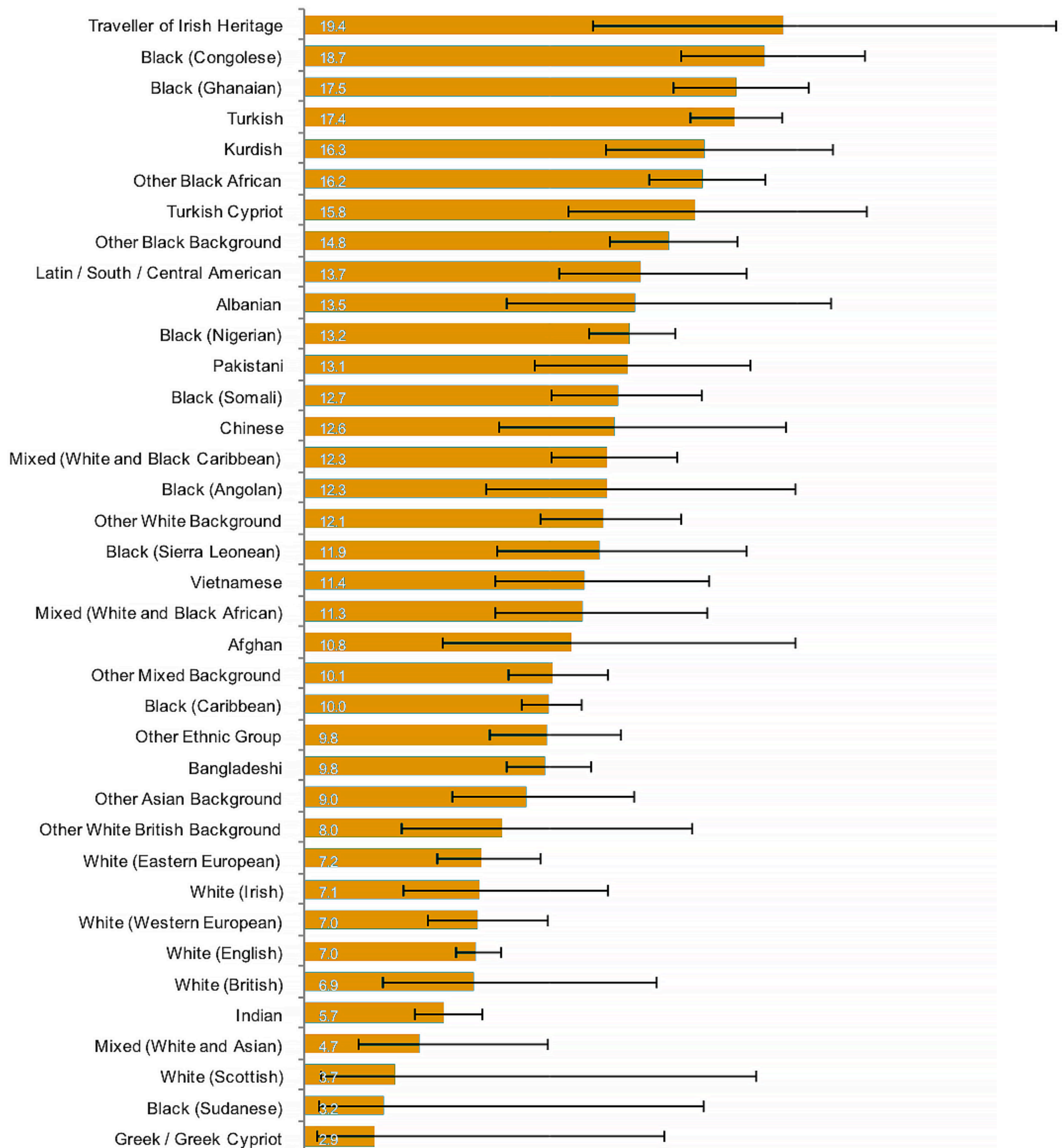


Figure 1: Prevalence of obesity by ethnicity in YR, pooled 2006-2013



Note that the black lines on the graph represent 'confidence intervals'. The longer the confidence interval, the smaller the sample size. A smaller sample size means that it is difficult to compare groups. Therefore it is recommended that these figures be taken with a pinch of salt and not used to generalise about ethnic groups; they are there to give an impression of obesity in different groups only. Hackney Council does not recommend comparing groups based on this graph; obesity affects children of all ethnicities and prevention work should encompass all groups.

4.1.3 Children's centre areas

Rates of overweight and obesity have been analysed by children's centre cluster. However, it is important to note that this is by school attended rather than place of residence, so conclusive results for children's centres cannot be ascertained. The information and figure below may be useful as a guide however.

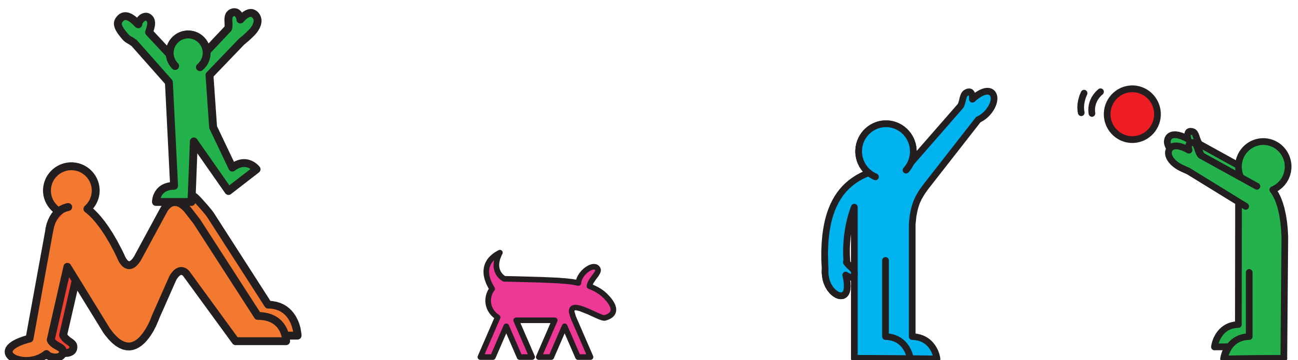
Figure 2 depicts overweight and obesity in YR children by children's service cluster. There is no statistically significant difference between the clusters.

Figure 2: Prevalence of overweight and obesity in YR by children's service clusters (by school location) 2013/14

Overweight and Obese (%)

Cluster	Overweight	Obese
A	10.2	14.0
B	14.1	12.3
C	13.5	13.8
D	11.8	12.9
E	12.8	17.0
F	14.3	15.4

Map labels: A, B, C, D, E, F



5. Commissioned services

Public Health commissions a range of services, both preventative and treatment focused, to tackle the issue of overweight and obesity. There is a lack of accessible policy-ready evidence of interventions to reduce inequalities in obesity[14], so Public Health has been piloting initiatives as part of the Get Hackney Healthy programme of work, explored in further detail below.

Below are the main services which cater for children aged 0 – 5 and their families.

5.1 HENRY (Health, Exercise and Nutrition for the Really Young)

HENRY's family programme – 'Healthy Families: Right from the Start with HENRY' – is an evidence-based child obesity prevention programme. It works with parents and carers of 0 to 5 year olds to help them develop a healthier and more active lifestyle for the whole family.

The HENRY programme has the strongest evidence base of any UK early years child obesity prevention scheme and more than 5,000 families across England and Wales have now joined a HENRY programme[15]. The programme has also been awarded the CANparent Quality Mark meaning that it can be relied on by parents to make a positive difference, is recommended by other parents, is evidence based and is monitored and evaluated[16].

HENRY uses a strength-based and solution-focused approach to help parents give babies and young children the best start in life by focusing on factors known to be associated with later obesity. These are:

- Parenting skills
- Eating patterns and behaviour
- Physical activity
- Emotional wellbeing

The eight week HENRY family programme is delivered each term at children's centres across the borough. Regular Turkish speaking HENRY family programmes are also available. For more information contact LEAP at **huh-tr.LEAP@nhs.net** or on **020 7683 4098**.

[14] Bambra, C. L., et al. (2012) 'Tackling Inequalities in obesity: a protocol for a systematic review of the effectiveness of public health interventions at reducing socioeconomic inequalities in obesity amongst children', Systematic Reviews, 1 (16). Available at: **www.ncbi.nlm.nih.gov/pmc/articles/PMC3351709** (accessed 11.09.15)

[15] More information available at: **www.henry.org.uk/homepage/why-henry/the-henry-approach** (accessed 10.09.15)

[16] More information available at: **www.henry.org.uk/canparent** (accessed 04.03.16)

5.2 LEAP (Lifestyle, Eat well, Activity, Positivity)

LEAP is a multi-disciplinary one to one or family weight management service for 0 – 18 year olds. Overweight children under 5 years will be seen if they have a BMI that is between the 91st centile and the 98th centile alongside medical co-morbidities or psychosocial dysfunction or complex needs such as a learning disability.

The clinic provides direct specialist support to children and their families. It accepts referrals from health care professionals regarding children aged 0 – 18 years, who meet the eligibility critera.

All children are offered an initial multi-disciplinary assessment with LEAP's paediatrician and dietitian.

After assesment children are offered a tailored care package of up to six additional sessions. These sessions will be tailored to the needs of the family but can include individual and/or joint sessions with psychology, dietetics, physiotherapy or paediatrics. Monthly drop in group cooking and exercise sessions are offered as part of this.

LEAP is provided by the Homerton University Hospital NHS Foundation Trust. For further information about this service contact LEAP at **huh-tr.LEAP@nhs.net** or on **020 7683 4098**.

5.3 Dietetics

The Dietetics service promotes key healthy lifestyles messages – eating well and moving more – through community based health promotion/prevention work to clients and other health professionals through training and education sessions, either individually or in groups/events.

The service provides support within children's centres for children under 5 years old and their families. The focus is on healthy weaning and there is also focus on identifying women and making referrals for maternal nutrition, as appropriate. The service provides diagnostic assessment and treatment advice to clients referred for nutritional issues, including those clients who fall outside the LEAP specialist weight management service and those for whom fussy eating is an issue.

The service includes working with hard to reach clients such as teenage mothers, families on low incomes, asylum seekers and travellers. Weaning sessions and breastfeeding support are provided in either group or one to one format for parents in the children's centre setting.

The service is provided by the Homerton University Hospital NHS Foundation Trust and can be contacted at **nutritionanddietetics@homerton.nhs.uk**

5.4 Healthy Start programme

5.4.1 National Healthy Start scheme

Healthy Start is a national scheme which provides free food vouchers and vitamins to women and children who receive particular benefits, or are teenage parents. The food vouchers can be exchanged at some shops and supermarkets for milk, plain fresh and frozen fruit and vegetables, and infant formula milk.

Who qualifies for Healthy Start?

You qualify for Healthy Start if you're at least 10 weeks pregnant or have a child under four years old and you or your family get:

- Income Support, or
- Income-based Jobseeker's Allowance, or
- Income-related Employment and Support Allowance, or
- Child Tax Credit (but not Working Tax Credit unless your family is receiving Working Tax Credit run-on only*) and has an annual family income of £16,190 or less (2014/15)

You also qualify if you are under 18 and pregnant, even if you don't get any of the above benefits or tax credits.

How to apply?

Application forms are available from midwives and health visitors and can be downloaded from the Healthy Start website (**www.healthystart.nhs.uk**). Applications for Healthy Start must be signed by a registered health professional – usually a midwife or health visitor (but it can be any registered nurse or doctor) and sent to:

Freepost RRTR-SYAE-JKCR
Healthy Start Issuing Unit
PO Box 1067
Warrington
WA55 1EG

For more information about Healthy Start visit the website: **www.healthystart.nhs.uk**

5.4.2 Healthy Start City and Hackney

To address concerns about vitamin D insufficiency/deficiency in Hackney's population, the City and Hackney Public Health Team fund vitamins to be given to all women who are pregnant or have given birth in the last year, and all children from four weeks old up to their fourth birthday. We call this scheme 'Healthy Start City and Hackney'.

Healthy Start vitamins are distributed through all community pharmacies in Hackney and two pharmacies in the City (Boots on Aldgate High Street and Niemans chemist on Goswell Road).

Applicants can go directly to their local pharmacy to fill out a registration form, enrol on the scheme and collect their vitamins. Registration forms are also available from a range of community services including midwives, GPs and health visitors.

Distribution of the vitamins through children's centres will also be piloted at Linden and Woodberry Down.

Please note, although all infants are eligible from four weeks of age, those who are fed infant formula will not need these vitamins until they have less than 500ml of infant formula a day, as these products are fortified with vitamin D.

Key messages

- Healthy Start City and Hackney provide free vitamins (non-means tested) for all eligible families in Hackney and the City
- Women should still be encouraged to sign up for the national Healthy Start scheme where eligible, which provides food vouchers as well as the vitamins

For more information on 'Healthy Start City and Hackney' and to download the registration form and supporting guidance notes, visit the website:
www.hackney.gov.uk/healthy-start-for-all

For enquiries please contact Jessica Veltman at **Jessica.Veltman@hackney.gov.uk** or on **020 8356 4206**.

5.5 Get Hackney Healthy

Get Hackney Healthy is a preventative programme of work funded by Public Health and sponsored by the Health and Wellbeing Board which aims to tackle childhood obesity through a focus on partnerships and a strong emphasis of resources on prevention and early years intervention (0 – 5s).

Several pilots have been included in the programme and there have been some promising emerging results, including Eat Better Start Better and Play Streets.

5.5.1 Eat Better Start Better

Eat Better Start Better works with early years settings to support the implementation of the Children's Food Trust Eat Better Start Better voluntary food and drink guidelines by providing training and support from an early years nutritional expert. Self-assessment packs are completed by early years settings and childminders. Feedback is then provided and settings submit a good practice portfolio. In 2014/15 the programme worked with 47 settings and 15 childminders, reaching approximately 2200 Hackney children.

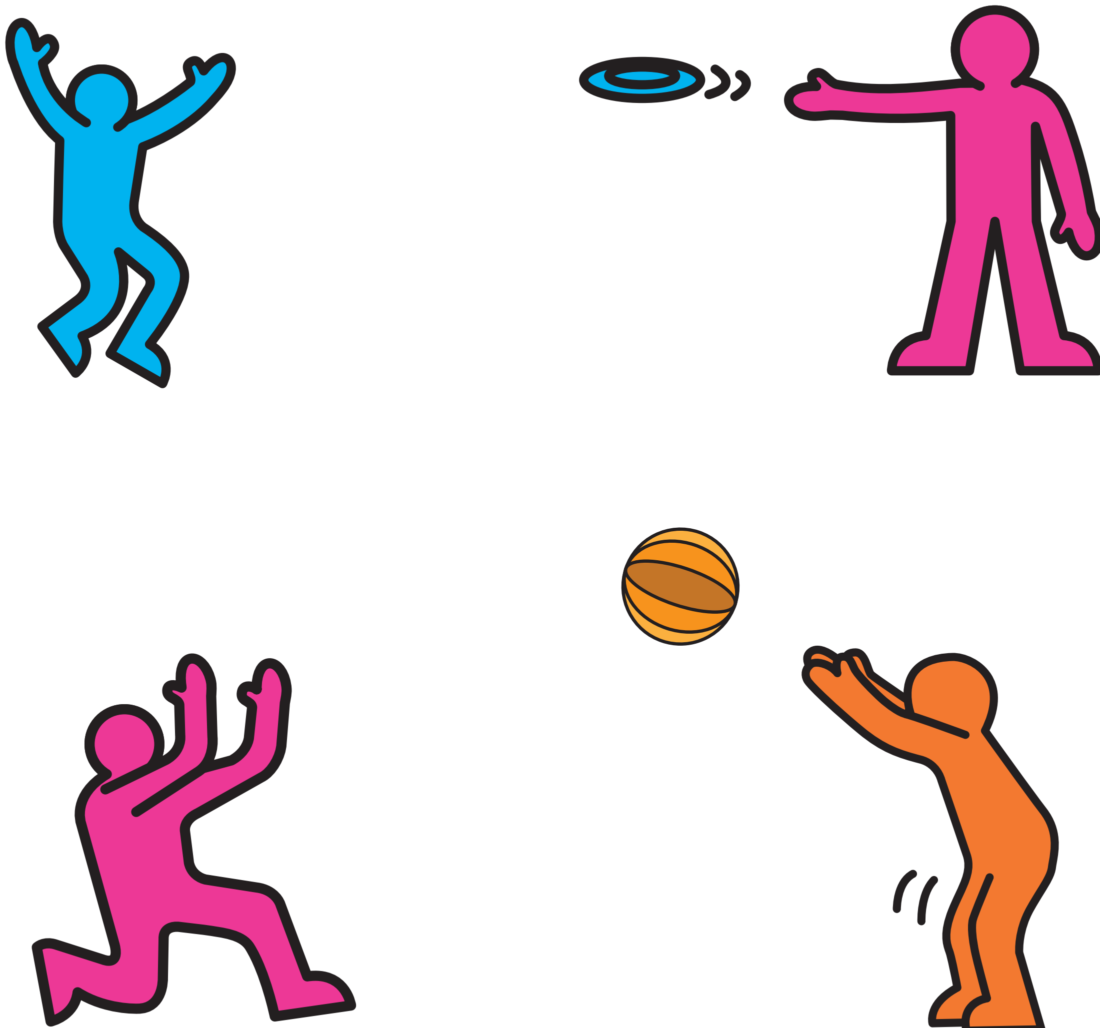
More information on the national programme can be found on the Children's Food Trust website[17]. For information on the local programme contact **Caroline.Hart@learningtrust.co.uk**

[17] **www.childrensfoodtrust.org.uk/childrens-food-trust/early-years** (accessed 04.03.16)

5.5.2 Play Streets

Play Streets provides a mechanism for streets to be closed for a regular playing out session and has rapidly expanded across the borough. Originally a way for parents on streets to allow their children to play out, the scheme has opened out to allow children's centres, schools and estates to have regular Play Street sessions. Mapledene and Queensbridge children's centres currently run sessions once per term, and six primary schools have also taken part.

More information can be found on the Play Streets website[18]. If you would like to organise a Play Street at your setting please contact Claudia Draper at **playstreets@hackneyplay.org** or on **07947 095 069**.



[18] **www.hackneyplay.org/street-play** (accessed 04.03.16)

6. Evaluation

Evaluation is a key part of the commissioning cycle of any project. It enables commissioners to see whether the project has had the desired impact (and if it has had any other impacts) and to judge the value of a project. The National Obesity Observatory (NOO) has produced guidance on how to ensure evaluation is effective in interventions pertaining to healthy weight. The key documents for children's centres will be the Standard Evaluation Frameworks (SEFs) for dietary interventions and physical activity[19].

The key principles of evaluation can be defined as follows:

- Evaluation should ideally be commenced before the project has been implemented.
- Projects need clear objectives that describe what they are aiming to do and how they will do it. A simple way to set objectives is to use SMART objectives:
  - Specific: objectives should specify what you want to achieve;
  - Measureable: measure whether or not objectives are being met;
  - Achievable: are the objectives achievable and attainable?
  - Realistic: can the objectives be realistically achieved with the available resources?
  - Time-bound: when should the objectives be met?
- The World Health Organisation (WHO) suggests at least 10 per cent of a health promotion's total project should be dedicated to its evaluation[20].

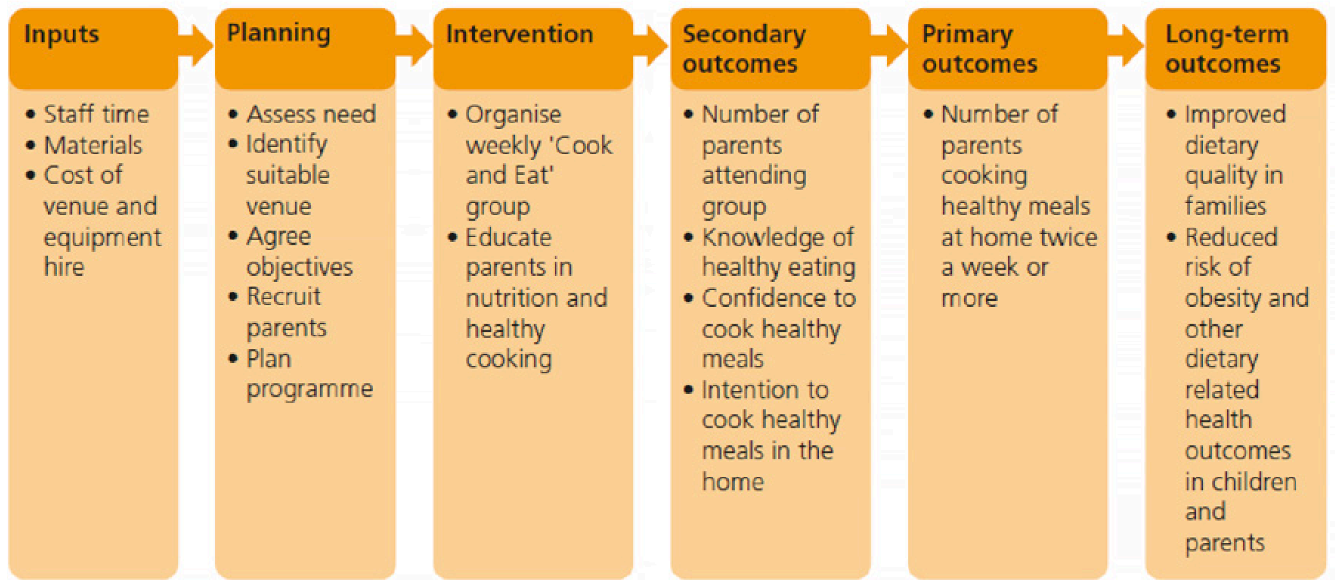
On a practical level, children's centres need to be able to conduct an evaluation that is simple and cheap. Projects and activities with small budgets cannot be evaluated in the same way as larger projects with bigger budgets and higher participant levels but there are some simple methods that can be used to look at impacts:

- An evaluation could compare measures from before the project with measures at other points in the project, including post-project. In this way, commissioners can see whether the project made a difference to the prevailing trend.
- A crucial part of any evaluation is agreeing a set of core measures. It is important to be realistic about the impact a project can have on wider key indicators such as obesity prevalence. It may be unlikely a project will have a measurable impact on BMI in the short term but it may change one or more of the other determinants of obesity such as eating behaviour and physical activity.
- Data collection may involve a mixture of direct objective collection such as height and weight and indirect collection such as a questionnaire survey.
- An evaluation can reveal unintended consequences. These are outcomes, both positive and negative, that might arise but were not originally intended. For example, evidence of eating behaviour changing at home as a result of a healthy food policy at the children's centre. It is therefore important to consider wider possible outcomes when designing the project and its evaluation. Aim to measure and assess some of the wider, often unplanned, possible outcomes.

[19] All frameworks available at: **www.noo.org.uk/core/frameworks** (accessed 10.09.15)

[20] WHO European Working Group on Health Promotion Evaluation (1998), Health promotion evaluation: recommendations to policy-makers, Copenhagen, WHO Europe. Available at: **http://apps.who.int/iris/bitstream/10665/108116/1/E60706.pdf** (accessed 10.09.15)

A "logic model" can be a useful tool for planning your intervention, as well as showing how the evaluation will be done. NOO uses the example below of how a cook and eat project might be evaluated:



NOO have a useful list of "dos and don'ts" when it comes to evaluation[21].

DO:

- Set a budget for evaluation.
- Build evaluation into the start of a project.
- Bring all stakeholders together and agree aims and objectives.
- Set out how the project will achieve its objectives.
- Find out what stakeholders think a successful project will look like.
- Agree what will be measured and how it can be measured.
- Use data collection methods which are appropriate to the available resources and will help answer the key evaluation questions.
- Consider the value of both quantitative and qualitative information, if possible.
- Scope out timing and logistical issues, and consider the impact they will have on the evaluation.
- Think creatively: there is no single way to evaluate a project.
- Keep evaluations simple and useful.
- Share your findings as widely as possible.

DON'T:

- Start the project without collecting baseline data.
- Try to measure everything.
- Only have one person responsible for the evaluation.

[21] National Obesity Observatory (2009), Standard Evaluation Framework for weight management interventions, [Online], Public Health England. Available at: **www.noo.org.uk/uploads/doc721_2_noo_SEF%20FINAL300309.pdf** (accessed 10.09.15)

- Spend so long designing a questionnaire that you do not have the time to use it.
- Collect data that will not be used.
- Construct a comprehensive evaluation plan then forget it as soon as you get the funding.
- Make claims from the evaluation that cannot be substantiated.

NOO also has a step by step guide to evaluation:

Step 1: What would you like to know?

- Who is the evaluation for?
- What does your project aim to achieve?
- What information do you need to collect?
- What are the outcomes of your project?
- What processes will your project go through from start to finish?
- What are the aims and objectives of your project?
- What funding exists for doing your evaluation?
- What style of evaluation will be appropriate?

Step 2: How are you going to find out what you need to know?

- What is the best way for your project to collect the information you need?
- Who will collect this information?
- What additional skills, resources or training are needed to do the evaluation?
- Do you have the appropriate people, time and evaluation methods?
- How are you going to analyse this information?
- Do stakeholders know the sort of information you will find out from the evaluation?
- Will the evaluation have any consequences, good or bad, for the way the project is designed and run?

Step 3: Find it out

- Are you checking the information you need is being collected?
- Are you on time for completing your evaluation?

Step 4: Look at the answers so you can make your judgement

- What do the results say?
- What did you expect them to say?
- Are there any unexpected results from your project?
- How will the results be used to change the project?
- Do the results indicate that the project should be stopped?

Step 5: Tell the people who need to know

- How are you going to share your project evaluation with others?

Appendix A: Risk factors for obesity

The causes of obesity are complex and multifaceted, and are still being explored. Although there are many reasons why an individual may become obese, it is now generally accepted that the current prevalence of obesity in the UK population is primarily caused by people's latent biological susceptibility interacting with a changing environment that includes more sedentary lifestyles and increased dietary abundance[22].

However, there are certain factors that have been linked to childhood obesity that professionals working with children and families should be aware of [23].

Family and social factors

- Parental obesity – the risk of developing obesity increases when parents are obese, particularly when both parents are affected
- Family history of heart disease or diabetes
- Poverty – there is a clear link between deprivation and obesity
- Race and ethnicity (see NCMP results above for local research on this)
- Sedentary behaviours

Pregnancy

- Maternal obesity
- Excess weight gain in pregnancy
- Gestational diabetes
- Smoking

Infancy

- Birth weight - babies who are born large for gestational age have an increased risk for obesity, with alterations in glucose metabolism already evident in the early months. At the other end of the spectrum babies born small for gestational age are also at increased risk for both obesity and type 2 diabetes, especially when rapid catch up growth occurs.
- Rapid weight gain - some low-birth-weight babies may be especially susceptible to catch-up growth, while others experience this as a direct consequence of their diet. Obese babies have ten times the risk of later obesity, and babies who gain weight rapidly (even if they are not obese) have six times the risk.
- Bottle feeding - breastfed babies show slower growth rates than formula-fed babies and this may contribute to the reduced risk of obesity later in life shown by breastfed babies.
- Early weaning.

[22] Foresight (2007), Tackling Obesities: Future Choices - Project Report, [Online], Government Office for Science. Available at: **www.gov.uk/government/uploads/system/uploads/attachment_data/file/287937/07-1184x-tackling-obesities-future-choices-report.pdf** (accessed 10.09.15)

[23] Rudolf, M. (2009), Tackling Obesity Through the Healthy Child Programme: A Framework For Action, Leeds, University of Leeds. Available at: **www.noo.org.uk/uploads/doc/vid_4865_rudolf_TacklingObesity1_210110.pdf** (accessed 10.09.15)

Appendix B: Impacts of obesity[24]

Being obese has both physical and emotional impacts. Research has shown that obesity in adults is associated with the following health conditions:

- Coronary heart disease
- Stroke
- Type 2 diabetes
- Cancers (esophagus, breast, endometrium, colon, kidney, pancreas, thyroid, gallbladder)
- Hypertension (high blood pressure)
- Dyslipidemia (high cholesterol or high levels of triglycerides)
- Gastrointestinal and liver disease
- Musculoskeletal problems (osteoarthritis and lower back pain)
- Reproductive and urological problems
- Respiratory problems (asthma and sleep apnoea)
- Psychological and emotional problems (depression, anxiety, low self esteem)

Moderate obesity (BMI 30-35) has been found to reduce life expectancy by an average of three years, while severe obesity (BMI 40-50) has been found to reduce life expectancy by eight to ten years.

Overweight and obese children are more likely to become obese adults, and have a higher risk of morbidity, disability and premature mortality in adulthood.

Research has shown that obesity in children can lead to the following early markers of more serious disease:

- Raised blood pressure
- Fatty changes to the arterial linings
- Hormonal and chemical changes (such as raised cholesterol and metabolic syndrome)

Other health risks of childhood obesity include:

- Type 2 diabetes (which has increased in overweight children)
- Early puberty
- Eating disorders such as anorexia and bulimia
- Skin infections
- Asthma and other respiratory problems
- Some musculoskeletal disorder
- Disturbed sleep and fatigue

The emotional impacts of childhood obesity can also include discrimination and teasing by peers, low self-esteem and anxiety and depression. Severely obese children and young people have rated their quality of life as low as children and young people with cancer on chemotherapy.

[24] Information sourced from the National Obesity Observatory website (part of Public Health England). Available at: **www.noo.org.uk/LA/impact/health** (accessed 11.09.15)

Appendix C: Common misconceptions around childhood obesity

There is evidence to show that parents don't always recognise that their child is overweight or obese or that this is a problem. Some common parental reactions to being told their child was overweight/obese were explored in a study on feedback from the National Child Measurement Programme (mentioned above)[25].

- Placing more importance on the child's emotional and physical health than their weight. If the child was seen as happy, some parents thought their weight did not matter.
- Placing more importance on a child's lifestyle than their weight i.e. thinking they were active and ate well so therefore they felt that their child was healthy and their weight was not important.
- Parents often thought that their child's excess weight was "puppy fat" and that they would grow into their weight as they got older.
- Some parents thought that their child's classification as overweight or obese was to do with their stature e.g. tall/short or being of big build.
- Some parents thought that their child was genetically predisposed to be overweight or that they were overweight because they had been big when they were a baby.
- A small number of parents thought that their children were extremely athletic and were upset by the notion that they were overweight.
- Parents did not think their children looked overweight, and some parents compared their own children to others they saw around them and felt that they didn't look overweight in comparison to them.
- Some parents of black and ethnic minority communities said that there was a cultural difference between 'traditional' British views of overweight and their own culture, where overweight was not viewed negatively and sometimes was seen as a positive thing.

Professionals can help to dispel some of the myths surrounding these beliefs:

- There is substantial evidence that obesity in childhood tracks into adulthood.
- Body Mass Index (BMI) – the method used to measure weight in the NCMP – takes into account the height to weight ratio and therefore whether a child is tall or short is irrelevant.
- It has been suggested that increasing prevalence of overweight may have normalised obesity, thus leading to parents believing their child is not overweight in comparison to other children.
- Evidence has shown that parents tend to overestimate the amount of physical activity and the healthiness of their diet.
- Professionals should emphasise the importance of a healthy diet and physical activity rather than solely focusing on weight measures such as BMI.

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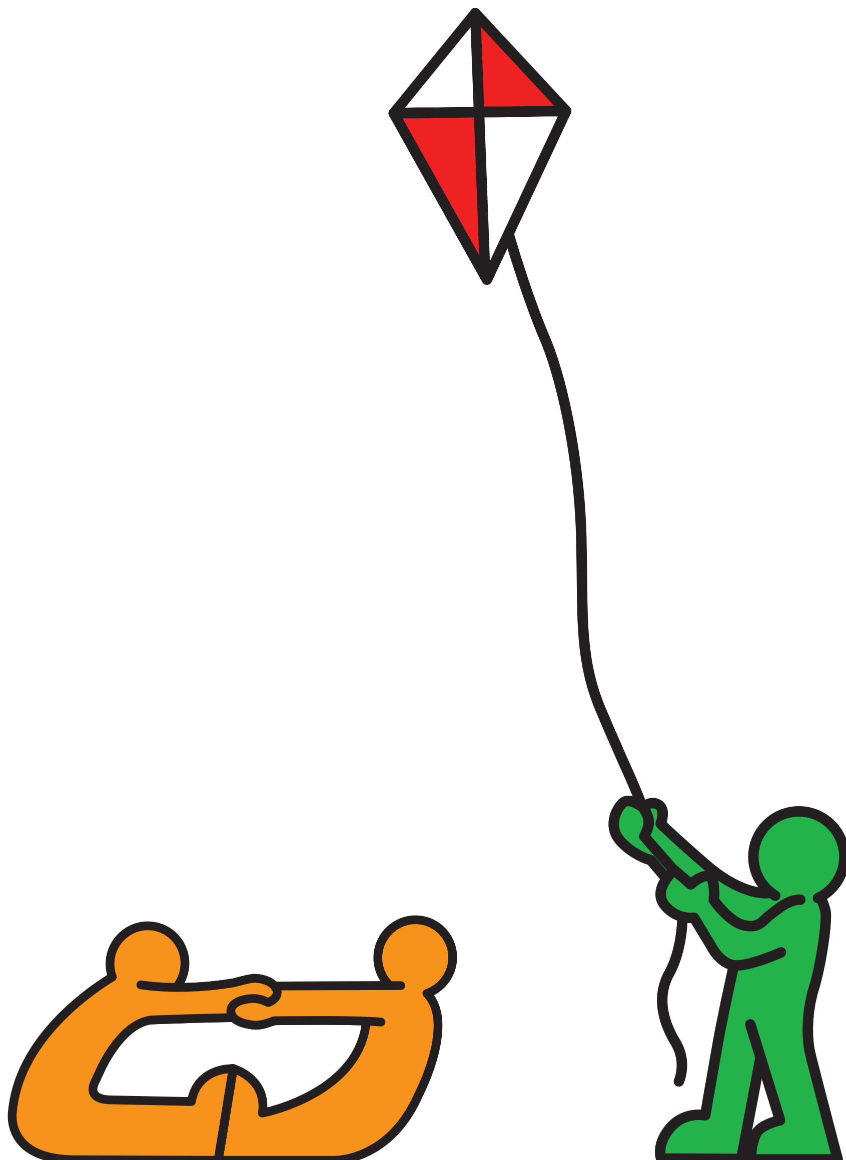

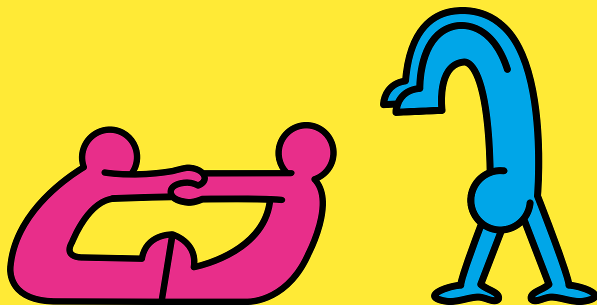

For more information on any of the issues raised in this document please contact **Lucy.Vanes@hackney.gov.uk** or **Amy.Wilkinson@hackney.gov.uk**

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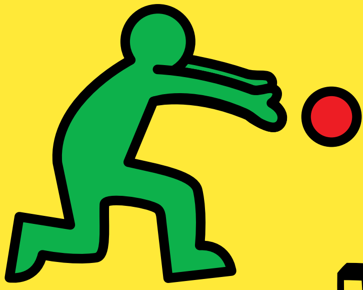


get healthy stay healthy

Activities to help your children achieve and maintain a healthy weight are available across Hackney and the City. There's lots of choice, from parks, adventure playgrounds, free swimming to healthy cooking and lifestyle courses. Get in touch directly with the organisers, using the contacts in this leaflet, or for general advice, call the number on the back.

change 4 life
Eat well Move more Live longer

CITY OF LONDON

NHS

Hackney

Healthy activities in the City

Swimming

Free swimming for under 3 year olds and low cost swimming for juniors aged 3-16 years is available from the Golden Lane Sport and Fitness Centre. A comprehensive learn to swim programme is also available, with weekly 30 minute swimming lessons offered to all ages for 50 weeks of the year.

Youth Community Sports Programme

Free weekly football coaching sessions based at City of London estates:
Avondale Square Ball Court (Wednesday, 17:30-19:00); Kings Square Court (Saturday, 10:30-13:30).

Junior Tennis

A fun beginner and intermediate tennis class run by qualified LTA coaches to develop skill and ability, Tuesdays 16:00-18:00 (term time only), Golden Lane Sport & Fitness. Ages 7-12, £3.75 per session.

Friday Night Project

Gym and Swim sessions for £1.50 per session on Friday evenings at Golden Lane Sport and Fitness, 18:30 – 20:30 for 12-16 year olds (Spice Time credits accepted).

Gymnastics

Saturday mornings, 9:00-12:00 at Golden Lane Sport and Fitness for 4-12 year olds (session time dependent on ability - contact Golden Lane Sport and Fitness for further information) - £49.80 for 12 weeks.

Coming soon

Cheerleading (girls only) for 12-16 year olds.

Contact details for all the above activities are:

Address: Golden Lane Sport and Fitness, Fann Street, EC1Y 0SH
Tel: 020 7250 1464
Email: **csd-col@fusion-lifestyle.com**

Boxing

The City of London Police Community Boxing Club offers boxing training with fully qualified Amateur Boxing Association coaches for people aged 10 and over (free for 10 – 17 year olds) at Wood Street police station. Please contact John Ryland for further information:
colpcommunityboxing@cityoflondon.pnn.police.uk

Youth clubs

Youth club provision for 10-19 year olds with aspects of dance, multi sports and fitness. More information, including addresses, available at
https://home.citygateway.org.uk/services/youth-work

Youth Club @ Golden Lane
Wednesday 18:00-20:00 at Golden Lane Community Centre

Youth Club @ Green Box
Thursday 18:00-21:00 at Portsoken Community Centre

Youth Club @ Artizan
Friday 18:00-20:00 at Artizan Street Library

HENRY

(Health, Exercise and Nutrition for the Really Young)

Free eight week healthy lifestyle and parenting programme for parents and carers with 0-5 year olds. Running across Hackney. **huh-tr.LEAP@nhs.net**

Fitness Fun Programme

Free physical activity sessions for 7 to 11 year olds, before or after school, ranging from street dance to capoeira, in over 30 schools across Hackney. Contact your child's school or **Samina Tarafder** on **020 8356 3282** or **Samina.Tarafder@hackney.gov.uk**

SHEL Multi-sports Camp

Subsidised holiday camp for 8-12 year olds. Sessions include physical activities with healthy eating messages. **Stephen Ogunjimi** on **07985 111237** or **stephen@generalworldsports.com**

Healthy Lifestyles Project

Free 10 week project for overweight 7-13 year olds and their families, combining healthy eating advice and physical activity sessions. Runs in Hackney. Des Ryner on **020 7613 9169, 07956 375078** or **des@corehealthandfitness.co.uk**

Healthy Lifestyles Project

Free 8 week project for overweight 13-19 year olds, combining healthy eating advice and physical activity sessions. Runs in Hackney. Des Ryner on **020 7613 9169**, **07956 375078** or **des@corehealthandfitness.co.uk**

Hackney Community Kitchens Programme

Free 6 week courses across 9 estates in Hackney in which families come together to prepare, cook and eat healthy affordable meals. Contact **Henry Muss** on **0208 356 6326** or **henry.muss@hackney.gov.uk**

ONE YOU Community Based £1 Fitness Classes

Hackney Council is supporting a programme of fitness classes for children and families in community centres, estates and churches across Hackney (some of the adult classes are at the same time and in the same location as children's classes to allow adults and children to attend classes simultaneously and some classes provide a crèche). Capoeira, judo, taekwondo and box-fit are offered for children as well as classes for adults such as Zumba and body conditioning, all for only £1. Contact Henry Muss on **0208 356 6326** or **henry.muss@hackney.gov.uk**
The latest timetables are at:
www.hackney.gov.uk/healthy-hackney

Adventure playgrounds

Free, inclusive, supervised play for children aged 6–15. Open after school, on Saturdays and during school holidays. Please follow the link for more information on locations and opening times:

www.hackney.gov.uk/parks-play-areas

Play streets

Children in Hackney are reclaiming the streets, thanks to a groundbreaking scheme enabling residents to close residential streets for a few hours to through traffic, turning them into play streets. Benefits include: allowing children to play near home, giving children the space to play energetically and increasing a sense of community by bringing neighbours together.

See **www.hackney.gov.uk/play-streets** for more details.

Leisure centres

Hackney residents who are under 18 swim for free in the following Hackney pools, includes some lessons:

Britannia Leisure Centre, Clissold Leisure Centre and **Kings Hall Leisure Centre**.

Please follow the link for more information on locations and opening times

www.hackney.gov.uk/swimming-pools

To find out what activities are happening at Hackney's six leisure centres visit **www.hackney.gov.uk/sports-and-leisure**

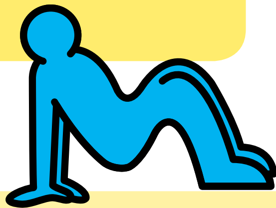
Young Hackney

Young Hackney services are for children and young people aged 6-19, and up to 25 years if the young person has a special educational need or disability. Services are delivered across the borough through a network of Young Hackney hubs, playgrounds, community halls and schools. The service provides youth clubs and sports and citizenship activities, as well as offering help for children and young people who need additional support.

Young Hackney youth work programmes are fun, educational and inspiring, providing young people with opportunities to engage locally, nationally and internationally. Regular activities include sports, healthy eating, cooking, healthy lifestyle and play programmes. Examples include: parkour, climbing, boxing, cycling, wheelchair basketball, girls groups and outdoor education. Young Hackney also commissions a number of sporting organisations who also offer activities for young people including: canoeing, kayaking, rowing and mountain biking as well as more traditional team sports. Whilst taking part in fun activities, young people can also gain qualifications including National Governing Bodies (NGB) Sports Awards or the Duke of Edinburgh Award Scheme. The majority of programmes are free.

Following the 2012 Olympics, the Youth and School Sports Unit was created to widen children and young people's participation in sport and physical activity. Staff work closely with primary schools and other partners to deliver enhanced sport and physical activities out of school hours, competitive school sport opportunities for young people who want to take part and fun activities that encourage the least active to exercise. Regular programmes include the 'Personal Bests' school sports programme, School Games competitions and the Tour de Hackney cycling programme. Leadership and training opportunities, such as the 'Sport Ambassadors' programme, involve young people shaping, organising and delivering sport and physical activity provision in the community, whilst talented young athletes are also supported to develop their potential through the Young Hackney Sports Fund.

For details on all of these activities go to the website: **www.younghackney.org** or the Facebook page at **www.facebook.com/younghackney** or follow us on Twitter **@younghackney**.



Hackney's Family Information Service (FIS) can help you find healthy eating support and physical activities available at children's centres, schools and youth clubs. Find out more about what is happening near you at **www.learningtrust.co.uk** or call **020 8820 7590** or email **fis@learningtrust.co.uk** FIS are also on Facebook **www.facebook.com/hackneyfis**

www.hackneyicare.org.uk also has a list of all activities, including sports clubs.

FYi is the City of London's Family and Young People's Information Service. We provide information about healthy activities, parks, playgrounds and other facilities for families and young people in the City and surrounding areas. You can search online using our FYi Directory at **www.fyi.cityoflondon.gov.uk** or call us on **020 7332 3126** or email **fyi@cityoflondon.gov.uk**. We are also on Facebook **www.facebook.com/CityFYi** and Twitter **@CityFamilyInfo**.

Help and Advice

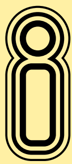
You can get help from healthcare professionals who will be able to help if your child is overweight, obese or underweight.

School nurse provides advice on diet and exercise. **GP** provides further assessment and advice on diet and exercise. Both can also refer you on to the following professionals:

Dietitian provides advice on any nutritional matter for children and families.

Paediatrician assesses children for medical problems that may contribute to, or result from them being overweight, obese or underweight.

LEAP (Lifestyle, Eat-well, Activity, Positivity) is a multidisciplinary service for children who are overweight or obese, made up of a dietitian, a child psychologist, a paediatrician and a physiotherapist.



If you want more information about how to access healthy weight services you can contact your child's school nurse (through the school reception) or the Dietetics department using the details below.

As well as providing information about healthy eating and other healthcare services, they will also be able to offer advice on how to access a range of other opportunities, including physical activity programmes.

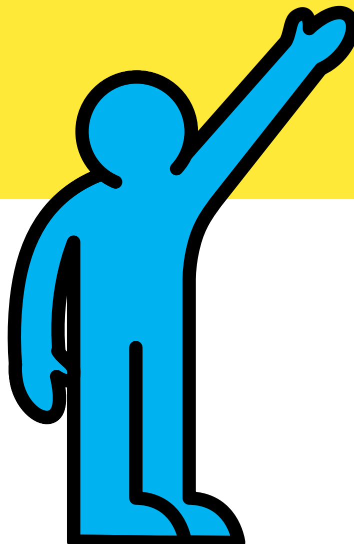
Dietetics department: **020 7683 4267**
Monday – Friday, 9am to 5pm
Email: **nutritionanddietetics@homerton.nhs.uk**

You can get general advice and will be directed to another service that can help if you need it.

For lots of ideas, recipes and games and to help you and your family become healthier sign up for **Change4Life** at **www.nhs.uk/change4life**

Follow Change4Life

Like Change4Life on Facebook



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Hackney

Report to Hackney Health and Wellbeing Board

Item No:		**Date:**	**8th March 2017**
Subject:		**Improving Outcomes for Young Black Men**	
Report From:		**Sonia Khan, Head of Policy and Partnerships**	
Summary:		Since January 2015, the Council, Hackney CVS and local partner agencies have worked with young people and parents to launch an ambitious programme to improve outcomes for young black men. This responds the fact that young black men (YBM) tend to fare worse than their peers in many ways, from poorer educational results to higher offending rates. This report highlights the key issues for the health and wellbeing board.	
Recommendations:		**Recommendations** **The Health and Wellbeing Board to note and comment on the relevant commitments** **The Health and Wellbeing Board to identify potential topics for development days**	
Contacts:		0208 356 5148 Sonia.khan@hackney.gov.uk http://hackney.gov.uk/young-black-men	

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1 Introduction

1.1 Overview of programme and ambitions

The Council, Hackney CVS and local partner agencies have worked with young people and parents to launch an ambitious programme to improve outcomes for young black men. This responds the fact that young black men (YBM) tend to fare worse than their peers in many ways, from poorer educational results to higher offending rates. This has been a problem for many years and there have been many responses from public bodies and from the community, but they have not had the impact needed. Rather than tackle individual problems, our approach involves local people, the voluntary and community sector and the statutory sector in shaping and delivering solutions, with young people at the heart of this.

The work is championed by Cllr Bramble, Deputy Mayor and lead Cabinet Member for Children and Young People and steered by a multi-agency partnership that was set up in January 2015. We seek to improve life chances for

future generations of young men as well as co-ordinating support and opportunities for those who are 18- 25 now. There are many black boys, young black men and black families that are succeeding in Hackney. It is vitally important that this work does not stereotype or problematize black men or the black community; the focus of this programme is on harnessing the potential of successful young black men, increasing their visibility as well as tackling inequalities where they do exist.

The programme sets some clear ambitions to reduce disproportionality over the next 10 years:

Within 10 years: Outcomes and opportunities for black boys and young black men should be the same as the wider population.

Within 15 years: We start to see cultural changes in terms of aspirations and in terms of trust of the state

Within 15 years: Working with other authorities, central government and the state, we also want to see changes in media representation and portrayals

1.2 Developing a theory of change

Since January 2015 we have engaged with partners from all sectors, young people, businesses and parents and have identified what we consider to be the key drivers to inequality and the possible solutions. Young people and parents have been at the centre of the engagement and enquiry; a youth advisory group has been established to work with the partnership to define issues and develop solutions and parents of black children were engaged as peer researchers to interview other parents about their experience of parenting in Hackney.

We have also engaged evaluators University of East London and Runnymede Trust and set up a dashboard of data to understand inequality and differentials across all key outcomes.

In November 2015 partners agreed a Theory of Change setting out the assumptions for why outcomes for young black men were disproportionately worse than the wider population. Partners also identified a series of actions to consider. This was published on line: http://hackney.gov.uk/young-black-men

Since then a number of working groups have been set up to further consider evidence and finalise a set of actions which will be taken between January 2017 and March 2018. Where possible quick wins have been identified which could be delivered during 2016 to improve outcomes or test a way of working. A final set of commitments which all members of the partnership have agreed to has now been developed under the following workstreams:

Improving Life Chances for Black Boys

- *Critical intervention points*

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- *Role of schools*
- *Trust between parents and the statutory sector*
- *Families*

Empowering the community

- *Community leadership*

Improving outcomes for young black men

- *Young men at risk and community safety*
- *Mental health*
- *Regeneration and opportunity*

Culture and Identity

- *Valuing heritage and celebrating success*
- *Behaviour, lifestyles, culture and identity*

The next step is to turn the commitments into measurable objectives with clear reporting milestones and performance indicators.

1.3 Key issues for health and wellbeing board

Improving life chances for black boys: focus on education

Commitment	Issues for Health and Wellbeing Board
Head Teachers to progress individual and shared actions to address achievement, exclusions, parental engagement and work with community based resources like supplementary schools (lead: Martin Buck)	How schools can be encouraged to take a wellbeing approach to managing exclusions and behaviour.
No need to exclude: Promote the No Need to Exclude policy to all schools (lead: Andrew Lee) and progress actions in response to the Children and Young People’s Scrutiny Review into exclusions once agreed (HLT). Encourage an approach based on restorative practice where possible.	
Ensure CAMHS is in each school: Progress actions to introduce CAMHS in every school so that a wellbeing approach is taken to managing exclusions and behaviour (lead: Andrew Lee)	

Improving life chances for black boys: health inequalities

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Commitment	Issues for Health and Wellbeing Board
Identify actions to address health and wellbeing inequalities: Children's Health and Wellbeing Board will progress actions to tackle health inequalities: Looked after children, Fixed term exclusions, Teenage pregnancy, Maternal obesity, Exclusive breastfeeding, Childhood obesity including physical activity, Serious mental illness and secondary mental health care service use, Non cigarette tobacco (Nicole Klynman/ Amy Wilkinson).	Seek regular progress from Children's Health and Wellbeing Board on their work to tackle the identified inequalities.

Commitment	Issues for Health and Wellbeing Board
Targeted work:	
Preventative mental wellbeing activities in community settings to reach people earlier and address stigma- based on strength based approaches and including parental engagement (Public Health and HCVS)	Possible topic for a development day
Good referral systems are developed to ensure that children and young adults who are at risk are referred to clinical mental health assessment support where this need is identified. Where appropriate this is embedded into frontline settings (Public Health and CCG).	
Mental health first aid training rolled out in different settings (Public Health)	
Targeted work / support to raise awareness about heavy use of cannabis working with the youth advisory group and Young Hackney Ambassadors to further target preventative work (Young Hackney)	
Commitment	**Issues for Health and Wellbeing Board**
Partnership and co-ordination:	
Review of available services and resources and of the offer available for 18-25 year olds to understand access and inclusion issues by considering: Referrals, take up and outcomes of services for black boys and young black	The outcome from this work could be reported to the Health and

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men (CCG and Public Health)	Wellbeing Board
Look at how clinical support can be offered to young people alongside other wellbeing / recovery support in an integrated care plan – with a better understanding of how trauma can be managed. This would ensure wrap around support was available for a young person for a longer period of time, in addition to counselling or therapy sessions (CCG and Public Health)	
Challenging institutional programmes for Hackney providers that tackles overt and covert racism (LBH Policy and Partnerships)	Could be a development day for the board
Improve information about mental health services, especially those targeting young black men (all partners to send to I care team)	

Improving outcomes for young black men: Mental health – earlier help

Commitment	**Issues for Health and Wellbeing Board**
Facilitate partnerships between probation and organisations that take a more holistic approach looking at: Support in custody Mental health support Resources in the wider community such as mentoring and employment support Attitudes of employers- to improve their understanding and promote best practice e.g. a business award for inclusive employer Best models from elsewhere. Improve the synergies between youth and adult probation services.	Role in identifying gaps in support in custody and probation

2 Financial Considerations

The recommendations arising from this report have no direct budgetary impact. However, it should be borne in mind that any initiatives that arise from the

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commitments and proposed development days will need to be financed from within existing budgetary cash limits.

3 Legal Considerations

The report and its contents are noted including the recommendations. There are no legal implications arising out of this report.’

4 Equality Impact Assessment

The purpose of this programme is to tackle inequalities for a group where there is clear evidence of disproportionately worse outcomes across a range of areas. The programme is therefore taking positive action towards young black men; however by focusing on this group there should not be a disadvantage on any other group. Indeed many of the commitments which have now been identified will benefit all groups. Furthermore the learning could be applied to other groups experiencing disadvantage.

5 Attachments

Full report setting out Progress Update and Summary of Commitments

Officer Responsible: ***(to be completed by the report author)***

Name: Sonia Khan	Ext: 5148
Directorate: Chief Executive	Department/Division: Policy and Partnerships

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Improving Outcomes for Young Black Men – Progress Update and Summary of Commitments – December 2016

Background to programme

The Council, Hackney CVS and local partner agencies have worked with young people and parents to launch an ambitious programme to improve outcomes for young black men. This responds the fact that young black men (YBM) tend to fare worse than their peers in many ways, from poorer educational results to higher offending rates. This has been a problem for many years and there have been many responses from public bodies and from the community, but they have not had the impact needed. Rather than tackle individual problems, our approach involves local people, the voluntary and community sector and the statutory sector in shaping and delivering solutions, with young people at the heart of this.

The work is championed by Cllr Bramble, Deputy Mayor and lead Cabinet Member for Children and Young People and steered by a multi-agency partnership that was set up in January 2015. We seek to improve life chances for future generations of young men as well as co-ordinating support and opportunities for those who are 18- 25 now. There are many black boys, young black men and black families that are succeeding in Hackney. It is vitally important that this work does not stereotype or problematize black men or the black community; the focus of this programme is on harnessing the potential of successful young black men, increasing their visibility as well as tackling inequalities where they do exist. The programme sets some clear ambitions to reduce disproportionality over the next 10 years:

> Within 10 years: Outcomes and opportunities for black boys and young black men should be the same as the wider population.
>
> Within 15 years: We start to see cultural changes in terms of aspirations and in terms of trust of the state
>
> Within 15 years: Working with other authorities, central government and the state, we also want to see changes in media representation and portrayals

In November 2015 partners agreed a Theory of Change setting out the assumptions for why outcomes for young black men were disproportionately worse than the wider population. Partners also identified a series of actions to consider. This is summarised in the diagram overleaf. The full background papers consider outcomes data alongside insight gathered from young black men, parents and businesses and good practice from elsewhere. These are available on the Council's webpage:

http://hackney.gov.uk/young-black-men

Theory of change – overview
Improving life chances for black boys
Critical Intervention points – co-ordinating support
Focus on education: achievement and exclusions
Improving family health and wellbeing
Focus on early years help
Empowering young black men and the wider community
Empowering the community:
Youth led programmes
Community led programmes
Parent led programmes
Culture and identity
Celebrating success
Valuing heritage
Challenging negative behaviour, culture and lifestyles
Improving outcomes for young black men
Reaching young men at risk and support for ex offenders
Mental health – earlier help
Engagement about regeneration and creating employment opportunities
Cross cutting enablers
Building trust between the community & the statutory sector
Addressing institutional culture & cultural competency
Honesty about how racial identity & culture drives inequality
Involving the whole community – not just the black diaspora
Putting young people are at the heart in shaping & delivering solutions
Long term commitment from partners
Common approach to youth development & empowerment
Continuous evaluation

Since November 2015, a number of working groups have been set up to further consider evidence and finalise a set of actions which will be taken between January 2017 and March 2018. Where possible quick wins have been identified which could be delivered during 2016 to improve outcomes or test a way of working. This report sets out progress towards agreeing a series of actions, the quick wins which have been delivered and the final set of commitments which all partners have agreed to. The next step is to turn the commitments into measurable objectives with clear reporting milestones and performance indicators.

Headline summary of key achievements

- A head teacher led programme has been established to address inequalities in exclusions, behaviour and achievement – recognising the impact that the individual actions of a school can have on the wider community
- The Children's Safeguarding Board have committed to tackle priorities together in an ongoing and systematic way
- All members of the partnership have agreed to participate in a challenging programme of culture change
- The Children's Health and Wellbeing board have identified the key inequalities for young black men and are identifying solutions needed
- The CCG have set up a Reach and Resilience Programme as part of the Child and Adolescent Mental Health Service to address specific community issues and community solutions, focusing in year one on black communities
- East London Foundation Trust are delivering workshops with young black men to test different ways of supporting mental wellbeing based on a strengths based approach
- Public Health have committed to run Mental Health First Aid training targeted at frontline workers to help your black men receive earlier help
- HCVS has continued to run a holistic personalised programme aimed at getting 18-24 year old black men into work, with 40% of young black men gaining employment

Key elements of the programme between January 2017 and March 2018

- Ensuring the head teacher led programme leads to tangible changes in the way behaviour and exclusions are approached
- Improving the access reach and take up of early help for black families – understanding barriers and better ways to community and engage
- Developing preventative mental wellbeing activities in community settings
- Supporting the transition of ex-offenders from custody to the end of their probation, to reduce re-offending
- Peer led work challenging negative identities and behaviours among young black men
- Tackle the barriers to employment beyond educational level and employability skills– raising the profile of black role models, encouraging employers to change their recruitment practice and increasing exposure for young black men to the world of work
- Inclusive leadership programme for all partners involved
- Reaching out as widely as possible to the whole community – to help build trust between the state and the black community, encourage residents to participate in the community led activities which are being developed and celebrate black identity and culture

1. Who do we mean by "young black men" and who are we trying to reach?

Our definition is broad. We want to engage with diverse sections of the African and Black diaspora which is as inclusive of all sections of the community as possible covering:

- Black African, African Caribbean and mixed race
- Faith and secular communities
- Representing the range of equality groups within the community - ie, age, gender, class
- A range of geographic locations
- Recent migrants and settled communities that might have lived in Britain for many generations

There are different sections of the community that the programme will reach in targeted ways:

- Young black boys from 0-16
- Young black men from 16-24
- Young black men from 25-34
- Parents and carers within the community
- The wider black community
- Black owned businesses

The largest group of Black people in Hackney are Black African (11.4%). This is also the third largest ethnic group in Hackney after White British and Other White. We have seen an absolute increase of 15% (+3686) since 2001 although the proportion of black Africans in the overall population has dropped slightly (0.6%) as Hackney's population has grown. The largest group within this category are the Nigerian community. Conversely, the Black Caribbean population in Hackney (7.8%) has decreased since 2001 both in absolute and relative terms. The proportion of people who say they are mixed heritage has increased in proportion and absolute number since 2001, both for mixed White and Black Caribbean and mixed White and Black African. In 2011, there were 4,614 young (age 16 to 24) black (including Black British and also Mixed: White and African and Mixed: White and Caribbean) men.

2. Progress update and commitments

In seeking to understand what is driving the disproportionality of outcomes, partners have had to adop an approach which is multi-dimensional and considers what is driving inequality that might be linked to:

- Direct or indirect discrimination based on gender, age, ethnicity and the intersection of all three
- Contextual or cultural drivers e.g. lack of trust between the community and state, cultural barriers
- Poverty and socio-economic inequality – the black community is more likely to be in low income households in Hackney and experience other socio-economic inequalities

They have had to examine data and insight to understand outcomes compared with the wider population, and also outcomes compared with other young men, and to analyse data and insight by different sections of the black diaspora.

In responding to the drivers of inequality they have considered what changes are needed within:

- Individuals and the community
- Institutions
- Wider society

There are two types of commitment set out below:

Partnership and co-ordination commitments bring about changes for all groups or make an offer or service more inclusive of all groups

Targeted commitments work with a specific cohort by ethnicity, gender, age, socio-economic group or an intersection of these

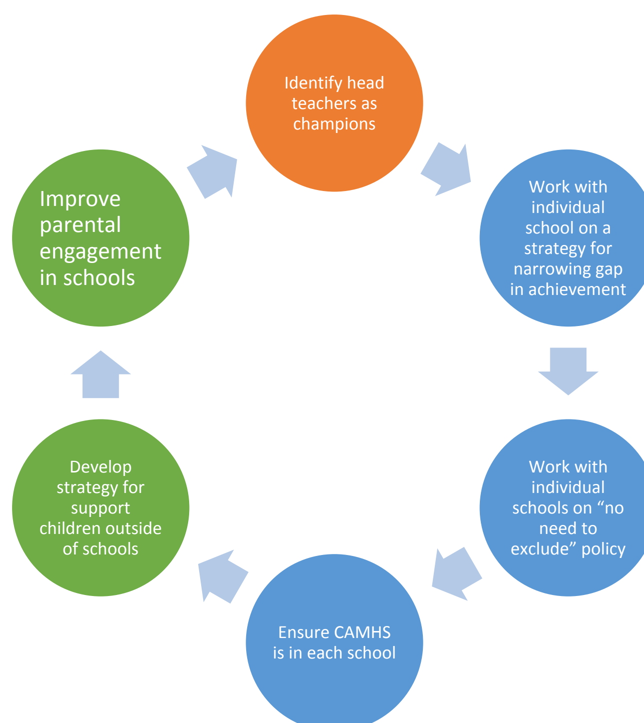
Improving outcomes for black boys

2.1 Improving life chances for black boys: focus on education

2.1.1 The assumptions:

There remains a gap in achievement between black boys and the wider school population. We need to collaborate with schools to look more closely at how we narrow the gap, how schools manage behaviour for black boys, as well as the relationship between parents and schools. This could be contributing to the higher rate of exclusions which in turn could lead to far worse life chances for those young people. We also need to understand why we have the highest rates of conduct disorder in the country. As school environments have changed and become more formal, some young people and parents have felt less engaged. Young black men and parents have reported being negatively stereotyped or labelled at school and there are studies about how this might lead to poorer attainment ("stereotype threat".)

2.1.2 Overview of actions to consider:



2.1.3 Progress to date:

Getting the buy in and engagement of schools

During 2015, Cllr Bramble started a dialogue with head teachers to make the case that schools should be looking beyond socio-economic reasons for ethnic inequalities and also that schools should think about the wider impacts on communities of exclusions. In summer 2016 a group was set up that is comprised of five primary heads, two secondary heads and two secondary deputy heads. Schools have acknowledged they need to work together and that they cannot solve the issues on their own. The main focus of the group is on a) achievement of YBM and b) disproportionality in exclusions (b) underlying factors identified through the YBM work. The group will also address parental engagement and working with supplementary schools and community organisations. The group have been meeting since July and have agreed three practical themes: transition with a focus on Y6-7, multi-agency working with identified/targeted parents and training – CPD (for school staff and new teachers) focused on cultural awareness and anti- discrimination. The full group will meet on a termly basis and there will be five thematic meetings as well. The group will report in spring 2017.

Highlights so far:

- The Headteachers' group have sent out a questionnaire to all school heads and this will be analysed in the new year to inform the actions they take. They have also visited each other's schools to look at behaviour management practices.

- The group has positively received a presentation on the 2015 peer research into parents' views which was undertaking through the Young Black Men Programme and two schools, Skinners and Cardinal Pole, are meeting HCVS to discuss practical ways that parental engagement can be improved.
- Several schools are also talking to HCVS about models of youth leadership, drawing on the experience of the Inspirational Leaders' Programme (see below).
- An ongoing dialogue has been started with Haringey Head Teachers who are also looking at these issues
- HCVS hosted an event for residents "De-colonising Education" to begin a dialogue with residents about how race and identity affect attainment. This has been followed up with a meeting for secondary and primary education professionals which explored tackling racial inequalities in attainment by challenging the Eurocentric nature of the national curricula and the education systems.

Quick wins – updates

Mentoring in schools:

Since 2015 a cohort of young people identified as at risk of not passing their GCSEs have been participating in mentoring in Stoke Newington, Haggerston, Cardinal Pole and Clapton Girls. An evaluation report will be produced next spring to identify the impact on participants in terms of attendance, behaviour and mock GCSE results. It will provide analysis to help us understand differential impacts by gender and ethnicity.

Other relevant updates, beyond the work of the programme:

Promoting the no need to exclude policy: This continues to be promoted. There is evidence in Haggerston and Cardinal Pole of ways that exclusions have been reduced through alternative internal actions.

Ensure CAHMS is in every schools

HLT continue to make this case, working with the CCG and Public Health. They have visited Camden where this is already in place.

2.1.4 Commitments from January 2017-March 2018

Targeted work:
• Head Teachers to progress individual and shared actions to address achievement, exclusions, parental engagement and work with community based resources like supplementary schools (lead: Martin Buck)
• **Parental engagement**: HCVS to work with Young Hackney and HLT on a programme engage black parents (lead: Pauline Adams and HCVS)
• **A De-colonising education network over education professionals** has been set up and will progress actions to consider good practice from elsewhere, facilitate sharing between teachers, create a shared resource for teaching and learning and engage young people in their work through the youth parliament and youth advisory group.
Partnership and co-ordination:
• **No need to exclude:** Promote the No Need to Exclude policy to all schools (lead: Martin Buck) and progress actions in response to the Children and Young People's Scrutiny Review into exclusions once agreed (HLT). Encourage an approach based on restorative practice where possible.
• **Ensure Child and Adolescent Mental Health Services are in all schools:** Progress actions to introduce CAMHS in every school (lead: Andrew Lee)

2.2 Improving life chances for black boys - Early help & family wellbeing-

2.2.1 The assumptions:

Trust between parents and the statutory sector

There seems to be issues of trust between some black parents and the state, and this was thought to be undermining opportunities to work constructively together to get the best for children or to deal with problems or issues at an early stage. Outside of the school environment, some parents describes concerns that they would be problematized if they sought help from children's social care. Some parents wanted their cultural heritage and identity to be valued more, seeing it as a source of strength rather than a problem or division. For this reason some parents valued supplementary schools that taught parents' first languages to children, or for helping to bridge the gap between school and home life.

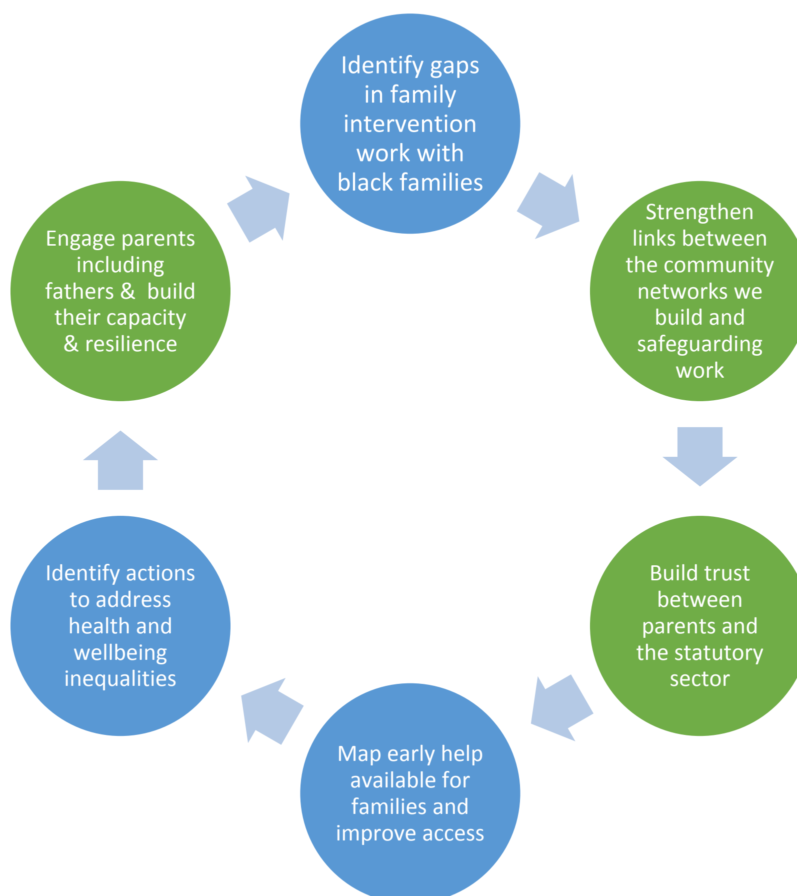
Families

There are concerns about the disproportionate level of violence and abuse within the black diaspora, both within families and in the community and how this affects children young people. Statutory social work assessment witnesses a disproportionate number of families where physical violence to discipline children is the norm. In addition Domestic Violence is a key issue in Hackney and needs to be addressed to safeguard women and children.

Partners have highlighted the critical importance of what happens in the early years of a child's life and the impact on outcomes. There is overwhelming evidence that children's life chance are most heavily predicted on their development in the first five years, starting before birth during pregnancy. Disadvantages experienced by young children accumulate across the life-cycle, with an increased risk across a range of outcomes.

Some parents identified multiple external strains that affected family life such as low income, financial difficulty and poverty, overcrowded housing and insecure immigration status. This cluster of issues suggests the need to look at how preventative safeguarding strategies and family support contributes to this agenda. It identifies the opportunity to scale up activity which is focused on challenging gender stereotypes.

2.2.2 Overview of actions to consider:



2.2.3 Progress to date:

Building trust between parents of black children and the statutory sector: HCVS and Young Hackney are working with an external facilitator to lead a session with parents and Children and Young People's Services to unpack issues identified in the peer research into parents' views specifically in relation to trust between parents and the state. This session will take a deliberative style to fully unpack issues and co-produce a series of solutions.

Strengthen links between the community networks we build and safeguarding work: the Children's Safeguarding Board and the community engagement sub group have both discussed the programme. At the Safeguarding Board, it was agreed that engagement with the programme was imperative. As a next step individual agencies were asked to provide

updates on what they were already doing to address the disproportionality in relation to early intervention and early help, share any community insight about the issue and data. The programme will also be a standing item at the community engagement board in order to strengthen links between safeguarding priorities, the engagement needed and the YBM programme an ongoing basis. The group was keen to train up young people as safeguarding champions as part of a wider scheme and also to involve young people in a focus group about safeguarding engagement and communication.

Map early help available for families and improve access: Young Hackney's Early Help offer is being promoted to schools through engagement and a booklet. This illustrates to professionals the range and breadth of the youth offer available within the schools environment both in terms of Young Hackney, Commissioning of youth sector providers.

Identify actions to address health and wellbeing inequalities: The Children's Health and Wellbeing Board have met to consider inequalities, scope what is going well, identify gaps and key Issues and agree a process for committing to additional work. The Health and Wellbeing Board will discuss the programme in January 2017 and explore possibility of a development day focused on this.

Quick wins- updates:

YBM Safeguarding resource review Congolese parents needs Monday 26 September 2016: There are specific safeguarding and support needs identified in the French speaking community. As part of our safeguarding of YBM Hackney CVS has worked with the NSPCC to review and refresh the safeguarding resource pack aimed at Congolese parents

YBM Young people Safeguarding Champions: 14 African heritage young people from 4 secondary schools have been trained in the NSPCC safeguarding children's course. Next steps - Support the young people to contribute the CHSCB website

2.2.4 Commitments from January 2017-March 2018

Targeted work:
Building trust between parents of black children and the statutory sector: Programme of work bringing parents and the statutory sector together to explore issues of trust and identify ways to build trust (Pauline Adams/ Jake Ferguson)
Identify actions to address health and wellbeing inequalities: Children's Health and Wellbeing Board will progress actions to tackle health inequalities: Looked after children, Fixed term exclusions, Teenage pregnancy, Maternal obesity, Exclusive breastfeeding, Childhood obesity including physical activity, Serious mental illness and secondary mental health care service use, Non-cigarette tobacco (Nicole Klynman/ Amy Wilkinson).
Engage parents including fathers and identify ways to work with them on parent led approaches to build their capacity & resilience HCVS will engage and empower parents to design solutions that build capacity and resilience among their peers in the local community
Strengthen links between the community networks we build and safeguarding work: the community engagement board of the Safeguard Board will strengthen links between

its work programme and the YBM programme on an ongoing basis by involving the lead officer for the YBM programme to join the board. As we develop deeper community networks within the black diaspora community we will link these networks to the preventative and community engagement work of the CHCSB. The programme has developed a group of young people as inspirational leaders whose role will now be to develop peer led outreach and engagement. Peer led programmes could ultimately help address some of the underlying issues which might lead to safeguarding risks e.g. challenging attitudes, risky behaviour, lifestyle choices. Further work to understand access, reach and effectiveness of early help and early intervention for black families could also help inform the work of the CHCSB (see below). The programme addressing issues of trust between parents and the statutory sector could also ultimately help the work of CHCSB. (Sonia Khan, Jake Ferguson)
Map early help available for families and improve access: Promote early help to schools and community settings. Identify gaps in current provision in terms of access, reach and effectiveness of early help and early intervention with relevant organisations and how these can be addressed. Develop communication and engagement strategy to identify ways to explain and communicate the early help which is available to families (Pauline Adams)

Improving outcomes for young black men

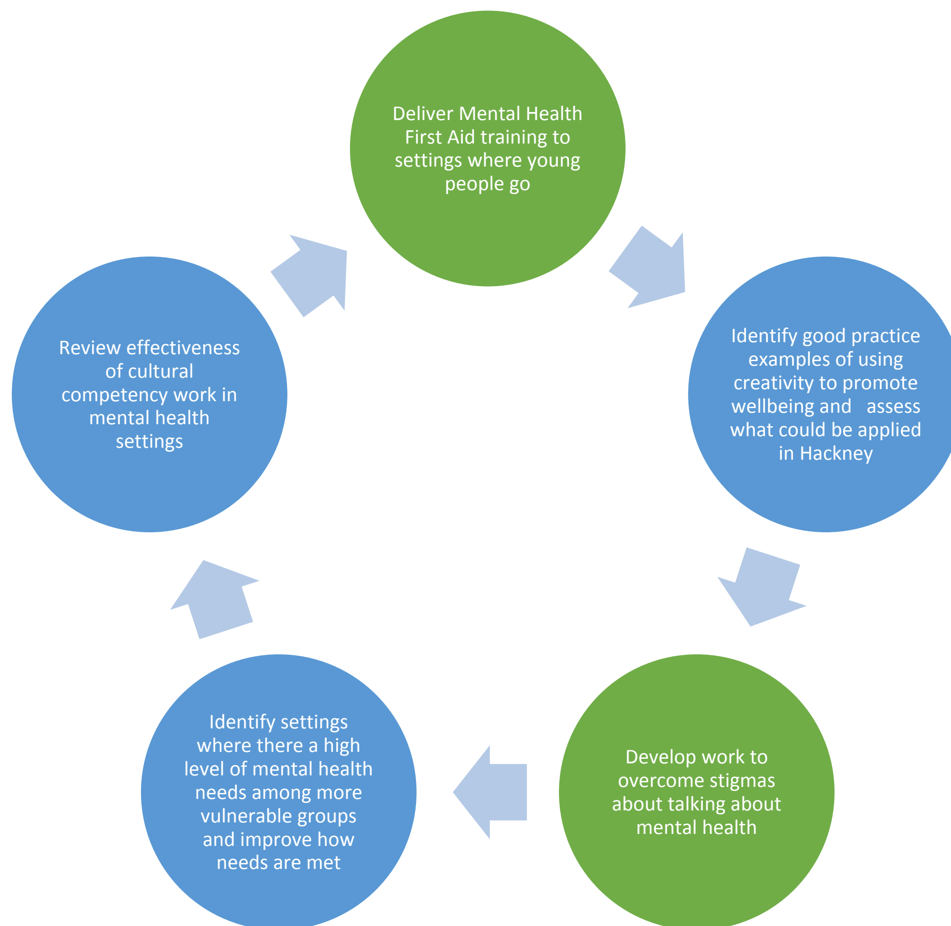
2.3 Improving outcomes for young black men: Mental health – earlier help

2.3.1 Assumptions:

Mental health issues are affecting wider outcomes of young black men; young people need to access support more quickly, but mental health services need to examine institutional bias and stereotyping. The extent of substance misuse (alcohol, cannabis) are seen by young people as a significant trigger of mental health problems among young black men.

In terms of accessing support, there can be a stigma in the black diaspora community around seeking mental health support. There is also a strong relationship between social networks and mental health: those with few social contacts are at increased risk of mental health problems. Focusing on roots and heritage can be a source of strength and recovery. Clinicians and stakeholders alike were interested in how creativity can promote wellbeing.

2.3.2 Overview of actions to consider:



2.3.3 Progress to date:

A working group has engaged a range of VCS organisations and statutory partners to identify good practice and to develop a theory of change for mental health to increase access, reach and take up of support for young black men. The working group has also identified existing work which seeks to improve outcomes or young black men and improved links between these programmes.

Quick wins – updates

CAMHS reach and resilience workstream: Working through HCVS, First Steps and ELFT, the aim of this workstream is to address specific community identified issues around mental health, and community solutions to these. The first year has concentrated on black communities. As part of this H CVS has trained a pool of parents to conduct mental health focus groups with their peers. Parents' facilitators learn how and when to use one of 8 core tools to gain insight from African heritage parents about the mental health support needs.

There is pilot work ongoing between ELFT and HCVS Tree of Life group to deliver peer focused work with young people and clinicians using the Tree of Life approach to build self esteem and a strengths based approach.

Deliver Mental Health First Aid training to settings where young people go: a pilot is being commissioned by Public Health, as agreed at the Children's Health and Wellbeing Board which will deliver first aid training to frontline workers and young people who are able to reach young black men.

2.3.4 Commitments from January 2017-March 2018

Targeted work:
Preventative mental wellbeing activities in community settings to reach people earlier and address stigma- based on strength based approaches and including parental engagement (Public Health and HCVS)
Good referral systems are developed to ensure that children and young adults who are at risk are referred to clinical mental health assessment support where this need is identified. Where appropriate this is embedded into frontline settings (Public Health and CCG).
Mental health first aid training rolled out in different settings (Public Health)
Targeted work / support to raise awareness about heavy use of cannabis working with the youth advisory group and Young Hackney Ambassadors to further target preventative work (Young Hackney)
Partnership and co-ordination:
Review of available services and resources and of the offer available for 18-25 year olds to understand access and inclusion issues by considering: Referrals, take up and outcomes of services for black boys and young black men (CCG and Public Health)
Look at how clinical support can be offered to young people alongside other wellbeing / recovery support in an integrated care plan – with a better understanding of how trauma can be managed. This would ensure wrap around support was available for a young person for a longer period of time, in addition to counselling or therapy sessions (CCG and Public Health)
Challenging institutional programmes for Hackney providers that tackles overt and covert racism (LBH Policy and Partnerships)
Improve information about mental health services, especially those targeting young black men (all to send to I care team)

2.4 Reaching young men at risk and support for ex offenders-

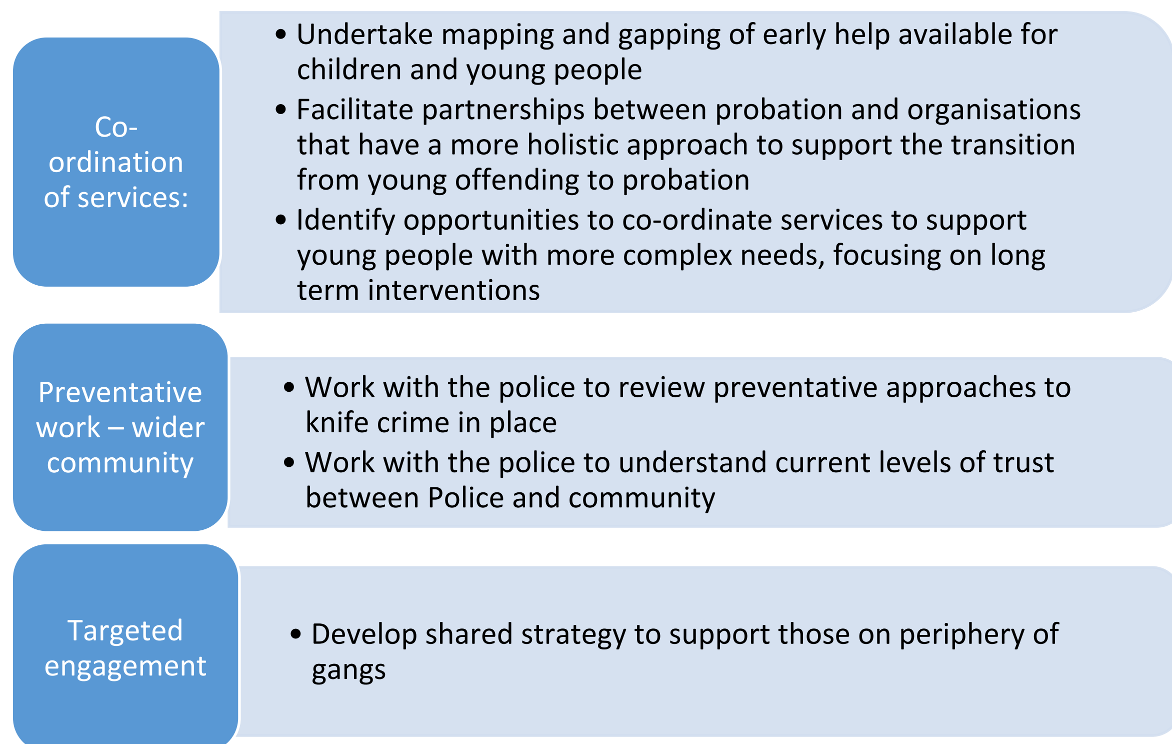
2.4.1 Assumptions:

The Gangs Unit estimate there are many young people on the periphery of gangs that need to be engaged positively to avoid getting more involved in gang life. There is a concern that without engagement the situation for young black men at risk can deteriorate more quickly because they do not know how to seek help or would not got to the statutory sector for support. Despite Hackney becoming a safer borough in recent years, getting around the borough safely can be an issue for some young black men because of postcode rivalry and gang activity and this risk limits their ability to take up opportunities. Knife crime and culture is once again a growing concern with crime rates on the rise across the country, with thids being normalized for young people and stabbing seen as a rite of passage within gangs.

Overall there is a need to continue to build a greater level of trust in the police that might increase reporting and reduce crime.

In terms of ex-offenders there was a strong view from stakeholders that support needs to begin whilst people are still in custody and then continue beyond probation, so that ex-offenders are supported to identify positive opportunities as opposed to thinking that a return to custody is inevitable. A positive transition from young offending to probation can also help prevent re-offending. As black men get older (25+) it can be more difficult for them to access help (employment support, housing, mental health) when they want to turn their life around, especially when they have a criminal record, and this can lead them back into the grey economy or into re-offending.

2.4.2 Overview of actions to consider:



2.4.3 Progress update:

Undertake mapping and gapping of early help available for children and young people: A Young Hackney's Early Help offer is being promoted to schools through engagement and a booklet. This illustrates to professionals the range and breadth of the youth offer available within the schools environment both in terms of Young Hackney, Commissioning of youth sector providers.

Facilitate partnerships between probation and organisations that have a more holistic approach to support the transition from young offending to probation:

A specific meeting has taken place between the Probation (CRC), LBH Policy and Partnerships and HCVS to discuss ways to develop a more holistic offer to ex offenders; the next step is to organise a meeting between Hackney CRC officers and the VCS to map out support and facilitate closer working

Identify opportunities to co-ordinate services to support young people with more complex needs, focusing on long term interventions

The Youth Justice Team are proactively looking at the underlying factors that contribute to disproportionate representation of Young Black Men in custodial sentences and remand. he Youth Justice Team are also working with the Youth Justice Board to pilot the implementation of the reducing re-offending tracker and the linked disproportionality toolkit which shows overrepresentation in the youth justice system

Young Hackney has run a nine-month programme to support young people at risks through group workshops and one-to-one coaching / mentoring which was ultimately intended to lead to tangible behavioural change. The ongoing relationship with the coaches and young people on the programme allowed for young people to meet weekly with their coach / mentor. In total:

- 40 young people were signed up to the Hackney Choices Programme
- 18 attended the week long intensive training programme
- 13 completed the 9 month coaching / mentoring programme (6 young people now have part time work)

Of the 13 young people who completed the intensive course, all have taken positive steps towards re-engaging with their continued education or work. Some of those who also had more immediate issues in their lives have used the support to act positively to resolve some of them, for example working with a barrister or student support at college. All of the young people have engaged regularly with their coaches / mentors, working on the goals that they have set themselves and have had positive results. 10 young people who reported being behind with their college course work at the start of the programme, all now report that they are now up to date and back on track. Three young people have been visiting universities and submitted applications for the next academic year.

Preventative work in the wider community:

Work with the police to review preventative approaches to knife crime in place: this is a priority in the Youth Justice Plan

Work with the police to understand current levels of trust between Police and community: this is being scoped out with the police and will report to the Community Resilience Partnership of the Community Safety Partnership

Other relevant updates, beyond the work of the programme:

The following actions are included in the Youth Justice Plan and support the programme to Improve Outcomes for Young Black Men:

- Develop early intervention approaches to reduce risk of offending/ gang involvement
- Further embed restorative approaches within CYP services
- Maintain partnership to reduce serious youth violence
- Extend the access to the Street Doctors programme as a knife carrying prevention programme / 1:1 Behind the Blade sessions
- Continued delivery of integrated gangs unit project delivered in Cookham Wood Young Offenders Institution
- Strengthened familial and support networks in preparation for release
- Training in anger reduction therapy
- The Youth Justice Prevention and Diversion Team was formed in late 2015 and supports the objectives of the Youth Justice Plan.

2.4.4 Commitments from January 2017-March 2018:

Targeted work:
Deliver the actions in the Youth Justice Plan to support young people with more complex needs to reduce reoffending: The Youth Justice Team are proactively looking at the underlying factors that contribute to disproportionate representation of Young Black Men in custodial sentences and remand The Youth Justice Team are working with the Youth Justice Board to pilot the implementation of the reducing re-offending tracker and the linked disproportionality toolkit which shows overrepresentation in the youth justice system (Youth Justice lead)
Develop a shared approach between the Young Black men Programme and the Gangs programme to support those on the periphery of gangs (Steve Bending)
Preventative work:
Work with the Youth Justice Prevention and Diversion Team with Children and Young People's Services to address the issues identified for young black men on an ongoing way (Pauline Adams)
Deliver the preventative approaches to knife crime identified in Youth Justice Plan (YOT lead)
Deliver a programme of community engagement and research to understand current levels of trust (Jo Edwards)
Consider how we better engage judiciary on the programme overall
Reducing re-offending and supporting ex offenders:
Work with lawyers who act as representatives for YBM – to identify their views on ways that outcomes can be improved when YBM enter criminal justice system
Facilitate partnerships between probation and organisations that take a more holistic approach looking at: • Support in custody • Mental health support • Resources in the wider community such as mentoring and employment support

- Attitudes of employers- to improve their understanding and promote best practice e.g. a business award for inclusive employer
- Best models from elsewhere.
- Improve the synergies between youth and adult probation services.

2.5 Improving outcomes for young black men: Engagement about regeneration and creating employment opportunities

2.5.1 Assumptions:

Young people felt that the Council needed to engage differently about the changes in Hackney rather than just provide information. They felt that many young people were in housing need or in temporary accommodation and this compounded their problems. Young people did not always know how they could benefit from the increasing prosperity in Hackney and that their aspirations were being limited whereas they may have had bigger ambitions. The programme to date had not actively engaged as many of the existing base of black owned businesses as had been anticipated, although a number were engaged through outreach. From this, the indication is that some of these businesses that were engaged are finding it difficult to survive and are not able to engage and make a wider community contribution.

2.5.2 Overview of actions to consider:

2.5.3 Progress to date

A working group have met twice to look at the scale of the employment disadvantage that exists for YBM in Hackney and the likely causes and have agreed the commitments set out below.

HCVS has led an holistic, personalised youth-work approach to getting 18 to 24 year olds into work has been extremely successful. The Hackney partnerships are the best performing on both initiatives with 40% of young people gaining employment. We want to see this

approach mainstreamed, including the provision of community-based resource to support it.

Hackney a Place for Everyone has also identified the need for businesses to think more about how they can be more inclusive and so this will be taken forward by the Council as a corporate priority.

The research from this programme has been shared as part of developing the new housing strategy and there will be priorities which reflect these needs such as meeting the housing needs of single young people.

A meeting has also been held with Better Homes partners to identify the contributions they can make to social regeneration. These commitments are set out below.

Quick wins: updates

An event, Inspiring young men, was held on 4th October 2016. This was a careers networking event and is part of the Council's celebrations for Black History Month this.

There are quick wins being gained from the employment engagement to date: e.g. as part of the partnership which we are exploring with ELBA, Broadgate Estates interviewed 4 young men identified through the YBM programme and 3 were offered a job

Urbanis took 8 young black men to Atlanta to meet black owned businesses. This immersive experience helped to expand their horizons and ambitions.

2.5.4 Commitments from January 2017- March 2018

Employment and businesses:
Identify improvements to formal careers advice provision in Hackney to make it more effective and relevant to black boys (Martin Buck)
Identify other settings where careers advice is given to ensure a more consistent targeted offer for black boys and young black men (Young Hackney / HLT)
Identify opportunities to raise the profile of young black men who can act as role models in careers literature and guidance and at events (HCVS/ Young Hackney)
Develop Hackney Council apprenticeships programme and run effective outreach and promote apprenticeships to other employers (Andrew Munk)
Work with local employers to promote youth-friendly recruitment and additional opportunities for young people (Andrew Munk)
Employment services in both the statutory and voluntary sector to share best practice and to agree a common approach to supporting young people into employment (Andrew Munk)
Train young people in recruitment to act as advisers in interviews: this gives them perspective of recruiters (Pauline Adams).
Housing related commitments:
Partnership and co-ordination:
Revisit how the Council engages effectively with social housing landlords, Council services and voluntary and community sector (Sonia Khan). This would be the most effective way to progress the suggestions below regarding:

- Youth Empowerment (key actions: communicate support and services available, involve social landlords in Young Hackney networks)
- Employment (visibility of employment support on housing estates / to social housing tenants)
- Young people at risk
- Data Sharing: Social housing landlords need to understand their tenants' support needs before they move into general needs housing in order to support tenancy sustainment (Housing Needs).
- Ensure that social housing landlords are seen as a key partner in offering wider community support around a local school (Housing Strategy).
- Work with Housing Strategy and Better Homes partners to develop actions to address housing inequalities for young black men in housing strategy (Housing Strategy).

Empowering young black men and the wider community

2.6.1 Assumptions:

Community leadership

The level of engagement so far by parents and young people is an indication of the interest within the community to shape and deliver solutions and responses to the considerable inequalities for young black men. This has highlighted the need to build a better understanding and mutuality between the black diaspora community and the statutory sector, in terms of valuing heritage, understanding the issues and challenges for young people growing up and exposed to "street life" and gang culture and in terms of trusting each other.

Valuing heritage and celebrating success

The insight work highlighted the need to focus more on black culture, identity and heritage (in all its diversity) which is not often celebrated or talked about. They also felt there was a need to counter negative stereotypes in wider society with positive presentations of young black men and their success stories. The cultural legacy of slavery was something which needed to be explored not suppressed because it created a "personal glass ceiling" that is holding the community back. Many parents engaged in the peer research saw their faith as a key aspect of their lives. Some young people also said that faith built their resilience but they also saw problems with their parents' faith if it meant that they turned to prayer when something went wrong rather than dealing with the issue.

Behaviour, lifestyles, culture and identity

The insight work with young men uncovered the extent to which some young black men feel alienated by mainstream society and angry about injustices; they therefore may distance themselves and behave in a defended manner. This can make gang lifestyle or criminal activity seem attractive, as a way of being empowered and accepted, without seeing the

negative consequences for themselves and others. There can also be strong gender stereotypes imposed on men within the black diaspora community. Challenging these and encouraging a more flexible approach to masculinity would offer boys and young men the opportunity to relate to a more nuanced and realistic identity. Some black girls and women look for the wrong things in relationships and make men feel that being “bad” is more attractive even though it will ultimately harm them.

2.6.2 Actions considered in 2016:

2.6.3 Progress to date:

There are currently 10 members of the Inspirational Leaders / Youth Advisory Group. On 2 November a new training programme was launched with 10 young men taking part in the Tree of Life training. This will be followed by racial equality, identity and self-visualisation workshops.

Over the summer the inspirational leaders delivered in Morningside and Stoke Newington Schools. HCVS are now in conversation with Young Hackney Forest Road and The Edge youth hubs to launch a series of discussion sessions around identity. A school leadership workshop and evaluation framework has been drafted with the Inspirational Leaders. We hope to be delivering in Skinners in the New Year. Conversations with the Learning Trust are underway to work also in Stoke Newington School, Bridge Academy and Cardinal Pole.

An Inspirational Leader, Emmanuel Akin, was elected to the Youth Parliament, which should support the interface between the Youth Forums and the work we are doing.

Inspirational leaders have been engaging directly with employers, deepening relationships with ELBA, TFL and the BBC

2.6.4 Commitments from January 2017- March 2018

Peer led engagement
Support a group of Inspirational Leaders to deliver peer-led workshops focusing on inspiring young men (Jake Ferguson)
Work closely with LBH and current employment partners to continue to grow opportunities for young black men locally. (Jake Ferguson/ Andrew Munk)
Develop partnerships of local voluntary and community sector (VCS) organisations that can help deliver outcomes for young black men. This will include the co-production of peer-led provision with Inspirational Leaders and local youth provision partners. (Jake Ferguson)
Pilot the set up and recruitment of youth work streams led by Inspirational Leaders that will develop peer-led work with one of the specific work streams as defined by the Theory of Change, such as mental health (Jake Ferguson)
Ensuring a youth perspective
Develop the roles of the Inspirational Leaders *vis a vis* their representation on YBM work streams and larger partnership meetings to provide a youth view (Jake Ferguson)
Ensuring continued ongoing recruitment to the Inspirational Leaders group, working together with local organisations and Young Hackney to ensure a wide range of young men (in terms of age, educational achievement) have the opportunity to join and benefit from the project. (Jake Ferguson)
Peer led research
Develop a peer-led research framework with LBH Policy Team so that insights gained from peer-led workshops are channelled back to the YBM programme.
Develop a Social Network Analysis model to measure the impact of interventions that aim to broaden young people's networks. (Sonia Khan/ Jake Ferguson)
Culture and identity
Set up work group to scope out a programme of work to achieve the following: •All YBM 'know where they want to get to'. That is, they have a realistic assessment of their own skills and are well informed about their options. This includes options beyond Hackney – not all YBM will want to stay. •All YBM know someone who is successful and black. Positive role models are easily within their reach. •YBM do not feel alienated from world of work – no cultural barriers. •Public services are seen as 'credible' by YBM.

3. Cross cutting actions updates

3.1 Communication and engagement

The Theory of Change which was adopted in 2015 was informed by insight gained through engagement with a range of stakeholders:

- Interviews with key partner agencies (April/ May 2015)

- Focus group on growth and change in Hackney with young people (July 2015) and follow up with theyoung people's advisory group (September 2015)
- Focus groups with young people on employment (April 2015)
- Engagement with local businesses (April – September 2015) to create group of businesses committed to creating opportunity and promoting inclusion
- Peer research led by HCVS with parents (87 parents) (April – August 2015)
- Specific cross sector workshops and discussions on employment and opportunity and Mental Health- Children (July 2015) and Adults (Sept 2015)
- Hackney Council Staff Equality Network discussion with 60 members of staff (July 2015)
- Co-production session in September with young people to develop draft theory of change
- Partnership meeting in October to develop theory of change
- Meeting with Head Teachers (Nov 2015)

Since then communication and engagement has largely focused on targeted conversations with parents, residents, partners and stakeholders through working groups.

There now needs to be a broadening out from these discrete forms of communication so that a wider group of young black men are engaged, along with parents of black boys and black men, and the wider community.

To make this effective we will develop a framework for participation and contribution based on the Theory of Change and the commitments set out above. This will outline the sort of contributions we need and the ways to get involved. The likely focus for this wider participation will be in relation to: culture and identity, wider mentoring opportunities and role models. This ramping up of communication and engagement is also a way of responding to the issues identified through Hackney a Place for Everyone. These relate to the black community being less likely to be satisfied with place or the Council, as well as being less likely to feel listened to. This insight also identifies a feeling that community assets were being lost and that the new opportunities and businesses in the borough were not "for them."

3.2 Inclusive leadership

In June, partners agreed to work together on a programme tackling institutional issues that affect outcomes for young black men. This was in part in response to the evaluation of the partnership by UEL which recommended that the partnership could focus more explicitly on how Hackney's organisations might be institutionally racist[1] (whether this is overt, or covert, unwitting and subtle) and reflect more on how institutional change might improve outcomes for young black men.

[1] As defined by Macpherson in the Lawrence Inquiry, institutional racism is the "collective failure of an organisation to provide an appropriate or professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes or behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantages minority ethnic people."

In November partners agreed a proposal for a leadership programme which helps us to think in a more multi-dimensional way about organisational approaches to equality that are more proactive and sophisticated. The proposal is for a blended programme of training and development to focus on how leadership impacts on public service outcomes. This will be challenging and provocative - to help all partners check their biases and assumptions and how this might impact on organisation strategy and delivery. Further details are provided in a separate document.

3.3 Evaluation

Hackney has identified an evaluation partnership, University of East London and Runnymede Trust. They carried out an initial evaluation as we were developing our Theory of Change and offered critical feedback about the analysis and partnership which has influenced the final draft and the current arrangements for partnership working. They have also developed an evaluation framework. We are now working with them on an evaluation proposal which focuses on our efforts to address institutional leadership and culture to assess if this impacts on outcomes for young black men. They have suggested we work with a partner local authority as a comparative authority and both Nottingham and Bradford are very interested in coming on board.

3.4 Influencing national and regional policy

Hackney is not the only area trying to tackle the underlying issues we have identified. At a national level we have seen a shift in narrative from leadership in recent years. The then Prime Minister David Cameron talked about racial discrimination among employers when recruiting and Theresa May has announced the need for the public sector to undertake a "race audit." Whilst we await further details, we understand that the audit will be led by a new dedicated Whitehall unit situated in the Cabinet Office, reporting jointly to CLG and Cabinet Office. The first data is expected to be published before the summer 2017, and will be updated annually. The aim is to allow members of the public to access data showing how their race might affect how they are dealt with in areas such as work, education and the NHS, along with detail on location, income and gender. Areas likely to be covered are access to good schools, acceptance to universities, graduation rates and progression to graduate jobs, and the take-up of services such as free childcare.

The Casey Review into opportunity and integration also identifies a set of recommendations requiring local government to take action when they identify "*economic exclusion, inequality and segregation*" and we will look to identify ways to align this programme with these broader recommendations.

We have also engaged with other authorities through an event organised by London Councils on the Lammy Review. Separately, Hackney Learning Trust have shared practice with head teachers in Haringey.

Now we are clear about the commitments we will be taking forward until 2018, we will engage more systematically with authorities to look at good practice that we can draw on as we design and deliver actions.

Report to Hackney Health and Wellbeing Board

Item No:		**Date:**	**8th March 2017**
Subject:		Integrated Commissioning across City and Hackney	
Report From:		Devora Wolfson: Programme Director: Integrated Commissioning (LBH, CCG and COLC)	
Summary:		In autumn 2016, NHS City and Hackney Clinical Commissioning Group and the London Borough of Hackney and the City of London Corporation formally agreed to explore the benefits of an integrated commissioning model in line with the Hackney devolution business case. This paper sets out the detailed proposals to establish an integrated commissioning model between LBH and the CCG. Parallel arrangements are also being established between the CCG and the City of London Corporation.	
Recommendations:		It is recommended that the HWB: 1. Notes the progress that is being made with integrated commissioning 2. Notes the specific aims of devolution and integrated commissioning that support the priorities of the HWB and the delivery of the JHWS in paragraph 1.7, in particular: • To focus our collective resources on improving the wellbeing of local people; • To better coordinate all the determinants of health and wellbeing including employment, education and housing. 3. Comments on the 'big ticket' items set out in paragraphs 3.8 to 3.10 and the plans for the system to work together more effectively. 4. Is asked to assess the impact that ICBs have had in delivering the improvements set out in the JHWS (9.4). 5. Notes the proposed reporting arrangements of the Integrated Commissioning Board set in section 10 of the report.	
Contacts:		Anne Canning – Group Director, Children, Adults & Community Health Services Paul Haigh, Chief Officer, NHS City and Hackney CCG	

1. INTRODUCTION

1.1 The London Borough of Hackney and City and Hackney CCG have been committed to working with partners to achieve the goal of closer integration of health and social care for many years. This paper sets out the next stage in that process which we hope will be a significant milestone in our journey towards delivering the joined up health and care services and support that our residents deserve.

1.2 Following the publication of the NHS Five Year Forward View in 2014, local areas are required to produce Sustainability and Transformation Plans (STPs) to show how health and social care organisations (known as systems) will work together to tackle issues of financial sustainability, quality of care and health inequalities. City and Hackney is part of the North East London STP and is one of the 3 local delivery systems for the STP ambitions.

1.3 Key senior stakeholders from the London Borough of Hackney, CCG, Homerton Hospital, East London NHS Foundation Trust, City and Hackney Urgent Healthcare Social Enterprise (CHUHSE) and the GP Confederation began meeting to discuss the problems in Hackney and how we could better work together to improve services and outcomes. We formally established a Transformation Board in early 2016 made up of the local leaders including the voluntary sector and Healthwatch to oversee the further development of our devolution business case and our service development plans.

1.4 Health and social care partners across City and Hackney share an ambition to improve health outcomes for local people by commissioning and delivering services across organisations in a more joined up/ integrated way that makes the most of our shared investment at a time when public sector funding has experienced significant reductions and increasing budgetary pressures. This is the ambition for the devolution pilot.

1.5 We have embarked on a significant joint planning programme across the CCG, the two local authorities, Adult social care and children's commissioners and the joint public health commissioners to review our existing plans and opportunities for greater alignment

1.6 We believe that a fully integrated commissioning model across health, public health and social care between the CCG and the two Local Authorities offers a number of exciting opportunities linked to our wider programme of work. We plan to look outside the traditional box of health and social care and think about how we can not only join up health, public health and social care but also join up with other services to tackle the wider determinants of health such as:

- Working across the LAs and CCG to commission not just health and wellbeing but wider community services and initiatives from a combined estates portfolio;
- Taking our quadrant delivery model beyond health and social care to wrap services around people at a local level and expand the offer on self-help and on social prescribing;
- A more integrated digital offer of advice and access to local people; and
- A fully integrated primary and secondary prevention strategy.

1.7 Our specific aims are:

- To focus our collective resources on improving the wellbeing of local people.
- To design out the gaps in services which citizens often experience.
- To design out duplication of effort in commissioning and providing.
- To move away from adversarial relationships to ones in which we are all working together, with citizens and with practitioners to design and deliver the services they want and need.
- To move towards place based commissioning and, in particular, to ensure that there is a clear focus on the needs of the City of London.
- Over time, to better coordinate all the determinants of health and wellbeing including employment, education and housing.

1.8 We have put in place organisational development support to review individual commissioner work plans, to undertake peer challenge of what we are doing and to explore the scope for where we could do more by working together, and aligning our approaches and contracts to deliver better outcomes for residents.

1.9 In Autumn 2016, Members of the London Borough of Hackney and the City of London Corporation, along with the NHS City and Hackney Clinical Commissioning Group Governing Body, agreed to explore the benefits of an integrated commissioning model as outlined in the Hackney devolution business case.

1.10 We are clear about the outcomes we need to achieve and we want to move to an approach whereby we use commissioning to:

- Drive improvements in outcomes and ensure our providers work together to take collective responsibility for achieving these improvements;
- Bring together patient, clinical and practitioner views, alongside best practice and benchmarked information, to define our plans; and
- Support providers to move to explore more integrated delivery arrangements in which the needs of our patients override organisational arrangements.

1.11 We believe that fully integrated commissioning across health, public health, adult social care and children's services is the next step in our integration journey towards a place-based health and care system that is more accountable to local residents.

1.12 This paper sets out the detailed proposals to establish an integrated commissioning model for health, social care and public health across City and Hackney from 1 April 2017. These proposals are being considered through the local authorities and the CCG's formal decision-making structures in late February and early March 2017.

1.13 Integrated commissioning offers a number of exciting opportunities linked to our wider devolution programme. If we start to look outside what is traditionally seen as health and social care, we can broaden our approach to commissioning; not just health and wellbeing but building wider community capacity and strengthening our communities by making better use of our shared estates portfolio.

1.14 The Hackney Health and Wellbeing Board is asked to comment on the proposed new arrangements.

2. THE INTEGRATED COMMISSIONING MODEL

1.15 The Integrated Commissioning Model is built around two separate commissioning boards - a board for the London Borough of Hackney and one for the City of London Corporation.

1.16 The Hackney Integrated Commissioning Board will be made up of two committees in common. These will be the London Borough of Hackney (LBH) Integrated Commissioning Committee and the NHS City & Hackney Clinical Commissioning Group (the CCG) Committee. Those two committees shall meet in common and shall be known together as the Hackney Integrated Commissioning Board.

1.17 A similar board will be created between the CCG and the City of London Corporation.

1.18 An Integrated Commissioning Fund, consisting of a pooled budget and an aligned fund (funds which cannot be legally pooled or which partners are not yet ready to pool) will be established for each Board and documented within a Section 75 Agreement (NHS Bodies and Local Authorities Regulations 2000).

1.19 Commissioning for core primary care will be outside of these integrated commissioning arrangements and will be discharged by a formal committee of the CCG. However, the Transformation Board and the Integrated Commissioning Boards will provide a steer and recommendations on core primary care services to the CCG primary care Committee.

1.20 From April 2017, the Transformation Board will form part of the governance arrangements for integrated commissioning - providing advice and recommendations to the two Integrated Commissioning Boards and taking responsibility for local delivery and implementation across the provider landscape.

1.21 The Transformation Board will be made up of commissioners and providers working in partnership with patient and public representatives. It will be chaired by Tim Shields, the Chief Executive of the London Borough of Hackney.

1.22 The Locality Plan is being developed and will form the basis of the Commissioning Strategy for integrated commissioning. The four priority areas of the Locality Plan are:

- Children and Young People;
- Prevention;
- Planned Care; and
- Unplanned Care.

1.23 The Locality Plan will incorporate the priorities of the HWB and the STP and will accelerate the delivery of the JHWS and the measurement of its impact.

1.24 Formal leadership arrangements are being established around these four priority areas to review current plans and services, identify areas for improvement and test out their potential impact. Pooled funds are aligned with each of these priority

areas. Each workstream will report to the Transformation Board who will make recommendations to the Integrated Commissioning Boards for decision (see Governance section below for more detail).

1.25 In the first year of operation, 2017-18, the integrated commissioning model will be based on existing contracts and service delivery. During that first year, the four workstreams will begin to identify where commissioning and services may change to better meet local needs, support more integration of service delivery, improve outcomes and deliver the aims of the locality plan.

1.26 The model will initially include health, adult social care and public health. Children's services will be considered for inclusion from 2018/19.

3. DEVELOPMENT OF THE WORKSTREAMS

1.27 Our ambition is to have the four workstreams fully established and functioning by autumn 2017 taking full responsibility for system delivery, transformation and financial balance. The unplanned care workstream has been meeting since December 2016 under the leadership of Tracey Fletcher with an indicative ring fenced budget; the prevention care workstream will be established next with the other two workstreams following this.

1.28 The workstreams will be made up of commissioners and providers working in partnership with patient and public representatives.

1.29 We are in the process of mapping out the responsibilities of the care workstreams which will be set out in a 'senders' pack' and the workstreams in turn can use this to clarify their operating model and action plans (as receivers)

1.30 In order for the care workstreams to operate effectively, we need to ensure that they have the right resources in place. Our intention is to second a senior manager to support each workstream for up to a year and backfill their substantive role. We will also define other lead roles within each workstream - PPI/user representative and a clinical/practitioner lead.

1.31 We will also need to ensure that the IT, workforce, primary care and estates enabler groups support the care workstreams and are supporting the delivery of their ambitions. The probable delegation of commissioning responsibility for core primary care to the CCG from NHSE in April provides a lever to refocus the current CCG Primary Care Quality Board to support the overall programme.

1.32 As workstreams develop, more control will transfer from existing governance arrangements, for example the CCG programme boards to the care workstream. We will need to co-design gateways and reporting arrangements to provide assurance that the care workstreams are ready to take on their additional responsibilities.

1.33 We have agreed that the "ask" of each workstream – reflecting outcomes, transformation, STP and local ambitions – is signed off by the Transformation Board to ensure consistency and alignment.

Big ticket items

1.34 A number of “big ticket” items have been identified- these are where there are opportunities to make a significant impact by working together as a system across health and the local authorities, fully integrating delivery and making a real difference to residents’ and patients’ outcomes. Some of these’ big ticket’ items, for example smoking, mental health and dementia are also within the Hackney Joint Health and Wellbeing Strategy (2015-18).

1.35 The ‘big ticket’ items that we will take forward through the workstreams are:

- Quadrant working, single point of coordination and hospital discharge – this work has already begun with the unplanned care workstream;
- Self-care including access to advice and social prescribing;
- End of Life Care;
- Employment, ways in to work and support for people with mental health, long-term conditions including learning disabilities;
- Making every contact count for smoking, exercise and mental health and a focus on a system wide approach to smoking
- Dementia - making all areas of the City and Hackney dementia friendly;
- Housing – linking to discharge, and housing for people with mental health and long-term conditions, including learning disabilities; and
- Continuing health care.

1.36 The HWBB is asked to comment on these ‘big ticket’ items and to note the way that health and social care system is planning to work together more effectively.

4. BENEFITS AND RISKS OF THE NEW MODEL

1.37 This model offers several potential opportunities for residents and patients in Hackney. The pooling of Adult Social Care and Public Health budgets with CCG monies through a Section 75 Agreement presents an opportunity to improve health outcomes for local people by commissioning and delivering services across organisations in a more joined up way that makes the most of our shared investment at a time when public sector funding has experienced significant reductions and increasing budgetary pressures.

1.38 It would provide:

- A London Borough of Hackney-based model responsive to London Borough of Hackney needs;
- A dedicated focus on Hackney residents and their needs with an identified health budget separate from the budget for City;
- More integrated services for most Hackney residents, reducing current complexities;
- A more direct line between the ambitions of the Health and Wellbeing Board and how these are delivered locally;

- Integrated contracting and procurement models should result in more efficient delivery and offer opportunity of longer-term cost savings; and
- More aligned plans across the CCG and LBH to allow the two organisations to make the best use of their budgets and powers to secure improved outcomes and more joined up services.

1.39 There are also some potential risks associated with this model:

- There would be potential loss of direct control over some budgets, although the scheme of delegation for the Integrated Commissioning Board addresses this; and
- The impact of managing and resourcing additional governance structures - this is addressed in paragraph 6.13 and 6.14.
- An initial equality impact assessment screening has been carried out on the proposed integrated commissioning model and has not identified any negative impacts on any particular protected characteristic under the Equality Act 2010. As a result, a full impact assessment has not been carried out.
- As the integrated commissioning model develops and existing services may change or new ones develop, specific full equality impact assessments would be undertaken.

5. CONSULTATIONS AND ENGAGEMENT

1.40 The following engagement has taken place about the integrated commissioning proposals:

- The four public Quadrant engagement events in December 2016 facilitated through Healthwatch;
- The two Health and Wellbeing Boards;
- The two Health Scrutiny Committees;
- The London Devolution Board;
- The NEL STP Board;
- NHSE;
- The Transformation Board;
- Articles in the Healthwatch newsletter and a City Healthwatch event on the STP and integrated commissioning;
- Event with local statutory providers (Homerton, ELFT, GP Confederation);
- Event with local community and voluntary sector providers;
- CCG Board to Board meeting with Homerton Hospital; and
- Event for all commissioning staff across the CCG and the two LAs.

6. FINANCIAL CONSIDERATIONS

Section 75 and Financial Framework

1.41 For each Integrated Commissioning Board, there will be an Integrated Commissioning Fund which will be made up of two parts, a pooled budget and an aligned budget.

1.42 The pooled budget will initially be made up of CCG, adult social care and public health resources where there has been agreement to pool these resources to deliver integrated commissioning and the Locality Plan. It will also include the Better Care Fund (BCF). It will be governed by a Section 75 Agreement (see legal framework below) including a schedule setting out the financial framework.

1.43 The aligned budget will be made up of the budgets which cannot legally be pooled using Section 75 legislation or budgets where partners are not yet ready to pool but want to work collectively to plan their use.

1.44 It is proposed that the London Borough of Hackney and the City of London Corporation will include all their Adult Social and Public Health commissioning budgets and some staffing resources, with the exception of budgets that cannot be legally pooled. Components of Children's services may be included in the model at a later date subject to a formal decision-making process. For the CCG, all funding will be included in the pooled budget apart from corporate services and a number of services which have to be legally excluded and which will sit in the aligned budget.

1.45 The total indicative pooled budget based on 2016/17 for Hackney is approximately £437 million (rounded up). This is made up of an indicative £111 million contribution from LBH and £325 million from the CCG. The indicative aligned fund for Hackney is £47 million made up of £52 million from the CCG and (£5) million from LBH.

1.46 The Section 75 pooled budget is profiled into four areas: Unplanned Care; Planned Care; Children's Services and Prevention. The pool will include budgets for services which are directly delivered by the Council and contracted services. It is recognised that it may be necessary to move monies between the four areas as integrated commissioning evolves and provision will be made in the agreement to do this.

1.47 The Financial Framework (Schedule 3 of the Section 75 set out in Appendix 5) for the Hackney Integrated Commissioning Board sets out the general rules and scope for the management and expenditure of funds which make up the Integrated Commissioning Fund and how conflicts in budget-setting priorities would be settled. The Section 75 details which budgets are included and which fund (pooled or aligned) they are in. The financial framework is agreed by partners on an annual basis.

1.48 The framework also sets out the requirements and makes provision for governance and accountability of:

- The Integrated Commissioning Fund and its boundaries;
- Financial planning and management responsibilities;

- Budget setting and budgetary control, including budget setting and management, managing conflicts, handling under and over spends; and
- Ground rules for its use and treatment of overspends.

1.49 The financial framework will be agreed annually by the statutory organisations and outline the frame and budget for the ICB for the coming year.

1.50 The Section 75 Agreement will be for a 2-year period with a break clause at 6 months' notice. This will ensure that the Council or the CCG is able to withdraw from these arrangements if they have concerns.

1.51 The budget and approach will be negotiated and agreed each year to reflect changing circumstances.

1.52 A meeting was held with the partners and external auditors in January 2017. The external auditors confirmed that the proposed arrangements per the Financial Framework were adequate and no issues flagged.

1.53 There will be a small team who will support the new integrated commissioning arrangements on behalf of the partners. This will include:

- The Finance Economy Group (Chief Financial Officers)
- The Finance Task and Finish Group (Deputy Chief Financial Officers or equivalent) who will oversee the monthly integrated reporting;
- Governance manager for the Integrated Commissioning Boards and the Transformation Board who will manage the business flows within the new arrangements; and
- An Integrated Commissioning Programme Director.

1.54 The CCG is funding any additional resources required for the team.

7. GOVERNANCE

1.55 Appendices 1 to 4 set out the overarching governance structure for integrated commissioning and how it links with other decision making structures within the individual organisations.

Transformation Board

1.56 The current Transformation Board is made up of system leaders (providers and commissioners) working in partnership with patient and public representatives who are responsible for developing and delivering improvement plans in relation to the devolution pilot.

1.57 From April 2017, the City and Hackney Transformation Board will form part of the governance arrangements for integrated commissioning - providing advice and recommendations to the two Integrated Commissioning Boards and taking responsibility for local delivery and implementation across the provider landscape..

1.58 The Transformation Board will be chaired by the Chief Executive of LBH. The Terms of Reference including the membership for the Transformation Board are attached at Appendix 2.

Integrated Commissioning Boards

1.59 The two Integrated Commissioning Boards for Hackney and for the City will meet separately. However, when discussing common issues, strategies or recommendations, the two Integrated Commissioning Boards could meet together.

1.60 Each Integrated Commissioning Board will function through committees in common established by City and Hackney CCG with either the City of London Corporation or London Borough of Hackney.

1.61 Hackney and the CCG's committees must reach their own separate decisions on matters when meeting together as the Integrated Commissioning Board and must do so by consensus.

1.62 The London Borough of Hackney's Integrated Commissioning Committee has authority to make decisions on behalf of Hackney, which shall be binding on the authority, in accordance with the Committee's terms of reference and the scheme of delegation and reservation. The CCG's Integrated Commissioning Committee has authority to make decisions on behalf of the CGG, which shall be binding on the body, in accordance with its terms of reference and the scheme of delegation and reservation.

1.63 The Hackney Integrated Commissioning Board, through the separate committees established, will make decisions together on use of the pooled budget on behalf of the statutory organisations. For aligned funds, the Board members will decide on the strategy and make recommendations to either the CCG Governing Body or the London Borough of Hackney for a formal decision. The Integrated Commissioning Boards will receive recommendations from the Transformation Board which has responsibility for delivery of the Locality Plan.

1.64 The LBH committee will consist of three councillors and the CCG Committee will consist of three members of the CCG Governing Body. There will also be additional representatives invited to attend each meeting as professional advisers, as detailed in the terms of reference in Appendix 4, including: - the Group Director for Children, Adults and Community Health, the Group Director for Finance and Corporate Resources from LBH and the Chief Financial Officers from the CCG and a GP representative from the CCG Governing Body. Legal advisers will also be in attendance.

1.65 The Chair of the Integrated Commissioning Committee will rotate on a 6 monthly basis between the Chair of the CCG and the Lead Member for Health, Social Care and Devolution, with whoever is not Chair, becoming the Deputy Chair of the Board. The Terms of Reference for the London Borough of Hackney Integrated Commissioning Board is attached at Appendix 4.

1.66 Hackney's Integrated Commissioning Board will be subject to the Council's and the CCG's Access to Information Procedure Rules, Executive Procedure Rules and other relevant Constitutional requirements. Decisions taken by the Committee shall be subject to call-in and scrutiny in accordance with the Council's and CCG's Constitution.

1.67 The Scheme of Delegation for the Hackney Integrated Commissioning Board is attached at Appendix 3. Each organisation retains responsibility for their statutory

responsibilities and will therefore hold the relevant Integrated Commissioning Board to account for operating within the schemes of delegation.

1.68 A conflict of interest statement has been developed for integrated commissioning to ensure the ongoing management of conflicts of interest within the integrated commissioning arrangements in a robust way.

1.69 The proposed governance arrangements are being considered through the council's and the CCG's formal decision-making processes in February and early March 2017.

1.70 The partners have agreed to review the governance arrangements after 6 months to ensure that they are robust and are providing accountability back to the three statutory organisations

Legal Framework

1.71 The pooling of health and local authority funding is enabled through a Section 75 Agreement which was established in the NHS Bodies and Local Authorities Regulations 2000.

1.72 The Section 75 Agreement will be a 2 year agreement with a six month break clause and a review after the first year.

1.73 The Legal advisers have confirmed that the three organisations are operating within their statutory powers in establishing these arrangements and the model is within the existing legislative framework

1.74 Nationally there are discussions about changing legislation to allow greater pooling of budgets (i.e. removing the split between aligned and pooled) and simpler governance. It is possible that any changes may come into effect in 2018 and the partners will need to review these arrangements should that occur

8. EQUALITY IMPACT ASSESSMENT

1.75 An initial equality impact assessment screening has been carried out on the proposed integrated commissioning model and has not identified any negative impacts on any particular protected characteristic under the Equality Act 2010. As a result, a full impact assessment has not been carried out.

1.76 As the integrated commissioning model develops and existing services may change or new ones develop, specific full equality impact assessments would be undertaken.

9. REVIEW

1.77 The terms of reference of the new Boards require a formal review after 6 months. The s75 agreement includes a break clause after one year – with any partner being able to serve notice.

1.78 Both of these are important mitigations and opportunities for partners to review these arrangements and ensure that they are making a difference and that the

arrangements which have been put in place are robust.

1.79 The commissioners have also agreed that it is important to evaluate the impact of integrated commissioning and whether it is making a difference for local people and supporting transformation beyond what could be achieved through existing structures and arrangements. We plan to discuss the evaluation of the local model with the London Devolution Board and other national partners to explore whether this could be included in the wider plans to evaluate the impact of devolution and health and social care integration

1.80 As part of evaluating the impact of the work of the ICBs, the HWB will be asked to assess the impact that ICBs have had in delivering the improvements set out in the JHWS.

10. FUTURE REPORTING

1.81 Dates for the ICB meetings are currently being finalised. The dates are being aligned as far as possible to the dates of the Transformation Board and to enable reporting into the key partner statutory body meetings including the HWB.

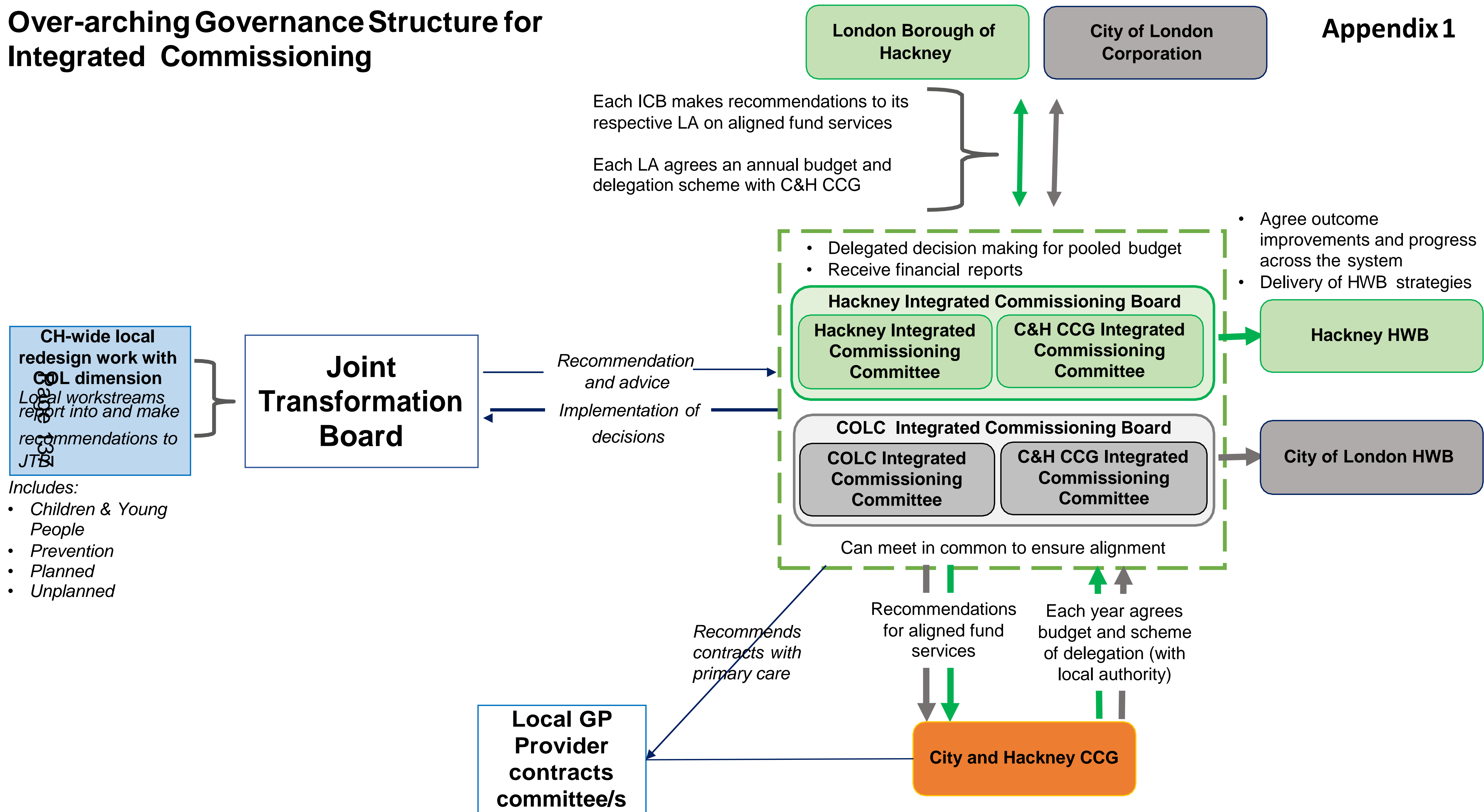
1.82 A forward plan will be drafted to enable clear and structured decision making by the ICBs. This will incorporate:

- Contracting activity relating to pooled budgets
- Transformation Board recommendations
- Integrated Commissioning Risk Management
- Performance review, monitoring and evaluation
- Integrated Commissioning strategy and planning
- Service re-design

1.83 The first report setting out our progress with integrated commissioning will be provided to the HWB at its meeting in July 2017.

11. ATTACHMENTS

Appendix 1 – Overarching Governance Structure
Appendix 2 -Terms of Reference for the Transformation Board
Appendix 3 – Scheme of Delegation for the Hackney Committees in Common
Appendix 4 – Terms of Reference for London Borough of Hackney Integrated Commissioning Board
Appendix 5 – Hackney Section 75 Agreement



Over-arching Governance Structure for Integrated Commissioning
Appendix 1
London Borough of Hackney
City of London Corporation
Each ICB makes recommendations to its respective LA on aligned fund services
Each LA agrees an annual budget and delegation scheme with C&H CCG
Delegated decision making for pooled budget
Receive financial reports
Agree outcome improvements and progress across the system
Delivery of HWB strategies
Hackney Integrated Commissioning Board
Hackney Integrated Commissioning Committee
C&H CCG Integrated Commissioning Committee
Hackney HWB
COLC Integrated Commissioning Board
COLC Integrated Commissioning Committee
C&H CCG Integrated Commissioning Committee
City of London HWB
Can meet in common to ensure alignment
CH-wide local redesign work with COL dimension
Local workstreams report into and make recommendations to JTB
Includes:
Children & Young People
Prevention
Planned
Unplanned
Joint Transformation Board
Recommendation and advice
Implementation of decisions
Recommends contracts with primary care
Recommendations for aligned fund services
Each year agrees budget and scheme of delegation (with local authority)
Local GP Provider contracts committee/s
City and Hackney CCG

NHS City & Hackney Clinical Commissioning Group, London Borough of Hackney and City of London Corporation Integrated Commissioning Fund

Transformation Board

Terms of Reference

Overview

The Transformation Board (the Board) is a working group of the Integrated Commissioning Boards (ICBs) established respectively by NHS City & Hackney Clinical Commissioning Group (the CCG) and London Borough of Hackney (LBH) and by the CCG and City of London Corporation (COLC).

The Board is a forum for discussion of service requirements and commissioning plans in the LBH and COLC areas, with the aim of making separate recommendations to each ICB reflecting the needs of each area unless it is more appropriate to make combined recommendations. The Board has no delegated authority so will take no decisions other than to agree recommendations to the ICBs. As the Board has no delegated authority, recommendations made by the Board shall in fact simply be a shared view of the individual members, each of whom shall individually be authorised to do so by his or her respective appointing organisation.

The Board will link to, and receive commissioning and service inputs from the CCG's consortia, Healthwatch within LBH and COLC, patient and public involvement groups, and other partners across the area to inform its plans.

It will:

- provide advice and recommendations to each ICB in a timely manner as appropriate reflecting the needs of each, to ensure that the local health and social care economy achieves performance requirements and remains in financial balance;
- make recommendations on plans required to improve health and social care outcomes for local people and achieve the locality plan;
- Take responsibility for the redesign, transformation and integration of services, overseeing and coordinating the system workstreams
- make recommendations on changes to contractual arrangements to achieve the plans and deliver integrated service provision; and
- ensure that plans achieve the Health and Wellbeing strategies of LBH and COLC, meet the statutory responsibilities of the commissioners, deliver the local contribution to the North East London Sustainability and Transformation Plan (NEL STP) and in doing so have regard to the need to reduce inequalities and improve outcomes.

Accountability and Reporting

The Board is accountable to the ICBs and it will submit recommendations to them for debate and approval.

Scope

The Board's remit is in respect of services that are within the Integrated Commissioning Fund (ICF), i.e. pooled fund services, and others, and i.e. aligned fund services that are excluded from the ICF. The CCG, LBH and COLC shall determine the funds, and therefore the services, that are to be pooled

and aligned at any time. Once defined, the remit will be stated in these Terms of Reference or in another appropriate document that is provided to the Board.

The Board shall make no decisions on any matter other than to make recommendations to the ICBs in respect of all services within its remit. For pooled funds the ICBs shall have delegated authority to make the necessary commissioning and procurement decisions. For aligned funds, or funds that are otherwise excluded from the pooled fund, the ICBs shall make recommendations to the CCG, LBH and COLC as appropriate.

The Board shall make recommendations to the ICBs in respect of primary care or local GP providers; where these cover core primary care, the authority to make decisions rests with the CCG's Local GP Provider Contracts Committee. Where these relate to other services to be commissioned from primary care providers the ICBs will seek independent advice and scrutiny on the Board's proposals from the CCG Local GP Provider Contracts Committee.

The Board is responsible for ensuring that there are robust delivery arrangements in place which fully integrate and align services to achieve improved outcomes and achieve financial balance.

The Board has agreed 4 key work-streams to organise our work – prevention, unplanned care, children and young people, and planned care – and a number of enabler work-streams to ensure that the infrastructure is in place to achieve our local delivery arrangements. All of these work-streams and groups report to the Board and operate under the direction of the Board.

The Board also has a responsibility to recommend to the ICBs the amount of the ICF that should be spent on commissioning management and administrative support, ensuring that this represents value for money when assessed against resident-facing services.

Objectives

To support the ICBs by discussing issues and making recommendations to enable the ICBs to:

Commissioning strategies and plans

- Lead the commissioning agenda of the locality, including inputs from, and relationships with, all partners
- Ensure financial sustainability and drive local transformation programmes and initiatives
- Determine and advise on the local impacts of commissioning recommendations and decisions taken at a NEL level
- Ensure that the Locality plan is delivering the local contribution to the ambitions of the NEL STP
- Lead the development and scrutiny of annual commissioning intentions including the monitoring, review, commissioning and decommissioning of activities and making recommendations on these to the ICBs
- Provide advice to the ICBs in respect of primary care to enable the ICBs to make recommendations, where necessary, to the CCG's Local GP Provider Contracts Committee

- Ensure that the locality plan delivers constitutional requirements, financial balance, and supports the improvement in performance and outcomes established by the Health and Wellbeing Boards
- Promote health and wellbeing, reduce health inequalities, and address the public health and health improvement agendas in making commissioning recommendations
- Ensure commissioning decisions are made by the ICBs in a timely manner that address financial challenges of both the in-year and longer term plans
- Ensure that local plans can demonstrate their impact on City ad Hackney residents and where appropriate City workers, are suitably tailored to meet the different needs of the 2 geographical areas.

Service re-design

- Review and recommend for approval all clinical and social care guidelines, pathways, service specifications, and new models of care. This will include new or revised pathways which support the movement of services into the community, contain demand and achieve service integration. In providing this support to the ICBs the Board will identify where there are material changes to existing arrangements, and therefore will advise on all contractual and financial enhancements or amendments as well as ensuring delivery and implementation
- Ensure all local guidelines, service specifications and pathways are developed in line with NICE and other national evidence, best practice and benchmarked performance
- Drive continuous improvement in all areas of commissioning, pathway and service redesign delivering increased quality performance and improved outcomes
- Ensure that services are designed and delivered, using “design lab” principles – i.e. co-developed by residents and practitioners working together.

Contracting and performance

- Oversee the annual contracting and planning processes and ensuring that contractual arrangements are supporting the ambitions of the CCG, LBH and COLC to transform services, ensure integrated delivery and improve outcomes
- Oversee local financial and operational performance and decisions in respect of investment and disinvestment plans
- Oversee generally the implementation of the ICBs' decisions in respect of commissioning and procurement of services to ensure that objectives are achieved.

Stakeholder engagement

- Ensure adequate structures are in place to support patient, public, service user, and carer involvement at all levels and that the equalities agenda is delivered,
- Ensure that arrangements are in place to support collaboration with other localities when it has been identified that such collaborative arrangements would be in the best interests of local patients, public, service users, and carers
- Ensure and monitor on-going discussion between the ICBs and provider organisations about long-term strategy and plans.

Programme management

- Oversee the work of the work-streams and enabler groups, including agreeing Terms of Reference and workplans, reviewing progress against action plans and ensuring system wide implications are considered
- Ensure that risks associated with integrated commissioning are identified and managed, including to the extent necessary through risk management arrangements established by the CCG, LBH and CoLC.

Integrated Commissioning Arrangements

An annual review will be undertaken of the integrated commissioning arrangements, including the operation of the s75 agreements, the Integrated Commissioning Fund and shall make recommendations to the ICBs.

Membership

The membership of the Board is as follows:-.

- Chief Executive of LBH
- Chief Executive Officer and Medical Director of
  - Homerton University Hospital NHS Foundation Trust
  - East London NHS Foundation Trust
  - City & Hackney GP Confederation
  - CHUHSE
- Chair and Chief Officer of the CCG
- Director of Public Health for LBH and COLC
- Director of Adult Services- London Borough of Hackney
- Assistant Director Commissioning & Partnerships - City of London Corporation
- Assistant Director People –City of London Corporation
- Group Director of Neighbourhoods and Housing- London Borough of Hackney
- Head of Early Years- London Borough of Hackney
- City of London Healthwatch
- Hackney Healthwatch
- Representative nominated by Hackney Community and Voluntary sector
- A person nominated by the Chief Financial Officers of the CCG, LBH and COLC
- CCG Lay member for PPI
- Local Pharmaceutical Committee Chair

The Chair will be the Chief Executive of LBH. The vice chair will be a local authority director/CCG Chief Officer. The vice chair will be elected by members of the Board on an annual basis.

The membership will be kept under review as the provider landscape develops and the Board can decide to include other significant local providers in its membership by agreement of the ICBs.

The members are expected to represent the area of responsibility for which they are a member of the Board. It is the responsibility of all those present to uphold the Nolan Principles and to comply with all other relevant requirements.

Attendees

The following individuals may attend the Board's meetings and are expected to contribute to discussions but shall not participate in decisions (to make recommendations):

- Work-stream leads
- CCG GP Consortia leads and CCG Programme Board leads as required

Conflicts of interests

The partner organisations represented in the Board are committed to conducting business and delivering services in a fair, transparent, accountable and impartial manner. Nevertheless, partners recognise the potential for conflicts of interest to arise, in particular for providers where there are discussions about service delivery and contractual arrangements.

Board members will comply with the Conflicts of Interest policy statement developed for integrated commissioning as well as the arrangements established by the organisations that they represent. A declaration of interest will be completed by all members and attendees of the Board and will be kept up to date in line with the policy. Before each meeting the each member or attendee will examine the agenda to identify any matters in which he/she has (or may be perceived to have) an interest. Such interests may be in addition to those declared previously. Any such conflicts should be raised with the chair and the secretariat at the earliest possible time.

The chair will acknowledge the register of interests at the start of the meeting as an item of business. There will be the opportunity for any potential conflicts of interests to be debated and the chair (on the basis of advice where necessary) shall determine whether any conflicts of interests exist and, if so, the arrangements through which they shall be addressed.

Particular account will be taken of the statutory duty which the executive directors of the NHS Foundation Trusts have to avoid a situation in which they have, or can have, an interest which conflicts or possibly may conflict with the interests of the NHS Foundation Trusts that they represent. In some cases it may be possible for a person with a conflict of interests to participate in a discussion but not the decision that results from it. In other cases it may be necessary for a person to withdraw from the meeting for the duration of the discussion and decision.

When the chair has a conflict of interests relating to an agenda item which obliges them to withdraw, the members of the board will select from among their number a chair for the whole or part of the meeting.

All declarations and discussions relating to them will be minuted. The register of interests will be published on the CCG and Local Authority websites.

Quoracy

The meeting shall be quorate where there are at least eight of the members present. Of the 8 at least 4 must be clinicians, 1 of the local authority Directors, a representative from both LBH and CoLC, 1 of the CCG, and 1 of Healthwatch/CCG PPI lay member must be present.

Meetings

The Board's Members will be given no less than five clear working days' notice of its meetings. This will be accompanied by an agenda and supporting papers and sent to each member no later than five clear days before the date of the meeting.

It is anticipated that the Board will routinely meet monthly. When the Chair of the Board deems it necessary in light of urgent circumstances to call a meeting at short notice this notice period shall be such as s/he shall specify.

Whilst the Board will not meet in public, minutes of each meeting will be submitted to the Integrated Commissioning Boards (which will meet in public). The Board recognises, however, that all information associated with it is subject to the Freedom of Information Act.

Any member of the Board may participate in its meetings by telephone or video conference, provided that all members are able to hear each other such that they can contribute to discussions and decisions.

Where it is necessary to deal with urgent business and it is not possible for the Board to meet, it may take decisions by written resolution with the prior agreement of the Chair. Any decisions taken by such means must be recorded in the minutes of the next scheduled meeting of the Board.

Minutes shall be taken of all of the Board's meetings by the secretariat support and they shall be presented to the ICBs.

Decision making

The Board shall only take a decision on any matter (which shall be limited to decisions in respect of recommendations to the ICBs) where a consensus exists among its members.

The Board shall not vote on any matter.

No organisation that is represented on the Board shall be bound by any decision of the Board (so no organisation that votes against a proposal to make a recommendation to the ICBs shall be bound to accept it or to have its name associated with it). Any decision by a provider organisation not to accept a decision to make a recommendation to the ICBs shall not prevent that organisation from agreeing subsequently to provide any services that are commissioned by the ICBs on the basis of the recommendation from the Board.

Review of Terms of Reference

These terms of reference will apply for the year from 1 April 2017 to 31 March 2018, subject to their agreement by the CCG, LBH and COLC.

The terms of reference will be reviewed not later than six months from initial approval and then annually thereafter, such annual reviews to coincide with reviews of the s75 agreements.

[Insert dates of approval of these TOR at each relevant forum within the CCG, LBH and COLC.] – To be added 16 February 2017

SCHEME OF RESERVATION AND DELEGATION FOR THE NHS CITY & HACKNEY CLINICAL COMMISSIONING GROUP AND LONDON BOROUGH OF HACKNEY COMMITTEES IN COMMON

Introduction

This document defines the authority reserved and delegated within the governance arrangements for the Integrated Commissioning Fund established by NHS City and Hackney Clinical Commissioning Group (the CCG) and London Borough of Hackney (LBH). The authority defined in this document is consistent with (and is referenced to) the Financial Framework (FF).

LBH has established an Integrated Commissioning Committee and the CCG has also established an Integrated Commissioning Committee. Those two committees shall meet in common and shall be known together as the Integrated Commissioning Board ("the Board").

LBH's Integrated Commissioning Committee has authority to make decisions on behalf of LBH, which shall be binding on the authority, in accordance with its terms of reference and this scheme of delegation and reservation. The CCG's Integrated Commissioning Committee has authority to make decisions on behalf of the CGG, which shall be binding on the authority, in accordance with its terms of reference and this scheme of delegation and reservation.

The authority of the LBH Integrated Commission Committee is subject to call-in arrangements (as set out in the terms of reference for the Board). The CCG's Integrated Commissioning Committee is subject to oversight from the CCG's Governing Body and Members such that they are assured that the Board does not breach any requirements.
The integrated commissioning governance arrangements include the Transformation Board (TB). The purpose of the TB is to discuss issues among its members and to support the ICB in its role. No authority is delegated to the TB so it does not appear below; its role is limited to making recommendations to the ICB.

This document distinguishes between "core primary care services", which are services commissioned by the CCG under authority delegated from NHS England, and "other primary care services" (such as enhanced services), have been and will continue to be commissioned directly by the CCG. Authority (for commissioning, procurement and other matters) in respect of core primary care services is reserved to the CCG's Primary Care Commissioning Committee; authority in respect of all other primary care services is delegated to the ICB.

No.	Description of authority reserved or delegated	CCG Governing Body	CCG Local GP Provider Contracts Committee		CCG officers	LBH Mayor and Cabinet (unless otherwise expressly delegated)	LBH Integrated Commissioning Committee	CCG Integrated Commissioning Committee
	Pooled Budgets and Services							
1.	Determine the budgets (and therefore services) that are pooled (to include Better Care Fund) at any time	Authority to approve				Authority to approve		
2.	Determine the amount of the Integrated Commissioning Fund that is allocated to commissioning management and administration support.	Authority to approve				Authority to approve		
3.	Approve the Integrated Commissioning Strategy (ICS) for services within the pooled budget						Authority to approve	Authority to approve
4.	Approve a commissioning strategy or plan for each service or pathway identified in the ICS and included in the pooled budget						Authority to approve	Authority to approve
5.	Approve the design of services identified in the ICS and included in the pooled budget, including pathways, specifications and models of care.						Authority to approve (Refer to FF 34)	Authority to approve (Refer to FF 34)

No.	Description of authority reserved or delegated	CCG Governing Body	CCG Local GP Provider Contracts Committee		CCG officers	LBH Mayor and Cabinet (unless otherwise expressly delegated)	LBH Integrated Commissioning Committee	CCG Integrated Commissioning Committee
6.	Approve expenditure from the pooled budget, including Better Care Fund budgets.						Authority to approve (Refer to FF 38.3)	Authority to approve (Refer to FF 38.3)
7.	Approve the procurement process to select providers to deliver services identified in the ICS and within the pooled budget						Authority to approve	Authority to approve
8.	Approve the appointment of providers to deliver services identified in the ICS and within the pooled budget						Authority to approve for	Authority to approve for
9.	Approve contracts with providers selected to deliver services identified in the ICS and within the pooled budget				Authority to approve. (Refer to FF 38.3)	Authority to approve (Refer to FF 38.3)		
10.	Approve action to address any variance from targets in respect of the performance of providers.						Authority to approve	Authority to approve

No.	Description of authority reserved or delegated	CCG Governing Body	CCG Local GP Provider Contracts Committee		CCG officers	LBH Mayor and Cabinet (unless otherwise expressly delegated)	LBH Integrated Commissioning Committee	CCG Integrated Commissioning Committee
11.	Approve the arrangements for the CCG and LBH to work together, including the role of the Transformation Board and any supporting committees or work programmes.						Authority to approve	Authority to approve
12.	Approve strategies and plans to secure the engagement of patients, the public and other stakeholders.						Authority to approve	Authority to approve
	Aligned Budgets and Services							
13.	Approve the commissioning strategy for aligned budgets and services.	Authority to approve				Authority to approve		
14.	Approve a commissioning strategy or plan for each aligned service or pathway.	Authority to approve				Authority to approve		
15.	Approve the design of aligned budget services, including pathways, specifications and models of care.	Authority to approve				Authority to approve		

No.	Description of authority reserved or delegated	CCG Governing Body	CCG Local GP Provider Contracts Committee		CCG officers	LBH Mayor and Cabinet (unless otherwise expressly delegated)	LBH Integrated Commissioning Committee	CCG Integrated Commissioning Committee
16.	Approve the procurement process to select providers to deliver aligned budget services.	Authority to approve				Authority to approve		
17.	Approve the appointment of providers to deliver aligned budget services.	Authority to approve				Authority to approve		
18.	Approve contracts with providers selected to deliver aligned budget services.				Authority to approve. (Refer to FF 38.3)	Authority to approve (Refer to FF 38.3)		
	Core Primary Care Services							
19.	Approve the commissioning strategy		Authority to approve					
20.	Approve a commissioning strategy or plan for each service		Authority to approve					
21.	Approve the design of services, including pathways, specifications and models of care		Authority to approve					
22.	Approve the procurement process to select providers to deliver services		Authority to approve					

No.	Description of authority reserved or delegated	CCG Governing Body	CCG Local GP Provider Contracts Committee		CCG officers	LBH Mayor and Cabinet (unless otherwise expressly delegated)	LBH Integrated Commissioning Committee	CCG Integrated Commissioning Committee
23.	Approve the appointment of providers to deliver services		Authority to approve					
24.	Approve contracts with providers selected to deliver services		Authority to approve					
25.	Approve the establishment or merger of GP practices		Authority to approve					
26.	Approve discretionary payments		Authority to approve					
27.	Approve the design of local incentive schemes		Authority to approve					
	Other Primary Care Services							
28.	Approve the commissioning strategy						Authority to approve	Authority to approve
29.	Approve a commissioning strategy or plan for each service						Authority to approve	Authority to approve
30.	Approve the design of services, including pathways, specifications and models of care						Authority to approve	Authority to approve
31.	Approve the procurement process to select providers to deliver services						Authority to approve	Authority to approve

No.	Description of authority reserved or delegated	CCG Governing Body	CCG Local GP Provider Contracts Committee		CCG officers	LBH Mayor and Cabinet (unless otherwise expressly delegated)	LBH Integrated Commissioning Committee	CCG Integrated Commissioning Committee
32.	Approve the appointment of providers to deliver services						Authority to approve	Authority to approve
33.	Approve contracts with providers selected to deliver services						Authority to approve	Authority to approve

[Insert dates of approval by the CCG's Governing Body and the relevant committee or officer in LBH]

DAC Beachcroft LLP
3 February 2017

NHS CITY & HACKNEY CLINICAL COMMISSIONING GROUP AND THE LONDON BOROUGH OF HACKNEY

Terms of Reference of the London Borough of Hackney Integrated Commissioning Committee and the NHS City & Hackney Clinical Commissioning Group Integrated Commissioning Committee ("known collectively as the Integrated Commissioning Board")

The London Borough of Hackney (LBH) has established an Integrated Commissioning Committee and NHS City & Hackney Clinical Commissioning Group (the CCG) has also established an Integrated Commissioning Committee. Those two committees shall meet in common and shall be known together as the Integrated Commissioning Board ("the Board").

LBH's Integrated Commissioning Committee has authority to make decisions on behalf of LBH, which shall be binding on the authority, in accordance with these terms of reference and the scheme of delegation and reservation.

The CCG's Integrated Commissioning Committee has authority to make decisions on behalf of the CGG, which shall be binding on the authority, in accordance with these terms of reference and the scheme of delegation and reservation.

Except where stated otherwise (in which case the term "committees" is used), all references in this document to the "Board" refer collectively to the two committees described above. The Role and Responsibilities of the Board, as described below, are the roles and responsibilities of the individual committees insofar as they relate to the individual committee's authority.

The CCG and LBH committees (i.e. "the Board") will manage the Pooled Fund element of the Integrated Commissioning Fund in the delivery of the Locality Plan. For Aligned Fund services the Committees act as an advisory group making recommendations to the CCG Governing Body or the LBH Cabinet.

<u>Role and Responsibilities of the Board</u>
The Board is the principal forum to ensure that commissioning improves local services and outcomes and achieves integration of service provision and of commissioning and delivers the North East London Sustainability and Transformation Plan (NEL STP). It is the forum for decision making and monitoring of activity to integrate the commissioning activities of the CCG and LBH (to the extent defined in the s75 agreement).

The Board's remit is in respect of services that are Pooled Funds (including the Better Care Fund budgets) within the Integrated Commissioning Fund (ICF). The Board also has a remit with regard to Aligned Funds, whereby it is an advisory group making recommendations to the CCG Governing Body or the LBH Cabinet.

The CCG and LBH shall determine the funds, and therefore the services, that are to be pooled or aligned at any time (and shall include requirements in respect of Better Care Fund budgets). Once defined, the remit will be stated in these Terms of Reference or in another appropriate document that is provided to the Board.

In performing its role the Board will exercise its functions in accordance with, and to support the delivery of, the City and Hackney Locality Plan and the North East London Sustainability and Transformation Plan (NEL STP).

In carrying out its role the Board will be supported by the Transformation Board.

The duties of the Board defined below are subject to its Scheme of Delegation and subject to the financial framework which outlines which budgets are pooled and which are aligned and the role of the Board in relation to each.

Specifically, the Board will:

Commissioning strategies and plans

- Lead the commissioning agenda of the locality, including inputs from, and relationships with, all partners
- Ensure financial sustainability and drive local transformation programmes and initiatives
- Determine and advise on the local impacts of commissioning recommendations and decisions taken at a NEL level
- Ensure that the Locality plan is delivering the local contribution to the ambitions of the NEL STP
- Lead the development and scrutiny of annual commissioning intentions as set out in the Integrated Commissioning Strategy, including the monitoring, review, commissioning and decommissioning of activities
- Provide advice to the CCG about core primary care and make recommendation to the CCG's Local GP Provider Contracts Committee
- Ensure that the locality plan delivers constitutional requirements, financial balance, and supports the improvement in performance and outcomes established by the Health and Wellbeing Board
- Promote health and wellbeing, reduce health inequalities, and address the public health and health improvement agendas in making commissioning recommendations
- Ensure commissioning decisions are made by the ICB in a timely manner that address financial challenges of both the in-year and longer term plans
- Ensure that local plans can demonstrate their impact on Hackney residents.

Service re-design

- Approve all clinical and social care guidelines, pathways, service specifications, and new models of care
- Ensure all local guidelines and service specifications and pathways are developed in line with NICE and other national evidence, best practice and benchmarked performance
- Drive continuous improvement in all areas of commissioning, pathway and service redesign delivering increased quality performance and improved outcomes
- Ensure that services are designed and delivered, using “design lab” principles – i.e. co-developed by residents and practitioners working together.

Contracting and performance

- Oversee the annual contracting and planning processes and ensuring that contractual arrangements are supporting the ambitions of the CCG and LBH to transform services, ensure integrated delivery and improve outcomes

- Oversee local financial and operational performance and decisions in respect of investment and disinvestment plans

Stakeholder engagement

- Ensure adequate structures are in place to support patient, public, service user, and carer involvement at all levels and that the equalities agenda is delivered,
- Ensure that arrangements are in place to support collaboration with other localities when it has been identified that such collaborative arrangements would be in the best interests of local patients, public, service users, and carers
- Ensure and monitor on-going discussion between the ICB and provider organisations about long-term strategy and plans

Programme management

- Oversee the work of the Transformation Board including their work on the workstreams and enabler groups ensuring system wide implications are considered
- Ensure that risks associated with integrated commissioning are identified and managed, including to the extent necessary through risk management arrangements established by the CCG and LBH.

Safeguarding

- In discharging its duties, act such that it supports the CCG and LBH to comply with the statutory duties that apply to them in respect of safeguarding patients and service users.

Geographical Coverage
The responsibilities for the Board will cover the geographical area of LBH.

It is noted that there will need to be decisions made about how to address the issues of resident and registered populations across the CCG and LBH.

Membership
The membership of the LBH Committee shall be as follows:

- LBH Lead Member for Health, Social Care and Devolution
- LBH Lead Member for Children's Services
- LBH Lead Member of Finance and Corporate Services

The membership of the CCG Committee shall be as follows:

- Chair of the CCG
- CCG Governing Body Lay Member
- CCG Chief Officer

As the two committees shall meet in common, the members of the LBH Committee shall be in attendance at the meeting of the CCG Committee, and the members of the CCG Committee shall be in attendance at the meeting of the LBH Committee.

The following shall be expected to attend the meetings of the Board, contribute to all discussion and debate, but will not participate in decision-making:

- CCG Governing Body GP
- CCG Chief Financial Officer
- LBH Group Director – Finance and Corporate Services
- LBH Group Director – Adults and Children's Services

The following shall have a standing invitation to attend the meetings of the Board, contribute to all discussion and debate, but will not participate in decision-making:

- LBH Director of Public Health
- A person nominated by the Chief Financial Officers of the CCG and LBH
- Representative of London Borough of Hackney Healthwatch
- Representative of Hackney Voluntary and Community Services.

Meetings of the Board shall be chaired by either (1) the Chair of the CCG or (2) the cabinet member for health, social care and devolution. The Chair shall rotate between CCG and LBH every six months, with whoever isn’t Chair becoming the Deputy Chair of the Board.

In the event of the Chair being unavailable for a meeting or when the Chair is conflicted regarding an agenda item and is required to leave the meeting, the Deputy Chair will assume the chairing of the meeting. Where the Deputy Chair is unavailable or is conflicted, a quorum of the members of each Committee will by consensus select a chair for the whole or part of the meeting concerned. Where the Board is making a decision to award a contract or funding to a local GP provider organisation or considering a recommendation to the CCG about core primary care services, that item will be chaired by the Deputy Chair if the CCG Chair is the Chair of the Board.

The membership will be kept under review and through approval from the CCG's Governing Body and LBH's elected Mayor. Other parties may be invited to send representatives to attend the Board's meetings in a non-decision making capacity.

The Board may also call additional experts to attend meetings on an ad hoc basis to inform discussions.

Meetings

The Board's members will be given no less than five clear working days' notice of its meetings. This will be accompanied by an agenda and supporting papers and sent to each member no later than five clear days before the date of the meeting. In urgent circumstances the requirement for five clear days' notice may be truncated.

It is anticipated that the Board will routinely meet monthly. When the Chair and Deputy Chair of the Board deem it necessary in light of urgent circumstances to call a meeting at short notice this notice period shall be such as s/he shall specify.

Meetings of the Board shall be held in accordance with partners' Access to Information procedures, rules, and other relevant constitutional requirements. The dates of the meetings will be published by the CCG and LBH. The meetings of the Board will be held in public, subject to any exemption provided by law or any matters that are confidential or commercially sensitive. This should only occur in exceptional circumstances and in accordance with the open and accountable local government guidance (June 2014).

There may be occasions where an Integrated Commissioning Board established by the City of London Corporation meets in common with the Board for Hackney to consider the same items of business. The terms of reference for the respective Boards still apply in such circumstances.

Secretarial support will be provided to the Board and minutes shall be taken of all the Board's meetings, with one set being prepared for each of the committees in common and submitted to the relevant forum as determined by the CCG and LBH. Agenda, decisions and minutes shall be published in accordance with partners' access to Information procedures rules.

Executive decisions made by the LBH committee may be subject to call-in by members of the Council in accordance with LBH's constitution. Executive decisions made by the CCG committee may be subject to review by the CCG's Governing Body and/or Members Forum in accordance with CCG's constitution. However, the CCG and LBH will manage the business of the Board, including consultation with relevant fora and/or officers within those organisations, such that the incidence of decisions being called-in is minimised.

Decision making

Each committee must reach its own decision on any matter under consideration, and must do so by consensus.

These decision-making arrangements shall be included in the review of these terms of reference as set out below.

Quorum

For the CCG committee, the quorum will be two of the three members.

For the LBH committee the quorum will be two of the three Council members.

Conflicts of interests

The partner organisations represented in the Board are committed to conducting business and delivering services in a fair, transparent, accountable and impartial manner. Board members will comply with the Conflicts of Interest policy statement developed for the ICBs, as well as the arrangements established by the organisations that they represent.

A declaration of interest will be completed by all members and attendees of the Board and will be kept up to date in line with the policy. Before each meeting each member or attendee will examine the agenda to identify any matters in which he/she has (or may be perceived to have) an interest. Such interests may be in addition to those declared previously. Any such conflicts should be raised with the chair and the secretariat at the earliest possible time.

The Chair will acknowledge the register of interests at the start of the meeting as an item of business. There will be the opportunity for any potential conflicts of interests to be debated and the chair (based on advice where necessary) shall determine whether any conflicts of interests exist and, if so, the arrangements through which they shall be addressed.

In some cases, it may be possible for a person with a conflict of interest to participate in a discussion but not the decision that results from it. In other cases, it may be necessary for a person to withdraw from the meeting for the duration of the discussion and decision. When the chair has a conflict of interests relating to an agenda item which obliges them to withdraw, the members of the board will select from among their number a chair for the whole or part of the meeting.

When considering any proposals relating to actual or potential contractual arrangements with local GP providers the Board will seek independent advice from the CCG Local GP Provider Contracts Committee who provide a scrutiny function for all such matters, particularly that the contract is in the best interests of local people, represents value for money and is being recommended without any conflict of interest from GPs.

All declarations and discussions relating to them will be minuted.

Additional requirements

The members of the Board have a collective responsibility for the operation of the Board. They will participate in discussion, review evidence, and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view. They will take advice from the Transformation Board and from other advisors where relevant.

The Board must operate within the schemes of delegation and financial framework agreed by the CCG and LBH, who remain responsible for their statutory functions and for ensuring that these are met and that the Board is operating within all relevant requirements.

The Board may assign tasks to such individuals or committees as it shall see fit, if any such assignments are consistent with each parties' relevant governance arrangements, are recorded in a scheme of delegation for the Board, are governed by terms of reference as appropriate, and reflect appropriate arrangements for the management of any actual or perceived conflicts of interest.

Reporting and relationships

- The Board will report to the relevant forum as determined by the CCG and LBH. The matters on which, and the arrangements through which, the Board is required to report shall be

determined by the CCG and LBH (and shall include requirements in respect of Better Care Fund budgets). The Board will present for approval by the CCG and LBH proposals on matters in respect of which authority is reserved to the CCG and/or LBH (including in respect of aligned fund services). The Board will also provide advice to the CCG about core primary care and make recommendation to the appropriate CCG Committee.

The Board will receive reports from the CCG and LBH on decisions made by those bodies where authority for those decisions is retained by them but the matters are relevant to the work of the Board.

The Board will provide reports to the Health and Wellbeing Board and other committees as required.

Review

These terms of reference will apply for the year from 1 April 2017 to 31 March 2018, subject to their agreement by the 2 statutory organisations.

The terms of reference will be reviewed not later than six months from initial approval and then annually thereafter, such annual reviews to coincide with reviews of the s75 agreements.

[Insert dates of approval of these TORS at each relevant forum within the CCG and LBH] – To be added

3 February 2017

Dated 2017

LONDON BOROUGH OF HACKNEY

and

NHS CITY AND HACKNEY CLINICAL COMMISSIONING GROUP

FRAMEWORK SECTION 75 AGREEMENT FOR THE DEVOLUTION OF HEALTH AND SOCIAL CARE SERVICES IN LONDON BOROUGH OF HACKNEY (INCLUDING THE BETTER CARE FUND)

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THIS AGREEMENT is made on day of 2017

PARTIES

(1) **LONDON BOROUGH OF HACKNEY** of Hackney Service Centre, 1 Hillman Street, London E8 1DY (the **"Council"**)

(2) **NHS CITY AND HACKNEY CLINICAL COMMISSIONING GROUP** of 3rd Floor, Block A, St Leonard's Hospital, London, N1 5LZ (the "**CCG"**)

each a "**Party**" and together the "**Parties**".

BACKGROUND

(A) The Council has responsibility for commissioning and may provide social care services on behalf of the population of the London Borough of Hackney.

(B) The CCG has the responsibility for commissioning health services pursuant to the 2006 Act in the London Borough of Hackney.

(C) The Parties wish to establish a pooled and aligned fund, and delegate the exercise of certain commissioning functions to each other, to integrate the commissioning of health and social care services, as set out in this Agreement.

(D) This Agreement also sets out the arrangements for the Better Care Fund, which supports 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 Parties pool those funds in accordance with Section 75 of the 2006 Act. The pooled fund established for the purposes of this Agreement is broader than the Better Care Fund, and the requirements of the Better Care Fund plan (in terms of reporting, for example), shall only apply to the Better Care Fund element of the pooled fund.

(E) 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.

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

(G) The main **aims and objectives** of the Parties in entering in to this Agreement are to:

(i) meet the National Conditions and local objectives;

(ii) integrate the commissioning activities of the Parties in respect of the relevant populations (resident and GP registered) of London Borough of Hackney in line with the Health and Wellbeing Board's vision of integrated health and wellbeing, and through the pooling or aligning of financial resources and integrated governance create a sustainable health and wellbeing system with improved system performance;

(iii) agree strategies and ensure commissioning activity to make more effective use of resources to achieve improved health and wellbeing for the local population, improved outcomes and integrated service delivery and prioritise prevention and early intervention by ensuring people receive 'the right care in the right place at the right time';

(iv) help people take control of their lives and communities and ensure children, young people and adults are safe and confident in their lives and communities and that

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people are treated with dignity and respect; and

(v) to deliver Integrated Commissioning that will focus on developing joined up, population based, public health, and preventative and early intervention strategies and services and adopt an asset based approach to providing a single system of health and wellbeing, focusing on increasing the capacity and assets of people and place.

(H) The Parties are entering this Agreement in exercise of the powers referred to in Section 75 of the 2006 Act, 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.

2012 Act means the Health and Social Care Act 2012.

Affected Party means, in the context of Clause 28, the Party 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.

Aligned Commissioning means mechanisms by which the Parties commission services that are not included within a pooled arrangement, but which are closely related to those pooled commissioned services; and which are incorporated within the design of the overall integrated commissioned service. For the avoidance of doubt, aligned commissioning arrangements do not involve the formal delegation of any functions pursuant to Section 75 of the 2006 Act.

Aligned Fund means budgets for commissioning prescribed services (as set out in Part 3 of Schedule 1) which will be managed alongside the Pooled Fund.

Annual Review has the meaning set out in clause 24.1.

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

Best Value Duty means the duty on local authorities to provide best value and to provide services efficiently, effectively and economically and to strive for constant improvement of all services as set out in the Local Government Act of 1999 and the Local Government Act of 2000 and any similar duty.

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 Parties.

Better Care Fund Plan means the plan attached at Part 1 of Schedule 6 setting out the Parties plan for the use of the Better Care Fund.

Budget Contributions means the budget contributions made by each Party to the Integrated Commissioning Fund in any Financial Year and the indicative budget contributions

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for the financial year 2017/2018 as set out under Part 2 of Schedule 1.

CCG Contracts means any contract that the CCG holds but has agreed that the Council should be the Lead Commissioner, and therefore the CCG appoints the Council to act as agent to manage the contract in accordance with Clause 15.

CCG Contingency Funds means funds apportioned by the CCG (in accordance with the Financial Framework) that the CCG has designated to cover financial risks where such risks are not otherwise mitigated through Service Contracts.

CCG Statutory Duties means the duties of the CCG pursuant to Sections 14P to 14Z2 of the 2006 Act and those duties that are set out in the 2012 Act.

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.

Chief Financial Officer(s) means either the person appointed by the Council pursuant to section 151 of the Local Government Act 1972 or the person appointed to the role of chief finance officer by the CCG in accordance with paragraph 11 of Schedule 1A of the Health and Social Care Act 2012 or both as the context requires.

Commencement Date means 00:01 hrs on 1 April 2017.

Commissioning Plans means the plans setting out details of how the Integrated Commissioning Strategies (including but not limited to the Locality Plans) will be implemented and delivered.

Confidential Information means information, data and/or material of any nature which any Party may receive or obtain about the operation of this Agreement and the Services and:

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

(b) the release of which is likely to prejudice the commercial interests of a Party 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.

Council Contracts means any contract that the Council holds but has agreed that the CCG should be the Lead Commissioner, and therefore the Council appoints the CCG to act as agent to manage the contract in accordance with Clause 15.

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 Party(s) to the Provider as a consequence of (i) breach by any or all of the Parties of an obligation(s) in whole or in part) under the relevant Services Contract or (ii) any act or omission of a third party for which any or all of the Parties are, under the terms of the relevant Services Contract, liable to the Provider.

Dispute Resolution Procedure means the procedure set out at Clause 27.

Exit Plan means the exit plan described in Schedule 7 (Exit Planning Obligations).

Expiry Date means 23.59 hours on 31 March 2019.

Finance Economy Group means a group responsible for the financial management of the

Integrated Commissioning Fund, as further set out in the Financial Framework.

Financial Framework means the financial framework agreed between the Parties in respect of this Agreement, as varied from time to time in accordance with Clause 34.2 and as set out in Schedule 3.

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 Party 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 from time to time as are relevant to the commissioning of the Services and which may be further described in the relevant Commissioning Plans, Service Specifications, Better Care Fund Plan and/or Scheme Specifications.

Host Partner means the Party that will host and provide the financial administrative systems for the Pooled Fund and undertake to perform the duties for which they will be responsible, as set out in paragraph 7(4) and 7(5) of the Regulations**.**

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.

Information Framework means the information framework agreed between the Parties in respect of this Agreement, as amended from time to time in accordance with Clause 34.2.

Integrated Commissioning means arrangements by which Parties Commission Services in relation to an Integrated Commissioning Strategy on behalf of each other; and in the exercise of commissioning of both the NHS Functions and Health Related Functions.

Integrated Commissioning Board (or "**ICB**") means the committees responsible for review of performance and oversight of this Agreement with the terms of reference as set out in Schedule 2.

Integrated Commissioning Fund means the total of the Pooled Fund and Aligned Fund.

Integrated Commissioning Strategies means the commissioning strategies and priorities agreed between the Parties about what services to commission within the area, and amended

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from time to time in accordance with Clause 34, and the agreed Integrated Commissioning Strategies as of the date of this Agreement are set out in Part 1 of Schedule 1.

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 Party(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 Party(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 Party commissions Services in relation to an Integrated Commissioning Strategy or Commissioning Plan on behalf of the other Party in exercise of both the NHS Functions and the Health Related Functions.

Lead Commissioner means the Party responsible for commissioning an individual Service under a Commissioning Plan.

Locality Plan means a strategy designated as such by the Integrated Commissioning Board.

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 of the CCG listed in Regulation 5 of the Regulations from time to time as are relevant to the commissioning of the Services and which may be further described in the relevant Commissioning Plans, Service Specifications, Better Care Fund Plan and/or Scheme Specifications.

NHS Standard Contract means a contract based on terms published by NHS England for the commissioning of health services in accordance with their obligations under Regulation 17(1) of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012.

Non-Recurrent Payments means funding provided by a Party to the Integrated Commissioning Fund in addition to the Budget Contributions pursuant to arrangements agreed in accordance with Clause 10.3.

Overspend means any expenditure from the Integrated Commissioning Fund in a Financial Year which exceeds the budget agreement for that Financial Year.

Performance Payment Arrangement means any arrangement agreed with a Provider and one or more Parties in relation to the cost of providing Services on such terms as agreed in writing by all Parties.

Performance Payments means any sum over and above the relevant Contract Price which is payable to the Provider in accordance with a Performance Payment Arrangement.

Permitted Budget means in relation to a Service, the budget that the Parties have set in relation to the Service or Services (including the budgets for all the commissioning

staff of each Party), such details being included at Schedule 1 (Integrated Commissioning Strategies and Budget Contributions).

Permitted Expenditure has the meaning given in Clause 7.2.

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

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

Pooled Fund Manager means such officer of the Host Partner for the relevant Pooled Fund as nominated by the Host Partner from time to time to manage the Integrated Commissioning Fund.

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

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

Scheme Specification means a specification setting out the detailed arrangements relating to a BCF Service within a Commissioning Plan agreed by the Parties to be commissioned under this Agreement as set out in Part 2 of Schedule 6.

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

Service Specification means a specification setting out the detailed arrangements relating to a Service within a Commissioning Plan agreed by the Parties to be commissioned under this Agreement.

Services mean such health and wellbeing services as agreed from time to time by the Parties as commissioned under the strategies set out in this Agreement.

Services Contract means an agreement for the provision of Services entered with a Provider by one or more of the Parties in accordance with the relevant Commissioning Plan, or, in 2017/18, in accordance with plans previously made by one of the Parties

Service Users means those individuals for whom the Parties have a responsibility to commission the Services.

Task and Finish Group means a group responsible for the operational financial management and reporting for the Integrated Commissioning Fund, as further set out in the Financial Framework.

Third Party Costs means all such third-party costs (including legal and other professional fees) in respect of each Service as a Party reasonably and properly incurs in the proper performance of its obligations under this Agreement and as agreed by the Parties.

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.

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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 Parties shall include their respective statutory successors, employees and agents.

1.5 In the event of a conflict between the terms in the main body of this Agreement, the Schedules, the Financial Framework and the Information Framework, this shall be resolved in the following order of priority (highest first):

1.5.1 the terms in the main body of this Agreement; and

1.5.2 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 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 Parties 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 and shall expire on the Expiry Date, subject to earlier termination in accordance with its terms or at law.

2.2 The duration of the arrangements for each Service shall be as set out in the relevant Services Contract, and the duration of the arrangements for each Scheme Specification (where different to the term of this Agreement) shall be set out within the relevant Scheme Specification.

3. GENERAL PRINCIPLES

3.1 Nothing in this Agreement shall affect:

3.1.1 the liabilities of the Parties 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 Parties 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 The Parties acknowledge that it is a requirement of the Better Care Fund that the CCG and the Council establish a Pooled Fund for the purposes of supporting the integration of health and social care and to seek to achieve the National Conditions and local objectives. The Parties have agreed to establish such a Pooled Fund pursuant to this Agreement and in accordance with the Better Care Fund Plan and the Scheme Specifications. For the avoidance of doubt, the Better Care Fund Plan and the Scheme Specifications (and any requirements therein) shall only apply in respect of the Services commissioned pursuant to those Scheme Specifications. The Parties acknowledge and agree that the Better Care Fund will form part of the Pooled Fund for the purposes of this Agreement, however, only that part of the Pooled Fund will be subject to the requirements in the Better Care Fund Plan.

3.4 The Parties shall comply with their respective obligations as set out in with the Financial Framework and the Information Framework. Any reference to the Financial Framework or the Information Framework is a reference to the Financial Framework or the Information Framework as varied in accordance with Clause 34.2 from time to time.

4. PARTNERSHIP FLEXIBILITIES

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

4.1.1 Integrated Commissioning;

4.1.2 Lead Commissioning Arrangements;

4.1.3 Aligned Commissioning;

4.1.4 the establishment of one or more Pooled Fund;

in relation to the Services (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 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 performing its obligations under this Agreement in conjunction with the Health-Related Functions.

4.4 Where the powers of a Party to delegate any of its statutory powers or functions are restricted, such limitations will automatically be deemed to apply to this Agreement and the Parties shall agree arrangements designed to achieve the greatest degree of delegation to the other Party 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 Parties can secure the provision of health and wellbeing 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 Parties.

5.3 Where the Parties add a new Commissioning Plan to this Agreement it will need to be agreed by both Parties in accordance with the governance arrangements set out in this Agreement and include as a minimum, detail of who will act as the Lead Commissioner, the budget and other resource contributions of each Party.

5.4 The Parties shall not enter a Commissioning Plan unless they are satisfied that the Commissioning Plan in question will improve health and well-being in accordance with this Agreement.

5.5 The introduction of any Commissioning Plans using Pooled Funds will be subject to business case approval by the Integrated Commissioning Board, unless otherwise agreed by the Parties.

5.6 The introduction of Commissioning Plans using Aligned Funds will be subject to business case approval by the Integrated Commissioning Board who will recommend them for approval by the relevant Party or Parties, unless otherwise agreed by the Parties.

5.7 The Parties agree to comply with the governance arrangements in Schedule 2.

6. COMMISSIONING ARRANGEMENTS

6.1 Where there are Integrated Commissioning arrangements in respect of individual Services, both Parties 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 Each Party shall be responsible for compliance with and making payments of all sums due from them to a Provider pursuant to the terms of a Service Contract.

6.3 Both Parties shall work in cooperation and endeavour to ensure that the relevant Services as set out in each Commissioning Plan are commissioned within each Party's Budget Contribution in respect of that Service in each Financial Year.

6.4 The Parties shall comply with the arrangements in respect of the Aligned Commissioning as set out in the relevant Service Specification.

6.5 The Parties shall comply with the obligations set out in Schedule 7 (Exit Planning Obligations).

6.6 Each Party shall keep the other Party and other stakeholders regularly informed, through agreed governance arrangements, of the effectiveness of the arrangements including the Better Care Fund and any Overspend or underspend in a Pooled Fund or Aligned Fund through the agreed governance arrangements.

Appointment and Role of a Lead Commissioner

6.7 From time to time the Parties through the Integrated Commissioning Board shall appoint one of them to act as Lead Commissioner for an Integrated Commissioning Strategy, Commissioning Plan or an individual Service and unless agreed otherwise the Lead Commissioner shall:

6.7.1 exercise the NHS Functions in conjunction with the Health-Related Functions;

6.7.2 endeavor to ensure that the NHS Functions and the Health Related Functions are funded within the parameters of the Budget Contributions of each Party in relation to each Service in each Financial Year;

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

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

6.7.5 comply with all relevant legal duties and guidance of both Parties in relation to the Services being commissioned;

6.7.6 where Services are commissioned using the NHS Standard 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;

6.7.8 put in place appropriate systems, as agreed by the Parties, to make sure that payments of all sums due to a Provider take place pursuant to the terms of any Services Contract;

6.7.9 provide the other Party with information in accordance with the Information Framework; and

6.7.10 keep the other Party and the Integrated Commissioning Board regularly informed of the effectiveness of the arrangements including the Better Care Fund and any Overspend or underspend in a Pooled Fund or Aligned Fund.

7. ESTABLISHMENT OF THE POOLED FUND

7.1 In exercise of their respective powers under Section 75 of the 2006 Act, the Parties have agreed to establish and maintain a Pooled Fund for revenue expenditure as set out in the Commissioning Plan.

7.2 The Pooled Fund shall be managed and maintained in accordance with the terms of this Agreement and it is agreed that monies held in the Pooled Fund (except for the CCG Contingency Funds) may only be used for the Permitted Budget and spent to commission prescribed services (as described in various legislation), services that the Parties agree will contribute to the effective delivery of the prescribed services and Third Party Costs ("**Permitted Expenditure**").

7.3 The Parties may only depart from the definition of Permitted Expenditure to include or exclude other revenue expenditure with the express written agreement of each Party. Failure to reach agreement on such issues may be resolved through the Dispute Resolution Procedure.

7.4 For the avoidance of doubt, monies held in the Pooled Fund may not be expended on Default Liabilities unless this is agreed by both Parties. The CCG Contingency Funds may only be used in accordance with the Financial Framework.

7.5 Pursuant to this Agreement, the Parties agree to appoint a Host Partner for the Pooled Fund who shall be responsible for:

7.5.1 administering the record of the funds contributed to the Pooled Fund on behalf of itself and the other Party;

7.5.2 administering the record of the funds expended by the Parties in relation to the Pooled Fund;

7.5.3 administering a record of the funds contributed and expended by the Parties in relation to Aligned Funds; and

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

7.6 For the avoidance of doubt each Party shall administer its own financial transactions initially within its own accounting ledger and seek reimbursement from the Host Partner out of the Pooled Fund.

8. POOLED FUND MANAGEMENT

8.1 The Parties hereby agree that the Host Partner shall appoint an officer to act as the Pooled Fund Manager for the purposes of Regulation 7(4) of the Regulations, subject to the consent of the other Party (such consent not to be unreasonably withheld).

8.2 The Pooled Fund Manager shall have the following duties and responsibilities:

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

8.2.2 preparing and submitting to the Integrated Commissioning Board bi-monthly reports (or more frequent reports if required by the Integrated Commissioning 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 Parties and the Integrated Commissioning Board to monitor the effectiveness of the Pooled Fund and to enable the Parties to complete their own financial accounts and returns; and

8.2.3 compliance with the obligations set out in the Financial Framework.

8.3 Pursuant to this Agreement, the Parties agree to establishing a Finance Economy Group and a Task and Finish Group, with the composition and responsibilities of such groups further specified in the Financial Framework.

8.4 In carrying out the responsibilities under Clause 8.2 the Pooled Fund Manager shall be accountable to the Parties and have regard to the recommendations of the Finance Economy Group, the Task and Finish Group, and the Integrated Commissioning Board. Furthermore, the Pooled Fund Manager must comply with the Financial Framework and the Information Framework.

8.5 Both Parties acknowledge the importance of ensuring that there is sufficient financial management support for the Integrated Commissioning Fund, and the Chief Financial Officer (or equivalent) of each Party shall be responsible for ensuring this support.

8.6 The Integrated Commissioning Board may agree to the viring of funds within the Pooled Fund (subject to any specific requirements of the Financial Framework).

9. ALIGNED FUNDS

9.1 Any Budget Contributions agreed to be held within an Aligned Fund will be notionally held in a fund established for commissioning that Service as set out in the relevant Commissioning Plan. For the avoidance of doubt, an Aligned Fund does not constitute a pooled fund for the purposes of Regulation 7 of the Regulations, and all non-pooled funds referred to in this Agreement shall be Aligned Funds.

9.2 Where an individual Service is being supported by an Aligned Fund, the Parties agree that responsibility for expending monies from an Aligned Fund shall not be delegated to the Lead Commissioner.

9.3 The Parties shall work together to establish the financial and administrative support necessary to enable the effective and efficient management of an Aligned Fund, meeting all required accounting and auditing obligations.

9.4 Where there are shared Aligned Commissioning arrangements, both Parties shall work in cooperation and shall endeavour to ensure that:

9.4.1 the NHS Functions funded from an Aligned Fund are carried out within the CCG's Budget Contribution to an Aligned Fund for the relevant Service in each Financial Year; and

9.4.2 the Health Related Functions funded from an Aligned Fund are carried out within the Council's Budget Contribution to an Aligned Fund for the relevant Service in each Financial Year.

10. BUDGET CONTRIBUTIONS

10.1 The Budget Contribution of the CCG and the Council to the Pooled Fund and Aligned Funds for the first Financial Year of operation of each individual Service (including details of how such contributions shall be made) shall be as set out in each Commissioning Plan and the Better Care Fund Plan (as relevant).

10.2 Future Budget Contributions going forward will be determined by the Parties, who shall seek to agree such details prior to 31 December of the preceding year and set out in writing on or before the 31 March of the preceding financial year in accordance with the Financial Framework.

10.3 Except for Clause 17, no provision of this Agreement shall preclude the Parties from making additional contributions of Non-Recurrent Payments to the Integrated Commissioning Fund from time to time by agreement. Any such additional contributions of Non-Recurrent Payments shall be recorded in Integrated Commissioning Board minutes and recorded in the budget statement.

10.4 Any grant contributions (or other ring-fenced funding) shall be subject to the relevant conditions that apply and both Parties hereby agree to comply with those conditions.

Non-financial contributions

10.5 Both Parties shall review non-financial contributions toward the Integrated Commissioning Fund including staff, 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) as part of the annual review.

11. CHARGING FOR SERVICES

11.1 The Services provided through this Agreement for which the Council normally charges will continue to attract a charge. There is no intention to increase or expand charging arrangements through this Agreement, although the Council reserves the right to do this at any time.

11.2 All charges will be collected by the Council.

11.3 Care plans will ensure that where a charge is made, it is carefully explained to Service Users at the outset, to avoid any misunderstanding that NHS services are being charged for.

11.4 Decisions about the charging policies to be adopted will rest with the Council. Changes of policy will be reported to the Integrated Commissioning Board. The Council will ensure that written operational policies exist which provide staff with clear guidance on which services are charged for and which are non-chargeable.

11.5 The Council shall be liable for and release and indemnify and keep indemnified the CCG from and against all costs, claims, expenses, demands and liability arising from or as a result of the Council charging forany services.

12. RISK SHARE ARRANGMENTS, OVERSPENDS AND UNDERSPENDS

12.1 The Parties have agreed that the arrangements and obligations as set out in the Financial Framework shall apply to this Agreement.

Overspends in Pooled Funds

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

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

12.4 If the Finance Task and Finish Group identifies an actual or projected Overspend the Pooled Fund Manager must ensure that the Integrated Commissioning Board is informed as soon as reasonably possible.

Overspends in Aligned Funds

12.5 Where either Party forecasts an Overspend in relation to an Aligned Fund, that Party shall as soon as reasonably practicable inform the other Party and the Integrated Commissioning Board.

Risk share arrangements

12.6 The Parties have agreed risk share arrangements which provide for financial risks arising within the commissioning of services from the Pooled Fund and an Aligned Fund; and the financial risk to the pool arising from any payment for performance element of the Better Care Fund.

12.7 If the Integrated Commissioning Fund records an Overspend or underspend in any year, the balance of Overspend is recorded in the Party that holds the statutory responsibility for the function or budget which incurred the Overspend or underspend. The mechanisms for sharing risk and reward are set out in further detail in the Financial Framework.

12.8 Unless the Parties agree to the contrary, where:

12.8.1 any Overspend that is recorded at the end of any Financial Year; or

12.8.2 any Overspend is offset, during that Financial Year, by contributions from fund reserves accumulated in previous Financial Years;

12.8.3 any Overspend is met from the CCG Contingency Funds

the Parties shall be entitled to recover their share of those Overspends, through adjustment to their future Financial Years' contribution to the Integrated Commissioning Fund.

13. INFORMATION FRAMEWORK

13.1 The Parties agree to share information with each other relating to the Services commissioned under Commissioning Plans, in accordance with the Information Framework.

14. PREMISES

14.1 The Parties shall be responsible for providing any premises which are necessary for the commissioning of the Services and, where these requirements are not set out in the relevant Service Specification, they will be agreed by the Integrated Commissioning Board.

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15. PRE-EXISTING CONTRACTS

15.1 Where from time to time the Parties have agreed to appoint a Lead Commissioner for a Service, the Party that is not the Lead Commissioner hereby appoints the other to act as agent to manage the CCG Contracts or the Council Contracts () from the Commencement Date. Each Party shall make available to the other copies of the CCG Contracts or the Council Contracts (as the case may be) to enable the other to carry out its role as agent.

15.2 The Parties may agree that, where necessary, and subject to the relevant contracting party's consent, the rights and obligations of the original contracting Party under the CCG Contracts or Council Contracts (as the case may be) may be transferred to the other Party by way of novation or assignment.

16. GOVERNANCE AND PERFORMANCE MANAGEMENT

16.1 The Parties shall comply with their respective obligations as set out in Schedule 2 (Governance) and Schedule 5 (Performance Arrangements).

17. CAPITAL EXPENDITURE

17.1 Neither Pooled Funds nor Aligned 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 Parties. If a need for capital expenditure is identified this must be agreed by the Parties and the capital expenditure must comply with any applicable grant conditions.

18. VAT

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

18.2 Further detail as to the agreement by the Parties about VAT is set out in the Financial Framework.

19. AUDIT AND RIGHT OF ACCESS

19.1 Both Parties 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 Pooled Fund in accordance with the Regulations and section 7 of the Local Audit and Accountability Act 2014.

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

20. LIABILITIES AND INSURANCE AND INDEMNITY

20.1 Subject to Clause 20.2 and 20.3, if a Party ("First Party") incurs a Loss arising out of or about this Agreement or a Services Contract because of any act or omission of another Party ("**Other Party**") which constitutes negligence, fraud or a breach of contract in relation to this Agreement or a Services Contract then the Other Party shall be liable to the First Party for that Loss and shall indemnify the First Party accordingly.

20.2 Clause 20.1 shall only apply to the extent that the acts or omissions of the Other Party contributed to the relevant Loss. Furthermore, it shall not apply if such act or omission occurred because of the Other Party acting in accordance with the instructions or requests of the First Party or the Integrated Commissioning Board.

20.3 If any third party makes a claim or intimates an intention to make a claim against either Party, which may reasonably be considered as likely to give rise to liability under this Clause 20 the Party that may claim against the other indemnifying Party will:

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

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

20.3.3 give the Other Party 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 to enable the Indemnifying Party and its professional advisers to examine such premises, assets, accounts, documents and records and to take copies at their own expense for assessing the merits of, and if necessary defending, the relevant claim.

20.4 Each Party 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.

20.5 Where a Party is the Lead Commissioner for any Service Contract, it shall ensure that any Provider that they appoint will have adequate insurance (or equivalent indemnity arrangements through schemes operated by the National Health Service Litigation Authority) including but not limited to employer's liability, public liability, professional indemnity insurance and clinical negligence, as appropriate to the services being undertaken by the Provider.

20.6 Each Party 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.

21. STANDARDS OF CONDUCT ANDSERVICE

21.1 The Parties will at all times comply with Law and ensure good corporate governance in respect of each Party (including the Parties' respective constitutions, standing orders, standing financial instructions and codes of conduct).

21.2 The Council is subject to the Best Value Duty. This Agreement and the operation of the Integrated Commissioning Fund is therefore subject to the Council's Best Value Duty and the CCG will co-operate with all reasonable requests from the Council which the Council considers necessary to fulfil its Best Value Duty.

21.3 The CCG is subject to the CCG Statutory Duties and these include a duty of clinical governance, through which it is accountable for securing continuous improvements to 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 Fund are subject to ensuring compliance with the CCG Statutory Duties and clinical governance obligations.

21.4 The Parties are committed to an approach to equality and equal opportunities as represented in their respective policies. The Parties will maintain and develop these policies as applied to service provision, with the aim of developing a joint strategy for all elements of the service.

22. CONFLICTS OF INTEREST

22.1 The Parties shall comply with their respective policies for identifying and managing conflicts of interest. Without prejudice to the generality of this clause, this should include:

22.1.1 any existing conflicts of interest or potential conflicts of interest;

22.1.2 any conflict of interest or potential conflict of interest that may arise in the future;

22.1.3 ensuring that additional employment (paid or voluntary) may not be undertaken by any staff working within this Agreement which conflicts with or is detrimental to any of the Parties' interests, or which in any way weakens public confidence or affects the ability of the Parties to discharge their duties under this Agreement;

22.1.4 providing that each Party shall require that any employee employed as part of this Agreement considers that a conflict of interest exists in relation to their own role or position in connection with this Agreement, they shall notify and request guidance initially from their line manager (who shall inform the Integrated Commissioning Board where necessary);

22.1.5 the Parties shall ensure that their respective policies for managing and identifying conflicts of interest are maintained and where possible, consistent.

22.2 The Integrated Commissioning Board shall maintain a register of conflict of interests.

22.3 In the event of a conflict arising between the Parties' respective policies the matter shall be referred to the Authorised Officers for resolution acknowledging that NHS standards are strictly enforced by NHS England. Should the Authorised Officers be unable to reach a resolution the matter shall be determined as a dispute in accordance with Clause 27.

23. GOVERNANCE

23.1 Section 75 of the 2006 Act states that the partner organisations retain the statutory responsibilities and remain accountable for the prescribed services set out for each in the relevant legislation.

23.2 Overall strategic oversight of the development of Integrated Commissioning is vested in the Council's Cabinet and the CCG's Governing Body, which shall remain the statutory decision making bodies.

23.3 The Health and Well Being Board will provide strategic oversight of partnership working between the Parties and shall make recommendations to the Parties as to any actions it considers necessary.

23.4 The Parties have established the Integrated Commissioning Board to provide oversight and leadership for delivery of Integrated Commissioning.

23.5 The Integrated Commissioning Board is based on a committee in common committee structure. The Integrated Commissioning Board terms of reference are included at Part 2 of Schedule 2. (Governance)

23.6 The Parties will ensure membership is appropriate to carry out the required functions of the Integrated Commissioning Board.

23.7 The senior management and officers delivering Integrated Commissioning will be given sufficient relevant delegated authority to carry out their role.

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

23.9 The Integrated Commissioning Board shall be responsible for making decisions relating to the Pooled Fund where necessary, in accordance with the relevant standing financial instructions and schemes of delegation. The Integrated Commissioning Board shall be responsible for making recommendations to the CCG's Governing Body or the Council's Cabinet or appropriate committee, where necessary, in relation to an Aligned Fund.

23.10 The Integrated Commissioning Board shall be responsible for the overall approval of Commissioning Plans and business cases, save for the approval of BCF Plans, which shall be approved in accordance with the terms set out in Schedule 6 (Better Care Fund Plan)

24. REVIEW

24.1 Save where the CCG's Governing Body and the Council's Cabinet or appropriate committee (as relevant) agrees alternative arrangements (including alternative frequencies) the Parties shall undertake an annual review ("**Annual Review**") of the operation of this Agreement, the Integrated Commissioning Fund and the provision of the Services within three months of the end of each Financial Year. The Integrated Commissioning Board will agree the frequency and scale of any other reviews, monitoring and reporting of activity and the performance of the integrated commissioning function.

24.2 The Integrated Commissioning Board shall within twenty 20 Working Days of the annual review prepare a joint annual report documenting the matters referred to in this Clause 24. A copy of this report shall be provided to the Parties.

24.3 In the event that the Parties fail to meet the requirements of the Better Care Fund Plan and NHS England the Parties shall provide full co-operation with NHS England to agree a recovery plan.

25. COMPLAINTS

25.1 In this Agreement, "complaints" shall include complaints, concerns and comments that come to the attention of the Parties through any source and in any medium; and shall include complaints about any aspect of the Services commissioned and about the function of commissioning.

25.2 The Parties agree that they and the Integrated Commissioning Board will adhere to the relevant policies of the Parties in responding to complaints. Complaints will be handled in accordance with the policies of the most appropriate Party. In the event of there being a dispute over which is the most appropriate Party, the role shall fall to the Lead Commissioner for the Service involved.

25.3 Analysis of the complaints handled by the Parties shall be reported to the Integrated Commissioning Board.

26. TERMINATION

26.1 Either Party may terminate this by giving not less than [nine (9) months'] written notice to the other Party, with the earliest date that such notice can take effect being the first anniversary of the Commencement Date, and thereafter, such notice may only be effective on subsequent anniversaries of the Commencement Date.

26.2 Each of the individual Services may be terminated in accordance with the terms set out i n the relevant Service Contract if the Parties ensure that the Better Care Fund requirements continue to be met, and the obligations under this Agreement are met.

26.3 If any Party (the "**Relevant Party**") fails to meet any of its obligations under this Agreement, the other Party may by notice require the Relevant Party to take such reasonable action within a reasonable timescale as the other Party may specify to rectify such failure. Should the Relevant Party fail to rectify such failure within such reasonable timescale, the matter shall be referred for resolution in accordance with Clause 27.

26.4 Expiry or termination of this Agreement (whether by effluxion of time or otherwise) shall be without prejudice to the Parties' rights in respect of any antecedent breach and the provisions of Clauses 19, 20 and 29.

26.5 Upon expiry or termination of this Agreement for any reason whatsoever the following shall apply:

26.5.1 the Parties 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 Parties is carried out smoothly and with as little disruption as possible to service users, employees, the Parties and third parties,

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so as to minimise costs and liabilities of each Party in doing so, and shall each commit sufficient resource to implement the Exit Plan;

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

26.5.3 the Lead Commissioner shall make reasonable endeavors 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 Party 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 Parties shall have agreed in advance who shall be responsible for any such payment;

26.5.4 where a Service Contract held by a Lead Commissioner relates all or partially to Services which relate to the other Party's Functions then, provided that the Service Contract allows it, the other Party may request that the Lead Commissioner assigns the Service Contract in whole or part upon the same terms mutatis mutandis as the original Service Contract;

26.5.5 the Integrated Commissioning 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

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

26.6 In the event of termination in relation to an individual Service the provisions of Clause 26.5 shall apply mutatis mutandis in relation to the individual Service (as though references as to this Agreement were to that individual Service).

27. DISPUTE RESOLUTION

27.1 The following principles are to be adhered to for any dispute resolution:

27.1.1 The resolution of a dispute under this Agreement must maintain the quality of health and social care provision now and in the future, deliver the best possible outcomes, support innovation where appropriate, make care more cost-effective, and allocate risk fairly.

27.1.2 The resolution of a dispute under this Agreement must promote transparency and accountability. It should hold the Parties to the Agreement accountable to each other and to Service Users and citizens, and facilitate the sharing of appropriate information to achieve the ambition of the Parties.

27.1.3 The Parties must engage constructively with each other within the dispute resolution process when working to reach agreement.

27.2 This dispute resolution process shall operate as follows:

27.2.1 The Parties may refer any disputes arising out of this Agreement to the members of the Integrated Commissioning Board for resolution. If any dispute referred to the Integrated Commissioning Board is not resolved within **14 days** of such referral, either Party, by notice in writing to the other, may refer the dispute to the chief executives (or equivalent) of the Parties, who shall co-operate in good faith to resolve the dispute as amicably as possible within 14 days of service of the notice;

27.2.2 If the chief executives (or equivalent) fail to resolve the dispute within the allotted time, the Parties will attempt to settle it by mediation either: (a) with the Centre for Effective Dispute Resolution ("**CEDR**"); or (b) if agreed in writing by the Parties, with any other alternative mediation organisation, using the respective model procedures of CEDR or such other mediation organisation.

27.2.3 To initiate mediation a Party shall:

27.2.3.1 give notice in writing ("**Mediation Notice**") to the other Party requesting mediation of the dispute; and

27.2.3.2 send a copy of the Mediation Notice to CEDR or an equivalent mediation organisation as agreed by the Parties asking them to nominate a mediator if the Parties are not able to agree such appointment by negotiation.

27.2.4 Neither Party may issue a Mediation Notice until the process set out in Clause 27.2.1 has been exhausted.

27.2.5 The mediation shall commence within twenty eight (28) days of the Mediation Notice being served. Neither Party will terminate such mediation until each Party has made its opening presentation and the mediator has met each Party separately for at least one hour or one Party has failed to participate in the mediation process. The Parties will cooperate with any person appointed as mediator, providing them with such information and other assistance as they shall require and will pay their costs, as they shall determine or in the absence of such determination such costs will be shared equally.

27.2.6 Should either Party dispute the outcome of the mediation process referred to in Clause 27.2.5, the Parties may refer the dispute for final resolution by arbitration. It is agreed that:

27.2.6.1 the tribunal shall consist of one arbitrator agreed by the Parties;

27.2.6.2 in default of the Parties' agreement as to the arbitrator within 14 days, the appointing authority shall be the Chartered Institute of Arbitrators in London;

27.2.6.3 the seat of the arbitration shall be London;

27.2.6.4 the law governing the arbitration agreement shall be English; and

27.2.6.5 the language of the arbitration shall be English.

27.3 Nothing in this Agreement shall prevent either Party seeking from any court any interim or provisional relief that may be necessary to protect the rights or property of that Party or that relates to the safety of Service Users or the security of Confidential Information, pending resolution of the relevant dispute in accordance with the CEDR or other mediation organisation procedure.

28. FORCE MAJEURE

28.1 Neither Party shall be entitled to bring a claim for a breach of obligations under this Agreement by the other Party, or incur any liability to the other Party for any losses or damages incurred by that Party, to the extent that a Force Majeure Event occurs and the Parties agree that such affected Party is / has been prevented from carrying out its obligations by that Force Majeure Event.

28.2 On the occurrence of a Force Majeure Event, the Affected Party shall notify the other Party 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 Party and any action proposed to mitigate its effect.

28.3 As soon as practicable, following notification as detailed in Clause 28.2, the Parties 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 28.4, facilitate the continued performance of the Agreement.

28.4 If the Force Majeure Event continues for a period of more than sixty (60) days, either Party shall have the right to terminate the Agreement by giving fourteen (14) days written notice of termination to the other Party. For the avoidance of doubt, no compensation shall be payable by either Party as a direct consequence of this Agreement being terminated in accordance with this Clause 28.4.

29. CONFIDENTIALITY

29.1 In respect of any Confidential Information a Party receives from another Party (the "**Discloser**") and subject always to the remainder of this Clause 29, each Party (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:

29.1.1 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

29.1.2 the provisions of this Clause 29 shall not apply to any Confidential Information which:

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

29.1.2.2 is obtained by a third party who is lawfully authorised to disclose such information.

29.2 Nothing in this Clause 29 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.

29.3 Each Party:

29.3.1 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

29.3.2 will ensure that, where Confidential Information is disclosed in accordance with Clause 29.3.1, the recipient(s) of that information is made subject to a duty of confidentiality equivalent to that contained in this Clause 29;

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

30. FREEDOM OF INFORMATION AND ENVIRONMENTAL INFORMATION REGULATIONS

30.1 The Parties agree that they will each cooperate with each other to enable any Party receiving a request for information under the 2000 Act or the 2004 Regulations 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 the other Party as appropriate and responding to any requests by the Party receiving a request for comments or other assistance.

30.2 Each Party acknowledges that the other Party is subject to the requirements of the 2000 Act and each Party shall assist and co-operate with the other, at their own expense, to enable the other Party to comply with its information disclosure obligations.

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30.3 Where a Party receives a request for information specifically in relation to a function of the other Party, it shall direct the request for information to the other Party as soon as practicable after receipt and in any event within two Working Days of receiving the request for information.

30.4 Where the request relates to functions of both Parties, the Party receiving the request will share the request with the other Party as soon as practicable after receipt and in any event, within two Working Days and that Party will assist and co-operate with the other as is necessary for it to respond to the request within the time for compliance. If either Party determines that information must be disclosed it shall notify the other Party of that decision at least two Working Days before disclosure. Each Party shall be responsible for determining at its absolute discretion whether the relevant information is exempt from disclosure or is to be disclosed in response to a request for information.

30.5 All agreements between the Parties as to confidentiality shall be subject to their duties under the 2000 Act and 2004 Regulations. No Party shall be in breach of Clause 29 or any other confidentiality clauses or agreements if it makes disclosures of information in accordance with the 2000 Act and/or 2004 Regulations.

31. INFORMATION SHARING AND DATA PROTECTION

31.1 In all instances where the Parties share information with each other; and in the functioning of the Integrated Commissioning Board, the Parties will adhere to the relevant policies and information governance protocols of each Party. In doing so, the Parties will ensure that the operation this Agreement complies with Law, the 1998 Act.

31.2 Subject to the following provisions of this section, and the Information Framework the Parties shall work together to establish effective arrangements to permit and control the exchange of information to support the Integrated Commissioning arrangements.

31.3 Without prejudice to any other provision of this Agreement, each Party shall always comply with the requirements of the 1998 Act in respect of any Personal Data howsoever acquired or processed for the purposes of, or in the operation of, the Integrated Commissioning arrangements and no Personal Data collected or processed for any purposes connected with this Agreement will not be disclosed to any other person otherwise than in strict accordance with the provisions of the 1998 Act.

31.4 Each Party shall ensure that to process any information for the purposes of this Agreement lawfully and fairly in accordance with the first data protection principle that it shall notify the subject of such personal information of the purposes for which it is gathered and for which it may be disclosed. Where necessary, the Parties will obtain the consent of Service Users and other data subjects to disclose personal information to be used for the purposes of this Agreement.

31.5 Any data disclosed by a Party to the other for use in carrying out the purposes of this Agreement will be held and processed strictly in accordance with the 1998 Act and any common law obligation of confidentiality.

31.6 Each Party shall:

31.6.1 keep confidential any information obtained about this Agreement and any Sensitive Personal Data, subject to the 1998 Act;

31.6.2 take appropriate technical and organisational measures against unauthorised or unlawful processing of such personal data and against accidental loss or destruction of or damage to such Personal Data;

31.6.3 only process Personal Data for and on behalf of the other Party, in accordance with the other Party's instructions and for the purposes of this Agreement and to ensure compliance with the 1998 Act; and

31.6.4 allow the other Party to audit its compliance with the requirements of this Clause 31 on reasonable notice and/or to promptly provide the other Party with evidence of its compliance with the obligations set out in this Clause 31.

32. OMBUDSMEN

32.1 The Parties will co-operate with any investigation undertaken by the Health Service Commissioner for England or the Local Government Commissioner for England (or both) about this Agreement.

33. PARTIES/NOTICES

33.1 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 Party shall be as set out in Clause 33. 3 or such other address as each Party may previously have notified to the other Party in writing. A notice shall be deemed to have been served if:

33.1.1 personally delivered, at the time of delivery;

33.1.2 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

33.1.3 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 Party sending the notice) and a hard copy of such notice is also sent by first class recorded delivery post (airmail if overseas) on the same day as that on which the electronic mail is sent.

33.2 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 facsimile was transmitted on a tested line or that the correct transmission report was received from the facsimile machine sending the notice, 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).

33.3 The address for service of notices as referred to in Clause 33. 1 shall be as follows unless otherwise notified to the other Party in writing:

33.3.1 if to the Council, addressed to:

Assistant Director of Commissioning, Hackney Council, Mare Street, E8 1EA [Council to confirm]; and

33.3.2 if to the CCG, addressed to:

Chief Officer, NHS City and Hackney CCG, 3rd Floor, Block A, St Leonard's Hospital, Nuttall Street, London N1 5LZ

34. VARIATION

34.1 Subject to Clause 3 4. 2, no variations to this Agreement will be valid unless they are recorded in writing and signed for and on behalf of each of the Parties.

34.2 The members of the Integrated Commissioning Board may choose to exercise their delegated powers on behalf of their employer organisation (which, for the avoidance of doubt, in each case must either be the CCG or the Council) to:

34.2.1 agree the addition of Commissioning Plans or Integrated Commissioning Strategies to this Agreement following the approval of a detailed business case by each of the Parties; and/or

34.2.2 consider the Annual Review of this Agreement pursuant to Clause 24 and implement agreed changes following the review; and/or

34.2.3 vary the Financial Framework, subject to the written approval of each of the Parties; and/or

34.2.4 vary the Information Framework, subject to the written approval of each of the Parties.

35. CHANGE IN LAW

35.1 The Parties 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 any Laws.

35.2 On the occurrence of any Change in Law, the Parties shall agree in good faith any amendment required to this Agreement because of the Change in Law subject to the Parties 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.

35.3 In the event of failure by the Parties to agree the relevant amendments to the Agreement (as appropriate), the Clause 27 (Dispute Resolution) shall apply.

36. WAIVER

36.1 No failure or delay by any Party 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.

37. SEVERANCE

37.1 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.

38. ASSIGNMENT AND SUB CONTRACTING

38.1 The Parties shall not sub contract, assign or transfer the whole or any part of this Agreement, without the prior written consent of the other Parties, 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 Party's statutory functions.

39. EXCLUSION OF PARTNERSHIP AND AGENCY

39.1 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 Parties or render either Party directly liable to any third party for the debts, liabilities or obligations of the other.

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

39.2.1 act as an agent of the other;

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

39.2.3 bind the other in any way.

40. THIRD PARTY RIGHTS

40.1 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.

41. ENTIRE AGREEMENT

41.1 The terms herein contained together with the contents of the Schedules, including the Financial Framework and the Information Framework, constitute the complete agreement between the Parties 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 Party.

41.2 The Parties acknowledge that there was an unsigned agreement relating to section 75 arrangements for learning disability services that had been circulated between the Parties. For the avoidance of doubt, that unsigned agreement is not in force and the content of this Agreement with regard to learning disability services prevails.

42. COUNTERPARTS

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

43. GOVERNING LAW AND JURISDICTION

43.1 This Agreement and any dispute or claim arising out of or about 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.

43.2 Subject to Clause 27 (Dispute Resolution), the Parties 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 arise out of, or about, this Agreement, its subject matter or formation (including non-contractual disputes or claims).

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IN WITNESS, WHEREOF this Agreement has been executed as a Deed by the Parties on the date of this Agreement

Executed as a Deed by affixing the common seal of **LONDON BOROUGH OF HACKNEY**

in the presence of:

………………………
Authorised Signatory

………………………
Authorised Signatory

Executed as a Deed by affixing the common seal of **NHS CITY AND HACKNEY CLINICAL COMMISSIONING GROUP**

in the presence of:

………………………
Authorised Signatory

………………………
Authorised Signatory

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SCHEDULE 1 – INTEGRATED COMMISSIONING STRATEGIES AND INDICATIVE BUDGET CONTRIBUTIONS

PART ONE –INTEGRATED COMMISSIONING STRATEGIES

The Integrated Commissioning Strategy is the joint commissioning between the CCG and the Local Authority. The Locality Plan is being developed and will form the detail and basis of the Integrated Commissioning Strategy. The four priority areas of the Locality Plan are:

- Children & Young People
- Planned care
- Prevention
- Unplanned care

Four work streams are being established for these priority areas to review current plans and services, identify areas for improvement and test out their potential impact. Pooled Funds are connected to each of these priority areas.

Each work stream will report to the Transformation Board. The Transformation Board is made up of the local system leaders and is responsible for developing and delivering improvement plans and making recommendations to the Integrated Commissioning Board for decision.

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SUMMARY OF SERVICES INCLUDED WITHIN THE INTEGRATED COMMISSIONING FUND 2017/18			
Section 75 Services			
Service Area (Work stream)	**Contract Type**	**2016/17 Budget £'000**	**2017/18 Budget £'000**
1. City & Hackney CCG			
Unplanned Care (BCF)	Section 75	4,805	TBC in Feb
Unplanned Care (non BCF)	NHS contracts and Alliance contracts	89,056	TBC in Feb
Unplanned Care Total		93,861	#VALUE!
Planned Care (BCF)	NHS contracts and Alliance contracts	13,915	
Planned Care (non BCF)	NHS contracts and Alliance contracts	169,773	TBC in Feb
Prevention (non BCF)	NHS contracts and Alliance contracts	5,309	TBC in Feb
Children/Young people	NHS contracts and Alliance contracts	42,563	TBC in Feb
	City & Hackney CCG Total:	**325,421**	**#VALUE!**
2. London Borough of Hackney			
Unplanned Care		6,126	6,126
Planned Care		67,662	65,500
Planned Care (via DFG Capital)		1,185	1,185
Prevention		36,277	35,416
	London Borough of Hackney Total:	**111,250**	**108,227**
Grand Total Section 75 Services including Efficiencies/QIPP		**436,671**	**#VALUE!**
Aligned Services			
1. City & Hackney CCG			
Non-excisable* health services	NHS contracts contracts	21,843	TBC in Feb
Corporate, Support and reserves		30,972	TBC in Feb
	City & Hackney CCG Total:	**52,815**	**#VALUE!**
2. London Borough of Hackney			
Non-excisable* social care services (income)		(5,609)	(5,726)
	London Borough of Hackney Total:	**(5,609)**	**(5,726)**
Grand Total Aligned Services including Efficiencies/QIPP		**47,206**	**#VALUE!**
In Collaboration Services			
1. City & Hackney CCG			
Primary care co-commissioning		-	TBC in Feb
	City & Hackney CCG Total:	-	**TBC in Feb**
Grand Total In Collaboration Services including Efficiencies/QIPP		**0**	**TBC in Feb**
Grand Total Integrated Commissioning Fund including Efficiencies/QIPP		**483,877**	**#VALUE!**

Notes

1. 2017/18 budget figures are expected in February and the above tables will be updated accordingly.
2. CCG budget split between Hackney and City of London patientsis based on proportion of GP registered patients for each local authority of the total [97% for Hackney and 3% for City of London) except where services are specifically commissioned for City or Hackney residents such as some of the services in the BCF.
3. The above tablesshowing pooled budgetsfor each organisation are shown at summary (workstream) level however, these summary documents are underpinned by service/contract level detail, a record of which isheld by each partner
4. The CCG pooled budgets do not in clude the following services which are not excisable under S75 :
    a. Surgery
    b. Endoscopy
    c. Termination of Pregnancies
    d. Radiotherapy
    e. Laser treatments
    f. Emergency Ambulance Services
5. The Local Authority pooled budgetsfor Adult Social Care and Public Health, do not include the following services which are not exercisable under S75:
    a. power to charge for services (see Aligned Income budget)

PART TWO – INDICATIVE BUDGET CONTRIBUTIONS

[NOTE: This will set out the budget contributions of the Parties for financial year 2017/2018, including:

- **details of the indicative contributions to the Pooled Fund;**
- **details of the indicative contributions to an Aligned Fund;**
- **details of staff and other administrative recharges.]**

PART THREE – ALIGNED FUNDS

The Aligned Funds for both parties are per below:

1. **CCG Aligned Funds:**

   This is comprised of commissioned services not ex ercisable under the Partnership Regulations as well as the CCG corporate management and support services commissioned services not exercisable under the Partnership Regulations:

   a. Surgery (the CCG has excluded Elective Surgery)
   b. Endoscopy
   c. Termination of Pregnancies
   d. Radiotherapy
   e. Laser treatments
   f. Emergency Ambulance Services

   Corporate management & support services: Include all management, administrative and support services such as contract management and finance, and, estates & facilities services.

2. **Local Authority Aligned Funds:**

   This comprises of income budgets arising out of local authority power to charge for services.

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SCHEDULE 2 – GOVERNANCE

PART ONE – OVERVIEW

1. The clinical and care principles by which the Pooled Fund will be operated will be overseen by the Integrated Commissioning Board. The Integrated Commissioning Board shall constitute committees in common of the Parties, and once the Partnership Regulations have been appropriately clarified, the Integrated Commissioning Board will constitute a Joint Committee of the CCG and the Council in compliance with the Local Government Act 1972 and the 2006 Act, which permit the creation of a joint committee.

2. The Integrated Commissioning Board represents the interests of both Parties in securing improved operation of the local health economy.

3. The Integrated Commissioning Board will set out the key priorities and principles for the Pooled Fund through which improvements to clinical and care outcomes and to financial sustainability will be secured.

4. Decisions to pool funding and management of Services or commissioning areas will be made by the Integrated Commissioning Board.

5. Decisions to deploy funds from the CCG Contingency Fund will require the written authorisation of the CCG's Chief Financial Officer.

6. The management of the Integrated Commissioning Fund is facilitated via the Pooled Fund Manager, the Finance Economy Group and the Task and Finish Group, as further set out in the Financial Framework.

7. As the Health and Wellbeing Board includes representatives of a number of organisations (including providers) who are not statutory commissioners of local health and care services, it is not appropriate to require the Health and Wellbeing Board to take decisions relating to the Pooled Fund. The Health and Wellbeing Board will however be kept informed of the performance of the Integrated Commissioning Fund.

PART TWO – TERMS OF REFERENCE OF INTEGRATED COMMISSIONING BOARD

[NOTE: The agreed Terms of Reference for the Integrated Commissioning Board will be inserted here]

PART THREE – TERMS OF REFERENCE OF THE TRANSFORMATION BOARD

[NOTE: The agreed Terms of Reference for the Transformation Board will be inserted here]

PART FOUR - STRUCTURE DIAGRAM OF THE GOVERNANCE ARRANGEMENTS

[NOTE: The completed structure diagram of governance arrangements will be inserted here]

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SCHEDULE 3 – FINANCIAL FRAMEWORK

[Note: The financial framework will be inserted in due course.]

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SCHEDULE 4 – INFORMATION FRAMEWORK

1. Background

This Information Framework provides guidelines as to the level of information to be shared between the Parties, for the purposes of facilitating effective Integrated Commissioning.

The Parties shall share information relating to the commissioning of Services by way of Services Contracts with Providers when acting as Lead Commissioner.

The Parties will also share information to help better understand financial issues that may be arising with regard to a Service Contract.

Whilst complying with their respective obligations under this Information Framework the Parties acknowledge and agree that any information sharing contemplated by this Information Framework shall take place subject to the terms of the Agreement, and specifically:

i) Clause 6.7.9 of the Agreement, which sets out the obligation for the Lead Commissioner to provide the other Party with information as set out in this Information Framework; and
ii) Clause 31 (Information Sharing and Data Protection).

2. Interpretation

In this Information Framework:

i) the notification or provision of information to a receiving Party shall mean notification or provision of the information by the Lead Commissioner to that Party's Authorised Officer; and
ii) references to any definitions, information or circumstances shall include references to the equivalent definitions, information or circumstances where the Lead Commissioner is entered into a contract by way of Council Contract, CCG Contract or otherwise.

3. Variations

This Information Framework and the Parties' obligations contained herein may be varied in accordance with Clause 34.2.4 of the Agreement.

4. Obligations as Lead Commissioner

The capitalised terms used in this section are, except for where provided for in the Agreement, defined terms under the NHS Standard Contract, and shall be interpreted accordingly.

Notifications

Each Party acknowledges and agrees that where it is Lead Commissioner for any Service Contracts it shall notify the other Party:

If it receives or serves any of the following:

- a Change in Control Notification;
- a Notice of an Event of Force Majeure;
- a Contract Performance Notice;
- a Service Variation;
- a Variation;
- a notice in relation to a Suspension Event;
- an Exception Report;
- a Remedial Action Plan or Immediate Action Plan;
- notice of the appointment of an Auditor;
- a Material Sub-Contractor Change in Control;
- notice of a request for information under the FOIA, EIR or DPA (subject access request);

- notice in relation to the Health Service Ombudsman;

If it becomes aware of one of the following events occurring:

- a material breach of the Provider or Commissioners obligations under the Service Contract;
- a Suspension Event;
- a Provider Insolvency Event;
- a change in Consents;
- a Provider committing a Prohibited Act;
- a Data Breach or any Information Governance Breach;
- any circumstances that have a material and adverse effect on the ability of the Provider to provide the [Services] AND/OR [Essential Services];
- any Provider default or Commissioner default (as contemplated by GC17.9 and GC 17.10 of the NHS Standard Contract);
- any breach of confidentiality obligations;
- any Information Breach;
- any publicity, coverage or publications which will both substantially and materially have a negative impact on either Party's or the Provider's reputation in relation to the Services or in the opinion of the Service Users

and provide information where requested by the other Party, in relation to the notification.

Disputes

The Lead Commissioner shall:

- advise the other Party 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 Parties as part of that process; and
- notify the other Party of the outcome of any Dispute that is agreed or determined by Dispute Resolution.

Consultation

The Lead Commissioner shall consult with the other Party before attending:

- an Activity Management Meeting;
- a Contract Management Meeting; and
- a Review Meeting; and
- a Joint Activity Review;

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

Reports and Record Provision

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).

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

- CQUIN Performance Reports;
- CQUIN Reconciliation Accounts;
- Essential Services Continuity Plans;
- Immediate Action Plans;
- Incident Response Plans;
- JI Reports;
- Joint Activity Reviews;
- Succession Plans;

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- Transition Arrangements;
- Review Records;
- Remedial Action Plans;
- Quality Requirements;
- Service Quality Performance Report;
- Safeguarding Policies;
- Activity Management Plans;
- Data Quality Improvement Plan (DQIP);
- Service Development and Improvement Plan (SDIP);
- Auditor's draft report;
- Auditor's Final Report; and
- HCAI Reduction Plan

Restrictions

The Lead Commissioner shall not:

- permanently or temporarily withhold or retain monies pursuant to the Withholding and Retaining of Payment Provisions;
- vary the Data Quality Improvement Plan (DQIP), Service Development and Improvement Plan (SDIP), Remedial Action Plan, Immediate Action Plan [or any other Provider plans];
- agree (or vary) the terms of a Joint Investigation or associated Immediate Action Plan;
- suspend all or part of the Services;
- serve any notice to terminate the Service Contract (in whole or in part);
- agree (or vary) the terms of a Succession Plan or Transfer Arrangements,
- agree any substantive changes to the Service Contract in relation to an Auditor's final report;
- give any approvals under the Service Contract;
- agree to, or propose, any variation to the Service Contract (including any Schedule or Appendices);
- serve any notice.

without the prior approval of the other Party (acting through the Integrated Commissioning Board), such approval not to be unreasonably withheld or delayed.

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SCHEDULE 5 – PERFORMANCE ARRANGEMENTS

1. INTRODUCTION

This Agreement between the Council and the CCG establishes a framework for joining together the commissioning, provision, finances, performance management, and governance for the Services covered by the Agreement.

This Schedule outlines the arrangements for the performance management framework for the Agreement.

2. PURPOSE

This Schedule aims to ensure that Parties adopt an integrated performance management framework to ensure they plan, deliver, review and act on relevant information to commission improved outcomes for the people of the London Borough of Hackney.

This approach will ensure that the actions and investment of Parties will lead towards the achievement of national, regional and local performance targets as well as improving outcomes for the people of the London Borough of Hackney.

3. DEFINITION

Performance management is the overall process that integrates planning, action, monitoring and review. Performance management means knowing:

- What you are aiming for (e.g. purpose, mission, corporate aims, strategic goals etc.);
- What you have to do to meet these aims (e.g. business plan, project plan etc);
- What the priorities are, and ensuring that there are sufficient resources (inputs);
- What the current performance is through monitoring and reporting; and
- How to review progress, detect problems and take action in a timely manner to ensure the outcome/target is achieved.

4. BENEFITS

Effective performance management enables relevant staff throughout the partnership to:

- Be clear what the strategic objectives are for commissioning; and
- Be clear what outcomes are to be delivered in any one Financial Year,

thereby ensuring better quality Services are delivered to local people.

5. OUTLINEFRAMEWORK

Essentially, the performance management framework consists of three processes in relation to joint commissioning, as set out below.

5.1 BUSINESSPLANNING PROCESS

5.1.1 Commissioning Plans that state the strategic objectives and key performance measures for a period of three to five Financial Years, and commissioning intentions for those objectives with timescales for achievement.

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5.1.2 Services Contracts that state how performance will be monitored, reported, reviewed and necessary action taken, including performance indicators.

5.2 REPORTING AND REVIEW PROCESS

5.2.1 Overall progress against delivery of the outcomes in the Commissioning Plans.

5.2.2 Overall progress against delivery on the Services Contracts and identification of reasons for under performance.

5.3 PERFORMANCE IMPROVEMENT PROCESS

5.3.1 Ensuring action is taken where the continuation of current performance would lead to an outcome/target not being met.

5.3.2 Application of a range of tools and techniques to improve overall performance.

6. FRAMEWORK DETAIL

6.1 BUSINESS PLANNING PROCESS

6.1.1 It is the responsibility of the Parties to develop, and annually review, a Commissioning Plan on a rolling three financial year basis for the particular Service to be commissioned. Each strategy will be developed by adherence to the 'commissioning cycle' and in consultation with Service Users and carers.

6.1.2 It is the responsibility of the Parties to develop an annual Commissioning Plan. This Commissioning Plan will state the outcomes to be achieved, by when and what the risks are if they are not achieved.

6.1.3 Each outcome in the Commissioning Plan should be aligned to one of the strategic objectives. Any outcome that is not so aligned should be reviewed as to why it is being considered.

6.1.4 The relevant Party (whichever Party is agreed to be the Lead Commissioner for the relevant Services Contract) should then go through a process of developing, negotiating and agreeing a Services Contract with each Provider regarding the outcomes they are to deliver. It will be clear which Services are to be discontinued e.g. in the advent of a budget reduction.

6.2 Services Contracts with Providers should:

6.2.1 Take account of the requirements of the Better Care Fund Plan (if applicable) and the agreed Commissioning Strategies and annual plans of the Council and the CCG;

6.2.2 Take account of legislative changes; and

6.2.3 Include a requirement on the Provider to develop a detailed service plan (e.g. stating what, by when, by who and the risk associated with not achieving the outcome) as to how the Provider intends achieving the said outcomes. It should also require the Provider to regularly measure progress against achieving the outcomes, to report this to the Lead Commissioner in a timely manner to an agreed frequency (e.g. monthly), and to provide a Performance Improvement Plan or Recovery Plan where financial under performance is significantly under target.

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6.2.4 Include a process whereby outcomes may be added / removed as a result of changing needs.

6.3 REPORTING AND REVIEW PROCESS

6.3.1 Regular meetings should be held between the Host Partner and the Provider to review performance.

6.3.2 The Lead Commissioner will monitor Services, as part of a basket of measures that contribute to the delivery of key outcome, having regard to national, regional and local key performance indicators including:

6.3.2.1 National ASCOF Measures;

6.3.2.2 BCF Indicators (where relevant);

6.3.2.3 Audit and inspection recommendations;

6.3.2.4 Relevant Operational Plan indicators; and

6.3.2.5 NHS Operating Framework targets.

6.3.3 These key indicators form part of a basket of performance measures. Activity and Financial indicators will be another part of the complete basket.

6.3.4 The basket of performance indicators will be monitored and reported to the Integrated Commissioning Board using, wherever possible, existing performance reports generated within either the Council or the CCG, and making it clear where the areas of good performance and those of concern are, i.e. using a simple traffic light scheme with exception reporting on the key issues.

6.3.5 The performance of all Providers should be reported, on a regular basis by the relevant Partner to the [Integrated Commissioning Board / Health and Wellbeing Board].

6.4 PERFORMANCE IMPROVEMENT PROCESS

Where necessary the Lead Commissioner should require the Provider to undertake specific performance improvement initiatives where performance is significantly under target.

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SCHEDULE 6 – BETTER CARE FUND PLAN

BACKGROUND

The Parties acknowledge that the Better Care Fund for 2017-19 is to be agreed, and the details of the Better Care Fund Plan, Scheme Specifications and BCF Reporting Requirements and Governance will be included in this Schedule following a formal variation agreed by the Parties.

The Better Care Fund will form part of the Pooled Fund, however the Parties acknowledge and agree that the Pooled Fund will not be subject to the BCF Reporting Requirements and Governance – only the Better Care Fund elements of the Pooled Fund will be subject to those terms. For the avoidance of doubt, the Pooled Fund shall not be considered to constitute the Better Care Fund, however the Better Care Fund will be an element of the Pooled Fund.

PART ONE – BETTER CARE FUND PLAN

The Parties agree that the Better Care Fund Plan will be inserted into this Part One once formally agreed by way of a variation to this Agreement.

PART TWO – SCHEME SPECIFICATIONS

The Parties agree that the Better Care Fund Scheme Specifications will be inserted into this Part Two once formally agreed by way of a variation to this Agreement.

PART THREE – BCF REPORTING REQUIREMENTS AND GOVERNANCE

The Parties agree that the BCF Reporting Requirements and Governance will be inserted into this Part Three once formally agreed by way of a variation to this Agreement.

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SCHEDULE 7 – EXIT PLANNING OBLIGATIONS

1. Within six (6) months from the commencement of this Agreement the Parties shall prepare an Exit Plan, which shall be mutually agreed by the Integrated Commissioning Board.

2. The agreed Exit Plan will be signed as approved by each party.

3. The Exit Plan shall provide comprehensive plans for the activities and the associated liaison and assistance which will be required for the successful unwinding of the Agreement.

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FINANCIAL FRAMEWORK

Between

City and Hackney Clinical Commissioning Group and

London Borough of Hackney

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Defined Terms

Defined terms in this Financial Framework shall have the same meaning as those give in the s75 Agreement. A selection of such defined terms (as well as other defined terms relevant for the Financial Framework) are included below for ease of reference:

Aligned Fund means budgets for commissioning prescribed services (as set out in Schedule 1 of the s 75 Agreement) which will be managed alongside the Pooled Fund.

CCG – City and Hackney Commissioning Group, one of two partners to the Integrated Commissioning Fund and the s75 agreement

Council – London Borough of Hackney, one of two partners to the Integrated Commissioning Fund and the s75 agreement

DH – Department of Health

Financial Framework – (this document) describes the ground rules under which the financial decisions relating to the Integrated Commissioning Fund will be made.

Health and Wellbeing Board – established as a Council committee under s194 of the Health and Social Care Act 2012, the purpose of which is to promote more joined up delivery of services and involves oversight of achievement of the objectives of the integrated commissioning function; and oversight of proper governance of the integrated commissioning function

Integrated Commissioning Board – Committee in Common which has delegated decision making authority from CCG and Council to make decisions binding on both parties on use of the Integrated Commissioning Fund in accordance with its terms of reference and the s75 agreement.

Integrated Commissioning Fund means the total of the Pooled Fund and Aligned Fund.

Partners – the CCG and the Council are partners to the s75 agreement and the Integrated Commissioning Fund.

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

Pooled Fund Host means the Partner that will host and provide the financial administrative systems for the Pooled Fund and undertake to perform the duties for which they will be responsible, as set out in paragraph 7(4) and 7(5) of the Regulations

Section 75 agreement (s75) – section 75 of the NHS Act 2006: the legislation that allows the establishment of pooled funds between NHS bodies and local authorities at a local level.

SoDA – scheme of delegation of authorities, or equivalent, of the CCG, the Council and the Integrated Commissioning Board.

Transformation Board – means the Transformation Board set up in accordance with Terms of Reference included in the s75

Terms of the Financial Framework

1. Consultation and approval

1.1 The process for consulting on management and oversight of the Integrated Commissioning Fund and the Section 75 agreement (s75) agreement will include, as a minimum:

- Approval of the CCG (Governing Body)

- Approval of the Council

1.2 This Financial Framework is to be reviewed on an annual basis and may be varied in accordance with the provisions of the s75 agreement.

1.3 The process of consultation for the Financial Framework will be aligned with the development of the s75 agreement and the arrangements for the development of the Integrated Commissioning Fund. It forms a Schedule to the s75 agreement.

1.4 Approval of the inaugural Financial Framework will be by:

- the CCG (Governing Body)
- the Council (Executive Cabinet)

2. Frequency of review and renewal

2.1 This Financial Framework will be reviewed and revised, as necessary on an annual basis. This review will involve the designated financial leads and governance leads of both Partners. The Integrated Commissioning Board will recommend approval of the reviewed Financial Framework to the:

- The CCG (Governing Body)
- The Council (Executive Cabinet).

2.2 The Partners may, at some point in the future, agree to extend the period between formal review and variation of the Financial Framework. Any changes will be subject to approval as above.

2.3 Detailed guidance about specific aspects of this Financial Framework may be issued from time to time. This guidance will be approved by the Integrated Commissioning Board, or by specific groups or individuals as delegated.

3. Scope of this Financial Framework

3.1 This Financial Framework lays out the general rules and sets the scope for the management and expenditure of public sector funds originating from NHS and Local Government sources.

3.2 It supports the relationship between the Partners via the Section 75 Agreement and the use of Aligned Funds. It:

- Provides detail of the framework of the formal relationship with regard to the management of the Integrated Commissioning Fund;
- Sets the expectation that the Partners will continue to work closely together; and with Providers, to ensure that the best quality care is provided and best value is achieved in the use of resources;
- Recognises the statute and regulations under which the Pooled Fund is established i.e. section 75 of the National Health Services Act 2006 and NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000.

3.3 This Financial Framework sets out the requirements and makes provision for governance and accountability of:

- The Integrated Commissioning Fund;
- Authorities and responsibilities delegated from the Partners

- Financial planning and management responsibilities;
- Budgeting and budgetary control, including forecasting.

3.4 This Financial Framework identifies the responsibilities of each Partner to:

- Support and facilitate the achievement of the objectives of the Integrated Commissioning Fund;
- Ensure that the objectives and functions of the Partners and of the Integrated Commissioning Fund are complementary and mutually supportive;
- Ensure due diligence and appropriate oversight of financial decisions;
- Ensure the achievement of the Partners' objectives.

Responsibilities

4. Partner responsibilities

4.1 The Partners have stated their commitment to developing Integrated Commissioning whilst ensuring the financial health of both Partners; and of other organisations in the local health and wellbeing economy.

4.2 The Partners recognise their obligation to comply with statute and regulations.

4.3 The Partners recognise that each Partner's ultimate responsibility for service provision and delivery is not changed. However, they will delegate decision making and administration, where this improves the way that services are commissioned and where it is feasible.

4.4 The Partners recognise specific responsibilities regarding services included within Integrated Commissioning:

- Obligations and commitments to the residents of; and patients registered within London Borough of Hackney;
- Obligations to the Provider community; delivering pace of change whilst creating a sustainable provider market.

5. Responsibilities of the Partner organisations' leadership

5.1 The Partners will agree and approve the strategic objectives for Integrated Commissioning. They will:

- Set the strategic objectives for the Partner organisation;
- Seek assurance that these are incorporated within the strategic priorities for Integrated Commissioning;
- Ensure that strategic objectives for integrated commissioning will be progressed through 2017/18 and annually thereafter, in line with the business planning timetable.

5.2 The Partners will approve the policy and performance framework (business plan) for Integrated Commissioning and will:

- Ensure the adequacy of the Integrated Commissioning function's business plan and alignment with the partners' plans
- Approve the adequacy of organisation, staffing and management of Integrated Commissioning
- Aim to have a harmonised business planning and monthly reporting timetable by Q1 of 2017/18

and going forward, such a timetable shall be available by Q3 of the preceding financial year.

5.3 The Partners will approve the authority and governance framework for Integrated Commissioning, including:

- Approving the key governance documents (where these are different from the Partner organisations' documents);
- Approve the use of the relevant Partners Standing Orders, Standing Financial Instructions, Schedule of Decisions Reserved, Scheme of Delegated Authorities etc. The Partners will endeavour to unify these where appropriate;
- Ensuring the performance of the Pooled Fund is scrutinised regularly and appropriately;
- Delivering scrutiny and pre-approval of significant new programmes and projects.

Governance documents are to be reviewed in accordance with what is specified within the relevant terms of reference (at least).

6. Responsibilities of the Partner organisations' Authorised Officers and Chief Financial Officers

6.1 Authorised Officer

6.1.1 Each Partner is required to appoint a member of the senior management team to be the Authorised Officer for their organisation.

- Signing approval of certain changes to the s75 Agreement (as identified in the s75 Agreement);
- Ensuring the record of minutes of meeting of the Integrated Commissioning Board is maintained.

6.1.2 The scope of these roles will be subject to the delegations approved by each Partner.

6.1.3 Authorised Officers are to be members of the Integrated Commissioning Board.

6.2 Chief Financial Officer

6.2.1 The overriding responsibility of the Chief Financial Officers will be to gain assurance as to the satisfactory standard of financial management, accounting and reporting of the Integrated Commissioning Fund. Each Chief Financial Officer will:

- Ensure that the Integrated Commissioning arrangements are appropriate and sufficiently secure to safeguard public funds;
- Ensure that financial governance and internal controls conform to the requirements of regularity, propriety and good financial management; sufficient to deliver successful operations;
- Ensure that reporting of Integrated Commissioning on strategic, operational and financial performance, budgetary control and risk management is adequate and reliable.

6.2.2 The Council Chief Financial Officer will ensure that the specific obligations of the s151 officer are delivered in respect of transactions involving the funds of the Council.

6.2.3 The Chief Financial Officer of each Partner will ensure the adequacy of arrangements to deliver new services, programmes and projects.

6.2.4 The Chief Financial Officer of each Partner will report assurance to their respective Audit Committees.

6.2.5 The Chief Financial Officers shall operate any risk sharing pooling arrangement and management of any contingency sums as specified in this Framework.

7. Responsibilities of the Host Partner

7.1 The decision on the appointment of the Host Partner is agreed by both Partners, after assessment of the relative merits of each holding the role. **For the Pooled Fund the Council has been appointed as the Host Partner.** This appointment will be reviewed periodically and may be re-assessed in the light of developments at each Partner or determined by external developments.

7.2 The scope of role of the Host Partner is determined, in the first instance, by the decision to seek to minimise organisational change resulting from the development of the Integrated Commissioning arrangement. As a minimum, the Host Partner will deliver the regulatory requirements:

- Appoint the Pooled Fund Manager;
- Deliver the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 7(4) and 7(5) requirements:
  - Accounts and audit
  - Managing the fund
  - Reporting to the partners and reporting frequency
  - Exercise NHS and health-related functions

8. Responsibilities and role of the Pooled Fund Manager

8.1 The Pool Fund Manager is appointed by the Host Partner in accordance with requirements of the Section 75 Agreement and associated regulations.

Management of the Pooled Fund

8.2 Financial management of the Pooled Fund will be overseen by the Partners' Chief Financial Officers (CFOs) or equivalent.

8.3 The CFOs will lead a 'Finance Economy Group' comprising also of the Partners' CFOs. This group will be responsible for the strategic financial management of the Pooled Fund

8.4 A 'Task and Finish' group comprising of the Partners' deputy CFOs (or equivalent) will be responsible for the Pooled Fund operational financial management and reporting.

8.5 A summary of the responsibilities of the Finance Economy Group and Task and Finish Group are set out in the table below:

Finance Economy Group	Task and Finish Group
Maintaining an overview of all joint financial issues affecting the Parties in relation to the Services and the Pooled Fund.	Ensuring that all expenditure from the Pooled Fund is in accordance with the provisions of this Agreement and the relevant Commissioning Plans.

Finance Economy Group	Task and Finish Group
Ensure arrangements are in place in order that the Task and Finish Group provides all necessary information in time for the reporting requirements to be met.	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.
Ensuring action is taken to manage any projected under or overspends relating to the Pooled Fund in accordance with the s75 Agreement.	Reporting to the Parties as required by the Integrated Commissioning Board and the relevant Commissioning Plans.
	Preparing and submitting reports to the Health and Wellbeing Board as required by it

8.6 The CFOs have responsibility for ensuring the Pooled Fund is adequately resourced in terms of finance support.

9. Termination of the Section 75 Agreement

9.1 The options for terminating the Section 75 Agreement are set out within the Section 75 Agreement.

9.2 This Financial Framework identifies the scale of risks that both Partners will accept, before considering the need to reduce the scale of the Integrated Commissioning Fund and/or terminate the Section 75 Agreement.

9.3 The Partners will agree mechanisms for entering emergency arrangements to reverse adverse trends, including:

- protocol for suspending the Host Partner's management arrangements for the Pooled Fund;
- structure of governance and management of the Section 75 Agreement or this Financial Framework in emergency measures.

9.4 The Partners agree that in the event that the financial forecast expenditure for the Integrated Commissioning Fund will exceed available resources (after application of any contingencies), a remedial action plan must be agreed by the ICB within 4 weeks and signed off by the two CFOs as providing assurance it will bring the fund back in to balance.

10. Cessation of the Pooled Fund

10.1 Where the Pooled Fund is to be ceased, due to the termination of the Section 75 Agreement, the Partners must (amongst other obligations) comply with the Exit Plan. This may include considering the ownership of assets, and where particular liabilities and commitments will be apportioned. If the relevant Partner is not clearly identified, ownership will fall to the Partner acting as the Lead Commissioner. This applies to:

- Ownership of invested assets;
- Ownership of consequential service obligations.

10.2 Where the Section 75 Agreement is to be terminated due to the financial failure of one or both of the Partners, the Partners will agree the stages for realising the losses accumulated by the Pooled Fund. The stages are:

- apportionment of financial risk;
- allocation and apportionment of financial risk as agreed between Partners;
- agreement of continuation of Services to Service Users.

The Partners acknowledge that they are public authorities, however "financial failure" in this context is interpreted to mean where the organisation is unable to provide viable recovery plans for both actual or forecast budgetary overspends or, where it cannot meet its financial obligations to its creditors. The Partners will need to both agree on whether a situation constitutes "financial failure" for the purpose of this section.

Scope and description of the Fund

11. Scope of Integrated Commissioning

11.1 The Partners have agreed that the scope of the Integrated Commissioning Fund shall be the maximum commissioning resource that it makes sense to pool, or align to deliver joined-up commissioning:

- a formal Pooled Fund has been established where possible;
- Aligned Funds will be used where there are specific barriers to pooling (including legislative and regulatory barriers).

11.2 Commissioning funding will be pooled or aligned, at service and/or contract level. All services falling within the scope of pooled funds will each be mapped to a relevant work stream of the four defined in the Devolution Business Case. Services not exercisable under Section 75 of the 2006 Act and, those services which are outside the current scope of the Pooled Fund but managed alongside the Pooled Funds will be mapped into Aligned Funds. Contracts will only be split where there is value in disaggregating the commissioning arrangement and where this can be managed effectively. The Partners' financial ledger record will be designed to allow for the pooled and aligned elements of the fund to be identified and disaggregated clearly.

11.3 Either Partner will be allocated the Lead Commissioner role for each service area, or contract, based on the most logical and effective design for the commissioning function, and this is set out in Schedule 1 of the s75 Agreement.

11.4 The Partners agree in principle that further Services may be added to the Integrated Commissioning Fund; or specific Services may be removed from the Integrated Commissioning arrangements, in future. The decision and approval approach to this process will follow best practice in business case development, analysis and challenge.

11.5 The Partners recognise that the London Borough of Hackney community is included in the approach to planning for commissioning of care in London Borough of Hackney. The Partners will maintain a close relationship with London Borough of Hackney for the health related service needs of the London Borough of Hackney residents and registered patients.

11.6 The scope of the Integrated Commissioning Fund is illustrated in Appendix 1 and includes both the CCG and Council's commissioning resources and costs of administering these.

12. Better Care Fund

[Note: This detail will need completing based on the future BCF arrangements for FY 17/18]

12.1 The BCF is an element of the wider Pooled Fund.

12.2 For clarity, the Pooled Fund established under the s75 Agreement shall not be designated as the Better Care Fund, however, the Better Care Fund forms part of the overall Pooled Fund.

12.3 The Pooled Fund is combined with the Aligned Funds to make up the total value of the Integrated Commissioning Fund.

13. Value of the Integrated Commissioning Fund

13.1 The Integrated Commissioning Fund comprises of the Pooled Fund and Aligned Fund which it makes sense to plan and manage in a coordinated way.

13.2 The details of the Pooled Fund and Aligned Fund are set out in Schedule 1 of the s75 Agreement.

13.3 The stated intention is to maximise the resources and the scale of commissioning to be included in the Integrated Commissioning Fund, as either a Pooled Fund or Aligned Fund. The prescribed services that cannot be pooled, as summarised in SI(2000)617: NHS Bodies and Local Authorities Partnership Arrangements Regulations includes:

NHS

- Acute surgical (unlikely to be able to disaggregate from hotel services);
- Emergency ambulance;
- Radiotherapy;
- Termination of pregnancies;
- Endoscopy;
- Laser treatments (class 4);
- Other invasive treatments.

Local Government

- Adoption services (Adoption & Childcare Act, 2003);
- Appointment of mental health professional (MHA, 1983);
- MHP powers of entry (MHA, 1983);
- Safeguarding children in care homes (Children Act, 1989);
- Appointment of director of social services (LASSA, 1970).

13.4 Where possible, these services will be included in the Integrated Commissioning Fund as an Aligned Fund.

14. Range of the Pooled Fund (cross boundary flows and issues)

14.1 The populations served by the Pooled Fund are not consistent between the Partners; and essential Integrated Commissioning extends beyond the boundaries of the Pooled Fund. The Partners agree to seek to avoid creating unnecessary barriers or inequalities of access for Service Users. They agree to seek to avoid creating perverse incentives in the design of commissioned and provided Services.

14.2 Funding inconsistencies are created by:

- Council residents registered with GPs outside of the London Borough of Hackney area;
- Non-Council residents registered with GPs within the London Borough of Hackney;
- Individuals not resident; and not registered with GPs in the area requiring services within the scope of the Integrated Commissioning arrangement;

- Service Users who receive Services who are not physically present in the borough.

14.3 Unwanted barriers and incentives to commissioning are created by:

- The 'footprint' of the main providers of NHS services extending into neighbouring areas,

14.4 Potential service level boundaries and inconsistencies may also occur as a result of the range of local government commissioned services that remain with the Council.

Statutory reporting requirements

15. Annual financial accounts

15.1 The value of the budget for the Pooled Fund, as described in the Section 75 Agreement, will be material to both Partners; and as such will be subject to appropriate levels of external and internal audit scrutiny.

15.2 The annual financial accounts of both Partners will be required to include sufficiently detailed notes of the financial performance and records of the Integrated Commissioning arrangement:

- The structure of reporting to be followed for a "Joint Operation", such as this Integrated Commissioning arrangement, is prescribed by the International Financial Reporting Standards (IFRS) in IFRS11(Joint arrangements) and IFRS 12 (Disclosure of interests in other entities);
- The Statement of Financial Performance of the formal Pooled Fund is to be reported in the Host Partner's accounts and reflected in the other Partner's accounts;
- The financial performance of Aligned Fund is to be reported within the body of the relevant Partner's accounts;
- The financial performance of the entirety of the Integrated Commissioning Fund; and the associated risk share arrangement, is to be reported as an explanatory note in both Partners' accounts.

15.3 Planning for accounts preparation and required audit arrangements will take account of:

- Timetables for producing the annual accounts, their audit and reporting requirements; recognising the earlier reporting deadlines for NHS accounts. It is acknowledged that Council reporting deadlines are susceptible to change;
- The scope of required reporting, including the contribution to the CCG Annual Report; and to the Council Annual Report;
- The evidence required to support the annual statement on governance; and for reporting any financial concerns with the Integrated Commissioning Fund;
- The evidence required to support the Head of Internal Audit Opinion and the external audit Regularity Opinion.

15.4 The annual financial accounts will be delivered within the requirements of the financial regimes and rules of each Partner, specific to over and underspending:

- CCG – Resource Allocation Budgeting impact and treatment of over and underspends – impact carried forward into next year's allocation;
- Council – not allowed to carry forward overspend for the year. Overspending to be met from reserves, but more likely to be addressed through service reviews across the Council during the year.

16. Arrangements for audit and counter fraud

16.1 The Partners agree that they will seek a joint approach and joined up arrangements for the internal audit of the Integrated Commissioning function and associated budget resources:

- Access arrangements for both sets of (internal and external) auditors will be agreed as part of the annual audit planning and scoping exercise;
- Deliver combined assurance to the CCG and Council where possible;
- Deliver each Head of Internal Audit (HoIA) opinion and shared assurance for both Partner organisations.

16.2 In terms of the external audit legal and regulatory requirement:

- The Integrated Commissioning arrangements will represent a material and significant element of each Partner organisation's audit;
- The audit will address the Pooled Fund fully within the Host Partner's accounts, with the required narrative note in the accounts of the other Partner;
- The audit will address the aligned elements of the fund within the accounts of the Partner with the originating budget, or the Partner to which the funds were transferred through s76 or s256 of the National Health Services Act 2006, if such transfers occur;
- A note will be included in the accounts of both Partners setting out the results; and the risk share impacts for the entirety of the Integrated Commissioning Fund.

16.3 The assurances required for the sign off of the audit of both sets of financial accounts will be agreed between the external auditors.

17. Local Counter Fraud and Security Management Services (LCFSMS)

17.1 NHS Protect has confirmed that its focus will continue to be on NHS resources. The Partners agree that coverage of counter fraud culture and issues within the Integrated Commissioning arrangement will be joined up, as far as is practicable:

- The CCG and Council will agree arrangements for sharing the approach to promoting the counter fraud culture; and for investigating and addressing instances of suspicion of illegal activity;
- The Council counter fraud functions will continue to be delivered by its internal audit provider and specific fraud team.

Budget Setting

18. Budget setting ground rules

18.1 The Policy for commissioning through the Integrated Commissioning Fund is compatible with and delivers effectively the strategic priorities of both Partners.

18.2 Funds can only be used to commission prescribed services (as described in various legislation); and services that the Partners agree will contribute to the effective delivery of the commissioning priorities.

18.3 Delivery of a balanced outturn is a pre-requisite of commissioning decisions.

18.4 (Future Target) Budgets subject to specified limitations; and budget resource will be transferrable between the Partners, to enable optimum delivery of commissioned services and ensure best value

in the use of resources. This will be recognised within each Partners medium term financial strategy.

18.5 The Partners agree that the Integrated Commissioning Fund will be reviewed during 2017/18 and updated accordingly in recognition of national funding decisions of the Government and associated agencies together with funding decisions taken by the Council and CCG.

18.6 Commissioning decisions take account of the potential impact on services retained by the Partners.

18.7 Commissioning decisions are sensitive to the potential impact on the wider community of Providers.

19. Budget setting methodology

19.1 Prior to the commencement of each financial year following the commencement of the s75 Agreement, both Partners need to be satisfied that the other Partner's methodology for setting the annual budget is robust and reliable. If they are not, the issue shall be escalated through the appropriate Dispute Resolution Procedure. Each Partner will agree the other's methodology for setting the inaugural budget contribution; and future years' budgets. The factors that will be considered include:

- Clarity of the Services to be included in the Integrated Commissioning arrangement and risk share (Pooled Fund and Aligned Fund);
- Verification of budget determined for each Service;
- Assumed and modelled trends in demand;
- Deliverability of the savings targets applied;
- Sufficiency of the budget applied (e.g. compared with previous year outturn).

19.2 The Partners will agree:

- A transparent approach to setting budgets shared between the Partners;
- Validation of the key assumptions and approaches used by each Partner to determine the budget;
- Plans for migration to a more consistent approach to budget setting and demand forecasting that recognises the modelling challenges specific to each organisation.

19.3 Both Partners recognise the risk to resources from unmet need and rationed Services from previous years.

20. Accuracy of activity projections, trends and interventions

20.1 The CCG approach differs depending on services but is a combination of totals agreed in contract negotiations with Providers and detailed demand modelling taking in to account of known activity, trends and forecast growth.

20.2 The Council approach is based on cost and volume analysis of likely trends in demand for Services. As part of this, the Council will:

- Determine the access eligibility thresholds for health related services, as defined by the Care Act 2014 and any flexibilities allowed;
- Determine the charges to be levied against Service Users, where this is an option.

21. Accuracy of cost projections

21.1 The Council commissioning budgets will be recognised in gross value, as well as in net value:

- Other budgets, where costs are partially offset by income from fees and charges and grants, will be included at their net value in the risk share calculations.

21.2 The Councils scope to assess the eligibility thresholds for access to services; and to set fees for services, will be taken into account when negotiating relevant contracts.

22. Addressing conflicts in budget setting priorities

22.1 It is expected that the Integrated Commissioning budget planning process will not adversely impact on the other commissioning obligations of the Partner:

- The Partners' oversight and scrutiny functions will have the opportunity to challenge any changes proposed. Any proposed changes to the budget planning process including harmonising the timetables will need to be signed off by the CFOs of each of the Partners. Any conflicting elements will be fed through to each Partner's governing body or equivalent.
- The scheme of delegations will provide a level of control over the approval of changes;
- Arrangements will be adopted for administering proposals for significant re-engineering; and compliance with business planning and investment proposal discipline, including comprehensive consultation.

22.2 It is expected that changes in the strategic direction of the Partners will not impact adversely on each other, or on the commissioning obligations of the Integrated Commissioning function.

23. Use of Integrated Commissioning Funds

23.1 As set out in the s75 Agreement, the Integrated Commissioning Funds shall only be used for Permitted Expenditure.

24. Future budget settlements

Risk to be addressed: Financial settlements and budget uplifts for future years are insufficient to meet rising demands and rising costs

Possible scenarios:

- Local Government grant funding from government (Revenue Support Grant) is projected to reduce significantly over the next 3 years. The main sources of funding will then be Council Tax and Business Rates;
- NHS funding earmarked for health related services (Better Care Fund) is expected to increase in the next years.
- The size and trend in the gap between the two funding streams over the next 5 years is not certain.
- Both Partners may be required to produce medium term efficiency plans in order to receive multi-year financial settlements.
- NHS England may impose the need for the CCG to provide financial support to other areas within the North East London health economy.

24.1 Principles of response to these risks and future pressures:

- As far as is possible, the value of the single budgets will be kept at their equivalent current value
- Treatment of remaining resource gaps is likely to be addressed as additional savings targets

24.2 Mitigations:

The Partners will agree a protocol for agreeing amendments to the budget setting model in subsequent years. This will include consideration of:

- Treatment of prior year overspends
- Treatment of efficiency savings delivered from previous years

25. Boundaries to the Fund

25.1 Budget setting will take account of boundaries on a number of planes:

- Pooled Fund versus retained funds;
- Pooled Fund versus Aligned Funds;
- Non-resident patients registered with GPs in London Borough of Hackney;
- London Borough of Hackney residents registered with GPs outside of London Borough of Hackney;

25.2 Budget setting will also to take account of patients registered with GP Practices in the London Borough of Hackney area, whilst recognising that they are outside of the Integrated Commissioning Fund arrangement.

26. Finalising the prior year position

26.1 Both Partners acknowledge that the financial performance of the relevant budgets in the current year should be regarded as a key indicator of future years' risks; and of the scale of the savings targets agreed between the Partners. The following constraints will need to be accommodated:

- Current year out-turn position will not be known until very late in the process.

26.2 The value of the Integrated Commissioning Fund will be based on the budget allocations

- Indicative savings targets will be identified by the Partners from time to time.

27. Treatment of historical overspends / underspends

27.1 CCG would account for prior year deficit as a negative balance on the RAB (Resource Account Budgeting) settlement and a prior year surplus as a positive balance.

27.2 The Council cannot record a year-end deficit; and must fund remaining overspends from reserves. Overspends identified during the year are addressed through service reviews and rationalisation of the scale of non-mandatory services provided, offsets from underspent directorates, or by allocation from reserves at the year-end.

28. Prior year and in-year overspends / underspends

28.1 The Partners recognise that differences in funding regimes and freedoms result in a different response to recorded "overspends":

- The CCG cannot carry "reserves" between years. Underspends and overspends are recognised within the annual resource allocation. Overspends in one year result in reduced allocation in the next. The CCG can set a budget that delivers a planned overspent position, but is expected to achieve balance over a 3 to 5 year period.
- The Council cannot record an overspend at the year-end; and has to account for overspent budgets through its reserves. But the reserves are limited and should be replaced through

budget targets set in the subsequent year.

28.2 The Partners agree, in principle, that they will use these differing “flexibilities” in a combined approach to maximise protection to the Integrated Commissioning function. Any unused contingency sums in the Pooled Fund must remain in the Pooled Fund hosted by the Council and will form reserves available to the Integrated Commissioning Board in subsequent years.

28.3 Further detail in relation to the CCG Contingency Fund is set out in section 33 of this Financial Framework. Other contingencies available to the Partners may be provisions made from the balance sheet or accumulated reserves. Release of such contingencies shall be made following the approval of the relevant Partner that holds such contingency.

29. Treatment of underlying and emerging deficit:

29.1 Underlying and emerging deficit will include:

- Unidentified deficit:
  - unmet need
  - unmet demand
- Identified deficit:
  - undelivered services
  - service delivery backlogs
  - waiting lists

29.2 The CCG and the Council agree to work together to identify responses to the threat of emerging unfunded demand pressures and growth in demand.

29.3 The first point of responsibility for addressing pressures through contracts will be the Lead Commissioner. A Lead Commissioner will be identified for each Service Contract.

29.4 Escalation arrangements will be agreed for Service Contracts and commissioning arrangements that appear to be overheating and indicate future losses. See section 9.3 of the Financial Framework.

30. Setting subsequent years’ budgets

30.1 The Section 75 Agreement specifies that the Integrated Commissioning Fund will be subject to annual review. This will be alongside the medium term financial plans of each Partners.

30.2 The Partners agree to a shared approach to:

- Identifying and agreeing future trends in demand and service design;
- Checking sufficiency of growth funding;
- Identifying and accounting for changes in cost pressures;
- Identifying and agreeing savings and efficiency approaches. Ensuring the robustness of planned savings programmes;
- Setting criteria for values for savings targets:
  - Minimum and maximum allowed;
  - Reality checked and deliverable.

30.3 The Partners agree to design a robust business case approach to service redesign; and to its financial impact. This will involve:

- Robust analysis of overall savings projections;
- Robust analysis of comparative impact on Partners; and recognition of the need to reflect (compensate) for these impacts in future budget setting;
- Agreement on the impact on the risk share.

30.4 Where the CCG is able to drawdown funds from prior year RAB surpluses, these funds shall only be committed by the Integrated Commissioning Board to support its programme of work. Such funds can only be applied non-recurrently.

30.5 Where CCG Contingency Funds have been applied to meet in year cost pressures, it is the responsibility of the Integrated Commissioning Board to ensure effective measures are put in place to restore the CCG Contingency Funds in the following year.

Risk Sharing Framework

31. Scenarios of operational pressures and risks in budget setting

31.1 The following sections set out a range of scenarios of risk:

Pressures on Partners' budgets

(A) Risk: Pressures within either Partner which results in shortfall in growth funding and/or increased savings targets

Possible scenarios are:

- Shifting priorities in the Council from other directorates and services;
- Internal pressure on overall CCG position resulting in pressure on budget allocation for London Borough of Hackney patients;
- Changes in targets set (externally) for performance in specific service area(s) within the Integrated Commissioning Fund.
- Increased savings targets set (externally).

Principles of response to these risks and future pressures:

- Impacts due to shifts in internal policy and priority have to be discussed by both Partners
    - Partners have to agree on how and when to apply accumulated savings;
- Impacts due to external policy and target changes to be regarded as required changes; and partners to agree response
    - Accumulated savings can be applied to offset, but need to recognise limited resource

(B) Risk: Available resources and budgets do not address current demand

Possible scenarios are:

- Growth rates in demand for services exceed available funding increase;
- New commissioning arrangements and single approach to commissioning identifies previously un-met need;

- Providers are carrying backlogs in activity that need to be delivered and need to be funded.

Principles of response to these risks and future pressures:

- The Integrated Commissioning function must seek to achieve a balanced financial out-turn;
- Providers of services will be encouraged, including through contracting, to manage service delivery costs within the allotted amount;
- Where possible, Services will be prioritised and needs assessed. Non-statutory services may be withdrawn, if impact is less significant than effect of rationing funds to areas of demand growth. Service rationing will not be organisation specific;
- Funds will be made available to promote more effective and streamlined provision of Services.

Savings targets, reserves and contingencies

(A) Risk: Efficiency savings targets applied within budgets are undeliverable

Possible scenarios are:

- A Partner is unable to show persuasive plans for achieving the savings expectations ;
- Savings target exceeds sensible levels;
- Savings proposals would have an adverse and costly effect on other elements of the overall service delivery.

Principles of response to these risks and future pressures:

- Agreed process for identifying efficiency savings targets:
    - From service delivery re-design;
    - From QIPP expectations;
    - From benefits expected of merged commissioning;
    - From share of organisation's overall target;
- Agreed approach to identifying benefit shares with Providers.
- Agreed process for verifying likelihood of delivery of the savings targets:
    - Arrangements for assessing schemes to deliver;
    - Risk assessment for schemes; and response to higher risk proposals.
- Agreed arrangements for sharing the risk of under-delivery of efficiency savings targets;
- Arrangements for allowing late amendments to budgets and savings target:
    - E.g. QIPP schemes determined late.

(B) Risk: Insufficient resources to allow for a contingency or reserve to be set

Principles of response to these risks and future pressures:

- Partners will agree rules specifying whether contingency (both recurrent and non-recurrent) is a required element of the annual budget; and what this level is:
    - Proportion of annual total allocation designated to contingency target to be agreed;

- Arrangements for agreeing contingency that is lower than the agreed target;

- Partners agree proposed treatment of any reserves brought into the Integrated Commissioning Fund:
  - Budgeted from savings in previous year(s);
  - Agreement of priorities and triggers for calls upon reserves ;
- Treatment of unspent contingency, or other underspend of the total budget to be determined by the Partners:
  - Proportion, or target value to retain within the Integrated Commissioning Fund;
  - Treatment of any underspend to be returned to the Partners;
- Agreement on accounting for reserves. The CCG is unlikely to be able to report resource balances to carry forward:
  - But, the CCG would report the net position across the whole. The performance of City and Hackney and the rest of the CCG may, in total, allow for shadow reserves to be identified for the London Borough of Hackney element.

32. Governance of service redesign

32.1 The Partners will agree a protocol for developing service re-design. Elements will be delivered within the Integrated Commissioning Strategy of the Integrated Commissioning Board. It will involve a formal project management procedure for planning significant changes in service delivery design, which:

- Identifies resource implications;
- Identifies staffing implications;
- Assesses the impact on commissioning intentions:
  - And status of agreements with providers;
- Assesses the impact on Service Contracts:
  - Potential differential share of savings between the CCG, the Council and the Provider;
  - Potential for budget shift impact in advance of risk share arrangement;
- Delivers alignment with wider service design agenda.

32.2 Formal approval arrangements will be implemented, involving both Partners and requiring formal sign-off of projects

32.3 The Partners will agree the approach to monitoring of the impact on budget allocations:

- Linked to potential recognition of impact in budget planning;
- Impact on financial risk share.

33. CCG Acute Contingency in the Pooled Fund

33.1 The CCG will apportion some contingency budget into the Pooled Fund which will be earmarked for CCG related pressures and risks. This is defined as the CCG Contingency Fund in the s75 Agreement. The CCG Contingency Fund will cover in-year cost pressures including acute contract over performance and managing any budgetary gaps that emerge.

33.2 The CCG Contingency Fund in the Pooled Fund will not include the 0.5% unallocated strategic risk reserve required by NHS England as part of a system-wide NHS risk management approach.

33.3 Use of the CCG Contingency Fund will require approval by the CCG Chief Finance Officer. The CCG CFO will determine the apportionment of the CCG Contingency Funds between the Pooled Fund and the Aligned Fund at the start of each Financial Year, based on an analysis of risks.

The CFO may, at their discretion, extend the use of the CCG Contingency Funds sitting in the Aligned Fund to the Pooled Fund, especially if such action will minimise pressures on health, such as avoiding bed blockage. The CCG Contingency Funds will not be used outside of the scope of the Pooled fund and Aligned fund.

33.4 Where CCG related budget pressures are unable to be contained within the totality of CCG's Pooled budgets, the CCG CFO must inform the Integrated Commissioning Board, and the Integrated Commissioning Board must take immediate mitigating action at its next meeting to ensure the Fund is in balance.

Note: For 2017/18, no Local authority contingency budget is included in the Pooled Funds.

34. Budget Virements

34.1 Budget virement means moving budgets between different budget lines. This process is designed to cover virements involving movement of budgets within the Pooled Funds (e.g. from one work stream to another or within a work stream from one service to another), or from Aligned Funds to Pooled Funds subject to approval from the relevant statutory body CFO.

34.2 The budget setting process aims to ensure that all budget holders receive realistic budgets at the start of the year in order that the business plan can be achieved. Nevertheless, there will inevitably be in-year changes, and this is where virement may be used.

34.3 There are occasions where virement are generally appropriate. These include:

- Adjustments to reflect changes that could not have been foreseen at the start of the year.
- Where planned actions by managers mean that resources previously allocated for one purpose are no longer required for that purpose and are used for another agreed purpose.
- Movement of Reserve budget to fund specific initiatives or mitigate budgetary risks where agreed by the Party funding the reserve.

34.4 Virement Rules and Processes

- A virement is not permitted from non-recurrent to recurrent expenditure
- A Virement is not permitted where the CCG or Council would be committed to additional recurrent funding in excess of commitments agreed within the CCG or Council's operating plan
- Virements within the Pooled Funds must be approved by the CFO/Finance Director for the relevant Partner seeking to make the budget change
- Virements to / from BCF parts of the Pooled Fund must be agreed by the Partners and in accordance with BCF guidance and rules.

35. Value of financial risk from the other Partner

35.1 The Partners recognise the high risk of overspending of the Integrated Commissioning Fund but

there is a shared commitment for the maximum resources to be included within the Integrated Commissioning Fund.

35.2 The Partners will be responsible for the management of their own deficit arising within the level of resources which they contribute to the Integrated Commissioning Fund. The detail of how this works operationally is set out in Clauses 12.7 and 12.8 of the s75 Agreement.

Managing the transactions of the Pooled Fund

36. Transactions within the Pooled Fund

36.1 Funding management arrangements, at the transaction level, will be designed in line with the principle of limited change and aim for consistency with the administrative approach of the previous year: Where practicable funds will remain with the respective Partner; and relevant transactions will be handled by them. If required, to fulfil specific s75 Pool rules, recharges will be applied to ensure that the entirety of the Pooled Fund record is accounted for within the Pooled Fund.

36.2 The mechanism of "cash" flow and contribution to the Pooled Fund is:

- Partner organisations will continue to access financial resources in the same way as they currently do: CCG draw down of funds; the Council transfer of cash. A regular reconciliation of transactions made by the Partners on behalf of the Pooled Fund shall be overseen by the CFOs and any net balance of the cash due to the Host Partner shall be enacted by the CFOs .

36.3 Expenditure from the Integrated Commissioning Fund:

- Contractual arrangements will be unchanged from the Partners' existing arrangements, unless evolving integration necessitates redesign.
- A Lead Commissioner will be identified for each contractual arrangement.

36.4 Specific arrangements and rules will be determined for the "direct payments" processes for Service Users (use of a holding bank account and "debit cards").

36.5 Any potential impact of VAT regime differences will be reduced through the planned consistency of approach to:

- Identify the scale and scope of the issue;
- Ensure that the correct VAT regime is applied to each transaction;
- Identify NHS service elements versus health related service elements.

36.6 The Partners agree to assume a "fair proportions" contribution to the input of non-financial resources (staff, premises, equipment, support services etc.), in accordance with the existing arrangements. This assumption will be reviewed during the first year of the Integrated Commissioning approach.

Managing Financial Performance

37. Budget management general arrangements

37.1 The starting principle is that the structure of the budget management and responsibility will evolve during 2017/18, rather than face a major re-structuring at the start of the year.

37.2 But the Partners expect to make clear and consistent progress, from the start of the financial year, towards a more joined up structure of budgetary control.

37.3 The financial regulations (SFIs, SoDA) of each Partner will be reviewed for consistency. Where required, the regulations will be amended to enable the proposed structures and res ponsibilities to

be implemented.

Review of in-year budget allocation

37.4 The basic principle is that budget allocations to the Integrated Commissioning Fund will not change (in-year) once they have been agreed however agree that they will be reviewed during 2017/2018 and updated accordingly in recognition of national funding decisions of the Government and associated agencies together with funding decisions taken by the Council and CCG.

37.5 Resources, identified during the year, and specific to the services in the agreement and to the population served, will be adjusted accordingly. Examples include:

- Specific grants;
- Funding from DH, NHS England, other government sources;

37.6 The Partners will agree a model whereby they retain the right to revisit allocations during the year provided that a minimum of three months' notice is given, unless both Partners agree otherwise (in writing)

- Risks arising from external sources (protocol for responding to pressures, faced by either partner, from external sources);
- Risks arising from internal sources.

38. In-year financial performance

Local operating rules

38.1 The Partners will implement administrative arrangements that will be based on existing arrangements, but will be developed, where beneficial, for the Integrated Commissioning function as a whole.

38.2 For individual schemes, the arrangements will reflect:

- Any legislative / funding restrictions or requirements
- strategic priority restrictions

38.3 Reporting of performance (financial, contracts, quality etc.) will be delivered in terms of gross income and expenditure.

38.4 The forecasting approach for the Pooled Fund and the wider Integrated Commissioning Fund will be determined by the Partners.

Monitoring performance

38.5 The Partners will develop a model for monitoring monthly performance of the Integrated Commissioning Fund. This model will include:

- Actual and forecast expenditure and income;
- Arrangements for identified accruals for activity delivered;
- Monitoring of service backlogs.
- Cash transactions for receipts and payments.

Responding to overspend trends

Alerting Partners of the likely overspend

38.6 The Partners will develop an agreed approach to addressing trends towards overspending in the Integrated Commissioning Fund. Design of the tool for alerting partners of likely overspend will include:

- Triggers and thresholds;
- Agreed sensitivity measures;
- Trend analysis and alerts;
- Analysis of impact of/on related activities;
- Impact of progress along the annual timeframe – forecasting and sensitivity analysis over the medium term.

38.7 Escalation rules will address

- Scope for managing the situation including agreed delegations;
- Process for escalating to the other Partner.

The Partners' approach to responding to adverse trends will vary, depending on the value of the potential overspend and the progress along the annual timeline:

- differentiating response (scale, threshold etc.) according to progress through the financial year.

Managing potential overspends

38.8 Escalation arrangements for responding to overspends forecast through the year will include assessment of options for:

- Management of contracts (and contract adjustments);
- Management of demand;
- Service redesign.

38.9 The procedure includes arrangements for agreeing the response to; and flexibility allowed within the Integrated Commissioning Fund for changes in allocations, in-year:

- Both Partners options to curtail the Service at any point during the year.

38.10 Where elements of the trend to overspend are specific to one Partner, the Partners will agree:

- The priority of demand on available funds to offset overspends;
- The approach to allocating and apportioning risk (in year and forecast outturn) between the Partners.

38.11 Where elements of the trend to overspend exist within Integrated Commissioning elements i.e. where both Parties would otherwise separately contribute to the Service, the Partners will agree:

- The approach to allocating and apportioning risk between the Partners

38.12 The Partners will agree arrangements for emergency management of any recovery position, including:

- suspension of Host Partner's management of the Integrated Commissioning Fund;

- agreed amendments to the structure of governance and management of the Integrated Commissioning Fund in emergency measures.

39. Responding to annual overspends

39.1 The Partners will develop arrangements for addressing Overspends not recovered at the year-end and/or projected in future years. These will include:

- Escalation thresholds for response, based on the value of the overspend;
- Mechanism of carry forward to next year's budget:
  - CCG accumulated loss;
  - The Council repayment to reserves (but more likely to have been addressed through reduction in service provision during the year);
- Apportion according to agreed risk share model for first element of overspend:
  - Split by % contribution to Pooled Fund;
  - Risk sharing limits set to identify maximum contribution to be made by either Partner;
- Allocate remainder according to overspend pattern, to responsible Partner:
  - In accordance with risk sharing agreement.

39.2 The Council's inability to carry-forward an Overspent position will be addressed through use of reserves, which will be recovered in the subsequent year(s).

40. Responding to annual underspends

40.1 The Partners will identify underspends as generated:

- By whole Pooled Fund;
- By specific Pooled Fund elements;
- By Partner responsibility.

40.2 Options for addressing underspends recorded at the year-end will include:

- Allocate to investment fund;
- Carry forward to next year's budget:
  - Legal restrictions (CCG RAB budgeting);
  - The Council scope to hold balance, but CCG to prove no draw-down in advance of need;
- Off-set against next year's budget;
- Return to Partners:
  - Mechanism for agreeing share of returns.

Other financial Considerations

41. Design of the financial ledger

41.1 Both Partners will design processes that deliver a clear audit trail of each element of the Integrated

Commissioning Fund.

- Assurance on the accuracy and completeness of the records will be provided by the Partners;

- Assurance of compliance with s75 may be through a self-assessment and self-certification. But the Partners agree that this will be subject to an IA review, as a minimum.

42. Financial reporting responsibilities of the Host Partner and the Pooled Fund Manager

42.1 The Partners will agree the arrangements for administering and managing the financial records of the Pooled Fund. Elements specific to the set-up of financial record include:

- Ledger and consolidations (developing the arrangement for combining the Integrated Commissioning Fund records of the Partners);

- Transactions (delivering the audit trail to show the transactions making up the Integrated Commissioning Fund record);

- Reporting.

42.2 The Partners will agree the financial performance reporting needs of each, including providing analysis and summaries of the financial performance of the Integrated Commissioning function, in accordance with the Partner organisations' requirements

- In accordance with timetables agreed by both Partners;

- Providing the details required by both Partners;

- Designed to meet the needs of the differing audience(s).

42.3 The Pooled Fund Manager will ensure the proper treatment specific aspects of the Pooled Fund and its transactions:

- Ring-fenced budgets, specific schemes and funding restrictions:

- VAT;

- Year-end treatment of surpluses;

- Audit.

42.4 The Pooled Fund Manager will ensure the provision of the annual return to Partners, identifying separately and in total: BCF and Pooled Fund

- Contributions to the Pooled Fund:

- Expenditure from the Pooled Fund:

- Treatment of the difference / risk share;

- Detail for ring fenced schemes and restricted funds;

- Reporting deadlines.

Requirements of partner organisations

42.5 The Partners will agree their respective requirements for the monitoring and reporting of the financial position:

- Financial contribution to the Integrated Commissioning Fund:

- Expenditure and commitments;
- Contract performance ;
- Overall performance of the Integrated Commissioning Fund.

42.6 Assurance framework requirements:

- Sources of assurance;
- Specific funding and ring fencing requirements in respect of appropriateness of spend.

42.7 Overview of management of the Integrated Commissioning Fund:

- Review arrangements;
- Access to records, including audit access;
- Ad hoc reviews.

42.8 And year-end requirements:

- Deadlines specific to NHS/LG and specific reporting requirements;
- Accountable Officer / s151 Officer assurance requirements;
- IFRS reporting requirement;
- Governance statement requirements.

43. Managing the cash position

43.1 The Host Partner will:

- Hold monies contributed to the Pooled Fund that are required for transactions generated from the Host Partner:
  - The timing of contributions will align to payment obligations;
- Administer the payment processes for its own transactions;
- Administer the consolidation of the financial records of the Pooled Fund.

43.2 The Partners will adhere to the rules and restrictions applying to them:

- The CCG is required to limit cash draw-down to the monies required, when they are required:
  - Not allowed to draw excess cash;
  - Not allowed to earn interest, or investment income;
  - Not allowed to have a cash balance at the year-end;
- The Council is allowed to invest available cash to earn income on its own resource allocation:
  - The Council will determine how interest income is used; and is not obliged to include any part of that interest income in the Integrated Commissioning Fund.

43.3 Banking arrangements will reflect existing arrangements.

43.4 Transaction payments from the CCG and the Council will be unchanged from current arrangements. The Council should not suffer a reduced capacity to generate investment income from retained cash

and investment balances. But, the Council will not be able to derive investment advantage through early draw-down of CCG funds.

44. Payment mechanisms

44.1 The Partners acknowledge responsibility for paying all sums due to Providers, in compliance with contract terms.

44.2 The Partners will agree arrangements for making payments to Providers, such that Providers are not affected by any changes to the structure of commissioning from the Integrated Commissioning Fund.

44.3 The design of payment mechanism will ensure that the Integrated Commissioning Fund structure delivers the full process of receipt of invoice, confirmation of service delivery and standards compliance, confirming amount due to invoice amount, instructing payment.

44.4 Providers will not be affected adversely by any specific rules that apply to certain services managed through the Integrated Commissioning Fund.

44.5 Any specific arrangements for LG and NHS to comply with will be identified and addressed, as necessary.

45. Direct Payments

45.1 The Partners recognise the growing importance and impact of direct payments to Service Users for purchasing their own agreed packages of care.

45.2 The design of the resource allocation arrangements will deliver:

- Discipline over approval of proposed care plans and direct payments approach;
- Security of funding ahead of spend by Service Users (e.g. “debit card”, pre-approved spend)
- Approach to recovering unused funding from individual Service Users.

46. Income opportunities

46.1 Grants and sponsorship

46.1.1 The partners will seek to maximise uptake of opportunities of funding offered, including:

- Government Grant funding:
  - As an annual allocation;
  - Through one-off projects;
- Grants from other organisations;
- Sponsorship;
- Opportunities to charge for enhanced services commissioned.

46.2 Chargeable health related services

46.2.1 The Council will retain responsibility for assessing the contribution (to a provided social service) to be paid by Service Users.

46.2.2 The Council will retain responsibility for collecting the assessed contribution.

47. VAT

47.1 The Partners will set out the details of the treatment of VAT in respect of the Services commissioned through the Integrated Commissioning Fund:

- Identify range of services for which VAT is reclaimable;
- Identify charged services which have to be subject to VAT;
- Identify controls for ensuring that VAT is treated correctly.

47.2 The Partners shall agree that for the treatment of the Pooled Fund for VAT purposes:

- the Council will be the Host Partner and will hold and administer the Pooled Fund for VAT purposes.
- The Lead Commissioner for each Service Contract will be specified in each Service Specification or Scheme Specification (as relevant).
- The Council will commission services for which it is the Lead Commissioner and recover VAT according to the local authority VAT regime (full recovery).
- The CCG will commission services for which it is the Lead Commissioner and recover VAT according to the NHS VAT regime (limited VAT recovery).
- Any funds passing between the Partners under this agreement does not represent consideration for a supply of services and shall be outside the scope of VAT.

48. Capital investment

48.1 The financial arrangements for the Integrated Commissioning Fund will recognise and allow for the Council approach to delivering future service improvement through capital grants to achieve improved quality, lower cost accommodation for services:

- Disabled Facilities Grant

48.2 The Council will retain ownership of any assets that are to be retained.

48.3 The Council has the option to arrange on behalf of both Partners unsupported borrowing to support capital investment in the London Borough of Hackney economy.

49. Resources contributed by Partners

49.1 Staffing, equipment, accommodation etc. resources provided by each Partner to the management and administration of the Integrated Commissioning Fund will be based, initially, on existing structures.

49.2 The Partners will agree the approach to ensuring a fair share of the cost of administering the Pooled Fund.

49.3 The Partners will identify the savings to be generated through the medium term plan to deliver greater levels of integration of CCG and the Council staff, to identify operational and financial benefits from integration; and will agree the resulting benefit share between Partners.

Report to Hackney Health and Wellbeing Board

Item No:		**Date:**	**8 March 2017**
Subject:		**Update on North East London Sustainability and Transformation Plan (NEL STP)**	
Report From:		**Ian Tompkins, Director of Communications & Engagement, NEL STP**	
Summary:		This report (to be given verbally at the meeting on 8 March by Ian Tompkins) provides a further update to the Board on the development of the north east London Sustainability and Transformation Plan (known as the NEL STP) and in particular the proposed shadow governance arrangements, which are currently 'work in progress'. On 21 October we submitted an updated narrative, updated summary and delivery plans to address our local priorities to NHS England. Further work is continuing to develop the plan in more detail; additional updates will be presented to the Board as they become available. For more information go to http://www.nelstp.org.uk or email: nel.stp@towerhamletsccg.nhs.uk	
Recommendations:		The Health and Wellbeing Board is recommended to: Note the verbal update on the NEL STP	
Contacts:		**Ian Tompkins** Director of Communications & Engagement, NEL STP NEL STP office: 020 3816 3813 or 07879 335180 E-mail address: ian.tompkins@towerhamletsccg.nhs.uk	

1 Financial Considerations

The NEL STP will include activities to address current financial challenges. There is a clear emphasis on reconciliation of activity and finance between organisations. Implications for estates and workforce are being considered as part of the development of the STP.

2 Legal Considerations

The NEL STP Board is developing a plan as stipulated by the NHS England guidance.

3 Equality Impact Assessment

An equality screening has been completed to consider the potential equality impact of the proposals set out in the NEL STP. This can be viewed at http://www.nelstp.org.uk and includes:

- An overview of all the initiatives included in the NEL STP narrative to determine at which level equality analyses should be undertaken i.e. NEL STP level, Local Area Level, CCG/borough level or London-wide level.

- An initial assessment of the NEL STP overarching 'Framework for better care and wellbeing'.

- Actions to be undertaken during further detailed equality analyses.

The screening recognises that the initiatives included in the STP will be implemented at different times, hence further equality analyses will need to be undertaken over the life of the STP programme.

4 Attachments

Background papers

Appendix 1: Update on north east London Sustainability and Transformation Plan (NEL STP) March 2017

Appendix 2: Presentation with overview of STP 'footprint', local health profiles and stakeholder engagement plans

Appendix 3: Transformation progress so far

Comments of the Corporate Director of Finance and Resources	N/A
Comments of the Corporate Director of Legal, HR and Regulatory Services	N/A

Appendix 1: Update on north east London Sustainability and Transformation Plan

March 2017

Transformation underpinned by system thinking and local action

1. Background

During 2016, health and care organisations (clinical commissioning groups, providers, local authorities and voluntary and community organisations) across north east London (NEL) [1] have worked together to develop a sustainability and transformation plan (STP). It sets out how the NHS Five Year Forward View will be delivered and how local health and care services will transform and become sustainable, built around the needs of local people. The STP builds on our positive experiences of collaboration in NEL but also protects and promotes autonomy for all of the organisations involved. Each organisation faces common challenges including a growing population, a rapid increase in demand for services and scarce resources. We all recognise that we must work together to address these challenges; this will give us the best opportunity to make our health economy sustainable by 2021 and beyond.

The plan describes how north east London (NEL) will:

- meet the health and wellbeing needs of its population
- improve and maintain the consistency and quality of care for our population
- close the financial gap.

A number of different specific local plans are aligned to the STP, enabling its ambitions to be delivered. The STP builds on these existing local transformation programmes and supports their implementation: including Barking and Dagenham, Havering & Redbridge (accountable care system) and City & Hackney devolution pilots; Newham, Tower Hamlets and Waltham Forest: Transforming Services Together programme; and the improvement programmes of our local hospitals, which aim to supports Barts Health NHS Trust and Barking, Havering and Redbridge University Hospitals NHS Trust out of special measures.

Crucially, the NEL STP is the single application and approval process for transformation funding for 2017/18 onwards.

2. Overview of the north east London Sustainability and Transformation Plan

We shared our initial thinking with NHS England in April 2016 and submitted a draft NEL STP showing our progress in June. During summer 2016, to facilitate public engagement on the STP, we produced a summary of progress to date and shared the draft STP on our website.

On 21 October we submitted an updated narrative, updated summary and eight delivery plans describing the main priorities of the STP to NHS England (NHS E) and NHS Improvement (NHS I). These are all available on the STP website. http://www.nelstp.org.uk/

[1] North east London includes: Barking and Dagenham, City of London, Hackney, Havering, Newham, Redbridge, Tower Hamlets and Waltham Forest.

The NEL STP narrative

The STP vision and priorities are shown below. A copy of our plan on a page is included in Annex A.

NEL STP Vision
1. To measurably improve health and wellbeing outcomes for the people of NEL and ensure sustainable health and social care services, built around the needs of local people. 2. To develop new models of care to achieve better outcomes for all, focused on prevention and out-of-hospital care. 3. To work in partnership to commission, contract and deliver services efficiently and safely.
NEL STP Priorities
• The right services in the right place: Matching demand with appropriate capacity in NEL • Encourage self-care, offer care close to home and make sure secondary care is high quality • Secure the future of our health and social care providers. Many face challenging financial circumstances • Improve specialised care by working together • Create a system-wide decision making model that enables placed based care and clearly involves key partner agencies • Using our infrastructure better

To deliver the STP we are building on existing local programmes such as borough based health and wellbeing strategies and end of life care plans, as well as setting up eight work streams to deliver the priorities. The workstreams are cross-cutting NEL wide programmes, where there are benefits and economies of scale in consolidating a number of system level changes into a single programme. These are:

1. Promote prevention and personal and psychological wellbeing in all we do
2. Promote independence and enable access to care close to home
3. Ensure accessible quality acute services
4. Productivity
5. Infrastructure
6. Specialised commissioning
7. Workforce
8. Digital enablement

Delivery plans have been developed for each of our workstreams; they are live documents which will continue to be updated as the programme develops.

Each work stream has a Senior Responsible Officer (SRO) and Delivery Lead, and task and finish work streams are being established to take forward implementation of the delivery plans. There is local authority involvement and leadership within a number of work streams, for example the Prevention workstream. As we now start to mobilise the work streams we are seeking to strengthen local authority involvement and leadership across them.

3. Links with Transforming Services Together and other plans

Plans to implement integrated place-based care were underway before we began working on the STP, with each local health economy pursuing an innovative and ambitious programme to make this a reality. In INEL this includes the City & Hackney devolution pilot, and in Newham, Tower Hamlets and Waltham Forest the Transforming Services Together programme, which are supporting the development of accountable care systems locally.. We will support and enhance these programmes by working together, but they will continue to operate independently with separate programme and governance structures which allow each area the flexibility to best meet local needs. We are actively seeking to collaborate across NEL where it makes sense to do so and have formed a NEL wide group to share learning from the devolution pilots and transformation programmes which underpin the emerging accountable care systems.

4. Timetable for implementation

Each of the eight delivery plans sets out the milestones and timeframes for implementation. A critical path for the implementation of the main milestones across the whole STP programme is attached at Annex B.

5. Engagement on the Sustainability and Transformation Plan

We recognise that the involvement of local people is crucial to the development of the STP and are committed to involving them and clinicians in any proposed changes. The requirement for the NHS to involve and consult patients on specific service changes is a statutory duty and we will meet that duty and ensure patient and public involvement. At present there are no specific service changes in the INEL area that are worked up and at the stage where public consultation is required.

We started our engagement process when we submitted the draft STP in June, and we have been involving partners, including Healthwatch, local councils, the voluntary, community and social enterprise sector, and patient representatives. The feedback we have received so far was incorporated into the revised STP for the October 2016 submission.

A summary of our engagement activities to date is shown below:

- Published the draft and summary versions of the plan on our website and published regular updates
- Offered to meet all MPs which has resulted in a number of 1:1 meetings. A further briefing for all NEL area MPs was held on 20 February.
- Arranged for elected members from each borough to meet the STP Independent Chair and Executive
- Actively sought involvement of the eight Local Authorities facilitated through the Local Authority representative on the STP Board.
- Local Authorities are represented on the Governance Working Group and have taken part in the workshops developing the plans for transformation (with a Director of Public Health leading the work on prevention).
- Engaged the Local Government Association (LGA) to provide support to individual HWBs to explore self-assessment for readiness for the journey of integration and to a NEL-wide strategic leadership workshop to consolidate outputs from individual HWB workshops.

- Engaged with council and partner stakeholders such as the Inner North East London and Outer North East London Health Scrutiny Committees (HSC); Barking, Havering and Dagenham Democratic and Clinical Oversight Group; the eight Health and Wellbeing Boards; Hackney and Tower Hamlets councillors; and Newham Mayor's advisor for Adults and Health
- Met with local Save our NHS and Keep our NHS Public campaign groups
- Presented at meetings to discuss specific clinical aspects of the STP, for instance the NEL Clinical Senate; the NEL maternity network and maternity commissioners' alliance; mental health strategy meetings; and clinical workshops on the specialist commissioning of cardiac services and children's services. The proposals have also been discussed at a number of Local Medical Committee forums.
- Started to discuss the plans with NHS staff – further engagement is planned.
- Discussed the plans in open board meetings of all our NHS partners and offered opportunities to talk to patients and the public at various annual general meetings and patient group meetings.
- Held wider events on specific topics and developments, e.g. urgent care events involving patients and a wide range of stakeholders such as the London Ambulance Services and community pharmacists.

Our communications and engagement plan (phase 2) sets out how communications with staff, patients, the public, partners and other stakeholders will be managed and delivered. It focuses on the six month period from October 2016 to April 2017. This will be regularly reviewed, refined where necessary and shared with all interested parties, with updates on the outcomes achieved.

The STP programme communications and engagement team is responsible for coordinating work that needs to be done across all CCGs, developing a core narrative and coordinating activity.

Ian Tompkins joined the STP team as Communications Director in November 2016. He has previously worked as a Director of Communications in local authorities (Hackney, Newham, Waltham Forest and Hounslow), the East London NHS Foundation Trust and Newham Clinical Commissioning Group. Ian is working with local authority and NHS colleagues to develop a collaborative approach to communications and engagement, making use of the many existing and productive networks, including those in public health and the voluntary sector.

A workshop for all NHS and local authority communications and engagement leads, as well as those for policy and strategy and public health, was held on 26 January. Another is being held on 9 March.

Local NHS communications teams are responsible for local delivery – understanding local issues and working at a much greater detail to develop local solutions; and engagement on plans that sit under the STP. All are responsible for (and have) links with local authority communications teams and Ian Tompkins will help encourage and support this

In order to ensure we develop the STP using all relevant patient and public views, to ensure efficiency and to reach a wide community of public and patients, we have asked local Healthwatch organisations to review the research and comments they have gathered in recent months and to use existing forums to discuss the STP (see section 6 of the communications and engagement plan).

Local Healthwatch organisations are working together to help us gather and understand the views of local people. They will make use of any other relevant consultation and engagement groups/networks, such as those of local authorities, where possible.

Our joint aim is to ensure engagement is relevant to local needs and that it builds on previous decisions made and the engagement and consultation work that has already take place across NEL on significant change programmes and developments. Healthwatch organisations will focus on gauging public views on a) promoting prevention and self-care b) improving primary care and c) reforming hospital services; with a local emphasis on:

- the Barking, Havering and Redbridge devolution pilot
- the Hackney devolution pilot
- Transforming Services Together in Newham, Tower Hamlets and Waltham Forest
- The vanguard project in Tower Hamlets

We will continue to exploit the full range of channels and formats for our communications and engagement activities to ensure we are reaching groups that are sometimes missed. We will carry on working with clinicians, local authorities and staff to ensure they too are actively involved in the development of the STP. We will encourage patients and local people to be involved at the design stage and work jointly with local authority engagement colleagues to help ensure a joined up approach; undertaking formal consultation when required.

We are committed to National Voices' six principles for engaging people and communities that set the basis for good, person-centred, community-focused health and care and will embed these across our work. We also believe staff have a crucial role to play in the success of the STP. We want them to contribute to its development, to understand and support its aims; to feel part of it and be motivated by it.

There will be many opportunities for everyone (including patients, service users, carers and the public) to have their say on the emerging plans, and to continue shaping their development and implementation during the next five years. Any proposals for significant changes that emerge from the plan will be subject to specific engagement and consultation where required.

In addition, we are committed to engaging with all trade unions on the workforce impacts of the STP. There is a member of the London Health Unions Lead Representative on the NEL workforce advisory board, and each NHS provider has its own joint staff side arrangements where STPs are discussed.

6. Governance for the NEL Sustainability and Transformation Plan

The launch of the STP process signalled the move towards working in larger geographical areas and the need to develop governance arrangements to support strategy development and change at a system level.

To achieve this, 20 organisations have been working together to develop the NEL STP. However, as we move into the next phase of the programme, focusing on the mobilisation and implementation of our delivery programmes, the governance and leadership arrangements are being updated to ensure they continue to remain effective with appropriate membership. As key players in the development and delivery of the STP, especially in ensuring it meets the needs of the many different communities, local authorities will be suitably represented.

A governance task and finish group (including health organisation and local authorities) was set up to review and update the governance arrangements to reflect this change in focus. Through this group we have developed a shadow governance structure, and initial terms of

reference for the key governance forums. We will be operating the governance in shadow form until April 2017 to enable us to test and review it.

This governance structure recognises and respects the statutory organisations, while providing the necessary assurance and oversight for system level delivery. In addition to reinforcing some of the existing governance forums (i.e. re-focusing the membership of the NEL STP Board), several new bodies have been added to strengthen the level of assurance and engagement, most notably:

- Community Council – A council of local people, voluntary sector, and other key stakeholders to promote system wide engagement and assurance
- NEL Political Leaders Advisory group - To provide a forum for political engagement and advice to the NEL STP
- Assurance Group – An independent group of audit chairs to provide assurance and scrutiny
- Finance Strategy Group -To provide oversight and assurance of the consolidated NEL financial strategy and plans to ensure financial sustainability of the NEL system.

We have developed a draft Memorandum of Understanding (MoU) for the governance arrangements of the North East London STP between the health and social care partners. The MoU will not be legally binding, but is intended to ensure a common understanding and commitment between the partner organisations on the NEL STP governance arrangements, specifically:

- The scope and objectives of the NEL STP governance arrangements
- The principles and processes that will underpin the NEL STP governance arrangements
- The governance framework / structure that will support the development and implementation of the NEL STP

The draft MoU was circulated to local authorities, Trust boards and CCG governing bodies in December 2016. A further draft, which takes account of comments received, is due to be published mid-March.

7. Finance considerations of the NEL STP

The basis for the financial modelling has been the refreshed draft five year CCG Operating Plan and provider Long Term Financial Model templates. These have been prepared by individual NEL commissioners and providers, all of whom followed an agreed set of key assumptions on inflation, demographic and non-demographic growth, augmented with local judgement on other cost pressures and necessary investments in services.

The individual plans have then been fed into an integrated health economy model in order to identify potential inconsistencies and to triangulate individual plans with each other. Activity has been modelled across NEL utilising the TST model. Specialised commissioning and any differences in contract assumptions are included in these projections. The local authority position is modelled separately and a summary is detailed below.

The forecast NEL FY20/21 ‘do nothing’ affordability challenge is c£578m to break even (an additional c£30m to reach 1% surplus target for commissioners). This assumes growth and inflation in line with organisations’ plans but that no CIP (Cost Improvement Plans, or Provider efficiencies) or QIPP (Quality, Innovation, Productivity and Prevention schemes, or commissioner savings) would be delivered in any year.

In the ‘do minimum’ scenario, in which ‘business as usual’ efficiencies of 2% across all years have been included, the affordability challenge would be c£336m by FY20/21. The Providers in NEL have committed to delivering a further stretch CIP of £84m meaning the estimated gap after achieving internal efficiencies is £251m. Of this, £160m of savings will be delivered through a variety of collaborative transformation schemes, mitigate down from £184m after applying a prudent risk rating. This includes £38m of savings from providers improving their collaboration on back office functions, as well as a total of £111m in a variety of service transformation across the seven boroughs over five years.

A number of factors are driving our rising expenditure. One significant factor is our growing and ageing population in line with GLA projections. We also face a non-demographic demand growth, due to factors such as new technology and increases in disease prevalence; we have assumed that this growth is approximately 1% per year. Pay and price inflation have been assumed in line with NHS I guidance. This results in a steady increase in expenditure over the planning period.

We see significant increases in CCG allocations throughout the planning period. However, Sustainability and Transformation Funding (STF) and some other non-recurrent provider income (such as gains by absorption) primarily affect the initial years and have no impact in the projections of in-year movements from FY18 onwards.

NEL local authority challenge
All NEL local authorities and the Corporation of London have provided financial data for the STP modelling, though it is recognised that further detailed work is required to confirm assumptions and what effect local authority funding challenges and proposed services changes will have on health services and vice versa.

For the ‘do nothing’ scenario, the combined FY17 Local Authority challenge is estimated as £87m reaching £238m by FY21. This figure is based on adult social care, Better Care Fund, children’s services and public health at all local authorities.

If Children Services were excluded from the gap analysis, the gap in FY17 would be estimated as £60m reaching £174m by FY21.

A ‘do minimum’ scenario, where ‘business as usual’ savings are assumed, will still need to be completed.

Contracts between providers and commissioners
Two-year contracts between all NEL providers and commissioners (including NHSE specialised commissioning) for the period 2017-19 were agreed in line with the national timeframe of 23rd December 2016, as well as two year operating plans which reflected these agreements.

STP partners have agreed to use the period January – March to refine the joint delivery plans that support the transformation schemes agreed in the contracts, designed to deliver the efficiencies required to achieve financial balance across the NEL STP footprint.

8. Equality considerations
An equality screening has been completed (December 2016) to consider the potential

equality impacts of the proposals set out in the NEL STP. It includes:

- An overview of all the initiatives included in the NEL STP narrative to determine at which level equality analyses should be undertaken i.e. NEL STP level, Local Area Level, CCG/borough level or London-wide level.
- An initial assessment of the NEL STP overarching '**Framework for better care and wellbeing'.**
- Actions to be undertaken during further detailed equality analyses.

The screening recognises that the initiatives included in the STP will be implemented at different times, hence further equality analyses will need to be undertaken over the life of the STP programme.

9. Your views on the NEL STP

The STP is a work in progress and this latest draft submission is currently being circulated to health and social care partners. We are awaiting feedback from NHSE/I (was anticipated early 2017), and will continue to evolve the STP following feedback from our local partners, local people and the national bodies. We welcome your comments and input as we further develop the plans.

Tell us what you think
We'd like to know what you think about our STP. It's still a draft, so the content can and will change. We'd like to hear from as many people as possible about what you think so we can refine our ideas and further develop our STP, based on your comments, before it is finalised later in the year. • **What do you think about what we've chosen to focus on?** • **Do you think we have the right priorities?** • **Is there anything missing that you think we should include?**

Please send us an email and tell us what you think: nel.stp@towerhamletsccg.nhs.uk

For more information about the NEL STP visit http://www.nelstp.org.uk/

Annex A: NEL STP Plan on a page

North east London STP plan on a page

Our vision

- Measurably improve health and wellbeing outcomes for the people of north east London and ensure sustainable health and social care services, built around the needs of local people.
- Develop new ways of working to achieve better outcomes for all; focused on prevention of ill health and out of hospital care.
- Work together to commission (buy) contract and deliver services efficiently and safely.

Challenges

- Demand for health and social care is increasing
- Care, quality and outcomes vary
- Many health and social care providers have financial issues
- The cost of providing specialist services and demand for them is increasing, while quality varies
- Organisations are structured and run with a local focus, making it harder to work together provide coordinated and integrated care
- Our workforce model and some buildings are outdated and don't always fit the way we want to provide care

Our priorities

Demand and capacity
- Deliver the right services in the right places
- Match demand with capacity

How care is delivered
- Encourage self care
- Offer care close to home
- Make sure secondary care is high quality

Sustainable health and social care providers
- Secure the future of health and social care providers
- Address financial **challenges**

Specialised Services

Work with partners to deliver high quality affordable specialised services

Working together to make decisions

Put in place leadership and governance to support delivery of our plans

Staff and spaces

Ensure fit for purpose, cost effective buildings

Develop our workforce to support new care models

Key areas of focus

Demand and capacity
- Make health and care services easier to use
- Develop an urgent and emergency care system that directs people to the right place the first time
- Empower people with the skills to stay healthy and care for themselves where appropriate
- Develop services that help people to avoid being admitted to hospital unless they need to be
- Improve how health and social care services work together to deliver productive, efficient patient centred care
- Making sure there are the right staff and spaces in place to care for people

How care is delivered
- Develop one clinical strategy for NEL
- Transform primary care, making sure all services are high quality
- Make urgent and emergency care better and easier to use
- Treat mental health and physical health equally.
- Support primary care practices to work together, sharing staff and supporting each other
- Improve the quality of hospital services and the experience of patients for planned care, surgery and outpatient care
- Provide better care for women during and after their pregnancies, with more choice

Sustainable health and social care providers
- Make sure people only go to and stay in hospital if they need to be there
- Share skills and resources across organisations
- Develop NEL-wide rates of temporary staff pay and a shared bank service so NHS organisations aren't competing for staff
- Work together to harness our collective buying power and save money
- Develop a shared IT service
- Look at how we can work more closely with councils through local devolution pilots

Specialised Services
- Take a long term focus on prevention, so fewer people need specialised care
- Make sure people are diagnosed and treated more quickly and receive better care from start to finish
- Make sure people with mental health conditions receive treatment that recognises their individual treatment needs
- Agree best ways of treating people with kidney disease and heart disease

Working together to make decisions
- Join up responsibility and accountability at local and NEL level to improve decision making
- Involve patients in decision making
- Have governance arrangements in place that can make difficult decisions and are accountable
- Agree a way for organisations to work together to improve patient experience

Staff and spaces
- Recruit, retain and develop staff so people want to work in north east London
- Maximise use of our land and buildings
- Sell unused buildings and land to reinvest proceeds in care
- Where needed, provide additional capacity
- Establish digital systems so we can use data to develop better plans and make better decisions

The impact / benefits of our plans

Demand and capacity / How care is delivered
- People are more independent and lead healthier lifestyles, reducing their chances of becoming unwell
- NHS services are high quality, well staffed and consistent in terms of quality and outcomes
- Better, joined up health and social care services mean fewer people go to A&E, they spend less time in hospital and are supported go home sooner with support and without delays
- Health issues are identified and addressed sooner, leading to improved outcomes

Sustainable health and social care providers
- By working together, organisations are more productive and save money
- More people sign up for permanent roles, reducing the need for temporary staff.

Specialised Services
- People are diagnosed and treated faster, leading to better outcomes
- Specialised services are high quality and consistent
- Our focus on prevention means fewer people have specialist illnesses

Working together to make decisions
- Patients are represented, heard and involved in decision making
- By identifying better ways of working together mean people have better care and better quality services

Staff and spaces
- Patients are cared for, and staff work in, modern fit for purpose buildings.
- People have more choice about where they receive care
- Better use of technology and data to deliver and plan care
- Our workforce is skilled, robust, and resilient.

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Annex B NEL STP Year 1 Critical Path

	Q3	Q4	Q1	Q2

Programme level
- Establish programme resource
- Establish programme governance
- Develop the NEL STP operating model
- Leadership OD
- Operating planning & contracting
- Resolution of contracts
- Update demand and capacity model
- Establish performance and quality management framework
- Go live
- Realignment of CSU support offer
- New CSU support offer in place

Transformation
- Clinical productivity review
- Select pilot pathways
- Implement agreed recommendations
- Clinical leadership review
- Implement recommendations
- Mobilise transformation programmes
- Recruitment of primary care resource
- Establish primary care quality improvement board
- Establish 8-8 primary care access
- Finalise Mental Health strategy
- 111 procurement
- Establish 7 day standards for UEC
- KGH ED – capital business case

Infrastructure
- Develop NEL estates strategy
- Develop SoC for WXH
- Barts Health Trust Board
- ETTF funding released

Digital
- Develop single consolidated NEL digital roadmap

Finance
- Confirm arrangements for accessing STF
- Confirm system / organisational control totals (and gap)
- Baseline finance and activity plans

Comms & Engmnt
- EQIA screening
- High priority EQIA
- Implement stakeholder engagement plan

Workforce
- NEL workforce strategy

Appendix 2: Presentation with overview of STP 'footprint', local health profiles and stakeholder engagement plans

NORTH EAST LONDON

SUSTAINABILITY & TRANSFORMATION PLAN

North East London Sustainability and Transformation Plan

During 2016, 20 organisations across eight local authorities have worked together to develop a sustainability and transformation plan (STP) for north east London.

The plan sets out how the ambitions of the NHS Five Year Forward View will be turned into reality and describes how north east London (NEL) will:

- Meet the health and wellbeing needs of its population
- Improve and maintain the consistency and quality of care for our population
- Close the financial gap.

It builds on the local transformation programmes below and supports their implementation:

- Barking and Dagenham, Havering & Redbridge (accountable care system) and City & Hackney devolution pilots
- Newham, Tower Hamlets and Waltham Forest: Transforming Services Together programme
- The improvement programmes of our local hospitals, which aim to support Barts Health NHS Trust and Barking, Havering and Redbridge University Hospitals NHS Trust out of special measures.

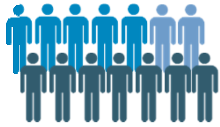
Delivering the NEL STP

Eight workstreams are being set up across the STP area to deliver the plan's priorities:

- Promote prevention and personal and psychological wellbeing in all we do
- Promote independence and enable access to care close to home
- Ensure accessible quality acute services
- Productivity
- Infrastructure
- Specialised commissioning
- Workforce
- Digital enablement

The draft STP is published in full at http://www.nelstp.org.uk/. It was submitted to NHS England (NHS E) and NHS Improvement (NHS I) on October 21. We now await their feedback.

Overview of the North East London STP footprint



Population: 1,945,800 (51.5% BAME)

Estimated population growth: 6.1% (4 year), 17.7% (15 year) – Equivalent to 1 new borough

Significant deprivation: 5 of 8 boroughs in worst IMD quintile

General increasing trend in life expectancy at birth in all NE London boroughs

7 CCGs - 333 GP Practices - Cumulative allocations (2016/17): £2.4 billion

7 London Boroughs plus the City of London

5 NHS Trusts:

6 Emergency departments (ED)	5 Co-located Urgent Care Centres (UCC)	7 Walk-in-centres (WIC)	1 Minor Injury Unit (MIU)

3 accountable care systems

2 national vanguards

2 devolution pilots

History of working together - Health for North East London Decision Making Business Case approved by Joint Committee of Primary Care Trusts in December 2010 – Reconfiguration of urgent and emergency care, maternity, children's services and King George Hospital (KGH)

Waltham Forest

Population: 276,000 (50% BAME)

Estimated population growth: 3% (4 year), 11.1% (15 year)

Deprivation (IMD rank): 15

Life Expectancy at birth: 79.4

Unemployment: 6.4%

CCG Allocation (2016/17): £339m

GP Practices: 44

Major Hospitals:

Whipps Cross [5]

City and Hackney

Population: 277,000 (44% BAME)

Estimated population growth: 5.2% (4 year), 16.9% (15 year)

Deprivation (IMD rank): 2 (Hackney) & 131 (City of London)

Life Expectancy at birth: 78.5 (Hackney)

Unemployment: 6.9% (Hackney)

CCG Allocation (2016/17): £370m

GP Practices: 43

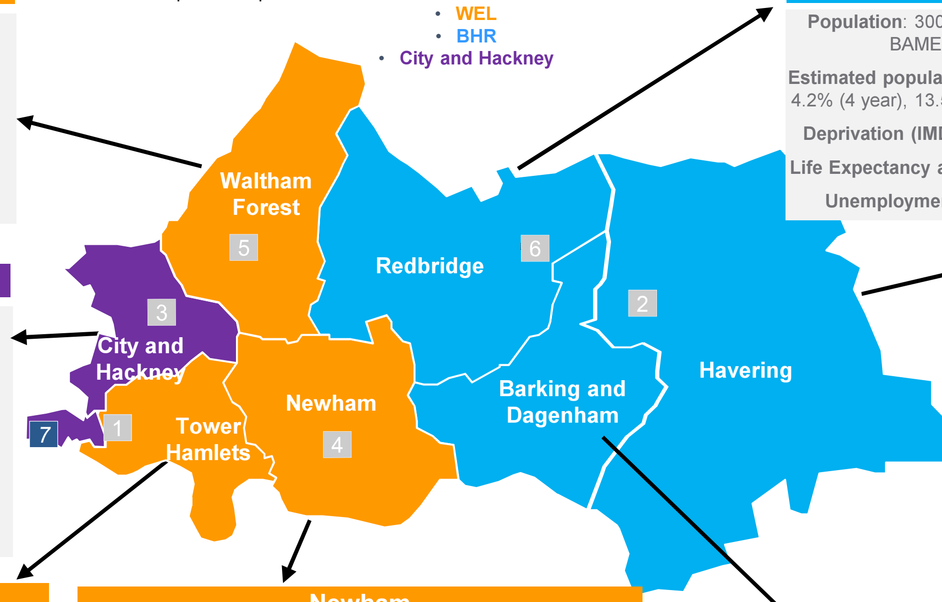
Major Hospitals

Homerton[3]

St Bartholomew's [7]

The area is made up of 3 local area partnerships:

- WEL
- BHR
- City and Hackney



Redbridge

Population: 300,600 (63% BAME)

Estimated population growth: 4.2% (4 year), 13.5% (15 year)

Deprivation (IMD rank): 80

Life Expectancy at birth: 80.9

Unemployment: 6.2%

CCG Allocation (2016/17): £336

GP Practices: 46

Major Hospitals:

King George Hospital [6]

Havering

Population: 250,500 (16% BAME)

Estimated population growth: 4.4% (4 year), 12.1% (15 year)

Deprivation (IMD rank): 102

Life Expectancy at birth: 80.2

Unemployment: 6.2%

CCG Allocation (2016/17): £342m

GP Practices: 57

Major Hospitals:

Queen's Hospital [2]

Tower Hamlets

Population: 296,300 (54% BAME)

Estimated population growth: 13.2% (4 year), 29.9% (15 year)

Deprivation (IMD rank): 6

Life Expectancy at birth: 78.1

Unemployment: 7.7%

CCG Allocation (2016/17): £353m

GP Practices: 36

Major Hospitals

Royal London [1]

Newham

Population: 338,600 (73% BAME)

Estimated population growth: 6.3% (4 year), 19.6% (15 year)

Deprivation (IMD rank): 8

Life Expectancy at birth: 78.5

Unemployment: 7.8%

CCG Allocation (2016/17): £418m

GP Practices: 61

Major Hospitals

Newham University Hospital [4]]

Barking and Dagenham

Population: 206,700 (49% BAME)

Estimated population growth: 6% (4 year), 20.2% (15 year)

Deprivation (IMD rank): 3

Life Expectancy at birth: 77.6

Unemployment: 9.8%

CCG Allocation (2016/17): £262m

GP Practices: 46

Local profile

Healthy London Partnership NHS

•North East London indicators

Locality	Smoking Prevalance	Physically inactive population	Increasing risk drinkers	Obese population	Atrial Fibrillation prevalence	Hypertensive population	Diabetes prevalence
London	**18.3%**	**27.5%**	**19.7%**	**7.3%**	**0.9%**	**11%**	**6.1%**
Barking & Dagenham CCG	Higher	Higher	Lower	Higher	Similar	Higher	Higher
Havering CCG	Higher	Higher	Lower	Higher	Higher	Higher	Similar
Redbridge CCG	Lower	Higher	Higher	Higher	Similar	Higher	Higher
City and Hackney CCG	Higher	Lower	Lower	Higher	Lower	Lower	Lower
Newham CCG	Higher	Higher	Lower	Higher	Lower	Lower	Higher
Tower Hamlets CCG	Higher	Higher	Lower	Lower	Lower	Lower	Higher
Waltham Forrest CCG	Higher	Similar	Lower	Lower	Lower	Similar	Higher

Higher than London as a whole

Similar to London as a whole

Lower than London as a whole

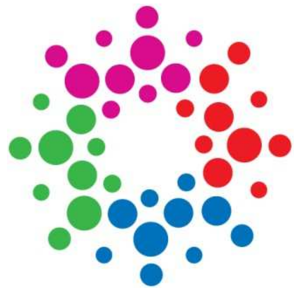
Prevalence data source: Calculated from PHE 2014/15 QOF prevalence data percentage applied to local population figures and 2009 Local Alcohol Profiles for England: http://www.lape.org.uk/data.html

More than a plan… It's a partnership

STPs got off to a bad start in terms of stakeholder involvement and public engagement. Criticised as being NHS-centric and shrouded in secrecy. Have become a 'toxic brand'.

Our approach is to be a partnership working together transparently on organisational development and improving outcomes for local people and not just the money - building on the strengths of those involved:

- **Long history of partnership working and integration – LSPs, 2012, regeneration. Shared desire to work together and improve quality of life for local people**
- **Ambitious plans to transform, integrate care and improve outcomes.**
- **Have some of the very best health professionals in the country – eg ELFT Trust of the Year; four CE's in the HSJ Top 50**
- **Collaborative local government – eg Local London.**
- **Strong community networks across all boroughs**



East London Health & Care Partnership

Members

Waltham Forest Clinical Commissioning Group

City and Hackney Clinical Commissioning Group

Tower Hamlets Clinical Commissioning Group

Newham Clinical Commissioning Group

Barking and Dagenham Clinical Commissioning Group

Havering Clinical Commissioning Group

Redbridge Clinical Commissioning Group

Barts Health NHS Trust

Barking, Havering and Redbridge University Hospitals NHS Trust

The Homerton University Hospital NHS Foundation Trust

East London NHS Foundation Trust

North East London NHS Foundation Trust

GP Providers/GP Federations

London Ambulance Service

London Borough of Waltham Forest

London Borough of Hackney

City of London Corporation

London Borough of Tower Hamlets

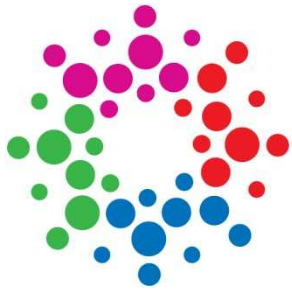
London Borough of Newham

London Borough of Barking and Dagenham

London Borough of Havering

London Borough of Redbridge

VCSE organisations



East London Health & Care Partnership

CCG Governing Bodies | **Provider Trust Boards** | **Local Authorities**

Local Programmes

- **BHR ACS**
- **TST ACS**
- **City & Hackney ACS**

Political Leaders Group
Represent the view of political leaders

Community Group
System-wide engagement/assurance

Assurance Group
Independent assurance and scrutiny

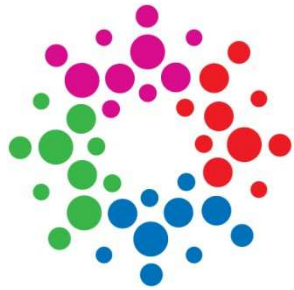
Partnership Board
Strategic direction and programme leadership

STP Executive
Operational direction, delivery and assurance

Clinical Senate
Clinical leadership and assurance

Social Care & Public Health Group
Professional leadership and assurance

Finance Strategy Group
Oversight and assurance of finance



East London Health & Care Partnership

Community Group

The Community Group is a subgroup of the East London Health and Care Partnership. Its purpose is to give key partners and stakeholders, community (patient and public involvement groups) and the VCSE sector a voice in helping to shape and develop the strategies and activities of the Partnership and decisions taken by the Board.

Aims

To collaborate with the wider Partnership (i.e. Board, other committees and member organisations) in the development of strategies, plans, activities and decisions;

To recommend the most appropriate ways in which the Partnership should seek to engage, involve, consult and collaborate with local people;

To support effective Partnership communications and engagement activity, especially through the members' existing channels;

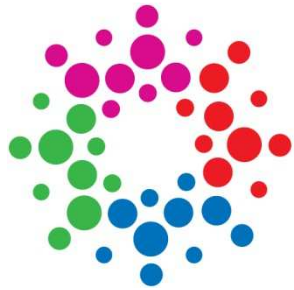
To support the Partnership's STP delivery plans and priorities

Membership

- Patient/Public Groups
- Community & Faith Groups
- VCSE
- Education
- Business
- Professional bodies/groups

  eg ambulance, fire, police, foundation trust governors

  trades unions



East London Health & Care Partnership

What's the story?

With a growing population, and more of us living longer, the challenge to keep us healthy and well has never been bigger.

Change must be allowed to happen, and things improved, if we are to protect the health and care services we value so much

The good work already being done to meet more localised needs will continue.

The East London Health & Care Partnership isn't afraid to tackle these challenges. It will build on the successes achieved so far and bring health and social care providers closer together than ever before.

Joining up the dots and making it easier for people to get the care they need

But the biggest single factor in the long term is to prevent illness – something we can all play a part in, everyone living and working in east London. It's not just down to the authorities.

Giving our nurses, doctors and care staff the best chance of success to look after you when you need them to.

The prize is that we are able to lead happy, healthy and independent lives – but get the care we can trust and rely on when we need it.

Our goal is to help the people of East London live happy, healthy and independent lives

Together, as a partnership, we will do all we can to support our nurses, doctors and care staff so they are able look after people to the best of their ability.

We want to protect vital services and provide better treatment and care built around the needs of local people, safely and conveniently, closer to home.

We also want to help prevent people from getting ill and enable them to be independent; capable of looking after themselves.

Our values - what we believe in and pledge to do

East London

Our pledge: We put the people of East London at the centre of everything we do. We are passionate about the area and want the very best quality of life for everyone that lives and works here.

Caring about people

Our pledge: Everyone is entitled to the highest quality care and should have access to services when they need them. We will provide care that addresses individual needs and aims for the best possible outcomes – focusing on our patients, service users, their families and carers, and our staff.

Being respectful

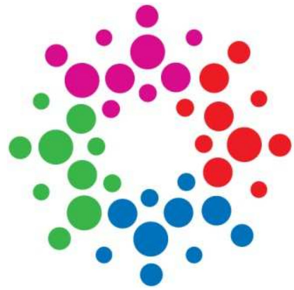
Our pledge: Everyone should be treated with kindness and respect. We will treat others as we would expect ourselves or our families to be treated and cared for.

Taking responsibility

Our pledge: We will take responsibility for our actions and any problems we encounter. We lead by example and will do all we can to make our services as safe as possible.

Spending wisely – every penny counts

Our pledge: We will manage budgets carefully and responsibly. We will be transparent about how and where money is spent and invest in the right tools and resources to do the job. We will ask people for their ideas about improving value for money, and our services in general.



East London Health & Care Partnership

Comms & Engagement

A flavour of what we are doing…

- NHS and local authority communications and engagement teams currently working together to identify and link comms channels and networks.
- Suite of briefing and public information materials being finalised for sharing with all interested parties across the area
- Simple "How to access NHS and care services" eg 111 information campaign being developed
- Working Healthwatch and public/patient groups to deliver major engagement plan across the spring and summer
- Formal launch of the East London Health & Care Partnership in June 2017
- Series of Partnership-wide prevention campaigns

Transforming

Some of our progress so far…

The Partnership:

- **Developing an Integrated Care and Urgent Care Pathway**

Will ensure patients across east London have a consistent way of entering into the urgent care system through the 111 telephone number. All seven CCGs are involved, sharing best practice and pathways so there are fewer layers for patients to navigate.

- **Mental Health Awareness and Job Centres**

Staff and service users at East London Foundation Trust (ELFT) are training all job centre employment support staff in mental health and stigma awareness. Only about 20% of people with severe mental health problems are employed compared to 65% of people with physical health problems and 75% for the whole adult population. Trust staff are training how to support service users more effectively and sensitively.

- **Clinical Improvement Work**

Violence reduction in acute inpatient mental health wards. 50% reduction in physical violence being seen across three boroughs (approx.18 wards) Estimated cost avoidance for the six wards in Tower Hamlets was £180k per annum. Work just published in British Journal of mental health nursing

- **Quality Improvement Work**

Mental health service users at ELFT are now preparing and sharing evening meals together each day, with average 60 per cent taking part. Helping to improve people's functional living and process skills. Project published in the BMJ.

Transforming

Some of our progress so far…

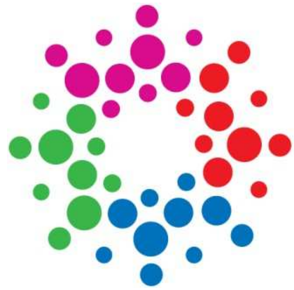
The Partnership:

- **Sharing information between consultants and GPs, has slashed waiting times for people with chronic kidney disease**

Unnecessary trips to hospital are being avoided thanks to the sharing of patient records between consultants and GPs. Experts at The Royal London Hospital are able to view the patients' test results and provide instant advice to their GP about the next steps for their care. It is freeing up appointments for those who do need to see a specialist face-to-face. Automatic triggers are also put in place to alert GP practices to patients most at risk following routine blood test results.

The scheme, which was piloted in Tower Hamlets by Barts Health NHS Trust, has now been extended to the Newham and City and Hackney commissioning areas, and will go-live in Waltham Forest this month. It means more than one million people living in the four boroughs will now have a live community kidney service.

It's one of the most dramatic examples so far of how the NHS can implement its national commitment to moving care closer to home, ensuring patients are treated in the community rather than in hospital.



East London Health & Care Partnership

Transforming

Some of our progress so far…

Barking and Dagenham, Havering and Redbridge

- **Redbridge Integrated Adult Health & Social Care Service**

North East London Foundation Trust and the London Borough of Redbridge have come together in an innovative partnership which is seeing multi-disciplinary community health teams set up across the borough based on GP clusters. It allows earlier intervention and prevention and a high quality of integrated care and support for people over the age of 18, with a single point of access. These include vulnerable older people, adults with a learning disability and/or on the autistic spectrum, those with a physical and/or sensory disability and people with a mental health issue. Four teams have been established so far. See here:

http://www.nelft.nhs.uk/news-events/redbridge-leading-the-way-on-integrated-health-and-social-care-services-2393/

http://www.nelft.nhs.uk/community-health-and-adult-social-care-service

- **K466 Partnership**

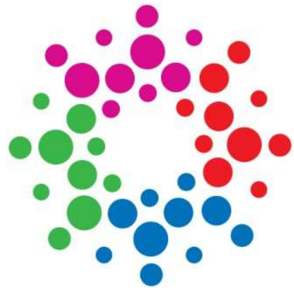
NELFT and London Ambulance Service are jointly providing the award-winning K466 service – a collaborative emergency response car scheme staffed by a community nurse and a paramedic to attend low acuity 999 calls for the over-65 population. The service enables patients to stay safely at home, avoid hospital admissions and releases frontline ambulances to attend other calls.

http://www.nelft.nhs.uk/search/text-content/k466-partnership-wins-another-award--1945

- **My Mind App – CAMHS**

My Mind is both a mobile app and a website designed to meet the growing need for better communication and universal support in children and adolescent mental health care. The app was co-produced with young people, clinicians and IT. The team behind the NELFT My Mind app has been shortlisted for the NHS Digital Pioneer Awards 2017.

http://www.nelft.nhs.uk/my-mind



East London Health & Care Partnership

Transforming

Some of our progress so far…

Barking and Dagenham, Havering and Redbridge

- **Pilot Local Social Prescribing Scheme**

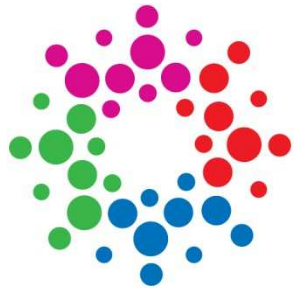
Redbridge Council is setting up a pilot local ‘social prescribing’ scheme in partnership with the NHS (CCG) and local community and voluntary sector. It provides a range of community based activities, information and advice, befriending and community transport services in order to improve the health of people with long-term conditions.

Social prescribing is a model that acts as a conduit for primary care services to refer people with long term health conditions or social, emotional or practical needs to a range of local, non-clinical/care services, some of which are provided by the voluntary/statutory sector.

The existing Redbridge First Response Service (ReFRS) will be integrated into the scheme.

- **Asset Based Approach to Public Health**

Redbridge Council is working with local communities to identify and collate all public health assets in the borough to improve accessibility to services for local people and reduce health inequalities.



East London Health & Care Partnership

Transforming

Some of our progress so far…

Barking and Dagenham, Havering and Redbridge

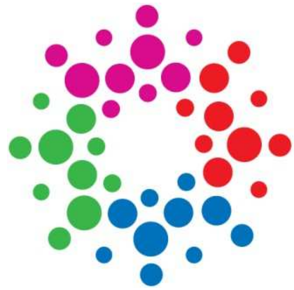
- **Integrated Care Partnership Pilots**

Havering Council is leading on integrated care pilots in north east London with partners from across the NHS, local pharmacies and voluntary sector to improve the way services work together. The pilots are learning from best practice across the rest of the country, Europe and the USA.

The aim is to allow social workers to spend more time doing direct work with families, supporting them to make and sustain positive change. An elite team of systemic family therapists has been created to examine and test new ways of working.

- **Patient Safety Campaigns**

Barking, Havering and Redbridge NHS University Hospitals Trust have created a unique and innovative series of patient safety campaigns to increase staff engagement and drive quality improvement. The campaigns feature staff promoting the message that patient safety is everyone's responsibility. Topics covered are: duty of candour; falls; medicines management; raising concerns; and patient records management



East London Health & Care Partnership

Transforming

Some of our progress so far…

Barking and Dagenham, Havering and Redbridge

- **Working with our Patients with Additional Needs**

Barking, Havering and Redbridge NHS University Hospitals Trust has done a huge amount of work to help support patients with additional needs, such as those who are deaf or hard of hearing, or have learning difficulties (LD). Working with patient representatives from these groups, the trust has developed and launched a wide range of initiatives improve the care and support they provide.

The trust's work to be more accessible for deaf patients has been recognised nationally and it has been nominated in the Communicating Effectively with Patients and Families category at the Patient Experience Network Awards 2017. The trust is also working to become the first London hospital accredited as 'deaf aware', which it hopes to achieve in early March.

New initiatives include:

- Set up a Deaf Working Group to improve their experiences at our hospitals
- Developed a training video so staff communicate better with patients
- Provided deaf awareness training to staff
- Developed a new Hospital Communication Book to help patients who face communication barriers access our services
- The first patient story shared at our Trust Board was Danny French, one of our LD patients and a great advocate for our Trust – we chat to him on Twitter!
- Introduced a Learning Disabilities Passport for our paediatric patients, which includes their personal information, so they feel comfortable and welcome
- We have a Paediatric Learning Disabilities Nurse in post

East London Health & Care Partnership

Transforming

Some of our progress so far…

Barking and Dagenham, Havering and Redbridge

- **Referral to Treatment Times Improve**

Last year the CCGs developed a referral to treatment (RTT) recovery plan with BHRUT to address unacceptably long waits for some patients. This work involved developing new pathways, contracting with alternative providers and increased efficiency in our hospitals.

As a result, the backlog of longest waiting patients has now been largely cleared, with GPs redirecting more than 20,000 patients so far to alternative settings mostly in the community.

- **More Late Evening and Weekend GP Appointments**

GP hubs give vital support to local urgent and emergency care services by providing bookable, same day appointments to anyone who needs urgent medical care but is not a serious emergency.

BHR CCGs have continued to support and invest in the hubs, and this year they have extended their opening hours. They are now open 8am to 8pm on weekends, as well as weekday evenings. Anyone registered with a GP in BHR can use the hubs, and appointments can be booked by calling 020 3770 1888.

- **Commissioning GP Services Locally**

Since BHR CCGs took on responsibility for commissioning local GP services, we have developed a Primary Care Transformation Strategy to help strengthen GP provision across BHR.

Early successes include setting up new GP networks, based around specific local areas, so practices can share ideas and pool resources. The networks are working together to learn and share best practice for managing people who are at risk of diabetes or stroke.

East London Health & Care Partnership

Transforming

Some of our progress so far…

City and Hackney

- **Improving Access to Psychological Therapies (IAPT) Waiting List Reduction**

Waiting list numbers down from 1,300 to 375 and average waiting times from referral to treatment down from six months to below 18 weeks.

- **Integrated Dementia Care Navigation Pathway**

A comprehensive pathway for service users, carers and providers has been developed. It shows the services available to them before diagnosis and following diagnosis, services available to support them to live well with dementia in the community, where to go for help when needed and how to prevent crisis.

- **Hackney Devolution Pilot**

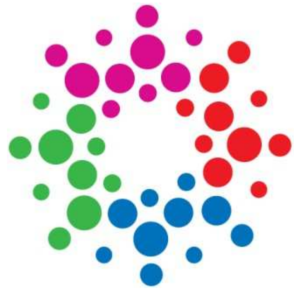
The nine partners - Homerton University Hospital, Hackney Council, City & Hackney CCG, East London NHS Foundation Trust, City & Hackney GP Confederation, City & Hackney Urgent Health Care Social Enterprise, City & Hackney Pharmaceutical Committee, Healthwatch Hackney, City & Hackney Health & Social Care Forum - are looking at how to better integrate health and social care, with a focus on prevention.

- **The One Hackney & City pilot**

The pilot is just coming to an end, but saw integrated teams of health, social care and voluntary sector navigators providing support to vulnerable, high risk patients across the area.

- **Mental Health Crisis Pathway**

Service User Network Crisis groups have reduced A&E usage by 1.9 visits per service user per annum and inpatient bed usage by 16.8 bed days per service user per annum. East London Foundation Trust has launched the Street Triage Pilot in City of London. The pilot has been warmly received by the police, who believe it is already beginning to make an impact on the high rate of 136 admissions from the City.



East London Health & Care Partnership

Transforming

Some of our progress so far…

Newham

- **Integrated Children's Health Transformation Programme – a Joint Commissioning Approach for Children's Community Health Services**

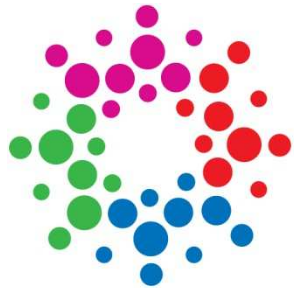
Through this programme, NHS Newham CCG, London Borough of Newham (LBN) and local health providers have worked together to re-shape community health services, and continue with improvements to maternity services and the interface between primary care and acute paediatric services.

Working with neighbouring CCGs, health professionals and stakeholders including GPs and Barts Health professionals, they are jointly reviewing, re-designing and improving the patient journey for children with long-term conditions i.e. Asthma and Diabetes.

- **Using Technology to Help People Manage Diabetes**

Back in 2011, the diabetes team at Newham University Hospital was routinely rearranging between a third and a half of follow-up appointments for young people because they didn't turn up. Now online video appointments via Skype are offered to patients with diabetes who do not require physical examination. The number of missed appointments has reduced each year since then and is currently running at a rate of about 12%. An outpatients improvement group is exploring extending remote consultations and the idea has been taken up in the north east London Sustainability and Transformation Plan.

More detail can be found here - http://bartshealth.nhs.uk/media/latest-news/2016/january/diabetes-skype-clinic-increases-young-people%E2%80%99s-attendance/



East London Health & Care Partnership

Transforming

Some of our progress so far…

Tower Hamlets

- **East London NHS in collaboration with Docklands Light Railway – project 'Back on Track', rail safety initiative for mental health service users in partnership with the DLR in Tower Hamlets**

This project aims to help people with mental health, social or psychological difficulties get more out of life and feel part of their local communities. Some people can find themselves limited when it comes to travel by feelings of anxiety, shyness, and a lack of confidence. This project aims to address these issues and get people out and about in East London, enjoying the facilities and experiences around them. The initiative has involved training of DLR staff to provide optimum support and guidance to people venturing onto the DLR. KAD Ambassadors alongside mental health workers have organised group trips and excursions to help people to get used to travelling with the support of others around them.

- **Building Resilience in Primary Care**

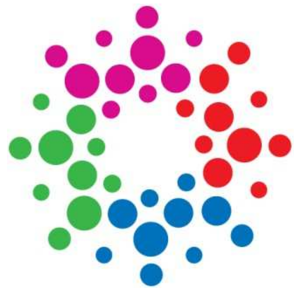
The *Building Resilience in Primary Care Programme* started in October 2015 and aims to empower Tower Hamlets practices by allowing them to make strategic, operational and team changes that would both directly and indirectly address challenges that they are facing in the short to medium term (i.e. growing population, increasing demand, changes in contracts, recruitment and retention). To achieve this, NHS Tower Hamlets CCG will provide the primary care workforce with a robust quality improvement methodology (QI training, QI coaching sessions, data software) that will help practices to think strategically, make operational changes and use data to track the impact of these changes.

After a year-long pilot phase in five GP practices in Tower Hamlets, NHS Tower Hamlets CCG is taking the programme to a further 22 practices in the borough.

- **Social Prescribing**

Following a number of pilots across practices in Tower Hamlets, NHS Tower Hamlets CCG has invested £240,000 to help roll-out social prescribing across the borough.

The idea for this programme is that all patients going to a GP practice in Tower Hamlets will have the opportunity to be signposted to local community and voluntary sector organisations that could help to meet their non-medical needs e.g. coffee morning and lunch clubs to alleviate social isolation. This holistic approach to health and wellbeing will be piloted until the end of March 2018 and the evaluation will be used to identify if the project has resulted in improvements in patient outcomes and/or their usage of the health system.



East London Health & Care Partnership

Transforming

Some of our progress so far…

Waltham Forest

- **New service to improve support for disabled young people**

Families with disabled children are receiving greater support after helping to shape Waltham Forest's new approach to providing education, health and social care services for young people with special educational needs and disabilities (SEND).

Following 18 months of engaging with local families, schools and health professionals, about changes and improvements they would like to see to disability support services in the borough, in September 2016 the council launched its new Disability Enablement Service (DES) for children and young people with SEND aged up to 25 – offering a single point of access for families seeking support from the range of services on offer in the borough. Through the DES, council officers aim to identify and assess need as early as possible in order to fully support the needs of children and young people with SEND in the area – in turn improving their education, health and social care outcomes.

- **Next Steps in Redeveloping Whipps Cross Hospital**

Barts Health NHS Trust is preparing to submit a bid to redevelop Whipps Cross hospital as a health care campus. If approved, this could see the 100 year-old site overhauled to combine hospital, community, primary and social care fit for the changing needs of patients in future.

Following a review by a team of experts, the Trust is preparing a case for change which shows:

- To fix all the ongoing maintenance issues across the hospital would end up being more expensive in the long-term than a redevelopment
- The A&E department is already one of the busiest in the country and now sees more than 450 emergency attendances a day
- The ageing buildings and sprawling layout makes it increasingly difficult to provide the breadth and depth of health services that patients expect
- The population of the area is growing and ageing and patients will need different packages of care in future to manage their conditions more effectively and appropriately

The case for change is being developed with the support of NHS Waltham Forest Clinical Commissioning Group, the London Borough of Waltham Forest and North East London NHS Foundation Trust. Following a public meeting last October, the organisations are setting up a group where residents can help shape the development of the plans.

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Report to Hackney Health and Wellbeing Board

Date: 8 March 2017	
Subject:	**Health and Wellbeing Board Performance Framework**
Report From:	**Dr Penny Bevan, Director of Public Health, London Borough of Hackney & City of London Corporation**
Summary:	This report provides an update on progress across a selection of shared local indicators, using a refreshed Health and Wellbeing dashboard, and incorporating amends as discussed at the March and July 2016 Board meeting. The dashboard is intended to be used for monitoring and reviewing progress across key areas and assessing the impact of the 2015-18 Joint Health and Wellbeing Strategy.
Recommendations:	The Health and Wellbeing Board is asked to: • consider the latest performance and trends in relation to the refreshed data set • comment on the usefulness of the dashboard, incorporating amends as suggested, to monitor progress on improving health and wellbeing outcomes in Hackney.
Contacts:	**Jayne Taylor, Consultant in Public Health, London Borough of Hackney** **Contact details: 0208 356 7885**

1 Introduction

In September 2013, the Health and Wellbeing Board agreed a joint performance framework to enable the Board to maintain an overview of the performance of the health and social care system, to help identify areas of achievement and improvement to inform the work of the Board. The performance framework is made up of indicators drawn from the three national outcomes frameworks including:

- indicators which are seen as critical to the priorities for improvement of the health of Hackney's population and Hackney's health and social care system
- indicators where performance is significantly below what is required.

Following a Health and Wellbeing Board development session in April 2015, during 2015-16 work was undertaken by representatives of Hackney Council Public Health and Performance teams and City & Hackney CCG to revise and refresh the dashboard, to ensure it contains the most relevant information for monitoring progress against the strategy and other joint work.

The amended outcomes framework was presented at the March 2016 Health and Wellbeing Board and, following feedback at this meeting, a number of further changes were made to create a more useful and user friendly dashboard. These changes were then discussed and agreed at the Board meeting in July 2016.

This report incorporates the refreshed dashboard following this work and highlights performance indicators in which Hackney is an outlier compared with other 'similar' areas. Additional indicators have been added to the dashboard to better reflect the Board's priorities as follows:

- percentage of referrals to IAPT which indicated a reliable recovery following completion
- one year survival from all cancers
- excess under 75 mortality rate in adults with serious mental illness
- Emergency hospital admissions: all conditions
- the outcome of short-term services: sequel to service (i.e success of reablement)

Other indicators have been proposed for retirement for this same purpose, as follows:
- potential years of life lost (PYLL) from causes considered amenable to healthcare
- under 75 mortality rate from liver disease
- unplanned hospitalisations for chronic ambulatory care sensitive conditions
- emergency admissions for acute conditions that should not usually require hospital admission
- emergency admissions for children with lower respiratory tract infections
- incidence of healthcare associated infections.

2 Current performance

The data booklet attached in Appendix 1 sets out performance against the key indicators. The report includes a RAG status rating to assist in comparative analysis of Hackney's performance, based on how other similar areas are performing and whether local performance is improving or worsening over time. The RAG rating incorporates assessments of 'statistical significance' to determine if any differences or trends are 'real'.

The key areas where performance is low or high compared to similar areas are listed below (similar areas used in this report include Barking & Dagenham, Brent, Camden, Ealing, Greenwich, Hackney, Hammersmith & Fulham, Haringey, Hounslow, Islington, Lambeth, Lewisham, Newham, Southwark, Tower Hamlets, Waltham Forest). These are summarised in the infographic attached in Appendix 2.

Areas for improvement

- Premature mortality from cardiovascular disease
- Delayed transfers of care attributable to social care
- Proportion of service users who receive self-directed support or direct payments
- Proportion of adults with learning disability in paid employment
- Alcohol related admissions
- Infant mortality
- Mortality rate from causes considered preventable
- Child excess weight in 10-11 year olds
- Cancer screening coverage – breast cancer
- % vaccination coverage (DTAP/IPV/Hib) at 1 year

Areas of good performance

- Unplanned hospitalisations for chronic ambulatory care sensitive conditions (proposed to retire)
- Emergency admissions for acute conditions that should not usually require hospital admission (proposed to retire)
- Emergency admissions for children with lower respiratory tract infections (proposed to retire)
- Long-term support needs of older adults met by admission to homes
- Proportion of older people (65+) who were still at home 91 days after discharge into reablement/rehabilitation services
- Cancer screening coverage – cervical cancer
- Breastfeeding prevalence at 6-8 weeks after birth
- Coverage of NHS Health Checks

5 Financial Considerations

6 Legal Considerations

8 Attachments

Appendix 1: Performance Framework Data Booklet

Appendix 2: Infographic – summary of key results

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Appendix 1: Performance Framework Data Booklet

How to read these tables:

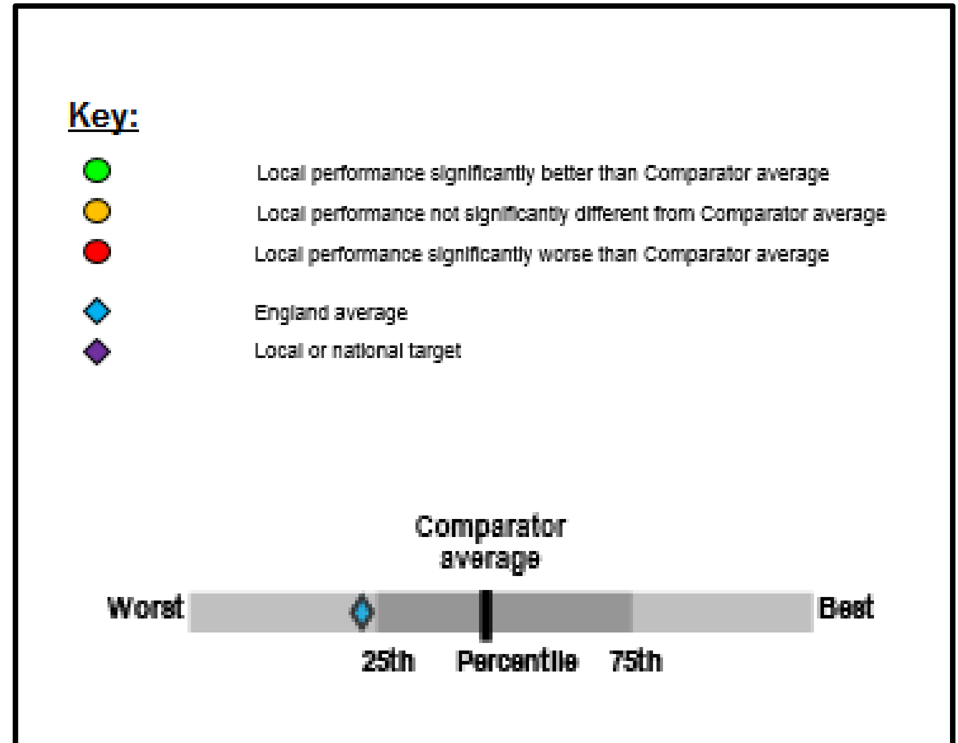
1) The bold line in the middle shows the average of the most similar London boroughs as **comparators** (Barking & Dagenham, Brent, Camden, Ealing, Greenwich, Hackney, Hammersmith & Fulham, Haringey, Hounslow, Islington, Lambeth, Lewisham, Newham, Southwark, Tower Hamlets, Waltham Forest)

2) The light grey area shows the range of values of the comparator boroughs, and the dark area shows the range of 25 to 75 % of values.

3) If available, the blue diamond shows the value for England, and the purple diamond any local or national targets.

4) The coloured dot shows the local value – coloured to indicate whether it is statistically significantly different to the comparator average.

5) Details of the data source, and other information is included in footnotes.



NHS/CCG indicators

Indicator	Local Number	Local Value	Comparator Average	Comparator Worst	Comparator Range	Comparator Best	Local Time Trend
1a Potential years of life lost (PYLL) from causes considered amenable to healthcare - adults	168	3377.2	3095.1	4386.0		2210.7	
1a Potential years of life lost (PYLL) from causes considered amenable to healthcare - men	89	3493.8	3491.8	5414.8		2270.1	
1a Potential years of life lost (PYLL) from causes considered amenable to healthcare - women	79	3287.6	2735.2	3437.7		2193.0	
1b Life expectancy at 75 - males	n/a	12.2	11.8	10.8		13.2	
1b Life expectancy at 75 - females	n/a	13.4	13.7	12.6		15.6	
1.1 - Under 75 mortality rate from all cardiovascular diseases	364	105.8	90.0	108.8		61.8	
1.2 - Under 75 mortality rate from respiratory disease	143	43.4	37.1	54.3		25.7	
1.3 - Under 75 mortality rate from liver disease	78	18.4	20.5	25.6		15.7	
2.1 Proportion of people feeling supported to manage their condition	646	59.9	57.6	63.0		51.0	
2.3i Unplanned hospitalisations for chronic ambulatory care sensitive conditions (adults; ASR per 100,000)	213	124.3	721.3	1099.3		124.3	
2.6i Estimated diagnosis rate for people with dementia (%)	886	70.2	68.2	61.5		77.9	
3a Emergency admissions for acute conditions that should not usually require hospital admission (ASR per 100,000)	468	211.4	983.6	1460.2		211.4	
3.2 Emergency admissions for children with lower respiratory tract infections (ASR per 100,000)	39	52.1	251.1	458.1		52.1	
4c Friends and family test for acute inpatient care	330	61.6	75.3	0.0		0.0	
4c Friends and family test for A&E	212	71.6	61.6	0.0		0.0	
5.2 Incidence of healthcare associated infections - MRSA	1						
5.2 Incidence of healthcare associated infections - C.difficile	10						
1.10 One year survival from all cancers	n/a	67.7	69.1	63.9		73.0	
4.09i - Excess under 75 mortality rate in adults with serious mental illness	n/a	281.2	328.6	394.4		250.1	
2.11a Percentage of referrals to IAPT which indicated a reliable recovery following completion	865	38.4	39.9	34.6		51.7	
P02173 Emergency hospital admissions: all conditions (ASR)	6971	3200.6	7896.9	9966.9		3057.8	

Social Care indicators

Indicator	Local Number	Local Value	Comparator Average	Comparator Worst	Comparator Range	Comparator Best	Local Time Trend
1A Social care-related quality of life	n/a	17.9	18.4	17.9		18.8	
1B Proportion of people who use services who have control over their daily life	n/a	67.8	70.1	60.5		78.1	
1C(1A): The proportion of people who use services who receive self-directed support	1805	79.3	84.8	62.1		100.0	
1C(2A): The proportion of people who use services who receive direct payments	369	16.2	26.3	16.2		62.6	
1D Carer-reported quality of life	n/a	7.4	7.4	6.6		8.0	
1E: The proportion of adults with a learning disability in paid employment	11	2.4	5.8	1.4		22.1	
1.18i - Percentage of adult social care users who have as much social contact as they would like	n/a	36.4	39.9	35.8		45.4	
1F: The proportion of adults in contact with secondary mental health services in paid employment	n/a	4.5	6.4	4.5		9.8	
2A(2) Long-term support needs of older adults (65+) met by admission to homes, per 100,000 population	76	393.1	610.6	1164.8		256.6	
2B(1) Proportion of older people (65+) who were still at home 91 days after discharge into reablement/rehabilitation services	254	92.7	88.2	79.5		98.1	
2C(1) Delayed transfers of care from hospital, per 100,000	21	10.3	8.1	13.2		4.2	
2C(2) Delayed transfers of care from hospital that are attributable to adult social care, per 100,000 population	13	6.1	3.5	6.1		1.2	
2D: The outcome of short-term services: sequel to service	198	71.0	71.5	44.1		94.8	
3A Overall satisfaction of people who use services with their care and support	n/a	60.2	59.4	55.0		63.6	
3D(1): The proportion of people who use services who find it easy to find information about support	5	71.9	70.9	64.4		75.2	
4A Proportion of people who use services who feel safe	n/a	56.8	56.3	47.6		65.2	

Public Health indicators

Indicator	Local Number	Local Value	Comparator Average	Comparator Worst	Comparator Range	Comparator Best	Local Time Trend
0.2iii - MALE Inequality in life expectancy: the slope index	n/a	4.8	5.8	10.0		2.5	
0.2iii - FEMALE Inequality in life expectancy: the slope index	n/a	2.6	4.3	7.7		2.0	
2.06i - Child excess weight in 4-5 year olds	673	24.7	23.2	27.4		20.2	
2.06ii - Child excess weight in 10-11 year olds	1065	43.3	39.9	43.4		34.6	
2.12 - Excess weight in Adults	n/a	53.2	57.3	70.6		46.5	
2.14 - Smoking Prevalence in adults - current smokers	n/a	19.9	17.5	21.9		12.3	
2.15ii - Successful completion of drug treatment - non-opiate users	197	38.9	39.7	61.8		29.0	
2.18 - Admission episodes for alcohol-related conditions - narrow definition	1185	630.3	577.8	753.3		482.3	
2.20i - Cancer screening coverage - breast cancer	11110	63.1	65.8	61.4		73.3	
2.20ii - Cancer screening coverage - cervical cancer	60791	66.9	65.4	58.8		69.8	
2.02ii - Breastfeeding prevalence at 6-8 weeks after birth	3228	81.5	75.8	71.8		81.5	
2.22v - Cumulative % of eligible population who received an NHS Health check	21257	38.3	36.5	27.2		49.9	
2.23iv - Self-reported wellbeing - people with a high anxiety score	n/a	17.3	20.3	30.6		11.9	
3.03iii - Population vaccination coverage - Dtap / IPV / Hib (1 year old)	3645	83.0	89.7	82.9		94.8	
3.03x - Population vaccination coverage - MMR for two doses (5 years old)	3402	82.2	82.8	64.4		89.2	
3.04 - HIV late diagnosis	97	32.2	33.2	48.7		20.3	
4.03 - Mortality rate from causes considered preventable	892	218.9	196.1	230.4		159.7	
4.01 - Infant mortality	73	5.4	3.7	5.4		2.2	
4.10 - Suicide rate	59	9.2	9.1	11.3		6.7	

Notes: NHS indicators

1A – PROPOSED TO RETIRE. Time trend 2013 to 2014. CCG OIS
1B – Time trend 2008-10 to 2013-15. NHS Outcomes Framework
1.1 – Previous 1 year indicator recently replaced by NHS Digital with 3 year PHOF indicator, shown. Time trend 2008-10 to 2013-15
1.2 – Previous 1 year indicator recently replaced by NHS Digital with 3 year PHOF indicator, shown. Time trend 2008-10 to 2013-15
1.3 – PROPOSED TO RETIRE. Previous 1 year indicator recently replaced by NHS Digital with 3 year PHOF indicator, shown. Time trend 2008-10 to 2013-15
2.1 – Time trend 2011/12 to 2015/16. NHS Outcomes Framework
2.3i – PROPOSED TO RETIRE. Time trend 2010/11 to 2015/16. NHS Outcomes Framework
2.6i – Data is March 2015. Time trend not available. Source – Primary Care Web Tool
3A – PROPOSED TO RETIRE. Time trend 2010/11 to 2015/16. NHS Outcomes Framework
3.2– PROPOSED TO RETIRE. Time trend 2013/14 to 2015/16. NHS Outcomes Framework
4c – December 2016 data, Time trend not available. Percent answering “extremely likely” of total. Data for HUH compared to other London hospitals.
5.2 – PROPOSED TO RETIRE. Data for HUH 2015/16
1.10 – NEW INDICATOR. Time trend 2007 to 2013. CCG OIS
4.09i – NEW INDICATOR. Time trend 2009/10 to 2014/15. PHOF
2.11a – NEW INDICATOR. Time trend 2013/14 to 2014/15
P02173 - NEW INDICATOR. Time trend 2009/10 to 2014/15. NHS Outcomes Framework

Notes: Social Care indicators

1A – Time trend 2011/12 to 2015/16. Data source: ASCOF
1B – Time trend 2011/12 to 2015/16. Data source: ASCOF
1C(1A) – Time trend 2010/11 to 2014/15. Data source: ASCOF
1C(2A) – Time trend 2010/11 to 2014/15. Data source: ASCOF
1D – Time trend 2012/13 to 2014/15. Data source: ASCOF
1E – Time trend 2010/11 to 2014/15. Data source: ASCOF
1.18i – Time trend 2010/11 to 2015/16. Data source: ASCOF
1F – Time trend 2010/11 to 2015/16. Data source: ASCOF
2A(2) – Time trend 2010/11 to 2015/16. Data source: ASCOF
2B(1) – Time trend 2010/11 to 2015/16. Data source: ASCOF
2C(1) – Time trend 2010/11 to 2015/16. Data source: ASCOF
2D – NEW INDICATOR. Time trend 2014/15 to 2015/16. Data source: ASCOF
3A – Time trend 2010/11 to 2015/16. Data source: ASCOF

Notes: Public Health indicators

0.2iii - Range in years of life expectancy across social gradient – most to least deprived 10%. Hackney residents. Data source PHOF. Time trend shows 3 year rolling averages, 2008/10 to 2012/14.
2.06i,ii – City & Hackney state school children. Data source NCMP. Time trend shows 2010/11 to 2015/16
2.12 - Percentage of adults classified as overweight or obese. Data source – Annual Population Survey. Time trend 2012-14 to 2013-15
2.14 - Data source – Annual Population Survey. Time trend 2012 to 2015
2.15ii Time trend 2010 to 2015
2.18 – Time trend 2009/10 to 2014/15
2.20i & 2.20ii – Hackney residents. Data source PHOF. Most recent data 2015. Time trend shows calendar years 2010-15.
2.02 – Time trend 2010/11 to 2014/15. No data for 2013/14. Some comparator data missing.
2.22v – No time trend
2.23iv – Data source – Annual Population Survey. Time trend 2011/12 to 2014/15
3.03iii – Time trend 2010/11 to 2015/16
3.03x – Time trend 2010/11 to 2015/16
3.04 – Time trend 2009-11 to 2013-15
4.01 – DSR per 100,000. Time trend 2008-10 to 2013-15
4.03 – Crude rate per 1,000. Time trend 2008-10 to 2013-15
4.10 – DSR per 100,000. Time trend 2008-10 to 2013-15

Appendix 2: Summary of key results