Tower Hamlets Together Board

Tower Hamlets Together (THT) is a partnership of health and care commissioners and providers who are working together to deliver integrated health and care services for the population of Tower Hamlets. Building on our understanding of the local community and our experience of delivering local services and initiatives, THT partners are committed to improving the health of the local population, improving the quality of services and effectively managing the Tower Hamlets health and care pound. This is a meeting in common, also incorporating the Tower Hamlets Integrated Care Board Sub Committee.

Meeting in public on Thursday 2 March 2023, 0900-1100

Room 404, Tower Hamlets Town Hall, 160 Whitechapel Road, London, E1 1BJ **and by Microsoft Teams at this link**

Chair: Amy Gibbs

AGENDA

	Item	Time	Lead	Attached / verbal	Action required
1.	**Welcome, introductions and apologies:** a. Declaration of conflicts of interest b. Minutes of the meeting held on 2 February 2023 c. Action log	0900 (10 mins)	Chair	*Papers* Pages 1 -12	 Note Approve Discuss
2.	**Questions from the public**		Chair	*Verbal*	Discuss
3.	**Chair's updates**		Chair	*Verbal*	Note
4.	**System emerging issues – by escalation only**		Chair	*Verbal*	Discuss
5.	**User Voice – Maternity**	0910 (30 mins)	Karen Wint	*Paper 5a* Page 13 – 28	Discuss
6.	**Future Deep Dive cycle**	0940 (10 mins)	Ashton West	*Paper 6a* Page 29	Discuss

7.	**Update on the Fuller Report**	0950 (30 mins)	William Cunningham-Davis & Jo-Ann Sheldon	*Papers 7a* Pages 30 – 41	Discuss
8.	**Place Sub-Committee Terms of Reference**	1020 (20 mins)	Charlotte Pomery	*Paper 8a,8b,8c* Pages 42 – 88	Discuss/ Approval
9.	**Updates from:** · Local Delivery Board · Local Infrastructure Forum	1045 (15 mins)	Chris Banks	*Paper 9a,9b&9c* Pages 89 – 120 *Verbal*	Discuss
10.	**Any Other Business:** · Health inequalities funding update and prioritisation	1055 (5 mins)	Chair	*Verbal*	Note

Date of next meeting: Thursday 6 April 2023, 0900-1100 – Committee Room 1 – Ground Floor, Tower Hamlets Town Hall, 160 Whitechapel Road, London, E1 1BJ

- Declared Interests as at 22/02/2023

Name	Position/Relationship with ICB	Committees	Declared Interest	Name of the organisation/business	Nature of interest	Valid From	Valid To	Action taken to mitigate risk
Chetan Vyas	Director of Quality Development	Barking & Dagenham ICB Sub-committee Barking & Dagenham Partnership Board City & Hackney ICB Sub-committee City & Hackney Partnership Board Havering ICB Sub-committee Havering Partnership Board ICB Population, Health & Integration Committee ICB Quality, Safety & Improvement Committee Newham Health and Care Partnership Newham ICB Sub-committee Redbridge ICB Sub-committee Redbridge Partnership Board Tower Hamlets ICB Sub-committee Tower Hamlets Together Board Waltham Forest Health and Care Partnership Board Waltham Forest ICB Sub-committee	Indirect Interest	North East London CCG	Spouse is an employee of the CCG	2014-04-01		Declarations to be made at the beginning of meetings
			Indirect Interest	Some GP practices across NEL	Family members are registered patients - all practices not known nor are their registration dates	2014-04-01		Declarations to be made at the beginning of meetings
			Indirect Interest	Redbridge Gujarati Welfare Association - registered charity in London Borough of Redbridge	Family member is a Committee member.	2014-04-01		Declarations to be made at the beginning of meetings
James Thomas	Member of the Tower Hamlets Together Board and Place ICB Sub-Committee	Tower Hamlets ICB Sub-committee Tower Hamlets Together Board	Non-Financial Professional Interest	Innovation Unit & Tower Hamlets Education Partnership	Non-Executive Director	2022-09-01		Declarations to be made at the beginning of meetings
Khyati Bakhai	Primary care clinical lead and LTC lead	Tower Hamlets ICB Sub-committee Tower Hamlets Together Board	Financial Interest	bbbhp	Gp Partner	2012-09-03		
			Financial Interest	Greenlight@GP	Director for the education and training arm	2021-07-01		
			Non-Financial Professional Interest	RCGP	Author and review for clinical	2021-03-01		

					material			
Roberto Tamsanguan	Clinical Lead	Tower Hamlets ICB Sub-committee Tower Hamlets Together Board	Non-Financial Professional Interest	Bromley By Bow Health Centre	Salaried GP	2018-09-01		
			Non-Financial Professional Interest	Medical Practitioner Tribunal Service	Sit as a medical fitness to practice tribunal member	2020-07-01		
			Non-Financial Professional Interest	NHSX/ NHS ENGLAND/IMPROVEMENT	Clinical lead	2020-05-01		

- Nil Interests Declared as of 22/02/2023

Name	Position/Relationship with ICB	Committees	Declared Interest
William Cunningham-Davis	Director of Primary Care Transformation, TNW ICP	Newham Health and Care Partnership Newham ICB Sub-committee Primary care contracts sub-committee Tower Hamlets ICB Sub-committee Waltham Forest Health and Care Partnership Board Waltham Forest ICB Sub-committee	Indicated No Conflicts To Declare.
Richard Fradgley	Director of Integrated Care	Mental Health, Learning Disability & Autism Collaborative sub-committee Newham Health and Care Partnership Newham ICB Sub-committee Tower Hamlets ICB Sub-committee Tower Hamlets Together Board	Indicated No Conflicts To Declare.
Sunil Thakker	Director of Finance; C&H ICP & Acting Director of Finance; TNW ICP	Barking & Dagenham ICB Sub-committee Barking & Dagenham Partnership Board City & Hackney ICB Sub-committee City & Hackney Partnership Board Redbridge Partnership Board Tower Hamlets ICB Sub-committee Tower Hamlets Together Board Waltham Forest Health and Care Partnership Board Waltham Forest ICB Sub-committee	Indicated No Conflicts To Declare.
Warwick Tomsett	Director of Integrated Commissioning	Tower Hamlets ICB Sub-committee Tower Hamlets Together Board	Indicated No Conflicts To Declare.
Matthew Adrien	Partnership working	ICP Committee Tower Hamlets ICB Sub-committee Tower Hamlets Together Board	Indicated No Conflicts To Declare.
Amy Gibbs	Independent Chair of Tower Hamlets Together	Tower Hamlets ICB Sub-committee Tower Hamlets Together Board	Indicated No Conflicts To Declare.
Christopher Banks	Partner	Tower Hamlets ICB Sub-committee Tower Hamlets Together Board	Indicated No Conflicts To Declare.
Zainab Arian	Chief Executive Officer of GP Federation working within NEL ICS	Tower Hamlets ICB Sub-committee Tower Hamlets Together Board	Indicated No Conflicts To Declare.

DRAFT Minutes of the Tower Hamlets Together Board
Thursday 2 February 2023, 0900-1100 in person and via MS Teams

Minutes

Amy Gibbs	Independent Chair of the Tower Hamlets Together Board	In person
Warwick Tomsett	Director of Integrated Commissioning, NHS North East London & London Borough of Tower Hamlets	In person
Roberto Tamsanguan	Tower Hamlets Clinical / Care Director, NHS North East London	MS Teams
Neil Ashman	Chief Executive Officer, Royal London & Mile End Hospitals, Barts Health NHS Trust	MS Teams
Richard Fradgley	Director of Integrated Care & Deputy Chief Executive Officer, East London NHS Foundation Trust	MS Teams
Chris Banks	Joint Chief Executive Officer, Tower Hamlets GP Care Group	MS Teams
Matthew Adrien	Service Director, HealthWatch Tower Hamlets	MS Teams
James Thomas	Director of Community and Children's Services, London Borough of Tower Hamlets	In person
Khyati Bakhai	Tower Hamlets Primary Care Development Clinical Lead, NHS North East London	MS Teams
Somen Banerjee	Director of Public Health, London Borough of Tower Hamlets	In person
Vicky Scott	Chief Executive Officer Council for Voluntary Services	In person
Muna Hassan	Resident and community representative/Community Voice Lead	MS Teams
Attendees:		
Ashton West	Programme Lead, ICB & LBTH, NHS North East London & London Borough of Tower Hamlets	MS Teams
Suki Kaur	Deputy Director of Partnership Development, NHS North East London & London Borough of Tower Hamlets	MS Teams
Liam Crosby	Associate Director of Public Health for Healthy Adults, London Borough of Tower Hamlets	MS Teams
Cyril Eshareturi	Public Health Programme Lead | BAME Commission | London Borough of Tower Hamlets	MS Teams
Jon Williams	Engagement and Community Communications Manager (Tower Hamlets), NHS North East London	MS Teams
Sufia Alam		MS Teams
Safia Jama		MS Teams

Andrea Antoine	Deputy Director of Finance, NHS North East London	MS Teams
Abidah Kamali		
Claire Hogg	Director of Planned Care, North East London Acute Provider Collaborative & ICS	In person
Charlotte Pomery	Chief Participation and Place Officer, NHS North East London	In person
Matthew Knell	Senior Governance Manager, NHS North East London	In person
Madalina Bird	Minute taker, Governance Officer, NHS North East London	In person
Apologies:		
Sunil Thakker	Director of Finance; C&H ICP & Acting Director of Finance; TNW ICP	

Item	Agenda item and minute
1.	**Welcome, introductions and apologies**
	The Chair, Amy Gibbs (AG), welcomed members and attendees to the Tower Hamlets Together (THT) Board meeting and introduced Vicky Scott the new Chief Executive Officer of the Tower Hamlets Council for Voluntary Services (THCVS) and Muna Hassan who joined the Board as Community Voice Lead
1.a	<u>Declaration of conflicts of interest</u> The Board's attention was drawn to the circulated Register of Interest, asking members to ensure that their declarations of interest are up to date. Members who are outstanding the completion of their declarations have been sent reminder emails. No interests were declared with regards to the agenda of the Board.
1.b	<u>Minutes of the meeting held on Thursday 5 January 2023</u> The minutes of the previous meeting, which had taken place on Thursday 5 January were accepted without change.
1.c	<u>Action log</u> The Board received the action log with 8 actions due at the February 2023 meeting. The remaining 5 actions are due at the end of the month, or in March 2023, while 6 actions have been closed since the last meeting.
2.	**Questions from the public**
	No questions had been raised by the public and AG clarified that the meeting was not taking place in public on this occasion, but that future meetings of the Board would take place in public on a monthly basis, with the details advertised online.
3.	**Chair's updates**

	AG updated the Board, noting the following: • Will Tuckley, Chief Executive of London Borough of Tower Hamlets will be stepping down at the end of March. Any appointment or interim arrangements will be announced soon • The £100k the Board agreed as an investment in Antiracism Education is live now. Board to be updated with new developments • AM, WT and Roberto Tamsanguan (RT) met with the LGBTQ+ representants at the December meeting and have agreed shorter term work to use current networks to get information, challenge stereotypes and a more inclusive practice on the front line. The group will also work on longer term educational development needs packages that can be put in place for the partnership and will bring a short proposal back to the Board
4.	**System emerging issues – by escalation only:**
	No issues raised
5.	**User Voice – Black and women of colours experience of Domestic Violence and services**
	Sufia Alam (SA) from the London Muslim Centre and Safia Jama (SJ) from Women's Inclusive Team (WIT) joined the Board to support a discussion on black and women of colour's experience of Domestic Violence and services. SJ started the discussion with background information about WIT as a registered charity that has been working in TH for the last 20 years and supports women and their families with two premises one in Bethnal Green and one in Whitechapel. The charity tackles inequalities, have a contract with ELFT and Barts around access to Health and race in the Borough enabling a number of valuable insights towards Domestic Abuse (DA) services. WIT's established a long-standing trust that members and their families have for the organisation, facilitating a smoother access to services such as the Haawa Project. The goal from the outset was to reach out to a large population of women who required DA services and provide them with information about DA and its associated risks. Especially Somali community who are at risk of DA but not accessing mainstream services due to cultural context, language, etc and hope to continue the support work in the future and support more women in need WIT has directly supported over 62 domestic abuse survivors in 12 months (women (80% Somali, 10% Bangladeshi, 10% other Black & Asian minorities) and reached over 500 people through awareness campaigns via online and in-person events, other online resources, and social media. WIT have been able to respond to the local needs of BAME women, who had previously been under-represented by the local Tower Hamlets domestic abuse agencies. Prior to this, only 1 Somali woman sought direct help between 2020-2021 in Tower Hamlets. SA joined the discussion on behalf of London Muslim Centre (LMC) as a safe environment for survivors of DA with community language where it can interpret, give advice about the rights of women and use faith as a driver to make changes. AG thanked the presenters for sharing their impressive examples of the culturally sensitive work and the sensitive stories from women and opened the discussion to the members: • The Board wanted to know more about the pilot that the charity run and raised the question of funding in Primary Care for DA. The Board was

	advised that PC has access to IRIS Interventions – a specialist domestic violence and abuse (DVA) training, support and referral programme for General Practices that has been positively evaluated in a randomised controlled trial across TH. IRIS is a collaboration between primary care and third sector organisations specialising in DVA. • Concerns re domestic funding from Mayor of London, was at risk – now re commissioned by ICB. • Roberto, Warwick & Somen to catch up on future of service outside of meeting. • Also, consideration of single point of access as future of service may be worth exploring. • Members also wanted to make the connection with the Somali female children and LGBTQ that experience violence an abuse in the community and need support. • The members recognised the need to consider resources and funding for the service and how the Board will respond and take the learnings forward and how it is going to tie in with the co-production workshops. • All recognised the need to work together not only at Borough level but wider community. Make sure that people are not lost in the system, building trust and taking responsibility. • This is a big piece of work so a future deep dive to feedback on progress was suggested and to think about how to build on the work done in future Board discussions. **Action:** Muna, Vicky & Jon to work together to develop workshop(s) covering co-production. **Action:** Roberto, Warwick & Somen to catch up on future of service outside of meeting.
6.	**Culturally Appropriate Health Communication and Engagement Toolkit**
	Somen Banerjee (SB) and Cyril Eshareturi (CE) attended the Board to present and talk the Board through the Embedding the Culturally Appropriate Health Communication and Engagement Toolkit that has been shared with the papers for the meeting Key points of note included: • Work has come to the Board before in July 2022 and addresses the production of communications with communities and how it can be done more effectively • The toolkit has been co-produced with residents and the plan is to embed it across the system over one-year period and build evidence of how effective is with a report coming back to the Board in December that demonstrates what was done and the context of impact that outlines the challenge, how the toolkit was used, the consequence and what needs to be maintained or change • The ask of the Board is for a discussion on how members would like to use the toolkit in different organisations and take forward the learning AG thanked SB and CE for their presentation and asked for more details of barriers experienced. Members were advised that traditional communication does not work in a diverse community and that this problem is system wide not only TH related. The toolkit should be the norm and embedded in the system not additional as needs to serve the community. The connection and in-depth discussion with comms teams across the system is also a barrier. Standing item to be added to LDB to check on progress and resolve any problems/ issues

	Members suggested rewording toolkit in more straightforward language to support wider use as the toolkit is currently written in a graduate level language and the workforce in some of the organisations has English as their secondary language Members also suggested the use of the toolkit system wide **Action:** Standing item to be added to LDB to check on progress and resolve any problems/issues **Action:** Suki to liaise with partner comms groups and introduce Cyril/toolkit **Action:** Partners to link in with Cyril on email outside the meeting to nominate organisational leads to rollout toolkit
7.	**New Tower Hamlets Plan**
	Abidah Kamali (AK) joined the meeting to talk the boar through the slides included with the pack. Present the work done so far to develop a new partnership plan for the next 5 years and seek views/advice from the Board on: • Discussion/opportunity to help shape the plan • What can be learned from THT and wider partnership on key issues in terms of partnership ways of working, what can be done differently or better • How the Plan can support the Board's priorities and objectives and what the Board would like to see in the plan that would add value to the work the partnership is doing. Does the Board think that the Plan has a role in improving the access a quality of public services? Comments from the Board included: • Members enquired about the time frame for sign off of the plan and were advised the sign off is in May with 15th July for submission to the Cabinet which gives the Board few months to contribute and influence. Members can contribute at the Task and Finish Group • Identify a representative @ Task and Finish Group and how to use Charlotte Pomery's role more effectively • The need to link with improving principals of the Health and Wellbeing Strategies and the localities work/Base plan and building on it • Need for a system that connects beyond just the Health and Care System eg. Housing Association
8.	**Deep Dive: Waiting lists and elective backlog**
	Claire Hogg (CH) joined the meeting to provide the Board with a briefing on the elective recovery & transformation across North East London with specific information on Barts Health & the Royal London Hospital included in the slides shared with the meeting papers. It was set out that London as a whole is in a better position and patients are seen faster than if they live outside London and that while the system is under enormous emergency pressures and that means there are limits to what can be achieved in Planned Care Comments from the Board included: • Members raised the question of what can the Board do as a partnership and system wide to help with the situation described?

	The Board was asked to think of ways to make sure that people are waiting well and kept well informed and encourage residents to think about having their treatment/procedure outside their local borough. • The Board was also informed that a new website for NEL residents will go live at the end of the month and will support people with links to 'My Planned Care' which will also have links to to the national platform where they can see how long the waiting time is on average for a particular speciality. The website can also be used as a resource where the people of NEL can be directed to the right services, how to manage their conditions and access to MH psychologists' services while they wait • Good communication for Primary Care is needed and a workforce plan is key • Go through the list proactively in Primary and Secondary Care data sets to identify who is the most vulnerable and support **Action:** THT team to check in on local messaging on waiting lists/patients, to ensure that support is in place and that local people are aware that appointments may be delivered at partners hospitals **Action:** THT team to look at associated waiting times in e.g., social care etc to bring in full partnership support for waiters, considering probable IG issues that may need to overcome **Action:** THT team to link in TH website to the NEL 'my planned care' website when live to ensure full suite of support for local people
9.	**AOB: Community pharmacy**
	Khyati Bakhai (KB) updated the Board on the conversations taking place around Community pharmacy through Public Health in Primary Care and Medicine Optimization Team. A group was convened and the team has come together to understand where Community pharmacy seats with three main key areas of work: • 1. Understanding what services are currently offered across the patch • 2. Second piece of work is around technical fixes between community pharmacy and primary care • 3. What services could be provided A Community pharmacy Clinical Lead has been appointed for NEL Work around Independent Prescribing has started as well and NEL needs to apply for funding Members that need to be involved in the work to contact KB to be linked in.
	Next meeting: Thursday 2 March 2023, 0900-1100, Location Committee Room 1, Tower Hamlets Town Hall, 160 Whitechapel Road, London, E1 1BJ

Tower Hamlets Together Board Action Log

Action Ref	Action Raised Date	Action Description	Action Lead(s)	Action Due Date	Action Status	Action Update
0311-07	03 November 2022	AG and WT to pick up political influence element and how to raise with Will and the Mayor. Also to discuss the NEL engagement and how to take to the ICB committee concerns with dentistry and lack of availability.	Amy Gibbs & Warwick Tomsett	31/03/23	Open	01/12 update: conversations have taken place with CP, a formal meeting to take place to discuss NEL engagement and how to take dentistry concerns to the ICB Committee. SF updated that a meeting has been arranged with the LDC Chair, health secretary and commissioning lead to discuss dentistry
0112-02	01 December 2022	Warwick Tomsett (WT) to link with Somen Banerjee (SB) to look at what work can be done to create local training models aimed specifically at the LGBT+ community for clinicians and trainees.	Warwick Tomsett & Somen Banerjee	31/03/2023	Open	UPDATE TBC
0112-03	01 December 2022	WT to look at what information and guidance is available on Tower Hamlets Connect and that system partners are aware of the information to share with LGBT community.	Warwick Tomsett	05/01/2023	Open	05/01 update: follow up meeting taking place in Jan
0112-05	01 December 2022	KH and Chris Banks (CB) to discuss how rapid social prescribing can be included as part of the winter package.	Kelvin Hankins & Chris Banks	05/01/2023	Open	05/01 update: To update following meeting due between Bromley by Bow Centre and Ben
0501-09	05 January 2023	Questions from the public: Jon Williams to think about ways to encourage engagement from wider public participation	Jon Williams	02/02/2023	Open	Update TBC
0501-11	05 January 2023	**Scarlet fever:** AG and Warwick Tomsett (WT) to discuss how to bring the matter to the board in their forward planning meeting	Amy Gibbs & Warwick Tomsett	28/02/2023	Open	Update TBC
0501-12	05 January 2023	**User Voice – Spotlight Youth Space:** JW/AG/WT to identify where the recommendations best sat and let the board know the best way forward	Jon Williams, Amy Gibbs & Warwick Tomsett	02/02/2023	Open	Update TBC
0501-13	05 January 2023	**Integrated finance report:** WT to look at infrastructure needed to support Board on quality discussions	Warwick Tomsett	31/03/2023	Open	Update TBC
0501-014	05 January 2023	AG & WT to discuss how the Board will need to adapt to discuss financial management in the future, and what information will be needed	Amy Gibbs & Warwick Tomsett	31/03/2023	Open	Update TBC
0501-15	05 January 2023	Partners to meet soon to discuss upcoming financial plans as result of allocations having been released	Warwick Tomsett	02/02/2023	Open	Update TBC
0501-16	05 January 2023	**Fuller Report** WT to check in on whether Neighbourhoods Development role has gone out for advert yet	Warwick Tomsett	02/02/2023	Open	Update TBC
0202-19 0202-20	02 February 2023	**User Voice – Black and women of colours experience of Domestic Violence and services** Muna, Vicky & Jon to work together to develop workshop(s) covering co-production Roberto, Warwick & Somen to catch up on future of (Black and women of colours experience of Domestic Violence) service outside of meeting.	Jon Williams/Muna Hassan/Vicky Scott Warwick Tomsett/ Somen Banerjee/ Roberto	02/03/2023	Open	Update TBC

Action Ref	Action Raised Date	Action Description	Action Lead(s)	Action Due Date	Action Status	Action Update
0202-21 0202-22	02 February 2023	**Culturally Appropriate Health Communication and Engagement Toolkit:** Suki to liaise with partner comms groups and introduce Cyril/toolkit Partners to link in with Cyril on email outside the meeting to nominate organisational leads to rollout toolkit	Suki Kaur Cyril Eshareturi/ all	02/03/2023	Open	Update TBC
0202-23 0202-24 0202-25	02 February 2023	**Deep Dive: Waiting lists and elective backlog:** THT team to check in on local messaging on waiting, to ensure that support is in place and that local people are aware that appointments may be delivered at partners hospitals THT team to look at associated waiting times in eg, social care etc to bring in full partnership support for waiters, considering probable IG issues that may need to be overcome THT team to link in TH website to the NEL 'my planned care' website when live to ensure full suite of support for local people	Warwick Tomsett	02/03/2023	Open	Update TBC


WHFS
WOMEN'S HEALTH
& FAMILY SERVICES

A community of women diverse backgrounds, lived experiences, languages and knowledge

Women accessing our support programmes (400)

Volunteers, The Radicals (volunteers) Ethics committee (65)

WHFS Team (17)

Board of Trustees

Annie Karlin (Chair) – Director, Huma (AI Healthcare), previously Associate Director of Strategy, Bart's NHS Trust
Wendy Olayiwola – National Maternity Lead Inequalities, NHSE
Kam Kaur – Director of Operations, GP Care Group
Kate Brintworth – London Regional Director, Maternity
Dong Chen – Credit Suisse Bank (Treasurer)
Ayan Gulaid – Strategy and Policy Officer TH, non-exec GP Care Group
Alesha – GP
Jo Fowler – Phoenix Group, Marketing and Brand Strategy
Camilla Hampton - IT Strategy and Partnerships, HSBC Finance
Charlene Chandrasekaran Executive Director, The Orr, Communications

Our programmes Putting Women's Health First

Sharing experiences and insights

Locally

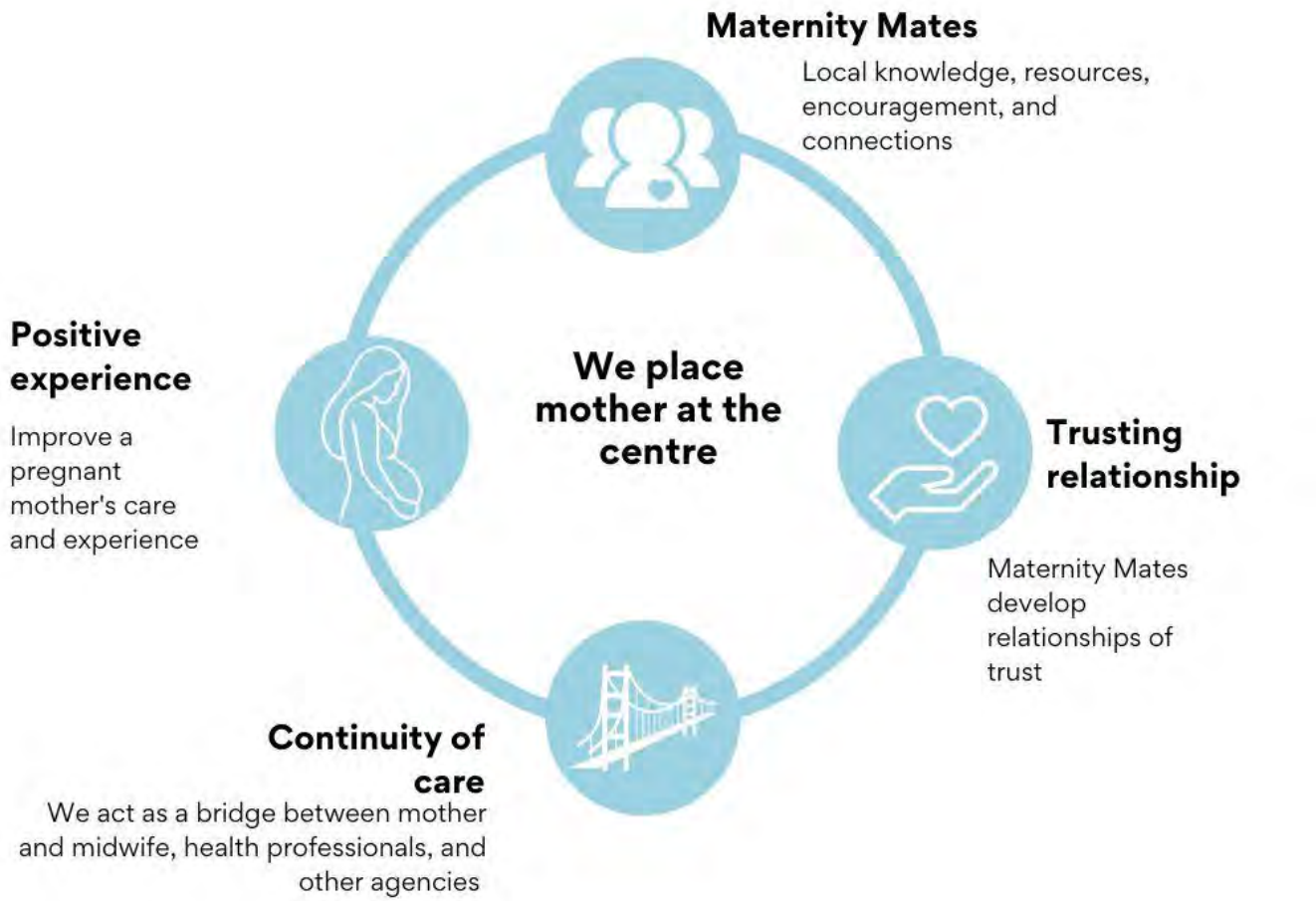
- Community Partner with NEL LMNS
- Maternity teams Bart's Health NHS Trust
- Early Years/Family Hub creation
- VAWG Committees

Nationally

- Co-chair the FGM National Network
- National Maternity Inequalities Committee member
- VAWG Metropolitan Police Committee
- NHSE VAWG and Women's Health
- National Charity partners e.g. Jo's Trust (Cervical Cancer), Solace (DA), NOUR (Trauma Counselling/women Asian backgrounds), Sharan Project (HBA)
- Research: Nottingham University/NIHR – role of virtual maternity care
- City University: Midwifery Degree courses
- Mental Health Foundation: How does the transport system affect access to maternal mental services

Maternity Mates

Improve pregnancy journey, rebuild confidence and agency



A journey with Maternity Mates

Referral & Matching

Support from 5th month
Initial call
MM and mum are introduced

Antenatal Support

Speak and meet regularly
Emotional support
Enabling mum think what is best for the baby
Birth plan

Pain relief options
Accompany in antenatal appointments
Advice and referrals to local services

Birth Support

Accompany mum during birth
Emotional support & encouragement
Emergency birth cover
Advocacy

Postnatal Support

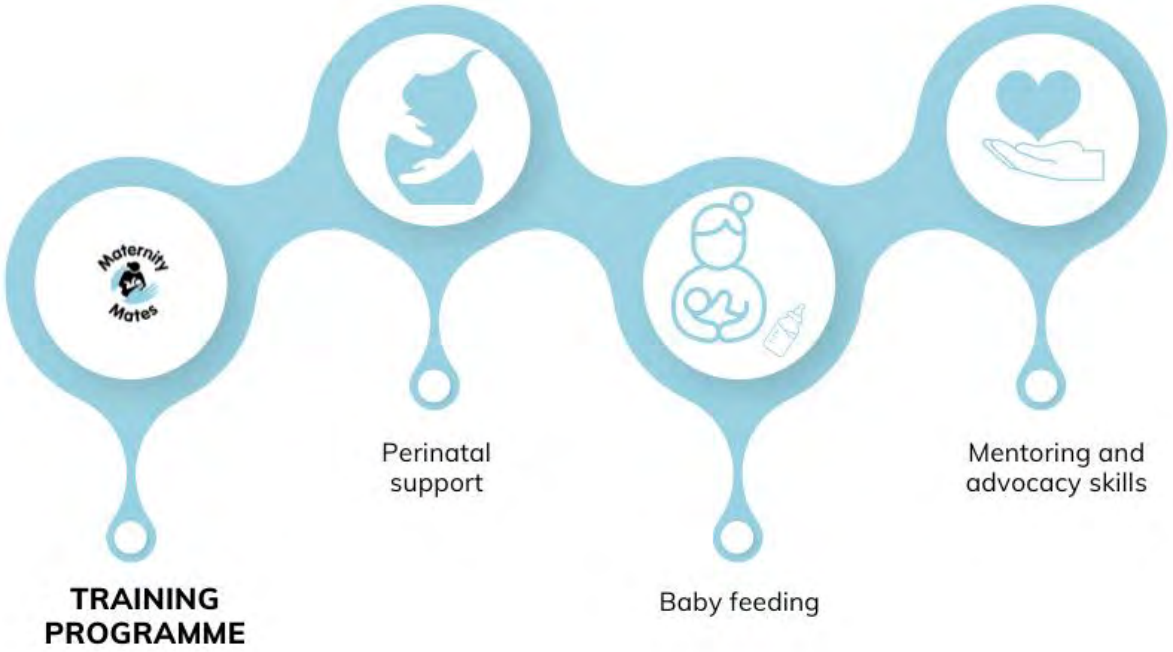
Up to 6 to 12 weeks
Postnatal visits to hospital
Baby feeding support
Introductions to local children's centres and mother & baby groups
Referrals to local services
Exit interview

Women we support
multiple, complex needs, intersectionality

Lack of support / isolated from family/friends	Recovering from domestic violence	Who have mental health issues (mild depression / stress/anxiety, OCD, panic attacks / previous traumatic birth)	English is not her first language
Financial difficulties (unable to work /access benefits)	Who are homeless (temporary accommodation)	Who have/had substance misuse	Women who are new to the UK and who are an asylum seeker or have refugee status

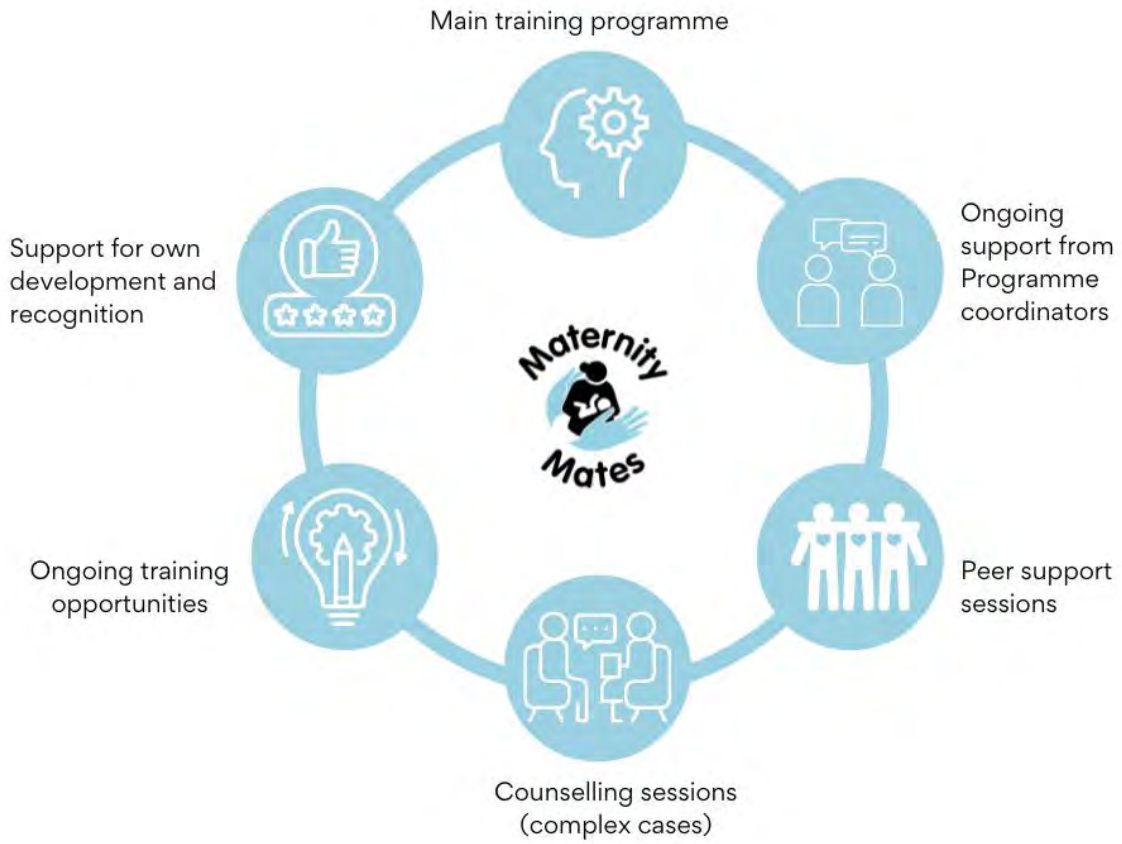
Ensuring we are always there

- **Out-of-hours service:** has been developed in response to mum and mates' needs. Staff are available evenings, weekends, and bank holidays.
- **Emergency Birth Cover:** for any mum who goes into labour outside of their estimated due date and their allocated MM is not available. An experienced MM steps in to support during labour, birth, and post-natal hospital visit.
- **Development of a pool of sessional bilingual workers** - On-going recruitment to fill the pool of languages needed for our mums.



Maternity Mates training programme
trauma informed and culturally competent

- All Maternity Mates undergo a 5-week training programme, which is accredited to Level 3 with the Open College Network (OCN).



Support for Maternity Mates

Amanda's Journey

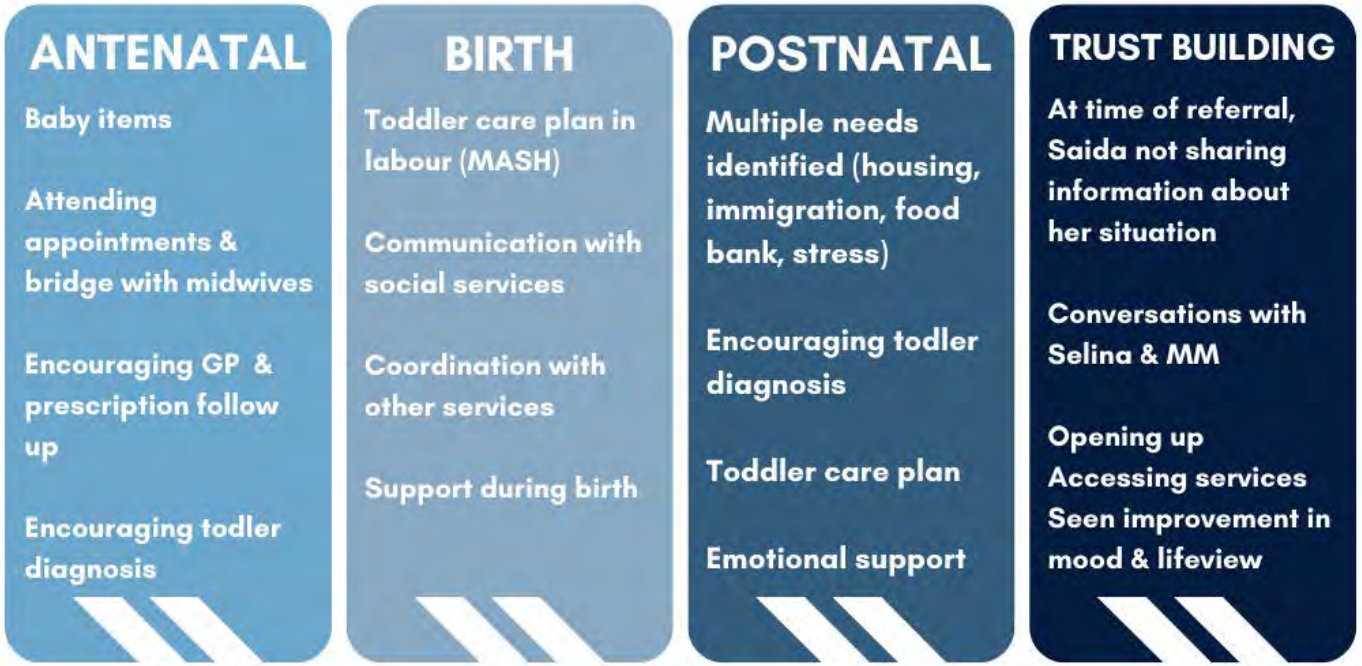
Amanda, 32, is pregnant with her second baby. She had a very traumatic c-section and postnatal experience with her first baby, that is still being investigated by the hospital. Her first child is very unwell with an uncertain prognosis. She would like a vaginal birth after caesarean (VBAC) and is very anxious.

Summary

- **Traumatic 1st birth** leading to **anxiety and fear** about returning to Whipps Cross for this pregnancy
- **Negative experience** with VBAC care pathway, felt **condescended**, **threatened** and **judged**
- Care improved upon referral to Birth Choices team, concerns remained that on the day of labour she would have to fight for her plan, so **requested MM support at birth help advocate in labour**
- From arrival in triage, midwives were **kind, understanding and compassionate** & had **read her notes** and birth plan
- **Supported her choices** - no negotiations were necessary
- MM ended up having to do no explaining or advocating because staff were respectful
- Admitted to birth centre, midwife was **calm, respectful and reassuring**
- Midwife **reassured & listened to mum** and encouraged her to follow her body - team effort with MM & mum's partner

Case Study 2

Saida and her 18 month old daughter were staying with a family whose son she was taking care of. They were sleeping in a sofa. It seemed she had overstayed in the UK and had no financial nor housing support available. She had no family or friends.



Outcomes

- Ongoing support during hardship
- Someone to talk to and share the experience of loss with someone who was there
- Improved relationship and collaboration with midwives and social services

- Saida and the baby are now living in a bretter flat in East Ham - receiving support for improvements
- She doesn't leave her baby's side

- She continues to receive support form local organisations
- She knows to attend Children Centre when needed
- She is working with a lawyer to sort immigration status before pursuing legal action


She is like an angel
Being there when she most needed it was one of the most wonderful things I could've done
She was like a sister
I'm really happy and lucky I found such support, so thank you
She was there for me
My MM gave me reassurance
I will never forget my first labour and my Maternity Mate support throughout the process. She stayed with me until the very end.
She's been amazing, encouraging, and empowering

Our asks

Innovate how we co-design with communities, meaningful engagement….

What can we do about the ‘bouncing effect’ ?

Housing!

For discussion: future deep dives / items

- Are the current topics still relevant?
- Can anything else be identified that should be added to the forward plan?
- Which of these (4-5) should be prioritised for discussion this year?

From current forward plan
Dementia
Children's needs post lockdown
Working age disabilities
Provider alliances – community, acute, primary care, MH
SEND services – programme of work
Workforce pressures
TH Local Primary Care Strategy

New suggestions received so far
GP access and capacity
Autism & ADHD
Cancer screening and 2 week referral waiting times
Childhood obesity
Equalities work

Tower Hamlets
- the Fuller Recommendations

2nd March 2023

Summary of key Fuller recommendations

1. Develop a single integrated approach to managing integrated urgent care to guarantee same day access for patients and more sustainable model for practices.
2. Strong emphasis on continuity of care particularly for people with long term conditions, multi-morbidity and complex needs.
3. Ensure all PCNs evolve into integrated neighbourhood teams providing better continuity and preventative healthcare as well as access, with a blended generalist and specialist workforce drawn from all sectors. This is a key aim of Fuller and PCN development should focus on enabling them to drive the integrated neighbourhood team.
4. Digital, Estates, Workforce, Data and Information all required to drive delivery of integrated neighbourhood teams.
5. Strong role at a Place and NEL system level to oversee and drive delivery.

Trying to drive change through general practice alone does not work – in order to deliver the changes that our residents want and need to see is everyone's challenge to address.

What the Fuller stocktake report means for key stakeholders

For Patients & Communities

- More **streamlined access to care** and advice for people who get ill but only use health services infrequently:
- **Increased choice** about how patients access care;
- **More proactive, personalised care** with support from a **multidisciplinary team of professionals** to people with more complex needs, including, but not limited to, those with multiple long-term conditions ;
- A more ambitious and **joined-up approach to prevention;**
- **Increased ability to influence quality of care**; through patient-reported experience measures;
- **Reduction in inequalities and variations** in access to and quality of care within their communities.

For Primary Care Networks

- Increased **joined-up working with different parts of the system** - including community and mental health, secondary care clinicians, community pharmacy, dentistry, optometry and audiology;
- Increased **support for primary care workforce resilience;**
- Increased need and support for **developing multi-professional care and clinical leadership within primary care;**
- Increased **representation of primary care in key health and care forums** at place level;
- Increased **population health-based personalisation of primary care offer** at neighbourhood level.

For the system

- Increased **support and imperative for integrated estates-planning to support co-location of multidisciplinary teams;**
- Increased **ability at "system level" to determine and access primary care funding**; and increased focus on primary care spending vis a vis system allocations

Fuller Stocktake report – initial high level mapping of Tower Hamlets against the Fuller recommendations

Completed by Primary Care, ELFT, Bart's, LBTH, CVS

Fuller Stocktake report – summary of key actions for Tower Hamlets

The Fuller Stocktake Report includes a framework for shared action, setting out **15** actions for ICSs, DHSC, NHS England and HEE.
The 8 actions specifically for ICSs and Placed Based Partnerships are:

Action *Numbering below reflects numbering in the Fuller report framework for action pages 34-36*	**What does this mean for us in Tower Hamlets? Where are the gaps?**	**Do we have examples already?**	**Alignment with existing workstreams**	**Provider**
1. Develop a single system-wide approach to managing integrated urgent care to guarantee same-day care for patients and a more sustainable model for practices. This should be for all patients clinically assessed as requiring urgent care, where continuity from the same team is not a priority. Same-day access for urgent care would involve care from the most clinically appropriate local service and professional and the most appropriate modality, whether a remote consultation or face to face. • Develop new metrics and standards for access including new patient-reported experience measures • Deliver better continuity of care by having better urgent care access • Co-locate teams around the needs of the population with blended expertise and easy access to diagnostics	TH does not have an integrated approach to managing same day UEC outside of A&E (GP, GP OOH, UTC, Community 2 hour response,111) Fuller review focus is on urgent care outside of the hospital and delivered at Neighbourhood level (30 to 50,000 population). The model indicates a need to join up triage of all same day requests at Neighbourhood level. The infrastructure for this is not currently in place	Advice and Guidance – new ways to interface between providers Emergency GP Hotline to RLH CHS Rapid response and falls prevention service Physician Response Unit .	Across all workstreams UCWG and/or Primary Care Transformation Group Promoting Independence Promoting Independence UCR/111 pilot (NEL Community Based Care Group)	Primary Care Barts ELFT Barts

Fuller Stocktake report – summary of key actions for Tower Hamlets

Action *Numbering below reflects numbering in the Fuller report framework for action pages 34-36*	What does this mean for us in TH? Where are the gaps?	Do we have examples already?	Alignment with existing workstream	Provider
3. Enable all PCNs to evolve into integrated neighbourhood teams, supporting better continuity and preventive healthcare as well as access, with a blended generalist and specialist workforce drawn from all sectors. Secondary care consultants – including, for example, geriatricians, respiratory consultants, paediatricians and psychiatrists – should be aligned to neighbourhood teams with commitments reflected in job plans, along with members of community and mental health teams. With teams collocated within neighbourhoods, to extend models of personalised care, embed enhanced health in care homes and develop a consistent set of diagnostic tests. At place level, bring together teams on admissions avoidance, discharge and flow – including urgent community response, virtual wards and community mental health crisis teams. Focus on community engagement and outreach, across the life course. Proactively identify and target individuals who can benefit from interventions in neighbourhoods, committing to delivering neighbourhood teams first for Core20PLUS5 populations by April 2023. Co-ordinate vaccinations, screening and health checks at place level, in accordance with national standards.	Teams are structured geographically by locality. AADS, reablement & rehab, SW, DN, CN, social prescribers, practice pharmacy but not integrated or led by joint management PCNs currently GP focused although do have Social Prescribers and Pharmacists. Initial discussions about strengthening links with pharmacy taking place. Indicates much greater involvement from acute and MH providers MDT cover is reliant on certain individuals	TH CHS Extended Primary Care Teams aligned with PCN localities & attend MDTs, and run locality-level Safety Huddles Joint Care Home MDT's with GP, care home staff, Consultant Geriatrician and mental health team Frailty Pilot Weekly rapid response team with Geriatrician MDT support NW7 Asthma/COPD Pilot Public Health communities team / Localities managers – work to support LHWBCs Locality / Ward profiles – publishing census and wider data at sub-borough level for local insight Local Enhanced Service; LTC, Integrated Care, and Physical	Across workstreams Promoting Independence Promoting Independence Promoting Independence Living Well Living Well Living Well Across	ELFT Barts Barts/Primary Care Barts Primary Care Public Health Public Health Primary Care

Fuller Stocktake report – summary of key actions for Tower Hamlets

Action *Numbering below reflects numbering in the Fuller report framework for action pages 34-36*	What does this mean for us in TH? Where are the gaps?	Do we have examples already?	Alignment with existing workstream	Provider
4. Co-design and put in place the appropriate infrastructure and support for all neighbourhood teams, across their functions including digital, data, intelligence and quality improvement, HR, finance, workforce plans and models, and estates. Specifically put in place sufficient support for all PCN clinical directors and multi-professional leadership development, and protected time for team development. Baseline the existing organisational capacity and capacity for primary care, across system, place and neighbourhood levels, to ensure systems can undertake their core operational and transformation functions.	Back office support to PCNs is a work in progress. PCNs starting to collaborate together, initiatives in place to enable PCNs to deliver on behalf of each other. Transformation programmes in place through enhanced service enablers. Some back office support provided by GP Federations Digital Exclusion Need to agree scope and baseline criteria to be used and impact of CHS capacity on PC capacity	Procuring EMIS licences for PCN inter-operability Digital patient self serve; NHS app uptake and note access. Allowing pts to book appts/see results freeing up receptionist capacity Digital Exclusion programme & Children and Young People access to primary care (PCN LES) PH Communities team "Locality Managers" - moving back to pre-pandemic role in supporting LHWBCs and others All referrals come via advice and guidance for frailty clinic reducing rejection Remote Patient Monitoring avoiding hospital attendance Virtual Wards initially supporting early discharge, and later admissions avoidance	PCTG PCTG PCTG Living Well Promoting Independence Promoting Independence/ Living Well Promoting Independence	Primary Care Primary Care Primary Care Public Health Barts Primary Care Barts
5. Develop a primary care forum or network at system level, with suitable credibility and breadth of views, including professional representation. Ensure primary care is represented on all place-based boards Encourage multi professional workforce and leadership	Primary care – GPs represented at the THT Board. Work progressing to look at role of broader primary care e.g. community pharmacy, dentistry in the partnership and delivery. Locality Health and Wellbeing	4 Locality Health & Wellbeing Committees with multi professional involvement Upcoming PLT Session focusing on blurring boundaries and practical joint working across system Primary Care Transformation Group has been relaunched	Living Well PCTG PCTG	Primary Care/CHS Primary Care Primary

Fuller Stocktake report – summary of key actions for Tower Hamlets

Action *Numbering below reflects numbering in the Fuller report framework for action pages 34-36*	What does this mean for us in TH? Where are the gaps?	Do we have examples already?	Alignment with existing workstream	Provider
6. Embed primary care workforce as an integral part of system thinking, planning and delivery. Develop system level workforce data to inform long term strategy. Improve workforce data. Support innovative employment models and adoption of NHS terms and conditions. Support the development of training and supervision, recruitment and retention and increased participation of the workforce, including GPs.	Needs to be closer alignment to workforce initiatives in other parts of the system i.e.. CHS	TH CHS willing to train primary care GP practice staff in specialisms	PCTG	ELFT
	Opportunities exist at Place and multi-place level for roles that work across the vertical integration boundaries	TH CHS willing to input into learning events where providers share learning	Across	ELFT
		Coaching and mentoring offer for junior nurses to try Primary Care	PCTG	Primary Care
		ICB funded PCN CD leadership development	PCTG	Primary Care
		PCN workforce review: Standardised T&C's to limit competition within the borough	PCTG	Primary Care
10. Develop a system-wide estates plan to support fit-for-purpose buildings for neighbourhood and place teams delivering integrated primary care, taking a 'one public estate' approach by using perspectives on access, population health and health inequalities. Maximise the use of community assets and spaces.	We have the Local Infrastructure Forum (LIF) which is being refreshed and will have an interim chair. There is a joint estates	PH and PC input into Infrastructure Delivery Plan	Living Well	Public Health
		PH input into development of next Local Plan	Living Well	Public Health

Fuller Stocktake report – summary of key actions for Tower Hamlets

Action *Numbering below reflects numbering in the Fuller report framework for action pages 34-36*	What does this mean for us in TH? Where are the gaps?	Do we have examples already?	Local Implication / alignment with existing workstream	Provider
12. Create a clear development plan to support the sustainability of PC & translate framework provided by Next steps for integrated PC into reality, across all neighbourhoods. Ensure a particular focus on unwarranted variation in access, experience and outcomes. Ensure understanding of current spending distribution across primary care, compared with the system allocation and health inequalities. Support primary care where it wants to work with other providers at scale, by establishing or joining provider collaboratives, GP federations, supra-PCNs or working with or as part of community mental health and acute providers. Tackle gaps in provision, including where appropriate, commissioning new providers in particular for the least well-served communities.		TH CHS leading a Quality Improvement project to improve communication with GPs Frailty clinic assesses MH as well as physical health so if needed can refer to MH services directly (rather than asking GP to do this) TH CHS Alliance ongoing Contract Review; Single Point of Access redesign; locality-level Safety Huddles run by TH CHS	Living Well and/or PCTG Promoting Independence Across	ELFT Barts ELFT
13 . Work alongside local people and communities in the planning and implementation process of the actions set out above, ensuring that these plans are appropriately tailored to local needs and preferences, taking into account demographic and cultural factors.		Healthspot – access to Primary Care within a Youth Centre with YP voice and input into service provision ELFT Annual Planning meetings engaging members of local community City of London work around evaluating co-production PH Outreach (currently 'community navigators' and 'Ambassadors' – but likely to re-model	Born Well Growing Well Across Across Living Well	Primary Care Primary Care Public Health Public Health

Fuller action at place	Comments from TH Fuller working group	Current status
13- Work alongside local people and communities	Should be priority 1	Variable delivery from practices and PCNs. Very much part of the health and well being communities redesign plan
5- Develop a primary Care Forum or network at system level	Focus at Tower Hamlets level	New primary care transformation meeting has been developed by merging previous meetings- mainly GP focussed currently (ICB/ PCN/ GPCG, chair Dr Khyati Bakhai)
10- Develop system wide estates plan – for neighbourhood and place teams delivering integrated primary care	-Needs strong ownership at THT level -Learning from the pandemic needs to include digital and the disability access and digital exclusion learning Stocktake done at NEL level made available to PCNs but not yet utilised	What are THT doing in this area? Not yet utilised

Fuller action at place	Comments	Current status
12- Create a clear development plan to support the sustainability of PC & translate Fuller stocktake framework into reality, across all neighbourhoods	-Current ICB funded OD for PCN CDs and CHS contract review align with this -Needs strong ownership at THT level- -Learning from the pandemic needs to include digital and the disability access and digital exclusion learning	Conversations across CHS contract providers need pulling together with the PCN/ primary care transformation work. First workshop 16/3/23
6- Embed PC workforce as an integral part of system planning & delivery	Is PCN/ GPCG workstream aligned with THT group?	Lots of work around ARRS roles/with CEPN for GP and PCNs- system focus needs further development
3- Enable all PCNs to evolve into integrated neighbourhood teams	Lack of strategic clarity/ grass roots ownership around this	
4- Co-design and put in place the appropriate infrastructure and support for all neighbourhoods	Taking a wide view of neighbourhoods to include health promotion and inequalities- public health	Planned THT localities and neighbourhoods redesign programme getting started (Suki Kaur- clinical leads Isabel Hodkinson and Kerry Greenan)

The journey so far and next steps

- Small working group convened across system – 2 meetings so far
- All teams contributed to initial mapping exercise
- What are we trying to do – do the principles of Fuller align with Locality development?
- Event - 16th March Workshop focussing on integrated neighbourhood teams/Joint working across system
- How do we go further:
  - Identify Leads
  - Consider resource needs
    - What is currently delivering and does not need resource
    - What resource do we need from THT & NEL
    - PMO support

Tower Hamlets Together place sub-committee

2 March 2023

Title of report	Place Sub-Committee Terms of Reference
Author	Anne-Marie Keliris, Head of Governance
Presented by	Charlotte Pomery – Chief Participation and Place Officer
Contact for further information	charlotte.pomery@nhs.net
Executive summary	Colleagues across the Integrated Care System (ICS) partner organisations undertook a considerable amount of work in advance of the Integrated Care Board's (ICB) establishment on 1 July 2022 to determine the form and governance of the seven Place Based Partnerships. Broadly, the seven Place ICB Sub-Committees have consistent terms of reference, and the seven Partnership Boards have recognisably similar terms of reference but with variation to reflect local preferences, needs and vision. Building on the pre-existing relationships across north east London and the collaborations already in place, the intention for the Place governance in 'year one' was to make use of the new flexibilities in the legislation to establish a governance mechanism which would enable: (a) more formal integrated ways of working involving the broad range of partners across the ICS; and (b) the lawful and efficient delegation of functions based on the principle of subsidiarity. It was also important to ensure the governance arrangements enabled 'an evolutionary approach' where Places could take on increasing responsibility for aspects of the ICB's work overtime. This was consistent with national guidance which encouraged systems to 'build by doing.' The Place Mutual Accountability Framework ('MAF'), which has been developed through engagement, is now a significant step forward in this evolution. The MAF describes the activities intended to be undertaken at Place in a user-friendly, narrative form. The MAF will continue to be developed overtime, alongside the ICB's financial framework which is also important for understanding Places' responsibilities. The MAF will also need to be considered alongside an equivalent document proposed for the provider collaboratives, in order to make clear the delineation between the work done at Place and the work done by the collaboratives. However, the MAF gives a good level of clarity about the delegation of functions to Place and it is appropriate to

	reflect that in the Place governance as we move beyond year one. Accordingly, the terms of reference have been updated to tie in the MAF. This has been proposed in a way which avoids substantial redrafting or disruption to the arrangements which are now bedding in. The proposed changes made to the terms of reference are shown in tracked changes. But, in summary, the amendments involve adding a number of cross-references to the MAF throughout the document (especially at Annex 1) and adding references to the ICB's financial framework whilst recognising that the financial framework will continue to be developed during 2023/24. It was originally envisaged that Annex 1 would include a list of specific services that Places would have delegated commissioning responsibility. However, the suggested approach of linking the Annex to the MAF enables the arrangements for delegation to be updated from time to time without the need for revision to the seven sets of terms of reference. The approach enables an appropriate level of flexibility to continue the ongoing conversation about where and how functions are best exercised (e.g. taking into account any relevant learning from emerging practice across other ICSs and developing NHS England and Government policy). However, given the significance of the MAF in describing the delegation of functions to Place, any revision to it will require approval by the ICB. This has been secured by incorporating the MAF into the ICB's Governance Handbook. The MAF therefore has a similar status to the ICB's Scheme of Reservation and Delegation (SORD) or its Standing Financial Instructions.
Action required	Approval
Previous reporting	A first draft of the mutual accountability framework has been discussed for feedback at each place partnership and the ICB Executive Committee
Next steps/ onward reporting	Formal approval through ICB Board and update to the ICB governance handbook.
Conflicts of interest	None
Strategic fit	The terms of reference and mutual accountability framework is designed to support place partnerships to contribute to the achievement of all of the north east London's integrated care system's objectives: • to improve outcomes in population health and healthcare; • to tackle inequalities in outcomes, experience and access; • to enhance productivity and value for money; and • to support broader social and economic development.
Impact on local people, health inequalities and sustainability	North east London has a long history of successful pace-based working. Strengthening and spreading this across the integrated

	care system is critical to our overall success because places are: • where the NHS, local authorities, and the voluntary and community sector integrate delivery, supporting seamless and joined up care; • where we will most effectively tackle many health inequalities through prevention, early intervention, and community development, including at neighbourhood level; • where diverse engagement networks generate rich insight into residents' views; • where we can build detailed understandings of need and assets on a very local basis and respond with appropriate support; and • where the NHS and local authorities as a partnership are held democratically accountable. This mutual accountability framework, when formally signed off, is designed to support place partnerships to fulfil these functions, in the interests of all residents.
Impact on finance, performance and quality	There are no additional resource implications (either revenue or capitals costs) arising directly from this report. However, the mutual accountability framework is designed explicitly to increase subsidiarity within north east London's integrated care system by empowering place partnerships with accountabilities across finance, performance, and quality. These will be captured in an updated version of the terms of reference for each Place's NHS north east London sub-committee.
Risks	There is a risk that, without clear articulation of the roles and responsibilities of each part of the integrated care system, partners will collectively not allocate resources and deliver transformation to best drive meaningful improvements to health, wellbeing, and equity in north east London. This document is, alongside complementary work being done on the accountabilities of other parts of the integrated care system, part of the mitigation of this risk.

TOWER HAMLETS
PLACE-BASED PARTNERSHIP

TERMS OF REFERENCE

Contents

INTRODUCTION

1. The following health and care partner organisations, which are part of the North East London Integrated Care System ('**ICS**') have come together as a Place-Based Partnership ('**PBP**') to enable the improvement of health, wellbeing and equity in the Tower Hamlets area ('**Place**'):

    (a) Barts Health NHS Trust ('**Barts**')

    (b) East London NHS Foundation Trust ('**ELFT**')

    (c) London Borough of Tower Hamlets ('**LBTH**')

    (d) Tower Hamlets GP Care Group ('**GPCG**')

    (e) The NHS North East London Integrated Care Board (the '**ICB**')

    (f) Tower Hamlets Council of Voluntary Services

    (g) Primary Care Networks

    (h) Healthwatch

2. 'Place' for the purpose of these terms of reference means the geographical area which is coterminous with the administrative boundaries of LBTH.

3. These terms of reference for the PBP incorporate:

    (a) As Section 1, terms of reference for the Tower Hamlets Together Board (the '**THT Board**'), which is the collective governance vehicle established by the partner organisations to collaborate on strategic policy matters and oversee joint programmes of work relevant to Place.

    (b) As Section 2, terms of reference for any committees/sub-committees or other governance structures established by the partner organisations at Place for the purposes of enabling statutory decision-making. Section 2 currently includes terms of reference for:

        - The Tower Hamlets Place ICB Sub-Committee of the North East London Integrated Care Board (the '**Place ICB Sub-Committee'**), which is a sub-Committee of the ICB's Population Health & Integration Committee ('**PH&I Committee'**).

4. As far as possible, the partner organisations will aim to exercise their relevant statutory functions within the PBP governance structure, including as part of meetings of the THT Board. This will be enabled: (i) through delegations by the partner organisations to specific individuals; or (ii) through specific committees/sub-committees established by the partner organisations meeting as part of, or in parallel with, the THT Board.

5. Section 2 contains arrangements that apply where a formal decision needs to be taken solely by a partner organisation acting in its statutory capacity. Where a

committee/sub-committee has been established by a partner organisation to take such statutory decisions at Place, the terms of reference for that statutory structure will be contained in Section 2 below. Any such structure will have been granted delegated authority by the partner organisation which established it, in order to make binding decisions at Place on the partner organisation's behalf. The Place ICB Sub-Committee is one such structure and, as described in Section 2, it has delegated authority to exercise certain ICB functions at Place.

6. There is overlap in the membership of the THT Board and the governance structures described in Section 2. In the case of the THT Board and the Place ICB Sub-Committee, the overlap is significant because each structure is striving to operate in an integrated way and hold meetings in tandem.

7. Where a member of the THT Board is not also a member of a structure described in Section 2, it is expected that the THT Board member will receive a standing invitation to meetings of those structures (which may be held in tandem with THT Board meetings) and, where appropriate, will be permitted to contribute to discussions at such meetings to help inform decision-making. This is, however, subject to any specific legal restrictions applying to the functions or partner organisations and subject to conflict of interest management.

8. All members of the THT Board or a structure whose terms of reference are contained at Section 2 shall follow the Seven Principles of Public Life (also commonly referred to as the Nolan Principles), which are: selflessness, integrity, objectivity, accountability, openness, honesty and leadership.

Section 1
Terms of reference for the THT Board

Status of the THT Board	1. Tower Hamlets Together (THT) is a partnership of health and care organisations who are working together to deliver integrated health and care services for the population of Tower Hamlets. Building on our understanding of the local community and our experience of delivering local services and initiatives, THT partners are committed to improving the health of the local population, improving the quality of services and effectively managing the Tower Hamlets health and care pound. 2. The THT Board does not have any formally delegated responsibilities from any of the respective partner organisations. The Board is, however, constituted by representatives of each of the respective partner organisations, who will represent the views of their organisation on matters relevant to Place, and who intend to work together in accordance with the THT values, vision, mission and purpose outlined below. 3. Where applicable, the THT Board may also make recommendations on matters a partner organisation asks the THT Board to consider on its behalf.
Geographical coverage	4. The geographical area covered will be Place, which for the purpose of these Terms of Reference is the area which is coterminous with the administrative boundaries of the LBTH.
Vision, mission and values	5. Our vision: (a) Tower Hamlets residents, whatever their backgrounds and needs, are supported to thrive and achieve their health and life goals, reducing inequalities and isolation. (b) Health and social care services in Tower Hamlets are high quality, good value and designed around people's needs, across physical and mental health and throughout primary, secondary and social care. (c) Service users, carers and residents are active and equal partners in health and care, equipped to work collaboratively with THT partners to plan, deliver and strengthen local services. 6. Our mission is to transform people's health and lives in Tower Hamlets, reducing inequalities and reorganising services to match people's needs. 7. Our values: (a) **We are collaborative** (b) **We are compassionate**

(c) **We are inclusive**

(d) **We are accountable**

Role of the THT Board

8. The THT Board is responsible for furthering the strategic development of health and social care with key partners, including the voluntary and community services sector, education, communities and with the scope to involve other key system partners at Place. It is responsible for building effective relationships across the system at Place.

9. The Board will have a leading role in promoting the health of the population of the borough and the oversight of health and social care integration, including service redesign, transformation and innovation. Integration is a key local priority. Board members will identify opportunities to improve outcomes and reduce costs, duplication and implement joint working to address this. The ethos of partnership working will underpin the programme of work, recognising that, on occasions, difficult decisions may be required by partners in order to deliver improvements for the Tower Hamlets population.

10. The THT Board has the following core responsibilities:

(a) In the domain of leadership at Place, to provide:

- visible and engaged collective leadership at Place, articulating to staff and citizens the benefits of the partnership and of integrated working beyond our respective partner organisations.
- leadership and direction in promoting the health of the Tower Hamlets population.
- leadership and direction in the integration of health and social care services in the borough.

(b) To prioritise and shape the overall approach to health and social care integration in the borough to best address local needs, which shall include setting a local system vision and strategy, reflecting the priorities determined by local residents and communities at Place, the contribution of Place to the ICS, and relevant system plans including:

- the Integrated Care Strategy produced by the NEL Integrated Care Partnership ('**ICP**');
- the 'Joint Forward Plan' prepared by the ICB and its NHS Trust and Foundation Trust partners;
- the joint local health and wellbeing strategy produced by the Tower Hamlets Health and Wellbeing Board

('**HWB**'), together with the needs assessment for the area;

- as appropriate, the Tower Hamlets Community Plan, developed by the Tower Hamlets Strategic Partnership, and the Healthy London Partnership and London Mayor's Health Inequalities Strategy.
- the Place Mutual Accountability Framework.[1]

(c) To develop the Place Based Partnership Plan for Tower Hamlets ('**PBP Plan'**), which shall be:

- aimed at ensuring delivery of relevant system plans, especially those listed above.
- developed in conjunction with the governance structures in Section 2 (e.g. the Place ICB Sub-Committee).
- agreed with the Board of the ICB and the partner organisations.
- developed by drawing on population health management tools and in co-production with service users and residents of Tower Hamlets.
- prepared with an emphasis on the monitoring of health and social care and related outcomes for the people of Tower Hamlets.
- prepared with a view to supporting the transformation of community services.

(d) As part of the development of the PBP Plan, to develop the Place objectives and priorities and an associated outcomes framework for Place. A summary of these priorities and objectives can be found here.

(e) To work in partnership with other statutory and non-statutory organisations to improve health and wellbeing and reduce inequalities.

(f) To ensure effective governance within the management of the partnership.

[1] The Place Mutual Accountability Framework describes what NHS North East London ICB asks the seven Place ICB Subcommittees and wider Place Based Partnerships to have responsibility for and, in turn, what the Place Based Partnerships can expect the ICB to achieve for them. The framework needs to be read alongside the equivalent document that focuses on the role of the provider collaboratives which operate across the ICS area. The current versions of these frameworks are published in the ICB's Governance Handbook.

(g) To develop new models of care that better serve the Tower Hamlets population, ensuring that such models take into account the above mentioned plans, while having a strong emphasis on the primacy of the Tower Hamlets locally owned delivery.

(h) To review and assess new and revised clinical pathways and models of care being proposed (which may have an impact on resources) as part of service transformation.

(i) To develop and agree a shared communications function at place.

(j) To identify and agree plans to submit for new opportunities or funding.

(k) To develop models for payment reform and the collective sharing of risk.

(l) To provide direction to the life course workstreams and receive regular reports on progress of priorities, transformation and delivery.

(m) To oversee delivery and performance at Place against:

- national targets.
- targets and priorities set by the ICB or the ICP, or other commitments set at North East London level, including commitments to the NHS Long Term Plan.
- the PBP Plan, the Place objectives and priorities and the associated outcomes framework.

(n) To provide a forum at which the partner organisations operating across Place can routinely share insight and intelligence into local quality matters, identify opportunities for improvement and identify concerns and risk to quality, escalating such matters to the NEL ICS System Quality Group ('SQG') as appropriate. Meetings of the THT Board will give place and local leaders an opportunity to gain:

- understanding of quality issues at place level, and the objectives and priorities needed to improve the quality of care for local people.
- timely insight into quality concerns/issues that need to be addressed, responded to and escalated within each partner organisation through appropriate governance structures or individuals, or to the SQG.

- positive assurance that risks and issues have been effectively addressed.
- confidence about maintaining and continually improving both the equity, delivery and quality of their respective services, and the health and care system as a whole across Place.

(o) To oversee the use of resources and promote financial sustainability and transparency. In particular this shall include overseeing the development and delivery of saving schemes at Place (such as relating to the plans above and the LBTH's commissioning strategies) and provider saving schemes. This will also include receiving recovery plans for programmes that are significantly off track (rated red).

(p) To review and assess the development of business cases in an approved format and make recommendations on the commissioning strategy including associated areas for investment, savings and QIPP as a result of service transformation, innovation, research and development.

(q) To make recommendations about the exercise of any functions that a partner organisation asks the THT Board to consider on its behalf.

(r) To support the ICS with the achievement of the 'four core purposes' of Integrated Care Systems, namely to:

- improve outcomes in population health and healthcare;
- tackle inequalities in outcomes, experience and access;
- enhance productivity and value for money;
- help the NHS support broader social and economic development.

(s) To support the North East London Integrated Care System to deliver against its strategic priorities and its operating principles, as set out here.

Statutory decision-making

11. In situations where any decision(s) needs to be taken which requires the exercise of statutory functions which have been delegated by a partner organisation to a governance structure in Section 2, then these shall be made by that governance structure in accordance with its terms of reference, and are not matters to be decided upon by the THT Board.

12. However, ordinarily, in accordance with their specific governance arrangements set out in Section 2, a decision made by a committee

	or other structure (for example a decision taken by the Place ICB Sub-Committee on behalf of the ICB) will be with THT Board members in attendance and, where appropriate, contributing to the discussion to inform the statutory decision-making process. This is, however, subject to any specific legal restrictions applying to the functions of a partner organisation and subject to conflict of interest management.
Making recommendations	13. Where appropriate in light of the expertise of the THT Board, the THT Board may also be asked to consider matters and make recommendations to a partner organisation or a governance structure set out in Section 2, in order to inform their decision-making. 14. Note that where the THT Board is asked to consider matters on behalf of a partner organisation, that organisation will remain responsible for the exercise of its statutory functions and nothing that the THT Board does shall restrict or undermine that responsibility. However, when considering and making recommendations in relation to such functions, the THT Board will ensure that it has regard to the statutory duties which apply to the partner organisation. 15. Where a partner organisation needs to take a decision related to a statutory function, it shall do so in accordance with its terms of reference set out in Section 2, or the other applicable governance arrangements which the partner organisation has established in relation to that function.
Collaborative working	16. The THT Board and any governance structure set out in Section 2 shall work together collaboratively. It may also work with other governance structures established by the partner organisations or wider partners within the ICS. This may include, where appropriate, aligning meetings or establishing joint working groups. 17. The THT Board may establish working groups or task and finish groups, to inform its work. Any working group established by the THT Board will report directly to it and shall operate in accordance with terms of reference which have been approved by the THT Board. *Collaboration with the HWB* 18. The THT Board will work in close partnership with the HWB and shall ensure that the PBP Plan is appropriately aligned with the joint local health and wellbeing strategy produced by the HWB and the associated needs assessment, as well as the overarching Integrated Care Strategy produced by the ICP. 19. In particular, the HWB has identified integration of health and care services as one of its five priorities. The THT Board will support the HWB with delivering against this priority, including the discharge of the HWB's duty under s 195 of the Health & Social Care Act 2012 to encourage health and social care services to work in an integrated manner. The Board will submit, from time to time, and at the request

	of the HWB, a report detailing progress in integrating health and social care services in the borough. *Safeguarding collaboration* 20. The THT Board will also work in close partnership with the Tower Hamlets Safeguarding Children Partnership and the Safeguarding Adults Board for Tower Hamlets.
Chairing and executive lead arrangements	21. The Chair of the THT Board will be the Independent Chair, referred below. 22. The Deputy Chair of the THT Board will be the Clinical / Care Director. 23. If for any reason the Chair and Deputy Chair are absent for some of all of a meeting, the members shall together select a person to chair the meeting. 24. The Chief Executive of LBTH will be the Place Executive Lead.
Membership	25. There will be a total of 15 members of the THT Board, as follows: *Joint ICB & LBTH role* (a) Director of Integrated Commissioning (ICB & LBTH) *ICB* (b) Clinical Care Director for Tower Hamlets (c) Director of Finance or their nominated representative (d) Director of Nursing/Quality or their nominated representative *LBTH* (e) Corporate Director Health, Adults & Community (f) Corporate Director of Children and Culture (g) Director of Public Health *NHS Trusts/Foundation Trusts* (h) Chief Executive Officer, Royal London and Mile End Hospitals, Barts (i) Director of Integrated Care, ELFT *Primary Care*

	(j) Joint Chief Executive, GPCG (k) Place Based Partnership Primary Care Development Clinical Lead *Voluntary sector* (l) Chief Executive Officer, Tower Hamlets CVS *Healthwatch* (m) Representative, Healthwatch *Others* (n) Independent Chair (o) Resident and community representative[2] 26. The members, set out above, will be expected to nominate a deputy to attend a meeting of the THT Board that they are unable to attend.
Participants	27. The following, or with the permission of the Chair their nominated deputy, shall be in attendance: (a) THT Programme Manager, Partnership Development team, ICB & LBTH (b) Deputy Director of Partnership Development, ICB & LBTH 28. The THT Board may invite others to attend meetings, where this would assist it in its role and in the discharge of its duties. This shall include other colleagues from the partner organisations or across the ICS, professional advisors or others as appropriate at the discretion of the Chair of the THT Board.
Meetings	29. The THT Board will operate in accordance with the evolving ICS governance framework, including any policies, procedures and joint-working protocols that have been agreed by the partner organisations, except as otherwise provided below: *Scheduling meetings* 30. THT Board will normally meet monthly with dates to be circulated three months in advance.

[2] Role title is TBC

31. On a bi-monthly basis, subject to a minimum of four occasions each year, the THT Board will hold its meetings in tandem with the Place ICB Sub-Committee.[3]

32. The expectation for such meetings to be held in tandem will not preclude the THT Board from holding its own more regular or additional meetings.

33. Changes to meeting dates or calling of additional meetings will be convened as required in negotiation with the Chair.

Quoracy

34. For a meeting of the THT Board to be quorate, at least six members will be present and must include:

    (a) Two of the members from the ICB;

    (b) Two of the members from the local authority;

    (c) One of the members from an NHS Trust or Foundation Trust;

    (d) One primary care member.

35. If any member of the THT Board has been disqualified from participating on an item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

36. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

Papers and notice

37. A minimum of seven clear working days' notice is required. Notice of all meetings shall comprise venue, time and date of the meeting, together with an agenda of items to be discussed. Supporting papers must be distributed at least five clear working days ahead of the meeting.

38. On occasion it may be necessary to arrange urgent meetings at shorter notice. In these circumstances the Chair will give as much notice as possible to members. Urgent papers shall be permitted in exceptional circumstances at the discretion of the Chair.

Virtual attendance

39. It is for the Chair to decide whether or not the THT Board will meet virtually by means of telephone, video or other electronic means. Where a meeting is not held virtually, the Chair may nevertheless

[3] ~~In the first financial year of operation the Place ICB Sub-Committee is only expected to meet on three occasions.~~

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agree that individual members may attend virtually. Participation in a meeting in this manner shall be deemed to constitute presence in person at such meeting. How a person has attended a meeting shall be specified in the meeting minutes.

Admission of the public

40. Where the Partnership Board meets jointly with the Place ICB Sub-Committee in accordance with paragraph 30, its meetings shall be held in accordance with the Place ICB Sub-Committee's terms of reference in Section 2. Otherwise, whether a meeting of the Partnership Board is to be held in public or private is a matter for the Chair.

Recordings of meetings ~~and publication~~

41. Except with the permission of the Chair, no person admitted to a meeting of the THT Board shall be permitted to record the proceedings in any manner whatsoever, other than in writing.

Meeting minutes & work plan

42. The minutes of a meeting will be formally taken in the form of key points of debate, actions and decisions and a draft copy circulated to the members of the THT Board together with the action log, as soon as practicable after the meeting having taken place. The minutes shall be submitted for agreement at the next meeting where they shall be signed by the Chair. In addition, the THT Board will maintain and oversee the implementation of a work plan.

43. Where it would promote efficient administration, meeting minutes, action logs and the work plan, may be combined with those of the Place ICB Sub-Committee and/or other place governance structures in Section 2.

Governance support

44. Governance support will be provided to the Partnership Board by the ICB's governance team.

Confidential information

45. Where confidential information is presented to the THT Board, all those present will ensure that they treat that information appropriately in light of any confidentiality requirements and information governance principles.

Decision-making

46. The THT Board is the primary forum within the PBP for bringing a wide range of partners across Place together for the purposes of determining and taking forward matters relating to the improvement of health, wellbeing and equity across the borough. It brings together representatives from across Place, who have the

	necessary authority from the partner organisation they represent to consider strategic policy matters and oversee joint programmes of work relevant to Place. 47. The THT Board is formally a sub-group of the Tower Hamlets Health and Wellbeing Board. 48. The THT Board does not hold delegated functions from the partner organisations, but each member shall have appropriate delegated responsibility from the partner organisation they represent to make decisions for their organisation on matters within the Partnership Board's remit or, at least, will have sufficient responsibility and be ready to move programmes of work forwards by holding discussions in their own organisation and escalating matters of importance. 49. Members 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 and reach agreement by consensus. 50. In the event that the THT Board is unable to agree a consensus position on a matter it is considering, this will not prevent any or all of the statutory committees/sub-committees in Section 2 taking any applicable decisions they are required to take. To the extent permitted by their individual terms of reference, statutory committees may utilise voting on matters they are required to take decisions on.
Conflicts of Interest	51. Conflicts of interests will be managed in accordance with relevant policies, procedures and joint protocols developed by the ICS, which shall be consistent with partner organisations' respective statutory duties and applicable national guidance. Notwithstanding such requirements: (a) There must be transparency and clear accountability of the THT Board. Members of the Board must declare any interest and/or conflicts of interest at the start of the meeting (as well as at the start of the financial year). Where matters of conflicts of interest arise, the Chair has the power to request that members withdraw from discussion/voting until the matter is concluded if this is deemed appropriate. (b) Where the Chair of the THT Board has a personal interest, previously declared or otherwise, in relation to the scheduled or likely business of the meeting, he or she must make a declaration and the Deputy chair will act as chair for the relevant part of the meeting.
Accountability and Reporting	52. Meeting minutes will be circulated to the partner organisations, as appropriate, and the THT Board will also report to the ICP.

	53. In addition, the THT work plan will be shared with relevant partner organisations and other interdependent bodies, committees or sub-committees as appropriate. 54. Members of the THT Board shall disseminate information back to their respective organisations as appropriate, and feedback to the group as needed. 55. Given its purposes at paragraph 10(n) above, the THT Board will regularly report upon, and comply with any request of the SQG for information or updates on, matters relating to quality which effect the ICS and bear on the SQG's remit.
Monitoring Effectiveness and Compliance with Terms of Reference	56. The THT Board will carry out an annual review of its effectiveness and provide an annual report to the ICP and to the partner organisations. This report will outline and evaluate the THT Board's work in discharging its responsibilities, delivering its objectives and complying with its terms of reference. As part of this, the THT Board will review its terms of reference and agree any changes it considers necessary.

Section 2
Terms of reference for the Tower Hamlets Sub-Committee of the North East London Integrated Care Board

Status of the Sub-Committee	1. The Tower Hamlets Sub-Committee of the North East London Integrated Care Board (‘**the Place ICB Sub-Committee’**) is established by the Population Health & Integration Committee (the ‘**PH&I Committee’**) as a Sub-Committee of the PH&I Committee. 2. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Sub-Committee and may only be changed with the approval of the Board of the ICB (‘**the Board’**). Additionally, the membership of the Sub-Committee must be approved by the Chair of the Board. 3. The Sub-Committee and all of its members are bound by the ICB’s Constitution, Standing Orders, Standing Financial Instructions, policies and procedures of the ICB. 4. These terms of reference should be read as part of the suite of terms of reference for the Tower Hamlets Place-Based partnership (‘**PBP**’), including the terms of reference for the THT Board (‘**the THT Board**’) in Section 1, which define a number of the terms used in these Place ICB Sub-Committee terms of reference.
Geographical coverage	5. The geographical area covered will be Place, as defined in the THT Board’s terms of reference in Section 1.
Purpose	6. The Place ICB Sub-Committee has been established in order to: (a) Enable the ICB to exercise the Delegated Functions at Place in a lawful, simple and efficient way, to the extent permitted by the ICB’s Constitution and as part of the wider collaborative arrangements which form the PBP; (b) Support the development of collaborative arrangements at Place, in particular the development of the PBP. 7. The Delegated Functions which the Place ICB Sub-Committee will exercise are set out at **Annex 1** and described in further detail in the Place Mutual Accountability Framework which the annex refers to. 8. The Place ICB Sub-Committee, through its members, is authorised by the ICB to take decisions in relation to the Delegated Functions. 9. Further functions may be delegated to the Place ICB Sub-Committee over time, in which case Annex 1 ~~will~~ may be updated with the approval of the Board, on the recommendation of the PH&I Committee. The remit of the Place ICB Sub-Committee is also described in the Place Mutual

Accountability Framework, which may be updated by the Board taking into account the views of the PH&I Committee.

10. The Delegated Functions shall be exercised with particular regard to the Place objectives and priorities, described in the plan for Place ('**the PBP Plan'**), which has been agreed with the PH&I Committee and the partner organisations represented on the THT Board. A summary of the PBP's priorities and objectives can be found here.

11. In addition, the Place ICB Sub-Committee will support the wider ICB to achieve its agreed deliverables, and to achieve the aims and the ambitions of:

    (a) The Joint Forward Plan;

    (b) The Joint Capital Resource Use Plan;

    (c) The Integrated Care Strategy prepared by the NEL Integrated Care Partnership;

    (d) The HWB's joint local health and wellbeing strategy for Tower Hamlets, together with the HWB's needs assessment for the area;

    ~~(d)~~(e) The Place Mutual Accountability Framework and the NHS North East London Financial Strategy and developing ICS Financial Framework;

    ~~(e)~~(f) The PBP Plan.

12. The Place ICB Sub-Committee will also prioritise delivery against the strategic priorities of the North East London Integrated Care System (see here) and its design and operating principles set out here.

13. In supporting the ICB to discharge its statutory functions and deliver the strategic priorities of the ICS at Place, the Place ICB Sub-Committee will, in turn, be supporting the ICS with the achievement of the 'four core purposes' of Integrated Care Systems, namely to:

    (a) Improve outcomes in population health and healthcare;

    (b) Tackle inequalities in outcomes, experience and access;

    (c) Enhance productivity and value for money;

    (d) Help the NHS support broader social and economic development.

14. The Place ICB Sub-Committee is a key component of the ICS, enabling it to meet the 'triple aim' of better health for everyone, better care for all and efficient use of NHS resources.

Key duties relating to the

15. When exercising any Delegated Functions, the Place ICB Sub-Committee will ensure that it acts in accordance with, and that its

exercise of the Delegated Functions	decisions are informed by, the guidance, policies and procedures of the ICB or which apply to the ICB. 16. The Sub-Committee must have particular regard to the statutory obligations that the ICB is subject to, including, but not limited to, the statutory duties set out in the 2006 Act and listed in the Constitution. In particular, the Place ICB Sub-Committee will also have due regard to the public sector equality duty under section 149 of the Equality Act 2010.
Collaborative working	17. In exercising its responsibilities, the Place ICB Sub-Committee may work with other Place ICB Sub-Committees, provider collaboratives, joint committees, committees, or sub-committees which have been established by the ICB or wider partners of the ICS. This may include, where appropriate, aligning meetings or establishing joint working groups. *Collaboratives* 18. In particular, in addition to an expectation that the Place ICB Sub-Committee and THT Board shall collaborate with each other as part of the PBP, the Place ICB Sub-Committee will, as appropriate, work with the following provider collaborative governance structures within the area of the ICS: (a) The North East London Mental Health, Learning Disability & Autism Collaborative; (b) The Combined Primary Care Provider Collaborative; (c) The North East London Acute Provider Collaborative; (d) The North East London Community Collaborative;~~.~~ ~~(d)~~(e) The evolving Voluntary, Community and Social Enterprise Sector Alliance/Collaborative. 19. Some members of the Place ICB Sub-Committee may simultaneously be members of the above collaborative structures, to further support collaboration across the system. *Health & Wellbeing Board and Safeguarding* 20. The Place ICB Sub-Committee will also work in close partnership with: (a) The Tower Hamlets Health and Wellbeing Board (which the THT Board is a sub-group of) and shall ensure that plans agreed by the Place ICB Sub-Committee are appropriately aligned with, and have regard to, the joint local health and wellbeing strategy and the assessment of needs, together with the NEL Integrated Care Strategy as applies to Place; and

(b) the Safeguarding Adults Board for the Place established by the LBTH under section 43 of the Care Act 2014; and

(c) the Safeguarding Children's Partnership established by LBTH, ICB and Chief Officer of Police, under section 16E of the Children Act 2004.

Establishing working groups

21. The Place ICB Sub-Committee does not have the authority to delegate any functions delegated to it by the ICB. However, the Place ICB Sub-Committee may establish working groups or task and finish groups. These do not have any decision-making powers but may inform the work of the Place ICB Sub-Committee and the PBP. Such groups must operate under the ICB's procedures and policies and have due regard to the statutory duties which apply to the ICB.

Chairing and executive lead arrangements

22. The Place ICB Sub-Committee will be chaired by the Independent Chair who is appointed on account of their specific knowledge, skills and experiences making them suitable to chair the Sub-Committee.

23. The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these terms of reference.

24. The Deputy Chair of the Place ICB Sub-Committee will be Clinical / Care Director.

25. If a Chair has a conflict of interest then the Deputy Chair or, if necessary, another member of the Committee will be responsible for deciding the appropriate course of action.

26. The Chief Executive of LBTH will be the Place Executive Lead.

Membership

27. The Place ICB Sub-Committee members will be appointed by the Board in accordance with the ICB Constitution and the Chair of the ICB will approve the membership of the Sub-Committee.

28. The Place ICB Sub-Committee has a broad membership, including those from organisations other than the ICB. This is permitted by the ICB's Constitution and amendments made to the 2006 Act by the Health and Care Act 2022.

29. The membership of the Place ICB Sub-Committee includes members drawn from the following partner organisations which operate at Place:

(a) The ICB

(b) Barts

(c) ELFT

(d) LBTH

(e) GPCG

(f) Tower Hamlets Council of Voluntary Services

(g) Healthwatch

30. There will be a total of 15 members of the Place ICB Sub-Committee, as follows:

Joint ICB & LBTH role

(a) Director of Integrated Commissioning

ICB

(b) Clinical Care Director for Tower Hamlets

(c) Director of Finance or their nominated representative

(d) Director of Nursing/Quality or their nominated representative

LBTH

(e) Corporate Director Health, Adults & Community

(f) Corporate Director of Children and Culture

(g) Director of Public Health

NHS Trusts/Foundation Trusts

(h) Chief Executive Officer, Royal London and Mile End Hospitals, Barts

(i) Director of Integrated Care, ELFT

Primary Care

(j) Place Based Partnership Primary Care Development Clinical Lead

(k) Joint Chief Executive, GPCG

Others

(l) Independent Chair

	(m) Resident and community representative[4] (n) Representative, Healthwatch (o) Chief Executive Officer, Tower Hamlets CVS 31. With the permission of the Chair of the Place ICB Sub-Committee, the members, set out above, may nominate a deputy to attend a meeting of the Place ICB Sub-Committee that they are unable to attend. However, members will be expected not to miss more than two consecutive meetings. The deputy may speak and vote on their behalf. The decision of the Chair regarding authorisation of nominated deputies is final. 32. When determining the membership of the Sub-Committee, active consideration will be made to diversity and equality.
Participants	33. Only members of the Sub-Committee have the right to attend Sub-Committee meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the Sub-Committee. 34. Meetings of the Sub-Committee may also be attended by any members of the THT Board (i.e. in Section 1) who are not also members of the Sub-Committee, which includes: (a) THT Programme Manager, Partnership Development Team, ICB & LBTH (b) Deputy Director of Partnership Development, ICB & LBTH 35. The Chair may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion on particular matters.
Resource and financial management	36. The ICB has made arrangements to support the Place ICB Sub-Committee in its exercise of the Delegated Functions. Financial responsibilities of the Place ICB Sub-Committee are contained in the list of Delegated Functions in Annex 1, and further information about resource allocation within the ICB is contained in the ICB's Standing Financial Instructions and associated policies and procedures, which includes the NHS North East London Financial Strategy and developing ICS Financial Framework. ~~36.~~37. The Chair will be invited to attend the Finance Performance and Investment Committee where the Committee is considering any issue relating to the resources allocated in relation to the Delegated Functions.

[4] Role/detail to be confirmed/agreed.

Meetings, Quoracy and Decisions

~~37.~~38. The Place ICB Sub-Committee will operate in accordance with the ICB's governance framework, as set out in its Constitution and Governance Handbook and the wider ICB policies and procedures, except as otherwise provided below:

Scheduling meetings

~~38.~~39. The Place ICB Sub-Committee will aim to meet on a bi-monthly basis and, as a minimum, shall meet on four occasions each year.[5] Additional meetings may be convened on an exceptional basis at the discretion of the Chair.

~~39.~~40. The Place ICB Sub-Committee will usually hold its meetings together with the THT Board, as part of an aligned meeting of the PBP. Although the Place ICB Sub-Committee may meet on its own at the discretion of its Chair, it is expected that such circumstances would be rare.

~~40.~~41. The Place ICB Sub-Committee acknowledges that the THT Board may convene its own more regular meetings, for instance where agenda items do not require a statutory decision of the Place ICB Sub-Committee.

~~41.~~42. The Board, Chair of the ICB or Chief Executive may ask the Sub-Committee to convene further meetings to discuss particular issues on which they want the Sub-Committee's advice.

Quoracy

~~42.~~43. The quoracy for the Place ICB Sub-Committee will be six and must include the following of which one must be a care or clinical professional:

(a) Two of the members from the ICB;

(b) Two of the members from the local authority;

(c) One of the members from an NHS Trust or Foundation Trust;

(d) One primary care member.

~~43.~~44. If any member of the Sub-Committee has been disqualified from participating on an item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

~~44.~~45. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

Voting

~~45.~~46. Decisions will be taken in accordance with the Standing Orders. The Sub-Committee will ordinarily reach conclusions by consensus. When

~~[5] In the first financial year of operation the Place ICB Sub-Committee is only expected to meet on three occasions.~~

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this is not possible, the Chair may call a vote. Only members of the Sub-Committee may vote. Each member is allowed one vote and a simple majority will be conclusive on any matter. Where there is a split vote, with no clear majority, the Chair of the Sub-Committee will hold the casting vote. The result of the vote will be recorded in the minutes.

Papers and notice

~~46.~~47. A minimum of seven clear working days' notice is required. Notice of all meetings shall comprise venue, time and date of the meeting, together with an agenda of items to be discussed. Supporting papers must be distributed at least five clear working days ahead of the meeting.

~~47.~~48. On occasion it may be necessary to arrange urgent meetings at shorter notice. In these circumstances the Chair will give as much notice as possible to members. Urgent papers shall be permitted in exceptional circumstances at the discretion of the Chair.

Virtual attendance

~~48.~~49. It is for the Chair to decide whether or not the Place ICB Sub-Committee will meet virtually by means of telephone, video or other electronic means. Where a meeting is not held virtually, the Chair may nevertheless agree that individual members may attend virtually. Participation in a meeting in this manner shall be deemed to constitute presence in person at such meeting. How a person has attended a meeting shall be specified in the meeting minutes.

Admission of the public

~~49.~~50. Meetings at which public functions of the ICB are exercised will usually be open to the public, unless the Chair determines, at his or her discretion, that it would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for some other good reason.

~~50.~~51. The Chair shall give such directions as he/she thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the business shall be conducted without interruption and disruption.

~~51.~~52. A person may be invited by the Chair to contribute their views on a particular item or to ask questions in relation to agenda items. However, attendance shall not confer a right to speak at the meeting.

~~52.~~53. Matters to be dealt with by a meeting following the exclusion of representatives of the press and other members of the public shall be confidential to the members of the Place ICB Sub-Committee and others in attendance.

~~53.~~54. There shall be a section on the agenda for public questions to the committee, which shall be in line with the ICB's agreed procedure as set out on our website here.

Recordings of meetings ~~and publication~~

~~54.~~55. Except with the permission of the Chair, no person admitted to a meeting of the Place ICB Sub-Committee shall be permitted to record the proceedings in any manner whatsoever, other than in writing.

Confidential information

~~55.~~56. Where confidential information is presented to the Place ICB Sub-Committee, all those who are present will ensure that they treat that information appropriately in light of any confidentiality requirements and information governance principles.

Meeting minutes

~~56.~~57. The minutes of a meeting will be formally taken in the form of key points of debate, actions and decisions and a draft copy circulated to the members of the Place ICB Sub-Committee, together with the action log as soon after the meeting as practicable. The minutes shall be submitted for agreement at the next meeting where they shall be signed by the Chair.

~~57.~~58. Where it would promote efficient administration, meeting minutes, action logs and the work plan, may be combined with those of the THT Board.

Legal or professional advice

~~58.~~59. Where outside legal or other independent professional advice is required, it shall be secured by or with the approval of the Director who is responsible for governance within the ICB.

Governance support

~~59.~~60. Governance support to the Place ICB Sub-Committee will be provided by the ICB's governance team.

Conflicts of Interest

~~60.~~61. Conflicts of interest will be managed in accordance with the policies and procedures of the ICB and those contained in the Handbook and shall be consistent with the statutory duties contained in the National Health Service Act 2006 and any statutory guidance issued by NHS England.

Conduct

~~61.~~62. Members will be expected to behave and conduct business in accordance with:

(a) The ICB's policies and procedures including its Constitution, Standing Orders and Standards of Business Conduct Policy which includes the Code of Conduct which sets out the expected behaviours that all members of the Board and its committees will uphold whilst undertaking ICB business.

(b) The NHS Constitution;

(c) The Nolan Principles;

~~62.~~63. Members must demonstrably consider equality diversity and inclusion implications of the decisions they make.

Disputes

~~63.~~64. Where there is any uncertainty about whether a matter relating to a Delegated Function is within the remit of the Place ICB Sub-Committee in its capacity as a decision-making body within the ICB's governance structure, including uncertainty about whether the matter relates to:

(a) a matter for wider determination within the ICS; or

(b) determination by another placed-based committee of the ICB or other forum, such as a provider collaborative,

then the matter will be referred to the Director who is responsible for governance within the ICB for consideration about where the matter should be determined.

Referral to the PH&I Committee

~~64.~~65. Where any decision before the Place ICB Sub-Committee is 'novel, contentious or repercussive' across the ICB area and/or is a decision which would have an impact across the ICB area, then the Place ICB Sub-Committee shall give due consideration to whether the decision should be referred to the PH&I Committee.

~~65.~~66. With regard to determining whether a decision falling within paragraph 65 shall be referred to the PH&I Committee for consideration then the following applies:

(a) The Chair of the Place ICB Sub-Committee, at his or her discretion, may determine that such a referral should be made.

(b) Two or more members of the Place ICB Sub-Committee, acting together, may request that a matter for determination should be considered by the PH&I Committee.

~~66.~~67. Where a matter is referred to the PH&I Committee under paragraph 65, the PH&I Committee (at an appropriate meeting) shall consider and determine whether to accept the referral and make a decision on the matter. Alternatively, the PH&I Committee may decide to refer the matter to the Board of the ICB or to another of the Board's committees/subcommittees for determination.

~~67.~~68. In addition to the Place ICB Sub-Committee's ability to refer a matter to the PH&I Committee as set out in paragraph 65:

(a) The PH&I Committee, or its Chair and Deputy Chair (acting together), may determine that any decision falling with paragraph 65 should be referred to the PH&I Committee for determination; or

(b) The Board of the ICB, or its Chair and the Chief Executive (acting together), may require a decision related to any of the ICB's delegated functions to be referred to the Board.

Accountability and Reporting

~~68.~~69. The Place ICB Sub-Committee shall be directly accountable to the PH&I Committee of the ICB, and ultimately the Board of the ICB.

~~69.~~70. The Place ICB Sub-Committee will report to:

(a) **PH&I Committee.** The PH&I Committee, following each meeting of the Place ICB Sub-Committee. A copy of the meeting minutes along with a summary report shall be shared with the Committee for information and assurance. The report shall set out matters discussed and pertinent issues, together with any recommendations and any matters which require disclosure, escalation, action or approval.

And will report matters of relevance to the following:

(b) **Finance, Performance and Investment Committee.** Such formal reporting into the ICB's Finance, Performance and Investment Committee will be on an exception basis. Other reporting will take place via Finance and via NEL wide financial management reports.

(c) **Quality, Safety and Improvement ('QSI') Committee.** Reports will be made to the QSI Committee in respect of matters which are relevant to that Committee and in relation to the exercise of the quality functions set out here.

~~70.~~71. In the event that the Chair of the ICB, its Chief Executive, the Board of the ICB or the PH&I Committee requests information from the Place ICB Sub-Committee, the Place ICB Sub-Committee will ensure that it responds promptly to such a request.

Shared learning and raising concerns

~~71.~~72. Where the Place ICB Sub-Committee considers an issue, or its learning from or experience of a matter, to be of importance or value to the North East London health and care system as a whole, or part of it, it may bring that matter to the attention of the Director who is responsible for governance within the ICB for onward referral to the PH&I Committee, the Chair or Chief Executive of the ICB, the Board, the Integrated Care

	Partnership or to one or more of ICB's committees or subcommittees, as appropriate.
Review	~~72.~~73. The Place ICB Sub-Committee will review its effectiveness at least annually. ~~73.~~74. These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Date of approval: 1 September 2022 (Initial version by ICB Board on 1 July 2022)

Version: 2.0

Date of review: 1 April 2023

Annex 1 - ICB Delegated Functions

Commissioning functions

In addition to the specific activities set out in this Annex 1 below, ~~T~~the Place ICB Sub-Committee will have delegated responsibility for exercising the ~~ICB's commissioning functions at Place in relation to the following~~ functions described in the Place Mutual Accountability Framework at Place. These functions are referred to below as 'the **Place Commissioning Functions**'.

The Place Mutual Accountability is contained in the ICB's Governance Handbook and should be read alongside the equivalent accountability framework which describes the role of the provider collaboratives.

Where Place Commissioning Functions relate to a particular service they must be exercised in line with the ICB's relevant commissioning policy for that service.~~specified services (the '**Specified Services'**), in line with ICB policy:~~

~~[section to be completed by end of 2022 following confirmation]~~

Health and care needs planning

The Place ICB Sub-Committee will undertake the following specific activities in relation to health and care needs planning, through embedding population health management:

1. Making recommendations to the PH&I Committee in relation to, and contributing to, the Joint Forward Plan and other system plans, in so far as relates to the exercise of the ICB's functions at Place.

2. Overseeing, and providing assurance to the PH&I Committee regarding, the implementation and delivery at Place of the Joint Forward Plan, the Integrated Care Strategy and other system plans, in so far as they require the exercise of ICB functions.

3. Overseeing the development of service specification standards needed ~~at Place~~ in connection with the exercise of the Place Commissioning Functions and ~~for the Specified Services,~~ in line with relevant ICB policy.

4. Working with the THT Board on behalf of the ICB, to develop the PBP Plan including the Place objectives and priorities and a Place outcomes framework.

    The PBP Plan shall be developed by drawing data and intelligence in coproduction with service users and residents of Tower Hamlets. It is aimed at ensuring delivery of the Joint Forward Plan, the Integrated Care Strategy, the HWB's joint local health and wellbeing strategy and associated needs assessment, and other system plans.

    In particular, this shall include developing the Place priorities and objectives to be set out in the PBP Plan, and summarised here, and an associated outcomes framework developed by the PBP.

    The PBP Plan shall be tailored to meet local needs, whilst maintaining ICB-wide operational, quality and financial performance standards. It shall also be consistent with, and aimed at delivery of, the Place Mutual Accountability Framework at Place.

5. Overseeing, and providing assurance to the PH&I Committee regarding, the implementation and delivery of the PBP Plan, in so far as the plan requires the exercise of ICB functions.

6. Overseeing, and providing assurance to the PH&I Committee regarding, the implementation and delivery of the Place objectives and priorities, contained within the PBP Plan and summarised here, in so far as they require the exercise of ICB functions.

7. Overseeing the implementation and delivery of the HWB's joint local health and wellbeing strategy, in so far as the strategy requires the exercise of ICB functions.

Market management, planning and delivery

The Place ICB Sub-Committee will undertake the following specific activities in relation to market management, planning and delivery:

1. Making recommendations to the Board of the ICB / PH&I Committee in relation to health service change decisions (whether these involve commissioning or de-commissioning).

2. Approving commissioning policies ~~in relation to the Specified Services~~connected with the exercise of the Place Commissioning Functions, in line with ICB policy.

3. Approving demographic, service use and workforce modelling and planning, where these relate to ~~ICB commissioning functions being exercised at Place.~~the Place Commissioning Functions.

Finance

The Place ICB Sub-Committee will have delegated financial management and control, as detailed below and within the ICBs SFI's. The Finance, Performance and Investment Committee will continue to have oversight of NEL wide financial decisions, including where coordination/planning for the services concerned is best undertaken over a larger footprint. However, there will be ongoing dialogue in order to ensure a joined up approach, ensure financial sustainability, and as the NHS North East London Financial Strategy and ICS Financial Framework develop.

1. Plan and monitor the budgets delegated to the Place ICB Sub-Committee and take action to ensure they are delivered within the financial envelope.

2. The committee will take shared responsibility, along with partners, for the health outcomes of their population, and will work with those partners to develop a shared plan for improving health outcomes and maintaining collective financial control.

3. Review and understand any variations to plan within the delegated budget and take appropriate action to mitigate.

4. Take responsibility, with partners, oversee any required recovery plans in order to ensure the drivers of the deficit are addressed to achieve a financial balance.

5. Ensure financial plans are triangulated with performance and quality.

6. Ensure any known financial risks are escalated to the ICB's Finance, Performance and Investment Committee and the ~~[~~ICS Executive~~]~~, as appropriate.

7. Review performance of the contracts within Place ~~, [in relation to the Specified Services,]~~ to ensure services and activity are being delivered in line with contractual arrangements.

8. Review and understand the financial implications of new investments and transformation schemes, and ensure there is sufficient funding across the life of the investment.

9. Oversee implementation of investments/transformation schemes, ensuring financial activity, KPIs and required outcomes are delivered.

10. Review and agree any procurement decisions in relation to ~~the Specified Services~~services connected with the Place Commissioning Functions, as appropriate, in line with the ICB's Standing Financial Instructions and Procurement Policy.

11. Ensure financial decisions are taken in line with the ICB's Standing Financial Instructions. and NHS North East London Financial Strategy and developing ICS Financial Framework.

12. In relation to financial risk share arrangements (including but not limited to section 75, 76 and section 256 agreements), the Place ICB Sub-Committee shall:

    - Review any current in year arrangements applicable to Place, ensuring that funding is spent appropriately in line with contractual agreements;
    - Review the risks and benefits of the allocation of funding and approve spend on pooled budgets based on recommendations from those leading the work and where all parties are in agreement;
    - Receive reports on the schemes funded through this mechanism to ensure it is delivering the expected outcomes and benefits;
    - Review the funding and arrangements for the subsequent financial year and ensure there is adequate governance and arrangements in Place that is consistent with other places across the ICB's area;
    - Review and make recommendations in relation to proposals for the ICB to enter into new agreements under section 75 of the 2006 Act with the local authority at Place. In accordance with the Constitution, any such arrangements must be authorised by the Board of the ICB.

Quality

The Place ICB Sub-Committee will undertake the following specific activities in relation to quality:

1. Providing assurance that health outcomes, access to healthcare services and continuous quality improvement are being delivered at Place, and escalate specific issues to the Population Health & Integration Committee, the Quality Safety and Improvement Committee and/or other governance structures across the ICS as appropriate.

2. Complying with statutory reporting requirements relating to the exercise of the Place Commissioning Functions ~~Specified Services~~, in particular as relates to quality and improvement ~~of those services~~.

3. In addition, the Place ICB Sub-Committee will have the following responsibilities on behalf of the ICB at Place, in relation to quality:

   - Gain timely evidence of provider and place-based quality performance, in relation to the ~~Specified Services;~~exercise of the Place Commissioning Functions at Place.
   - Ensure the delivery of quality objectives by providers and partners within Place, including ICS programmes that relate to the place portfolio.
   - Identify, manage and escalate where necessary, risks that materially threaten the delivery of the ICB's objectives at Place and any local objectives and priorities for Place.
   - Identify themes in local triangulated intelligence that require local improvement plans for immediate or future delivery.
   - Gain evidence that staff have the right skills and capacity to effectively deliver their role, creating succession plans for any key roles within the services being delivered at Place.
   - Hold system partners to account for performance and the creation and delivery of remedial action/improvement plans where necessary.
   - Share good practice and learning with providers and across neighbourhoods.

4. Ensure key objectives and updates are shared consistently within the ICB, and more widely with ICS and senior leaders via the ICS System Quality Group ('SQG') and other established governance structures.

Primary Care

The Place ICB Sub-Committee will undertake the following specific activities in relation to primary care:

1. To develop arrangements for integrated services, including primary care, through local neighbourhoods.

Communication and engagement with stakeholders

The Place ICB Sub-Committee will undertake the following specific activities in relation to communications and engagement:

1. Overseeing and approving any stakeholder involvement exercises proposed specifically in Place, consistent with the ICB's statutory duties in this context and the ICB's relevant policies and procedures. Such stakeholder engagement shall include political engagement, clinical and professional engagement, strategic partnership management and public and community engagement.
2. Overseeing the development and delivery of patient and public involvement activities, as part of any service change process occurring specifically at Place.

Population health management

The Place ICB Sub-Committee will undertake the following specific activities in relation to population health management:

1. Ensuring there are appropriate arrangements at Place to support the ICB to carry out predictive modelling and trend analysis.

Emergency planning and resilience

The Place ICB Sub-Committee will undertake the following specific activities in relation to emergency planning:

1. At the request of the any of the PH&I Committee or the Board, in relation to a local or national emergency, prepare or contribute to an emergency response plan for implementation at Place, coordinating with local partners as necessary.

FINAL DRAFT, FOLLOWING FEEDBACK

North East London Health & Care Partnership

A framework for mutual accountability between north east London's place partnerships and NHS North East London

Introduction

North east London's place partnerships are uniquely placed to drive the integration between health and care that will improve residents' wellbeing, through co-produced approaches that build on community assets. As partnerships, they understand their communities and the inequalities that residents face. Reshaping north east London's health and care system so that it is equitable, delivers improved wellbeing for everyone, and is financially sustainable, will happen only if we work together to deliver at neighbourhood, place, collaborative, and system. Each element of the system needs to be accountable for its part of our improvement journey and to work together alongside residents and communities to effect change sustainably.

This draft document continues our discussion about what NHS North East London asks place partnerships to hold accountability for and, in turn, what the partnerships can expect NHS North East London to achieve for them. It will sit alongside an equivalent document that focuses on the role of provider collaboratives to help build our understanding of how the system overall will work best.

We recognise that our system is new and evolving, and much of this draft document seeks to outline the principles which will guide this evolution to support improved health and wellbeing for local residents.

Zina Etheridge – Chief Executive Officer, NHS North East London

Background

The North East London Health and Care Partnership (NELHCP) brings together the NHS, local authorities, and community organisations across north east London to work in partnership with local people to support them to live healthier, happier lives.

Our approach is built on an understanding that partnership, conversation, and collaboration underpin all that we do. We see that place shapes and strengthens system and that system enables and builds place, underlining our appreciation of the need for our workforce to participate through a range of inter-connecting networks (operating at neighbourhood, place, collaborative, system, region, and nation) in order to be most effective in improving outcomes for everyone. NHS North East London has adopted the principle of subsidiarity to encapsulate this approach as applied to governance, decision-making, strategy, and delivery of models of care. This means we will facilitate tasks being performed at the most local level, closest to those most likely to be directly affected, and only carry out tasks that cannot be carried out at that more local level.

As north east London's integrated care system, we are ambitious and actively draw on best practice locally and internationally. We are clear that we are moving beyond performance management to maximising value, and beyond our individual responsibilities to create a shared endeavour and mutual accountability for delivering benefit and opportunity for our residents. We are committed to continuous improvement and innovation across and with all partners, meaningful

co-production and resident participation, and working in integrated ways together to provide better health and care outcomes for our growing and diverse population of over two million people. At the heart of our partnership is a shared commitment to meaningful participation with residents and partners, a passion for equality and addressing health inequalities, and ensuring that system collaboration underpins continuous improvements to population health and the integrated delivery of health and care services. To operate effectively, we understand that our system needs to develop continually, to be resilient, and to respond coherently and in partnership to emergencies and emerging challenges.

Our seven place partnerships and our five provider collaboratives are crucial building blocks of North East London's integrated care system. Together they play distinct but crucially interdependent roles in driving the improvement of health, wellbeing, and equity for all residents. As we mature as a system, we will increasingly call on each other to support the achievement of outcomes and to enable the collaboration and partnership on which we all rely. We recognise that this support will look different for different pathways but we recognise the fundamental importance of building relationships, sharing perspectives and working alongside local residents to facilitate this support.

The places of north east London have a long history of successful pace-based working. Strengthening and spreading this across north east London is critical to our overall success because places are:

- where the NHS, local authorities, and the voluntary and community sector integrate delivery, supporting seamless and joined up care;
- where local authorities can seek partner input into, and support for, their work to improve the wider determinants of health, which extends into areas including housing, education, employment, food security, community safety, social inclusion and non-discrimination, leisure and open spaces, and air pollution;
- where we will most effectively tackle many health inequalities through prevention, early intervention, and community development, including at neighbourhood level;
- where diverse engagement networks generate rich insight into residents' views;
- where we can build detailed understandings of need and assets on a very local basis and respond with appropriate support; and
- where the NHS and local authorities as a partnership are held democratically accountable, through health and wellbeing boards and overview and scrutiny committees.

Aligned to this, our collaboratives play a critical role in bringing together NHS provider trusts, primary care networks, and VCSE organisations across the whole of north east London to make use of their combined resources and expertise. We have collaboratives for acute care; mental health, learning disabilities, and autism; community services; primary care; and the VCSE sector. Across these five collaboratives, partners are focused on:

- reducing unwarranted variation and inequality in health outcomes, access to services and experience;
- improving resilience by, for example, providing mutual aid;
- ensuring that specialisation and consolidation occur where this will provide better outcomes and value;
- spreading innovation and best practice; and
- ensuring a strong voice for users of their services and other provision in ICS decision-making.

Principles for working together as place, collaborative, and system

- Our approach is built on a shared understanding of subsidiarity: that decisions are best taken closest to those most affected by them. There is freedom to lead, innovate, experiment, and deliver through place partnerships, without non-value-adding interventions from NEL-wide structures.
- Subsidiarity will be enabled by financial and functional delegation to place sub-committees and to provider collaboratives where required.
- Aligned to this is a shared belief that the place partnerships created in our new arrangements are equal partnerships, with organisations, including collaboratives, coming to the table as equal partners to improve outcomes for local residents.
- Our model of working together sees place partnerships holding responsibility for the health and wellbeing of their local population, for key local outcomes, for improving care and support, and for reducing health inequalities, calling on collaboratives and NHS North East London to support.
- Our ambition is for system to support the journey towards greater integration strategically and operationally, building on best practice in places and recognising this might look different in each place.
- We are committed to working from existing arrangements in each place to develop the capacity and infrastructure that best supports place partnerships to respond to the specific and varied health and wellbeing needs of their local populations.
- NHS North East London will play a role in facilitating partners across the patch to enable effective place working, including problem-solving with and on behalf of place partnerships, advocating for the centrality of place, and organising teams and processes in ways that recognise the relevance of place.
- NHS North East London supports the approach that places shape the system and the system shapes places, and will address behaviours that promote the idea of it as an organisation standing apart from places rather than built from them, such as how its teams communicate and how north east London-wide work is described.
- Place partnerships and provider collaboratives are equal and co-dependent partners in the improvement of health, wellbeing, and equity. They will frequently rely on each other to achieve their objectives. For example, provider collaboratives will often depend on place partnerships for the insight required to ensure that north east London-wide programmes of work meet the varied needs of communities across north east London. Equally, place partnerships will rely on provider collaboratives to leverage the capacity and expertise that enables their residents to be cared for in the quickest and safest way possible. The links between place partnerships and provider collaboratives will come from the overlap of leaders, focused engagement on particular areas work, and formally through the population health and integration committee of the Integrated Care Board.
- Place partnerships will recognise their role within, and contribution to, the wider system in line with the principle of subsidiarity. This means that, whilst places work principally to respond to the needs and aspirations of their local residents and communities, they will also work in alignment with co-created wider approaches and, along with provider collaboratives, to deliver local elements of wider programmes. Whilst some such approaches and programmes may span north east London, some may cover identified geographies within this or dedicated communities for example.

Delivering care and support that improve health, wellbeing, and equity

Our shared work to improve health, wellbeing, and equity combines outcomes and priorities identified by each place partnership with north east London-wide programmes in which places play a critical strategic and delivery role alongside collaboratives and NHS North East London.

We are already identifying clear and quantifiable outcomes goals – co-produced with our residents – so that we can be clear about the impact we are making. Where these already exist, they will be at the front and centre of the outcomes model.

Area	Place partnership accountabilities
Overall ambition	Place partnerships will be responsible for the health and wellbeing of their local populations. In order to support this, a key role of place partnerships will be to convene a range of partners and enable their contribution to the delivery of integrated local care, based on smaller neighbourhoods and reflecting the system and community assets held locally. Each place will facilitate and co-ordinate the work necessary across collaboratives and geographies to ensure that all residents can access same-day urgent care when they need it and deliver continuity of care for agreed cohorts of residents in line with the Fuller Stocktake and any associated policy or legislative developments. Through prevention and earlier intervention, focused on the wider determinants of health and wellbeing, place partnerships will help to reduce the proportion of the population needing the most acute health and social care, including hospital stays and residential and nursing care, creating health and wellbeing for a wider range of residents for longer. Partners will also work together in integrated ways to minimise pressure on the social care front door, including by promoting earlier intervention and the use of community assets that support residents to avoid reaching crisis. In the context of a rapidly growing population, this approach is key to moderating the growth in demand for both NHS health provision and local authority social care, which is critical to our system's long-term sustainability.
Leadership and infrastructure	Places hold a number of key strategic functions for the integrated care system, including: • relationships with local authorities, local providers, community groups, and residents; • participation and co-production with residents; • the insight to understand and tackle local population health and inequalities; • supporting system financial sustainability; and • building integrated models of insight, planning, and delivery. In order to fulfil these functions, places will need the resources identified in the proposal for core place teams, as well as support from north east London-wide teams who will provide embedded teams or individuals working at place. Places will be supported by an effective financial strategy and the requisite delegations for decision making. We envisage the leadership role at place as a system leadership role that builds on the strengths and assets of local communities and of our system, actively convening conversations, facilitating different perspectives, hosting partners to share best practice and building collaborative approaches. We will need to remind ourselves constantly of our system gaze, scanning a range of elements to build the strengths-based system we need.

Neighbourhood working	The place partnership will facilitate strong connections within each neighbourhood, building integrated teams encompassing NHS and social care services, the wider local government offer, and community-led care and support. Along with a central role for primary care, including the primary care collaborative, this joined-up locality working will strengthen the integration of health and care and directly drive better local outcomes. ➢ *How NHS North East London will help* Where a lack of geographical coherence of primary care networks poses a challenge to neighbourhood working in a place, NHS North East London will work with the primary care collaborative and places to support and drive the alignment of footprints to maximise the impact of neighbourhood working.
Partnership working	The place partnership will promote and enable the widest possible view of partnership working. This means working beyond statutory health and care organisations and ensuring that representatives from (for example) the voluntary sector, housing, and police are actively involved in the work of the partnership. This wide view of partnership includes a default to meaningful engagement of, and co-production with, residents. The place partnership lead and NHS North East London will together support the development of the partnership as a high-functioning executive team. This includes the encouragement of peer collaboration and constructive debate between partners, along with transparency and candour about organisational challenges. The Place Partnership Lead, the Director of Partnerships, Impact and Delivery, the Clinical Lead, and the collaboratives' leads in each place will together manage the business of the partnership as well as leading co-production, innovation, and the sharing of best practice. On safeguarding specifically, there is an important opportunity to join up existing statutory forums with the work of the broader partnership. Statutory arrangements are not affected by the development of the place partnership or the sub-committee of NHS North East London. However, the place partnership can play a vital role in facilitating the contribution of safeguarding leads' expertise into the broader agenda of the place partnership, including care model and pathway design. Equally, the place partnership can help to facilitate all partners' contribution towards additional preventative work across the safeguarding agenda. ➢ *How NHS North East London will help* NHS North East London will connect place partnerships with each other, including robust mechanisms to share learning and leading practice across place partnership leads, clinical and care professional leaders, and staff from all levels in partner organisations. NHS North East London will also provide elements of development support across the seven places, by agreement with the place partnership leads.
Mental health and wellbeing	The place partnership, working closely with provider collaboratives at place, will develop and, through its partners, deliver integrated services that enable residents with mental ill-health to live well in the community. This will focus on agreed priority cohorts and prioritise prevention and more equitable access to services. The place partnership lead will ensure a strong focus on the wider mental wellness agenda, including access to employment and access to community-based care and support networks, rather than our collective historic default to focus on the acute end of mental health services.

Babies, children, and young people	Place partnerships, working closely with provider collaboratives at place, will make sure that north east London's places are the best places for babies, children and young people to develop and grow. Place partnerships will take an all-age approach, with parity between the needs of babies, children, young people, and adults, as the basis for sustainable long-term improvements to population health and wellbeing. The place partnership lead will drive creation of a coherent approach to early years, adolescents, and young people up to the age of 24, bringing in partners from across the NHS, local government (families, education, housing), and community organisations, working with parents and families and building holistic support for all babies, children and young people.
Workforce	The place partnerships will lead local design of more integrated workforce models, based around neighbourhoods and focused on community delivery by a broad range of clinical and care professionals alongside VCSE. Place partnerships will also enable local employment by forging effective links with local education and training institutions. The place partnership lead will sponsor this work whilst participating in, and facilitating broader place contributions to, NEL-wide work on broader systemic issues relating to recruitment, retention, design of new roles, and skills development across north east London.
Long-term conditions	Place partnerships have a significant role in ensuring a strong focus on prevention and early intervention, convening work across collaboratives, places and system and facilitating the creation of health-promoting communities and neighbourhoods. Partnerships will support the co-ordination of end-to-end pathway responses for residents at risk of and experiencing long-term conditions, working at different geographies to facilitate the best outcomes for local residents and communities. Please see the annex for further detail.
Community-based care	Place has a significant role in co-ordinating care in the community, ensuring a strong focus on prevention and early intervention, working across collaboratives, places and system and creating health-promoting communities and neighbourhoods for all. Much of the focus will be on a multi-agency approach to Ageing Well, ensuring that north east London is a good place to age, for example with dementia-friendly policies which could be met by the all-age approach supported by place partnerships. Place partnerships will seek to ensure residents can be supported at the end of their lives, dying with dignity in the place of their choice. This could include ensuring good information, advice, and guidance, palliative care at home, effective community support, and residential options are all available, reflecting the cultural and specific needs of our diverse populations. Place partnerships will ensure informal carers are well supported through the experience of end-of-life care for their loved ones. Please see the annex for further detail.
Learning disability and autism	Recognising the leadership role for local authorities in valuing people with learning disabilities and autism to lead fulfilling lives, place partnerships will bring together partners at a place level, including to improve the levels of employment, independent living, and quality of life for people with a learning disability. Place partnerships will enable good system working and ensure the

	needs of people with learning disabilities and autism are considered across all pathways. Place partnerships will work with all partners to seek to ensure people with learning disability and autism do not experience inequality of outcomes across any health or wellbeing domain, as reflected here and in performance and quality metrics. Place partnerships working across partners will be accountable for improving the rates of Learning Disability Health Checks carried out annually, and how the outcomes of these checks are followed through. Place partnerships will work with the Mental Health, Learning Disability and Autism Collaborative to ensure that Transforming Care responses are timely and support the principles of independent, community-based living for this cohort.
Carers	Place will play an active role in facilitating and joining up work across partners to ensure that carers are valued, supported to care, and able to enjoy fulfilling lives beyond their caring responsibilities. This will include developing a joint carers' strategy and action plan, as well as delivering on the NHSE metrics and deliver against specific targets on carer assessments, commissioning carer support agencies, etc. Place partnerships will work with local authority leads to ensure carers' strategies reflect wider system working and build awareness of the need for identification and support to carers to be system-wide. Place partnerships will deliver strengthened carers' offers that reflect the needs of their local communities and build best practice.
Homelessness	Recognising the leadership role of local authorities, place partnerships will be responsible for improving the health and wellbeing of those sleeping rough or facing homelessness by: • ensuring GP registration and primary care support to this cohort; • improving access to secondary and tertiary care as appropriate; • recognising the needs of the homeless population for all levels of support, care, and treatment across mental and physical health; and • co-ordinating local support to the street homeless population and participating in work led by local authorities work to improve their health and wellbeing outcomes.
Asylum seekers and refugees	Recognising the leadership role of local authorities, place partnerships will be responsible for improving the health and wellbeing of asylum seekers and refugees, including those accommodated in Home Office hotels, by: • ensuring GP registration and primary care support to this cohort; • improving access to secondary and tertiary care as appropriate; • recognising the needs of the asylum seekers for all levels of support, care, and treatment across mental and physical health; and • co-ordinating local health and wellbeing support to the asylum seeker and refugee population and participating in work led by local authorities to improve their health and wellbeing outcomes.
Person-centred care	Place partnerships will be held accountable for enabling person-centred care in their local area. This will include bringing together a range of initiatives that support residents and communities to be at the centre of decisions that are made around their care, reflecting the principle of 'Nothing about us, without us'. Ways of testing effectiveness in this area could include rates of

	satisfaction and levels of personal health budgets and direct payments in a specified area and for specific communities.
Health creation and primary prevention	Place partnerships will lead for ensuring that the wider determinants of health are effectively understood and influence approaches to all areas of accountability. Place partnerships will lead on the involvement of the whole local authority and wider partners to build an effective model for addressing wider determinants and their impacts on health and wellbeing. Place partnerships will be held accountable for supporting models to reduce health inequalities and improve health and wellbeing through a series of performance and quality metrics, attached.
Immunisations	Place partnerships are key in enabling uptake of immunisations across all communities in a local area. They will be accountable for the vaccination and immunisation rates of their local population, across children and adults and for routine and reactive vaccination programmes. Places will be required to ensure capacity for all vaccination and immunisations activity and to support take up with a focus on inequalities and ensuring equitable take up across all communities.
Local system flow	As the principal forum for local health, care and wellbeing partners, place partnerships have a critical role in addressing more immediate operational pressures whose resolution require input from multiple organisations. The place partnership lead will ensure that place-based mechanisms exist to convene relevant partners as required to maintain consistent and adequate system flow, as well as to respond to periodic additional pressures. This will be with the support of the relevant commissioning and transformation teams from within NHS North East London and will ensure the pressures on all parts of the system are paid equivalent attention.

Accountability for improving performance and quality at place

Many of the performance and quality metrics – and related outcomes for residents – that NHS North East London is required to deliver can be achieved only through effective collaboration in place partnerships. Each partnership is working on a performance and quality metrics framework that will set out in greater detail the metrics for which place partnerships are responsible and will be held accountable, whether the lead is with the NHS, the local authority, or other partners.

These metrics are a combination of performance and quality metrics contained in NHS North East London's operating plan, which is agreed each year with NHS England; the Better Care Fund Plans approved by Health and Wellbeing Boards in each local authority area; and in place partnership delivery plans, based on locally-identified priorities. The partnership will monitor performance and quality, identify trends and clusters of concern, agree and implement corrective action where necessary, and sense check data quality, with the support from the relevant local and north east London-wide commissioning and transformation teams from NHS North East London.

How NHS North East London will help

NHS North East London will direct its people to work with place partnerships to develop their approaches in each of the areas described above, specific to the local context. This includes offering the tools, capacity, and skills required. It will build up north east London-wide approaches from work done at place. These north east London-wide approaches will aim to remove systematic barriers which obstruct effective place-level work. It will also work with places to direct additional available financial resources to support work in these areas.

Additional commitments from NHS North East London:

Theme	Commitment
Localism and subsidiarity	• NHS North East London will operate, and shape the wider north east London health and care partnership, around a *default to place* – the assumption that places (and neighbourhoods within them) are the optimum organising footprint for our work unless there is a clear reason for operating at a larger scale • NHS North East London will provide its leaders at place with sufficient autonomy and flexibility to work in the ways required to deliver for their places, as well as encouraging and enabling this way of working in provider trusts • NHS North East London will ensure the ICB Board effectively delegates to Place Sub-Committees the functions and financial influence required to deliver its accountabilities – with an objective of this coming into place from 1 April 2023, with the requisite place-level engagement on new sub-committee terms of reference approvals happening in advance of this
Capacity to deliver	• NHS North East London will lead all partners across the health and care partnership to devise an integrated workforce strategy that sets out how the workforce needed in each place will be delivered • NHS North East London will organise its own workforce so that it supports the work of each place partnership, including through a core team based permanently in each place and an extended team at place drawn from colleagues working in NEL-wide structures • NHS North East London colleagues who are part of the extended team will spend time in the places to which they are aligned, building local knowledge and relationships

	• NHS North East London will encourage other partners who work across multiple places to align their structures and teams to place partnerships, where this supports delivery of place partnerships' objectives • NHS North East London will fund the substantial portion of clinical and care professional leadership roles operating at place
Money	• NHS North East London will lead the codesign of a system-wide financial strategy, including place partnerships, which will move investment into community health services and support the transformation required for place partnerships to deliver their objectives • This will include NHS NEL working with partners to agree the specific budgets for which place sub-committees hold responsibility, along with and the associated requirements (such as reporting and treatment of over/under-spends). NHS NEL's objective is that, subject to system agreement, place sub-committees take on these responsibilities during the 2023/24 financial year (potentially at different points in the year for different places), with all places responsible for delegated budgets ready for the 2024/25 planning round • An underpinning principle of the financial strategy will be that allocations are made to trusts and place sub-committees on the assumption of active and meaningful engagement with partners in how they are invested, through the place sub-committees and the broader place partnerships as well as through the provider collaboratives • NHS North East London will support the development of a strategic overview of all funding enabling health and wellbeing in each place – including money spent by the NHS, local government, the direct schools grant and other education spending, and other public services – to create the insight required for each place partnership to exert influence across a greater spread of relevant investment • NHS North East London's financial strategy will drive a levelling up agenda so that the money spent on health services in each place is increasingly in line with relative need and reflects the pressures of population growth
Data and insight	• NHS North East London will provide place partnerships with the shared data and insight collectively agreed to be required to improve local outcomes, focused on outcome measures, service performance, and the information needed to plan and evaluate local transformation work • This will be in the form of a defined data set agreed between NHS NEL and the place partnerships • As part of the financial development programme, NHS NEL will lead the co-design of a suite of reports and tools that support discussions between place partners within places about the best allocation of capacity. These will include benchmarking of finance and performance and operational data and support transparency within and between places. • NHS North East London will provide capacity for bespoke local analysis commissioned and directed by place partnerships

	• NHS North East London will also lead on working across partners to resolve issues that inhibit effective provision and sharing of data, including information governance, conflicting data sets, and unclear points of contact

Annex

We recognise that there are some specific areas where place partnerships and collaboratives working together will need to determine by pathway how we best enable population health and wellbeing.

Examples of areas where we may work to define roles in more detail include:

- **Long Term Conditions**
  - In addition to the roles and functions outlined above, places could be required to:
    - understand local needs, have insight into local communities and plan for future needs;
    - deliver engagement and outreach into our diverse communities to build awareness and community support;
    - innovate to deliver primary and secondary prevention;
    - identify and manage long-term conditions;
    - develop integrated teams that support people with rising and complex needs, which will encompass a lot of long-term conditions management (Fuller);
    - empower patients to manage their own health as far as possible;
    - support people to live independently and well at home, avoiding admission to hospital or long-term care;
    - develop out of hospital services that support people with long-term conditions;
    - implement a consistent community-based rehabilitation offer; and
    - share best practice, identifying opportunities to work on a cross-borough basis and making pathways into secondary care as simple as possible.
- **Ageing Well**
  - In addition to the roles and functions outlined above, places could be required to:
    - understand local needs, have insight into local communities and plan for future needs;
    - deliver engagement and outreach into our diverse communities to build awareness and community support;
    - innovate to deliver primary and secondary prevention for older residents and those in need of community-based care;
    - develop integrated teams that support people in need of community-based care, aligning with implementation of the Fuller Stocktake;
    - empower patients to manage their own health as far as possible;
    - support people to live independently and well at home, avoiding admission to hospital or long-term care;
    - develop out-of-hospital services that support and are accessible to local residents;
    - implement a consistent community-based rehabilitation offer; and

- share best practice, identifying opportunities to work on a cross-borough basis and making pathways into secondary care as simple as possible.

MEETING:	Tower Hamlets Together Executive
DATE:	22 February 2023
TITLE:	**Local Delivery Board Update**
AUTHORS:	Chris Banks
CONTACT DETAILS:	Chris.banks5@nhs.net

Purpose
Quarterly update to the THT Executive on the activities and issues arising from the Local Delivery Board.

Impact
None except as noted in individual sections or papers.

Next Steps
Note contents of paper and consider any recommendations.

RECOMMENDED ACTIONS:
This paper is for information unless a specific recommendation is made within the narrative.

1. Overview of Local Delivery Board (LDB)

The LDB meets monthly and comprises senior management from the system health and social care partners i.e. Barts Health, ELFT, (community services and mental health), GP Care Group, Adult Social Services, Children's Social Services, VCS and ICB. It does not have service user representation.

The LDB is responsible for overseeing the delivering the priorities set annually by the Tower Hamlets Together (THT) Board. This programme is derived priorities set by the THT Board and its three life-course workstreams: Born Well Growing Well, Living Well and Promoting Independence. It is therefore a mix of national, regional and borough projects requiring the participation of one or more members of the strategic local partnership as an integrated care system. It has not had direct oversight or involvement in the Urgent and Emergency Care Workstream. As such the LDB is primarily focussed on service improvements in out of hospital community care.

The LDB does not have a performance management role but does receive a system temperature report. It also receives service issue updates from the three organisations currently delivering the community health services contract: Barts Health, ELFT and GP Care Group.

A summary report of progress on all the projects in the programme is produced at least bi-monthly and has been submitted to THT Executive twice in the last year by way of routine updates.

2. Programme Status

The last programme report is attached as an appendix to this update. Risks and concerns were noted by the LDB and actions taken. There is nothing in the programme that requires escalation to THT Executive at this juncture.

3. Issues for 2023/24

a) The Community Health Services contract will be in its second and final annual extension. A review is being conducted by system partners to determine what and how community health services will be delivered post 31 March 2024. This is subject to a separate report to THT Executive.

b) The local priorities are due for review. Some of these will be derived from the CHS review but we also look to the life-course workstreams to advise on their priorities for 2023/24.

c) The continued and prolonged re-organisation of the ICB is creating considerable uncertainty for colleagues within the ICB and a vacuum in decision making and funding allocation for 2023/24. This vacuum appears to extend to the governance within the northeast London ICS and hence into the Borough governance. Sadly this is leading to delays in establishing a new service improvement programme, delays in delivering it, inefficient use of tax-payer funds, loss of workforce, poorer service for service users and therefore poorer outcomes than might otherwise have been achieved.

4. LDB Membership Survey

To get on the front foot, the LDB has been discussing its current role and what may be required in the future. It has not ventured into the maelstrom than is the ICB reorganisation but has asked itself some basic questions about role, effectiveness and areas for improvement.

A summary of the survey containing suggestions for the LDB's role in future is attached for information. The fact there is no real consensus is, in my view, a reflection of the lack of clarity about what governance is required in Place and what will be delegated to Place. I hope in time that will be resolved. It needs to be.

5 Parting Comments

This report is deliberately short. I chose not to spend a lot of time writing it. When we have provided detailed updates for the THT Executive in the past they have been consigned to the back end of agendas, and the meetings have run out of time to discuss them. If the THT Executive is serious about governance, its needs to work out what it is there for and it needs to make the time to do it properly.

This is my last report for the LDB and last meeting as a member of the THT Executive. The LDB evolved from the CHS Alliance Partnership Board which was established when the CHS contract started in 2017. I have chaired it since then in my capacity as CEO of GP Care Group, which was the Alliance Partnership Manager. It has been a privilege to do so, and I am very grateful to members of the LDB past and present for their contributions over the last 6 six years.

I extend my sincere thanks to Ashton, Suki, Tamatha and Ely who are the PMO powerhouse behind the programme that the LDB oversees. They are a brilliant group of colleagues, full of ideas and focussed on getting things done. The fact that I and they are employed and paid by different organisations is irrelevant. They work as an integrated team, which I have thoroughly enjoyed being part of, and have learned so much from them. I wish them, the LDB and THT all the best.

Priorities and health inequalities programme delivery update

04/01/2023

Ashton West, Programme Lead – LBTH & NHS NEL

LCG	Priority	Status
Children & Families	Enhancing CYP mental health & emotional wellbeing access and outcomes	MINOR ISSUES
	Enhancing SEND services	ON TRACK
	Promoting healthy childhood weight	ON TRACK
	More integrated ways of working	MINOR ISSUES
	Mitigating poverty and economic hardship	ON TRACK
Living Well	Improving access to contraception	MINOR ISSUES
	Embedding a trauma informed care approach	ON TRACK
	Better integrating pharmacies into the local system	MINOR ISSUES
	Improving access to services for disabled residents	ON TRACK
	Improving oral health outcomes and access to services	TBD
Promoting Independence	Embedding MDT and care coordination – pilot focusing on moderate frailty	ON TRACK
	Achieving more effective long term conditions management – pilot focusing on diabetes	ON TRACK
	Providing the new model for homecare	ON HOLD
	Coproducing a transitions pathway into adult services for CYP with complex conditions	MINOR ISSUES

Children & Families overview

Priority	Status	Phase	Update
Enhancing Mental Health & Emotional Wellbeing access and outcomes	MINOR ISSUES	Delivery	• A programme with 17 projects has been developed - all projects mapped and being captured in one programme plan. Lead is working to attain more detailed feedback. • Most on track or delivering with minor issues with exception of Kooth online mental wellbeing service which is not meeting KPIs – this is being raised at NEL level. • Projects include TH Education Wellbeing Service, CAMHS personal health budgets, extended Crisis hours, eating disorder service, support for sexual abuse victims
Enhancing SEND services	ON TRACK	Delivery	• Priority focuses on: leading SEND, early identification and assessment, commissioning effective services, good quality education provision & supporting successful transitions • Co-production successfully embedding across local area; Well-received focus groups on new EHCP processes. SEN Co-ordinators developing confidence & skills in co-production approach - full roll out spring 2023 • New EHCP template & Quality Assurance (QA) Matrix developed to support quality & consistency. QA group meets every half term to audit new plans • 90% of new plans accurately reflect advice received but quality of advice needs more work • More diagnostic decisions/discharges due to increased ASD diagnostic capacity & new pathway • Barts Health, Phoenix School & local parent delivered successful partnership ASD Training Session; 120 families & professionals attended

Children & Families overview

Priority	Status	Phase	Update
Promoting childhood healthy weight	ON TRACK	Delivery	• Programme has 3 focus areas: healthy places, healthy settings, healthy services • Play charter established, with priorities agreed and a Play Manager being recruited to lead on Healthy Borough play initiative. • Successful bid to fund school food improvement programme (SFIP) over 3 years. SFIP manager recruited. Working group established, logic model and overall plan agreed. • Currently working with Communications to develop a partnership comms strategy on healthy weight. Proposed campaign: 'living well for less', aimed at families. • Healthy weight pathway mapped out. Healthy weight service directory developed.
More integrated ways of working	MINOR ISSUES	Delivery	• Current work focusing on early help provision and services. There has been significant progress in developing a road map towards more a unified cross partnership way of supporting families. • A project plan is in place with key goals and milestones identified with the ambition of creating an effective Early Help Eco system with a common practice approach by Jan 2023 - yet to confirm the practice framework we will lead with on for the forthcoming pilot
Mitigating poverty and economic hardship	ON TRACK	Delivery	Work underway with LBTH Tackling Poverty team and other partners to provide support • Direct cost of living payments being made to 25-30k households • 7 food pantries opened and supplying 60 VCS orgs and schools with food through hub • Delivered the Easter and Summer holidays programme – 65k meals and activity days • Provided £390k of grants through residents support team • Training CYP frontline staff to better support families, e.g. to apply for benefits and grants

Living Well - overview

Priority	Status	Phase	Update
Improving access to contraception	MINOR ISSUES	Delivery	• LARC hub was set up by the GPCG (May 2022) and the ICB have supported this through their extended access provision with Public Health funding the fittings. The LARC hub delivery has been increasing each month and are running one evening in the week (for triaging patients referred by GPs) and Saturdays. • Training based at the LARC hub will start in about 2 months (practical training every month on a Saturday with the support a Faculty of reproductive health trainer for implants). GPCG have approved the governance arrangements for this and they have also applied for a grant to support training for coil fittings. • Issues currently around securing appointment slots and funding sustainability
Embedding trauma informed care	ON TRACK	Delivery	• 4 pilot projects have been undertaken to embed trauma informed approaches – 2 hostels, LBTH employment service & RLH maternity service – produced a range of results, reflections and change ideas • UEL was commissioned to review the pilots and make recommendations about how to enable the borough to become more trauma informed – discussed at THT • Social care specific training for LBTH Adult Social care and Supporting Families is being implemented throughout November and December 2022. • Community of practice - Recurring events about every 6 weeks – previous and upcoming sessions can be seen here: https://padlet.com/towerhamletstraumainformed/meetingsandevents

Living Well - overview

Priority	Status	Phase	Update
Improving access to services for disabled residents	ON TRACK	Delivery	• Project has now been commissioned to Real for delivery. • 4 groups of volunteers comprising minimum of 4-5 vols each are in place. • Best practice guide (endorsed by NHS) ready to support training of frontline workers and sessions produced, rehearsed & delivered by volunteers. • 2 practices have signed up to trial embedding deaf and disability access in GP practices. • 3/8 board presentations given, including Barts Equalities Board.
Improving oral health outcomes and access	TBD	Scoping	• Discussions have been ongoing between the relevant people and services. Initial scope has been set to focus on 1) promoting good oral health in early years and 2) access to NHS dentistry services – need to determine if this is still the case. • Project lead has left – currently confirming new lead and confirming action plan.
Better integrating pharmacies into the local system	MINOR ISSUES	Delivery & Scoping	• A covid vaccination hesitancy pilot programme is currently being undertaken in a small number (9) of local pharmacies and has seen a good increase in the take up of the vaccine: 50% of those initially hesitant decided to have the vaccine. • Planning is underway, but not yet complete, to identify other services (e.g. smoking cessation, healthy weight management) to be commissioned to pharmacies. • A pharmacies needs assessment is currently being undertaken with pharmacies and is being regularly reviewed at Living Well group

Promoting Independence - overview

Priority	Status	Phase	Update
MDT Care Coordination	ON TRACK	Delivery	• Pilot is underway in PCN 7 with moderate frailty service users. Members of MDT across health and social care are fully engaged. • The SOP was approved at October LDB. Project lead currently collecting and monitoring outcomes to be used in the December project mid-review.
LTC management	ON TRACK	Delivery	• Small group consultations started already in St. Paul's way GP practice and the plan to expand the group will start once additional resources i.e. HCA 3 and 4 have been appointed. • The funding has been approved and the MOU is in the process of approval also, the recruitment plan is in progress.
New model of homecare	ON HOLD	Delivery	• Procurement is on hold due to requests for change from the new administration. • A Cabinet paper is being prepared for December to formally request a 12 month extension to the current homecare contracts to end December 2023 and permission to recommence procurement activity.
Transitions from CYP to adult services	MINOR ISSUES	Scoping	• Scoping still underway but making progress. Meetings held between colleagues from Barts and CFE group to define cohort – Continuing Care. • Outcomes and outputs being drafted – will focus on coproducing a pathway which supports independence for this cohort once they reach adulthood. Wider plan to be shared by December.

Highlighted issues / risks

Project	Status	Risk /issue	Mitigation
Improving access to contraception	High	The ICB support will unfortunately end at the end of October as these appointment slots released for the LARC hub need to be allocated for same day urgent care only – there is a risk the service may need to stop	GPCG are trying to address issues with the PCNs to continue with the LARC hub
	Medium	There is uncertainty about how the LARC hub will be funded going forward	Working group members are currently exploring other ways to fund the LARC hub over the next few weeks
CYP MH & EW	High	Kooth online service not meeting current KPIs	NEL wide service; NEL to review KPIs
Enhancing SEND services	Medium	Caseload & waiting time remain high; it will take time for these to reduce to appropriate levels. Average referral rate doubled from 30 to 60 per month since 2021.	Non-recurrent funding approved for additional paediatrician assessments
	Medium	Recruitment of therapists remains challenging	Barts exploring staff-mix to address capacity / sustainability issues

Health Inequalities Programme

Improving Equity Programme	Identifying areas of inequity relating to health and wellbeing across our borough and seeking to address these as part of a structured and supported Quality Improvement learning programme	ELFT + 14 CVS, LBTH & health teams
Barts Extended Placement Scheme	Engaging underemployed groups in the community with careers advice and access to employment in Barts Health Trust – funding for 20 placements for 4 months each with the expectation that this leads to onward employment	Barts Health Trust & LBTH Workpath Team
BAME Disparities Project	Extension of our BAME Disparities project – particularly the leadership programme – to improve BAME engagement, representation and community insights across THT decision making and delivery systems	Tower Hamlets Council for Voluntary Services
Equalities Networks insights survey	Building a comprehensive 1,000 case insight into health inequalities across the 7 Equalities Networks in TH using the coproduced THT resident outcomes (i-statement) framework to give us a more comprehensive base line of insights across communities	Tower Hamlets Council for Voluntary Services
Coproducing accessible comms for disabled residents	Embedding coproduction in generating accessible communications for residents with disabilities – to ensure more accessible health communications and services produced for disabled people	Real
CAMHS receptive bilingualism	Developing multi-family therapy to improve clinical outcomes for those children and young people who interact with their parents via receptive bilingualism	ELFT
Social prescribing community chest	NEL wide programme to support selected VCFSE grantees providing social prescribing activities as part of the Community Chest, with micro-grants being subsequently managed locally in each place-based partnership	NEL ICB

Health Inequalities Programme

Progress updates

Project 1, Improving Equity Programme: development of project charter, project team assembly, and QI training workshop design to support teams underway.

Project 2, Barts Extended Placement Scheme: 24 Placements secured for the scheme in the first instance. Two cohorts planned before Mar 2023: 6 candidates have started in the first cohort, currently recruiting for cohort 2. Candidates to undergo training early in December with placement start date set for mid January 2023.

Project 3, BAME Disparities Project: Developing the next phase of the programme. Planning a survey with other BAME led organisations, event for the sector and learning event with key decision makers. Delivered 2 Peer to Peer sessions.

Project 4, Equalities Networks Insights Survey: Developed survey for agreement with Equalities hub. Will present to THT board on the approach.

Project 5, Co-producing accessible comms for disabled residents: Delivery team in place. Project scope is in development with with partner organisations. Establishing relationship between project providers and key comms departments. Joint working between Comms department and disability co-production groups taking place. Widening engagement to more disability organisations.

Project 6, CAMHS receptive bilingualism: Awaiting update

Project 7, Social Prescribing Community Chest: Currently at preparatory stage and gathering insights into gaps in provision. Liaising with key community connector services to understand gaps in provision. Also liaising with procurement leads to explore funding options.

Local Delivery Board Survey Results

Tamantha Hearne February 2023

TOWER HAMLETS TOGETHER

Delivering better health through partnership

TOWER HAMLETS

GP CARE GROUP CIC

thcvs Council for Voluntary Service

NHS Barts Health NHS Trust East London NHS Foundation Trust Tower Hamlets Clinical Commissioning Group

NHS North East London Clinical Commissioning Group

Methodology and Intentions

- We asked all members of the Local Delivery Board to participate in a brief (5 minute) survey to test its effectiveness, impact and value.
- The questions are specifically intended to understand Board member's own experiences:

Attendance, Understanding, Inclusivity:

- *How often do you usually attend The Local Delivery Board?*
- *Is the membership of the Local Delivery Board about right, and consistent with achieving outstanding objectives?*
- *The role of the Local Delivery Board and what is expected from its members is clear.*
- *At meetings, I am able to contribute and make my voice heard.*
- *At meetings, I am able to influence discussions and decisions.*

Value:

- *The Local Delivery Board provides a space to share and gather information about my own and other people's services.*
- *The Local Delivery Board provides value as a space to tackle problems and innovate solutions.*
- *The Local Delivery Board helps to achieve outcomes and focuses on priorities that matter to local people.*
- *The Local Delivery Board helps me to build relationships with people in other organisations.*
- *Change has been achieved that would have been harder without the Local Delivery Board.*

Operations:

- *Going forward should the Local Delivery Board be retained as it is, reformed, replaced or removed?*
- *What could be done to make the Local Delivery Board more effective?*
- *What else would be required if not in the form of the Local Delivery Board?*

Executive summary of findings

How well attended, well understood and inclusive is the LDB?

- The LDB is generally very well attended
- Whilst 50% agree that the LDB is consistent with outstanding objectives, 50% do not agree.
- Responses were split as to whether the role of LDB and what is expected from members is clear with 50% neither agreeing or disagreeing with this statement.
- Overall, the majority of members feel that they are able to contribute in influencing discussions and decisions.

Does the LDB add value?

- Overall, the majority of members over 80% agree that the LDB adds value as a space to share and gather information.
- Although most agree that the LDB provides a space to tackle problems and innovate solutions, some were undecided (25%).
- Despite 50% of members agreeing that the LDB helps to achieve outcomes, focusing on priorities that matter to local people, 33% were uncertain.
- Most members 75% agree that the LDB helps them to build relationships in other organisations.
- 33% of members were undecided and 25% disagreed that achievements would have been harder without the LDB

Going forward, how should the LDB operate?

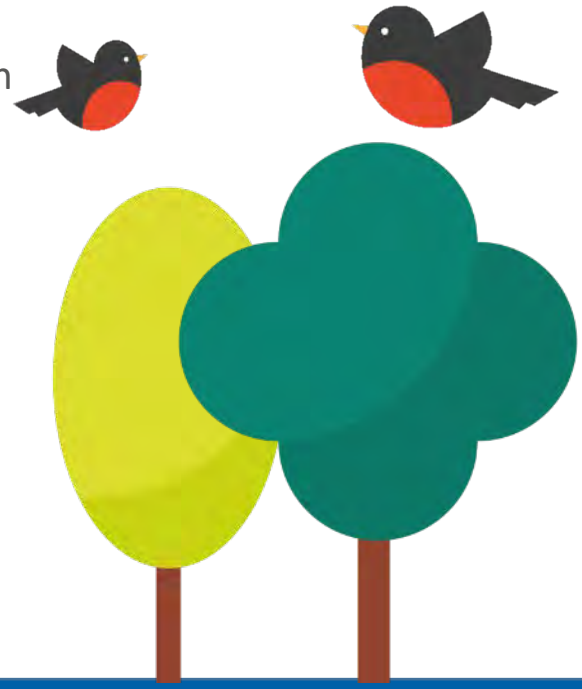
- Although some felt that the LDB should be retained as is, the majority of members (66%) are in favour of retaining the LDB but only if reformed.

What can be done to make the LDB become more effective?

- Depends what its' role is in the future. If it is focussed more on delivery than on overseeing a programme it may need to spend more time on performance, finance and quality and less on the prioritised projects.
- It should be the platform to initiate change and transformation.
- Invite public health representation. Be clearer on how the programme of work (projects) link back to each organisation and in particular the localities and their workplans.
- The LDB could be the engine room for TH Place. It should be retained and the TOR refreshed to create clarity on the forward plan for 23/24 and the outputs from all participants.
- To be more operational and action focussed. The meeting has fallen to become a service update style of meeting. Also question whether a monthly meeting can really be operational as so much time passes in between. Smaller group may enable more honest conversations and progress work.
- More challenge and more evidence to present.
- Themed workshops or meetings to provide a space for innovation, spark ideas and bring about change. There is too much 'noise' or updates that do not add value.
- Greater focus on performance. Whilst this is a regular item, it doesn't usually feel like some of the issues are explored in enough detail. We should try and understand where we are underperforming, why, and what we can do as a partnership about it. There should be more space to bring ongoing and ad hoc system challenges and pressures as a place for discussion and resolution.
- We also need a space for less formal updates e.g. as things arise on issues, demand, resources etc.
- Possibly a smaller membership, with others joining as necessary.
- A more frequent meeting – perhaps fortnightly and combine this with the existing ops group.

What else would be required if not in the form of the LDB?

- We need a strategy for Health and Care for TH Place. If the Local Delivery Board is not required then a review of the current structure of meetings would be required to understand whether there is another forum that could deliver the Place agenda.
- An informal fortnightly operational management group for TH with key persons from across our borough.
- Data driven, performance driven delivery board (section 1), projects (section 2), presentations (section 3) and AOB (section 4).
- There would need to be some kind of Place based forum for Providers to strategically work together.
- Is there replication with other local meetings?
- We do need to get the enabler groups back up and running and supporting the partnership, overseen by the LDB.
- We need a space to have routine, regular updates at a forum such as quality, performance, programme updates – as we currently do, but with more focus on action and escalation – need to also consider how we get more feedback from lifecourse groups straight to THT Exec



Survey data collection and sample size

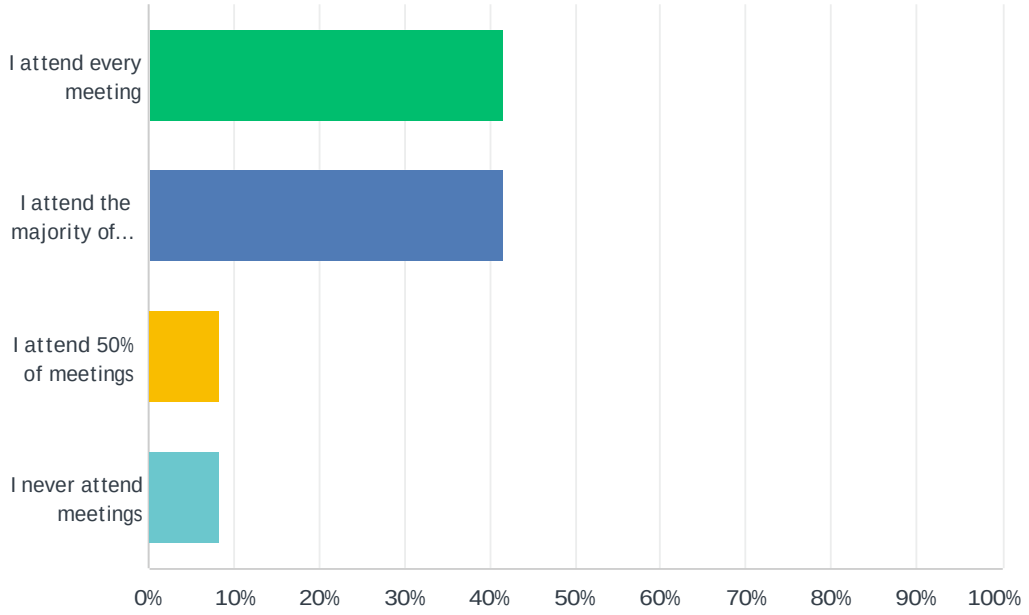
- The survey was emailed to all LDB members and was open for 1 week
- 12 responses (50%) were received from 25 members
- 1 member sent through an email with suggestions for the LDB going forward which has been added to slides 4 and 5.

How well attended, understood and inclusive is the LDB?

Executive Summary

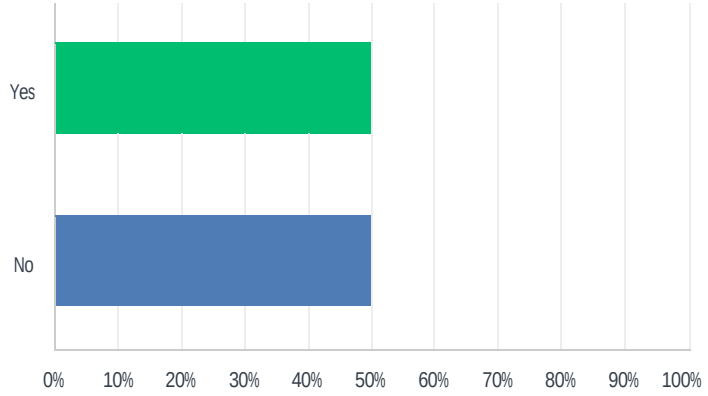
- Overall, a significant 92% regularly attend LDB, with only one member stating that they never attend.
- 50% agree that the LDB is about right and is consistent with achieving outstanding objectives, whilst 50% do not agree.
- 58% disagreed or could neither agree nor disagree that the role of the LDB and what is expected of its members is clear.
- 92% of members agreed that they are able to contribute and makes their voices heard.
- The majority of members 75% feel that they are able to influence discussions and decisions.

Attendance



Overall, the LDB is well attended: 92% of members personally attend either all or a majority of meetings. 1 member claims to have never attended the LDB.

Consistent and about right in achieving outstanding objectives

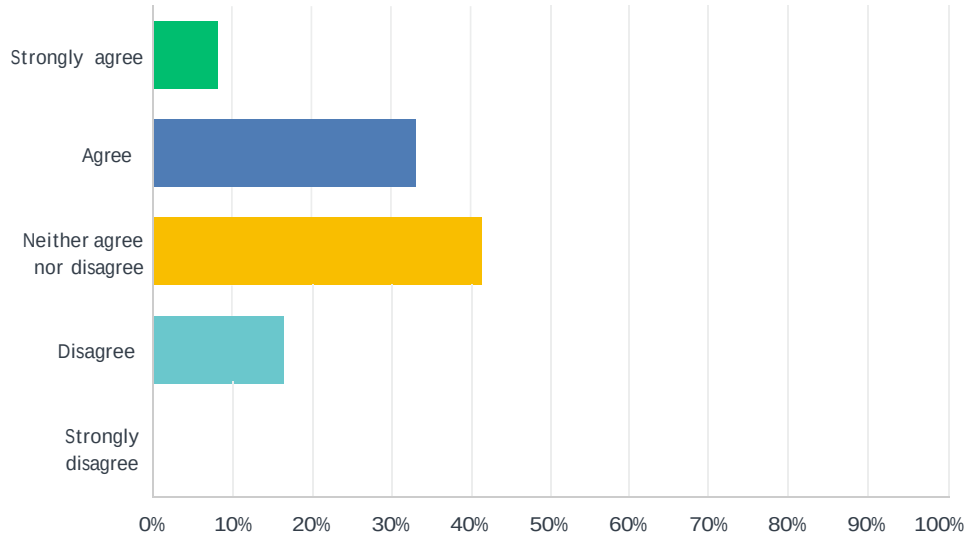


Whilst 50% agree that the LDB is consistent with achieving outstanding objectives, 50% do not agree.

If No, who should be/shouldn't be there:

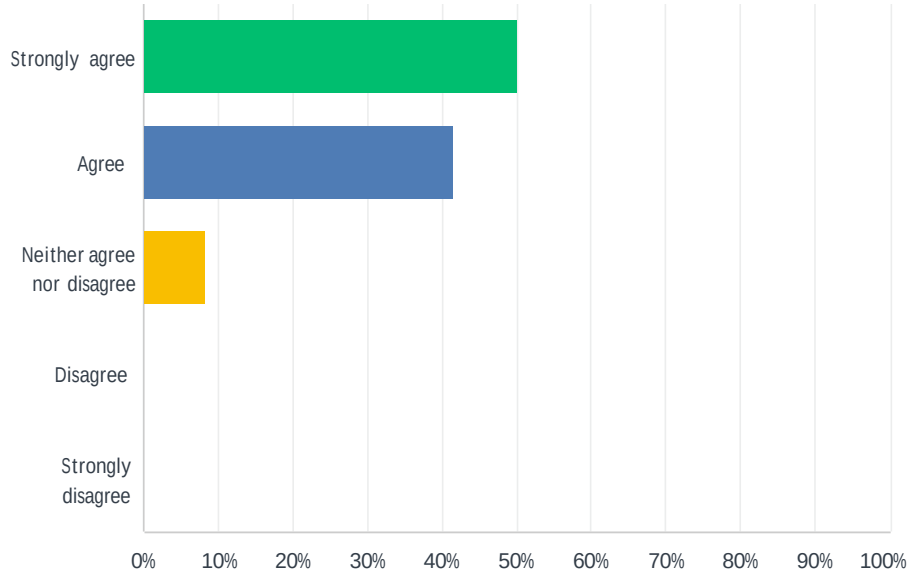
- It has been about right as the project oversight board for the local priorities. It may not be right if the LDB's role moves more to system delivery, though it would seem that urgent care is still going to sit outside it, in which case membership may be okay.
- Public Health CD from primary care perhaps?
- Public Health representation should be there.
- Should it be more operational middle managers from across the system?
- If a core member unable to attend, encourage to send proxy to maintain representations across the sectors.
- Membership needs to be reviewed. It would be helpful to have a list of the current membership in a table, to use this to indicate who should not be there and add who should.
- I don't think that Public Health and Children's services are adequately represented at present.

The role of the LDB and what is expected from members is clear



Whilst 42% members generally agree that the role of LDB and what is expected from them is clear, a significant 58% could neither agree nor disagree or just disagreed with this statement.

Member's perceived ability to contribute to the LDB and feel their voice is heard

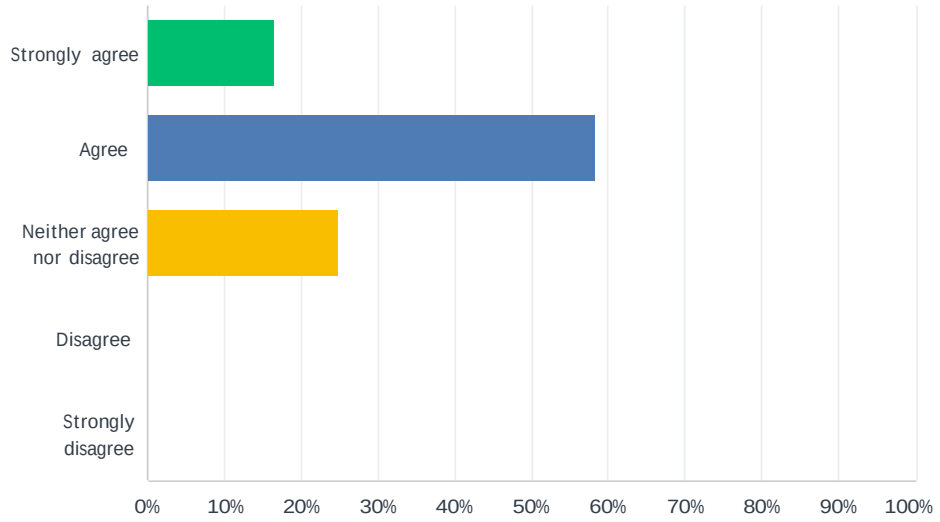


A significant 92% feel able to contribute to the LDB and feel that their voice is heard.

1 member selected neither agree nor disagree with the comment below:

- I think it might be timely to review the terms of reference given the Chair, Chris Banks is stepping down.

Member’s perceived ability to influence decisions and discussions



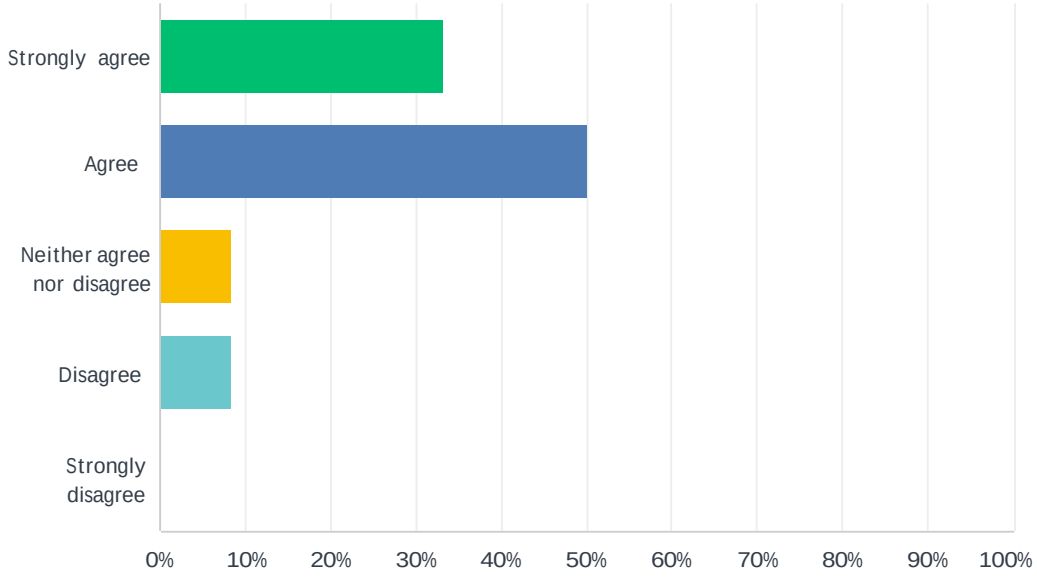
Overall the majority of members 75% feel able to influence decisions and discussions. Interestingly, 25% neither agreed nor disagreed.

Does the LDB add value?

Executive Summary

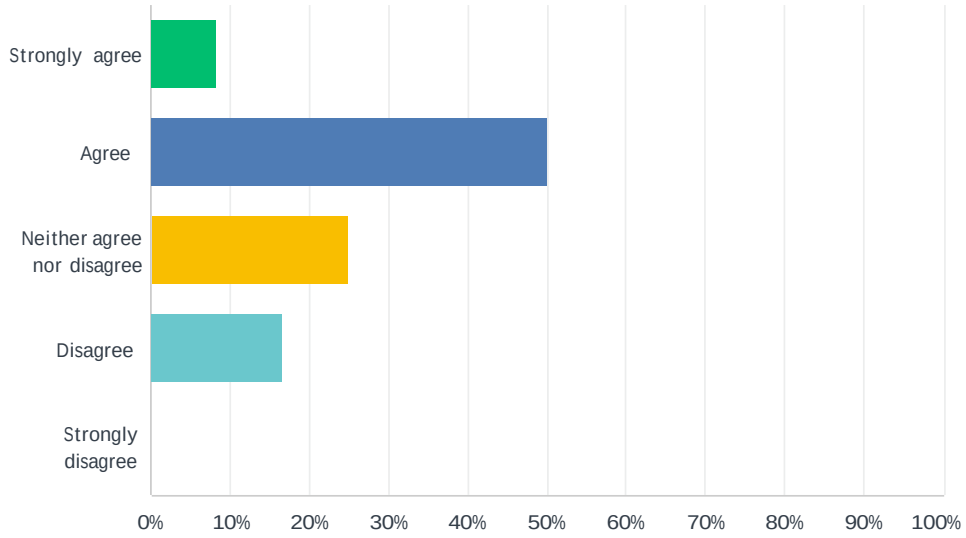
- Overall, 83% members feel that the LDB provides a space to share and gather information across services.
- Members generally agree (58%)that the LDB provides a space to tackle problems and innovate solutions, however a minority of 25% neither agree nor disagree with this statement.
- Only half of respondents (50%) generally agreed that the LDB helps achieve outcomes and focuses on priorities that matter to local people.
- 75% members felt that the LDB helped them build relationships with other organisations, but a small minority disagreed.
- 33% members could neither agree nor disagree that change achieved would have been harder without the LDB, with a further 25% who disagreed with this statement.

The LDB provides a space to share and gather information about my own and other people's services



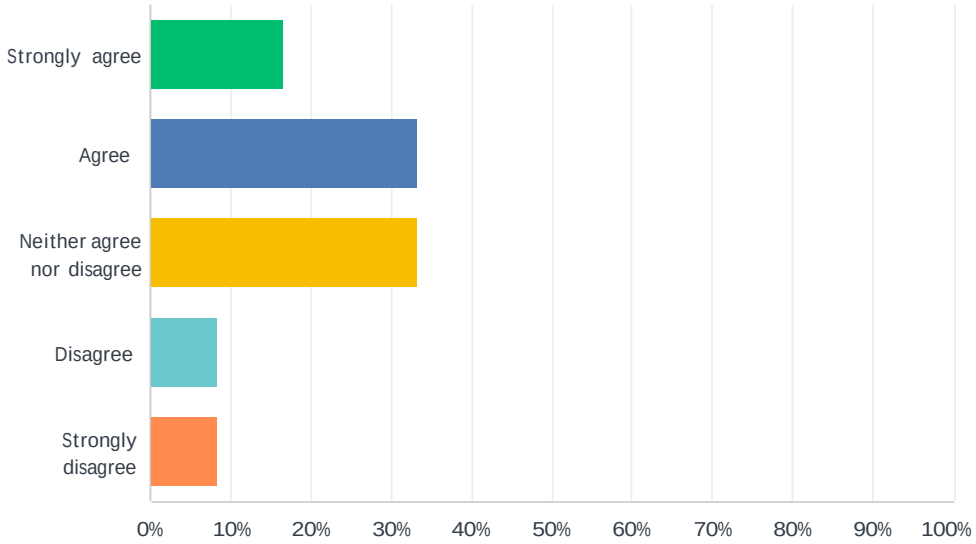
A sizeable majority of members 83% feel that the LDB provides a space to share and gather information. Surprisingly, 17% neither agreed nor disagreed or just disagreed with this statement.

The LDB provides value as a space to tackle problems and innovate solutions



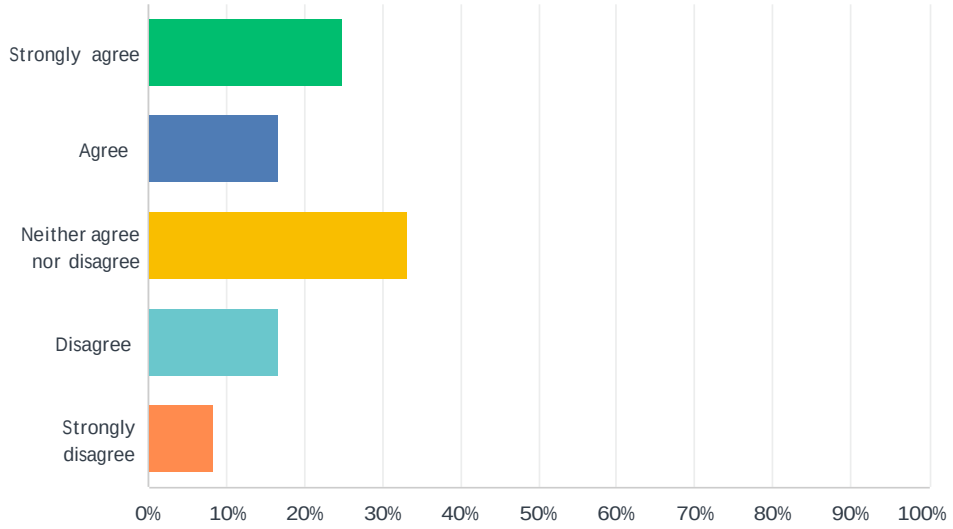
42% of members do not feel that the LDB provides a space to tackle problems and innovate solutions including 25% who are undecided, however 58% do agree with this statement.

The LDB helps to achieve outcomes and focus on priorities which matter to local people



An even split here where 50% either disagreed or neither agreed nor disagreed that the LDB helps to achieve outcomes and focus on priorities that matter to local people, 50% of members do agree with this statement.

Change has been achieved that would have been harder without the LDB



Although 42% of members agreed the LDB helped to achieve change that would otherwise have been harder, a minority of 25% disagreed, followed by 33% undecided.

How should the LDB operate going forward?

Executive Summary

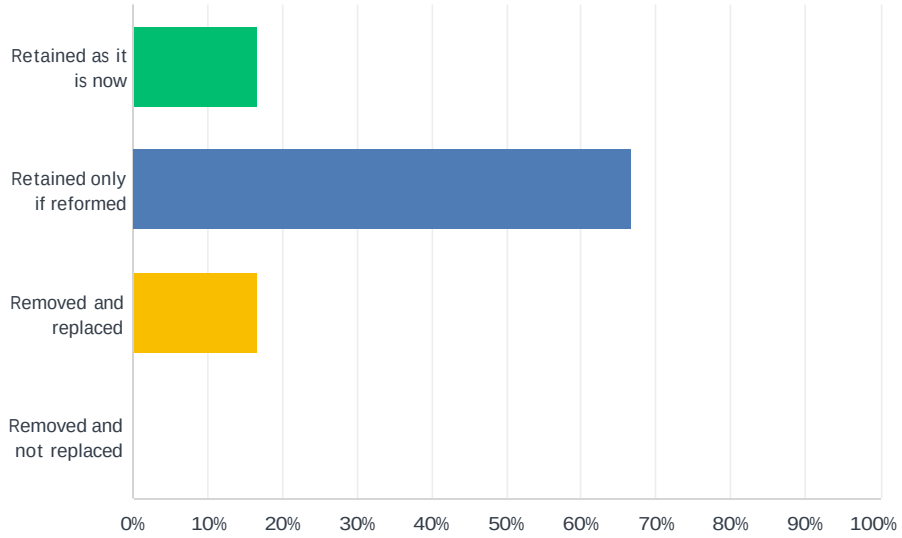
- Although some 17% of members felt that the LDB should be retained in its current form, the majority of members (66%) are in favour of retaining the LDB but only if reformed, a further 17% would have preferred to have seen the LDB removed and replaced.

Members have outlined various reforms they felt would enhance the effectiveness of the LDB:

- Including public health representation
- More operational and action focused
- An informal fortnightly operational management group.
- Being clear in programmes of work and how they link back to organisations
- Overseeing enabler groups

Full list of suggestions on slides 4 and 5

Should the LDB be retained, reformed, removed, or replaced?



Although some 17% of members felt that the LDB should be retained in its current form, the majority of members (66%) are in favour of retaining the LDB but only if reformed, a further 17% would have preferred to have seen the LDB removed and replaced.

Next steps..

The results of this survey will be discussed at the LDB Planning meeting 16th February 2023