

Tower Hamlets Together Report

Health Overview and Scrutiny Committee - April 2021

Amy Gibbs, Independent Chair

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Focus of this report

1. Delivery of our mission, vision and objectives
2. Partnership working and service integration
3. Putting patients and citizens at the heart of our work
4. Financial collaboration



1. Delivery of our mission, vision and objectives

What we want to achieve: our plan on a page

MISSION	VISION	OBJECTIVES	PRIORITIES FOR ACTION
<p>Transform people's health and lives in Tower Hamlets, reducing inequalities and reorganising services to match people's needs</p>	<ul style="list-style-type: none"> Tower Hamlets residents, whatever their backgrounds and needs, are supported to thrive and achieve their health and life goals, reducing inequalities and isolation 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 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 	<ol style="list-style-type: none"> 1. Transform health and tackle inequalities Achieve better health and wellbeing outcomes for all Tower Hamlets residents, as set out in the THT Outcomes Framework, shaped by local people 2. Improve quality of care Continue to strengthen service quality in line with national standards, local operational priorities and residents' views and needs 3. Commission and deliver high value services Commission resilient and sustainable services, tackling variation and waste, and ensure the Tower Hamlets pound is spent wisely 	<ol style="list-style-type: none"> 1. Develop our partnership Collaborate as health and care providers and commissioners, with service users and carers, to plan and solve problems together 2. Deliver on health priorities and inequalities Support individuals, families and communities to live healthy thriving lives 3. Design care around people Provide accessible and responsive health and care services, and deliver person-centred integrated health and social care for those who need it 4. Develop our teams and infrastructure Ensure THT staff and teams have the right support, skills, knowledge and approach

What we will deliver: Primary Health, Community Health and Social Care Interventions

We have identified 3 key building blocks which our interventions will be aligned to and seek to achieve, examples of which are shown below.

1. Building the resilience and wellbeing of our communities

- Further developing strength based approaches to social care, supporting people to connect to their community, access universal services and the community / voluntary sector
- Continuing to support people to access information and advice and social prescribing
- Developing one shared profile of the population, disease prevalence and social factors
- Ensuring that people with severe mental illness can access better care closer to home
- Delivering the Covid-19 Vaccination Programme across Tower Hamlets

2. Maintaining people's independence in the community

- Implementing care coordination and MDT working across the borough
- Further implementing a personalisation approach, including personal health budgets
- Implementing a new model of homecare with enhanced nursing support
- Ensuring medium-long term housing options are found for the homeless & rough sleepers
- Implementing 24/7 Primary Care Hubs as part of 'Help Us Help You' and a 24/7 crisis helpline
- Remote monitoring of adults and CYP with eating disorders

3. Reducing the time people need to stay in hospital

- Further embedding the Integrated discharge hub and discharge to assess culture
- Continuing to protect and support care and nursing homes
- Integrating rehabilitation and reablement services
- Improving long term condition management via greater use of technology
- Supporting rapid community/social care response, including same day care packages

What this means for our residents: our outcomes framework

The outcomes we are committed to delivering were developed in collaboration with staff and residents. Through the partnership we want to ensure our residents' experiences reflect the statements set out below across five distinct domains.

Domain	I-Statement			
Integrated health and care system	I feel like services work together to provide me with good care	I believe the trust, confidence and relationships are in place to work together with services to decide the right next steps for us as a whole community		I want to see money being spent in the best way to deliver local services
Wider determinants of health	I am able to support myself and my family financially	I am satisfied with my home and where I live	I am able to breathe cleaner air in the place where I live	I feel safe from harm in my community
Healthy Lives	I am supported to make healthy choices	I understand the ways to live a healthy life		
Quality of Care & Support	Regardless of who I am, I am able to access care services for my physical and mental health	I am able to access safe and high quality services (when I need them)	I am confident that those providing my care are competent, happy and kind	I have a positive experience of the services I access, overall
Quality of Life	I have a good level of happiness and wellbeing	I am supported to live the life I want	My children get the best possible start in life	I play an active part in my community

Delivering: our work programme and priorities for 2021

- Across the partnership we have over 40 interventions underway to deliver new or improved services that will work towards realising our vision and the outcomes we want to achieve for our residents
- Our lifecourse workstreams lead on delivering these interventions for their population groups, bringing together a wealth of partners to do so
- We also now have a dedicated Local Delivery Board that oversees and supports with the operational delivery of our programme of work
- Whilst we are committed to delivering all interventions, the following have been identified as our top priorities for this year:
 - Delivering the Covid-19 vaccinations programme
 - Implementing the MDT and Care Co-ordination model
 - Embedding and improving our integrated discharge pathway
 - Improving CYP mental health services and access
 - Establishing a new model of Homecare
 - Reviewing the ASD pathway
 - Enhancing our EOL care offer



2. Partnership working and service integration

Partnership working: what we have achieved

Working in partnership to achieve joint outcomes is THT's primary function and together the partnership has achieved outcomes that we are proud of and which have won or been nominated for national awards.

Asthma and Wheeze Project

- The Asthma and Wheeze Project was overseen by the Tower Hamlets Together workstream Born Well Growing Well.
- As a system, the primary and secondary drivers for admissions were mapped and the need to commission interventions that provided a clinical and non-clinical response was agreed.
- From the interventions delivered, 92% of the children and young people involved have seen Asthma Control Test scores improve by an average of five points, highlighting a significant reduction in risk. In addition, non-elective admissions reduced by 22% and clinical metrics, as well as self-reported wellbeing, have improved while also reducing the cost of £142k minimum to the system.
- The project won the LGC award in 2020 and was nominated for a HSJ Value award in 2021.



<https://vimeo.com/386820362>

First Borough helpline launched to help at-risk groups book Covid-19 vaccines

- Launched 2 February – first borough in London to set up a vaccine helpline, which was established very quickly when the need to support residents with queries relating to the Covid-19 vaccination programme became apparent.
- The team includes a number of different council teams (public health, integrated commissioning-CCG/LBTH, strategy and policy team, Idea Stores) and the GP Care Group working with the 38 GP practices across the borough.
- The helpline, staffed with call handlers who can speak community languages, works to ensure eligible residents, including those who are digitally excluded and vulnerable, all get Covid-19 vaccine appointments. The team have also worked with primary care to follow up with residents who have not booked in, to encourage them to do so. **The team receive more than 200 calls per day.**
- This has been a vital part of our approach to encouraging take up of the vaccine across the borough, and addressing hesitancy. It has also given useful insight into the issues and concerns that residents have had about the vaccine, which we have been able to use to plan more effectively. The fact that it was established so quickly and has been operating so consistently is invaluable, and other local authorities across NEL and London have looked at how we have done this so they can replicate.
- In the first 2 weeks of operation the helpline received over a 1000 incoming calls and the staff made **4,000 outgoing calls to residents in priority groups 1-4 to offer them an appointment..**



'Outstanding service and professionalism shown by the Covid helpline, when I called the service for assistance they patiently and thoroughly dealt with all of my queries and went above and beyond what I presume are the scope of a call handler's duties and subsequently completing my booking for a vaccination'

Resident feedback



Service integration: what we have achieved

Integrating our services to make them more effective and efficient at providing improved patient outcomes is a key element of THT's role, with notable progress achieved so far.

The Integrated Discharge Hub

- The IDH is a multi-disciplinary team established from ELFT's Admissions Avoidance Discharge Service, LBTH Hospital Social Work Team, ELFT Continuing Healthcare Team and LBTH Reablement and Brokerage.
- The team are responsible for all hospital discharges from the Royal London Hospital, including non-Tower Hamlets patients.
- At the height of the first Covid wave, between March – May 2020, over 300 patients were referred, with just over 50% of these Tower Hamlets residents. Of these, 90% of patients were successfully discharged home, with 10% discharged to nursing and residential homes, supported accommodation, and newly commissioned step-down facilities. 25% of patients were discharged the same day, and over 50% within 1 day.
- This rapid pathway has improved recovery for patients assessed in the familiar environment of their home, with data showing 66% of people requiring either reduced or no care packages on discharge.

"I was not in hospital for long which was good, I don't like going and staying in hospital"

"Feel more relaxed"

"Good level of communication"

"It was much quicker and efficient"

(Recent patient feedback)

Supporting Older People's Care Homes during Covid-19

The THT partnership, in conjunction with the commitment, engagement and proactivity of the homes in the borough, have worked jointly and rapidly to respond to the changing demands and pressures presented by Covid-19.

Daily "situation reports" (SITREP)

Care homes have been contacted each working day (from 24 March 2020) by a member of the Integrated Commissioning team.

Care Homes Service Operating Plan

Key resource for care home staff, updated regularly by the Bronze Group, advising of the actions to take to prevent and manage outbreaks.

Care Homes Bronze Group

Part of the borough's pandemic governance structure, the group has been meeting on a weekly or fortnightly basis since 27 April 2020.

Care Homes Provider Forum

Weekly group, with the care homes and THT partnership in attendance. Collectively, all have worked together to share experiences.

Enhanced GP service

Weekly "check in" to review patients identified as a clinical priority for assessment and care, in-hours urgent response where GP support is available within two hours of a request being made.

Multidisciplinary team (MDT) support

Weekly MDTs include GPs, community health services staff, community geriatricians, mental health and medicines management specialists.

Each care home has a designated community health services clinical lead, which complements the primary care offer.

CHS teams delivered 15 virtual training sessions in the care homes on a number of issues, such as identifying and managing pressure ulcers and continence care. Care home staff have now started to undertake these tasks themselves, in place of District Nurses, thus reducing foot fall and the risk of infection.

Service integration: what we are working towards

- **A new integrated information and advice offer** across health & social care which will bring together health, welfare and social care information and advice provision under a single offer. This will provide early help to residents and adult carers through up-to-date content on a digital portal and telephone-based triage/information service that will function as the adult social care front door, supported by outreach in the community;
- **Further embedding home care into locality-based health and social care arrangements.** In particular, looking into opportunities for home care to be part of shared assessments and care planning arrangements, as well as considering alternative workforce models, such that roles and responsibilities across the services are better defined and co-ordinated;
- **Further integrating the LBTH Reablement and NHS rehabilitation services** so there is a clear offer for both short-term and long term support for residents within the borough, with health and social care staff working side-by-side in single teams;
- **Brand new primary care network mental health teams** will be established to provide wraparound support for people with varying levels of need, including those with longer-term and complex requirements; and will be tailored to meet the needs of local populations.



3. Putting patients and service users at the heart of our work

Our plan for putting service users at the heart of our work

- **We ensure residents' voices are heard** via representation at Boards, engagement with existing advisory groups, people stories, events, focus groups and public questions at meetings.
- **We have a Stakeholder and Engagement Plan**, which articulates our approach to engagement and co-production and uses the strengths of existing forums across the partners to develop an overarching space to connect all the good work that happens across the borough. This is spearheaded by a lay member sitting on the exec board who now has a wider remit and stronger mandate, with support from the Independent Chair (also a lay member).
- **The Plan is supported by a separate enabler workstream**, which is led by our Engagement Manager. There is also a fund of £50,000 for non-staff costs, which is used to develop case studies and engagement materials in support of health and social care integration.
- **We have developed a reward and recognition policy** to recompense service users/carers and voluntary and community sector organisations to demonstrate the value that THT places on their input and to ensure that any recompense is consistently applied across THT led projects.

Co-production with our service users

We strive to co-produce services with our service users wherever we can and to utilise their lived experience to ensure we really do improve outcomes. A recent example of this has been our Digital Inclusion workstream.

THT Digital Inclusion workstream

- The THT engagement group, made up of partners from the Local Authority, NHS and the Voluntary sector, identified during the pandemic that the digital divide was growing as more services were moving online. It was agreed to run a series of pilot projects coordinated through THCVS to test out solutions that could potentially be scaled up to address the issues.

How we worked with our service users

- Insights were gathered from residents by Healthwatch, REAL, St Josephs compassionate neighbours, Providence Row, Create Day Centre and other VCS organisations
- Community commissioning panel members were involved in designing the projects and giving feedback to the GP Care group on their experiences of accessing health care via online consultations
- Service users were involved in designing the Personalisation action plans and will be involved in the review of their plans
- Residents gave feedback to the Health and Wellbeing board on their experiences of being digitally excluded and how the programme supported them to be able to access support

Listening and acting on our service user's feedback

At every THT Executive Board, we invite a service user to give their story and reflect and act on what we can do as a partnership to address any issues or concerns raised. Recent examples of this have included:

- Two SEND parent ambassadors who spoke with passion about their voluntary work and the major challenges families raise with them, including barriers to approaching professionals and lengthy delays in getting Education, Health and Care Plans. In response, the Board committed to helping the SEND parent ambassadors to raise the profile of their work with health professionals, and they have already been invited to attend the GPCG quarterly forum to do this. In addition, the Council is looking into the wider performance of EHCPs as a strategic issue.
- A dental patient who has been left with no further support midway through his treatment, due to the covid-19 restrictions on dentistry, with serious consequences. In response, the Board will hold a deep dive session on this critical topic soon and drive greater engagement with local dentists and to improve connections across the system.
- In addition, THT is working closely with Healthwatch to use their rich analysis of community insights into people's experience of health and care services to further integrate and embed patient voice into our ways of working. This data will be made readily available to clinical teams and Healthwatch will provide community insights for the THT Board linked to the user voice theme each month.

Championing inclusion and anti-racism

Inclusion and anti-racism is a major priority for the THT Exec Board, from leadership and governance through to frontline practice, and we know we have much more work to do - recent discussions have focussed for example on vaccines, trauma-informed care and workforce in relation to our different ethnic communities. Actions we are currently undertaking include:

- The Board has committed to undergo anti-racism training provided by the equality charity brap to support us on our journey, facilitating four sessions to guide and challenge us as individual and collective system leaders. This work will be further strengthened by the revamped Associate Lay Member for Patient and Public Engagement, whose remit now includes equality and diversity, sustainability and social value.
- Our THT Workforce and OD strategy, which we signed off in March, sets out a number of concrete actions we will take to increase the equality and diversity of our workforce at all levels which will be overseen by our Workforce and OD enabler group.
- We have held engagement sessions with community organisations, such as Coffee Afrik CIC, a local Somali social enterprise founded and led by people with lived experience, to connect with our community's feelings on inequality and inclusion and to ensure our actions are aligned with their expectations, and this has already led to follow up meetings with partners on implementing practical next steps.
- We have enthusiastically received the health-related recommendations from the Council's recent Black, Asian and Minority Ethnic Commission, and are committed to implementing these.



4. Financial collaboration



Financial collaboration through THT

- Our financial situation and outlook remains challenging, and has been impacted heavily by the requirement for additional spending to combat Covid-19. It is therefore vital that we work closely together as a partnership to make best use of our resources.
- Every quarter, the CCG and Council jointly present a financial system overview to the Executive Board, with partner organisations also updating on their respective positions. This facilitates discussions and awareness raising of pressures and savings proposals so that all partners are aware and can act accordingly.
- Across the partnership, we currently have a commissioning budget for health and social care services of approximately £760 million, with our forecast spend set to exceed the budget available by £6m.

Financial collaboration: The Better Care Fund

- Since 2017, shared resources through the Better Care Fund and Improved Better Care Fund have been used to enable significant improvements in integration.
- The BCF is essentially core funding, but delivers against our THT priorities.
- Last year, our BCF Plan had a pooled annual resource of £53.78m and delivery highlights included:
 - Developing joint funding of ‘early help for adults’ services such as Linkage Plus and a new integrated information and advice offer;
 - Improving the performance of the Reablement service (measured as the proportion of older people, 65+ who were still at home 91 days after discharge from hospital into reablement/rehabilitation services) with rates increasing from 70.35% in 2017/18 to 87.18% last year. The CQC has also rated the service ‘Good’;
 - Embedding a ‘Home First’ culture and working to review the residential admissions process, which has seen the number of residents aged 65+ placed in homes fall year on year from 91 in 2018/18 to 87 last year, putting Tower Hamlets ahead of target.
- We are currently developing a new BCF plan for 21/22 and opportunities for further aligned budgets.