HM Government

NHS England

BCF narrative plan template

This is a template for local areas to use to submit narrative plans for the Better Care Fund (BCF). All local areas are expected to submit narrative BCF plans. Although the template is optional, we ask that BCF planning leads ensure that narrative plans cover all headings and topics from this narrative template.

These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 25 pages in length.

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their excel planning template.

Cover

Health and Wellbeing Board(s).

Tower Hamlets Wellbeing Board

Bodies involved strategically and operationally in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils).

The 2023-25 BCF plan has been agreed by:

- Stephen Halsey – Interim Chief Executive for the London Borough of Tower Hamlets
- Warwick Tomsett – Acting Corporate Director of Health, Adults and Community for the London Borough of Tower Hamlets
- Councillor Gulam Kibria Choudhury who is the lead member for Health, Wellbeing and Social Care and Chair of the Health and Wellbeing Board.
- Charlotte Pomery – Chief Participation and Place Officer for NHS North East London, our North East London Integrated Care Board (ICB).

The Better Care Fund is overseen by the Health and Wellbeing Board and the Tower Hamlets Together Partnership Board. On 1st July 2022 the Tower Hamlets Together Board became the new place subcommittee of the ICB. Both these Boards are made up of a wider range of stakeholders from across our health and care system including voluntary sector representatives.

The plan will be formerly considered by the Tower Hamlets Health and Wellbeing Board for approval on the 20th July 2023. The board membership includes the London Borough of Tower Hamlets council officers who manage Adults and Health, Children Services, Public Health, NHS North East London Integrated Care Board (NEL ICB), Royal London Hospital (part of Barts Health NHS Trust), East London Foundation Trust, GP Care Group, Healthwatch and Council for Voluntary Sector (CVS). Housing representation is covered indirectly through the Council representatives on the Boards.

In 2021, the Health and Wellbeing Board published its strategy covering 2021-2024. The strategy sets out system wide improvement principles that the Board will focus on and ambitions for a 'Healthy Borough' reflecting the health and wellbeing outcomes that matter to residents (below). The strategy was co-developed with residents, the voluntary and community sector, health and Council. The BCF is a key driver to deliver the strategy, with elements being reconfigured to better meet current and future needs i.e. more investment is being made in prevention.

System wide improvement principles:

1. Better targeting
2. Stronger networks
3. Equalities and anti-racism in all we do
4. Better communications
5. Community first in all we do
6. Making the best use of what we have

Ambitions for a 'healthy borough'

1. Everyone can access safe, social spaces near their home to live healthy lives
2. Children and families are healthy, happy and confident
3. Young adults have the opportunities, connections, and local support to live healthy lives
4. Middle aged and older people are supported to live healthy lives and get support early when they need it
5. Anyone needing help knows where to get it and is supported to find the right help

Our Tower Hamlets 2023-24 BCF plan is an evolution of the 2022-23 arrangements which were approved by NHSE in December 2022. The priorities have been developed through Tower Hamlet Together (THT), the borough based integrated health and care partnership, which includes key members from the Health and Wellbeing Board.

In 2021, prior to the planning guidance being released, we used the initiative to carry out a local review of the BCF. It was important to take stock of what had been delivered, what had worked, lessons learnt and understand how the scale of ambition for integration will be delivered. In essence, the priority for 2021-22 was to develop a plan for the plan and the focus in 2022-23 and 2023-24 has been the continued delivery of this, whilst developing our new governance arrangements through the NEL ICB.

Our aim is to carry out another review during 2023 of our BCF plan with an intention to update the 2024-25 plan for the next return.

There remain challenges that risk our delivery ambitions which we are working together as system partners to mitigate:

1. Staff recruitment poses a real challenge, the pandemic and continued pressures has resulted is a large number of health and care workers leaving without sufficient replacements being available.
2. The cost of living crisis comes on the back of a pandemic, years of austerity and a long term underfunding of social care. Services already stretched are having to work harder to support a great number of residents struggling to afford to live whilst also being impacted by the inflation.
3. This winter will be another challenging year whilst dealing with the backlog of hospital elective work and the imminent flu season. This plan will help with some of those pressures but this will remain an area of focus for our system.

We have a smaller working group between the Council and the ICB which includes finance leads where we work on the details of the plan.

A joint finance report which includes the BCF is presented to the Tower Hamlets Together Board on a quarterly basis alongside a joint performance report. The latest report is due to be delivered on 6th July. This Board is also the Tower Hamlets ICB subcommittee.

For more information about our health and care partnership – Tower Hamlets Together – please visit https://www.towerhamletstogether.com/about/the-board

How have you gone about involving these stakeholders?

The outline plan was shared with the Health and Wellbeing Board on the 23rd May 2023 and will be formerly considered by the Tower Hamlets Health and Wellbeing Board for approval on the 20th July 2023. The board membership includes the London Borough of Tower Hamlets council officers who manage Adults and Health, Children Services, Public Health, NHS North East London Integrated Care Board (NEL ICB), Royal London Hospital (part of Barts Health NHS Trust), East London Foundation Trust, GP Care Group, Healthwatch and Council for Voluntary Sector (CVS). Housing representation is covered indirectly through the Council representatives on the Boards.

The outline plan was also reviewed by the Tower Hamlets Together Board on the 4th May 2023. This board also includes a resident, Healthwatch and the Council for Voluntary Sector.

In summary, our plan is being carried forward from 2022-23 where engagement took place. Each individual scheme within the plan also has its own engagement processes. We plan to carry out a review of our BCF plan in 2023 with the intention of increasing the BCF amount for 2024-25. This will involve extensive engagement.

Governance

Please briefly outline the governance for the BCF plan and its implementation in your area.

Strategic oversight of the Better Care Fund in Tower Hamlets is devolved from the Health and Wellbeing Board to the Tower Hamlets Together (THT) Board which is now also the ICB subcommittee.

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.

The Tower Hamlets Together Board/ICB sub committee

- Oversees joint strategic commissioning of services in Tower Hamlets for children and young people, adults and public health.
- Coordinates the development of joint strategies for the relevant service areas and ensure necessary arrangements are in place to implement strategies and procure service changes.
- Oversees strategic market development and management, and oversee plans to re-commission and de-commission services, aligning this work with joint strategic procurement plans.
- Reports key decisions to the Tower Hamlets Together Executive and related Operational Boards as well as to relevant executive and governing bodies of the ICB and Council.
- Acts as the formal subcommittee of the North East London ICB.

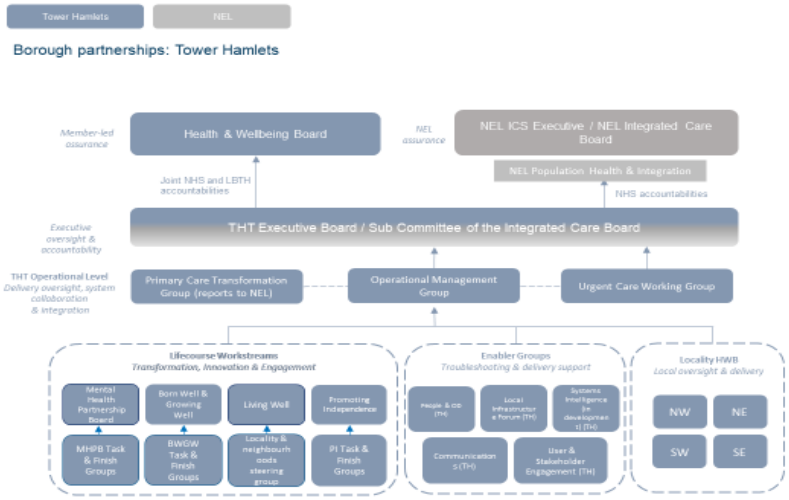
The THT Board is based on a joint working group structure and includes members from;

- London Borough of Tower Hamlets (Council)
- North East London Commissioning Integrated Care Board (NEL ICB)
- East London Foundation Trust (ELFT)
- Barts Health
- Tower Hamlets Council for Voluntary Services (TH CVS)
- GP Care Group (GPCG)
- Healthwatch
- Resident representing the community voice

Members have delegated responsibility from the partner employing them to make decisions which enable the THT Board to carry out its objects, roles, duties and functions. The THT Board is responsible for the overall approval of Individual Schemes, ensuring compliance with the Better Care Fund Plan and the strategic direction of the fund. Each scheme specification confirms the governance arrangements in respect of the Individual Scheme and how it is reported to the Tower Hamlets Together Board.

The Partners produce a Quarterly Finance Report which is presented to the THT Partnership (and Health and Wellbeing Board at least annually) and sets out information as required by national guidance and any additional information required by the Health and Wellbeing Board or relevant partners (for e.g. finance data and updates on metrics).

A copy of the Tower Hamlets Together structure is below.


Tower Hamlets
NEL
Borough partnerships: Tower Hamlets
Member-led assurance
Health & Wellbeing Board
NEL assurance
NEL ICS Executive / NEL Integrated Care Board
NEL Population Health & Integration
Joint NHS and LBTH accountabilities
NHS accountabilities
Executive oversight & accountability
THT Executive Board / Sub Committee of the Integrated Care Board
THT Operational Level
Delivery oversight, system collaboration & integration
Primary Care Transformation Group (reports to NEL)
Operational Management Group
Urgent Care Working Group
Lifecourse Workstreams
Transformation, Innovation & Engagement
Mental Health Partnership Board
Born Well & Growing Well
Living Well
Promoting Independence
MHPB Task & Finish Groups
BWGW Task & Finish Groups
Locality & neighbourh oods steering group
PI Task & Finish Groups
Enabler Groups
Troubleshooting & delivery support
People & co (TH)
Local Infrastructur e Forum (TH)
Systems Intelligence (in developmen t) (TH)
Communication s (TH)
User & Stakeholder Engagement (TH)
Locality HWB
Local oversight & delivery
NW
NE
SW
SE

Executive summary

This should include:

- Priorities for 2023-25
- Key changes since previous BCF plan.

Priorities for 2023-25

Our partnership priorities and work programme for 2023-25 is below. The programme is overseen by our Operational Management Group (OMG) which is chaired by our Joint Director of Integrated Commissioning and is attended by key operational leads from across our health and care partnership. The Operational Management Group takes on the operational focus from the Tower Hamlets Together Board and includes the BCF schemes such as reablement, discharge and community health and care teams.

The overall programme management of the individual transformation projects are themed under the following three headings:

a. Care Close to Home - maintaining people's independence in the community
b. Hospital to Home - reducing the time people need to stay in hospital
c. Prevention - building the resilience and wellbeing of our communities

The following are the key priorities from our work programme which fall under each of the three headings above and are delivered by our four integrated lifecourse workstreams:

1. **Children and Young People – Born Well and Growing Well workstream**

- Children's mental health and emotional wellbeing
- Special Education Needs and Disabilities (SEND)
- Healthy Childhood Weight
- Ways of working –including pathways for long term conditions, a shared practice framework, a shared model of locality and Multi-Disciplinary Team working
- Poverty and economic hardship

2. Complex Adults – Promoting Independence workstream

- Establishing a new model of homecare which includes MDT approaches e.g. working closer with District Nursing
- Long term conditions management – diabetes focus
- Enhancing local care coordination – moderate frailty focus
- Ensuring a smooth transitions process for young people with complex needs from CYP to adults services
-

3. **Mainly Healthy Adults – Living Well workstream**

- Improving access to health services for disabled residents
- Developing our localities and neighbourhoods (includes Fuller recommendations) – multi year
    - Developing system wide health intelligence (data) for localities and primary care networks/neighbourhoods
    - Stregthening locality and PCN structures to address health inequalities
    - Engaging communities to improve health and wellbeing
    - Long term conditions prevention and management: improving pathways between communities and preventative services

Our plan is being rolled forward from 2022-23 to 2023-24. We will be reviewing our schemes during 2023 with the intention of increasing the pooled amount for 2024-25. This will involve extensive work.

Key changes in the BCF Plan for 2023-24

To support the delivery areas above, the BCF funded schemes are carried forward from the previous year with the following additions:

· Discharge Fund: Local Authority (LA) Grant and ICB Allocation. The schemes funded by the Discharge Fund fall fully within the BCF plan following the initial roll-out in Quarter 4 (January – March) 2022/23.

The recent fortnightly and monthly discharge reporting has also caused difficulty in its completion due the vast pull on our workforce.

National Condition 1: Overall BCF plan and approach to integration

Please outline your approach to embedding integrated, person centred health, social care and housing services including:

- Joint priorities for 2023-25
- Approaches to joint/collaborative commissioning
- How BCF funded services are supporting your approach to continued integration of health and social care. Briefly describe any changes to the services you are commissioning through the BCF from 2023-25 and how they will support further improvement of outcomes for people with care and support needs.

For at least the last decade, Tower Hamlets has been working towards greater collaboration between health and social care partners and the voluntary and community sector. We have developed from being an NHS England 'Integrated Care Pioneer' in 2013 and part of the national Vanguard programme in 2015 to forming our current Tower Hamlets Together (THT) place-based partnership in 2016. Over the last 6 years this partnership has continued to strengthen and was key to managing our Covid-19 response. In 2023, THT is a mature partnership and we have seamlessly integrated the role of becoming a sub-committee of the ICB into our place-based partnership and we look forward to the greater responsibility, autonomy and impact that will result.

Since 2018 we have had an integrated commissioning service, bringing together commissioners from both social care and health services, such as adults, children's, community and mental health, overseen by a Joint Director of Integrated Commissioning.

Localities and Neighbourhoods Programme (includes Fuller recommendations)
At a place level Tower Hamlets have been taking a whole population approach and in 2016 developed three THT lifecourse workstreams and recently added a fourth focus on mental health through establishing a partnership board. The four workstreams are:

1. Born Well and Growing Well – focussing on maternity, children and young adults
2. Living Well – focussing on mainly healthy adults
3. Promoting Independence – focussing on complex and older adults
4. Mental Health Partnership Board – focussing on mental health for adults and children

On behalf of the THT Board, each workstream takes a leading role in promoting the health and well-being of the sector of the population with which it is concerned. It also has an oversight role of health and social care integration, including service redesign, transformation and innovation. Workstream members identify opportunities to improve outcomes, reduce costs, system duplication and promote joint working in developing system priorities. The workstreams are multiagency and include service users.

At the locality level, THT have four Health and Well Being Committees. These have a wider remit that involve not only the delivery of integrated care but also to make the health and social care system more sustainable which will focus on the wider determinants of health, with the long-term aim of reducing health inequalities. Work is now commencing to further evolve these into health and wellbeing **communities** which are multi-disciplinary teams organised around primary care networks as part of the drive to creating integrated neighbourhood teams.

At the Primary Care Network (PCN) level or neighbourhoods Tower Hamlets have

its seven GP networks across the borough, which is another key part of the national approach to integrated care and provides one of the foundations for the Multi-Disciplinary Team ("MDT") arrangements operating across the borough. These are supported by locality-based community health teams and the mental health teams have organised around the locality model too. The council has also aligned its operational adults and children's social care services around localities. The next stage of this work is to review how these teams work as truly integrated teams wrapped around locality or neighbourhood footprints. This links to the Fuller recommendations and the Tower Hamlets Community Health Services Alliance contract review.

Having aligned our health and care services around localities, the next phase of work for THT is to understand what impact this has had and to understand what is required at a neighbourhood/PCN level. Almost £1m has been allocated by the ICB and Local Authority within the Better Care Fund to support the work at the locality and neighbourhood level. This is where we see the greatest potential in achieving our integration ambitions.

It is proposed to work over the next 3 years to develop a blue print for the locality and neighbourhoods' model, understanding requirements at a local and national level across health and social care, benchmarking ourselves against this and then delivery of a roadmap for improvement and implementation as required. This can only be done in collaboration within the THT partnership and with stakeholders across Tower Hamlets at a borough and at a local level (such as residents, PCNs, social care, etc.). This will take into account the review of the BCF we are doing in 2023 with aim of increasing the pooled fund from 2024 onwards.

Tower Hamlets Together – Our System Plan on a Page

Overall our partnerships ambition can be explained through the following joint mission, vision, objectives and priorities for action. At the heart of this plan is the voice of the Tower Hamlets residents.

Put the voice of Tower Hamlets residents at the heart of all our decisions, strengthening engagement, participation and co-production processes to achieve this

MISSION	VISION	OBJECTIVES	PRIORITIES FOR ACTION
Transform people's health and lives in Tower Hamlets, reducing inequalities and reorganising services to match people's needs	• 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	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	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

Our Vision through our system wide Outcomes Framework

As a partnership we have co-produced a series of 'I' statements with local residents that articulate their aspirations for improving health and wellbeing, and include statements such as 'I play an active part in my community', 'I feel like services work together to provide me with good care' and 'I have a good level of happiness and wellbeing'.

These statements are broken down across five domains: 'Wider Determinants of Health', 'Healthy Lives', 'Quality of Life', 'Quality of Care & Support', and 'Integrated Health and Care System'. Each domain and statement has a narrative and a set of indicators to measure progress towards the outcome and proposed aspirational indicators that could be adopted across the system and are increasingly being used by colleagues from providers across the partnership develop and plan services, helping to build a consistent, system-wide approach.

For example the 'I'-statements have been used by commissioners when designing service specifications and by policy teams when developing borough-wide strategies.
For more information on our Outcomes Framework, please visit
https://www.towerhamletstogether.com/the-challenge/outcomes-framework

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

National Condition 2

Use this section to describe how your area will meet BCF objective 1: **Enabling people to stay well, safe and independent at home for longer.**

Please describe the approach in your area to integrating care to support people to remain independent at home, including how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to help people to remain at home. This could include:

- steps to personalise care and deliver asset-based approaches
- implementing joined-up approaches to population health management, and proactive care, and how the schemes commissioned through the BCF will support these approaches
- multidisciplinary teams at place or neighbourhood level, taking into account the vision set out in the Fuller Stocktake
- how work to support unpaid carers and deliver housing adaptations will support this objective.

Personalisation and Personal Health Budgets

In Tower Hamlets, primary care networks are leading on the promotion of personalisation and the use of personal budgets. This enables people to have choice and control over decision about their care and the budget that is available to meet their needs. The scheme has been expanding and it cuts across various areas and needs i.e. frailty, mental health and homeless and rough sleepers.

Personalised care consists of six components:

- enabling choice, including legal rights to choose
- shared decision making
- personalised care and support planning
- social prescribing and community-based support
- supported self-management
- personal health budgets

Part of enabling choice is to provide residents with information about their condition, in language which can be understood. This will help you recognise the choices you have and how they may it impact on the residents.

Shared decision making - aims to acknowledge ‘patient knows best’ and allow the health professionals to hear the resident's personal preferences, values, beliefs, circumstances, and goals.

In personalised care, the resident has input into the care they receive. There are new roles being embedded within both primary care networks and secondary care, who are there to build a positive relationship with the patients and explore the goals relating to their health that they want to achieve.

Health professionals provide expertise and advice regarding (1) treatment options (2) what the evidence suggests and the risks and benefits of each in language the patient can underdstand

Personalised care support plans (PCSP)

When patients are working with a health professional towards a recognised goal, a personalised care support plan will be created.

This focuses on ‘what matters to me?’ meaning the plan will pay attention to the patient needs and wellbeing.

The patient is central in developing their PCSP. Time is given to explore and develop this, considering what goals are to be achieved, for example: lose weight, reduce blood pressure, increase social relationships.

The PCSP is flexible and unique to each individual.

Social prescribing and community-based support

The social prescriber's role is to support patients with social factors impacting on their overall wellbeing and quality of life.

Social prescribing link workers, will offer time to explore goals which will then be reviewed. They can offer ongoing support for approximately six sessions if needed. The aim is to help improve overall quality of life by connecting residents with local community.

Social prescribers use the personalised care approach to support patients. They offer the time needed to explore your goals and work together with you to create a personalised care support plan (PCSP).

Health and wellbeing coaches (HWBC)

Some primary care networks offer additional support in order to change behaviour, for example increasing activity levels – through the support from a health and wellbeing coach who is trained in behaviour change approaches.

Personal Health Budgets (PHB)

A personal health budget is an amount of money to support someone’s health and wellbeing needs. This is planned and agreed between residents or their representative and the local PCN.

It is not new money, but rather a different way of spending health funding to meet the needs of an individual.

Personal Health Budgets are a way of personalising care, based around what matters to people and their individual strengths and needs. The budget gives disabled people and people with long term conditions more choice, control and flexibility over their healthcare.

Anticipatory Care and Proactive Care Model

Tower Hamlets has been pioneering proactive care model in areas where negative impact of health inequalities can be reduced.

In quarter three of 2022-2023, Tower Hamlets has piloted a frailty care coordination MDT model which is based on early identification of cohorts using validated population health management tools and the delivery of proactive care to support residents' health care and care planning before they become unmanageable.

The care coordination model seeks to develop a multidisciplinary approach using set of defined characteristics and measures as part of the model of care together with personalised care and support plan built into the standard operating procedure and multi-disciplinary working.

Residents within identified cohorts are proactively approached, working out who is suitable for care coordination and who is likely to benefit from it. Defining the cohort has many benefits, it enables the neighbourhood/place to develop appropriate plans and strategies to support the group of residents. This may help to address long-standing issues with service provision in an area and MDT be able to identify those who could receive support via care coordination - this will support the development and expansion of cohorts in the future.

The frailty proactive care coordinated MDT has generated (1) joined-up approach across health, social care and voluntary sectors (2) process and pathway to deliver the monthly care coordination MDT meetings (3) reduction of unnecessary GP visits and duplication of referrals (4) improve communications across health and social care (5) enhance personalised care and support plan and finally (6) identify the need to locality/neighbourhood in early identification, population health management and reducing health inequalities

In preparation to scale up the model (meaning additional primary care network will be involved in the delivery), thorough planning is underway to ensure the expansion of integrated care approach is aligned across the networks.

The expanded model (locality) will need a dedicated 1 WTE network care coordinator (each PCN) to help continue deliver the success of the monthly care coordination MDT. The focus of the expansion will remain on frailty however additional long-term conditions will be considered i.e. COPD, heart failure etc.

In addition, Tower Hamlets Together Partnership has identified another priority for 2023-2024; care coordination of homeless and rough sleepers. The care coordination approach to be used for homeless and rough sleepers will be proactive care model and will operate using 6 key approaches **(1)** case identification **(2)** holistic assessment **(3)** personalised care planning **(4)** MDT working **(5)** coordinated care **(6)** interventions and support.

Housing, safeguarding, adult social care, GP practice, community mental health, rough sleeper navigator and hostel teams are among services involved in the discussion and the planning of the delivery of care coordination MDT.

Care coordination of frailty with long term conditions and homeless and rough sleepers are excellent exemplar of integrated work across the borough – bringing proactive care model to identify residents needing support before they tip into crisis.

The vision for the localities and neighbourhoods enabling people to stay well, safe and independent (links with the Fuller recommendations)

A governance structure is being developed for this work including reporting lines and in order for the vision for our localities and neighbourhoods to be realised it needs to effectively support and work across the system and all workstreams. We have appointed a Programme Lead who will start in post from July 2023. The first job will be to develop a clear vision for our localities and neighbourhoods programme which all partners are signed up to. Though

not yet agreed, the vision for the localities and neighbourhoods could be similar to the below which aligns to our THT vision and aims.

1. Improve the overall health and wellbeing for the Tower Hamlets population
2. Reduce inequality of access to services and reduce inequalities in health and social outcomes for the Tower Hamlets population
3. Focus on the wider social and economic determinants of health for the whole population enhancing early intervention & prevention models
4. Coordinate and plan services with residents around their individual needs
5. Create empowered communities who are better able to support themselves
6. Prevent ill-health and increase their ability to sustainably manage their own wellbeing
7. Listen to and act on what matters to residents and patients
8. Improve the quality of care received and patient experience in a sustainable way

The Approach - the programme approach will commit to a way of working where changes to the delivery of care are co-produced by staff involved in the delivery of care and residents at a local level. Change should not be directed from a central top down position with pre-prescribed models of care.

The programme will put in place a robust governance structure to maintain an overview of the changes being tested across the entirety of the programme, ensuring that these are in-keeping with the agreed vision and goals and ensure that these local bottom up changes are appropriately tested and able to be spread sustainably. We aim to use quality improvement methodology to support the testing of new models of care. This will be underpinned by the triangulation of robust information, provider and resident views

A series of underpinning/cross-cutting work streams will need to provide a foundation to the localities and neighbourhoods specific work. These will look at how to improve underlying processes and communication to support change.

The work will require a strong co-production/bottom up approach to design which allows focused work between primary care and providers, both strengthening working relationships and trust but allowing new models of care to be tested in a controlled way before wider roll out.

We will identify or develop a resident/patient panel to provide overview, challenge and scrutiny for co-production plans across the programme - The Patient Panel will take a lead on developing an initial engagement model for neighbourhood residents and testing this in an agreed neighbourhood.

Below is a highlevel delivery plan on how the Localities & Neighbourhoods Programme will be delivered:

Phase 1 - Developing the Case for Change – June 2023

- Understand the national and local drivers for delivery across neighbourhoods and localities.
- Define what neighbourhoods and localities mean for Tower Hamlets staff, residents and agree the vision and goals.
- Development of a structure to support neighbourhood & localities governance
- Undertake formal and informal engagement with residents and staff.
- Development of neighbourhood identities and collaboration across primary care ***(linked to Fuller)***
- Develop a framework for delivery, including identifying how the different requirements of the Primary Care Networks, Health and Wellbeing Strategy fit together at a local level
- Identify what enablers are needed to make this programme work. ***(linked to Fuller***
- Establish within the framework how to measure progress using existing TH outcomes framework

Phase 2 – Develop Locality Models – test and learn – Dec 2023

- Using agreed framework undertake neighbourhoods/locality assessment and identify progress and areas for development.
- Develop the Neighbourhoods and Locality Operating Model, which set out the service model, ways of working and population health approach and a multi-year plan to achieve this.
- Complete delivery of the integrated multi-disciplinary neighbourhood team and care coordination model and look at care pathways that would bring teams together. ***(linked to Fuller)***

Phase 3 - Transformation in agreed priority areas – 2024 onwards

- Transformation in the core neighbourhood & locality based services and building on the integrated neighbourhoods team. ***(linked to Fuller)***
- Transformation work in community navigation, community pharmacy, children services, long term conditions and anticipatory care.
- Place based OD and people project to ensure there is a cultural shift to realise the benefits of integrated neighbourhood working. ***(linked to Fuller***
- Develop a model for community and voluntary sector partnerships, and resident involvement in each neighbourhood or locality.
- Develop a model for addressing health inequalities on a neighbourhood and/or locality footprint which brings together the voluntary and community partnership.

Phase 4 - Formal review, scaling and implementation of new ways of working

Supporting unpaid carers and housing adaptations in Tower Hamlets

The 2021 census results tell us that there are 18,551 unpaid carers in Tower Hamlets - 6% of the overall borough population of 310,306. Whilst this represents a reduction in the overall number of unpaid carers in the borough compared to the 2011 census when 19,356 unpaid carers were identified, we know that the needs of carers have increased, with more carers providing longer hours of care (25.4% of carers provided more than 50 hours of unpaid care in the 2011 census, compared to 28.6% in 2021).

In 2022/23, the council spent £1.85m on carers' services, and BCF contributes £699k to this from the CCG minimum spend. A range of support is provided to carers caring for someone in Tower Hamlets. This includes respite provisions and in person and digital preventative services, from whole-population measures aimed at promoting health and wellbeing, to more targeted interventions aimed at improving skills or functioning for one person or a particular group. Carers benefit from information, advice, and practical support to help them develop the knowledge and skills to care effectively and look after their own health, wellbeing and welfare.

The Council is committed to making Mandatory Disabled Facilities Grants available to all eligible owner-occupiers and private sector tenants so that they can remain living independently in their own homes. A disabled owner-occupier or tenant may apply for a Disabled Facilities Grant for various purposes which will primarily improve access and comfort.

Mandatory Disabled Facilities Grants will continue to be available to eligible owner- occupiers and private sector tenants. The maximum mandatory Disabled Facilities Grant is £30,000.

Applications for Discretionary Disabled Facilities Grant above the maximum mandatory £30k limit will be considered on a case by case basis by the Home Improvement Agency (HIA) Grants Panel. Approval is subject to the client not be able raise the necessary funds to complete the works, which would then result in the adaptation not being carried out.

In addition, the Disabled Facilities Grant can be used for the following purposes:

- **Relocation Grants** – Relocation grants would enable the Council to assist homeowners to move to a more suitable property where an in situ solution cannot be provided. Grants could cover removal costs, reconnection fees and legal costs.

- **Hospital discharge Grants** – Bed blocking caused when a resident's home is not suitable for them to return to is both expensive to the NHS and not in the patient's interest. Using DFG grant for fast track works including deep cleaning, decluttering and minor repairs can speed up this process and potentially save the public purse thousands of pounds.
- **Dementia Grants** – Dementia grants can be used to replace gas, electric cooking facilities with microwaves and specialist assistive technology such as GIS tracking devices where appropriate.
- **Assistive technology and equipment**

The Council provides comprehensive assistive technology and equipment services including deaf/blind aids. Tenants of Tower Hamlets Homes are able to apply for Disabled Facilities Grants and a more streamlined process has been developed between the Occupational Therapist and Tower Hamlets Homes who have a dedicated budget for adaptations.

Tower Hamlets set-up a board to ensure there is oversight on decisions that will enable adaptations project to be delivered on time, cost and quality requirements. To ensure sufficient resources are released or made available as required by the adaptations project and manage the delivery of the Adaptations project plan and associated mitigation or remedial activity for the effective management of risks, assumptions, issues, and dependencies. The board members are representatives from providers, suppliers, project lead, local authority and service users.

The board also aim to achieve the following outcomes:

- Develop clear understanding of end-to-end process for DFG in Tower Hamlets (for all pathways)
- Develop clear understanding in how it supports improved outcomes for residents and how this is measured
- Reduce duplication and explore opportunities to streamline process for DFG end to end
- Understand how DFG is allocated and utilised to full benefit
- Ensure that DFG guidance for Local Authorities is central to our review of this work

National Condition 2 (cont)

Set out the rationale for your estimates of demand and capacity for intermediate care to support people in the community. This should include:

- learning from 2022-23 such as
    - where number of referrals did and did not meet expectations
    - unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
    - patterns of referrals and impact of work to reduce demand on bedded services – e.g. admissions avoidance and improved care in community settings, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- approach to estimating demand, assumptions made and gaps in provision identified
    - where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?

  how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

Demand and Capacity for Intermediate Care to Support People in the Community

Learning from 2022-23

Our demand and capacity plans were mostly aligned in 2022-23. Our work on admissions avoidance is detailed later in this narrative and our performance is good.

Approach to estimating demand, assumptions made and gaps in provision

We used a similar approach to last year in estimating our intermediate care demand and capacity assumptions. We plan to review our intermediate care services inline with NICE guidelines in the coming year working with our partners but currently our community care works well in supporting discharges and we have access to step down beds in a neighbouring borough if required.

We are planning for stakeholders across the partnership to come together at regular meetings to develop our intermediate care pathway. We will use the National Institute for Health and Care Excellence (NICE) guidance and focus on data collection, mapping and exploring existing intermediate care services we can integrate. We will then focus on developing a roadmap and design principles.

Some of the key areas for consideration in our planning group will include:

- Embedding a home first approach including within our integrated discharge hub (IDH)
- Developing our reablement offer to better support independent living
- Ensuring best use of our crisis support teams such as rapid response
- Reviewing opportunities to integrate our therapeutic services
- Further developing a single point of access and “no wrong front door” approach and a joined up (single) assessment
- Aligning with our virtual ward developments for frailty and respiratory pathways

National Condition 2 (cont)

Describe how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25, and how these services will impact on the following metrics:

- unplanned admissions to hospital for chronic ambulatory care sensitive conditions
- emergency hospital admissions following a fall for people over the age of 65
- the number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population.

BCF funded activity supporting unplanned admissions to hospital and falls

Within Tower Hamlets we have a range of services and approaches to reduce attendance and admissions for our residents at acute hospitals and support them in their homes for longer. These include:

- Launched a Falls Pick Up service in the borough as part of our Rapid Response Service. The new pathway is available to Primary Care, Ambulance Crews, self-referral, Care Homes, 111 and 999 to refer into. The service will respond within 2 hours.
- Expanded our 2 hour response time for Community Services. Rapid Response has been expanded to ensure that they are able to respond appropriately within 2 hours where clinically appropriate. The service has been expanded to include nursing, AHP, Social Workers, Domiciliary care and linked to medical advice and support. The service also provided dedicated access to local care homes and an in-reach component to support care homes to better understand what is available and avoid contacting London Ambulance.
- Each Care Home in our borough has a dedicated GP Practice attached as per the requirements of the Enhanced Health in Care Homes model. This includes regular ward rounds of the care homes and robust care plans being put in place, they link into existing community services to ensure timely intervention.
- We have expanded the catchment area of the Physician Response Unit (PRU), which is a joint initiative between Bart's Health and London Ambulance Service. The PRU is a team which is dispatched to the patient's own home. The service in essence brings the Emergency Department to the patient's location through a senior emergency medicine doctor and ambulance clinician attending. Over 50% of patients seen do not get conveyed to hospital.
- The theraists within the Extended Primary Care Teams identifiy people at both risk of falling and those who have fallen to undertake strength and balance exercise programmes.

In addition, NEL has collaborated to develop a pathway for rough sleepers and complex homeless from hospital with the aim to minimise readmissions. This includes a specialist team to work within the Integrated Discharge Hub (IDH) and step down accommodation. The pathway will work on a cross borough level to maximise the opportunity. Service users can stay for a maximum of 4 weeks whilst their next steps are identified. The wider aim is to establish whether this type of model is effective in improving outcomes and reducing system costs.

The council are currently transforming their leisure services and we are working to look at opportunities for "age appropriate" exercise classes to promote strength and balance to reduce falls. The working group are also thinking about how we reach at risk groups who may not go near a leisure centre.

Other BCF funded schemes are also:
Reablement helps people mitigate illness or disability, by learning or re-learning the skills necessary for daily living, following deterioration in health and/or an increase in support needs. To promote and optimise independent functioning, and help people to do as much for themselves as possible, and in particular:

Community Equipment Services in Tower Hamlets include:

- Community Equipment Service
- Telecare Service
- Independent Living Hub
- Wheelchair service / Pharmacy prescriptions

The Community Equipment Service procures stores, delivers, installs, maintains, collects, cleans and recycles daily living, paediatric, moving & handling and sensory impairment equipment, and carries out minor adaptations and alterations to property.

The **Telecare Service** provides a range of front-line services that include: referral processing, alarm installation, alarm call monitoring, emergency visiting response and a regular visiting service. The

service operates 24/7 365 days a year. The service is also the first point of contact for Social Care referrals received Out of Hours, and is responsible for taking referrals relating to Children and Adults Social Care; on behalf of the Out of Hours Emergency Duty Team. Assistive technology delivers and fits a range of innovative technology to residents which enables them to remain at home and independent with sustained life choices, the focus is on prevention and a reduction in hospital admission and readmission. The strategy arm of the team raise awareness among health and social care professionals through training and reinforcing of good practice at team level. The Sight and Hearing service helps anyone who is deaf, blind, suffers from hearing loss, visual loss or a dual sensory loss. The service provides social work support, general information and advice, rehabilitation training and equipment to encourage independent living skills. Work is undertaken with individuals apart from the self-assessment which would need to be re-evaluated in light of any changes and the low vision clinic which is external to the contractual arrangements.

TH Connect (Information, Advice and Guidance service) supports the council to manage demand on its adult social care front door and those of health partners by providing free, quality assured information, advice and advocacy across health, social care and social welfare. Equipping residents with the correct information and advice support at the right time will enables residents to support themselves, live fulfilling lives and to be as independent as possible. The service offers early help and support to residents and carers through a digital portal, a help/advice telephone line service and face-to-face support in community and primary care settings. A key element of the information and advice offer is the Tower Hamlets Together Digital Portal. This website is the digital front door for all residents with or without health or care needs. It provides residents with a suite of information and advice pages, a service directory, and an events calendar.

Linkage Plus is a preventative service which will support this vision by providing Tower Hamlets residents aged 50 and over universal access to:

- Community outreach;
- A wide range of physical and social activities;
- Information and low level Advice, including signposting and onward referrals as required; and
- A range of health-related services

Residential and Nursing Homes

Tower Hamlets spends £13.5 million on residential/nursing care placements per annum.There are currently approximately 380 Service Users in residential/nursing care placements.

The latest ASCOF data shows the people aged 65+ moving to residential/nursing care in 2020/21 was recorded as 317 per 100,000, which is lower than the London rate of 371. Tower Hamlets has a young age profile. It is the only local authority area where less than 6% of residents are aged 65+ compared to 12% in London and 18% in England.

The Council currently commissions from five residential Providers which offer support to 65+ age group, two of which offer nursing provision and four of which are large scale Providers. The Council also procures a significant number of out of Borough placements (47%). Residential Care occupancy levels are running at comparatively high rates at 87% and nursing at 80%.

These figures demonstrate that local market capacity is an increasing issue for the Council and there is limited choice for residents. The Council is currently updating its Housing and Care Strategy to look at care estate needs over the next 10 years and beyond to address these issues.

The Council is also in close dialogue with other neighbouring Boroughs over future residential care provision as Tower Hamlets is a small geography and there may be benefits in looking at these market sufficiency challenges on a sub-regional basis. Land prices are high in the Council's area which can deter new entrants.

65+ Residential and Nursing Care Homes Market

The Councils strategic intention is to move away from an historic overreliance on residential based care packages, in line with its strategic intentions to support people to live independently, by investing in other models of care and supporting people to live independently at home where possible.

The Council is actively developing its future market strategy for bed-based care and expects the new strategy to be in place by April 2024. This new strategy will seek to directly tackle the market sustainability issues and risks outlined above. Key changes are likely to include:

Paying a fairer cost of care - The Council understands the cost pressures arising from the FCOC work and is in the process of reviewing funding arrangements and has set out a funding plan below. This funding plan will seek to provide an increase in the weekly prices the Council pays for Residential and Nursing Care, in line with its local approach to market contracting. The Council believes that this is a major step towards delivering a fairer and consistent cost of care for this market which provides high quality services in Borough.

Sustainable workforce - Strategy work on Housing with Care will address approaches to a sustainable and well-supported workforce, looking at training, development, progression and working with Providers at values-based approaches to attracting and retaining new entrants. This is a critical area of concern for the Council at present and over the medium to long term.

Addressing the mix of bed-based provision in the care estate - The Council fully expects that the trend over the last 12 months and the strategic imperative to keep people living independently is likely to mean that the Council will continue to develop supported living, extra care and Shared Lives options and investment to support people in the community. There will be ongoing developments in support to enable people to live in their own homes such as DFGs, assistive technology, reablement and support for informal carers. However, the strategy work will also consider the future requirements for Residential and Nursing Care. It is also likely that there will be increasing joint planning with neighbouring authorities to seek to ensure that sub-regional provision meets forecast care needs.

New market models - The Council will be bringing a number of new bed-based care contracts to market over the next two years and will seek to introduce a range of new market models which should help Providers to innovate, take more control of their cost base and to improve efficiency as well as providing new benefits to Residents. This is likely to include:

- grouping and/or extending contract lengths to provide better market opportunity and income stream certainty
- moving to coproduced and outcome-based contracts
- working with Providers to drive up quality or service, develop capacity and seeking to ensure fair pay and career development opportunities for carers
- introduction of payment incentives to align Providers and Council objectives
- using technology more effectively to improve the efficiency of delivery models

- working more closely and collaborative with Providers and using “open book” accounting to increase transparency and partnership working

Engagement with our in-borough care home providers took place during March 2023, their feedback indicated:

Workforce - Providers have established workforce recruitment, development and retention initiatives, however support to facilitate and increase international recruitment would be supported. Tower Hamlets will be making a North East London (NEL) wide partnership bid (led by the London Borough of Havering) on behalf of all ASC providers in this sub region. This will include a request for funding for an education, training, induction, and social integration programme to ensure that any workers are equipped to manage their new life in the UK and understand how ASC operates here.

Training - Providers appreciate the training that the local authority provides. A suggestion is that training is provided on site at the care home, this would enable providers to manage staff cover, minimising the need for agency cover. Providers also suggested that the Council could directly employ a dedicated trainer who could provider train the trainer expertise to care home management and deliver tailored training.The Council will continue to promote and support care homes to develop their care home managers core competencies by encouraging participation in the My Home Life programme or other similar programmes will investigate the potential for this to support our in-borough care homes in sustaining quality in care.

Quality improvement - Providers understand the need for contract monitoring, however on-site meetings that are collaborative to discuss issues and inform working practices between the council and the care homes will take place in addition to this.

One of the workstreams of the Adult Social Care Transformation Programme (ASCTP) is the Technology Enabled Care project. It’s first priority is technology for people who need social care, to support people to maintain their independence and using technology to achieve their goals. One of the outputs of this priority is to delay the individuals’ need for homecare, thereby maintaining their independence while allowing the Council to better manage budgets. Two other projects within the ASCTP are Information, advice and early help and Direct Payments, in relation to homecare these projects will allow providers to advertise themselves on the Tower Hamlets Connect website, allowing individuals to purchase services via direct payments or self-funding.

National Condition 3

Use this section to describe how your area will meet BCF objective 2: **Provide the right care in the right place at the right time.**

Please describe the approach in your area to integrating care to support people to receive the right care in the right place at the right time, how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to support safe and timely discharge, including:

- ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support, in line with the Government's hospital discharge and community support guidance.

- How additional discharge funding is being used to deliver investment in social care and community capacity to support discharge and free up beds.

- Implementing the ministerial priority to tackle immediate pressures in delayed discharges and bring about sustained improvements in outcomes for people discharged from hospital and wider system flow.

. During 2022 we partnered with Newton Europe and London Boroughs of Waltham Forest and Newham to review our Discharge to Assess pathways.
The purpose of the review was to understand:
How well is our offer working? Understanding our current D2A model and the outcomes we deliver. What are the strengths of our model? What are the biggest issues we face? How do these impact outcomes?
What is the context for change? Understanding the environment for change within the system. Which change enablers are in a strong position? What barriers do we need to overcome to deliver meaningful, lasting change?
How do we build shared priorities? Identifying the system-wide priorities to take forwards. What areas should we focus our efforts on in order to have the biggest impact? How do we build alignment on these?
How do we take this forward? Outlining the key next steps to address the priority focus areas identified for the system. What is our plan to tackle these challenges? What are our measures of success?
The review involved all partners involved in discharge across Adult Social Care, Community Service Providers, Acute sites and primary care. The programme also sought views from residents who had been discharged on our Discharge to Assess Pathways. As part of the review local experts reviewed 61 random selected discharges and interviewed 8 residents who had recently been discharged on the pathway. The review highlighted for Tower Hamlets that 56% of cases reviewed had the right long-term outcomes post discharge highlighting that in less ideal discharges some people going into residential or nursing care when they should have returned home, some people not accessing appropriate rehab and reablement pathways in a timely manner and the use

of interim step-down bed facilities, although often valid reasons for use, not resulting in residents returning home.
Following the review, the priorities for improvement for 2023/24 include:
(1) Putting in place a consistent proactive discharge planning process, with earlier discussions for discharge within the patient's hospital journey to ensure appropriate planning and focus on supporting residents to return home under Home First Principles. It is anticipated that earlier discharge planning will also increase the use of rehab and reablement pathways and (2) Reduction in use of interim step-down facilities.

National Condition 3 (cont)

Set out the rationale for your estimates of demand and capacity for intermediate care to support discharge from hospital. This should include:

- learning from 2022-23 such as
    - where number of referrals did and did not meet expectations
    - unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
    - patterns of referrals and impact of work to reduce demand on bedded services – e.g. improved provision of support in a person's own home, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- approach to estimating demand, assumptions made and gaps in provision identified
- planned changes to your BCF plan as a result of this work.

- where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?
- how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

Demand and Capacity for Intermediate Care to Support Discharge from Hospital

Learning from 2022-23

Our demand and capacity plans were mostly aligned in 2022-23. Our work on discharge has been detailed in the narrative above. We focus on a home first approach and support people to be discharged to their normal place of residence and use available 4 weeks funding to bridge the gap between discharge and long-term funding arrangements. Where somebody is unable to return home, we use interim beds available in a neighbourhing borough to support residents around their long-term care needs. The interim beds are available for a maximum of four weeks.

Approach to estimating demand, assumptions made and gaps in provision

We used a similar approach to last year in estimating our intermediate care demand and capacity assumptions. We plan to review our intermediate care services inline with NICE guidelines in the coming year working with our partners but currently there is a lot of emphasise in our system to support discharges and we have access to step down beds in a neighbouring borough if required.

We are planning for stakeholders across the partnership to come together at regular meetings to develop our intermediate care pathway. We will use the National Institute for Health and Care Excellence (NICE) guidance and focus on data collection, mapping and exploring existing intermediate care services we can integrate. We will then focus on developing a roadmap and design principles.

Some of the key areas for consideration in our planning group will include:

- Embedding a home first approach including within our integrated discharge hub (IDH)
- Developing our reablement offer to better support independent living
- Ensuring best use of our crisis support teams such as rapid response
- Reviewing opportunities to integrate our therapeutic services
- Further developing a single point of access and “no wrong front door” approach and a joined up (single) assessment
- Aligning with our virtual ward developments for frailty and respiratory pathways

National Condition 3 (cont)

Set out how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25 and how these services will impact on the following metrics:

- Discharge to usual place of residence

R**eablement** helps people mitigate illness or disability, by learning or re-learning the skills necessary for daily living, following deterioration in health and/or an increase in support needs. To promote and optimise independent functioning, and help people to do as much for themselves as possible, and in particular:

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

The service also seeks to ensure:

- The safe transfer of support between acute care, community health and social care services and to support service users' return to independent living
- The prevention of unnecessary hospital admissions and the facilitation of early supported discharge
- To the provision of information and onward referral to other services, so that users/patients and their carers can make choices about support needs
- The prevention of premature admissions to residential and nursing care.

Community Equipment Services in Tower Hamlets include:

- Community Equipment Service
- Telecare Service
- Independent Living Hub
- Wheelchair service / Pharmacy prescriptions

The Community Equipment Service procures stores, delivers, installs, maintains, collects, cleans and recycles daily living, paediatric, moving & handling and sensory impairment equipment, and carries out minor adaptations and alterations to property.

The **Telecare Service** provides a range of front-line services that include: referral processing, alarm installation, alarm call monitoring, emergency visiting response and a regular visiting service. The service operates 24/7 365 days a year. The service is also the first point of contact for Social Care referrals received Out of Hours, and is responsible for taking referrals relating to Children and Adults Social Care; on behalf of the Out of Hours Emergency Duty Team. Assistive technology delivers and fits a range of innovative technology to residents which enables them to remain at home and independent with sustained life choices, the focus is on prevention and a reduction in hospital admission and readmission. The strategy arm of the team raise awareness among health and social care professionals through training and reinforcing of good practice at team level. The Sight and Hearing service helps anyone who is deaf, blind, suffers from hearing loss, visual loss or a dual sensory loss. The service provides social work support, general information and advice, rehabilitation training and equipment to encourage independent living skills. Work is undertaken with individuals apart from the self-assessment which would need to be re-evaluated in light of any changes and the low vision clinic which is external to the contractual arrangements.

TH Connect (Information, Advice and Guidance service) supports the council to manage demand on its adult social care front door and those of health partners by providing free, quality assured information, advice and advocacy across health, social care and social welfare. Equipping residents with the correct information and advice support at the right time will enables residents to support themselves, live fulfilling lives and to be as independent as possible. The service offers early help and support to residents and carers through a digital portal, a help/advice telephone line service and face-to-face support in community and primary care settings. A key element of the information and advice offer is the Tower Hamlets Together Digital Portal. This website is the digital front door for all residents with or without health or care needs. It provides residents with a suite of information and advice pages, a service directory, and an events calendar.

Linkage Plus is a preventative service which will support this vision by providing Tower Hamlets residents aged 50 and over universal access to:

- Community outreach;
- A wide range of physical and social activities;
- Information and low level Advice, including signposting and onward referrals as required; and a range of health-related services.

National Condition 3 (cont)

Set out progress in implementing the High Impact Change Model for managing transfers of care, any areas for improvement identified and planned work to address these.

During 2022 we undertook a diagnostic in partnership with Newton Europe of our discharge to assess arrangements. The diagnostic covered Newham, Waltham Forest and Tower Hamlets and was designed to help us to identify areas of good practice and areas for improvement for supporting our residents on a discharge to assess model. The diagnostic was aligned to the High Impact Change model and informs our transformation ambitions for improvement.

Discharge Transformation is aligned to the High Impact Change Model with a focus in 2023/24 on improvements in Early Supported discharge planning, home first with increased discharges to people own residence and building on the Pathways Homeless Service to ensure that people are supported to an appropriate place of safety

National Condition 3 (cont)

Please describe how you have used BCF funding, including the iBCF and ASC Discharge Fund to ensure that duties under the Care Act are being delivered?

Adult Social Care Discharge Fund is being utilised to fund 4 week packages of care, the integrated discharge hub and mental health discharges.

An agreement between ICBs and relevant Local Authorities on how the additional funding to support discharge will be allocated for ASC and community-based reablement capacity to reduce delayed discharges and improve outcomes.

Discharge performance has not been identified as a concern in relation to the delivery plan for UEC. Discharge does remain however as a key programme for the partnership with a focus on improvements on Home First.

Through services funded via the BCF, we work closely with local VCSE organisations to support everyone to be able to access:

· Clear advice on staying well through our information and advice portal

· A range of preventative services

· Simple, joined up care and treatment when this is needed.

· Proactive support that keeps people as well as possible, where they are vulnerable or at high risk.

The BCF funded services in Tower Hamlets include community services, community navigators, benefits advice, and access to community-based support for people with sensory and mental health needs.

Tower Hamlets Connect (THC) is one of the points of access to community services.

Support for unpaid carers including young carers, carers who are working and older age carers - further details can be found in the next section.

IBCF

IBCF is being used by the council to address a number of high priority needs, including demographic pressures, safeguarding and ethical care and to meet inflationary pressures within the care system. To strengthen the stability and sustainability of the provider market, it is also proposed to increase nursing home provision in the borough. This will complement already agreed uplifts in care funding to improve the quality of residential/nursing provision and wider support in the community, such as enhancing home care linked to hospital discharge and improving reablement approaches in day support. Further investment of approximately £1.4m in a full year is being made that will benefit health services in the borough. This includes provision to enhance capacity and skills in the Community Health Social Work team to increase the number of people it is able to support on the integrated care pathway. It also includes the enlargement of the Hospital Social Work Team to get more people home quickly and safely and reduce the need for residential placements. In addition, the IBCF is being used to fund social work support to strengthen the continuing

healthcare process. A number of initiatives are being funded that are designed to address unmet need in mental health services. These include projects targeted young people transitioning from children's services to adults' and working with people at risk of anti-social behaviour. For instance, a Community Multi-Agency Risk Assessment Case Conference, MARAC, is being established, along with an Independent Anti-Social Behaviour Victim Advocate post. A scheme for people at risk of self-neglect and self-harming behaviours is also being funded. A number of areas of unmet need and services experiencing demand pressures will also be supported via IBCF. Initiatives include a project to reduce isolation among vulnerable older people. Additional resources are also being directed to the reablement service to address rising demand, and a significant sum has been allocated to commission additional support to address assessment and review backlogs in adult social care. Finally, the IBCF is being used to support the implementation of a number of adult social services transformation initiatives.

Supporting unpaid carers

Please describe how BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

The 2021 census results tell us that there are 18,551 unpaid carers in Tower Hamlets - 6% of the overall borough population of 310,306. Whilst this represents a reduction in the overall number of unpaid carers in the borough compared to the 2011 census when 19,356 unpaid carers were identified, we know that the needs of carers have increased, with more carers providing longer hours of care (25.4% of carers provided more than 50 hours of unpaid care in the 2011 census, compared to 28.6% in 2021).

The bi-annual carers' survey of 2021/22 reported a decrease from 2018/19 in the overall satisfaction of carers with services, ease of finding information and advice and involvement in discussions about the cared for. Much of the decrease is likely to be linked to the pandemic and post pandemic resulting in changes to many support services and reduced physical contact, carers reported increase in; carer burn out, isolation and poor mental and physical health.

In 2022/23, the council spent £1.85m on carers' services, and BCF contributes £699.5k to this from the CCG minimum spend. A range of support is provided to carers caring for someone in Tower Hamlets. This includes respite provisions and in person and digital preventative services, from whole-population measures aimed at promoting health and wellbeing, to more targeted interventions aimed at improving skills or functioning for one person or a particular group. Carers benefit from information, advice, and practical support to help them develop the knowledge and skills to care effectively and look after their own health, wellbeing and welfare.

The integrated Commitment to Carers Action Plan (2023-25) has been drafted through extensive co-production that reflects how carers will be supported with an increase in the identification, recognition, and practical support to carers. The draft plan identifies a range of priorities to support unpaid carers; increasing the identification of carers, involving carers in the decision making and care planning process, improving the health and wellbeing, having a life outside of caring and supporting carers stay in work and education and young carers in transition. These priorities informed the future carers offer in Tower Hamlets. Health and social care partners have accepted responsibility to support carers and to align health and social care services that support, educate, and enable carers to continue in their caring role.

The Carers Centre Tower Hamlets is commissioned to provide front door service to unpaid carers to enable them to continue caring and minimising the risk of relationship breakdowns between the cared and the cared for and deliver many of the priorities outlined in the Commitment to Carers Action Plan. The wide range of services includes; dedicated information, advice and advocacy service including services from the Royal London Hospital, day and overnight breaks from caring, carer's assessment, counselling, massage therapy, carer's academy provision of training, education and peer support. Carers Centre supported c.2000 people in 2022/23. Care and support packages include respite services for carers following an assessment as well as provisions of a one off direct payment for carers who do not meet Care Act eligibility but due to their caring role, there is a significant impact on their wellbeing. A refreshed and co-produced service will be reprocured and live from 01 April 2024.

During and after the pandemic, carers reported they were feeling exhausted, socially isolated, and close to burning out and so the council supplemented existing services for 2022/23. This included enhancing advice and advocacy services, provision of funds for carers to access to run activities in their local area, day and overnight breaks, massage therapy, yoga sessions and counselling.

Excelcare is commissioned to provide an emergency respite service in real time to support carers who are not known to adult social care and at risk of/experiencing a crisis and short term support will enable them to continue their caring role. Thereby reducing the risk of relationship breakdown and supporting the carer is accessing support services. This service will be re-procured from 01 April 2024.

The council is co-producing what carers' service and offer should include from April 2024 onwards and will be seeking bids which are aligned to the Commitment to Carers Action Plan and to what carers need to continue in their caring role that enables them to stay safe, well and caring for longer, should they wish to do so. This redesign includes an ambitious intention to review and improve carer support and services across health and social care; ensure that support for carers is developed in a coordinated manner and on a multi-agency basis; review and realign existing systems across the partnership, and the development of a borough-wide information resource for all health and social care staff when engaging with carers, so that carers have a better journey and are recognised as equal and expert partners of care.

Disabled Facilities Grant (DFG) and wider services

What is your strategic approach to using housing support, including DFG funding, that supports independence at home?

The Disabled Facilities Grant (DFG) plays an important part in Tower Hamlets' approach to integrated care.

The local authority provides services to clients requiring adaptations through its Occupational Therapist service and Home Improvement Agency. It works closely with Registered Providers who own the majority of social housing in the Borough. The tenants of the borough's Registered Providers account for around 75% of DFG expenditure. This spend reflects the relatively low level of owner occupied housing in the borough.

We are currently exploring options for a cross divisional DFG Working Group to be established to review the DFG programme, consider a pathway redesign for DFG and the DFG's integration with assistive technology and other Home Care services with a focus on supporting people to maintain their independence in the community for longer. This is being undertaken by the TEC (Technology Enabled Care) Board.

The Working Group will also give some consideration to how it can make better use of the flexibility allowed in DFG spending by the Regulatory Reform (Housing Assistance)(England and Wales) Order 2002 to support innovative solutions such as care technology.

In 2018, our Place Directorate carried out a full review of emerging good practice in regards to the wider use of DFG and engaged with Foundations, the Government's appointed advisory agency for best practice in the delivery of DFGs and extended use of the grant allowed under the RRO. In order to create greater flexibility within the fund and address housing issues on a wider preventative basis, it was agreed by the Mayor in Cabinet in to extend the fund on a discretionary basis to allow the use of the grant in the following areas:

- **Relocation Grants -** Relocation grants enable the Council to assist homeowners to move to a more suitable property where an in situ solution cannot be provided. Although they are rarely likely to be used, grants could cover removal costs, reconnection fees and legal costs.
- **Hospital Discharge Grants –** DFG grants are available for fast track works, including deep cleaning; decluttering and minor repairs which can speed up the hospital discharge process.
- **Dementia Grants –** Dementia grants can be used to replace gas, electric cooking facilities with microwaves and specialist assistive technology such as GIS tracking devices where appropriate.
- **Assistive Technology and Equipment** - The Council provides comprehensive assistive technology and equipment services including deaf/blind aids. DFG spend is used to supplement this service where an unmet demand can be identified.

Tower Hamlets have recently contributed to the first London DFG data survey, although there were not as many submissions as there could have been, Tower Hamlets have proved that they are doing an excellent job and showing a strong mid-table position.

There is always more to do and we hope by the introduction of the TEC Board recommendations and the refresh of the internal DFG policy Tower Hamlets will continue to serve its residents to the best possible standard.

Care Technology

Following the Care Technology diagnostic that was conducted earlier this year the Council is now working on a full business case for a transformed Care Technology function that will deliver the opportunities identified in the diagnostic to improve our offer, reach and support more residents and prevent and delay the need for adult social care services as a result. The Technology Enabled Care

Project Board is established and underway and overseeing a number of projects to take this work forward and to implement a new service model once it has been agreed.

What difference will it make?

- It will mean more people have more control over their care.
- It will improve people's experience of social care by providing the right care at the right time and providing another way of getting support.
- It will reduce delays in the social care process by staff spending less time on administrative tasks.
- It will support people to remain independent in their own homes for longer.
- It can improve the experience carers have when interacting with staff, giving them more control and access to information.

In order to implement and manage this transformation a Technology Enabled Care Board has been established and is underway.

Additional information (not assured)

Have you made use of the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO) to use a portion of DFG funding for discretionary services? (Y/N)

NO

If so, what is the amount that is allocated for these discretionary uses and how many districts use this funding?

Click or tap here to enter text.

Equality and health inequalities

How will the plan contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include

- Changes from previous BCF plan
- How equality impacts of the local BCF plan have been considered
- How these inequalities are being addressed through the BCF plan and BCF funded services
- Changes to local priorities related to health inequality and equality and how activities in the document will address these
- Any actions moving forward that can contribute to reducing these differences in outcomes
- How priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5.

Within Tower Hamlets, the Tower Hamlets Together (Place-Based) Partnership is committed to identifying and addressing health inequalities and inequalities for those with protected characteristics in our borough and we are undertaking work in a number of ways to do this.

Firstly, identifying where health inequalities exist is paramount to then seeking to address these, and we have done so through utilising regional and local intelligence resources and initiatives, as well as engagement and coproduction with our residents, for example:

Recent population health analysis has been conducted by North East London ICB to understand how our local population's health needs and current outcomes compare against the national average, and has shown that compared to the England average, Tower Hamlets experiences:

- lower healthy life expectancy for females;
- A higher number of children in absolute low income families;
- lower vaccination rates;
- higher air pollution rates;
- worse screening rates for breast, bowel and cervical cancer;
- higher mortality rates for cardiovascular diseases;
- higher prevalence of diabetes;
- higher prevalence of common mental disorders;
- higher under 75 mortality rates for severe mental illness (also the highest in North East London).

Our Public Health team has conducted research to understand where health inequalities exist between different ethnic groups to understand the relationship between ethnicity and access and experience of our services, and has found that:

•Black patients (72%) were less likely to be on optimal anti-hypertensive treatment compared to patients of White (76%) or South Asian (77%) ethnicities;

•South Asian adults make up 34.1% of the GP registered population, but account for 63.3% of the patients with diabetes. Diabetes prevalence is 3.2% in the White population and 7.6% in the Black population;

•Due to Covid, a reduction in NHS Health Checks will have had an impact on identifying those at risk of diabetes. Clinicians have raised concerns that this has disproportionately impacted on BAME communities;

•Whilst there is a large population of Black residents with serious mental illness, fewer residents of Black ethnicity are accessing IAPT;

•Tower Hamlets has one of the largest differences in rates between Black (42%) and Mixed (40%) women attending A&E during pregnancy compared with White (26%) women;

•There are higher rates of asthma incidence amongst children in South Asian and Black groups;

•Preschool children in East London from a White Eastern European, Bangladeshi and Pakistani background are likely to experience significantly poorer oral health than their White British counterparts;

•Unplanned hospital admissions are higher for BME patients compared to White patients, with the highest unplanned admission rates being seen in the Bangladeshi population.

London Borough of Tower Hamlets enacted a Black, Asian and Minority-Ethnic (BAME) Commission, set up in 2021, to understand where inequalities existed for our BAME residents across the wider determinants of health and wellbeing and found that:

•Many BAME residents in Tower Hamlets live in poorer housing, which may be overcrowded, damp and in a state of poor repair. This has a significant impact on health outcomes;

•Black, Asian and Minority Ethnic residents are more likely to be digitally excluded (either through low IT literacy or lack of access to devices);

•Current communication channels and methods do not always reach our diverse communities. Most communication is only in English which excludes people with language barriers;

•The lack of representation of BAME communities can lead to services being less able to appreciate the culture of the people they treat, and being dismissive of symptoms;

•There is a difference of 27 percentage points between the Employment rate for White residents (81%) and the Employment rate for BAME residents (54%).

We have also been looking into the experience of residents with a disability accessing health services, particularly during Covid. Over 50 coproduction workshops have been held, involving 450 disabled residents, with the findings being that nearly all participants reported challenges when accessing health services due to their communication and support needs not being met, and around 50% of participants found ‘some’ or ‘all’ Covid health information to be inaccessible and hard to understand.

To address health inequalities, including but not restricted to those mentioned above, our partnership is taking action in a number of ways, in the form of several workstreams. This links to the Core20+5 framework in that all the work we are doing will be delivered across the entirety of Tower Hamlets borough, large parts of which do fall within the most deprived % of the national population. E.g. recent data shows that 30% of the TH population is within the 20% most deprived LSOA’s in England, with 60% within the 30% most deprived.

Deprivation for older and younger people is even starker than this: 27.3% of children are in relative low income families and 21.4% in absolute low income families (highest in London) and 44% of older people live in income deprived households (the highest rate in England and more than double the average). In addition, many of our projects are addressing needs of groups likely to be identified within the NEL 'Plus' groups, including BAME communities, people with long term conditions and disabilities, learning disabilities and age/gender.

Through our NEL ICB funded 2022/23 Inequalities Programme we are currently delivering the following projects:

1.An improving equity programme, which any team or community group across the borough can join to address a health inequity through QI methodology, supported by a specialist team and a budget to fund improvement initiatives. We have good QI expertise in our partnership, and have recently won several awards for a QI project we ran to improve children's asthma outcomes. There are currently 16 projects on the programme which include a wide range of projects seeking to reduce health inequalities, e.g. promoting employment for older black males, with another focusing on Bengali women, a crisis café to support substance misusers and various projects related to mental health within BAME groups.

2.A placement programme at Barts Health Trust to offer underemployed young women from Bengali and Somali backgrounds paid employment to gain work experience and hopefully transition into full time employment in the health service, addressing a key wider determinant of health and wellbeing and increasing the diversity of our workforce.

3.An engagement survey, delivered through our VCS partners and through our Equalities Hubs designed on the protected characteristics, to engage with these groups to provide up-to-date insights on their health and wellbeing needs and opinions so we can better understand where inequalities may exist and can be addressed through targeted interventions.

4.A BAME community leadership programme which will improve BAME engagement, representation and community insights across our partnership decision making and delivery systems.

5.A project, delivered through our VCS partners, to coproduce more accessible communications for disabled residents by working with a number of disability coproduction groups and advocacy services and linking these to our partner's comms teams.

6.Funding a bilingual CAMHS family therapist to improve outcomes for children and young people accessing mental health support where there are language barriers within the family – this is especially an issue within our Bangladeshi community.

7.Participating in a 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. The focus of the community chest is reducing social isolation.

We are currently finalising our plans for our 2023-26 NEL Health Inequalities funding allocation. This is still subject to sign-off at our partnership board in July but will include a focus on reducing health inequalities across all four parts of our lifecourse approach and will include projects which relate to all 5 of the national inequality focus areas as set out in the CORE20PLUS5 framework:

•Children and young people – with interventions planned for CYP in care, CYP with communication needs, on continuing care plans, transgender/questioning, with mental health needs, and maternity outcomes.

•Adults with mental health and learning disabilities – with a focus on improving the physical health of those with severe mental illness. An LD project is yet to be determined but will be included in this programme to address inequalities within this cohort.

•Older adults and those with complex conditions – focusing on inequalities within dementia access and outcomes, support for unpaid carers of those with dementia and enhancing support available in the community for homeless people.

•Generally healthy adults – focusing on working within primary care networks and with local communities to reduce specific inequalities in each area related to preventing long term conditions from occurring or worsening, including hypertension, COPD and early cancer diagnosis.

•In addition we have ringfenced funding which will specifically be used to fund our community and voluntary sector and will focus on supporting our partnership aims to implement the Fuller agenda through promoting community resilience.

Our partnership has adopted an Anti-racism action plan which seeks to improve racial equity across health and wellbeing through focusing on four key areas: 1) education and training; 2) inclusive leadership; 3) workforce equity; and 4) racial equity in service provision. Work on this programme includes:

•Our partnership's Executive Board having undergone anti-racism training, with a wider training and OD programme for staff, including HR professionals, across the system to embed ant-racist culture and understanding due to commence shortly.

•The partnership has developed a joint Workforce and Organisational Development strategy which includes a priority on workforce equity which aims to agree diversity targets and measure and publish progress against goals to have representative leadership.

•We have coproduced a Culturally Appropriate Communications Checklist with residents from diverse backgrounds which will assist services with communicating more effectively them and move on from a one-size fits all approach – this checklist is currently being trialled before being rolled out to all teams across the system.

•The partnership will undertake three pathway re-design projects, in partnership with communities to identify, unpack and address systemic racism throughout the health and care journey. The first of these will relate to Somali mental health, with a further two areas to be identified.