# Tower Hamlets Together Update for Health and Wellbeing Board

TOWER HAMLETS TOGETHER
Delivering better health through partnership

19th September 2023

www.towerhamletstogether.com #TH2GETHER

TOWER HAMLETS · GP CARE GROUP · thcvs · NHS North East London · NHS Barts Health NHS Trust · NHS East London NHS Foundation Trust · healthwatch Tower Hamlets

# Tower Hamlets Together (THT)

THT is all about health and social care organisations working more closely to improve the health and lives of people living in Tower Hamlets.

This means a more coordinated approach to providing services, reducing duplication and improving the overall experience and outcomes for the people who need them.

THT is a partnership of health and care organisations that are responsible for the planning and delivery of prevention and health and care services.

The partnership includes:

- London Borough of Tower Hamlets
- North East London Integrated Care Board (NEL ICB)
- Tower Hamlets GP Care Group
- East London NHS Foundation Trust
- Barts Health NHS Trust
- Tower Hamlets Council for Voluntary Service
- Healthwatch Tower Hamlets

**THT values**

We are compassionate

We collaborate

We are inclusive

We are accountable

# System Plan on a Page: Mission and Vision + key influencers

| MISSION | VISION | OBJECTIVES | OUTPUTS |
|---|---|---|---|
| **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<br>• 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<br>• 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. Building the resilience and wellbeing of our communities - including maintaining the capacity to mobilise residents to deliver wellbeing and support within their communities, particularly to the most vulnerable and those who are isolated – for children and adults<br>2. Maintaining people's independence in the community - ensuring multi-agency working across primary, community, acute and social care to meet needs effectively and reduce the need for avoidable admission or for escalation of support unnecessarily – for children and adults<br>3. Reducing the time people need to be in bed-based settings - ensuring people are cared for in the community or their own homes whenever this is safe – for children and adults | 1. Develop our partnership<br>Collaborate as health and care providers and commissioners, with service users and carers, to plan and solve problems together<br>2. Deliver on health priorities and inequalities<br>Support individuals, families and communities to live healthy thriving lives<br>3. Design care around people<br>Provide accessible and responsive health and care services, and deliver person-centred integrated health and social care for those who need it<br>4. Develop our teams and infrastructure<br>Ensure THT staff and teams have the right support, skills, knowledge and approach |

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

# Defining our Vision Through Our System Wide Outcomes Framework (I Statements)

In collaboration with staff and residents, we developed a specific population focused outcomes framework. This framework, consisting of I statements, is intended to ground the services we design and deliver in line with the needs and expectations of our service users.

Our intention as a partnership is to map our deliverables to this outcomes framework to ensure we are contributing to achieve these in the work we undertake and to measure and track improvements as a result of this work, in line with these outcomes.

| 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 |

# NEL Strategic Context

## The Fuller Review

Key elements for ICBs to respond to within Fuller:

- developing neighbourhood level 'teams of teams'
- establishing a system level model of same day urgent care access
- delivering continuity of care by improving personalised care services
- using primary care to create healthier communities by more preventative care
- three key enablers of change: workforce, estates, and data

Two recommendations to ICSs, which need to:

- enable all PCNs to evolve into integrated neighbourhood teams
- co-design and put in place the appropriate infrastructure and support for all neighbourhood teams

The framework urges integrated care systems to:

- develop a primary care forum or network at system level
- embed primary care workforce as an integral part of system thinking, planning and delivery
- develop a system-wide estates plan to support fit-for-purpose buildings for neighbourhood and place teams delivering integrated primary care
- create a clear development plan to support the sustainability of primary care and translate the framework provided by 'Next steps for integrated primary care' into reality, across all neighbourhoods
- work alongside local people and communities in the planning and implementation process of these actions

## The NEL Integrated Care Strategy

**Our integrated care partnership's ambition** is to
"Work with and for all the people of north east London
to create meaningful improvements in health, wellbeing and equity."

| Improve quality & outcomes | Deepen collaboration | Create value | Secure greater equity |
|---|---|---|---|

**6 Crosscutting Themes underpinning our new ICS approach**

- Tackling **Health Inequalities**
- Greater focus on **Prevention**
- Holistic and **Personalised** Care
- **Co-production** with local people
- Creating a **High Trust Environment** that supports integration and collaboration
- Operating as a **Learning System** driven by research and innovation

**4 System Priorities for improving quality and outcomes, and tackling health inequalities**

- Babies, Children & Young People
- Long Term Conditions
- Mental Health
- Local employment and workforce

**Securing the foundations of our system**

Improving our **physical** and **digital infrastructure**
Maximising **value** through collective financial stewardship, investing in prevention and innovation, and improving sustainability
Embedding **equity**

# Health and Wellbeing Strategy

As a sub-component of the Health and Wellbeing Board, the THT partnership has a role in delivery of The 2021-2025 Tower Hamlets Health and Wellbeing Strategy has six system wide Improvement Principles and five Ambitions for a Healthy Borough.

Tower Hamlets Health and Wellbeing Board

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 a community

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 lived healthy lives and get support early if they need to it

5. Anyone needing help knows where to get it and is supported to find the right help

# What we are delivering together - snapshot

# What we are delivering as a partnership

**Our transformation and integration priorities** set annually across our six workstreams aim to improve outcomes through joined up provision:

- Born Well Growing Well
- Living Well
- Promoting Independence
- Mental Health
- Primary Care Transformation
- Urgent Care

In addition, these workstreams also collaborate to deliver various other projects on behalf of their population cohorts and/or service areas, some of which are funded through our Better Care Fund

**Our Tackling Health Inequalities Programme**, which aims to reduce identified health inequalities impacting our residents in line with the CORE20+5 framework:

- We have delivered a number of projects in 2022/23, including our Improving Equity Programme
- We have just agreed and are now implementing our programme for the next 3 years (2023-2026)

**Our system wide Enabler Groups** have various action plans they are delivering to provide enabling support to our partnership to better achieve our aims. Those currently operating and implementing actions are:

- People and Organisational Development
- User and Stakeholder Engagement
- Communications
- Estates and Local Infrastructure

**Our Anti-Racism Action Plan**, through which we as partners have committed to becoming an anti-racist health and social care system by implementing actions across four key thematic areas:

- Anti-racist education
- Inclusive leadership
- Workforce equity
- Racial equity in service provision

# How we developed our work programmes

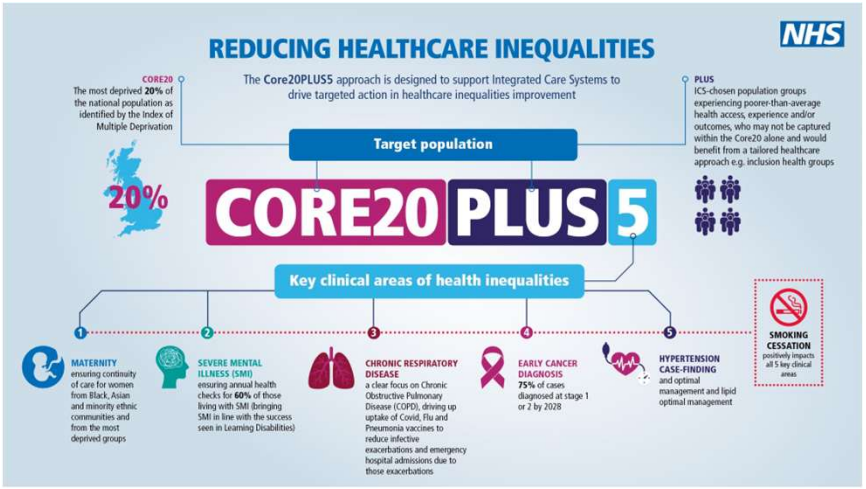
**Our transformation and integration priorities** were determined in line with system-wide strategies, population health need, the I statements framework and resource availability. E.g. our priority for CYP Mental Health:

**Strategic alignment:**

- NHS NEL strategy = Improve access to mental health services
- Every Chance for Every Child strategy = Improve access to timely CAMHS support
- THT I statements (co-produced with residents) =
  - I am able to access care services for my physical and mental health
  - I feel like services work together to provide me with good care
- Population Health need = In 2021 0-17 mental health admissions were the highest in NEL (74 per 100k) and above London average (61 per 100k).

**Our system wide Enabler Groups** developed their action plans through partnership wide forums and engagement with staff and in some cases residents and community groups.

**Our Tackling Health Inequalities Programme**, was largely informed by, and followed, the national CORE20+5 framework + also applying local intelligence on inequalities and need




**Our Anti-Racism Action Plan** we developed with the help of the anti-racism charity brap who worked with the THT Board in 2021

brap
making equality work for everyone

# Workstream priorities

| LCG | Priority |
|---|---|
| Children & Families | Enhancing mental health & emotional wellbeing access and outcomes for children and young people |
| | Improving our SEND services, experience and outcomes |
| | Promoting healthy childhood weight |
| | Achieving more integrated ways of working together to improve outcomes, with a focus on early years |
| | Mitigating poverty and economic hardship for children, young people and their families |
| Living Well | Localities and Neighbourhoods Programme:<br>1. Developing system-wide health Intelligence ("data") for localities and primary care networks/neighbourhoods<br>2. Strengthening Locality & PCN structures to address health inequalities<br>3. Engaging communities to improve health and wellbeing<br>4. Long-term conditions prevention and management: improving pathways between communities and preventative services |
| | Improving access to services for disabled residents |

| LCG | Priority |
|---|---|
| Promoting Independence | Delivering proactive care through care co-ordination and MDT working to improve outcomes |
| | Working in partnership to improve and streamline our discharge to assess pathway |
| | Reviewing and refreshing our model and approach for providing Community Health Services |
| | Providing support to carers through delivering the Carer's Action Plan |
| | Enhancing and extending our personalisation of care offer |
| Mental Health | Reducing health inequalities in access, experience and outcomes |
| | Creating paid employment opportunities |
| | Improving neurodevelopmental pathways to improve outcomes for Autism and ADHD |
| | Promoting and developing a more preventative approach |
| | Improving the experience and outcomes for young people transitioning to adult services |

# Workstream priorities

| LCG | Priority |
|---|---|
| Primary Care Transformation | Vaccination programme – children's/covid/flu |
| | Patient communication and education |
| | Enabling PCNs to evolve into integrated neighbourhood teams |
| | PCN organisational development programme |
| | Implementing national and local initiatives to improve access |
| | Developing a single system-wide approach to integrated urgent care to guarantee same day care for patients |
| | Primary and secondary care interface |

| LCG | Priority |
|---|---|
| Urgent Care | Reviewing the Urgent Treatment Centre |
| | Reviewing the discharge pathway |
| | Transfer of the Integrated Discharge Hub to Barts |
| | Virtual ward mobilisation for frailty and respiratory |
| | Winter planning |
| | Review of the end of life pathway |

# Enhancing mental health & emotional wellbeing access and outcomes for children and young people

## Objectives:

- All CYP will receive timely, appropriate support and have choice of services
- Reduce inpatient admissions, reoccurrence and Length of Stay for CYP in crisis
- Increase and join up the offer for prevention and early intervention, reduce stigma and raise awareness of services
- Eliminate barriers to services and improve experience by adopting the Thrive framework for integrated, need led offer
- CYP mental health plans will align with those for children and young people with learning disability, autism, special educational needs and disability (SEND), and health and justice
- Reduce inequalities and improve health outcomes

## Strategic alignment:

- NHS NEL strategy = Improve access to mental health services
- Every Chance for Every Child strategy = Improve access to timely CAMHS support
- HWBB Strategy = Children and families are healthy, happy & confident
- THT I statements (co-produced with residents) =
  - I am able to access care services for my physical and mental health
  - I feel like services work together to provide me with good care
- Population Health need = **In 2021 0-17 mental health admissions were the highest in NEL (74 per 100k) and above London average (61 per 100k).**

## Deliverables:

- New ELFT ICCS service (intensive community crisis service)
- Pilot the Key Worker to support CYP in the Transforming care cohort navigating the system and support agencies to work more jointly
- New S.76 contract for LBTH funded CAMHs provision, between LBTH and NEL ICB, and integrated service specification
- Re-commission service for Personal Health Budgets in CAMHS
- Develop a clear offer for schools/ school age children including TH Educations Wellbeing Service
- Barnardo's Kooth and other community services
- Scope out website for CYP mental and emotional wellbeing services

## Measuring success:

- By 2024 to have 24/7 age-appropriate crisis services
- Access and waiting time targets met; reduced crisis presentations; CYP feedback
- Self-referral; clear signposting for users and professionals
- Increased access to early intervention services as Kooth and Barnardo's for CYP age 10 -25 including care leavers and those with SEND
- Eliminate inappropriate admissions for LDA related crisis;
- Defined pathways for CYP in the justice system
- 95% CYP accessing Eating Disorder treatment within 1 week for urgent cases and 4 weeks for routine cases

# Tackling health inequalities

## Children and Families

- Supporting health needs of children in care
- Supporting Continuing Care cohort
- Improving maternity outcomes
- Enhanced CAMHS support for Bangladeshi young people and CYP who are transgender/questioning

## Promoting Independence

- Providing support for homeless and rough sleepers
- Supporting those suffering with dementia and their informal carers

## Living Well

- Preventing and early detection of long term conditions, incl. CVD, COPD, diabetes and cancer in certain communities more at risk

## Mental Health Partnership

- Improving the physical health of those with severe mental illness
- Learning disability focus

## Voluntary and Community Sector

- To fund our VCS to improve health equity through the community sector

# Living Well Plan - Community Health Facilitation for Prevention and Early Detection of LTCs

## What is being proposed?

- Locality-based project, to work with patients and communities to participate in and co-design preventative activities.
    1. To enable people at risk of LTCs to take part in prevention activities and to detect LTCs early, through co-produced community prevention and engagement activities.
    2. To enable communities to identify and overcome barriers to participation in preventative and detection interventions.
- This will complement existing interventions to prevent LTCs; it is focused on addressing inequalities in uptake of those interventions. It will complement plans to strengthen Locality Forums (as per the Localities & Neighborhoods programme)

## What is the context or rationale?

- Long-Term Conditions like Cardiovascular Disease, COPD, Diabetes and cancer drive health inequalities. Hence these make up 3 of CORE20+5.
- Recent CVD, Diabetes JSNAs have shown locally these conditions are much more prevalent in deprived communities, among Bangladeshi and minority ethnic groups.
- Strategic fit with plans to enable Localities and Neighbourhoods to take a Population Health approach.
- Evidence for community-centred interventions as per NICE guidance NG44; PH35;

## What will be delivered?

- "Community Health Facilitator" in each Locality
- To deliver local community-centred LTC prevention projects, co-produced evidence based participatory process eg: asset-based stakeholder engagement/participatory budgeting
- Trained volunteer/ champions providing in reach
- Local active 'case finding' – using Primary Care Network lists and proactive outreach to find people at risk of LTCs who would benefit.
- Locality level KPIs for numbers of residents engaged from target groups
- Complement plans to strengthen Locality Forums

## How could improvement be measured over time?

- Improvement in inequalities in update of preventive interventions eg health checks, weight management etc.
- Changes in diagnosis rates;
- Before and after measures of residents perceived ability to manage health – eg: I statement survey
- Qualitative feedback
- Reduction in LTC related complications from residents from socio-economically deprived backgrounds as well as specific target groups, such as socially isolated individuals, those with language barriers, residents of care homes, and individuals facing financial barriers.

# Anti-racism action plan

| Anti-racism education | Inclusive leadership | Workforce equity | Racial equity in services |
|---|---|---|---|
| £100k investment in anti-racism education to reach system leaders, managers and HR professionals | Diversify membership of THT Board and all structures incl via CVS leadership programme | Deliver THT Workforce and OD strategy incl diversity targets, inclusion ambassadors, governance | Race equity goals in all THT plans and scrutiny of quant + qual data at Board and workstreams |
| Self-critique in the Board, watch/check own practice (impact not intention) | Responsive, accountable citizen voice across THT incl. 'You Said, We Did' | Barts extended placement scheme (NEL funding) | Culturally appropriate comms toolkit rolled out |
| Cascading conversations about racism/anti-racism within teams: "each one teach one" | Build on successful co-design e.g. Covid champs and establish inclusive co-design group to hold Board to account | Scrutiny of workforce data, esp. inequities in progression and leadership, at THT Board | Flourishing Communities programme with more PCNs and CAMHS receptive bilingualism project (NEL funding) |
| Expectations of THT system leaders to educate, challenge and address racism in all forms | Ongoing investment in lay rep for citizen voice, inclusion and anti-racism + positive action to recruit | Anti-racism commitment and expectations built into THT workforce events | Three pathway re-design projects to tackle racism at each stage of journey |