BCF narrative plan template for Tower Hamlets

This is an optional template for local areas to use to submit narrative plans for the Better Care Fund (BCF). These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

Although the template is optional, we encourage BCF planning leads to ensure that narrative plans cover the headings and topics in this narrative template.

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 15-20 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

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

How have you gone about involving these stakeholders?

Strategic Approval

The 2021-22 BCF plan has been agreed by:

- Denise Radley – Director of Health, Adults and Community for the London Borough of Tower Hamlets. Councillor Rachel Blake who is the lead member for health and Chair of the Health and Wellbeing Board has been briefed on the return.
- Siobhan Harper – Transformational Director for North East London CCGs working specifically with Tower Hamlets, Newham and Waltham Forest.

The Better Care Fund is overseen by the Health and Wellbeing Board and the Tower Hamlets Together Executive Board. Both these Boards are made up of a wider range of stakeholders from across our health and care system including voluntary sector representatives.

Timescales have not allowed the 2021-22 plan to be submitted for approval prior to 16th November. The plan will be considered by the Tower Hamlets Health and Wellbeing Board for approval on the 1st December. 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 Clinical Commissioning Group (NEL CCG), Royal London Hospital (part of Barts Health NHS Trust), East London Foundation Trust, GP Care Group, Healthwatch and Council for Voluntary Sector (CVS).

The 2021-22 BCF plan is an evolution of the 2020-21 arrangements. The priorities have been developed through the Tower Hamlet Together (THT) Executive Board, the borough based integrated health care partnership, which includes key members from the Health and Wellbeing Board.

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 on what's been delivered, what's worked, lessons learnt and understand how the scale of ambition for integration will be delivered. In essence, the priority for 2021-22 is to develop a plan for the plan. These conversations have been within health and the council mainly and we will start VCS and resident involvement in the New Year (2022) once the local ICS arrangements gain clarity.

The tight deadlines provided to develop the plan have limited the scale of engagement on the specifics of the 2021-22 BCF Plan.

We have a smaller working group between the Council and the CCG 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 Executive Board on a quarterly basis alongside a joint performance report.

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

Executive Summary

This should include:

- Priorities for 2021-22
- key changes since previous BCF plan

Our priorities and work programme for 2021-22 is below. The programme is overseen by our newly developed Local Delivery Board (LDB) which is chaired by our CEO of the GP Care Group and is attended by key operational leads from across our health and care partnership.

Local Delivery Board – the overall programme management of the 42 individual transformation projects are themed under the following five headings:

1.Care Close to Home - maintaining people's independence in the community
2.Hospital to Home -reducing the time people need to stay in hospital
3.Prevention -building the resilience and wellbeing of our communities
4.Mental Health and Learning Disabilities
5.Children and Young People

The following are the key priorities from our work programme which fall under each of the five headings and are delivered by our 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
•Childhood Obesity
•Ways of working –including pathways for long term conditions, a shared practice framework, a shared model of locality and Multi-Disciplinary Team working

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

•To improve the experience of residents accessing reproductive health services (e.g. sexual health, contraception, termination of pregnancy) through a joint commissioning approach across the CCG and Local Authority.
•Developing and implementing virtual health checks.
•Integration of IT across pharmacy and GP for living well services.
•Implement the local physical activity programme jointly with Public Health and Primary Care
•Deliver the Covid-19 Vaccination Programme across Tower Hamlets
•Integrate the Community Phlebotomy service

3. **Complex Adults –Promoting Independence workstream**

•Develop a plan for wider implementation of Personalisation and Personal Health Budgets.
•Establishing a new model of homecare which includes MDT approaches e.g. working closer with District Nursing.
•Redesign of older people's day centre provision.
•Developing an integrated rehab/reablement service

Whilst the three workstreams continue with delivering against their priority areas for their chosen population segment, the Local Delivery Board agreed it needed to keep a tighter focus on the following 6 and 12 month priority areas as their core focus. These were the areas felt as key to supporting the recovery from the Covid-19 pandemic and preparing for any future waves of the virus.

6 month priorities (April 2021 to Sep 2021)

- Delivering the Covid 19 vaccinations programme
- Implementing the MDT and Care Coordination model to 1) improve MDT identification and care planning for people who are vulnerable which includes providing them with 2) integrated care plans 3) care co ordination and 4) case management approach
- Embedding and improving our integrated discharge pathway to support discharge for patients at the Royal London Hospital who no longer meet the criteria to reside. Ideally within 24 hours.

12 month priorities (April 2021 to March 2022)

- Improving CYP mental health services and access
- Delivery of expanded CAMHS crisis service to meet the 35% access standard for CAMHS services & delivery of CAMHS ED waiting times standard
- Consider adding additional CYP schemes to the BCF and Section 75 (where appropriate and beneficial)
- Establishing a new model of Homecare to ensure that the model of home care responds to the specific needs/aspirations of the population and exploits the opportunities for integration with health, e.g. district nursing and social prescribing
- Reviewing the ASD pathway - all services within the pathway to have a collective understanding of the immediate and long term priorities/objectives in supporting children and families from pre diagnosis through to transition into adult services. All services to have closer dependencies and join up in meeting the agreed objectives
- Enhancing our EOL care offer - work with Primary Care to identify people in the last months/year of their life but are not on the palliative care register; Once identified work with multi-disciplinary teams to undertake holistic needs assessment and then develop a person centred plan for the patients.

The Local Delivery Board (LDB) takes on the operational focus from the Tower Hamlets Together Executive Board. The programme plan for the LDB includes some of the schemes from the BCF plan such as reablement, discharge and community health and care teams.

Key changes in the BCF Plan for 2021-22
With the delay of the official BCF guidance, we took the decision locally to review our BCF and make changes ahead of the official guidance. The key changes from the 2020-21 BCF are below:

New schemes added for 2021-22

- Brokerage support for hospital discharge (£100,778)
- Adult Learning Disability Services - Lead on Hospital Admission and Discharge (£27,853)
- Initial Assessment Service - Support for Hospital Discharge (£66,327)
- Initial Assessment Service - Support for Safeguarding (£55,706)
- AMHP Service - Support for Hospital Discharge (£66,327)
- Practice Development - OT Joint Practice Lead (£30,000)
- Locality Development Fund (£968,487)

Key changes to the Section 75 for 2021-22

- Community Equipment Service now shown as separate lines split across Medequip contract, contribution to Telecare and Independent Living Hub, Pharmacy Prescription and Wheelchair Service. Allocation from minimum and additional contribution shows 50/50 spilt between LA and CCG.
- Carers Services renamed to Carers Support to better reflect nature of the scheme (Carers Centre and subscriptions)
- Community Outreach Service and Dementia Café combined into one scheme now called 'Dementia Diagnosis and Community Support'
- Two iBCF schemes added to the main BCF 'Shared Lives' and 'Developing Capacity in Learning Disability'
- Local Incentive Scheme renamed to 'Locality Development Fund CCG contribution' and combined with LA contribution to create circa £1M pot to support strategic development of localities (further integration of PCNs into THT for e.g.)

It would be ideal if planning for the future years BCF e.g. 2022-23 onwards could be started prior to the next financial year, so that we can tie this is with the operating frameworks for the CCG and Councils. We would like to better reflect our BCF in future years with our local place based developments in line with the ICS changes. Therefore, timely BCF planning guidance would support this ambition.

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) Executive Board.

The Tower Hamlets Together Executive Board

- 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 Delivery Boards as well as to relevant executive and governing bodies of the CCG and Council.

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 Alliance (formerly THCCG)
- East London Foundation Trust
- Barts Health
- Tower Hamlets Council for Voluntary Services
- GP Care Group

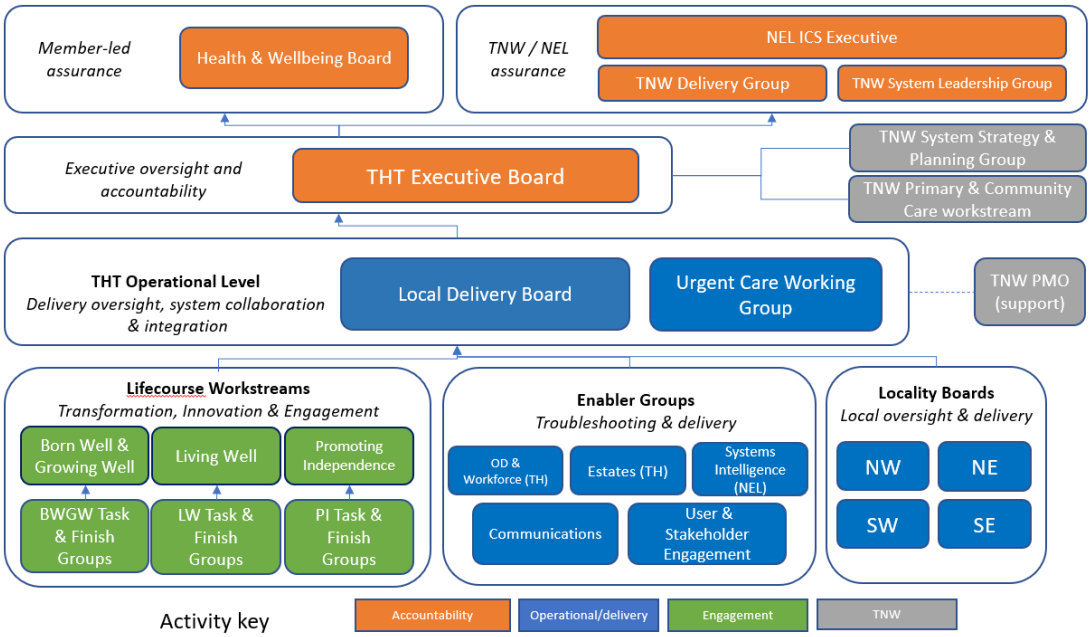
Members have delegated responsibility from the partner employing them to make decisions which enable the THT Executive Board to carry out its objects, roles, duties and functions.

The Tower Hamlets Together Executive Board is responsible for the overall approval of Individual Schemes, ensuring compliance with the Better Care Fund Plan and the strategic direction of the Better Care Fund.

Each Scheme Specification confirms the governance arrangements in respect of the Individual Scheme and how that Individual Scheme is reported to the Tower Hamlets Together Executive Board.

The Partners produce a Quarterly Finance Report which is presented to the THT Executive 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.



Note that TNW stands for Tower Hamlets, Newham and Waltham Forest (the Barts Health footprint)

Overall approach to integration

Brief outline of approach to embedding integrated, person centred health, social care and housing services including

- Joint priorities for 2021-22
- Approaches to joint/collaborative commissioning
- Overarching approach to supporting people to remain independent at home, including strengths-based approaches and person-centred care.
- How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2020-21.

For a number of years Tower Hamlets has been on a journey towards integrated, person and community-centred care – from the original integrated care model primarily for over 65s with complex needs leading to attaining Vanguard status; to the decision in 2017 to establish the Alliance Partnership to deliver the Community Health Services (CHS) with greater focus on population health and establishing a lifecourse focus in 2018; and in 2019 to transition from the development stage of the community integration work to delivery at scale focussing on four care models.

All partners have shared how hard this journey has felt, even at the best of times – and in common with systems across England and around the world, never have the challenges for us individually and collectively been greater than in the recent months of the Covid-19 outbreak.

In February 2020 we committed to the next phase of our health and care integration as part of the WEL and NEL ICS developments – with shared priority areas of implementing our Primary Prevention, Complex Care, Urgent and Long Term Conditions Models;

transforming our Community Mental Health Services; mobilising our Community Assets; working with our Voluntary and Community Sector partners; and further strengthening our four localities and Primary Care Networks – no-one could have foreseen what the next phase would fully bring.

Since the beginning of March 2020, when the history of our partnership working currently as Tower Hamlets Together (THT) became the epicentre of our work with local partners on supporting each other in responding to Covid-19 – bringing together, as it has, on a weekly basis senior representatives of the acute, community, mental health, social services, primary care networks, voluntary and community sector, CCG and broader council – we have solidified the foundations of a system that we believe will enable us to drive improvements in health and wellbeing, reductions in inequalities, and the sustainable use of our collective resources to meet current and future demand across these areas and our health and wellbeing priorities as a whole.

Following on from the unprecedented challenges of re-purposing our health and care systems to meet the challenges of Covid-19, the process of continuing to manage safety and risk; capacity and flow; support for both existing and new long-term conditions and care needs; and of accelerating the journey of integration across the partnership; is an even bigger ask of our workforce, our relationships, and all of those who are involved in delivering care in our communities.

As we recognised in February 2020, our four locality Health and Wellbeing Committees covering the eight Primary Care Networks will be critical to the success of this, with primary care at the heart of our borough recovery plan. But it is only by working together as a single team, in support of all of the people of Tower Hamlets, that we will succeed in delivering safe, effective care which harnesses the diverse assets of our organisations and our partnership – enabling all of those we care for to 'Start Well', 'Live Well, Work and Age Well'.

Tower Hamlets Together – System Plan

Overall our partnerships ambition can be explained through the following mission, vision, objectives and priorities for action.

Mission
Transform people's health and lives in Tower Hamlets, reducing inequalities and reorganising services to match people's needs

Vision

- 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 service

Objectives

- 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

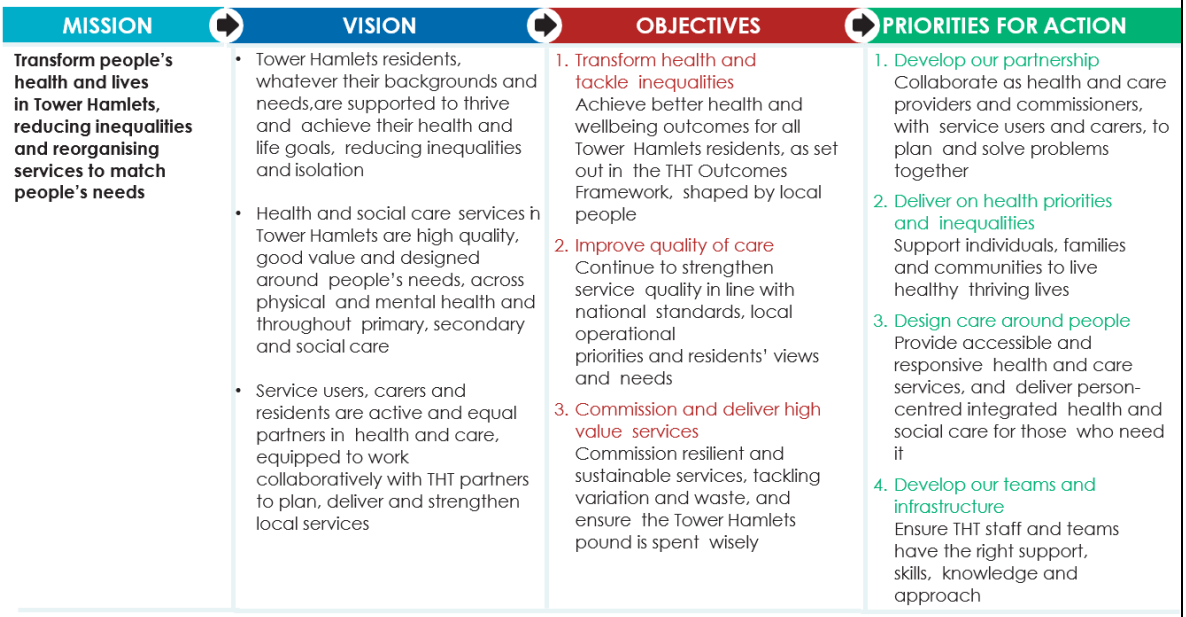
- Improve quality of care Continue to strengthen service quality in line with national standards, local operational priorities and residents' views and needs

- Commission and deliver high value services Commission resilient and sustainable services, tackling variation and waste, and ensure the Tower Hamlets pound is spent wisely

Priorities for Action

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 system plan on a page



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

Key developments since March 2020

At the start of the Covid-19 outbreak in London, a decision was taken to co-ordinate the Tower Hamlets response through the Pandemic Committee, chaired by Tower Hamlets Council's Director of Public Health, with senior representation from all local partners. Reporting to the Pandemic Committee group were various silver operational groups, including a Health & Social Care Operational Group chaired by the Joint Director of Integrated Commissioning. There has been significant learning, with much more to do, but examples of the achievements across the partnership since the beginning of March 2020 include:

- **Collaboration with providers** –we refocused to ensure daily contact with our main providers – care homes, home care agencies and hostels had priority focus but also including our day centres and our mental health and learning disability providers, as well as our carers centre and local link services. We provided high levels of support in terms of public health advice, PPE mutual aid arrangements and testing.
- **Integrated Discharge Hub** - a multi-disciplinary team established from ELFT's Admissions Avoidance Discharge Service, the Councils Hospital Social Work Team, ELFT Continuing Healthcare Team and LBTH Reablement and Brokerage. The team are responsible for all hospital discharges from the Royal London Hospital, including non-Tower Hamlets patients. Between March – May over 300 patients were referred, with just over 50% of these Tower Hamlets residents. 90% of patients were successfully discharged home. 10% were discharged to nursing and residential homes, supported accommodation, and newly commissioned step-

down facilities. 25% of patients were discharged the same day, and over 50% within 1 day.

- **Adapting services** – primary care provided staff and patient testing directly in Care homes and GP's provided support for homeless people in the special hostels. GP practices switched swiftly to remote consultation including health checks where possible to limit unnecessary contact/journeys, using video/telephone consultation
- Direct Payments – we put in place a 10% contingency for all residents who receive direct payment and provided PPE for those who needed it. We provided advice and support across the board and worked closely with our local disabled people's organisation, the local provider of direct payment support and others to produce local advice and guidance. We focused on strong communications to promote this.
- Community mobilisation –supported the co-ordination of the community efforts around wellbeing, befriending etc.
- **Home monitoring service** – provided by General Practice for COVID symptomatic patients to avoid face to face care, reduce conveyances and enable safe discharge home
- **Shielding -** worked closely across the partnership to ensure the most vulnerable in our borough were identified, contacted, and supported. A contact operation was established with GPs, Council and health partners calling vulnerable residents.
- **Travel Assistance** – whilst the number of children requiring home to school travel assistance reduced, the team continued to support those families of key workers and vulnerable children to safely attend school where possible. As well as this the team used their skills and experience to offer a service to Royal London Hospital to increase transport capacity should there be a need for mass discharge of none Covid patients.
- **Homelessness & rough sleeping** - close working with housing meant an effective approach in terms of homelessness, rough sleepers and our large hostel population. This has included additional accommodation for homeless people and linking GPs and health service support around those sites; and ensuring our settings are prepared for managing outbreaks, supporting social distancing and self isolation etc.
- **PPE** –rapidly created a team, a process and a supply chain to ensure we had sufficient PPE for staff and for our commissioned services, and with clear guidance in place about when and how to use this – despite the difficulties nationally with PPE.
- **Placements** –increased the system wide collaboration between the Children's Integrated Commissioning Team, the Children's Placement Team, SEND and Children with Disabilities, utilising existing structures and arrangements, namely the local area risk register meetings to care plan and source placements, using our collective capacity and resources to increase capacity. This approach kept some of the children with the most complex and challenging behaviours safe and at a reduced risk of requiring tier 4 MH services.
- **Financial support and market sustainability**-moved swiftly to change payment and contractual arrangements for our home care providers and commissioned care homes

Supporting Discharge (national condition four)

What is the approach in your area to improving outcomes for people being discharged from hospital?

How is BCF funded activity supporting safe, timely and effective discharge?

The Integrated Discharge Hub (IDH) was established on 30th March 2020, following the publication of the national service requirements on hospital discharge on 19 March 2020

- The requirements set out that all hospitals must have a 8-8/7 day a week discharge service, which is able to facilitate the timely discharge of all medically optimised patients

- In Tower Hamlets the service pulled together in just over a week as a multi-disciplinary team established from ELFT's Admissions Avoidance Discharge Service, the London Borough of Tower Hamlets Hospital Social Work Team, ELFT Continuing Healthcare Team, as well as LBTH Reablement and Brokerage.

Overall the hub is responsible for coordinating care for all residents on pathways 1, 2 and 3 who are residents of our borough. This includes arranging packages of care, ordering of equipment, arranging reablement or community rehabilitation and supporting those residents who can't return back home by either supporting discharge to a step-down bed or into long term placement. In all cases residents are supported to return home and we work on a home first principle. In Tower Hamlets, we have the Royal London Hospital which includes not only Tower Hamlets patients but many out of borough patients. Therefore the team work closely with other discharge teams across London to ensure patients return home safely.

We take a continuous approach to improvement and have a borough-based Discharge Transformation Group, which reports into the Urgent Care Working Group which in turn reports into the A&E Delivery Board and the Partnership Executive. Our Discharge Transformation Group has a wide membership from partners including Community Health Services, CCG, Local Authority and the Hospital.

In addition, we also meet monthly with other Integrated Discharge Hubs, alongside the Bart's Health site, with the aim to collaborate across borough boundaries, share good practice and improve performance for challenging pathways. The borough-based Discharge Group and the system discharge group have aligned action plans for service improvement, which are reviewed monthly and have identified transformation support.

The borough-based groups and the wider group uses local data to identify trends and areas for service improvement and have a standard data pack supporting discussions. Areas reviewed monthly includes:

- Length of Stay (+7, +14 and +21days)
- Discharge verse referrals to IDH
- Numbers discharged within 24hrs (from referral to IDH)
- Numbers discharged within 48hrs (from referral to IDH)
- Reasons for delay.

Where a trend is identified for improvement we would then undertake a local audit and review of that aspect of the pathway to identify areas of challenge for improvement. A particular focus is how we reduce length of stay for our residents and enable same day or next day discharges through our discharge to assess model.

As per national guidance we use the Hospital Discharge Scheme to fund the first four weeks of care post discharge to enable long term care assessments to take place in the community. We also use the funding to enable our system to have effective step-down bed provision for nursing, residential and intermediate care.

Outcomes

- Over 300 patients have been referred through the service since the service commenced, with just over 50% of these Tower Hamlets residents

- 90% of patients have been successfully discharged home with care and support. The remaining 10% have been discharged to nursing and residential homes, supported accommodation, and newly commissioned step-down facilities.

- 25% of patients have been discharged the same day, and over 50% within 1 day, a big improvement on historical discharge times

- New relationships have been established across historical boundaries (ELFT, LBTH, Barts) and regular team meetings and learning sessions ensure discharge processes are continuing to improve

Supporting Admissions Avoidance

Within Tower Hamlets we have a range of services and approach to reduce attendance and admissions for our residents at acute hospitals. 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. Service went live over the summer.

-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, Domilicary 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 contact 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, which is a joint initiative between Bart's Health and London Ambulance Service, which 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.

-Across the Barts Health sites, the Same Day Emergency Care Gold Standard "in hospital pathways", which are available for Primary Care to refer into as well as manage patients who walk into the acute sites, have been launched which are:

•Abscess
•AKI
•Atrial Fibrillation
•Cellulitis
•DVT
•Fall

•Hyperemesis
•Low Risk Chest Pain
•Pulmonary Embolism
•Pyelonephritis

The next phase of the programme includes implementing the Same Day Emergency Care Symptom Pathways which will be available for 111 and 999 to refer into and finalised for the Barts sites over the coming weeks. The symptom based pathways are:

•Abscess
•Bleeding in early pregnancy
•Dysuria, loin pain and fever
•Falls
•Low risk chest pain
•Palpitations
•Unilateral swollen lower limb
•Vomiting in early pregnancy

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

Reablement

To help 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.

The service also has the following organisational objectives:
- To reduce admissions and readmissions
- Financial benefits, in the form of reduced support packages required post-reablement
A sustainable reduction in medium-term support packages, 6-12 months post-reablement.

Joint Triage Test and Learn (Reablement)

Since 1st April 2021 we have been piloting a Joint Triage Test and Learn pilot.

Services in scope

- Community rehabilitation Team AADS & Rapid Response
- Social Care Reablement service including the sensory team

Project aim: To introduce a Single point of access and a single referral form

- The service to have a Triage Team –their function is to review referrals and allocate to the most appropriate pathway
- To have a data entry principle of read all, write in one
- Test and learn for Referral, Triage and allocations

Progress to date including service user story
During the Integrated Triage recently, a Social Worker joined the conversation with AADS (Admission Avoidance and Discharge Service) and Reablement to discuss a potential referral to Reablement, and it was established the patient was currently being seen by an EPCT (Extended Primary Care Team) Physio. The discussion helped the Social Worker to understand the role of EPCT better and what the different services offer and to avoid duplication.

This also helped the Social Worker understand what is involved in terms of rehabilitation and to distinguish between a focus on activities of daily living and on regaining independence in the wider sense, for example working on balance and gait. The EPCT Physio was invited to a further meeting, which resulted in a period of Reablement Officer support, which benefited this resident with regaining some confidence.

Overall, this meant that this resident received care that was planned between providers and professionals rather than being contacted by each provider separately with a similar offer.

Effective Communications
Integrated Triage has also enabled staff to learn about referrals being received by each other's services, and to know whether someone has had recent input from social care or community health services, and whether this was beneficial

Understanding of Services
Staff from the respective services have started to get to know each other and build working relationships

Community Equipment

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.

7-Day Community Equipment Provision Team

This scheme will permit community equipment services to be provided to people able to leave hospital for longer hours on a 7 days a week basis. Community Equipment Service personnel will be available to receive requisitions for simple aids to living and complex pieces of equipment, such as hoists, special beds, pressure care, hand rails and so on via dedicated secure electronic faxes, telephone calls and secure emailing.

The service will:

- avoid unnecessary admissions and trips to A&E, by providing emergency deliveries, repair and replacement of hoisting, special beds and mattresses and other essential toileting and mobility equipment over extended hours.
- support hospital teams to carry out safer discharges by providing an out of hours service
- minimise and prevent readmissions and Delayed Transfer of Care (DTOC).
- facilitate safe, integrated and seamless transfer of patients between hospital, community health and social care services.

TH Connect (Information, Advice and Guidance service)
Tower Hamlets Connects 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
This 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.

Disabled Facilities Grant (DFG) and wider services

What is your approach to bringing together health, care and housing services together to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people?

The Disabled Facilities Grant (DFG) plays an important part in Tower Hamlets' approach to integrated care however there is recognition that we could be doing more.

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.

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.

Care technology next steps

We will carry out a care technology-diagnostic to see where we do well with technology-enabled care and where we could do more. The diagnostic will help us decide if and how much we need to invest in this area and identify longer-term potential financial benefits.

As a result of the diagnostic we expect to improve our current offer and introduce new technology including but not limited to -

- Innovative telecare and tech solutions (e.g. smart home sensors, alarms)
- Artificial Intelligence (AI)
- Predictive analytics
- Tools that help us share data between health and social care (e.g. Care Plans, understanding who is involved in a person's care and support)
- Digital directory of services
- Prepaid cards and virtual wallets for people who organise their own care with a direct payment.
- We will support people who are new to technology to start using it.
- Digital directory of services

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 we intend to establish a Technology Enabled Care Board.

Equality and health inequalities.

Briefly outline the priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services. This should include

- Changes from previous BCF plan.
- How these inequalities are being addressed through the BCF plan and services funded through this.
- Inequality of outcomes related to the BCF national metrics.

Managing Population Health & Tackling Inequalities

Tower Hamlets has a population of over 319,000 people and is referred to as densely populated. There were 344 confirmed deaths of residents since 1st October 2020 from Covid-19 as of 4th November 2021.

Tower Hamlets has an ethnically diverse population, with White 45%, Asian/Asian British 41% and 7% from Black/African/Caribbean/ decent. The population is relatively young compared with the rest of the country but people typically start to develop poorer health around ten years earlier. 5.9% of the population are over 65 and already live with a degree of frailty. According to the most recent census data Tower Hamlets population includes 19,356 carers, often looking after older people with Long Term Health conditions who are at higher risk from Covid-19, and needing greater support to recover. During the Covid-19 pandemic there were over 9,000 shielded people living in the borough.

The Covid-19 pandemic has shone a light on inequalities (socio-economic, young people, older people, BAME, women, people with disabilities) and risk is that these will be exacerbated going forward. The Public Health England disparities report (summarised below) highlights the overlapping and interconnected narratives in Tower Hamlets impacting on the pattern of Covid-19 in the borough.

- The public health response to the pandemic adapted to consider digital exclusion. A Covid-19 helpline was set-up to resolve issues and book vaccines, with call handlers who speak community languages. Posters and signs in community languages were placed around the borough in relation to Covid-19. Somali and Bangladeshi community organisations delivered outreach and support and codesigned tailored prevention and protection messages to the life course groups within these communities.

- In Barts Health NHS Trust, work has been undertaken with renal medicine (the largest user of remote access), which included reviewing access to bilingual health advocacy, advocacy staff calling non-English patients prior to video consultations to assess their needs and any concerns. As a result, setting up setting up 3-way consultations when necessary. - Covid-19 vaccine clinics for people who are undocumented or with no recourse to public funds have been organised, explicitly promoted to people who may be worried

- The Tower Hamlets Together (THT) Board has completed an anti-racism leadership development programme provided by the equality charity Brap. This has included a focus on systemic racism and systemic change. - THT partners have agreed a joint Workforce and Occupational Development (OD) Strategy in March 2021 with commitments to tackle Black, Asian, and Minority Ethnic inequality amongst staff. - Barts Health NHS Trust has committed to 3% year on year growth of Black, Asian, and Minority Ethnic staff in senior positions. This has been achieved over the last year, maintaining this growth would allow the trust to achieve representative leadership by 2028. - The Health and Wellbeing Board and Tower Hamlets Together partnership have gathered community insights to support better understanding of causes of health inequalities amongst Black, Asian, and Minority Ethnic communities.

- The Board has used the insights to agree a Health & Wellbeing Strategy for 2021-2025 with key principle of addressing inequalities and being antiracist in everything the partnership does. - The council has developed anti-racism practice in adult social care including establishing a board which aims to ensure the social care workforce has substantial knowledge of anti-racism in practice and that social care

has a diverse workforce reflective of the community, who are supported, included and have development opportunities.

The partnership has also committed to a number of key deliverables for 2022 in response to the Tower Hamlets Black, Asian, and Minority Ethnic Inequalities Commission which are set out below

- By March 2022 the partnership will gather and analyse data across the system, manage an audit of key public information in community languages and organise translations, coordinate 'you said, we did' work related to coproduction. It will also arrange a 'lessons learned' exercise in relation to Covid-19 approaches by April 2022, targeted at Black, Asian and Minority Ethnic communities that we may want to replicate in future for other health issues. The partnership has also developed a digital inclusion action plan with the aim of better coordinating digital inclusion activities across the borough to ensure residents have the tools and skills they need to participate in, contribute to, and benefit from a digital world.

- The Health & Wellbeing Board has commenced work on developing a robust evidence base to form a better understanding of key health inequalities and the impact it has on our Black, Asian and Minority Ethnic communities. As part of this research there will be significant emphasis on engagement with Black, Asian and Minority Ethnic communities to identify key issues and solutions. This will be supported by Healthwatch Tower Hamlets who will gather their own intelligence on the experience and issues for patients at the Royal London Hospital. Both workstreams are expected to be completed by December 2021 and will provide evidenced based solutions to address health inequalities and inform future activities of the partnership.

- The Partnership will better recognise and meet the cultural needs of patients through the development of anti-racist practice. The success of the antiracism leadership programme delivered by BRAP to the Tower Hamlets Together Executive Board, the partnership will invest in an anti-racism leadership programme beyond 2021. This will help to drive deep cultural change and tackle the pervasive racial microaggressions, bias and stereotypes that exist in society and service provision.

- The partnership will continue to support the delivery of the Disparities project which aims to work with Black Asian and Minority Ethnic residents to amplify and sustain the impact and influence achieved during the response to the pandemic. The project will provide a locally driven, co-production support programme targeting Black, Asian and Minority Ethnic communities with an emphasis on prioritising mental health. This will lead to improvement in access to services and better satisfaction amongst local people.

- Through the insights on local inequality the partnership will work as one voice to influence and lobby for further resources for Tower Hamlets. The partnership will support local campaigns to improve access to health services by lobbying against the hostile environment polices and reduce the checking of immigration status of service users and patients.

We have also identified a number of areas for future investment (through the Public Health Reserve - £350k and Contain Outbreak Management Fund - £200k) to achieve the following outcomes on health:

- Improved access to health and care services for Black, Asian and Minority Ethnic residents.
- Leaders in health and social care champion and actively address heath inequalities faced by Black, Asian and Minority Ethnic residents.
- Better representation of Black, Asian and Minority Ethnic staff at all levels in health services.
- Black, Asian and Minority Ethnic residents are meaningfully involved and engaged in design and delivery of health services.
- Health and wellbeing key messages reach Black, Asian and Minority Ethnic residents and deliver intended outcomes

Case Study, Somali Mental Health (Task and Finish Group)

Purpose
The Somali Mental Health Task and Finish Group was set up to conduct an in-depth review on the impact of mental health and neurological conditions within the Somali community from February 2021 to October 2021.

Why a 'Task and Finish' group focusing on Mental Health for this community?
- Somali Working Group expressed growing concerns (exacerbated by Covid-19) over mental health and its impact on the Somali community
- To build stronger networks between the community and service providers.

What evidence was gathered?
Presentations from and discussions with key internal and external stakeholders including CCG, Adults Social Care Commissioning, Phoenix School, Youth Services, Age UK, THCVS and ELFT.

Engaged with community members of the Mental Health Task and Finish Group for lived experience in this area (Women's Inclusive Team, Somali Citizen's Club, Ashaadibi Centre, Numbi Arts and other local residents who know people in the community affected by mental health or neurological conditions).

Four sessions were held with community members and partners on different mental health themes

Specific issues highlighted by the community

- **Mental health in Somali men** – potentially at higher risk of mental health difficulties due to challenges they face (i.e. racial trauma, exclusion from school, and social deprivation).
    - Heavy representation in the most restrictive parts of mental health services
    - Inaccessibility of mental health services
    - Lack of Somali health workers
    - Timings of assessment and treatment – often in serious crisis before they arrive at services
    - Inadequate data collection
- **Autistic child and family support** – need for effective partnership work across education, health and social care.
    - Need for regular review and evaluation to ensure the quality, type and amount of provision available to meet local need with long term outcomes for individual children.
    - Perceived high proportion of Somali young people with SEND
    - Need for more space and/or opportunities for young people to discuss issues

    - Access to specialist schools for Somali young people
- **Mental health and neurological conditions in older people**:
    - Need for greater sign-posting to support services available for people dealing with dementia
    - Support/care services available for family members with Alzheimer's - dementia befriending.
    - Need for more access to GPs for older people with options for interpreters, varied mobility access and sensory/cognitive impairment
    - Isolation and lack of social contact/stimulation
- **Mental health in young people**:
    - Need for more data and access to youth provision to deal with isolation
    - Need for greater awareness of mental health support services available to them
    - Likelihood of experiencing racism, resulting in anxiety and other mental health issues
    - Increased need for talking therapies for young people

Based on these findings a number of recommendations have been pulled together and these were presented to the THT Executive Board asking them to -

- Take the lead on ensuring the delivery of the recommendations and embedding actions to enable that within existing/emerging THT workstreams
- Commit to how Somali Working Group members will be engaged in shaping mental health services
- Feed back to the Somali Working Group on delivery against recommendations on at least an annual basis