Department of Health & Social Care | Department for Levelling Up, Housing & Communities | Local Government Association | NHS England

BCF narrative plan template
Tower Hamlets Health and Wellbeing Board

1. Cover

Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils) - how have you gone about involving these stakeholders?

The 2022-23 BCF plan has been agreed by:

- Denise Radley – Director of Health, Adults and Community & Deputy Chief Executive for the London Borough of Tower Hamlets
- Councillor Gulam Choudhury who is the lead member for health 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 was considered by the Tower Hamlets Health and Wellbeing Board for approval on the 20th September 2022. 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. It's worth noting that the Tower Hamlets BCF includes elements of Adult Social Care and the Community Health Services contract.

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 lived 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 2022-23 BCF plan is an evolution of the 2021-22 arrangements. 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 has been the continued delivery of this, whilst developing our new governance arrangements through the NEL ICB.

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 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 challenging 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.

The move towards Fairer Cost of Care offers a huge opportunity to address long term challenges in the care sector. This needs to be underpinned by the right level of financial investment. Without this commitment, the plan poses risks to the local systems financial sustainability.

Delivery is also restricted by the continuous late announcements of the BCF and tight deadlines provided to develop the plan which limited the scale of engagement on the specifics of the 2022-23 BCF Plan.

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 was delivered on 1st September which was also the first meeting of 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

2. Executive Summary

Priorities for 2022-23

Our partnership priorities and work programme for 2022-23 is below. The programme is overseen by our 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 individual transformation projects are themed under the following five 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
d) Mental Health and Learning Disabilities
e) 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
- 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. Mainly Healthy Adults – Living Well workstream

- To improve equal and informed access to contraception
- Embedding a trauma informed approach to care
- Integrating pharmacies into the local system
- Primary Care Network coproduction with local communities to address health inequalities
- Improving access to health services for disabled residents
- Improving access to oral health services

3. 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 adult services

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 priority areas as their core focus. These were the areas felt as key to supporting the recovery from the Covid-19 pandemic and overlap with the BCF schemes.

Key Local Delivery Board focus areas

- Implementing the MDT and Care Coordination model to improve MDT identification and care planning for people who are vulnerable which includes providing them with integrated care plans, care coordination and a 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 and ideally within 24 hours
- 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.
- Enhancing our end of life care offer by working 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 Board and includes the BCF schemes such as reablement, discharge and community health and care teams.

Key changes in the BCF Plan for 2022-23

There are no new items that have been added to the 2022-23 BCF plan from 2021-22 as it has been rolled over. The only changes are:

- A further £338,676 has been added for additional assistive technology spend

It would be ideal if planning for the future years BCF e.g. 2023-24 onwards could be started prior to the next financial year, so that we can tie this in with the operating frameworks for the ICB 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.

The new capacity and demand template has also caused some difficulty in its completion due to the vague guidance and the data not being readily captured. This sits alongside the winter planning process which is done separately. It would make sense if this requirement is aligned to the winter planning process if required ongoing.

3. Governance

Governance for the BCF plan and its implementation

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

- 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 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
- East London Foundation Trust
- Barts Health
- Tower Hamlets Council for Voluntary Services
- GP Care Group

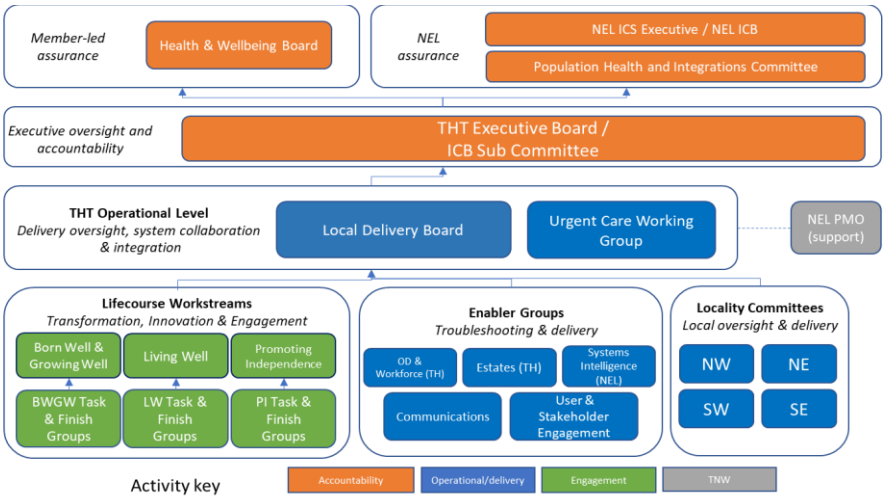
Members have delegated responsibility from the partner employing them to make decisions which enable the THT Board to carry out its objects, roles, duties and functions.

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.



4. 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 2022-23 and approaches to joint/collaborative commissioning.

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 last two years since 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 seven 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 – Our System Plan on a Page

Overall our partnerships ambition can be explained through the following 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 h 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

How are BCF funded services supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2022-23.

Rapid response and Reablement

Since April 2022, the integrated out of hours support to Rapid Response (RR) therapists via the Reablement Service (the out of hours service run by the Reablement Service 17:00 – 22:00 weekdays and 07:00 – 22:00 at weekends) has been available to the AADS Rapid Response (RR) therapists, who operate an 8 – 20:00 service seven days a week to prevent hospital admission. AADS is the Avoidable Admissions and Discharge Service operated by ELFT. The aim was to prevent service users being seen after 17:00 and at weekends by RR therapists being admitted to hospital due to lack of social care support. Prior to this, if a RR therapist visited a person at home out of hours and urgent social care support was required to prevent hospital admission and they did not have rehab goals, they had to contact the Emergency Duty Team (EDT) who were often not able to assist as they also had to conduct mental health assessments and were not able to commission new care, only increase existing. In some cases, this meant the person had to be admitted to hospital. Now, if a RR therapist refers a person for urgent support after 16:30 on a weekday or between 8 and 20:00 at weekends, the out of hours home care supervisors will set up urgent support via Reablement officers, or commissioned care if there is no RR capacity. The case will then be reviewed the next day in integrated triage and the appropriate pathway for the person decided on.

Progress to date including service user story:
A RR therapist saw a service user at home on a Friday at 18:00. Service user had a package of care in place, but she had a urine infection (UTI), so her mobility had significantly deteriorated and she required additional support in the evenings. The therapist arranged for intravenous antibiotics at home, delivered by RR nursing team and referred to Reablement out of hour's service, who were able to arrange reablement officers (ROs) to deliver the additional support from the next day. This integrated approach prevented the person being admitted to hospital and allowed them to be treated at home for their UTI, while ensuring that their social care needs for increased support during this time were also met. On the Monday, the next working day, the person was reviewed in integrated triage and passed onto her allocated Social Worker in another team, who set up urgent short term support with a home care agency (freeing up RO capacity to work with service users with rehab goals).

The Advanced Care Planning Team

East London Foundation Trust's (ELFT) advance care planning team provide specialist care to end of life patients. The team includes District Nurses, LD Nurse and an Occupational Therapist who all aim to avoid unnecessary hospital admissions in the final year of life. Following a referral, the team visits, understands and supports the individual's wishes such as being able to die at home with their family around them. They work using a multi-disciplinary approach involving different health and care professionals based on individual needs, and also offering tailored referrals and support for families. The team recently presented their work at the THT Board meeting and members were full of praise for this service which has very rapidly been able to support people to die well in a place of choice.

Progress to date including service user story:
The ACP team recently supported a 60 year old woman with mild learning disabilities, type 2 diabetes, COPD, Ischaemic Heart Disease with safeguarding concerns and was admitted to hospital with urinary sepsis. The team organised a joint visit with her GP to discuss the do not resuscitate process (DNACPR) and to complete the Coordinate My Care (CMC) care plan. Several MDT case conferences were held working closely with the Adult Social Care team and they completed the hospital LD passport, liaised with the LD liaison nurse and ensured hospital staff were aware of reasonable adjustments. The patient's family and carers were extremely grateful and said they felt listened to.

Integrated Social Workers in Reablement

Since April 2022, two social workers have been embedded into the Reablement team to help support timely intervention for safe-guarding concerns, Care Act assessments and longer term support planning. The aims were to have

- Social Workers provide support across Reablement and AADS to lead on safe-guarding concerns and respond to concerns within one working day
- Between 9 and 16:30 weekdays, Social Workers provide support to Rapid Response' (RR) therapists in AADS team who visit people at home within two hours to prevent hospital admission and set up urgent support if required.
- To reduce the length of time for Care Act assessment for users discharged from AADS
- To reduce the length of time for support planning for users discharged from Reablement and AADS

Progress to date including service user story:
A service user was referred to Reablement to review bath transfers. During a conversation with the referrer, it transpired that the user/patient had fallen the previous day and required urgent therapy review. Joint working between Reablement, AADS/rapid response facilitated a co-ordinated effort to review the user/patient's ability. The AADS therapist completed an urgent home visit the same day, provided a walking aid and education on pain medication management to optimise function. Additionally, it was identified that the user/patient required short term formal support whilst they commenced managing their pain. The Reablement Social Workers commissioned short term support to commence the next day, based upon the AADS/rapid response therapist recommendation. The Social Worker will follow up with the user/patient in the next week to assess their support needs and once their pain is better managed, refer the user/patient back to Reablement therapists to increase their functional ability and return to independence.

5. Implementing the BCF Policy Objectives (national condition four)

National condition four requires areas to agree an overarching approach to meeting the BCF policy objectives to enable people to stay well, safe and independent at home for longer and provide the right care in the right place at the right time.

As noted in section 4 Tower Hamlets Together have identified four priorities for action and our third priority for action, to design care around people, is especially important to people who have complex health and/or care needs as they are much more likely to be in touch with multiple services. Tower Hamlets Together partners take a 'population segmentation' approach which identifies those who are most at need of coordinated support. The population is primarily divided into three segments; whole population, people with complex needs and healthy people. The aims for each population grouping, as defined by the partnership, are listed below. These aims are addressed through three life-course workstreams - 'Born Well, Growing Well' (children 0-18) 'Living Well' (mainly healthy adults) and 'Promoting Independence' (complex and older adults).

Whole population (overseen by Born Well, Growing Well and Living Well workstreams)

- Support individuals and communities to self-care
- Simplify the health and care system, making it easier to understand and access
- Deliver a streamlined urgent care pathway
- Tackle the wider determinants of health and reduce health inequalities
- Ensure service users and carers are equal and active partners

People with complex needs (overseen by the Promoting Independence workstreams)

- Provide whole person, mental physical health and social care
- Support people to meet life, as well as health goals
- Support people to remain as close to home as possible, with smooth transitions between care settings when these occur

Healthy people (overseen by Born Well & Growing Well and Living Well workstreams)

- Provide accessible and responsive assessment and diagnostic services and support for self-management
- Promote primary and secondary prevention and access to universal services

In order to deliver against these key aims the Tower Hamlets Together model of care is also organised around four geographic localities in the borough: north-west, north-east, south-east, and south-west. Each locality is comprised of one/two networks of 4-5 GP practices which cover a population of around 60-70k. Many of our services are now organised by locality, such as the below, which are also in our BCF plan:

- Extended primary care teams of district nurses and therapists
- Community mental health teams
- Longer-term social care teams
- Home care agencies (two commissioned per locality)
- Community-based support services e.g. Linkage Plus

'Locality Health and Wellbeing Committees' act as local collaborative leadership forums and are continuing to develop a systemic view of local population assets and needs, and develop a broader network of local organisations and individuals to drive improvements in outcomes (e.g. VCS, care homes, home care, faith groups, schools, etc.)

There is significant work underway to support population health improvement on a locality basis, including locality public health leads, locality Joint Strategic Needs Assessments, and the development of Health Ambassadors (previously the Covid champions) programme which is a Health and Wellbeing Board priority (along with developing an integrated system).

In 2018, the Tower Hamlets CCG and council appointed a Joint Director of Integrated Commissioning under whom the commissioning teams were brought together across health and social care. The integrated commissioning team includes joint leads for mental health, children's and older people. Key

developments have included align/integrating commissioning and service delivery and further work is yet to be done.

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.

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.

BCF funded service contributing to national condition 4

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:

- 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

Avoidable Admissions

A programme plan for all the Barts Health hospital sites including the Royal London Hospital in Tower Hamlets has been developed and agreed with the Trust to ensure all three acute sites (Royal London Hospital, Newham Hospital and Whipps Cross Hospital) are aligned to the Same Day Emergency Care (SDEC) priorities. This is to ensure equity of access of patients, ensure the data is being accurately captured and reported, to maximise the use of existing pathways as well as further develop them. We have taken the approach across the Barts Health group as residents of Tower hamlets access all three acute sites and it was important that residents receive the same care and support irrespective of which acute site they access. Task and Finish/Steering Groups have been implemented with the relevant stakeholders to ensure the work is being progressed.

Current progress to date:-

- a Key Lines of Enquiry (KLOE) has been completed to look at the variation and current pathways across the 3 sites
- Covid swabbing has been aligned
- London Ambulance Service direct conveyances have been agreed (for low risk chest pain, palpitations, unilateral swollen limb)
- LAS/111 Early Bleeding in Pregnancy pathway has been agreed to go via the Remote Emergency Access Coordination Hub (REACH) into the Early Pregnancy Unit
- 3 SDEC engagement workshops have been held with local GPs/Primary Care to ask how they currently access SDEC. This will support with further development /modelling around access
- Winter principles gap analysis is being completed with sign off with each of the 3 sites, to look at ensuring the SDEC baseline is being met and any additional work/support is required for this coming winter pressures
- The agreed GOLD Standard pathways are for - Abscess, Acute Kidney Infection, Atrial Fibrillation, Deep Vein Thrombosis, Hyperemesis, Low Risk Chest Pain, Cellulitis, Pulmonary Embolism, Pyelonephritis
- The agreed 111 symptom pathways via REACH are for: Abscess, Bleeding in Early Pregnancy, Vomiting in Early Pregnancy Dysuria, Loin Pain & Fever, Low Risk Chest Pain, Palpitations, TIA, Unilateral Swollen Limb
- Work is currently underway to review the falls/frailty pathway
- An SDEC Data specification has been completed with support from NEL Business Intelligence. This will help to develop the new SDEC Dashboard for Barts Health and ensure alignment of SDEC reporting requirements for NHS NEL
- Discharge to usual place of residence & Hospital Discharge

The approach taken in Tower Hamlets has been to develop an integrated discharge model with a single discharge team and pathway across Community, Social Care and Acute colleagues with the development of the Integrated Discharge Hub (IDH). The Hub works as a single team and will support any Tower Hamlets resident irrespective of which hospital they are in, and works seven days a week 8am to 8pm.

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 to support residents around their long-term care needs. The interim beds are available for a maximum of four weeks. To ensure that we do not delay residents in hospital and have a negative impact on their rehabilitation we have set ourselves performance standards, which are closely monitored by the place-based discharge leads. The standards include:

- Number of people on the medically optimised list
- Percentage of people discharged within 24hrs and 48hrs from being medically optimised
- Discharges onto pathways 1, 2 and 3.
- Readmission rates

As all discharges on pathways 1, 2 and 3 are managed as a discharge to access pathway the minimum amount of assessments take place within the hospital and residents are followed up in the community within 48hours where over the next four weeks we will work with residents and their families on long term care arrangements. Through the BCF we have made funding available to fund the first weeks of care whilst the respective eligibility assessments and care planning can take place.

We have undertaken a self-assessment against the High Impact Change Model and the new Hospital Discharge Guidance which has informed part of our 2022/23 Action Plan. The areas covered in our plan include:

- Developing a Discharge to Assess model for people who are homeless
- System approach to MADE events and undertaking lessons learnt
- Developing specialist discharge pathways for older people with behaviour that challenges, tracheostomy and people with neurological conditions.
- Development of a new choice policy
- Improvement in patient and family information and communication.

Urgent Community Response (UCR)

North East London ICB has been running an overarching programme of work to align place based urgent community response services to the national specification for 2-hour urgent community response to reduce variation in outcomes across NEL ICS/ICB. The standard states that all systems in England must deliver crisis response care to people within their homes or usual place of residence with >90% performance in two-hour response, we are meeting this standard across all boroughs. Within Tower Hamlets we have invested significantly from the Ageing Well SDF into the Tower Hamlets Rapid Response service to ensure we are able to meet the national model and respond to the increase in 2-hour response and deliver a falls pick up service.

In line with National Requirements Tower Hamlets have a rapid response services that run a minimum of 8am to 8pm, 7 days a week. In 2021 we also expanded our services to include a Falls Pick up pathway resulting in ensuring that all areas of the national model are available to Tower Hamlets residents. The service is available to 111/999 and ambulance crews to access as per the Directory of Services and we have also been working closely with 111 to ensure we maximise the number of referrals to the service from them.

Across Tower Hamlets we also have the Physician Response Unit (PRU) which can support patients who are more medical, but do not need admission, they are also able to refer to 2-hour response services where appropriate as well as provide clinical advice and support to Rapid Response.

Anticipatory Care and Proactive Care Model

Tower Hamlets is piloting a frailty care coordination MDT model, the model is based on early identification of cohorts using validated population health management tools and the delivery of anticipatory care to support residents' health care and care planning before they become unmanageable.

The care coordination model will seek to develop a multidisciplinary approach to identification and proactive care for those who are frail, using set of defined characteristics and measures as part of the model of care, in the first instance. A personalised care and support plan will also be developed and this has been built into the standard operating procedure.

In Tower Hamlets, approximately 35% of total frailty residents have moderate frailty and who shares many characteristics and key features of the common long term conditions. Chronic obstructive pulmonary disease (COPD) is a multisystem disease that resembles the accumulation of multiple impairments seen in aging. Residents with COPD would be frailer than a comparator group free from respiratory disease.

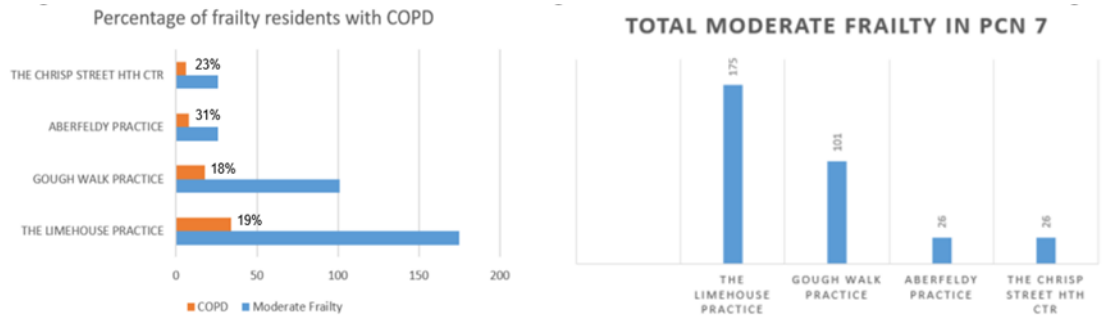
Residents within identified cohorts are proactively approached, working out who is suitable for care coordination and who is likely to benefit from it. Defining the cohort has many benefits, it enables the neighbourhood/place to develop appropriate plans and strategies to support that group of residents. 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 near future.

The pilot will be hosted by one of the Tower Hamlets Primary Care Networks (PCN) where the birthplace of Frailty Care Coordination MDT happens. This PCN is known as PCN 7 and has a

mature integration and good examples of collaborative working across health, social care and voluntary sectors.

PCN 7 is composed of 4 GP practices, The Limehouse, Gough Walk, Chrisp Street and Aberfeldy GP practices. Since the pilot will initially focused on moderate frailty, the data analysis below will provide an understanding of how residents can benefit from care coordination to effectively resolve resident's underlying health and care issues.

Primary Care Network 7 has a total of 328 moderate frailty residents, 20% of which has COPD.



***Source: NEL CSU, end of the month reporting 30/06/2022*

Care coordination helps residents to live well and independently for longer through proactive care and case finding. Typically, this involves population health management, structured proactive care and support from a multidisciplinary team (MDT). Care coordination focuses on groups of residents with similar characteristics (for example people living with multi-morbidity and/or frailty) identified using validated tools (such as the electronic frailty index) supplemented by professional judgement, refined on the basis of their needs and risks (such as falls or social isolation) to create a dynamic list of residents who will be offered proactive care interventions to improve or sustain their health.

Proactive care will operate using 4 key approaches and will be the backbone of care coordination:

- **Cohort identification** – identifying which residents are most at risk to tipping over, cohorts proactively identified on the basis of priorities and needs
- **Proactive care system** – cohorts are proactively identified using risk stratifications, agreed set of criteria and other validated data
- **Digital MDT** – multiagency delivering cutting edge approach to personalised case discussion, management and problem solving
- **Care coordination** – the heart of proactive care and corner stone of MDT where residents and professionals work together to achieve goals

The MDT is a geriatrician led meeting which is made up of experienced and skilled professionals from primary care, Barts Health, ELFT, local Authority and voluntary sectors. The joined-up approach will be guided by population health management data, professional judgement and continuous resident engagement to care and support planning. Another entity of the pilot is the utilisation of practice's Physician Associates to contribute to the delivery of proactive/anticipatory care. The pilot has a 6-month duration and will conclude end on March 2023.

The pilot design output will aim to deliver a comprehensive evaluation, proof of concept and recommendation to support the (1) development of future proactive care coordination model (2) residents engagement to further support frailty cohorts (3) identify further resources i.e. workforce required to deliver the model beyond a neighbourhood level.

6. 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.

Since 2011 the number of people in our borough has increased by 22.1%, from around 254,100 in 2011 to 310,300 as per Census 2021. 19,356 people identified themselves as unpaid carers in the 2011 census. Caring is a fluid role so the number of carers in the borough at any one time can fluctuate. However, with the accelerated population growth in Tower Hamlets, currently there could be as many as 25,200 carers, of which 3,800 would be aged under 24 years old, rising to 27,800 by 2024 of which 4,100 will be under 24 years old. The recent 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 contact, carers reported increase in; carer burn out, isolation and poor mental and physical health.

In 2021/22, the council spent £1.53M on carers' services, and BCF contributes £699K to this from the CCG minimum spend. A range of support is provided to carers. This includes respite provisions and in person and digital preventative services, from whole-population measures aimed at promoting health, to more targeted interventions aimed at improving skills or functioning for one person or a particular group. Carers benefit from support to help them develop the knowledge and skills to care effectively and look after their own health and wellbeing.

The co-produced integrated Tower Hamlets Together Commitment to Carers Action Plan identified 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 carers offer in Tower Hamlets.

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.1700 people in 2021/22. 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 due to their caring having a significant impact on their wellbeing.

Age UK East London 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. Thereby reducing the risk of relationship breakdown and supporting the carer is accessing support services.

Throughout the pandemic, most unpaid carers have had to provide more care as well as new carers have suddenly taken on a caring role. It has left many exhausted, socially isolated, and close to burning out and so the council has supplemented existing services for 2022/23. This includes; 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. In addition, several discovery projects will run in 2022/23 to provide enhanced services to identify carers in underrepresented groups accessing mainstream services which includes; Chinese, Vietnamese, Somali and LGBTQ community as well as young carers transitioning into adult carers.

The 2022-25 Action Plan is being refreshed with carers and health and care practitioners through extensive co-production. All Tower Hamlets Together partners have accepted equal 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 council is also co-producing what carers' service and offer should include from 2024 onwards and will be seeking bids which are aligned to the 2022-25 Commitment to Carers Action Plan and to what carers need to continue in their caring role. 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.

7. Disabled Facilities Grant (DFG) and wider services

What is your approach to bringing together health, social 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.

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.

8. 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.

The Tower Hamlets Together 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 this summer (2022) 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 has 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.

We recently bid for and received inequalities funding from North East London ICB to run a number of projects to address health inequalities in our borough, these include:

- 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. We will use some of the insights we have gathered from population health data into health inequalities to understand how to most effectively target this programme to meet population health need;
- A placement programme at Barts Health Trust to offer underemployed young women from Bengali and Somali backgrounds into 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;
- A project, 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;
- A BAME leadership programme which will improve BAME engagement, representation and community insights across our partnership decision making and delivery systems;
- 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 communications teams;
- 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.

Each year, our partnership sets a number of transformation priorities to deliver, across our population cohorts. This year we are focusing on health inequalities by, for example:

- Improving the transitions process from CYP services into adult services for CYP with a learning disability in our Continuing Care cohort;
- Working closely with Primary Care Networks to connect them with local residents to understand the inequalities that exist in their areas and co-produce solutions, e.g. targeting health checks at certain groups or conditions, particularly those that have worsened due to Covid;
- Establishing a model to better provide service access and pathways for residents with long term conditions;
- Improving equal and informed access to women's sexual health and contraception services;
- Improving access to services for residents with a disability;
- Targeting additional support to children and families at heightened risk during the cost of living crisis.

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 plans to invest in a wider training and OD programme for staff, including HR professionals, across the system to embed ant-racist culture and understanding;
- 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 will be rolled out to all teams across the system;
- The partnership will undertake three pathway re-design projects, in partnership with communities to identify and address systemic racism throughout the health and care journey. These will be focussed on Somali mental health, Chinese and Vietnamese community access to services and a specific priority working with the Bangladeshi community in one of our four localities.