TOWER HAMLETS
TOGETHER
Delivering better health through partnership

OUR VANGUARD STORY...TOWER HAMLETS TOGETHER

ALL TOWER HAMLETS SCENERY PHOTOGRAPHY BY JEROME JOHN

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INNOVATION BUILT ON A STURDY FOUNDATION: THE TOWER HAMLETS TOGETHER VANGUARD

Tower Hamlets has an extensive history of integrated working and partnership, which latterly has seen real joined up thinking around our Health and Wellbeing strategy and a strong focus on public health within the borough. As a GP, it's been a real asset that General Practice culture has been aligned for some time with delivering good health outcomes for the people of Tower Hamlets, and with working at scale, in a transparent way, across our eight borough-wide GP networks. Our willingness to support projects, such as Year of Care for Diabetes, Pioneer Integrated Care Status and the current Integrated Personal Commissioning pilot site, has helped to support an ongoing culture shift among our NHS providers from asking: "What is the matter with you?" to "What matters to you?".

> On changing the culture...
>
> *"What matters to me" rather than "What is the matter with you?"*

Vanguard Aims:

> We believe that if we focus on our community's wellbeing, 'health' will mean more than 'a lack of illness'

> Our model of care will encourage the citizens of Tower Hamlets to find and develop resources and skills within themselves and their communities and to have confidence to work in partnership with our services in order to improve their own and their families' health and wellbeing, from cradle to grave.

Improving the health and wellbeing of our local population and the quality of our care services is at the heart of Tower Hamlets Together, while ensuring that we spend wisely the money that is available to us.

Our services are person-centred, co-ordinated and make a tangible and positive difference to people's lives. We have a strong commitment to deliver in a joined-up way with a strong local Tower Hamlets focus, working in partnership with people, their communities and voluntary and statutory providers, we will make good on our aspiration to become one of the best systems of interconnected health and care in the country as outlined in our Health and Wellbeing Strategy.

The Tower Hamlets Together Vanguard has been a vital enabler in driving forward our ambitions with a strong emphasis on 'population health'. Our outcomes and emerging working structures are aligned across the needs of segments of our population rather than across diseases or service delivery and highlights forward-thinking support for people and their communities to help them have fulfilling lives.

There has been a strong tradition within local general practice, of joining up data and using best practice methods, to deliver quality improvements and this has increased through being part of the national programme as our Vanguard status has helped us think, even more, about system-wide intelligence. The East London NHS Foundation Trust continues to roll out quality improvement methodology in partnership with the Institute for Health Improvement (IHI) and we are sharing this learning and supporting the development of these skills across the Tower Hamlets Together system.

Planning and commissioning towards achieving a joint outcomes framework and aligning operational health and care teams in the community allows us to design services together which addresses our local priorities. At the same time, we are able to work along wider planning footprints with neighbouring boroughs and progress with our Sustainability and Transformation Plans (STP).

We hope this document gives a flavour of our Tower Hamlets Vanguard journey, and through reading about some of the projects, work streams and activities that we have undertaken in the last three years and earlier, we hope to demonstrate our strong commitment to giving the people of Tower Hamlets the best health and care and to sharing our learning.

Isabel Hodkinson,
Tower Hamlets Together Chair

A TIMELINE OF OUR TOWER HAMLETS TOGETHER JOURNEY

The journey of health and care integration in Tower Hamlets began a number of years ago. The willingness of Tower Hamlets organisations to work together is key to how the local health and care landscape has been able to respond to the needs of its residents. This timeline illustrates some of the key partner developments, and step change points of health and care integration in Tower Hamlets.

2004-2006

The Integrated Care Vision was first widely articulated in the borough

2009

Eight networks of GP Practices formed across the borough (eventually becoming legal structures in 2010)

2011

NHS Barts Health started managing the borough's Community Health Services

2011

Tower Hamlets Clinical Commissioning Group (CCG) formed as a membership organisation of 36 GP practices across Tower Hamlets, which saw NHS managers and GP members become responsible for the local health budget

2012

Waltham Forest, Newham and Tower Hamlets come together as Waltham Forest and East London (WEL) in the Integrated Care Pioneer Programme

2013

Tower Hamlets Integrated Provider Partnership (THIPP) formed as part of the Pioneer Programme

2013

Public Health Service transfer to Local Authority

2014

Transforming Services Together (TST) was established to deliver collective work across the NHS Barts Health (WEL) footprint

2014

The procurement process of the Community Health Services contract began

2014

The GP Care Group formed as a federation linking all 36 GP practices in Tower Hamlets

2014

The Care Act 2014 is enacted

2015

Better Care Fund – a programme spanning both the NHS and local government which seeks to join-up health and care services, so that people can manage their own health and wellbeing, went live

2015–18

THIPP/TST becomes new model of care – our Vanguard

2016

The Sustainability Transformation Plan for North East London is developed. Tower Hamlets falls within this footprint

2016

Launch of Joint Commissioning Executive, linking commissioning across the council and the CCG, initially just across the Better Care Fund but with an increasing shared remit and pooled budget year on year

2017

The procurement of Community Health Services (CHS) is finalised with mobilisation of a CHS Alliance Contract with the CCG, GPCG, ELFT and Barts Health

2017

Recruitment of Joint Commissioning Director across LA and CCG, expected to enhance the joint commissioning functions and scale of the pooled budgets

2018

Alignment of Adult Social Care services with the CHS service model

2018-19

Integration of Health and Adult Social Care services

TOWER HAMLETS TOGETHER: OUR VISION, MISSION, VALUES, PURPOSE, PRIORITIES AND CHALLENGES

JACKIE AND KINGSTON. IMAGE COURTESY OF CANINE PARTNERS

Our Vision

To work together to improve the health and wellbeing of the people of Tower Hamlets.

Our Mission

To improve the health and wellbeing of people who live in Tower Hamlets and to improve the quality of the care services we provide, ensuring that we spend the money we have available, wisely. Our services will be person-centred, co-ordinated and will make a real and positive difference to people's lives.

Our Values

- We are collaborative
- We are compassionate
- We are inclusive
- We are accountable

Purpose of the Tower Hamlets Together Board

The THT Board is made up of senior colleagues from across the partnership who are responsible for furthering the strategic development of health and social care with key partners, including the voluntary and community services sector, education, communities. Building effective relationships across the system is a central part of their mission.

Our Priorities

The borough's approach to the development of integrated care sits within the overarching strategic framework of the Tower Hamlets Health and Wellbeing Strategy. The priorities are:

- Communities Driving Change – changes led by and involving communities
- Creating a Healthier Place – changes to our physical environment
- Employment and Health - changes helping people with poor working conditions or who are unemployed
- Children's Weight and Nutrition - changes helping children to have a healthy weight, encouraging healthy eating and promoting physical activity
- Developing an Integrated System - changes which will join-up services so they are easier to understand and access.

A snapshot of our population

Tower Hamlets has a rapidly growing resident population of almost 305,000 people, estimated to rise to 364,500 by 2026.

The borough is tackling some of the toughest health inequalities in the UK caused by deprivation and related housing and employment needs. Our population is diverse, young and mobile. Partnership working, which sits at the heart of everything we do, is vital and we recognise that no one organisation can do everything alone. Learning from our demonstrable track record of innovative strategy and service delivery, we have seized the opportunities offered by the Vanguard to drive forward our efforts to improve local health and wellbeing at a quicker pace.

To illustrate some of the challenges faced in the system in Tower Hamlets, here are some examples of complex health and care needs that need to be considered and catered to in the borough.

Joan

Joan is 73 years old, independent and stoic. Since her husband died five years ago, she lives alone and has little contact with her son who lives in Essex. She has significant anxiety (and is on medication) and often mentions her loneliness. She also has severe chronic obstructive pulmonary disease (COPD) and has attended A&E six times in the last year with exacerbations but has not been admitted. She visits her GP practice frequently.

Peter

Peter is 55 with type 2 diabetes. He has had an amputation due to complications as well as being partially sighted. Up until last year Peter, was working full time but he struggles with living skills and he recently moved into sheltered accommodation. The team suspects he may be depressed. He does not attend his appointments and does not like people visiting him at home. His family are worried he may become physically very sick. When previously admitted to hospital, he discharged himself against medical advice. As he is not engaging with staff at the sheltered accommodation they are planning to serve him notice and help find independent accommodation somewhere else.

Zainab

Zainab is a 32-year-old mother with three children under the age of eight. Her eldest child has autism and attends a special school. Although she has depression, Zainab has not sought help as she feels she does not have the time due to looking after the children. The youngest child is two years old and is showing behavioural problems. Zainab is struggling with this and is worried that he is not reaching milestones such as being potty-trained or playing with friends.

HOW WE GET IT RIGHT CASE STUDY

Following a severe assault sustained while on duty as a Met police officer, Jackie was finding it difficult to adjust to her life as a disabled person. Like many people, she rebelled against her disability and the wheelchair she was in. Finding that society looked at her differently, she went through periods of depression and stopped taking her medication.

She became involved in a peer group working with Tower Hamlets Clinical Commissioning Group (CCG) as part of the Integrated Personal Commissioning programme. The group was aimed at ensuring the programme of personalising people's care was built upon the principles of coproduction. Jackie managed to secure a personal health budget of £3,000 a year, which pays for her assistance dog, Kingston. Kingston helps to manage her physical disabilities and emotional wellbeing. He has given her a new lease of life.

The impact that Kingston has had on Jackie's life has been transformational, and she is now able to manage her health much better. She no longer requires physiotherapy, visits the GP less often and most importantly, he has given her a purpose in life. He knows just under 200 commands, can put her clothes on the bed for her, open the front door, fetch her mobile phone and bring her a blanket. He can let himself out into the garden, post a letter and take things off shelves in the supermarket, even handing the debit card to the cashier.

Crucially, Kingston also helps to manage Jackie's physical disabilities and prevented more than 60 ambulance trips last year alone. Kingston can alert Jackie to an epileptic seizure 45 mins before it happens, and predict her hypo and hyperglycaemic attacks, sounding an alarm and opening the door for paramedics when they arrive.

Jackie would like her story to inspire others. She feels Kingston has helped her take more responsibility for her own health and the GP now sees her as the expert in her own care.

INTEGRATION IN THE SYSTEM: PARTNERSHIP DEVELOPMENT AND GOVERNANCE

The end of the Vanguard programme in March 2018, means that the infrastructure is being mainstreamed and built upon. Steps are being developed to sustain the partnership to deliver a complex agenda. A detailed organisational development programme is supporting the creation of a refreshed governance structure, reaffirming our vision, priorities and our commitment to the partnership.

The THT Board's Terms of Reference have been refreshed to reflect the development of our integrated care system and we have developed a 2017/18 Operating Framework.

The Board will therefore have various responsibilities regarding the development and oversight of system planning, with a requirement to submit a report to the CCG Strategic Finance & Investment Committee at various specified points in the course of the planning cycle, in the event of any particular risks, and at the request of the committee.

The Board does not have any formally delegated responsibilities from any of the respective partner organisational boards, however, representatives of each of the respective partner organisations, will represent the views of their organisation on relevant matters, with everyone working together in accordance with the THT values, vision, mission and priorities.

New governance arrangements for the THT Board, include the Board providing support to the Tower Hamlets Health and Wellbeing Board to discharge its duty under section 195 of the Health & Social Care Act 2012 to encourage health and social care services to work in an integrated manner.

The THT Board operates in a complex and changing policy environment, with various responsibilities for planning health services resting with the East London Health & Care Partnership (the North East London Sustainability & Transformation Partnership) and the Waltham Forest & East London Service Delivery Board. The Board will ensure that the development and delivery of commissioning strategy is aligned with, and utilises opportunities for added value in, developments within WEL and ELHCP.

In terms of ensuring provider partnerships, the Community Health Service has supported this, particularly with regard to due diligence, and confronting some very tricky questions about how resources, assets, and risks, would be shared across providers. It has meant that true system functioning across THT has been possible since the contract went live in April 2017 due to more honest and open discussion.

Our workstreams

The legacy of vanguard and greater cross-system working has given us the opportunity to think about how we organise ourselves and services around the population that we serve, as we enter the next phase of Tower Hamlets Together. In order to do this and avoid duplication we have developed three workstreams to bring stakeholders together from across the THT partners around the following population groups:

- Children – Born Well and Growing Well
- Healthy adults – Living Well
- Complex adults – Supporting and Promoting Independence (name tbc).

These workstreams replace similar forums that exist in individual organisations and are currently going through a phase of organisational development to ensure they fully achieve the ambition of having a system-wide approach to these population groups.

The next steps are to develop the capability and capacity for the Board and workstreams to lead the partnership. This will be supported by a review of existing system enablers.

THE 'ASK' OF THE WORKSTREAMS

The workstreams will work closely with each other to ensure a system-wide approach is taken. Each work-stream will need to balance work that should be completed in the short-term with the development of longer-term thinking and strategy along a two to five-year horizon.

Each workstream will need to clarify what it will deliver after three months, six months and a year. Organisational Development sessions will support this thinking.

The triple ask of the life course workstreams:

- Understand and oversee what is happening now, beginning to use the overarching system outcomes as a lens
- Explore and develop transformational programmes to improve the value of what is offered to the people of Tower Hamlets within our constrained resource to translate into system cost savings
- Identify one population initially, to use for the Quality Improvement (QI) project to enable learning about how to use this methodology. The population should be:
  - A clearly definable population where the criteria for definition is stable
  - That we can capture data against
  - Where we already have people and communities engaged around what matters to them
  - Where we can identify the potential for better value – might be cash releasing but could be reducing aspects of system waste or pressure relieving for staff.

How will we mobilise the life course workstreams?

By building infrastructure and capacity/capability to lead on:

- In year delivery
- 2019/20 planning

Life course work streams are tasked to:

- Take a whole population approach:
  - base decision-making on data and information on population needs, including an understanding of particular vulnerable groups
  - ensure relevant resident information from the Community Intelligence Network is included in plans and activities
  - ensure activities are truly co-produced, with equal decision-making between residents and staff
  - consider how the above priorities are impacted by residents' wider determinants of health and include action to tackle them
  - ensure activities are evidence-based and evaluated
  - use quality improvement techniques. Practical support will be provided with this.
- Bring Local Authority and CCG commissioning together
- Be clear about each other's business cycles and priorities – align the work
- Create a thinking space – agreeing outcomes collectively
- Be clear where we need to redesign and where it is 'okay for the time being'

- Find ways to add system value as a priority
- Think about resources and workforce – as a system
- Come up with answers that change the system – creating new pathways, new service design and new approaches to contracting
- Focus on redesigning delivery with a 2-5 year horizon using our outcomes framework to ensure that activities are planned around what residents have told us is important - but there will be some short term thinking too
- Keep the public on board so they understand how things are changing and why
- Be responsible for bringing the right stakeholders into the conversation.

The THT Board has started thinking about what resource support will be required to help the workstreams in delivering their objectives. Particularly with regard to senior leadership, administration, data and analytics. This offer will be developed alongside the ongoing Organisational Development sessions.

DESIGNING AND DELIVERING THE SERVICE MODEL
PUTTING PLANS INTO ACTION

Our application to the Vanguard programme set out our transformation intentions to redesign and integrate community health services. We had several of the building blocks in place and our modest aspiration was to make reasonably good adult community services much better. During the Vanguard assessment process, we were encouraged to be more ambitious and decided to focus on four areas.

Progress was initially both helped and hindered by the re-procurement of Community Health Services: helped because the bid set out the blueprint for a costed integrated service model; hampered because the procurement process meant commissioners and providers could not talk until the process was completed.

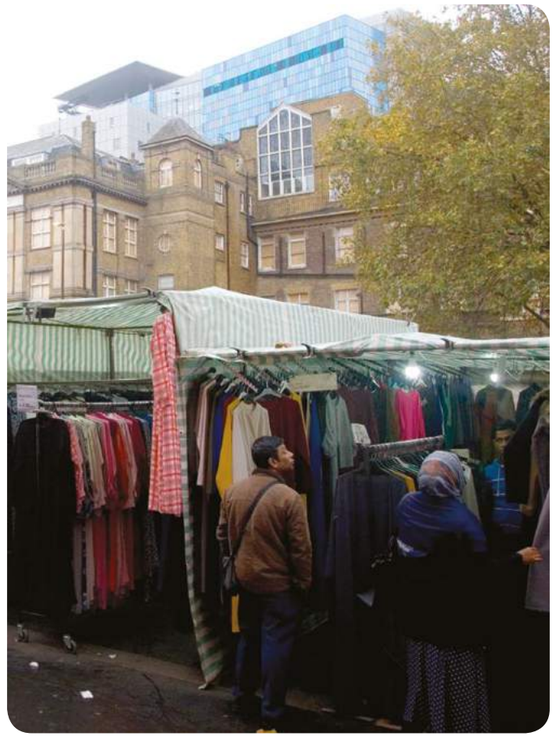
However, once the provider alliance was selected as preferred bidder, we started on the system redesign and have made very good progress, especially since the contract began on 1 April 2017. Our new models of care, which in some cases are old models but with better technology, include:

Universal

- A place-based shared vision for improving the health of our local population
- An Alliance Partnership Contract for Community Health Services, with our GP Federation as the alliance manager
- A single point of access for all health and social care services
- IT that works, with mobile working being rolled out to all peripatetic community staff
- An emerging culture of "multiple partners, one way of working"
- Quality improvement tools and expertise that has transformed mental health services and is now transforming community services and general practice
- Promoting prevention and self-care, including social prescribing and a wellbeing hub
- A large and well-resourced psychiatric liaison service truly embedded across the large teaching hospital site including A&E and wards and providing frequent attenders support.

Adults

- Extended "whole person care" primary care teams of community nurses, therapists, mental health workers and social workers
- Shared care plans, shared patient records, care navigators and care coordinators
- An integrated community rehabilitation service that has replaced two hospital-based rehabilitation wards



- An integrated frailty assessment service
- A rapid response community service for unplanned community care
- A physician response unit that takes an Emergency Department consultant to the patient
- Admissions Avoidance and Discharge Service that brings together the admission avoidance, hospital at home, home support pathway and in-reach community liaison team
- A primary care mental health service for people with stable but serious mental illness
- Multi-disciplinary Team support to care homes, a team including a consultant geriatrician, psychiatrist and occupational therapists specialising in person-centered dementia care and falls
- Specialist services for adults working across acute and community
- Integrated services providing End of Life Care
- Piloting Buurtzorg approach* to community nursing and home care
- A GP based virtual clinic for early diagnosis and treatment of kidney disease.

Children

- A virtual ward for children with complex conditions
- Integrated early years transformation
- A potential children's hospital at home (subject to business case).

Whole population health and wellbeing

- Data sharing agreements for all organisations working in health and social care
- A whole population dataset providing rich data about the needs of our community, going beyond their use of health and care services
- An outcomes framework upon which some of our contracts, such as the Community Health Services contract is based, with up to 25% of contract value dependent upon delivery of agreed outcomes in year five
- Developing a new population-based payment mechanism
- Training front-line staff in making every contact count and health coaching to foster a culture of prevention and person-centred care
- Social prescribing to link primary care support for patients in wider social needs.

**Visit our website to find out more about Buurtzorg*

INTEGRATED EARLY YEARS: CHILDREN'S TRANSFORMATION

Over the last 18 months, local partners within children's services have been developing an integrated model for early years services in Tower Hamlets. At the core of the model is the transformation of local children's centres into multi-agency hubs for child and family services to provide accessible, responsive, 'joined up' universal services, as well as some targeted services for vulnerable children and families and those with identified additional needs.

The model will provide a foundation for, and link to, the development of wider partnerships and integrated models of care for older age groups. In parallel, we will strengthen specialist services for children with disabilities and long-term health conditions. A prototyping phase will kick start the transformation, in which four children's centres will pilot the new integrated model. These children centres will become the new child and family hubs, with one being located in each of the four GP localities in Tower Hamlets.

Children and Family Hubs:

Each hub is developing a focus project to strengthen partnership working (Early Identification at Meath Gardens, Antenatal at Chrisp Street, Child Nutrition & Poverty at Mile End and Physical Activity and healthy Growth at Ocean).

Thematic focus areas for early years are emotional wellbeing, nutrition (oral health and healthy weight), managing minor ailments and early identification of need. These were identified in consultation with a wide group of stakeholders including local communities.

Emotional health and wellbeing and Early Identification of needs

There are a number of multi-disciplinary training programmes which started with our early years staff across health and social care in the borough. The training covers a host of priorities based on parent and infant wellbeing:

1. **Five to Thrive:** This is an attachment-based framework for early intervention and positive parenting aimed at supporting multi-disciplinary practitioners with the core knowledge, skills and confidence to support parents to promote healthy parent child relationships.

2. **Family Nurse Partnership (FNP) knowledge and skills exchange:** this is about sharing the existing FNP skills and will support implementation of 'Five to Thrive'.

3. **Multidisciplinary Reflective Practice:** Aimed at supporting early years multi agencies to ensure more effective partnership working across services and organisations working on the 0-19 pathway, improve communication and address silo working, as well as helping staff to develop insight and solutions to the complexity of the work, through sharing knowledge and skills, reducing the feeling of isolation in holding risk.

4. **Brazelton:** Will help promote attachment by enabling professionals to assess the infant's responsivity and potentially identify early communication issues. It will help demonstrate to the parent the baby's ability to interact with them and how to recognise nonverbal communication cues.

5. **Maternal Early Childhood Sustained Home-Visiting (MECSH) programme:** This covers both emotional wellbeing and early identification of needs. It targets disadvantaged and vulnerable pregnant women and aims to support women's transition to parenthood to improve maternal and child health and wellbeing.

Managing Minor Illnesses

(Care Confident #whattodowhentoworry)

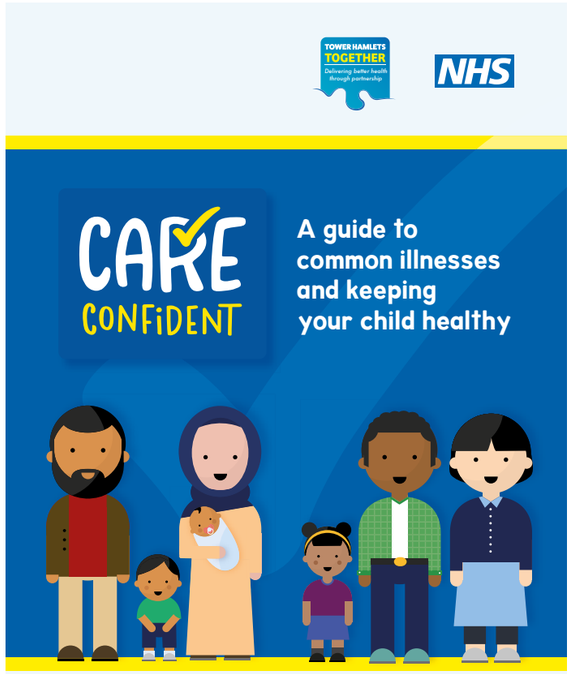
This work is aimed at improving outcomes around minor ailments amongst parents and families with children who are under five years old. A series of focus groups and a wide-reaching survey were commissioned to understand parents and professionals' perceptions on managing minor ailments. The result is a communication campaign and educational initiative called Care Confident: what to do, when to worry.

Care Confident, the name and slogan of which were also co-designed with local parents, educates families with under 5s on the signs and symptoms of the most common childhood ailments and to learn about the much better alternatives to A&E. There are also peer group educational sessions being delivered through the new Children and Family hubs. These weekly sessions have been designed using the core principles and methodology of the DIY Health project due to its successes in parent behavioural change in relation to minor ailments.

Nutrition (Healthy Weight and Oral Health)

At the heart of this work is an academic piece of research completed by an external organisation to get a better understanding of nutritional practices, and factors affecting it, amongst parents of one to two-year olds. This qualitative piece of research was also about better understanding infant and child feeding practices, parental knowledge and attitudes, key influences (knowledge, family, social etc.) and more importantly, how best to support healthy practices. One recommendation taken forward includes multi-disciplinary training that integrates child nutrition and oral health to support consistent messages amongst a broad range of services and organisations in contact with families of young children. The training has since been completed, informing new early year's nutrition services being commissioned by Public Health.

Posters, booklets and animations will be shared across the borough.



UNDERSTANDING THE NEEDS OF THE LOCAL POPULATION AND PLANNING FOR BEST OUTCOMES

Whole Systems Data Set Project

This project is about linking the NHS and the Local Authority's data to help us to describe and understand the relationship between inequalities in health and wellbeing, health and care service use and the impact of the wider determinants of health across Tower Hamlets. This ground-breaking project looks at data in an integrated manner not only across health, social and community care, but across wider local authority services such as education, benefits, crime, environment and housing. It builds on the evidence around what we know about the impact on wider, social issues on health and wellbeing and will inform the strategic direction, commissioning and resource allocation of the health and social care system in Tower Hamlets. As it is the first time a linkage of this nature has been attempted, there was a need to address previously untested data protection and information governance requirements, including the role of national bodies. A guidance document outlining how to conduct the project has been written and will be available on the Tower Hamlets Together website.

Taking a population health approach

Population Health can be very broadly defined as "the health outcomes of a group of individuals, including the distribution of such outcomes within a group". Taking such an approach builds on work around integrating care services but has a broader focus on promoting health and reducing health inequalities across whole populations.

Developing a Population Health Strategy was made possible by the additional capacity afforded through the vanguard programme and was developed to highlight to the THT Board the approach, and, the current activities that are underway that provide the building blocks for the approach. It demonstrates how Tower Hamlets has a long history of delivering population health activities and how our involvement with the vanguard programme has taken us further toward achieving a population health system by delivering activities such as those highlighted in this section and others such as Community Insight Network and the Staff Innovation Fund (see page 28). The strategy has also informed the development of the THT workstreams (see page 12) to ensure they take a population health approach and that we continue to have the relevant building blocks in place.

Social Prescribing

In deprived areas, patients often visit their GP for reasons other than clinical problems as a result of not knowing where to get support for the wider social issues, which have a significant, negative impact on their health and wellbeing. Tower Hamlets has a history of successfully delivering social prescribing in a small number of GP practices within the borough with GPs referring to Social Prescribers who have the capacity and knowledge to connect their patients to a range of support for their wider needs. Social prescribing has now been expanded to all GP practices in Tower Hamlets.

The vanguard funding has enabled the programme to have additional leadership capacity which has ensured social prescribing is firmly embedded within the local health and care system, and that there is alignment with other initiatives. Additional capacity enabled through the vanguard programme also allowed the scheme to be evaluated. The evaluation showed that in the first eight months of the service expansion, our Social Prescribers had worked with 2,270 patients, connecting them to 333 services and activities across 279 organisations to support them with issues such as physical activity, anxiety and stress, social isolation and debt and employment. As a result, patients reported improvements in their general wellbeing around the issue that was most troubling them, which was mostly social. A survey of social prescribing referrers found that 99% felt it had benefited their patients and 89% felt it provided benefit to them in their professional role in providing a holistic service to their patients. Data analysed in one local area, has shown a 12.3% reduction in GP appointments between the six months before and six months after patients' appointments with a Social Prescriber.

Making Every Contact Count (MECC)

Tower Hamlets has high rates of smoking, obesity, alcohol drinkers with potentially harmful drinking patterns, common mental health disorders, and sexually transmitted infections, alongside low rates of physical activity. Telling people what to do around these issues is not always the most effective way to support them to make changes. MECC is a half day training session to support frontline staff to pick up on conversational cues to address the issues that people themselves want to make changes on. It gives staff:

- the tools to spot when an issue can be addressed
- the knowledge and confidence to engage on the issue
- information about where people can be signposted for further support.

The vanguard funding has enabled an existing local training programme to continue, meaning that an additional 1,200 frontline staff will have been trained by the end of the vanguard programme. Currently, staff have been trained from across 90 local organisations, including 46 voluntary and community organisations. An evaluation of the programme showed that 95% of those trained felt more confident to raise matters with clients and 92% felt they had improved skills to help clients make lifestyle changes. In addition, 49% reported making a change in their own lives as a result of training.

[1] UCL (2010) Fair Society Health Lives 'The Marmot Review'. https://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

[2] Kindig D, Stoddart G. What Is Population Health? American Journal of Public Health. 2003;93(3):380-383. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447747/

[3] Kings Fund (2015) Population health systems: From integrated care to population health

NOT ALWAYS A&E: URGENT CARE OUT OF HOSPITAL EXTENDED PRIMARY CARE TEAMS

In tandem with the Vanguard, four extended access primary care hubs were set up, giving people additional access to GPs, nurses and pharmacists outside of normal office hours and on weekends and bank holidays. Through the Alliance partnership (as described on page 24), we are now developing extended primary care teams. The philosophy is to wrap integrated care around patients with long term conditions to help them cope at home, and to avoid or deal with exacerbations without resorting to going to hospital unless it's necessary.

To do this we are building on the eight well-established GP networks in our borough, each with four or five practices within them. Two networks in each quadrant of Tower Hamlets form the basis of a locality primary care team covering a population of 70-80,000. We are attaching to each locality, an integrated community team comprising community nurses, community therapists, mental health workers, social workers and pharmacists. Together these form our extended primary care teams.

They have laptops and tablets to facilitate mobile working. They also share care plans, patient records, care navigation and care co-ordination, and are co-ordinated through a single point of access, which is a call centre and website. We are redesigning the way multi-disciplinary teams and case review system, works. We have also set up Locality Health and Wellbeing Committees comprising leaders from the agencies working in each locality to oversee service delivery and ensure that it addresses specific local needs. It also has a locality public health lead, and will be attended by some of the borough-level specialist services such as the hospice, paediatrics, etc.

Admission Avoidance and Discharge Service (AADS)

This service, formed in September 2016 and run by the East London NHS Foundation Trust, operates seven days a week from 8am to 6pm. Initially the result of a CCG-funded pilot to respond to winter pressures, today the service includes among its staff, two social workers, four occupational therapists, two physiotherapists, three nurses and one rehabilitation support worker. Patients are given an assessment on the day of referral, and if required, receive up to six weeks' community input post-discharge. Short-term night care is also possible.

Rapid Response Service

Our Rapid Response Service launched at the end of March 2017, runs seven days a week from 8am-8pm. Overseen by the Clinical Lead for the Admission Avoidance and Discharge Service, a multidisciplinary team, initially manned by temporary staff, was put in place to respond to suitable referrals within two hours or refer on as necessary. Referrals received via the THT Single Point of Access are triaged by the service to ensure that they are appropriate.

Physician Response Unit

The Physician Response Unit (PRU) despatches medical support to people in their home. With a senior doctor on board, the clinical experience of the medical crew enables the PRU team to treat a wider range of illnesses and injuries at scene. The PRU carries advanced medication, equipment and treatments usually only found in hospital such as instant result blood tests, urine tests and sutures to stitch serious wounds. This means the PRU can treat patients where they are, avoiding a trip to hospital.

Patients can be under the care of the team for up to five days to stabilise the situation and ensure an unnecessary admission is avoided, and if required they are then referred back to the community health team staff or on to the Admission Avoidance and Discharge Service (AADS) Intermediate Care Team for up to six weeks rehabilitation or clinical intervention.

Image credit: London Evening Standard. Pictured: Dean Buttery, ambulance clinician, Dr Sophie Mitchinson, emergency registrar and Dr Tony Joy, clinical lead for the physician response unit.

CAPTURING THE NEEDS OF THE MOST VULNERABLE

The Bridge Virtual ward

Tower Hamlets Together funds the Bridge Virtual Ward, a service which offers children and young people with complex care needs and high rates of admissions and/or length of stay in secondary care, a programme of co-ordinated and integrated support across health, education and social care.

The programme, now covering a maximum of 50 children in the community, was built on an initial pilot that ran between February and July 2014 caring for 20 children. Through multi-disciplinary working, the project aims to deliver a reduction in inappropriate use of A&E, length of stay and non-attendance at out-patient appointments. More importantly, it aims to empower and enable the families of children with complex health needs by giving them the tools they need to coordinate their child's long-term care needs. Each individual child's personal impact will also be monitored throughout the year, as well as their personal goals.

Planned Multi-disciplinary Team (MDT) meetings are attended by representatives from secondary care, community nursing, physiotherapy, school nurses, school teachers, occupational therapists and community paediatric doctors. Specialist Bridge meetings are also organised with representatives from palliative care, specialist respiratory physiotherapy and epilepsy specialist nurses. Parents are contacted before each meeting to see if they have any specific concerns that they would like to share. Each child is discussed monthly, and outcomes of meetings are distributed to all members of the MDT.

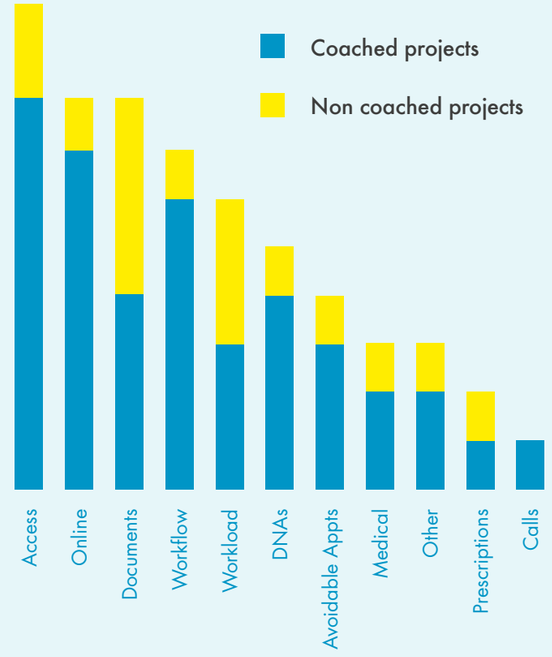
ENHANCING PRIMARY CARE AND COMMUNITY CARE

GP resilience: Quality Improvement through the EQUIP programme

This programme builds on our partner organisation, East London NHS Foundation Trust's learning from the Institute for Healthcare Improvement's quality improvement methodology to support change within general practices, enabling them to become more effective, deliver better value and going forward, to scale good practice across the borough and wider.

Current areas of work is outlined below. The work was piloted in four practices in 2016-2017, and during 2017-18, it was rolled out across 27 of our 36 GP practices, thanks to Vanguard support.

QI Life projects by themes August 17



PROGRESS TO-DATE

6 coaches recruited and deployed

Edenbridge installed in **25** practices

200 QI Life licences allocated

21 data walls sessions delivered

67 projects up and running on QI Life

200 people trained on QI (basics of QI, project lead, QI Coaches)

> Gets Drs, Nurses and Health Care Assistants talking to each other about real obstacles faced to bring about good change

> The most impact has been within the admin team. Everyone wants to be involved and do various process mapping audits to streamline services and in-house pathways

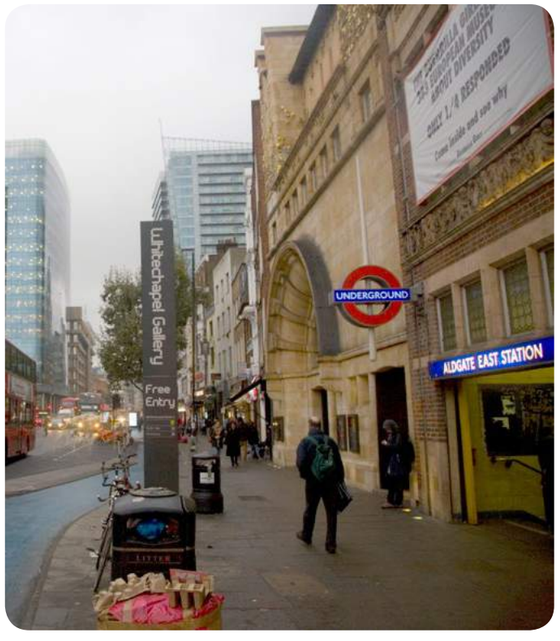
> Really enjoyed interactions and discussions with members from other practices

COMMUNITY HEALTH SERVICES FOR THE FUTURE

Our original plan for the community health services contract was to structure it as a prime contract, with the GP Care Group taking the prime contractor system integrator role, and NHS Barts Health and East London NHS Foundation Trust being sub-contractors. However, following contract award and during the course of due diligence it was apparent that placing the main contract through the smallest and newest formed organisation, the GP federation, was an excessive commercial risk. The parties changed course and opted for the New Care Models team's newly proposed Alliance Partnership model.

Each of the provider organisations has contracted directly with the CCG for the services it was going to operate under the prime contractor model, and then the three providers and the CCG have signed up to an Alliance Partnership Agreement, which governs how the partnership will work. The GP Care Group has been appointed the Alliance Manager.

This creates two governance strands - a collaborative approach through the Alliance Partnership Board, and a contractual approach through monthly Clinical Quality Review Meetings (CQRM) with the CCG's contracting and performance team. Although there are three separate contacts for services, the three providers attend the CQRM together, and our sense is that over time, as we demonstrate delivery of the service development improvement plan (SDIP), that the Alliance Partnership rather than CQRM will be the normal way of doing business. Furthermore, as service integration goes beyond community health services and involves much wider service integration, more partners will join the Alliance. For example, the Alliance Partnership Board is already routinely attended by Senior Managers from Adults and Children's Social Services.



TRANSFORMING IT

All our GP practices are on the EMIS platform and our community teams are on EMIS Community, which facilitates full interoperability.

Through the EQUIP programme, GP practices have been developing their use of the Edenbridge Apex product which allows much better reporting of the details of workflow and this work is beginning to be taken into EMIS Community as well.

The systems are linked to the hospital information system, so the Emergency Department can see GP patients' records as can the extended access hubs and the GP Out of Hours service. EMIS Community enables our community-based teams to work in real-time when they are with a patient or service user and reduces their need to return to base to write up notes.

Our single point of access will allow a call centre to co-ordinate out of hospital planned and unplanned care through a directory of services. It can take calls and co-ordinate services from 111. It already operates for a number of community services and more are being added over the coming months. At the moment it is only accessible to care professionals, but we plan to provide access to patients and carers too. We are developing, in tandem, a patient-facing portal which offers patients and service users advice and access to public services and community and voluntary services, and ultimately this will link through to the single point of access website, enabling direct booking to services.

All our GPs are using e-Consult, which is flagged prominently on their websites and gives people, easy, online access to a GP consultation. We are working with a tech partner on developing a local version of GP at Hand so that people can have an online face-to-face consultation with their GP without having to de-register from their practice.

What GP staff are saying:

"Gets people talking differently"

"It brought more scientific rigour and discipline in the group"

"I feel involved in the change and development and really perked up to see improvement in the work undertaken"

"Meetings rules are really helpful and the coaches presence keeps us on track"

"Very practical training and lots of activities"

"Enjoyed learning about the data and how to analyse it"

"Great opportunity to create fertile ground for change"

"Equalise knowledge and voices in the room: I felt empowered"

HOW WE'VE WORKED WITH RESIDENTS

People at the heart of our work

Getting the relationship right between services and local people is at the heart of how Tower Hamlets Together operates. This drives our person-centred approach, is embedded in our design principles, underpins the 'Communities Driving Change' priority of Tower Hamlets Health and Wellbeing Strategy and defines frontline practice in our People Charter.

OUR PEOPLE CHARTER DESCRIBES OUR BEHAVIOURS...

We aim to provide person-centred, coordinated care to everyone who uses our services. This means you can always expect us to:

- Be polite and respectful to you
- Respect your confidentiality
- Let you know who we are and what we do
- Communicate clearly and openly with you in the way you need us to
- Respond to phone calls, emails and letters quickly
- Ensure that you only need to tell your story when you choose
- Ensure that we take into account your mental, physical and social needs
- Be informed and prepared for appointments with you and have read your notes
- Work with you as an active and equal partner, jointly agreeing your care plan to incoude your personal goals and wishes
- Support you to support yourself where possible
- Involve and listen to carers involved in your care
- Involve sevice users and carers in services, planning and evaluation
- If we don't know how to help initially, we will explore other options and get back to you quickly

We value our staff and support them to provide high-quality whole-person care, including mental and physical health, social care and wellbeing. We will work with service users and carers to build mutually respectful and trusting relationships. This includes keeping appointments, exploring self-management (when appropriate) and giving constructive feedback.

A snapshot of how we coordinate engagement and involvement with residents

We recently identified more than 100 different kinds of activity underway with residents, for example:

- Working with a range of service user and carer groups to listen to what people think, including the Older People's Reference Group and one for housebound older people, the Carer Forum at the Carers' Centre, 'Local Voices' for residents with a disability and 'Have Your Say' for those with a learning disability, the Bangladeshi dementia café sessions, the Mayfield House Centre for Somali elders and others, anchored in an understanding of community need

- Board meetings begin with patient stories from the evaluation currently being undertaken by University College London

- Service user-led training on the needs of people with mental health problems for organisations, such as Docklands Light Railway and JobCentrePlus

- Discovery interviews about patient experience undertaken by service users and carers, non-medical staff and voluntary and community sector representatives used to drive service improvement and staff development

- Pulling together the views of local people, including those less often heard, in the Community Insights Network and the Healthwatch online repository to review and develop existing and new ways of working.

Our ongoing challenge is how to ensure all of this makes a positive difference for local people. To help do this, engagement and involvement leads from each of the THT partners have worked together with Healthwatch, the Tower Hamlets Council for Voluntary Services, individual voluntary and community groups, patients and carers at the User and Stakeholder Focus workstream since 2014.

The monthly workstream meetings bring a stronger service user and carer voice into the development of the new model for community health services, undertaken spotlights to improve partner performance, worked with Healthwatch on a series of 'Your Voice Counts' community events and participated in the NHS Barts Health Patient Experience Conference.

'Measuring what matters': outcomes that make sense for everyone

Communicating the benefits of integrated care, partnership and collaboration among staff, patients and carers, the wider community and stakeholders is incredibly important to us. We recognise that getting this right involves building trust, confidence and respect, supported by dialogue which learns from previous good practice.

In 2016, the THT Board developed an outcomes framework describing our collective ambition to improve the health and wellbeing of the population in a way that's understandable both to professionals and the people they serve. Overseen by a reference group of clinicians, other professionals and a local carer to guide the process and drawing on the messages from previous engagement and involvement, further discussion led to the development of a set of 'I' statements to head the outcomes framework, informed by what matters most to local residents.

In 2017, the New Economics Foundation tested our framework's legitimacy and concluded that "the majority of outcomes identified by THT have been reflected in some shape and form with the residents of Tower Hamlets." While they discovered that "most of the assets people valued in Tower Hamlets are linked to how they impact on their health and wellbeing", they also challenged us to think beyond health and social care, towards a broader focus on life outcomes thus reinforcing the importance of partnerships – no one organisation alone can do the things that are required.

We are able to say that the community has given a clear message about what is important to them. This should give us the confidence to drive forward the new framework, inspiring senior leaders, all staff and partners under the banner of 'measuring what matters'. Plans are underway for the framework to drive the commissioning and provision of services from April 2018.

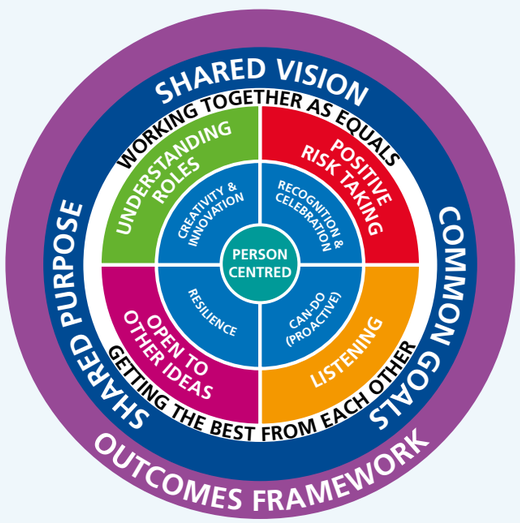
After using Tower Hamlets Together services we want residents to be able to say...	
Around me	I feel safe from harm in my community
	I play an active part in my community
	I am able to breathe cleaner air in the place where I live
	I am able to support myself and my family financially
	I am supported to make healthy choices
	I am satisfied with my home and where I live
	My children get the best possible start in life
My doctors, nurses, social workers and other staff	I am confident that those providing my care are competent, happy and kind
	I am able to access safe and high quality services (when I need them)
	I want to see money is being spent in the best way to deliver local services
	I feel like services work together to provide me with good care
Me	I understand the ways to live a healthy life
	I have a good level of happiness and wellbeing
	Regardless of who I am, I am able to access care services for my physical and mental health
	I have a positive experience of the services I use, overall
	I am supported to live the life I want
Tower Hamlets Together	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

HOW WE'VE WORKED WITH STAFF: WHAT WE CAN DO DIFFERENTLY: ENGAGING WITH STAFF

Since April 2015 we have run 12 quarterly engagement events reaching more than 1,000 people. Open to all staff working under the THT partnership, they have provided progress updates, showcased success stories and facilitated conversations across professions and disciplines about 'working together'. Each event is different. In January 2018, the spotlight was on social care, October 2017 was about 'Our THT Stories, Updates and Reflections', which saw frontline staff share how they deliver integrated care. The 'Primary Care and Community Fair' in July 2017, allowed 21 different services to explore how they could better support each other and build stronger relationships as well as with service users.

This eagerness to work together was most clearly demonstrated by the reception of the Staff Innovation Fund in January 2016 where £300k was available to encourage service improvement initiatives.

Tower Hamlets Together – The Wheel of Partnership



Forty-nine ideas, totalling over £1million, were submitted for consideration. Each one was assessed for its potential to strengthen integrated health and social care, improve quality and safety, build more robust partnerships across services and with the voluntary and community sector and local residents, develop new ways of using information technology and other enablers, enhance the skills of the workforce, increase efficiency and effectiveness to improve value for money. Following the assessment, 22 proposals were supported and 16 have now been delivered covering a range of issues including:

- Embedding a pharmacist in the Mission Practice to enable the self-management and empowerment of patients
- Using an 'ELFy' app to support self-management, particularly focused on women from Black, Minority, Ethnic communities
- Health promotion through the arts: workshops to address child exploitation
- Working together with young mothers and female patients at the Aberfeldy Practice to increase exercise and other activity
- Creating over 60 Practice Health Champions at St Paul's Way
- Bringing the Blithedale Practice and William Davis primary school closer together through the 'GROW – kids' health club'
- Practice Health Awareness events at Chrisp Street Health Centre for elderly and vulnerable patients and their carers and young people.

The next steps are for the four most successful projects to explore innovation alongside the development of the new Locality Health and Wellbeing Committees.

Both the engagement events and the Staff Innovation Fund show how easy it is to unleash interesting and innovative ideas based on staff's frontline experience, and their willingness to learn. Supporting this has been the role of the THT Workforce and Organisational Development (OD) workstream. Meeting monthly, it brings together the OD leads from each of the THT partners building the relationships that make it easier to get things done. It has helped increase the focus on cross-partner programmes, such as the Making Every Contact Count (MECC) and created access to educational opportunities offered by the Community Education Providers Network (CPEN). The workstream has also been able to make connections beyond health and social care so that more than 50 schools were involved in recent 'Mental Health First Aid' training.

During the last year of the Vanguard, a competency framework was developed which identifies the key skills, knowledge and behaviours critical to providing person centred integrated care. The OD work stream will focus on embedding this 'Wheel of Partnership' across the integrated teams to further enhance the success of Tower Hamlets Together.

THE FUTURE: INTEGRATED CARE SYSTEM

As we look to the future in Tower Hamlets, our current emphasis remains on the further development of system functioning for population health rather than an organisational focus. Our primary commitment is to deliver a difference for the people of Tower Hamlets as judged against our outcomes framework.

We seek to build on and widen our existing relationships to shift our local culture to a collective focus on people and communities, who become themselves key players in our system. We are on the cusp of delivering system data infrastructures to enable us to describe relevant subpopulations and to be able to track outcomes and impacts for the people in the subpopulations and we have realigned our transformation teams to align with our three main life course groups; children and young people, complex adult/end of life and mainly healthy adults.

We are creating a clear joint work plan for the next six to eight month 'sprint' but with a strong emphasis on collective learning and development and checking back with our constituent bodies as we go, continuing our programme of staff engagement and team development, with a focus on their learning and ownership of improvement and quality.

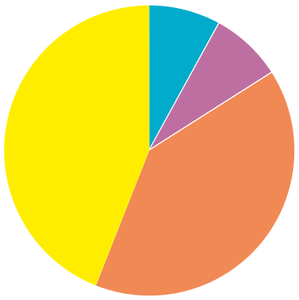
As the Vanguard programme comes to an end, we reflect on the huge benefits that being part of the national programme has brought for our local population. Following through on our work across highly complex systems within systems continuing to focus on where we need to deliver local improvements as well as working on a larger footprint to share best practice and innovation.

Jane Milligan
Accountable Officer
NHS North East London Commissioning Alliance (City and Hackney, Newham, Tower Hamlets, Waltham Forest, Barking and Dagenham, Havering and Redbridge CCGs) Senior Responsible Officer North East London Sustainability and Transformation Partnership

OUR VANGUARD ALLOCATION
AN OVERVIEW OF THE FIGURES

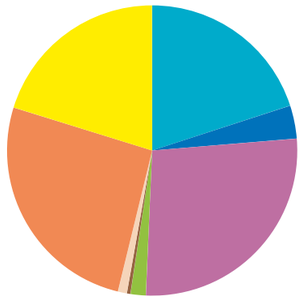
Total Vanguard funding over three years = £10.8m

1. Total % spend 15/16



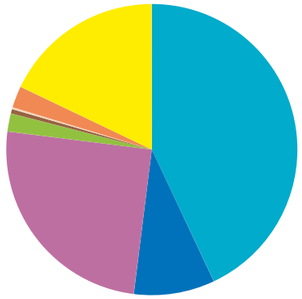
- Whole population **8%**
- Urgent care needs **0%**
- Ongoing care **8%**
- Highest care needs **0%**
- Contract, commissioning and funding **0%**
- Flexible use of workforce and estates **0%**
- Information analysis & technology **40%**
- Culture and leadership **44%**

2. Total % spend 16/17

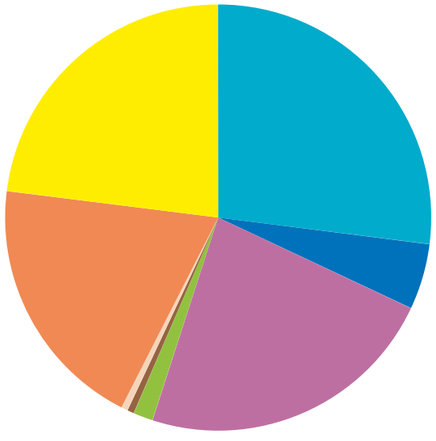


- Whole population **20%**
- Urgent care needs **3.7%**
- Ongoing care **27%**
- Highest care needs **1.7%**
- Contract, commissioning and funding **0.4%**
- Flexible use of workforce and estates **1%**
- Information analysis & technology **26%**
- Culture and leadership **20.2%**

3. Total % spend 17/18



- Whole population **43%**
- Urgent care needs **9%**
- Ongoing care **25%**
- Highest care needs **2%**
- Contract, commissioning and funding **0.5%**
- Flexible use of workforce and estates **0.2%**
- Information analysis & technology **2.4%**
- Culture and leadership **17.9%**



4. Total % spend over 3 years

- Whole population **27%**
- Urgent care needs **5%**
- Ongoing care **23%**
- Highest care needs **1.5%**
- Contract, commissioning and funding **0.5%**
- Flexible use of workforce and estates **0.5%**
- Information analysis & technology **19.5%**
- Culture and leadership **23%**

Total allocation of vanguard funding by partner organisations

Organisation	Percentage
CCG	14.1%
LBTH	12.3%
BARTS	12.9%
GPCG	24.6%
ELFT	36.1%
Total	100%

Projects: 80 projects benefited from vanguard funding to deliver the New Care Models programme over the three years

Organisation	Number of projects	Percentage
Standalone Project Completed: Outcomes and learning shared	20	26%
Project mainstreamed New way of working embedded	29	34.6%
Project successfully delivered Potential to scale or develop further	17	21.8%
Leadership and enabler investment	14	17.6%
Total	80	100%

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towerhamlets.gov.uk • gpcaregroup.org • thcvs.org.uk

NHS Tower Hamlets Clinical Commissioning Group
NHS East London NHS Foundation Trust
NHS Barts Health NHS Trust
TOWER HAMLETS
GP CARE GROUP CIC
thcvs Council for Voluntary Service

For further information about the Tower Hamlets Together Vanguard, including published case studies, evaluation pieces and more, visit the Tower Hamlets Together website: www.towerhamletstogether.com

To learn more about other vanguards and how they are developing blueprints for the NHS moving forward, visit: www.england.nhs.uk/new-care-models

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