Tower Hamlets Together

Working together to transform people's health and lives in Tower Hamlets

TOWER HAMLETS TOGETHER

Delivering better health through partnership

Borough Plan refreshed post Covid-19

May 2021

TOWER HAMLETS

GP CARE GROUP CIC

thcvs Council for Voluntary Service

NHS Barts Health NHS Trust East London NHS Foundation Trust Tower Hamlets Clinical Commissioning Group

NHS North East London Clinical Commissioning Group

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KEY

THT
Tower Hamlets Together

THHWB
Tower Hamlets Health and Wellbeing Board

CCG
NHS Tower Hamlets Clinical Commissioning Group

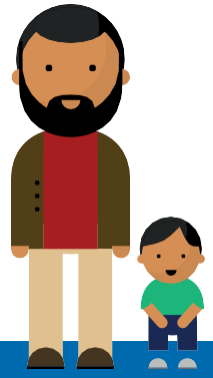
LBTH
London Borough of Tower Hamlets

ELFT
East London Foundation Trust

STP
Sustainability & Transformation Partnership which is now called the East London Health and Care Partnership

WEL CCGs
Waltham Forest, Newham and Tower Hamlets CCGs

NEA
Non elective activity



Introduction to Tower Hamlets Together

Introduction

Tower Hamlets Borough Plan

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

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

When, after significant discussion and self-reflection, we committed in February 2020 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.

However, as we look back on those last few months 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.

This is not to suggest that the next steps will be easy – in many ways, 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, our four locality Health and Wellbeing Committees covering the eight Primary Care Networks will be critical to the success of this, with primary care at the heart of our borough recovery plan. But it is only by working together as a single team, in support of all of the people of Tower Hamlets, that we will succeed in delivering safe, effective care which harnesses the diverse assets of our organisations and our partnership – enabling all of those we care for to be **"Start Well, Live Well, Work and Age Well"**

About THT

THT is all about health and social care organisations working more closely to improve the health and lives of people living in Tower Hamlets
This means a more coordinated approach to providing services, reducing duplication and improving the overall experience and outcomes for the people who need them.

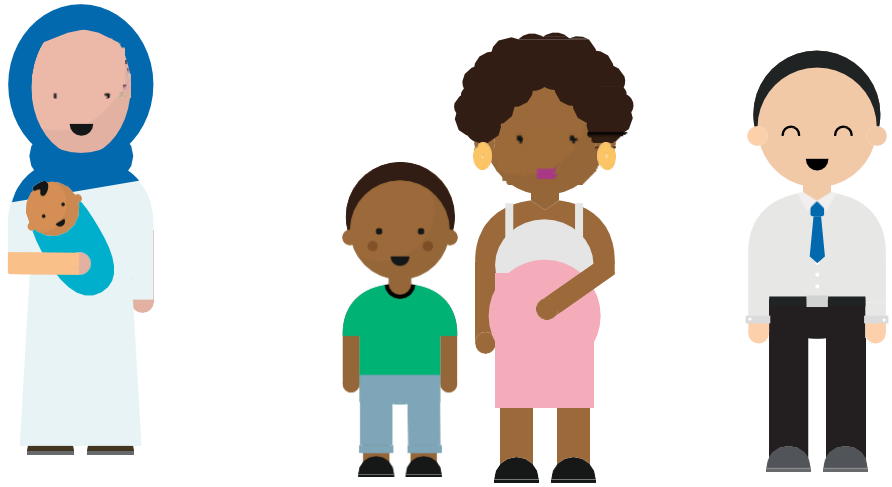
THT is a partnership of health and care organisations that are responsible for the planning and delivery of prevention and health and care services.

The partnership includes:

- London Borough of Tower Hamlets
- WEL Clinical Commissioning Group (Tower Hamlets, Newham & Waltham Forest)
- Tower Hamlets GP Care Group
- East London NHS Foundation Trust
- Barts Health NHS Trust
- Tower Hamlets Council for Voluntary Service

THT values

We are compassionate We collaborate
We are inclusive
We are accountable



Aims and Principles

The 9 Aims

1. Empower people to meet their own needs
2. Enable people to meet their own aspirations
3. Improve health, wellbeing and quality of life
4. Co-produce services and care with people who use them
5. Simplify the system, make it easier to understand and access
6. Ensure the right support, in the right place, at the right time – as close to home as possible
7. Be flexible and responsive to meet personal needs, wishes and outcomes
8. Deliver value for money, making best use of resources across the system
9. Develop self supporting, thriving communities

The 6 Principles

1. All money is public money and that all staff work for the benefit of Tower Hamlets residents
2. Every penny counts, and there are no gaps in services between different agencies
3. Services meet the identified needs of Tower Hamlets residents
4. THT will review and reorganise services and budgets where necessary to ensure that it achieves the maximum health and care improvements from its collective resources
5. Assume there is no new investment due to national policies – and budgets will reduce
6. Partnership working through THT is 'how we do business' in Tower Hamlets

Our Vision Through Our System Wide Outcomes Framework

The outcomes we are all signed up, as partners, to delivering were developed in collaboration with staff and residents. We have developed specific population outcomes based on the following:

- Residents live the healthiest lives possible, especially the most deprived and vulnerable
- Children and young people have a great start to life and achieve their full potential
- Residents are able to access the health and social care services they need in a timely manner
- Residents are satisfied with the health and care services they receive and feel that their needs are being well met
- The system exceeds the required national performance standards within the available resources.

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

The System Plan on a Page *(agreed in 2018/19)*

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

MISSION

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

VISION

- Tower Hamlets residents, whatever their backgrounds and needs,are supported to thrive and achieve their health and life goals, reducing inequalities and isolation
- Health and social care services in Tower Hamlets are high quality, good value and designed around people's needs, across physical and mental health and throughout primary, secondary and social care
- Service users, carers and residents are active and equal partners in health and care, equipped to work collaboratively with THT partners to plan, deliver and strengthen local services

OBJECTIVES

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

PRIORITIES FOR ACTION

1. Develop our partnership
   Collaborate as health and care providers and commissioners, with service users and carers, to plan and solve problems together
2. Deliver on health priorities and inequalities
   Support individuals, families and communities to live healthy thriving lives
3. Design care around people
   Provide accessible and responsive health and care services, and deliver person-centred integrated health and social care for those who need it
4. Develop our teams and infrastructure
   Ensure THT staff and teams have the right support, skills, knowledge and approach

Managing Population Health, Tackling Inequalities and the Financial Challenge

Managing Population Health & Tackling Inequalities (1)

- **Tower Hamlets has a population of over 300,000** and is referred to as densely populated. There were 280 confirmed deaths from Covid-19 per 100,000 population as of 24th June 2020 and has the 4th highest death rates in London, when adjusted for age. **Tower Hamlets has an ethnically diverse population**, with White 45%, Asian/Asian British 41% and 7% from Black/African/Caribbean/ decent. The population is **relatively young compared with the rest of the country but people typically start to develop poorer health around ten years earlier**. 5.9% of the population are over 65 and already live with a degree of frailty. A**ccording to the most recent census data Tower Hamlets population includes 19,356 carers**, often looking after older people with Long Term Health conditions who are at higher risk from Covid-19, and needing greater support to recover. **During the Covid-19 pandemic there were over 9,000 shielded people** living in the borough.

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

Age and sex

- Diagnosis & death rates increase with age
- Working age men 2x as likely to die as females
- Those >80 70x more likely to die compared to <40s

Geography

- London had highest diagnosis rates
- Death rates in London 3x higher than South West

Deprivation

- Mortality rates in most deprived areas more than double least deprived areas
- This adjusts for age, sex, region and ethnicity

Ethnicity

- Diagnosis highest in Black ethnic group
- Death rates highest in Black and Asian (particularly Bangladeshi) ethnic group

Occupation

- Higher death rates in men working as security guards, taxi drivers, chauffeurs, drivers, chefs, retail assistants, construction and processing plans
- Higher death rates in men and

Inclusion health

- Higher death rates in people born outside UK, especially parts of Africa and South East Asia
- Likely to be much higher infection rates in rough sleepers

Care Homes

- Deaths in care homes accounted for 27%
- 2.3x deaths from all causes compared to previous years

Comorbidities

- Diabetes on 21% of death certificates
- Higher for BAME Groups (43% Asian and 45% Black)

Managing Population Health & Tackling Inequalities (2)

The Public Health England Disparities Report Recommendations

The recommendations must be absolutely **key** to any commissioning and delivery of services that we undertake, especially given the diverse population of Tower Hamlets:

1. Mandate comprehensive and quality **ethnicity data collection and recording** as part of routine NHS and social care data collection systems, including the mandatory collection of ethnicity data at death certification, and ensure that data are readily available to local health and care partners to inform actions to mitigate the impact of COVID-19 on BAME communities.
2. Support **community participatory research**, in which researchers and community stakeholders engage as equal partners in all steps of the research process, to understand the social, cultural, structural, economic, religious, and commercial determinants of COVID-19 in BAME communities, and to develop readily implementable and scalable programmes to reduce risk and improve health outcomes.
3. Improve **access, experiences and outcomes of NHS, local government and integrated care systems commissioned services** by BAME communities including: regular equity audits; use of health impact assessments; integration of equality into quality systems; good representation of black and minority ethnic communities among staff at all levels; sustained workforce development and employment practices; trust-building dialogue with service users.
4. Accelerate the development of **culturally competent occupational risk assessment tools** that can be employed in a variety of occupational settings and used to reduce the risk of employee's exposure to and acquisition of COVID-19, especially for key workers working with a large cross section of the general public or in contact with those infected with COVID-19.
5. Fund, develop and implement **culturally competent COVID-19 education and prevention campaigns**, working in partnership with local BAME and faith communities to reinforce individual and household risk reduction strategies; rebuild trust with and uptake of routine clinical services; reinforce messages on early identification, testing and diagnosis; and prepare communities to take full advantage of interventions including contact tracing, antibody testing and ultimately vaccine availability.
6. Accelerate efforts to **target culturally competent health promotion and disease prevention programmes** for non-communicable diseases promoting healthy weight, physical activity, smoking cessation, mental wellbeing and effective management of chronic conditions including diabetes, hypertension and asthma.
7. Ensure that **COVID-19 recovery strategies** actively **reduce inequalities caused by the wider determinants of health** to create long term sustainable change. Fully funded, sustained and meaningful approaches to tackling ethnic inequalities must be prioritised.

Managing Population Health & Tackling Inequalities (3)

Covid-19 has had and will have a significant impact on the wider determinants of health.

Healthy Life Expectancy

- Working age males with Covid twice as likely to die as females. Possible influence of occupation. But rate of death in women in LBTH higher than UK average
- Has amongst the lowest healthy life expectancy in t he country (although this improved significantly for men in data release 2014-16)
- Varies significantly across the borough and is linked to deprivation
- Lower for females, which is unusual

Deprivation

- Pre-Covid deprivation levels high but improved. Economic impacts of the pandemic mean greater levels of unemployment & deprivation likely
- Covid mortality rates are more than double for those in deprived areas vs least deprived areas
- Third highest proportion of the population living in the most deprived areas. This suggests that the impacts of deprivation could be becoming increasingly concentrated in the borough

Early death and long-term health issues

- 91% people who died with Covid had at least one pre-existing condition-diabetes, high blood pressure, cardiovascular all key issues
- Covid-19 likely having a negative impact on this e.g. as a result of paused cancer screenings
- Early deaths from the major killers (cancer, cardiovascular disease and respiratory disease, liver disease) remains well above the national average
- Levels of diabetes are higher compared to elsewhere
- Levels of common mental health issues (e.g. anxiety and depression) are amongst the highest in the country

Health behaviours

- Some negative impacts from Covid-19 (e.g. sedentary lifestyles) but also evidence of increased interest in healthy behaviours (e.g. smoking cessation)
- Higher levels of low birth weight indicate poorer maternal health
- Higher levels of childhood obesity and poor oral health
- The diet of the adult population is significantly less healthy than elsewhere
- High levels of smoking and substance misuse
- High levels of sexually transmitted infections and HIV
- Low uptake of screening services (bowel,breast,cervical)

Physical environment

- Use of physical environment changed with Covid-19 and likely to continue for some time
- Supports the health and wellbeing of its residents significantly less than elsewhere
- High levels of crime impact adversely on people's sense of safety

Social and economic factors

- Risk of school attainment levels dropping as a result of school closure during pandemic
- Risk of increase in homelessness when eviction ban is lifted as a result of economic downturn
- Low levels of employment contribute to lower self-perceived health
- Income deprivation impacts on health, particularly on children /families and older people
- Excellent educational outcomes for children will mitigate the impacts of deprivation and affect future life expectancy
- High levels of insecure housing and overcrowding lead to poor sense of wellbeing

Mental and Physical Health in Tower Hamlets (4)

Pre-Covid, Tower Hamlets had higher than average reported levels of mental health issues – likely due to the prevalence of 'wider determinants'. It is evident that since lockdown, this has had a negative impact on peoples mental health & wellbeing and expect to see increase in demand for mental health services going forward .

47% of people with a serious mental illness smoke, compared to **20%** of the population

30% of people with a serious mental illness are obese compared to **10%** of the population

38% of people with a personality disorder have a long-term condition, and are more likely to have three conditions than two or one

45.8% of people with COPD have a mental health condition

42.1% of people with a learning disability have a long-term condition

34.3% of people with heart disease have a mental health problem

35% of emergency admissions at the Royal London are for people with a mental health condition

44% of emergency bed days at the Royal London are for people with a mental health condition

10% of people with dementia and known to the Trust are seen in three or more specialities in acute outpatients

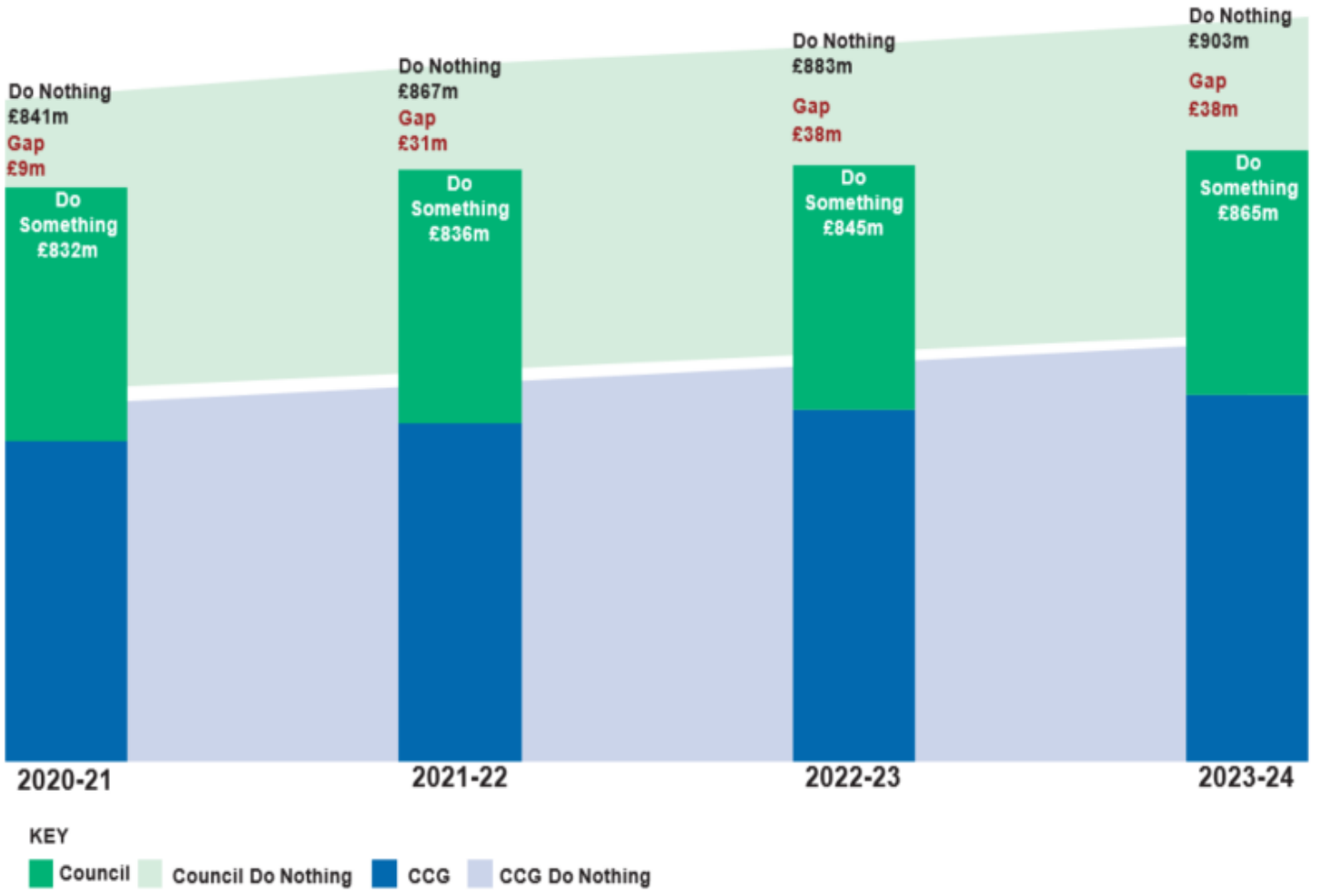
37% of people on the Tower Hamlets Integrated Care Programme are currently or previously known to the Trust, **44%** to adult mental health services

The **2.3%** of the population known to ELFT use **25%** of the services (including mental health)

The **11.2%** on the primary care registers for mental illness use **43%** of the services (including mental health)

Tower Hamlets Financial Challenge – CCG & LBTH

- In response to COVID a temporary financial regime has been put in the place for all CCGs from 1st April 2020 to 31 July 2020. This will be extended to August 2020, and possibly September 2020, but no formal notification has been issued.
- NHSE/I expect CCGs to breakeven on an in-year basis. To achieve this, where costs have been deemed reasonable, CCG allocations will be non-recurrently adjusted.
- The 2020-21 CCG allocations for the remainder of the year have not yet been confirmed as a result of Covid-19.
- The impact of Covid-19 on Tower Hamlets council like all councils across the country has been significant. The current estimated full year costs are c£33m with a range of support provided by central government to communities, business and local government to deal with the wider financial impact.

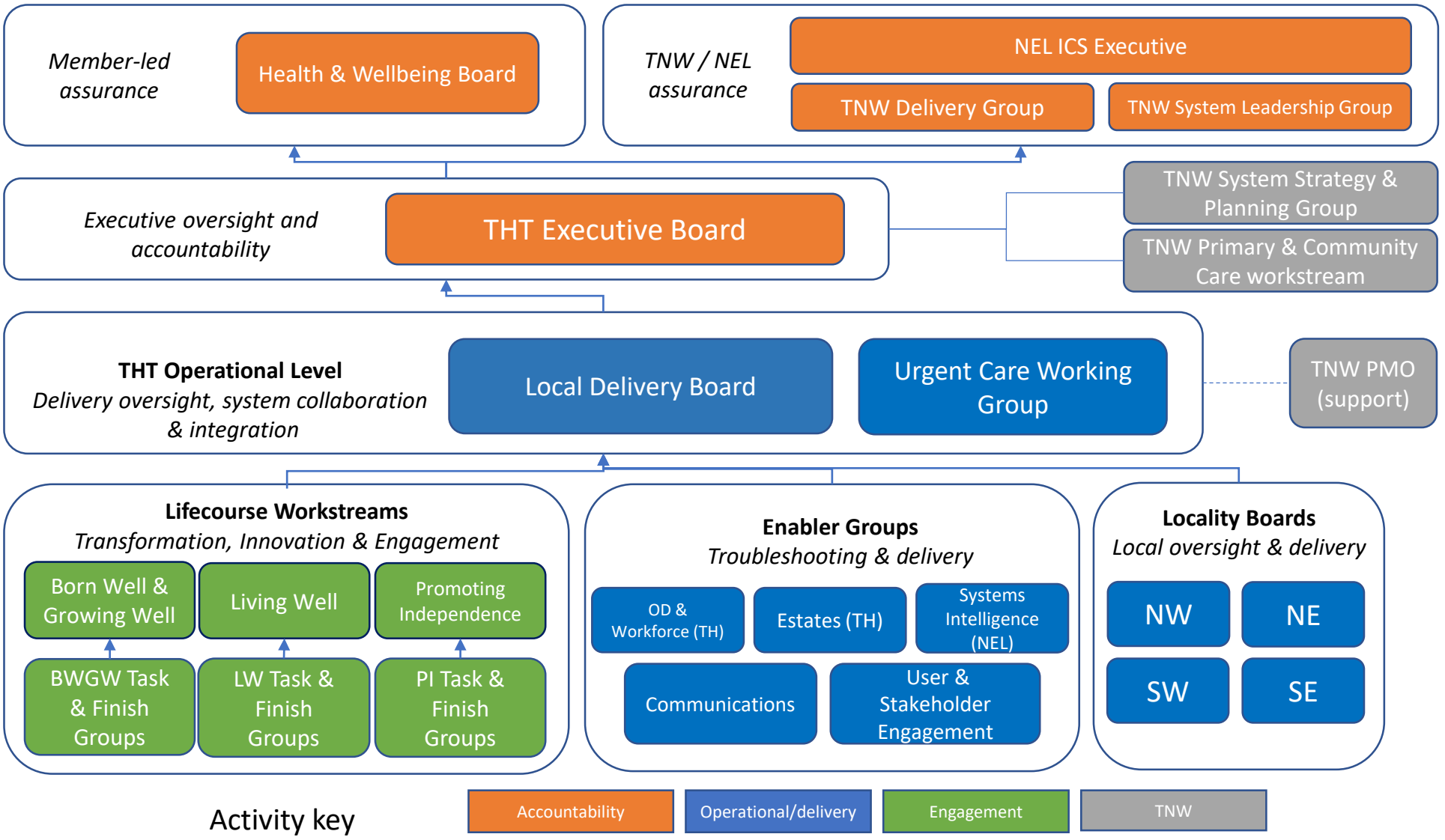


- The impact of covid-19 has affected the ability of the council to deliver on savings plans and continue with a range of transformational activity that is necessary to deliver a balanced budget in the short term. Longer term delays to the delivery of savings and transformation activity will have an impact on delivering future balanced budgets. Urgent action is needed to deal with the projected financial gap in future years.

Operating Context and Our Learning from Covid-19

Operating Context

Tower Hamlets Together Governance



Working Together
What's worked well and learning from our Covid-19 response

It is easy to list the many changes that have taken place across Tower Hamlets since March 2020, to celebrate the way in which services have responded and transformed to meet the demands upon them, as well as to recognise the lessons-learnt both for future management of Covid-19 and future approaches to our health and wellbeing as a whole.

Whilst the rapid adoption of digital technologies is perhaps one of the most obvious effects of the outbreak, it is also just one example of how we have moved as a partnership from a process of piloting or being '*stuck*' on certain issues over many months; to rapid implementation of major changes across the whole of Tower Hamlets in a matter of days and weeks.

Underpinning these more profound changes have been the thousands of daily conversations between colleagues across Tower Hamlets, supporting each other and those they are caring for, throughout the evolution of the pandemic.

We have seen our Primary Care Networks and practices come together as never before to work together and to ensure the resilience of our primary care system upon which the rest of our joint working relies; mirrored in the collaboration across broader acute, community, mental health, public health, social services and our voluntary and community sector to help safeguard our population and to continue to provide vital services to those in need.

Our recovery plan recognises the importance of continuing this work, and particularly, of ensuring that those on the frontline continue to have the autonomy to make the decisions needed in the interest of the individuals and communities of which they are a part.

Our plan recognises that there is particular learning around how we protect our care homes and successfully shield those at greatest risk from Covid-19 infection, even as we also work on the wider health and wellbeing needs of individuals across Tower Hamlets a whole.

We will ensure that we stand-up preventative services as a priority and over coming months, our resources for managing winter pressures; and build on the wider contribution of the voluntary and community sector, including in social prescribing, supporting self-management, identifying and aiding victims of abuse, and managing the impact of Covid-19 on the wider socio-economic determinants of health.

We want to change the way we deliver support to people and do this through developing the market place and through closer working with our voluntary and community sector. In addition we need to ensure that any gaps in the market are addressed for the BAME community – this includes looking at how how we will work with church's, Mosque and the faith community to support development of the offer.

Last but not least, we recognise that we could not have done any of this without the commitment of our staff, across all health and local authority services. Their welfare must be a core part of our plan for providing a high-quality response to all of our patients and residents, in the months and years to come.

Working Together
key developments since March 2020

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

- **Collaboration with providers** –we refocused to ensure daily contact with our main providers – care homes, home care agencies and hostels had priority focus but also including our day centres and our mental health and learning disability providers, as well as our carers centre and local link services. We provided high levels of support in terms of public health advice, PPE mutual aid arrangements and testing.
- **Integrated Discharge Hub** - a multi-disciplinary team established from ELFT's Admissions Avoidance Discharge Service, the Councils Hospital Social Work Team, ELFT Continuing Healthcare Team and LBTH Reablement and Brokerage. The team are responsible for all hospital discharges from the Royal London Hospital, including non-Tower Hamlets patients. Between March – May over 300 patients were referred, with just over 50% of these Tower Hamlets residents. 90% of patients were successfully discharged home. 10% were discharged to nursing and residential homes, supported accommodation, and newly commissioned step-down facilities. 25% of patients were discharged the same day, and over 50% within 1 day.
- **Adapting services** – primary care provided staff and patient testing directly in Care homes and GP's provided support for homeless people in the special hostels. GP practices switched swiftly to remote consultation including health checks where possible to limit unnecessary contact/journeys, using video/telephone consultation
- **Direct Payments** – we put in place a 10% contingency for all residents who receive direct payment and provided PPE for those who needed it. We provided advice and support across the board and worked closely with our local disabled people's organisation, the local provider of direct payment support and others to produce local advice and guidance. We focused on strong communications to promote this.
- **Community mobilisation** –supported the co-ordination of the community efforts around wellbeing, befriending etc.
- **Home monitoring service –** provided by General Practice for COVID symptomatic patients to avoid face to face care, reduce conveyances and enable safe discharge home
- **Shielding -** worked closely across the partnership to ensure the most vulnerable in our borough were identified, contacted, and supported. A contact operation was established with GPs, Council and health partners calling vulnerable residents.
- **Travel Assistance** – whilst the number of children requiring home to school travel assistance reduced, the team continued to support those families of key workers and vulnerable children to safely attend school where possible. As well as this the team used their skills and experience to offer a service to Royal London Hospital to increase transport capacity should there be a need for mass discharge of none Covid patients.
- **Homelessness & rough sleeping** - close working with housing meant an effective approach in terms of homelessness, rough sleepers and our large hostel population. This has included additional accommodation for homeless people and linking GPs and health service support around those sites; and ensuring our settings are prepared for managing outbreaks, supporting social distancing and self isolation etc.
- **PPE** –rapidly created a team, a process and a supply chain to ensure we had sufficient PPE for staff and for our commissioned services, and with clear guidance in place about when and how to use this – despite the difficulties nationally with PPE.
- **Placements** –increased the system wide collaboration between the Children's Integrated Commissioning Team, the Children's Placement Team, SEND and Children with Disabilities, utilising existing structures and arrangements, namely the local area risk register meetings to care plan and source placements, using our collective capacity and resources to increase capacity. This approach kept some of the children with the most complex and challenging behaviours safe and at a reduced risk of requiring tier 4 MH services.
- **Financial support and market sustainability**-moved swiftly to change payment and contractual arrangements for our home care providers and commissioned care homes

Planning for Recovery and the Second Wave

Planning for Recovery and Second Wave

Our priorities for Tower Hamlets build on the progress to-date in responding as a partnership to Covid-19, but recognise the specific challenges ahead, including in restoring access to services and support across our population, including both shielded and non-shielded individuals, adults and children, and those requiring mental and physical health and care support.

The fundamental purpose of this plan is to ensure that we are organised to deliver health and care services to meet the needs of our population. This incudes:

1) **prevent and control COVID infection**, providing a safe environment to care for our population and giving them confidence to present to us when they have a need.

2) **recommence the delivery of services** that have been suppressed over the initial COVID peak, to prevent the build up of unmet need in the population.

3) **meet new or changing needs** of our population as a result of Covid19

4) **ensure services are capable of responding to surging demand and local outbreaks,** based on agreed system indicators which point to a rising tide in the local system and which would trigger a range of responses, including expanded community provision and care models

5) **continue to operate within capacity and resources** across the system and ensure everyone who needs care is able to receive it.

Achieving these objectives means some fundamental changes to how we deliver care as a system:

- ❑ Segregating services across the system to control COVID infection
- ❑ Consolidating elective services, improving our ability to efficiently deliver safe elective care
- ❑ Enhanced primary and community services to provide care without the need for hospitalisation wherever possible
- ❑ Where possible, delivering services virtually

In order to achieve this, we will need to consider **workforce requirement.** We will also need to ensure that **screening and testing** processes ae in place and that **PPE supply** is good.. Finally, many of these changes will require significant **capital investment** to operationalize.

Planning for Recovery and Second Wave

To achieve this we need to reduce NEA at the Royal London Hospital by 20%

Potential non-elective reduction opportunity	WXH	RLH	NUH	SBH	HUH	BHRUT	NEL total
Admission avoidance	-6.7%	-10%	-4.7%	n/a	-6.7%	-6.7%	-7%
Length of stay reduction	-13.3%	-10%	-9.3%	n/a	-8.3%	-13.3%	-11%
Proposed opportunity during COVID troughs	**-20%**	**-20%**	**-14%**	**n/a**	**-15%**	**-20%**	**-18%**
Additional suppression during COVID peak due to social distancing and local lockdown measures in line with national policy	-13%	-13%	-13%	-13%	-13%	-13%	-13%
Proposed opportunity during COVID peak	**-33%**	**-33%**	**-27%**	**-13%**	**-28%**	**-33%**	**-31%**

At the same time, we want to ensure we manage the level of demand across both Adult and Children's social care by strengthening signposting to universal and early help services as well as increasing the use of the voluntary sector in supporting low level needs. For Adult services the aim will be to promote a strength based focus to ensure people are able to live in their home for as long as possible, whilst reducing the need for a costed support packages. For young people this is likely to mean continuing to focus support for children with underlying health and medical conditions to remain at home through continued support to families in their own home as well as providing a range of different respite options where it is safe to do so.

These can be measured by the following outcomes:

- Numbers of cases through Information and Guidance
- Number of people still at home after receiving re ablement
- Number of contacts not progressed to an assessment.
- Number of contacts progressed to Care Act assessment.
- Number of contacts that receive a care package after an assessment.
- Number of residents being supported through assistive technology
- Number of residential care home admissions

Integrated Community Model

What Does the Integrated Community Model Look Like for Tower Hamlets?

Our model of care is organised around four localities, north-west, north-east, south-east, south-west, each of which comprises two networks of 4-5 GP practices, and which covers a population of c. 60-70k.
We have already organised many of our care services around localities, e.g.:

- Extended Primary Care Teams of district nurses and therapists
- Community Mental Health Teams
- Longer term social work teams
- Home care agencies (two commissioned per locality)
- Community based support services e.g. Linkage Plus, Day centres

Locality Health & Wellbeing Committees, as local collaborative leadership forums, will increasingly develop a systemic view of local population assets and needs, and develop a broader network of local organisations and individuals to drive improvement (e.g. VCS, care homes, home care, faith groups, schools etc.)

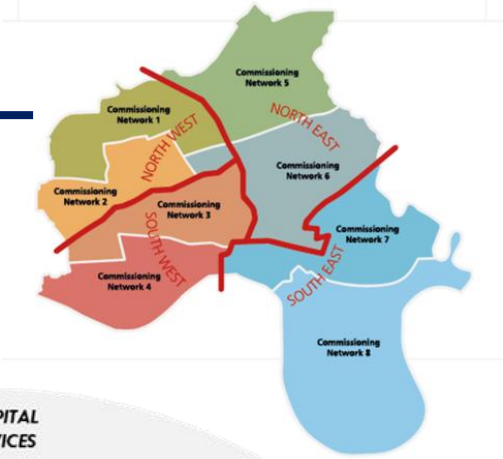
There is significant work underway to support population health improvement on a locality basis, including locality public health navigators, locality JSNAs, and the communities driving change programme (HWBB priority)

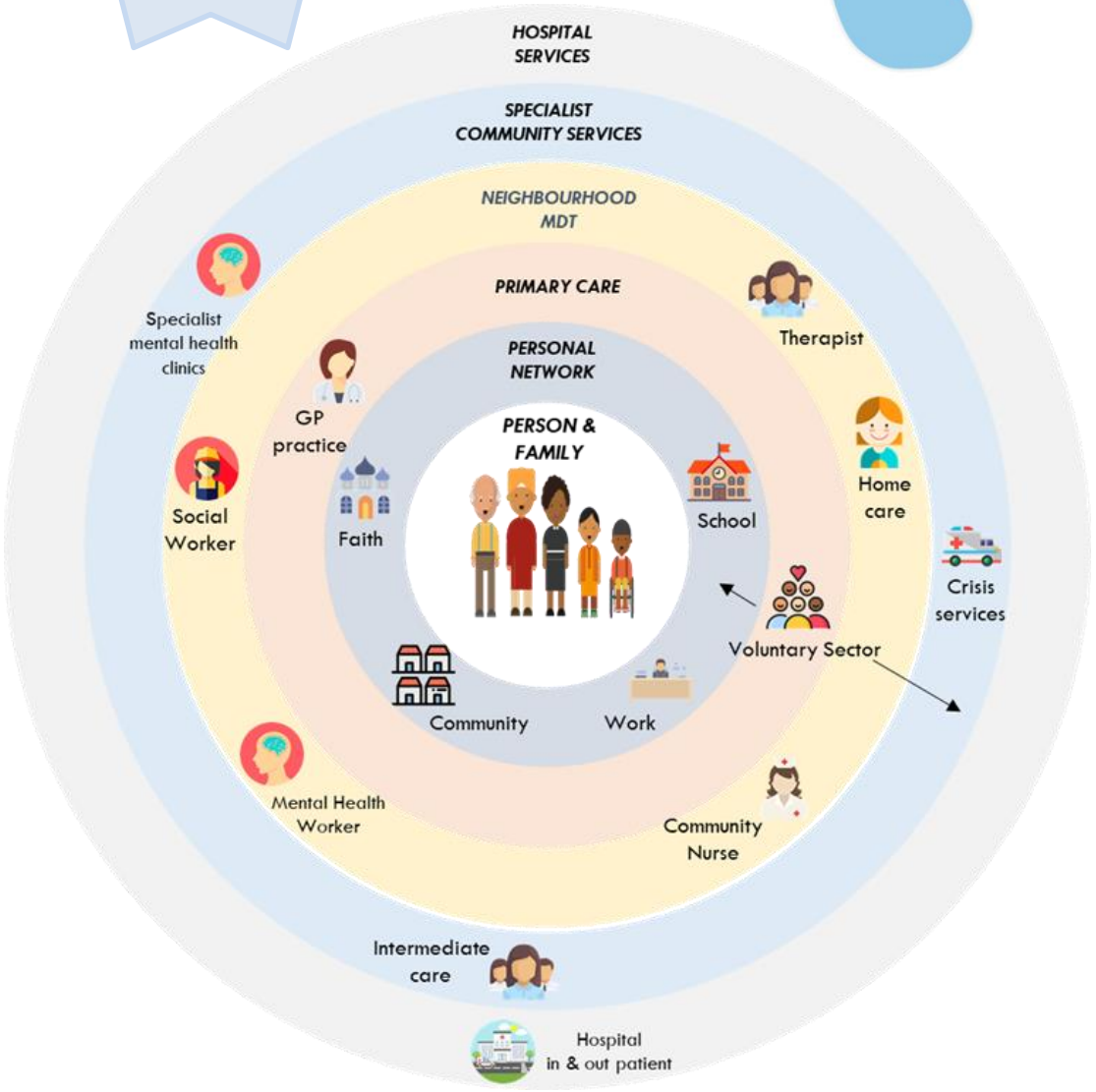
Neighbourhood based multi-disciplinary teams are a foundational component of the national Integrated Care System strategy.

The principles of a neighbourhood based around a population of c. 50,000 is that:

- Teams of local health and care practitioners will know the communities they serve best.
- A population of 50,000 is sufficiently small to allow health & care practitioners to build a strong and personal network between them.
- For people with complex needs, in particular, it is important to deliver integrated care close to home, with health & care practitioners working closely to provide streamlined person-centred care
- There are opportunities for broader networks of local organisations and individuals to be formed around neighbourhoods, with a focus on building community involvement, resilience & capacity, for example the communities driving change programme.
- There are opportunities, over time, for neighbourhoods to take on micro-commissioning responsibilities.

THT Outcomes framework





How will this be different for Joseph?

Joseph's story

- *Joseph, 78*
- *Expected to die within six months*
- *Lives alone and wants to die in his own home*

Joseph is a retired teacher of physics. He is extremely knowledge-able and insightful about his condition but also obstructive and very cynical. His resistance to conventional health and social care management had been vehement and sustained. He had a stent in situ and was expected to die within six months

Close to being bed bound, Joseph had low hemoglobin, although a transfusion was not indicated. He was losing weight and food supplements were his only nutrition. He had chronic constipation but refused conventional treatment for this

Some weeks ago Paul, a friend of him visited, and insisted on calling the rapid response team who decided to admit him to hospital

He was really difficult to hospital staff and insisted on being discharged home arguing that his disease was incurable and he was not looking for cures. The situation causes significant stress to his old friend Paul

What would happen in an integrated care system

Joseph's GP places him on **an integrated care plan.** His desire to die in his own home, with no relatives to support him, involves considerable challenges and risks

Joseph is referred to the **community matron, who visits him weekly** and coordinates the support required by Joseph, including defining a **care package** for him

For the following 4 months, he receives a package of care comprising of **Marie Curie nurses, rapid response team, Care Plus Agency, district nurses, Hospice care nurse and his GP**

Joseph dies at home – rapid response and the community matron were present

SOURCE: Disguised Tower Hamlets patient story

How will this be different for Sufia?

Sufia's story

- *Sufia, 89*
- *Lives with her husband Vishal, 91, who she looks after*

Sufia usually manages reasonably well. A carer visits once a day and district nurses visit to help her with her incontinence. She became unwell with a UTI and saw her GP who gave her antibiotics

The antibiotics didn't give the expected results and Sufia's condition deteriorated. She became confused and had a fall. She then had to be admitted for a fractured hip.

While Sufia wasn't in the hospital being treated for her hip, Vishal had nobody to look after him anymore. He was admitted into respite care

Sufia is discharged but can no longer take care of Vishal given her condition. They are both admitted into a nursing home

What would happen in an integrated care system

Sufia's GP places her on an **integrated care plan**. Her **carer** is in close contact with the nurses to discuss anything that might affect Sufia's health.
Sufia has **a number she can call** if she is unwell

A **nurse visits Sufia every day over the next 5 days** to monitor her condition very closely to ensure it doesn't deteriorate.

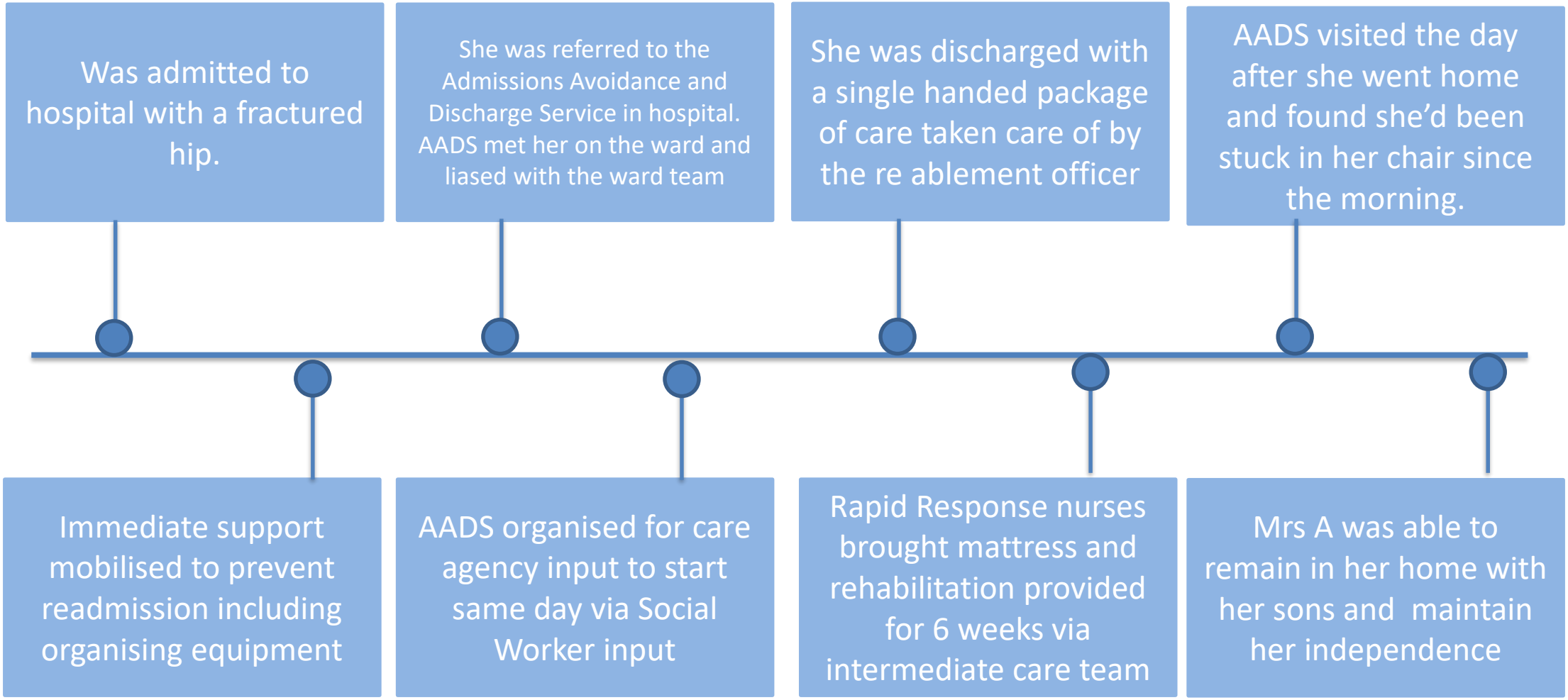
Social care is notified when Sufia is admitted, letting them know that Vishal now has no carer. The **social care team assess Vishal** to determine the optimal support for him and ensure he can remain at home

Sufia recovers from her UTI. The **nurse now visits her at a lower frequency** to make sure she doesn't get another infection. Social care conduct a **reablement assessment** to determine any ongoing needs

SOURCE: Disguised Tower Hamlets patient story

How will this be different for Mrs A?

- 81 year old somali woman
- Lives in Stepney with her two sons
- Has dementia and arthritis and suffers with anxiety
- Was supported by the Admissions Avoidance & Discharge Team (AADS)



Priorities for Action

Primary and Community Health and Social Care Interventions

In order to deliver this plan we consider that there are three main building blocks supported by an overarching population-based approach:

1. Building the **resilience and wellbeing** of our communities including maintaining the capacity to mobilise residents to deliver wellbeing and support within their communities, particularly to the most vulnerable and those who are shielded.

- Developing the four locality Health and Wellbeing Committees
- Further develop strength based approaches to social care, supporting people to connect to their community, access universal services and the community / voluntary sector.
- Continue to support people to access information and advice, as a means of reducing needs and access to social prescribing
- Community mental health transformation aims to dissolve the boundaries between primary, community and secondary mental health care and to ensure that people with severe mental illness can access better care closer to home.
- Developing one shared profile of the population, disease prevalence, social factors, negative trends, and understanding specific impact from COVID-19, including on BAME communities and people with diabetes, heart disease, and obesity; and
- Access to IAPT for vulnerable & BAME communities
- Deliver the Covid-19 Vaccination Programme across Tower Hamlets
- Integrate the Community Phlebotomy service

2. **Maintaining people's independence in the community** - ensuring multi-agency working across primary, community, acute and social care to meet needs effectively and reduce the need for avoidable admission or for escalation of support unnecessarily – for children and adults

- Implementation of care coordination and MDT working across the borough
- Wider implementation of Personalisation approach including Personal Health Budgets and direct payments
- Ensuring medium-long term housing options are found for the homeless & rough sleepers and ensure that their physical health, mental health and substance misuse needs can be supported and managed
- New model of homecare with enhanced nursing support
- Ensure appropriate support is in place to support those most vulnerable and needing shielding
- Primary care led use of Advice & Guidance with community based support from specialist services i.e. neuro, diabetes, ARCARE, stroke
- 24/7 Primary Care Hubs as part of 'Help Us Help You'
- Continue to support people to access reablement and the independent living hub to optimise individuals ability to meet their own needs and promote independence.
- 24/7 all age crisis line in place
- Remote monitoring of adults & CYP with eating disorders

3. **Reducing the time people need to stay in hospital** - ensuring people are cared for in the community or their own homes whenever this is safe.

- Further embed the Integrated Discharge Hub and D2A culture – why not home, why not today to support proactive care planning upon admission with timely, accurate assessment of discharge
- Trusted assessor roles for staff to reduce duplication of roles / intervention in ASC and provide low level equipment / adaptations to meet needs and increase preventative intervention
- Continue to protect care and nursing homes by providing them with support
- Integration of rehabilitation & re ablement services
- Improved Long Term Condition management via greater use of technology e.g. telecare & tele health
- Support rapid community/social care response including same day care packages

The Interventions for adults

Tower Hamlets integrated primary, social & community care

Care provided in the **community and in people's homes** is a critical enabler of some of the key requirements of the WEL **hospital system**, including:

- doubling critical care capacity;
- working off the elective backlog in twelve months; and
- achieving a non-elective bed occupancy of 92%.

Care provided outside of hospital must support this by sustaining an overall reduction in non-elective non-covid activity of ~17%, through:

- admissions avoidance; and
- minimising time in hospital.

These need to drive reductions in non-elective non-covid activity of – WXH: 20%, RLH: 20%, and NUH: 14%.

Care provided in social care is key to the overall aim and will be measured by

- Numbers of cases through Information and Guidance
- Number of people still at home after receiving re ablement
- Number of contacts not progressed to an assessment.
- Number of contacts progressed to Care Act assessment.
- Number of contacts that receive a care package after an assessment.
- Number of residents being supported through assistive technology
- Number of residential care home admissions

1. Building the resilience and wellbeing of our communities

- Support for those with complex needs
- Improving Population Health

2. Maintaining people's independence in the community by multi-agency working across primary, community, acute and social care to avoid crisis and admission

- Responsive care services inclu rapid same day support
- 24/7 urgent access to care

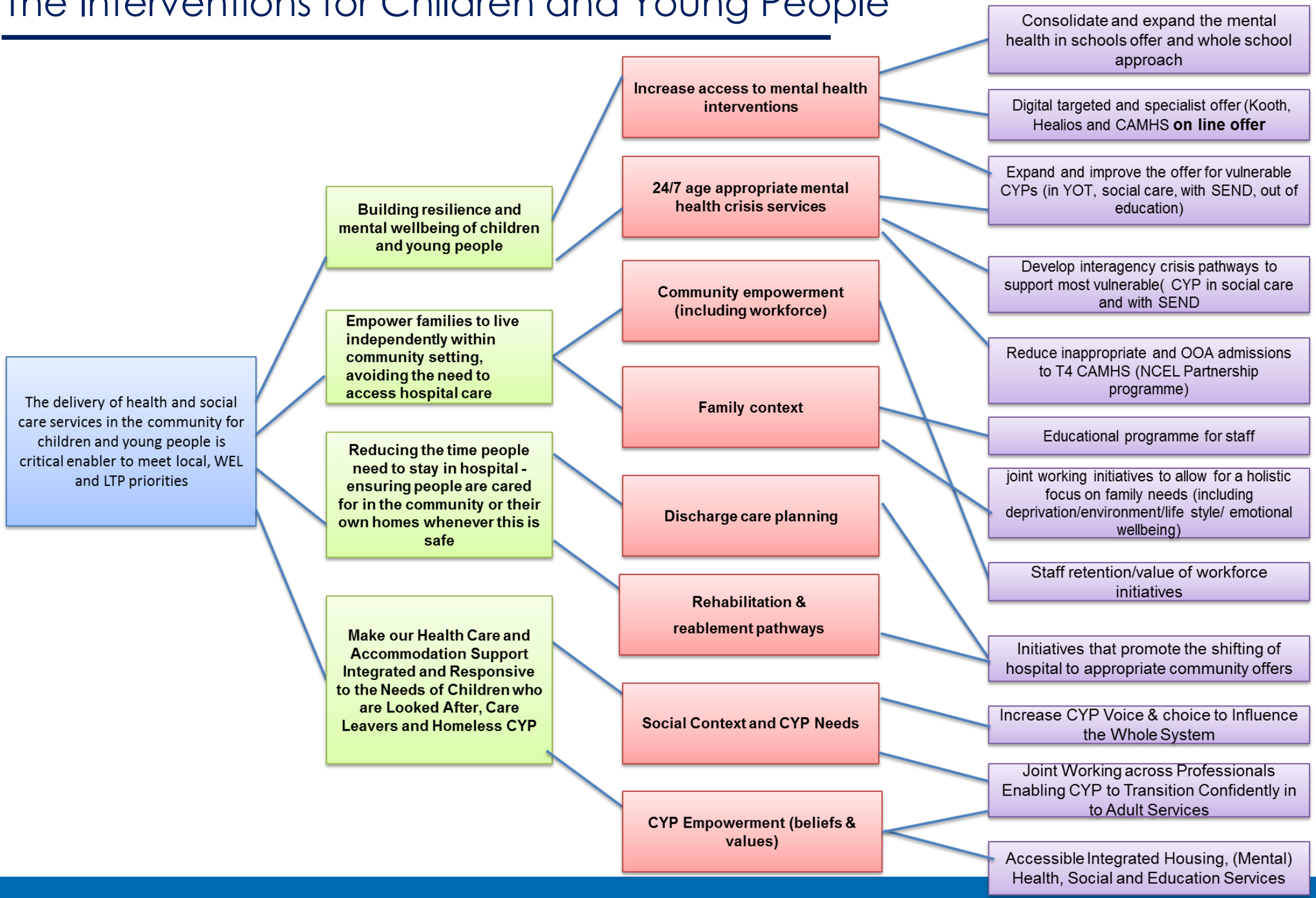
3. Reducing the time people need to stay in hospital - ensuring people are cared for in the community or their own homes whenever this is safe

- Discharge care planning
- Rehabilitation & re ablement pathways

We can achieve the necessary reduction in non elective activity by increasing capacity in existing services and by introducing new interventions which will be modelled and costed

1. Virtual wards, integrated care plans/care co-ordination/case mgt/MDTs high risk patients (child & adults & shielding/ vulnerable) incl LD/MH & frailty incl. community therapy for the frail
2. Improved Long Term Condition management via greater use of technology e.g. telecare & tele health
3. Enhanced support in care homes with virtual ward rounds
4. New model of homecare with enhanced nursing support
5. Support for people at EOL to die at home
6. Social prescribing & access to support including care/financial and promotion of Information & Advice Guidance portal
7. Improve access to remote based care & digital poverty
8. Rapid community/social care response including same day care packages
9. Develop Physio First services across all practices
10. 24/7 Primary Care Hubs as part of 'Help Us Help You'
11. Integrated Discharge Hub to include tertiary care repatriation.
12. Proactive care planning upon admission with timely, accurate assessment of discharge
13. Primary care led via Advice & Guidance with community based support from specialist services i.e. neuro, diabetes, ARCARE, stroke

The Interventions for Children and Young People



Tower Hamlets, Our 2020-2022 Work Programme

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

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

Children and Young People – Born Well and Growing Well

- Children's mental health and emotional wellbeing
- Special Education Needs and Disabilities
- Childhood Obesity
- Ways of working – including pathways for long term conditions, a shared practice framework, a shared model of locality and Multi Disciplinary Team working

Mainly Healthy Adults – Living Well

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

Complex Adults – Promoting Independence

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

Tower Hamlets, Our 2021/22 Delivery Priorities

6 month priorities – April 2021-Sep 2021

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

12 month priorities – April 2021-Mar 2022

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