Tower Hamlets Together:

Versorgung nach den Bedürfnissen der Bevölkerung in London

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"every person across the spectrum of need, having **choice** and **control** over the shape of his or her support, in the most appropriate setting…"

- Green Paper on *Independence, Well-being and Choice* (Department of Health, 2005)
- *White Paper on Our health, our care, our say: a new direction for community services* (DoH, 2006)
- *Putting People First' (HM Government, 2007)*
- ***Transforming Social Care**. DoH 2008.*

Integrated Social and Health care in the UK since 2008

- Personalisation
  - Focus on the individual
  - Promoting independence, well-being, and dignity
  - Multi-disciplinary team working

- Multiagency working
  - To facilitate cooperation between organisations providing care for patients with similar needs
  - Prevention of crisis, early intervention or reablement programmes.

- Transforming Social care. Department of Health 2008.

"Tower Hamlets Together is a partnership of local health and social care organisations with an ambition to improve the health and wellbeing of people living in Tower Hamlets"

TOWER HAMLETS TOGETHER

Delivering better health through partnership

www.towerhamletstogether.com #TH2GETHER

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

Values, mission and aims

Our values: To make a positive difference for the people of Tower Hamlets we work passionately to be: **Collaborative, Compassionate, Inclusive, Accountable.**

Our mission:

To improve outcomes and experience for **adults with complex health & social care needs and their carers** through delivering and building on the integrated care programme

To improve outcomes and experience for **children and their parents/carers** through developing and delivering new ways of working for children and young people and their carers

To improve the health and wellbeing of Tower Hamlets residents through promoting **self-care and prevention and tackling health inequalities**

Our aims:

For people feel in **control** of their health and well-being

For people have the **best possible** resolution to their priorities at any contact with services

To deliver a cultural change, such that the **resident/service relationship** is mutually supportive

Working across teams

Care for adults with complex needs across boundaries

Case 2 - Timothy, aged 85

- GP receives e-notification from Admission Avoidance & Discharge to Access Service:
  - Patient discharged from hospital
  - Home visit planned by social worker

- 2 months before, patient's neighbour called GP due to confusion
  - Patient not answering GP's call, but police and ambulance state patient "OK"
- 24 hours later, @ GP home visit
  - Patient unkempt, confused, soiled, heart rate 136 bpm, temp 39C
- Admission to intensive care unit (3 weeks)
  - Sepsis, renal failure, and dementia

Case 2 - Timothy continued…

- Patient lives alone, no relatives, only friend lives outside London

- Home visit by social worker
  - Patient welcoming, mobile & independent around the house
  - Kitchen desolate, faeces on floor and bed, mouse pellets
- Patient consents to entering the Admission Avoidance Service
  - Care navigator for hospital appointments and team coordination
  - District nurse & Reablement Team
  - Pest control
- 2 weeks later, flat empty, re-admitted to hospital
  - Care navigator: Care package inadequate
  - Help with shopping and Telecare service

Tower Hamlets Integrated Care & Admission Avoidance Services

Rapid Response team (Nurse sees patient within 2 hours)

Admission avoidance team: GPs, nurses, therapies

Discharge to Assess team: Social worker, occupational therapist, physiotherapist, reablement officers (first 6 weeks after hospital discharge)

Locality Services: District nurses, matrons, care navigators, therapists, (psychologist)…

Adapted from: Bussu S, Lalani M, Marshall M. RCGP Research Conference. 2018.

Multi-disciplinary team (MDT) meeting for patients with complex needs

MDT members	
Advanced nurse practitioner	▫
GP	▫
Social worker	▫
Care navigators	▫
Social prescriber	▫
Pharmacist	▫

Complex care team at St Andrews Health Centre

Services offered (selection)

Complex care
- Palliative Care, Dementia, Nursing home

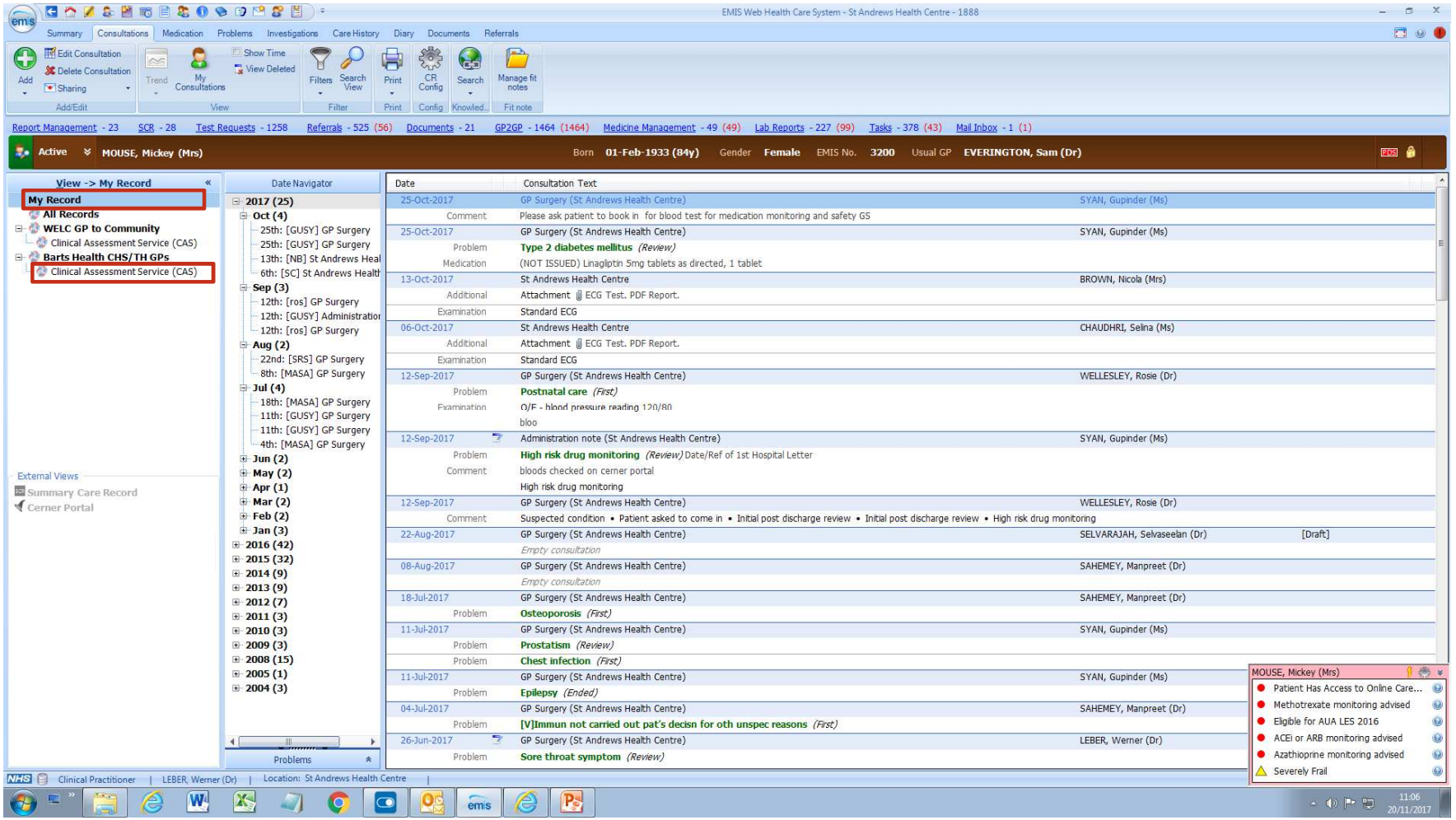
Care planning
- Long term conditions
- Cancer
- Severe mental illness

Part A: Processes
- Depression & dementia screening
- BP, BMI, QRisk
- Blood and urine tests

Part B: "What matters to me"
- Self-management & wellbeing support
- Medication review
- Mental health capacity assessment

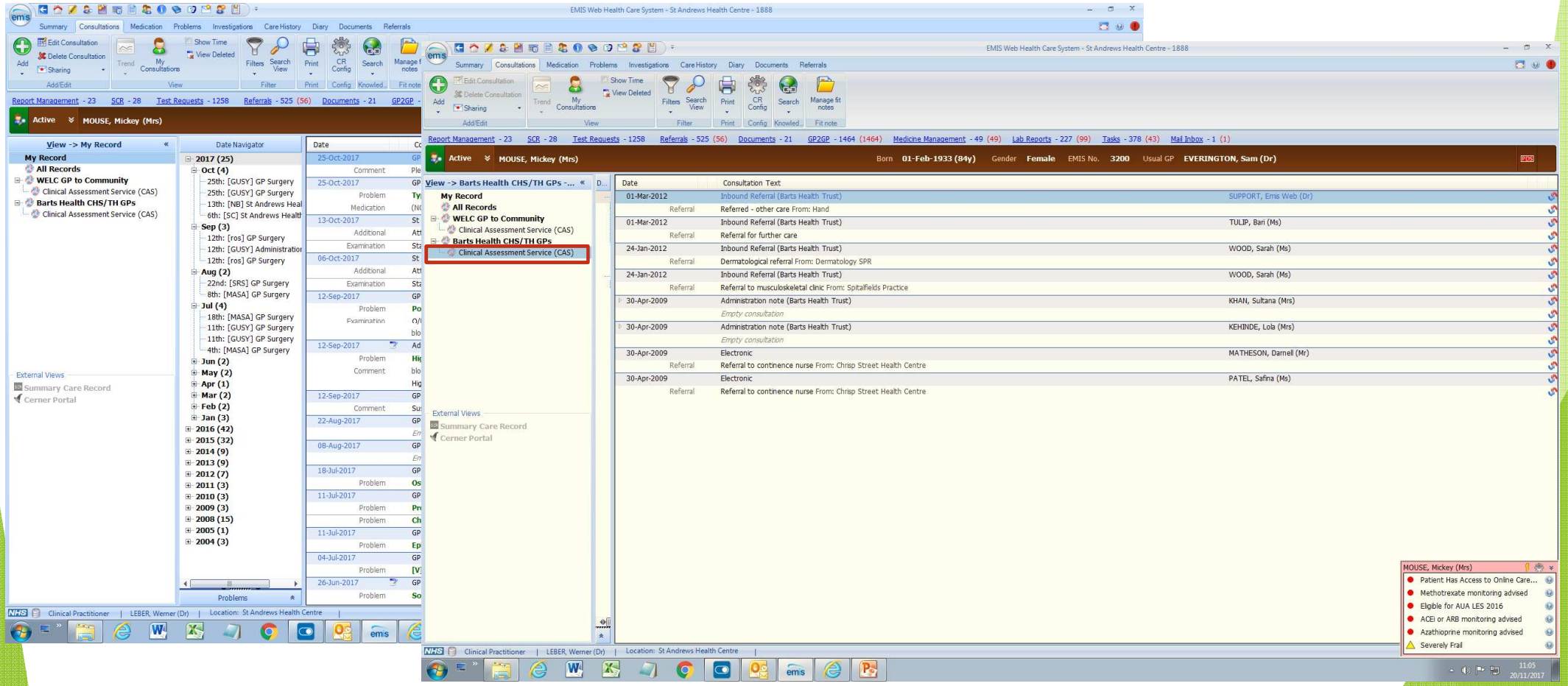
MDT meetings with specialists
- Geriatrician, diabetes specialist, psychiatrist, etc.

Shared EMIS Web* primary care computer system – GP view



*EMIS…Egton Medical Information Systems, UK.

Shared EMIS Web*
- Community health services view

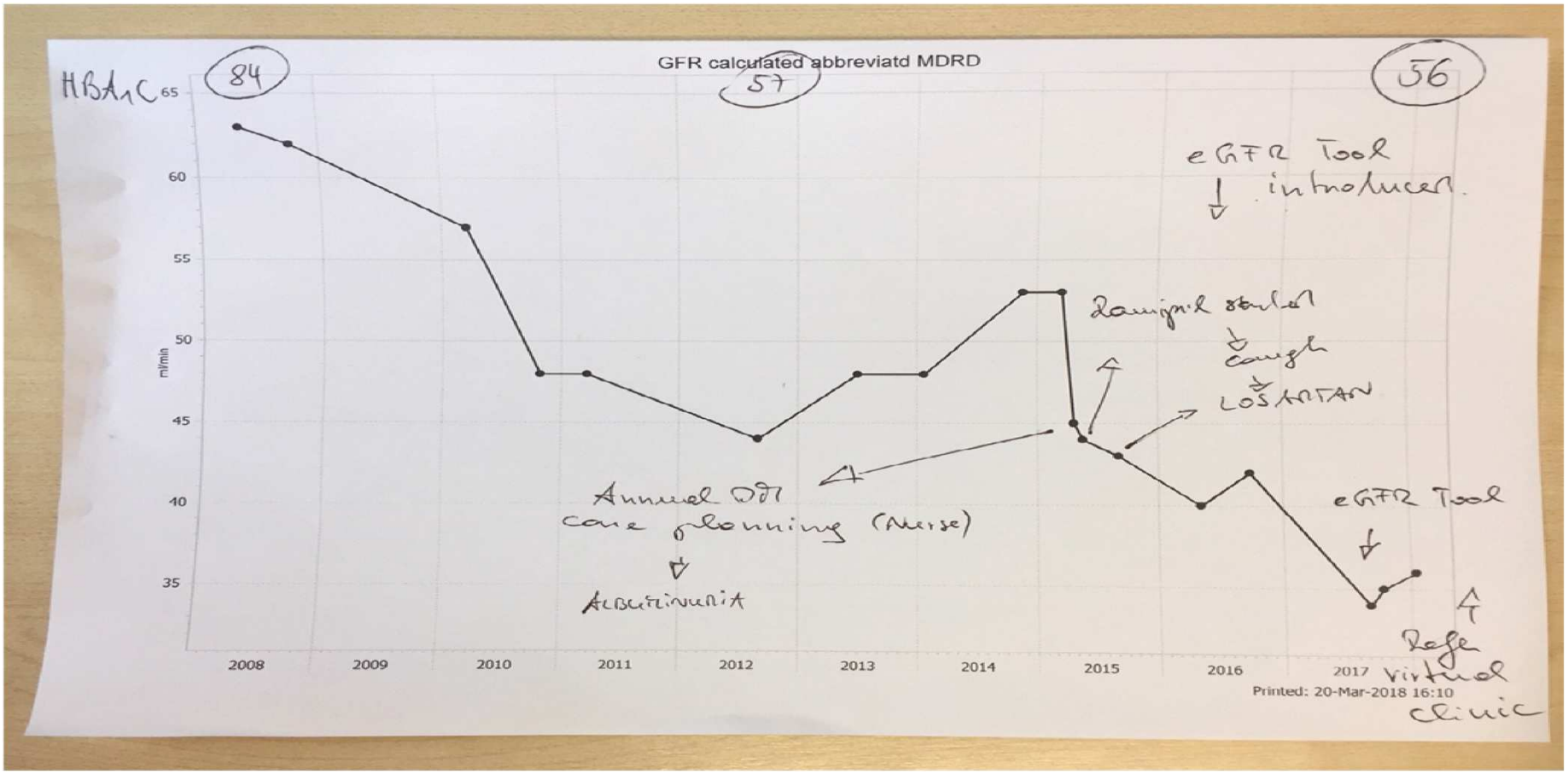


*EMIS…Egton Medical Information Systems, UK.

Working across teams

Tower Hamlets Renal Community Service (Virtual clinic)

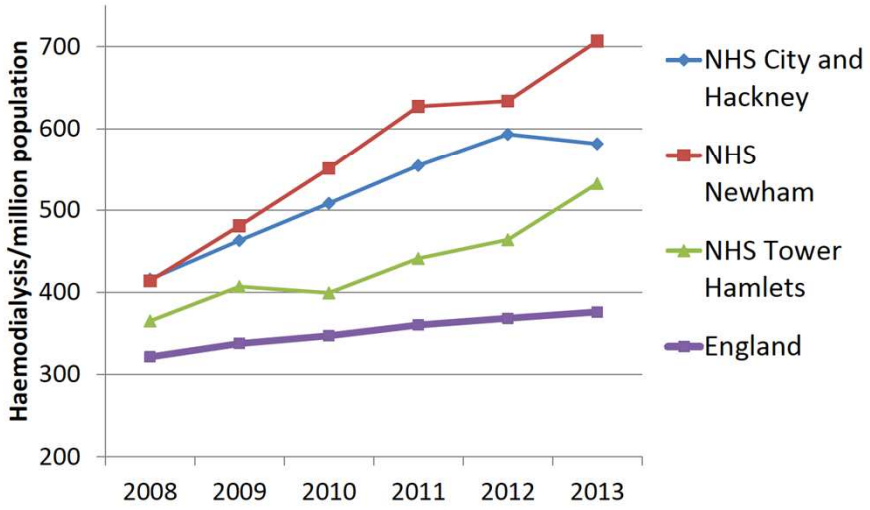
Case 2 - Syeda, aged 72



High rates of haemodyalisis in east London

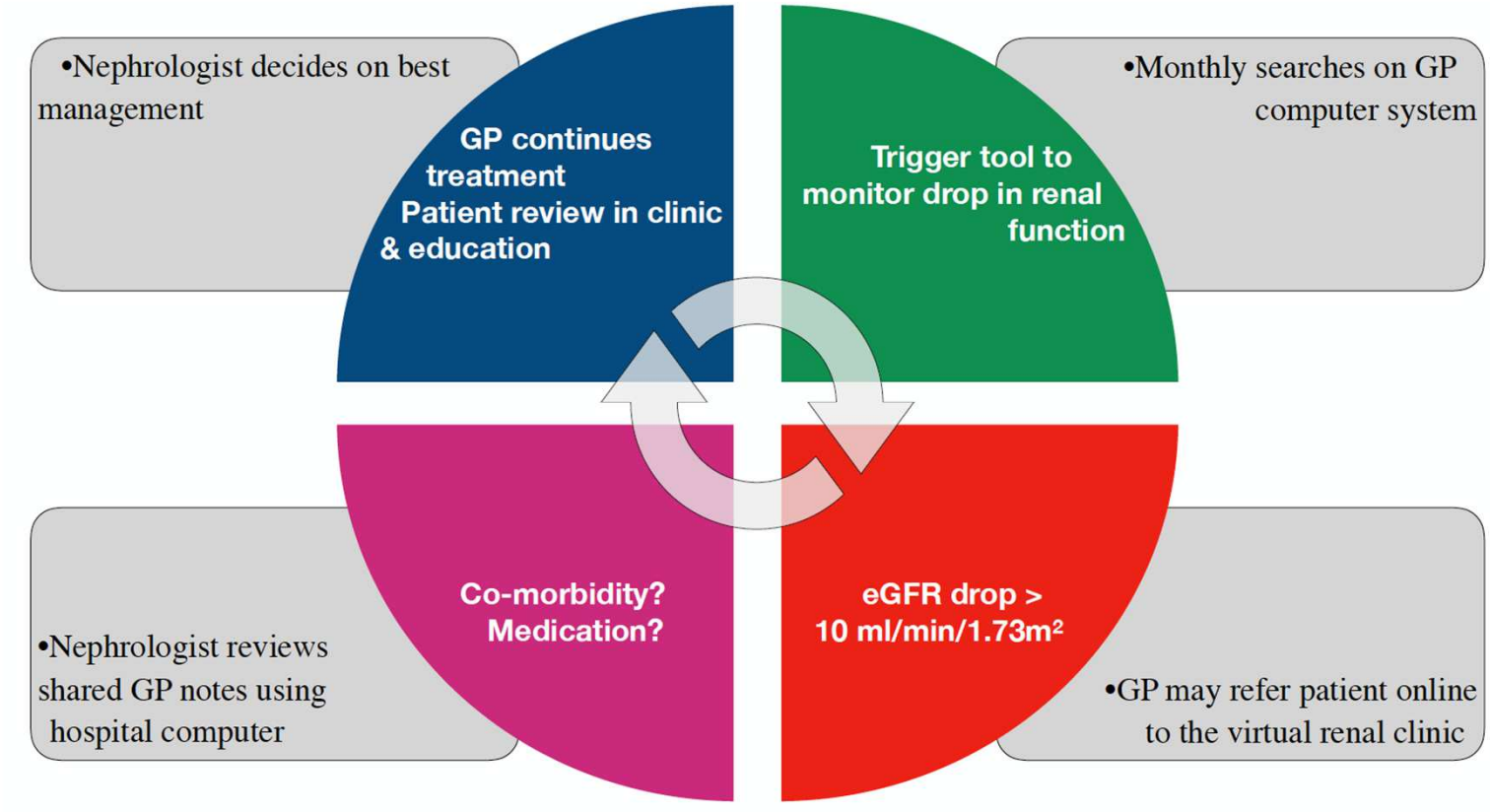
What is the Problem?

Fast rising ESRD rates in East London – ever more people needing dialysis
Haemodialysis rates per million population, 3 East London Boroughs



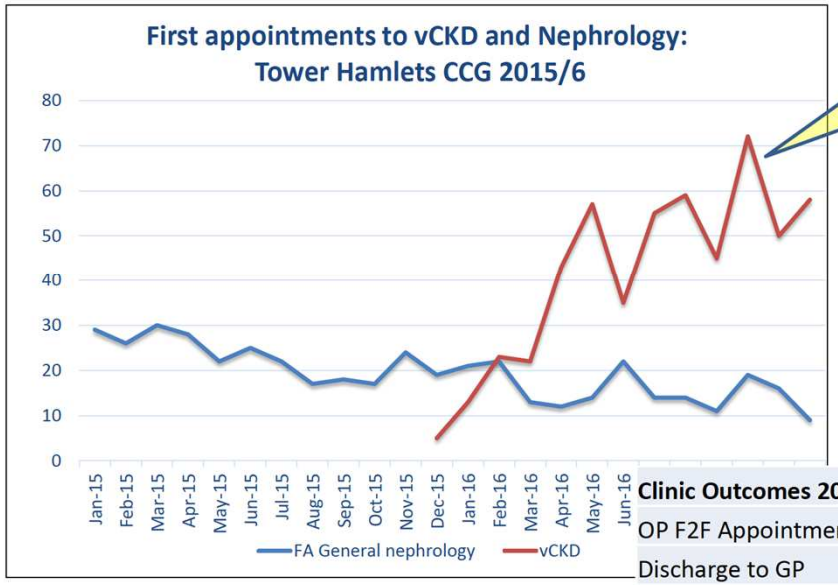
Data from the UK Renal Registry 2015

Tower Hamlets Community Renal Service



Increased access to specialist care

Change in clinic activity: Tower Hamlets 2015/6



About 20% of patients require a face to face appointment

98% of patients with CKD continue to receive renal care with the GP

Clinic Outcomes 2016	No.	%
OP F2F Appointment	111	21.5
Discharge to GP	255	50
Review in vCKD	143	27.5
Other	5	1
Total	**514**	**100**

Source: https://www.qmul.ac.uk/blizard/ceg/the-renal-health-service/#form

Consultant: *"We can provide comprehensive management advice whilst avoiding unnecessary duplication of tests"*

GP: *"We have never met these people (the nephrologists) but I feel I have a relationship with them now….you cannot underestimate that."*

Working across teams

Collaborative psychology care for people with poorly controlled long term conditions

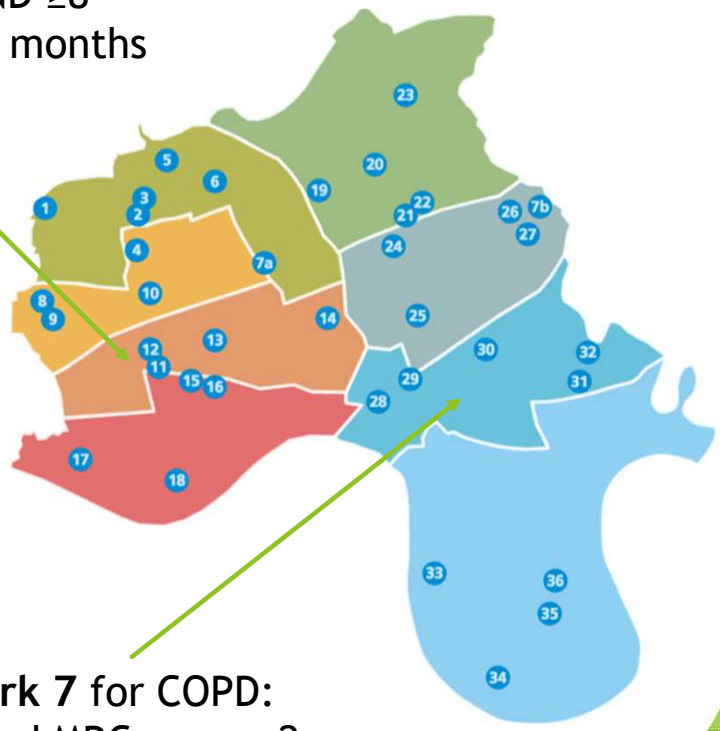
Case 3 - Rosie, aged 58

Source: https://www.youtube.com/watch?v=2RV2lek-JXQ, RCGP, 2015

Case 3 - Rosie, aged 58

Collaborative psychology care pilot: Study outline

Network 2 for Type 2 diabetes:
HbA1c ≥75 mmol/mol AND ≥8
GP appointments last 12 months



Eligible: GP registered adults (~300 patients/network)

Intervention: One clinical psychologist embedded per network to:

- Train GP staff
- See patients face to face, and run workshops

Outcomes:

- Feasibility and acceptability to staff and patients
- Standard clinical and process outcomes
- Difference in costs.

Duration: 18 months

Network 7 for COPD:
modified MRC score ≥2
(GOLD categories B and D)

What do our team psychologists say?

"I have received a positive reception in all GP practices in the network, by all services that I have encountered (whether they be NHS or not), by the patients I have been contacting and seeing and especially the Network Team.
This has made the post particularly enjoyable and has allowed for some creative and collaborative thinking."

"My ability to have access to staff, patients, services and systems places me in a position where I can connect people. Be it patients with interventions, services or activities; or staff with information and services.

Connecting the dots can create a clearer pathway for everyone involved."

What Margaret, our patient team member, wants to let you know

Summary

- Tower Hamlets has successfully implemented patient-centred services
- Shared values and aims of working together across all health and social care teams have been key
- Single shared computer records facilitated delivery of best possible care.

THANK YOU!

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