

Tower Hamlets Together:

Versorgung nach den Bedürfnissen
der Bevölkerung in London

Dr. Werner Leber PhD

- ▶ NIHR CLAHRC Clinical Lecturer in Primary Care, Barts Institute for Population Health Sciences, Queen Mary University of London (QMUL)
- ▶ Clinical Lead for Long Term Conditions, Tower Hamlets Clinical Commissioning Group (CCG)
- ▶ Salaried GP, St Andrews Health Centre

“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



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

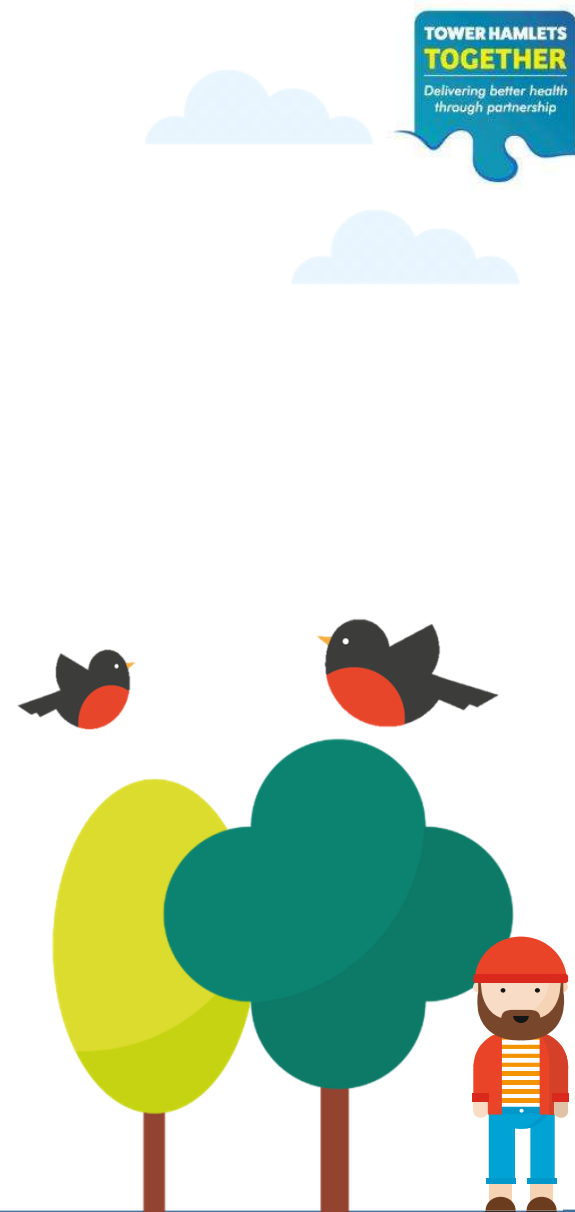
To improve the health and wellbeing of Tower Hamlets residents through promoting **self-care and prevention and tackling health inequalities**

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

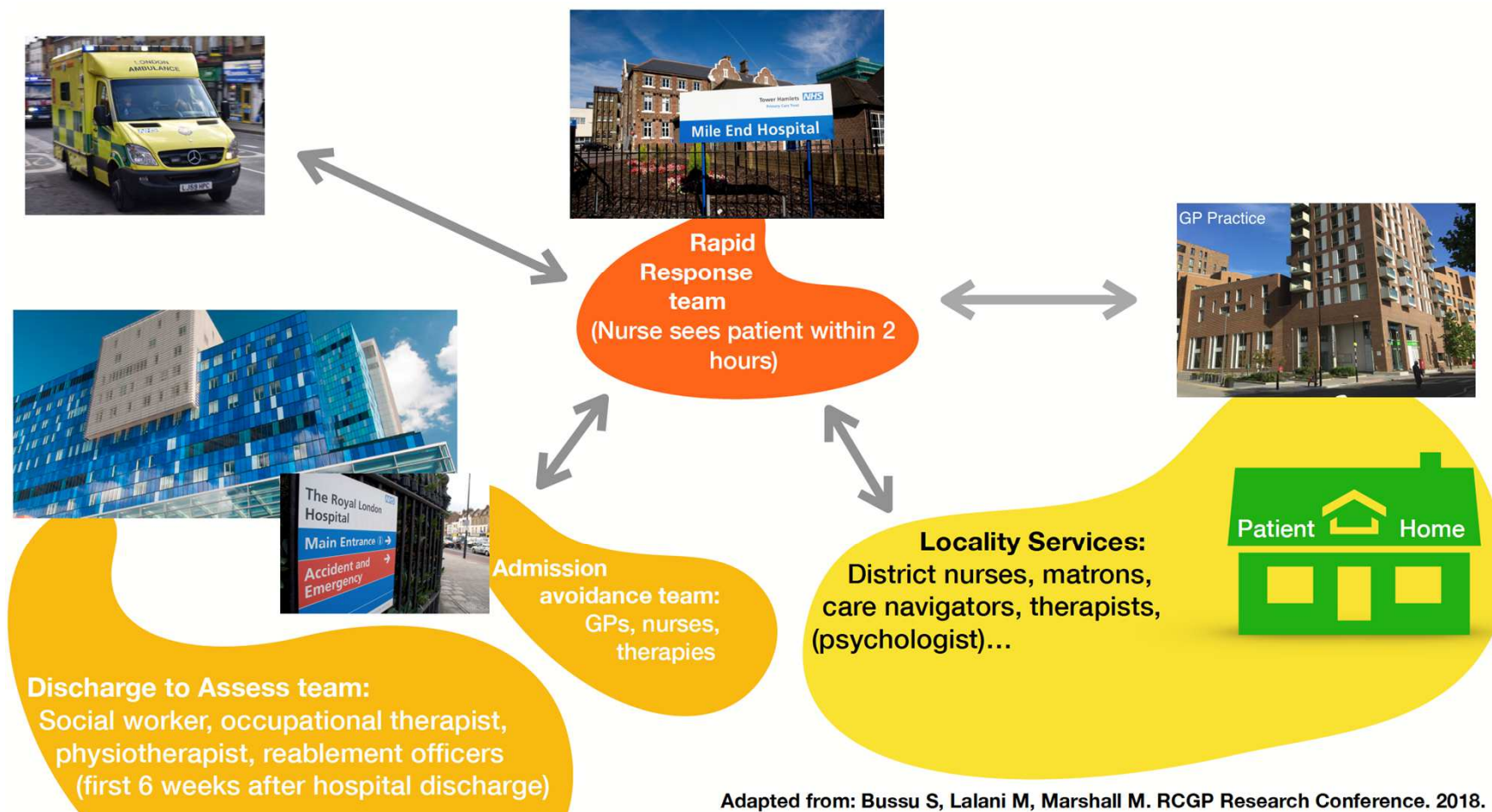
Case 2 - Timothy, aged 85

- ▶ 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



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	<input type="checkbox"/>
GP	<input type="checkbox"/>
Social worker	<input type="checkbox"/>
Care navigators	<input type="checkbox"/>
Social prescriber	<input type="checkbox"/>
Pharmacist	<input type="checkbox"/>

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 Web Health Care System - St Andrews Health Centre - 1888

Summary Consultations Medication Problems Investigations Care History Diary Documents Referrals

Active MOUSE, Mickey (Mrs) Born 01-Feb-1933 (84y) Gender Female EMIS No. 3200 Usual GP EVERINGTON, Sam (Dr)

View -> My Record

My Record

All Records

WELC GP to Community

Clinical Assessment Service (CAS)

Barts Health CHS/TH GPs

Clinical Assessment Service (CAS)

External Views

Summary Care Record

Corner Portal

Date Navigator

2017 (25)

Oct (4)

25th: [GUSY] GP Surgery

25th: [GUSY] GP Surgery

13th: [NB] St Andrews Health Centre

6th: [SC] St Andrews Health Centre

Sep (3)

12th: [ros] GP Surgery

12th: [GUSY] Administration

12th: [ros] GP Surgery

Aug (2)

22nd: [SRS] GP Surgery

8th: [MASA] GP Surgery

Jul (4)

18th: [MASA] GP Surgery

11th: [GUSY] GP Surgery

11th: [GUSY] GP Surgery

4th: [MASA] GP Surgery

Jun (2)

May (2)

Apr (1)

Mar (2)

Feb (2)

Jan (3)

2016 (42)

2015 (32)

2014 (9)

2013 (9)

2012 (7)

2011 (3)

2010 (3)

2009 (3)

2008 (15)

2005 (1)

2004 (3)

Problems

Consultation Text

25-Oct-2017 GP Surgery (St Andrews Health Centre) SYAN, Gupinder (Ms)

Comment Please ask patient to book in for blood test for medication monitoring and safety GS

25-Oct-2017 GP Surgery (St Andrews Health Centre) SYAN, Gupinder (Ms)

Problem Type 2 diabetes mellitus (Review)

Medication (NOT ISSUED) Linagliptin 5mg tablets as directed, 1 tablet

13-Oct-2017 St Andrews Health Centre BROWN, Nicola (Mrs)

Additional Attachment ECG Test. PDF Report.

Examination Standard ECG

06-Oct-2017 St Andrews Health Centre CHAUDHRI, Selma (Ms)

Additional Attachment ECG Test. PDF Report.

Examination Standard ECG

12-Sep-2017 GP Surgery (St Andrews Health Centre) WELLESLEY, Rosie (Dr)

Problem Postnatal care (First)

Examination O/F - blood pressure reading 120/80

12-Sep-2017 Administration note (St Andrews Health Centre) SYAN, Gupinder (Ms)

Problem High risk drug monitoring (Review) Date/Ref of 1st Hospital Letter

Comment bloods checked on corner portal

High risk drug monitoring

12-Sep-2017 GP Surgery (St Andrews Health Centre) WELLESLEY, Rosie (Dr)

Comment Suspected condition • Patient asked to come in • Initial post discharge review • Initial post discharge review • High risk drug monitoring

22-Aug-2017 GP Surgery (St Andrews Health Centre) SELVARAJAH, Selvaseelan (Dr) [Draft]

Empty consultation

08-Aug-2017 GP Surgery (St Andrews Health Centre) SAHEMEY, Manpreet (Dr)

Empty consultation

18-Jul-2017 GP Surgery (St Andrews Health Centre) SAHEMEY, Manpreet (Dr)

Problem Osteoporosis (First)

11-Jul-2017 GP Surgery (St Andrews Health Centre) SYAN, Gupinder (Ms)

Problem Prostatism (Review)

Problem Chest infection (First)

11-Jul-2017 GP Surgery (St Andrews Health Centre) SYAN, Gupinder (Ms)

Problem Epilepsy (Ended)

04-Jul-2017 GP Surgery (St Andrews Health Centre) SAHEMEY, Manpreet (Dr)

Problem [V]Immun not carried out pat's decision for oth unspc reasons (First)

26-Jun-2017 GP Surgery (St Andrews Health Centre) LEBER, Werner (Dr)

Problem Sore throat symptom (Review)

MOUSE, Mickey (Mrs)

- Patient Has Access to Online Care...
- Methotrexate monitoring advised
- Eligible for AUA LES 2016
- ACEI or ARB monitoring advised
- Azathioprine monitoring advised
- Severely Frail

NHS Clinical Practitioner LEBER, Werner (Dr) Location: St Andrews Health Centre

11:06 20/11/2017

*EMIS...Egton Medical Information Systems, UK.

Shared EMIS Web*

- Community health services view

The screenshot displays the EMIS Web Health Care System interface for a patient named MOUSE, Mickey (Mrs). The interface is divided into several sections:

- Top Navigation Bar:** Includes tabs for Summary, Consultations, Medication, Problems, Investigations, Care History, Diary, Documents, and Referrals.
- Left Sidebar:** Contains a 'My Record' section with a date navigator and a list of external views. A red box highlights the 'Barts Health CHS/TH GPs' section.
- Central Area:** Displays a list of consultations with columns for Date, Consultation Text, and Referral. The list includes entries from 2012 and 2009.
- Right Sidebar:** Contains a list of consultations with columns for Date, Consultation Text, and Referral. The list includes entries from 2012 and 2009.

A red box highlights the 'Barts Health CHS/TH GPs' section in the left sidebar, indicating the current view.

MOUSE, Mickey (Mrs)

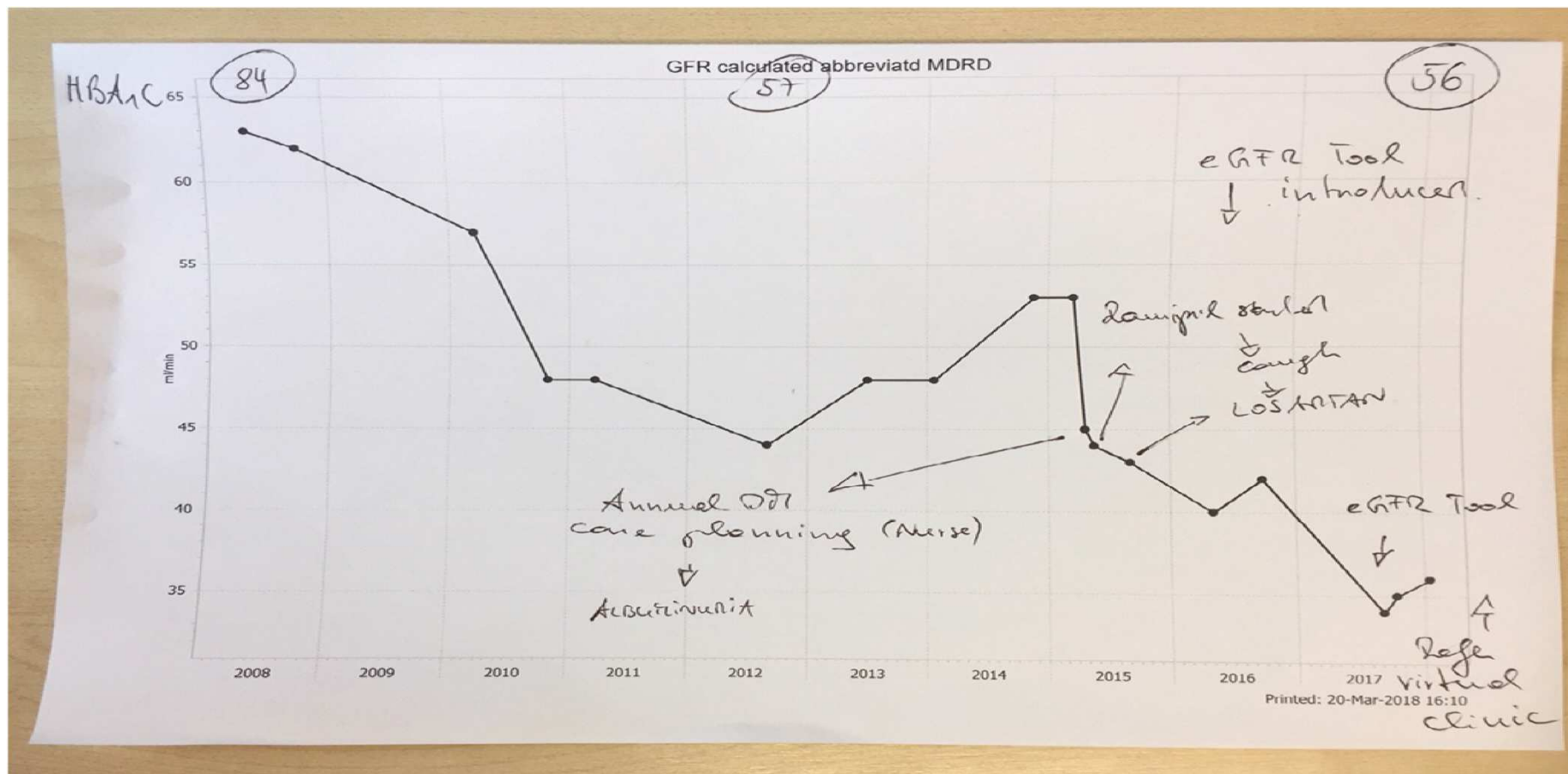
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*EMIS...Egton Medical Information Systems, UK.

Working across teams

Tower Hamlets Renal Community Service (Virtual clinic)

Case 2 - Syeda, aged 72

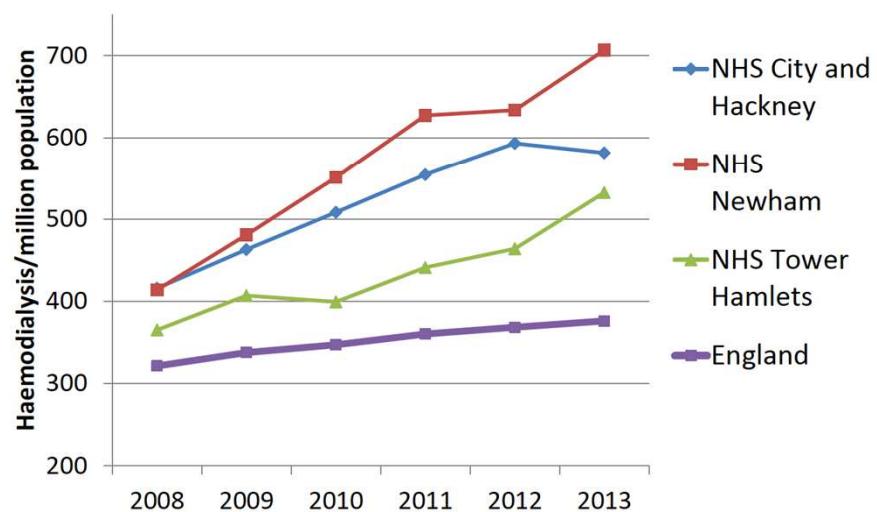


High rates of haemodialysis in east London

What is the Problem?

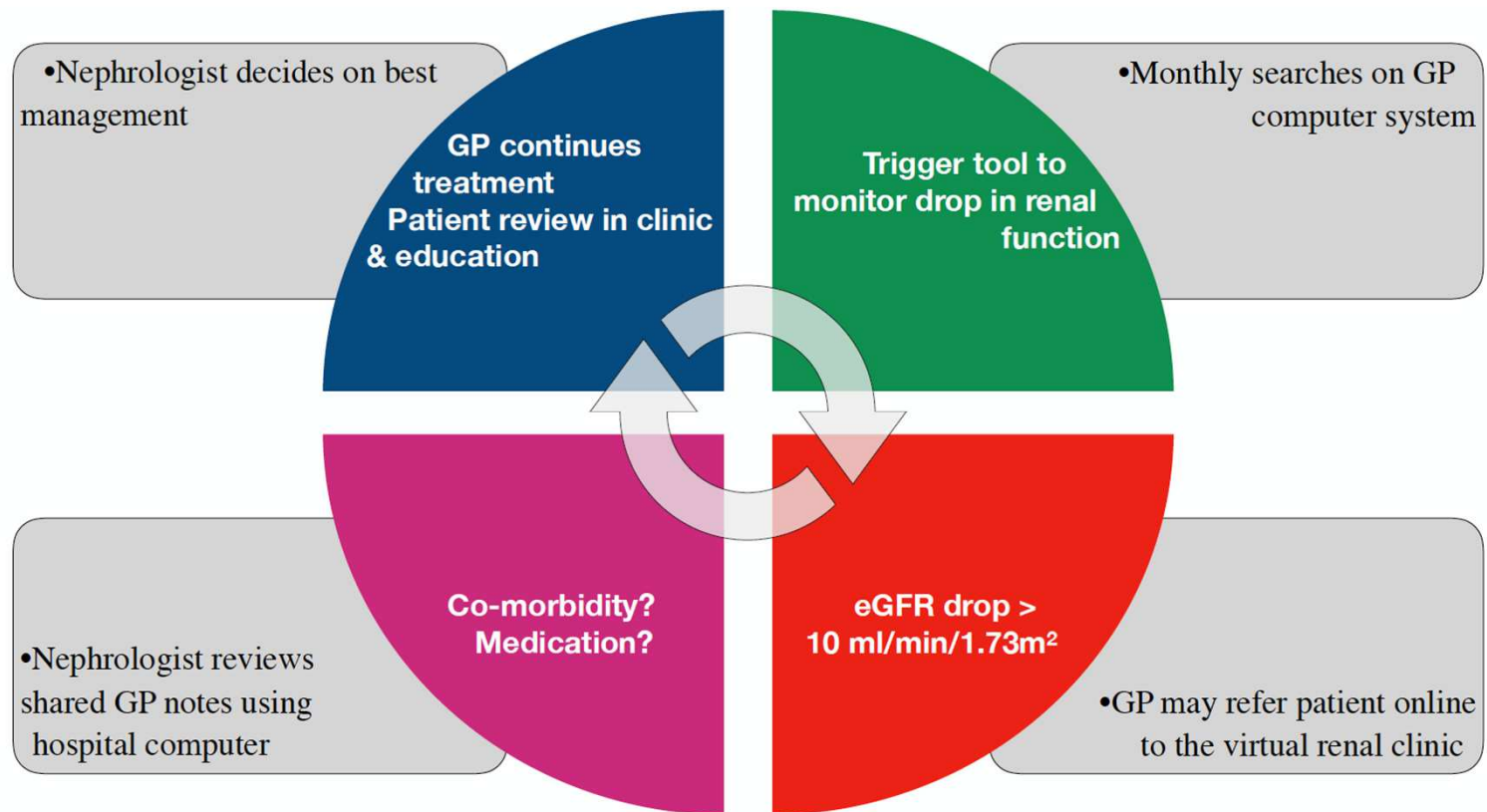


Fast rising ESRD rates in East London – ever more people needing dialysis
Haemodialysis rates per million population, 3 East London Boroughs



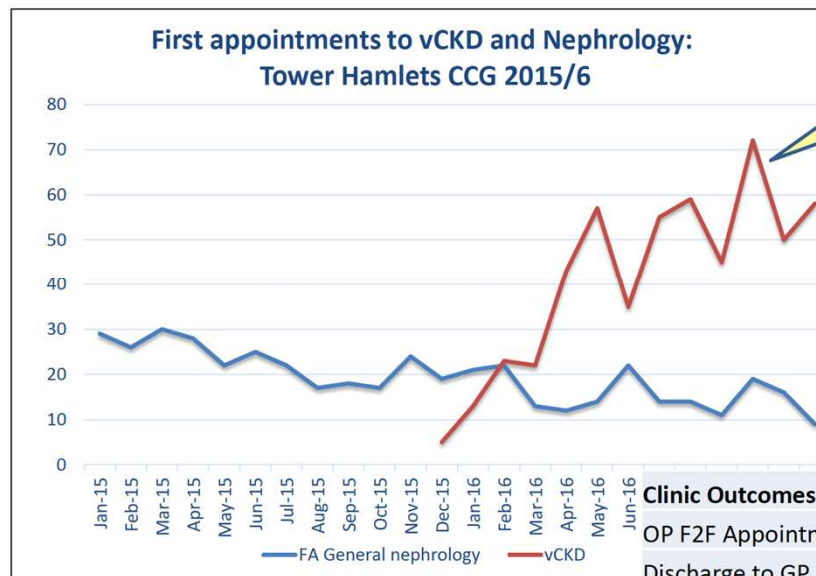
Data from the UK Renal Registry 2015

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

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)

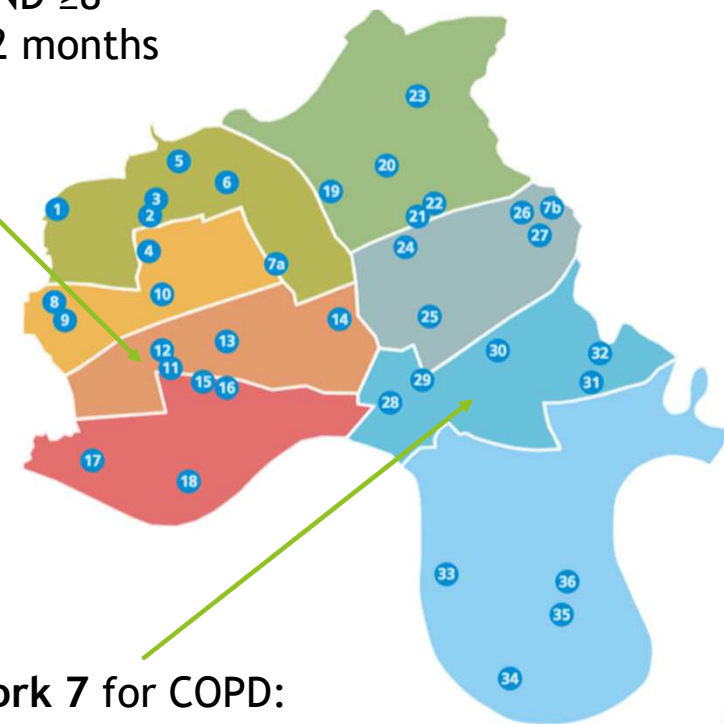
Intervention: One clinical psychologist embedded per network to:

- 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."

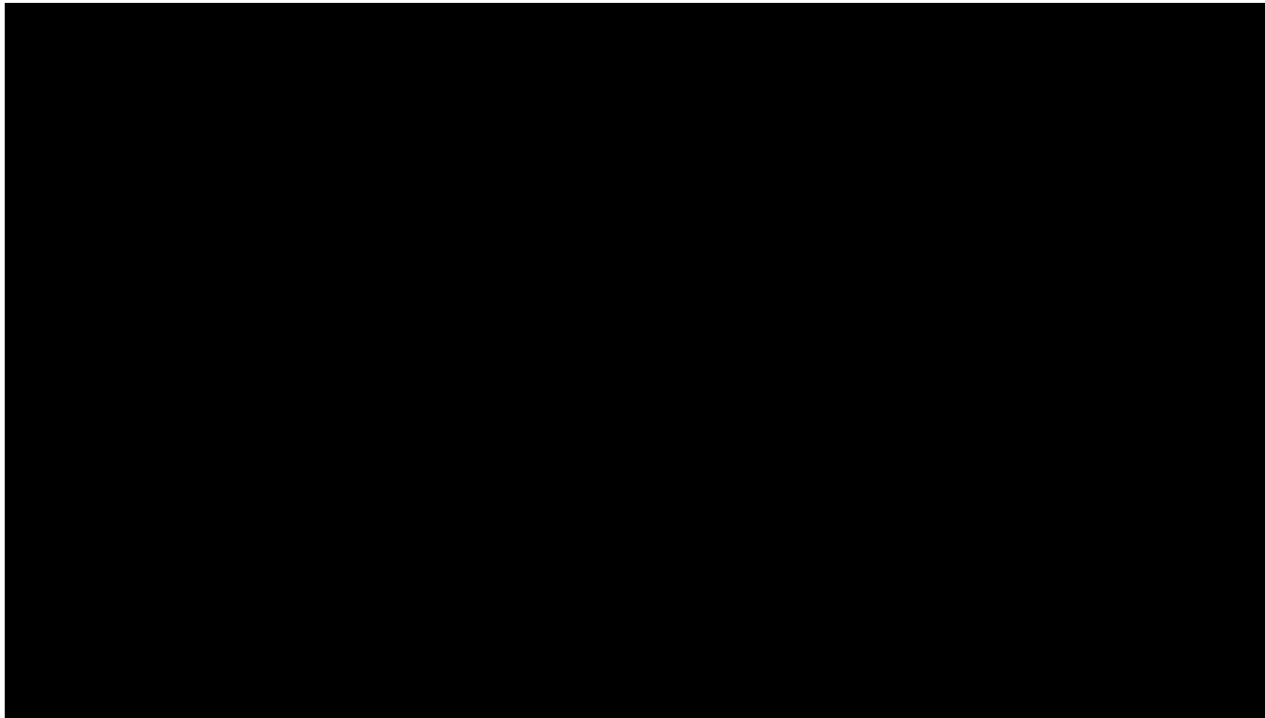


"My ability to have access to staff, patients, services and systems places me in a position where I can connect people. Be it patients with interventions, services or activities; or staff with information and services."

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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- ▶ Salaried GP, St Andrews Health Centre
- ▶ Contact: w.leber@qmul.ac.uk
- ▶ Twitter: [@wernerleber](https://twitter.com/wernerleber)