# Tower Hamlets Together Board

Tower Hamlets Together (THT) is a partnership of health and care commissioners and providers who are working together to deliver integrated health and care services for the population of Tower Hamlets. Building on our understanding of the local community and our experience of delivering local services and initiatives, THT partners are committed to improving the health of the local population, improving the quality of services and effectively managing the Tower Hamlets health and care pound. This is a meeting in common, also incorporating the Tower Hamlets Integrated Care Board Sub Committee.

**Meeting in public on Thursday 9 January 2025, 0930-1130**

**Chair: Roberto Tamsanguan**

**AGENDA**

| | **Item** | **Time** | **Lead** | **Attached / verbal** | **Action required** |
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| 1. | **Welcome, introductions and apologies:**<br>1. Declaration of conflicts of interest<br>2. Minutes of the meeting held on 5 December 2024<br>3. Action log | 0930<br>(5 mins) | Chair | Papers<br><br>Pages 3-5<br><br>Pages 6-11<br><br>Pages 12 | <br><br>Note<br><br>Approve<br><br>Discuss |
| 2. | **Questions from the public** | | Chair | Verbal | Discuss |
| 3. | **Chair's updates** | | Chair | Verbal | Note |
| 4. | **System resilience and urgent issues** | 0935<br>(5 mins) | All | Verbal | Note |
| 5. | **Operational Management Group highlights** | 0940<br>(5 mins) | Zainab Arian | Verbal | Note |
| 6. | **Community Voice item: Gestational diabetes and health literacy** | 0945<br>(25 mins) | Muna Jibril and Alison Roberts | Verbal | Discuss/ Note |

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| 7. | **Same Day Access** | 1010 (30 mins) | Jo-Ann Sheldon, Julie Dublin and Mary Jamal | Papers Pages 13-44 | Update/ Discuss |
| 8. | **THT priorities** | 1040 (30 mins) | Ashton West and SROs | Papers Pages 45-62 | Update/ Discuss |
| 9. | **Roadmap to integration** | 1110 (15 mins) | Anna Carratt and Belinda Yolden | Papers Pages 63-89 | Engage ment |
| 10. | **Any Other Business** | 1125 (5 mins) | Chair | Verbal | Note |
| Date of next meeting: Thursday 06 February 2025, 0930-1130 | | | | | |

- Declared Interests as at 03/01/2025

| Name | Position/Relationship with ICB | Committees | Declared Interest | Name of the organisation/business | Nature of interest | Valid From | Valid To | Action taken to mitigate risk |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Charlotte Pomery | Chief Participation and Place Officer | Barking & Dagenham ICB Sub-committee<br>Barking & Dagenham Partnership Board<br>City & Hackney ICB Sub-committee<br>City & Hackney Partnership Board<br>Community Health Collaborative sub-committee<br>Havering ICB Sub-committee<br>Havering Partnership Board<br>ICB Audit and Risk Committee<br>ICB Board<br>ICB Population, Health & Integration Committee<br>ICB Quality, Safety & Improvement Committee<br>ICP Committee<br>ICS Executive Committee<br>Newham Health and Care Partnership<br>Newham ICB Sub-committee<br>Patient Choice Panel<br>Redbridge ICB Sub-committee<br>Redbridge Partnership Board<br>Tower Hamlets ICB Sub-committee<br>Tower Hamlets Together Board<br>Waltham Forest Health and Care Partnership Board<br>Waltham Forest ICB Sub-committee | Non-Financial Personal Interest | Pomery McGregor Consultancy Limited | Director of consultancy company, with husband who is also a director of the company. There are no employees and I have not carried out work through the company since 2011 and have never carried out any work in north east London. | 2009-06-01 | | No action required as no conflicts declared. |
| Chetan Vyas | Director of Quality | Barking & Dagenham ICB Sub-committee<br>Barking & Dagenham Partnership Board<br>City & Hackney ICB Sub-committee<br>City & Hackney Partnership Board<br>Clinical Advisory Group<br>Havering ICB Sub-committee<br>Havering Partnership Board<br>ICB Quality, Safety & Improvement Committee<br>Newham Health and Care Partnership<br>Newham ICB Sub-committee<br>Patient Choice Panel<br>Procurement Group<br>Redbridge ICB Sub-committee<br>Redbridge Partnership Board<br>Tower Hamlets ICB Sub- | Indirect Interest | Some GP practices across NEL | Family members are registered patients - all practices not known nor are their registration dates | 2014-04-01 | | Declarations to be made at the beginning of meetings |

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| | | committee<br>Tower Hamlets Together Board<br>Waltham Forest Health and Care Partnership Board<br>Waltham Forest ICB Sub-committee | | | | | | |
| | | | Indirect Interest | Redbridge Gujarati Welfare Association - registered charity in London Borough of Redbridge | Family member is a Committee member. | 2014-04-01 | | Declarations to be made at the beginning of meetings |
| James Thomas | Member of the Tower Hamlets Together Board and Place ICB Sub-Committee | Tower Hamlets ICB Sub-committee<br>Tower Hamlets Together Board | Non-Financial Professional Interest | Innovation Unit & Tower Hamlets Education Partnership | Non-Executive Director | 2022-09-01 | | Declarations to be made at the beginning of meetings |
| Kerry Greenan | ICB Clinical Lead for Population Health and Homelessness | Tower Hamlets ICB Sub-committee | Financial Interest | St. Andrews Health Centre / Bromley-by-Bow Health Partnership | I am a Partner at BBBHP, based at St. Andrews. | 2024-01-01 | | Declarations to be made at the beginning of meetings |
| | | | Non-Financial Professional Interest | Bromley-by-Bow Centre | I am part of the Population Health Team at BBBHP, so linked with the Bromley-by-Bow Centre. | 2022-08-01 | | Declarations to be made at the beginning of meetings |
| Khyati Bakhai | Primary care clinical lead and LTC lead | Primary Care Collaborative sub-committee<br>Tower Hamlets ICB Sub-committee<br>Tower Hamlets Together Board | Financial Interest | Bromley by Bow Health partnership | Gp Partner | 2012-09-03 | | |
| | | | Financial Interest | Greenlight@GP | Director for the education and training arm | 2021-07-01 | | |
| | | | Non-Financial Professional Interest | RCGP | Author and review for clinical material | 2021-03-01 | | |
| Richard Fradgley | Director of Integrated Care | Community Health Collaborative sub-committee<br>Mental Health, Learning Disability & Autism Collaborative sub-committee<br>Newham Health and Care Partnership<br>Newham ICB Sub-committee<br>Tower Hamlets ICB Sub-committee<br>Tower Hamlets Together Board | Non-Financial Professional Interest | Compass CIC | Director of Compass CIC | 2024-05-31 | | |
| Roberto Tamsanguan | Clinical Director Tower Hamlets | Clinical Advisory Group<br>Tower Hamlets ICB Sub-committee<br>Tower Hamlets Together Board | Financial Interest | Bromley By Bow Health Partnership | GP Partner | 2024-01-01 | | Declarations to be made at the beginning of meetings |

- Nil Interests Declared as of 03/01/2025

| Name | Position/Relationship with ICB | Committees | Declared Interest |
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| Sunil Thakker | Director of Finance and Partnership Services | Barking & Dagenham ICB Sub-committee<br>Barking & Dagenham Partnership Board<br>City & Hackney ICB Sub-committee<br>City & Hackney Partnership Board<br>Havering ICB Sub-committee<br>Havering Partnership Board<br>ICB Audit and Risk Committee<br>ICB Finance, Performance & Investment Committee<br>Newham Health and Care Partnership<br>Newham ICB Sub-committee<br>Redbridge ICB Sub-committee<br>Redbridge Partnership Board<br>Tower Hamlets ICB Sub-committee<br>Tower Hamlets Together Board<br>Waltham Forest Health and Care Partnership Board<br>Waltham Forest ICB Sub-committee | Indicated No Conflicts To Declare. |
| Jeanette Weismann | Senior Quality and Safety Manager | ICB Finance, Performance & Investment Committee<br>Tower Hamlets ICB Sub-committee | Indicated No Conflicts To Declare. |
| Jonathan Williams | Engagement and Community Communications | Tower Hamlets ICB Sub-committee<br>Tower Hamlets Together Board | Indicated No Conflicts To Declare. |
| Matthew Adrien | Partnership working | ICB Quality, Safety & Improvement Committee<br>ICP Committee<br>Tower Hamlets ICB Sub-committee<br>Tower Hamlets Together Board | Indicated No Conflicts To Declare. |
| Vicky Scott | CEO | ICP Committee<br>Tower Hamlets ICB Sub-committee<br>Tower Hamlets Together Board | Indicated No Conflicts To Declare. |
| Zainab Arian | Chief Executive Officer of GP Federation working within NEL ICS | Tower Hamlets ICB Sub-committee<br>Tower Hamlets Together Board<br>Waltham Forest Health and Care Partnership Board | Indicated No Conflicts To Declare. |
| Helen Jones | tower hamlets named GP for child safeguarding, tower hamlets clinical lead for CYP MHEW and LD | Tower Hamlets ICB Sub-committee | Indicated No Conflicts To Declare. |
| Somen Banerjee | Director of Public Health | Tower Hamlets ICB Sub-committee<br>Tower Hamlets Together Board | Indicated No Conflicts To Declare. |
| Warwick Tomsett | Joint post | Tower Hamlets ICB Sub-committee<br>Tower Hamlets Together Board | Indicated No Conflicts To Declare. |
| Shakil Islam | Plannings and outcomes officer | Tower Hamlets ICB Sub-committee | Indicated No Conflicts To Declare. |
| Muna Hassan | Community Voice Lead | Tower Hamlets ICB Sub-committee<br>Tower Hamlets Together Board | Indicated No Conflicts To Declare. |
| Roberto Tamsanguan | Clinical Director Tower Hamlets | Clinical Advisory Group<br>Tower Hamlets ICB Sub-committee<br>Tower Hamlets Together Board | Indicated No Conflicts To Declare. |

**DRAFT Minutes of the Tower Hamlets Together Board**
**Thursday 5 December 2024, 0930-1130 in person and via MS Teams**

# Minutes

| **Members:** | | |
|---|---|---|
| Roberto Tamsanguan (Chair) | Tower Hamlets Clinical / Care Director, NHS North East London | In person |
| Warwick Tomsett | Director of Integrated Commissioning, NHS North East London & London Borough of Tower Hamlets | In person |
| Zainab Arian | Joint Chief Executive Officer, Tower Hamlets GP Care Group | In person |
| Somen Banerjee | Director of Public Health, London Borough of Tower Hamlets | In person |
| Vicky Scott | Chief Executive Officer Council for Voluntary Services | In person |
| Fiona Peskett | Director of Strategy and Integration<br>Barts Health – Royal London and Mile-End Hospitals | In person |
| Georgia Chimbani | Corporate Director of Health and Adult Social Care, London Borough of Tower Hamlets | MS Teams |
| Khyati Bakhai | Tower Hamlets Primary Care Development Clinical Lead, NHS North East London | MS Teams |
| Sunil Thakker | Director of Finance, NHS North East London | |
| Layla Richards | Covering Director, Commissioning and Youth Children's Services | MS Teams |
| Matthew Adrien | Healthwatch Service Director | MS Teams |
| **Attendees:** | | |
| Charlotte Pomery | Chief Participation and Place Officer, NHS North East London ICB | MS Teams |
| Ashton West | Deputy Director of Partnership Development – Tower Hamlets Together and NHS North East London | MS Teams |
| Eleasar Reas | Deputy Director of Partnership Development – Tower Hamlets Together, NHS North East London | In person |
| Carys Esseen | East London NHS Foundation Trust | In person |
| Jon Williams | Engagement and Community Communications Manager (Tower Hamlets), NHS North East London | MS Teams |
| James O'Donoghue | Deputy Director of Acute Finance & Tower Hamlets Place | MS Teams |
| Chandrika Kaviraj | Community Voice item presenter | MS Teams |
| Anna Carrat | Deputy Director of Strategic Development, NHS North East London | In person |
| Amy Whitelock Gibbs | Co-chair THT health equity lead | MS Teams |
| Dr Farah Bede | Co-chair and clinical lead | MS Teams |

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| Madalina Bird | Minute taker, Governance Officer, NHS North East London | In person |
| **Apologies:** | | |
| Richard Fradgley | Director of Integrated Care & Deputy Chief Executive Officer, East London NHS Foundation Trust | |
| Muna Hassan | Resident and community representative/Community Voice Lead | |
| Steve Reddy | Interim Corporate Director, Children's Services London Borough of Tower Hamlets | |
| Neil Ashman | Place Lead and Chief Executive Officer Royal London & Mile End Hospitals, Barts Health NHS Trust | |
| Kat Davison | TH UCWG Chair; Chief Operating Officer, RLH, Barts Health NHS Trust | |
| Chetan Vyas | Director of Quality, North East London Integrated Care Board | |

| Item No. | Item title |
|---|---|
| **1.0** | **Welcome, introductions and apologies** |
| | The Chair, Roberto Tamsanguan welcomed members and attendees to the December Tower Hamlets Together (THT) Board meeting held in public, noting apologies as above. |
| **1.1** | **Declaration of conflicts of interest** |
| | The Chair reminded members of their obligation to declare any interests they may have on any issues arising at the meeting which might conflict with the business of the committee.<br><br>No additional conflicts were declared. |
| **1.2** | **Minutes of the meetings held on 7 November 2024** |
| | The minutes of the previous meeting held on Thursday 7 November 2024 were agreed as an accurate record of the meeting. |
| **1.3** | **Actions log** |
| | 0712-51 – WT to pick up with Jo Sheldon and update<br>0205-58 – Work ongoing. Item will be brought to the Board, date tbc<br>0205-59 – Work ongoing. JW will update<br>0509-65 – Work in progress, need to make sure key messages are pulled and shared with the partnership<br>MB to request updates and bring to the next meeting |
| **2.0** | **Questions from the public** |
| | No questions from the public have been received in advance of the meeting. |
| **3.0** | **Chair's updates** |
| | The chair remarked that it is December, end of the year and a good time to reflect on how much work has been achieved for Tower Hamlets residents on behalf of the partnership |
| **4.0** | **System resilience and urgent issues** |
| | Issues flagged, to note: |

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| | • RLH remains (majority of time) in OPEL 4 which means is running at capacity in Emergency Department with knock on effect on the patient flow throughout the hospital and the ability to treat elective procedures as scheduled and on time<br>• Mitigating actions are put in place to ensure constitutional standards are meet<br>• Winter plans are being reviewed and working with partners to meet challenges<br>Comments and questions from the attendees included:<br>• Need to address hospital transport delays and changes to the system to improve service and hospital flow. Conversation can be picked up outside the meeting |
| **5.0** | **Operational Management Group (OMG) highlights** |
| | Zainab Arian (ZA) verbally updated the Board members and attendees on the key discussion points highlighting:<br>• CQC presentation and discussion<br>• Barts Health RLH system pressures flagged<br>• ELFT flagged funding pressures for services coming to an end in March 2025<br>The Board noted the update |
| **6.0** | **Community Voice** |
| **6.1** | **Lead Annual Report** |
| | Jon Williams presented the report on behalf of Muna Hassan, Community Voice Lead who sent apologies due to sick leave.<br>The report is the first Annual Report of the independent Community Voice Lead. It sets out reflection on the impact of the role, the Board Community Voice session and engagement activity of THT Partners. The report further outlines initial planning for engagement on the development of the THT Engagement Strategy including supporting the Anti-Racism and Health Equity Steering Groups engagement.<br>The chair thanked JW and MH for the wok done and remarked on the importance of the Community Voice role in the partnership<br>Members also welcomed the report and its recommendations and discussed the following key points:<br>• Need to address issues raised by Carer's Centre around how people are supported to present at the Board.<br>• Accountability and transparency<br>• Acknowledge the successes and challenges faced. Welfare legal advice work has been a big success and good example of partnership working<br>• Adress the CVS financial difficulties. Suggestion to look at what Hackney is doing and to avoid duplication. Need to work with London funders to look at inclusive cross funding to address issues<br>• Need to acknowledge the work done around the single co-production framework and toolkit and how to hold partnership to account around it. Think about what the baseline is now and how to demonstrate progress, to track how is embedded. Follow up discussion on how to develop baseline, accountability and progress going forward<br>• Adress the feedback received at the Scrutiny Committee from maternity services at Barts Hospital on how to improve/ get better at communication and how to look creatively at reaching Bengali and Somali communities through different social media. Ensuring maternity is a fully inclusive service. Transformation required.<br>• Comms Group to support partners to become an Anti-Racist system. What are different organisations doing to support this ambition, and how to promote this more<br>The Board noted the report. |
| **6.2** | **You said, we did** |

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| | Jon Williams presented the report that covers April to date highlighting the work done following the Community Voice item presented in October: Cornerstone Good Practice Guide that has been incorporated into the THT Co-production Toolkit.<br>The toolkit requires promotion to staff and within this process this Guide will be highlighted. THT Team needs to consider how to further embed the Guide within the THT partnership.<br>Members discussed the report and key points were:<br>• Cornerstone Project is a result of two years of co-production. Is a project aimed to create a model for voluntary sector and public sector wanting to work with local communities to address inequalities within policy making services in Tower Hamlets. To do this it created a partnership bringing together the community organisations representing the borough's diversity and public sector to create a good practice guide and resource for carrying out Equality Impact Assessments across the borough. Not an easy process and it needs to be continued<br>• Members agreed partnership needs to make sure the trust build is not lost now that the project has come to an end, but build on the connections and work relationships already established<br>The Board noted the report. |
| **6.3** | **Board reflection on Community Voice Process** |
| | Jon Williams also introduced Chandrika Kaviraj who raised concerns about the way the Board receives the Community Voice item presenters following her attendance and presentation at previous meeting highlighting:<br>• Board members should be sensitive to safeguarding and be trauma informed<br>• Build trust to get a diversity of opinions (patients lived experiences not only look at issues from a professional point of view). Need to have conversations as equal partners<br>• Patient voice representation is vital (view also highlighted in the Darzi report). Need to ensure it is embedded in practice not just an add on<br>Two proposals put forward for the Board on how to improve and enhance work:<br>1. Duty of Care approach<br>• The THT Board will take a duty of care approach in line with the legal duty to provide a reasonable standard of care to patients and to act in ways that protect their safety. A duty of care exists when it could reasonably be expected that a person's actions, or failure to act, might cause injury to another person.<br>• The THT Board recognises its meeting format has the potential to be challenging for some people. It will continue with its practice of the independent Community Voice Lead and Engagement and Community Communication Lead pre-meeting with people speaking to support their presentation and give focus to their ask of the Board.<br>• At the start of the Community Voice session, the chair of the THT Board will explain to the presenters of the Community Voice session who is attending the meeting and the purpose of the session. The chair will emphasis to the Board the importance of actively listening to the presenters, and specifically where someone is sharing their story, to listen first with empathy and secondarily to focus on solutions.<br>2. Developmental training<br>• As leaders it is important the THT Board demonstrates their commitment to trauma informed care and safeguarding. It is proposed trauma informed care and safeguard should be part of the next Board developmental session.<br>Chair thanked the presenters and opened the discussion to the members with key points as followers:<br>• Members expressed regret at the poor experience with the palliative care service and thanked CK for her work, support and suggestions to improve the service going forward |

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| | • Need to reflect on how to radically change the approach to commissioning and commissioning policies/ processes. How to embed the principals of anti-racism in the commissioning process. Outside conversations needed to take the work forward<br>• Connection to the discussion around the co-production framework and the anti-racist commissioning and what it means in terms of how the partnership commissions services. There are good examples where it was done well that need to be identified and highlighted as good practice.<br>• Work is ongoing to improve the end-of-life care services at NEL level<br>• Members agreed and supported the proposals put forward. Concrete actions need to be worked out<br>• Need to identify meetings that will benefit from community voice representation. Conversations outside the meeting needed. Palliative Care has different pathways and delivered by different partners in hospital and in the community. Suggestion for the work to be picked up at the Promoting Independence Group<br>CK flagged that from experience palliative care is delivered by different partners and that not everyone is doing their bit or want to work in collaboration with one another. System needs to change and partners need to work together.<br>ACTION: JW and MH to work on and bring back concrete actions for the Board to improve Community Voice Process<br>ACTION: AW to flag issues raised around palliative care with the Promoting Independence Group and add discussion to the agenda |
| **7.0** | **Tower Hamlets Anti-Racism update** |
| | Amy Whitelock Gibbs, Co-chair THT health equity lead and Dr Farah Bede, Co-chair and clinical lead presented the report had three proposals for the Board:<br>1: Medical racism co-design remedies<br>2: Anti Racism Campaign<br>3: Anti Racism Framework<br>Comments and questions from the Board included:<br>• Anti-racism is one of the 6 THT priorities<br>• The roadshow is a great idea to reach out to staff. Great if it could be extended at RLH and Mile End Hospital sites<br>• Explore the programme manager post sourcing from the partner organisations<br>• Partnership EDI Leads to work with the Steering Group to share the work happening in the system and help to map work that needs to be done to avoid duplication, share good practice and data<br>• Need to make a cultural change for the change on the way services are being delivered to be sustainable<br>ACTION: Members to connect AWG and Dr FB with their organisation EDI Leads<br>The Board noted the update and agreed with the proposals and recommendations set out |
| **8.0** | **NEL Anti-Racism Framework** |
| | Anna Carratt presented the report that provides an overview of the initial work to create a North East London ICS anti-racism strategy.<br>Members welcomed the update and made the following comments:<br>• Paper feels managerial, new version needs to be more grounded in the reality. Appendix document in the new iteration includes data on the impact on workforce and health inequalities within the system, not equitable as far as the outcomes that people are receiving. Next version will include case studies and examples, building on what the system has done well, good practice work<br>The Board noted the report |
| **9.0** | **Strategic vision 2035** |

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| | Somen Banerjee presented the report highlighting the THT Vision is to work together to improve the health and wellbeing of the people of Tower Hamlets:<br>• Residents live the healthiest lives possible, especially the most deprived and vulnerable.<br>• Children and young people have a great start to life and achieve their full potential.<br>• Residents are able to access the health and social care services they need in a timely manner.<br>• Residents are satisfied with the health and care services they receive and feel that their needs are being well met.<br>• The system exceeds the required national performance standards within the available resources<br>A new shared vision: Residents and partners working together to improve quality of life, advance equality, opportunity, and empowered communities.<br>Board noted the update, and the following points were made:<br>• THT plan on a page and longer Place plan can feed into the strategy. Need to start and build on what is already in place<br>• Need to address the issues raised in the Best Values Report by the Voluntary Community Sector around the ways of working (around administration, the role of politicians, how to work together together). Really good examples of cross sector partnerships like the social welfare legal advice work<br>• Members were advised the ways of working will be reviewed, changed. Focus needs to be on having the healthiest population<br>• Outcomes framework and Leadership values might be values that the wider partnership can adopt<br>• Health and Wellbeing Strategy will need to be refreshed as well, overarching work<br>• Adress the changes in ratio between young and old population in the borough. Need to achieve balance going forward as TH has the biggest increase rates in the aging population and demand of adult social care for over 65s<br>The Board noted the update |
| **10.0** | **Any Other Business** |
| **10.1** | AW updated the Board on:<br>• TH Plan on a page is ready and will be shared with the members for dissemination following the meeting<br>• TH priorities will be brought to the Board going forward for update and discussion<br>• Finance Enabler Group is being set up. Members need to identify the right people to attend. Finance integrated report will be brought to the Board together with savings and cost pressures across the system/ different organisations<br>• Work ongoing to make a better version of the Data dashboard to bring back to THT Board |
| **10.2** | RT thanked attendees and wished everyone a Happy New Year |

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# Tower Hamlets Board action log

| Colour | Key |
|---|---|
| Green | Closed this month, or open & due in the future |
| Amber | Open, due this month |
| Red | Open, overdue |

| Action Ref | Action Raised Date | Action Description | Action Lead(s) | Action Due Date | Action Status | Action Update |
|---|---|---|---|---|---|---|
| 0712-51 | 07-Dec | Primary care commissioning team to understand what the Primary Care Improvement Week learnings/project/work and resource implications are and identify where the resources are available in the system and what is required as additional | Warwick Tomsett and Jo Sheldon | tbc | In progress | As part of the primary care bid for S256 funds around THT priority to improve access, some funds were awarded to support this work in TH.<br>Update June Board: TH Primary Care and EQUIP teams are developing a plan for best use of these funds alongside the wider improvement week support through the ICB<br>Update December Board: WT will pick up with JS and update |
| 0205-58 | 02-May | AW to start work on a risk register to collate and report collective live risks | Ashton West | 09 January 2025 | Closed | Update August Board: Meeting is scheduled to speak to the ICB to take forward the work<br>Update December Board: work ongoing. Update will be brought to a future meeting<br>A comprehensive register in place which is being updated on an ongoing basis. |
| 0205-59 | 02-May | Work on a 'ticket home' leaflet that will allow people to transit safely from one episode of care to their homes as effectively as possible. NA and WT to advise on time frame and Partnership roles | Jon Williams | tbc | In progress | Meeting organised on 25/06 – present were FP/MB from RLH/MEH, Jon Williams and Rachel Vincent.<br>The 14 page discharge leaflet in question is with ELFT – new action now required for Jon and Rachel to follow up with ELFT.<br>Update December Board: Melaine King, ELFT, is working with Rachel and other patient reps to develop two guides, one inner (ELFT) and the other outer (NELFT) |
| 0509-65 | 05-Sep | Team to send a presentation with key messages about ASC CQC inspection that partners can share with colleagues. | Emily Fieran-Reed/ all | tbc | In progress | Work in progress, need to make sure key messages are pulled and shared with the partnership |
| 0512-66 | 05-Dec | JW and MH to work on and bring back concrete actions for the Board to improve Community Voice Process | Jon Williams and Muna Hassan | tbc | In progress | JW drafting papers for review |
| 0512-67 | 05-Dec | AW to flag issues raised around palliative care with the Promoting Independence Group and add discussion to the agenda | Ashton West | 09 January 2025 | Closed | Discussion will be picked up at the February End of Life Care Board |
| 0512-68 | 05-Dec | Connect AWG and Dr FB with organisation EDI Leads | Ashton West | 09 January 2025 | Closed | EDI Leads details shared |

Page 1

Tower Hamlets Same Day Access Programme

# A&E Front Door Redesign
# **Integrated Model – Progress Update**

# Executive Summary

Tower Hamlets Same Day Access Programme

This Programme aims to enhance the quality and experience of patients requiring access to 'same day' urgent unplanned care, optimising the patient pathway and implementing an **improved integrated service** for Tower Hamlets across Primary and Secondary Care.

THT has prioritised stakeholders across Primary & Secondary Care to work together to support Tower Hamlets Place redesign the care pathway under a single coordinated Programme split into two domains:

The **Urgent Unplanned Care Domain** is responsible for coordinating the redesign of the pathway elements that occur **within/on** the RLH site, and includes the NHS 111 service.

The **Primary Care Domain** is responsible for coordinating the redesign of the pathway elements that occur **outside** of both the RLH site and scope of the NHS 111 service.

The Programme has mapped the current patient pathway **to and through the 'front door' of RLH** and has identified changes that should streamline the patient experience and benefit the local health system under a cost-effective delivery model. These are the changes this Programme seeks to examine and implement.

TOWER HAMLETS TOGETHER

# General Programme Principles

- Co-production of the new pathway with all key stakeholders is desirable to ensure that the proposed new pathway is workable and operationally practical.
- The parties have no intention of changing the Barts clinical streaming/redirection criteria.
- Proposed changes should improve patient flow and experience.
- Proposed changes should be cost effective.
- Redesign should bring patient redirection to an earlier stage in the journey through A&E to UTC so that UTC does not undertake a redirection function (see following pathway slides).
- Redesign should seek to increase patients redirected from A&E to the Primary Care SDA service.
- Establish appropriate KPIs that provide incentive for all system partners to deliver the proposed model.

# Contractual Context

Both current UTC and OOH contracts expire on 31 March 2026. Any procurement process to ensure a provider is appointed to guarantee provision from 1 April 2026 must start by June 2025. Therefore, the **current pathways through A&E and UTC must be reviewed, and any changes determined, by 31 March 2025** to meet the necessary governance requirements before the procurement.

The current NEL NHS 111 contract also expires on 31 March 2026. Any local changes to the Urgent Care pathway that impact on the NHS 111 service must be communicated to the NEL NHS 111 Procurement Team so that they are reflected in the new specification/service.

From 1 January 2025 the capacity of the current SDA service receiving redirections from A&E, UTC and NHS 111 will reduce from 60 to 30 appts/day (Mon-Sat). These appts will only be available for A&E/UTC redirections, the NHS 111 capacity being re-provided by PCN SDA pilots.

On 31 March 2025, the GPCG Cable St Service will cease in its current form. From 1 April 2025, **all Primary Care capacity** to receive NHS 111, UTC and A&E redirections will be re-provided by a combination of PCN SDA pilots and a modified GPCG service.

The contract between Barts Health and NEL ICB can be varied by mutual agreement to reflect contractual changes necessary for implementation of any amended pathway.

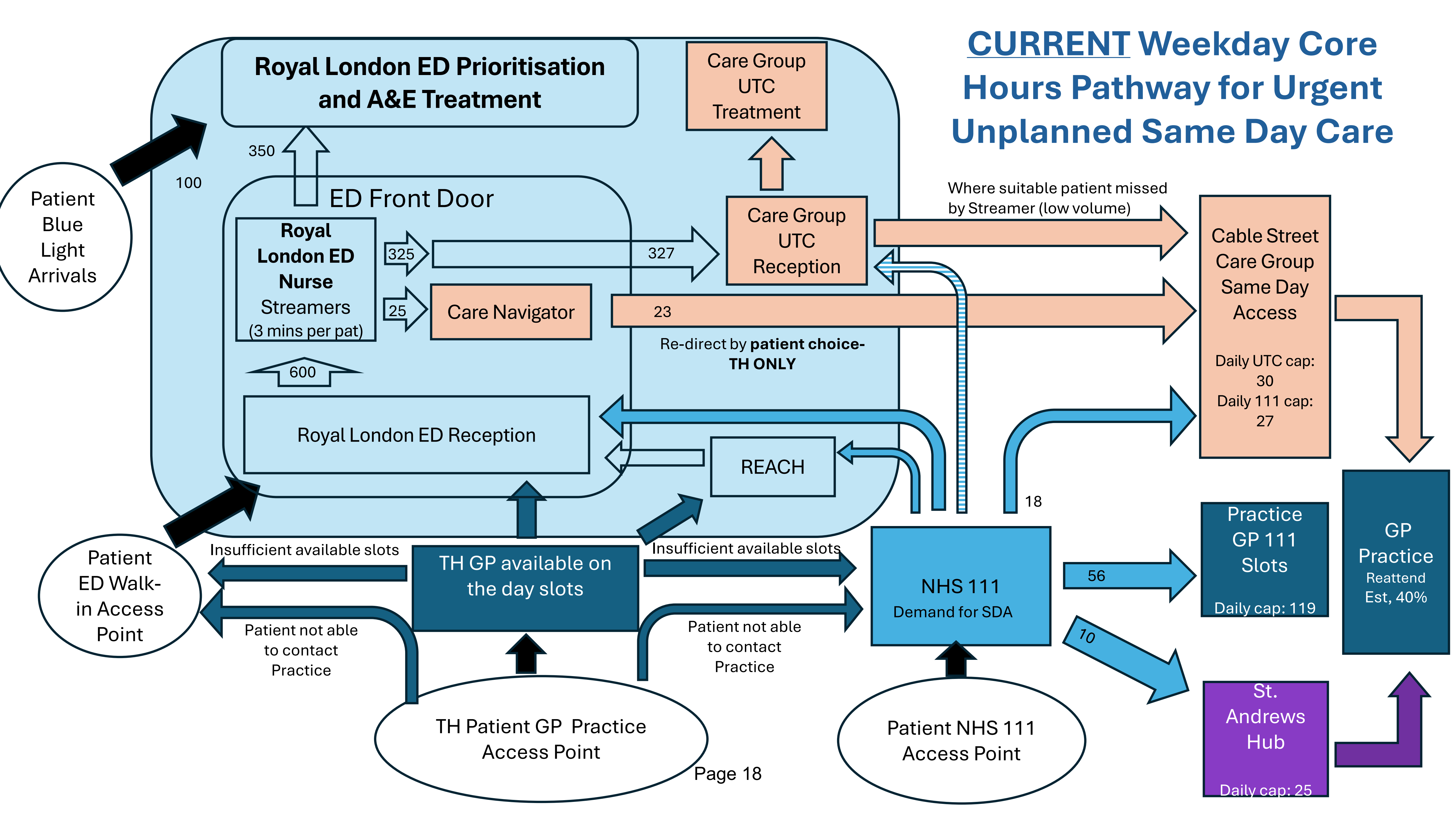
Tower Hamlets Same Day Access Programme

# Weekday Core Hours Pathway for Unplanned Same Day Care

This Programme has mapped the current patient pathway ***to and through*** the ‘front door’ of Royal London Hospital on the following slide, and has identified **changes** to the pathway that should improve patient experience and benefit the local health system.

***The different provider organisations involved in the pathway are identified using the colour scheme below:***

- Barts Health
- NHS 111
- Tower Hamlets GP Care Group
- Bromley By Bow Practice
- Tower Hamlets GP Practices
- Tower Hamlets PCNs



CURRENT Weekday Core Hours Pathway for Urgent Unplanned Same Day Care
Royal London ED Prioritisation and A&E Treatment
Care Group UTC Treatment
350
100
Patient Blue Light Arrivals
ED Front Door
Royal London ED Nurse Streamers (3 mins per pat)
325
327
Care Group UTC Reception
25
Care Navigator
23
Where suitable patient missed by Streamer (low volume)
Cable Street Care Group Same Day Access
Daily UTC cap: 30
Daily 111 cap: 27
Re-direct by patient choice- TH ONLY
600
Royal London ED Reception
REACH
18
Patient ED Walk-in Access Point
Insufficient available slots
TH GP available on the day slots
Insufficient available slots
NHS 111
Demand for SDA
56
Practice GP 111 Slots
Daily cap: 119
GP Practice
Reattend Est, 40%
10
Patient not able to contact Practice
Patient not able to contact Practice
TH Patient GP Practice Access Point
Patient NHS 111 Access Point
St. Andrews Hub
Daily cap: 25

# FOCUS ON current A&E streaming and redirection part of the pathway

Tower Hamlets Same Day Access Programme

NHS

TOWER HAMLETS

TOWER HAMLETS TOGETHER

What is the role of the Digital Front Door?

Patient registered with a pilot practice walks into A&E (Mon-Sun 8am-8pm)

Patient details taken at A&E Reception

Barts Nurse Streamer

Action → Decision

Patient seen for Initial Assessment (3 mins)

Patient streamed to Royal London ED → Patient attends Royal London ED

*Or*

Patient streamed to UTC → Patient attends UTC at RLH (GPCG)

Redirection following Triage

*Or*

Patient meets the criteria and agrees to be redirected to SDA service → Patient booked into SDA slots by Care Navigator → Patient attends Cable Street SDA Service (GPCG)

# Why is change to the current pathway needed? (1)

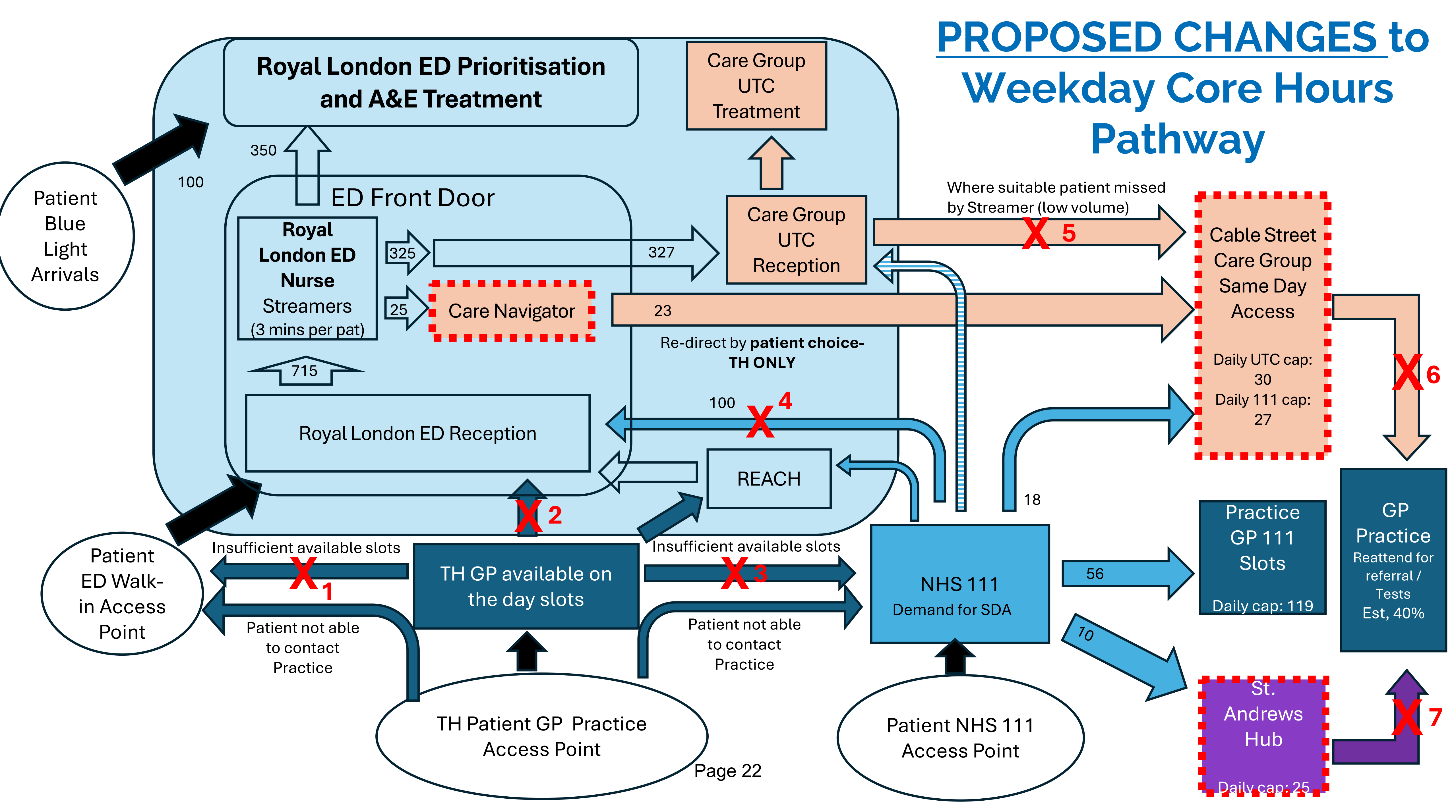
Tower Hamlets Same Day Access Programme

- The current pathway of redirection via the UTC **is not optimal for patients:** waiting time for patients suitable for redirection is longer, and the process more repetitive than it needs to be.
- **There have and will be further changes to the SDA service:** it will provide comprehensive consultations, clinicians will have access to patient records, be able to order tests and make referrals (where appropriate) and act on clinical record alerts. **This should have significant benefits for patients over the current service and over streaming to UTC**.
- **The current pathway does not represent value for money**. A patient streamed to UTC who is subsequently redirected to SDA costs £134.84, compared with £43.84 for a patient redirected from A&E. The ICB cannot agree to recurrently fund £1.4M to support the current pathway.
- **Without change to the pathway and either a reduction in A&E attendance and/or increase in redirections to SDA, it is anticipated that A&E/UTC activity will continue to grow** as the borough's population expands and patient habitual use of A&E and NHS 111 increases. Given the shortage of funds to invest in additional capacity, the ICS will struggle to meet waiting time targets.

# Why is change to the current pathway needed? (2)

Tower Hamlets Same Day Access Programme

- A caseload review of 50 UTC patients by the Urgent Care Lead and a TH CD indicated that **c82% of cases could have been directed to the SDA service <u>based on presenting systems and using the existing clinical criteria,</u>** indicating significant scope to increase the number of patients redirected to SDA from the current level of 30 per day.
- A Healthwatch survey of patients waiting in A&E indicated **a higher than anticipated willingness to accept a same-day redirection** from A&E to the SDA service: 68% of patients.
- Is there a need for patients to register at A&E ***and*** be assessed by the IA Nurse when they have been directed by NHS 111 to UTC?
- Does the proposed **Digital Front Door** for the RLH A&E impact on the pathway?


PROPOSED CHANGES to Weekday Core Hours Pathway
Royal London ED Prioritisation and A&E Treatment
Care Group UTC Treatment
350
100
ED Front Door
Royal London ED Nurse Streamers (3 mins per pat)
325
327
Care Group UTC Reception
25
Care Navigator
23
Where suitable patient missed by Streamer (low volume)
X 5
Cable Street Care Group Same Day Access
Daily UTC cap: 30
Daily 111 cap: 27
Re-direct by patient choice- TH ONLY
715
100
X 4
X 6
Royal London ED Reception
REACH
18
Patient Blue Light Arrivals
X 2
Insufficient available slots
X 1
TH GP available on the day slots
Insufficient available slots
X 3
NHS 111
Demand for SDA
56
Practice GP 111 Slots
Daily cap: 119
GP Practice
Reattend for referral / Tests
Est, 40%
Patient ED Walk-in Access Point
Patient not able to contact Practice
Patient not able to contact Practice
10
St. Andrews Hub
Daily cap: 25
X 7
TH Patient GP Practice Access Point
Patient NHS 111 Access Point

# FOCUS ON proposed changes to A&E streaming and redirection part of the pathway

Tower Hamlets Same Day Access Programme

NHS | TOWER HAMLETS | TOWER HAMLETS TOGETHER

What is the role of the Digital Front Door?

Patient registered with a pilot practice walks into A&E (Mon-Sun 8am-8pm)

Patient details taken at A&E Reception

Barts Nurse Streamer

Action → Decision

Patient seen for Initial Assessment (3 mins)

Patient streamed to Royal London ED → Patient attends Royal London ED

*Or*

Patient streamed to UTC → Patient attends UTC at RLH (GPCG)

*Or*

Patient meets the criteria and agrees to be redirected to SDA service → X8 → Patient booked into SDA slots by Care Navigator → X8 → Patient attends TH PCN SDA Service

Re[illegible]ion follow[illegible] Triage X5

# Proposed changes & potential £ cost savings (1)

Tower Hamlets Same Day Access Programme

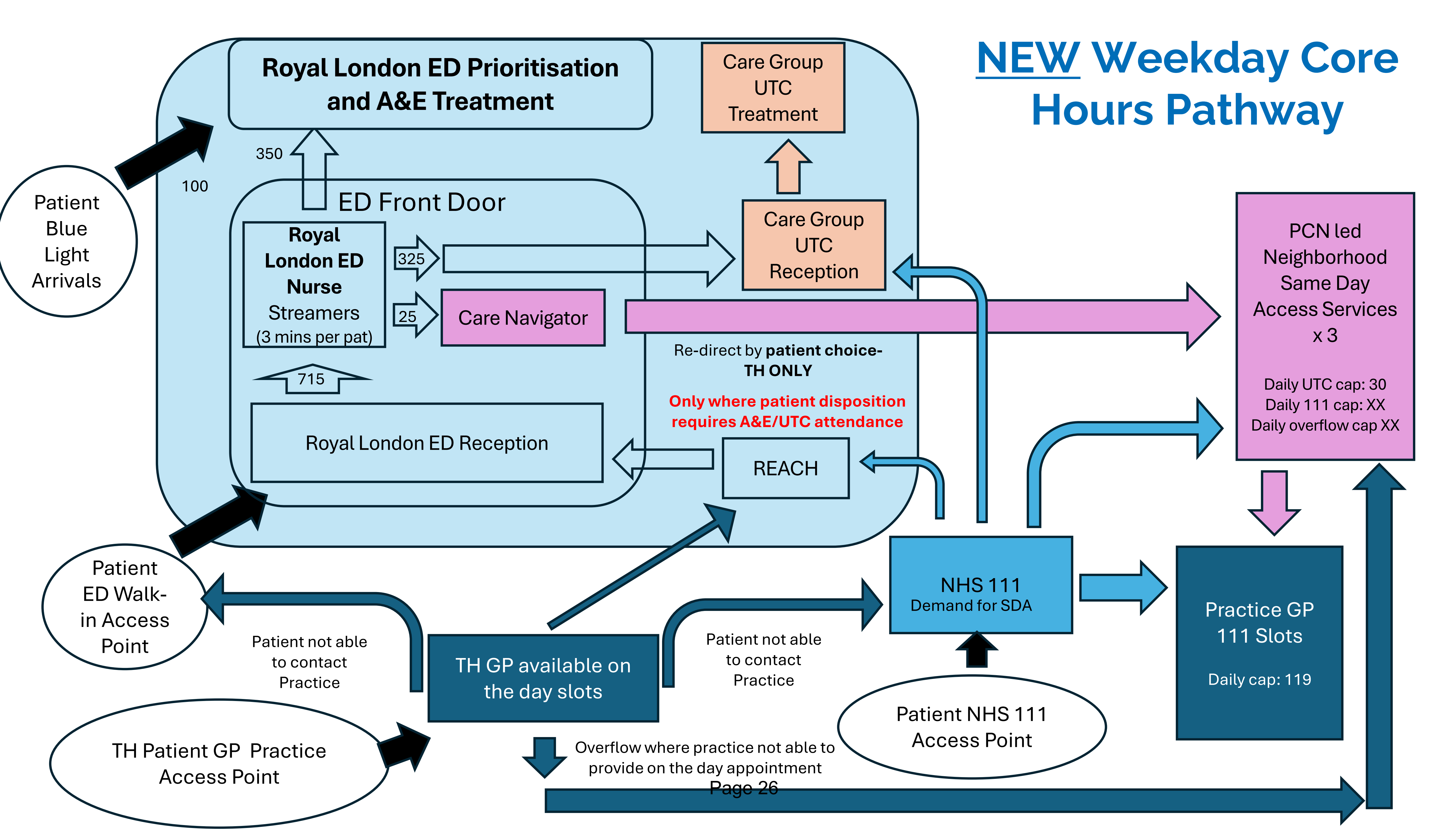
***Red crosses indicate pathway changes on slide 10***

| X | Description of change | Reason for change | Potential £ recurrent saving of change |
|---|---|---|---|
| X1 | Patients **stop attending** A&E due to insufficient GP practice on the day slots | New SDA service provides overflow capacity for GP practices | If 1 in 5 of patients attending SDA overflow slots would have otherwise gone to A&E/UTC, this could save the system **c£250,000 pa** |
| X2 | GP practices **stop referring** patients to A&E due to insufficient GP practice on the day slots | | |
| X3 | Patients **stop calling** NHS 111 due to insufficient GP practice on the day slots | | |
| X4 | NHS 111 **stops referring** patients to A&E/UTC due to insufficient GP practice on the day slots | New SDA service provides additional capacity to receive NHS 111 redirections | Data suggests the SDA service is reducing redirections from NHS 111 to UTC by c50%, saving **c£200,000 pa** |

# Proposed changes & potential £ cost savings (2)

***Red crosses indicate pathway changes on slide 10***

| X | Description of change | Reason for change | Potential £ recurrent saving of change |
|---|---|---|---|
| X5 | UTC **stops redirecting** patients to the SDA service | All appropriate patients have already been redirected earlier in pathway by Barts IA nurse | This avoids a UTC tariff and could save **c£500,000 pa.** |
| X6 | Reduction in patients **reattending** at their own GP practice following SDA consultation | Patients have had a more comprehensive /appropriate consultation at SDA | This save c15 hours of GP time per week. |
| X7 | St Andrews Hub service has ceased and NHS 111 redirection capacity offered by that service has been re-provided by the PCN SDA pilots. NB. St Andrews did not receive redirections from A&E/UTC | | N/A |
| X8 | **Increased** number of patients being appropriately streamed straight to SDA pilots by Barts IA nurse **without going via UTC.** | | This could save a further **c£500,000 pa** assuming a doubling of 30 to 60 redirections per day. |
| | **TOTAL POTENTIAL RECURRENT ANNUAL SAVING OF PROPOSED NEW MODEL** | | **c£1.5MILLION PA** |



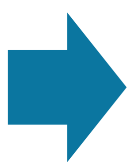
NEW Weekday Core Hours Pathway
Royal London ED Prioritisation and A&E Treatment
Care Group UTC Treatment
350
100
Patient Blue Light Arrivals
ED Front Door
Royal London ED Nurse Streamers (3 mins per pat)
325
25
Care Navigator
Care Group UTC Reception
PCN led Neighborhood Same Day Access Services x 3
Daily UTC cap: 30
Daily 111 cap: XX
Daily overflow cap XX
715
Re-direct by patient choice- TH ONLY
Only where patient disposition requires A&E/UTC attendance
Royal London ED Reception
REACH
Patient ED Walk-in Access Point
NHS 111
Demand for SDA
Practice GP 111 Slots
Daily cap: 119
Patient not able to contact Practice
TH GP available on the day slots
Patient not able to contact Practice
Patient NHS 111 Access Point
TH Patient GP Practice Access Point
Overflow where practice not able to provide on the day appointment

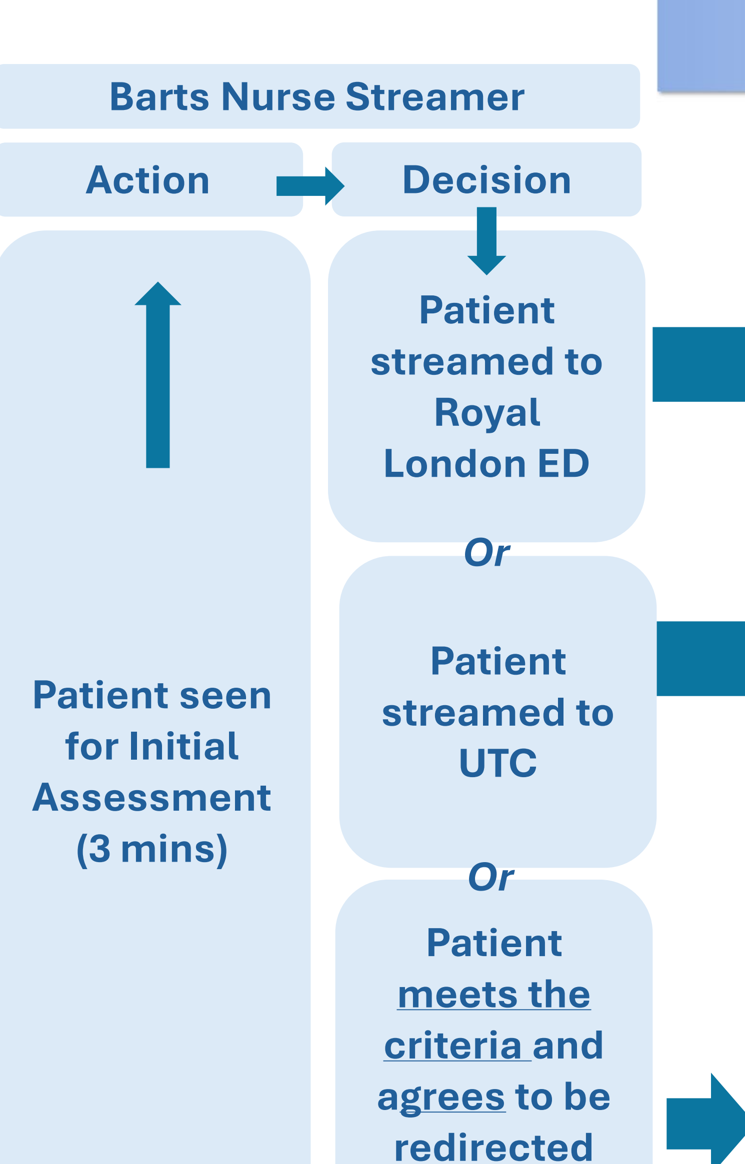
# FOCUS ON proposed new A&E streaming and redirection part of the pathway

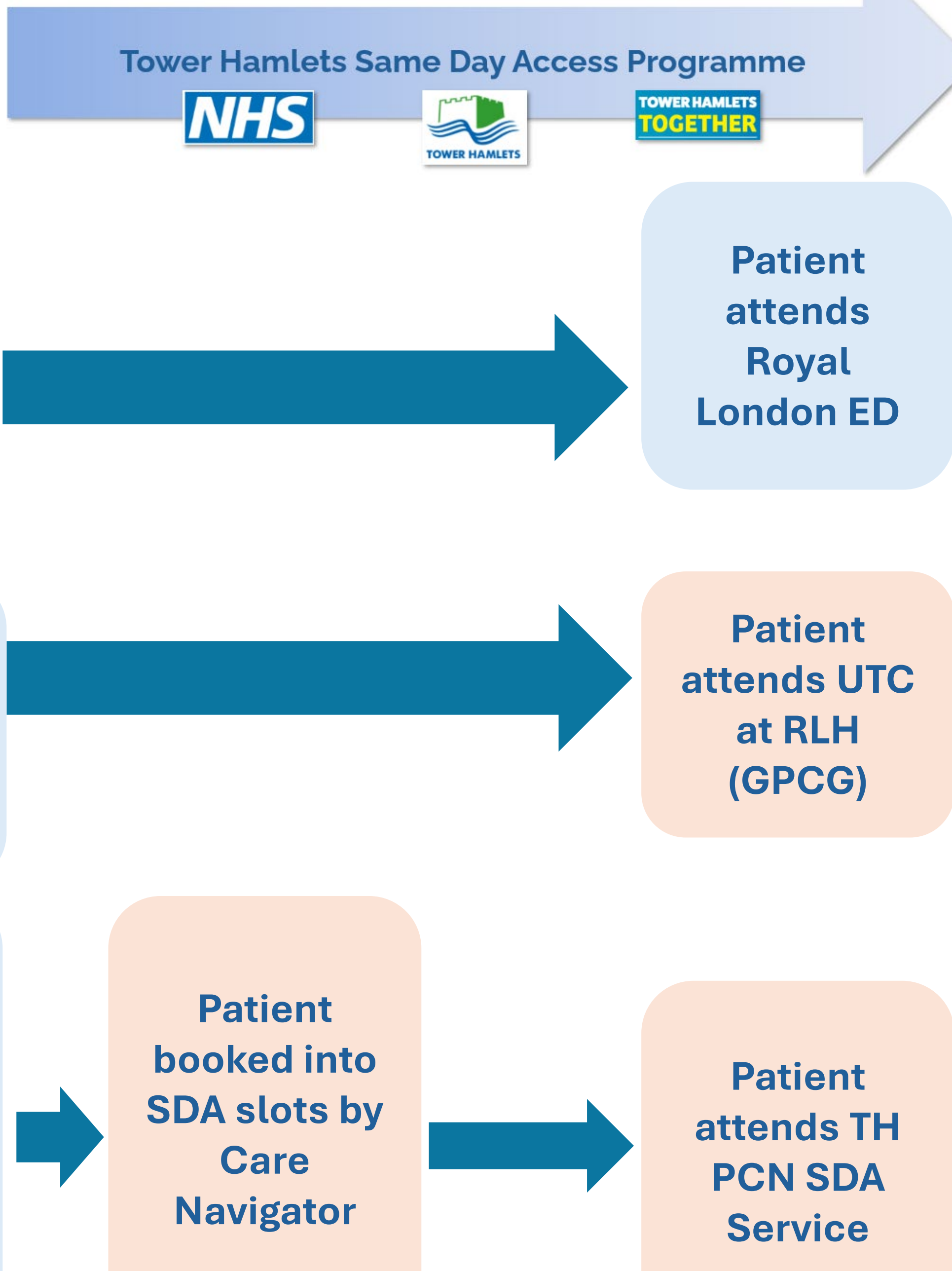
What is the role of the Digital Front Door?

Patient registered with a pilot practice walks into A&E (Mon-Sun 8am-8pm)

Patient details taken at A&E Reception





# Key programme risks

Tower Hamlets Same Day Access Programme

NHS

| | Risk | Initial Assessment | | | Mitigation (if any) | Revised Assessment | | |
|---|---|---|---|---|---|---|---|---|
| | | Likelihood (L) | Impact (I) | Assessment | | Likelihood (L) | Impact (I) | Assessment |
| | | (1-5) | (1-5) | L x I | | (1-5) | (1-5) | L x I |
| 1 | Barts IA nurse is not able to redirect to the SDA, either because of contractual restriction, staff skillset, or insufficient (3 min) time allocation | 4 | 5 | 20 | 1. Parties could mututally agree to vary contract<br>2. Existing staff could be supported or higher grade staff (at higher cost) used in delivery of initial assessment<br>3. Additional time could be provided for initial assessment. All under discussion with Barts | 1 | 5 | 5 |
| 2 | Additional funding is required by Barts in order to implement redirection by IA nurse | 4 | 5 | 20 | It may be possible to reallocate money between providers as part of redesign process i.e. a reallocation from UTC funding to funding of Barts IA nurse. Discussions ongoing with GPCG & Barts. | 1 | 5 | 5 |
| 3 | Care navigator isn't funded and/or supported to book into SDA service with appropriate tech | 3 | 5 | 15 | Funding is being requested in business case. | 1 | 5 | 5 |
| 4 | Primary Care doesn't provide sufficient capacity to receive all appropriate redirections Monday-Sunday | 4 | 5 | 20 | Discussions ongoing with PCNs and GPCG to meet requirements. | 1 | 5 | 5 |
| 5 | Funding required to meet additional UTC capacity and support ongoing pilot SDA provision isn't met by system | 4 | 5 | 20 | Programme Team is working together to produce successful business case | 1 | 5 | 5 |
| 6 | Proposed A&E Digital Front Door isn't compatible with new pathway | 3 | 4 | 12 | Discussions ongoing between ICB and Barts. | 1 | 4 | 4 |
| 7 | New pathway is so successful that patients prefer to use it to access same day GP appts rather than contacting their GP directly | 2 | 5 | 10 | Ongoing discussions about how this can be mitigated, including educative role of Care Navigator and SDA service | 1 | 5 | 5 |
| 8 | Risk patients won't accept redirection | 2 | 4 | 8 | Healthwatch survey undertaken at A&E indicates 68% of patients would accept redirection to SDA | 1 | 4 | 4 |
| 9 | Clinical risk of redirecting patients away from UTC | 1 | 5 | 5 | These are low risk patients, and Programme isn't changing Barts streaming and redirection criteria. | 1 | 5 | 5 |



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# Conclusion

The THT Board is asked to acknowledge the work that has been collaboratively undertaken to date on the programme and endorse the proposed direction of travel for the new Tower Hamlets Urgent Unplanned Care/ Same Day Access model, in particular the focus on ensuring that patient redirections occur at the earliest appropriate point in the pathway. This would improve not only the patient experience of the service but also deliver recurrent cost savings and efficiency to the system.

The THT Board is also asked to acknowledge the key risks to the programme:

1. The complexity of delivering more patient redirections to the SDA as part of the initial assessment in A&E and potential associated costs, although it should be possible to meet costs through redistribution of funding.
2. The proposed model assumes that the overall funding of the component parts of the pathway in 2024/25 is also available in 2025/26, and that additional funding required to develop the pilots in Primary Care is granted. These costs for 2025/26 should be viewed as transitional costs with the aim of achieving recurrent savings and permanent cost reductions in future years following changes to the pathway.
3. The timescales associated with the new pathway design because of a challenging procurement timetable.

# Next steps

Further to the first workshop on 17 December, additional workshops have been scheduled for January 2025 to finalise the model.

The business case requesting the rollover of the UTC contract at current value, continued funding for SDA pilots, appropriate estates funding to support potential local SDA redirection site and Care Navigator role will be submitted to the Investment Revenue Group (IRG) by 5 February 2025 and be presented on13 February 2025.

A model to ensure full redirection capacity, including at weekends, will be agreed by Tower Hamlets PCNs in early 2025.

Produced by Collaborations4Health on behalf of Tower Hamlets Together.

# Tower Hamlets Primary Care Same Day Access Programme

# Improving Access to Primary Care

**Progress on Core Priority for THT Board**

# Summary

- The following information provides an update on the **Primary Care** element of the Tower Hamlets Together Priority *Improving access to primary and urgent care - Ensuring residents can equally access high quality primary and urgent care services when and where they need them'*
- The Primary Care element of the Programme, led by Jo Sheldon, has **initially focused on Same Day Access to Primary Care** and how this is integrated into the Same Day Urgent Care Pathway including the A&E and UTC at the Royal London Hospital site and the NHS 111 service.
- The Urgent Care element of the Programme, led by urgent care leads, is focussed on the redesign of the pathway elements that that occur within/on the Royal London Hospital site (A&E and the UTC). Urgent Care will update separately on its progress.
- There is a separate NEL ICB programme associated with the redesign and procurement of NHS 111 services.

# Deliverables

## TH Priority

*Improving access to primary and urgent care - Ensuring residents can equally access high quality primary and urgent care services when and where they need them'*

The initial focus of this Priority has been on Same Day Access to Primary Care; an examination of the care pathway, how the current services can be improved and properly integrated into the Same Day Urgent Care Pathway to improve patient experience and provide better value for money.

The aim is to use test of change pilots to pilot changes that improve the ability of Primary Care to take redirections from both NHS 111 and the Royal London A&E/UTC, provide an overflow for practices when they run out of on the day appointments and provide a more holistic service to patients reducing the need to reattend their own practice after attendance at the pilot. The Priority is broken down into the following sub priorities

**Sub Priority 1: Establish Governance Structure**
**Sub Priority 2: Building an understanding of the care Pathway**
**Sub Priority 3: Test of Change Pilots**
**Sub Priority 4: Develop new service model from Test of Change Pilots**
**Sub Priority 5: promote the use of Pharmacy First by practices and Royal London A&E/ UTC**
**Sub Priority 6: Every Contact Counts**

# Deliverables, Progress & Outcomes

## Sub Priority 1: Establish Governance Structure

- **Deliverable**: Establishment of two Programme Groups: **Advisory Group** (responsible for coordination between Primary and Urgent Care) and **Design & Operations Group** (responsible for coordinating redesign of Primary Care Same Day Access Pathway elements.
- **Progress**: Groups established . Fortnightly meetings of both groups
- **Outcomes**: Service model discussion/development, shared learning, programme management

## Sub Priority 2: Building an understanding of the care Pathway

- **Deliverable**: Mapping of the Same Day Urgent Care pathway. Survey of patients attending Royal London A&E, UTC clinical caseload audit
- **Progress**: Core Hours pathway mapped (included in Annex 1 of this pack) non-core hours pathway almost completed. Patient Survey Complete, UTC clinical caseload audit almost complete
- **Outcomes**: Valuable data and information, feeding into the redesign of the care pathway (see annex 2 for redesigned core hours pathway) refinement of pilots and progression of programme.

# Deliverables, Progress & Outcomes

## Sub Priority 3: Test of Change Pilots

- **Deliverable:** Design, approval and implementation of 3 x Same Day Access pilots operated by Tower Hamlets PCNs, with borough-wide coverage
- **Progress**: All three pilots in operation. One extended to 31 March 2025, others expected to be extended. Clinical Directors sharing learning
- **Outcome:** on course for achievement of KPis (improvement in utilisation of practice 111 slots & reduction in percentage of patients with Primary care disposition redirected from NHS 111 to A&E/UTC)

## Sub Priority 4: Develop new service model from Test of Change Pilots

- **Deliverable:** Establish a new effective and efficient service model for Primary Care Same Day Access that fully integrates with, and supports, the Same Day Urgent Care Pathway building on the experience and data from the Test of Change Pilots.
- **Progress**: ongoing
- **Outcome:** Achievement of Programme KPIs.

# Deliverables, Progress & Outcomes

## Sub Priority 5: promote the use of Pharmacy First by practices and Royal London A&E/ UTC

- **Deliverable:** Increased redirection to Community Pharmacies under the Pharmacy First Scheme
- **Progress**: Ongoing
- **Outcome:** better use of an alternative mechanism for managing patient demand for Same Day Primary Care services.

## Sub Priority 6: Every Contact Counts

- **Deliverable:** Ensure that consultations provided by the pilots and subsequent new service conform to the 'every contact counts' approach
- **Progress**: ongoing
- **Outcome:** to provide a better more holistic service to patients and gain greatest system efficiency from patient consultations

# KPIs

Tower Hamlets Primary Care Same Day Access Programme

Early Pilot data indicates this is being achieved

Early Pilot data indicates this is being achieved

Review completed data to be analysed

Survey completed and data analysed

Activity ongoing

# KPIs

Tower Hamlets Primary Care Same Day Access Programme

| KPI description<br>Primary Care Deliverable | KPI Target 24/25 | System Impact |
|---|---|---|
| Testing new approaches to the management of NHS 111 demand and excess practice on the day demand | Testing to be undertaken 1st July – 30 September through PCN pilots | Contribute to redesign of front door and same day access service |
| Encourage uptake of pharmacy first | 10% increase in utilisation–Dec 24 | To support the management of demand for primary care same day access |
| | | |
| | | |

All three pilots mobilised

To be commenced

# Next Steps for Remainder of Year

- **Ongoing Monitoring and Evaluation of 3x pilots**
- **Feedback and refinement of pilot activities**
- **Expansion of pilots to take redirections from Royal London and UTC**
- **Introduction of ‘every contact counts’ philosophy to pilot consultations**
- **Develop increased use of Pharmacy First by Practices and A&E/UTC**

# Issues & Risks

**Key Risks**

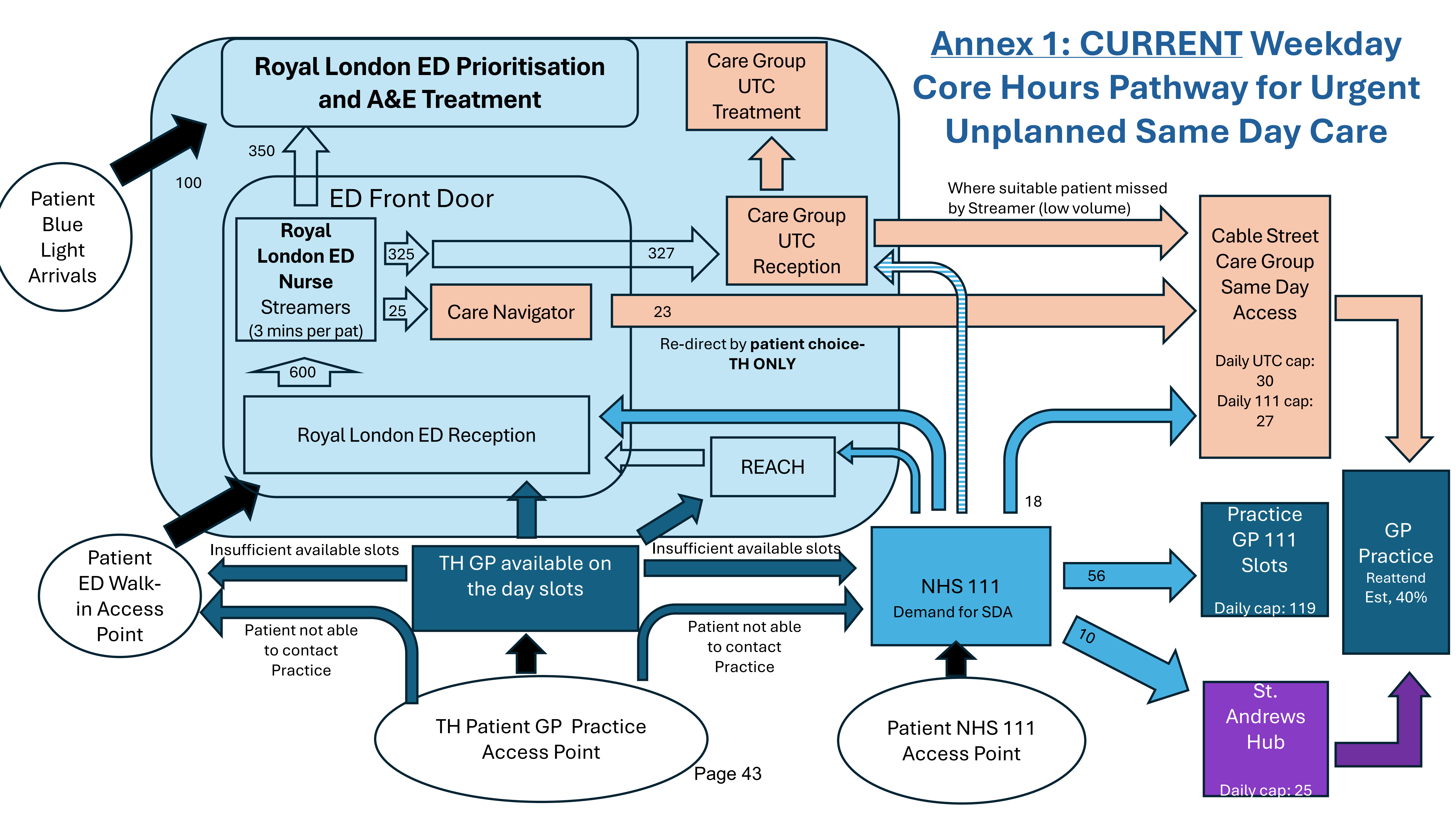
- **The transformation of the pilots to mainstream service in 2025/26 is dependent upon the success of a business case for additional funding. Because of the projected impact of the cessation of the pilots resulting in an increase in A&E/UTC demand, this case will form part of wider Urgent Care Business case for funding for 2025/26.**
- **Redirection pathways from the Royal London A&E /UTC remain under discussion and need to be rapidly resolved before the GPCG Cable Street Service contract expires**
- **The ability to obtain data within the urgent care system to the level required to monitor the progress and impact of the Primary Care same day care pilots.**
- **These pilots are led by primary care PCNs in Tower Hamlets for TH patients. Approx 40% of patients that attend for urgent care are from other boroughs**

# Annexes 1 and 2

This Programme has mapped the current patient pathway ***to and through*** the 'front door' of Royal London Hospital on the following slide, and has identified **changes** to the pathway that should improve patient experience and benefit the local health system (slides next two slides)

***The different provider organisations involved in the pathway are identified using the colour scheme below:***

- Barts Health
- NHS 111
- Tower Hamlets GP Care Group
- Bromley By Bow Practice
- Tower Hamlets GP Practices
- Tower Hamlets PCNs



Annex 1: CURRENT Weekday Core Hours Pathway for Urgent Unplanned Same Day Care
Royal London ED Prioritisation and A&E Treatment
Care Group UTC Treatment
350
100
Patient Blue Light Arrivals
ED Front Door
Royal London ED Nurse Streamers (3 mins per pat)
325
327
Care Group UTC Reception
Where suitable patient missed by Streamer (low volume)
Cable Street Care Group Same Day Access
25
Care Navigator
23
Re-direct by patient choice- TH ONLY
Daily UTC cap: 30
Daily 111 cap: 27
600
Royal London ED Reception
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18
Practice GP 111 Slots
Daily cap: 119
GP Practice
Reattend Est, 40%
Patient ED Walk-in Access Point
Insufficient available slots
TH GP available on the day slots
Insufficient available slots
NHS 111
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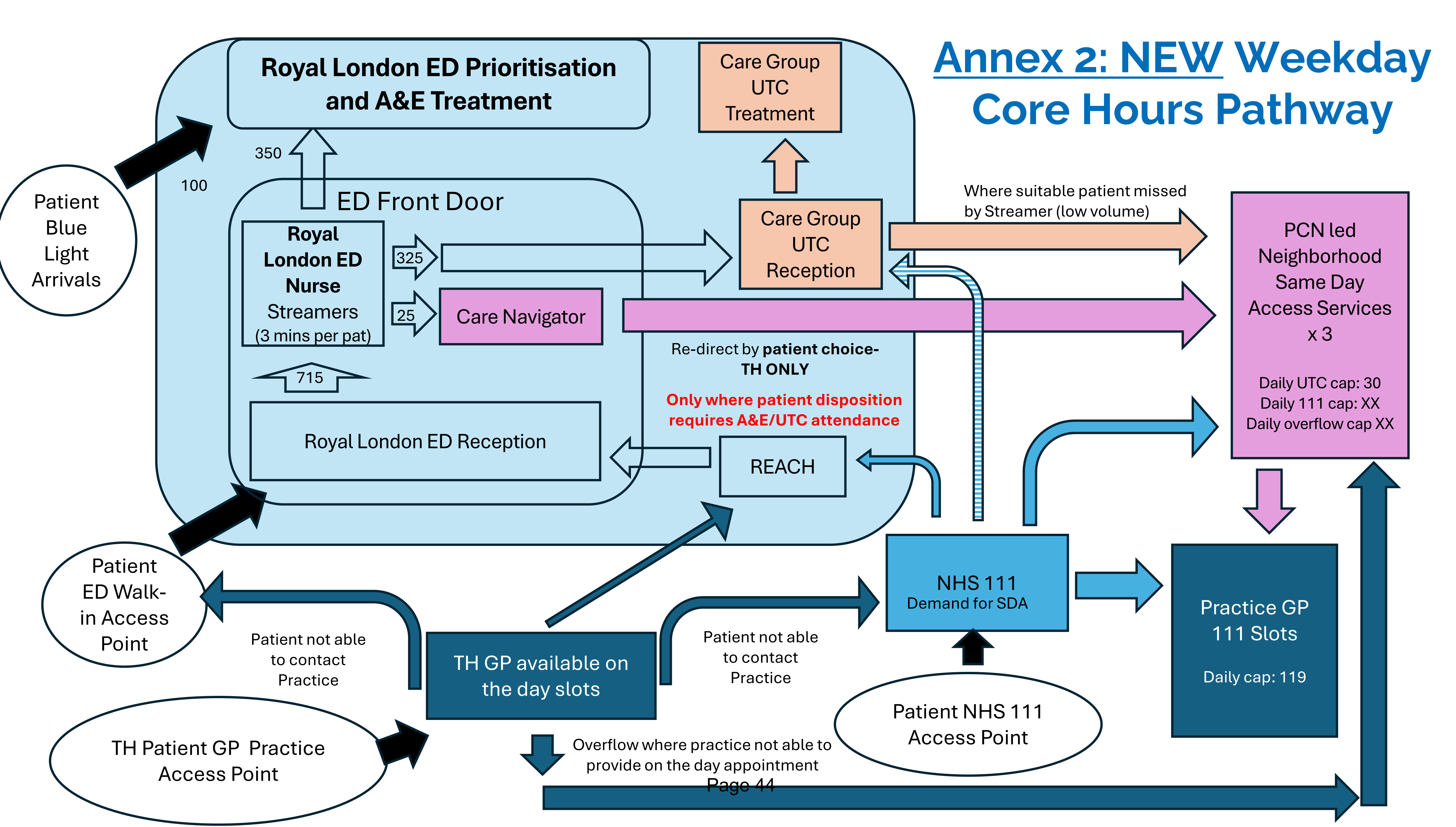
Patient not able to contact Practice
Patient not able to contact Practice
St. Andrews Hub
Daily cap: 25
TH Patient GP Practice Access Point
Patient NHS 111 Access Point



Annex 2: NEW Weekday Core Hours Pathway
Royal London ED Prioritisation and A&E Treatment
Care Group UTC Treatment
350
100
Patient Blue Light Arrivals
ED Front Door
Royal London ED Nurse Streamers (3 mins per pat)
325
25
Care Group UTC Reception
Care Navigator
Where suitable patient missed by Streamer (low volume)
PCN led Neighborhood Same Day Access Services x 3
Daily UTC cap: 30
Daily 111 cap: XX
Daily overflow cap XX
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Re-direct by patient choice- TH ONLY
Only where patient disposition requires A&E/UTC attendance
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Patient ED Walk-in Access Point
NHS 111 Demand for SDA
Practice GP 111 Slots
Daily cap: 119
Patient not able to contact Practice
TH GP available on the day slots
Patient not able to contact Practice
Patient NHS 111 Access Point
TH Patient GP Practice Access Point
Overflow where practice not able to provide on the day appointment

# Tower Hamlets Together

## Health and Social Care Place Based Partnership

Priorities update
Ashton West, Deputy Director of Partnership Development
January 2025

www.towerhamletstogether.com #TH2GETHER

NHS
East London
NHS Foundation Trust

# Overview

- **Improving access to primary and urgent care**
  Ensuring residents can equally access high quality primary and urgent care services when and where they need them
- **Enabling healthy living and providing the best support to prevent and manage long term conditions**
  Working across services and with residents and communities to build greater resilience and self-care to more effectively prevent long term conditions from occurring and to better manage existing conditions to prevent deterioration
- **Implementing a localities and neighbourhoods model**
  Ensuring that every resident can access the health and care services they need to support their continued health and wellbeing within their local area or neighbourhood, including GP, pharmacy, dental and leisure facilities
- **Facilitating a smooth and rapid process for hospital discharge into community care services**
  Working across services to ensure there is a smooth and rapid process for discharging residents from hospital to suitable community-based care settings when they are ready for this transition, and to prevent avoidable bed-blocking and improve outcomes
- **Being an anti-racist and equity driven health and care system**
  Ensuring our health and care system and services are achieving equitable outcomes for all residents and addressing inequalities that exist, e.g. access, experience, representation and outcomes
- **Ensuring that Babies, Children and Young People get the best start in life**
  Delivering a range of priorities that will ensure that babies, children and young people (and their families) are supported to get the best start in life, especially where they have additional needs
- **Providing integrated Mental Health services and interventions**
  Providing integrated services and interventions to promote and improve the mental wellbeing of our residents

- THT has identified 7 core priorities that the partnership is currently working together to achieve
- All priorities have commenced and developed programmes of work to drive them forward
- All priorities have a named SRO, PM, delivery board and clinical leads
- This update will outline each priority in turn, including its outcomes and how these map to our resident outcomes framework + progress made during 2024 and next steps for 2025
- This report is for noting and comment
- All priorities will provide more detailed updates to this Board at their allotted deep dive meetings

# Resident Outcomes Framework

| Domain | Description | I-Statements |
|---|---|---|
| Integrated health & care system | This is about the integration of health and social care organisations collaborating on the variation in health inequalities and health outcomes of its population. This is to bridge the gap in health inequalities. | • I feel like services work together to provide me with good care<br>• 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<br>• I want to see money being spent in the best way to deliver local services |
| Wider determinants of health | Given that these are deemed the most important factor of whether citizens are healthy or not, it is acknowledged that these issues cannot be addressed through the health and care system alone and requires a much broader approach to tackling these issues. | • I am able to support myself and my family financially<br>• I am satisfied with my home and where I live<br>• I am able to breathe cleaner air in the place where I live<br>• I feel safe from harm in my community |
| Healthy Lives | This reflects the health behaviours and life styles of citizens which are leading risk factors associated with the most common physical causes of morbidity and mental health issues. | • I am supported to make healthy choices<br>• I understand the ways to live a healthy life |
| Quality of care & support | This is reflected as the extent to which care, support and information is provided to the residents of Tower Hamlets to improve population health outcomes and overall satisfaction and experience of accessing and engaging with health and care provision. | • Regardless of who I am, I am able to access care services for my physical and mental health<br>• I am able to access safe and high quality services (when I need them)<br>• I have a positive experience of the services I access, overall<br>• I am confident that those providing my care are competent, happy and kind |
| Quality of life | This is reflected as the physical, social, emotional and cultural wellbeing of the population and how the health and care system works in partnership with citizens to support the achievement of life and health goals. | • I am supported to live the life I want<br>• I have a good level of happiness and well-being<br>• My children get the best possible start in life<br>• I play an active part in my community |

# Improving Access to Primary & Urgent Care

Deep dive update:
January 2025
SRO: Zainab Arian

This priority is split into 2 domains:

1) The **Primary Care Domain** is responsible for coordinating the redesign of the pathway elements that occur **outside** of both the RLH site and scope of the NHS 111 service
2) The **Urgent Unplanned Care Domain** is responsible for coordinating the redesign of the pathway elements that occur **within/on** the RLH site, and includes the NHS 111 service

Primary Care Programme key deliverables

- Establish Governance Structure – 2 programme groups – Advisory group and Design & Operations group
- Build an understanding of the care pathway
- Test of change pilots – 3 Same Day Access PCN pilots
- Develop new SDA service model
- Promote use of Pharmacy First by GPs, RLH A&E & UTC
- Use Every Contact Counts Approach

Urgent Care Programme key deliverables

- New SDA service to provide:
  - Overflow capacity for GP services
  - Additional capacity to receive NHS 111 redirections
  - Patients with a more comprehensive /appropriate consultation at SDA
  - Barts IA nurse to increase number of patients being appropriately streamed straight to SDA pilots without going via UTC

# Improving Access to Primary & Urgent Care

| Priority Outcomes | Alignment to Resident Outcomes Framework |
|---|---|
| Patients stop attending / being referred by GPs to A&E / UTC due to insufficient GP practice on the day slots | **I am able to access safe and high-quality services (when I need them)** |
| Patients stop calling NHS 111 / NHS 111 stops referring patients to A&E/UTC due to insufficient GP practice on the day slots | I feel like services work together to provide me with good care |
| Increased number of patients being appropriately streamed straight to SDA pilots by Barts IA nurse without going via UTC | Regardless of who I am, I am able to access care services for my physical and mental health |
| Reduction in patients reattending at their own GP practice following SDA consultation | 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 |
| Increased redirection to Community Pharmacies under the Pharmacy First Scheme | I have a positive experience of the services I access, overall |
| Provide a better more holistic service to patients and gain greatest system efficiency from patient consultations | I am confident that those providing my care are competent, happy and kind |
| Deliver annual cost savings of circa. £1.5m per annum through streamlining appropriate access to the right parts of the system | I want to see money being spent in the best way to deliver local services |

# Improving Access to Primary & Urgent Care

| Progress to date (2024) |
|---|
| Primary care access governance groups established – meeting fortnightly |
| Primary care core hours pathway mapped, non-core hours pathway almost completed. Patient Survey complete, UTC clinical caseload audit almost complete |
| All three PCN pilots in operation. One extended to 31 March 2025, others expected to be extended |
| The urgent care programme has mapped the current patient pathway *to and through* the 'front door' of Royal London Hospital, and has identified changes to the pathway that should improve patient experience and benefit the local health system |

| Next steps (2025) |
|---|
| Ongoing monitoring and evaluation of 3 PCN pilots |
| Expansion of pilots to take redirections from Royal London and UTC |
| Introduction of 'every contact counts' philosophy to pilot consultations |
| Develop increased use of Pharmacy First by Practices and A&E/UTC |
| The business case requesting the rollover of the UTC contract at current value, continued funding for SDA pilots, appropriate estates funding to support potential local SDA redirection site and Care Navigator role will be submitted to the Investment Revenue Group (IRG) on 13 February 2025 |
| A model to ensure full redirection capacity, including at weekends, will be agreed by Tower Hamlets PCNs in early 2025. |

# Enabling healthy living to prevent and manage LTCs

Deep dive update:
March 2025
SRO: Somen Banerjee

Preventing long-term conditions and the harms that are caused by 'Vital 5' risk factors requires a system-wide approach. All parts of the health and care system can have a role to play.

We have structured our approach into four "Pillars", which are themselves underpinned by two cross-cutting enablers.

**1. Linking to better support** around 'wider determinants' of health

**2. Community-centered prevention** and health promotion

**3. Detection and enabling self-care** to reduce the risks that cause poor health

**4. Active management and secondary prevention** for those with identified clinical risks & diseases

**Vital 5 Communications**

**Insight: Vital 5 Epidemiology and Outcomes Framework**

# Enabling healthy living to prevent and manage LTCs

| Priority Outcomes | Alignment to Resident Outcomes Framework |
|---|---|
| Residents and patients are supported to access help with the underlying factors that cause poor health | **I am supported to make healthy choices** |
| More efficient referral pathways, reducing wait times for residents | **I understand the ways to live a healthy life** |
| Increased awareness and utilisation of a range of community connector / link-worker roles | I feel like services work together to provide me with good care |
| At-risk communities have effective, co-designed services that support them to reduce their risk of LTCs | 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 |
| New resident-led initiatives to promote health are developed + more community spaces are available to support LTC prevention | Regardless of who I am, I am able to access care services for my physical and mental health |
| Health inequalities in the Vital 5 are reduced (including inequalities in access to prevention services) | I am able to access safe and high-quality services (when I need them) |
| Unwarranted variation in support for people with LTCs is reduced | I have a positive experience of the services I access, overall |
| LTC support services are aligned to the real needs of local people | I have a good level of happiness and well-being |
| | I am supported to live the life I want |

# Enabling healthy living to prevent and manage LTCs

| Progress to date (2024) | Next steps (2025) |
|---|---|
| Completed review of Social Prescribing | Implement new digital tools to enable a range of social prescribing and connector roles to link people to support |
| Pilot of Social Welfare Advisors in all practices in TH | Strengthen the social prescribing workforce, including through continued co-working, collaboration and knowledge sharing |
| Communities Keeping Well established | Maximise the ability of existing community-centred initiatives to promote health and impact on Vital 5 |
| Localities and PCNs are delivering community-centred health promotion | Ensure the voices of residents from the most deprived communities in the borough inform action |
| Established new Workplace healthchecks pilot | Ensure universal and targeted services to detect Vital 5 risks – like health checks, CVD checks - are available to, and accessed by, those who need them most |
| Developed MECC training offer for workforce | Increase the accessibility of support services like smoking, weight management and alcohol support |
| Increased capacity for smoking cessation support and specialist weight management | Strengthen secondary prevention and management for people who are diagnosed with common long-term conditions (LTCs) |
| A strong LES offer in primary care to manage long-term conditions | |
| We have a range of services in health and community settings to support prevention – e.g. T2DAY, NDPP, Good Moves | |

NHS North East London

# Implementing a Localities & Neighbourhoods Model

Deep dive update:
February 2025
SRO: Warwick Tomsett

The Localities and Neighbourhoods priority's core purpose is to ensure that every resident can access the health and care services they need to support their continued health and wellbeing within their local area or neighbourhood, including GP, pharmacy, dental and leisure facilities.

Currently, this is split across 3 key deliverables:

1) Integrated Neighbourhood Teams – to design, test and implement a model for integrated neighbourhood teams in Tower Hamlets

2) Neighbourhood Forums – to build structures that support resident voice to influence decision making and resource allocation at a PCN/locality level and enable community organisations and health and care partners to work collaboratively in order to ensure accessibility for unheard groups

3) Social Welfare and Health Inequalities – to develop and integrate Social Welfare Legal Advice as a core service in healthcare and other settings in Tower Hamlets to reduce health inequalities

# Implementing a Localities & Neighbourhoods Model

| Priority Outcomes | Alignment to Resident Outcomes Framework |
|---|---|
| Reduce inequality of access to services and reduce inequalities in health and social outcomes | **I feel like services work together to provide me with good care** |
| Create empowered communities who are better able to support themselves | **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** |
| Improve the quality of care received and resident experience in a sustainable way | I am supported to make healthy choices |
| Build local relationships between residents, VCS, health | I understand the ways to live a healthy life |
| VCS and health partners work collaboratively in order to ensure accessibility for unheard groups | Regardless of who I am, I am able to access care services for my physical and mental health |
| Increase in provision of social welfare advice & greater integration of social welfare advice in healthcare settings | I am able to support myself and my family financially |
| INTs will empower residents and enable access to inclusive, high-quality, person-centred care by coordinating health, social care, council, community and voluntary sector services | I have a positive experience of the services I access, overall |
| | I have a good level of happiness and well-being |
| | I am supported to live the life I want |
| | I play an active part in my community |

# Implementing a Localities & Neighbourhoods Model

| Progress to date (2024) | Next steps (2025) |
|---|---|
| Neighbourhood Forums nearing end of year-long pilot. Evaluation and recommendations going to THT Board in February 2025 | Implement recommendations from Neighbourhood Forums pilot once signed off by THT |
| Social Welfare Advice stocktake and recommendations presented to THT Board in November 2024 | A more detailed and phased plan to implement the Social Welfare Advice recommendations will be devised |
| Established task and finish group and completed activity mapping for Integrated Neighbourhood Teams | Integrated Neighbourhood Teams workshop is scheduled for March 2025 to continue the development of the Tower Hamlets model. Conversations with NEL ICB and across THT partners are planned in preparation for the workshop |

# Being an anti-racist and equity driven health system

Deep dive update:
December 2024
SRO: Roberto Tamsanguan

Tower Hamlets is a borough of great diversity: it has a larger number of global majority, LGBTQ+, disabled and homeless residents than both the London and England averages. Thus, it is vital that we ensure our health and care system is equitably providing for these residents and as such the partnership has made being an anti-racist and equity driven health system one of its core priorities.

Our core purpose is: Anti-racism and equity beyond EDI – to take actionable steps to drive change on all forms of health and social care racism, ethnic health disparities, misogyny, violence against women and girls, ableism and mental health discrimination, ageism, classism, and LGBTQ+ oppression related to Tower Hamlets.

We will work with staff across THT, the community and our partners to ensure we respond to the health and social care challenges that people face and promote an anti-racist, inclusive culture to drive equitable change. We will shape how the refresh of the anti-racism action plan will be carried out over next 3-4 years, with resident engagement to co-produce action plans and interventions.

We will also oversee the NEL funded 2023-2026 Health and Inequalities programme, ensuring regular monitoring of delivery and outcomes of the programme.

# Being an anti-racist and equity driven health system

| Priority Outcomes |
|---|
| Drive change on all forms of health and social care racism, ethnic health disparities, misogyny, violence against women and girls, ableism and mental health discrimination, ageism, classism, and LGBTQ+ oppression |
| Monitor and review the collection of ethnicity datasets in relation to health and social care to identify opportunities for service quality improvement |
| Strengthen direct monitoring by collecting firsthand anti-racist and anti-discriminatory data, by devising and piloting an online reporting form |
| Respond to local evidence presented to the THT Board in 2023-24 about unequal access, experiences and outcomes to improve equity across our health and care services |
| Understand how racism and other forms of discrimination affects the lived experiences of local residents through direct engagement with the community, to identify opportunities and barriers to transformational change |

| Alignment to Resident Outcomes Framework |
|---|
| **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 access, overall |
| I am supported to live the life I want |
| I play an active part in my community |
| My children get the best possible start in life |
| I have a good level of happiness and well-being |
| 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 am confident that those providing my care are competent, happy and kind |

# Being an anti-racist and equity driven health system

| Progress to date (2024) | Next steps (2025) |
|---|---|
| All schemes within the NEL funded 2023-2026 health inequalities programme have now commenced – several have completed | Confirm and implement the CVS element of the health inequalities programme – likely focus is domestic abuse / VAWG and mental health |
| An anti-racism and health equity steering group has been established, has met throughout the year and includes community reps from our Bengali, Somali, LGBTQ+ and disabled residents | Hold roadshows in the community to help co-produce what our anti-racist and health equity interventions should be |
| An inequalities fact finding survey has been undertaken with our seven equalities networks to understand their views and the key issues RE health and wellbeing that each demographic has | Respond to the findings of the local community led medical racism report by co-designing solutions jointly with the community and primary care |
| We have largely delivered against all the actions set in our current anti-racism action plan – this now needs a reset | Implement a partnership wide anti-racism framework, in line with that used in the North West of England |
| Recommissioned the Barts Women in Health Scheme and extended to primary care + placed 2nd in the national MJ awards this year | Recognising and partaking in Race Equality Week in February |
| Have implemented several other schemes, such as Pride in Practice, Somali Autism Research and accessible communications work for disabled residents | Reset the partnership's anti-racism plan for the next few years |
| | Bring together EDI leads from partners to map current EDI work being undertaken, share data and identify gaps for joint work |

# Ensuring that Babies, Children and Young People get the best start in life

Deep dive update:
April 2025
SRO: Steve Reddy

- The Tower Hamlets Children and Families partnership strategy Accelerate! launched in February 2024
- Children and Families Executive partnership oversees delivery
- Wider partnership is engaged in delivery through the Every Chance for Every Child Forum

The strategy is organised into delivering its 8 ambitions so that BCYP:

1. Have a great start in life
2. Enjoy the best possible health during childhood
3. Get support for good mental health and wellbeing when they need it
4. Get the right help at the right time of they have special educational needs or a disability
5. Feel safe and secure
6. Achieve their best in education and have opportunities to develop a career
7. Support families to be resilient in the cost of living and child poverty crisis
8. Champion co-production, equality and anti-racism

# Ensuring that Babies, Children and Young People get the best start in life

| Priority Outcomes | Alignment to Resident Outcomes Framework |
|---|---|
| BCYP have a great start in life | **My children get the best possible start in life** |
| BCYP enjoy the best possible health during childhood | I am supported to live the life I want |
| BCYP get support for good mental health and wellbeing when they need it | I have a good level of happiness and well-being |
| BCYP get the right help at the right time of they have special educational needs or a disability | I feel like services work together to provide me with good care |
| BCYP feel safe and secure | 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 |
| BCYP achieve their best in education and have opportunities to develop a career | I am able to support myself and my family financially |
| Support families to be resilient in the cost of living and child poverty crisis | I feel safe from harm in my community |
| Champion co-production, equality and anti-racism | I am supported to make healthy choices |
| | 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 access, overall |

# Ensuring that Babies, Children and Young People get the best start in life

| Progress to date (2024) |
| --- |
| Roll out of family hubs across the borough |
| Expanded opportunities for children and young people to be more physically active through the council leisure service |
| New SEND Strategy launched |
| Frontline staff working with families trained to use benefits calculator with families |
| Young Tower Hamlets opening safe spaces for young people across the borough |
| Successful Local Authority Children's Care inspection |
| Celebrating Refugees Week |
| Free school meals roll out |

| Next steps (2025) |
| --- |
| SEND improvement |
| Early help |
| Strengthening the antenatal and maternity pathway |
| Centring the child/young person's voice in all we do |
| New strategic data dashboard will help us prioritise partnership action for 2025 across all eight ambitions |
| Improving Post 16 Education |

# Tower Hamlets Together Board

09/01/2025

| | |
|---|---|
| **Title of report** | Integration Roadmap Development |
| **Author** | Belinda Yeldon, Head of Integration |
| **Presented by** | Anna Carratt, Deputy Director of Strategic Development, and Belinda Yeldon, Head of Integration |
| **Contact for further information** | Belinda Yeldon |
| **Executive summary** | This report presents the draft Integration Roadmap developed by the ICB Strategy Team, outlining our approach to strengthening integration across North East London's health and care system. The roadmap, when complete, will establish a framework for delivering integrated care, focusing on three key aspirations: managing population health growth, reducing health inequalities, and reducing unwarranted variation.<br>The roadmap has been developed through engagement with system partners and provides:<br>• A clear definition and vision for integration within North East London<br>• A structured approach to both horizontal and vertical integration<br>• Detailed implementation pathways across system, place, neighborhood, and individual levels<br>• Key enablers and focus areas to support successful integration<br>Please note, this is a working version for discussion purposes. We are seeking input and further information that will help us to further build on the document, and creating a helpful and meaningful structure. |
| **Action / recommendation** | The Board/Committee is asked to:<br>1. Review and provide feedback on the draft Integration Roadmap, including where further information is needed<br>2. Discuss and consider the key enablers to be included in the Integration Toolkit<br>3. Support the engagement approach across the Place<br>4. Consider what this means for Tower Hamlets Place and partners |
| **Previous reporting** | • Initial concept presented to Executive Management Team (EMT)<br>• Development updates shared through Place-based partnerships |

| | |
|---|---|
| | • Collaborative engagement meetings with Place Directors, Providers and ICB Transformation Programme leads (summer 2024) |
| **Next steps/ onward reporting** | • Further engagement with Places and Collaboratives (January 2025)<br>• EMT review (early February 2025)<br>• PHIC review (February 2025)<br>• Board consideration (March 2025) |
| **Conflicts of interest** | No conflicts of interest have been identified in relation to this report. Meeting to discuss if any further have arisen. |
| **Strategic fit** | Which of the ICS aims does this report align with?<br>• To improve outcomes in population health and healthcare<br>• To tackle inequalities in outcomes, experience and access |
| **Impact on local people, health inequalities and sustainability** | The Integration Roadmap will directly impact local people by:<br>• Creating more seamless care pathways and reducing fragmentation<br>• Improving access to services through better coordination<br>• Reducing health inequalities through targeted interventions and improved service integration<br>• Supporting sustainable service delivery through efficient resource use |
| **Has an Equalities Impact Assessment been carried out?** | An Equalities Impact Assessment has not undertaken as part of the roadmap development. Full EIA will be completed following stakeholder engagement and before final implementation of any of the respective programmes, as part of the Integration Toolkit. |
| **Impact on finance, performance and quality** | **Financial Implications**<br>Implementation of the integration roadmap will be accomplished using existing organisational resources through careful realignment of current services and structures. This approach ensures fiscal responsibility while maximising the impact of our current investments.<br>The integration of services presents significant opportunities for efficiency gains across the system through streamlined processes and reduced duplication of efforts.<br>The Better Care Fund offers substantial opportunities for alignment and pooled funding arrangements to support our integration goals. We will work closely with partners to leverage these opportunities and create sustainable funding models that support long-term integration objectives.<br>**Performance & Quality Impact** |

| | |
|---|---|
| | It is anticipated that the Roadmap is for direction setting, but it is expected the utilisation of his Roadmap will improve service coordination as a result of new integrated care pathways, and models of care, and improved communication between providers across all levels of care.<br>The standardisation of care pathways and reduction of unwarranted variation will lead to measurable improvements in clinical outcomes and patient safety.<br>Patient experience will be significantly enhanced through more coordinated care delivery and simplified access to services across the system.<br>Further work is ongoing to determine the most appropriate metrics to measure improved integration. |
| **Risks** | **Stakeholder Engagement** The risk of insufficient stakeholder engagement could significantly impact implementation success and sustainability. Partners may have varying levels of commitment or conflicting priorities that could affect their focus.<br>Local communities and service users might not be adequately represented in the development process, potentially leading to solutions that don't fully meet their needs.<br>**Mitigation**: centres on a bottom-up delivery approach where the roadmap serves as a strategic signal rather than a prescriptive plan. Places and Collaboratives will lead the development of local integration initiatives based on their specific needs and contexts, with the roadmap providing directional guidance<br><br>**Implementation Capacity** There is a risk that existing resources may be insufficient to deliver all aspects of the integration programme simultaneously across all areas. This includes both staffing constraints and operational capacity. Some partners may struggle to commit necessary resources while maintaining business as usual activities.<br>**Mitigation**: We will implement a carefully phased approach to delivery, prioritising key initiatives based on impact and feasibility.<br><br>**System Complexity** The complex nature of our health and care system presents risks through multiple interdependencies, varying organisational cultures, and different operating models. These complexities could lead to delays in decision-making and implementation.<br>**Mitigation** establishing clear governance structures with defined decision-making processes and escalation routes |

| | |
|---|---|
| | through the Integrating Enablers Working Group and the Strategic Development Group. We will implement regular monitoring and reporting mechanisms to identify and address issues early. A dedicated programme management office will coordinate activities and manage interdependencies.<br><br>**Change Management** Significant organisational and cultural change will be required, which may face resistance from staff and stakeholder. Staff may experience change fatigue, particularly given other ongoing transformation initiatives.<br>**Mitigation**: This will be addressed through a comprehensive project plan including clear communication plans, targeted stakeholder support, and dedicated change management resources. |

# Integration Roadmap for North East London

# Executive Summary and Contents

## Executive Summary

| Contents | Page |
| --- | --- |
| Key Questions | 3 |
| Engagement Feedback | 4 - 5 |
| Theory of Change | 6 - 11 |
| Detailed Considerations regarding Aspirations and Workstreams | 12 - 20 |
| Roadmap for Change | 21 – 26 |
| Governance | 27 – 29 |
| Next Steps | 30 – 31 |
| Case Studies – Integration work already in train | 32 - 50 |

# Key Questions

## Theory of Change:

1. How well does proposed theory of change, with its focus on Models of Care, Pathways, Partnerships, People, and Processes align with your key priorities? Are there any areas where we need to recalibrate to ensure full alignment?

2. Are the enablers listed (Culture, Organisational Development, Finance, Commissioning & Contracting, Data & Digital, Estates, Workforce) comprehensive enough to support the proposed workstreams? Are there any additional enablers we should consider?

## Roadmap for Change:

1. Is the proposed 6-stage approach (Start, Stabilise, Standardise, Strengthen, Sustain, Scale) appropriate for our integration journey? Does it allow for enough flexibility while providing a clear direction?

2. To what extent do we wish to use this roadmap to fundamentally alter our healthcare delivery model? Do want change multiple things at once or deliver change in stages?

3. Do you see this work as genuinely system wide or primary ICB driven? How effectively do you feel we can use this roadmap to leverage our collective input and expertise across the system?

# Engagement Feedback

# Key Stakeholder Findings

**Strategic Approach and System Design**
- Current approaches to population health growth are limited, necessitating new strategies.
- There is an imbalance between the micro and macro focus, requiring a shift towards broader, systemic approaches, that transcend place-based partnerships
- Balancing standardisation with local needs remains a persistent challenge. Inconsistency in core offerings across providers complicates service alignment and creates gaps in care
- Insufficient connections between programmes and collaboratives hinder true system integration
- While integration is a critical concept, implementation efforts face significant challenges and lack robust evidence of effectiveness in practice

**System Alignment and Incentives**
- Misaligned incentives across different parts of the health and care system obstruct collaborative efforts.
- Integration may lead to consolidation, and streamlining, where volumes are too low to justify current service provision
- Outdated contract specifications and unclear expiration timelines create additional obstacles

**Service Provision and Optimisation**
- Operational realities may not be the same as what the business case presented in terms of integration efforts
- Integration may lead to consolidation, and streamlining, where volumes are too low to justify current service provision

**Organisational Culture and Change Management**
- A shift in organisational culture and mindset is essential, to transition from a competitive to a collaborative system
- Siloed thinking and resistance to change impede progress towards a more integration system

**Financial Constraints and Resource Allocation**
- Financial constraints significantly hinder innovation and implementation of new ideas, paradoxically, our financial position could serve as a key driver for change
- Funding is limited, raising questions about alternatives to costly double-running programmes
- Short-term funding cycles and inadequate evaluation impede scaling up pilots and hamper long-term strategic planning

| Stakeholder Group | Stakeholders |
|---|---|
| ICB Leads | • Portfolio Directors,<br>• Place Directors,<br>• Transformation Leads<br>• Health improvement and Inclusion |
| ICS wide Partners | • Acute Trust Heads of Integration<br>• Acute Trust Directors of Strategy and Partnerships<br>• Acute Trust CEO |
| Enablers / Cross-Cutting Functions | • Performance and Outcomes Leads<br>• Contracting Leads<br>• Workforce Leads<br>• Infrastructure Leads<br>• Communication leads |
| National, Regional, Thinktanks | • The Kings Fund<br>• Nuffield Trust<br>• NHS Confederation |

# Theory for change

# Defining Integration

Integration as a concept within healthcare is not new. There have been a number of different definitions developed both globally and in the UK over the last 20 years.

Whilst it is recognised that numerous definitions and benefits, it is not proposed that we develop a north east London definition, but work to agree an agreed understanding of what integration would mean within north east London and what the benefits would mean to our residents and their health and social care needs.

## What is integration:

- An enabler to achieve some of our strategic priorities
- Coordination and alignment of services and functions across providers and pathways
- Enabling more comprehensive, efficient services
- Reducing the barriers between services for residents
- Enabling residents to navigate health and social care more effectively
- Seamless pathways for patients and staff with improved transitions between services
- Moving away from siloed condition-based commissioning

## What is integration not:

- A singular way to achieve better outcomes or efficiencies
- The same thing at all levels and in all Places
- A means to an end

## Why integration?

Our health and care services can sometimes be fragmented, disease-centred and difficult for residents to navigate. As a result, too many people experience lower levels or care, often in the wrong settings with undesirable outcomes.

## What does good look like?

Just as there is no one definition of integration, there is no singular benefit, however successful integration would deliver

- Manage population growth
- Reduce health inequalities
- Care closer to home
- Reduce unwarranted variation
- Generate efficiencies
- Improved resident experience

# Case for Change

## What is the role of health & social care?

Health & social care is essential for maintaining & enhancing well-being, providing treatments and preventive measures to help manage health conditions and promote healthy lifestyles

Effective healthcare extends life expectancy by preventing diseases & managing chronic conditions but also empowers local people enabling them to make informed decision

Services also play a key role in addressing key social determinants like housing, employment, and education, which are crucial for reducing inequalities and improving health outcomes

## Why do we need integration?

We aim to make sure all our **health and care services work better together,** so everyone in North East London can enjoy healthier lives

By getting different parts of the system to collaborate, we can support everyone to **get the care they need when they need it**

We want everyone, especially those with ongoing health issues, to experience **streamlined & reliable care**, no matter where they are treated

Integration can helps us **use our resources more wisely**, so we can continue to support everyone's health needs, as our population grows & we **focus on more preventative care**

## What are the macro issues we are trying to solve?

1. **We will assist the system in managing population health growth and increasing prevalence**
   - **Slow processes and delays** can affect diagnoses and treatments.
   - By making care more streamlined **local people can get the care and support they need faster**
2. **We will look to reduce health inequalities for residents**
   - We acknowledge that people can fall through gaps in the system.
   - We need to making sure that everyone can **access the full range of services they need.**
3. **We will look to reduce unwarranted variation**
   - **Different parts of the system have different goals, pathways and service models**, which can make things confusing and unequal for local people. We need to equalise these so that **our focus is always on what is best for local people**

## What could integration look like in practice?

- **Local communities are actively engaged** in their care. This involves both in planning & delivery and involving local people in decision-making processes
- Services that **meet the needs of each community**, which focus on what matters most to local people
- **Patient-centric care**, that put the needs and experiences of local people first. Ensure that everyone, especially those with complex or chronic conditions, receives coordinated, timely, and high-quality care
- **A shared commitment** to the best possible outcomes for all local people and their communities
- Deliver **integration at and between every level** of the system. This includes for individuals, neighbourhoods & communities, place & system

# What is the role of Integration?

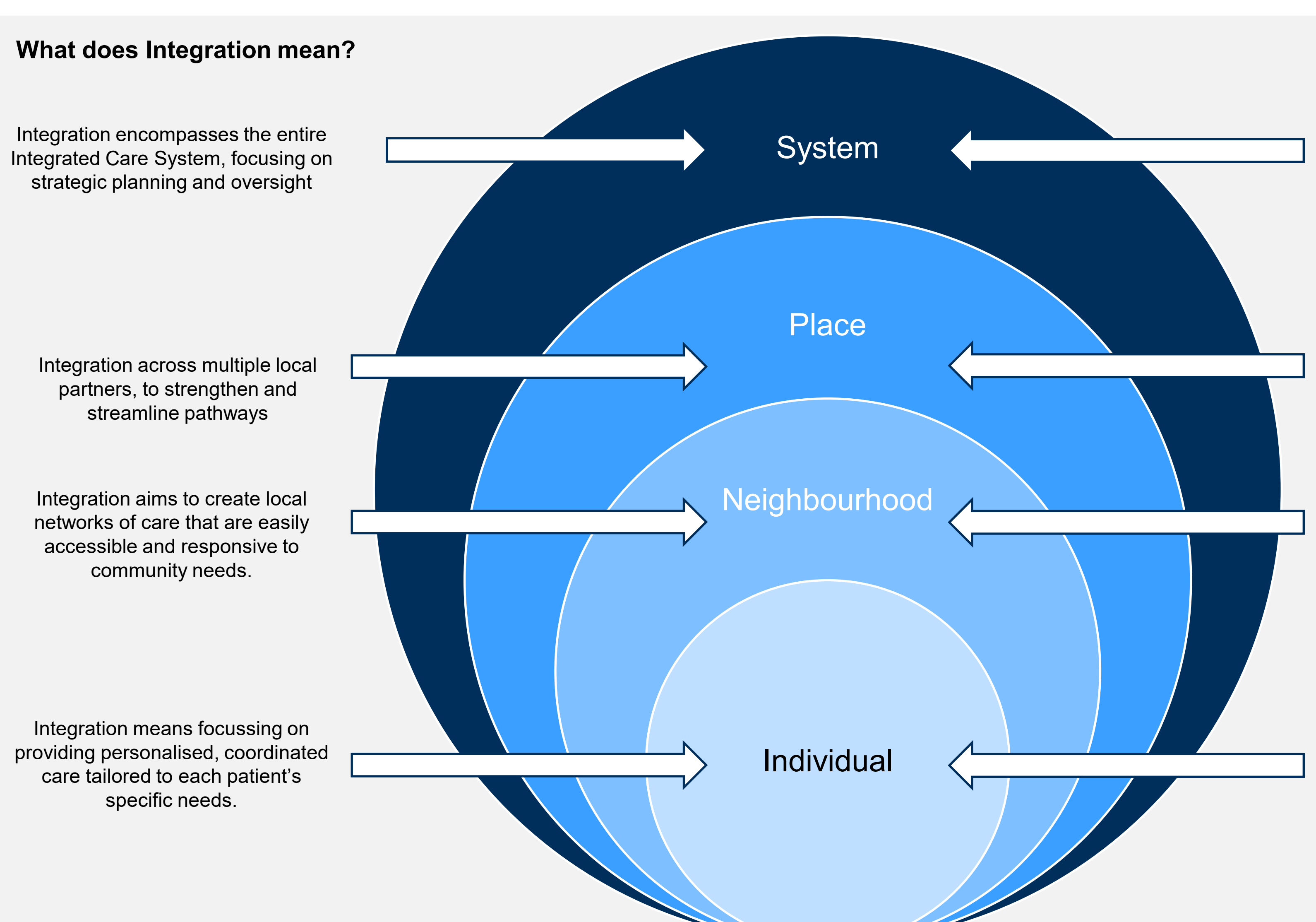
**What does Integration mean?**

Integration encompasses the entire Integrated Care System, focusing on strategic planning and oversight

Integration across multiple local partners, to strengthen and streamline pathways

Integration aims to create local networks of care that are easily accessible and responsive to community needs.

Integration means focussing on providing personalised, coordinated care tailored to each patient's specific needs.




**What is the role of each level of the system?**

- Setting overarching strategies, priorities and goals for improving population health
- Addressing unwarranted variation, and supporting the scaling of effective models of care and pathways
- Developing system-wide policies and standards
- Fostering collaboration between different sectors
- Implementing large-scale transformation initiatives, incl. across enabling programmes, and patient pathways
- Allocating resources effectively to meet the diverse needs of different communities

- Coordinating care across various providers within each borough to improve pathways
- Collaborating with health and social care partners
- Pooling resources and budgets to address health priorities more effectively

- Establishing INTs, of healthcare professionals working together in local settings
- Developing strong links between primary care, community care and acute care
- Implementing preventative health programmes tailored to the specific needs of the local population

- Creating personalised care and support plans
- Regular communication between different healthcare providers involved in an individual's care
- Empowering patients to actively participate in their own health management
- Utilising technology, incl. electronic health records to maintain a holistic view of the patient's health history and needs

# How can we enhance our Integration efforts?

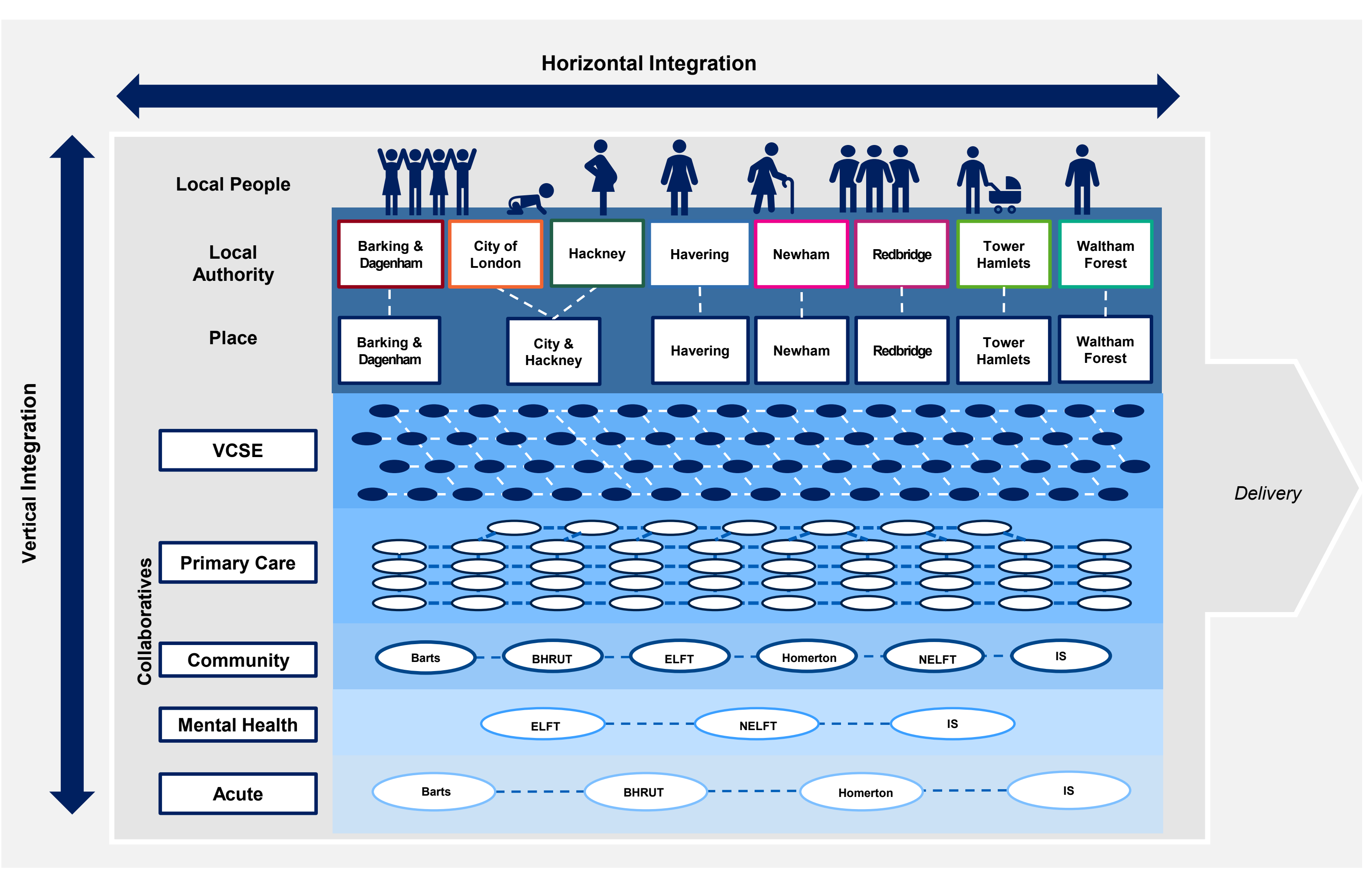
To effectively achieve our integration efforts, we need to focus on both horizontal and vertical integration strategies. By strengthening collaboration across different levels of the system, providers, areas, and communities we aim to create an environment which enables more coordinated health and care experience for local people in North East London.

**Examples of Horizontal Integration:**

- **Primary Care Networks:** Strengthening links between general practice through PCNs to increase service offer to patients
- **Places**: working together across areas to learn from and strengthen understanding of population health approaches

**Examples of Vertical Integration:**

- **Primary Secondary Interface:** Work ongoing to tackle day to day issues local people are experiencing with their care transitions
- **Health and Social Care:** Better Care Fund – pooled funding. Bridging health & social care to address the broader determinants of health
- **Integrated Neighbourhood Teams:** working together across health, social care, voluntary and community sectors with local people to understand population needs and cater for specific populations



# Route to Achieve our Aspirations

**Aspirations**

**Aspiration 1**

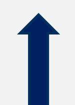
**Managing population health growth and increasing prevalence**

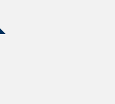
**Aspiration 2**

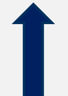
**Reduce health inequalities for residents**

**Aspiration 3**

**Reducing unwarranted variation**







**Key Areas of Focus**

**Models of Care**

The frameworks that describe how healthcare services are delivered, including the way patients receive care across different healthcare settings and providers.

**Pathways**

The patient's journey; the clinical and non-clinical sequence of interactions, experiences and touchpoints encompassing a patient has from the initial point of contact through to the completion of their care episode.

**Partnerships** (including collaborative relationships)

The collaborative relationships between different healthcare organisations, providers, and how they collaborate and work together to deliver the best possible patient care.

**People** (including empowered residents)

The local individuals and community members who live in NEL, use local health services, and contribute to the community's overall health and wellbeing.

**Processes**

The structured series of actions, methods, and protocols implemented within and across healthcare organisations to deliver integrated care

**Enablers**

- Culture & Values
- Organisational Development
- ICS & LA Devolution
- Finance
- Commissioning & Contracting
- Data & Digital
- Estates

In Draft - to be completed in collaboration with Places, and Collaboratives)

# Roadmap for Change

# Roadmap for Integration

| | Start | Stabilise | Standardise | Strengthen | Sustain | Scale |
|---|---|---|---|---|---|---|
| | *Initiating key activities and laying the groundwork for integration* | *Refining initial efforts, and identifying and addressing areas of bad practice, and ensuring financial stability* | *Establishing consistent practices across different areas of integration, as well as standardising best practice across the system* | *Enhancing and optimising delivery by deepening collaborations and implementing more advanced integrated care practices.* | *Maintaining the progress made, continuously improving based on outcomes and feedback, and ensuring the long-term viability* | *Expanding successful models, practices, and initiatives to broader populations, services or geographical areas* |
| **Models of Care** | Design new model of care | Refine models and address ineffective practices | Establish consistent care models across settings | Enhance model effectiveness through data-driven improvements | Maintain and update models based on outcomes | Expand successful models to new Places or populations |
| **Pathways** | Begin mapping initial patient journeys | Identify and rectify areas of poor care in pathways | Implement standardised pathways across the system | Optimise pathways, including with digital solutions | Continuously improve based on patient feedback | Extend optimized pathways to additional service areas, Places and populations |
| **People** | Initiate patient engagement efforts | Address inequities in community involvement | Develop standardised engagement practices | Increase community leadership in health initiatives | Maintain high levels of co-production and community empowerment | Expand community-led initiatives across the system |
| **Partnerships** | Identify key stakeholders and initiate collaborations | Establish frameworks for partnerships | Standardise partnership agreements and processes | Deepen collaborations and expand to new partners | Evolve partnerships based on shared goals | Replicate successful partnership models in new contexts |
| **Processes** | Begin developing integrated protocols | Eliminate inefficient practices | Implement standardised processes across the system | Introduce advanced integrated care protocols | Regularly review and update processes | Spread best practices across the wider health system |
| **Enablers** | Lay groundwork for change | Address misalignments and secure resources | Standardise enabling systems and processes | Enhance data sharing and joint commissioning | Ensure ongoing alignment with integration goals | Develop scalable enabling infrastructure |

# Roadmap for Integration

In Draft - to be developed in collaboration with Places, and Collaboratives)

| | Start | Stabilise | Standardise | Strengthen | Sustain | Scale |
|---|---|---|---|---|---|---|
| | *Initiating key activities and laying the groundwork for integration* | *Refining initial efforts, and identifying and addressing areas of bad practice, and ensuring financial stability* | *Establishing consistent practices across different areas of integration, as well as standardising best practice across the system* | *Enhancing and optimising delivery by deepening collaborations and implementing more advanced integrated care practices.* | *Maintaining the progress made, continuously improving based on outcomes and feedback, and ensuring the long-term viability* | *Expanding successful models, practices, and initiatives to broader populations, services or geographical areas* |
| Models of Care | Preventative model<br>Population Health Management<br>Community models<br>Digital-first Care | Same Day Access<br>Virtual Wards | Integrated Long Term Condition Management<br>End of Life Care | INTs | CYP hubs<br>Personalised Care Programmes | Ageing well hubs<br>System-wide Specialist Services<br>Centres of Excellence |
| Pathways | Innovative Pathway Redesign | Waiting List Management<br>Discharge Optimisation<br>MSK Pathways | End-to-End Pathway Design<br>Primary Care Interface<br>Care Coordination Standards | Cross Provider Service Collaboration<br>Care Home Integration | | |
| People | Supporting Self-Management | Voluntary Sector Integration | | Patient Driven Care Design<br>Health Literacy | Proactive Outreach | Community Empowerment |
| Partnerships | | Social Care Integration | | Joint Planning and Decision Making | | Voluntary Sector Integration<br>Collaboration Events |
| Processes | | Efficiency Reviews<br>Waste Reduction | Performance Monitoring<br>Quality Standards | Digital Transformation<br>Automated Workflows | Continuous Improvement<br>Performance Management | Quality Improvement<br>Best Practice Spread<br>Innovation Adoption |

# Enablers

### How does this workstream contribute to achieving integration?

- Provides essential support and infrastructure for implementing care models and pathways and achieving overall health system goals.
- Enables efficient resource allocation and utilisation across the healthcare system.
- Facilitates data-driven decision making and performance monitoring to improve health outcomes.
- Supports the development of a skilled and adaptable workforce to meet changing healthcare needs.
- Ensures financial sustainability and optimal use of resources to support long-term health system improvements

### Areas for Further Exploration

- Commissioning
- Contracting
- Data and Digital
- Estates
- Finance
- Workforce

### What are the key challenges in implementing this workstream?

- Aligning diverse stakeholders, organisations and operating models across the system.
- Managing complex change processes while maintaining ongoing operations.
- Addressing potential resistance to new ways of working and new technologies.
- Ensuring data interoperability and security across multiple platforms and providers.
- Balancing short-term operational needs with long-term strategic goals.
- Developing and retaining a skilled workforce to work across the system

### How can we measure success in this workstream?

- Improved operational efficiency and resource utilisation
- Increased data available for quality decision-making
- Higher levels of staff satisfaction and retention
- Improved financial performance and sustainability
- Positive feedback from healthcare providers on enabling functions

### How can we ensure that the workstreams are supported by enablers?

Establish an integrated working group to assess feasibility, size, and scale of enabler support across:

- Workforce
- Finance
- Prevalence
- Demand / Activity
- Estates

# Detailed Considerations regarding Aspirations and Workstreams

# Aspiration 1 - Managing population health growth and increasing prevalence

**Why do we need to focus on managing population health growth and increasing prevalence**

- **Addressing the growing and aging population:** The demographic landscape of NEL is shifting, with an increasing proportion of older adults and a rising life expectancy. This change brings unique challenges in managing complex health needs and long-term conditions.
- **Tackling the rise in chronic conditions and multimorbidity:** We are seeing a significant increase in frailty, diabetes, Cardiovascular disease, and mental health conditions. Many individuals in North East London are now living with multiple long-term conditions, requiring more complex and coordinated care.
- **Ensuring sustainable healthcare delivery in the face of increasing demand:** As health needs grow and become more complex, there is mounting pressure on our health and care services. We need to find innovative ways to meet this demand while ensuring the sustainability

**What part can Integration play in supporting this aspiration?**

- Integration allows us to consider all factors affecting health, including social, environmental, and behavioral determinants, leading to more comprehensive and effective interventions across partners, particularly in community care.
- Integration can facilitate early intervention and prevention strategies. By breaking down silos between different parts of the health and care system, we can implement coordinated prevention programmes and identify at-risk individuals earlier.
- Integration improves continuity of care for individuals with complex needs: An integrated system can provide seamless care across different settings, crucial for managing long-term conditions and multimorbidity.
- Integration supports the development of population health management approaches, allowing for proactive interventions based on data-driven insights across the entire health system.
- Integration enables the creation of comprehensive care models that can adapt to the changing needs of an aging population and the increasing prevalence of chronic conditions.

**Key questions to consider:**

1. How can we redesign and create integrated care models to address the complex needs of an aging population with increasing multimorbidity?
2. What integrated approaches can we implement to enhance early intervention and prevention strategies?
3. How can we design pathways that provide seamless care transitions for individuals with long-term conditions, and patients experiencing episodic care?
4. What strategies can we employ to identify and intervene earlier in the patient journey, particularly for chronic conditions?
5. Which cross-sector partnerships are crucial for addressing the wider determinants of health?
6. How can we strengthen collaboration between different healthcare organisations?
7. How can we empower residents to take a more active role in managing their own health and preventing chronic conditions?
8. What approaches can we use to engage the community in co-designing integrated health services?
9. How can we streamline processes to provide seamless care across different settings for individuals with complex needs?

# Aspiration 2: Reduce health inequalities for residents

**Why focus on this objective?**

- **Addressing unfair and avoidable differences in health across the population:** Health inequalities result in significant disparities in life expectancy and quality of life between different groups in North East London.
- **Improving overall population health and well-being:** By focusing on those with the poorest health outcomes, we can raise the health status of the entire North East London population and improve overall community well-being.
- **Enhancing social cohesion and community resilience:** By working to reduce health inequalities, we can contribute to wider social value by creating more equitable, harmonious, and resilient communities.

**What part can Integration play in supporting this aspiration?**

- Integration enables a holistic approach to addressing health inequalities by considering social, economic, and environmental factors alongside healthcare delivery.
- It facilitates the development of targeted interventions for underserved populations by combining data and insights from multiple sectors and services.
- Integration supports the creation of comprehensive care pathways that address the specific needs of marginalised communities, ensuring equitable access to services.
- It enhances our ability to address wider determinants of health: Integration, particularly with social care and other public services, allows us to tackle issues like housing, education, and employment that significantly impact population health.
- Integration allows for more effective resource allocation, directing support to areas and communities with the greatest health disparities.

**Key questions to consider**

1. How can we adapt our care models to specifically address the needs of underserved populations?
2. What integrated approaches can we implement to tackle the social determinants of health inequalities?
3. How can we ensure equitable access to care pathways across different demographic groups?
4. What strategies can we employ to identify and address barriers to care for marginalized communities?
5. Which community organisations and local groups should we partner with to reach underserved populations?
6. How can we foster partnerships hat address the root causes of health inequalities beyond the healthcare system?
7. What approaches can we use to build trust and engagement with communities that have been historically underserved?
8. How can we involve residents from diverse backgrounds in the co design of services to ensure cultural appropriateness

# Aspiration 3: Reducing unwarranted variation

**Why focus on this objective?**

- **Improve the quality of care:** Reducing unwarranted variation helps ensure that all patients receive high-quality, evidence-based care regardless of where they access services. Standardising best practices across the system can lead to better health outcomes for the entire population.
- **Fostering: Innovation:** We can spotlight opportunities for improvement and drive innovation
- **Reducing Waste:** Eliminating unnecessary variations in care can improve the overall efficiency of the healthcare system
- **Informed Decision Making:** By identifying and addressing variations, we can gather valuable data to inform policy and resource allocation decisions

**What part can Integration play in supporting this aspiration?**

- Integration supports the standardisation of care practices across different settings and providers, reducing variations in care quality and outcomes
- It allows for the development of consistent care pathways and protocols, ensuring patients receive similar high-quality care regardless of their entry point into the system
- Integration facilitates the implementation of system-wide quality improvement initiatives
- It enables the sharing of best practices and evidence-based interventions across the entire health and care system
- Integration enables us to view resources at a system level, allowing for more strategic allocation to areas of greatest need or potential impact, thereby reducing unwarranted variation in resource distribution.

**Key questions to consider**

1. How can we standardise care models across our integrated system while still allowing for necessary local adaptations?
2. What mechanisms can we implement to identify and spread best practices across the system?
3. How can we design integrated pathways that reduce variation in patient outcomes across different Places, providers, and settings?
4. What strategies can we employ to ensure consistent implementation of evidence-based practices along the entire care journey?
5. How can we foster a collaborative approach to reducing unwarranted variation among different healthcare providers?
6. \What partnership models can support shared learning and continuous improvement across the integrated care system?
7. How can we engage healthcare professionals in efforts to identify and address unwarranted variations in their practice?
8. What strategies can we use to empower patients to self-manage and expect, high-quality care regardless of where they receive it?

# Models of Care

**How does this workstream contribute to achieving the three aspirations?**

- Supports population health management through comprehensive care frameworks. These frameworks enable a holistic approach to healthcare delivery, considering not just individual treatments but the overall health needs of the entire population. By doing so, they allow for more effective resource allocation and targeted interventions that can address health issues at a neighbourhood level.
- Addresses health inequalities by tailoring care models to diverse needs. This approach recognises that different population groups may have unique health challenges and barriers to care. By customising care models, we can ensure that traditionally underserved or marginalised communities receive appropriate and accessible healthcare, thus working towards reducing health disparities.
- Reduces variation by standardising best practice models of care across settings. By identifying and implementing evidence-based practices consistently across different settings, we can minimise unwarranted variations in care quality and outcomes. This standardisation helps ensure that patients receive high-quality care regardless of where they access services within the integrated system.

**Areas for Further Exploration**

- Integrated Neighbourhood Teams
- Preventative Models
- Ageing well hubs
- Children's hubs

**What are the key challenges in implementing this workstream?**

- Care models need to work effectively across various healthcare settings, from primary care to specialist services and to services broader than healthcare Achieving this seamless integration requires not only, shared protocols, and a culture of collaboration among different providers, but also common geographical footprints for partnerships and care activity to form around models of care
- While standardisation is crucial for reducing unwarranted variation, it is important to maintain flexibility to meet individual patient needs. Striking the balance between these two aspects requires careful planning and ongoing adjustment of care models
- Overcoming resistance to change. New care models often require significant changes in established practices and processes. This can lead to resistance from individuals who are accustomed to traditional ways of working. Addressing this challenge involves effective change management strategies, including clear communication, training, and demonstrating the benefits of new models.
- Managing resource allocation for new care models. Implementing care models often requires initial investments in infrastructure, training, and technology. Balancing these upfront costs with long-term benefits and ensuring equitable resource distribution across the healthcare system can be challenging. It requires careful financial planning and potentially new funding models.
- Aligning incentives across the system. Different parts of the system may have conflicting incentives that can hinder the implementation of integrated care models. Addressing this challenge involves restructuring payment systems and performance metrics to encourage collaboration and focus on overall population health outcomes rather than individual service metrics.

**How can we measure success in this workstream?**

- Improved outcomes across population segments
- Reduced hospital admissions, a&e attends and delayed transfers of care.
- Increased patient satisfaction and engagement.
- Cost-effectiveness of new care models. *Initial implementation may require investment, successful care models should demonstrate cost-effectiveness over time*.
- Successful adoption rates of new care models across the system

**How can we ensure this workstream remains adaptable to future changes?**

- Review and update models based on outcomes
- Incorporating flexibility to accommodate local needs
- Embracing technological innovations
- Maintaining feedback channels with patients and providers

# Pathways

## How does this workstream contribute to achieving the three aspirations?

- Enables coordinated care journeys for complex health needs. By mapping out and optimising the patient's journey through the healthcare system, pathways ensure that individuals with complex needs receive seamless, coordinated care. This approach reduces gaps in care and improves overall health outcomes, contributing to better population health management.
- Reduces inequalities by ensuring consistent access to care. Well-designed pathways can help standardise the care process, ensuring that all patients, regardless of their background or location, have equal access to necessary services. This consistency in care delivery is crucial in addressing health inequalities across different population groups.
- Minimises unwarranted variation in patient experiences and outcomes. By establishing clear, evidence-based pathways, we can reduce variations in care that are not justified by medical need or patient preference. This standardisation helps ensure that all patients receive high-quality care, regardless of which healthcare providers they encounter along their journey

## Areas for Further Exploration

- Alternative Access
- Innovative Pathway Redesign
- Proactive Wait List Management
- Optimised Discharge
- Cross Provider Service Collaboration
- Primary Secondary Care Interface

## What are the key challenges in implementing this workstream?

- Coordinating multiple providers and services along the pathway. Healthcare pathways often involve various providers and services, each with their own processes and priorities. Ensuring smooth coordination and communication among all these organisations can be complex and challenging
- Ensuring smooth transitions between different care settings. As patients move between primary, secondary, and community care, or between health and social care settings, there is a risk of information loss, and gaps and delays in care. Overcoming these transition challenges requires careful planning and effective information sharing mechanisms.
- Managing information flow across the entire patient journey. Ensuring that all relevant patient information is available to the right providers at the right time is crucial for effective pathway implementation. This often requires overcoming technical barriers and addressing data privacy concerns.
- Balancing standardised pathways with individual patient needs. While standardisation is important for reducing unwarranted variation, pathways must also be flexible enough to accommodate individual patient needs and preferences. Striking this balance can be challenging and requires ongoing refinement of pathway designs.
- Overcoming organisational silos and competing priorities. Different parts of the healthcare system may have their own goals and ways of working, which can hinder the implementation of integrated pathways. Addressing this challenge involves fostering a culture of collaboration and aligning incentives across organisations.

## How can we measure success in this workstream?

- Reduced waiting times and delays in care transitions
- Improve clinical outcomes for specific conditions
- Increased satisfaction with their care journey
- Reduction in duplicate tests or interventions
- Cost savings through more efficient care delivery

## How can we ensure this workstream remains adaptable to future changes?

- Pathway reviews and updates based on national standards and new evidence
- Incorporating feedback in pathway redesign
- Levering digital technologies for pathway management

# People

**How does this workstream contribute to achieving the three aspirations?**

- Empowers residents to actively manage their health, supporting population health goals. By engaging and educating individuals about their health, this workstream enables people to make informed decisions and take proactive steps in managing their wellbeing. This active participation is crucial for preventing diseases and promoting overall population health.
- Reduces health inequalities by improving health literacy and access. Reaching out to and involving various community groups, including those that are traditionally underserved, helps address disparities in health knowledge and access to care.
- Promotes consistent patient expectations, reducing unwarranted variation. By educating and engaging people across the healthcare system, we can create a shared understanding of what good care looks like. This consistent set of expectations can drive demand for high-quality, standardised care, thereby reducing unwarranted variations in service delivery.

**What are the key challenges in implementing this workstream?**

- Overcoming health literacy barriers in diverse populations. Different groups within the population may have varying levels of health literacy, which can affect their ability to understand and act on health information, and self manage their health conditions.
- Ensuring equitable access to health information and services. Some segments of the population may face barriers in accessing health information or services due to factors such as cultural barriers, language, technology access, or geographical location.
- Balancing community needs with system capabilities. While communities may have specific health needs and preferences, the healthcare system has limited resources and capabilities. Finding ways to meet diverse community needs within system constraints requires careful prioritisation and resource allocation.
- Maintaining long-term engagement in health initiatives. While initial engagement in health programmes may be high, sustaining this engagement over time can be challenging. Developing strategies to keep individuals and communities actively involved in their health over the long term is crucial for lasting impact.
- While local people have been involved in engagement and to some extend care planning, empowering local residents and communities to look after their health and self manage is a more novel approach. With no current funding explicitly committed, making this a priority amongst other system priorities may be challenging.

**How can we measure success in this workstream?**

- Increased levels of patient activation and engagement
- Higher rates of preventative care utilisation
- Increased participants in community health and research initiatives

**How can we ensure this workstream remains adaptable to future changes?**

- Continuous gathering of patient feedback and preferences.
- Regular community needs assessments
- Foster a culture of life long health learning

# Partnerships

**How does this workstream contribute to achieving the three aspirations?**

- Fosters a collaborative system. By building strong relationships between diverse stakeholders, partnerships create an environment where different perspectives, expertise and resources can be combined to address complex healthcare challenges.
- Facilitates collaborative efforts to address health inequalities. By bringing together various stakeholders, partnerships can provide a platform for open dialogue a and shared learning, building trust and a shared understanding between organisations serving different communities. This increased understanding enables more effective coordinated efforts to address the root causes of health inequalities.
- Promotes sharing of best practices to reduce unwarranted variation. Partnerships create channels for knowledge exchange between different organisations and sectors. This sharing of expertise and successful strategies helps in identifying and spreading best practices, thereby reducing unwarranted variations in care across the system.

**What are the key challenges in implementing this workstream?**

- Aligning goals and priorities across diverse organisations. Different partners may have varying missions, priorities, and ways of working. Finding common ground and aligning these diverse perspectives towards shared objectives can be complex and time-consuming.
- Overcoming historical competition or mistrust between partners. In some cases, potential partners may have a history of competition or lack of collaboration. Building trust and fostering a collaborative mindset requires time, transparency, and demonstrated mutual benefits.
- Ensuring equitable resource allocation and risk-sharing. Partnerships often involve sharing resources and risks. Establishing fair mechanisms for this sharing, especially when partners have different sizes or capacities, can be challenging and may require careful negotiation.
- Maintaining effective communication across partnership boundaries. As partnerships involve multiple organisations, ensuring clear, consistent communication can be difficult. Overcoming differences in organisational culture, language, and communication styles is crucial for effective collaboration.
- Navigating different organizational cultures and working practices. Each partner organisation will have its own culture, processes, and ways of working. Harmonising these differences to create effective joint working arrangements can be a significant challenge requiring flexibility and compromise.

**How can we measure success in this workstream?**

- Successful implementation of joint initiatives and projects
- Stronger alignment of strategic plans
- Improved information sharing and collaborative decision making

**How can we ensure this workstream remains adaptable to future changes?**

Investing in relationship building and joint workforce development programmes at all system levels

Building joint scenario planning capabilities within Places and Collaboratives

Regular reviews of partnership working across the system