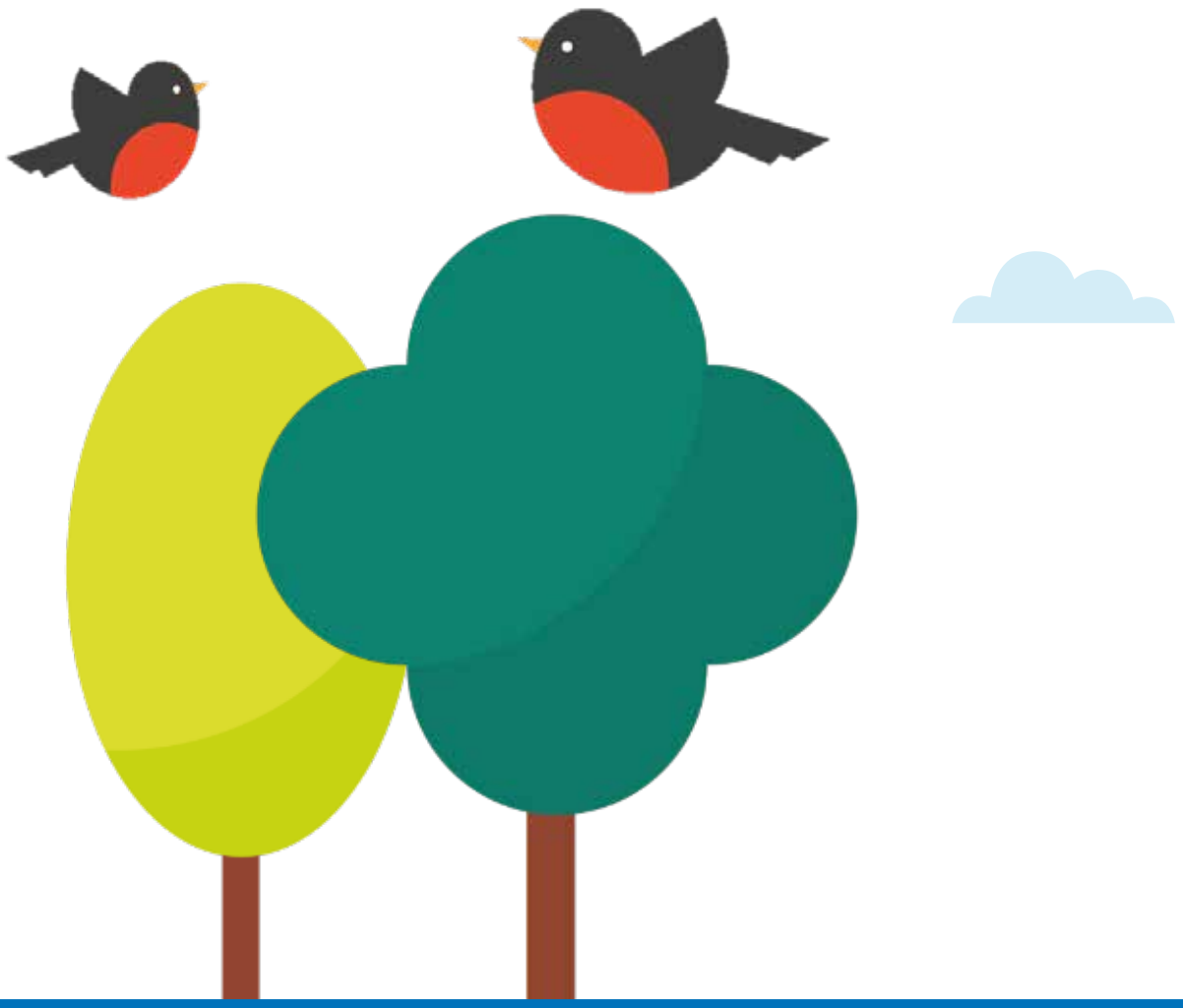
TOWER HAMLETS TOGETHER

Delivering better health through partnership

WELCOME

Tower Hamlets Together
Primary Care and Community Fair
4 July 2017

www.towerhamletstogether.com #TH2GETHER

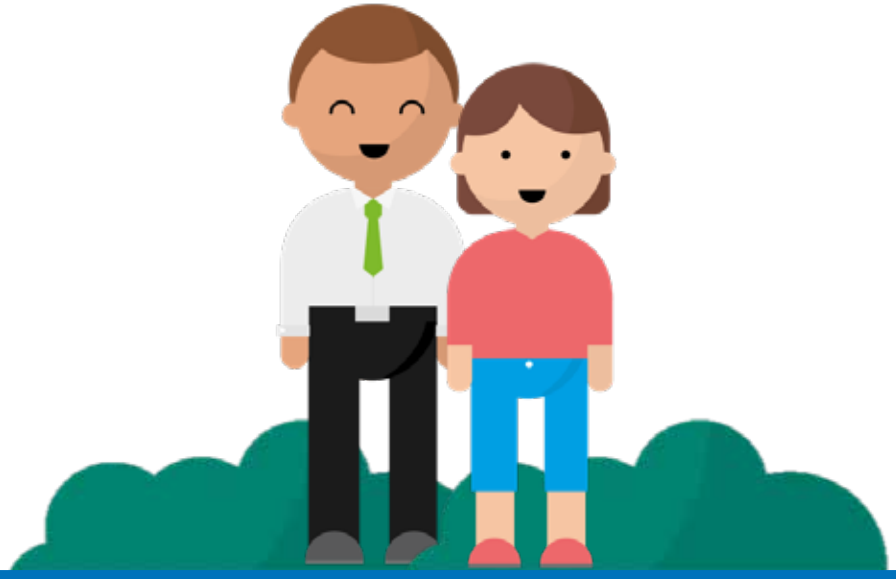


Take a moment to read this…

- Why the Tower Hamlets Together Primary Care and Community Fair?

- Our context:
  - Who we are
  - Our map
  - Our starting point
  - Our design principles
  - Our People Charter
  - Our outcomes framework

- Making today work for you:
  - Thinking about our residents
  - Working with other services and teams (including contact information)
  - Feedback and ideas about next steps



Why the Tower Primary Care and Community Fair?

Today is about strengthening connections and relationships across all Tower Hamlets Together partners in primary care and the community.

A wealth of great things happen to help the borough's residents but we are often too busy to find out about them - unsure about where to locate the information, who to ask or meet.

Our Primary Care and Community Fair is your opportunity to put names to faces, find out more about other teams and services, how they might support your work and help us build stronger relationships with each other as well as those who use our services.

We invite you to meet new colleagues, ask questions, provide honest (and constructive) feedback and help us work out what the next steps should be.

There may even be some surprises in store so enjoy yourself!

Who we are…

Tower Hamlets Together is a patient-centred integrated health and social care partnership involving Barts Health, East London Foundation Trust, London Borough of Tower Hamlets, Tower Hamlets CCG, Tower Hamlets GP Care Group and Tower Hamlets Council for Voluntary Services

www.towerhamletstogether.com #TH2GETHER

Our map (is only the tip of the iceberg)…

Our starting point…

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

Our mission:

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

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

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

Our aims:

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

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

To deliver a cultural change with a mutually supportive relationship between residents and services

Our design principles…

Local people
Local staff
Local care

Our People Charter describes our behaviours…

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

- Be polite and respectful to you
- Respect your confidentiality
- Let you know who we are and what we do
- Communicate clearly and openly with you in the way that you need us to
- Respond to phone calls, emails and letters quickly
- Ensure that you only need to tell your story when you choose
- Ensure that we take into account your mental, physical and social needs
- Be informed and prepared for appointments with you and have read your notes

- Work with you as an active and equal partner, jointly agreeing your care plan to include your personal goals and wishes
- Support you to support yourself where possible
- Involve and listen to carers involved in your care
- Involve service users and carers in service planning and evaluation
- If we don't know how to help initially, we will explore other options and get back to you quickly

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

Our Outcomes Framework…

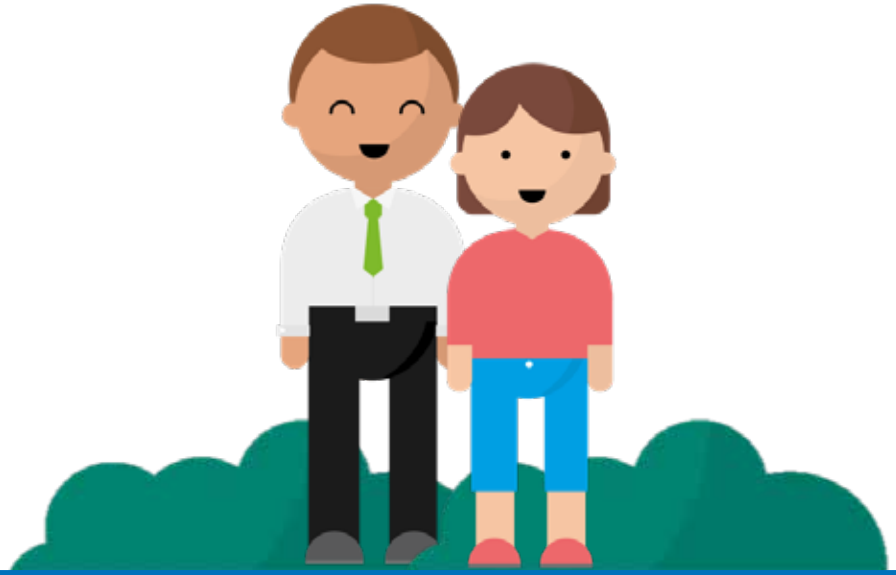
After using Tower Hamlets Together services we want residents to be able to say…	
Around me	I feel safe from harm in my community
	I play an active part in my community
	I am able to breathe cleaner air in the place where I live
	I am able to support myself and my family financially
	I am supported to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

Making today work for you…

Think about the people who use your services and need more help than you or your team can offer alone...

- **What other services should be involved?**
- **What is your experience of connecting with them?**
- **How could improved partnership working make a positive difference?**

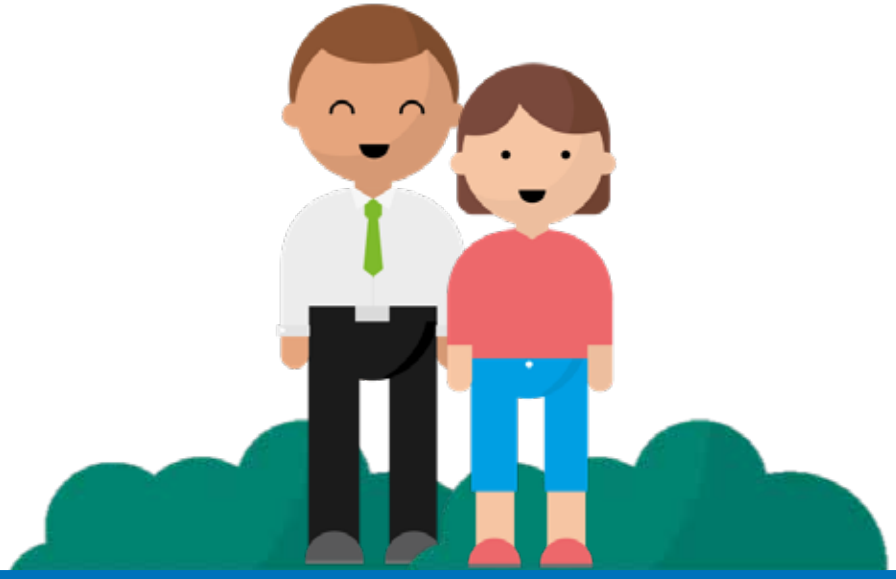
Here are some examples to help get you thinking...



Abdul

Aged 47 Abdul is known to have drug and alcohol dependency but has not accepted help when it has been offered in the past. The police have been called to his flat a number of times due to noise and anti-social behaviour and complaints have been made to the council about vermin affecting neighbouring properties. He is not registered with a GP and does not want to be. When social services have tried to become involved he has refused to open the door.

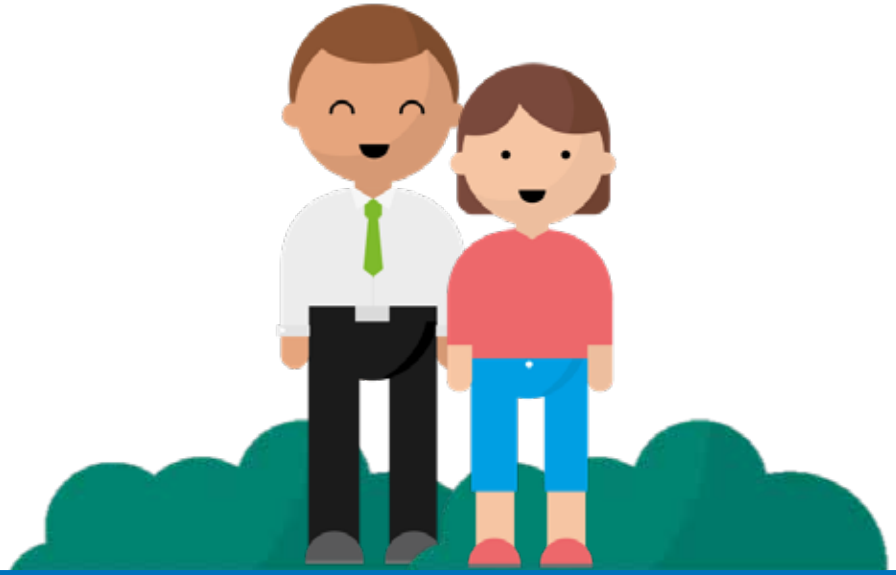
- **What services are available here today to help Abdul?**
- **How would you work in partnership with them?**
- **What else would we need to do collectively to improve Abdul's situation?**



Joan

One of your favourite patients, Joan is 73 years old, independent and stoic. Since her husband died 5 years ago, she lives alone and has little contact with her son who lives in Essex. She has significant anxiety (and is on medication) and often mentions her loneliness. She also has severe COPD and has attended A&E 6 times in the last year with exacerbations, but has not been admitted. She tends to attend the GP practice frequently.

- **What services are available here today to help Joan?**
- **How would you work in partnership with them?**
- **What else would we need to do collectively to improve Joan's situation?**



Abioye

39 year old Abioye has no family or close friends in the UK. He has Epilepsy and a Learning Disability, He has low literacy levels, sleeps a lot and everyday tasks take him a lot of time as he is always worried about having a fit. Several times in the past he has burned himself and now only eats microwaveable meals.

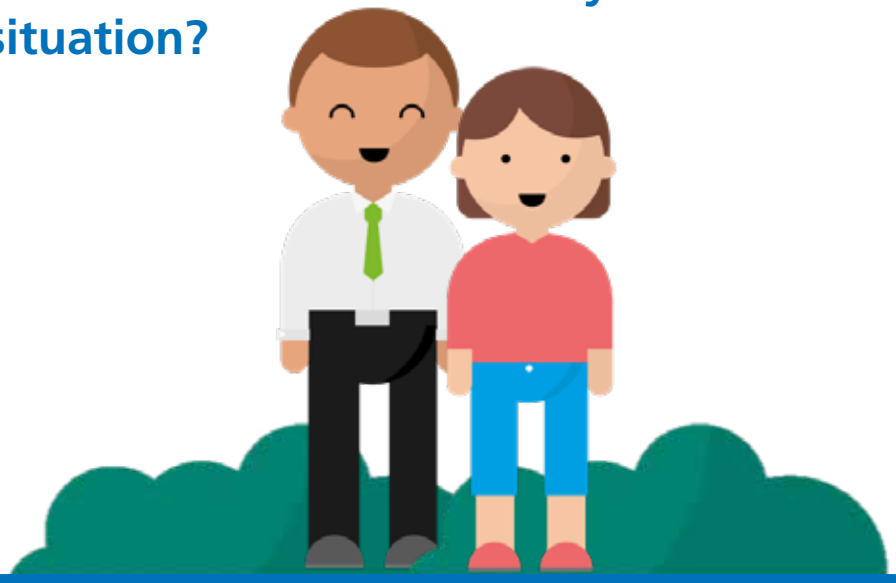
Abioye takes pride in being as independent as possible. He used to receive Disability Living Allowance but as it will be changing to Personal Independence Payment he now has to fill in a new form. For the last 5 months he hasn't been able to find anyone to help him complete the form. Although he did see a welfare advisor, the 30 minutes appointment wasn't long enough and the advisor has been fully booked ever since. The deadline, which has been postponed many times, is in 3 days' time, and he arrives at reception very upset.

- **What services are available here today to help Abioye?**
- **How would you work in partnership with them?**
- **What else would we need to do collectively to improve Abioye's situation?**

Peter

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

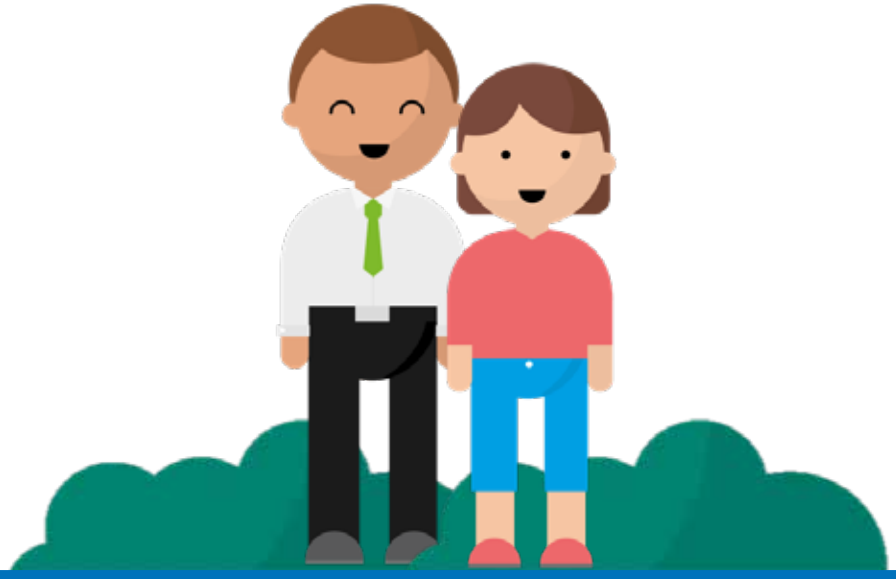
- **What services are available here today to help Peter?**
- **How would you work in partnership with them?**
- **What else would we need to do collectively to improve Peter's situation?**



Zainab

Zainab is a 32 year old mother with three children under the age of 8. Her eldest child has autism and attends a special school. Although she has depression Zainab has not sought help as she feels she does not have the time because of looking after the children. The youngest child is 2 years old and is showing behavioural problems. Zainab is struggling with this and is worried that he is not reaching milestones such as toileting or playing with friends.

- **What services are available here today to help Zainab?**
- **How would you work in partnership with them?**
- **What else would we need to do collectively to improve Zainab's situation?**



FIND OUT MORE ABOUT TOWER HAMLETS TOGETHER AND TODAY…

- **Visit our website: www.towerhamletstogether.com**
- **Register for our newsletter: http://www.towerhamletstogether.com/contact-us**
- **Follow us on Twitter: #TH2GETHER**
- **Send an email: thccg.towerhamletstogether@nhs.net**
- **Copies of this booklet will soon be available from: www.towerhamletstogether.com**

Admission Avoidance & Discharge Service (AADS)

The service has 4 components/pathways:

- Community Rapid Response Team
- Intermediate Care Team (ICT), including a "discharge to assess" model
- In-reach nurses
- Admission Avoidance Team (AAT) in the Emergency Department, RLH

The overall service aim is to prevent unnecessary hospital admission and to facilitate early discharge from hospital. The Community Rapid Response team launched at the end of March 2017 and is the newest part of the service, providing urgent assessment, treatment and care within the person's home.

The In-reach nurses, AAT and ICT case find patients at RLH, but also accept telephone referrals from the multidisciplinary teams at RLH and other hospitals. The team comprises nurses, occupational therapists, physiotherapists, rehabilitation support workers and two social workers. There is also close working with the integrated community health teams and if required, patients will be referred on their services. The maximum period of intervention in the community for AADS is 3-5 days for the RR Team and 6 weeks for the ICT.

Referrals for the Rapid Response Team are made via the Single Point of Access (SPA) 020 7377 7151. Referrers should complete the CHT referral form and tick the Rapid Response (within 2 hours) Requirement box on page 2 that states: "Imminent risk of hospital admission and patient is in crisis requiring urgent interventions".

Operational hours

7 day service: Rapid Response 8.00am - 8.00pm (last new referral for same day visit - 6.00pm), Intermediate Care Team 8.00am - 6.00pm, AAT 9.00am - 8.00pm (7.00pm weekends), In-reach 9.00am - 5.00pm (Monday - Friday, contact AAT at weekends)

Location

- ICT, RR Team - Ground floor Therapy Office, Bancroft Unit, Mile End Hospital. Tel: 020 3594 4843 (AADS administrator)
- AAT – Emergency Department, RLH. Tel: 020 3594 5727
- In-reach nurses – Room 711, John Harrison House. Tel: 020 3594 6014 or request mobile numbers from administrator.

For further information contact
Fiona Davies, Clinical Lead
Tel: 020 8223 8317

Alzheimer's Society Tower Hamlets

Our aim is to let people affected by dementia know we are here for them. We can provide them information, advice and support. Our Dementia Adviser service provides immediate support and advice for anyone worried about their memory or who have received a diagnosis of dementia. Our Carers Support Service provides ongoing advice and information for carers. Our BAME Services provide culturally specific advice and practical help. All our services can provide a home visit for carers and people with dementia.

We also run Dementia Cafes locally within Tower Hamlets, where people can

join in activities and share experiences, find out more about dementia or simply relax with a cup of tea or coffee.

Who can access our services?

- Anyone who is worried about their memory, or who may be worried about a family member, friend or relative
- Carers of people with dementia
- Professionals who provide services to people affected by dementia

How is your service accessed?

- Anyone can make an enquiry about any memory related matter
- We accept referrals from health professionals
- Anyone can self-refer

Contact details:

By phone:
020 8121 5626

By email:
towerhamlets@alzheimers.org.uk

In person:
visit us at Robinson Centre, Mile End Hospital, Bancroft Road, E1 4DG

ARCaRe

The Adult Respiratory Care and Rehabilitation service is a community focused multidisciplinary team of physiotherapists, nurses, occupational therapist, psychologist, home oxygen specialist, dietician, and physiologists with the aim of supporting patients with respiratory disease within the borough of Tower Hamlets. The service provides expert advice both in and outside of the hospital to patients, carers, staff and other healthcare professionals in the management and treatment of respiratory conditions, such as COPD, Asthma, and Pulmonary Fibrosis. The Team works 7 days per week, 52 weeks of the year. Evidence based Pulmonary Rehab classes run from 5 community locations across the Borough.

Who can Access?

The service can be accessed by patients referred from GP's/ Practice Nurses for the diagnostic spirometry or pulmonary rehab. Admission avoidance patients should be referred using the SPA referral form, alongside a phone call to the Triage phone. Referrals are also accepted from Consultants and other CHT's

How is the Service Accessed?

GPs/PNs can directly refer by completing referral form on EMIS (Patient Electronic Record system) for spirometry and pulmonary rehabilitation. Admission avoidance patients should be referred using the SPA referral form, alongside a phone call to the Triage phone.

Contact Details

ARCaRe Office: 0208 223 8509
Triage Number: 07983 177719
for urgent queries
Monday - Friday, 8.30am - 6.00pm
Weekends and BH, 8.30am - 4.30pm

Assistive Technology Strategy Team

The Assistive Technology (AT) project is an ambitious attempt to fully integrate the use of existing and leading-edge technology into mainstream social care and health provision, to enable residents to live independently in their own homes, to reduce or delay the need for further social care intervention, and assist with hospital discharge. It uses a range of communication and training methods to promote a fully integrated approach to providing AT equipment across health and social care, including general training and awareness sessions, training for specific teams or types of device, presentations at team meetings and 1:1 support.

Who can access the service?

Social care or health staff who require training, support or information on the AT equipment available in Tower Hamlets and how to access it, should contact a member of the AT Team.

Contact details:

Steve Nye – AT Strategy Manager - 020 7364 7659

Audiology

The Audiology Service run by Barts Health provides hearing assessment, digital hearing aid fittings, a home visit service for assessment, fittings and repairs, specialist service for people with learning disabilities, hearing aid services for complex hearing loss and a Tier 2 community paediatric service.

They provide Tinnitus Management, help with sensitivity to loud noises, communication tactics and support with adjusting and acceptance of hearing loss issues.

They also offer Specialist Electrophysiological hearing tests, speech audiometry, balance assessment and balance rehabilitation.

Hearing Aid Drop-in Repair Sessions

Monday: 9.30am - 11.00am
Wednesday: 2.00pm - 4.00pm
Friday: 9.30am - 12.30pm

Repairs are also provided at some GP surgeries and health centres.

Tel: 020 7377 7673 or email: towerhamlets.adultaudiology@nhs.net

Barts Health Outpatient Physiotherapy Service and the Integrated Musculoskeletal and Pain Service (IMAPS)

IMAPS includes Musculoskeletal Clinical Assessment Service and the Persistent Pain Service.

This is led by Extended Scope Physiotherapists, Hand Occupational Therapists, GP's with Special Interest (GPSI's) and the Persistent Pain Team. Referral is via an SPA form from GPs for any patients with a Tower Hamlets GP.

The service provides:

- All MSK and Persistent Pain expert triage
- Comprehensive and holistic assessment and investigation of complex MSK and Persistent Pain

patients
- Referral into the patient's definitive treatment
- GP Education Programme

The Physiotherapy service provides outpatient musculoskeletal physiotherapy for patients with a Tower Hamlets GP. Referrals are accepted from GPs, or from Secondary Care providers such as Orthopaedics and Rheumatology. All GP referrals are being seen at Mile End Hospital using EMIS (paper light), and all secondary care referrals are seen at the RLH on CRS (Cerner Millennium). Partial booking is in full use in physiotherapy. Routine patients sent letter and call for an appointment. We contact all Urgent patients by telephone. From 3rd April we are piloting a referral stream for Out of Area elective orthopaedic patients. The orthopaedic team have been given the appropriate referral paperwork.

The service can be contacted via:

- Email - BHNT.BartsHealthTherapies@nhs.net
- Phone - 020 7377 7872
  Healthwatch Tower Hamlets

The Bridge Virtual Ward

The Bridge Virtual ward offers children and young people with complex care needs and high rates of admissions and/or length of stay in secondary care, a programme of co-ordinated and integrated support across health, education and social care.

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

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

The Bridge now also works closely with all members of the MDT to ensure young people transitioning from Beatrice Tate Special Needs School to adult services have a transition that is both co-ordinated and timely with minimal stress and disruption for the young person and their families.

Contact details:

Bridge email:
thebridgeproject@bartshealth.nhs.uk

Bromley by Bow Advice Service

Social Welfare Advice Service

A variety of services offered for those who would like help and support with benefits. Our team provides advice on benefit issues to help people understand their rights and what benefits they'll be entitled to receive.

We run Drop in sessions that operate on a first come first served basis – Monday, Wednesday and Friday. Please ensure you arrive before 9.00am to save your space.

Legal Advice

Helping individuals with a wide range of legal issues including support with appeals and tribunal representation.

HMRC – Digital Inclusion

Apply for Crisis Grants/white goods for new tenants. Tuesdays – 10.00pm

East End Energy Fit

Offering support with utility arrears, managing energy bills and getting the best deal from your provider. Can also help with grant applications for white goods and funeral costs.

eastendenergyfit@bbbc.org.uk
020 8709 9745

Getting on with Money

Supporting you to manage your money in a way that works for you including help with budgeting, bank accounts and how to get the best deal. One-to-one and workshop sessions available as well as volunteering opportunities.

gettingonwithmoney@bbbc.org.uk
020 8709 9745

Who can access your service?

All Tower Hamlets residents

The Bromley by Bow Employment and Skills team

The Employment and Skills team can help:

- Improve your English Language skills with ESOL for work
- Find learning and training that is right for you
- Secure Employment
- Improve your interview and presentation skills
- Provide 1 to 1 support and group work job search
- Understand the local job market
- Search and apply for jobs
- Develop your basic IT Skills
- Develop your CV

Contact us:

Monday - Friday, 9.30am to 4.00pm.
020 8709 9706
Bromley by Bow Centre, St Leonard's Street, Bromley by Bow, E3 3BT
employmentsupport@bbbc.org.uk

The Cardiac Rehabilitation Service

The Cardiac Rehabilitation Service is a multidisciplinary team that works across sites providing cardiac rehabilitation to local patients in Tower Hamlets. The aim of cardiac rehabilitation is to promote the recovery of patients and lifestyle modification post cardiac event through exercise, education and

psychological support. We provide all phases of cardiac rehabilitation from inpatient support, initial follow up post discharge, exercise programme in both community and hospital settings and sign posting to other local and voluntary services. Our community service includes a Bengali programme with language advocates. In-scope patients are those with stable angina, post PCI/stent, NSTEMI & STEMI, stable heart failure & device therapy and post coronary artery bypass graft/valve. We are happy to receive referrals to our generic inbox or by letter from GPs, other clinicians and patients may self-refer however we proactively recruit our patients as they are discharged from the hospital.

Contacts:

St Barts Hospital 020 3465 6593
Royal London Hospital 020 7377 7344
Email:
BHNT.CardiacRehabilitation@nhs.net

Care Home Liaison team/Dementia Specialist and Falls Prevention

The team provides training and advice to care homes and enhanced sheltered schemes. The role is primarily to work with the staff to increase their knowledge, skills and confidence when working with people with dementia. We offer individual assessment and advice regarding behaviours that challenge. The team work with the homes to improve care for residents with dementia.
The team provide training and falls prevention work that includes assessing mobilising residents using a multi factorial falls assessment. If further needs are identified, the team signpost the care home staff to the relevant services. This is an enhanced service to care homes and isn't intended to replace existing services.

Community Cardiovascular Prevention Service

The community CVD Prevention service consists of nurse specialists and support staff. The service delivery model includes a patient facing service and an educational remit. The service operates from Monday to Friday 8.00am to 5.00pm (excluding bank holidays). The objectives of the cardiovascular prevention team are:

Proactive training role in developing practice nurse and HCA competencies in the following areas:

- taking ECG
- Ambulatory Blood pressure monitoring
- Blood pressure taking
- Pulse rate and rhythm check in people over 65

Supporting wider educational needs to prevent CVD including:

- MDTs
- PLTs
- supporting training in general practice

Providing specialist support in the management of patients with the high risk factors of CVD (particularly in the uncontrolled group) via clinics in general practice. This will include undertaking:

- BP
- Cholesterol

- Other appropriate medication
- Smoking cessation support
- Supporting lifestyle modification
- Supporting post MI review

The CVD Prevention nurses engage with 3rd sector organization and the wider health and social care environment fostering partnership and integrated working as appropriate; to promote education and improve management of cardiovascular disease.

The work programme plans for the CVD team include Patient facing CVD nurse led clinics.

- The nurse led - consultant supported-service will provide quality preventative care optimizing management of CVD risk factors which will result in fewer CVD events and increase quality of life for people.
- Patient education is delivered in the CVD nurse consultations which emphasises risk factor management strategies for reduction of CVD risk.
- CVD nurses work with CVD network clinical leads to assist the delivery and facilitation of CVD education across the practice networks. The CVD nurses support, advice and deliver education on CVD management to professionals in primary care practices, CHS, voluntary sector and other identified groups as required. Work with Network Managers in developing educational programmes and other requirement.
- Promote the use of competencies in primary care to facilitate improvement in the management of CVD.
- The service facilitates and supports appropriate health research. Health promotion 3rd sector working: at health events across the borough CVD nurses raise awareness of CVD and promote CVD prevention through education. They increase awareness and educate on CVD risk factors to optimise cardiovascular health in the Tower Hamlets population.

The team is based in Mile End Hospital and the contact number is 020 8223 8658

Community Dietitians (Adults)

Registered dietitians are qualified health professionals that assess, diagnose and treat diet and nutrition problems at an individual and wider public health level. Uniquely, dietitians use the most up-to-date public health and scientific research on food, health and disease, which they translate into practical guidance to enable people to make appropriate lifestyle and food choices. Dietitians are statutorily regulated, with a protected title and governed by an ethical code, to ensure that they always work to the highest standard.

The Adult Community Nutrition and Dietetic team in Tower Hamlets, sit within the wider Barts Health Nutrition and Dietetic Department. They are currently based at Mile End Hospital. There is a separate team of Diabetes Dietitians that are an integral part of Tower Hamlets Diabetes Service.

Current Service:

- Community service to patients requiring Home Enteral Nutrition

- Community Service to Housebound patients, at risk of malnutrition and requiring oral nutritional support
- Pulmonary Rehabilitation and Cardiac rehabilitation Dietitian (funded via a Service Level agreement)
- Nutritional training to Health Care Staff and Care Homes on malnutrition, oral nutritional support and Enteral Tube feeding

Service accessed via a referral form or via the Single point of access.

Referrals are accepted for adults living in Tower Hamlets with malnutrition, or at risk of malnutrition with a MUST score of 2 or more, and for patients requiring enteral tube feeding.

Contact number: 0208 223 8971

Email: TowerHamletsDietitians@bartshealth.nhs.uk

Tower Hamlets Community Education Provider Network (CEPN)

Overview

The CEPN is a localised model for the planning and delivery of education and training for the health and social care workforce within the community. The model has been initially pump prime funded through a Health Education England pilot initiative that has been rolled out in various parts of the country. The CEPN has been active since April 2014, and is hosted by the GP Care Group. There is now a growing partnership working with agencies beyond health and care who have influence on the wellbeing of the residents of the Borough. These include Education, Employment, Enforcement, Housing, Transport, Voluntary sector, Sports and Leisure. The CEPN also has a strategic workforce planning role in supporting local recruitment (including apprenticeships) and retention, and is also key player in driving forward the GP forward view.

Accessing CEPN training

Most of the training opportunities that CEPN offers are advertised via the ever growing network members. The CEPN also now has a dedicated website www.thcepn.com. The website has attracted over 10,000 visits over the last 15 months.

Further information

For further details contact the programme manager Ekramul Hoque: ekramul.hoque@nhs.net

Community Neuro Team

The Tower Hamlets Community Neuro Team provides multi-disciplinary assessment/support for adults with neurological difficulties such as traumatic brain injury, spinal cord injuries and neurodegenerative disorders. The team comprises of occupational therapists, physiotherapists, speech and language therapists, clinical psychologists, rehabilitation support workers, a care navigator and a neuro navigator. We see people at their own home, at Mile End Hospital or in other community settings as appropriate.

Please contact the Single Point of Access (SPA) for a referral form (020 7377 7151). Referrals can be emailed to the Single Point of Access on btl-tr.chsreferrals@nhs.net or chs_ooh@bartshealth.nhs.uk

Emails must be sent from a secure server, e.g. nhs.net to nhs.net. We also accept self-referrals to SPA by telephone.

The Community Health Team Social Care

The Community Health Team Social Care (CHTSC) has been set up as a pilot project and has been in existence since 2013 initially under the umbrella of the Community Virtual ward (CVW) until the restructuring in Health and hence was rebranded. It provides support to Adults age 18 and above.

The team work with individuals on the Integrated Care Patient List (ICP) and this list is generated by GP's who use a matrix to assess patients risk level including comorbidities.

Patients on the ICP list have to consent for their information to be shared with other professionals within the multidisciplinary team. The full ICP list currently as a total of 6500 patients and less than half of those individuals are on the Adult social care IT system.

The ethos of the team is to provide social care function within the locality multidisciplinary teams which comprises of other professionals to provide a more integrated service and support. The CHT SC work with patients who are deemed to be in the very high risk category and currently there are around 800 clients in this group; the team is working with just under 400. It is envisaged that the team will be working with other group of patients and this will include patients who are palliative and those living with Dementia.

There are four localities within the borough and these are the Northwest, Southwest, Northeast and Southeast. Each locality has two laps and in total there are 8 Laps in the borough. The 36 GP practices are linked to one of the Laps which falls in their Locality.

There are 8 Social workers one for each Lap and in addition there are two Neuro social workers working with individuals with long term neuro condition and in receipt of active rehabilitation.

The service can be accessed via a CHC SC referral form being completed by any of the professionals. i.e. care navigator, GP etc. Social workers also take on referrals from the multi-disciplinary meetings (MDT).

Tower Hamlets Contraception and Sexual Health Services (THCASH), Sylvia Pankhurst Centre (SPC)

THCASH provides care to patients on two different contracts: SRH and Women's Health on THT contract with the CCG, and integrated health services on contract with Tower Hamlets Council via Public Health

- THT contract: pregnancy counselling and abortion service, menopause and premenstrual syndrome clinic, African women's service including

Female Genital Mutilation Care.

- LA contract: free, confidential sexual health, women's health and contraceptive services. THCASH operates a number of services within Tower Hamlets. The spoke at SPC, Mile End Hospital offers testing and treatment for STI's, all contraceptive methods. There are also community spokes, while the main hub is the Ambrose King Centre at the Royal London Hospital

Who can access the service?

The sexual health service is open to men, women and young people, people with disabilities and LGBT people of all ages. The THT services are women only.

How is your service accessed?

There are limited bookable and also walk in slots for the sexual health clinics. The abortion service is self-referral for women only with a GP in Tower Hamlets with no GP. The menopause clinic is by GP referral, and the FGM clinic is self-referral regardless of address.

Contact details

THCASH at MEH- Tel: 020 73777870
Email enquiries: BNHT.THCASH@nhs.net

Diabetes Care Centre, Mile End Hospital, London

We are a dedicated team of professionals involved in the care of adults with diabetes who receive on-going support from Diabetes Specialist Nurses, Lay Educators, Link workers, Consultants, Dietitians, and Clinical Psychologist in our service.

We deliver structured education for people with Type 1 and Type 2 Diabetes, and awareness training for people at high risk of developing diabetes (Pre-diabetes). X-PERT structured education for Type 2 diabetes and Pre-diabetes Awareness Training (PAT) are delivered in English and Bengali. Type 1 education (DIANA – Daily Insulin Adjustment for Nutrition & Activity) is delivered in English only. These education programmes are designed to support and empower people with diabetes to self-manage their condition. One to one education sessions with an interpreter are provided for other language users.

Nurse and Dietitian led clinics are held in the Diabetes Care Centre and Tower Hamlets General Practices for assessment, education and review of people with diabetes. Where required they optimise their glycaemic control, with changes to or addition of treatments in line with NICE and local guidance.

Prior to Ramadan each year we deliver 10-12 educational sessions, held in the Diabetes Centre and venues in the community, including the East London Mosque and GP surgeries. The Ramadan sessions are run in English and Bengali by Lay Educators and Diabetes Nurses.

They provide advice on safe diabetes management during the fasting period including recommendations for changes in medication doses and timings. The sessions are very popular, with approximately 268 people attending across various venues this year.

The centre also provides a service for insulin pump therapy for people with Type 1 diabetes.

The Diabetes Care centre is also involved in delivering education for health professionals such as MERIT and Year of Care.

Referrals to diabetes clinics are criteria driven. People can access these clinics by a referral from their primary care clinician or hospital teams post-discharge. Self-referrals are accepted for X-PERT structured education and clinical psychologist.

Opening times:

Monday - Friday 8.30am to 5.00pm.

Address:

Diabetes Care Centre
2nd Floor Mile End Hospital
Bancroft Road, London E1 4DG
Tel: 0208 223 8836

Extended Primary Care Teams

The Extended Primary Care Teams (formerly the integrated community health teams) are based in each of the 4 localities and work in alignment with the GP practices across Tower Hamlets. The multidisciplinary teams include district and community nurses, occupational therapists, physiotherapists, social workers, care navigators, mental health nurses and support workers.

The service is available to adult residents of Tower Hamlets, who are over the age of 18 and is accessed via the central Single Point of Access (Telephone Number: 0300 033 5000).

Referrals are then directed to the appropriate locality where they are triaged by the clinical team. The teams provide an integrated approach to the care of patients in the community. They work with patients who are at risk of hospital admission and offer support with early discharges rehabilitation and the enablement of self care. The teams also work with people who are at the end of their lives.

The Prince's Trust – Fairbridge programme (Poplar)

The Fairbridge programme is a fantastic personal development programme for young people who are NEET aged 16 to 25 living in London, they do not need to be claiming benefits or have access to public recourse. Young people who are in Education or Training less than 14hrs and young people who are working less than 16hours are also are eligible.

This programme uses flexible one to one support, which includes one to one mentoring and goal setting, literacy and numeracy support through a functional skills tutor, employability workshops, art therapy and counselling sessions and much more.

How is your service accessed?

Induction appointment with young person to assess their level of need.

Contact:

Moshin Hamim 07436790198 or email: outreach.london@princes-trust.org.uk

GP Care Group

We are a GP federation, made up of all 37 GP practices in Tower Hamlets, caring for a registered population of over 312,000 people. We are a partner

in Tower Hamlets Together. We provide Health visiting, GP extended hours, GP out of hours Advocacy, Social prescribing, CEPN, Open doors and are a partner on the new CHS contract. We aim to promote and support Primary care and the GP Networks.

Who can access your service?

All registered patients.

How is your service accessed?

Varies depending on service

Contact details

See www.gpcaregroup.org

Healthwatch

Healthwatch Tower Hamlets listens to local people's views of the local health and social care system and then voices those views to local decision makers so that services and support can improve .We also provide information to help people access local health and social care services; and finally if we're really worried about the quality of care we report our concerns to Healthwatch England, who can then recommend that the Care Quality Commission take action.

Through our members and volunteers, we can act as the eyes and ears of the people of Tower Hamlets, working closely with existing voluntary and community groups and our partners so together, we will see and investigate the important local issues and trends.

We have a wide range of volunteering opportunities that enable local residents to learn new skills, help the community and meet new people.

Who can access your service?

Anybody who lives or works in Tower Hamlets and uses local services.

How is your service accessed?
Contact details

People can leave feedback on line on our website
www.healthwatchtowerhamlets.co.uk

Phone us on 020 8223 8922 or
Freephone: 0800 145 5343.

Email:
info@healthwatchtowerhamlets.co.uk
Tweet us: @HWTowerhamlets

Integrated Care Mental Health Liaison Team

The Integrated Care Mental Health Liaison Team improves links between community health teams, GPs and secondary mental health services as well as providing mental health assessment and interventions to people on the integrated care pathway not known to other secondary mental health services. The aim of this service is to promote a joined up approach to mental and physical health.

Each Locality Team has a full time Mental Health Professional (Community Mental Health Nurse). They provide specialist mental health advice, consultation and liaison to the CHT's. They undertake joint assessments, provide short term interventions, attend relevant meetings e.g. GP integrated MDT meetings and locality board meetings and support joint working between CHT's and mental health services. They also provide training in mental health and dementia.

Referral; All routine and emergency mental health referrals should continue to be directed to the appropriate mental health teams within ELFT. The mental health worker in your locality team can signpost you to the appropriate team.

Referral to the mental health workers will initially be via a clinical discussion with the link mental health worker in each locality or via the Community Health Team SPA referral. Please note patients do not have to have a mental health diagnosis to be seen by the nurses.

Contact

Team Manager:
020 8121 5650 / 0790 324 3595

Please note this service operates from 9.00am - 5.00pm.

OOH's use GP/A&E/ RAID for telephone advice and signposting.

Integrated Early Years Service

Our vision is to give every child in Tower Hamlets the best possible start in life through reducing inequalities and improving outcomes. Our Children Centres provide opportunities for children and their families to be safe, healthy and happy, so that they are able to reach their full potential.

The Children Centres provide early intervention services including Family Support, Stay and Play, Employment Advice, Parenting Programmes and Adult Education trainings. It works in partnership with a range of service providers including Educational Psychology service, Idea Store Learning, Parental Engagement and Health to ensure a holistic provision is available for families accessing the service.

Integrated Early Years also work with PVI settings and nursery schools in order to give support around maintaining and improving quality of provisions including SEN support.

The service also deal with childcare inquires and promote the placement of children through ELG 2 grant for borough's disadvantaged 2 year old children.

Who can access your service?

IEYS service is free and accessible to all families living in the borough with children under five. Some provisions are available to families with children under the age of 11 if they have siblings who are under five.

How is your service accessed?

Most of our services are universal

The service is accessed through referrals from the network of our partners as well as parents dropping in to local centres, speaking to colleagues and self-referring.

Contact details

For further information about the service please contact Pauline Hoare, Head of Early Years' Service or contact one of our 12 Children's Centres.

The Marie Curie Helper Service

Volunteer Support for people living with or caring for someone with a terminal illness.

The Marie Curie Helper Service matches specially trained volunteers to people with any terminal illness and their carers. The volunteers visit people in their homes to offer companionship and support for a few hours each week, all completely free of charge.

Tel: 0800 304 7408 / 0800 304 7403

Location

Marie Curie Helper North East London
Marie Curie
Hospice Hampstead, 11 Lyndhurst Gardens, NW3 5NS

St Joseph's Hospice
Mare Street, Hackney, E8 4SA

Support offered in the following boroughs:

- Camden Islington Haringey
- Enfield
- Barnet
- Waltham Forest
- Hackney & City
- Newham
- Tower Hamlets

Email:
eastlondonhelper@mariecurie.org.uk
northlondonhelper@mariecurie.org.uk

Referrals to the Helper service can be made via telephone or a referral form can be requested via telephone or email

ELFT Neighbourhood Care Team

The Neighbourhood Care Team is a team of community nurses, district nurses and healthcare assistants taking part in a pilot scheme to bring Buurtzorg, a Dutch model of community nursing, to East London NHS Foundation Trust. The word buurtzorg means "neighbourhood care", and the model aims to deliver the highest level of community nursing with a "re-ablement" feel using self-managed nursing teams and smaller patient caseloads. The pilot will run for one year, after which the success of the pilot will be evaluated.

For the foreseeable future, we will be taking on patients who are registered with Jubilee Street and are not currently known to established district nursing teams in the locality. Referrals can be made by anyone (i.e. GPs, practice nurses, RHL wards, MEH wards, social services etc. but the patient must be registered with Jubilee Street). We will stay in regular contact with the practice by attending the Critical Friends groups and other meetings at the surgery.

Patient referral criteria: 18+ years old, registered with Jubilee Street practice; have just nursing or nursing and re-ablement needs; receive most of their care at home; not currently known to other district nursing teams.

The team works 7 days a week from 8.00am - 8.00pm and are contactable by patients, staff and any other colleagues on our team mobile: 07741234190

The Physician's Response Unit

The Physician's Response Unit (PRU) is a doctor and paramedic responding to 999 calls in North East London and as of August 2017 it will operational Monday to Sunday 8.00am - 8.00pm. It has been a

joint venture between Barts Health NHS Trust, London's Air Ambulance (LAA) and London's Ambulance Service (LAS). As well as responding to 999 calls we will also use electronic patient data to target the patients in our community who are the highest risk of hospital admission. As part of the "250" work being developed by Tower Hamlets we hope to provide enhanced care for these patients in an emergency. When looking at this group it was clear they played a huge role in health service utilisation. Sixty-two of these patients were responsible for 377 LAS Conveyances, 435 ED attendances and 2334 Inpatient days to the Royal London Hospital in just 18 months.

The PRU aims to bring a senior doctor with access to point of care diagnostics and treatments early in the patient journey. They will aim to see and treat patients in the community, and enhance their care in the event of a hospital conveyance. We will build strong links with our Rapid Response Community Team, Frailty Clinic and ArCare Service to enhance the ability to keep patients well at home. Ultimately we hope that this emergency response will lead to a proactive and collaborative style of care for the most at risk patients in our community.

Providence Row

Providence Row tackles the root causes of homelessness to help people get off, and stay off, the streets. We offer a range of services, including a series of activities and services to support people develop their learning and wellbeing.

What is the Learning and Wellbeing Programme?

The Learning and Wellbeing Programme is an all-year round programme of activities for people who have experienced homelessness. It's part of the Recovery and Progression Service at Providence Row. More information (written and audio) can be found here: http://www.providencerow.org.uk/recovery-and-progression-services

We support clients in addressing their mental health, substance misuse needs and general wellbeing by building a positive relationship with the person. We focus on their interests, potential and hopes and not just on their problems. We work with people to improve their self-esteem and confidence, helping them rediscover their skills, get back into work and training and build stronger support networks. This could be through making art or music with others, building language and literacy skills in English, developing computer skills, or joining groups that enhance relaxation skills, discussing films, addiction, men's or women's issues (in our women-only and men-only groups). The referral unit of Reset (the Tower Hamlets service providing drug and alcohol treatment to 18+) is also based here and facilitates these offering a unique pathway from our activities to further drug and/or alcohol treatment. In fact, signposting on to other more specialist organisations and/or supporting clients to progress onto other learning, training or wellbeing opportunities in the local forms an important part of what we can offer.

Who can access the service?

The programme is open to anyone with a connection to Tower Hamlets or City boroughs who has experienced homelessness or is at risk of homelessness. We can also offer a 3 month service to those who have a connection to the boroughs of Newham, Waltham Forest and Hackney.

All over the age of 18 are welcome.

How do I get there?

We're open 5 days a week, Monday to Friday, 9.30am – 4.00pm.

Our address is:

Providence Row, The Dellow Centre, 82 Wentworth Street, E1 7SA

Just ring the buzzer to the left of the gate and make your way to reception by following the floor lights across the courtyard to the turquoise doors.

How do I register?

To join in with the activities, you'll need to register first. This involves finding out a bit more about the activities and us finding out a bit more about your interests and you. To do this, you can

- Drop in, visit us and book an appointment (see address above)
- Come along with your keyworker and try out a session to see if it's something you'd like to do.
- Arrange an appointment through email or over the phone (details below)
- Ask your keyworker to make a referral for you

Who can I contact to enrol or refer someone?

You can drop in at reception, call us on 020 7375 0020 or email us at Activities@providencerow.org.uk

For referrals, just send us an email of the person with what they're interested in and any significant information (such as, risks or additional needs), or pass on the above contact details for them to get in touch.

Older Person's Clinic (Frailty Assessment)… Coming Soon to Tower Hamlets

A new service is being launched in August 2017 for people over 65 years who are showing signs of physical and/or mental decline. GPs and health and social care professionals will be able to refer people they are concerned about for a comprehensive assessment which will consider their physical, mental and social needs. The service aims to assess people who are showing a decline in their overall health and functional ability and to intervene before a crisis emerges.

Often, an older person or those around them will notice small signs of deterioration that when considered in isolation may not appear to be significant enough to do something about. However, collectively they may have a significant impact. This service will consider the person as an individual and assess their needs as a whole.

The team will include a Consultant Geriatrician, Mental Health Professional, Occupational Therapist

and Physiotherapist. Until now these assessments have taken place separately and the patient would not have received the benefit of being able to discuss their care with relevant professionals in one place. This clinic will ensure that problems are not viewed in isolation but that the person in assessed in an integrated manner to ensure they receive the best assessment possible for them!

The service will be based at the Royal London Hospital. For more information, contact Lisa Nolan or Claire Dow (Community Geriatrician)

Reablement Service

Reablement Service is a 6 week Occupational Therapy-led Service that supports people to regain skills and abilities to manage everyday tasks, enabling them to live as independently as possible, following an accident, ill health, disability or a stay in hospital. We provide a person centred, needs led but outcome focused, strength based approach, focusing on the person's strengths and abilities. We work with individuals around the goals they set ranging from personal care to accessing the community or using the internet to carry out their own shopping. Our approach is strengths-based which is about protecting and promoting the person's independence, resilience, choice and wellbeing.

Who can access your service?

- Aged 18 +
- Resident in Tower Hamlets.
- Willing to accept the service in their own environment.
- Need short term support to facilitate hospital discharge or to remain in the community.

AND

- Have potential to achieve greater independence.

OR

- At risk of becoming dependent on long-term care.

How is your service accessed?

If service user is at home access referral could be made through: Adult Social Care on 02073645005 or named Social Worker if known (Personalisation and Review teams)

If in hospital through the Hospital Social Work Team Community Health Teams' Occupational therapists can also refer to Reablement under our Reablement Officers Only joint working procedure.

Main contact number – 02073645005 (Assessment and Intervention Team – Adult Social Care)

The team is known as Community health Team, Adult social care.

Contact details for the team is:

Community Health Team
(Adult Social Care)
Hospital and Integrated Community Team
Adult Health And Wellbeing
London Borough of Tower Hamlets
3rd Floor, John Onslow House
1 Ewart Place, London E3 5EQ.

Duty Contact no: 0207 3644277
E-mail: cht.sc@nhs.net or community.health@towerhamlets.gov.uk

RESET outreach & referral service

Reset is a free service offered to residents in Tower Hamlets to help people reduce their alcohol and/or drug dependency.

Providence Row run the Reset Outreach and Referral Service, in partnership with Mind in Tower Hamlets and Newham (MiTHN)

What we offer:

A route into drug and alcohol services in the Borough.

Information and advice on the risks of drugs and alcohol.

Reset keyworkers will provide community and street outreach work, through groups, on to-one key-work and at other local centres

Signposting to other services who can help, both in and outside the local Borough. An onsite and a mobile needle exchange service

Who can access the service?

Residents of tower hamlets can access the service

Anybody from the age of 18 with a substance related need can access our service

Contact details:

Providence Row, The Dellow Centre,
London, E1 7SA.
0800 802 1860
Email: reset@providencerow.org.uk.

Routes to Roots (Providence Row)

Routes to Roots works within the Royal London Hospital to prevent patients who are homeless or at risk of homelessness being discharged onto the street. We help and support patients to get suitable accommodation in the area they have the strongest local connection, as this is the area they will have the best chance of receiving support from the local council. This can be anywhere within London or the UK.

If they are not from the UK and not entitled to benefits, we can also support them to return to their home country.

Who can access the service?

Anyone who is homeless or vulnerably housed, accessing medical care within Tower Hamlets, but who is not entitled to local authority housing within the borough.

How is the service accessed?

By sending a referral to the team via email with information regarding the patient's homelessness situation and support needs.

Contact details

For all enquires 020 7422 6394
routestoroots@providencerow.org.uk
www.providencerow.org.uk/routestoroots

St. Joseph's Hospice

At St Joseph's Hospice, we offer a wide range of specialist palliative care services including nursing and medical care, physical and psychological therapies, information and advice, and social support.

Our services include in-patient care, short-term respite care, day hospice, community palliative care and supportive care, which includes social work, spiritual support, psychological support, bereavement support and a wide range of therapy services. We provide 24/7 telephone advice and support, and an information and advice service based in the hospice with outreach groups in the community.

We also have a number of community projects, many of which are delivered by volunteers, including the award-winning Compassionate Neighbours and Empowered Living Team, and a Namaste care service.

Who can access your service?

Any adult over 18 with a life-limiting or terminal illness can access our services. We also offer support to families and carers. We welcome people from all backgrounds, faiths and cultures.

How is your service accessed?

All referrals are made via our First Contact Team on 0300 30 30 400 (Monday to Friday between 8.00am and 6.00pm).

Contact details:

0300 30 30 400 / info@stjh.org.uk / www.stjh.org.uk

Social Prescribing Tower Hamlets

Each GP Surgery in Tower Hamlets now has access to a Social Prescriber who links people up with local services and organisations that can improve people's health and wellbeing, like exercise groups, ESOL classes, welfare advice and volunteering opportunities.

Knowing what is available has helped many people to spend more time doing things they enjoy, be more active, connect with others and decrease stress. However everyone is unique, so Social Prescribers will work together with each individual to find out what works for them.

Macmillan also offers Social Prescribing for specifically for people living with & beyond cancer, they are based at the Bromley-By-Bow Centre.

Who can access your service?

Anyone 18 or over (some 16) who is registered with a GP in Tower Hamlets.

How is your service accessed?

At the moment, the service is organised per Network so access can vary. Patients can always ask at GP Reception to be referred to a Social Prescriber. Most GP Surgeries offer face to face appointments. Other Health Care Professionals can refer too by contacting the Social Prescriber that works in the GP Surgery of the particular patient.

Tower Hamlets Recovery College

What we offer:

- We support wellbeing and mental health recovery through education and learning
- Courses co-designed and co-delivered by tutors with lived experience of mental health and tutors working in mental health wellbeing
- Courses are co-received by students who have experienced mental health difficulties and students who have not
- Three 10 week terms per year
- 20 courses per term
- Class sizes of 10-12
- Courses provide tools and approaches to gain a deeper understanding of yourself, your experiences and the experience of others; education about mental and physical health; tips on practical life skills, how to get more involved in educational and vocational opportunities; how to support other people's recovery journeys

Who can access:

- Tower Hamlets Recovery College is for everyone.
- You can register as a student if you are over 18 and live, work or study in the London Borough of Tower Hamlets.

How our service is accessed:

You can register with the college by:

- Completing the Tower Hamlets Recovery College Registration Form available on: https://www.elft.nhs.uk/service/377/Tower-Hamlets-Recovery-College and e-mailing it to: thrc@elft.nhs.uk or
- Phoning the college on 020 7426 2449 to register by telephone or
- Coming to Tower Hamlets Recovery College to register in person

The prospectus can be downloaded from the link found on the website below:

- https://www.elft.nhs.uk/service/377/Tower-Hamlets-Recovery-College

Contact details:

Tower Hamlets Recovery College
86 Old Montague Street
London E1 5NN

Tel: 020 7426 2450
Text: 07908 429 239
E-mail: thrc@elft.nhs.uk

Opening hours:
9.00am – 5.00pm Monday to Friday

Visual Care Options

We provide NHS eye exams to individuals unable to go out independently (and who would normally qualify for free exams under NHS guidelines). This could be due to physical disabilities, learning difficulties or conditions like dementia. We will visit an individual's home (or day centre), carry out the eye exam and supply spectacles if needed. Patients are referred onto hospital or social services teams if further management is required. Our care is ongoing with continual follow up examinations. A Bengali speaking Optometrist is also available, which many patients have

found beneficial in Tower Hamlets.

How service is accessed

Patients can self refer. Family members, carers and other professionals can also refer on someone's behalf. They can either phone, email (nhs.net mail) or make a request in writing (referral forms are available for other teams/ professionals on request).

Contact details

Our contact number is freephone: 0800 047 0425

Email (general enquiries): eam@visualcareoptions.co.uk

Address:

Visual Care Options
Coppergate House, 16 Brune Street, London, E1 7NJ

Warmth

Groundwork London has been commissioned by Tower Hamlets Council to deliver free home energy & well-being visits called WARMTH. A 'Green Doctor' will visit the resident at home for up to 1½ - 2 hours, depending on the needs of resident. Key elements of the home visit are as follows.

- Improve energy efficiency of properties by installing small measures and referring for larger measures ensuring a long term sustainable solutions to eradicate fuel poverty and its negative health implications.
- Improve resident understanding of utility bills by 1-2-1 advice and hand holding residents through an energy bill switching service (average saving of £200/year). Addressing high water bills and applying for water bill discounts and/or assistance funds (halving water bills or clearing water debt if eligible)
- Further support residents to access help from energy companies by applying for debt assistance (Groundwork have cleared debts of up to £1,500 on some occasions), Priority Services Register and WHD (£140).
- Provide a gateway for other related services by connecting residents to home, home safety, health/well-being services.
- Integrated 1-1 behaviour advice to embed long-term change and further improve health and finance.

The scheme is primarily aimed for:

- people with a physical disability or suffering from long term illness
- people with mental health issues
- those who are pregnant or have a child under 5 and on a low income
- older person (over 65)
- young person (16-25) on a low income.

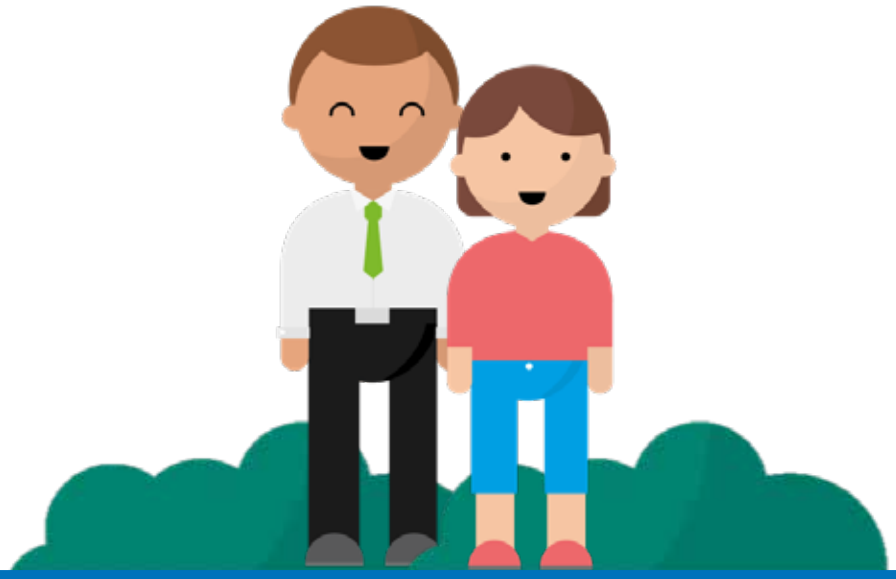
Referrals can be made by:

- calling 0300 365 5003
- or emailing WARMTH@groundwork.org.uk

Let us have your feedback…

- **What have you learned today?**

- **What will you do differently as a result?**



P.T.O.

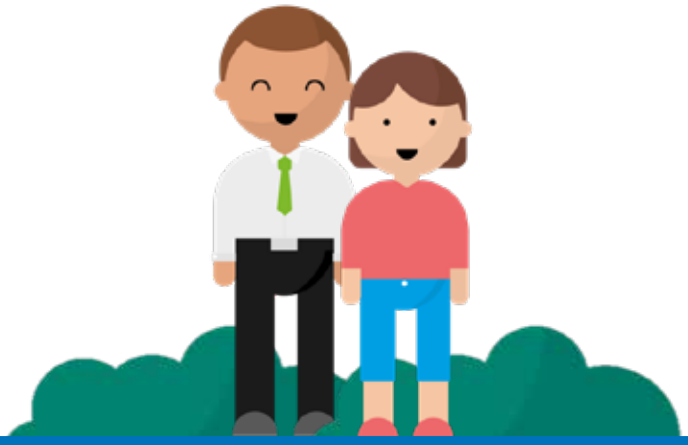
- **What gaps in existing services have you noticed?**

- **How can we further improve our partnership working?**

- **What ideas do you have for how Tower Hamlets Together can help you?**

PLEASE HAND THIS IN ON YOUR WAY OUT...

Useful Notes



TOWER HAMLETS
TOGETHER

Delivering better health through partnership

www.towerhamletstogether.com #TH2GETHER