TOWER HAMLETS TOGETHER

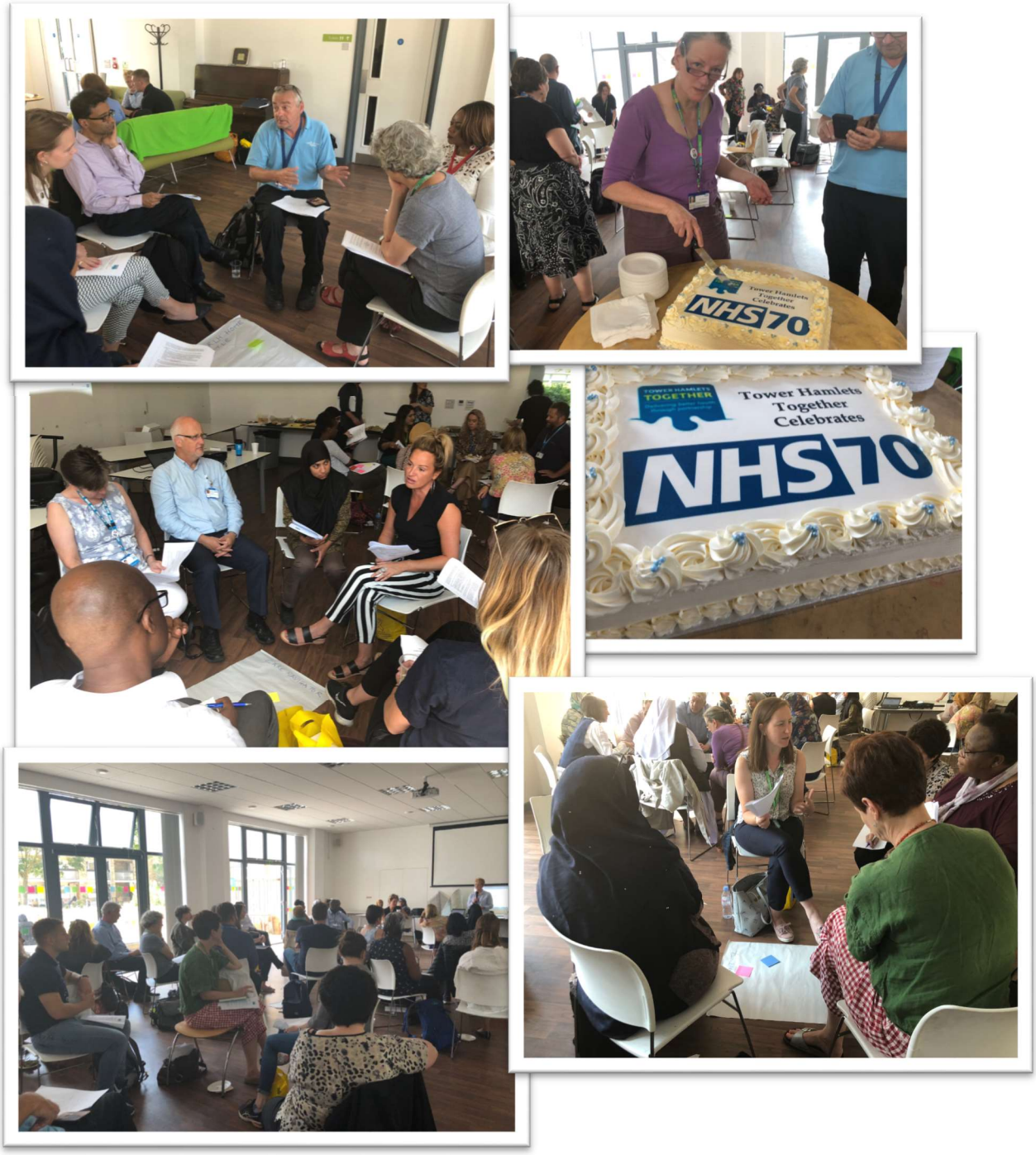
Delivering better health through partnership

"THT keep doing the work – you are far ahead and you are a reference to others"

Tower Hamlets Together

Staff Engagement Event
July 2018

The report



Watch a short clip of images from the day…
https://www.youtube.com/watch?v=0aPkXZeERGo

What happened on the day?

More than 75 people from across all six partner organisations in Tower Hamlets Together (THT) came together to attend the 13th Staff Engagement Event on 12 July 2018 at the Southern Grove Community Centre.

With the conclusion of the Vanguard programme in March 2018, the event explored how the Tower Hamlets Together partnership is now 'business as usual'. Against the background of NHS 70, the event also provided an opportunity to celebrate local achievements and to reflect on next steps. The aim was therefore to:

- Ensure staff and partners feel fully engaged with THT as it evolves
- Share with staff the latest progress in integrated health and social care
- Give an opportunity to explore the challenges and opportunities of managing change
- Discuss next steps, and how to make them happen.

Facilitated by Richard Fradgley, Director of Integrated Care, East London Foundation Trust, the initial session '***where we are at***' saw participants: Dr Isabel Hodgkinson (Chair of the THT Board), Chris Banks (Chief Executive, GP Care Group) and Helen Byrne (Director of Integration and Strategic Development, Barts Health), give updates on latest developments. This session highlighted the importance of communicating the vision of senior leaders and provided further detail about new structures and processes such as the life course workstreams and the locality health and wellbeing boards.

The second session, '***what went well? managing winter pressures***' was an opportunity to hear stories about integrated care in practice from teams including Admissions Avoidance and Discharge, the A&E Consultation Service (RAID), Age UK Royal London Hospital Home and Settle**,** Care Navigators, Delayed Transfers of Care, Flu Busters, the Neighbourhood Care Team, Significant 7 and Smart Care. Participants heard three stories each and welcomed the chance to explore how their colleagues operate. *The stories and feedback from this session are detailed in Appendix One.*

Following an explanation by Georgina Birch, from ELFT, about the THT Wheel of Partnership, a tool designed to help teams and individuals develop the core competencies for integrated working, in the '***what's next? open to new ideas***' section, participants broke into small groups and used the 'liberating structures' method to reflect on the following characteristics:

- Commitment to conflict resolution
- Understanding of the interplay between physical and mental health
- Taking account of the impact of culture, equality and diversity

- Trusting and acknowledging the actions of individual team members
- Taking an enquiring approach to person-centred care
- Adopting behaviour change strategies.

Each group took one of these and (i) made a list of all they could do to achieve the worst possible result, (ii) examined this to think about anything they currently do that in any way resembles this and (iii) decided what steps will help to stop creating these undesirable results. *A summary of the discussions is detailed in Appendix Two*.

Although some participants found the 'liberating structures' approach a bit negative there is potential to develop its use to support future organisation development work.

The next session, '***what's available to help you?***' used a 'fishbowl' question and answer session to spotlight local support and learning opportunities to strengthen integrated care with a focus on:

- The THT health coaching programme: contact alison.jukes@nhs.net
- The Community Education Providers Network: contact ekramul.hoque@nhs.net
- Using the THT outcomes framework to develop team plans: contact anne.page@towerhamlets.gov.uk

See Appendix Three for details of some of the training offers.

In the final session of the event, '***spreading the word: getting communications right***', Joy Joses, the GP Care Group Communications Lead, introduced the new THT website and outlined the opportunities it provides – visit: www.towerhamletstogether.com

The feedback from the event was generally positive. Some comments included:
"Each locality to delegate two frontline staff besides care navigators."

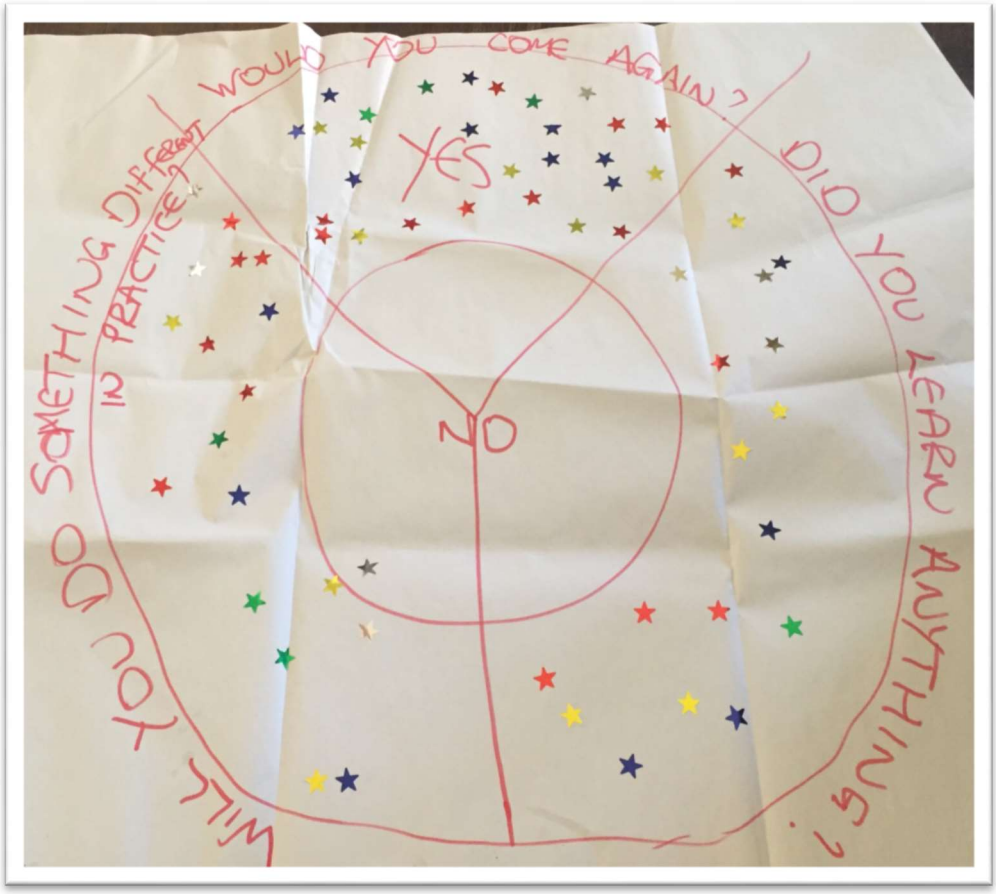
"THT keep doing the work – you are far ahead and you are a reference to others."
"Keep growing the THT partners' network."

"Explore how to involve frontline community health team staff to attend staff engagement event to make them aware of the strategic agenda driving their frontline work."

"Yes I will attend again – Very useful to meet and talk to other people – I will strive to do something different – I understand the challenges that may prevent this from happening and will try to overcome them."

"Group work exercises and case studies – interesting to hear about the challenges and successes of other services within THT."

"Groups and storytelling very good."



The THT Workforce and OD workstream reflected on the Staff Engagement event at its meeting on July 18 and made the following observations:

- Only one 'No' – because we are already integrating (see image above).
- Grumble about the lack of meat and fish but agreed to continue providing food as a way of encouraging people to attend and providing an opportunity for soft networking.
- Story circle was well received and raises profile. We should add the stories to the website and promote for training purposes.
- Time and workloads are pressure spots – some staff asked when is there time to develop relationship?
- Definition of integrated care was raised. Richard Fradgley quoted "national voices definition" at the staff event. We agreed something on the website would be useful but need to decide what. We reflected on the onion principle – different layers – it will mean different things depending where people are working and with whom.

It was agreed that the next event will be in October and that the CCG will book hall and provide food and drink. Healthwatch and patients will also be invited.

Suggested agenda items included:

- Evaluation feed back

- Health coaching
- Life course workstream plans – feedback
- John Owen – personalisation review?
- Ask staff what they would like the Workforce and OD Group to focus on

The commitment to running a market place session was re-asserted as it was very well received when last organised in July 2017. The proposed date for this is April 2019.

Appendix One: Telling the THT stories about managing winter pressures

Admission Avoidance and Discharge Service: An 81 year old Somali woman is discharged from hospital in the morning having been admitted with a fractured hip. By afternoon she is stuck in the chair, unable to stand. What happened next?

- Mrs. A, an 81-year-old Somali woman, was admitted to hospital in January 2018 with a fractured hip. She lives in Stepney with her two sons, has dementia and arthritis and is prone to being anxious. She was referred to AADS service, which met her on the ward and liaised with the ward team. She then went home with a single-handed package of care – one Re-ablement officer carer in the morning, recommendation from ward had been two carers 4 x day.

- AADS team visited the day after she went home and found she had been stuck in the chair since morning. Mobilised immediate support to prevent re-admission, included transferring her on to the stair lift so she could go upstairs to bed, increasing care package, providing equipment.

- Other services helped – social worker organised care agency to start that night with increased care, Rapid Response nurses brought a mattress. Rehabilitation provided for next six weeks via AADS Intermediate Care Team.

- The aim was to facilitate Mrs. A being able to stay at home with her sons and maximise her independence to enhance her quality of life.

- Our team and other services worked together with her and her son, everyone "went the extra mile".

- Learned what is possible if teams communicate well and have a "can do" approach. Staff worked late as keen to help her stay at home, and then continued to assess the situation.

- We worked across boundaries to problem-solve the situation and didn't give up when the challenges were evident!

- Admission avoidance really supported 81 year old woman well – able to meet her needs
- Leaflet to detail service to people on admission would be helpful
- Need shared IT system to aid communication
- Should planning start from day of admission?
- Do we need more resource in the community?

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A&E Consultation Service (RAID Team)
• A lady was referred to the A&E Frequent Attender Team, highly vulnerable, chaotic and challenging in A&E. She was pregnant and there were safeguarding concerns. • A multi-agency plan was developed to support the lady and protect the unborn child. • The aim was to be able to engage with the patient and improve her circumstances. • The highlight was that the multi-agency plan was adhered to by an external service. • The learning was the importance of partnership working, the value and support of other agencies • The wider learning included the importance and value of identifying and addressing safeguarding concerns and the method and approach of the care plan
• Example of persistence and integrated MDT working • Good communications • Went above and beyond • Importance of digital software to share medical concerns • Interaction, intervention, outreach
Paul Fuller **Senior Nurse Practitioner** **Royal London Hospital A&E Consultation Service** **p.fuller1@nhs.net** **020 3594 6704**

Age UK Royal London Hospital Home and Settle
• Patient needed a hospital bed at home. • Liaised with Age UK and handy persons for moving furniture, pharmacy for key safe, Admissions Avoidance and Discharge service for post-discharge support. • The aim was to make a difficult discharge easier. • The highlight was seeing the patient comfortable at home. • The learning was the importance of always keeping the patient's needs in mind.

- We could learn that we work best when we all know what each other are doing.

- What would we do without Chris in Tower Hamlets – great job!
- Key ingredients – availability, speed of response, responsive to needs
- Good communications and relationships so can call on when needed

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Integrating physical, mental health and social care needs to promote independence: A Care Navigator Story

- Recently discharged from hospital following a fall and hip fracture, 'Fred', aged 63, was referred by his social worker to the Care Navigation team to support links with community services. While in hospital, he was also unfortunately diagnosed with prostate cancer. Previously fully independent, Fred lived alone and was not well known to health and social care services.

- After my initial assessment it was evident that Fred was struggling to cope in the community and presented with severe anxiety particularly about falling again. A few times each week he called emergency services and presented at A&E complaining of feeling unwell and that he was going to fall, although there was no indication of this.

- I supported Fred to manage at home by working closely with the following services:
  - Fred refused to see a psychologist but did accept medication from his **GP**. He appeared to benefit from medication to manage his mental state.
  - **Physiotherapy and occupational therapy** to assess his functioning build confidence and improve independence in mobility and other daily activities. He also attended the falls management group.
  - **Social services and Re-ablement** worked with Fred to encourage independence in activities such as preparing meals and going out regularly.
  - Introduction to a **befriending service**
  - There was also a **safeguarding** issue with one of his neighbours.

- Over five months, Fred gradually regained his independence and increased his confidence so that he was discharged from all services apart from befriending and no longer presented to emergency services.

- My role was to be a consistent contact, helping Fred contain his anxiety. I spent a lot of time preparing him for changes to care and providing short-term follow up when services were withdrawn. As I got to know Fred well, I was able to provide accurate information to other services about his needs and abilities as he often underestimated them himself. I was also able to provide consistent feedback to Fred about his progress and potential for recovery.

- Since discharging him, I have seen Fred out and about and feel pleased that, by working together, we were able to help him regain his independence and self-belief, particularly given his relatively young age.

- Excellent team to have in the community
- Would like to know who the care navigators are
- Where do they sit – in surgery or locality?

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Delayed transfers of care

- During winter, there is a senior operational hub call that occurs on a Tuesday, Wednesday and Friday.
- All partners in the system work together to support the call
- The aim of the call is to focus on people, who are delayed transfers of care both in and out of borough, and to try and get them home as soon as possible. The longer people stay in hospital the higher the risk is of them becoming unwell again.
- The calls have been helpful in highlighting the following:
  - More system ownership and understanding of the issues
  - Learning – we are now looking at particular cases and learning lessons from these
  - The importance of the choice policy and people being made aware of their choices
  - Discharge planning should begin on admission – which we all know
  - The challenges with the number of homeless people we have in the borough
  - Some issues with particular boroughs – we now have regular meetings with key colleagues in other boroughs
- Overall Learning – The importance of working together as a system and learning from each other. Perseverance and developing relationships are key. This enables supportive challenge to resolve issues.

- Acting in best interest
- Patient may lack capacity
- High rate of deterioration for patients with delayed discharge
- Knowing staff in different organisations opens up possibilities
- Complex patient caseload requires close working across organisations

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Flu Busters Campaign 2017/18

Flu season…

- Staff worked together to ensure front line staff were vaccinated to keep people safe from flu and out of hospital.
- *'It isn't just about keeping yourself safe, it's about protecting your family, your colleagues and your patients. You can carry and pass the virus on to others without having any symptoms yourself so, even if you consider yourself healthy, you may still be risking the lives of others.'*

- Aim: To vaccinate 100 per cent of front line staff
- 'Get a jab - give a jab' meeting UNICEF raising £10,000 which will immunise over 115,000 children against tetanus in a developing country
- Tower Hamlets Community Health Services vaccinated 63 per cent of front line staff against flu; across the Trust 2,434 staff were vaccinated.

- Lots of myths about flu!

- Having a flu champion in each team works better than drop-in clinics.

- Making the flu campaign fun through a bright and energetic communication plan


- Sharing evidence to show effectiveness of job – stats, research, and references
- Alternative options to flu jab would be good to highlight, e.g. how to prevent flu
- Keep staff safe can reduce sick leave
- Interactive and engaging and making the ads fun
- Making the vaccination available to non-ELFT staff, third sector and all age groups are covered
- Raising money and donations to a good cause – very good idea and thoughtful

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Neighbourhood Care Team
• The Neighbourhood Care Team (NCT) is the new test and learn Buurtzorg project, which began in June last year and consists of six nurses and one healthcare assistant. The model is based on small and self-managing teams with no hierarchy. The team works and is based in the designated GP practice. • The story is about a palliative patient GS, referred to the team mid last year, with both personal and medical need. Following a joint assessment with GS and his family, uniquely tailored to his needs, the patient was allowed to stay at home and receive the palliative care needed without going into hospital or hospice. • The patient received integrated care coordinated by the neighbourhood nurses and involving his GP and the respiratory, physiotherapy, occupational therapy, tracheae and the St Joseph's community palliative teams as well as the Tower Hamlets Equipment service. • Working together the teams delivered the care much faster and quicker. • The patient and his family were given a direct number to contact the team if they needed advice or help with any aspect of the care. The NCT nurses had more time which allowed them to get to know their patient and his needs and be able to deliver the patient centred and individually tailored care. • NCT team will present the story with patient's wife ZS.
• Feeling safe and cared for and supported • Above and beyond care delivery • Holistic patient-centred support from health and social care • Nurses could be trusted and able to collaborate with other agencies • Good relationship between patient and family • How might the learning from this shape the frailty work at Barts? • Staff equality and good retention • Seeing users more than once in a day and when user wants visit • Managing all issues without having to be managed directly
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Significant 7
• As part of the falls prevention project, we discovered that care home staff weren't noticing early signs of decline in physical health – leading to falls and avoidable hospital admissions. We heard about Significant 7, a tool to

identify the seven early warning signs of deterioration in care home residents, designed for use by care home staff

- Aim was to reduce falls caused by decline in physical health (and reduce avoidable hospital admissions)
- Highlight was when staff recognised early signs of a chest infection, contacted the GP before the person became very unwell. The person recovered quickly and was a key moment for staff when they realised this was possible
- Success required support from the care homes, GP surgery and practice nurse. Lots of ongoing training and support for care homes is also required

- Great confidence booster for care staff to be skilled up in this way
- Needs GP to be on board for proactive care at home
- Community version for care agencies and family carers launched at carers event
- QI initiatives to encourage take-up by others
- Awards, certificates, ratings, CQC relevance
- User feedback to promote establishment

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SMART Care Project (Occupational Therapy)

- When in hospital patients can become **deconditioned** and have ongoing care needs when being discharged into the community. At the stage of planning the discharge if the patient uses **manual handling equipment** 2 carers will most commonly be allocated.
- Care agencies are **stretched** and have **limited capacity** for new patients, the more double handed cases a care agency has the less work they will be able to take on.
- SMART Care has run over 2 phases previously and with use of innovative manual handling equipment and techniques cost savings of **£600K were made across 85 cases**, this by enabling single handed care (1 carer). Double handed care (2 carers) has its role and at times is essential however previous SMART Care phases suggest care packages can be reduced in roughly **40% of cases**.
- SMART Care Phase 3 (which is currently running) focuses on hospital discharge and aims to **prevent** double handed care packages, whenever possible, by implementing the right manual handling equipment at the earliest stage.

• In this role I link with the hospital teams as well as the hospital social workers and community teams such as The Admission Avoidance and Discharge Team. I have built **strong working relationships** and it has been great to bridge the gap between **health and social care**. • The right care package and the right manual handling equipment can promote service user **engagement**, increase **dignity**, **wellbeing**, independence and **individual choice**.
• Important of equipment provision • Increasing independence and wellbeing • Cultural shift - working in partnership and moving away from institutional thinking • Joint working and collaboration should start from children's services • How to refer? • Cost savings?
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Appendix Two: Open to other ideas

Commitment to conflict resolution **Facilitator: Tracey Upex**	
Achieving the worst possible result	*Steps to stop these undesirable results*
• Answer is always no • Arguing over budgets • Not sharing important information • Working in silo • Not attend important meetings • Start presenting other people's work as your own • Blaming someone else • 'Not my job' • Having a go at people: why hasn't it been done yet? • Not answering calls and emails • Promote some people while overlooking others without going through the due process • Do a restructuring process without any evidence based on data and information to support it • Get a national platform and present old ideas as new to secure funds at others' expense • Threatening each other • Jobs worth! • Do everything possible to reinforce organisational boundaries • Never answer the phone or email • Gossip about other people and how rubbish their work is • Make decisions about your team's role and revisit without checking whether another team is already doing this • Blaming • Ignoring • Been inflexible • Argue • Intimidating • Disagreeing	• Health of teams • Agreed behaviours • Coaching training • Joy in work • Recognise achievements • Develop all of the team • Think – why are they behaving that way? • Communication • Calling it out when you see it nicely • Look after each other • Leadership training principles

• People not getting themselves updated with current information • Be as rude as possible whenever you talk to anyone • Being an arrogant know-all • Shout • Not being truthful or misleading • Letting minor things get in the way • Be a jobs worth and bureaucratic as possible when asked to help • Refer to rules and regulations	

Understanding the interplay between physical and mental health Facilitator: Daniel Tanganyika	
Achieving the worst possible result	*Steps to stop these undesirable results*
• Not understanding mental health as much • Not a big network for mental health • Don't want to talk about mental health • Stigma • Not wanting to get involved in the other aspects of a person's health • Easy to diagnose physical health not mental health	• Accessing the support for mental health • Awareness of mental health • Access to RIO shared system information • Education and training on different types of mental health • Simpler pathway to access mental health

Taking account of the impact of culture, equality and diversity Facilitator: Sophie Dissanayake	
Achieving the worst possible result	*Steps to stop these undesirable results*
• Not respecting the ethnicity, culture and background • Work individually – ignore history • Not listen to people and not ask questions • My way or the highway – I am right – you are wrong • Making people feel humiliated and unaccepted • Language barrier • Not recognise personal limitations • Don't celebrate diversity • Racist/sexist/ageist	• Communication – listen – respect • Respecting of culture, race, religion and background • Use of interpreting where possible – facilitating translation • Trying to avoid making assumptions • Celebrate diversity • Effective listening – asking questions • Commitment to understanding what is being said • Maintain awareness

• Not acting as a part of an integrated team – lack of team spirit • Not protecting people's privacy and dignity • Scapegoating people – being disinterested • Lack of knowledge of things happening around • Not talking with or listening to the other services or service users • Not appreciating other people's values • Prejudices • Being unaware of the services • Make assumptions	• Educating people to combat ignorance • Treating everyone fairly • Exploring learning opportunities • Don't make assumptions – be aware of our own assumptions and challenge them • Learn to listen to other people • Avoid judging from one's own perspective

Trusting and acknowledging the actions of individual team members Facilitator: Alison Jukes, THT OD Lead	
Achieving the worst possible result	*Steps to stop these undesirable results*
• Not wanting to change • Not being open to working in an integrated way • Being closed minded • Not trusting colleagues to take on certain responsibilities or being competent in job • Blaming culture and disrespect • No respect • No trust • Scared of change • Gossip • Negative attitude • Don't ask other opinions before you change something • Mistrust • Ignorant • Not trusting individual's competency • Blaming culture • Don't have any team meetings • Ignoring colleagues • Undermining • Silo working • Confused points	• Competency issues solved by team meetings • Learning from mistakes at seminars, team meetings and in training and supervision • Social – team building activities in work time • Weekly team meetings and breakfast • Counselling • Buddy system • Away day • Appreciate • Respect • Praising • Approaching team member • Equal treatment • Listen • Good sharing of information • Team player • Good communication and good relationship • Giving and receiving feedback • Regular updates • Open door policy as a manager

• Repeat actions • Lack of direction • Mistakes and lack of clarity • Lack of personality • Not open to new ideas from team members • Undermining others • Lack of communication • Not listening • Favouritism • Ask for opinions then disregard	• 360-degree communication • Mentors for support • Training – self-confidence • Team meetings to avoid blame culture • Newsletters and emails • Fact-finding before you start • Discuss with the person • Communicate you are listened to • Leadership • Vision • Coaching • Shared learning • Positive culture • Patient outcomes positive • Compliments • Smile

Taking an enquiring approach to person-centred care Facilitator: Juliet Usiade	
Achieving the worst possible result	*Steps to stop these undesirable results*
• No names – don't introduce e.g. 'hip beds' • Don't listen – tell • Don't allow advocates • Don't use share records/don't share information • IT systems not linking • Not communicating with colleagues • Letting OT systems govern and restrict practice • Send vulnerable patients to hospital instead of using local services • Don't ask what want – blanket rules • Respecting the patients' needs – don't ask questions • Risk • Not encouraging self-care • Being resistant to change • Being too rigid in thinking • Rushing tasks	• Respect patients' beliefs – meeting the need of the patient • Awareness - Encourage ownership – parent coaching – sharing – local control • IT resources ruling – social space – maintain and update • Using interpreting and advocacy services • Involving service users, carers and staff

• Adopting a 'one size fits all' approach • Not involving advocates and representatives • Prescriptive care • Don't have a directory of services so we don't know what we all do • Don't involve everyone who could help • Not wanting to understand or see bigger picture • Not asking what they want or feel they need • Not listening • Not respecting individuals • Making assumptions • Putting people into pre-prescribed box • Don't respond in time when asked for help • Not sharing information • Not listening • Lack of information • Do more tasks and not finish any • Don't have a plan for what happens with an exacerbation • Not improving communications • Use of jargon • Don't ask the patient what they feel or need • Not informing or consulting with the client of their families • Target driven • Putting in a package of care to avoid risk as opposed to what the person wants and needs to increase independence • TDS – QDS – no rehab equipment • Rushing decision making legal assessments • No advocacy • Moving clients around – interim beds when severely confused • One fits all	

Adopting behaviour change strategies Facilitator: Georgina Birch	
Achieving the worst possible result	*Steps to stop these undesirable results*
• Hierarchy and silo • Not allowing access to training • Not asking people their name • No understanding of person-centred care • Institutionalised care processing – hospital • Not listening to clients and carers • Disempowering • Calling people by their ailment • Not signposting • Tell them what to do prescriptive • Not treating people as an individual • Take away choice • Make health and social care professionals think they have all the answers • Go back to silo work • De-professionalise people as only psychologists can do • Not asking what matters to them • Not give people any time for meaningful conversations • PJ paralysis	• 'What matters to you?' campaign • Health and wellbeing rollout • Staff development and OD programme on joint integrated working • Joint training • Tell everyone working – people as partners in care not their business • Leadership that helps drive culture change – covering professionals as well as public • Consult with service users as well as staff and understand better how other organisations operate • Full patient involvement hearing all voices – co-production

Appendix Three Training support

At the event, an update was provided on the training and development support on offer for all across THT and wider partners

Making Every Contact Count (half day)

Making Every Contact Count (MECC) is about encouraging and helping people to make healthier lifestyle choices to achieve positive long-term behaviour change. Frontline staff working in Tower Hamlets have excellent relationships with their patients and service users and therefore have valuable opportunities to help them make decisions that bring positive changes to their lives. However, it is not always easy for staff to do this and they might not be aware of local services available to support the changes they want to make. A bespoke half day training programme to support staff to develop the relevant knowledge, skills, and confidence to be able to deliver behaviour change interventions through effective conversations, resulting in signposting to relevant local services. It is about connecting with the public and using the appropriate language to do this effectively.

Find out more about MECC here ….

Suicide Prevention & Mental Health First Aid Courses

Perhaps surprisingly, thoughts of suicide are not always related to mental ill health. The reasons can seem challenging and complex. Furthermore, it is not always obvious when a person is at risk of suicide. Being suicide alert and talking about the reasons for wanting to live and die has been proven to help. We teach World Health Organisation (WHO) approved courses developed by LivingWorks that facilitate and promote this discussion while keeping both the caregiver and the person at risk safe.

ASIST: Applied Suicide Intervention Skills Training (2 days)	safeTALK: Suicide Alertness For Everyone (half day)	MHFA: Mental Health First Aid (2 days)	MHFA LITE (half day)
This is an intensive 2-day course for caregivers and key community members. It teaches suicide alertness and an easy to remember framework of practical skills to safely initiate, complete and follow-up on a full suicide intervention. ***Find out more about ASIST..***	safeTALK is a half-day (3.5 hours) training course that can help you make a difference. Know what to do if someone's suicidal by following the easy to remember TALK steps - Tell, Ask, Listen and Keep-safe. These practical steps offer immediate help to someone having thoughts of suicide and helps you both move forward to connect with more specialised support. *Find out more about safeTALK….*	Over two days, the MHFA course teaches how to recognise the signs and symptoms of common mental health issues, provide help on a first aid basis and effectively signpost towards support services. ***Find out more about MHFA...***	This is an introductory half-day session to raise awareness of mental health. We advise all non-mental health service staff to attend this. ***Find out more about MHFA LITE...***

Coaching for Health and Well-being (2 days)

A two-day programme for frontline staff giving you the skills to apply coaching to conversations with service users, patients, carers and their families. This programme supports the THT principles of integrated working and person centred care. Attached flyer.

Click here for more information and registration