ealth and care integrated model development

- Strategic Drivers and background

STP	Better Care Fund
ision – the Healthiest population on the planet	**Vision for Integration** – With people at the heart of decision making, we will use evidence to develop a common purpose and agreed outcomes for people, with people. We will take a whole system approach to leading, designing and delivering services.
riorities/ Programmes: revention, Neighbourhoods/ Out of Hospital, uture Fit, GP 5 Year Forward View	**Priorities:** Prevention, Admissions Avoidance, Transfers of Care
elated workstreams: Social Prescribing Care Navigation GP 5 YFV – 10 high impact model Frailty Diabetes prevention	**Related workstreams:** • Social Prescribing • Integrated support services • Fire Safe and Well • Resilient Communities • Diabetes prevention

What roles do we have?

nunity Care Coordinators £350,000	Let's Talk Local £85,000	Social Prescribing £300,000 (appro
nical roles typically based in GP Practices to e support to patients using non-medical ntions often based on social or practical ns. Referrals are made via the clinical team in ctice. support patients at risk of loss of ndence and hospital admission as a uence of unmet social care needs (mainly 5 year olds 85% 0 – 65 15%but more recently e practice population Patients are rised into the following:- ex – repeated contact and prolonged ment with referral to other organisations ate – home visit or further contact with l to other agencies – sign posting and information giving s are then signposted or offered support dent on their level of need and availability of ce in the community uild relationships with statutory and non- ry (including voluntary) organisations and nkages to local care support groups.	Provision of information and support through locality based The Let's Talk Local sessions staffed by paid staff and volunteers in identified 'centres' across Shropshire. Trained social care practitioner provides social care information and advice and, if appropriate, Care Act assessment. Additional information offered on issues such as housing support, benefits, assistive technology, occupational therapy and about services and support available in the local community, covering different areas of a person's life. One on one support using a structured conversation with key prompts to guide and tease out relevant issues relating to the individual which is recorded and an action plan created with agreed goals. The practitioner is able to make links and referral to other services as required, encouraging people to self-manage where possible by enabling them to find their own solutions.	One to one support to individuals and their fa taking referrals from GP's, ASC, the voluntary (focusing on at risk target groups) as well as proactively accessing data through the practi records to identify those at risk groups (long conditions, CVD, carers, mental health issues, diabetes, loneliness) Works with the individual to identify realistic and develops an action plan to achieve those Applies skills based on motivational interview lifestyle and behaviour change and recognise capabilities of each individual. The social prescription is co-designed betwee advisor and the individual and a nonclinical community based intervention identified to w referral is made. Additional follow up support offered via one to one, telephone, email, text Reliable measurement tools are used at the i appointment and post intervention with mid- review.

Community and care navigation onion

Functions of Teams

Social Prescribing Advisor, Community Care Coordinator & Let's Talk Local:
Develop locality based one team approach to:

- Proactively identify at risk practice population
- Connect people to support needed through social prescribing, signposting or social care
- Community support via services and VCSE
- Use an asset based model to support community resilience
- Collect relevant information to track progress and wellbeing

VCSE as providers:

- VCSE organisations providing a range of services in communities to help people improve their health and wellbeing and remain independent for longer

Community Enablement Team:

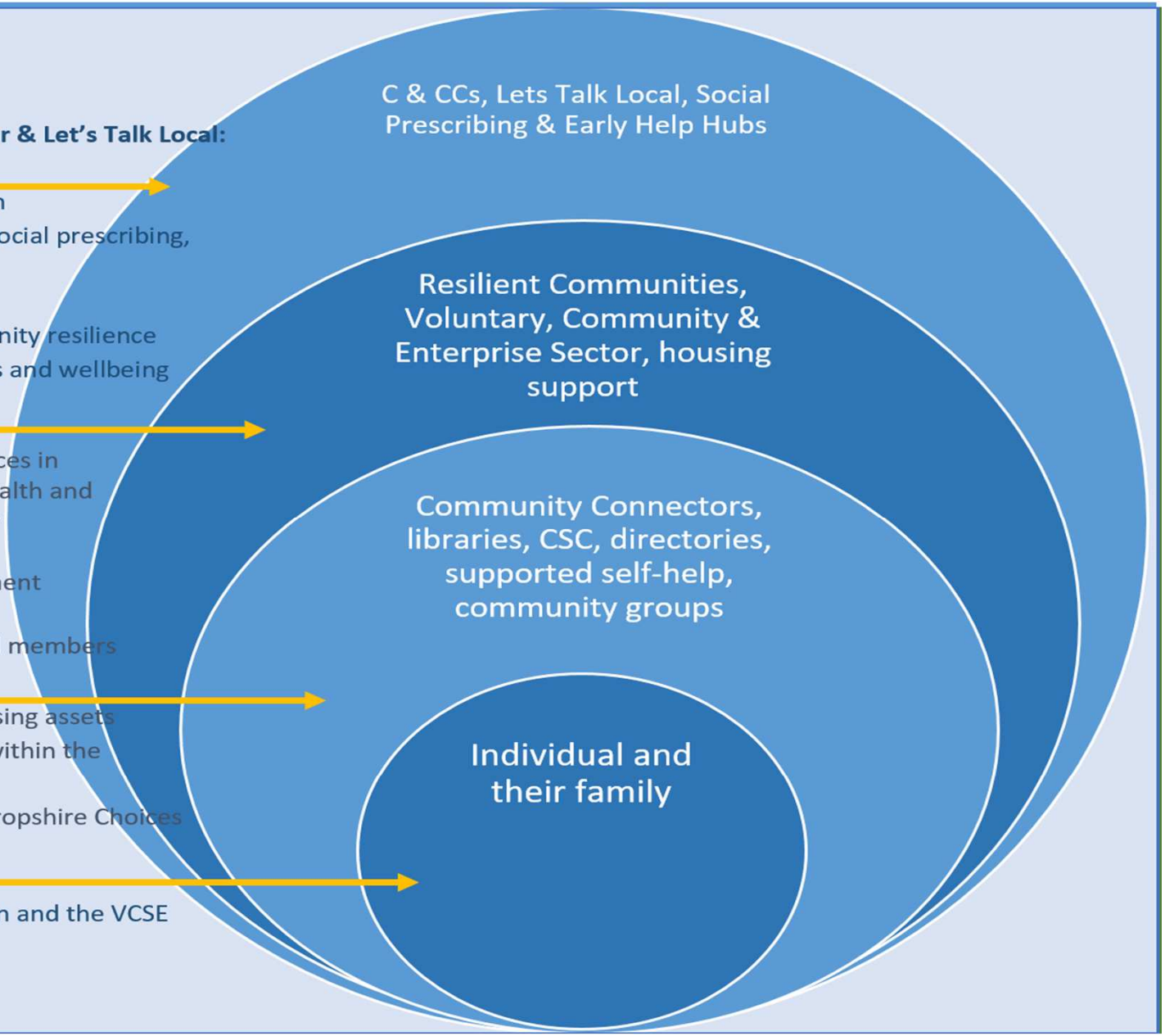
- Supporting asset based community development
- Linking services with communities
- Advisory role for decision makers and elected members

Community Connectors:

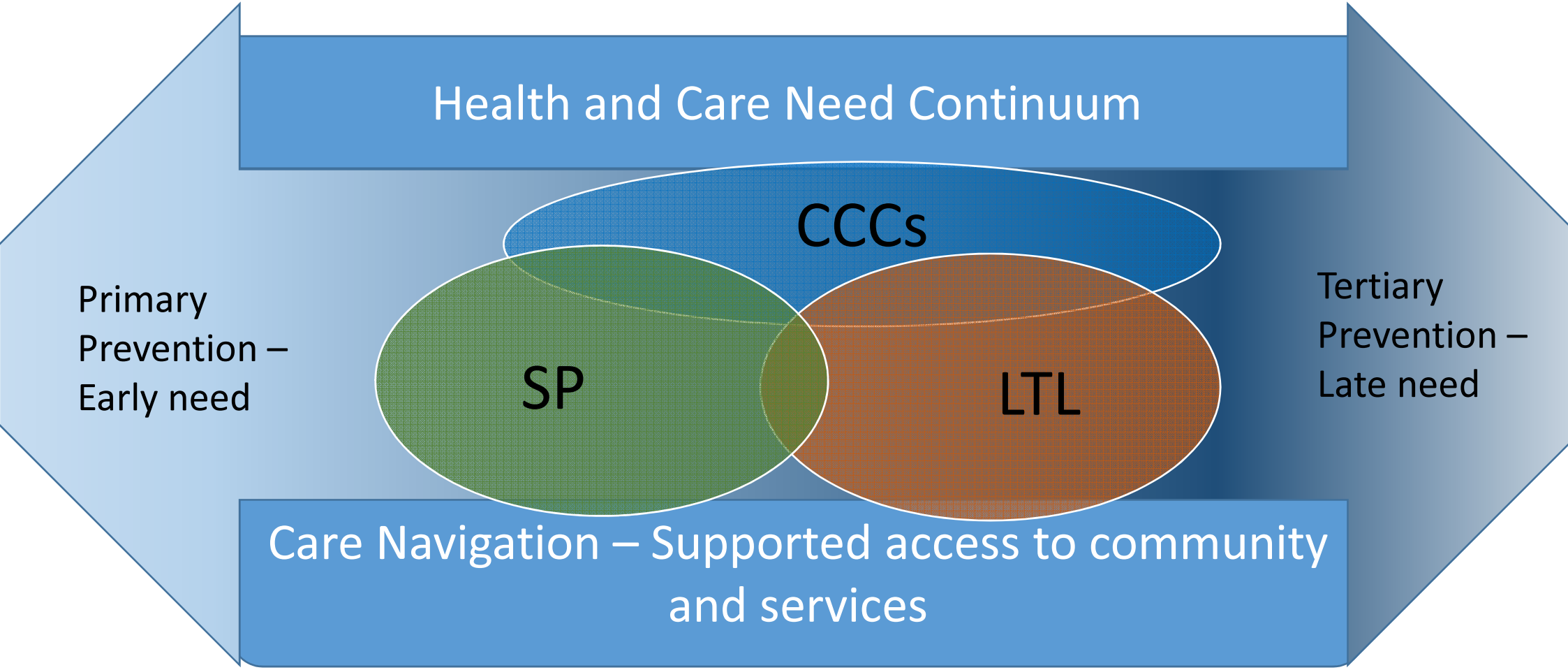
- Communities supporting each other and utilising assets
- Ensuring availability of assets and networks within the community
- Development of hyper local directory and Shropshire Choices

Individual assets, strengths and capabilities:

- Supported by the community, care navigation and the VCSE to improve self-care and resilience



Care navigation across health and care – how do we want this to look?



All levels of prevention (primary, secondary, tertiary) working with communities and the VCSE