**Telford and Wrekin: The Community Solution Across Health and Social Care**

**Paper for Future Fit Programme Board**

## 1. Background

In 2015 the CCG and Council began work on a collaboration to design and deliver a programme called 'Neighbourhood Working' across Telford and Wrekin. This programme was adopted as part of the Shropshire, Telford and Wrekin STP. Neighbourhood Working encompasses all elements of community based developments including volunteering, development of community health services and joint working between GP practices. The work includes a broad range of changes which aims to improve quality of life for the people living in Telford and Wrekin and amongst other aspirations will reduce admissions to hospitals. This will be achieved through primary prevention, strengthened community support and by taking a more proactive approach for patients with known illness. In the summer of 2017 the CCG outlined their current position around neighbourhood working in the Pre Consultation Business Case (PCBC) which was produced to support the acute reconfiguration known at that point as Future Fit.

This document presents a position statement on Neighbourhood Working. It has been produced as an update to inform wider discussions around Future Fit. The report revisits some of the underlying principles and vision before moving onto highlight some of the main changes in the national and local context which have, and will continue to have, an influencing factor on the programme. It also considers progress and next steps for each work stream and provides a brief activity and finance update on the agreed projects.

## 2. The vision and guiding principles

There has been significant change across health and social care over the last few years both locally and nationally. This has included policy change, central directives on the inclusion/delivery of certain services, an increased 'command and control' culture from NHSE and increased demands on both health and social care budgets. There has also been a growing body of publications which aim to guide commissioners and providers on new ways of working to promote innovation and integration. Despite all these changes the underpinning principles agreed in 2014 as part of the Future Fit work are still relevant and act as a useful guide; in particular 'Home is Normal', 'Empowerment' and 'Integrated Care'.

The vision for Neighbourhood Working also remains applicable with an overarching theme to improve resilience and independence. The approach evolved as a response to a series of issues which are ever present in Telford and Wrekin. These include the need to challenge the current deficit based model of care which promotes dependency. Budget cuts coupled with an increased demand on statutory services have created further financial pressures across health and social care in 2017/18. There is still a heavily acute hospital dominated health system across Telford and Wrekin.

The Council and CCG continue to respond to these challenges in seeking to maximise opportunities associated with creative solutions. Developments aim to address peoples personal goals and support the growth of vibrant and health communities which promote independence. Plans are progressing

to move care traditionally delivered in hospital settings within peoples own homes or in community settings. Integration remains fundamental to new models of care in Telford and Wrekin, bringing together professionals from different organisations and professions to mobilise care around the patient.

The Neighbourhood Working programme is a complex set of activities bringing together all aspects of community centred approaches. There is no single model of care, rather this is a collection of approaches and services each with their own description all contributing to the achievement of the outcomes below:

- Communities will be connected and empowered
- People will stay healthy for longer
- Clinical outcomes will be optimised for patients
- Services will be available closer to home for patients
- People will feel support during times of crisis (both physical and mental health)
- People and their carers will be supported at the end of their lives

## 3. Changes in the national and local context

During the last 12 months there has been a growing momentum around locality and neighbourhood working throughout the country. Many areas are looking to implement place based approaches which include a strengthened community response as well as a move to self-managed integrated teams. This is illustrated in the Primary Care Home's 'transformed state' and described well in the following link https://www.youtube.com/watch?v=3YdlV1DsK54&feature=youtu.be. This increased national focus has led to a sharing of information, particularly case studies, about what has happened elsewhere in the country. Telford and Wrekin are now part of a regional network to support these developments which provides a forum to share the latest guidance and consider the challenges in a supportive environment.

There have been some key issues across the local health economy which has had an influencing factor on the programme. The 'Right Care' programme has indicated a need for improvements in care for people with CVD and diabetes. Latest Rightcare data (November 18) has indicated further opportunities in the management of Respiratory conditions. As such these have been adopted as the key clinical priorities for the CCG and will be built into all aspects of the programme particularly with healthy lifestyles, early identification of disease and improved management in primary care.

Over the last year there has been more activity in hospital than planned. This and other contributing factors have worsened the financial situation for the CCG. It now means that the projects within Neighbourhood Working are expected to deliver both financial savings as well as quality improvements. Their financial pressures are mirrored across the local health economy.

There are also increased pressures in the local urgent care system. A&E performance remains a challenge and a proposal has been made to temporarily reduce the opening times of the emergency department at the Princess Royal Hospital. This expedites the need to consider alternatives to hospital solutions to support people in the community as well as keeping people well.

## 4. Progress against each of the 5 work streams of neighbourhood working

Over the last year the CCG and local authority have had a continuous process to review and progress all aspects of Neighbourhood Working. The activities are now grouped into five work streams. The tables below consider each of the work streams in turn outlining an overview of the work, progress made and next steps.

### 5.1 Work stream one: Prevention & Encouraging Healthy Lifestyles

**Prevention & Encouraging Healthy Lifestyles**

**What is included in the work?**

The work stream aims to support people to stay healthy with a combination of approaches for the whole population and targeted programmes for priority groups in Telford and Wrekin.

The work stream was added to the programme during 2017. Many long term diseases are closely linked to known behavioural risk factors. With at least 80% of all premature heart disease and over 40% of all cancers prevented through healthy diet, regular exercise and not smoking. Local data continues to highlight the high number of admissions associated with preventable disease. In particular around alcohol and obesity.

The work stream includes a range of activities and interventions to help improve healthy lifestyles, supporting people to make healthy life choices. The work has been driven by the Health and Wellbeing Board, led by the Council and improving healthy lifestyles is a priority for Telford and Wrekin. Whilst this is distinct work stream there are clearly links between this area and other projects.

The Healthy Lifestyle Service is provided by Telford and Wrekin Councils Health Improvement Team. The team consists of a small number of Advisors who support local people to make improvements to their lifestyle with a particular focus on healthy eating, weight management, emotional health and wellbeing, physical activity, reducing alcohol consumption and support to quit smoking.

**What progress has been made?**

Achievements:

- Healthy Telford has 3,359 twitter followers (75% Telford residents). Our average engagement rate is 1.2%, considered ‘very good’ and the newsletter distribution list has 1,444 subscribers including professionals and volunteers working with vulnerable residents.
- Trained 550 staff and volunteers to ‘Make Every Contact Count’ - learning how to successfully raise a lifestyle issue with an individual and where to direct them for further support if needed.
- Coordination and delivery of ‘Active Signposting’ training to 140 Practice reception staff.
- Provided lifestyle advice to 17,378 people, brief interventions to 27,087 and completed health checks with 2,689 people. 1503 people referred to the service committed to a Personal Health Plan with 61% achieving their primary lifestyle goal. 79% had one or more long term conditions. 11,620 referrals were made (including signposting) to support services and community projects provided by partner organisations to support people to achieve their lifestyle goals.
- Successful transfer and integration of the Healthy Families Service and Quit Smoking Service

into the overall service offer for Healthy Lifestyles.

- Simplified pathways, data recording and administrative processes – 80% of advisor time is now spent directly with people wanting to make improvements to their lifestyle.
- Improved engagement with General Practice and wider NHS partners - now making up 73% of all referrals to the Healthy Lifestyle Service.
- Weekly healthy lifestyle clinics in all but one Medical Practice across Telford - some GP clinics have increased from 1 half-day session to 2 full days due to the clinics being 100% booked and the GP's being encouraged by the positive outcomes achieved by patients along with a reduction in GP visits.
- Worked collaboratively with the Midlands Partnership NHS Foundation Trust to address the physical health needs of patients on the psychosis pathway particularly those patients with low self-esteem and where medication has led to weight gain.
- Achieved a 54% increase in the number of people with long term conditions committing to a Personal Health Plan - this can be attributed to our increasing work with the musculoskeletal team and clinics within Euston house and the hospital, raised presence in the practices and more structured health care professional referral pathways for clients with long term conditions into the service.
- Secured £90,000 over three years from the British Heart Foundation (Sept 18) to implement a community blood pressure monitoring programme.
- Worked collaboratively with partners to produce the Annual Public Health Report – Tackling excess weight and obesity. The report summarises 40 high level actions that the council with partners will prioritise over the next 12 months and makes 24 recommendations for key partners.
- 30 local Pharmacies (79%) have achieved their Healthy Living Pharmacy Accreditation (Level 1) which recognizes the positive contribution of pharmacies too promoting health, wellbeing and self-care.
- Established governance arrangements for the Living With and Beyond Cancer Programme (system wide across the STP); collaborative programme funded by Macmillan Cancer Support for three years. The programme is hosted by the Shrewsbury and Telford Hospitals in partnership with: local people living with and beyond cancer, Telford and Wrekin and Shropshire Commissioning Groups, Powys Health Board, Shropshire Council and Telford and Wrekin Council, Macmillan Cancer Support, Severn Hospice and The Lingen Davies Cancer Fund. Programme includes two new posts funded by Macmillan and hosted by SaTH.

**What are the plans for the future?**

- On-going implementation of the Making Every Contact Count Training programme with a focus on our adult social care workforce.
- On-going delivery of the Healthy Lifestyle service.
- Working with partners to develop our approach to social prescribing - whilst our approach for healthy lifestyles is well developed work is required to develop our local programme. This will include further development of our referral pathways, identification of more link workers, community arts programmes, community learning (including Reading Well programmes) and strengthening links with services that provide local support for social issues (unemployment, welfare and debt).
- Leading a whole system approach to reducing excess eight and obesity.
- Implementation of the Community Blood Pressure Testing programme.
- Implementation of the Living With and Beyond Cancer Programme.

## 5.2 Work stream two: Community Resilience

### Promoting Community Resilience

**What is included in this work?**

The council and NHS, together with the third sector, have vital roles to play in building confident and connected communities as part of efforts to improve health and reduce health inequalities. Community-centred approaches seek to mobilise the assets within communities, promote equity and increase people's control over their health and lives. Telford and Wrekin Council, working with partners, has a long history of neighbourhood working. Over recent years we have seen a significant increase in the active involvement of residents within their neighbourhoods. This activity includes higher rates of volunteering, establishment of new community based groups and delivery of projects and some services by community organisations. While many people already make a contribution to community health, this work stream recognises that more could be done to realise the full potential of communities and address social exclusion. The assets within communities, such as the skills and knowledge, social networks, local groups and community organisations, are building blocks for good health.

Our approach has been to:

- Strengthen communities - through community development, asset based methods and developing social networks
- Develop volunteer and peer roles - enhancing individuals capabilities to provide advice, information and support or organise activities around health and wellbeing in their communities
- Develop collaborations and partnerships – working with health partners, communities and the voluntary sector to design and or deliver services and programmes
- Improving access to community resources – connecting people to community resources, information and social activities

Ref: A Guide to Community Centred Approaches for Health and Wellbeing (2015: NHS England & PHE)

**What progress has been made?**

Restructuring of the public health team to create four Health Improvement Practitioner roles to support this work stream

A number of projects were identified as priorities in 2016. These projects are listed below with a brief summary of progress.

**Commissioning a Mental Health Hub**

The Branches mental health hub was jointly commissioned by the council and CCG to provide practical and emotional support for people who are suffering with mental ill health and dual diagnosis. The Hub and its weekly programme of support groups and training courses attracts 750 attendances each month and is supported by nearly 60 volunteers. Case studies highlight how the hub has supported individuals through crisis and avoided attendance at A&E, admissions to the Section 136 suite and referrals to the mental health service.

**Wellbeing Care & Support Networks**

The Wellbeing Hubs Network is now recognised as an independent consortium led by T&W CVS. The network has 40 Members connected by the common aims to improve Community Care with people for people including care, support, housing and assistive technology. The network has established community 'Hubs' within Wellington and surrounding areas and hold regular 'Art of Wellbeing Events.' The Hubs coordinate community activities, provide local information and raise awareness of care and support across all ages.

The network has coordinated a number of community care initiatives. Examples include:
**Living well with dementia in the community** (SPIC, Wellington Library & CCG) - The 'Keeping Active Live well with Dementia Collection' is a service that increases dementia awareness and supports carers to be aware of a range of items available to include jigsaws, books, puzzles, DVD's, table top games, inflatable games and activities **Wellbeing Groups** – focussing on empowering family carers to keep resilient, avoiding crisis and breakdown, dealing with common challenges with others through peer-led support groups, a social scene, promoting health & wellbeing and strengthening personal networks.

**Enterprising Communities**

- Six community businesses have been supported in year one in extending their work into health and social care
- A further 35 community businesses and entrepreneurs have received support to apply for funding, access training and have been signposted to a range of other organisations.
- Work with Birmingham University has started to gather evidence to demonstrate outcomes and value.

**Health Champions and volunteering**

- 53 community Health Champions are taking an active role in improving the health and wellbeing of their local community
- 19 Feed the Birds volunteers have been matched with lonely and/or socially isolated people and are regularly visiting clients in their home on a weekly basis as part of the project
- 8 Community Connectors working in partnership with Citizens Advice Telford & Wrekin and CVS to support families at an early stage to prevent escalation of health and social care needs and higher tier support
- All volunteering programmes are evaluating well for improving the health and wellbeing of the client and the volunteer

**Wellbeing for Carers**

- A range of offers available to carers to access throughout their caring journey. This includes access to creative activities, education and wellbeing workshops – outcomes include improved wellbeing; personal resilience and improved connectivity with other carers reducing isolation.

**Establish a virtual system to capture community assets**

- Live Well Telford is in the development phase – progress includes: stakeholder engagement; migration of data and information from existing systems; completion of live testing, website

configuration; and branding.

**What are the plans for the future?**

The ethos of community resilience is the golden thread that will run through all the elements of Neighbourhood Working. The Council's health improvement team and community participation team will support developments; commissioning (including any procurement) work will consider how it can promote resilience through social value and new initiatives/projects/innovations are planned as the community drives change. Mores specific areas include:

- Recruitment of additional volunteers.
- Launch of the community directory 'Live Well Telford' to allow people to access information and advice easily and be signposted to the care and support they may need in order to help themselves or those they care for.
- The public health team will work to produce locality plans in each of the localities providing a strong leadership role at strategic and community level. These plans will include elements of the healthy lifestyle work identified in work stream one and will also focus on broader health and wellbeing outcomes including reducing excess weight and obesity, smoking and addressing social isolation. They will bring together key partners including voluntary sector and general practices. They will co-produce improvement plans which will include consideration of assets such as; skills and knowledge, social networks and infrastructure. The team will focus on building community capacity to support development of our social prescribing programme with a focus on physical activity and arts and health.
- Establish the links for partners to support work around 'Compassionate Communities' with the Hospice.

## 5.3 Work stream three: Direct care in the community

There are a number of key developments within this work stream that provide additional capacity in the community. They all have a strong 'health' focus and an aim to promote integration across health and social care. They each bring together professionals from different organisations in a multi-disciplinary team approach to proactively care for patients who already have developed illness or have significant risk factors. The teams will all help people stay well in community settings and provide either links to, or provision for patients as an alternative to hospital should their condition exacerbate

### 5.3.1 Care Homes

**What is included in this work?**

The CCG has commissioned a dedicated multi-disciplinary team to support local care homes, providing inspiration and support to facilitate care home staff to provide confident, comprehensive care until the end of life for their residents. Evidence has shown that a focused, targeted approach can help to achieve the anticipated reduction in avoidable unplanned admissions to hospital from care homes.

Team objectives in the first year:

- Reduce attendances and admissions to hospital from 6 early focus homes by 9%
- Develop protocols/pathways and support to use these for the following: Delirium, UTI,

pneumonia, dehydration, end of life and falls

- Ensure Emergency Passports are in place for residents in 6 early focus homes
- Implement Red Bag scheme in 6 early focus homes
- Increase in number of Advanced care plans and DNARs

**What progress has been made?**

The team are now in place embedded within the Rapid Response team. The profile of rapid response has been raised; an increase in calls to the team has been observed from the targeted care homes with staff contacting the team first rather than dialling 999 when they are worried about a resident.

Following an intervention by rapid response (whether patient is admitted or not), the team support the care home to carry out a route cause analysis to understand what happened, why, and how it can be prevented from happening in future.

In addition to the reactive work described above, the team are carrying out a supporting function which focuses on prevention and proactive working, specific to the needs of the home and residents, including more intensive input following training provided by Shropshire Partners in Care (SPIC).

The team have successfully formed working relationships with the dementia workers and have been actively raising the profile of dementia within care homes, in addition to participating in neighbourhood MDT meetings.

- In June 18 the team commenced an intensive roll out of "Emergency Passports" for the residents in the six targeted homes. There are documents providing a snapshot of an individual's "normal" function and behaviour to aid paramedics in their decision making. Feedback from homes and WMAS has indicated that this is impacting on the need to convey patients to hospital.

- The team have been working with the hospitals and the Dementia Team to develop a "Red Bag Scheme" which has been evidenced as successful by the Vanguard sites (http://www.suttonccg.nhs.uk/News-Publications/news/Pages/The-Red-Bag--Improving-life-for-care-home-residents.aspx). This scheme is a transfer pathway designed to support care homes, ambulance and acute hospital on transition between in-patient and care homes and went live in the six early focus homes on 15th October 18. This scheme is to be nationally mandated in March 2019.

In addition to falls prevention awareness, the "I-Stumble" protocol has been implemented in the six homes by the team, which is a tool aimed at care homes for use in assessing falls, and includes guidance for staff on what to do during and after a fall, and when it is appropriate to call 999.

The team have been collating case studies and feedback from homes to demonstrate impact and admission avoidance. As of month 5 project performance was on track demonstrating an 8% reduction in cost and performing 7% above target for expected reduction in non-elective activity (*NB the numbers are very small*).

This project is working with a small cohort of patients and will not necessarily impact on the way it "feels" at the front door of A&E. This project is about improving quality of life and experience for

patients living in care homes and their families (for example, dying in their preferred place), whilst delivering a small NET saving to ensure sustainability of the team.

**What are the plans for the future?**

Over the next three years the care home team will increase the number of care homes they are working with, adapting their approach as appropriate. More specifically during the next 12 months the teams will:

- Roll out of Emergency Passports across 30% of care homes in Telford and Wrekin (by April 2019).
- Implement phase 2 of Red Bag Scheme in additional 6 homes (January 2019)
- Implement phase 3 of Red Bag Scheme in a further 6 homes (March 2019)

## 5.3.2 Integrated Teams

**What is included in this work?**

The development of integrated teams is one of the most fundamental projects within the neighbourhood working programme. The aspiration is to form dynamic, integrated teams who will have a strong emphasis on building resilience (in individuals, families and communities), early intervention and prevention when delivering care. The teams will consist of people from multiple organisations, harnessing the skills and knowledge of the professionals working within them. The patients who will be targeted will be those in the 'medium risk' cohort as defined by a risk stratification tool.

The team *functions* are as follows:

1. *Find the patients*: Proactively case finding (includes use of risk stratification tools but not limited to e.g. contacting patients over the age of 80)
2. *Form a team around the patient*: Deliver a multi-disciplinary approach to looking after a patient e.g. establish joined up processes, strong relationships, sharing information, holistic view of the patient
3. *Prevent deterioration*: Preventing deterioration of patients to prevent future admissions by supporting patients with long term conditions to manage their illness (i.e. "tomorrow's admission")
4. *Prevent admission*: Ensuring care plans in place, outlining what support is available for patients in crisis and making links with services such as Rapid Response.
5. *Improve clinical outcomes for CVD and diabetes*
6. *Inspire*: Establish the "One Team" ethos, team around the patient, to influence and inspire current workforce to change their ways of working

The *interventions* that the team will deliver are as follows:

A) Find the patient
B) Carry out multidisciplinary assessment (bio-psycho-social)
C) Develop Care Plans

- Mapping networks of informal care
- Identify formal care needs
- Care delivery
- Supporting the patient in their usual social environment

D) Interventions:

- Promoting self-care and independence
- Connecting people to community help and support
- Therapy interventions (mobility, activities of daily living, dietary)
- Nursing support (comprehensive assessments, signposting, coordination of care, health education, administration of drugs)
- Addressing loneliness and isolation, housing issues, financial, relationships
- Offer a point of contact for patients and their carers

The team *formation:*
Direct team: Nurses, occupational therapists, psychological wellbeing practitioners, care navigators, early help and support workers, social worker, speech and language therapist and dietician.

The following people will be include in a wider virtual team


The number of teams has yet to be determined and recommendations will be made once the prototype team are in place (as detailed below)

**What progress has been made?**

The original plan was to align existing professionals from Shropshire Community Trust and the Council to each of the four groupings of practices to form close working teams. The community nursing teams from Shropshire Community Trust have begun that alignment with groups of practices. Similarly workers from the local authorities have been linked to practices. Multi-disciplinary team meetings have taken place in two of the four localities to discuss better joint ways of supporting identified patients.

Whilst these activities have led to some improved working relationships and improvements for individual patients, the different organisations (and staff working within them) were finding it difficult to change culture, introduce new ways of working and create new joined up working practice/processes whilst delivering their existing 'day job'. In addition too much responsibility was given to the practices to drive the processes and changes without sufficient managerial support. The scale of work now needs to be increased to achieve the changes quicker and harness the motivation and enthusiasm across Telford and Wrekin to work in a different way. It has been recognised that the change needs to be provider led to be effective. A significant amount of learning has been achieved during this work e.g. the initial geographical split of teams across practice populations is not effective and a different approach to align teams to primary care networks is needed.

**What are the plans for the future?**

In order to develop integrated working more quickly a proposal has been agreed to form a completely new team who will be responsible for both the design and testing of a sustainable integrated model of care. This team will be the catalyst for the transformation of community

services, creating a detailed prototype with proven benefits that can be rolled out across the whole CCG area.

The team will reduce the number of people at risk of being admitted to hospital by better supporting patients. It will be formed from existing service providers who will work together in partnership under an Alliance arrangement. The host provider will appoint a Project Lead to manage the transformation project. The Project Lead will co-ordinate activities across the alliance partnership (or similar mechanism) and oversee and provide direction to the team to ensure the solution is outcome focussed and can be rolled out at scale.

The main priority for this team will be to target those patients in the second tier of the at risk triangle. There are currently limited services available to support these people so very often their conditions deteriorate, their needs escalate and they end up being admitted to hospital. The team will find the cohort of patients who would most likely benefit from intervention, deliver interventions and monitor the results. A bid for funding has also been submitted via the STP digital workstream for an intelligence tool that will enable the measurement of the impact on the whole system (e.g. savings to primary care, number of acute beds saved).


A team will be mobilised quickly to find a solution that works for Telford and Wrekin. It will draw on the national findings and utilise a PDSA (Plan Do Study Act) type of improvement methodology to implement change, and then amend working practice according to the results. As part of their work they will help to inspire and motivate the current community staff and roll out the model to ensure a sustainable solution is reached. The team will be given the remit that they are “safe to fail”, and supported to test ways of working and change what is not effective first time.

The people delivering this model need to be the people to design it and drive it forward. It will take 3 months to get the team in place, a further three months to design the processes and begin some delivery of care, then a further 6 months to refine the prototype so it is fully functioning and maximising the opportunities for the cohort of patients it is serving. During that time some in roads should also be made into improvements with other teams.

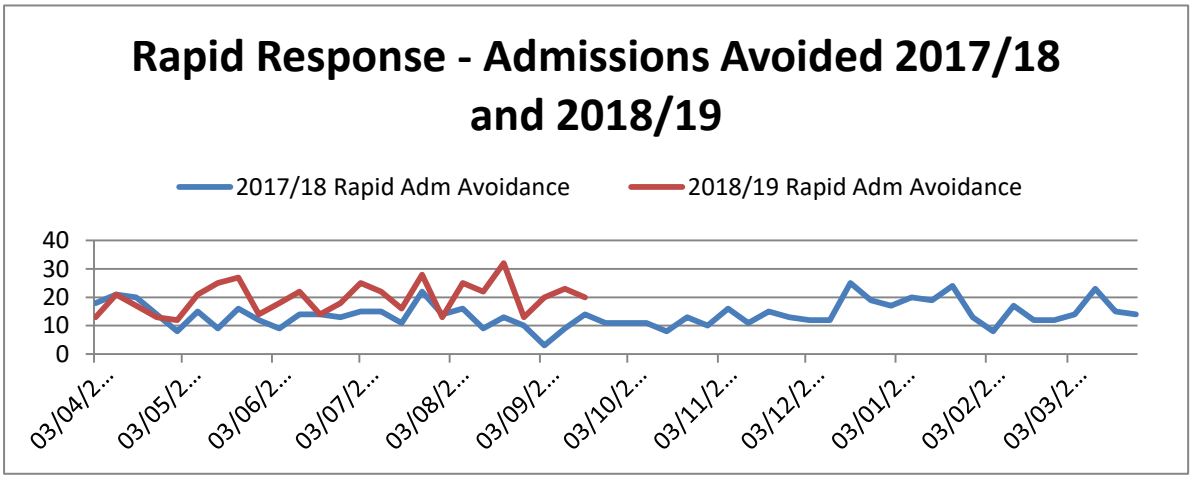
**5.5.3 Rapid response**

**What is included in this work?**

The Rapid Response Team provides urgent clinical interventions to support patients in their permanent residence (home or residential home). The criteria for referral is that the patient’s condition must be due to a deterioration in health condition that without rapid clinical intervention would require an admission to the emergency department or acute medical unit. Response is within 2 hours of referral. The service is in place from 8am -10pm 7 days a week

**What progress has been made?**

Other the past few years the capacity of the team has been increased and working relationships/processes with the local authority, WMAS, SaTH and practices has improved significantly. This has led to an increase in the number of patients supported and admissions prevented. The graph below illustrates the increase in admissions avoided this year compared to last




**What are the plans for the future?**

However, there are a few changes taking place which will increase referrals to the team and ensure the current capacity is maximised.

- Better links with care homes to prevent admissions as detailed in section 5.3.1.
- An improved access point to ensure GPs can easily refer to the team
- Rapid response will develop joint working protocols with the new prototype team. Patients supported by the prototype team will know who to contact in a crisis (i.e. rapid response) and this will documented in their care plan. Patients who are supported by rapid response team during a crisis will be stepped back down to the prototype team after stabilisation.
- Consideration of the skills and competences within the team to make better use of the resources e.g. nurse prescribing.
- Inclusion of the team in the 'frailty front door team' as detailed below in 5.5.4
- Introduce Emergency Passports to patients at risk, who live in their own homes

N.B. No additional activity/finance savings are included against the rapid response team per se, instead they will fall under savings for care homes and frailty front door. This will avoid any duplication

The requirement to further consider how avoidable admissions for those in the under 75 age group can be realised may expand the role and capacity within the team. This work is in its formative stages and is being clinically led by a Board GP.

### 5.5.4 Frailty front door

**What is included in the work?**

In 2017 a dedicated frailty team was introduced in Royal Shrewsbury Hospital (RSH). There is now a plan to develop a similar model based in PRH supporting admission avoidance before and at the Front Door of the Emergency Department (ED) and through ED/AMU/ CDU. The model (supported by the Acute Frailty Network) is based around three inter-linked processes:

- *Admission avoidance before the Front Door*: The Frailty Front Door team (FFD) acts as a triage for WMAS, CCC, Care Homes, SPOA, GPs to divert patients to community options including Rapid Response/ ICT before and instead of conveying to hospital

- *Admission avoidance at the Front Door*: The team will be based within ED/ CDU and AMU. They will meet frail patients at the front door so they can divert or turnaround if necessary. They will ensure timely diagnostics and assessment are carried out before discharge from ED/ ADM/ CDU. The Team will follow the patient and/or co-ordinate with other community teams for alternative support

- *Shorten Length of Stay*: the team will work within ED/ AMU/ CDU to produce care plans so if the patient is admitted to the deep bed base there is already a plan for discharge

**Team make up**

The intention is to utilise current staff to support this early identification, treatment and risk assessment and planning for frail patients. This includes SATH clinicians, SATH Frailty Team, Rapid Response who currently attend ED, TICAT social workers and Matron, carer workers and independent sector capacity (British Red Cross). A recent plan do study act (PDSA) cycle has suggested that additional staff are needed (Senior Doctor, Emergency Care Practitioner and therapist). The team will also liaise and work with GP Streaming, CCC, WMAS, primary care and community teams to link into existing frailty expertise, resources and skills.

*[NB At the time of writing the issue of funding has not been finalised i.e. who will fund the additional costs and what the costing structure will be for payment of either the team or the activity]*

**Expected benefits**

- Improved patient experience delivering care in the right place at the right time in line with patient choice and care need
- Improved use of system capacity to meet patient care
- Reductions in conveyances to SATH
- Reductions in emergency admissions, length of stay and occupied bed days
- Some impact on 95% ED target
- Support the implementation of Criteria Led Discharge through care planning in ED
- Support implementation of End PJ paralysis through care planning in ED
- Improved dignity in dying
- Seamless/integrated working between acute and community teams

**Potential savings**

Evidence and audits including the recent 6 As Audit show at least 15%+ of admissions are avoidable and 40-50% of patients stay in hospital longer than clinically needed. Strategic CSU analysis suggests there is potential to reduce admissions by 5-6 per day and reduced occupied bed days c6000 per year.

Admission avoidance targets *before the Front Door* have been identified as 4 per day, due to reduced conveyance to hospital.

Admission avoidance *at the front door*: The initial working assumption is to achieve an 8% reduction in A&E conversions to admissions (75+ years based on identified procedures) for the Frailty Team at the Front Door. This equates to 1 patient not being admitted per day

| Activity | 8% reduction | 16/17 Spend | 8% saving |
|---|---|---|---|
| 3,431 | 274 | £9,909,879 | £712,790 |

**What progress has been made?**

*Admission avoidance before the Front Door*

Planning meetings have taken place with WMAS and SCT to develop admission avoidance schemes. Current actions include:

- Rapid Response team are working with the crews at Donnington Ambulance station to review live information on conveyances. The weeklong PDSA in October 2018 to test the impact of this approach i.e. rapid response working alongside crews diverted 15 calls. During this cycle there is a target to reduce two admissions per day.
- Rapid Response team are working with the crew member from Donnington Ambulance station to act as first responders to calls when identified on the WMAS CAD system. This commenced on 2nd November and will continue for the month. The first week averaged 3 visits a day.
- Rapid Response is working with high admitting GP practices. A Rapid Response nurse makes direct contact with the duty GP and encourages referrals for patients whose admission could be avoided. This commenced from 29/10/18 to test the approach. A third practice is committing to work with this approach. Again, there is a target to reduce two admissions per day.
- All new patients to Rapid Response will have a completed Emergency Passport as part of their intervention. This will commence from 19/11/18 as a trial and review.

*Admission avoidance at the Front Door*

- A PDSA was carried out in July creating a temporary team from existing resources to measure the potential impact of the change and consider which model would work best. This identified the need for additional capacity of senior doctor; emergency care practitioner and therapist.
- A '6As audit' of inpatients at PRH highlighted that 20% of admissions could have been managed in the community and a significant percentage could have been discharged earlier. This highlighted the opportunities associated with a different model
- Existing capacity (Rapid Response, social worker and SATH therapists) continue to attend the hospital to identify patients whose admission could be avoided

*Shorten Length of Stay*

- Frailty scoring being completed at PRH

**What are the plans for the future?**

Whilst the principles of the service have been agreed, the team will utilise PDSA methodology to test and evolve their approach. This will also help to better assess the impact of the change and which interventions maximise admissions avoidance. Key next actions include:

- Seek agreement for additional staffing to fully implement Frailty at front Door of PRH
- Further improve pathways within ED to maximise potential for admission avoidance
- Continue to develop admission avoidance before the Front Door using PDSAs to maximise

learning and impact
- Monitor impact against the targets

## 5.4 Work stream four: Speciality Review

**Speciality Reviews**

**What is included in this work?**

In addition to undertaking work around healthy lifestyles, community resilience and development of teams to provide care in the community it was agreed that speciality reviews should be carried out to improve care from prevention through to end of life. The initial priorities for action were to consider the respiratory pathway, hypertension and diabetes. These reviews consider information on clinical outcomes (particularly from Right Care), best practice guidance and local intelligence on areas for action. Cross cutting themes are also considered to ensure that a single disease focus is not reinforced and more holistic solutions are considered. The reviews consider all elements of the pathway. This ranges from the promotion of prevention programmes to avoid development of the disease, early intervention, delivery of care and support in end stages of the disease.

**What progress has been made?**

The right care methodology was utilised for each area with the production of project plans and logic models. After considering a breadth of information key areas for action were decided and changes implemented. Some of the progress against those plans are considered below:

**Diabetes**

- An aspirational 'three tier' model of care was developed with local stakeholders including patients.
- Funding was secured from NHSE to implement changes around enhanced patient education and to improve treatment targets
- Additional diabetes structured education classes were commissioned which are now up and running including shorter 'taster sessions'
- A GP incentive scheme was carried out to help improve achievement of the three clinical treatment targets. Most practices achieved their defined goal
- The National Diabetes Prevention Programme commenced in April 2018

**Respiratory**

Telford and Wrekin already had well established respiratory services, with the specialist community teams working well with both practices and acute clinicians.

- Self-Management Coaching and Workshops were commissioned for COPD patients at the greatest risk of admission (as identified by the Respiratory Specialist Nursing teams and GPs). The first workshop started in June 17 provided by the British Lung Foundation.
- IAPT workers were recruited and trained to work as part of the integrated Respiratory Team. Named workers are now aligned to the team to provide LTC specific IAPT support. Initial figures suggest a decrease in admissions after receiving support from the IAPT workers
- These and other actions have helped to reduce costs associated with respiratory admissions (approx. £100k) and the CCG is achieving well in the various performance metrics outlined in Right Care. Whilst Telford and Wrekin are considered to have achieved best practice in many areas, recent Right Care data (November 2018) has identified that there is further opportunities for the CCG to improve. A cross agency group has been established to explore these opportunities further.

**Hypertension**

The main aspirations were to increase the reported to estimated prevalence of hypertension, improve management of blood pressure and as a consequence see a reduction CVD related admissions. During 2017 a range of activities were undertaken which included staff awareness sessions and trialling the use of modern technology in practices to detect problems. There was also a workshop including national organisations (e.g. British Heart Foundation), patient groups, voluntary sector organisations (e.g. the rotary group) and providers. The work around health promotion has continued throughout the year led by the public health team and a successful bid was made to the British Heart Foundation to support the work. This is still seen as a priority area and from here on in will be included in the wider CVD programme described below in future plans.

**What are the plans for the future?**

The most up to date information indicates that the CCG still has some of the poorest CVD related outcomes when compared to its peers from elsewhere in the country and significant opportunities for improvement. Therefore there has been a renewed focus on cardio vascular disease including both diabetes and hypertension with a clear commitment from the CCG to improve health in these areas. An all new comprehensive CVD programme is being launched. A logic model and action plan has been drafted to demonstrably improve performance across these areas. Key actions include:

- Implementation of the 'Bradford Healthy Hearts' programme including a full communication plan and practical changes to achieve medicines optimisation
- Improvement in the management of diabetes within primary care to better meet local need. This will include practices working together to share best practice and introduction of initiatives such as targeted multidisciplinary clinics for those patients most vulnerable
- A more innovative and flexible approach to the delivery of structured education will be taken to ensure it is accessible to target groups
- Improved diabetic foot care

## 5.5 Work stream five: Primary Care Networks

**Primary Care Networks**

**What is involved in this work?**

Refreshing NHS Plans for 2018-19 set out the ambition for CCGs to actively encourage every practice to be part of a local primary care network so that these cover the whole country as far as possible by the end of 2018/19. Primary care networks will be based on GP registered lists, typically serving natural communities of around 30,000 to 50,000. Since publication of the planning guidance NHSE have developed further guidance on definitions and a tool to assess maturity. The following video provides a useful explanation.

https://www.youtube.com/watch?v=W19DtEsc8Ys

**What progress has been made?**

Whilst the term 'Primary Care Networks' has only recently been introduced, as part of Neighbourhood Working and the implementation of the General Practice Forward View, practices have been considering how they can work together more closely. They formed into groupings of four localities across Telford and Wrekin. Both the approach and the extent of change have been quite

different in each of the areas but some progress has been made in all areas. Some examples are outlined below:

- Work across the 7 practices in South East Telford to align the vision, share learning, improve care (e.g. alcohol/substance misuse pathways) and agree practical ways of working together (e.g. production of a single website). The group have also taken steps to create a coherent approach to improve the management of diabetes
- Delivery of 'extended access' on behalf of other practices
- Development of a clear vision for Newport by the two constituent practices who became an early implementer 'Primary Care Home' sites
- Testing of the 'super practice' model by TELDOC achieved through merging a number of local practices. They are currently in the process of systematically unifying processes and practice and have ambitious plans to increase efficiency across the sites. They also have some innovative models of care planned to improve care including speciality based clinics and improved pathways for frail older people

**What are the plans for the future?**

The CCG will work with the practices to explore the notion of primary care networks. To aid this thinking a work shop style meeting will be held with practices. This will help illustrate the different models, the benefits of different ways of working and any national guidance/supporting documentation. It will also provide thinking time to consider whether current groupings are appropriate and define aspirations for the future. It is suggested that groupings of practices are referred to as Primary Care Networks (rather than neighbourhoods) to avoid confusion with wider work. The maturity matrix will be used to assess current performance, which will inform plans to progress work as defined by practices themselves. In the future, primary care networks could be used as a basis for improved governance and planning across the CCG. Strengthened PCNs also form the local bones of a fuller Integrated care system.

## 5. Evaluation of the programme

During the development of the programme, a light touch PMO has been employed to help define projects, set KPIs for each of the work streams and aid reporting. A simple project management methodology has been useful in planning and assessing achievement against those plans. The use of logic models has also been useful to clearly articulate the inputs, outputs and anticipated outcomes.

However, as previously articulated this is a complex programme with multiple activities and stakeholders. In order to consider the impact of the programme overall, the Strategy Unit have been commissioned to produce an evaluation strategy. A logic model forms the basis of this evaluation and was co-produced with the key stakeholders.

It is vital that it is understood that the multiple projects within Neighbourhood Working are cross cutting and contribute to the same outcomes. A whole system understanding and approach is required to assess the true impact on people and measuring projects by individual monetary targets (i.e. reduction in non-elective admissions) is not effective and not an accurate representation of the impact on people. Rather than an over simplified, reductionist approach a more dynamic approach is needed.

1. **What are the revised activity trajectories?**

   In the PCBC a set of planned activity reductions were outlined against each of the known projects. As indicated in the progress report above a number of these have progressed/changed and new projects included. The table below summarises the revised predicted activity and financial reductions associated with each project. There is also an indication of the investment needed to achieve the change. In addition to these reductions, as per the PCBC, the work streams around healthy lifestyles and community resilience will help to reduce the impact of demographic growth. Therefore they are considered as part of employing a 'realistic' growth figure in projections for acute activity.

| | 18/19 | | | | 19/20 | | | | 20/21 | | | | 21/22 | | | | Total impact | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Activity reduction | Financial reduction | Investment | **Net** | Activity reduction | Financial reduction | Investment | **Net** | Activity reduction | Financial reduction | Investment | **Net** | Activity reduction | Financial reduction | Investment | **Net** | Activity Reduction | Financial Reduction | Investment | **Net Financial Reduciton** |
| | | £000s | £000s | £000's | | £000s | £000s | £000's | | £000s | £000s | £000's | | £000s | £000s | £000's | | £000s | £000s | £000's |
| Activity reduction committed to in Pre Consultation Business Case | 883 | 1668 | 1167 | 501 | 428 | 711 | 498 | 213 | 445 | 772 | 540 | 232 | 438 | 723 | 506 | 217 | 2194 | 3874 | 2711 | 1163 |
| **Neighbourhood Schemes in Delivery or with a development plan** | | | | | | | | | | | | | | | | | | | | |
| Diabetes programme | 27 | 52 | 23 | 29 | 24 | 46 | 0 | 46 | | | | 0 | | | | 0 | | | | |
| CVD programme (non elective) | 95 | 180 | 0 | 180 | 89 | 65 | 46 | 19 | 89 | 65 | 46 | 19 | 89 | 65 | 46 | 19 | | | | |
| CVD programme (elective) | | | | | 44 | 84 | 59 | 25 | 44 | 84 | 59 | 25 | 44 | 84 | 59 | 25 | | | | |
| Care Home Support Team | | 117 | | 117 | 19 | 67 | | 67 | 10 | 37 | | 37 | 5 | 11 | | 11 | | | | |
| Development of integrated teams * | | | | | 243 | 462 | 220 | 242 | 243 | 462 | 220 | 242 | 243 | 462 | 220 | 242 | | | | |
| Frailty Front Door (before the front door) | | | | | 91 | 237 | 166 | 71 | 91 | 237 | 166 | 71 | 91 | 237 | 166 | 71 | | | | |
| Frailty Front Door (at the front door) | | | | | 205 | 534 | 320 | 214 | 69 | 178 | | 178 | | | | 0 | | | | |
| Respiratory | 110 | 209 | 8 | 201 | | | | | | | | | | | | | | | | |
| **Total Schemes in Progress** | **232** | **558** | **31** | **527** | **715** | **1495** | **811** | **684** | **546** | **1063** | **491** | **572** | **472** | **859** | **491** | **368** | **1965** | **3975** | **1824** | **2151** |
| **Balance - Schemes in development** | **651** | **1110** | **1136** | **-26** | **-287** | **-784** | **-313** | **-471** | **-101** | **-291** | **49** | **-340** | **-34** | **-136** | **15** | **-151** | **229** | | | |
| **Examples of schemes in early development** | | | | | | | | | | | | | | | | | | | | |
| Urgent Care Under 75's Project | | | | | | | | | 134 | 198 | 138 | 60 | 134 | 198 | 138 | 60 | 268 | 396 | 276 | 120 |
| Respiratory Phase 2 | | | | | | | | | 41 | 59 | 0 | 59 | 41 | 59 | 0 | 59 | 82 | 118 | 0 | 118 |

In addition to a reduction in the number of admissions, projects may also contribute to a reduction in length of stay. Further work needs to be carried out as certain schemes have this as an explicit aspiration and when the impact is combined could lead to a small reduction in the number of beds needed for Telford and Wrekin. In particular, the care home project has already shown to reduce the length of stay for patients who are admitted from the 6 participating homes by 2 days. The frailty front door will also reduce length of stay by supporting discharge planning from the point of admission.

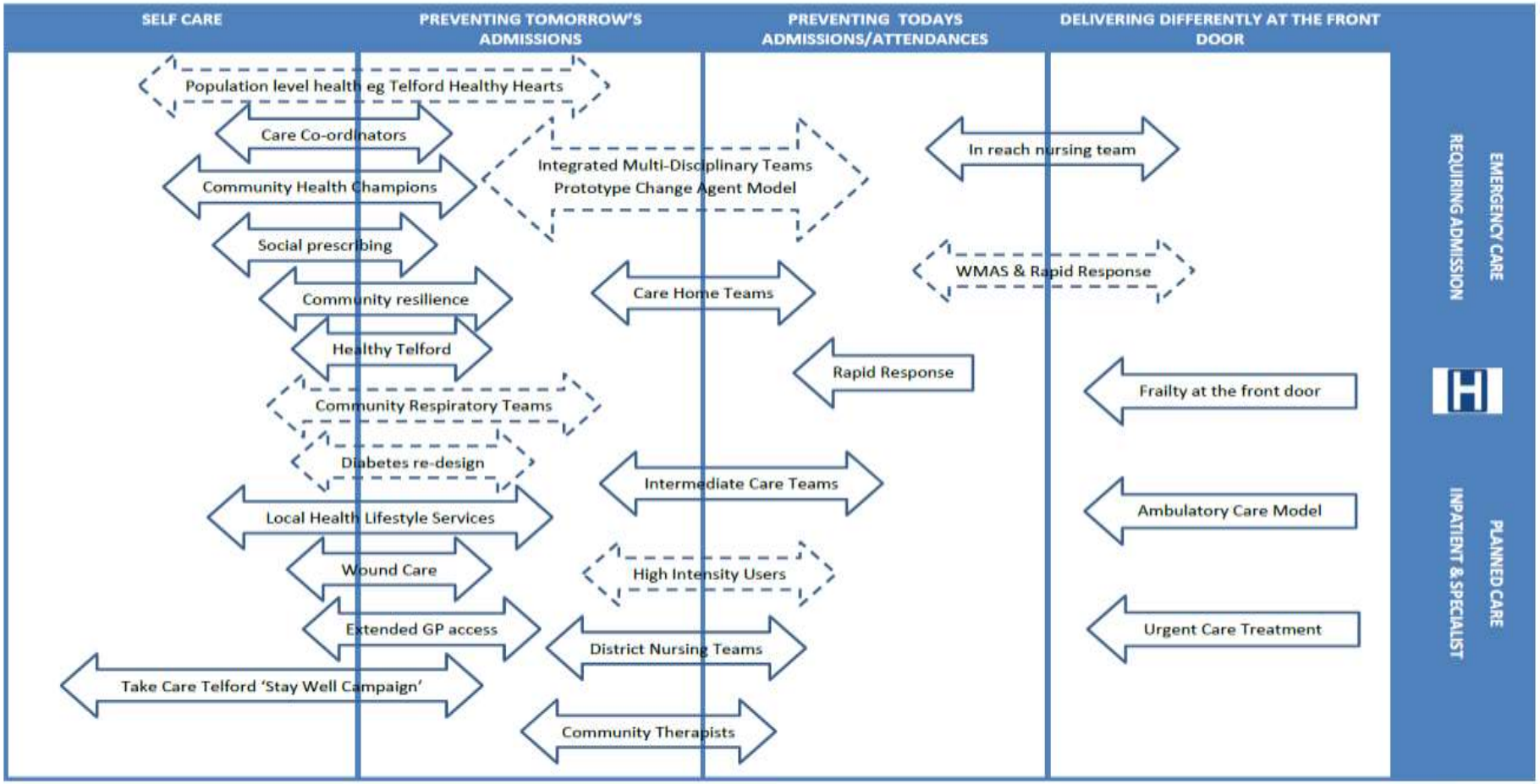
The finance lead for STP is currently creating a dynamic financial tool which will assist in the on-going work. It will allow assumptions to be changed and calculations revised as implementation commences and testing begins.

## 2. Conclusion

Neighbourhood Working across Telford and Wrekin has progressed significantly over the past 18 months. Relationships have been established, a series of developments have begun, new teams introduced and plans created to increase the pace of change in community based solutions. Appendix One describes the work in the context of demand reduction on acute care based on a multifaceted approach which addresses ill health across a continuum with an emphasis on prevention.

Together all these programmes have and will strengthen a place based approach but the momentum needs to be maintained; the programme needs to owned and driven from the top of organisations as well as evolving from the community and front line staff. A greater systems wide approach is also required to maximise the opportunities and actively remove some of the barriers to change created by isolated organisational working. Delivering differently in the community will require closer working with acute physicians to manage more individuals closer to home supported by community systems. Together these areas of work will help to establish an identity for Telford and Wrekin and create foundations to move towards a much more innovative integrated model of care across the health economy.

Appendix 1




**OUTCOMES**

1. Communities will be connected and empowered
2. People will stay healthy longer
3. Clinical Outcomes will be optimised for patients
4. Services will be available closer to home
5. People will feel support during times of crisis (both physical and mental health)
6. People and their carers will be supported at the end of their lives

**NEIGHBOURHOOD PROGRAMMES**

1. Encouraging Healthy Lifestyles (targeting obesity, smoking & alcohol)
2. Community Resilience
3. Direct care in the community (inc Integrated Teams, Care Home Team & I C beds)
4. Specialty reviews (inc diabetes)
5. Primary Care Networks

V1.2