



Integrated Care System

Shropshire, Telford and Wrekin

**Local care –
Our neighbourhood approach
A system wide nomenclature**

July 2024

Purpose of this document

- The purpose of this document is to:
 - Enable a consistent and meaningful system wide nomenclature for Local Care
 - Enable common descriptors and visual representations of our STW wide neighbourhood approaches including neighbourhood teams, community navigation and community hubs
- This document is intended for internal use
- This document has been discussed at the Local Care Board, Shropshire Integrated Place Partnership and Telford & Wrekin Integrated Place Partnership. This has led to a number of enhancements, leading to an agreed system set of materials as at end of June 2024.



Shropshire, Telford and Wrekin's local care neighbourhood approach

Working together to improve health and wellbeing

- **Our neighbourhood approach** is about joining up local services in the community and fostering community connections so that everyone in a neighbourhood can thrive. Providing more services closer to home and taking a neighbourhood approach is at the heart of our wider vision to improving wellbeing and preventing illness and poor health.
- In Shropshire, Telford and Wrekin we are taking a person-centred neighbourhood approach to care as we have listened to and understand that people require joined up care and support as close to home as possible. We know that local areas have different needs and our neighbourhoods will develop in a tailored way to reflect this, e.g. what's needed in Lawley in Telford, may not be the same as the priorities for Ludlow in South Shropshire.
- By adopting a data driven approach and being focused on understanding local health needs, neighbourhood approaches will contribute to tackling health inequalities



Local care - our neighbourhood approach

- In neighbourhoods, we are committed to fortifying existing networks while forging new connections and fostering collaboration. By bringing together teams and services across health, care, the voluntary and community sector, businesses, and other key partners - including police, housing, and education - we aim to provide proactive, person-centered care.
- Our collective efforts are geared towards better addressing the diverse needs of the local community, ultimately striving to build thriving neighbourhoods that cater to the unique requirements of the local population.
- Various teams, sometimes referred to as 'a team of teams,' will operate within neighbourhoods with a range of different remits, for example multi-disciplinary teams (MDTs) supporting people with specific needs, one example is an MDT approach for people with frailty and multiple long-term conditions, as well as specialist teams focused on tackling local issues such as widening the range of activities available for local children.
- Through resource pooling and information sharing, these teams can streamline access to services and provide more proactive, preventative and personalised approaches.

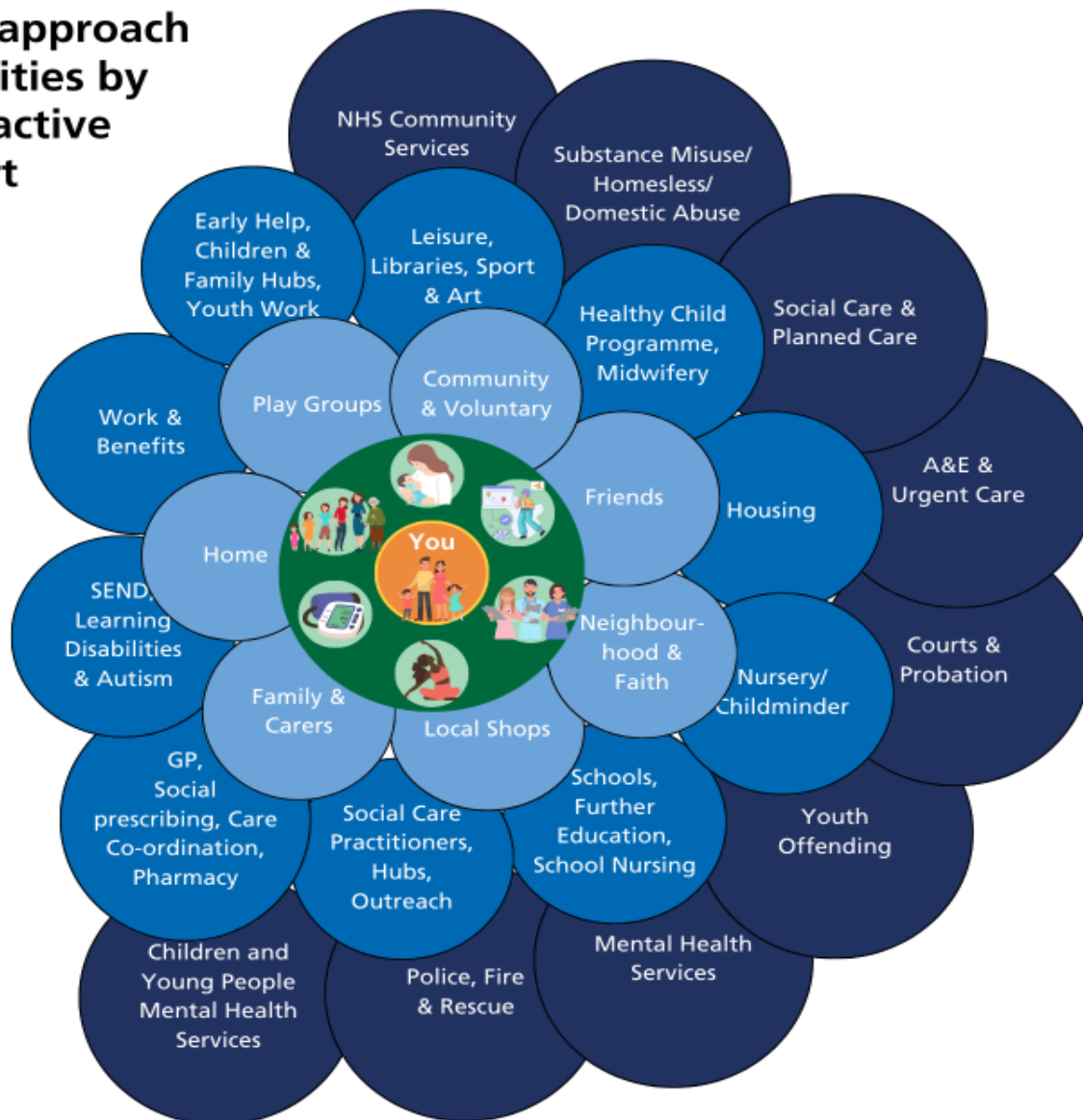


A visual concept of our neighbourhood approach

Our local care neighbourhood approach will cultivate thriving communities by focusing on collaboration, proactive healthcare, and holistic support

Our aims are to:

-  Improve outcomes for children, young people, and families.
-  Promote early diagnosis and prevent avoidable illnesses in the first place.
-  Support people of all ages with self-care and managing long term conditions.
-  Implement person-centred multidisciplinary care approaches.
-  Achieve a greater emphasis and use of social prescribing.
-  Ensure people can access the right help, at the right time, in the right place within the local community.



Our neighbourhood approach could include:

Collaborating with our residents and local communities to:



1. Improve outcomes for children, young people, and families



2. Promote early diagnosis and prevent avoidable illnesses in the first place



3. Support people of all ages with self-care and managing long term conditions



4. Implement person-centred multidisciplinary care approaches



5. Achieve a greater emphasis and use of social prescribing



6. Ensure people can access the right help, at the right time, in the right place within the local community

These initiatives collectively aim to cultivate thriving communities by focusing on collaboration, proactive healthcare, and holistic support

'Teams of teams' working in neighbourhoods

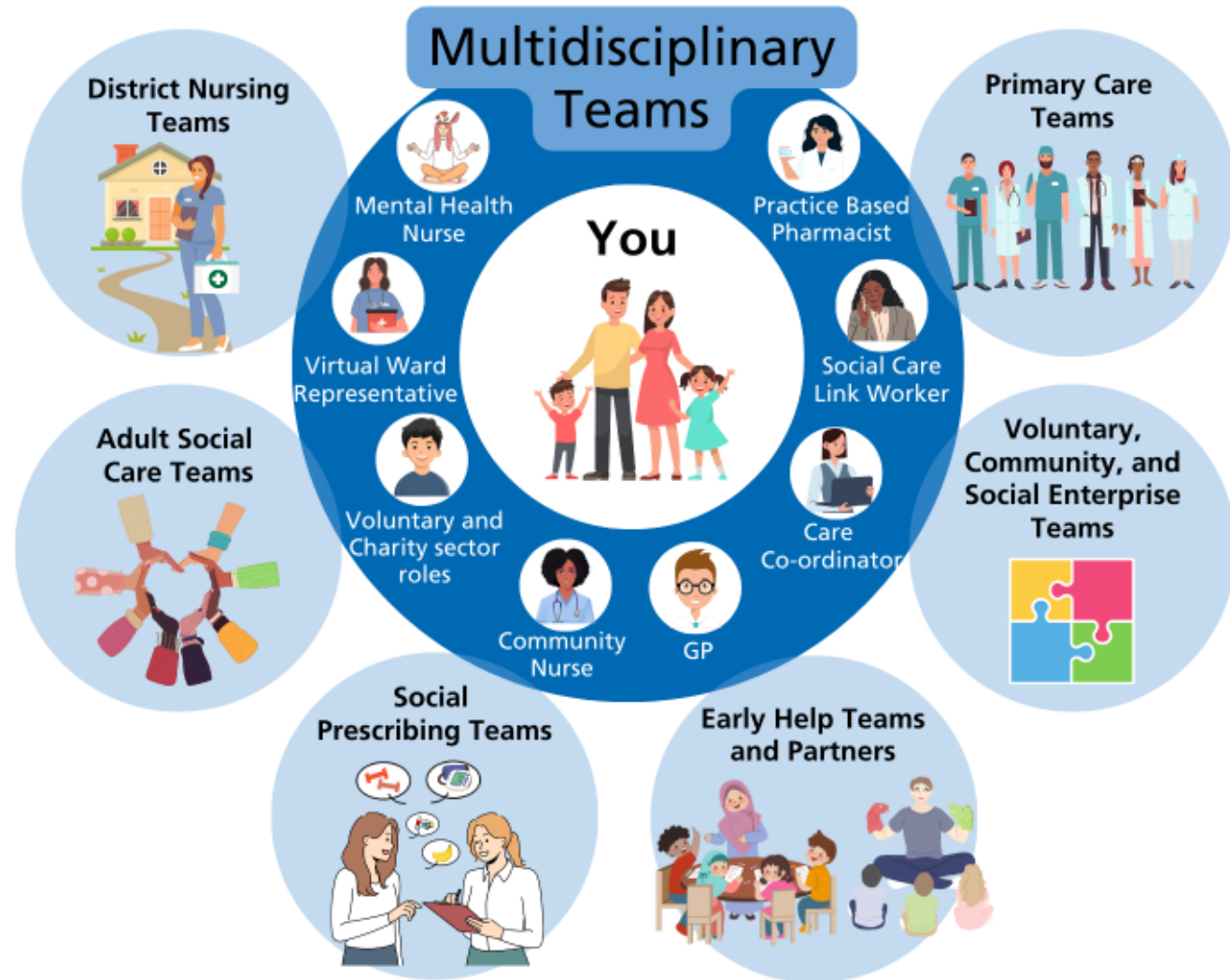
'Teams of teams' of local people, voluntary and community sector, health, education and care services coming together to support the local community – this can involve people caring for individuals or groups of people.

Some characteristics of 'Teams of teams' include:

- In a neighbourhood, multiple teams can form and change over time. People might be part of more than one team.
- Some teams focus on supporting specific needs, such as supporting people with frailty and multiple long-term conditions to live as well and independently as people
- Other teams may have wider social objectives that reach larger groups – e.g., providing local activities for children and families
- Teams that bring together health and care professionals are intended to result in more personalised, joined up, and proactive person-centred.
- **There is no limit to the number of teams – anyone can create a team!**
- 'Teams of teams' is not only about professionals working better together; its' about empowering residents to come together to create thriving communities.

'Teams of teams' working in neighbourhoods

'Teams of teams' work in neighbourhoods, they are not restricted by geographical boundaries and link together providing personalised care, centred round individual needs.



Neighbourhood Multidisciplinary Teams (MDTs)

The Multidisciplinary Teams (MDTs) should include all professionals who are required to meet the needs of the individual from across the system, including partners from the social and voluntary sectors.

- The MDT should be tailored to the individual's requirement and could potentially encompass general practitioners, district nurses, therapists, mental health specialists, voluntary sector representatives, social care workers, and other municipal services. Some MDTs may include care-coordinators, case managers, social prescribers or health coaches dependent on the needs of local people.
- They are interconnected with numerous support organizations and specialized services, effectively forming 'teams within teams'.

The MDT's role is to agree the **Personalised Care and Support Plan (PCSP)** and then plan, coordinate and deliver a package of care and support for the individual.

Different MDTs will provide proactive and person-centred care for different individuals such as those with adults with frailty and multiple long-term conditions and those who are at risk of developing preventable illnesses.

At its core, it's about prioritizing residents in Shropshire, Telford, and Wrekin, placing them at the forefront of our efforts.



Neighbourhood Multidisciplinary teams (MDTs)



Impacts

- People are often supported separately by different parts of the health and care system. As a result, residents and professionals sometimes find it difficult to know what support is available and how to get help. MDTs can help to co-ordinate that support and link up services.
- By sharing resources and information and focusing on the needs of the person, the teams can work together more collaboratively to simplify and streamline access to services, reducing duplication
- By focusing on the needs and goals of the person, multi-disciplinary care teams will meet people's needs in a holistic way rather than treating specific complaints or conditions in isolation.
- The joined approach aims to deliver better coordinated, more proactive and person-centred care at a local level that will help to keep people safe and well in their own local surroundings.
- For people with frailty and long-term conditions, this approach can help to improve functional independence and quality of life, and as a result help to avoid unnecessary hospital admissions, enable early supported discharge, and avoid premature admission to long-term residential care.
- For staff, the opportunity to work as part of integrated multi-disciplinary teams focused on the needs of residents can be empowering and rewarding, with staff feeling more empowered and supported. This can lead to potential improvements in job satisfaction and attracting and retaining staff.



Community hubs and navigation

- **Community hubs** offer a range of services to the local community including signposting to other facilities and services. This could be one building, or a variety of different public spaces/community buildings that offer a space for teams to support people individuals or groups access services or navigate to other services in the local area.
- **Community navigators** are people who can help you find out what support is available and can provide assistance to help people access these services.



COMMUNITY HUB VISUAL

Example 1A – multiple facilities; connected services

'Community hubs provide a range of health, care and wellbeing services
- a place where 'teams of teams' can come together to connect'



COMMUNITY HUB VISUAL

Example 1B – multiple facilities; connected services

'Community hubs provide a range of health, care and wellbeing services
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COMMUNITY HUB VISUAL

Example 2 co-located services in a hub location

**'Community hubs provide a range of health, care and wellbeing services
- a place where 'teams of teams' can come together to connect'**

