NHS Shropshire, Telford and Wrekin

NHS Shropshire Community Health NHS Trust

NHS The Shrewsbury and Telford Hospital NHS Trust

NHS Midlands Partnership NHS Foundation Trust
A Keele University Teaching Trust

Primary Care Networks

healthwatch Telford and Wrekin

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TELFORD & WREKIN
TOGETHER
MAKING A DIFFERENCE
CHANGING LIVES

Telford & Wrekin Integrated Place Partnership (TWIPP)

Priority Pack

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Priority areas for 2024-2026

1. **Supporting General Practice** by working together to reduce and manage demand for GP services/appointments

2. **Improving all-age mental health services and support** (prevention, early intervention and specialist services)

3. **Healthy Ageing - preventing, reducing and delaying frailty**

Sources of evidence:

- JSNA
- STW Big Conversation 2023
- NHS GP Experience Survey
- Healthwatch Telford and Wrekin GP Access Report
- Telford & Wrekin Council's Resident's Survey 2023
- Health & Wellbeing Strategy Consultation 2023
- Annual Public Health Report 2024
- Other strategy development consultations
- Experts by Experience/ group feedback
- Elected Members feedback from conversations with constituents
- Scrutiny, Health and Wellbeing Board and Integrated Care Board discussions
- NHS England

Priority area 1: Supporting General Practice

What is the evidence telling us?

- Demand on GP services is high - 9% increase in appointments in General Practice since pre-pandemic (ICB, Dec 2023 report). Not all appropriate demand.
- Inequality of access and quality across Telford and Wrekin. From the 2023 GP Patient Satisfaction Survey, results varied from 5% of people find it easy to get through to someone on the phone to 80%. Similarly, those reporting good experiences of GP practices varied from 42% to 91% across the practices.
- Impact on people – feedback from residents through various evidence routes (see previous slide) not only highlights how important it is to them but the impact of not being able to access good quality sustainable general practice is significant.
- Impacting on acute services – if people think they cannot get a GP appointment, they go elsewhere such as to A&E. In STW, we have some of the most stretched A&E departments in the country, impacting on waiting times and ambulance delays. (ICB, Dec 2023 report)
- People want joined up, high quality, accessible health services
- Significant opportunities for health and care integration across place to support improvements. Including but not limited to:
  - Integrated Neighbourhood Teams based on a proactive care model
  - Community Prevention approaches (e.g. Live Well Hubs)
  - Prevention and early intervention services
  - More care closer to home
  - Supporting residents to understand what services are available and how to access them in their community

"Once you manage to get into the surgery, the treatment/care is excellent"

"Saturday & late evening phone appointments have also been very helpful"

"Waiting times must be reduced"

"Had to go 30hours in A&E with pneumonia because I … can't get to speak to a dr"

Priority area 2: All age mental health services and support

“Early help is needed”

What is the evidence telling us?

- Premature morbidity in adults with severe mental illness is worse in TW than England average. The suicide rate in the borough for 2019-21 (11.4 per 100,000) was similar to the England average (10.4) but was the highest rate recorded for the borough since 2012-14.
- The rate of pupil suspensions at secondary school is higher than the national average (T&W rate of 26.2 compared to England rate of 14.0) (source DfE LAIT Tool 2021/22)
- Residents are reporting, through various routes mentioned in slide 3, a poor experience (pre-specialist service active involvement)
- Impact of Adverse Childhood Experiences and the impact of the pandemic on mental health is significant.
- Concerns raised around:
  - Accessibility
  - Waiting lists and availability of appointments
  - Support before reaching crisis point not available
  - Providing more services locally
  - Lack of awareness of how to manage own mental health
- Significant opportunities for health and care integration across place to support improvements. Including but not limited to:
  - Mental health prevention and early intervention services for all ages
  - More support/care closer to home
  - Role of VCSE
  - Supporting residents to understand what services are available and how to access them in their community

“It should be easy to access mental health services”

“Lockdown causing isolation and now the cost-of-living crisis and other global events together clearly affecting their mental health and emotional wellbeing and their motivation and hopes for the future”

“There is more support that I am looking for but it is hard to find and I don’t drive or use buses...”

Potential priority area 3: Healthy Ageing (Frailty)

What is the evidence telling us?

- Frailty is generally characterised by issues like reduced muscle strength and fatigue. Around 10% of people aged over 65 live with frailty. This figure rises to between 25% and a 50% for those aged over 85. Frailty (rather than age) is an effective way of identifying people who may be at greater risk of future hospitalisation, care home admission or death.
- TW Population of 65+ increased 35.7% since the previous census (this was the largest increase in the West Midlands and one of the largest in England). 14.9% of those 65+ reported they had bad or very bad health.
- 30% of people aged 65 and over will fall at least once a year. For those aged 80 and over it is 50%. They are the number 1 reason older people are taken to A&E.
- People want to stay as independent as long as they can and to be able to remain living in their own home.
- Concerns raised around:
  - Access to primary care services for health checks and mental health support
  - Access to support groups locally
  - Access to health screen and vaccinations locally
  - Support to age well
  - Risk of loneliness and isolation
  - Lack of joined up health and care
- Significant opportunities for health and care integration across place to support improvements. Including but not limited to:
  - Multi-disciplinary approaches using risk stratification and population health management approach to target those most at risk
  - Role of VCSE
  - Falls pilots and pathways

Community-centred approaches - prevention and reducing demand on care and support services

Strengthening communities

- Use of data and insight
- Place based projects (health inequalities and prevention)
- Live Well Hubs

Volunteer & peer roles

- Health Champions
- Feed the Birds (loneliness & isolation)
- Cancer Champions
- Blood Pressure Champions

Collaborations & partnerships

- TWIPP
- Ageing Well Strategy
- All-age Carers Strategy
- Mental Health Strategy
- Excess weight prevention
- Physical Activity

Connecting people to community resources & practical help

- Making Every Contact Count training / staff health & wellbeing
- Social Prescribing
- Healthy Lifestyles Services (Independent Living Centre & in the community
- Calm Cafes
- Falls Prevention 'Moving On' classes
- CVS
- Age Concern
- Low level support for people leaving hospital

Example: Development of local 24/7 supported accommodation

- No provision locally for people with mental health needs resulting in out of area placements
- Multi-agency work to develop local option (including commissioners, housing, a local developer, operational health and care teams)
- Rehab teams involved in the local delivery of care and support
- Multi-agency approach to prioritising placements whilst ensuring compatibility and reducing risk

- **Impact for residents:**
  - ✓ Moving back to telford, closer to family, friends and support network
  - ✓ Have their own front door
  - ✓ Develop daily living skills and increasing independence in their own home

- **Additional community support;**
  - ✓ Re-location of a Calm Café to the same locality to enable residents to access this preventative support and access other community services
  - ✓ Connections to the Donnington Energize project which will provide residents opportunities to increase their levels of physical activity to secure wider health benefits

Acura Living - White Cottage Apartments (youtube.com)

Example: Community Preventing Falls through Exercise

- Public health funding to support the delivery of weekly ‘Moving on’ sessions in the community
- Mary joined the Falls Prevention class following an unsuccessful knee operation. Mary’s walking has now improved, and she regularly attends the local Moving On session. She can now walk 2-3 miles at once; she volunteers and leads local walks close to where she lives.

“I feel good about the classes, they keep me going and allow me to do the things I do”

Telford’s NEW over 50's gentle exercise classes are here!

Classes start across Telford from **April, 8 2024** and only **£3 per class** or buy 4 classes for £10

Find out more information at **fit4allonline.co.uk/movingon**

For further information on TWIPP please contact: Sarah Downes, sarah.downes@telford.gov.uk