TELFORD & WREKIN COUNCIL

HEALTH AND WELLBEING BOARD – 26 SEPTEMBER 2019

INTEGRATION OF HEALTH AND SOCIAL CARE – TELFORD'S 'PLACE' APPROACH AND PROGRESS

REPORT OF ASSISTANT DIRECTOR OF ADULT SOCIAL CARE, TWC & DEPUTY EXECUTIVE INTEGRATED CARE, CCG

LEAD CABINET MEMBER – CLLR ANDY BURFORD

PART A) – SUMMARY REPORT

1. SUMMARY OF MAIN PROPOSALS

1.1. 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.

1.2. Following the release of the NHS Long Term Plan in January 2019, Neighbourhood Working was reviewed to ensure it aligned to the Long Term Plan as well as the current and future needs of Telford and Wrekin. Consequently, 'Neighbourhood Working' evolved into the 'Integrated Place Programme', including the expansion of the Neighbourhood Steering Group into the Telford & Wrekin Integrated Place Partnership (the membership of which now includes senior representative from Shrewsbury and Telford Hospital Trust, Shropshire NHS Community Trust, Midlands Partnership Foundation Trust and Primary Care Network clinical directors) to drive the directional change to delivering community based support to the people living within the boundaries of Telford and Wrekin.

1.3. This report outlines the objectives of Integrated Place Programme, highlights the progress made so far and summarises the next steps for this programme over the next 6-12 months.

2. RECOMMENDATIONS

The Health and Wellbeing Board is asked to:

2.1 Note the progress set out in this report and request a further update report in March 2020.

2.2 Endorses the Integrated Place Programme and its objectives for 2019/2020.

3. SUMMARY IMPACT ASSESSMENT

COMMUNITY IMPACT	Do these proposals contribute to specific Co-operative Council priorities?	
	Yes	• Protect and support our most vulnerable children and adults • Support communities and those most in need and work to give residents access to suitable housing • Improving health & wellbeing across Telford and Wrekin)
	Will the proposals impact on specific groups of people?	
	No	The programme of work will impact on all residents.
TARGET COMPLETION/DELIVERY DATE	Ongoing programme of work aligned to the Sustainability and Transformation Partnership (STP).	
FINANCIAL/VALUE FOR MONEY IMPACT	Yes	The Council's contribution to the delivery of this programme is met from within existing resources, including the Better Care Fund and the Public Health Grant. It is anticipated the Council will need to find further savings anticipated to total £25m over the next two years, 2020/21 and 2021/22 and this may impact on the funding for this programme. *(TS, TWC 16/8/19)* NHS Telford and Wrekin CCG contributes to the support of this programme from within existing management costs. The delivery costs of the programme are within the current NHS Shropshire Community Trust Budget and the health contribution to the Better Care Fund and Primary Care Budgets. Whilst there are no plans to disinvest from commissioned services for 2019/20 HWBB will be aware that as a system further savings are required to maintain financial sustainability going forward. *(TJ, CCG, 01.08.2019)*
LEGAL ISSUES	Yes	A duty of the Health and Wellbeing Board under Section 195 of the Health and Social Care Act 2012 is to encourage integrated working in the provision of health and social care services and in particular to provide such advice, assistance or other support as it thinks appropriate for the purpose of encouraging arrangements to be made

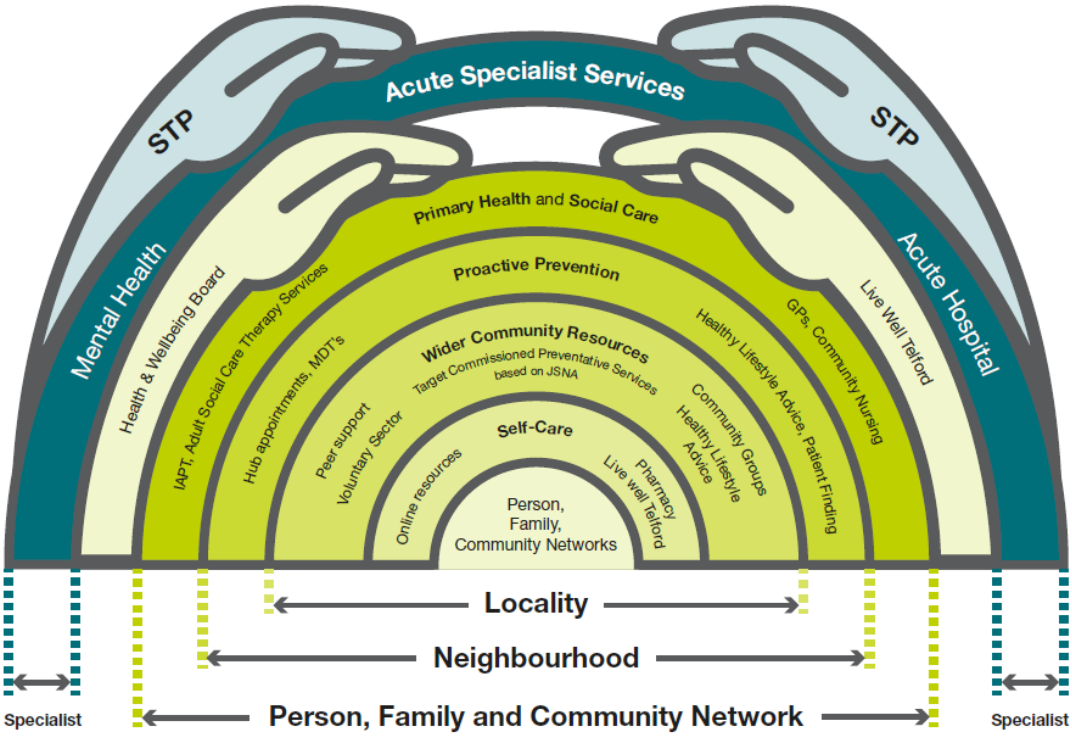
		under Section 75 of the National Health Services Act 2006 [2006 Act] The Board may also encourage commissioners of health-related services in its area to work closely with the Board and encourage commissioners of any health or social care services and commissioners of health-related services in its area to work closely together Accordingly, the proposals in respect of the Telford & Wrekin Integrated Place Programme set out in this report will assist the Board in meeting its legal obligations. This continuing commitment to integrated working is also a requirement of the Board's Terms of Reference and links to the Joint Health and Wellbeing Strategy prepared under Section 116A of the Local Government and Public Involvement in Health Act 2007 *(KF, TWC 05.09.2019)* The NHS Long term plan published Jan 2019 requires the NHS to move towards a new model of care .GP practices – typically covering 30-50,000 people – will be funded to work together to deal with pressures in primary care and extend the range of convenient local services, creating genuinely integrated teams of GPs, community health and social care staff. New expanded community health teams will be required under new national standards to provide fast support to people in their own homes as an alternative to hospitalisation, and to increase NHS support for people living in care homes. *(TJ, CCG 01.08.2019)*
OTHER IMPACTS, RISKS & OPPORTUNITIES	Yes	There are opportunities relating to sustainability and improved efficiencies through delivering on the integration agenda.
IMPACT ON SPECIFIC WARDS	Yes	The programme of work impacts across the population of the Borough and includes targeted activity within those wards reporting higher levels of health and wellbeing need and inequalities.

PART B) – ADDITIONAL INFORMATION

4. BACKGROUND

4.1. 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' encompassed all elements of community based developments including volunteering, development of community health and social care 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 hospital and residential care. This will be achieved through primary prevention, strengthened community support and by taking a more proactive and collaborative approach across the system.

4.2. Following the release of the NHS Long Term Plan in January 2019, Neighbourhood Working was reviewed to ensure it aligned to the Long Term Plan as well as the current and future needs of Telford and Wrekin. Joint working between the Council and CCG led to the development of the following high level model that was based around 'place' and enabled further integration of services/teams.



4.3. Consequently, 'Neighbourhood Working' evolved into the 'Integrated Place Programme', including the expansion of the Neighbourhood Steering Group into the Telford & Wrekin Integrated Place Partnership (now includes providers and Primary Care Network chairs) to drive the directional change to delivering support to the people living within the boundaries of Telford and Wrekin.

4.4. The Telford & Wrekin Integrated Place Programme is accountable to the Telford & Wrekin Health and Wellbeing Board (HWB) and the Shropshire and Telford & Wrekin Sustainability and Transformation Partnership (STP). Please see Appendix A for a copy of the current governance structure of the STP.

4.5. Whilst the Integrated Place Programme is not accountable to the Safeguarding Partnership, it does include aspects of work that deliver the prevention agenda for safeguarding and as such will engage with them when required.

5. OUR STRATEGIC APPROACH

5.1. The Integrated Place Programme is a complex set of activities bringing together all aspects of community centred approaches under the same strategic vision and principles of working to achieve the following outcomes:

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

5.2. To ensure there was a consistent narrative across the Borough, a strategic plan for the programme was developed and agreed at the Telford & Wrekin Integrated Place Partnership by all members. This plan has 6 strategic priorities for the next year:

- **Building Community Capacity and Resilience** - strengthening communities through community development, asset based methods, developing social networks, volunteer and peer roles, developing collaborations and partnerships and improving access to community resources.
- **Prevention and Healthy Lifestyles -** support people to stay healthy with a combination of individual and whole population approaches.
- **Early Access to Advice and Information** - integrated approach to information and advice, including use of the voluntary sector, online directories, development of locality hubs and an independent living centre.

- **Integrated Care and Support Pathways (including out of hospital)** - all organisations in Telford and Wrekin delivering services which connect and empower people to stay healthier for longer and preventing unnecessary admission to hospital.

- **One Public Estate** - developing and using existing and new estate to enable delivery of integrated support.

- **Governance** - shared local commitment, leadership, accountability, performance metrics and governance.

5.3. Please see Appendix B for a copy of the Strategic Plan 2019/20 which details more information on the direction of the travel for the programme.

6. CURRENT WORK PROGRAMME

6.1. Building Community Capacity and Resilience

What is included in the work?

The aim of this priority is to build on the assets within our communities, voluntary organisations and the Council to help create confident, connected and resilient communities.
 	
To deliver this the following areas of work have been agreed:
• Information Advice and Guidance to Voluntary, Community and Social Enterprise (VCSE) Sector;
• Individual Support to VCSE Organisations;
• Delivery of Council Funded Grant Programmes;
• Identifying gaps in community provision with ASC colleagues including:
  ○ Community Connectors
  ○ Flexible Volunteering
  ○ Personal Assistants;
• Receiving referrals from ASC and Children's Services for Community Support; and
• Volunteering including:
  ○ Lead on Council policy and practice for volunteering
  ○ Manage number of Council volunteering schemes
  ○ Develop new volunteering schemes
  ○ Support Council services and Voluntary Sector to develop volunteering
  ○ Promote volunteering

What progress has been made?
• Community Business Support has been transitioned into the Community Participation Team, allowing for an increase in appropriate provision within the community that will help reduce the pressure on health and social care services.

- **Information, advice, guidance and support to the Voluntary, Community and Social Enterprise (VCSE) sector**:
  - The TWC Community Support website provides a range of online toolkits that assist the start–up and development of community-based provision. 680 individuals accessed these toolkits in 2018/19, an increase of 419 from the previous year.
  - 84 VCSE groups were provided with individual tailored support and advice during 2018/19 to help the development of their community provision, and
  - 23 new VCSE groups received support (in 2018/19) to set up a range of provision that provide support for older people, people with mental health difficulties, people with disabilities, children and families and peer support groups.

- Facilitated **3 community 'Health Matters' workshops** to raise awareness of health inequalities, to support the community to identify health and well-being priorities and to map and agree that collective action we can take to make improvements.

- Delivery of **Council funded grant programmes** - in 2018-19
  - £2m was allocated through Telford@50
  - 2 programmes of events grants - £50,000
  - 2 capacity fund grants were launched for the growth of community-based activities and services that benefit health and social care projects:
    - Get Started – 13 groups, £15,741
    - Develop – 8 groups, £63,180
  - Councillors' Pride Fund - £54,000 support social community projects and £54,000 supported environmental community projects.
  - Community buildings and facilities grants:
    - £234,000 to small grants
    - £750,000 to large grants

- Developed two rolling course **programmes to help target more people into care work**, in particular Personal Assistants (PAs). 22 attended the introduction to care courses and 2 are now employed. 7 achieved Level 1 'Preparing to Work in Adult Social Care' of which 4 progressed to further training, 1 is in part-time work and 2 are volunteering. 93 PAs have been recruited.

- A volunteer scheme (**Community Connectors**) was developed to recruit, train and DBS check local volunteers who are matched with clients who are socially isolated and/or lonely and/or lack self-esteem/confidence. 40 referrals were received, but several challenges outweighed the positive outcomes - the scheme is currently being revised and will be re-launched in autumn 2019.

- **Hoarding Support and Prevention** – following the TW Safeguarding Adult Board launching a new Hoarding policy and associate

procedures in 2018 a community based hoarding support project and service was set up. 10 individual cases are receiving support. 2 cases have had successful outcomes with individuals being able to leave long term (12 weeks) hospital respite care and return home as well as receiving therapeutic support to prevent future hoarding behaviour.

- **Support provided to Adult Social Care and Children's Services** for community support – 74 enquires with 90% able to support with information about community-based provision that could assist clients.

- **Volunteering:**
  - Co-ordinate and Chair the Volunteer Manager's Forum that focuses on corporate policy and practice through the year.
  - Managing volunteers across the Borough including: Health Champions, Feed the Birds, Community Connectors, Street Champions and Snow Wardens.
  - Ongoing support is provided to the volunteers through training, communications, risk assessments, shared supervision meetings and evaluation.
  - At the end of 2018/19 the overall total of Council Volunteers stood at 1,412 (up from 942 the previous year).
  - In 2018/19, 10 teams were supported with developing/managing new volunteer schemes to support Council Services.
  - Volunteer Telford website has 76 organisations offering 158 volunteering opportunities. The total number of hits on the website in 2018/19 was 22,416, an average of nearly 2,000 per month.
  - Volunteering is promoted throughout the year in a variety of ways:
    - Ongoing through social media - on the Volunteer Telford Facebook page and Twitter account.
    - The Council's Volunteer web pages
    - Volunteer Telford website
    - National Volunteers Week – a borough wide campaign ran annually the first week of June
    - In the weekly Community Participation E Newsletter
    - Targeted recruitment at events- the focus this year being on younger people (under 18s), people with physical and learning difficulties and job seekers.
    - Other themed activities – for example the Great British Spring Clean campaign - March/April 2019

Case Study: Feeding the Birds

"*Volunteering leaves me with a feeling of fulfilment and knowing that we are benefiting someone else life. Seeing the vast improvement in Freda who suffers with dementia, depression and anxiety is outstanding, over time we have built a great relationship and the admiration Freda has for my daughter is wonderful*."

Click here to read the full story

What are the plans for the future?

- Further develop and build the Personal Assistant market
- Launch themed grant promotion rounds based on the borough's needs (first themed round launched Summer 2019)
- Development of flexible volunteering schemes to support Pathway '0' (Pilot scheme operational by September 2019)
- Development of Youth Health Champion volunteer programmes (recruitment of first Youth Health Champions in September 2019)
- Re-launch Community Connectors (Autumn 2019)
- Supporting VSCE groups to grow capacity (completion by March 2020)
- Taking forward the actions from the local Call to Action: Loneliness Conference including developing a local campaign and maximising the continuation of the Council's cultural offer (completion by March 2020)
- Development of local libraries as hubs for health and wellbeing (completion by March 2020)

6.2. Prevention and Healthy Lifestyles

What is included in the work?

The aim of this priority is to support people to stay healthy with a combination of individual and whole population approaches.

To deliver this the following areas of work have been agreed:

- Mobilisation and launch of the British Heart Foundation community blood pressure testing programme;
- Delivery of the NHS Diabetes Prevention Programme;
- Delivery of the Macmillan Living with and Beyond Cancer Programme;
- Development of the Healthy Lifestyle Advisor Role as a link worker for social prescribing;
- Rolling out Making Every Contact Count Training to Adult Social Care and GPs; and
- Delivery of a whole system approach to reduce childhood and adult obesity.
- Implementation of 'Telford Healthy Hearts' aimed at maximising medical management of risk by primary care in cardiovascular disease combined with promotion of self-care and healthy lifestyle choices.

What progress has been made?

- The **community blood pressure testing programme** has commenced. The programme launched in April 2019, initially offering testing in-house to Council staff at the main office sites and extending to off-site employees. Testing is now being carried out in community venues, at community events, and through a planned programme with contractors such as Veolia, Ideverde, local employers such as Ricoh and other partners (e.g. Police). My mid-august they had tested 820 people, with almost 100 of these supported to carry out home testing

using a loaned monitor. Of those who needed home monitoring, about half have a final result in the normal range, and half show sustained high blood pressure – these people are then directed to their GP. An additional 6 people had an initial result which require immediate medicate advice or intervention.

- The **Healthy Lifestyle[1] Advisor** role has been further developed and they are now also the 'link worker' for social prescribing. This will result in increased capacity within general practice and the community to deliver social prescribing – connecting patients to community based support and reducing demand on services.

Case Study: How I went from playing PC games 12 hours a day to a budding triathlete

"*By making small changes in his lifestyle, local resident Shane is managing to turn his life around*"

Click here to read the full story

Shane reaching the finishing line of his first triathlon

During 2018/19 The Healthy Lifestyle Advisors have received 1803 referrals and 1544 Personal Health Plans were agreed with clients. 64% of these achieved their primary goal in behaviour change. The number of clients with a long term condition committing to a Personal Health Plan has increased by 43%. Many clients will have more than 1 long term condition and this number is represented in the total which demonstrates some of the complexities the team are working with. The main source of referrals to Healthy Lifestyle Advisors is from GP's - 71%. The Smoking Team receive 82% of their referrals from GP's and the Healthy Families Team receive most of their referrals from Community settings. The team offers 81 clinics across Telford, including evenings and weekend – these vary in location and include GP Surgeries, Libraries, Live Well Hubs and Centres, Children's Centres, Salvation Army and Christian Centres, Sikh Temple, Newport Cottage Care, PRH, Schools, Pharmacies, Leisure Centres and Residential Homes.

- **Health Champions** have been upskilled to support community based service delivery including health checks, taking blood pressures, supporting events and promotions and offering support to residential homes and support living housing. This will result in increased

[1] The Healthy Lifestyles Service is a holistic service offering behavior change support across all ages.

capacity to provide healthy lifestyle advice within communities through the use of trained volunteers.

- **Mass participation campaign #LetsGetTelfordActive** launched to support, encourage and inspire residents to increase Physical Activity. Now supporting over 22 local groups/organisations through TWC Get Telford Active Grants to assist them in delivering & promoting events targeted at people who are doing no/limited activity.

- Targeted work with Early Years and School Settings supporting a whole setting/school approach to deliver **positive change around physical activity**, P.E & sport and in food culture and behavior implementing national and locally developed pilots/programs: Active 30:30, Daily Mile (gone from 3 to 29), Active Families and Food for Life.

Case Study: How the Daily Mile is making schools better

Pupils and teachers from Grange Park Primary School on their Daily Mile track

"*The Daily Mile improves concentration in lessons, gives pupils time to unwind and improves physical health*"

Click here to read the full story

- Established **community initiatives that promote health & wellbeing** e.g. 'Men in Kitchens' Wrekin Housing Trust, 'For the Record' (Forge Urban Revival @The Wakes) bringing people together through activity, creativity or food.

- In conjunction with the Community Participation Team supported the **setup of Holiday Activities and Eat Well Fund** which aims to reduce the pressure during school holidays, on CYP and families in Telford who receive Free School Meals and those who are on low incomes through community holiday clubs. Groups and Organisations has expressed interest in the fund to provide clubs that have regular and accessible provision of a diverse range of positive activities which include physical activity and a healthy nutritious meal.

- Following the inspirational and successful **Social Isolation & Loneliness conference, a call to action** to tackle this issue we are reigniting support through specific task & finish groups: age friendly communities, volunteering, culture and young people. In addition following up how the 80+ Loneliness Champions are progressing with their pledges - showcased as part of Loneliness Awareness Week 17 – 22 June #TelfordTalksLoneliness. The image on the right shows some pledges made and what has happened since:

- The first element of the **Telford Healthy Hearts**, year long programme has commenced and addresses the drug management of cholesterol risks alongside promoting healthier lifestyle choices. There are four main groups of people that we are targeting through the cholesterol work:
    - People who have taken statins before but have stopped
    - People who are prescribed atorvastatin at a dose that is classed as low or moderate intensity – national guidance recommends that we should be using high intensity doses
    - People who are prescribed a statin other than atorvastatin at a dose that is classified as low or moderate intensity – national guidance recommends that we should be using atorvastatin at a 'high intensity' dose (this is a dose that reduced LDL cholesterol by more than 40%)
    - Those people who have already got heart disease or are at a significant risk of getting it (≥10% risk of developing cardiovascular disease in the next 10 years), but are not on a statin.

  The results below show that more people are now being prescribed effective doses of statins that will reduce their overall risk of having a stroke or heart attack.

  The total no patients prescribed statins = 22,492 (July 2019) (20,562 May 2018)
  Number Rx high intensity statins = 15,027 (66.8%) (July 2019) (10,595 (51.5%) May 2018)
  Number Rx low/medium intensity statins to be prioritised for review = 7,465 (33.2%) July 2019 (9,967 (48.5%) May 2018)

Telford Healthy Hearts also promotes awareness of risk factors and the CCG has developed a website with links to other programmes of work within our integrated place partnership. In response to patient feedback a local clinician and patient have starred in a video that will be used in surgeries and on websites to compliment the written leaflets, posters and pull up banners in surgeries. Watch it here: https://www.youtube.com/watch?v=TQQ5N6GtBzc

What are the plans for the future?

- Completing 10,000 new blood pressure tests by March 2021
- Supporting the local delivery of the NHS Diabetes Prevention Programme, including raising awareness of local support services
- Supporting the local delivery of the Macmillan 'Living with and Beyond Cancer Programme'
- Working with Community Early Help and Support in relation to prevention pathways
- The Healthy Lifestyle Support within Clinical Pathways to increase referrals for patients with mental health problems, learning disability, long term conditions and MSK.
- Delivering Making Every Contact Count training to Adult Social Care and GPs
- Working with key partners to coordinate implementation of the excess weight and obesity action plan.
- Facilitating 'Community Centred Approach to Health & Wellbeing' workshops with interested individuals/groups from across the communities of Malinslee, Leegomery and Madeley to be part of a local conversation that will identify community-driven neighbourhood initiatives that support local communities to live well.
- Implementation of hypertension, atrial fibrillation and heart failure elements of Telford Healthy Hearts.
- Implementation of a Population Health Management approach to reducing risk factors for newly diagnosed Type 2 Diabetes patients.

6.3. Early Access and Advice and Information

What is included in the work?

The aim of this priority is to develop an integrated approach to information and advice, including use of the voluntary sector, online directories, development of locality hubs and an independent living centre.

To deliver this the following areas of work have been agreed:

- Further integration of the Information, Advice and Guidance Services - new tender for the expansion of the current My Choice Service to include the integration of the Carers Services into the existing specification;
- Development of Live Well Hubs in the community localities to provide a one stop shop for people to access services within their local community;

- Development of an Independent Living Centre (Smart House) as an all-purpose environment to promote independent living and to reduce costs of care and support.
- Development and launch of an online community asset resource directory;
- Lean review of Adult Social Care front door to help determine whether there is potential for a single point of access to health and social care; and
- Integration of the upcoming specification and tending of the alarm/monitoring systems in the Borough.

What progress has been made?

- **Living Well Drop Ins have been developed in the community** localities with Adult Social Care this is allowing for early identification of issues and prevention of escalation of health and social care needs. The current locations for hubs are:
    - Newport Library
    - The Wakes, Oakengates
    - Hub on the Hill, Sutton Hill
    - Lawley Bank Court, Lawley
    - Wellbeing Community Café, Madeley
    - Dawley Christian Centre, Dawley,
    - Community Centre, Brookside
    - Stirchley Medical Practice

  More Hubs are starting up over the next few months, including in Leegomery and Wellington. Positive feedback from attendees includes:
    - Being seen quickly,
    - Leaving with an outcome to work towards, including applications to extra care housing and assistive technology completed at the time and signposting to the Citizens Advise Bureau (CAB)
    - Ability to book in to see Social Worker at one of their bookable appointments; and
    - Being able to sign up to the Carers Centre at the time.

- **Live Well Telford** (online community asset resource directory) has been launched (https://livewell.telford.gov.uk/):
    - A communication and action plan for Live Well Telford has been developed to further promote the benefits of the new website with the community and partners
    - A comprehensive, all age, online community assets directory for Telford that is available and accessible for all Residents, Professionals, Providers, Voluntary Organisations, Carers and Family and Friends
    - A self-help tool, not only for individuals but for professionals to find information, advice and services in the local area, which will reduce reliance on health and social care services
    - Offering early help with a view to preventing crisis, promoting the five ways to wellbeing such as continued learning, getting

active and preventing issues such as social isolation by presenting the community options and opportunities as well as events in the community.
    - Went live in May 2019 with a soft launch approach by demonstrating LWT, including at Operational team meetings, Public Health Social Isolation Event, ASC Communication Sessions, Safeguarding Boards, SMT, Parish Council and Ward Clerk Meetings, Wrekin Area Committee Parish Forum, Police Cadets, Healthwatch Meeting, Market Place Event, Partnership Boards.
    - Google analytics monthly monitoring to measure number of 'third party users' registering their services and data around usage of LWT itself

- Work is underway on the **Independent Living Centre/Smart House** project with the following areas already being achieved:
    - A suitable central location has been identified and negotiations are underway to get it agreed.
    - The offer has been devised and is illustrated in the following picture:

    - The interior renovation of the venue has been designed and final agreements being made with the relevant service about what they need to deliver the offer.
    - An early programme for the use of the space has been developed which includes information, advice and guidance, Assistive Technology showcasing, Assistive Technology Hub sessions, Occupational Therapy assessments, access to early

help (including booked appointments) and group meetings/presentations. It is anticipated that the venue will be open for a late night/Saturday opening.

What are the plans for the future?

- Expanding the Live Well Drop Ins to include public health, 3rd Sector, SCHT and signposting services (by September 2019)
- Developing a digital inclusion offer as part of the Drop Ins and Independent Living Centre – this will include supporting people 'to get online' increasing access to information and advice.
- Deliver the Independent Living Centre project (including building refurbishment, workforce development, outcome measures and communications) and launch in November 2019.
- Deliver the communication plan for Live Well Telford.
- Consideration of a single point of access for health and social care.
- Integrating the upcoming specification and tending of the alarm and monitoring systems in Telford and Wrekin.

6.4. Integrated Care and Support Pathways (including out of hospital)

What is included in the work?

The aim of this priority is to ensure all organisations in Telford and Wrekin deliver services which connect and empower people to stay healthier for longer and preventing unnecessary admission to hospital.

To deliver this the following areas of work have been agreed:

- Review and further development of health and social care integrated pathways,
- Launch of booked appointments for adult social care and other partners to help reduce waiting times and preventing escalation to a crisis situation;
- Further development of Multi-Disciplinary Teams (MDTs) attached to GP surgeries – including risk stratification tools;
- High Intensity Service Users Project;
- Pilot co-working between Social Workers and Occupational Therapists in the Hadley Locality;
- Rollout of the Emergency Passports, Red-Bag Scheme and I-Stumble protocols in care homes (Care Homes MDT Model);
- Frailty at the Front Door team; and
- Zoning of Domiciliary Care to increase capacity in the market.

What progress has been made?

- **Admission avoidance pathways reviewed** through:
    - Consultation with carers about what would enable the person they are caring for to remain at home; and
    - A multi-agency workshop held at the end of June, 2 workshops were led by NdTI (National Development Team for Inclusion)

with the aim of looking at the ways in which we can work together to avoid admission to acute services (e.g. hospital, residential beds). Almost 100 professionals attended from health, social care, housing, voluntary sector and commissioning. They discussed their vision for what the support needed to keep people at home should look like, as well as their principles and what behaviours they would expect to see.

- Some of the development suggestions from those involved:

This information was presented to senior leader across the health and social care landscape and is being used to shape future provision, as well as providing some excellent examples of what is working well and what could be developed further.

- **Pathway Zero has been developed across Telford and Wrekin and Shropshire.** Pathway Zero is preventative Pathway to support discharge from hospital, sitting alongside the pre-existing Complex Discharge Pathways 1, 2 & 3. Pathway Zero is aimed at people below the normal threshold for support. The aim of Pathway Zero is to direct people and carers to a network of community based options, which will support and maintain them in their normal place of residence. Across Telford and Wrekin and Shropshire there is a wide network of this type of provision. For example using technology enabled care, community centres, groups working to improve balance and mobility, places to get meals, groups aimed at improving social isolation and loneliness. The person can have an appointment to see a Social Worker, locally to them or if their need is more complex discussed in a Multi-Disciplinary Team Meeting at their GPs. Three hospital wards (Ward 10 at Princess Royal Hospital and Wards 22 and 32 at Royal Shrewsbury Hospital) are piloting this approach to help inform how this pathway works operationally as well as training workshops, videos and pop up events in Princess Royal Hospital at the beginning of September.

- **Booked appointments in adult social care have been set up** which is helping to reduce the adult social care waiting list as well as prevent admissions to hospital and carer breakdown. This is enabling people to get a solution to their need quicker by the right service and preventing potential escalation of the need.

- **Primary Care Multi-Disciplinary Team (MDT) Meetings** are now being held in 3 pilot sites across the Borough. MDTs are a means to enable practitioners and other professionals in health and social care to collaborate and reach solutions based on an improved collective understanding of the person's needs. **I**nitial successes include:
    - Patients being able to remain in their own home/supported housing due to a different approach (e.g. use of a cleaner to enable the person to concentrate on remaining well, rather than exhausting themselves cleaning the property, and a person avoiding admission by being seen by the Home Treatment Team.
    - A shared understanding by all professionals involved of the person's needs and of the agreed solution;
    - Deeper understanding of each other's roles and responsibilities; and
    - Resources being used more efficiently through reduced duplication, greater productivity and preventative care approaches.

  A review of the MDT pilots is being undertaken by the CCG and TWC to look at how this approach can be rolled out across the Borough.

- **New Diabetes Foot Care Pathway has been agreed** with Podiatry Service and Primary Care Colleagues which will enable moderate and high risk patients to receive increased levels of support.

- **Care Home Team Rollout** of Emergency Passports, Red Bag Scheme and I-Stumble protocols across further care homes. The emergency passports and Red Bag Scheme aim to document in one place information about the individual, medical and personal so that if they should be admitted to hospital the staff there can understand about the individual's needs and preferences. It aims to ensure that the decision taken by people who choose not to be admitted into hospital especially at end of life can be implemented.

- **Frailty at the Front Door team** in now place 5 days a week at the PRH. This team of therapists supported by nursing and medical staff aim to identify frail, usually older people, who would be better managed in community settings rather than being admitted for a stay within an acute hospital. They will do this through a comprehensive assessment. This scheme is the start of a wider focus on Frailty within the community with the aim of looking at how individuals could be better supported to prevent them attending the emergency department.

- Development and approval of business case to **pilot Post Exacerbation Domiciliary Pulmonary Rehabilitation** in partnership with Shropshire NHS Community Trust. This will enable people who due to medical reasons cannot attend the existing groups to receive this important self-care and exercise advice and intervention. Pulmonary Rehabilitation has been shown to reduce the frequency of exacerbation (worsening) of Chronic Obstructive Pulmonary Disease

(COPD). Research has shown that with better controlled COPD people are less likely to be admitted into the acute hospital.

- Over the last 12 months TWC have worked with domiciliary care providers to **redesign the way we deliver domiciliary care** to make it more flexible and to encourage people to become workers in that market. One of the outcomes of this is through zoning. There will be 5 zones across the borough and each will have some primary and secondary domiciliary care providers. The providers will work alongside voluntary orgs, care homes and carers to deliver person centred care in a more efficient manner. Formal communication of the providers and their zones will be completed in August with contracts going live in October 2019.

- Ahead of the CCG Clinical Change Agent starting in September, the CCG has invested in support from a nurse working in a management consultancy role who is working with the Shropshire Community Health Trust to undertake a **productivity/workforce review** to understand capacity/capability to work differently (supply predictions). In addition this individual will identify pre-requisites for successful implementation of risk stratification and map out expected demand in emerging medium to high risk segments by PCN and practices (demand predictions).

- **Modelling of potential admissions avoidance impact** aligned to Shropshire CCG through use of Optimity data/methodology (opportunity predictions) has been completed. This is an important piece of work to indicate what the potential could be to deliver sub-acute care within the community. This work will be ongoing to assist in business cases in relation to increased community investment in the future.

- Work to map the **alignment of services to Primary Care Networks/ Neighbourhoods** in the Borough has been completed and demonstrated the work that has already been undertaken to help us achieve our wider goal of integrated teams. Please see Appendix C for a copy of the current alignment of services as at June 2019.

What are the plans for the future?

- Continued engagement, consultation and collaboration with people with lived experience, carers, practitioners, parish and town councils and the voluntary organisations to ensure pathways and services meet the needs of the community.
- Evaluation, further development and roll out of Pathway Zero.
- Evaluation of the pilot MDT sites to inform roll out of GP based MDTs across the Borough.
- Consideration of a joint single Point of Access for health and social care with an integrated response team including developing a pilot to inform long term plans.

- Embedding the booked appointments and then expanding to enable other partners to be part of the booked appointments (e.g. SCHT, MPFT) and roll out the ability to book to other agencies to book (e.g. WMAS, Police).
- STP level Diabetes redesign as part of Population Health Academy Approach.
- Locally from a Telford focus there has been a redesign and refresh of the diabetes self-care/education programmes commissioned from the Community Trust to focus on areas of highest prevalence and to explore evening and weekend courses to enable greater participation. This will be evaluated for impact and re-targeted as necessary during the remainder of the year.
- STP level Respiratory Service redesign through joint working with Shropshire Medical Director in lead STP role. Locally, the initial Telford focus is on the delivery of Post Exacerbation Domiciliary Respiratory Rehabilitation.
- Full implementation of Frailty model at the front door.

6.5. **One Public Estate**

What is included in the work?

The aim of this priority is to develop and use existing and new estate to enable delivery of integrated support.

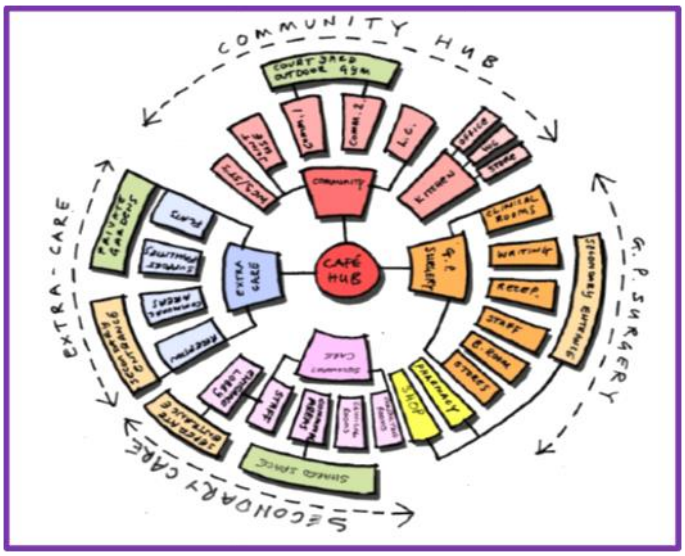
To deliver this the following areas of work have been agreed:

- Host a stakeholder event to aid in future planning of new estate to enable development of multi-functional space through joining up locally and using shared resources.
- Identify and progress where appropriate potential development sites within the borough where an integrated approach to development could be used.

N/B Please note this is a specific work stream of the STP and more detailed updates will be provided by the STP update reports.

What progress has been made?

- In May the workshop with all partners around One Estate was delivered using the below diagram as a model of working. This was extremely well attended and follow up project meetings were agreed and set up.



- The first project meeting took place on 1st July, with colleagues from Telford & Wrekin Council, CCG, together with the SPT leads. The meeting discussed the potential opportunities for some of the projects that were highlighted as possibilities at the May workshop and these will now be progressed through conversations with stakeholders before setting up a project steering group to develop the project. It is expected that this will then form a blueprint to take other options forward.

What are the plans for the future?

- Further development of a new extra care scheme to include health and social care services
- Set up a project steering group to develop the estate projects.

6.6. Governance

What is included in the work?

The aim of this priority is to ensure there is shared local commitment, leadership, accountability, performance metrics and governance to deliver this programme.

To deliver this the following areas of work have been agreed:

- Re-launch and develop the Neighbourhood Steering Group;
- Develop an overarching plan and vision for the work including principles of working;
- Develop appropriate programme management tools, including a programme plan, risk register, communication and engagement plan and integrated scorecard;

- Identify the most appropriate way to engage with the voluntary sector on a strategic basis;
- Review the organisational and workforce development needs to deliver the programme (in line with the STP's work-streams); and
- Review the relationships between the Integrated Partnership and the Health and Wellbeing Board.

What progress has been made?

- **Telford & Wrekin Integrated Place Partnership (TWIPP) is in place**, replacing the Neighbourhood Steering Group, and enables strategic integration and driving delivery of it across all health and social care partners. The partnership meetings are chaired by Director for Adult Social Care, Telford & Wrekin Council and are attended by the Clinical Commissioning Group, Shrewsbury and Telford Hospital Trust, Shropshire Community Health Trust, Midlands Foundation Partnership Trust, Primary Care Network Clinical Directors, Healthwatch and TWC Adult Social Care, Public Health and Commissioning.

- As outlined in Section 5 of this report, the **Strategic Plan for the Partnership** has been agreed. (Please see Appendix B for a copy.)

- **Programme Management tools** are in place including a programme plan, risk register and engagement log. This will enable the partnership to keep driving delivery of the programme effectively and efficiently.

- **Communication and Engagement** Strategy and Plan is in development but initial activities include:
    - Integrated Place newsletter – first iteration distributed beginning of August with the next one due end of September
    - Live Well Telford twitter account is being used to promote integration work - @livewelltelford
    - Various engagement and collaboration events/sessions with stakeholders over the past few months to share work – carers, Telford Patient First Group, practitioners, voluntary sector, housing, STP, Parish and Town Councils, Assuring Involvement Committee and NHS England.

- **Integrated Place Programme Portal established** to provide a one stop shop for all integration related documents and timelines.

What are the plans for the future?

- Finalising the Communication and Engagement Strategy and agreeing a multi-agency delivery plan, aligning with the STP's (October 2019);
- Developing a 'Partnership Agreement' to formalise the agreement by all partners to deliver this work (October 2019)
- Developing an integrated performance dashboard for the partnership to

monitor impact (October/November 2019);

- Host a stakeholder event for the voluntary sector to share the work and look how we engage and work with them on a strategic and operational level (Oct 2019); and
- Facilitate a joint workshop between the HWB and TWIPP members to look in more detail about the work of integration and what difference it will make to our community (November 2019).

7. CONCLUSION

7.1. The Integrated Place Programme in Telford and Wrekin has progressed significantly over the past 6 months. Relationships have been established, developments are underway, new teams introduced and plans created to increase, and maintain, the pace of change in place based solutions.

7.2. The programme is owned and driven from the top of organisations as well as evolving from the community and front line staff. Together these areas of work will enable us to have a more innovative and integrated model of care across the health and social care economy in Telford and Wrekin.

8. PREVIOUS MINUTES

Health and Wellbeing Board – 21 March 2019
Health and Wellbeing Board – 12 September 2019

9. BACKGROUND PAPERS

Health and Wellbeing Board – 21 March 2019 – Agenda Item 4 and 5.
Health and Wellbeing Board – 12 September 2019 – Agenda Item 7.
NHS Long Term Plan
Sustainability and Transformation Partnership Plan

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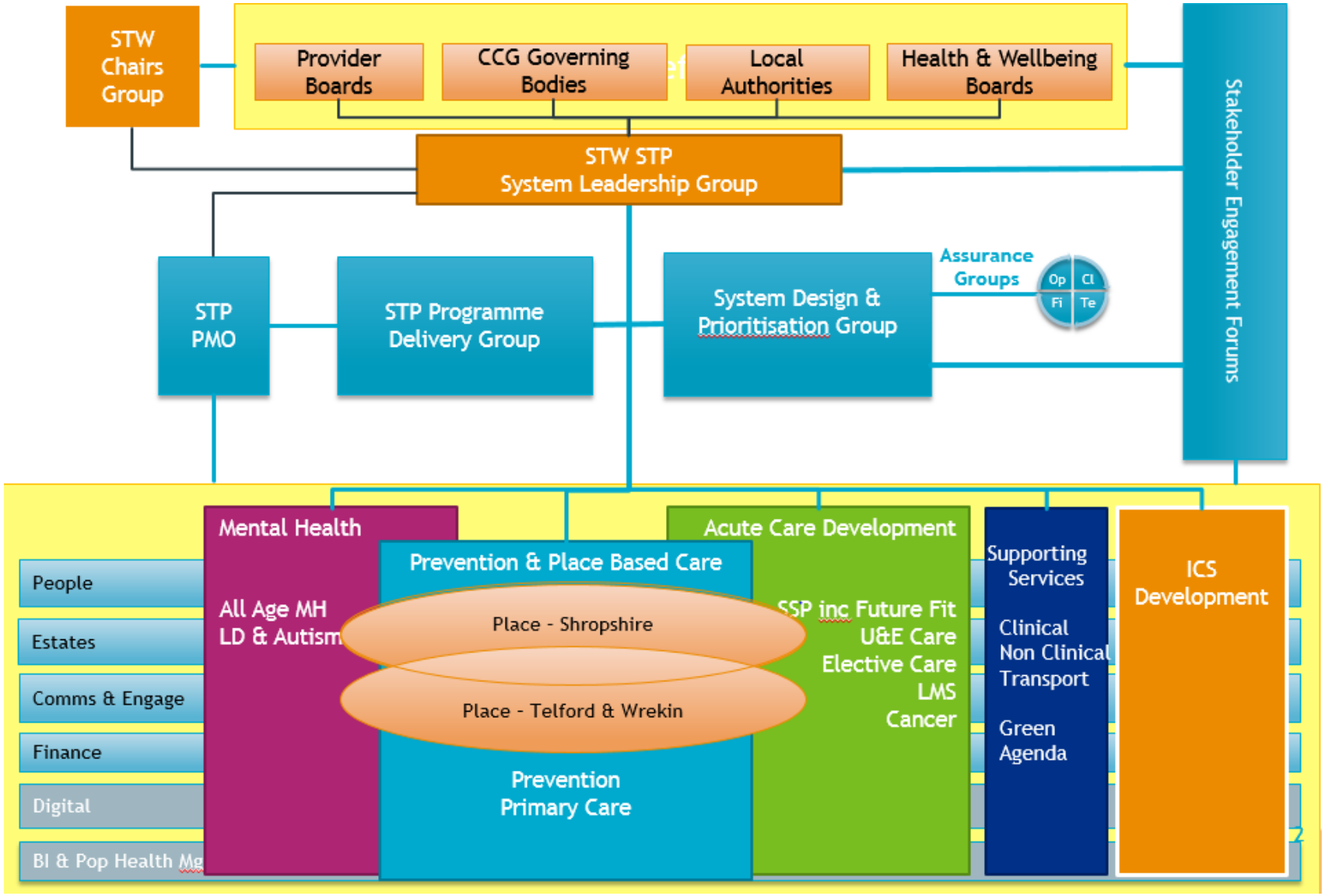
Appendix A

Shropshire and Telford & Wrekin Sustainability and Transformation Programme (STP) Governance Structure – as at June 2019



Appendix B

Telford & Wrekin Integrated Place Partnership
Strategic Plan 2019 – 2020

"Working together to achieve the healthiest, most fulfilled people in Telford and Wrekin"

Our Strategic Priorities:

1. **Building Community Capacity and Resilience** - strengthening communities through community development, asset based methods, developing social networks, volunteer and peer roles, developing collaborations and partnerships and improving access to community resources.
2. **Prevention and Healthy Lifestyles** - support people to stay healthy with a combination of individual and whole population approaches.
3. **Early Access to Advice and Information** - integrated approach to information and advice, including use of the voluntary sector, online directories, development of locality hubs and an independent living centre.
4. **Integrated Care and Support Pathways (including out of hospital)** - all organisations in Telford and Wrekin delivering services which connect and empower people to stay healthier for longer and preventing unnecessary admission to hospital.
5. **One Public Estate** - developing and using existing and new estate to enable delivery of integrated support.
6. **Governance** - shared local commitment, leadership, accountability, performance metrics and governance.

Our outcomes:

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

Our Principles:

Person Centred and Strengths based approach
Local and place based
Maximising independence and fostering self-help
Prevention
Being radical

What does good look like?

One conversation and one point of contact

The right information and advice at the right time

Integrated and seamless services - 'One team'

We will deliver this by:

- Developing a shared vision for integration and a health and social care system fit for the future.
- Shifting capacity from acute to preventative and community services as per NHS Long Term Plan.
- Maximising the use and development of community based support and volunteering opportunities.
- Utilising our community assets as hubs for health and wellbeing.
- Using technology as a solution wherever possible, including:
  - Self-service and early help
  - Integrated case management records
- Deliver evidence based integration projects, including:
  - An integrated support plan,
  - A universal risk stratification tool to help predict health and social care needs,
  - Multi-Disciplinary Teams,
  - Hubs, and
  - Independent Living Centre.
- Reviewing and developing integrated place based estates.
- Engaging the workforce and public to develop the health and social system.
- Demonstrating effectiveness through joined up performance data.

Appendix C – ***Alignment of Services to Primary Care Networks/Neighbourhoods as at June 2019***