TELFORD & WREKIN COUNCIL

HEALTH AND WELLBEING BOARD – 10 JUNE 2020

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

REPORT OF DIRECTOR OF ADULT SOCIAL CARE, TWC, DIRECTOR OF HEALTH, WELLBEING AND COMMISSIONING, TWC & DEPUTY EXECUTIVE INTEGRATED CARE, CCG

PART A) – SUMMARY REPORT

1. SUMMARY OF MAIN PROPOSALS

1.1. Following the release of the NHS Long Term Plan in January 2019, joint working between the Council and CCG led to the development of the Telford & Wrekin Integrated Place Partnership (TWIPP). This built on joint work previously undertaken by Telford and Wrekin Council (TWC) and Telford and Wrekin Clinical Commissioning Group (TWCCG).

1.2. The purpose of TWIPP is to drive directional change to the delivery of support to the people living within the boundaries of Telford and Wrekin, ensuring it is based around 'place' and enables further integration of services/teams.

1.3. This report outlines the progress made by TWIPP over the last 6-9months and the difference it has made to our residents and the system as a whole. The report also focuses on the work of the pilot Health and Social Care Rapid Response Team which started in November 2019.

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 December 2020;

2.2 Support and promote the local, place based work, of the Telford & Wrekin Integrated Place Partnership; and

2.3 Support the need for the Telford & Wrekin Integrated Place Partnership, to remain a key part of the STP / and emerging Integrated Care System.

3. SUMMARY IMPACT ASSESSMENT

COMMUNITY IMPACT	Do these proposals contribute to specific Co-Operative Council priority objective(s)?	
	No	• 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) and the Health and Wellbeing Board Strategy.	
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. In addition the Council has provided extra investment from one off resources to support some elements of the TWIPP work. It is anticipated the Council will need to find further savings estimated to total £18m over the period 2021/22 and 22/23 and this may impact on the funding for this programme. Whilst it is not possible at this stage to identify the financial benefits of this programme in the longer term, its successful development and implementation should result in better outcomes for individuals and the community, resulting in longer-term financial benefits across the whole system by reducing the pressure on acute services. *(TS, TWC 28/05/2020)* 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,27.05.2020)*
LEGAL ISSUES	Yes	S.195 of the Health and Social Care Act 2012 places a duty upon the Health and Wellbeing Board to encourage integrated working in the provision of health and social care services. The HWB is also required to provide advice, assistance and other support as it thinks appropriate for the purpose of encouraging arrangements that improve the delivery of health functions undertaken by the NHS or the local authority. 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 The proposals set out in this report will assist the Board in meeting its legal obligations. *(AL, TWC 27/05/2020)*
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

5. BACKGROUND INFORMATION

5.1. Following the release of the NHS Long Term Plan in January 2019, joint working between the Council and CCG led to the development of the Telford & Wrekin Integrated Place Partnership (TWIPP). This built on joint work previously undertaken by Telford and Wrekin Council (TWC) and Telford and Wrekin Clinical Commissioning Group (TWCCG). The Partnership comrpises senior officers from TWC, TWCCG, Primary Care Networks, Midlands Partnership Foundation Trust, Shropshire Community Health Trust, Shrewsbury and Telford Hospital Trust and Healthwatch; it also links into the Voluntary, Community and Social Enterprise Sector through bi-annual network meetings.

5.2. The purpose of the (TWIPP) is to drive directional change to the delivery of support to the people living within the boundaries of Telford and Wrekin, ensuring it is based around 'place' and enables further integration of services/teams.

5.3. The TWIPP is accountable to the Telford & Wrekin Health and Wellbeing Board (HWB) and the Shropshire and Telford & Wrekin Sustainability and Transformation Partnership (STP). Whilst the TWIPP 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.

6. OUR STRATEGIC APPROACH

6.1. 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**

6.2. To ensure there was a consistent narrative across the Borough, a strategic plan for the programme was developed and agreed at the TWIPP by all members in June 2019. This plan has 6 strategic priorities:

- **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.

6.3. The Strategic Plan for the programme will be updated over the coming months to reflect the changes and opportunities for further integration brought about through changes in delivery and opportunities developed through dealing with the COVID-19 pandemic.

7. PROGRESS OVERVIEW

7.1. In the last 9 months, work has continued at pace to deliver the Integrated Place Programme. This section of the report highlights some of the progress (please note that this is as at 12 March 2020, pre-COVID-19).

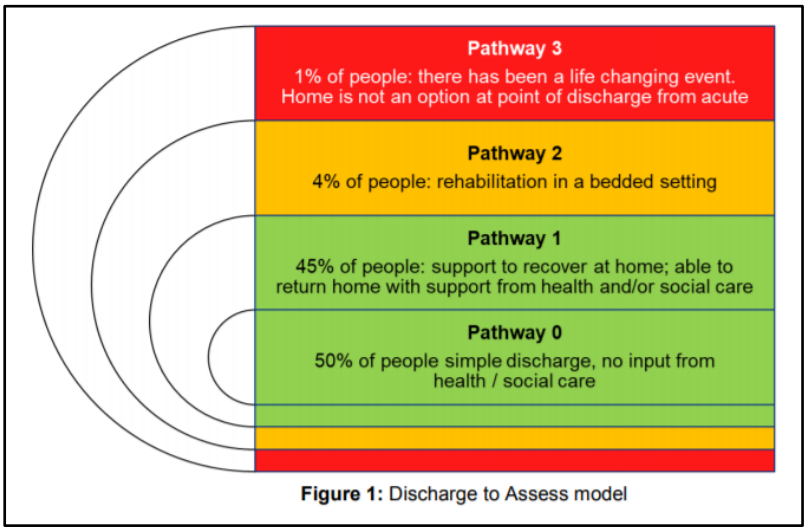
Nº	Deliverable	Timescale	Progress update March 2020
Building Community Capacity and Resilience			
1.1	Grant Rounds to develop provision of additional community groups	2019-2020 **Completed**	Our Capacity Building Fund has two grants that are open throughout the year for applications at any time, they are; • "Get started" – awarding up to £2,000 to support the development of grass roots community and voluntary organisations which facilitate community self-help, create resilient communities and reduce demand on council services. In 2019-2020 4 grants were approved for a total of £4,274. • "Develop" - Up to £10,000 helping communities to build capacity, in order to empower and encourage them to self-help and rely less on Council and other public services. This grant does not support the development of new groups but supports those that are existing to

			develop their organisation or their "offer". In 2019-2020 2 grants were approved for a total of £14,480.
1.2	Increased volunteering capacity within the community	2019-2024	The Council leads on volunteering by: • Delivering volunteer schemes on behalf of the Council – currently the Council manages 21 different volunteer schemes that support service delivery ranging from environmental, health and wellbeing, care and support to young people, arts and culture, leisure and libraries. To put this into context the total number of Council volunteers that we support is just over 1500. • Providing advice and guidance to services that identify opportunities for working with volunteers. • Make sure our volunteers are well looked after and supported. As part of developing volunteer roles/schemes, all Council volunteers are supported by dedicated Volunteer Co-ordinators. • Provide support, advice and partnership working externally to individuals, community groups and organisations. So far this year we have supported 40 voluntary and community organisations with planning and setting up volunteer schemes and attended 14 community events to promote what is available. • Manage the Volunteer Telford website – currently we have over 80 organisations registered on the site, with over 180 opportunities being promoted and typically we get over 3,000 hits a month from people searching the site. During Covid-19 pandemic, volunteering has become an instrumental part in supporting the Council to help those who are shielding or vunerable in the Borough. 1,147 volunteers registered with the Council and have been supporting the borough's residents in a variety of ways: • Guardian and Keep in Touch calls to vulnerable residents • Dog walking • Collection/Delivery of prescriptions • Shopping/food deliveries • Supporting food banks • Home Library Delivery Service The whole community response, which includes support from volunteers, community groups and TWC staff, have supported, or offered support, to over 18,000 households.
1.3	Development of the Personal Assistant (PA) role and support development of a PA+/Micro-provider role	2019-2021	Project team and action plan in place. Currently progressing: • Development of Live Well Telford PA pages to support information and advice needs, and includes a new PA register to assist recruitment. • Use of Care Certificate and Skills for Care training provision. • Well-developed marketing plan and materials ready to go.

			Next steps: • Formalisation of a new PA pay rate agreement. • Developing the in-house PA support offer. • Consider further ways of offering paid support
Prevention and Healthy Lifestyles			
2.1	British Heart Foundation community blood pressure testing programme	2019-2021	Telford and Wrekin were on stage at the National CVD Prevention conference in London on 06 Feb 2020, show-casing our BHF funded Community Blood Pressure Programme and sharing early findings with delegates from across England. In a session chaired by Jacob West, Director of Healthcare Innovation at BHF, Ann Marie McShane, the programme lead, described how the Telford Community programme is raising awareness of the importance of blood pressure, motivating people to get tested and loaning monitors for people to carry out home monitoring where they have a high initial reading. The conference was an opportunity to show how primary care in Telford are supporting this work and responding when patients are signposted with a new diagnosis of hypertension. The project has now tested over 2250 people in community venues and workplaces in Telford. If you have any questions about the programme please contact ann-marie.mcshane@telford.gov.uk
2.2	Living with and Beyond Cancer Programme	2020	Community based delivery of living well sessions are continuing in 2020. Patients are signposted during the treatment phase but no referral is necessary – the session are open to patients at any stage of the cancer pathway also relatives friends or family can attend. Living Well Video has been produced and was launched on World cancer day on 04 February 2020. The video is available at: https://www.sath.nhs.uk/wards-services/az-services/cancer-services/livingwithandbeyond/videos/
2.3	Development of the social prescribing role in PCNs	2020	• South East Telford, PCN – two link workers recruited / established social prescribing model in place (coordination via Court Street Medical Practice in partnership with Telford MIND) • CET / TELDOC and Newport PCN's are still in the planning phase • Donnington Medical Practice (via Jim Hudson) have been identified as a priority area for the STP Integrated Volunteering Project (bid has been submitted to NHS England for funding) • Public Health Team are working with the Sutton Hill Community Trust (part of SET) to embed a Community Sport and Health Apprentice within the partnership to support local arrangements for social prescribing and community support with a focus on physical activity

2.4	Implementation of Telford & Wrekin Smoke Free Plan	2019-2022	Telford & Wrekin Council continues to offer high quality stop smoking services, achieving better than average quit rates since April 2013. The local smoking prevalence has been reducing, which demonstrates the impact of our local service offer and our work with partners on the smoke free plan. The Council's Public Health Team lead work with the local NHS to reduce smoking, particularly with maternity services, to tackle the high local rates of smoking in pregnancy. The Council's Trading Standards Team are especially proactive, working closely with partners, such as HMRC to disrupt activities around illicit tobacco, provide vital intelligence to other partners to take action on illicit supplies and to tackle under age sales.
2.5	Delivery of whole system approach to reduce obesity	2019-2022	Work is ongoing to deliver our whole system approach to reducing excess weight and obesity (in line with the actions set out in our Annual Public Health Report). Over the last 12 months our work with local schools and nurseries has been encouraging and we are seeing an increasing number of settings take a whole school approach to encouraging healthy eating and physical activity. TWC were the top local authority for seeing the biggest improvement in physical activity levels for adults and we also reported a significant increase in children's physical activity levels. We are working with Shropshire Council and the STP Programme Management Team.
Early Access to Advice and Information			
3.1	Ongoing development and promotion of Live Well Telford. (Information Portal)	2020-2021	• A review of the categories has taken place to refine results presented to users, for example 'Community & Leisure' has a category named 'Things to do – Adults' with a large number of results presenting this has now been split into various themes such as Dance, Nature & Gardening, Reading & Poetry to ensure that users are presented with relevant results. • We are working with the CCG to deliver Chatty Pals, Health & Social Care information drop ins across Telford. • We are currently booking to attend Carers Wellbeing Groups across Telford. Attendance at three groups has been confirmed, these are in Dawley, Newport and Hadley. • We continue to attend Council libraries and have booked to attend community libraries to promote Live Well Telford to local residents. • A new Live Well Telford marketing campaign is currently being developed which will include testimonials/case studies from services registered on Live Well Telford these will be written quotes but also some short video clips. We will also be using telephone campaigns to

			encourage services such as opticians, dentists and pharmacists to register with Live Well Telford.
3.2	Establishment of an Independent Living Centre/Smart House	2019-2020	Due to ensuring the right central location was found the timescale for completion of this project has been set back until Summer 2020. Since the first iteration of plans the inclusion of the voluntary sector in centre has been further developed. CVS are now an integral part of the centre's development and a central location has been identified which will become available at the beginning of July. Detailed implementation planning is now taking place.
Integrated Care and Support Pathways (including out of hospital)			
4.1	Implement the Health and Social Care Rapid Response Team (HSCRRT)	2019-2020	Please refer to the following section which provides an in depth look at the progress of the HSCRRT.
4.2	Rollout of Care Home Team & exploring early intervention team for care homes	2019-2020	The Care Home team is part of the wider Telford and Wrekin CCG Integrated Care programme of work to enable people to remain in their own homes to receive care whenever possible. Whilst the data shows a positive trend in admission reduction, the ambition is to decrease this further and to ensure links across system working. The current actions the team have undertaken are a renewed focus on promotion of ensuring all care homes know of admission avoidance support services and alternative pathways to 999 such as the Health and Social Care Integrated Rapid Response Team. The team have also been working collaboratively with WMAS and care homes to support the use of 111 *6 and 111 for residential homes with a specific aim at out of hours.
4.3	Hospital pathways development – inc Pathway Zero	2019-2020	Pathway Zero is a preventative pathway, pre-empting and identifying those who may be readmitted to hospital without a level of support. At the start of the pilot a target was set of 5% of discharges to occur through this pathway. Over the first 5 months of the pilot the approach has exceed expectations with: ✓ 9% being discharged home on Pathway Zero, which has decreased the number of people being discharged into bed-based enablement by 2%-point. ✓ A 22%-point reduction in rate of re-admissions. ✓ 27%-point increase in people discharged with equipment or assistive technology (e.g. community alarms, fall prevention…etc) ✓ 37%-point increase in number of people booked into a local community based social care hub for a follow up appointment – helping to maintain independence

			✓ 14%-point increase in number of carers support inventions and formal assessments. In January 2020, the senior leaders reviewed the progress made and agreed to roll the pilot out, taking it from one ward at the hospital to all wards. This is being monitored through the A&E Delivery Group. Following the embryonic work started in Telford & Wrekin Adult Social Care in September 2019, which became Pathway Zero, it was further developed across Telford & Wrekin Council and Shropshire County Council. The model has been adopted Nationally and is included in the Department of Health and Social Care's COVID-19 document: Hospital Discharge Service Requirements (March 2020) as the below diagramme illustrates.  **Figure 1:** Discharge to Assess model *Diagram taken from DoHSC Hospital Discharge Service Requirements, March 2020, page 4*
4.4	Development of a telehealth option to deliver care for long term conditions.	2020-2021	Funding secured for small scale pilot in Telford working with ShropCom respiratory service for patients with COPD, due to go live April 2020. Evaluation of impact 3 months after implementation.
4.5	Delivery of national service specifications for PCNs	2020-2021	Initial guidance advised of five services to be delivered was released on 23 December 2019. After national feedback the 'PCN DES' these have been reduced to three; structured medication reviews, enhanced care in care homes and early cancer diagnosis. During the covid 19 period the work on progressing the national DES has been stepped down. However, as part of the response to supporting individuals in care homes, work has been on going in strengthening the community and Primary care response to care homes.

4.6	Consolidation and further development of domiciliary care zone model	2020-2021	We are 5 months into the Zones and can see from our mapping and client data that clear 'zones' are now starting to take effect. There is still work to integrate providers with voluntary organisations and we continue to promote #everydayisdifferent #caringmatters to support recruitment and retention with our zonal providers. The 6-month cycle of contract management will commence in April 2020 and we will assess the level of integration and plans in increase this.
One Estate			
5.1	Development of new integrated estates/extra care facilities	2020-2024	Progressing New College site with partners. Next steps include developing a master plan and requirements list with partners and ensure the onsite provisions are complimentary.
Other TWIPP Deliverables			
6.1	Implementation of the Hertfordshire Family Safeguarding Model (CYP)	2020-2022	The following are basic elements of the Family Safeguarding Model, how Telford & Wrekin Council became involved in the programme and the proposed timeline for implementation: • The DfE Strengthening Families, Protecting Children Programme: grants to local authorities to adopt one of the three successful innovation projects. • Relevant children's services departments in England were invited to bid for one of these projects to be launched in their area. TWC are one of five local authorities that have been successful in securing grant funding to implement the Family Safeguarding Hertfordshire Model – Walsall Council, Lancashire County Council, Telford & Wrekin Council, London Borough of Wandsworth and Swindon Borough Council. • The Hertfordshire programme team visited on 18th – 19th February to meet key team members of the team in Telford & Wrekin Council. • The programme team will return early summer 2020 to undertake an updated diagnostic and to finalise budget proposals for the Department for Education in readiness for the programme implementation. • The programme team will be here in Telford & Wrekin doing the bulk of work in September/October 2020.
6.2	Mental Health - place based approach	2020-2023	*STP work stream priorities include – All age out of hours crisis services, redesign of rehab pathways to reduce out of area placements, improving access to services for people with autism and LD, and digital solution to support trauma informed care.* A planning session with the leads was arranged for early April, with a place based workshop planned for May. Due to Covid-19 this did not take place and will be rescheduled in due course.

			One place based pilot approach, Calm Cafes, were launched in January 2020 providing 4 sessions in three venues across the Borough. The Calm Cafes utilised short term funding to test the impact of proactive and local engagement on people's mental health and maintaining and improving their outcomes. Professionals from different agencies are on hand, including a social worker, to listen, signpost and help calm situations so people are able to leave feeling more in control and less anxious. The pilot will also inform future commissioning intentions.

8. INTEGRATION HIGHLIGHT - THE HEALTH AND SOCIAL CARE RAPID RESPONSE TEAM

8.1. Telford and Wrekin have continued to see increasing demands on health and social care services, with no additional resources. Senior Leaders across the local sector recognised that in order to achieve a sustainable and successful health and social care system new ways of working needed to be considered.

8.2. In August 2019, Senior Leaders through the Telford & Wrekin Integrated Place Partnership, agreed for an integrated community rapid response pilot service to be developed. This was influenced by multi organisational workshops held in June 2019. The purpose of this pilot was to establish whether, through integrated community working, avoidable unplanned admissions could be reduced and patient experiences and outcomes improved. Simultaneously, the pilot would also enable senior leads to understand the benefits of joined up working to help inform system wide integration moving forward.

8.3. On 18 November 2019, the Health and Social Care Rapid Response Team (HSCRRT) was launched. The aim of the service is to:

- Improve the person's experience,
- Reduce avoidable unplanned admissions to hospital or care homes,
- Reduce the number of crisis referrals,
- optimise follow up care to reduce re-admissions,
- Improve access to a range of community services,
- Happy and productive staff, and
- Provide data and information to support future decision making and service models.

8.4. The co-located service is comprised of Community Nurses, Social Workers, Physiotherapists, Occupational Therapists, General Practitioner Clinical Advisors and Call Handlers. The team also has access to equipment and assistive technology.

8.5. The service supports any person aged over 18 who are experiencing a rapid decline of their health and are in crisis. Some examples of presenting needs have been unexplained falls, urinary tract infections, deteriorating palliative care, reduced mobility, struggling at home and no end of life provision/pathway.

8.6. Individuals referred to the team are assessed within two hours of being referred; following which the team will then put in place a plan to resolve the immediate health crisis, work to help prevent crisis recurrence, and allow the individual to remain as independent as possible in their own homes. This can include:

- Urgent calls will be dealt with by direct professional to professional contact,
- Assessments within two hours,
- Provision of urgent health care response to avoid admission,
- Provision of urgent equipment to avoid admission,
- Assessment for domiciliary care,
- Admission to community bed-based services where appropriate,
- Liaison with the person's GP to effectively manage clinical care at home, and
- Liaison with the wider health and social care system to support the person at home.

8.7. Between 18 November and 22 May 2020, the service has received 895 referrals (averaging 33 referrals a week), of which 876 were accepted. The 19 referrals were declined because they did not meet the service criteria as outlined in 8.5, e.g. they were from out of area.

8.8. The referrals received were from a wide variety of agencies. As at 22 May 2020:

- 28% from GPs, Practice Nurses and GP Out of Hours,
- 19% from Family Connect,
- 15% from Community Health and Social Care Services,
- 15% from WMAS,
- 3% from Care Homes,
- 2% from VSCE sector, and
- 2% from carers or care agencies.

With the remaining 16% from a wide range of agencies/services, including the hospital, 111, CCC, Hospice, Mental Health Teams, ShropDoc, Wrekin Housing Trust and Urgent Care Practitioners.

8.9. One of the key aspects of the team is providing a 2 hour response to a referral. This means that from the point of accepting the referral, the team have two hours to make contact with the person to ascertain next steps. 80% of all of the accepted referrals were completed within the two hour timescale. The timeliness has been impacted by the change in type of referrals that have come as a result of Covid-19. E.g. there have been more lower level referrals to support the TWC's Community Support Service which have not required a 2 hour response, so other cases were prioritised and this has impacted on the overall timeliness measure.

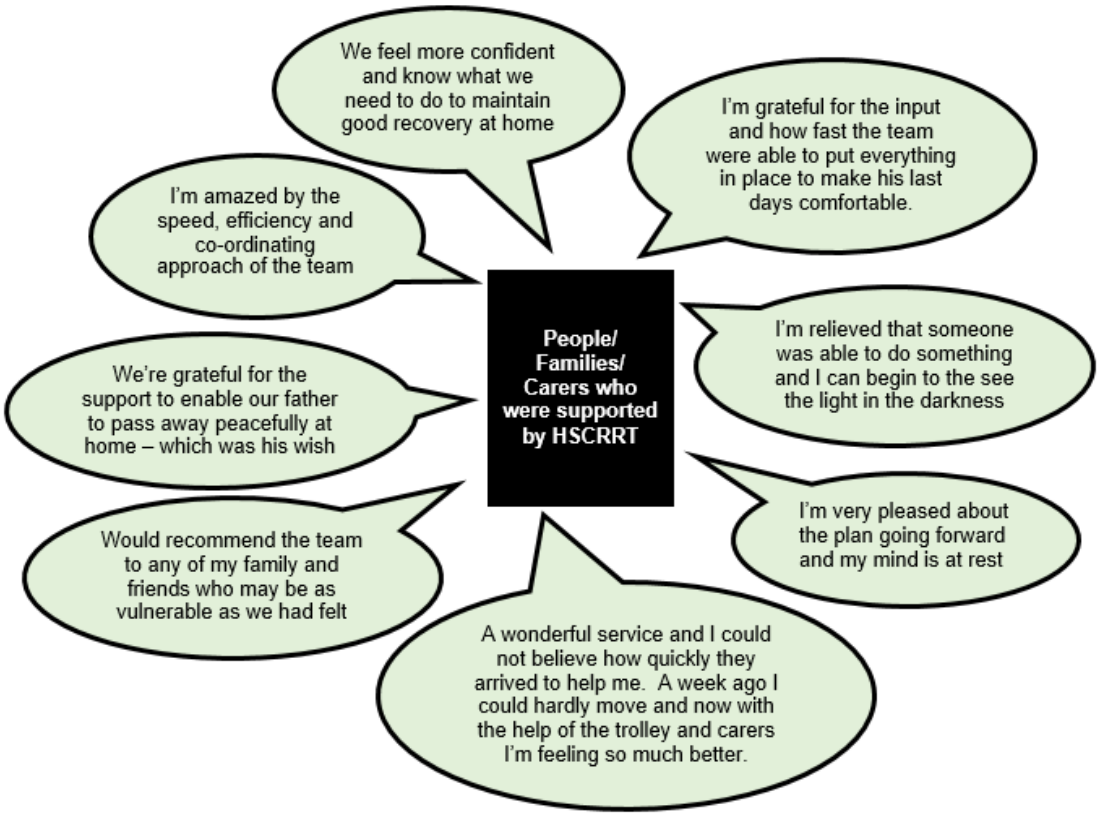
8.10. One of the main aims of this pilot was to avoid admission to an acute setting, either hospital or beds. Of all of the accepted referrals the recorded admission avoidance rate was 96%.

8.11. Over the course of the pilot the team have also seen additional impacts, including:

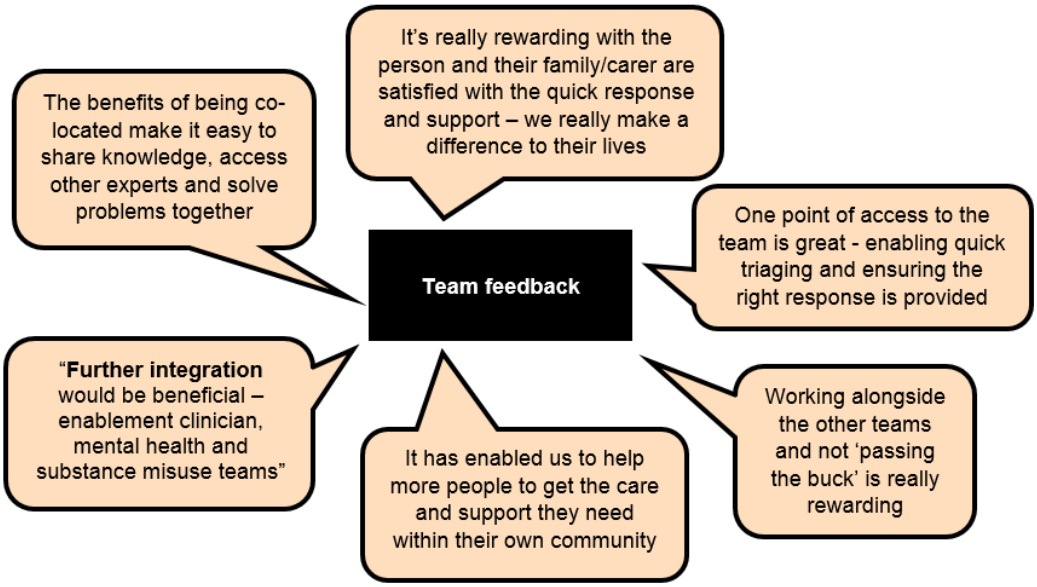
- ✓ More referrals from the ambulance service who would have previously conveyed to hospital;
- ✓ Overcoming information sharing and governance issues to share patient information in real time as part of assessment and treatment planning;
- ✓ Joint working across the specialist teams; and
- ✓ The motivation to look for solutions in a positive way to overcome and obstacles that arise.

8.12. **What difference has it made to people?**

As part of the pilot, feedback from those receiving a service, their family/carers, staff and stakeholders was gathered to enable continuous improvements to be made to ensure the service is efficient and making a difference.


People/ Families/ Carers who were supported by HSCRRT
We feel more confident and know what we need to do to maintain good recovery at home
I'm grateful for the input and how fast the team were able to put everything in place to make his last days comfortable.
I'm amazed by the speed, efficiency and co-ordinating approach of the team
I'm relieved that someone was able to do something and I can begin to the see the light in the darkness
We're grateful for the support to enable our father to pass away peacefully at home – which was his wish
I'm very pleased about the plan going forward and my mind is at rest
Would recommend the team to any of my family and friends who may be as vulnerable as we had felt
A wonderful service and I could not believe how quickly they arrived to help me. A week ago I could hardly move and now with the help of the trolley and carers I'm feeling so much better.


Stakeholder feedback
They have been instrumental …to reduce the avoidable admissions
It enables the person to get the best support in a timely manner
Being able to refer people to this services has certainly been a benefit and provided timely support and avoided hospital admissions
Very impressed with how quick the team responded. We like calling the team as they get things done and we can call for advice too
Thank you for your help
They have given good advice, and support which has enabled the resident to be cared for in the care home
Always get a prompt response and the staff are really helpful



8.13. **Where next?** As we progress out of this phase of Covid-19 and into the resettling of the system we will be looking at moving forward with HSCRRT.

9. CONCLUSION

9.1. Building on the strong foundations of Neighbourhood work started by TWC and TWCCG, TWIPP has developed strong partnerships, designing and delivering integrated place based services in Telford and Wrekin. Progress has been rapid with learning and change developed within the projects as evidenced within this paper.

9.2. The cross-system learning that is being captured during the COVID-19 period will be crucial to developing the approaches moving forward.

9.3. TWIPP is integral to ensuring that the developments are place based and improve outcomes for Telford and Wrekin residents.

10. PREVIOUS MINUTES

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

11. 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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