Appendix 1 Neighbourhood working – Telford & Wrekin

The Telford and Wrekin Model of Care aims to promote:

- Community resilience
- Teams working around the patient
- Intermediate care

What is our approach to developing neighbourhoods?

- Building some prototypes around natural neighbourhoods.
- Optimising the total resource in the neighbourhood
- A community centred approach that increases access to community resources to meet health needs and increase social participation
- Supporting the development of strong neighbourhoods that can work collaboratively to take action together on health and the social determinants of health
- Needs to be locally determined and accept there are a variety of drivers for change and starting positions
- Incremental and organic change
- Support people properly to make the change (from front line staff to senior teams)
- Empower a broader spectrum of people to support the transformation, rather than the 'usual suspects'!
- Ensure we are embedding the principle of improved patient experience as one of our improved quality expectations

Telford and Wrekin - Community Resilience

Community Resilience

Vision and aims

Telford will have strong and connected communities. The community will drive the development of local assets and people will :

- Have friends and support networks
- Feel empowered to improve their own and their families health
- Things to do
- A feeling of being safe and belonging to their community
- Confidence to go and help and ask for help
- Centres or 'connecting points' to go to

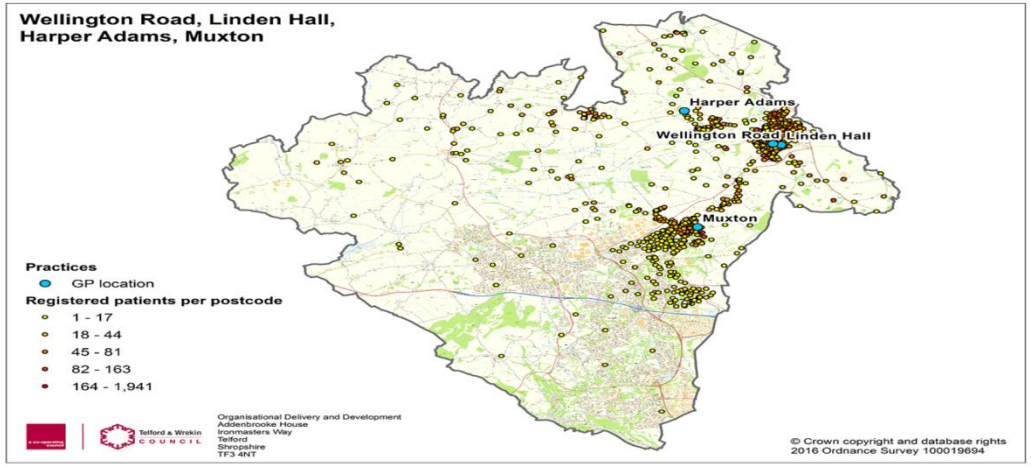
Why?

- Traditional models of statutory services are no longer fit for purpose: They promote dependence, they are expensive and outcomes could be better
- There is a strong and growing evidence base about the importance of building confident and connected communities in improving outcomes for people
- Individuals benefit from contributing to the wellbeing of others
- Significant proof that poor health can be prevented or delayed
- Needs escalate and peoples health and wellbeing deteriorate because they don't have enough support in the community
- People depend on services because they have very limited alternatives in their own communities

Telford and Wrekin - Neighbourhood Care Teams

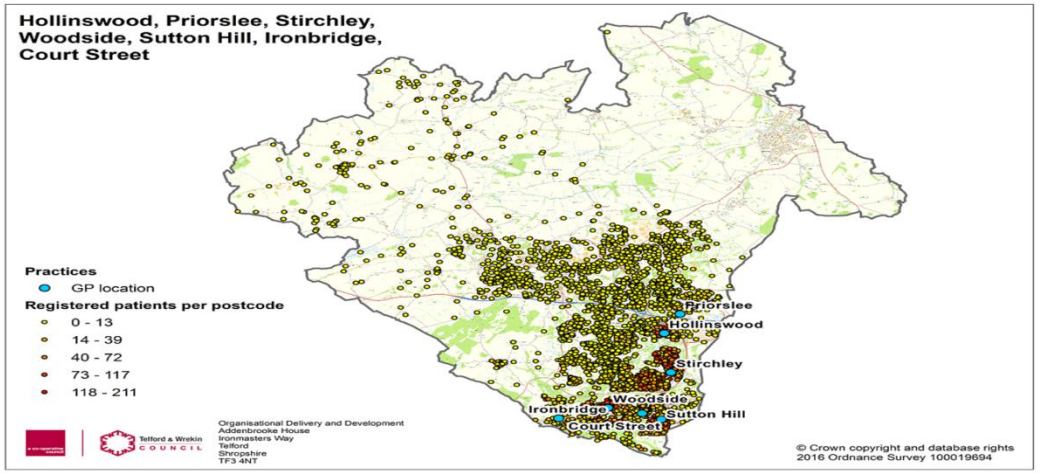
Telford Neighbourhood Care Teams
Vision and aims
People with an identified long term health condition will be supported to live their life to their full potential • The notion of care 'from cradle to grave' will be reinvigorated • Individual professionals will take responsibility for the delivery of as much care as possible, drawing on specialists where necessary • Professionals will work together to seek out those who would most benefit from an intervention/support • People will share their story once in a way that is right for them • People will understand their condition and how to deal with it and people will self care/self manage where possible • Carers will be supported
Why?
• We need a much greater focus on prevention • We need to find people earlier in their disease progression so they can manage their condition better, earlier • A greater number of people have become more dependent on statutory services • Current services tend to do things to and for people, rather than promoting self-management • Multiple individuals from different organisations are providing care for any one patient at any one time • The current way of working is not the most effective way of supporting people • We have lost a holistic nature of care by focusing on 'tasks'

Telford and Wrekin - Pilot sites



Newport Neighbourhood (pop. 33,000)
Priorities:

- Integration of nursing, therapy and care workforce and mental health and learning Disability professionals across a single area
- Utilise a different model of care based on Buurtzorg principles
- Align dementia related services with the practice and enhance early diagnosis
- Map and better utilise community assets (including local buildings)
- Develop the local offer within this market town, including range of diagnostics and outpatient clinics
- Better support to residential homes

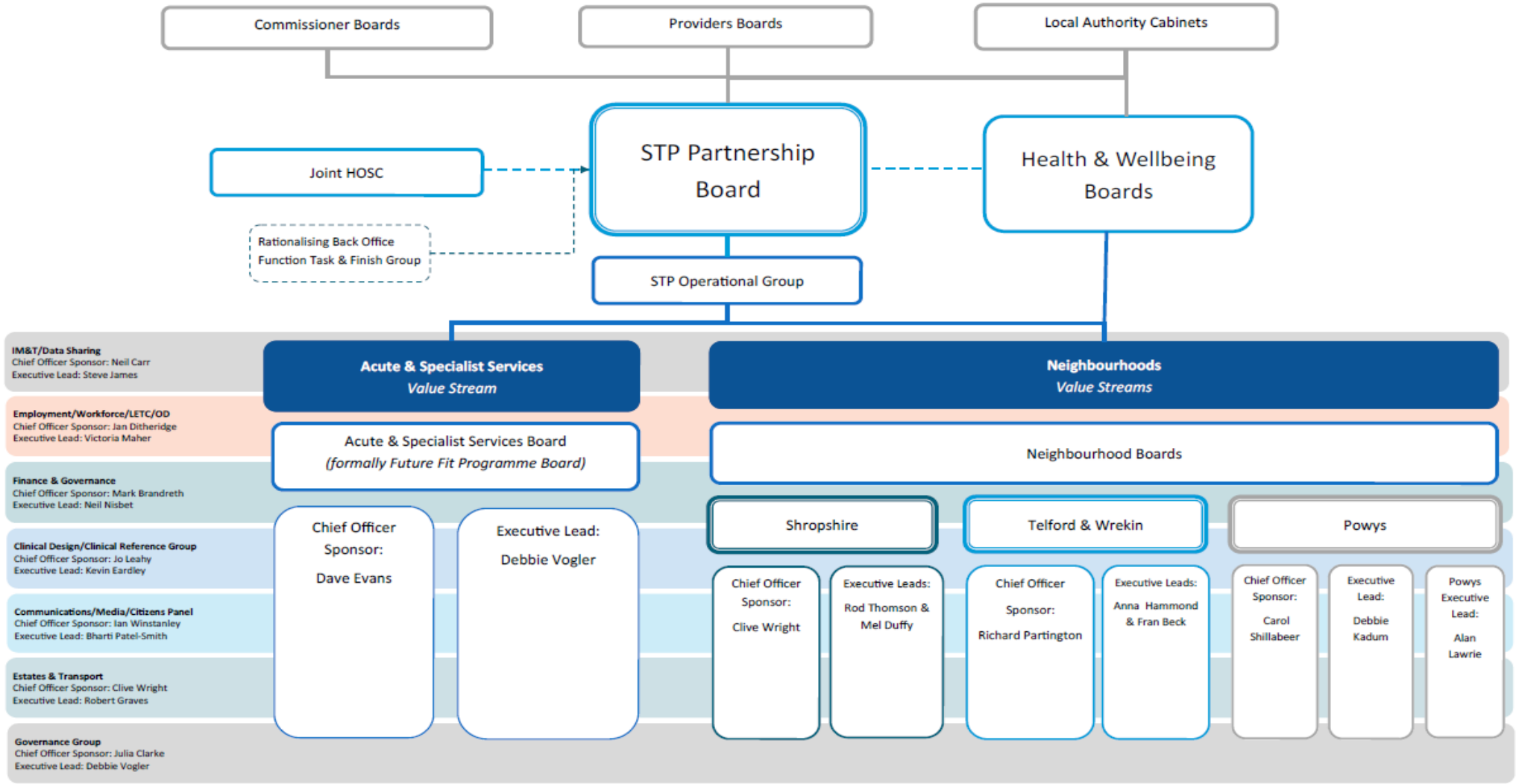


South Telford Neighbourhood (pop. 44,000)
Priorities:

- Integration of health and social care teams
- Greater involvement of drug and alcohol services
- Consideration of those aged 0-5, initially through improved alignment of health visiting
- Implementation of creative support planning and other links with local authority teams

4 Neighbourhoods	
TELDOC	49,615
South Telford	45,427
Newport	27,412
Group 4	59,155

Appendix 2 Governance



Appendix 3 – The STP Compact

- The overarching purpose of STP is to create a patient centered, sustainable system of health and social care. By implementing STP we learn how to collaborate to deliver care to an ageing population with less overall resource.
- We recognize the work that lies ahead will take discipline and a long-term commitment. In the end ***Shropshire, Telford and Wrekin will be the healthiest population on the planet.***
- We recognize achieving this vision will require unprecedented levels of trust, cooperation, collaboration, and working across traditional boundaries.

The purpose of our compact is to support this partnership way of working. The elements are:

GIVE - In our work together, we all agree to:

- Address hard issues [“lance boils”] in constructive ways
- Avoid defensive reactions – listen to feedback
- Say what we need to say in the meetings not outside
- Keep our commitments to this group
- Think and work upstream; invite participation, don’t hand others fully baked solutions
- Be transparent regarding data/finances
- When it comes to the money, align our behavior so that all organisations have positive bottom line within five years
- Share knowledge with each other
- Seek to understand the impact of decisions your organisation takes on others
- Demonstrate commitment to this work to our boards and staff. Inform them regularly using agreed-to talking points.
- Be disciplined about meeting start and stop time
- All take responsibility for successful meetings (not just the chair)

We expect to GET:

- Results including system surplus, 7 day/week care, the services our population needs delivered here
- Aligned outcomes
- Collective power and influence
- Robust meetings, constructive conversations
- Better decisions and greater confidence in our decisions
- More resilience and mutual support
- Trust that agreements we make to each other will be followed through
- Able to learn from failures or shortfalls and thereby accelerate progress

These outcomes should be indicators that our agreements are being lived and we are willing to modify our “gives” as necessary to make progress relative to these outcomes