

TELFORD & WREKIN COUNCIL HEALTH & WELLBEING BOARD**7 MARCH 2018****STRENGTHENING OUR COMMUNITIES AND COMMUNITY BASED SUPPORT
PRIORITY UPDATE INCLUDING NEIGHBOURHOOD WORKING****REPORT OF: ANNA HAMMOND – DEPUTY EXECUTIVE FOR COMMISSIONING AND
PLANNING (INTEGRATED CARE), T&E CCG; LOUISE MILLS – SERVICE DELIVERY
MANAGER, PREVENTION & HEALTH IMPROVEMENT, TWC****LEAD CABINET MEMBER – CLLR ARNOLD ENGLAND****PART A) – SUMMARY REPORT****1. SUMMARY OF MAIN PROPOSALS**

The Local Authority and CCG have been working together on the Neighbourhood Working programme for over a year. This is now considered the major piece of work to develop community centred approaches to improve health and wellbeing across Telford and Wrekin. The approach taken has been to work collaboratively between health, social care and the voluntary sector. Wherever possible the work is driven by communities and or those working in communities. Many of the projects have developed organically, driven by local leaders rather than a 'one size fits all' approach.

Our approach has been to:

- Strengthen communities - through community development, asset based methods and developing social networks
- Develop volunteer and peer roles - enhancing individuals capabilities to provide advice, information and support or organise activities around health and wellbeing in their communities
- Develop collaborations and partnerships – working with health partners, communities and the voluntary sector to design and or deliver services and programmes
- Improving access to community resources – connecting people to community resources, information and social activities

A large number of projects are now in the implementation phase and can be broadly categorised under four themes:

- Encouraging Healthy Lifestyles and prevention
- Promoting Community Resilience
- Direct Care in the Community – including integrated teams, care home support and intermediate care
- Speciality Reviews including diabetes and respiratory

This reports summarises progress to date and outlines the priorities for the next 6 - 12 months.

2. RECOMMENDATIONS

The Board notes the content of this report.

3. IMPACT OF ACTION - (How it is intended that action will make a difference)

- People know how and feel able to live well
- People feel connected with others - with friends and support networks
- People have confidence to know, when their health concern is beyond their knowledge & skills, how to get support that is easy and proportionate to what their needs are
- Our Care services enable and empower patients rather than create dependency
- Our Care system delivers care right first time – better for patients and better for the system
- Our Care services are able to deliver care in the most efficient way across the system – support the shift in care
- Reduced demand on adult social care services

4. SUMMARY IMPACT ASSESSMENT

COMMUNITY IMPACT	Do these proposals contribute to a specific HWB Priority	
	Yes	Strengthen our communities and community based support Priority Encouraging Healthier Lifestyles priority Improving mental health and wellbeing
	Do these proposals contribute to specific Co-Operative Council priority objective(s)?	
	Yes	To improve the health and wellbeing of our communities and address health inequalities
	Will the proposals impact on specific groups of people?	
	Yes/No	Yes
TARGET COMPLETION/DELIVERY DATE	Ongoing programme of work	
FINANCIAL/VALUE FOR MONEY IMPACT	Yes/No	The Council holds specific resources which will support the delivery of this programme. In 2017/18 these resources were £1.25m The Public Health grant allocation to the

		<p>Council has been reduced by around 10% over the last 3 years (to 2017/18) with a reduction of £0.33m advised for 2018/19. Further reductions and changes in this grant and other Council funding is expected in future years. The Council will need to find a further £30m of savings between 2018/19 and 2020/21 and this may impact on the availability of resources to support this work stream.</p> <p>It is anticipated any work associated with the recommendations in this report will be met from within existing resources but this will be kept under review as part of the programmed monitoring process.</p> <p><i>(ER 27.02.18)</i></p>
LEGAL ISSUES	Yes/No	<p>The HWBB has a statutory obligation to encourage integrated working and to encourage commissioners of health-related services to work closely with the HWBB (section 195, Health and Social Care Act 2012). Accordingly, the proposals in this report will assist the HWBB in meeting its legal obligations.</p> <p>This continuing commitment to integrated working is also a requirement of the HWBB's terms of reference.</p>
EQUALITY & DIVERSITY	Yes/No	
IMPACT ON SPECIFIC WARDS	Yes/No	<p>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.</p>
PATIENTS & PUBLIC ENGAGEMENT	Yes/No	<p>Yes</p> <p>Involvement of PPG's and advocacy groups</p> <p>Strong community engagement for some projects</p>
OTHER IMPACTS, RISKS & OPPORTUNITIES	Yes/No	None

PART B) – ADDITIONAL INFORMATION

1. INFORMATION

Approximately 30 different projects are in the implementation phase.

1.1 Encouraging healthy lifestyles and prevention

Healthy Telford led by the council's public health team is a vibrant innovative network of key partners and communities working collaboratively to improve health and wellbeing and to better support local people in their neighbourhoods

To date Healthy Telford has supported 550 plus staff and volunteers to attend Making Every Contact Count training – through this training people have learnt how to successfully raise a lifestyle issue with an individual (where appropriate) and where to direct them for further information and support.

We have worked with our key partners to identify shared priorities and have worked collaboratively to develop bespoke training programmes to meet their learning needs. Practice Managers have co-produced a training session for GP Practice Receptionists which incorporates the requirements of 'Active Signposting' as one of the High Impact Changes for GP's identified in the NHS England 5 year forward view. 140 reception staff have completed this training over recent months.

Our approach has included maximising the use of social media to engage, inspire and to nudge local people to make lifestyle improvements whilst raising the profile of the health and wellbeing resource available to residents to support them to self-care.

Our Healthy Telford social media network consists of: a Twitter account @HealthyTF; our [Healthy Telford blog](#) which provides a mechanism to share local stories, news, ideas and best practice; and a [newsletter](#). Healthy Telford has 3,123 twitter followers (75% Telford residents). Our average engagement rate is 1.2%, considered 'very good'. The newsletter distribution list consists of 500 staff and volunteers working with vulnerable residents. We have an open rate of 37% (compared to a public sector average of 21%).

Everyday Healthy Lifestyle Advisors are changing people's lives in the Telford community through offering advice and behaviour change support to help people to move away from unhealthy behaviours to sustainable positive health behaviours.

Our Healthy Lifestyle Service is integrated within our customer contact centre at Southwater One and service provision includes outreach support in our community venues including GP surgeries, Community Centres, Libraries, Pharmacies, Leisure Centres and Work Places. The Healthy Lifestyle Advisors also have a presence regularly within Probation Services, the Sikh Temple, Branches (mental health Hub), Assisted Living homes, Residential Homes and Adult Mental Health Services.

The team has recently 'lean processed' the service and looked at opportunities for 'channel shift projects' to extend the reach of the service. We have successfully achieved this:

- The service has increased its clinic coverage in GP services from 70% to 98% over this year
- Some GP clinics have increased from 1 half-day session to 2 full days due to the clinics being 100% booked and the GP's being encouraged by the positive outcomes achieved by patients along with a reduction in GP visits
- Nearly 20,000 people have benefitted from a healthy lifestyle brief intervention with over 1000 adults being supported to develop a Personal Health Plan. Our year end position is expected to demonstrate a significant increase in reach compared to our outturn position for 2016 / 17 which was 19,259 brief intervention
- 7,600 people have been signposted to community based support
- 70% of service users have reported achieving their lifestyle goal.
- 52% of service users are from our most deprived communities

There has been a focus on the detection and management of hypertension of people living and working in Telford and Wrekin. There have been multiple events to target people for health checks including leisure centres and workplaces. Work continues to increase the number of people screened.

There have been a range of awareness raising activities to improve the uptake of all screening programmes (cervical, bowel and breast), particular emphasis on cervical screening at present as uptake (nationally) is at a 9 year low. A task and finish group has been established to look at this.

1.2 Promoting Community Resilience

A network of 36 community Health Champions are voluntarily bringing their ability to relate to people and their own life experience to transform health and well-being in their communities. They are delivering health conversations to friends, family, neighbours and their local community; embedding the Health Champion's role into existing volunteering; engaging with and supporting existing initiatives and starting up their own small community projects.

Enterprising Communities is a collaborative partnership supporting people who are currently running a community business and have an interest in extending their work into health and social care and supporting the development of 'new' community businesses in areas where we have high demand for care and support.

The introduction of 'Branches' has been a major achievement with a true community service which continues to support hundreds of people in emotional distress each month.

Feed the Birds is tackling social isolation by connecting vulnerable people with local volunteers who visit once a week to feed the birds in their garden. 17 volunteers have completed compassionate communities training which focuses on communication skills, bereavement, boundaries and confidentiality as well as practical bird feeding tips. 6 volunteers have been successfully matched with vulnerable adults and are undertaking weekly visits.

The local authority Community Participation Team has successfully supported communities who want to take greater ownership of local issues. Four of our local Community Centres (Sutton Hill, Brookside, Donnington & Arleston) are now managed by Community Organisations. They are employing local people; involving local people as volunteers; making their own decisions about what services are delivered and how; and applying for their own funding for projects.

Over recent months it has been a priority to work with GP Practices and local communities to develop models for social prescribing.

Social prescribing recognises that getting people involved in community life, keeping them active and improving social connections is good for both health and wellbeing. It uses a person centred approach to enable patients with social, emotional or practical needs to access a range of supportive non-clinical services and activities. To date social prescribing activity is underway in the Newport Locality and Central Telford Locality.

Key achievements include:

- Establishment of the Newport & District Community Patient Group to support co-production of the programme
- A Weekly link worker clinic at Newport Cottage Care. Clients are presenting with low level mental health issues, anxiety, depression, loneliness & isolation (including carers)
- Development of a number of small community projects
- Local delivery of the Feed the Birds befriending project (partnering with Shropshire Wildlife Trust)
- Bench to bench; Initiated by Newport Rotary Lite and now linked with Walking for Health, adding to their range of low level supported walks.
- Nordic Walking group: local resident now qualified as Nordic Walk Leader and leading weekly walks
- Citizen's Advice clinics now established within Donnington and Charlton Medical Practices
- Music to movement sessions for the inactive at Donnington surgery. Patients are being signposted from Long Term Conditions reviews

Adult Social Care are working with partners to pilot three 'hubs' across three localities (Stirchley, Newport and Wellington). The 'hub' will improve access to information and advice for early help and support, occupational therapy and assistive technology. Healthy Lifestyles advice will be included in the offer. The first hub session will be launched in April.

1.3 Direct Care in the Community – including integrated teams, care home support and intermediate care

A 'Care home team' is being introduced to better support people in care homes and reduce admissions to hospital

Multidisciplinary teams (MDT) have been coming together in the neighbourhoods bringing together health and social care staff to identify patients who are at risk of admission to hospital, and support patients with long term conditions. These teams include nurses, rapid

response workers, social workers, therapists and mental health workers. MDT meetings have been established in Newport neighbourhood, and a trial is planned in Donnington at the end of February. All staff within the multidisciplinary teams will be aligned to their practices/neighbourhoods by 1st April and there will be further roll out of the MDT meetings.

The neighbourhood GPs have guided the design of these teams around their practice populations and have articulated the priority areas that they would like to focus on in their neighbourhoods. Initial feedback from community staff and GPs involved with the neighbourhood MDTs has been positive.

A new model of care is being rolled out which includes the introduction of dementia companions and brings the memory service to neighbourhoods.

Speciality Reviews including diabetes and respiratory

Building on the strong service provision, there has been a focus on the improvement of respiratory care including more education available for patients to better understand and manage their condition. Initial indications demonstrate improvements for those who completed the course

Improved diabetes care, including more education and an improved management of people in primary care, has already shown improved clinical outcomes. For example 546 more people have achieved all three treatment target values (HBA1C, cholesterol and blood pressure) and are now at reduced risk of diabetes related complications, for example amputations

Next Steps

The early signs of success are promising and both the CCG and Local Authority are keen to increase the scale of the work and pace of change. Over the next year the following changes will be seen:

- Strengthened programme management
- Development of a framework of outcome indicators to measure success and to demonstrate impact
- Fully functioning multidisciplinary teams in each of the four neighbourhoods
- The Strategy Unit have been commissioned to help us to understand the evidence base for similar changes and develop an evaluation strategy so we can measure successes and adapt accordingly
- Wound care hubs will be introduced in each of the four neighbourhoods by the end of the year. This will improve wound healing times and also help to address social isolation for this group of patients
- The 'intermediate care response' will be improved to help avoid hospital admission and further support earlier discharge from hospital
- 'Healthy lifestyles' will feature as a more prominent part of the programme including the development of neighbourhood plans and partnership working with established organisations to develop their health improvement role

- Delivery of a communications and engagement plan to better help the public and professionals understand the opportunities and galvanise support
- Development and launch of a 'community directory' providing accurate information about community health services and community based support and activity

2. **IMPACT ASSESSMENT – ADDITIONAL INFORMATION**

3. **PREVIOUS MINUTES**

- None

4. **BACKGROUND PAPERS**

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