



Telford & Wrekin

C O U N C I L



Telford and Wrekin

Clinical Commissioning Group

Telford and Wrekin Neighbourhood Working Programme

A collaborative programme of work
between Telford & Wrekin CCG and
Telford & Wrekin Council

Neighbourhood Working

Our Vision

Resilient Communities
– strong and
connected



*People
supported to
stay well*



Treatment in the community

*People with LTCs supported to live their life
to their full potential*

Our Approach



How Does It Fit?



futurefit
Shaping healthcare together

The Journey So Far....



COPD self-management coaching programme

From June 2017 we will be running 6 COPD self-management programmes across Telford.

- 1 Run by qualified professionals
- 2 Includes telephone coaching and group workshops
- 3 Focus on behaviour change

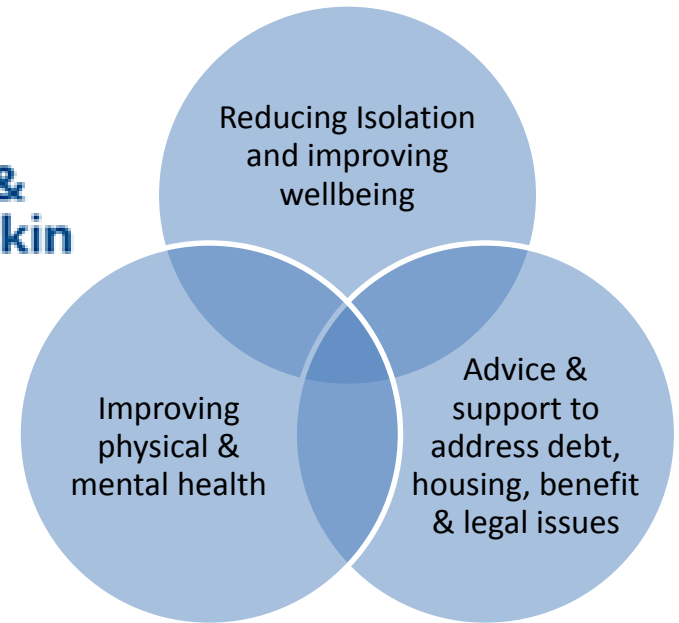
Example 1: Branches



Example 2: Community Prescribing



**Telford &
the Wrekin**



Example 3: Diabetes



- New Three Tiered model
- 546 more people have achieved all three target values and are now at reduced risk of diabetes related complications, for example amputations.

Case Study

Patient Story

John, 39 years old

John, 39, was referred into service after several admissions into SaTH for Diabetic Ketoacidosis. The gentleman had Type 1 Diabetes since his teens and had been poorly managed. During the 6 months leading up to his referral he had been admitted to SaTH 8 times in DKA.*

John lived in a Nursing Home and relied on the nursing staff to give him his insulin, which had been written up in conjunction from consultant/GP. When the team first met John, his insulin regime was “completely inappropriate” resulting in multiple problems, and he was being fed by a peg tube.

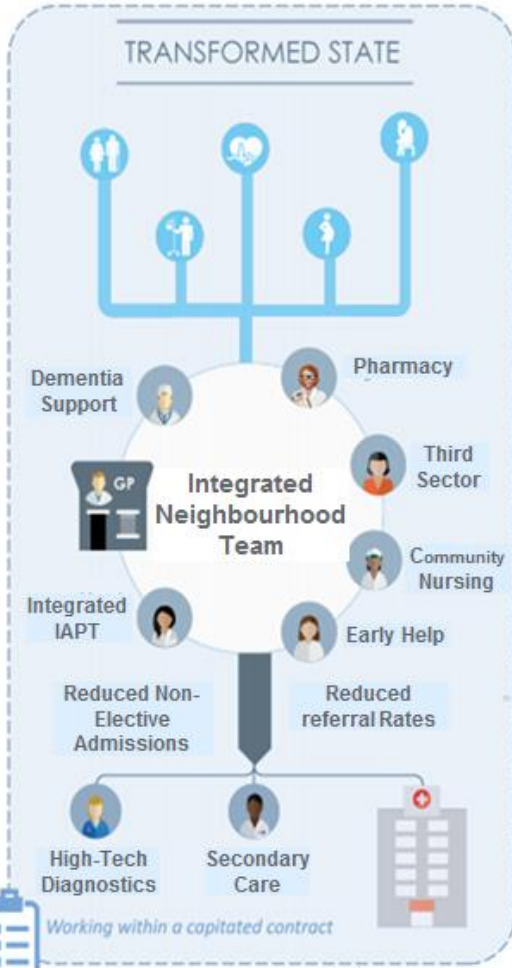
When the team became involved, they changed his background insulin to a more appropriate one, but more importantly, taught John to give his QA insulin in conjunction with a dose advising meter, and empowered Rob to take control of his Diabetes. Within 6 months, Rob had not had 1 admission with DKA, he was able to tolerate a normal diet, his PEG had been removed, and he became fit enough to undergo a pancreas/kidney transplant. John is now living an independent life in his own home.

**Patient name changed for privacy purposes*

Some other outcomes achieved so far....

- Health Champions - 27 new volunteers have been recruited
- MECC Training – Making Every Contact Count Training has been delivered to 50 staff with a further 100 scheduled this month
- Respiratory – 15 patients have been identified in the area who are the most at risk of unplanned admission to hospital; these patients have since commenced a course for self-management.
- Diabetes – improvement in patient outcomes has been achieved
- Hypertension – An increase in the number of individuals being screened and identified is currently being achieved
- Dementia – Named consultant psychiatrist now linked to each Neighbourhood
- Branches
- Citizens Advice - outcomes achieved include an estimated £15,200 in welfare benefit gains
- Cancer Detection – 2 pilots have taken places with practices, both achieved an increase in screening for bowel cancer.
- Reduction in demand on social care

What Next?



Adapted from: <http://www.napc.co.uk/primary-care-home>

- One Team
- Early Help and Support Teams
- Staff alignment around Neighbourhoods
- Risk Stratification
- Wound Care
- Estates Planning
- Communications and Engagement