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TELFORD & WREKIN COUNCIL HEALTH & ADULT CARE SCRUTINY COMMITTEE

12th September 2018

Strengthening our communities and Community Based Support Priority Update including neighbourhood working

REPORT OF Anna Hammond (CCG) & Louise Mills (TWC)

PART A) – SUMMARY REPORT

1. SUMMARY OF MAIN PROPOSALS

The Neighbourhood Working programme led jointly by the local authority and CCG 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 the following 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 – Diabetes

This reports summarises progress to date.

2. RECOMMENDATIONS (AND TO WHOM ACTIONS APPLY eg CCG, Council)

That the content of this report is noted

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	The Council holds specific resources which will support the delivery of this programme. In 2018/19 these resources were £1.33m, including £0.27m of one-off resources. Further reductions and changes to Public Health Grant allocations, and other Council funding is expected in future years. Public Health England have already advised a further reduction to Public Health Grant of £0.3m in 2019/20. The Council will need to find further savings of between £20m and £25m over the next two years, 2019/20 and 2020/21, and this may impact on the funding for this work stream. It is anticipated any work associated with the recommendations in this report will

		be met from within existing resources and this will be kept under review as part of the programmed monitoring process. *(ER 05.09.2018)*
LEGAL ISSUES	Yes	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. This continuing commitment to integrated working is also a requirement of the HWBB's terms of reference.
EQUALITY & DIVERSITY	No	
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.
PATIENTS & PUBLIC ENGAGEMENT	Yes	Yes Involvement of advocacy groups Strong community engagement for some projects
OTHER IMPACTS, RISKS & OPPORTUNITIES	Yes/No	None

PART B) – ADDITIONAL INFORMATION

1. INFORMATION

1.1 Encouraging healthy lifestyles and prevention

The Healthy Lifestyle Service is provided by Telford and Wrekin Councils Health Improvement Team. The team consists of a small number of Advisors who support local people to make improvements to their lifestyle with a particular focus on healthy eating, weight management, emotional health and wellbeing, physical activity, reducing alcohol consumption and support to quit smoking.

This year the council took the decision to allow the contract with an external provider for the provision of our quit smoking service to expire and we insourced the service from the 1st April. We have also incorporated lifestyle support for children and young people so we are now able to offer a holistic behaviour change support service for children, young people and their families.

A performance overview for 2017/18 for the Healthy Lifestyle Service is summarised below:

- Brief lifestyle advice to 17,378 people
- Brief interventions (30 minute health chat) to 27,087 people
- Health Checks were completed for 2,689 people; of these 70% had one or more long term conditions
- The service received 1,842 referrals; of these 1,503 committed to a Personal Health Plan; 79% had one or more long term conditions
- 61% achieved their primary lifestyle goal
- 11,620 referrals were made (including signposting) to support services and community projects provided by partners organisations to support people to achieve their lifestyle goals
- 1501 people set a quit date – of these 50% successfully quit smoking at their 4 week follow up

Priority has been given to developing referral pathways to improve access to healthy lifestyle support. Engagement with General Practice and wider NHS partners has improved significantly over the past 12 months now making up 73% of all referrals to the service. This programme of work contributes to improving outcomes for diabetes and CVD prevention and treatment which are priorities of the CCG.

Healthy Lifestyle clinics take place in all Medical Practices across Telford with the exception of one practice, where due to current room availability this is not possible and an alternative community venue is used. 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. The number of patients with a Personal Health Plan varies considerably across practices ranging from 18 – 242.

The team has also worked collaboratively with the Midlands Partnership NHS Foundation Trust to address the physical health needs of patients on the psychosis pathway particularly those patients with low self-esteem and where medication has led to weight gain. The number of people with long term conditions committing to a Personal Health Plan has increased by 54%. This can be attributed to our increasing work with the musculoskeletal team and clinic within Euston house and the hospital, raised presence in the practices and more structured health care professional referral pathways for clients with long term conditions into the service.

Working with partners to develop our approach to social prescribing is a current priority. Whilst our social prescribing approach for healthy lifestyles is well developed work is required to develop our local programme. This will include further development of our referral pathways, identification of more link workers, community

arts programmes, community learning (including Reading Well programmes) and strengthening links with services that provide local support for social issues (unemployment, welfare and debt).

1.2 Promoting Community Resilience

1.2.1 Community Directory – Live Well Telford

Telford's OCC Market Place (product name for the Community Directory Portal/website) has been named Live Well Telford. Live Well Telford will enable people to access information and advice easily and be signposted, if appropriate, to care and support they may need in order to help themselves or those they care for.

It is being designed to help people find the right help, at the right time to promote their independence. Workshops have been held providing the implementation project team with an overview of the portal's functions, together with an overview of the migration of data functions (to aid the harvesting of data from existing directory's e.g. MyLife and Family Connect).

Since the migration workshops the Live Well Telford Lead has been working with the supplier, internal ICT and Web Services to test the data uploader tool to ensure that it populates into Live Well Telford correctly. There are two rounds of testing for Live Well Telford scheduled during August and September 2018, involving project staff and stakeholders. During this time, the configuration of the website and branding will be implemented. Key stakeholders involved in the implementation of Live Well Telford include: Community Participation and Community Champions; voluntary sector organisations and groups; providers of services (Health and Social Care); Public Health; CCG and links to health, including GPs and Pharmacies; Adult Social Care; and Children's Social Care

1.2.2 Health Champions

The council's Community Participation Team have successfully created a network of 52 community Health Champions. Our Health Champions are all local people who, with training and support 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. Health Champions work closely with our team of Healthy Lifestyle Advisors.

1.2.3 Feed the Birds

Feed the Birds is delivered in partnership with Shropshire Wildlife Trust. The project supports people who are lonely and/or socially isolated get closer to nature, by feeding the birds in their garden and contributing to their overall health and wellbeing. Clients are identified and referred by colleagues and partner agencies. Once a client and volunteer match has been identified, the volunteer visits the client in their home,

once/twice a week for up to an hour, to help feed the birds. For the clients the project has a positive impact on the client's quality of life including becoming more socially active, building confidence and developing new skills. For family members they see a positive change in their loved one. For the volunteer they have a positive experience taking part in the pilot, knowing they are making a difference to the quality of people's lives. To date 17 volunteers have been trained and matched with a client and plans are in place to recruit and support an additional 16 volunteers over the next 12 months.

1.2.4 Branches Mental Health Hub

The Branches Mental Health Hub was commissioned to provide practical and emotional support for people who are suffering mental ill health and dual diagnosis issues. The service is averaging 743 attendances a month. 57 volunteers support service delivery and to date have contributed nearly 10,000 volunteering hours. There are five mental health support groups running weekly including topics such as Anxiety & Depression, Family & Carers Group, Understanding Personality Disorders, and Grief & Loss. Branches also have an office in the Park Lane Centre in Madeley two days per week to cover South Telford & runs six days a week from Strickland House. Various training courses and qualifications are also being offered to service users, staff and volunteers as well as to those in the wider community.

1.2.5 Enterprising Communities

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. Six community businesses were supported in year 1 and a further six have been identified for support in year 2. Work has started with Birmingham University to gather evidence to demonstrate outcomes and value. An additional 35 community businesses and entrepreneurs have received support to apply for funding, access training and signposting to a range of organisations.

Case Study

Craft group community reunited after support from the Enterprising Communities Project

When their old day centre closed down at short notice, the Cottage Crew craft group were determined to stay together and to find a new venue – one which would help them to become more integrated in the neighbourhood. August saw the group reunited at a new venue. Community Catalysts worked with the council's Community Participation Team to find and facilitate the use of a new venue, a vibrant arts and craft community café called Forge Urban Revival. Together, they were also able to source support workers from another local community business, Hub on the Hill. Finalising the details and organising logistics around finances proved to be a

challenge, and the team spent some time in negotiations, but in the end the Cottage Crew were able to resume their crafting activities after just a four-week break. The group members are really pleased to be back together.

"We're delighted to have been able to help them with their mission. It's been a real team effort, with the council, community businesses and former staff and volunteers. It has brought the community closer together. *"Chris Clarke, Community Business Coordinator at Community Catalyst*

1.2.6 Wellbeing Hubs Network

The Wellbeing Hubs Network is now recognised as an independent consortium led by T&W CVS. The network has 40 Members connected by the common aims to improve Community Care with people for people including care, support, housing and assistive technology. The network has established community 'Hubs' within Wellington and surrounding areas and hold regular 'Art of Wellbeing Events.' The Hubs coordinate community activities, provide local information and raise awareness of care and support across all ages.

The network has coordinated a number of community care initiatives. Examples include:

Living well with dementia in the community (SPIC, Wellington Library & CCG) - The 'Keeping Active Live well with Dementia Collection' is a service that increases dementia awareness and supports carers to be aware of a range of items available to include jigsaws, books, puzzles, DVD's, table top games, inflatable games and activities https://library.telford.gov.uk/web/arena/keepingactivedementia ;

Wellbeing Groups – focussing on empowering family carers to keep resilient, avoiding crisis and breakdown, dealing with common challenges with others through peer-led support groups, a social scene, promoting health & wellbeing and strengthening personal networks.

1.2.7 Carers

The wellbeing of the carer is paramount to enable them to carry out their caring role as well as build their own personal resilience. As part of the local carers strategy there is a range of offers available to carers to access throughout their caring journey. This includes access to creative activities, education and wellbeing workshops – outcomes include improved wellbeing; personal resilience and improved connectivity with other carers reducing isolation.

Case Study

Telephone Befriending Service – a Peer-Led Service

Iris approached us to become a volunteer after seeing our volunteer section in the Carers Newsletter. Iris has become a valued Phone Friend, calling her carer every

week to offer conversation, advice and support. Her assigned carer is dealing with the same issues as Iris has experienced herself – a husband with dementia – and is able to give the carer valuable dementia insights. At 86 years old she is our oldest volunteer and freely admits that her role with the Carers Centre keeps her mind agile and she contributes a long way to continuing well-being, despite several medical issues of her own.

Well-being Volunteer

Carer JR cares for his wife who has Multiple Sclerosis: On attending the Well-being Sessions as a carer JR has learnt Reiki and has now become a carer volunteer. As a volunteer he now provides Reiki treatments and also provides 'peer' support to carers. JR was recognised in the 2017 Active Lifestyle Awards for his outstanding contributions to volunteering and carer support.

1.2.8 Locality Plans

The Public Health team working with partners has taken a strong leadership role at a strategic and community level in developing neighbourhood working to improve health and wellbeing and resilient communities. Asset based community development has been at the heart of our approach building social capital, connecting people and organisations to work collaboratively to improve wellbeing. General Practice and the voluntary sector are key partners supporting our approach.

A Health Improvement Practitioner has been assigned to each locality. Population profile information has been reviewed and emerging priorities have been identified for the next 12-18 months. These are:

- Excess weight and obesity (across all localities)
- Emotional mental health & wellbeing (across all localities)
- Loneliness & isolation (across all localities)
- Smoking (Hadley Castle)
- Smoking in pregnancy (Lakeside South)

Over the next few months practitioners will be working with council service delivery teams, key partners and communities to co-produce a locality health improvement plan. Plans will adopt the Community centred approaches framework developed by Public Health England. The assets within communities, all of which are building blocks for good health include:

- skills and knowledge,
- social networks – friendships, neighbours, local groups and community organisations,
- facilities and resources and
- physical, environmental and economic infrastructure

Whilst plans are still in the development phase the small team of Health Improvement Practitioners have started to work directly with communities and voluntary sector

organisations to strengthen their health improvement role. Early achievements include:

- Secured 'Food for Life' Funding for 4 Telford schools with the highest obesity levels
- Working with Silver Threads Hall (Donnington) to support development of two wellbeing groups
- A successful National Lottery Small Grant of £10,000 for Donnington Community Hub (physical activity)
- Big Local (Brookside) has funded an outdoor gym for residents – Health Practitioner supporting the training and development of local residents to lead sessions
- Supporting planning and delivery of a 'Fit and Fed - Holiday Hunger' summer programme for Woodside, Sutton Hill, Donnington & Dawley. Also receiving support from the national Street Games Park Activator programme.
- Secured £15,000 from the Telford Trust – funding will be used to support community based physical activity programmes
- Delivered a successful community event to connect the Arts and Care sector
- Partnership working with the Wakes around arts activity with the aim of reducing social isolation

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

1.3.1 Development of Integrated Teams

Integrated teams are made up of people from multiple organisations, harnessing the skills and knowledge of the professionals working within them. This work brings together professionals from within health, social care and voluntary sector and involves GPs, social workers, community nurses, therapists, health care assistants, pharmacists, care navigators and mental health workers.

Encouraging health and social care services to work together in Neighbourhood Teams will allow these services to consider an individual's physical, mental and social needs as a whole, instead of just focusing on a single part and will mean that people will only have to tell their story once. This programme of work uses a strength based approach to improve care and respond more appropriately to rising demand.

Health and social care staff have been realigned to specifically work in one of four neighbourhoods and two of the four neighbourhoods are running multidisciplinary meetings to review patient needs. This work is in its very early stages but will be a priority for the CCG over the next few months.

Case Study

A local GP was concerned about a lady who was attending the GP practice an average of 200 times a year for non-medical reasons. She did not leave the house, other than to attend the practice or go to A&E. Via the MDT approach with both health, social and third sector, the integrated team were able to explore different ways of working with the patient. This individual is now volunteering full time, has not

accessed the GP or A&E, and has said she is "delighted", describing her experience as "life changing"

1.3.2 Care Homes Team

The CCG has commissioned a dynamic, inspiring and supportive mutli-disciplinary team who facilitate care home staff to provide confident, comprehensive care until the end of life for their residents. This is a small team embedded within the Community Rapid Response Team, and their functions include:

- Following an intervention by rapid response (whether patient is taken to hospital or not), the dedicated care homes staff follow this up with the home, supporting them to carry out a route cause analysis to understand what happened, why, and how it can be prevented from happening in future.
- Providing a supporting function which focuses on prevention and proactive working, specific to the needs of the home and residents. This includes more intensive input following training provided by Shropshire Partners in Care (SPIC) to enable care home staff to have the competencies to apply learning to ensure confidence in delivering care to their residents, with a particular focus on end of life. Progress to date includes:

    - Increased profile of the rapid response team – care home staff are contacting the team first rather than dialling 999 when they are worried about a resident.
    - The team have successfully formed working relationships with the dementia team and have been actively raising the profile of dementia within care homes, in addition to participating in neighbourhood MDT meetings.
    - Intensive roll out of "Emergency Passports" for the residents in some settings. This is already recognised and used by the ambulance service in the Walsall area and has achieved a reduction in conveyances to hospital.
    - The team are also working with SATH and the Dementia Team to develop a "Red Bag Scheme"
    - In addition to falls prevention awareness, "I-Stumble" protocol has been implemented in the six homes by the team, which is a tool aimed at care homes for use in assessing falls, and includes guidance for staff on what to take during and after a fall, and when it is appropriate to call 999.
    - The team have been collating case studies and feedback from homes to demonstrate impact and admission avoidance.

Case Study

Feedback from a local care home:

"We have been trialling the new Emergency Passports with the Care Home MDT and I have to say it has so far been entirely successful for us as a Residential Care Home.

We allowed admission of a lady, Jane, with Type 1 diabetes and were advised by family prior to admission that this lady's diabetes was very well managed. However, upon admission it transpired that this was not the case. Jane had settled very well onto the unit and Rapid Response were coming into the home to administer her insulin both morning and night. There were episodes happening during the day where we were unsure whether it was diabetes related and very few care assistants had received training in checking blood glucose levels.

Julie was immediately on hand to attend the Scheme and provide staff members with the training they required to be able to check blood glucose levels and understand what they needed to do if these readings were outside of Joan's usual parameters. This has saved countless 999 calls and GP/Shropdoc visits as we are able to manage this in house and are now learning the signs of hypos and hypers in Joan. This training was invaluable. The support of care home MDT meant that Joan was able to stay with us.

We have had approximately three emergency 999 calls following falls since the introduction of the emergency passport and these have been graciously accepted by the ambulance service and they have confirmed and agreed that the passports contain all of the information required in one place. Usually we would need to provide them with MAR sheets and this prevents the need for them to carry copious amounts of paperwork and avoids that information becoming lost in transport. The emergency passport is one document which follows the patient and is much simpler for us to provide and keep up to date.

The support from the Care Home MDT has been invaluable and I appreciate all of their help. I know and understand that if I have any concerns regarding any of our residents, I can ring them for advice and they get back to me and avoid unnecessary GP calls and prevents issues from deteriorating to the point we need to consider hospital admission. I feel much able to manage the residents and keep them here.

1.4 Speciality Reviews – Diabetes

Improvement of outcomes for people with diabetes is now one of the CCGs top priorities. Comparisons with other areas demonstrates that people with diabetes in Telford and Wrekin may be more likely to have health issues. Over the next year a lot of work will take place to promote early diagnosis and with GP practices to make sure patients with diabetes are receiving the best possible care and advice. This is in addition to encouraging adoption of healthy lifestyles to try and avoid development of the disease wherever possible'

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. Partners continue to work together to:

- Have a clear vision and strategic plan across the health and social care system to balance the 'bottom up approach' that the programme has taken to date - this work is being supported by the LGA
- Develop a framework of outcome indicators to measure success and to demonstrate impact
- Work with the Strategy Unit to develop an evaluation strategy so we can measure successes and adapt accordingly
- Agree a communications and engagement plan to better help the public and professionals understand the opportunities and galvanise support

2 IMPACT ASSESSMENT – ADDITIONAL INFORMATION

3 PREVIOUS MINUTES

- None

4 BACKGROUND PAPERS

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