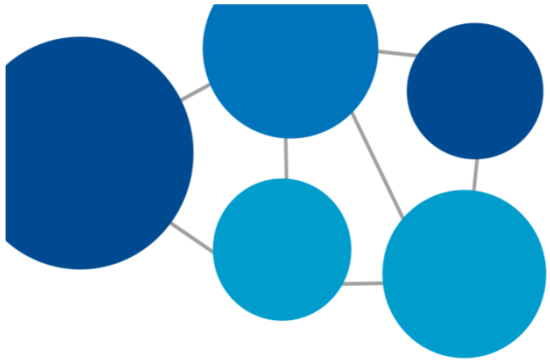
NHS

futurefit

Shaping healthcare together

Community Reference Group



futurefit
Shaping healthcare together

Welcome

Dr Jo Leahy
Chair, Telford & Wrekin Clinical Commissioning Group

Dr Stephen James
GP Board Member, Shropshire Clinical Commissioning Group

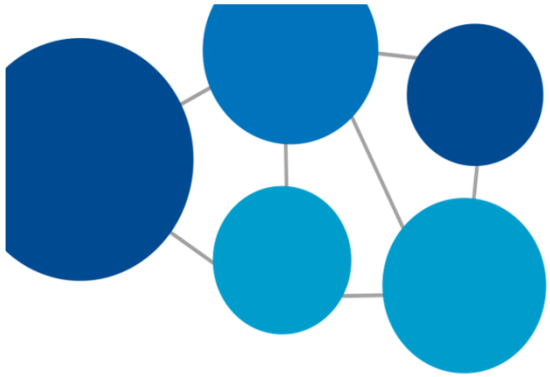
NHS

Agenda

futurefit
Shaping healthcare together

Time	Item	Lead
1815	**Arrival & Welcomes** Light buffet available from 1800	Steve James and Jo Leahy
1820	**Welcome & Purpose of the Event** Why are we here?	Jo Leahy and Steve James
1825	**Sustainability & Transformation Plan – Neighbourhoods** Where do the "old" Future Fit/Community Fit and Rural Urgent Care initiatives sit moving forward?	Mel Duffy
1840	**Neighbourhoods Ambition for Shropshire and Telford & Wrekin** Our ambition for the neighbourhoods and the key functions which are to be available at Neighbourhood level	Mel Duffy and Fran Beck
1900	**What will be different?** • Progress on Pathway Development • How can technology support us to deliver care differently	Emma Pyrah Steve James
1915	**Examples of supporting work** MCP Framework, Veteran association etc	Steve James and Jo Leahy
	REFRESHMENT BREAK	
1940	**Neighbourhood Review** Review and test work in progress in the neighbourhood against local needs to confirm fitness for purpose and highlight any gaps	Mel Duffy and Fran Beck
2030	**Next Steps** To plan next steps and delivery timetable.	Jo Leahy and Steve James
2040	**Thank you and Close**	

NHS



futurefit
Shaping healthcare together

Neighbourhoods Shropshire

NHS

Shropshire Community Health NHS
NHS Trust

Neighbourhoods Development

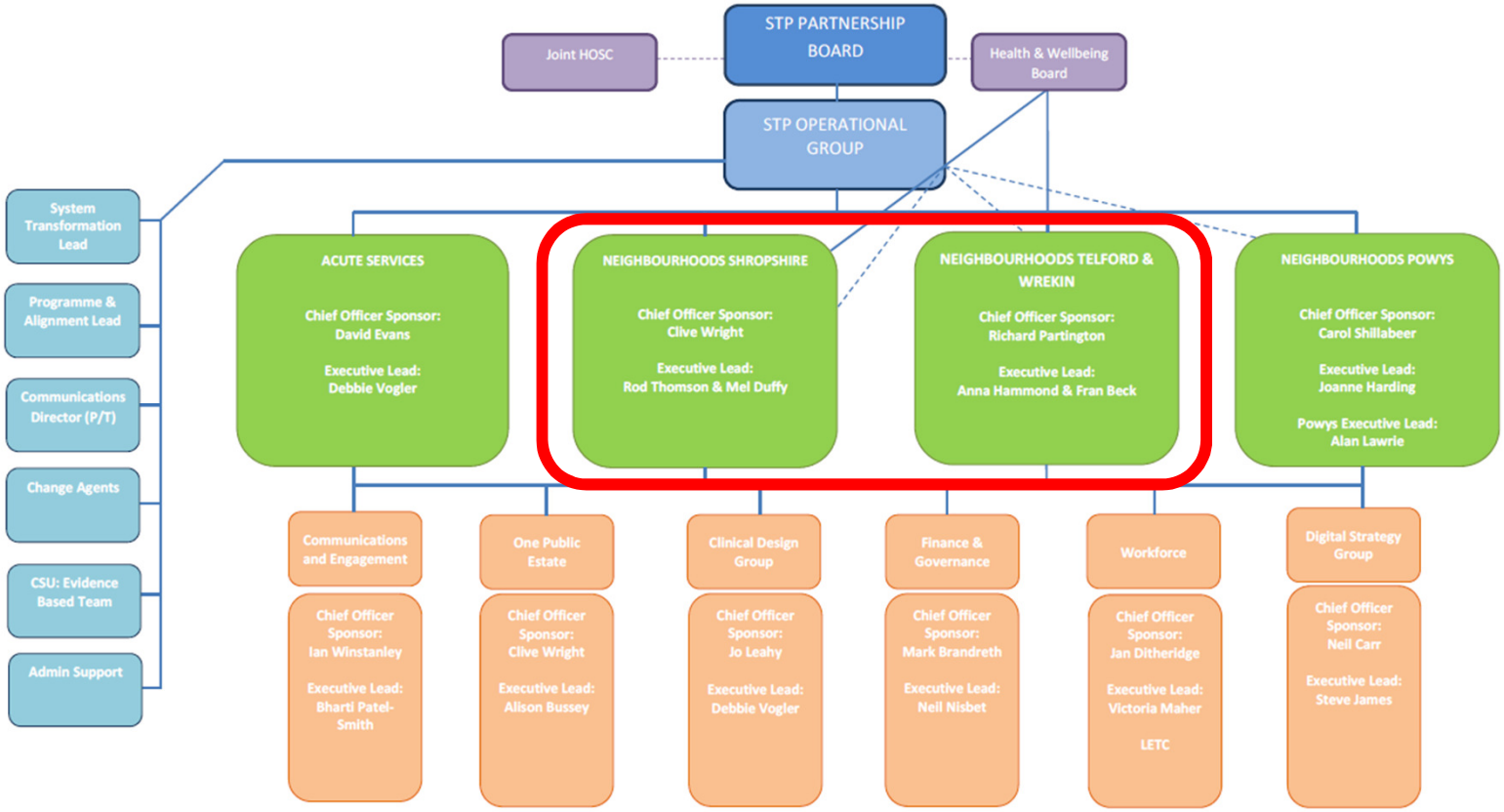
Shropshire

Improving Lives In Our Communities

Purpose of this session

1. To update on the development of the community offer
2. To share the planning timetable

STP Structure - Recap

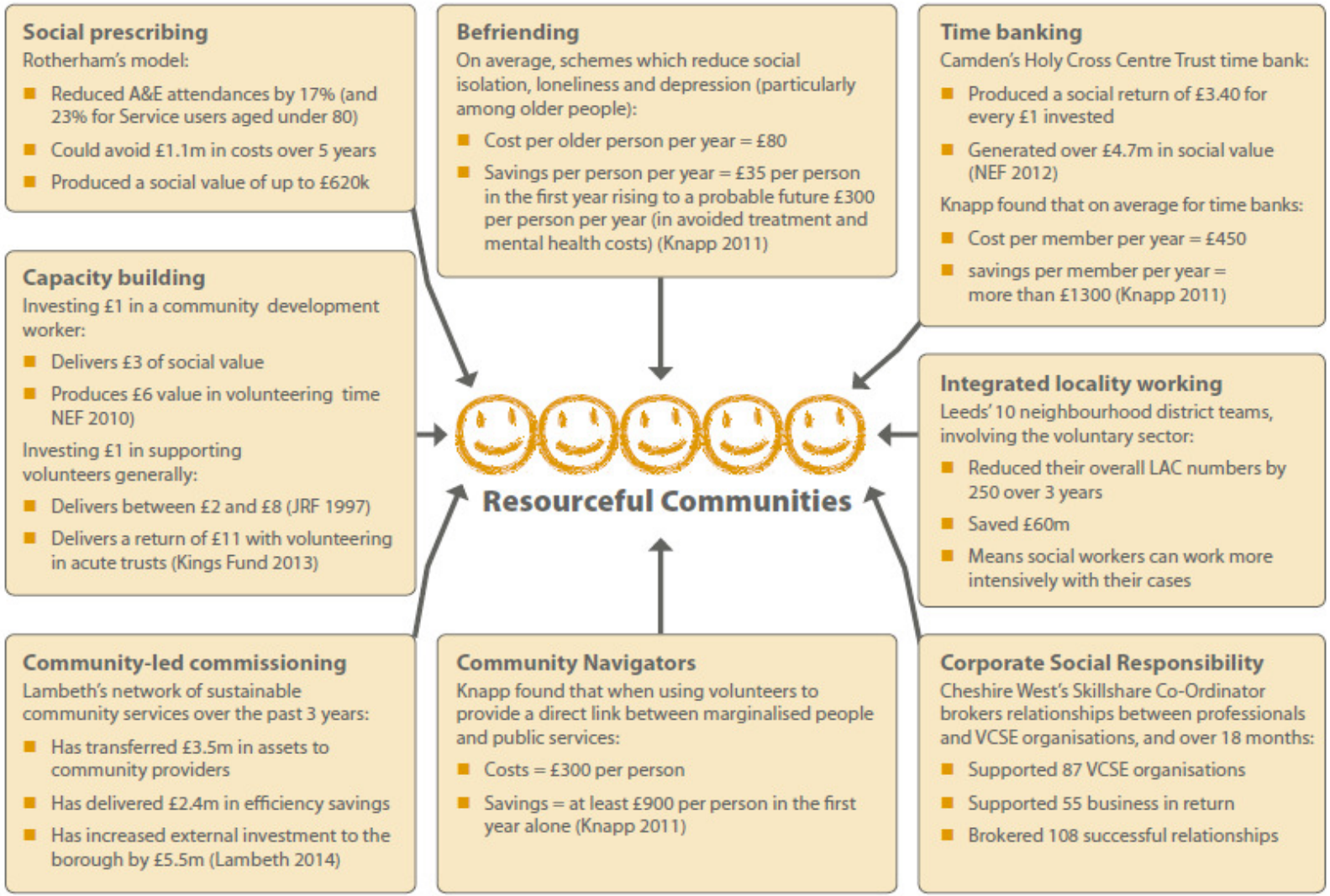


Neighbourhoods Transformation Groups

Improving the health and well-being of local communities

Delivering care closer to home through sustainable primary and community health and care services

Ways of working that builds and supports social action –



Ways we work that builds and supports social action

- Shropshire Council's **Community Enablement Team (CET)** supports voluntary and community groups, town and parish councils and elected members to engage with the wider public sector and the services it is delivering. The CET delivers the Resilient Communities initiative, commissions local services, delivers joint local governance arrangements through Local Joint Committees and builds community capacity to enable social action
- Shropshire has a culture of strong cross-sector partnerships, which can be place based or thematically focussed and provide the opportunity for community representatives to be involved in the delivery of services or resolving complex issues
- Shropshire also has a long history of impactful and effective community-led planning, resulting in a local evidence base covering the county that identifies opportunities and risks within communities that can be maximised or mitigated through partnership working
- Shropshire Council **locality commissions** community based services such as libraries, customer service points, amenity spaces as well as proactively transferring its local assets into community management
- Supporting the creation and development of **community hubs within libraries, enterprise centres, health and well-being centres, village halls and leisure centres**. These community assets are being used by a diverse range of organisations to support the health and well-being of local people

Ways we work that builds and supports social action

- Increasing and improving local communication and sources of information and advice to support a **'communities first, services second'** approach. Shropshire's directories – the Community Directory, Shropshire Voices and hyper-local directories – are used by professionals and individuals to easily access and share information that supports a happy and healthy life
- Shropshire Council engages with communities and responds to the feedback it receives. It does this in a number of ways including **the Big Conversation** that has informed the council's priorities for future financial investment, the structure of Local Joint Committees where elected members, town and parish councils and residents can come together to discuss important local issues and its elected members who are community champions
- Shropshire's Voluntary & Community Sector Assembly, Shropshire Association of Local Councils and the Community Enablement Team provide the infrastructure support for organisations that builds the capacity and confidence that enables and facilitates social action
- Utilising 18 **place plan areas** to develop local area JSNAs

Shropshire Communities First and Social Action – What do we already have?

- **Let's Talk Local hubs delivered within communities by People 2 People** – Shropshire Council's Adult Social Care team – the hubs offer support and advice to people on issues such as risk of loss of independence, the role of carers, social isolation, access to benefits and housing, and provide an opportunity for professionals to connect people with the resources available within their communities
- Children & Young People Service's Early Help's locality approach to delivering **Strengthening Families** – Shropshire's Troubled Families initiative
- Health & Well-Being Board **Communities First** Steering Group bringing together a group of community focussed and resilience building projects
- **Resilient Communities** – is the cross cutting workstream that underpins and supports all aspects of the Better Care Fund Plan and its overarching vision. Local residents are signposted by those working in the first points of access in health and social care to existing local community resources for support and activity that results in good outcomes. Where there is an identified gap in a needed resource or activity, the community will be supported to create the right thing for their locality to fill it. Community Hubs, Community Connectors and hyper-local directories are key elements of Resilient Communities and these have been developed initially in 4 Shropshire towns with other areas following

Shropshire Communities First and Social Action – What do we already have?

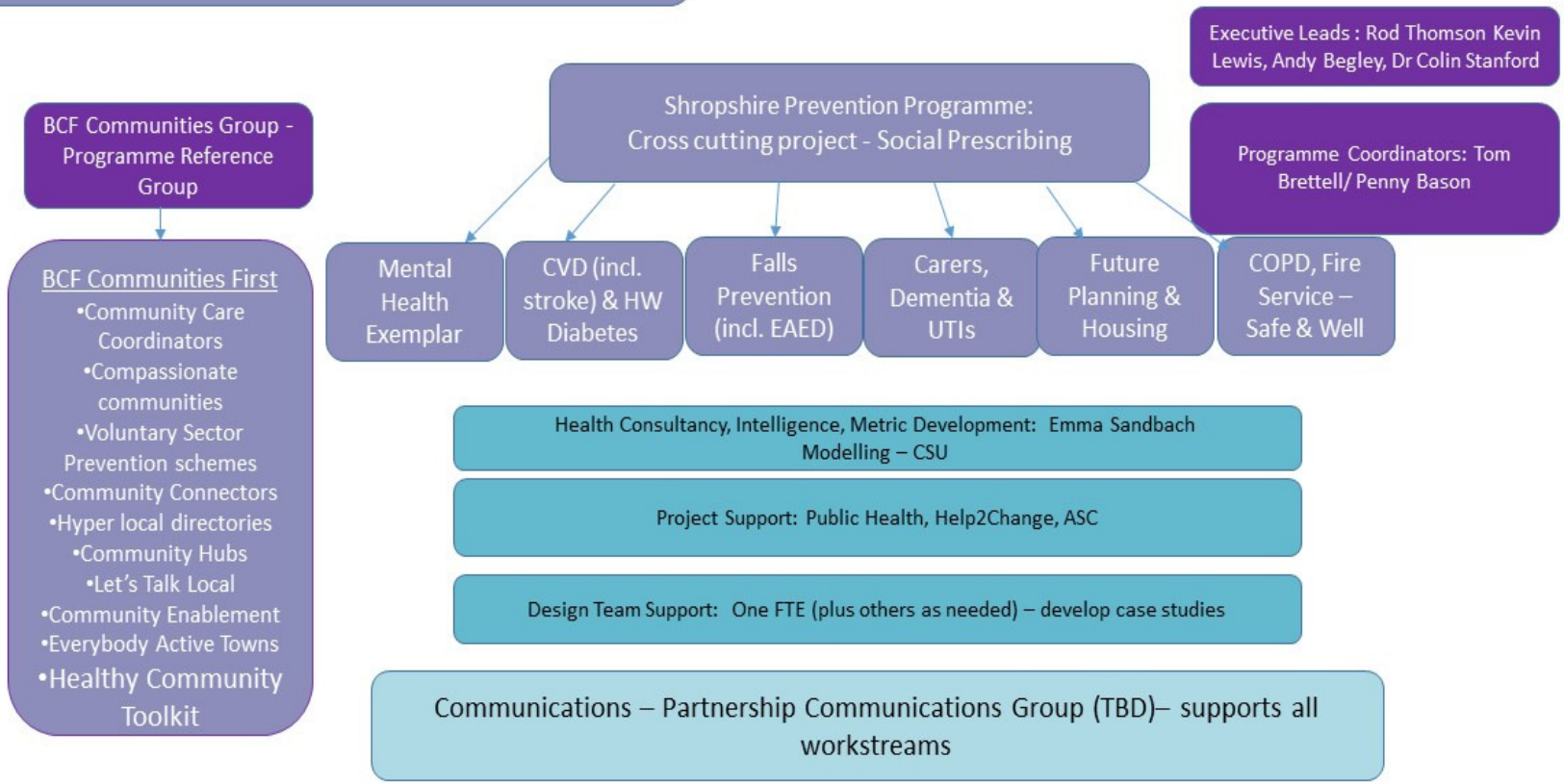
Care & Community Co-ordinators – a Better Care Fund project based in GP practices assisting patients in need of help, support and advice by signposting them to useful services. They help people to keep socially active and maintain their independence

Compassionate Communities – a Better Care Fund Project known as Co Co, involves towns and villages setting up their own volunteer befriending service to help people with long-term illnesses stay in touch with their local community. Teams of trained Co Co volunteers not only provide friendship, they also offer practical help such as taking a patient to the shops, picking up prescriptions or helping with the gardening. The scheme works with a number of local communities and medical practices. The initiative is not run by any one organisation but the community itself with the support of Severn Hospice which provides training and ongoing guidance for volunteers

The Health & Well-Being Board has 3 exemplar or development projects – Mental Health, All Age Carers Strategy, Healthy Weight and Diabetes Prevention. The development of these will rely on everyone playing a part in working together to improve health and well-being

Everybody Active Towns - residents, community groups and organisations in 4 towns across Shropshire have been invited to take action to address physical inactivity. Projects to encourage physical activity, in particular amongst the less active communities can receive public health funding with proposed projects competing for funding through a public vote in their town

HWBB & BCF Prevention Programme Delivery Structure



Aim of Community Fit

To design and implement a community based care model and neighbourhood services that deliver more care in the community and closer to patients' homes, support more people to take control of their own health and wellbeing and enable the shift from people becoming acutely unwell and requiring care in acute hospitals.

Scope of Community Fit

Urgent Care

- Supporting people in crisis with access to rapid response care and interventions in their home or a community setting
- Supporting patients who have accessed Emergency Care to return to their home as soon as clinically appropriate

Scope of Community Fit

Planned Care

Supporting the left shift from acute to community settings, delivered though lower cost workforce models

Scope of Community Fit

Late Prevention

Supporting people living with an existing health issue(s) to manage their chronic condition and live well thereby preventing or delaying complications

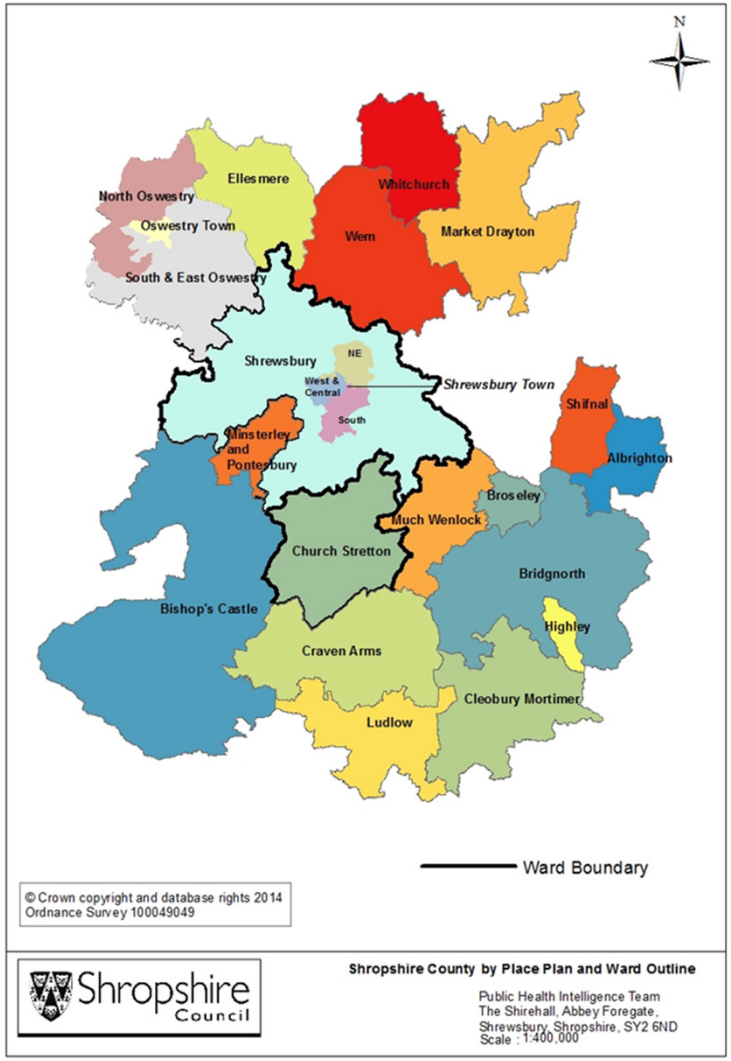
Neighbourhood Care Model Development

Progress to date

- Neighbourhood definition and service mapping
- Identification of health needs
- High Level Care Model development
- Identification of
  - Levels of Care, Activities and Interventions
  - Skills/competence gap analysis
  - Critical success factors

  for Neighbourhood Teams and Hubs
- Engagement with key partners

Place Plan Areas



Identifying Health Needs

QoF Indicators by Place Plan areas

	Hypertension (2014-15)	Stroke (2014-15)	CHD (2014-15)	Obesity (2014-15)	Depression (2014-15)	Osteoporosis (2014-15)	Diabetes (2014-15)	Atrial Fibrillation (2014-15)	Heart Failure (2014-15)	Peripheral Arterial Disease (2014-15)	Asthma (2014-15)	Chronic Kidney Disease (2014-15)	Dementia (2014-15)	Learning Disabilities (2014-15)	COPD (2014-15)
Albrighton	19.1%	2.8%	5.2%	9.2%	3.5%	0.1%	7.5%	3.7%	1.4%	1.3%	8.0%	7.1%	1.4%	0.3%	2.5%
Bishop's Castle 2	17.9%	2.6%	4.0%	8.0%	6.5%	0.3%	5.8%	2.3%	0.6%	1.0%	6.2%	6.0%	0.8%	0.8%	1.5%
Bridgnorth 2	15.3%	2.5%	4.0%	8.0%	4.1%	0.2%	6.4%	2.3%	1.1%	1.1%	6.3%	5.7%	1.3%	0.4%	1.8%
Broseley	14.8%	2.2%	3.9%	10.2%	6.6%	0.1%	6.2%	2.0%	1.0%	0.9%	6.9%	5.7%	0.6%	0.4%	2.1%
Church Stretton 2	25.8%	3.2%	4.6%	9.4%	6.6%	0.2%	6.1%	3.1%	0.8%	1.5%	6.3%	9.4%	1.5%	0.2%	1.4%
Cleobury Mortimer 3	15.2%	2.6%	3.9%	8.3%	9.3%	0.2%	7.3%	2.0%	0.7%	0.8%	6.8%	3.3%	1.0%	0.1%	1.6%
Craven Arms 3	17.7%	3.3%	5.0%	16.1%	11.5%	0.5%	6.9%	2.4%	1.3%	1.1%	8.0%	7.5%	0.9%	0.5%	2.7%
Ellesmere2	18.5%	2.5%	4.2%	9.2%	6.7%	0.3%	6.6%	2.7%	0.9%	1.1%	5.9%	6.9%	1.2%	0.4%	2.4%
Highley 2	19.2%	2.3%	3.7%	11.3%	13.8%	0.1%	7.6%	2.1%	0.7%	1.5%	3.8%	7.5%	0.9%	0.4%	2.9%
Ludlow3	19.7%	2.8%	4.3%	7.2%	11.6%	0.2%	6.0%	2.7%	0.9%	1.2%	7.1%	8.0%	1.5%	0.4%	1.6%
Market Drayton	14.9%	2.2%	3.3%	7.6%	6.6%	0.0%	6.4%	2.3%	0.9%	1.0%	5.7%	5.9%	0.9%	0.3%	1.8%
Much Wenlock	17.3%	2.1%	4.1%	7.2%	7.1%	0.2%	6.0%	2.4%	0.8%	0.9%	6.0%	6.0%	0.9%	0.4%	1.1%
Oswestry	15.0%	2.3%	3.6%	9.4%	8.8%	0.2%	6.2%	2.1%	0.9%	0.9%	6.2%	4.6%	1.1%	1.0%	1.9%
Pontesbury and Minsterley 2	15.5%	2.4%	4.1%	6.5%	13.8%	0.2%	6.1%	1.8%	0.5%	1.0%	9.0%	5.7%	1.2%	0.7%	2.2%
Shifnal	14.3%	1.9%	3.8%	8.7%	6.7%	0.3%	6.2%	1.8%	0.8%	0.9%	6.3%	5.4%	0.6%	0.3%	1.5%
Shrewsbury	14.6%	2.2%	3.4%	8.4%	8.9%	0.2%	5.8%	2.0%	0.6%	1.0%	7.2%	5.8%	1.0%	0.6%	1.6%
Wem	15.9%	2.6%	4.0%	7.6%	7.5%	0.1%	7.0%	2.3%	0.6%	1.3%	6.6%	5.2%	0.9%	0.3%	1.6%
Whitchurch	15.5%	2.5%	3.8%	13.9%	7.4%	0.2%	6.8%	2.1%	1.1%	1.0%	7.0%	6.3%	1.3%	0.4%	2.3%
Shropshire	15.9%	2.4%	3.8%	8.7%	8.1%	0.2%	6.2%	2.2%	0.8%	1.0%	6.7%	5.9%	1.1%	0.5%	1.8%

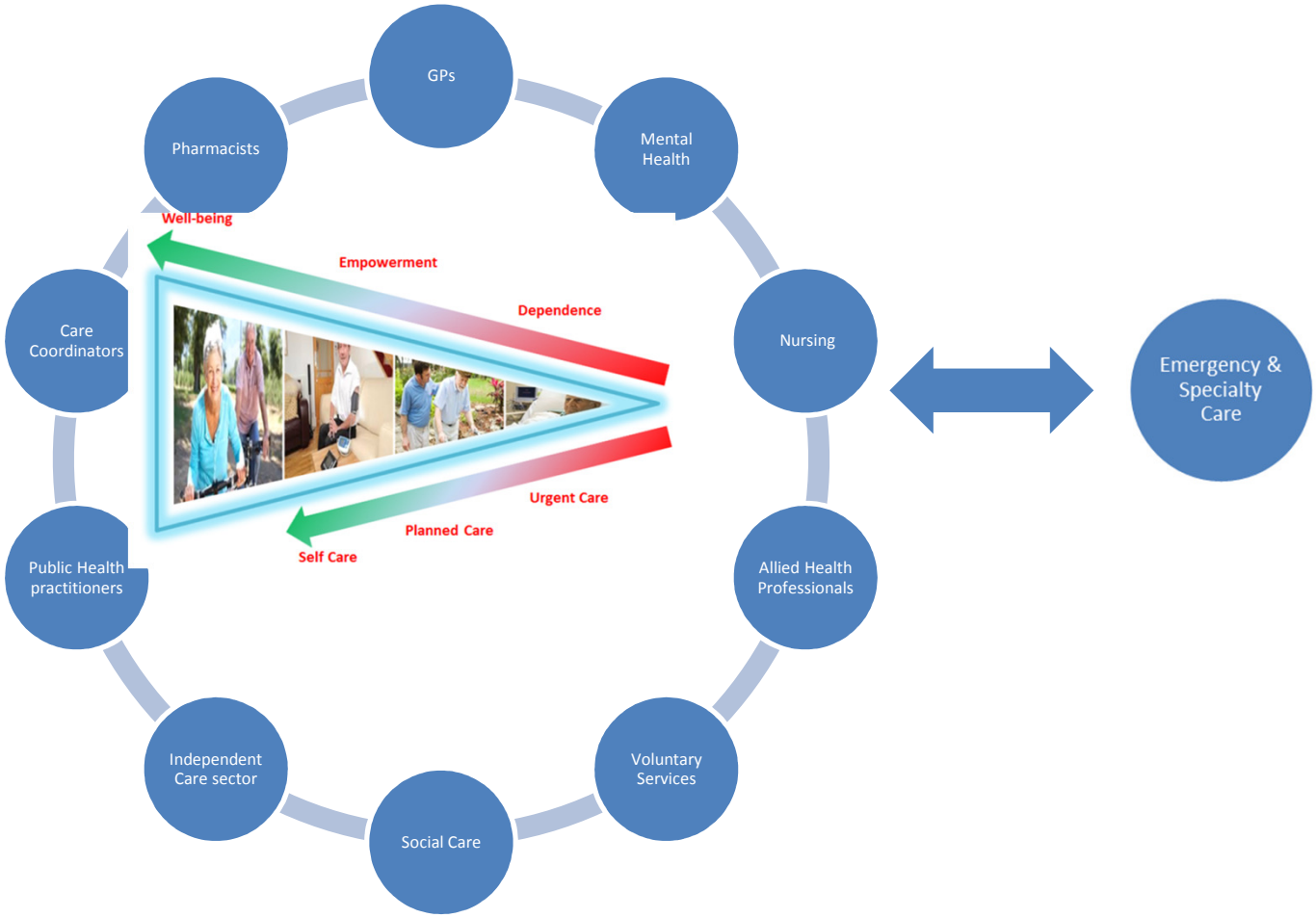
Identifying Health Needs

Top 10 inpatient admissions by Place Plan areas (Primary diagnosis)

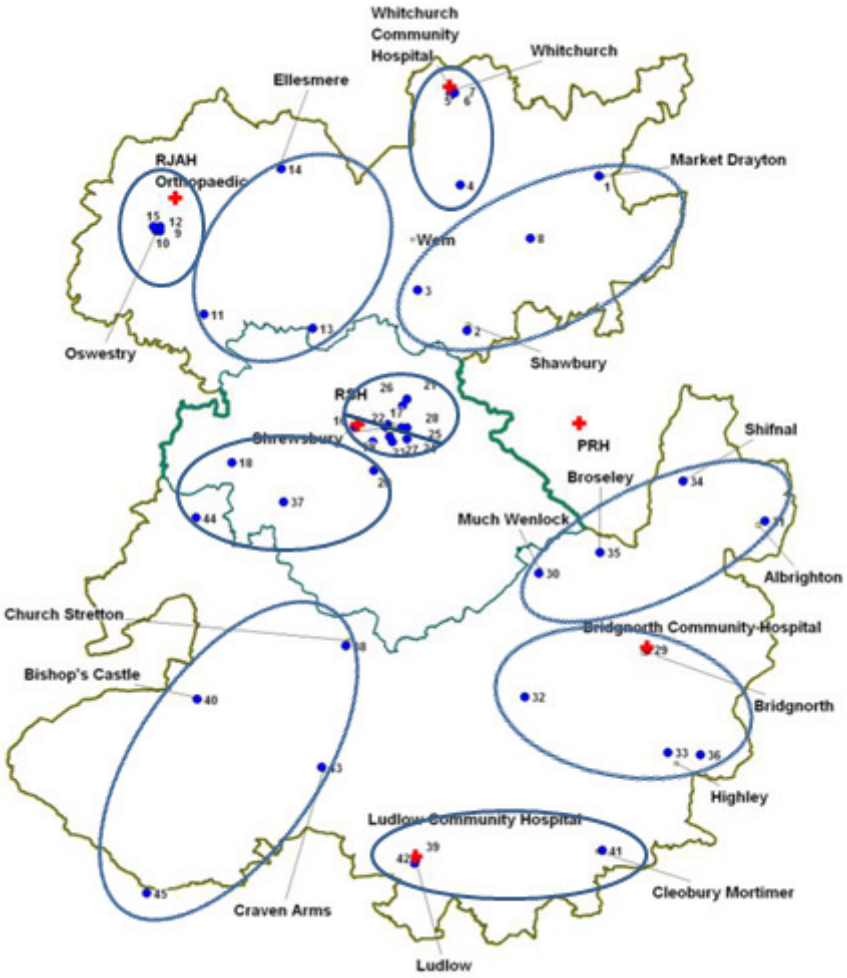
Shropshire Age Standardised Rates per 100,000 population - all ages by top 10 ICD10 codes	I21 Acute myocardial infarction	I63 Cerebral infarction	J18 Pneumonia, organism unspecified	J22 Unspecified acute lower respiratory infection	J44 Other chronic obstructive pulmonary disease	N39 Other disorders of urinary system	R07 Pain in throat and chest	R10 Abdominal and pelvic pain	R55 Syncope and collapse	S72 Fracture of femur	Total Top 10 ICD10 Codes
Albrighton	265	252	778	414	76	788	846	1120	182	191	4080
Bishop's Castle	159	149	533	233	81	473	336	431	106	271	2176
Bridgnorth	176	149	977	376	165	714	478	435	165	279	2962
Broseley	267	247	1465	275	425	849	598	630	129	191	3725
Church Stretton	191	167	692	249	210	613	486	513	187	278	2954
Cleobury Mortimer	96	113	587	302	83	424	181	392	34	257	1856
Craven Arms	330	213	870	490	170	956	487	845	190	268	3832
Ellesmere	175	103	847	229	197	506	615	460	114	211	2724
Highley	262	225	1040	262	297	707	389	539	146	208	2982
Ludlow	103	85	328	205	164	458	342	415	66	129	1889
Market Drayton	170	175	940	477	269	743	635	571	158	133	3212
Much Wenlock	118	130	473	230	62	336	161	213	98	178	1472
North East Shrewsbury	203	209	1109	755	403	1181	896	776	246	243	4440
North Oswestry	103	55	509	274	110	485	205	252	136	111	1664
Oswestry Town	157	105	715	408	103	488	526	436	196	213	2668
Pontesbury and Minsterley	200	127	1015	362	202	902	749	715	154	254	3672
Shifnal	137	167	1097	393	190	493	691	683	77	158	3083
Shrewsbury Rural	178	136	947	384	222	884	758	736	291	235	3725
South & East Oswestry	142	182	771	400	118	725	484	538	215	244	2873
South Shrewsbury	177	167	897	440	257	736	674	698	227	163	3512
Wem	210	280	761	419	157	1035	913	943	301	293	4294
West and Central Shrewsbury	143	211	979	508	168	813	730	672	206	228	3674
Whitchurch	173	181	823	494	196	731	506	599	191	248	3217
Shropshire	172	164	821	399	196	719	590	601	181	214	3173

Mapping of Partner Services

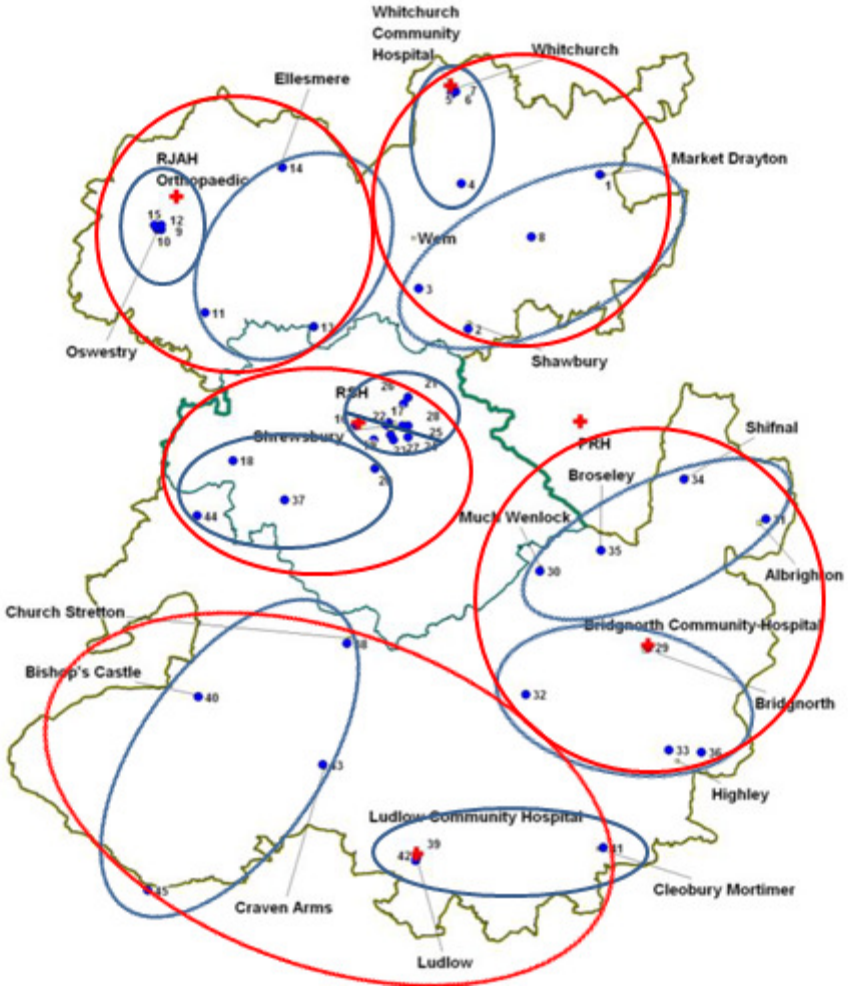
Neighbourhood Care Model



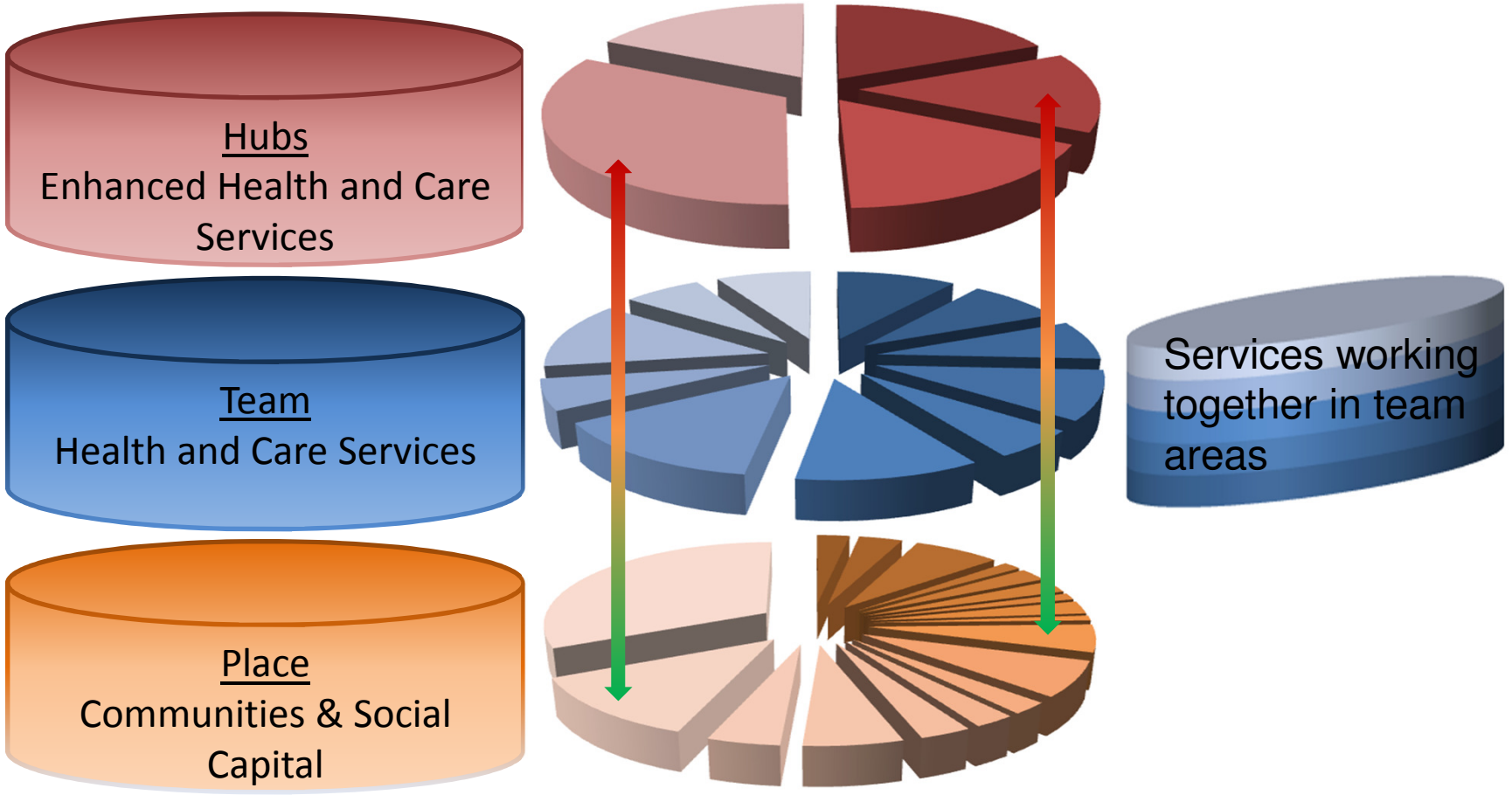
Neighbourhood Team Definition



Community Hub Definition



Neighbourhoods



Identifying Levels of Care for Partner Services Neighbourhood teams – Community Health

Levels of Care provided by neighbourhood teams

- Planned Care
- Condition specific pathways (Frailty/CKD etc)
- Long term condition management
- Interface between teams and Social Capital/Voluntary Sector (step up & step down)
- Point of Care Testing
- End of Life
- Domiciliary Care
- Early intervention for Mental Health conditions

Identifying Levels of Care for Partner Services Hubs – Community Health

Levels of Care provided by Community Hubs

- Same Day response
- Unplanned and or an Increase Care/Support
- Expert advice & reassurance
- Rural Urgent Care (MIU/DAART/Ambulatory Care)
- ICS – Admission avoidance
- Therapy coordination/pathways
- Specialist Nursing Teams
- Mental Health Specialists.
- Comprehensive Geriatric Assessment
- Point of Care Testing
- Diagnostics

Neighbourhood Service Initiatives in Development

- Extended Urgent Care in Bridgnorth focussing on frailty and same day urgent access to local assessment, diagnostics and treatment
- Extended Urgent Care in Ludlow through closer working between primary care and MIU

Neighbourhood Service Initiatives in Development

- Community Hub development in Market Drayton
- Virtual clinics between GPs and Community teams in Whitchurch to review patients and case loads

Next Steps for Neighbourhoods

- Continuation of service mapping
- Linking the services to the social capital
- Quantify demand/activity for each team/hub
- Agree how we will work with key partners
- Identify enablers and how they will impact on resource requirements (Technology, Workforce, Estate)
- Financial appraisal

Timetable for STP

- 16 September – Finance submission
- 29 September – STP and Finance plan to Trust Board
- 21 October – Full STP submission including finance template

Trust Planning Timetable

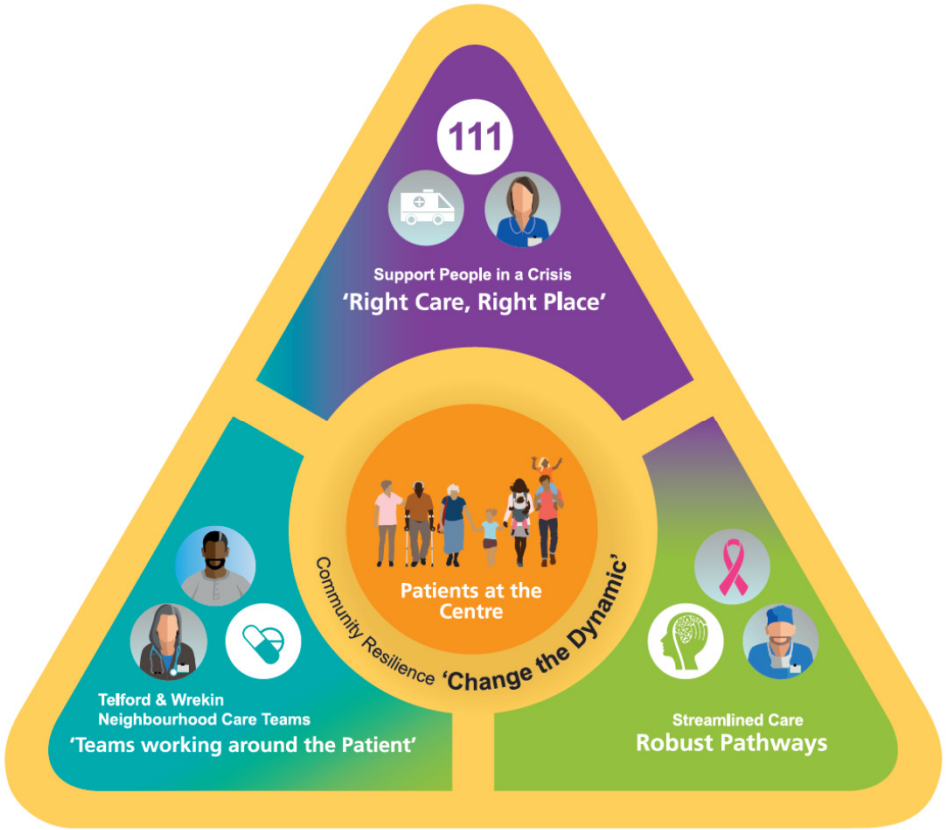
- 20 September – Publication of Planning Guidance for 2017/18- 2018/19
- End November – CCGs and NHS Providers to share 2 year operational plans
- End December - CCGs and NHS Providers to finalise 2 year operational plans

Neighbourhoods Telford & Wrekin

Contents

- Overview of the priorities for Telford and Wrekin including vision and rationale for *neighbourhood working* and *community resilience*
- Outline of ‘who’ will be involved in neighbourhood working
- Description of the functions to be delivered in neighbourhoods
- Update on the neighbourhood development so far
- List of the outcomes we hope to achieve
- Potential areas of investment

Telford and Wrekin Model of Care



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 it 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'

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
- 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
- A growing proportion of the population are suffering from problems associated with *preventable* disease
- Needs escalate and peoples health and wellbeing deteriorate because they don't have enough support in the community
- People depend on services because there have very limited alternatives in their own communities

Who could be involved in the neighbourhood teams?

Target Population: Those with identified health risks.

Informal networks: including friends, family, neighbours

Professionals supporting people through the formation virtual teams from;

- Practice teams
- Community nursing teams
- Home workers within the Local Authority
- Community mental health teams
- Third sector organisations
- Outreach teams from Shrewsbury and Telford Hospitals
- Carers

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'!

Who have we talked to?

This conversation is on going and will be supported through digital communications which will begin in September!

What will functions will be carried out within neighbourhoods?

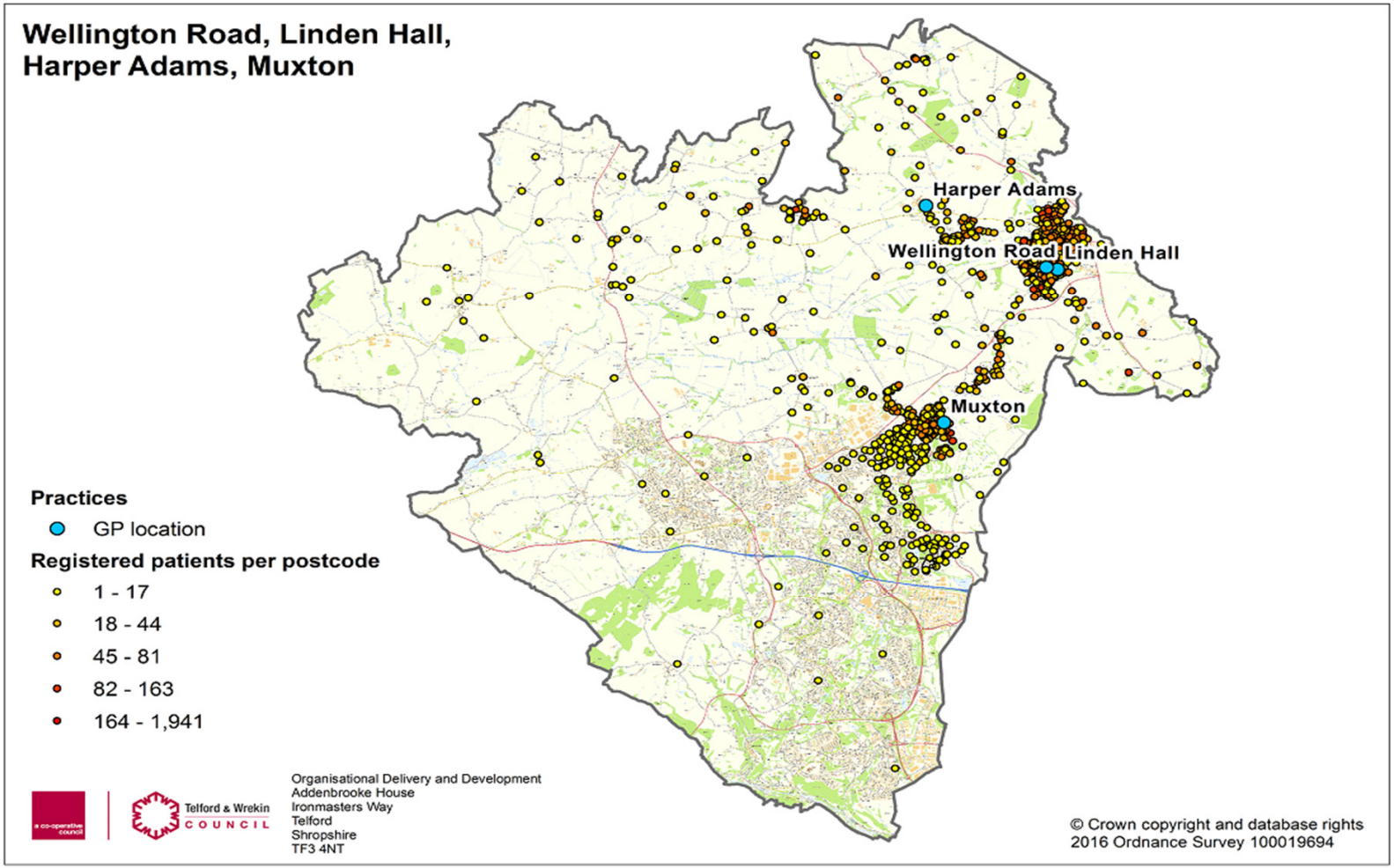
Point of care testing	Delivery of 'care' (social/health)	Diagnostics
Prevention and lifestyle advice	Support for people with complex needs	Surgery
Support at end of life	Outpatient clinics	Signposting

……But this could look different in different areas!

What areas will neighbourhoods cover?

- The neighbourhoods will be based around groups of practice populations (usually between 30k and 50k)
- These must be ‘natural neighbours’ and work for those working in and with the community
- Two prototype areas have been identified so far: Newport (2 practices) and South Telford (6 practices)
- Other practices are in discussions with each other and the CCG

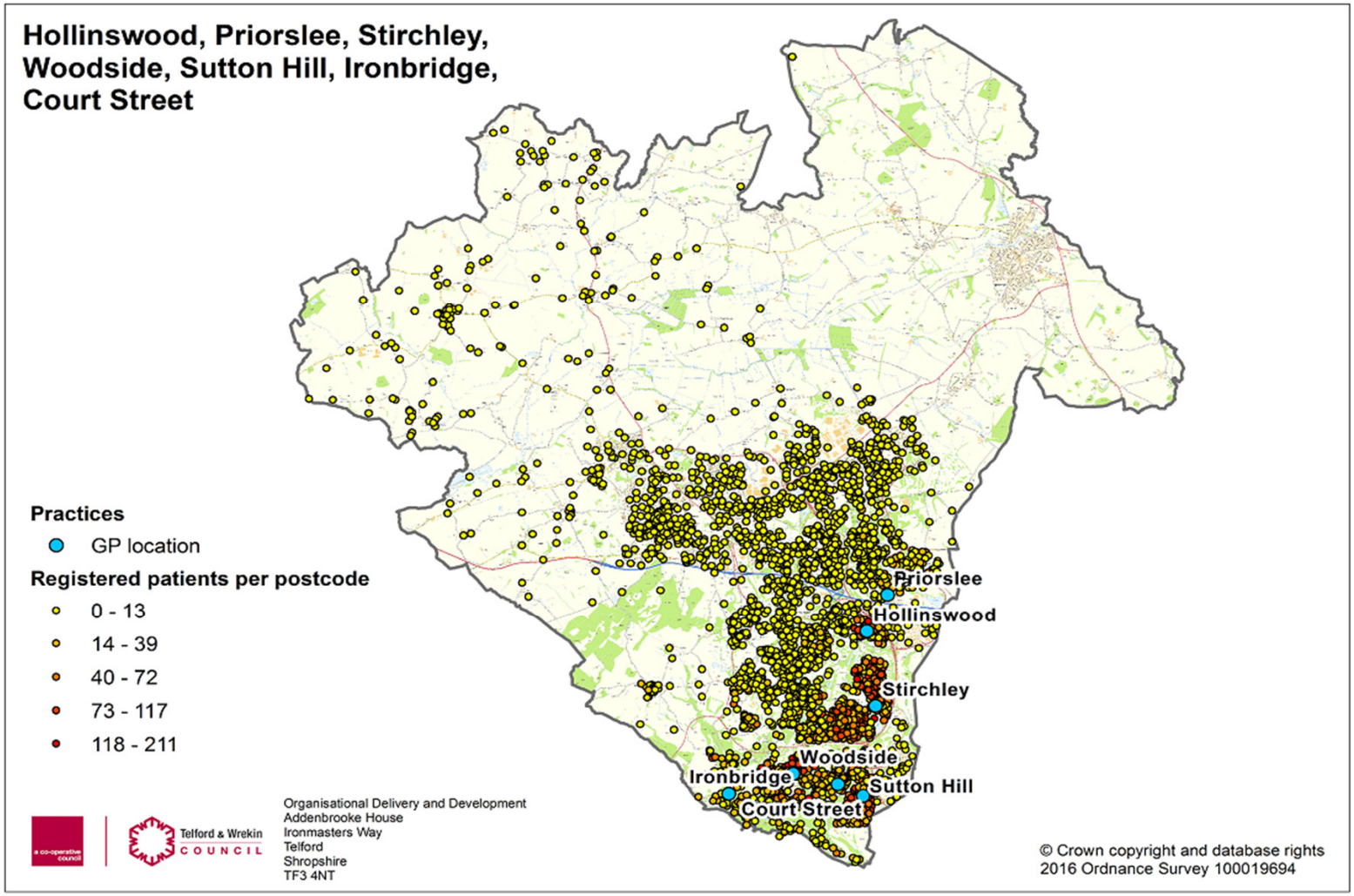
Newport Neighbourhood (approx 33,000 population)



Newport: Priorities for action

- Increase community nursing capacity
- Utilise a different model of care based on Buurtzorg principles
- Align dementia related services with the practice
- Map and better utilise community assets (including local buildings)
- Forward planning to consider transfer of additional diagnostic services to community settings
- Better support to residential homes

South Telford Neighbourhood (approx 44,000 population)



South Telford: Priorities for action

- 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

What outcomes will we hope to achieve ?

- Support the shifts in the outline business case for future fit (and more!)
- Reduce dependency on statutory services
- Strengthen communities
- Capacity freed up in primary care to proactively support people with long term conditions

What additional resource will be need to support this change

- Significant increase in community healthcare provision will be needed
- Moving to the Buurtzorg model would suggest workforce needs to increase between two or three times
- Investment to adapt existing facilities in community settings
- Additional support from experts and ‘hands on’ support to manage the change
- Investment to support sustainable change in community capacity