Shropshire and Telford & Wrekin STP

Shropshire Neighbourhoods Programme

Update to HWBB

Shropshire Neighbourhood

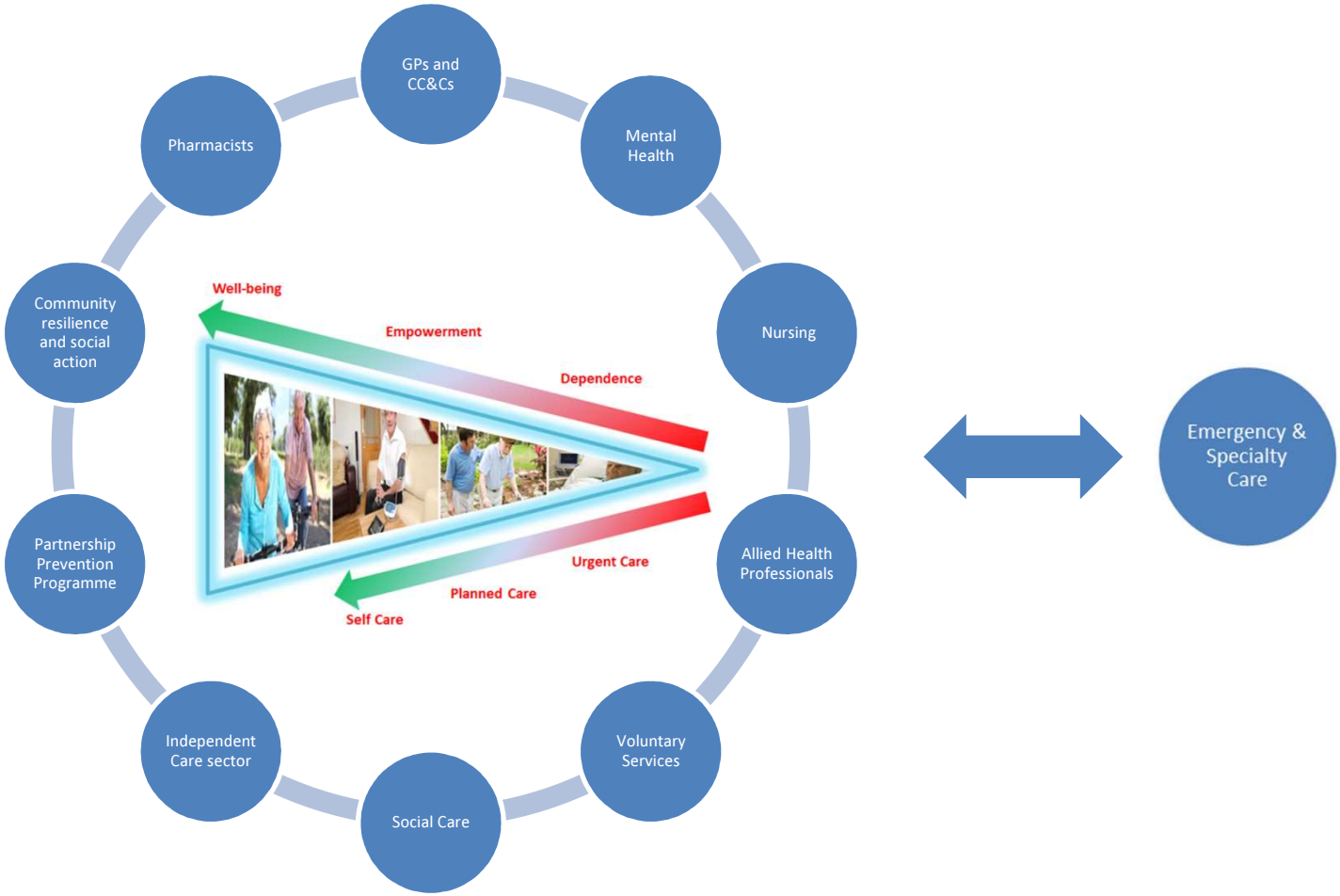
Improving the health and well-being of local communities

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

The Shropshire Neighbourhoods Group will use place based planning to reduce demand on acute services by:

1. Building resilient communities and developing social action
2. Developing whole population prevention by linking community and clinical work – through identification of risk, behaviour change support, and social prescribing
3. Designing and delivering neighbourhood care models

Shropshire Neighbourhood Model



Whole population approach to prevention

Health Intelligence				
○ Social demographics ○ Population risk profile ○ Community assets ○ Patient views	○ Diet ○ Smoking ○ Alcohol ○ Physical inactivity	○ Patient risk profiles ○ Health age	○ Patient activation measures ○ Predictive risk modelling	○ Case reviews

Wider determinants of health	Health behaviours	Rising risk factors	Rising disability	Frailty
• Public health policy • Community development • Social prescribing	• Social marketing • Behaviour change support	• Personalised risk management • Health monitoring tools	• Supported selfcare • Early intervention	• Integrated health and care services • Personalised care planning • Carer support

Community Resilience and Social Action

- Asset based community development
- Community based approach to shape the local factors that have an impact on health and well-being
- Generating social value and social action
- Community Enablement Team
- Established local governance
- Locality commissioning

Community Resilience and Social Action

- Active and effective VCS – at risk from reducing grant/contract funding
- Active community groups - need support to thrive
- Formal and informal volunteering – needs strategic development
- Resilient Communities
- Care & Community Co-ordinators
- Compassionate Communities
- Let's Talk Local hubs
- Early Help Strengthening Families

Resilient Communities – BCF workstream

‘Communities First – services second’

Place based governance and delivery – cross-cutting across sectors and themes

Hyper-local directories of activity and services

Networks of Community Connectors

Well developed in Oswestry – using the above -

CET, C&CCs, Let’s Talk Local Hubs, C&YPS Early Help hub of services, volunteers to support these, local voluntary groups, community activity

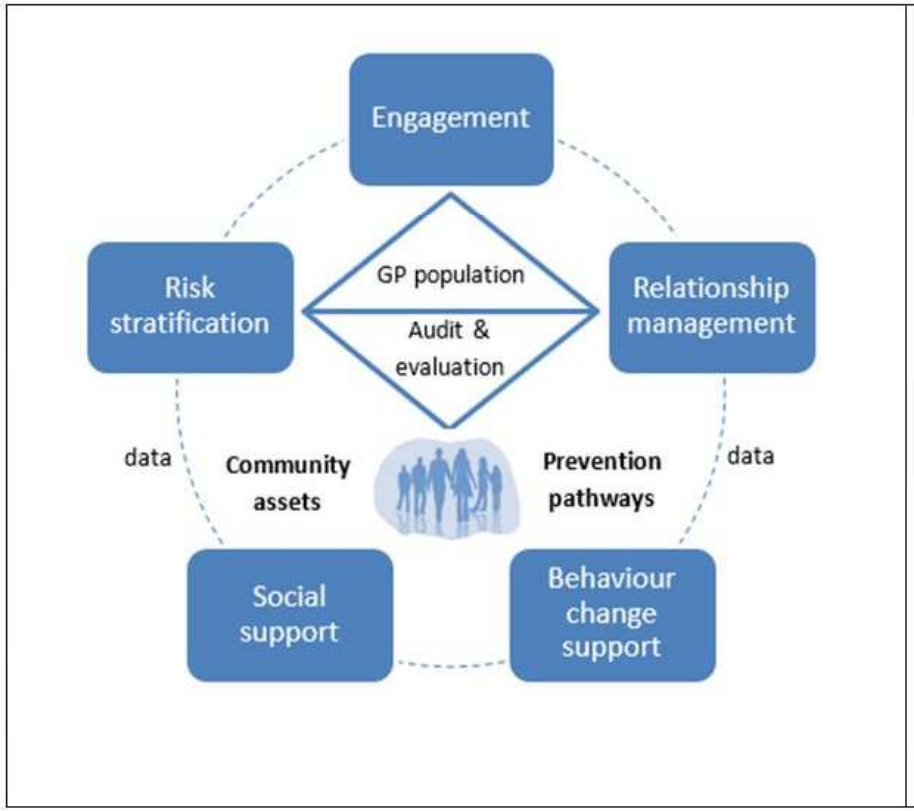
Partnership Prevention Programme

- Linking clinical world to the community through behaviour change support and social prescribing
  - Community and Care Coordinators, community enablement
  - Community assets (health, care, vcs, buildings, groups etc)
  - **Healthy Lives** model in development

- Key prevention programmes include
  - Social prescribing
  - Diabetes & CVD Prevention
  - Mental Health
  - Falls Prevention
  - Carers & Dementia/ UTIs
  - Future planning & housing
  - Respiratory & Fire Service Safe and Well

Healthy Lives programme

The Healthy Lives programme aims to support individuals, families and communities to take control of their health, viewing health as a positive resource on which they can build their future and achieve their potential. It provides a bridge between GP practice populations and communities, and seeks to reduce dependence on treatment services.



Risk stratification

- Audit tools
- NHS Health Check
- JSNA & Place Plans
- Adult Social Services
- Children's Social Services
- Other health and care professionals

Engagement

- Community and Care Co-ordinators
- Every Contact Counts, Safe and Well & FPOC
- Let's Talk Local
- Social marketing
- Website- inlcluding Shropshire Choices

Relationship management

- Digital health platform- Shropshire Choices
- Telephone support line, FPOC
- Membership incentive scheme
- Mobile health clinic
- C&CC

Behaviour change support

- Help2Quit
- Help2Slim
- Alcohol services
- Future Planning and self care, One You,
- other health, care and council services including Leisure services, EXPERT course, OT services, other...
- VCS - prevention services , advice services

Social support

- Social prescribing
- Compassionate Communities
- Resilient Communities
- Let's Talk Local
- Benefits advice
- other supportive services through the VCS, volunteering

Healthy Lives Model Pilot - Oswestry

Working with:

- GP practices (3 in Oswestry)
- Community Enablement Team
- Community health services
- Social Care
- VCSE
- Elected Members
- Private sector

To:

- Proactively identify those at health risk (e.g. Pre-diabetes, isolation, CVD)
- Connect people with risk to behaviour change options, community support, clinical support (where necessary), social support
- Awareness raising - communicate and engage with the population about how to reduce health risk

Aim of the Neighbourhood Care Model

To design and implement a community based care model and neighbourhood services that:

- delivers more care in the community and closer to patients' homes
- supports more people to take control of their own health and wellbeing
- enables the shift from people becoming acutely unwell and requiring care in acute hospitals.

Neighbourhood Care Model Scope

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

Planned Care

- Supporting the left shift from acute to community settings, delivered though lower cost care delivery models.

Maintenance and 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/ Community Fit

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

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

Maintenance and Planned Care

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

Identifying Levels of Care for Partner Services Hubs – Community Health

Urgent and Specialist Community Care

- Same day response to crisis, including
  - Urgent Care
  - Comprehensive Geriatric Assessment
  - Admission avoidance

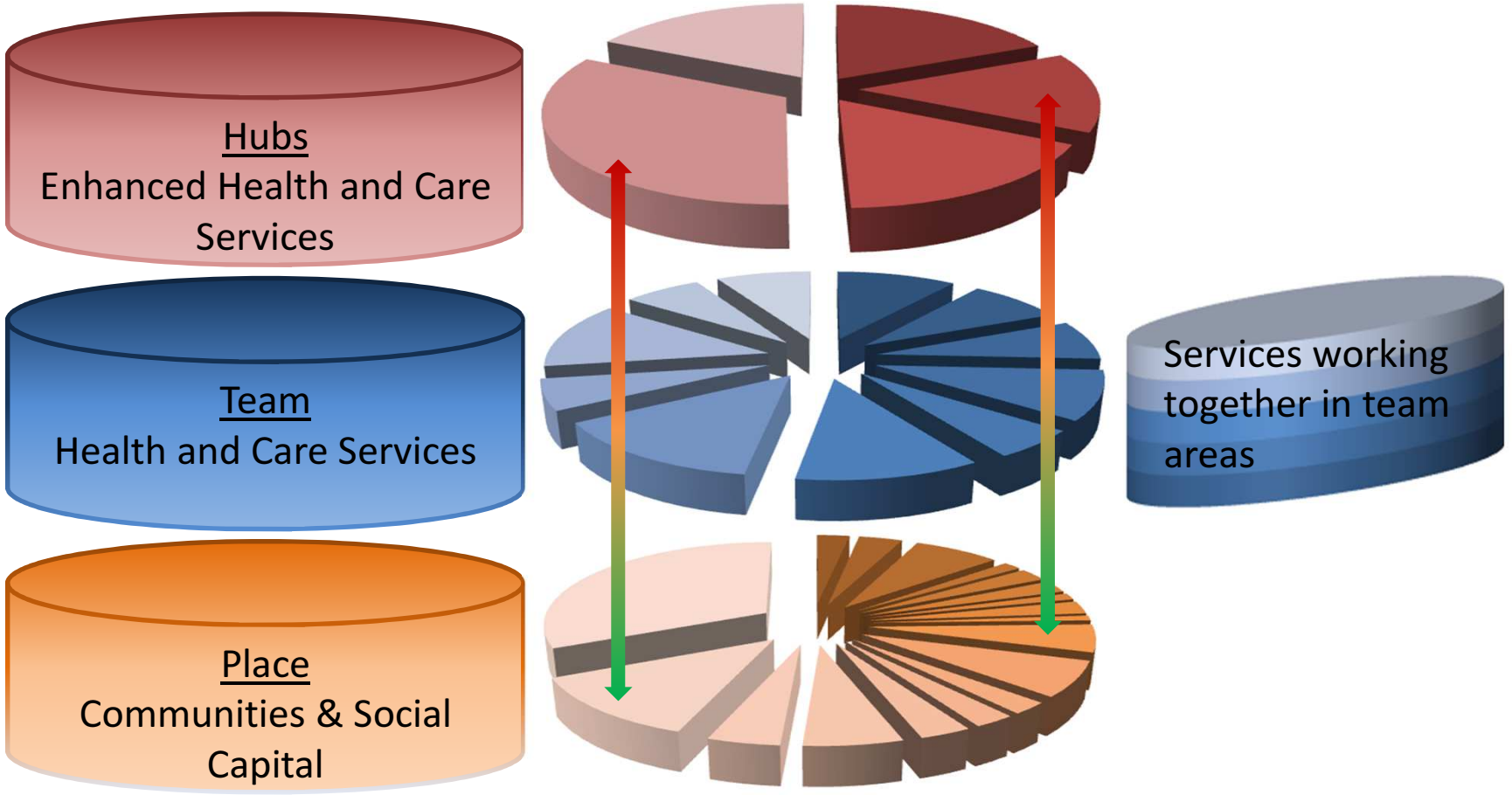
Hubs will also provide a focal point of care in the community, delivering specialist community services, closer to home. Services to be provided will include:

- Ambulatory Care and Intervention
  - Specialist Nursing
  - Mental Health Specialists
  - Point of Care Testing
  - Diagnostics

Examples of Neighbourhood Care Model 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
- Community Hub development in Market Drayton
- Virtual clinics between GPs and Community teams in Whitchurch to review patients and case loads
- Integrated community nursing teams in Alveley

Neighbourhoods



Impact on equalities and social inclusion

Need for redesign to consider:

- Impact on groups with protected characteristics
- Rural proofing of services– a vital consideration in Shropshire
- Accessible Information Standard
- The wider public sector financial position going forward

Communication and Engagement:

- How to engage with communities of place and of interest
- Importance of engaging with, and through with elected members and Local Joint Committees
- Aligning these messages with current or planned large scale current engagement e.g. new Carer's Strategy, Big Conversation

Programme Implementation

- Community Resilience, Social Action and VCS
  - 4 pilot areas implemented, roll out for rest of county ongoing
  - Development of Oswestry as pilot for linking community activity with behaviour change support, social prescribing and service redesign (Autumn 2016)

  - Assumption – continued funding available for community enablement teams, community care coordinators, housing support/ prevention activity

Programme Implementation

- Partnership Prevention Programme
  - Social Prescribing model development –Autumn 2016
    - Engagement with GPs, VCS, and all stakeholders Autumn 2016
    - Pilot November 2016
    - Roll out Spring 2017
  - 6 key additional programme areas
    - Pilot Diabetes & CVD Prevention– Oswestry Autumn 2016
    - Mental Health – Suicide prevention strategy (in development)
    - Safe and Well visits – January (T&W and Shropshire)
    - Future planning – Autumn 2016
    - Carers/ Dementia/ UTIs – all age carers strategy and action plan November 2016
    - Falls Prevention – roll out of Community PSI (start Autumn 2016), New Service Specification (April 2017), link to Fire Safe and Well
  - Assumption – continued funding available for community enablement teams, community care coordinators, housing support/ prevention activity

Next steps

- Continuing to map the services/programmes in scope
- Aligning this activity to available and potential social action
- Set out the elements of services and programmes in a consistent way to understand outcomes, impact and metrics
- Develop placed based governance, e.g. working groups to
- understand demand/activity for each Neighbourhood Team/Hub and scope potential redesign
- Sense testing within localities (eg clinical pathways, prevention programme)
- Secure additional resources to meet our identified needs in this development work
- Develop our approach to understanding impact in relation to equalities and rurality