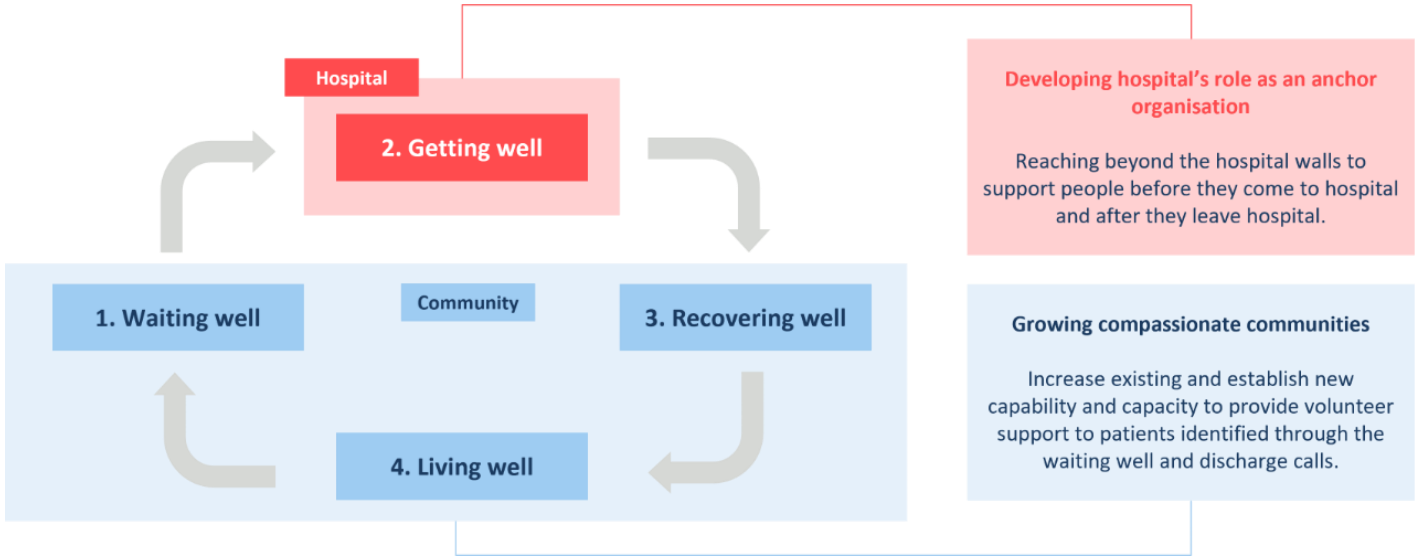
Community Integration

Community Integration - the starting point

Warwickshire North



Developing hospital's role as an anchor organisation

Reaching beyond the hospital walls to support people before they come to hospital and after they leave hospital.

Growing compassionate communities

Increase existing and establish new capability and capacity to provide volunteer support to patients identified through the waiting well and discharge calls.

Helpforce role as part of the 'BtHP Communities' workstream:

- Support development of plans
- Support community engagement and provide expertise around the approach to community integration.
- Lead on creation and execution of evaluation plan - baseline and ongoing

What were GEH trying to achieve?

To **work across place** in the development of Health and Care volunteering solutions to:

- **build relationships** with community organisations:
  - **Understand** local provider issues
  - Identify exiting community plans that **align** to the BtHP or that BtHP needs to align with.
- **reduce overlap** and develop **shared solutions** to health and care issues affecting the community and in particular growing health inequalities e.g. long waiting lists and related isolation, deterioration, accessibility of services
- develop a **network of organisations** that can both receive referrals and refer into the Back to Health Pathway.

Back to Health Volunteering Model

The Back to Health volunteering model being developed across Warwickshire North by George Eliot Hospital and Helpforce is made up of five key components of volunteer intervention across the patient pathway – Comfort Calls, Waiting Well, Accessibility Responders, Discharge Responders and Help at Home.

Waiting list data has been gathered and analysed, and a co-production workshop with Place partners has taken place to look at where to initially roll out the programme. It has been agreed to pilot in North Arden and Nuneaton Central and South PCN areas. This represents both a rural and urban locality, and these PCNs are engaged with the programme.

The Comfort Calls service, which comprises of an initial call to patients waiting for appointments or procedures, has been trialled and successfully completed. The service is now moving to become embedded into business as usual and extended to further cohorts of patients than the trial cohort of 74+ years old. George Eliot's Patient Forum is helping to design a training package for volunteers for this service as it matures, and a Voluntary Services Officer has been recruited with the initial focus of further developing the Comfort Calls service with Place partners.

The next round of co-production workshops has been planned and the programme has engaged with patients about their experience of being on waiting lists, to understand what support would improve their experience as we further progress with delivering the model.

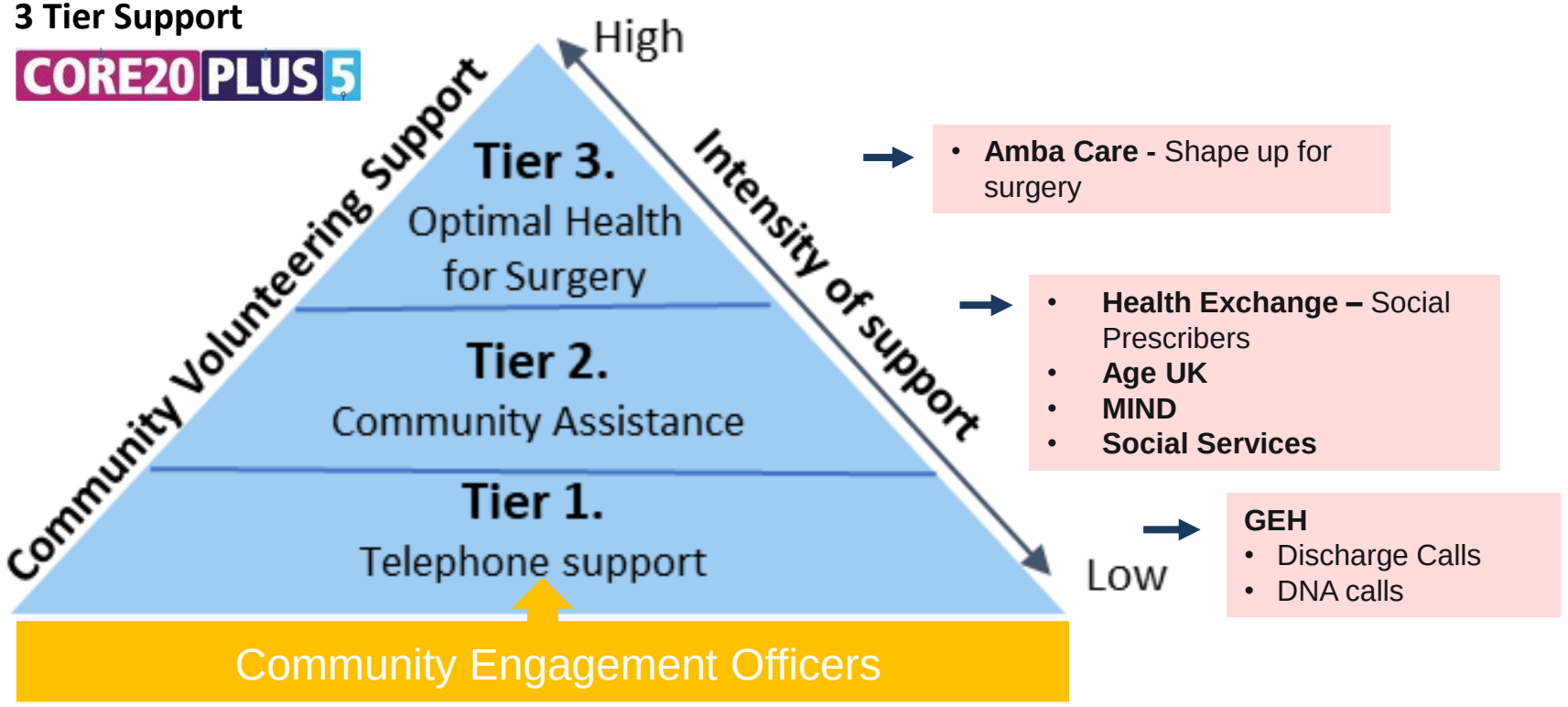
Back to Health Volunteering Model identified as an achievement (page 17) in the Warwickshire North Place Plan.

BtHP Community Model

Working with existing compassionate activities within a community/ neighbourhood, with the intention of improving the health and care of those receiving and giving support.

3 Tier Support

CORE20 PLUS 5



- **Amba Care -** Shape up for surgery

- **Health Exchange –** Social Prescribers
- **Age UK**
- **MIND**
- **Social Services**

GEH
- Discharge Calls
- DNA calls

Approach

- **Develop an asset-based approach**
  - ↪ Identify local community groups to fund/ build on their capacity/ capability to deliver aligned services
  - ↪ Collaboration
- **Establish a cross place steering group**
  - ↪ Community agreement to pilot locations
  - ↪ Mechanism to ensure alignment/ reduce duplication
  - ↪ Support and champion project
  - ↪ Mechanism to share progress and discuss issues/ concerns

Building Foundations

GEH community development (compassionate community) principles:

- Building relationships
- Facilitating communication/ introductions
- Asset based approach
  - Collaboration and co-design
  - Inclusion of hyper local organisations
- Making every contact count
- Learning and sharing knowledge

1. Identify a pilot location
   - Understand the demands that the local populations put on local providers/ statutory services and build solutions into the BtHP (demand)
   - Identify places where good collaboration between statutory and voluntary sector already exist (supply)

1. DATA ANALYSIS

Bringing together of multiple data sources to inform and evidence stakeholder decision making.

Demand data types:

- Data from WCAVA
- Data from District Councils' Community Engagement teams
- Effective Ward councils
- Have a "Neighbourhood Plan"
- etc.
- Opinion of Social Prescribers working for PCNs
- Evidence / opinions from other about where good collaboration already exists
- Places where forums already exist

Supply, data types:

- Public health data incl. JSNA data
- Hospital data - who is waiting or being regularly readmitted?
- Where do they live?
- What ethnicity?
- Health condition
- Community Health data from CCG?
- Experience and knowledge of partners
- Other data relating to wider determinants of health e.g. IMD data

2. STAKEHOLDER WORKSHOPS

Series of workshops including:

- District Councils
- GEH
- Healthwatch
- PCNs
- SWFT
- UHCW
- WCAVA
- WCC
- WN Place
- Voluntary Sector Orgs

3. WARWICKSHIRE NORTH BOARD

Present recommendations for pilot location.

- Highlight collaboration used to come to make decision
- Present evidence base rationale:
  - Capacity
  - Capability
  - Knowledge e.g. Pressure of services
  - Budget
- Request Boards agreement to progress in the identified 2 x PCN's

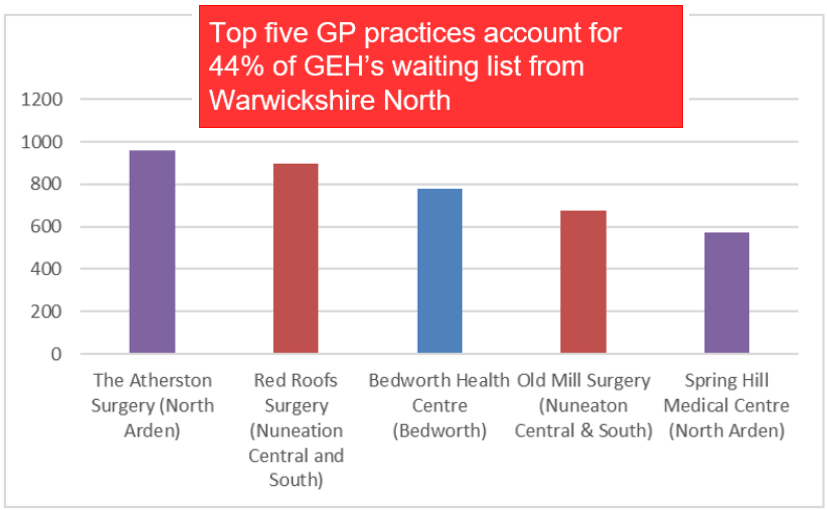
5 key learnings

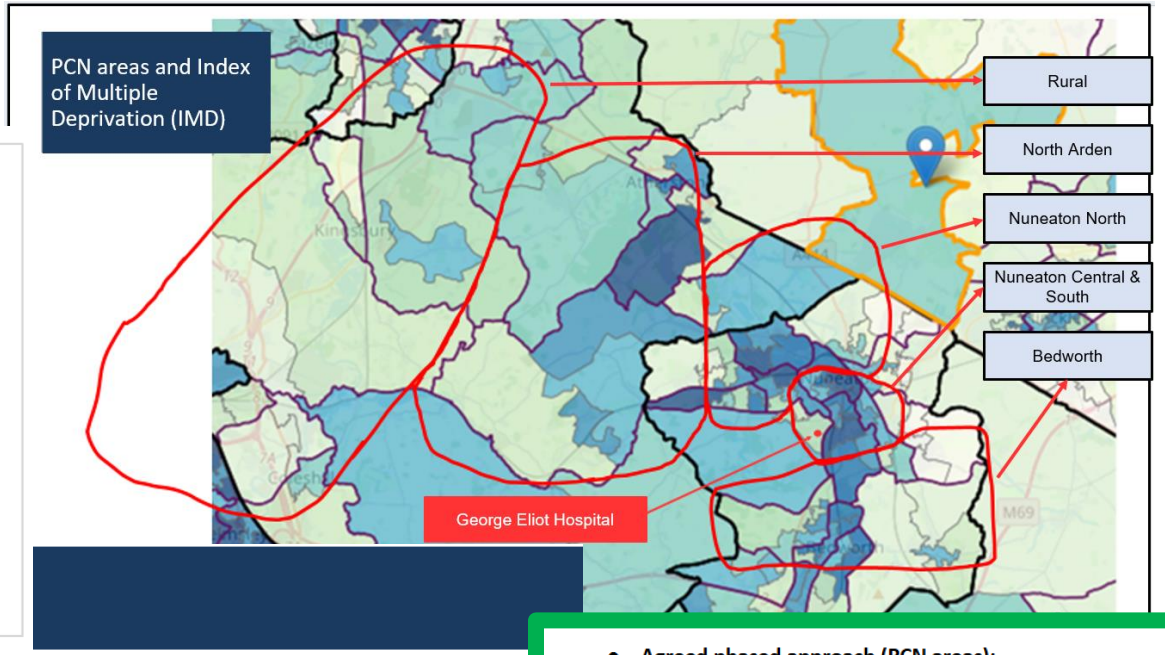
1. **Inclusive and realistic planning,** allocate appropriate time in the project to build relationships and allow mindsets to shift. People involved in the project may need time to build trust to engage effectively with the project team. Well planned and inclusive interventions will reduce risks associated with rushed/ best intention can be worse than doing nothing.
2. **Partner with community-led organisations** as they are best placed to sustain community-led missions and can support statutory providers to maintain good relationships with local stakeholders.
3. **Use a community led approach,** what works in one community won't necessarily work in another even if they seem very similar, so empower and support each community to implement their ideas and solutions.
4. **Take a holistic approach** to supporting people's needs to ensure a balance between social structure and medicalised solutions.
5. **Taking an asset-based approach,** identify and encourage the use of existing skills, capabilities, knowledge, resources, connections and potential in a community.

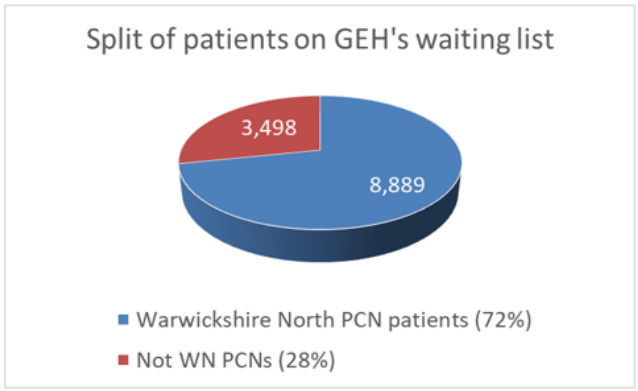
3 final take aways

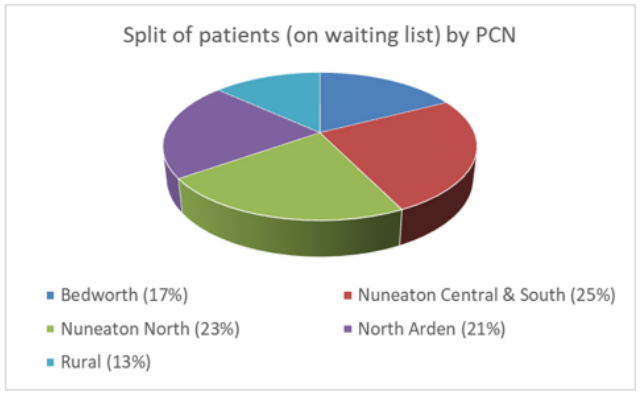
1. **Use a project** to bring people together over a shared purpose
2. **I**t's ok to **start small** even if you have a big ambition – learn, iterate, incrementally scale
3. **Be patient** – it's an investment in time that's needed to build strong foundations

1. Data led









- **Agreed phased approach (PCN areas):**
  - Phase 1 Nuneaton Central & South and North Arden
  - Phase 2 Rural, Nuneaton North, Bedworth
- **Justification:**
  - Covers both District Council areas
  - Waiting list data supports this decision (44% of GEH's WN waiting list from these two PCNs)
  - IMD data supports this decision
  - Covers one urban and one rural PCN
  - Proximity to GEH

To get to this point

Stakeholder engagement; meetings, workshops resulting in buy in, commitment of active support from:

- ❑ Primary Care
  - ❑ PCNs
  - ❑ GPs
  - ❑ Community nursing
- ❑ WN CCG
- ❑ District Councils
- ❑ GEH
- ❑ Healthwatch
- ❑ SWFT
- ❑ UHCW
- ❑ WCAVA
- ❑ WCC
- ❑ WN Place
- ❑ CW Partnership Trust

NHS George Eliot Hospital NHS Trust

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2. Stakeholder workshops

- Stakeholder mapping
- Planning
  - How long? (1.5hrs)
  - Getting the most out group
    - Breakout rooms?
  - How best to present information
- 1:1's needed ahead of workshops?
- Learning
  - Who was bought in?
  - Who wasn't bought in?

ALWAYS ASK, WHO ELSE SHOULD BE INVITED

Plans for PCN based workshops

Aim of workshop
To plan how we are going to deliver the elements of the Back to Health Framework that will involve closer work in the community. I.e. what can volunteers in the community do to support:

- Waiting well tiers 2 and 3
- Aspects of help at home

Who are we hoping will attend?
1. District council
2. PCN
3. Adults social care / Reablement
4. Domiciliary care providers
5. Any major local Residential care homes
6. Community Nursing (SWFT)
7. GEH
8. UHCW
9. Community Groups - to be advised by WCAVA and others

Data we want to share at the meeting:
Data from different key local providers about the demand that the PCN's patients place on them broken down by (including others)

- Age
- Gender
- GP Practice
- Medical condition
- Ethnicity

Data to be provided by

- GEH
- UHC&W
- Warwickshire County Council
- SWFT
- Others?

What other information are we hoping to gather?
We need to develop a more detailed understanding about what is going on locally so that we can support such relevant activity being undertaken by

- SPLWs
- Community Groups
- Faith Groups
- Organisations that have already been commissioned by the local council or CCG
- Etc.

Outcomes from workshops
We want to emerge from the meetings (in each PCN) with a plan for developing a plan that sets out:

- the patients or cohorts of patients we are looking to support
- the organisations that we know can support with building and deploying volunteers
- how local community groups will be supported and funded to undertake this work
- the referral pathway for different patients accessing this support
- the impact we are hoping to have on patients, volunteers, and statutory providers
- the way we will track, measure and report on findings
- the governance structures we need to put in place to manage this community workstream and ensure it aligns to the rest of the programme
- timings of the above

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