Transforming Local Care

CONNECTING CARE
WAKEFIELD DISTRICT
Wakefield district has an estimated population of around 333,759 (367,370 people are registered with the district’s 40 GP practices) of this, 12% of the population are aged over 70 years, and it is predicted that by 2021 over 22% of people will be aged over 65 years.

Wakefield district ranks as the 65th most deprived district in England (out of 326), and over 40,000 people live in neighbourhoods that are in the top 10% most deprived in England. There are however, neighbourhoods of considerable affluence and the overall trend is considered to be one of improvement and development.

The health of Wakefield people is generally worse than the national average for England (JSNA Wakefield), there is a combination of an ageing population and unhealthy lifestyle choices and an increasing prevalence of long term conditions, such as diabetes, arthritis, asthma, coronary heart disease and chronic obstructive pulmonary disease (COPD).

To address these issues partners from social care, health, housing and voluntary organisations across the Wakefield district have been working together to co-design a care system that meets the support needs of local people. This work started out as integration, progressed to Connecting Care and in the future will create system wide change under Connecting Care +.
The journey to transform and integrate health and social care in Wakefield began in 2010, when partners came together to develop forward thinking, innovative and sustainable principles for care delivery.

The Wakefield vision has also provided a platform to support the development of the Mid-Yorkshire Health and Social Care Transformation Programme, which brought together partners across North Kirklees and Wakefield, to design and deliver a major reconfiguration of acute hospital services, supported by enhanced community services.

A full business case was developed for the reconfiguration of hospital services, and support was secured from the Secretary of State in March 2014, to progress to implementation, following formal consultation. When fully implemented in 2017, there will be 171 less hospital beds across the system as capacity shifts to community settings and services.

The reduction in bed days has informed the approach to the £58.5 million Better Care Fund for Wakefield, which will be used as a catalyst to transform Primary and Community care, to support reduction in emergency admissions and length of stay.

In January 2015, the district was awarded Pioneer status for delivery of care and support in the community, and was invited to join Wave Two of the national Integrated Care and Support Programme. Two months later, in March 2015, the district became the only area nationally to have two successful applications selected to lead the vision, outlined within the NHS Five Year Forward View, as Vanguards for new Models of Care in two categories:

- Integrated Care in Care Homes
- Multispecialty Community Provider (MCP).

Wakefield is also part of the West Yorkshire Urgent and Emergency Care Vanguard, which overall reaches around 2.6 million people.

These principles are:

- Patients are practically managed at or close to their homes
- Only those people who need to be in hospital are admitted
- Once admitted into hospital people only stay for as long as is clinically necessary.

Supported by the Local Government Association System Leadership Team, partners in Wakefield reflected on the challenges and the solutions to enable health and social care first came together to develop a shared vision for local care.

The vision enabled all partners to take forward integrated approaches to care, targeted at the most vulnerable people, with a strong focus on self-care and proactive intervention to promote well-being for both children and adults.

In April 2014, six GP practices formed as West Wakefield Health and Wellbeing and attained Wave One Prime Minister’s Challenge Fund support to extend access to Primary Care. West Wakefield Health and Wellbeing has been able to test innovative technologies in the delivery of care and has taken forward integration within their patient population of 64,000.

Wakefield has a strong partnership ethos, reflected in the commitment of all partners to work together to agree ‘business rules’ for integrating care across the district. This was demonstrated in 2016/17, when the district was shortlisted for two Health Service Journal national awards and two local government awards.

The first ‘proof of concept’ integrated care team for adults was launched in April 2014 to test a new approach to delivering care in the community. This model encouraged the NHS, local government and the voluntary and community sector to work together to meet the holistic needs of citizens.

In April 2014, the West Wakefield Health and Wellbeing Ltd. is formed after attaining the Wave One of the Prime Minister’s Challenge Fund support.

The journey so far...

- **2010**
  - Partners from across health & social care first came together to develop a shared vision for local care.

- **March 2015**
  - Wakefield becomes the only area nationally to have two successful Vanguard applications.

- **March 2016**
  - Vanguard celebrates its first birthday.

- **April 2014**
  - Bullenshaw Connecting Care Hub opens. This is the first hub to launch.

- **April 2014**
  - West Wakefield Health and Wellbeing Ltd. is formed after attaining Wave One of the Prime Minister’s Challenge Fund support.

- **October 2014**
  - NHS Five Year Forward View is released.

- **November 2014**
  - Waterton House, the final Connecting Care hub opens.

- **October 2014**
  - Castleford Civic Centre Connecting Care hub opens.

- **November 2014**
  - Wakefield is awarded Pioneer Status.

- **January 2015**
  - Future: April 2017- MCP vanguard spreads across Wakefield District Care Home Vanguard expands in 2017/18 to take on additional care settings. Elite model commences in July 2017 to provide closer working between Geriatricians and General Practice. Extended Access to General Practice commences in July 2017 across the Wakefield District.
Connecting Care became the delivery mechanism used by partners for integration across Wakefield and district. It has been an exciting journey which has developed through several milestones.

A key milestone in the development of the model for Connecting Care has been the integration of health and social care ‘hubs’ covering the whole district. Created in 2014, the hubs offer a wider health and social care service and focus on crisis intervention, to prevent avoidable hospital admission and support services to enable people to be discharged from hospital earlier. This model is designed to support citizens to achieve better health outcomes, closer to home, and at the same time generate the capacity required to enable acute hospital reconfiguration to be delivered.

The hubs are aligned to five GP Networks, with Adult Community Nursing teams serving those networks. In addition to co-locating therapists, community matrons and social workers, the teams have established new roles for the voluntary and community sector organisations who are working directly in the hubs (including Age UK Wakefield District and Carers Wakefield and District), with new health roles such as community based pharmacists working as integral members of the team.

Connecting Care+ means doing things more effectively, and ensuring services work together as one. To achieve seamless health and social care, services such as; district nurses, therapists, social workers, mental health workers, volunteers, GPs and pharmacists, will be part of a new approach in Wakefield, which works together, shares information, plans care together and joins up care for patients.

Care often covers many services, this includes; NHS care for patients. Connecting Care+ will see care delivered closer to home, fewer trips to hospital, improved coordination of care for patients.

Connecting Care became the delivery mechanism used by partners for integration across Wakefield and district. It has been an exciting journey which has developed through several milestones.

The commitment to deliver the Connecting Care Hubs in real terms has meant Wakefield has ensured 1,321 fewer people being admitted to hospital during 2015.

Success of the hubs has been measured on the delivery of Connecting Care through an assurance framework that was developed to deliver the following outcomes:

- Care is co-ordinated and seamless
- Nobody is admitted to or kept in hospital or residential care unnecessarily
- People are supported and in control of their condition and care, enjoying independence for longer
- Care is cost-effective and within available budgets
- All staff understand the system and work in it effectively
- Unpaid carers are prepared and supported to care for longer.

The next step for Connecting Care is to build on the work of the hubs and take forward the learning from the work undertaken by the district’s transformation programme, to make the vision for a truly connected care system in Wakefield come alive across the district. This is Connecting Care+.

Connecting Care+ means doing things more effectively, and ensuring services work together as one. To achieve seamless health and social care, services such as; district nurses, therapists, social workers, mental health workers, volunteers, GPs and pharmacists, will be part of a new approach in Wakefield, which works together, shares information, plans care together and joins up care for patients.

Care often covers many services, this includes; NHS services, social care, voluntary sector, housing or mental health. We know from what people have told us that getting support from different organisations which are unable to be co-ordinated can be frustrating, people want services that are more joined up. Connecting Care+ will deliver on this.

Connecting Care+ will mean patients in Wakefield are able to say yes to all the following:

- I can access information and support that is clear, up to date and consistent
- My care and support is responsive, timely and joined up
- My support is provided by caring, considerate people with the right skills
- I live in a safe and positive community
- I am encouraged and supported to stay healthy
- I am assured that services and resources are efficient.

The Connecting Care+ model is designed to dismantle divides and improve the co-ordination between separate groups of staff and organisations. It involves redesigning care around the health of the population, irrespective of existing institutional arrangements. It is about creating a new system of care delivery, supported by an effective and robust financial and business model.

This means developing and embedding innovative patterns of engagement throughout a system that currently exists in separate parts. The promotion of public health, effective deployment of multidisciplinary teams, ease of access for the public to services, and the best use of technology are all elements which cannot operate in isolation. These must be utilised and delivered in collaboration, in order to ensure the best patient benefits.

Connecting Care+ will see care delivered closer to home, fewer trips to hospital, improved coordination of support, better access to specialist care in the community, and a promotion of public health and wellbeing and the tools for greater self-care.

The new model of care in Wakefield will strive to ensure equality of health and social care provision across the district, no matter where people live in their community, whether in their own home, a care home or an assisted living environment.
There are five Vanguard types, these are:

- **Integrated Primary and Acute Care Systems** – joining up GP, hospital, community and mental health services
- **Multispecialty Community Providers** – moving specialist care out of hospitals into the community
- **Enhanced Health in Care Homes** – offering older people better, joined up health, care and rehabilitation services
- **Urgent and Emergency Care** – new approaches to improve the coordination of services and reduce pressure on A&E departments
- **Acute Care Collaborations** – linking local hospitals together to improve their clinical and financial viability, reducing variation in care and efficiency.

In March 2015, the first 29 Vanguards were selected by NHS England. Within this selection, Wakefield was chosen as the only district nationally to take forward two Vanguard programmes. The Vanguards are another addition in the Wakefield system to join up health and social care services, through partnership working, to develop pioneering new models of care across Wakefield. This is also part of the Connecting Care story.

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### Wakefield Vanguards:

#### Enhanced Health in Care Homes Vanguard

Wakefield is one of six Enhanced Care Home Vanguard sites in the country which aims to enhance integration between health and social care. The Vanguard is led by NHS Wakefield Clinical Commissioning Group and is made up of, and supported by, a wide range of organisations from across the local health economy.

The Care Home Vanguard aims to tackle loneliness and fragmented care by joining up services for older people in supported living schemes and care homes, to help people live longer, healthier lives at home and within their communities.

There are currently 15 care homes and two extra care facilities within the Vanguard in Wakefield and in 2017/18 this will be expanded to take on 12 additional homes.

**Key Vanguard features:**

- Collaboration between health, social care, housing and the voluntary sector
- Focusing on the wider determinant of well-being – ‘somewhere to live, someone to love, something to do’
- Reablement and rehabilitation services and the development of community assets to support resilience and independence
- Enabling people to live in the most independent setting for as long as possible
- Proactive, multi-disciplinary assessment and care planning by GPs, community nurses, therapists, pharmacists, voluntary workers and care home staff for people in care homes
- Enhanced Primary Care support (working with 25 out of 40 GP practices in Wakefield), to allow access to a consistent, named GP and wider primary care services
- A joined up support package for people in independent living schemes to keep them socially connected to activities in the scheme and in the wider community, working with Carers Wakefield, Age UK and NOVA; providing holistic care to reduce the risk of deterioration and dependence
- Increasing the confidence, capability and continuity of staff working in care homes through continued training, overall reducing the frequency of emergency call-outs

### Benefits for residents:

- Keeping residents and their families in control of their care
- Helping residents maintain optimum health
- Reducing accidents and health deterioration which result in urgent GP calls and hospital attendance or admission
- Ensuring every resident has an end of life plan—allowing people to die in their place of choice instead of experiencing the distress of being transferred to hospital in their last hours
- Reducing the number of people choosing to go from independent living into care settings to escape loneliness
- Enabling couples to be supported to stay together in independent living schemes.

**Successes so far:**

From January 2016 to July 2016 (phase one of the pilot), the Vanguard saw:

- 28% reduction in emergency admissions (reduction of 4% more than the control group)
- 21% reduction in A&E attendances (reduction of 5% more than the control group)
- 14% reduction in ambulance call outs (an impact of 22%. In the control group, call-outs actually increased by 8%)
- 34% reduction in hospital bed days (reduction of 8% more than the control group).

**Multi-disciplinary Team (MDT) support including coordinated health and social care, and expert advice and care to help professionals, carers and individuals with complex needs navigate the health and care system.**

**One in 25 people move into a care home when they could have been better supported in a more independent setting**

**JJ, Director of Wakefield Provider Alliance**
Case study

Care Home Vanguard: Delivering joined up care...

Mr K.L is a resident at a care home in Wakefield which is part of the Vanguard. The care homes support team (MDT) had received a referral from a nurse practitioner attached to Mr K.L’s GP practice, which stated she felt that the resident had given up. Mr K.L was low in mood and was currently under mental health services.

A mental health nurse and general nurse completed a face to face screening which included reviewing Mr K.L’s care plan, speaking to care home staff and speaking to him and his wife.

Following this face to face screening, a care plan was drawn up which included; input from other members of the MDT and a referral to an external agency. It was felt that the resident would benefit from input from the general nurse, the dietitian, occupational therapist and physiotherapist from the Vanguard MDT support team. It was also felt that the resident’s wife would benefit from support from Carers Wakefield.

The screening highlighted many interventions that needed to take place to improve Mr K.L’s health and wellbeing.

The successes of this intervention are presented below:

- Mr K.L was referred to the befriending service to help improve his social isolation and low mood.
- Mr K.L has benefitted from better movement, sitting balance and repositioning since working with the MDT physiotherapist, alongside a reduction in requests for painkillers.
- Mr K.L’s wife received support from Carers Wakefield.
- Registered nurse in charge of the unit reported that the resident is more active.
- By working with the GP medication has been altered to reduce discomfort.
- Staff on the care home unit were taught how to handle, stretch and mobilise Mr K.L’s limbs, in order to prevent chronic soft tissue changes, contractures and pain. Registered nurse reports they have “come alive” and grown in confidence since the support from MDT.

West Wakefield Health & Wellbeing is a federation of six GP practices, covering around 65,000 patients and is one of 14 sites which was selected nationally in 2015, to develop and deliver the MCP new model of care. The Vanguard has focused on providing a larger, more diverse Primary Care team that delivers services “on the ground”, and has so far introduced specialist care into GP practices, including physiotherapists, pharmacists and specialist clinicians.

One of the Vanguard’s key aims is improving the way people access services and support through a better ‘care navigation system’. The improved system has helped to direct people more efficiently, to get the right care at the right time, and has made it easier and quicker for patients to get the help they need.

Other work underway in the MCP Vanguard includes:

- Extended operating hours for GP services with plans to roll this out to the other GP networks linked to the Vanguard.
- The development of integrated community teams with members from physical health, mental health and social care services, who care for the most vulnerable people.
- Improved technology for sharing patient information; as needed to prevent hospital admission and support earlier discharge.

The Vanguard is also creating more ways for people to access healthcare digitally, through an online directory of local services and a library of helpful health apps, including one designed by primary school pupils in Wakefield. Self-service kiosks in practices will help patients access these and other digital resources.

Successes:

- Over 2,400 hours of GP time have been saved at local GP practices in West Wakefield thanks to pharmacists being introduced into general practice. Over 7,300 medication reviews/repeat prescriptions have been reviewed and just 4.7% of over 19,500 interventions so far have needed to be referred back to a GP.
- GP practices in West Wakefield have successfully tried and test a new care navigation model of care. Since April 2016, it has helped to signpost over 9,500 patients to other health, care and community professionals, aside from the GP, to receive the right care quicker. It has also saved over 1,145 hours of GP time that has gone back to community professionals. Since April 2016, it has helped to signpost over 9,500 patients to other health, care and community professionals, aside from the GP, to receive the right care quicker. It has also saved over 1,145 hours of GP time that has gone back to community professionals.
- Over 2,600 patients have been given advice on self-care, including one designed by primary school pupils in Wakefield. Self-service kiosks in practices will help patients access these and other digital resources.
- Over 7,300 medication reviews/repeat prescriptions have been reviewed and just 4.7% of over 19,500 interventions so far have needed to be referred back to a GP.
- Over 1,145 hours of GP time that has gone back to community professionals.
- GP practices in West Wakefield have successfully tried and test a new care navigation model of care.

What is next for the MCP in Wakefield?

In April 2017, system partners will take the learning from the West Wakefield pilot and use it when delivering a new model of Connecting Care+ across Wakefield and district.

Wakefield will deliver the new MCP framework and share and spread the learning with other health and social care economies.

Urgent and Emergency Care Vanguard - West Yorkshire

Wakefield is also a part of the Urgent and Emergency Care Vanguard which operates across West Yorkshire and is led by the Healthy Futures Programme. The Vanguard has a collective local vision that all patients with cancer, mental health and urgent and emergency needs in West Yorkshire will get the right care in the right place, first time, every time.

To achieve this, the Vanguard will:

- Transform services provided by local communities and Primary Care.
- Provide urgent, acute and mental health services out-of-hospital where appropriate.
- Support communities and individuals to self-care.
- Ensure that emergency medical centres have the facilities and expertise to provide the highest levels of care.
- Improve integration of information and services to streamline the system.

Multispecialty Community Provider (MCP) Vanguard - West Wakefield Health & Wellbeing

An MCP is a new type of organisation that has been created to provide a wide range of health and social care services to people in their homes and communities. It focuses on moving specialist care out of hospitals while also:

- Redesigning care around the health of the population, irrespective of existing institutional arrangements.
- Focusing on prevention.
- Improving health and wellbeing.
- Reducing avoidable hospital admissions and elective activity.
- Unlocking more efficient ways of delivering care.
- By working with the GP medication has been altered to reduce discomfort.
Early Help Hubs, now known as Children First Hubs, work closely with families in Wakefield to provide the right level of support at the right time, for families with children under the age of five.

The Children First Hubs bring together different professional groups who offer a whole range of support for families. Their support includes: support for under fives through the Children’s Centres, access to health visitors and health care and, family support, support to Young Carers and targeted interventions supporting a range of issues. Their focus is by getting help early enough to struggling parents prevents problems from growing or getting out of hand.

The hubs link with partner organisations to provide an approach that supports the whole family; from pregnancy to 19 years (25 years for young people with special educational needs). The range and level of service provided in each locality will be determined by the needs of the children, young people and families in that community.

Children First Hubs, deliver:

- Quality services which improve the safety, health and well-being of children, young people and their families
- Services from locations within the area that are accessible and convenient to children and families
- Children’s centre services provided within a locality as part of the Early Help Offer, rather than a focus on buildings
- Targeting services at those most in need and those most difficult to reach, including more outreach and home based working.

A range of services are available to children, young people and families, which include:

- Children's centre services
- Key worker support
- Health care and advice
- Family support and parenting
- Support with Domestic Abuse
- Support with education, employment and training
- Debt/financial management
- Positive activities
- Volunteering.

Services based in the hubs will include parent and family support, early years, support for young carers, education, information, advice and guidance, community development, school nursing, health visiting, troubled families, neighbourhood policing teams, some elements of children’s social care and family assessment.

There will be a hub building in each of the seven localities from April 2015, where multi-agency teams will be based.

These will be at:

- Wakefield Central Hub – City Limits, Wakefield
- South East Hub – Platform 1 Centre, Hemsworth
- Normanton and Featherstone Hub – Normanton Town Hall, Normanton
- Wakefield Rural Hub – Havercroft Library, Wakefield
- Castleford Hub – Five Towns Centre, Castleford
- Wakefield North West Hub – Ossett Town Hall, Ossett
- Pontefract and Knottingley Hub – Pontefract Municipal Offices, Pontefract.
Adult Community Nursing is a key part of the Connecting Care vision, ‘for citizens of the Wakefield district to live longer, healthier lives supported by people with the right skills in the right place’ and provides individual, tailored care to the patient, involving carers and referring to other healthcare teams, when necessary.

During 2015, colleagues in Primary Care and community services worked together to develop a new approach for nursing in the district.

Through a new service specification, the system addressed the different roles, responsibilities and skills required from Adult Community Nurses, re-defining their role in the delivery of nursing services, whilst identifying key objectives and deliverables in line with local and national requirements.

This specification has therefore shaped the way the ACN Service is currently being delivered across the Wakefield district.

What do Adult Community Nurses cover?

ACNs are part of the Community Nursing Team and are based within each of the GP networks. They provide nursing care for adult housebound patients (in the setting where they reside) and those in residential care homes.

The ACN Service is accessible 24 hours a day, seven days a week and uses agile mobile working in community settings, to deliver patient-centred care through integrated working.

What are the aims and objectives of the ACN Service?

The ACN Service is integral to ensuring individuals are able to remain in their own homes and communities, and therefore aim to:

- Deliver a service which communicates effectively across critical professional interfaces, including: Primary Care, acute sector, adult social care, integrated discharge teams, third and voluntary sector (not exhaustive), placing the patient at the centre
- Work with other health and social care providers to support Continuing Healthcare (CHC) assessments in nursing home settings and undertake fast track CHC assessments as the “eligible clinician”
- Participate in the application of the CHC framework including checklists and the multi-disciplinary team approach to decision support tools in cases where Adult Community Nursing input is required, including in the patient’s home.

Training Successes in 2016

Since April 2016, all education and training required across the ACN Service and Primary Care specification has been reviewed and planned. Training completed has included; ear care training, which was accessed by a total of 109 staff, from MYHT and from 37 of the 40 Primary Care practices, and wound care training which was accessed by 96 staff from MYHT, care homes and from 33 of the 40 Primary Care practices.

Moving forward

The ACN Service will continue to:

- Complete required training and conduct ongoing training needs analysis
- Review and implement policies and procedures to ensure the successful and accurate implementation of services
- Develop a flexible, mobile workforce to meet the needs of patients in Wakefield
- Host monthly meetings between ACNs, GP practice staff, MYHT and other partners to develop collaborative working across the teams
- Reach and excel on all Key Performance/Quality Indicators and local operational data reporting conducted by MYHT.

“100% of patients who require responsive nursing on discharge from hospital are accepted onto the ACN Service caseload on their planned day of discharge- this is against a local target of 95%.”
Approximately 1 in 4 adults and 1 in 10 children suffer from mental health problems each year within the UK.

The vision for Wakefield is to improve the mental health and psychological wellbeing of people across the district. To achieve this we need to:

- **Support the prevention of mental health problems**
- **Invest in early intervention**
- **Promote self-management of mental health problems**
- **Focus on recovery**
- **Ensure services meet physical and mental health needs, and that no one falls through the gaps**
- **Ensure service user and carer participation in everything we do.**

In 2016 alone, we have developed a range of services, programmes and initiatives across Wakefield, in partnership with many health, social, community and voluntary organisations. The following is just a snippet of the areas of Mental Health we are covering in Wakefield.

### Primary Care Mental Health Workers

The service aims to provide person-centred, holistic care to those individuals suffering co-morbid physical and mental health conditions; in order to improve their outcomes.

Three Primary Care Mental Health workers are co-located in the Connecting Care hubs and deliver the service. Their role involves focusing on:

- **Patients/individuals who might benefit from a holistic assessment to address their physical and mental health needs**
- **Early intervention and promoting self-directed support and recovery**
- **Developing a culture of raising awareness, promoting positive choices and empowering service users to control their own recovery**
- **Collaborating with a wide range of organisations to facilitate onward referral into appropriate services to support individuals.**

### Improving Access Psychological Therapy (IAPT)

In 2016, the IAPT service was recommissioned through a tender process, allowing the continued development of a new service model under the new name Turning Point Talking Therapies. The new model includes online counselling and three talking shops located across Wakefield, operating seven days a week. Focusing on ease of access and a smooth transition into secondary services, the new model further provides a wider offer of prevention and early intervention through a blend of online and face to face counselling.

### Dementia Pathway

Our focus is on improving care pathways and working with General Practices to support care planning and diagnosis, while developing a Dementia Friendly Wakefield. As part of the Healthy and Active Life Fund, NHS Wakefield Clinical Commissioning Group has developed partnership working between Public Health and Age UK and are offering one-off grants to organisations who are looking to become more Dementia Friendly.

### Local expansion of NHS Personal Health Budgets

Personal health budgets (PHB) can offer more choice and control over the money spent on meeting an individual’s health and wellbeing needs, and are part of the standard care offer for children and adults receiving Continuing Healthcare in Wakefield. From 1st of April 2016, PHB will further be offered to people with learning disabilities as part of our expanded local offer.

### Development of a Clinical College for Mental Health in Wakefield

The Clinical College for Mental Health is a virtual college hosted on the NHS Wakefield Clinical Commissioning Group’s intranet. The College provides an opportunity for primary and secondary care clinicians, who have an interest in mental health, to work together in partnership to create an evidence-based way of working, sharing clinical intelligence, data collection and action learning. Offering a blend of face to face collaboration alongside the interactive, online platform, the long term goal of the college is to support an improvement in patient care, treatment and recovery.

### Programme of work to improve the physical health of people with serious mental illness

Evidence clearly shows a reduced life expectancy among people with the most severe forms of mental illness, largely attributable to poor physical health. Our joint work undertaken by the Yorkshire and the Humber Academic Health Science Network and Wakefield Primary Care will encourage health professionals, particularly those who are generally the first point of contact for these patients, to carry out these important physical health checks.

### Awards & Recognition:

**Winners of the Best Project Award - Resolve Antisocial Behaviour (ASB) Annual Conference Awards, 2016**

When dealing with complex cases of ASB, housing providers such as Wakefield District Housing (WDH) are often faced with limited capacity and expertise to respond to people with poor mental health, or to gain access to appropriate mental health services. This is especially relevant when individuals do not engage with their own GP or support services.

The Mental Health Navigation Project is therefore a partnership between NHS Wakefield Clinical Commissioning Group, WDH and South West Yorkshire Partnership Foundation Trust. It is jointly funded to support three Mental Health Navigators (MHN), trained mental health nurses, who work directly with the WDH Wellbeing Team to provide a clinical assessment of need, referral and support to WDH tenants with low to moderate mental health concerns.

**Shortlisted for the Mental Health Integration in 5YFV New Models of Care (Supported by NHS England) Award - The National Positive Practice in Mental Health Awards, 2016**

We were highly commended for our “looking through a different lens for Mental Health Integration” programme in the Wakefield Care Homes Vanguard.
What is the Better Care Fund (BCF)?

The BCF was set up by the Government in 2013. It means that the NHS and the Council are encouraged to pool some of their money. In Wakefield, the NHS and Council will spend almost £660m on health services and adult social care this year (2016/17). Some of this money pays for the care people need when they are ill or have a particular problem. But some of it pays to help people stay well for longer and to live more independent lives.

In Wakefield, we are already underway with a joint work programme for health and social care. We are already seeing that this approach is improving people’s wellbeing. That’s why we have decided to put more of our money into the BCF than the minimum which the Government tells us we should. In 2016/17, £58.5m of funding was pooled together for Wakefield’s BCF.

Why is the BCF better for Wakefield residents?

It aims to provide care that:

- Is more joined up
- Keeps people independent for longer
- Helps people to stay out of hospital unless they need to be there
- When people need hospital care, helps them get home quicker.

Who’s involved in the BCF?

The money is pooled by the Council and the local NHS to pay for services from statutory organisations, such as the hospitals and social care. And more than that, it also helps voluntary organisations to add their special skills to the mix.

What are the outcomes from the BCF so far in Wakefield?

The BCF Q2 return to NHS England shows that we are achieving all of the national conditions required. These include the following aspects:

- We are on track to meet the BCF target for Delayed Transfers of Care
- Care home admissions from those aged 65+ per 100,000 population has decreased
- The proportion of older people (65 and over) were still at home 91 days after discharge from hospital into reablement/rehabilitation services. We are on track to meet this BCF target, with Q2 showing us meeting above the national target
- Our Care Home Vanguard Programme within the Better Care Fund has shown a reduction in hospital admissions and attendances.

VCSE organisations can be used as a valuable tool in tackling, preventing and improving local health and social problems. They are able to provide a personalised and more flexible approach than traditional health and social systems, taking the pressure away from larger healthcare organisations, whilst providing a more tailored care experience, which is wrapped around the patient.

We therefore work alongside many VCSE organisations across the Wakefield district, covering both Primary and Secondary Care, from within our Connecting Care hubs, where we have VCSE organisations such as Age UK working alongside clinical colleagues, to within our care homes and hospitals.

Connecting Care

Within Connecting Care is the Provider Alliance, which is made up of 11 organisations who deliver integrated care services within the district. Out of these 11 organisations, four of these are from the VCSE sector, including; Age UK, Carers Wakefield and District, Nova and Spectrum CIC.

Below is just one example of the many innovative services delivered by VCSE organisations in Wakefield.

‘Hospital to Home’ Service delivered through Age UK Wakefield

Many older people end up in A&E due to non-medical or non-urgent issues. Once assessed and deemed medically fit and well enough to return to their communities, there are often problems with low level needs that may prevent them from returning, unless they receive some support.

It is the lack of help with some of these low level needs, that often results in a crisis which in turn end up with an attendance at A&E. Hospital to Home is a new service commissioned by NHS Wakefield CCG and delivered through Age UK Wakefield. The approach is to avoid hospital admissions by supporting discharge and transport from Pinderfields and Pontefract A&E and hospital wards.

The service is best described as a non-medical model for patients that are stable and fit to return to their place of residence or to step down from hospital beds. Patients may further require transport and some basic one-to-one care, such as food and drink preparation, contacting their family, ensuring they have a warm house and that there is food in the fridge etc.

The service is available seven days a week and is provided by Age UK support workers. Support will be provided short term with signposting to other voluntary and statutory services, and also the Connecting Care hubs, if necessary for longer term need.

Hospital to Home won the ‘Innovation in Partnership Working’ award at the 2016 “Celebrating Innovation and Good practice in the System” event hosted by Wakefield and North Kirklees Clinical Commissioning Groups.
Community Anchors

Working with VCSE organisations at neighbourhood level is essential in developing resilient communities to address the wider determinants of health in Wakefield. Following a review of community development by Public Health, it was identified that the Wakefield district has comparatively few Community Anchor organisations. Community Anchors are independent (generally registered charities) multi-purpose organisations, based in geographically defined neighbourhoods and used by the whole community. They provide a place for local people to access social and economic opportunities and also provide an opportunity for health and social care to engage with communities, to understand their needs.

As a result, Public Health has invested in the VCSE sector and the development of Community Anchors across the Wakefield district. Nova Wakefield District Limited has been funded to co-ordinate this work.

This has led to the development of a Community Anchor Network across Wakefield, which works collaboratively with the Connecting Care agenda whilst utilising the 'Five Ways to Wellbeing Model'. Community Anchors have benefited from the Micro Commissioning Grants Programme, which has been managed by Nova Wakefield District Ltd, and funded by West Wakefield Health and Wellbeing Ltd. Examples of micro commissioned projects funded in the Community Anchors include; Dementia cafes, support for the homeless, and a choir which supports mental wellbeing. Other Community Anchors are hosting services which have been funded through the programme. An example of this would be the Wakefield District Sight Aid hubs which have been set up in various Community Anchors.

As part of the Community Anchor development in Wakefield District, a Sustainability and Innovation Fund, funded through Public Health, has been set up to support organisational development in Community Anchors. Examples of what the fund has currently been used for include equipment, health and safety auditing and staff training.

Community Anchors in Action

As part of the Care Homes Vanguard, Community Anchors in Wakefield have paired up with care homes in the district to provide health and wellbeing activities, for care home residents, both in the community and in home settings.

An example of this is St George’s Community Centre working together with Croftlands Independent Living Scheme. Funded through the Micro Commissioning Programme, St George’s held a 40’s themed afternoon tea party and six Croftlands residents were picked up by St George’s and brought to the tea party.

The tea party was a great success and everyone involved enjoyed the afternoon.

Case study

Sharing Information

When health and social care is required, it is often the case that several organisations will be involved in providing this. The NHS works with many partner agencies such as social services, education, housing and the voluntary sector. Therefore, to enable seamless and integrated care, patient information needs to be shared between the staff in these different organisations.

To help us share information, we will be extending the use of one of our clinical ICT systems across our Connecting Care hubs and within the Care Home Vanguard. This will help provide a complete view of key patient health and care information, and will ensure GPs, hospital doctors, nurses, social workers and other health and social care professionals have an overview and understanding of a patient’s care, so that they can make the best decisions about diagnosis and treatment, to provide a seamless care plan.

The sharing of information will mean:

- Patients don’t have to keep repeating medical or social care history to different care professionals
- Care professionals will have access to the right information when they need it
- We will be able to reduce duplicate appointments and tests
- Patients will receive the right treatment and care more quickly.

Patient information will always be shared in the safest way, and it can only be accessed by health and social care staff who are involved in an individual’s care and wellbeing. Staff will only have access to the information they need to help design and deliver an appropriate service, and they will always discuss with patients what information they are sharing and why. Patients can ask staff if they have any concerns.

Digital Services

Digital services can be used as a valuable tool in enabling self-care to support patients to take greater control of their health and wellbeing, whilst providing more choice, convenience and control in how GP services can be accessed.

The GP Online Service allows patients to access a range of services via computer, tablet or mobile. Once patients have signed up, they will be able to:

- Book or cancel appointments online with a GP or nurse
- Renew or order repeat prescriptions online
- View parts of their GP health record, including information about medication, allergies, vaccinations, previous illnesses and test results.

The service is free and everyone who is registered with a GP can have access to their practice’s online services.

The Future

We still have a good amount of progress to make in both Wakefield and across West Yorkshire, and our planning specifically includes:

- Developing the digital care record
- Unifying communications across the district
- Mobilising our staff
- Developing the online consultation systems for patients and clinicians.
In 2013, Wakefield commissioned a three-year evaluation of the Connecting Care initiative. The evaluation was conducted by Niche Health and Social Care Consulting and Healthwatch Wakefield.

There were three main methods used in the evaluation:

- Interviews of staff involved in the delivery of Connecting Care
- Interviews with patients/service users, and carers of service users, who received services from Connecting Care, and;
- An analysis of relevant and available local data.

During the course of the evaluation, six monthly formative reports were produced to inform the development and evolution of the integration of health, care and the voluntary sector. The work was completed in December 2016, with the final summative report published in January 2017.

The report presents the results of almost 1000 interviews with service users, carers, and staff of the services involved; producing quantitative data about the activities of Connecting Care, and of the services, on which it was hoped it would impact on.

Headlines for the report are:

- 97% of people interviewed felt they had been treated with kindness and compassion by the Connecting Care staff
- 85% of people interviewed by Healthwatch rated the Connecting Care service as very good or good
- 66% said it helped them cope better at home and 63% said it helped them stay more independent
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- 86% of people felt they were definitely, or to some extent, as involved as they wanted to be in making decisions about their care and support
- 79% of people said they felt that their friends and family who cared for them had been as involved as they wanted them to be in decisions about their care and support.

Qualitative data from staff interviews also includes the following feedback:

- "It’s amazing! No emails or writing referrals… it’s all there."
- "We are nearer patients and more local. In an emergency we can respond quicker."
- "It has streamlined processes and prevented admissions for some people."
- "It’s been positive working with different agencies… if we are not sure what to do, if we have a query we can ask. We go to meetings where we all talk about cases. We get together and discuss cases and everyone can ask questions. Connecting Care has built my confidence."

Qualitative feedback from patients also included:

- "Daughter reports that dad has had good care, has been offered services which he hasn’t accepted, the staff are brilliant and flexible and she says she cannot praise them enough, they have been lovely."
- "They have been brilliant, nothing but praise"
- "GP wanted her to go into hospital but by having the nurses around to care for her at home, she was able to stay at home which is what she wanted."

Analysis of responses over time

The questions in the survey that measured the integration of Connecting Care have shown improvements over time, with a few peaks and troughs. By the end of the evaluation period, more people were reporting that they hadn’t had to wait for the service, that services always or mostly worked well together, and that where appropriate, information had been given to them about other services that might be helpful.

From 2014 to 2016, an improvement in the rating of Connecting Care from service users and carers of services users can be traced, with a growth from 68% to 88% of people stating that Connecting Care was very good or quite good overall. There has also been reporting of positive outcomes in health and wellbeing circumstances as a result of Connecting Care interventions.