Healthier Wigan Partnership

Working together to help people live healthy, happy and fulfilled lives
Welcome to our first end of year report for the Healthier Wigan Partnership. We are a partnership of health and social care providers in the borough with an ambition to integrate the way we deliver services. We want to improve services for local people, support people to be independent, to be in control of their own lives, and ensure we have an affordable health and care system for the future.

We have signed up to ‘The Deal for Health and Wellness’ and have come together to deliver the Wigan Locality Plan, ‘Further Faster Towards 2020.’

Our focus is primarily out of hospital care, and we want to ensure high quality, flexible services are delivered close to where people can easily access them. We are bringing staff from across our organisations to work together around the needs of local people.

We have made significant progress this year, working together to introduce Integrated Community Services; Community Nurses working alongside Social Care Workers, enablement staff and therapists, to provide seamless support to residents with long term medical conditions and reduce admissions to hospital.

We have introduced GP clusters, with GP practices working together, in local areas for populations of 30-50,000 patients. They are supporting each other to be resilient and meet local demands, and testing out new ways of working with a wider set of partners to address the causes of poor health, for example; housing and debt.

Importantly we are working together to reduce demand on our hospital services and looking at how we ease the need for unnecessary attendance at A&E, with initiatives such as out of hours access to GP services, integrated discharge teams and integrated community services.

Take a look through this report to see how we are working together in new ways to improve the health and wellbeing of the people in the Wigan borough.

‘ We aim to give local people the confidence and knowledge to look after themselves and to build on their strengths’
Who we are

The Partnership Commitment

The Healthier Wigan journey is well underway, with a core set of partners working together in primary, community, social care, and the local hospital to transform out of hospital services.

We are working with a wider range of public services, including schools, Police, Fire and others, as well as the voluntary and community sector through our newly formed reference group to join up our services at a local level. We are all working to improve the lives of local people.

Together, we are taking an asset based approach, having a different conversation with people to identify their strengths, helping them to help themselves and to tap into the wealth of community as support where they live.
The commitment to our local people

All partners are fully behind the Deal for Health and Wellness and for the boroughs local people this includes a pledge on how we will help them to keep well and connected to their local communities. With an emphasis on prevention of illness by our local people taking responsibility for themselves and their family.

Our Part

- Ensure there are a wide range of facilities within local communities including parks, open spaces, leisure, safe cycling routes, good quality housing.
- Ensure easy, timely access to good quality GP services, seven days a week, to screen, diagnose and treat and prevent disease as early as possible.
- Support families to ensure their children have the best start in life.
- Support people to live well, helping those who are unemployed into work or training and helping them benefit from the fastest growing economy in the UK.
- Assist people to age well by keeping them healthy and connected to their communities for as long as possible in their own home.

Your Part

- Keep active at whatever stage of life.
- Register with a GP and go for regular check-ups – taking charge of your own health and wellbeing.
- Quit smoking. Drink and eat sensibly and encourage your children to do the same.
- Take time to be supportive parents or guardians, encouraging children to be the best they can be.
- Take advantage of training and job opportunities, setting high aspirations for yourself and your family.
- Support older relatives, friends and neighbours to be independent for as long as possible.
- Get involved in your local communities.
Before we are able to reduce the demand on our local hospital, we’ve identified the main health and social challenges facing the borough.

**Ageing population**
An ageing population with multiple complex chronic conditions

**Constrained funding**
Constrained funding means that all partners in the borough are facing an unprecedented financial challenge

**Integration**
A lack of integration between different providers in the system leading to inefficiency and a compromised patient experience

**Increasing demand**
Increasing demand from individuals with complex dependency who have been used to taking action only when their need was acute

**Skills and workforce gap**
A skills and workforce gap that threatens the safety of the system and impacts its ability to invest in improvements and changes

**School readiness**
Children who are not ready for school meaning they may face a lifetime of disadvantage

**Poor health**
High levels of obesity and tobacco and alcohol consumption – important determinants of poor health

**Lifestyles**
Adults of working age trapped in chaotic lifestyles and dependent on multiple public services

The partnership has been considering sustainable ways where integrated local health and care services are wrapped around primary care clusters.
A new design for the future

Based on our boroughs challenges and feedback we’re designing our services differently for the future:

Our design principles
• **GP’s practices at the heart** of the new health and care system.
• **Neighbourhood Areas** - 7 Service Delivery Footprints (SDFs) joining up a range of services from across the health, public and voluntary and community sector to meet the needs of local people. We call this ‘place based working’
• **Staff and People assets** - Build on the assets of our staff and people by promoting peoples strengths and assets in the community.
• **Focus on Wellbeing** - concentrate on the physical, mental and social wellbeing of the Wigan population.
• **Tackle the causes** of poor health such as housing, domestic abuse, social isolation and employment
• **Focus on the needs of individuals and their families**, better coordinating our care.

In 2014 we undertook a borough-wide engagement exercise to find out what residents want from integrated services:

- ‘The professionals to be there ...stepping in when I need them’
- ‘Care centred around me as the patient’
- ‘Multi-agency approach to delivering seamless care’
- ‘First call for the patient needs to be the GP’
- ‘Everyone should work to a single care plan that has been agreed with me and my family’
- ‘There will be someone who looks after the whole needs of the individual – a ‘Care Co-ordinator’
- ‘I want to be treated as an individual’
- ‘Access to practical support- understanding all my needs’
- ‘It’s about an individual plan and how we achieve that through systems and processes’
- ‘The voluntary and community sector needs to be there from the word go’
- ‘Practical, proper support for self-management’

Take a look at how we have continued the conversation overleaf.....

“I feel so much better in myself, I can tackle anything now”

Wigan resident, 43
In 2017 we’ve been out and about in the community listening to local views.

We’re working closely with our workforce too, to understand what works well for local people in the way we deliver services and what stops us providing good services.

Engaging and communicating clearly and regularly with all those who work in the partnership is really important. We launched our first staff newsletter in August and will be producing quarterly editions.

Other engagement highlights:

- Startwell Phase 2 - public and staff engagement on the future design of services
- Two-month patient engagement programme
- Bridgewater NHS Community Trust – The ‘Big Conversation’ with residents
- Attending community events, such as Higher Folds Community Fun Day

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<th>112 Survey responses</th>
<th>3258 Total overall contacts</th>
<th>60 ‘Other’ comments</th>
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<td>People at Design Workshops, June 2017</td>
<td>People at engagement event, April 2017</td>
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Read the experiences of those already striving towards a Healthier Wigan over the next few pages
You said, ‘Care centred around me as the patient.’
A GP in Hindley was contacted by a family concerned about a patient who had been discharged after previously receiving treatment for a mental health condition. The family felt that the individual concerned was not coping well and were going to ring for an ambulance, as they were at crisis point and could not cope.

The immediate response
The GP referred the patient into our new Integrated Community Services. One of our Community Matrons, at the Hindley Hub, undertook a review of the patient. Our Hospital at Home team, visited the patient, taking bloods and blood pressure readings, as well as undertaking general observations. Results were passed back to the Community Matron team for review.

Whilst waiting for the results, the Community Matrons team contacted other partners including the GP, to gain greater understanding of the patients circumstances and condition. They also kept in contact with the patient’s daughter to reassure her that her concerns were being taken seriously.

From initial discussions with the GP, family and Hospital at Home, the Community Matron Team were able to call on the Rapid Assessment Interface and Discharge team (RAID), and the Single Point of Access team to deliver a co-ordinated approach and support to the patient.

The outcome for the patient was that they received the range of support required to enable them to remain in their own home with their family, the family felt comforted and listened to, and had confidence in an Integrated Community Services approach.
You said ‘Everyone should work to a single care plan that has been agreed with me and my family’

Charlotte, one of Wigan’s Community Link Workers had an elderly lady referred by the GP for help at home. The lady had a history of stroke, falls and poor mobility and other regular care needs. Her husband was her main carer and had a fall resulting in a broken foot himself but he had already arranged support with shopping, meals, cleaning and laundry.

The couple were both concerned about their ability to deal with left sided weakness and pains in an arm and shoulder. With both very hard of hearing communication by phone added complexities to their care. Their son was providing help when he could but he did not live nearby and had other care commitments with his wife. Charlotte discussed some local services with the couple before presenting their case at the Service Delivery Footprint (SDF) meeting. She talked about the barriers they were facing such as not being able to communicate over the phone.

From the meeting, priority was given to a joint visit with Charlotte and a social care officer. Charlotte felt reassured as she was able to discuss with multiple professionals around the table and facilitated by the Service Delivery Footprint manager.

She updated the couple in person and explained that the next visit would be with herself and a social care officer who could present their support options. A joint visit was carried out and social care assessment was completed to assess what needs the couple had and how we could meet them. They wanted to know what choices they had with regards to carers and the cost involved and together Charlotte and the officer explained their options.

Charlotte’s actions empowered the couple to make informed decisions on their own care needs and control their future ones for as long as possible.

“I explained that I would update them in person with next steps from the SDF meeting”

Charlotte
Jean stepped in when one of her patients was concerned that a hospital stay would mean her children may be taken in to care; as she had no family support. When Jean found out that this was why her patient was missing appointments they planned together for the safe care of her children. In future she doesn’t have to worry.

Jean, a Community Matron, (pictured right) told us her story about helping to co-ordinate support for one of her patients.

Jean didn’t do this alone; she had support from colleagues at Startwell, the police, housing and others, through a multi disciplinary team approach in her local area. She reached out to a range of professionals in her local area to provide, ‘A Multi agency approach to delivering seamless care’. This was another ask of residents to help them navigate a range of complex services.

“We are all delighted with the way that everyone has worked together to achieve this fantastic outcome for the patient, including the Integrated Community Services, Hub, the Multi-Disciplinary Teams and other agencies. A credit to everyone involved.”

Jean, Community Matron

From the survey in 2014 local people said they wanted ‘a care co-ordinator’ - someone who would look after all of their needs and help them to get the right support when it was needed.

The care she received from Jean was not just for her medical needs. The patients home situation meant she found it difficult to take care of herself and plan how she could manage her health conditions. Jean looked at what was stopping her patient to keep well from housing, to concerns over her children and focused on helping with them as well as her medical condition.
You said, ‘The voluntary & community sector needs to be there from the word go’

Tony’s Story

Before Tony was referred to Inspiring Healthy Lifestyles he had two diagnoses of severe and enduring mental health conditions (Anxiety and Depression). It started not long after completing six years in the Armed Forces, but it wasn’t until his first admission to hospital that he started to “pile the weight on”.

Due to his mental health conditions, he never left the house and struggled to find any form of motivation. The only time his wife could convince him to leave the house was to go for a short car journey but as soon as he left he just wanted to get back home.

With information from Active Choices Tony was encouraged to join his local football group, and this has improved his physical and mental health.

“If it wasn’t for the football group I don’t know where I would be or what I would be doing. More than likely I will still be at home feeling sorry for myself. If it wasn’t for the staff and participants at the football group I would never have had the drive and motivation to overcome my anxiety and gain the self-confidence to be in this position I am today”

Tony

You said you wanted, ‘Access to practical support - understanding all my needs’

Barry and Lynn’s Story

Barry has spondylosis (spinal osteoarthritis) diagnosed around 15 years ago and also uses a walking stick. He has tinnitus & his eye sight over the past few years has significantly reduced. Lynne his wife is his main carer.

He was diagnosed with Alzheimer’s back in 2011 – As a consequence his confidence has slowly been eroded and he is often quite emotional as the effect of all of the above weighs heavy on his mind. He struggles to find the words to explain how he is feeling in conversation he has said “its not right my head its all wrong.”

Attending the Active Café in Leigh has been a great help to them both, Barry is very sociable but doesn’t like noisy groups or crowded areas so this group has been especially helpful to them both.

When the Dementia Friendly swim session was set up Lynne & Sue, their specialist activity worker, discussed how Barry would feel getting back in the pool. Lynne was understandably anxious but Barry said “yes I will come if you are there Sue.”

“We are both looking forward to coming next week– it’s been good for both of us and I need not have worried for him but I think I always will. All these great things going on in the community have been a lifeline”.

Lynne
During the 12-months prior to referral, the client presented on 27 occasions to A & E and also accessed 12 COPD service assessments at Wigan Infirmary. Post-intervention the client has presented to A & E on 6 occasions with one visit to Wigan Infirmary COPD service.

Integration in action
Tackling cause of poor health

You said, ‘the first call for the patient needs to be the GP’
We know patients want to visit a GP in the first instance, and that they often have a range of problems impacting on their health. We now have Community Link Workers in place, who are there to support patients referred by their GP in addressing a wider range of concerns, by linking into other services that can help.

A Community Link Worker’s story
‘I received a referral to see a gentleman from the GP surgery. The patient suffers from Chronic Obstructive Pulmonary Disease (COPD). He lives alone and has slight learning difficulties. During our appointment he revealed to me that he had a poor electric heating system that was expensive and not very affective. This gentleman had over 40 hospital admissions over the last 12 months that were linked to his COPD and breathing difficulties.

The patient gave me permission to refer him to the AWARM service regarding the issue with his heating system. We had great news that the gentleman qualified for a heating grant but there was no gas connection for his home. Undeterred the staff at AWARM applied to the National Grid on his behalf. He is now one of only 2 people in the country that a gas supply has been given to.

Thanks to the staff at AWARM he is now awaiting a brand new heating system. This will help to improve the management of his condition and health, and reduce future hospital and GP admissions.'
Annmarie, a social care officer from South Wigan, has helped one local family by identifying the specific causes to a variety of challenges the family was facing.

By working with other health and social care professionals, and other agencies, Annmarie was able to coordinate a range of support working alongside the family, to address their needs. The future is now looking brighter and more manageable for them.

“The way that Annmarie and the others approached my situation means I am no longer facing eviction, my daughter is opening up at school and my mum is helping too. I feel a weight has been lifted off my shoulders now that we are getting help and support”.

Wigan Mum, 30
Our team

The Healthier Wigan Partnership is supported by a small dedicated programme team, who are working across all partners to make change happen. Coming from a range of different backgrounds they bring a diverse set of skills to this work, but most importantly they are focused on what will work for residents and building a responsive, affordable and flexible health and care system.

Our work includes the development and delivery of a wide range of programmes to improve the health integration and health outcomes for local people and also enable programmes to ensure that our staff can do the best possible job, supported by effective IT, estates, good communications, workforce changes and more.

Progress so far

IT – Investment in a secure NHS network, so that our health professionals can retrieve patient information quicker to support patient diagnosis.

Share to Care – We are sharing information across Healthier Wigan partners. So GP’s have to up-to-date information on their patients from across a range of health service providers.

Enabling change to happen

**Estates** - We are co-locating our teams in areas closer of our communities. For example in Hindley Town hall we have brought together community nursing teams, social workers and other staff, such as occupational therapist to work together around the needs of patients. We are facilitating co-location, by investing in IT and buildings to bring services closer to home for residents.

**Workforce** – We are bringing our staff together through co-location and working in ‘huddles’. These are multidisciplinary teams who work within our seven Service Delivery Footprint areas. By working together to better join up our services we are reducing duplication and coordinating our services better.
Enabling change to happen

Communications and engagement - The first phases of our public engagement are already underway on integrated working and the shaping of The Healthier Wigan Partnership.

We are building a Healthier Wigan Partnership website which will be launched in early 2018 along with a structured communications plan.

We’re developing our internal communication, working across all of our organisations to start new channels of communication to keep staff up to date, with newsletters, events and information.

Quality – We all share a common goal to ensure the greatest and fastest possible improvement to health and well being for local people. Working to ensure we achieve on both of these is our Quality Enabling Group.

To date 54 of our GP practices have been rated good or outstanding in recent CQC visits. Which is good news for our patients.

Business Intelligence – By the end of the year The Healthier Wigan Partnership will have key metrics and agreed population outcomes in place. The population outcomes are a high level set of outcomes, agreed by partners as priority for the whole health and social care system. Together we will be striving to transform the way we deliver services to achieve these outcomes.
Enabling change to happen
Using our assets

Building on the assets of people and places

One of our core principles in the way we work is to have an asset based approach. This is sometimes also described as a ‘strengths based’ or ‘patient centred’ approach. This style underpins everything The Healthier Wigan Partnership is aiming to do.

We have trained our staff to have a different conversation with people, to identify and build on their strengths. We have invested in developing community assets and are connecting people to the assets available in their community through our online Community Book.

We are co-locating our teams and promoting multi-agency working across our partners, and giving our staff the freedom to redesign and innovate our services.

This approach has been successful in Adult Social Care and other partners, such as GP practices and community services are rolling out this approach.

Examples of one GP practice’s changes include:

• Asking questions and having conversations with patients to find out what is really going on for a patient, and with their permission referring them to a Community Link Workers to access a wider range of support.

• Running group sessions where patients with similar conditions, so that they can connect and support each other.

“Most of the expertise was held by the patients not the doctors. They could share their tips and tricks and support each other”

• Longer appointments for vulnerable patients, investing more time upfront to understand their complex needs, for example, working on the root causes of anxiety with the result that some patients were less likely to call out their GP or emergency services.

• Helping to connect patients to a wide range of community-based support through their Community Link Workers and the Community Book.

• Giving permission to staff to work differently and take time to connect with people, so that they can more fully address their needs. Getting them the right support at the right time, and also building their resilience and independence.
Thank you to all those in 2017 who have started to share the vision for a Healthier Wigan.

We have made a great start and the achievements of teams such as Startwell, Integrated Community Services, GP Clusters and place based teams are already making a difference to individuals lives in Wigan and the wider borough.

Staff from across health and social care have been fantastic. They have embraced substantial changes, supporting the ethos of asset based working and improving our services together. We will continue to bring wider groups of staff together and other partners who can help us to achieve our aims.

We will continue to work with a wider number of public sector partners to tackle poor health and the determinants of poor health; including closer working with the voluntary & community sector. Helping local people access practical support and better understand their needs assisting them to achieve self reliance and resilience. We want to promote prevention and early intervention to ensure that people stay well, and when they have long term conditions or need health services that they are accessible and close to home, where possible.

Most importantly we want to continue our conversation with local people and engage them more fully in the future design of our staff, alongside staff who are delivering services on the ground.

As a partnership Healthier Wigan will continue to grow and develop over the next year and we plan to formalise our arrangements through forming the Healthier Wigan Alliance. Through this alliance we will sign up to an ambitious programme of change to ensure that health and social care services in Wigan are affordable and sustainable in the future.

We are at the start of our journey and look forward to continuing in our journey in 2018.

Rebecca Murphy
Healthier Wigan Partnership Director

*All information correct as at 30th November 2017. Some names have been changed to protect local people.