CONNECTING CARE
WAKEFIELD DISTRICT

Transforming *Local Care*

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SECTION 1:
INTRODUCING WAKEFIELD

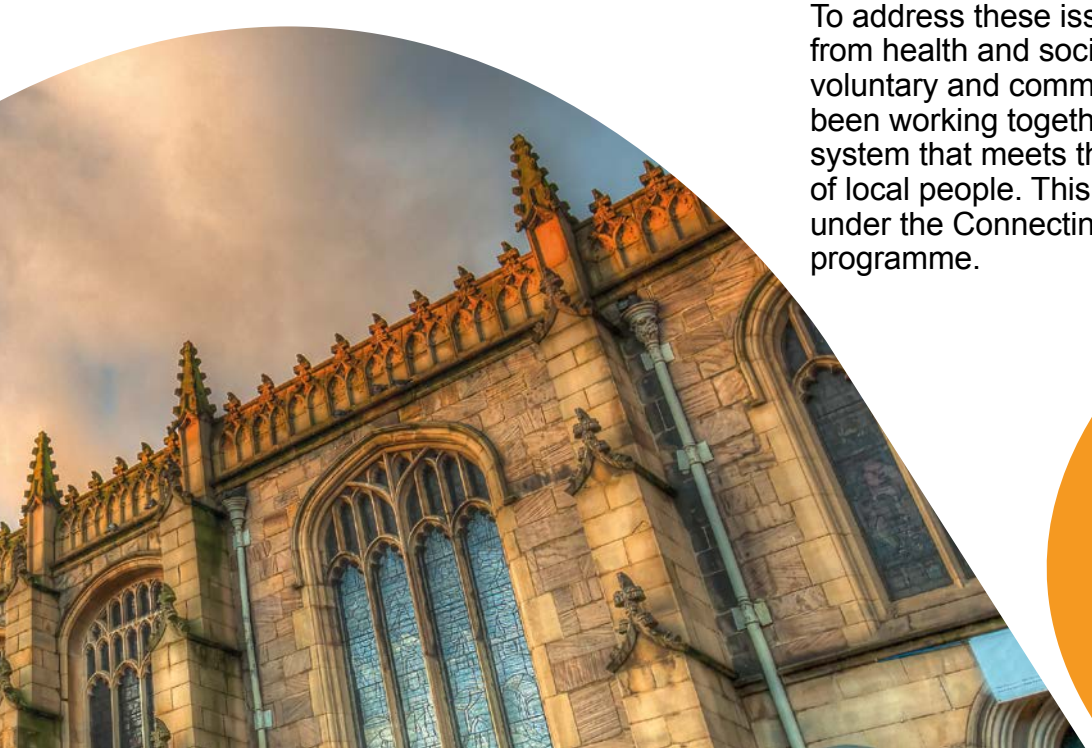
Wakefield district has an estimated resident population of around 336,834 (371,559 people are registered with the district's 38 GP practices). Of this, 12% of the population are aged over 70 years, and it is predicted that by 2021 over 22% of people will be aged over 65 years.

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. Within our Joint Strategic Needs Analysis we have identified 10 key facts for the health of Wakefield district:

1. **We are living longer, with more illnesses than ever before**
2. **People dying from cancer and cardiovascular disease in those aged under 75 is increasing**
3. **Mental ill health makes up a large part of morbidity faced by Wakefield district's population**
4. **People experience unequal levels of health and duration of life**
5. **Smoking remains a problem for the Wakefield district**
6. **Excess weight in the population is a challenge**
7. **Alcohol harm and the violence associated with alcohol is increasing**
8. **Air pollution in Wakefield is linked to hundreds of deaths a year**
9. **Infectious diseases still pose risk to Wakefield and district residents**
10. **Dental health for children and adults in Wakefield is poor.**

To address these issues, local organisations from health and social care, housing and voluntary and community organisations have been working together to co-design a care system that meets the support needs of local people. This work operates under the Connecting Care+ programme.



SECTION 2:

ABOUT CONNECTING CARE+

Connecting Care+ is made up of local health, social care, voluntary and community sector organisations from across the Wakefield district. These organisations work together as partners to deliver health and social care integration to deliver innovative methods of care to local people.

Our shared vision:

The Connecting Care+ vision is to ensure that local people receive person-centred coordinated care, which is delivered at the right time, in the right place and by the right person.

In order to achieve this vision, certain principles were outlined by partners. These principles are:

- **PATIENTS ARE PRACTICALLY MANAGED AT OR CLOSE TO THEIR HOMES**
- **CARE IS CO-ORDINATED AND SEAMLESS**
- **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**
- **PEOPLE ARE SUPPORTED AND IN CONTROL OF THEIR CONDITION AND CARE, ENJOYING INDEPENDENCE FOR LONGER**
- **UNPAID CARERS ARE PREPARED AND SUPPORTED TO CARE FOR LONGER**

Our Connecting Care+ partners:

Wakefield CCG is responsible for planning and paying for local health services in the Wakefield district. The CCG is made up of 38 GP practices, and is led by GPs and nurses who work together with patients and GP practices to ensure the right NHS services are in place to support local people's health and wellbeing.

Wakefield Council is the Local Authority for Wakefield. The council provide adult and children social care services across the district, alongside estates such as the Connecting Care Hubs.

WDH manages more than 31,000 homes across Wakefield. Within Connecting Care+,WDH provide support to elderly and vulnerable people through their Independent Living Schemes, Care Link and Mental Health Wellbeing service.

South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) provides mental health and wellbeing services within the Connecting Care+ programme.

Spectrum Community Health CIC (Spectrum) is a social enterprise that delivers a range of community healthcare services on behalf of the NHS and Local Authority Public Health services, including sexual health and substance misuse services. Spectrum lead on workforce transformation within Connecting Care+.

The Mid Yorkshire Hospitals NHS Trust (Mid Yorks) provides services to more than half a million people living in Wakefield and North Kirklees. It offers services in three main hospitals – Pinderfields (Wakefield), Dewsbury and District and Pontefract. Within Connecting Care+, Mid Yorks delivers Community and Acute Services to provide care closer to home.

Age UK Wakefield District lead on the implementation of the District Frailty Strategy & Cohesion Sub – Group, establishing community based solutions to meet the needs of vulnerable older adults.

Nova's role is about building a vibrant community sector in Wakefield specifically through the Community Anchor Network and through micro-commissioning grants, whilst developing and influencing the approach to Connecting Care+ services.

Carers Wakefield and District is a registered charity providing support for unpaid adult carers.

Conexus Healthcare Limited is an organisation consisting of all five GP Federations in Wakefield, covering all 38 GP practices across the district. Conexus provide Primary Care services and support locally.

Turning Point is a social enterprise providing specialist and integrated services which focus on improving lives and communities across mental health, learning disability, substance misuse, primary care, the criminal justice system and employment.

The journey so far:

The journey to transform and integrate health and social care began in Wakefield in 2010, when partners came together to develop a shared vision for local care.

In April 2014, our first Connecting Care Hub was launched which allowed multiple organisations to work together to support patients with complex needs who could otherwise receive disjointed care, with multiple referrals and handovers.

In October 2014, the Five Year Forward View was released. Our two vanguards applications were accepted, and began to operate under the Connecting Care programme.

The West Wakefield Health and Wellbeing Ltd. Multispecialty Community Provider (MCP) Vanguard allowed us to pilot new and innovative Primary Care services. Since March 2015, our Enhanced Health in Care Homes Vanguard has allowed us to pilot and work with local care homes and Independent Living Schemes to deliver new care models.

From April 2017, the West Wakefield MCP pilot finished and the model was rolled-out across the district, launching new services, as well as developing those from the pilot. The roll-out of MCP model saw the work of Connecting Care develop and expand into Connecting Care+.

Connecting Care+ builds on the learnings from the original Connecting Care programme and will be delivered as Wakefield's New Model of Care.

For the full Connecting Care journey, please see the previous Transforming Local Care booklet.

SECTION 3:
VANGUARDS

Under the national New Care Models Programme, 50 vanguards were chosen across England to support and improve the integration of services under the Five Year Forward View.

Wakefield was selected as the only district in the country to take forward two of these vanguard programmes. The vanguards operate under the partnership-led Connecting Care+ programme and deliver the Five Year Forward View locally in two models; Enhanced Health in Care Homes Vanguard and Multispecialty Community Provider (MCP) Vanguard.

Enhanced Health in Care Homes Vanguard

Wakefield is home to one of the six Enhanced Health in Care Homes Vanguard sites in the country. The vanguard aims to tackle loneliness and fragmented care by joining-up services for older people in supported living schemes and care homes.

Launched in March 2015, the vanguard was originally piloted across 15 care homes and two extra care facilities. However, following the success of the vanguard, this was expanded in 2017 to 27 care homes and six Independent Living Schemes, covering 1,594 active beds.

Part of the care homes vanguard's role is to pilot new services and initiatives to deliver innovative methods of care across the district which can be shared with other health and social care economies.

Key part of our vanguard: Multi-disciplinary Care Home Suppport Team (MDT)

Our MDT is made up of healthcare professionals including a general nurse, mental health nurse and physiotherapist. The team meet every Monday where they plan personally-tailored care plans that will be offered to the residents they are working with. Each team member brings a different specialism to the table; allowing the team to build up a complete picture of how best to help each resident, delivering the Connecting Care+ vision of "person-centred" care.

A unique aspect of the MDT is the strong relationships they have built with care home staff. In the past, relationships between health and social care organisations and care homes were very fragmented. However, homes now work collaboratively with our team to shape the future of care in Wakefield.

The team have built confidence in care home staff through ad-hoc training sessions and advice. Such sessions include Staying Steady and Posture, Position and Pressure training; empowering care home staff with the confidence to handle, stretch and mobilise residents. This overall provides quality of life for residents, minimising falls and upskilling staff.

Key part of our vanguard: Holistic assessments and Community Anchors

Holistic assessments are a valuable aspect of our model and identify that people's health and wellbeing depends on a broad range of factors. Holistic assessments are carried out using 'listening tools' from our Connecting Care+ partners. Portrait of a Life (POAL) is an example of a holistic tool used. The POAL toolkit focuses on life-story work, to support care home staff to engage with residents who have health and/or social care needs, such as dementia.

Following the holistic assessment by the MDT, options are considered about the best way to meet residents' needs. We understand that care homes cannot provide everything that someone might need to enhance their health and wellbeing, so we have built relationships with local Community Anchors who provide health and wellbeing activities for residents both in the community and at home. Examples of these include:

- Providing volunteers to deliver group activities, such as chair-based exercise, befriending residents and supporting them to follow their interests
- A resident identified that his health and wellbeing would be improved by spending some time gardening - this was one of the things that he had missed since moving into the care home. As the care home doesn't have a garden, staff contacted the local Community Anchor and arrangements have been made for the resident to work on their garden.

Holistic assessments have made a significant difference to the care provided to residents; this was recognised during a recent CQC inspection of one of the care homes, where staff were praised for their person-centred care and focus on individuals.

Key part of our vanguard: Reducing demand on Secondary Care

In line with our Connecting Care+ vision, we focus on caring for people as close to home, and out of hospital where possible. A number of unique initiatives rolled-out through the vanguard have supported this approach:

Red Bag:

The Red Bag is a hospital transfer initiative designed to support care homes, ambulance services and local hospitals to improve and speed up transfers in and out of hospital for care home residents.

Originally launched in Sutton Homes of Care Vanguard, the scheme aims to standardise handover processes and tackle previous problems experienced by care home staff, ambulance crews and hospital staff, ensuring smoother communications between care homes and hospitals so residents are discharged from hospital as soon as they are able.

Funded by Age UK Wakefield and District and developed in partnership with NHS Wakefield CCG, care home managers, Yorkshire Ambulance Service and The Mid Yorkshire Hospitals NHS Trust, the Red Bag initiative launched on the 1st of May 2017 in Wakefield. Since its launch, the Red Bag has helped to reduce the number of calls to and from Wakefield care homes to Pinderfields and Pontefract hospitals and has received praise from care home managers who have used it.

Following the successful pilot in the 15 Wakefield care homes, the Red Bag hospital transfer initiative has now been rolled-out in a phased approach in December 2017 across all Wakefield residential and nursing homes which accommodate residents aged 65 and over.

The wider roll-out of the Red Bag has further seen care homes utilising luggage tags featuring the "Forget Me Not" flower. The tags can be attached to the Red Bags, to help identify and provide improved support for dementia patients when they are admitted to hospital. There is also a window sticker for care homes to promote the red bag scheme to families, carers and visitors to the home.

"By having the Red Bag we are able to send all of the resident's belongings and paperwork in one bag. Some residents do not have a bag suitable to take to the hospital, so the Red Bag enables the resident to have some dignity."

Care Home Capacity Web Portal:

During November and December 2017, Wakefield launched a new Care Home Capacity Web Portal, which enables care homes to share their bed vacancies with local hospital discharge teams, social care teams and others at the touch of a button.

The portal, which is free to all, is designed to minimise delayed transfers of care – and enables users to instantly search for available nursing and residential beds across Wakefield, without having to call numerous homes – which can frequently be the case.

When using the new portal, care homes are required to update their availability as soon as there is a change in the number of vacant beds. As a result, the displayed information will be as near to real-time as possible. Care homes can also publish important operational messages, such as information about temporary closures.

The portal has already been used successfully in Manchester and South Yorkshire, and will eventually be rolled out across the whole of the Wakefield district. The roll-out will occur in a phased approach, beginning with those care homes which are part of the Enhanced Health in Care Homes Vanguard, and will eventually include Intermediate Care Beds and under 65 care homes, once fully operational.

Airedale Telemedicine:

In June 2017, three Wakefield care homes, which are part of the Connecting Care+ Vanguard, were selected to trial the Airedale NHS Foundation Trust (ANHSFT) Telemedicine system to reduce GP and ambulance call-outs.

The Telemedicine system is part of a range of digital healthcare services offered by ANHSFT and provides 24/7 remote video consultations between healthcare professionals and patients within the care homes. It focuses on reducing unnecessary GP and ambulance call-outs, patients' lengths of stay in hospital whilst also supporting care outside hospital, including early discharge.

The three care homes were chosen to trial the system due to their high number of ambulance call-outs, with staff within the care homes receiving training from the Airedale Telemedicine team.

A successful six month trial of the system saw 90% of residents, who placed a call to the digital care hub, remaining in their place of residence. In December 2017 alone, 79 calls were received from the Wakefield care homes trialling the system. 23 of these calls were initial consultations, four follow ups and 52 GP Triage calls. The outcome of the calls was recorded as 73 patients remaining in their place of residence & only six ambulances being called to assess.

Further care homes within the vanguard have been chosen to pilot the system from January 2018.

Benefits of the tool:

- **Helps care homes fill vacant beds**
- **Prevents users having to make numerous calls to care homes to find a vacancy**
- **Helps minimise delayed transfers of care**
- **Prevents paper vacancy reporting which can be time consuming and inefficient.**

What results has the Enhanced Health in Care Homes Vanguard seen?

From April 2016 - March 2017, care homes with the vanguard led to the following decreases in Secondary Care activity (against those care homes who are not part of the vanguard):

13% reduction in emergency admissions
6% reduction in A&E attendances
5% reduction in ambulance call-outs
28% reduction in bed days.

Throughout 2014/15, 38% of residents in Supported Living Schemes within the care homes vanguard had to terminate their tenancy and move into residential care homes to receive more support for their health and wellbeing needs. However, in 2015/16, following the first operating year of the vanguard, this reduced to 0% of terminated tenancies, ensuring that tenants could stay independent for longer.

Multispecialty Community Provider (MCP) Vanguard

An MCP is a New Model of Care that has been created to provide a wide range of health and social care services to people in their homes and communities, to move specialist care out of hospitals. From 2015 until 31st March 2017, West Wakefield Health and Wellbeing, a federation of six GP practices, tested and delivered different models of care as part of the MCP vanguard pilot. West Wakefield created a “blueprint” of new ways of working for becoming an MCP, and has shared this with other health and social economies.

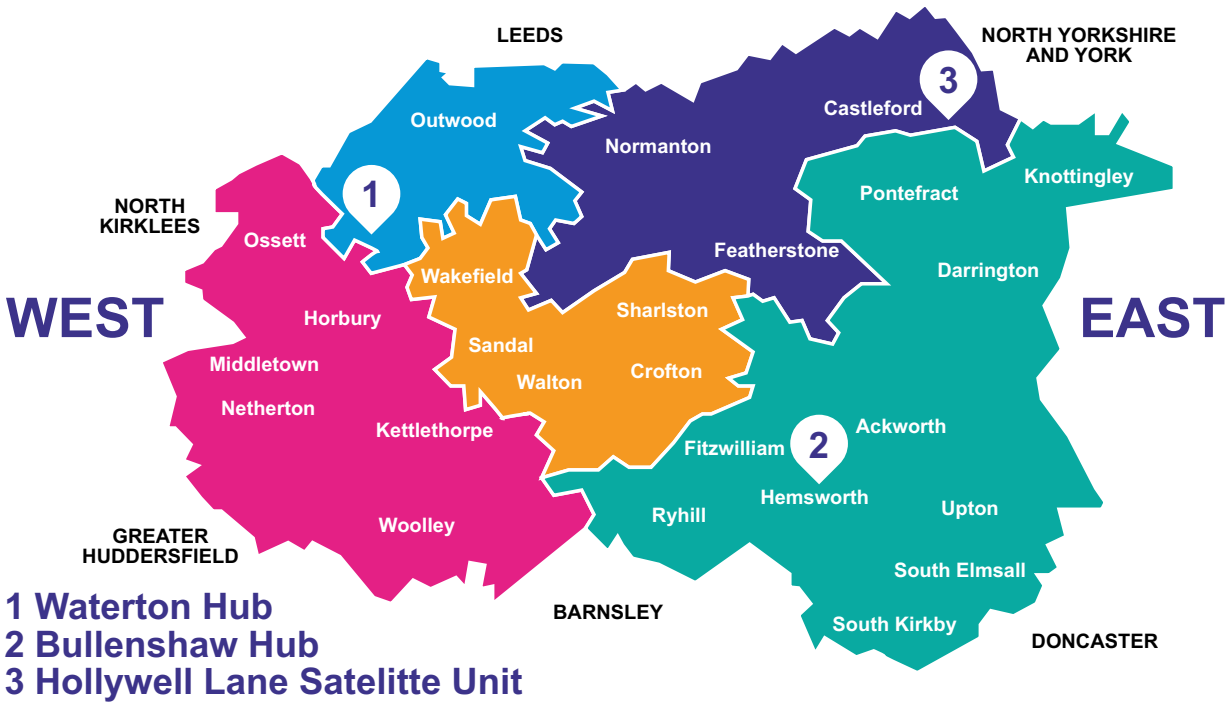
From April 2017, the services and work of the West Wakefield pilot continued across the district as a Wakefield-wide MCP model of care. This work is led by Wakefield’s New Models of Care Board, with leaders working together from across local voluntary, housing, health and social care organisations to deliver this.

Connecting Care Hubs

Having a long term condition or poor health and wellbeing, generally means lots of visits to the GP, hospital or other services. Getting help can be frustrating because health, social care and community services are not joined-up and people find themselves telling their story over and over again to different professionals.

Health and social care services across Wakefield are focusing on delivering a new integrated care co-ordination model, in partnership with other voluntary and community sector agencies, through the Connecting care Hubs. There are two Connecting Care Hubs in Wakefield; Waterton Hub which is in the West of the district and Bullenshaw Hub which is in the East, alongside a satellite unit in Castleford.

Covering the whole district, the Hubs are aligned to five GP Federations, with Adult Community Nursing teams serving those Federations. The Hubs allow multiple organisations to work together more seamlessly to support patients with complex needs who could otherwise receive disjointed care, with multiple referrals and handovers.

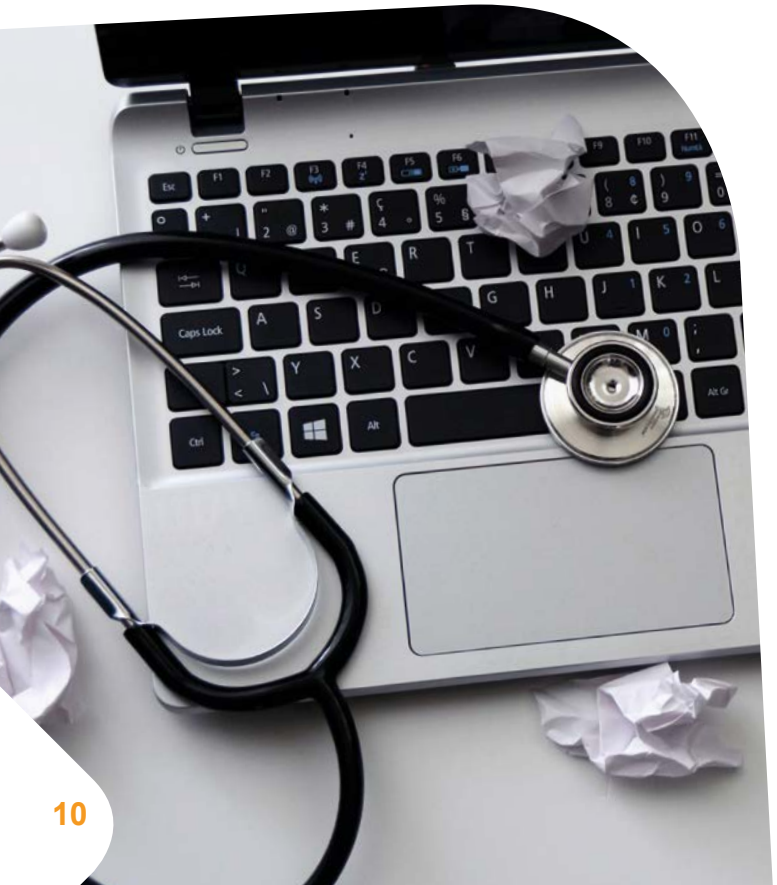


1 Waterton Hub
2 Bullenshaw Hub
3 Hollywell Lane Satelitte Unit

Made up of specialist workers from different health, social care, voluntary and community organisations across Wakefield, patients are referred directly into the Hubs to receive an integrated care plan. The Hubs allow staff from each organisation to work seamlessly together to support patient/service user's health and care requirements. This integrated approach provides individual and bespoke support packages to help those people most at risk stay well and out of hospital. This ensures that all service users referred into the Connecting Care Hubs get the right care, at the right time, in the right place and by the right person.

The partner organisations within the Connecting Care Hubs are:

- Wakefield Council Adult Social Care (City of Wakefield Metropolitan District Council)
- NHS MY Therapy (Mid Yorkshire Hospitals NHS Trust)
- NHS Community Matrons (Mid Yorkshire Hospitals NHS Trust)
- Age UK Wakefield District
- Carers Wakefield and District
- NHS Pharmacy (Mid Yorkshire Hospitals NHS Trust)
- WDH
- SWYPFT Mental Health Navigators
- Wakefield Hospice.



Sharing information

A huge milestone in rolling-out our Hub model in Wakefield is the creation of the Personal Integrated Care (PIC) file. The PIC file went live in December 2017, and kicked off the early implementation of the Connecting Care Hubs before the wider roll-out across the district starting in January 2018.

The PIC is a shared electronic care record that provides an integrated overview of the interventions a patient/service user receives regarding a particular episode of care. This holistic approach enables complex competing needs to be seamlessly addressed and appropriately supported by multiple partner agencies.

Under previous systems, there was no seamless and straightforward way in which GP practices, social care, voluntary sector or community services could have a single shared view of the care and support a patient was currently receiving within their care plan. The PIC therefore holds summary information from all the agencies involved with the episode of care and is used to track recommendations and tasks, allowing access to the interventions undertaken to those organisations involved in the care package.

The sharing of information will mean:

- Patients receive an improved holistic and co-ordinated care package tailored to their specific needs
- 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
- Patients will receive the right treatment and care more quickly
- Efficiency saving such as a reduction in multiple assessment visits/duplicate appointments/tests etc
- Prevention of worsening health needs/ escalating social needs as support.

We take protecting patient information very seriously and always ensure it is shared in the safest way, compliant with data protection regulations, and it can only be accessed by those professionals who are involved in an individual's care and wellbeing. Patients can ask staff if they have any concerns.

Connecting Care Hubs in action

A case study of Mary

Patient: Mary, a 72 year old woman.

Symptoms: Shortness of breath.

Patient action: Mary makes an appointment with her GP regarding her shortness of breath.

GP action/investigation: The GP conducts a physical examination of Mary and finds that her breathing seems normal. More questions are asked by the GP as to when the shortness of breath occurs. For example, does exercising trigger this? Does Mary have a cough? Is there any pain when she breathes?

When Mary answers no to all of the above, the GP begins to ask about her lifestyle. Has she ever smoked or worked in a smoky environment? Are there any current issues in Mary's life which may be making her stressed or anxious?

Mary explains to the doctor that she has smoked since the age of 17, although only around three cigarettes a day. She further goes on to explain that her husband has recently moved into a care home, and she is struggling to manage the financial implications of this and to keep up with payments to WDH for their house. This is making her feel very anxious. In addition, since her daughter moved abroad she hardly sees anyone and is feeling very socially isolated also.

In the past: The GP would have had to make separate referrals to:

- Mary's local Mid Yorkshire Hospitals NHS Trust (Mid Yorks) hospital for a chest X-ray, to rule out any lung conditions such as Emphysema
- The WDH Wellbeing Workers team to help support Mary with her WDH housing payments, which in turn should help with her anxiety also
- Age UK Wakefield and District to join the be-friending scheme to help combat her social isolation.

Benefit of the PIC file: However, with the Hubs and PIC file in operation, the GP simply needs to:

1.) Make a referral to Mid Yorks for the X-ray

2.) E-refer or telephone-refer directly into the Hubs with the information provided during Mary's appointment.

The X-ray referral will be organised separately by Mid Yorks. The Hub referral will arrive at the Hubs who will create a PIC file and determine the relevant organisations which Mary requires; facilitating Mary's integrated care package of appropriate services. Each organisation (Mid Yorks, WDH and Age UK), alongside Mary's GP, will be able to view and input summary notes into the PIC file so Mary's care and outcomes can be seen by all involved with her care. Overall, ensuring a real time overview of Mary's care is provided.

GP Care Wakefield
Extended GP Operating Hours

From September 2017, GPs in Wakefield worked together to develop a new scheme to enable patients across the district to have access to GP support after normal practice hours.

GP Care Wakefield, part of the Connecting Care+ programme, enables patients to access medical advice and, if required, access to a Wakefield GP appointment, through calling their own GP practice telephone number between:

18:00 and 22:00hrs Monday to Friday

09:00 to 15:00hrs Saturday, Sunday and Bank Holidays.

Patients will be provided with medical advice from a dedicated nursing team, who will assess the patients need, offer self-care advice, signpost to the most appropriate service, or book patients into a same-day GP appointment at one of two sites across the district. It is anticipated that patients will be able to receive support quicker and therefore no longer seek to go to A and E for conditions that are not suitable.

The service offers routine Primary Care that includes access to simple diagnostics (blood tests, spirometry and ECG), family planning and support for simple chronic disease management, for patients whose conditions are stable.

Utilising a patient record sharing system, the scheme enables the service to have access to the patient's records if the patient gives consent.

From September to December 2017:

4,587 patients have accessed the Clinical Advice and Booking Service

3,109 patients have seen a GP or ANP in the service

243 patients have seen a practice nurse for: pill checks, asthma reviews, dressings, etc.

98% of patients were either extremely likely or likely to recommend the service

Care Navigation

In Wakefield, we define Care Navigation as ***"a person-centred approach that uses signposting and information to help Primary Care patients and their carers move through the health and social care system, as smoothly as possible, to ensure that unmet needs are met."***

Originally established in Wakefield by West Wakefield Health & Wellbeing Limited, as a Multispecialty Community Provider (MCP) pilot vanguard site, Care Navigation is now rolled-out district-wide and is delivered by South West Yorkshire Partnership NHS Foundation Trust under the Connecting Care+ programme. Care Navigation utilises trained frontline GP practice staff, known as Care Navigators, to provide patients with more information about local health and wellbeing services, both inside and outside of Primary Care.

Care Navigation focuses on providing the patient with 'choice not triage' to access the most appropriate service first. Other health and social care professionals may offer more appropriate and specialised support, which overall ensures that patients receive the right care quicker. As a result, this frees up GP appointments for other patients.

Currently there are 22 GP practices across Wakefield district supporting the programme, with 260 trained Care Navigators. From April to October 2017, over 11,600 patients accepted navigations, overall ensuring more GP appointments were available for patients who required GP support.

Wakefield has further seen improved patient outcomes, as highlighted by the published Healthwatch report, where 97% of patients surveyed stated they were happy to see the alternative healthcare professional they were signposted to. Patients' feedback further included "Care Navigation is a good idea. I didn't have to wait for a GP appointment."

Care Navigation in action

Melanie Crew, Care Navigator at Chapelthorpe Medical Centre:

"We had a patient who used to call the practice repeatedly and request home visits from a GP.

"After speaking to the patient and asking for a little bit more information as to why he required a home visit, it became apparent that the patient's wife had recently moved into a care home, and he was struggling to manage the financial implications of this, alongside the fact he was feeling socially isolated.

"I chose to refer the gentleman to the Live Well Wakefield Service, who offered him social prescribing amongst many other services including financial advice. Since the navigation, we have not heard from the patient, and are confident he is receiving the correct care he requires."

"Care Navigation is a good idea. I didn't have to wait for a GP appointment."

Clinical Pharmacy in General Practice

Following the success of the clinical pharmacy in general practice pilot in West Wakefield, the programme has now been rolled-out across the whole district as part of the MCP vanguard.

NHS Wakefield CCG's medicines optimisation team worked closely with practices to develop and roll-out the service. The model focuses on using Federation-based clinical pharmacists and technicians who split their time across practices within the Federation they are part of.

Within the model, each Federation has the following staff, covering around 50,000 of patient population:

1x Band 8A Pharmacist

1x Band 6 Senior Pharmacy Technician

1x Band 5 Pharmacy Technician.

The service supports local patients who have long term conditions or complex care needs to receive regular planned reviews to ensure they are on the correct medications, and to receive expert advice and support as to how to better manage their medications. Both the pharmacists and technicians working under the model are also on hand to resolve everyday prescription queries and their role further includes:

- Undertaking face-to-face annual medication reviews with patients on repeat medication
- Offering advice on how to manage medications safely and effectively
- Supporting transfer of medications on discharge from hospital
- Working with community pharmacists
- Avoiding unplanned admission to hospital through intensive drug monitoring
- Reauthorising of prescriptions
- Resolving medication queries and shared care requests from Secondary Care
- Providing urgent care support
- Working with local care homes
- Evaluating and streamlining repeat prescribing procedures.

From May to November 2017, clinical pharmacists and technicians have completed over 3,350 interventions. From these interventions:

20% of patients had an unidentified prescribing need identified

£600K in prescribing savings

37% of patients had their treatment simplified

12% of patients had a redundant item removed.

Physiotherapy in General Practice

Patients in Wakefield are now able to book themselves an assessment directly with a physiotherapist, as an alternative to seeing a GP.

Physio Line

Physio Line is a pilot telephone-based programme where patients can speak to a physiotherapist via telephone who will provide information, advice and work with patients who have musculoskeletal problems to develop appropriate management plans.

Following a telephone assessment with a physiotherapist, patients who do not need to see a physiotherapist in a face-to-face appointment will be provided with a personally-tailored physiotherapy home exercise programme. This is accessible through the Physiotec software, and can be accessed via computer, tablets and smart-phones, as well as being sent via post to patients.

The programme focuses on supporting patients who have non-urgent conditions and are amenable to self-care. It should prevent unnecessary GP appointments in the first instance and reduce face-to-face appointments with physiotherapists. Some patients may receive follow-up or onward referral to other services including community physiotherapy. However, this will only occur if the issue is deemed to be of a more complex nature and requires further support.

The pilot was launched in June in three GP practices.
The pilot has so far seen the following reductions:

41% reduction in first appointments to community physiotherapy

34% reduction in follow-up appointments.

Whilst the rest of the district has seen the following outcomes:

3% increase in first appointments in community physiotherapy service

7% reduction in follow-up appointments.

Self Care

Wakefield CCG is leading on a district-wide Self Care Strategy, as part of the Connecting Care+ programme, to enable more people with long term conditions to feel confident in managing their health and wellbeing independently.

Self care includes all the things people do independently to recognise, treat and manage their health. This includes things like:

- Treating minor ailments such as coughs, colds and tummy upsets
- Managing a long term health condition
- Maintaining a healthy and balanced diet
- Getting enough exercise
- Stopping smoking
- Knowing where to find information or local support that can help
- Taking steps to improve mental wellbeing.

As part of the Self Care Strategy, Wakefield launched a new self care tool in June 2017.

The Patient Activation Measure (PAM) tool is a mechanism used to measure people's level of knowledge, skills and confidence in managing their own conditions.

Wakefield CCG has been awarded 2,000 licenses from NHS England, over a three-year period, to use the tool to help tailor local programmes and provide insight on behalf of the patient, to the type of support that will offer the most benefit.

The tool is currently being utilised with patients that have long-term health conditions, and is currently accessible through the Live Well Wakefield Service, alongside WDH's Wellbeing Team. Four Wakefield GP practices are also using the PAM tool as part of their care planning processes.

From July to November 2017, over 60 patients have taken part in assessments. Findings have shown that the greatest completion rate is from those individuals who are measured as "Level One" on the PAM tool, these are those who are more typically disengaged with managing and understanding their own health and wellbeing needs. 73% of these Level One individuals increased their score, and improved their level on the PAM tool following their participation in a self care programme.

Adult Community Nursing

Provided by the Mid Yorkshire Hospitals NHS Trust (MYHT), the Adult Community Nursing Service (ACN) plays an integral part in supporting the health and wellbeing of residents in the Wakefield district and allows residents to be cared for as close to home as possible.

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 via the Single Point of Contact (SPoC), and uses agile mobile working in community settings to deliver patient-centred care through integrated working.

The ACN services are central to the capacity of individuals to remain in their own homes and communities and therefore aim to:

- Provide holistic care for all adults referred to the service, designing and delivering tailored care plans to meet individual health needs, which is evaluated, monitored and reported
- Enable patients with long term and degenerative conditions to continue to live as independently possible in their own home
- Avoid unnecessary hospital admissions
- Facilitate early discharge from Acute Trust Providers and prevent admission to long term residential care
- Support patients and families in fulfilling their goal of dying in their preferred place of death and supporting the delivery of choice at end of life
- 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 NHS CHC framework including checklists and the MDT approach to Decision Support Tools (DSTs) in cases where Adult Community Nursing input is required, including in the patient's home.

The interim ACN service specification was rolled out in April 2016. It has been developed in review of the policies, procedures and training requirements of both Primary Care and ACN as a whole. The specification has addressed the different roles, responsibilities and skills required from Adult Community Nurses, redefining 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, and will support the full revision of the ACN service specification, which will be carried out as part of the wider integration agenda in the future.

Since April 2016, all education and training required across the ACN 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 then 40 GP practices and Wound Care training which was accessed by 96 staff from MYHT, care homes and from 33 of the then 40 GP practices.

Late Visiting Service

In August 2017, 10 GP practices across Wakefield were chosen to trial the Late Visiting Service. The service focuses on supporting GPs to carry-out appropriate urgent visits through Community Matrons, who will conduct home visits to housebound patients that require an urgent same-day appointment in the afternoon.

Previously, patients who were unable to receive a visit or treatment by the doctor would typically call 999, or access other NHS services such as A&E. The Late Visiting Service helps to prevent this and ensures that patients are treated at home on the same day.

The Late Visiting Service was piloted in five practices in the West of Wakefield and five practices in the East of Wakefield, covering a practice population of 92,200.

The data from the pilot is currently being reviewed to provide options for rolling-out the model across the whole district.

In September 2017, 49 patients accepted referrals into the service, overall avoiding 33 hospital admissions

In October 2017, 25 patients accepted referrals into the service, overall avoiding 15 hospital admissions

In November 2017, 36 patients accepted referrals into the service, overall avoiding 17 hospital admissions.

Wakefield General Practice Workforce Development Academy

In 2016/17, the Health Education England Workforce survey identified that Wakefield is facing a decreasing number of GPs, alongside an ageing practice nurse and practice manager population. The survey highlights not only the difficulty in recruiting and retaining GPs but also in the transition into a new primary care team model.

Launched on 1st April 2017, the Wakefield General Practice Workforce Development Academy (WGPWDA), hosted by Five Towns Health Federation, is tackling current and future workforce challenges by:

- Leading and facilitating innovative workforce developments across general practice to meet the needs of the Wakefield population
- Transforming learning by commissioning, providing and facilitating local, affordable, innovative and quality training and education that meets the current/future needs of a changing workforce across general practice in Wakefield.

28% of Wakefield practice nurses and 52% of extended role practice nurses are aged over 55.

The ambition to help recruit a future workforce, develop the current workforce and support the current workforce by 2020 is huge. By "growing our own" staff and developing, owning and delivering the education, training, supervision and support they require, we can begin to address the recruitment, retention and retraining of the workforce locally.

In 2017, the WGPWDA produced a Workforce Intelligence report that supported the development of the strategy and following objectives delivered during the year:

1. **Workforce planning** – worked with practices to regularly collect data and use the intelligence obtained to inform future workforce modelling
2. **Growing talent and resilience** – development and delivery of:
   - A role-specific professional development and leadership educational programme
   - A mandatory and essential training framework
   - Preceptorship and clinical supervision programmes.
3. **Redesign of new roles and new ways of working** - working with:
   - The Wakefield Advanced Training Practice to increase numbers of nurse mentors, nursing students, GPN Ready nurses and HCA apprenticeships
   - Connecting Care+ partners Spectrum CIC and SWYPFT, to develop a Physicians Association Rotation Scheme
   - External organisations and practices to lead the recruitment of apprentices for training programmes to develop Nurse Associates, Registered General Nurses and International GPs.
4. **Leadership Development** - The Academy has launched the ILM Level 5 programme for Practice Managers in partnership with WDH. Leadership programmes are also an integral component of the professional development programme.
5. **Engagement** – Working with local schools to engage and provide internships and work experience to children of different ages within health and social care in Wakefield.

Case Study:

Airedale Academy pilot leads to success for students

In October 2017, Wakefield General Practice Workforce Development Academy facilitated a pilot work experience scheme to widen access to health and social care careers for sixth form students at Airedale Academy in Castleford.

The pilot provided vocational work experience placements for seven Year 13 Health and Social Care BTEC students in a variety of health and social care roles.

The students each completed 100 hours of work experience with a number of different local health and social care providers working together as part of the Connecting Care programme.

The pilot was the first stage of a wider plan to offer vocational work experience placements, internships and apprenticeships in general practice to school and college students across the district.

Placements were personally tailored for every student according to their individual career goals and ambitions. Airedale students were placed in a variety of roles across Wakefield, including:

- General practice nursing
- Residential care with Wakefield Council
- Dementia Support Services and childcare at The Mid Yorkshire Hospitals Trust
- Elderly Care at The Mid Yorkshire Hospitals Trust
- Mental health nursing at WDH
- Fire and Rescue community services with West Yorkshire Fire and Rescue.

Due to the success of the programme, some of the students have decided to extend their placements on a voluntary basis.

Liz Harrap, Head of Sixth Form at Airedale Academy, said: “We were delighted to be the first school involved in the initiative and to be able to offer such a wide range of opportunities to our students.

“The programme has opened so many doors for our students and has been a real confidence boost for them.”

Currently the Academy is developing a model for continuation of the programme, which will continue to grow and develop from April 2018 onwards.

“The programme has opened so many doors for our students and has been a real confidence boost for them.”

Approximately 1-in-4 adults and 1-in-10 children suffer from mental health problems each year in the UK.

Mental Health

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.

Connecting Care Hubs: 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.

Primary Care Mental Health Workers from South West Yorkshire Partnership NHS Foundation Trust are co-located in the Connecting Care Hubs and deliver the service. Their role includes:

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

40% of older people living in care homes are affected by depression.

Care Homes

The work within the Enhanced Health in Care Homes Vanguard has supported many residents to improve their mental health and wellbeing through holistic assessments and multi-disciplinary team working, with South West Yorkshire Partnership NHS Foundation Trust providing the mental health nurses which are part of the team.

In addition, NHS Wakefield CCG has worked with South West Yorkshire Partnership NHS Foundation Trust and the Alzheimer's Society to develop a Dementia Friend's Guide for Care Homes. The guide is available to all care homes in Wakefield and guides them in achieving their Dementia Friendly status.

For more information on the care homes vanguard see pages 6 to 8.

From April to December 2017, the IAPT service saw over 7,300 people in Wakefield.

Improving Access to Psychological Therapy (IAPT)

IAPT is delivered locally through Turning Point Talking Therapies, and is commissioned by NHS Wakefield CCG. The Talking Therapies model uses online and face-to-face counselling, workshops, groups and self-help materials alongside two Talking Shops, to support local adults with low level depression and anxiety amongst other mental health issues. The Talking Shops are located on the high streets in Wakefield city centre and Castleford and are open seven days a week.

Focusing on ease of access and a smooth transition into secondary services, the model provides a wider offer of prevention and early intervention, to allow people to access talking therapies services away from a traditional GP or medical setting.

In order to achieve the Government's ambition that 25% of people that would benefit from psychological therapy are able to access it by 2020, Wakefield CCG and Turning Point are looking to grow the current service. Working with physical health care partners including GPs and The Mid Yorkshire Hospitals NHS Trust, there will be new therapists recruited and trained to support people suffering anxiety and depression associated with their physical long-term conditions.

Mental Health Navigators

In March 2015, WDH and NHS Wakefield CCG entered into a partnership to fund a team of three Mental Health Navigators, who support people with low level mental health issues. The team help people to sustain their WDH tenancy or home and to prevent them entering into secondary services. The team also work very closely with the WDH Wellbeing Coordinators.

Development of a Clinical College for Mental Health

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.

Live Well Wakefield in action

Case study of John

John lived alone and only had one family member, who lived abroad. John referred himself to the Live Well Wakefield team as he was feeling socially isolated and hardly left the house - other than when attending medical appointments.

The Live Well Wakefield team visited John at his home, where it became apparent that John had multiple long term conditions and was struggling at times to live independently while managing these conditions.

John told the team he was still driving, but found it difficult walking from the car to different locations, and was worried that he would have to give up driving and lose more independence. Discussions followed in regards to applying for a Blue Badge to allow John to park closer to different locations. An application for a Blue Badge was sent to John who was supported by the team to complete this. Alternative transport options were also discussed such as the Access Bus in case John wished to use different methods of transport.

John was also having difficulty bathing, which was causing him anxiety. He felt a loss of pride - being from a military background he prided himself on being 'well kept'. John only had a bathroom with a shower fitted and following a recent history of falls he had begun to feel it was unsafe to use the shower. The Live Well Wakefield team spoke about aids available for the shower and John felt he would benefit from some grab rails. A referral to handyperson service was discussed and agreed to be made.

To address John's feelings of social isolation the team provided him with a local directory of social events and groups, and options were discussed and recommended for John's abilities. He was interested in one group in particular for their chair based gentle exercises options and coffee mornings and an application was attained for John which was completed.

Live Well Wakefield

Live Well Wakefield Service - Social Prescribing

Launched on 1st April 2017, Live Well Wakefield is a social wellbeing service, commissioned by Wakefield Council and jointly delivered by Nova Wakefield District and South West Yorkshire Partnership NHS Foundation Trust.

The service is for all adults (18+), who are Wakefield district residents in need of information, advice and support in coping with everyday life. The team recognise that there are many things that can affect people's ability to feel healthy and remain independent, so the service focuses on:

- Supporting people to cope with their long-term conditions; or those of someone they may care for; increasing independence to enable and empower people to self-manage their own health and wellbeing
- Reducing social isolation; supporting those who are feeling lonely and looking for social opportunities to get more involved in the community
- Signposting people with social, emotional or practical needs to a range of local services, often provided by the voluntary and community sector
- Promote a holistic approach to health and wellbeing by focussing on the wider determinants of health and supporting people to access relevant services e.g. housing, welfare advice, employment programmes as well as health promotion services such as smoking cessation and physical activity.

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NHS South West Yorkshire Partnership NHS Foundation Trust

wakefield council working for you

GP Online 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.

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
- Re-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.

At December 2017, 37 out of the 38 practices across the district currently had over 10% of patients registered to use the services.

GP practices across Wakefield are encouraged to share best practice and innovative methods of how they have boosted registrations and reached milestone targets.

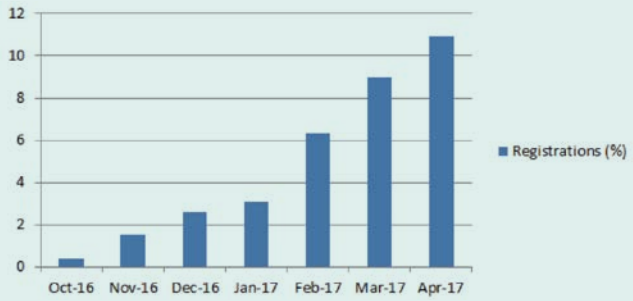
Tieve Tara Medical Centre, Castleford, has shared its journey in the below case study, which shows how they increased registrations from 0.4% to 10.9% over a seven-month period. The case study includes top tips on how to maximise opportunities to register patients, while also engaging with local organisations to share the benefits and gain support.

Hitting the GP Online Services 10% Target

Case Study Tieve Tara Medical Centre

NHS Wakefield Clinical Commissioning Group

GP Online Services - Tieve Tara



What?

Data monitored over a seven-month period of the amount of patients registered to use GP Online Services at Tieve Tara.

The results:

October 2016 = **0.4%**
April 2017= **10.9%**
(Number of registered patients: 5151)

Tieve Tara's top tips:

- Use your website - Tieve Tara now have a clear and easy-to-use webpage on their website dedicated to online services
- Include a GP Online Services application form in all new patient registration packs
- Use your receptionists as GP Online champions! Your receptionists are the eyes and ears of the practice and are a great asset in promoting services both face-to-face and over the phone to patients
- Advertise on reception screens- use a PowerPoint to show patients how to use the services
- Target cohorts of patients that the online services would really benefit. For example, Tieve Tara contacted those patients on repeat prescriptions to tell them that they can re-order online using the service
- Work with local care homes to sign up residents that are patients at your practice. Tieve Tara visited a local care home to show staff how to use the services and share the benefits of this time, ease, co-ordination
- Speak to your nearest pharmacies and ask them to push online services when patients are picking up repeat prescriptions.

SECTION 4:

WAKEFIELD'S BETTER CARE FUND 2017/18

The Better Care Fund (BCF) is a programme spanning both the NHS and local government which seeks to join-up health and care services, so that people can manage their own health and wellbeing, and live independently in their communities for as long as possible.

The BCF, set up by the UK Government in 2013, supports the New Care Models Programme in-line with the Five Year Forward View. It funds services from statutory organisations, such as the hospitals and social care, as well as voluntary organisations through pooled budgets arrangements and agreed integrated spending plans.

In Wakefield, our Connecting Care+ partnership programme is already delivering a joined-up approach to health and social care, which is improving local people's wellbeing. Wakefield has chosen to submit a BCF plan that has a pooled budget of £78m (£53m more than the required minimum) to demonstrate our ambition and commitment in achieving integration.

What did the BCF achieve in 2016/17?

Our BCF schemes incorporate multiple services funded by partners under the banner of Connecting Care+. The Wakefield BCF has been successful during 2016/2017, and through partnership working via the Better Care Fund we achieved a great deal last year.

In 2016/17 Wakefield achieved all the Better Care Fund national conditions. We also achieved the targets for:

- The proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services
- The proportion of adult social care users who had as much social contact as they would like.

The Better Care Fund non elective target was achieved in 2016/17 with 3,246 fewer admissions than the plan.

The Delayed Transfers of Care target was also achieved with 2,360 fewer delayed days than in 15/16.

Other key milestones achieved so far include the launch of a new intermediate care bed model in April 2017, alongside other service launches including; the Patient Activation Measures (PAM) tool, the Late Visiting Service pilot and the launch of GP Care Wakefield in general practice for urgent and routine care in October 2017.

SECTION 5:

VOLUNTARY, COMMUNITY AND SOCIAL ENTERPRISE SECTOR (VCSE) IN WAKEFIELD

Wakefield has recognised the invaluable contribution that the VCSE sector can bring to the quality of health and wellbeing services delivered in Wakefield. Within Connecting Care+, four out of our ten partner organisations are from the VCSE sector. Our VCSE organisations work across Primary and Secondary Care and across both our vanguards, covering care homes, hospitals and the Connecting Care Hubs.

By embedding the VCSE sector within health and social care in Wakefield, we are able to provide innovative and flexible services that focus on not only tackling, but preventing, health and social care issues before they arise. Overall, delivering the Connecting Care+ mission of delivering innovative care as close to home as possible.

Community Anchors

Community anchors are independent (generally registered charities) multi-purpose organisations, based in geographically defined neighbourhoods and used by the whole community. They are hubs that reach into communities to provide a wide range of opportunities to improve health & wellbeing for all ages. Community Anchors develop social enterprises to offer services not met elsewhere, they support volunteer development, and provide an umbrella for the support of small groups whilst bringing significant funds into the district.

In 2015, Nova was commissioned by the Public Health Department at Wakefield Council to develop the Community Anchors provision across the district. This included the development of a Community Anchor Network (CAN), which focuses on identifying areas of needs within the district, whilst raising awareness of Community Anchors to local people. The CAN works collaboratively with the Connecting Care+ programme and uses the 'Five Ways to Wellbeing' model.

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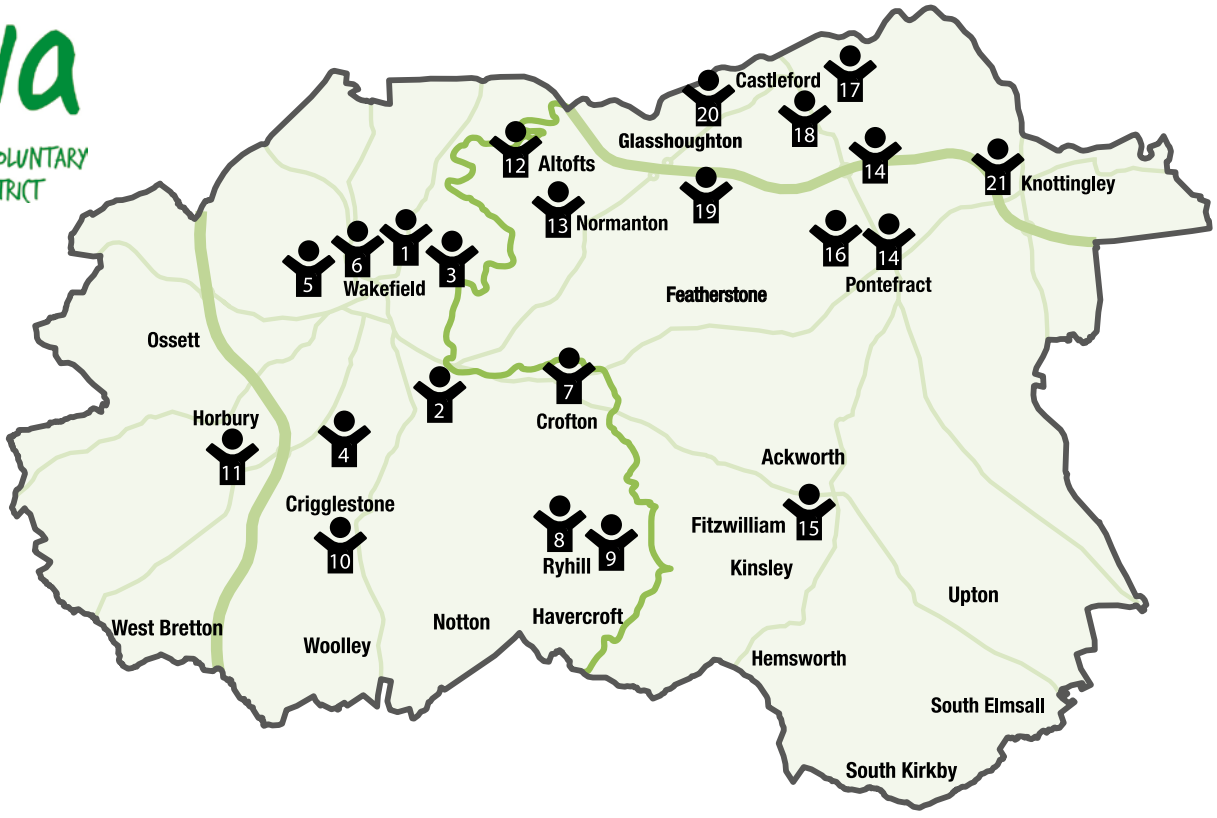


Case study of Croftlands & St George's: Intergenerational Project

The tenants of Croftlands Independent Living Scheme expressed to their local Community Anchor, St George's Community Centre, that that they would like to spend more time with the younger generation.

St George's worked with both Croftlands tenants and staff to find out what activities the tenants would like to take part in. From this, St. George's organised for the younger generation of their community centre to stage a performance based on the lives of the tenants.

The Community Anchor employed a sessional worker who specialises in drama, writing and performance to work with the young people, and over the next few weeks the young people spent time with the tenants to pull together the performance.

The performance made its debut on the 30th August 2017 and was a huge success with both the tenants and younger generation. The project demonstrated how intergenerational work brings people together in purposeful, mutually beneficial activities which promote greater understanding and respect between generations and contributes to building more cohesive communities.

SECTION 6:

HEALTH, HOUSING AND WELLBEING

The right home environment is essential to health and wellbeing. Housing has one of the biggest impacts on health outcomes.

The Building Research Establishment estimates that the cost to the NHS of poor housing for those over the age of 55 is about £624m per year.

The condition and availability of housing can have a significant impact upon health and wellbeing. Poor housing has been shown to have a detrimental impact on both physical and mental health, worsening some medical conditions and contributing to accidents and injuries such as trips, falls and burns. Whereas, the right home environment will protect and improve health, and enable people to manage their care and health needs, to ensure they can remain in their home.

The right home environment can greatly impact on delaying or reducing the need for primary care and social care interventions, preventing hospital admission and supporting timely discharge from hospital to home.

13% of Wakefield's private housing stock has a hazard that is classified as a risk to health. It is this stock that is housing some of our most vulnerable residents.

It is estimated that poor housing conditions are responsible for over 1,164 harmful events requiring medical treatment every year in Wakefield.

What are we doing about this in Wakefield?

The Wakefield Health and Wellbeing Plan clearly defines the need for the Wakefield health and care system to understand the role all public sector organisations can play in tackling some of the wider determinants of health and wellbeing; with housing being one of these determinants.

Wakefield partners, including NHS Wakefield CCG and WDH, have therefore come together to create a Housing, Health and Social Care Partnership group (HHSCP) which sits under the wider architecture of the Health and Wellbeing Board.

Housing, Health and Social Care Partnership

The impact of housing on health is widely acknowledged. At a national level, almost 30 high profile organisations representing housing, health and social care have signed a Memorandum of Understanding (MOU) of improving health through the home. To support taking forward the MOU, Public Health England have produced a check list for local plans and policies, to review the extent to which they acknowledge housing's role in improving health and wellbeing.

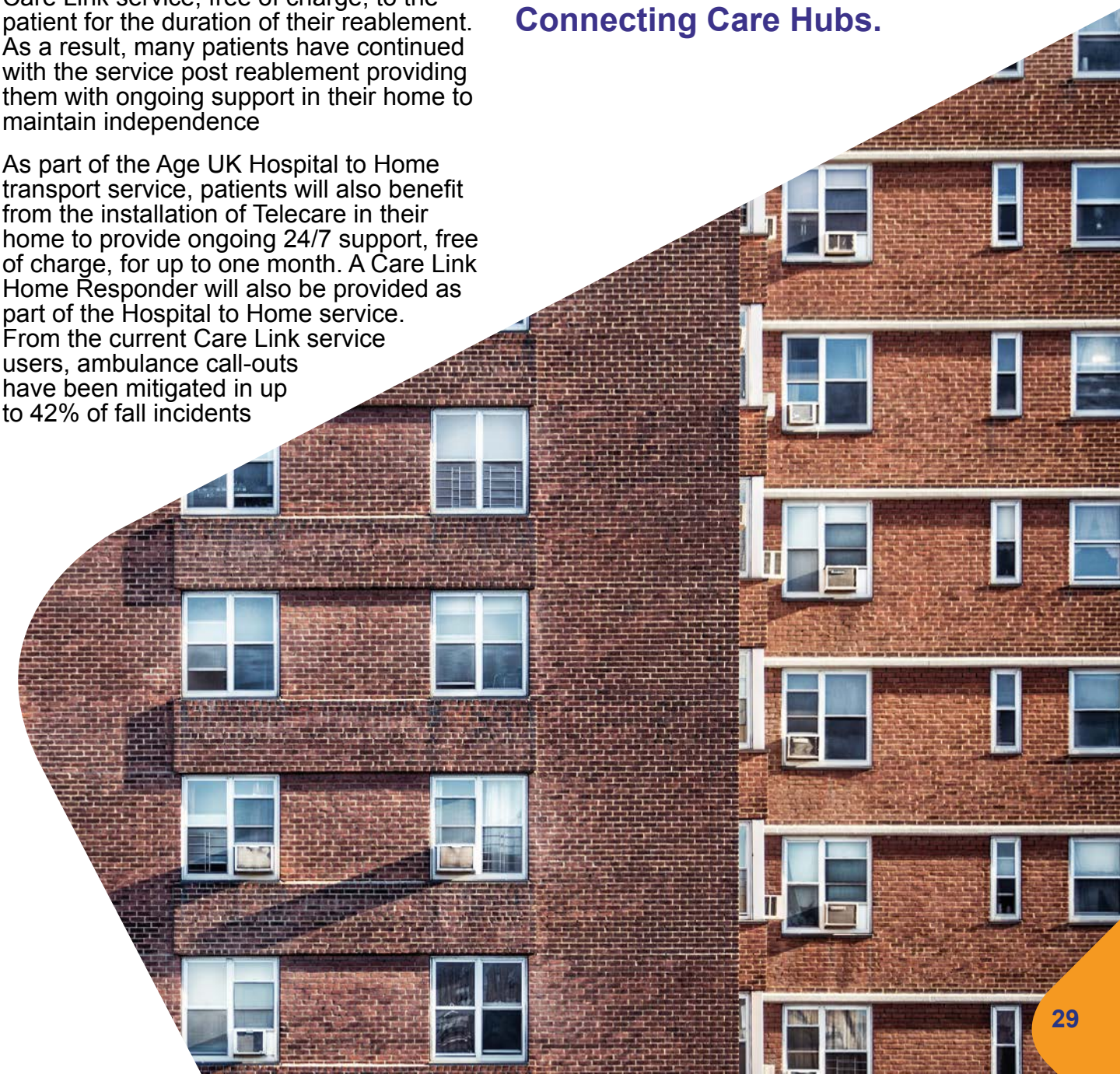
All Wakefield partners have agreed that the checklist will be used across the Wakefield System. The HHSCP will progress this as an important strand of work in the wider context of a potential refresh of the Wakefield Health and Wellbeing Plan.

It has also been highlighted through the work of the HHSCP that there are a number of patients who are delayed when leaving hospital due to a housing issue. Housing pathways and coordination is being reviewed with The Mid Yorkshire Hospitals NHS Trust (MYHT), with a view to making hospital discharge more efficient where housing issues are present.

Progress to date within the HHSCP includes:

- From October 2017, Telecare is now offered as a standard part of the Reablement Service. This is provided through the WDH Care Link service, free of charge, to the patient for the duration of their reablement. As a result, many patients have continued with the service post reablement providing them with ongoing support in their home to maintain independence
- As part of the Age UK Hospital to Home transport service, patients will also benefit from the installation of Telecare in their home to provide ongoing 24/7 support, free of charge, for up to one month. A Care Link Home Responder will also be provided as part of the Hospital to Home service. From the current Care Link service users, ambulance call-outs have been mitigated in up to 42% of fall incidents
- As part of the resource for winter planning, guest flats within WDH Independent Living and Extra Care schemes will be accessible for patients who are ready for hospital discharge but are unable to return to their own home immediately
- Housing pathway and coordination is being reviewed with MYHT with a view to making hospital discharge more efficient where housing issues are present.

WDH employees are now based within the Connecting Care Hubs.



SECTION 7:

PUBLISHED EVALUATIONS AND LEARNINGS

The final evaluation of the Connecting Care Hubs (2013-16)

In January 2017, the results of nearly 1,000 interviews with service users, carers, and staff of the Connecting Care Hubs were published in an independent evaluation of the programme.

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."

Headline findings

Below are just a few examples of the feedback we received during the evaluation:

85% of people rated the Connecting Care service as very good or good

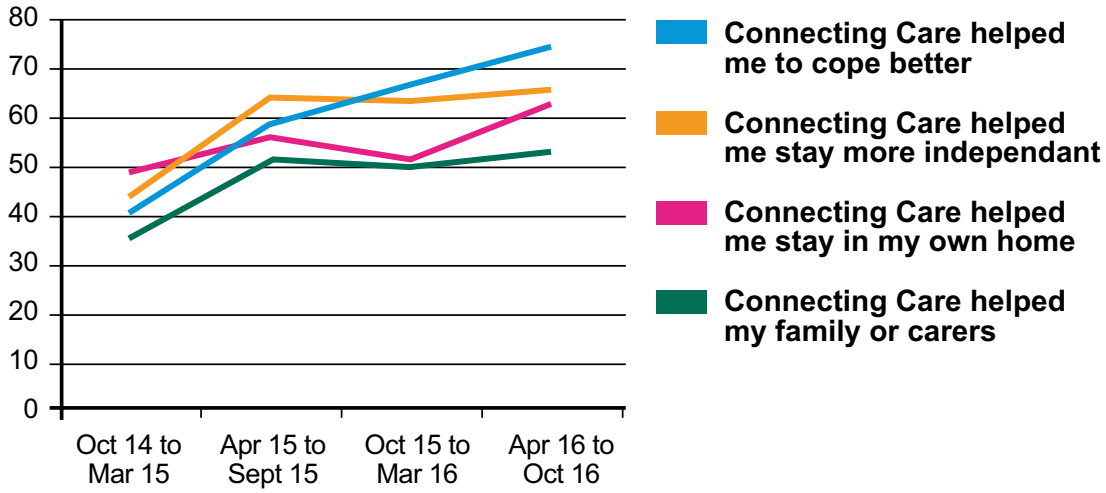
97% of people interviewed felt they had been treated with kindness and compassion by the Connecting Care staff

The vision for Connecting Care is to help people to live longer, healthier lives closer to home

66% of people said Connecting Care helped them cope better at home, while 63% also commented that the programme helped them stay more independent

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.

This supports our goal to deliver person-centred care in Wakefield.



Multispecialty Community Provider (MCP) Vanguard:

The final evaluation report for the West Wakefield MCP vanguard, covering the 2016/17 financial year, was published in September 2017.

West Wakefield piloted the MCP model in GP practices within the West of Wakefield to test and deliver different models of care. The model has included development of services, some of which have been rolled-out across the district following the success of the pilots, including; Care Navigation, Physio First, Pharmacy in General Practice and Extended Operating Hours (EOH).

Report findings

The report details the findings of the evaluation, provides learning for implementation in other areas, alongside some recommendations for future evaluation and service delivery. Featuring both qualitative and quantitative data provided by Healthwatch Wakefield, researchers and health economists from NECS, the evaluation features responses from both staff and patient participants, with a some highlights listed below:

- 97% of patients who were care navigated successfully said they were ok with being offered an alternative service, with one patient stating “It’s a good idea, I didn’t have to wait for a GP appointment”
- 97% of people who had an EOH appointment were satisfied or very satisfied with the service, with one patient stating “This service means I did not have to attend A&E and waste their time”
- There was a reported decrease of 2,105 (8.2%) walk-in centre attendances from GP practices in the West of Wakefield in comparison to 15/16 attendances.

Enhanced Health in Care Homes Vanguard:

The year-long evaluation of the Enhanced Health in Care Homes Vanguard has now been published.

Conducted across 10 care homes which were part of the phase one cohort, the evaluation covers a total of 659 available beds, and focuses on collecting both quantitative and qualitative data to answer key questions about the vanguard, including:

- Is care more coordinated and seamless?
- Has the vanguard reduced the demand on secondary care from care homes?
- Which elements of the intervention have had the greatest impact and could they be replicated elsewhere?

Headline findings

The evaluation highlights that there are encouraging signs that the vanguard is reducing demand on secondary care from care homes. Headline findings include:

- Total bed days in the phase one cohort have fallen by 28% compared to the baseline, and by 22% compared to the control group
- Ambulance call-outs specifically for falls have seen a 27% reduction in activity. This suggests that the work of the MDT, who carried out over 200 falls risk assessments on high risk individuals, contributed to this reduction.

Future evaluations

In 2018/19, the Connecting Care+ programme will conduct 12 further evaluations across the programme. Evaluations will include a pharmacy patient experience report and a Connecting Care Hub PIC File report.

MCP wider roll-out findings

Since the MCP was rolled out across the whole of the district, from April to October 2017, Wakefield has seen the following outcomes in the over-65 cohort (those most likely to benefit from interventions):

Reduction of 1.5% in A&E attendances
Reduction of 5.4% in admissions
Increase of 1.2% in bed days
Reduction of 2.3% in ambulance conveyances

CONNECTING CARE WAKEFIELD DISTRICT

Need more information, or just want to keep up to date with the Connecting Care programme?

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