Telford & Wrekin Health and Social Care Rapid Response Team

a co-operative council

Telford & Wrekin COUNCIL

Making a difference through co-production and feedback

"We're grateful for the support to enable our father to pass away peacefully at home – which was his wish"

"We feel more confident and know what we need to do to maintain good recovery at home"

"A wonderful service and I could not believe how quickly they arrived to help me. A week ago I could hardly move and now with the help of the trolley and carers I'm feeling so much better."

"I'm relieved that someone was able to do something and I can begin to see the light in the darkness"

"Their experience instilled us with confidence and the fact that we were able to contact them easily helped us feel not so alone… this model of immediate, practical assistance from experienced professionals is gold standard care in the community"

"During this strange new time and altered ways of working, the team have really excelled…demonstrated leadership and innovation …working coherently as a team"

"Where do I start! To have them in our team during this Covid wave has enhanced our service to the patients, preventing hospital avoidance, faster treatment and supported recovery"

"They have been instrumental in reducing avoidable admissions"

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Original Proposal

- Reducing hospital admissions through a multi-agency community response – the Health and Social Care Rapid Response Team. The pilot recognises that people recover quicker at home, with their families, carers, community and local networks supporting them - this service enables this and provides an alternative to hospital admission where appropriate.

- Although the pilot had commenced the Policy Prototype funding would be used to further support its development and evaluation. The £1500 would be spent specifically on developing and implementing an enhanced communications offer (including a video similar to ‘Mrs Andrew’s story) to help get the message across the health and social care system about the difference having a multi-agency community response can, and does, make to our residents.

- To help with filming the real life aspects of the video we would use our ‘Roving Reporters’ – adults with learning disabilities who are currently accessing services in the Borough – who would also benefit from this grant as the money would support them to further develop their media skills.

Impact of Covid on the Original Proposal

The proposal has been severely affected by Covid-19 so much so that it has not been able to be completed and as such no funding has been drawn down.

- Using the Roving Reporters to develop the video was not able to progress due to Covid, social distancing and the need to reduce any additional risks of contracting the virus for people with Learning Disabilities.

- Plan B had been to utilise either the Council's or partner's communication teams to develop the video. Unfortunately due to the Covid-19 communications pressures, alongside a restructure of the Council's communications service, meant that this capacity was no longer available. After attempting to seek support from other local health partners we came across the same challenge as they were all overstretched due to the amount of communications required around the Covid response. Along with the 3rd National Lockdown this has impacted on our ability to complete this project.

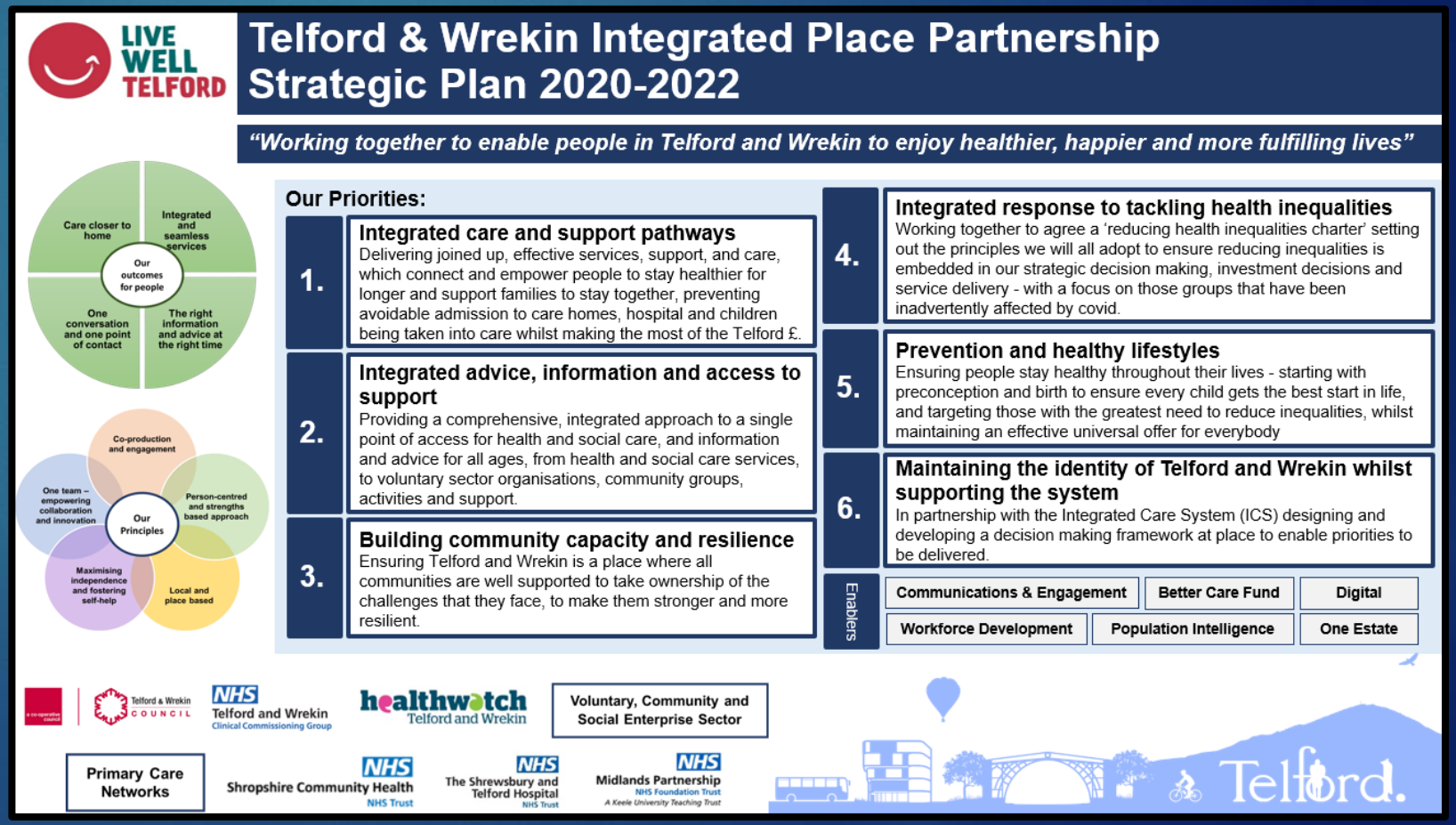
- The Health and Social Care Rapid Response Team however has not stopped evolving and this report summarises its evolution over the last 18 months and the difference it has made.

Integration in Telford and Wrekin

Telford & Wrekin Integrated Place Partnership (TWIPP) was set up by Telford & Wrekin Council and the Clinical Commissioning Group in 2019 to lead, drive and deliver place based integrated health and social care services in Telford and Wrekin. It's latest strategic plan is in the image below.

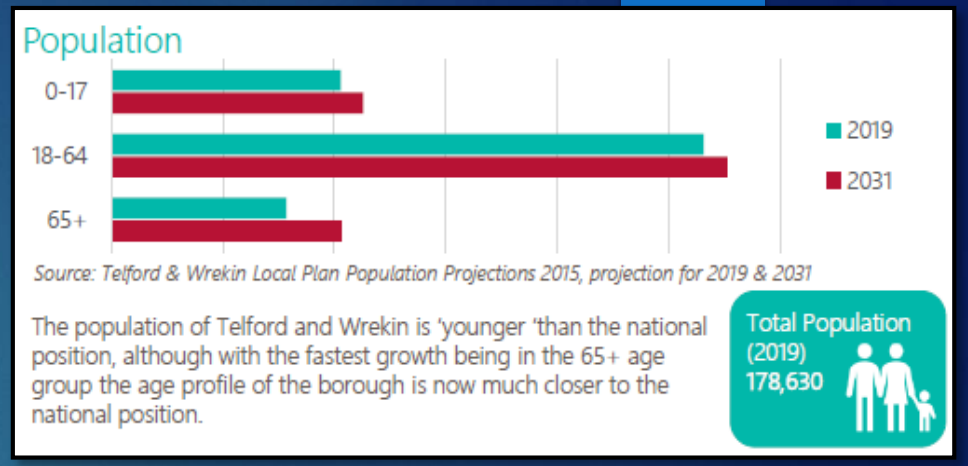
TWIPP fits in with the overall strategy of the Council and is at the forefront of how the Council delivers its priorities.

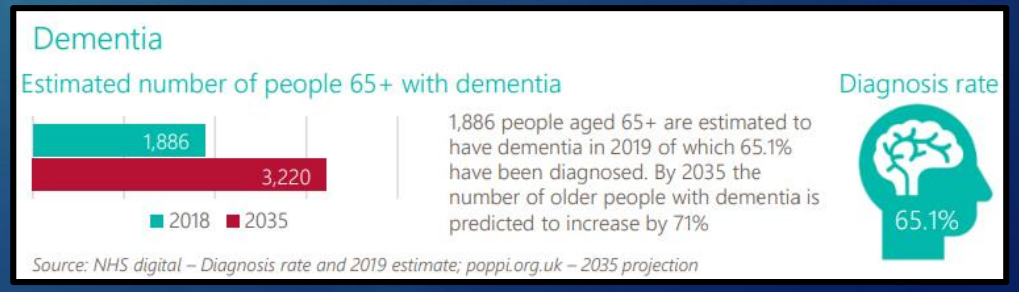
One of the TWIPP innovations to help deliver its outcomes is the development of the Health and Social Care Rapid Response Team.



The Challenge

- The population of Telford and Wrekin continues to grow above national rates.
- One of the biggest challenges for the area remains health inequalities - most evident in the most deprived communities with key challenges including a lower life expectancy, higher rates of long term illness and high rates of admissions to hospital.
- Increasing demands on health and social care services in Telford and Wrekin which has not been matched with increased level of resources.
- The need to achieve a sustainable health and social care system with best use of resources.
- Although a wide range of community services are available due to complex and multiple access points the default solution was to present at hospital.
- Data highlighted that despite having a rapid response service (single organisation) they were being underutilised and avoidable admissions were being conveyed to hospital and admitted.





Engagement informing developments

Engagement

- Engagement with people with lived experience and carers
- Place based workshops for staff across the whole health and social care system
- Engagement with senior place based leaders

Engagement Outcomes

- Simplified access to community services
- Seamless urgent care through a single point of contact
- Integrated team to deliver rapid response
- Raising awareness of community services available
- Vision and principles of working together agreed

Focus agreed

- Engagement outcomes prioritised
- Agreed to focus on development of an integrated rapid response function = Health and Social Care Rapid Response Team
- Multi-agency project group set up including patient representatives, third sector and primary care.

Co-production model development

- Review of best practice
- Workshops to develop model
- Consultation with CCG Integrated Leadership Programme
- Outcomes and principles agreed
- Challenges, risks and mitigations identified
- Plan, Do, Study, Act approach

Implementation

- Business case and model of working agreed by TWIPP
- Pilot approach agreed with potential for scale up should outcomes be met
- Rapid implementation agreed (2 months from agreement to launch)

Implementation challenges

Challenges:	Resolutions:
Co-location & IT provision	✓ Existing space in CCG building identified ✓ Office furniture sourced from all organisations involved ✓ Initial investment in IT to provide equipment
Data capture and sharing	✓ Manual data capture system implemented until system development completed ✓ Secure communication methods utilised ✓ Data sharing agreements reviewed
Relationships with ambulance and primary care services (frequent conveyers to hospital)	✓ Regular meetings with ambulance service at their operations base ✓ Specific communications packs ✓ Involvement of primary care in the service set up ✓ Inclusion of GP Clinical Advisor in team
Team development – operating as a multi-disciplinary team	✓ Co-location with real time conversations ✓ Shared leadership ✓ Weekly MDT meetings and daily huddles
Workforce development	✓ Testing involvement of different disciplines being part of the team ✓ Future workforce requirements fed into system wide discussions
Limited resources to implement and deliver	✓ Utilised and redeployed existing staff from across a range of organisations to test the model

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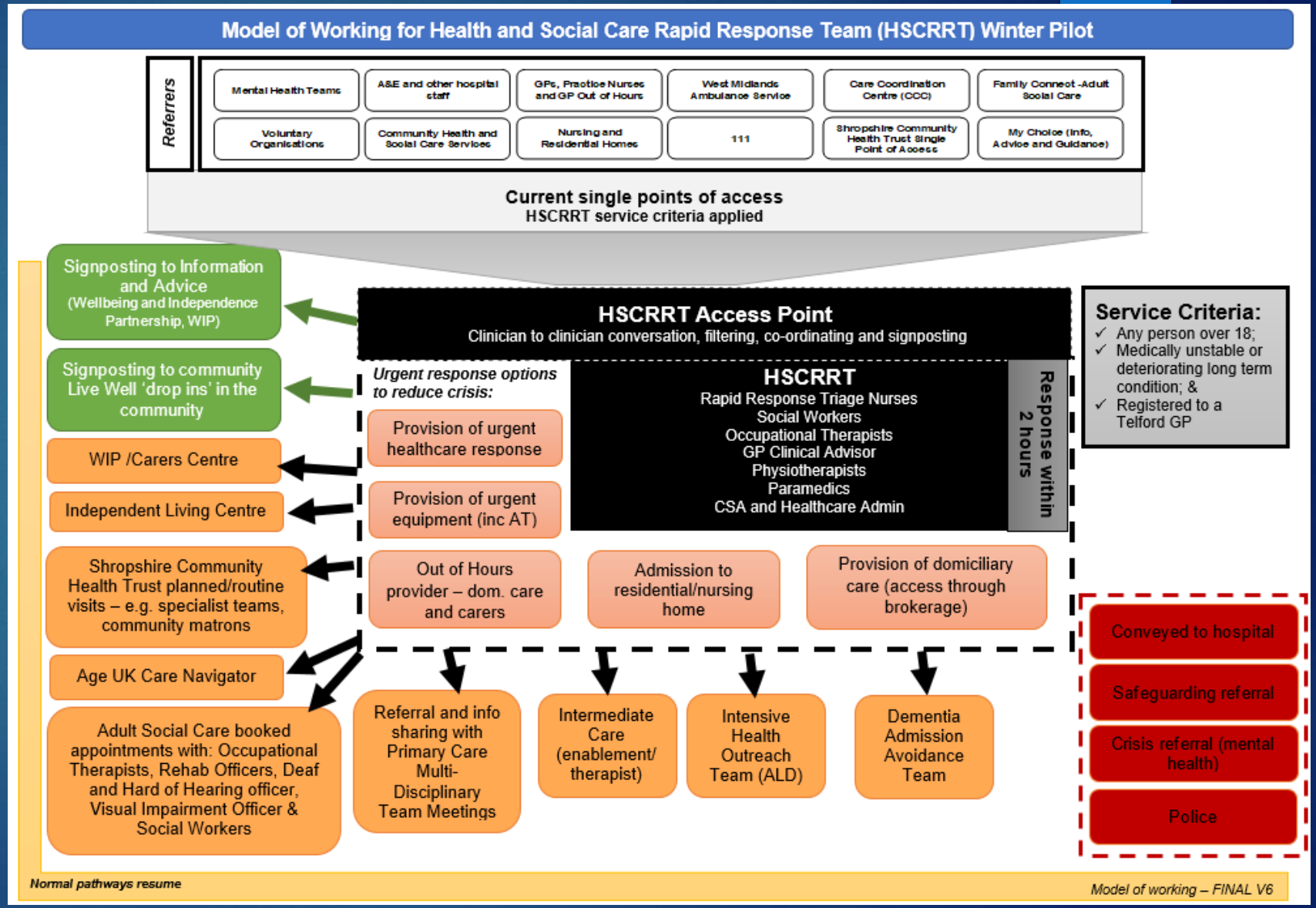
The model of working

- Health and Social Care Rapid Response Team (HSCRRT) is a co-located integrated community rapid response service.
- HSCRRT:
  - Supports any person aged over 18 who are experiencing a rapid decline of their health and are in crisis.
  - Provides a 2 hour response, 7 days a week, 8 am to 10pm.
  - Includes Community Nurses, Social Workers, Physiotherapists, Occupational Therapists, General Practitioner Clinical Advisors, Paramedics and Call Handlers.
- Presenting needs include unexplained falls, urinary tract infections, deteriorating palliative care, reduced mobility, rapid decline in health (physical and mental), and no end of life provision/pathway agreed.



Anticipated Outcomes

- Improved patient experience
- Reduced avoidable unplanned admissions
- Reduced duplication of referrals
- Potential reduction in follow up care
- Improved access to a range of services
- Happy and productive staff
- Provide data and information to support future decision making and service models

What difference has HSCRRT made?

- **Improved patient experience** - timely, appropriate and seamless delivery of community services
- Increasing the diversity of health care professionals in the team has attracted different types of referrals as there is a broader range of assessments that can be delivered at pace in someone's home = **wide range of presenting needs supported in the community**
- **Improved multi-agency working and productive staff** - staff have developed their skills and learnt different approaches by working alongside a different range of professionals
- **Reduction in duplicate referrals** due to HSCRRT single point of access and integrated triage and response
- **Improved and more streamlined access** to range of services
- Increased follow up interventions to meet identified needs, reduced re-referrals and maintain at home

"Working alongside the other teams and not 'passing the buck' is really rewarding.

But I think the best thing is when the person and/or their family are satisfied with the quick support – we really make a difference to their lives."

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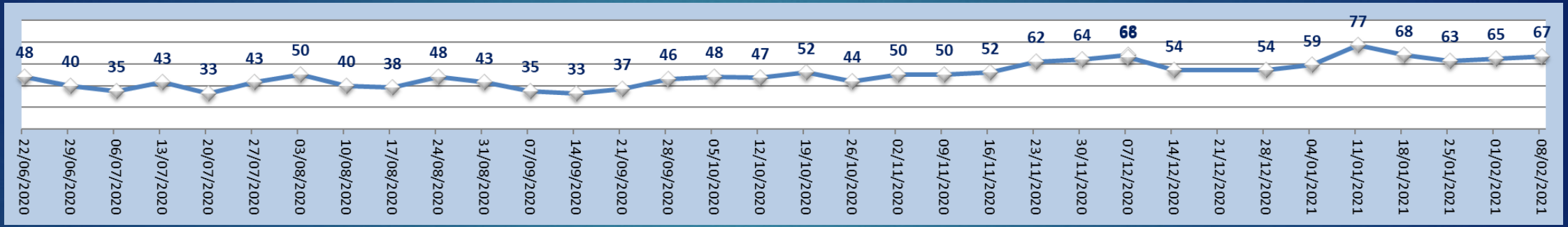
What difference has HSCRRT made?

- **93% admission avoidance rate** (within set criteria)
- **Increasing referrals** from an average of 28 a week in November 2019 to 67 a week in February 2021:



- **Low re-referral rates** to HSCRRT
- **Low admission rates to hospital** from people who received support from HSCRRT – i.e. after their support ended they were not re-referred or admitted to hospital as they had the right support they needed at home.
- Cost savings - **£490,000 saved over 14 months**. This is potential system savings based on the number of hospital conveyances and admissions avoided.

£490,000 saved
to health and social care system by not conveying to hospital

HSCCRT Pilot Outcome

- In September 2020, the pilot's evaluation recommended the HSCRRT to remain a part of the system and be a key priority for the Sustainability and Transformation Partnership (now the Integrated Care System).
- Due to the success of the HSCRRT Pilot and the difference it made to people's outcomes, as well as the system, it was agreed at both the Telford & Wrekin Integrated Place Partnership and the STP to **embed as business as usual**.
- The service's model of working is now being implemented in other parts of the Integrated Care System.

HSCRRT continued development

Using the Plan, Do, Study, Act (PDSA) approach has enabled the team to continually evolve its operations since the service launched in November 2019.

Some of the more significant changes include:

- Inclusion of a Voluntary Sector Link Worker, Assistant Community Led Support worker, Paramedic and Physiotherapist
- Increase in HSCRRT social work capacity by 2.5FTE
- Changed operating hours of 9-5 to 8am to 10pm
- Daily review meetings of potential referrals with hospital
- Enhanced pathways to Enablement therapies and specialist community interventions has improved re-ablement performance
- Regular meetings with WMAS resulting in increases in referrals by 500%
- Review of the re-referrals to learn lessons about practice and implemented required changes.

During Covid-19 further changes happened (required to meet government guidelines and support the wider system's response to the pandemic):

- Supporting lower level referrals from the Telford & Wrekin Council Community Support Helpline
- Virtual Multi-Disciplinary Meetings
- Home working from home
- Increase in numbers of telephone assessments, contacts and reviews via telephone to minimise transmission
- Supported further referrals from the ambulance service to avoid conveying to hospital.

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HSCCRT Next Steps

- Provide further investment into the service to further increase admission avoidance numbers
- Promotion of the service, and other community services, with residents
- Ongoing development of the service in line with post-covid needs and system requirements
- Ongoing workforce development
- Further development of real time information as the Integrated Care Record is implemented in 2022.

Contact details

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