Cornwall and the Isles of Scilly Pioneer Programme – Profile

1.1 What is your area like?

Cornwall is a rural county and a popular holiday destination. The health of people in Cornwall is mixed compared with the England average. Deprivation is lower than average. About 17,000 children live in poverty, however. Life expectancy for both men and women is higher than the England average. Life expectancy is 5.9 years lower for men and 5.2 years lower for women in the most deprived areas of Cornwall than in the least deprived areas.

The county's population is growing due to increases in both the population of older people and of migrant workers.

Cornwall has the highest volunteering rates in the country (about one in three people).

The joint health and wellbeing strategy (JHWS) for Cornwall is focused on three long-term outcomes:

- Helping people live longer, healthier lives
- Improving the quality of people's lives
- Fairer life chances for all

1.2 What are you aiming to achieve?

Living Well aims to help people who are socially isolated and highly dependent on health and social care services to improve their quality of life. It aims to reconnect people with their communities – facilitating change rather than fixing problems, building on the support infrastructure that's already there. Living Well is a partnership between the voluntary sector, health, social care and local people. All health providers, the clinical commissioning group and the council are signed up. The project team spans health, social care, private and voluntary sectors, and is driven by local GP champions.

Our three specific aims are:

- Improved health and wellbeing
- Improved experience of care and support
- Reduced cost of care and support

Criteria for entry to the programme are:

- A minimum of two long-term conditions from a specified list
- Or a social care package in place meeting a specified list

The building blocks for the work of our integrated teams are:

- Conversation and goal setting
- Aiding recovery with help from volunteers
- Community support and network development
- Specialist support

A model of wraparound care for people with long-term conditions supported by trained volunteers and paid coordinators was tested in a Newquay Pathfinder project beginning in summer 2012. In 2014, Penwith Pioneer Programme was set up on the same model and was expanded into East Cornwall.

Our programme is led and invested in by the voluntary sector. Until very recently none of the public sector has invested in the programme except in terms of time. See case study: According parity of esteem to volunteers.

The Living Well programme is sustainable and replicable. It is based on people and community resources so that each individual and locality can shape their own solutions. Robust, shared performance monitoring ensures we can demonstrate and monitor delivery.

1.3 What have been the highlights of your first year?

- Started Penwith Pioneer Programme in six local practices
- Started Living Well – East in the east of the county in October 2014
- Obtained whole-system sign-up to the Living Well financial model based on linked data
- Developed and agreed outcome measures
- Developed and agreed an evaluation framework
- Developed online repository of information for sharing – the 'Knowledge Bucket': http://knowledgebucket.org
- Information governance agreement signed off by all partners
- Induction training package produced
- Community Line proposal developed and Line in place
- Multi-disciplinary team/care co-ordination proposal developed

1.4 Details of the year

The Newquay pilot demonstrated a 4:1 return on investment (cost of average unplanned hospital admission for the cohort = £2,500, maximum cost of Living Well support per person = £400). The Newquay cohort expanded to 250 in 2014. Also in 2014 we started our Penwith Pioneer programme, drawing on some of the early successes and learning from Newquay. Later in 2014, we started Living Well – East, in the east of Cornwell, focusing on the same triple aims, but with an added focus on hospital discharge, in the form of the Welcome Home programme, led by Volunteer Cornwall.

Each project is overseen by a board drawn from representatives of health, local authority, voluntary sector, HealthWatch Cornwall and local stakeholders. Boards meet monthly with quarterly locality stakeholder groups and an overarching Living Well Chairs Group.

1.4.1 Penwith Pioneer

The service:

- Targeted, wraparound support motivating ‘at-risk’ older people to achieve their aspirations through a ‘guided conversation’
- Individuals supported by an Age UK worker to identify their goals and to co-ordinate a management plan delivered by co-ordinating statutory and community services and support
- Volunteers aim to build people’s social networks, community connections and resilience
- Age UK worker is part of a multi-disciplinary team (MDT) which includes GP, district nurse, matron and social workers
- Joint working between partners to develop and agree a joint performance framework, with Age UK being the central data processor
- A conversation became a quiet revolution as practitioners worked across organisational boundaries to focus on the people they were supporting

The people:

- Recruited cohort now at over 800
- 67 volunteers and 12 co-ordinators

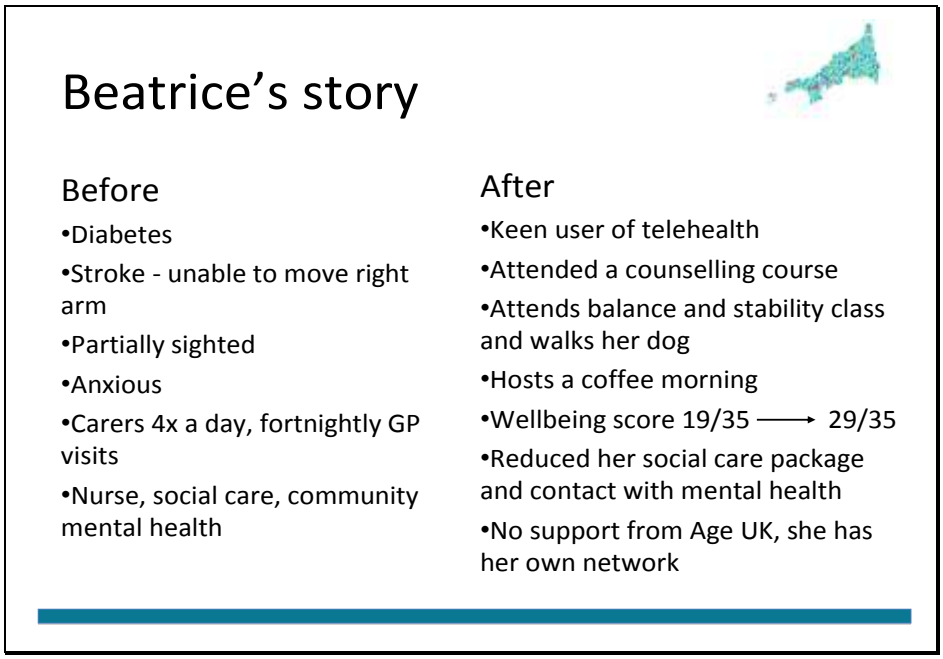
The benefits:

An analysis of the first phase of people supported by Living Well in Penwith has shown:

- a 49 per cent reduction in non-elective admissions;
- a 36 per cent reduction in emergency department attendances;
- a 28 per cent reduction in the number of people being admitted to a community hospital;
- a 20 per cent reduction in the length of time people stayed in a community hospital;
- a 20 per cent self-reported improvement in mental wellbeing;
- an eight per cent reduction in social care costs; and
- a four per cent increase in out-patient appointments.

Although we are still in the early months of the support to those people, we are hoping this improvement will continue to be shown by the longer term evaluations we are putting in place.

The programme, methodology and the final results are being evaluated by University of Exeter, Public Health England and Public Health Cornwall, the Academic Health Science Network and The Nuffield Trust.



1.4.2 Living Well – East

A new project started in the east of the county in October 2014, with funding support from the Cabinet Office.

- Age UK Cornwall team co-located with district nurses
- 350 referrals by November 2014
- Strong relationships developed with community organisations and practitioners
- Work begun around community engagement, awareness raising and MDTs
- MDT guidance developed by Living Well – East board and offered to practices with facilitation and support
- Board is also overseeing the development of guidance for practitioners (including volunteers) on community pharmacy support and how to access it
- Welcome Home advanced discharge planning services now running

1.4.2.1 Community Line proposal

Co-designing the approach with people, practitioners and volunteers identified confused and complicated referral systems, with variable case co-ordination by MDTs. People suggested a community phone line to be manned by the voluntary sector, providing a clear single route 'in' with trusted and shared research and co-ordination, linking people with key workers and a robust MDT system for complex discussions.

Resources were reallocated from Age UK Cornwall, to start a basic line from January 2015, with the intention of reallocating additional resources to grow the line and its functions. All the MDTs in Penwith were mapped and surveyed and this information was used to inform a process to link MDTs to the Community Line. The line is supported with clear guidance and a trained pool of facilitators to support MDTs.

1.4.2.2 The Knowledge Bucket

Funded through Age UK National and NESTA, this is a central place for us all to store and access anything to do with Living Well, from latest news, films, reports, progress, leaflets, case studies and a live form. The first stage went live in December 2014. In the 2015 the site will be expanded to include a public-facing section. We are also working with BT to provide free Skype to people on the programme and also in West of Cornwall Hospital. http://knowledgebucket.org/

1.4.2.3 The evaluation framework

We have developed an evaluation framework based on our three core aims. See case study: An evaluation framework linked to outcomes.

1.5 What has been the most exciting aspect?

It has been great to unleash some of the potential in the front line and see staff working together in a way they've never done before. People from 'back offices' have also been involved in the design process. We have had very challenging conversations with some colleagues but have tried to keep reconnecting with the people we are there to support, for example through videos and stories. It was very gratifying to hear a member of technical staff from the community health organisation say, "This is the first time I've understood the impact of what I do".

It was exciting when we first began to see results both improvements in people's mental wellbeing and reductions in unplanned hospital attendance and admissions. We also saw reductions in social care packages. This was people saying, "I don't want this package of care because I'm busy doing other stuff".

1.6 What has been the most challenging aspect?

A big challenge is in moving from running projects in a small number of areas to ensuring that the work becomes 'business as usual' and is scaled up across a whole health and social care economy. The new model has to be put in place before the old system changes and this is hugely challenging in terms both of time and resources for both commissioners and providers.

1.7 What are you planning to do next year?

- Assuming that funding is confirmed, we expect the total cohort benefiting Living Well to increase to 1,000 by spring 2015
- Throughout the course of the year we expect five new sites for the Living Well programme to go live in preparation for the rest of the county going live in 2016
- We will be expanding the frontline teams to include police, troubled families workers and housing

We saw some great examples in Denmark and Sweden, where a hospital discharge programme offering people a supportive visit within hours of discharge showed a marked reduction in readmissions and an improved quality of life. This approach is being developed as part of the winter resilience programme, Welcome Home.

Elsewhere we are looking at new models for future care delivery, from accountable care organisations in the USA to social impact bonds in Peterborough.

1.8 What is your advice for areas starting on their own integration journey?

The success of Living Well has been dependent on a number of enablers of cultural change – traditional methods of project management just won't deliver. Chief among enablers we would highlight:

- Pull together a design team from many sectors – no one person here has the word 'pioneer' in their job title. This means that the work will be sustainable when the pioneer programme is over
- Building trust – spending time engaging and building the multi-disciplinary team as well as sharing learning and using informal social events is vital to ensure effective working and case management. The level of trust in our programme is shown by the fact that all the providers for health and social care have opened their financial books to enable financial planning
- The power of language – creating a new language to overcome organisational and cultural boundaries – we talk about people and practitioners, not patients and professionals
- Real people's stories to demonstrate the impact which stops the focus being all about the money
- Empowering frontline practitioners, including fostering strong GP buy-in – to redesign services around the individual, putting people first
- Focus on what people can do – treating people as active participants, not passive recipients of care
- Our funding was set up on the principles of a social impact bond – we believe that if the work is shown to be 'investor ready' it is also 'commissioner ready'
- Developing shared outcomes and measures
- Agreeing a methodology for cost/benefit data analysis up front and define an evaluation framework at the start
- Using information governance as an enabler not a blocker

We have worked to the following principles that we would commend to other areas:

- Stop creating new layers – support existing groups and connect people together
- Communicate what's available and where in a way that people find useful
- Encourage local leadership and engagement
- Be bold and brave!

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