# Intergrated Neighbourhood Teams Living Well Partnership PCN update



## Stage 1: Scope and Planning

A small working group (Community Wellbeing Services Lead, Public Health Lead, GP Lead, Lead Pharmacist, Senior Non-Clinical Lead) provided initial scoping.

LWP has deveoped a Community Wellbeing Service and with almost 2 years of feedback from patients and the community on their issues, challenges and barriers, have informed the planning.

We will continue to gather feedback through outreach, 1-1, validated tools, coding, community groups, working groups.

## Our Aims

Our pilot aims, through collaborating with partners, to facilitate an agile framework to respond to the individual needs of a resident and to respond to emerging themes within and across neighbourhoods.

LWP approach is mobilising three workstreams with the aim of having a meaningful impact on patient care this winter whilst building a framework for sustainable collaboration.

Communities provide opportunities

Timing is key

Communication & collaboration

Identify key themes

Sustainable /
Future
development

### Workstreams

# Focus on frail patients with an avoidable admission

### Identify cohort

Use of PHM to search avoidable admission, IMD 1&2, 3+LTC.

Map to EMIS for eFI, Frailty,
Diagnosis, Polypharmacy,
Housebound/Care Home, Carer.
Data review and cleanse.
Plan interventions
Group 1 - Mild/Moderate Frail.
Group 2 Severly Frail

#### Engage

Care Plan review with patient and Care Coordinator.
Identify Pt objectives/plan care.
Involve community and HWC.
Facilitate MDT as needed.

**Capture Themes** 

Sustainability & future scope

Outcomes from tools/PHM.

Patient feedback and
outcomes.

Collaborator feedback.

Integrated Neighbourhood
learning team to focus on
addressing themes.

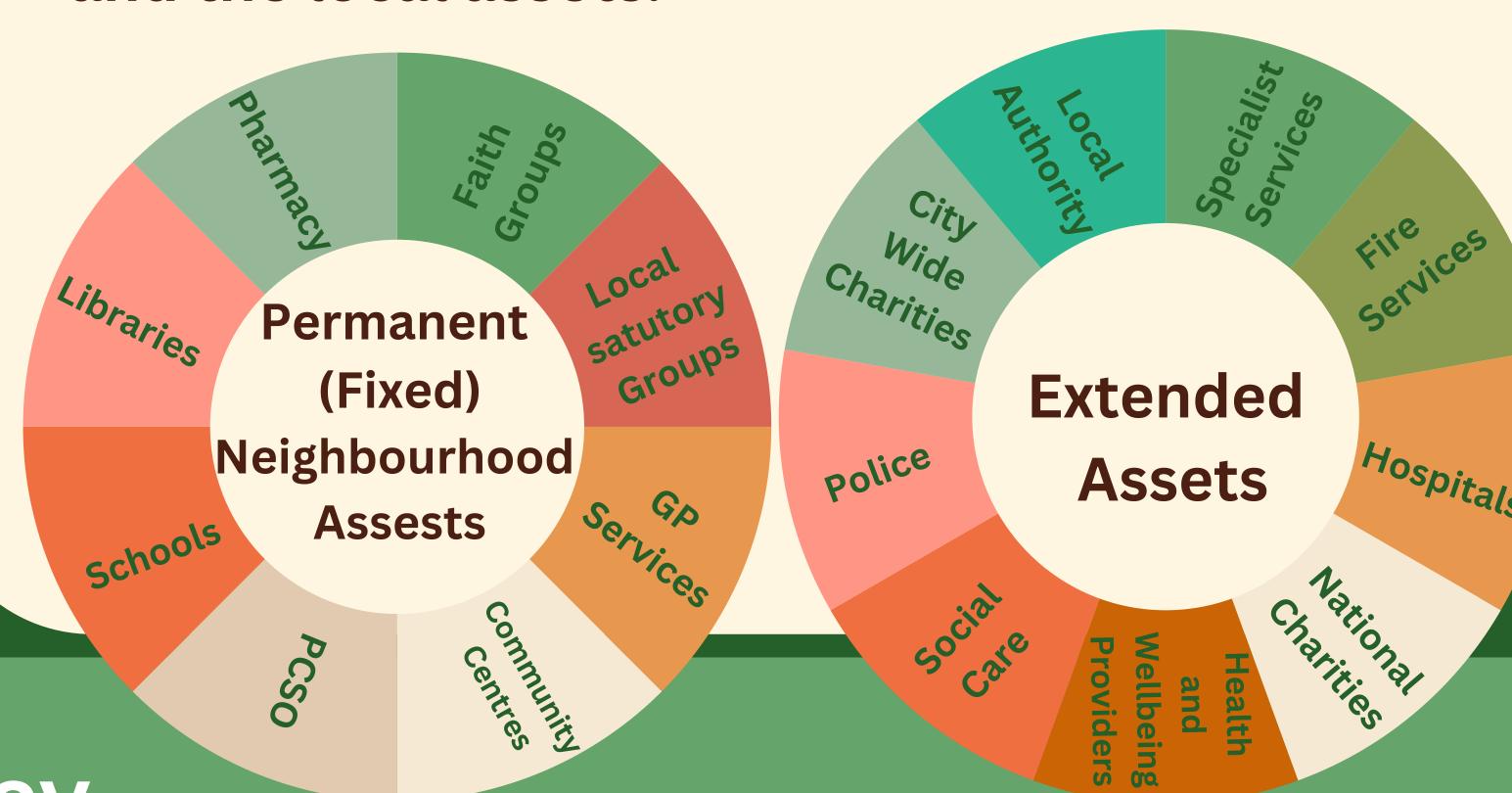
Evaluate

Use validated tools for pt mobilisation and progress.
Review/Revise Plan.
Explore themes with "neighbourhood"
Capture outcomes, achievements and learnings.

Mobilise

# Building collaboration

- · Identify the assets and resources available to a neighbourhood for residents.
- · Understand the barriers to collaboration and how we can overcome them.
- Understand the objectives and needs of the participating organisations / groups
- Establish a forum for exploring the themes affecting residents identified in Workstream 1 and the local assets.



## Patient Journey

Our third workstream is to explore, at a very high level, the journey of a frail patient into hospital and to home. It intends to understand the flow of information and care planning that follows the patient, who updates it, what is updated, who it is visible to, when, how and why? To support identifying individual needs, key themes within the neighbourhood and opportunities for the system



NAVIGATE

Support patient to navigate neighbourhood identifying opportunities.

**ENGAGE** 

Patient understands
what support is available
based on WMTM and able to
MAP out their plan.

Support patient to identify current needs based on WMTM