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# Collated Outputs from the Shropshire Care Closer to Home Stakeholder Event

## Wednesday 25th July 2018

On Wednesday 25th July 2018, a Shropshire Care Closer to Home Stakeholder event took place, in the form of a workshop, involving 70 people from NHS Shropshire Clinical Commissioning Group (CCG), Shropshire Council, Shrewsbury and Telford Hospital NHS Trust (SaTH), Shropshire Community Health NHS Trust and Midlands Partnership NHS Foundation Trust along with patient representatives and members of the voluntary and care sector.

The workshop included a progress update on Phase 2 of the Shropshire Care Closer to Home Programme, namely Risk Stratification and Case Management, as well as providing a forum to explore the emerging model.

The event also provided an opportunity to further review the communications and engagement strategy, with group work on helping to inform target audiences and methods of communication. In addition, the 'What Matters to Me' campaign was used again with a dedicated stand allowing people the opportunity to make any comments and suggestions.

There were three group exercises during the day, as well as the 'What Matters to Me' stand and a space where people could park any suggestions, thoughts and comments. The exercises explored the understanding of the Shropshire Care Closer to Home programme, its plans and the work done to date, as well as providing an opportunity to contribute to the communications plan by suggesting approaches and organisations to be approached.

The outputs, comments and feedback provided by the people who attended the Stakeholder workshop event were captured and are included here for information. These, along with feedback from previous workshops and 'What Matters to Me' events are, and will continue to be, used as part of the development of a new model of care. This ensures that we develop and deliver a change that is meaningful and beneficial to the people of Shropshire; designed around the suggestions and comments that are made.

Whilst some of the comments may be abbreviated, or provide challenge, they are shared here as verbatim from the stakeholders who attended the event, and are accurate comments as they were captured on the day of the Stakeholder workshop event.

Kind regards,

Shropshire Care Closer to Home Team

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## What Matters to Me Comments

| | |
|---|---|
| **Comment 1** | • Not everyone wants to die at home. Palliative Care Services in our hospitals – South Shropshire.<br>• Palliative care rooms with access to outdoor space. Ludlow has no way of getting bedbound patients outside. My father died in a side room – not outside for weeks.<br>• Mother-in-law died at St. Michael's Hospice, Hereford, outside in the sunshine! That was her wish. My dad wanted the same but unable to get outside.<br>• EMI unit needed. Patients with Dementia get stuck in hospitals awaiting EMI beds. It would be lovely to have a dedicated unit with trained staff in Dementia care and secure outside space. A general hospital is not the right place. Patients end up with one–to-one care on hi/low beds – this is not how people should be treated.<br>• Maternity services on the doorstep. I would have had my children on the A49 had Ludlow Hospital not been there to deliver them.<br>• Treatment for ex-COPD, infections etc. We could treat at Ludlow if we had a DAART similar.<br>• Staffing! We can never recruit - why? Not having any student nurses for 12 months now as not enough on the course from our area. Need to go into schools and start early. Army/Navy/Tesco/Capita at Ludlow school – where is the NHS?<br>• Why just elderly rehab? Ludlow used to assess and treat the young, could do so much more. Need more doctor/GP support. |
| **Comment 2** | • Any change in systems needs to focus on quality and patient outcomes and allow for staffing levels to be able to deliver good quality care. |
| **Comment 3** | • Timely availability of treatment and standard of good basic support and care.<br>• Use of clear common language.<br>• Respect breeds respect. Who are the customers? What is the service for? |
| **Comment 4** | • Better information: One central service of information.<br>• One telephone number<br>• Better use of the Community Care Co-ordinator in and attached to GP Practice.<br>• Consideration to the problem of cross border services in South Shropshire/Wales. |
| **Comment 5** | I think it is essential to see much more integrated "care pathways" across Primary, Secondary, and Community Care. Two examples come to mind:<br>• A young friend developed Chronic Renal Failure in her early 30's. The liaison between hospital and her GP was poor. The only support she had "out of hours" was a hospital-based nurse. There was no advice or support on diet or self-management so her renal function fell to less than 5% within 6 years; with consequent reliance on renal dialysis while still very young and with a young family. Fortunately she received a donor Kidney and is doing well – but long term conditions don't just affect the "elderly."<br>• Stroke services. In 1992 in a different part of West Midlands we adopted the slogan "Integrated Stroke service to save lives." Essentially the approach was similar to the FIT described by Finola, but with rehabilitation services based in the community. 27 years later, Shropshire still has no integrated care pathway for people living with Stroke, with consequent high costs of social care because of untreated disability and very poor rehabilitation services at a local level. I hear that there are proposals to abolish the one small element of Community Enablement Officers at the one time when their services are most needed. |

## How Can We Best Tell the Story?

### What is Care Closer to Home?

- It is putting the patient at the centre, having one care plan that a multidisciplinary team can use that is proactive and not reactive - integrating all aspects of health and social care.
- Reduction in time and energy travelling to acute hospitals.
- Closer care.
- Better organised care and support.
- Proactive care and support to live well, prevent problems if possible, identify needs, plan for care early.
- Better care for over 65s with multiple conditions.
- Suggest this is around identifying individuals at risk and tailoring their care - not just for "older people".
- I don't understand/know about Phase 3.
- Redesign and integration of community services.
- Keeping patients in own home.
- Person centred, tailored to patients' needs.
- Point of contact.
- Partnership working.
- Proactive, preventative care.
- Transforming care in the community - wraparound care/patient centred.
- Individualised care planning.
- Philosophy of care that supports a person in their home environment where possible.
- Proactive, people centred, case management, delivered consistently, a means through which people can work together.
- A programme of change that is being organised and co-ordinated by Shropshire CCG.

**Why Do You Think We Are Doing It?**

- Better outcomes for people.
- Our health system has outdated our rising elderly population and in order to meet their needs we need to review how care in the community is delivered, focussing on prevention.
- To make the best use of financial resources.
- Promote independence.
- Promote choice.
- We can look after people better.
- Current model not working, doesn't meet our needs.
- To help people look after themselves better.
- Keep people where they want to be.
- Reduce admissions.
- Save money.
- Careful monitoring to identify potential problems early.
- Eliminate disjointed incremental services.
- More effective, personal, proactive care.
- Better patient experience.
- React to changing population needs.
- Research, better outcomes.
- Reduce acute hospital admissions.
- More sustainable.
- Better use of resources.
- Right thing to do.
- Supporting people to live well even if living with long term conditions.
- Improve efficiencies; prevent the patient re-telling their story to several professionals.
- Better outcomes for the patient - keeping people who don't need admission out of hospital.
- To achieve better value care for our population.

**What Do You Think We Have Done So Far?**

- Frailty Team, RSH.
- Introduced FIT at RSH.
- Planning is in hand for Case management (Care Management).
- Started Social Prescribing in parts of Shropshire.
- Have a Frailty Team at RSH, rolling out to PRH.
- Frailty Intervention Team - Phase 1.
- Brought together everyone involved in care and support of frail people.
- Worked in localities to look at needs of local communities.
- A few short-term funded local pilots.
- Very poor communication with the public about "their" community hospitals and how they will fit into the new model.
- Demonstrate how this model complements the clinical model of Future Fit.
- People don’t want to feel all the consultation and "engagement" on hospital services isn't "followed-up."
- F.I.T - very successful, positive results.
- Locality involvement.
- Engaged with providers.
- Integrated national recommendations, NHS plans aligned.
- Lots of discussion.
- Proactive over reactive.
- Phased approach.
- What matters to you?
- PLTs.
- IT discussions.
- Lots of listening.
- Phase 1 - Pilot - Frailty Front Door.
- Phase 2 - Case Management - Design and scoping/engagement and consultation re model for the future.
- Engagement; Developed collaborative model for case management; Fit Team Pilot; Home First Pilot; Lots of separate initiatives - need to join up
- Frailty at the front door - phase - going to PRH. Case management - phase 2. Modelling risk strategy for case management

**What Do You Think Will Happen Next?**

- Case Management.
- Care Plans.
- Case Management developed and rolled out.
- Enhanced Community.
- Services will follow.
- Joining up services with social prescribing which will be expanded.
- Case Management.
- Implementation of Phase 2 - bringing together dedicated teams to identify frail people, clarify their needs - Individual Care Plans.
- Start to think how best to provide crisis care, rehab, hospital at home and community care and consult on how.
- Light the blue torch paper on "Community Hospitals".
- Clarity on the local population/communities around which case management is to be designed.
- Case management.
- Formation of an Alliance.
- Design of Phase 3.
- Change culture.
- Comms and Engagement.
- Continuing consultation.
- IT Workstream - Shared Care Record – Telehealth.
- Phase 3. Developing of new services - Rapid response, Crisis resolution (1st Aug - early 2019).
- Phase 3: Hospital at Home, Rapid Response, Step up beds
- Hospital at home consultation

**Who is Doing It?**

- Collaborative between Health and Social sectors, Voluntary sector.
- NHS, Council, Voluntary Sector and Private (to include Dom care).
- Joint working by providers.
- Collaborative partnership - Health, Social, Voluntary agencies.
- All Partners.
- Patients.
- All Providers, Commissioners, Voluntary sector.
- Everyone has got to engage.
- Who is the leader? Are there several?
- Everyone! Health, social, community, patients, public.

**How Do You Think We Are Doing It?**

- Task and Finish Group.
- Forming an Alliance between all partners/stakeholders. Engaging with stakeholders. Researching.
- Jan said 'at pace'. Collaboratively with our stakeholders and community involvement.
- Working together - talking, to design an integrated service around people/patients.
- Tailor the 'message' to the audience - e.g. what will be the model for the local community, not what is the grand scheme of things.
- Different messages e.g. for staff who you want to act as ambassadors.
- Use much simpler language. The "key messages" column uses "patient," "unnecessary," "reducing risk of hospital admission," - all performative and/or patronising.
- Dependent on Alliance agreement
- A pilot
- Redistribution of resources.
- Avoid duplication.
- Shared records/care plans.
- Communicating with whole teams consistently
- Aspiring to trusting relationships
- Looking at models nationally, research, involvement of stakeholders, consulting, communications team regular postings CCG website, public and stakeholder providers, task & finish groups

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**Using adjectives that feel right for you, please tell us what you think about Shropshire Care Closer to Home?**

- Logical
- Sensible
- Challenging
- Collaborative
- Valuable
- Joined up
- Ambitious
- Needed
- Collaborative
- Local
- Personal
- Partnership
- Positive
- Proactive
- Optimistic
- Excited
- Energised
- Innovative
- Forward-thinking
- Culture change
- Comforting
- Kind
- Caring
- Involved
- Professional
- Pro-active
- Person-centred
- Wanted
- Needed
- Pace needed
- Scale needed
- Exhausted
- Concerned
- Improve individual's health and wellbeing.
- Complex - important to give the public both the future "big picture" as well as smaller steps to realise it.
- Exciting
- Logical
- "The right thing to do"
- Theoretically brilliant - want to see action.
- Not a cheap option - may take a long time for cost benefits to be realised.
- Rewarding
- Proud
- Energetic
- Comprehensive
- Innovative

**Please provide any advice that could help us to deliver Shropshire Care Closer to Home:**

- Focus the message around patient outcomes.
- Messages need to be more emotive with real life examples - videos or cartoons.
- Extra staff.
- Support of change.
- Lisa's report to Shropshire CCG to include strategic major operational risks.
- Use the detailed data analysis for community, hospital and social care done by the CSU for "Community Fit," with the 6 practices' data as well.
- There was a lot about long term conditions risks related to costs and involvement with multiple agencies.
- Quickly as possible (antidote to Future Fit)
- Learn to trust and respect each other.
- Cultural change in organisations.
- How to build/write your care plan as a worked example of what underpins CCH ethos/philosophy.
- Involve SALT (speech & language therapies).
- Use of wellbeing hubs.
- Please ensure wide communication across generations i.e. YouTube channel, social media, radio, Shropshire Star.
- Include clinical staff during planning and implementation process.
- Where are SaTH? WMAS? Cross Border Services - Cheshire, Powys, Stafford, Wales?
- Joining local authority and health together.
- Integration! Pool budgets!

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**Understanding of Case Management**

**What do you think about what you have heard on Case Management today?**

- Makes sense.
- Patient is central to the plan, essential.
- How does domiciliary care fit into this initiative?
- Concept is brilliant - but needs to be properly resourced. (Geographical challenge).
- Also needs to be used appropriately to be effective - need to ensure risk stratification tool is right.
- Worried about the numbers of people that risk stratification will identify.
- Positive.
- Care Plans.
- Needs to have an equitable and standardised approach - everyone has access to the same offer/way of working.
- The proactive approach is needed and will put preventative actions in place.
- Aids planning and evaluation of services.
- Co-ordinated approach.
- Patient centred - should be person centred. (right approach).
- More scope to link in with wider needs and assets e.g. Social Care/voluntary care providers.
- Term "case" - sounds like a number. How to talk about the programme with the public?
- Involvement of patient in the care - ownership of care plan. Will patient hold copy of notes?
- Responsibility.
- Integrated team working – getting the right skills
- Puts patient first.
- The term is restricted to the top tier of the "need" pyramid.
- People want their care to be managed.
- People don't want to be "cases."
- Unclear the level of population the case management team will cover - approach is an urban setting. Different from the Western rural communities.
- Are the care plans going to be patient held? Some people would be horrified to be on a register - think of language presentation.
- How to tackle problems of data sharing? What is a 'shared care record?'
- Frailty prevention - patient of whole system/focus on risk stratification on priority cases.
- Joined up approach but:
    - Will need time to complete the risk stratification process.
    - Will this add to the burden of GPs?
- No brainer.
- Complex.

**What Do You Like About Case Management?**

- Patient focussed/patient first.
- Patient centred.
- Puts patient at centre.
- Person centred approach - "What matters to you?"
- Personal - point of contact.
- Joins everybody together - good for managing multiple needs.
- Joined up working - proactive rather than reactive.
- Joined up approach.
- Continuity.
- Collaborative work.
- Collaboration (the promise of).
- Builds patient- professional relationships.
- Holistic.
- Holistic and preventative approach to health and care.
- Good orientated.
- Involves carer/s.
- Patient and care has plan.
- One consistent care plan regardless of provider/issue.
- There are people out there struggling - this could be a life-saver.
- Quality of life goes up.
- Good practice.
- Proactive approach.
- Like proactive preventative approach - usually reactive and responsive.
- Proactive approach proposal - identifying people at increasing risk.
- Information sharing and providing information.
- Co-ordinated.
- Different formats to meet needs of different generations, moving forward.
- Keeps people in own environment.
- Preventing hospital admissions.
- Individual.
- Ownership.
- Knowledge of patient (throughout their journey).
- Upskilling of staff.
- Improve resistance of teams/staff.
- ICS model has improved access to community services, but there are gaps which this approach seems to plug.
- Carers have borne the brunt of negotiating the system. Their role and needs must be fully engaged in the model.
- We like early decision making at point of entry and discharge but "what matters to the patient?"
- Opportunity for Voluntary sector to play a part/family/friends.

**What Do You Think Is Necessary To Make It Work?**

### Theme "Working together"

- Collaboration and communication between all providers.
- All services need to understand what all other services provide - NHS, Council, Voluntary sector.
- 'Whole system' approach to making it work across sectors and organisations.
- Collaborative not 'doing to' terminology.
- Staff. All signed up to the model.
- Alliance.
- Would there be Community Hubs? This will help collaboration/communication. If so, how many? Where would they be?
- Challenge of responsiveness and frequency of collaborating.
- Needs all partners to buy in e.g. Social Services.
- All providers involved.
- Involvement of providers of social care.
- Link between physical and mental health.
- Integrated team working - right skills.
- Essential to integrate with the Healthy Lives, Community Resilience and Social Prescribing approaches developed by the Council and develop Apps etc. for better self-management/monitoring of long term conditions.
- Correct skill mix/professionals/clinicians in team.
- Integrated primary care, hospital, social services
- Link up with prevention work - plan for everyone.
- Relationship building with people (practitioners/patients/carers).
- Working boundaries are different for organisations – need to be aligned.

### Theme "We need the technology/share information"

- Technology.
- Effective information sharing.
- Technology is key here - all providers need access to some technology.
- Data sharing.
- Better source of information for the public.
- Patients and carers need access too!
- A focus/attention paid to carers as well as patients.
- Would RIO work? Ideal world iPad.

### Theme "Single plan"

- Need to create and develop single care plan for everyone.
- Need a "Key worker"/ Case Manager.
- Each provider is good at case managing within own speciality, huge cultural shift to provide this.
- Could be very inefficient if all areas discussed by all providers, so need a clear process for focussing on the most challenging e.g. through MDT meetings.
- Risk stratification tool really needs to be robust.
- Resources - enough staff to do this effectively in our geography.
- It is the individual's plan i.e. should go with the 'patient.'
- Patient held record essential.
- Consistent care/case management.

### Theme "Engagement and understanding"

- Pay-in by everybody (not just defaulting to health).
- Cultural shift in population expectation, willing to self care.
- Education of patients that hospital is not always the right place is vital.
- Education and awareness within the whole system - sharing information.
- Willingness of staff to be flexible to make model work.
- Assumption/expectation that all patients want to be independent.

### Theme "Cutlure change"

- Learning culture.
- Change/culture - adapting to new ways of working.
- Culture change.
- Culture shift to use this shared record - same language?

### Theme "24/7 working"

- Pump-priming to get it started.
- Needs to be 24/7 service.
- Must work 24/7.
- 7 day working.
- Information systems - single patient record (or at least can be accessed by all agencies).
- Understanding of this new model by the wider community.
- How to tie-in cross border? Needs to be built into the system.

## Theme "Upskilling staff"

- 'Support' to have confidence in a new model.
- Training.
- Re-engineering structures and frameworks to improve integration between organisations.
- Use skills already in place/knowledge/expertise.
- Support for accessing diagnostics in the community e.g. blood tests/results e.g. facilitate patients receiving Antibiotics therapy in the community.

## Theme "Leadership"

- Sustainability (e.g. funding). Leadership.
- Communication - need people to 'trust.'
- Dosh.
- Leadership.
- Needs to be open and visible on how that point was reached.
- Commitments.

## Theme "Needs to meet local needs"

- Appropriate sites/location within localities.
- A locality/flexible approach that responds to local needs/demographics/circumstances.
- Local knowledge for signposting into community support.
- Understanding peoples networks of support.

## Miscellaneous

- Availabiliy of care in crisis situations.
- Availability information for patients to maintain health i.e. exercise classes.
- OOH working.
- Plans for younger people coming through with long term conditions.

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**Communications & Engagement**

**Who Do You Think We Need to Engage With?**

## Meet their needs

- Voluntary & Community organisations
- Patients/people
- Population >65 & carers
- Leaflet for partners to meet
- Individual letters send to target population?
- Why current system not working? What ultimate system will look like. Give realistic idea of timeframes? Reassurance there will be careful monitoring of any problems and addressing
- Explain phased approach – focusing on specific high risk groups will rollout more widely later
- Beware of engagement fatigue!, Beware of jargon!
- Not just patients – people
- ICS webpage and leaflets
- Surgery websites
- Patient Group website
- Healthwatch
- Volunteer Sector websites
- Churches
- Patient groups
- Parish Councils
- Carers – young carers
- Post offices
- Local shops
- Local pubs
- Voluntary sector
- WI
- Target cohort of patients and those approaching eligibility criteria
- Wider public
- Local media
- Carers
- What's On guides

- Websites and social media
- Community Centres
- General Public
- Chamber of commerce
- League of Friends
- Existing comms channels (videos)
- Friends in retirement
- Social services – emergency duty and LA
- Seldom heard groups, i.e. LGBT & Polish communities

**Key player – proactive**

- GPs
- Hospice
- Age UK
- PPG
- VCSA
- Voluntary groups – disease specific – can do a lot to promote informing patients and others
- NHS employess – need to understand so can communicatte to their communities
- Key local figures – involve them in how to best reach their communities
- RCC
- SPIC/care homes
- Hospices
- Community enablement officers
- Town and Parish Councils
- Parish and Town newsletters
- WMAS
- Local Authority Comms / Social Care
- Health and Wellbeing Board Comms Group
- Friends of Hospital Groups
- MPs & Councillors
- Nuffield
- Some PPGs are well placed to inform their local population
- Community Trust staff have many contacts with “at risk” people – they must be both

well – informed and enthusiastic to share the concepts

- True for council staff and NHS staff in general
- Use the condition – specific voluntary sector organsiation to “spread the word” and collect views eg Diabetes UK, Stroke Association, Age UK, MIND etc.
- Acute Trust/SaTH
- SCHT – social services
- All GP Practices – CCC
- Voluntary Sector ie Age Concern, Red X, ILP, NH IRH
- Transport Groups
- Mobility organisations
- Bristish Red Cross
- Local gyms
- Men in Sheds
- HOSC
- Healthwatch
- NHSE
- Leads in provider organisations
- Local media
- Locality GP Boards
- Fire brigade/service
- Urgent care
- Police
- Universities
- Housing
- Gas / Electric
- HR Departments
- Communications teams in all organisations
- CEOs of health, social, third sector partners
- Locality service managers – SCHT
- ShropDoc
- Existing providers incl. GP practices, NHS Trusts, contracted third sector
- Boards and front line staff
- SPIC/domiciliary care

## Groups to keep updated

- Nuffield
- Private providers e.g. physio & occupational health
- Charitable services – Rotary Club
- Foodbanks
- Homeless organisation
- Libraries
- Churches – Church Together
- Faith organisations
- Places people go/congregate eg leisure/supermarkets/cafes/pubs/restaurants/older people clubs/social groups
- Virtual Communities (Facebook, Twitter)
- What will it mean for the person/patient? What can they expect?
- Focus comms on initial services users i.e. >65s with long term conditions and their carers - other people don't need to know so much yet
- Consider how it integrates with planned care – at the moment seems very focused on emergency care
- Perception is that this is only about emergency/unplanned care – need to explain is also about proactive & planned care
- Local parish and town councils need to understand the issues and be encouraged to be involved in local service "design"
- Database
- MPs / Political Groups
- Provider workforce
- Partner organisation
- GP practice staff
- Police
- Shropshire Seniors
- Sure Start
- Schools / Education Establishments
- NFU
- Sports and social clubs
- Rotary
- The Lord-Lieutenant Sir Algernon Heber-Percy
- Pressure / campaigning groups

- WI
- Small businesses e.g. plumbers, hairdressers, local papers
- Social services
- Pharmacy
- Tissue viability nurses
- Patient Groups
- Media
- General public
- Local Medical Council

## Groups to involve

- Community care & care co-ordinators
- Community nurses
- Directors of nursing
- Local GPs
- SPG
- Local PPGs – they know their patch and who to talk to
- Patient groups
- Over-65s – current and potential patients
- Carers (via carer groups at GP services)
- Local councillors are very engaged with health and other concerns of their constitents
- Similarly – take care with language the “key message” read as purely health (e.g. patient); unplanned hospital admissions (“un-necessary” hospital stays are insulting to people who would like nothing more than to go home as soon as they are able)
- Kate Garner’s slides used much more “inclusive” language. It would be good to use the same phrases to demonstrate a single aim.
- Voluntary and Community Sector Assembly:
    - Age UK
    - NFU
    - SIAS
    - Red Cross
    - Carers Trust
    - RCC
    - Alzheimer’s Society
    - SPIC (Care Workforce Development Partnership)

  - Macmillian
  - SAND
  - Senior Citizen Forums
  - Carer organisations
  - Dementia Companions
- Voluntary Sector
- Nursing
- Practice Staff
- Care co-ordinators
- Carer's Trust
- Community Matrons
- Community First Responders
- Hospice
- Pharmacists
- NHS Trusts & support services
- All providers
- Healthwatch
- Health interest groups
- Third sector service providers
- Housing Associations
- Fire service
- University
- Community dementia service leads – MPFT
- ICS/IDT Team leaders – Community Trust
- Rehabilitation Pathway Co-ordinators – SCHT (Stacey Greenan, Bev Kipling, Lynn Roberts – therapy)
- Advanced Nurse Practitioners – community hospitals – SCHT – Julie Rogers
- AHP professional lead – Liz Hagon – SCHT
- DAART clinical lead SCHT – Phil Atkins
- T&W Rapid Response
- Council
- Service providers
- Qube (Oswestry) a support centre
- Mayfair Centre (Church Stretton)

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**Activity Schedule**

**What is the activity? - When and where is it? - Do you know the contact?**

- Shrewsbury Flower Show - August 10/11th - Quarry
- Burwarton Show - 2 Aug
- Minsterley – 18 Aug
- Season for shows in local area
- MPFT - staff meetings – monthly, collective leadership forum - TBA
- Carnival Wem – 1 Sept
- Ludlow Food Festival – 6/7/8 Sept
- Bridgnorth Butterfly Café – 1st Friday of every month
- Church Stretton Arts Festival – 28 July
- Church Stretton Mayfair Centre & Health & Wellbeing Centre & Library
- Midlands Game Fair Weston Park – 15 Sept
- Shrewsbury Market Square / regular events
- Parish councils and councillors – can advise on local resources
- Whitchurch – library – monthly makers market
- Pontesbury – library
- Advertise at local events eg Flower show, food fair, local markets
- Craven Arms – comm centre
- Local media – Radio Shropshire, local magazines, newsletters eg Stretton Focus, Church magazines
- Needs to be succinct + tailored to that local community
- GP Practices
- Remember border issues – publicising in GP practices where many patients live in Wales and won't be able to access this
- Community enablement team – via Maria Jones
- Local events in each market town
- Shropshire seniors
- Staff intranets
- SC
- Large employers – Muller – local business networks
- GP Surgeries
- Whitchurch ?Resources Event (health/volunteer sectors) – Community Centre (Civic) yearly – Nov/Dec unknown
- Clun Good Neighbours Annual General Meeting – Hazelhurst Sheltered housing scheme Common

Room – Autumn/yearly – Judy Maud

- ICS Team Meeting North – Whitchurch / Oswestry – Bev Kipling
- Staff Away Days – Various location – SCHT
- Clun Patients Group – once a month (The Sun Inn) – Mary Eminson
- Clun Community Newsletter – monthly – Joan Carey
- Monthly Booklets in areas around Shropshire ie Bayston Hill, Whitchurch - Monthly – GP Practice
- Village Fetes – all over Shropshire all year round
- Clun Valley
- Large directory on website
- What's on in Shrewsbury & Shropshire
- Lots of large festivals/events/flower shows/fetes/horticultural events
- Radio Shropshire
- Theatre programmes
- Buses
- Local newspapers
- Locaility Board Meetings – Shrewsbury, North, South monthly/ bi-weekly – locality chairs
- Staff briefings – WFH, monthly – Claire Turner
- Flower Show – August, Quarry
- SaTH Fun Day – June RSH - Julia Clarke
- Ludlow Food Festival
- Oswestry Show - August, Oswestry Showground
- West Mid Show – August, West Mids Showground
- Christmas Events
- Team leader meetings (IDT Shropscom) – weekly Wednesday morning 10am – Jayne Richards / Vickie Clayton
- Locality Meeting North West IDT Oswestry – monthly Oswestry HC – Donna Jones
- School fetes – locally based
- Community Trust Leadership Group – Venue varies & date – via Shropscom Exec PA office
- Schwartz Rounds – Once a month. Venue varies – Sonia Orr, Shropcom
- WIs – across Shropshire
- Locality meeting in each community locality – monthly in each locality – NW, NE, Central, Telford, SE, SW – Community Locality Managers
- Parish Magazines – Local communities / monthly – Parish council meetings
- Shropshire Patient Groups – locality groups

- Alzheimers Carers Groups – monthly – Whitchurch, Shrewsbury, Church Stretton
- Ludlow Food Festival
- Folk Festival
- Open Gardens
- Summer Fayre
- Wise & well days
- School events
- Summer camps
- Reading clubs
- Gyms
- Recruitment events
- Shrewsbury Football Club
- Rugby Club Event/Sports
    - Whitchurch
    - Shrewsbury
- Carers event (Meole Brace)
- Faith Events
- Parish Magazines
- Allotment Open Days
- Garden Trail Associations
- Care & Share Groups
- Sure Start
- Memory walk – Ironworks
- Boat Race – Dragon Boat
- Moat Project (Learning Disability) – Shrewsbury, Bridgnorth, Albrighton

NHS
Shropshire
Clinical Commissioning Group

**Suggestions, Thoughts & Comments to Park**

Frailty

- What are the plans to backfill the community match from the IDT teams in Shropshire?
- How many people send/discharged home early are readmitted within days?
- Congrats on enthusiam + early pilot. Funding is on an annual short term basis. What funding is required to operate a full scale (24/7) live pilot?
- I have a common case that was not picked up by FIT. It concerns an elderly person in central Shrewsbury – after 7 days in hospital – sent home. No case plan/physio/OT or social services. Needs 24 hours care being done by family including a family member under 16.
- If increased to seven days a week will community matron working hours change? Currently Mon-Fri
- Can community hospital staff come and shadow your team please?
- Major achievement; fully integrate; enthusiastic & committed team; sustainable; finance & staff; expand; carry out this activity "before the front door going forward".
- Over 20 years ago a local health visitor worked with the local community to develop a group to consider needs of local elderly and create measures to address these. When roles of health visitors changed this initiative died.

Patients

- Must differentiate between:
    - What I want
    - What I need
- Clear communication

Culture Change

- This applies to both:
    - staff & people
- Communicate

Cross border

- What plans are being made to take account of cross border services ie England and Wales?

Phase 2

- Should be "care" management not case management. People don't want to be "cases" to be managed they want their care managed.

ICS

- Please tell me what ICS isn't doing as we need a rapid response service.