Background

In January 2015, One Ilfracombe invited its partners who are involved in the health and wellbeing of Ilfracombe's residents to work together better integrate the work of NHS & non-NHS public services together with community provision recognising that better outcomes could be achieved if we work collaboratively and use our collective skills and resources to improve the health of Ilfracombe's residents.

One Ilfracombe's Living Well Together team includes representatives from health, mental health, palliative and social care together with other public service providers such as housing, jobcentre and the fire service alongside community and voluntary sector representatives.

The current situation

There are many dedicated service providers who have been working hard in Ilfracombe for years and we know that many services have had excellent results in individual spheres of work. They have received excellent feedback and messages of appreciation from many of their service users and yet despite this, the statistics regarding Ilfracombe residents' health and wellbeing remain poor. In addition, the increasing demand on services and reduced budgets means that public services need to think differently about ways in which they can use their collective resources to best effect.

Ilfracombe in 2015

Low wages, seasonal employment

Highest rate in Devon of working age sickness (twice Devon rate at 8.5%)

High rate of private rented accommodation, much of it sub-standard

Highest rate in Devon of 65+ residents receiving residential-nursing care

Relatively isolated, poor transport links

Highest rate in Devon of adults with mental health condition receiving community based care (almost twice Devon rate)

Significantly higher rate of alcohol and cardio-vascular related hospital admissions

Result:

Life expectancy lowest in Devon

Highest deprivation index in Devon; central ward in top 5% most deprived wards in country.

£84 million spent annually on public services

Ilfracombe's public services

Reduced budgets, increased demand

No mechanism to join up services delivered by different agencies

Opportunities to highlight risk or needed support by other services are missed

There is variable recognition and understanding of what support the community and voluntary services can offer

Result:

Our emergency intervention is unscheduled and costly and does not allow us to be as effective as we could be

Any door is the right door. Why is this needed?

Some service users say:

I have to tell my story many times to multiple agencies

I don't know enough to make an informed choice so rely completely on experts

There are a lot of services I am involved with, but no single person or service seems to be co-ordinating it all

I can't get the support I need early enough so end up in crisis needing urgent support from services

I don't always know who I should talk to about my issues. I don't know what help is out there.

It sometimes feels like I'm only able to get help when I'm in a real emergency

I've found the mental health processes hard to understand and confusing. I would like a much clearer explanation of what is available and who or where I can turn to. (Ladies Group Participant)

I would like to be able to access services at times and places convenient to me (Hospital user)

Some families have said it would help if the hours they had didn't have to be at a regular time as appointments etc aren't always possible to arrange for those times (TTVS support worker)

We are expected to signpost whatever the issue. It's easier said than done as it's hard to keep in touch with what projects are still funded. (CAB Advisor)

Yesterday someone came in with anxiety issues and I tried to help but we haven't really had training in how to help from a service point of view. (NDC customer service advisor)

There is no person or agency to access support or advice on how to deal with dementia (NDH Older Person's Support Advisor)

People fall through the net. I don't always know if they get the right answers. (CAB Advisor)

I have sometimes passed on information that one family has discovered to another as there doesn't seem to be a standardised information service about what is available. Even going to a different doctors practice seems to make a difference (TTVS support worker)

Front-line workers say:

We have many customers with multiple needs , so for example we can help them with their housing benefit but not their JSA/ESA queries so we signpost to CAB but they are only here two days a week (NDC customer service advisor)

So for example we have people registered with Devon Home Choice, someone had a problem with a (RSL) and they thought we could help but we can't (NDC customer service advisor)

If I could change one thing in Ilfracombe to make things easier for people with dementia and their carers, I would have better co-ordination between us and doctors, carers, families & this would be preventative support as opposed to reactive (NDH Older Person's Support Advisor)

Programme Vision

The Living Well Together team has the following vision:

To improve health & wellbeing in Ilfracombe by creating a new and innovative service that is seamless, holistic and responsive. Making best use of the statutory, community and voluntary provision, it will support people at an early stage to reduce escalation and the need for crisis intervention.

The Approach

ONE ILFRACOMBE APPROACH

Get a better understanding of the problem from the individuals affected

Redesign the service around the person, not the agency

Focus on prevention and reducing demand

Develop a co-ordinated, multi-agency, multi-sector, multi-disciplinary approach and central point of contact

Foster community responsibility and support volunteers to help design and provide the solution.

Establish value for money

Explore potential for One Ilfracombe to be the commissioner of services

The First Projects

By considering feedback from service users and front-line staff, alongside the agreed approach, it is felt that some elements of the programme for better integration could be taken forward immediately. We would like to explore ways in which we could provide a multi-sector early support system that builds resilience in individuals and allows support to be triggered earlier to deliver the best outcomes. One factor that would help to enable this would be by providing an 'any door is the right door' experience into all of Ilfracombe's health & wellbeing services – a joined-up approach with care and support co-ordinated across organisational boundaries with people only needing to tell their stories once.

Any door is the right door

Project vision and aims

People have told us they are often unsure which organisation provides a particular service, how to access it easily and they find it frustrating when they have to explain their circumstances and fill in very similar forms for separate organisations (and sometimes within the same organisation) over and over again. They sometimes feel passed from one organisation to another and front-line workers have also expressed frustration at not always knowing the best way to refer to another organisation or having an up to date understanding of what's available locally. The ethos will be similar to that of One Ilfracombe's Town Team whereby a member of the public can report any issue to any of the Town Team members regardless of whether the issue is the responsibility of that agency.

Project aims:
People will be able to quickly find the right pathway into services that will meet their needs with a single point of entry or multiple points of entry into all of the health & wellbeing support available.

Intended outcomes:

- Increased confidence in and less frustration with public services for service users
- Increased use of preventative services
- Reduced worry that help will not be available if a person's situation rapidly deteriorates
- Ability to choose own appropriate support
- Service providers better able to support their service users with help appropriate to their circumstances