

# People, Place, Purpose

Shaping services around people and communities through the Newquay Pathfinder

You treat me like a human being and not an old worn out thing in a chair



# Our quiet revolution has changed the behaviour of everyone who has been involved and here are some of their stories

“ Alfred, who lost his wife and his confidence, kept having falls and was worried about being a burden; now he is more mobile and hosts a regular social group at his home ”

Beryl, who was finding it hard to get about after 12 days in hospital following heart failure; she has attended over 20 support groups and social events, regularly shares her experiences with new groups and has not been in hospital since

Catherine, who was becoming more reliant on her husband and had diabetes, heart disease and dementia; now goes on outings independently as well as sharing activities with her husband, who said that the support they had probably saved him from having a breakdown

“ Daphne, who spent long periods in hospital following repeated falls, had dementia and was living in one room, highly dependent on carers; now she can move about the house and get to the bathroom to wash her hair, which was what she really wanted to do ”

“ Edward, who fell in the garden and was unable to move for ten hours and became anxious and depressed about leaving the house; he and a volunteer started talking together over a cup of tea at home and gradually his confidence increased so that he could go out once a fortnight to a nearby café - now he regularly attends a walking group and has had no further falls ”

“ Fred, who has diabetes and recently had a stroke, reliant on frequent home visits from nurses and care staff; now he is able to go out and about and recently hosted a social event at home – he has also reduced his own care package ”

A volunteer who retired early due to stress as a teacher, now has a part time counselling job which she loves as a result of her involvement with the pathfinder and still volunteers for us

“ The pharmacist who decided that he would train one of his team to work in an integrated way and do home visits for everyone on the Pathfinder ”

The performance manager who said that designing a shared outcomes framework had connected her to improving the lives of real people “the most inspirational project I’ve ever worked on

“ The district nurse when delivering a commode to an individual who was at risk of falling, asked herself “what am I doing shrinking this person’s world”, turned around and returned with a volunteer falls prevention buddy ”

The GP who genuinely talks about how it has transformed her thinking and the lives of people she had thought were “at the end of the line” - now she has more magic to offer people than simply medication

“ The commissioner who said that for years, she has been commissioning the wrong things. ”

# Foreword

The contribution of the following organisations in developing and delivering the programme, as well as preparing this document is gratefully acknowledged



Kernow Clinical Commissioning Group

**CELL consulting LTD**  
*energising change*



The Penwith Pioneer Project Board would like to introduce and endorse the results from Newquay pathfinder and we are looking forward to building on this work with the roll out of our Cornwall Pioneer programme. The technical evaluation report will be produced by Age UK national and we would like to thank them for their substantial contribution to the Newquay Pathfinder project.

Dr Mathew Boulter  
Chair of Penwith Pioneer Project Board

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# Newquay Pathfinder Summary

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## Programme vision

To improve the quality of life for older people in Newquay by helping them identify ways to build their self-confidence and self-reliance, providing practical support to help them achieve their aspirations. This reduces dependency on health and social care, including hospital admissions.

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## Programme outcomes

- 1 Improved health, wellbeing and quality of life
  - 2 Integrated working works
  - 3 Cost reduction across the whole system
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## The service

- Targeted wrap around support motivating ‘at-risk’ older people to achieve their aspirations through a ‘guided conversation’
  - Individuals are supported by an Age UK worker to identify their goals and to co-ordinate a management plan that is delivered by coordinating statutory and community services and support
  - The support using volunteers aims to build peoples social networks, making them better connected to their community and more resilient
  - Age UK worker is part of a multi-disciplinary team which includes GP, district nurse, matron and social workers
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## The benefits

- 23% improvement in peoples self reported wellbeing
  - 87% of practitioners say integration is working very well and their work is meaningful
  - 30% reduction in non-elective admission cost
  - 40% drop in acute admissions for long term conditions
  - 5% cost reduction and reduction in demand for adult social care
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## Highlights and Innovation

- ‘Guided conversation’ – starting point is a conversation between equals, with time to listen to the person’s story and to understand their motivations and aspirations
  - Ripple effect – change of clinical practice observed within the integrated care team as staff (particularly district nurses and GPs) sought to proactively reduce dependency rather than control risk
  - Joint working between partners to develop and agree a joint performance framework, with Age UK being the central data processor
  - What started as a conversation became a quiet revolution as practitioners worked across organisational boundaries to focus on the people they were supporting
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## Summary of Key Recommendations

- We must continue to develop the model and test this with other population groups in Cornwall focusing on a whole person/whole life approach
  - Leaders must understand that transformational change is complex, messy and doesn’t fit neatly into a project box
  - Agree a methodology for cost/benefit data analysis up front and define an evaluation framework at the start
  - Identify innovators and champions at all levels in organisations, engage their passion and use this to create sustainable change
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# Background

In 2010, Age UK Cornwall and the Isles of Scilly, with support from Duchy Health, Volunteer Cornwall, local authority, health and private sector partners, invited older people, carers, relatives and members of the Cornish community to join them to celebrate Age and Ambition.

Over 1,000 people and 40 organisations came together to discuss what we loved and what we wished for as we collectively grow older in Cornwall. Our Wall of Wishes and Trees of Talent began a dialogue with our community which has changed the way we provide and deliver services and resulted in the Newquay pathfinder.

What we heard loud and clear was that people want to be at the centre of services we deliver. That we should focus on the skills, experience and talent people have, reshaping what we offer around a conversation with them.

This learning was the foundation for the Newquay Pathfinder and there are three pillars to the approach:



## 1. It starts with a conversation:

- Changing lives is about conversations - with individuals, with practitioners and with communities
- It starts with people's aspirations, understanding their story and supporting them to reach their goals
- It is about trust and relationships that matter. Seeing people as human beings who have skills and experience to contribute to their community and their care.

## 2. It changes the way we live, the way we work and the way we feel:

- People who were patients becoming volunteers, people who were volunteers becoming practitioners, people who were practitioners becoming radical champions for change
- Giving practitioners permission to work collaboratively across organisations, responding to peoples aspirations
- People feel they can reach their goals and feel confident to play an active part in their community

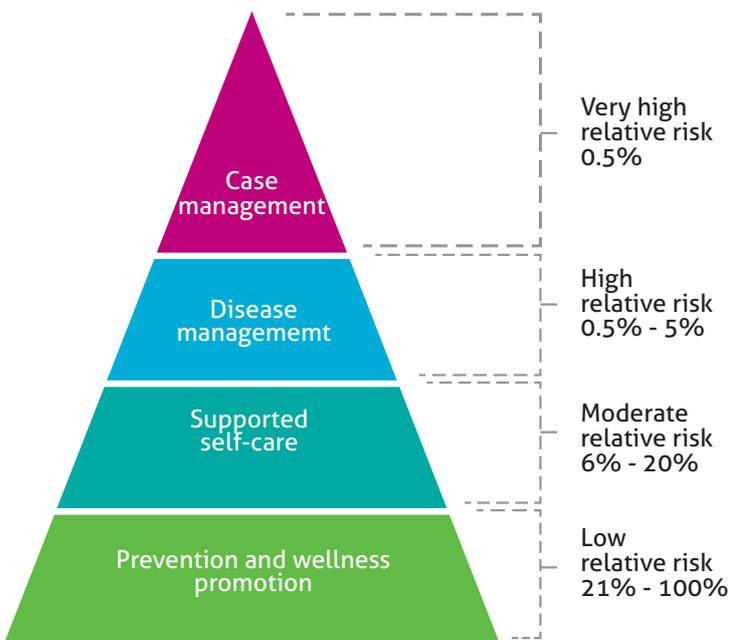
## 3. It is sustainable and replicable:

- The programme is based on people and the resources in a community so that each individual and locality can shape their own solution
- Robust, shared performance monitoring ensures we can demonstrate and monitor delivery

## Cohort identification and characteristics

The cohort was identified using a primary care risk stratification tool and then matched against agreed criteria. People were selected if they had a high risk of a hospital admission and had to have at least two long term conditions that had the potential to be managed in a community setting.

The final phase of the selection process was to review the cohort list with practitioners to screen out those people who had a terminal diagnosis, clinical need for a regular hospital admission or would not respond to the Newquay approach.



“ People were selected if they had a high risk of a hospital admission ”

Our Newquay pilot was based a small sample of 106 people the majority of whom were female and over the age of 85. Only 27% of those in the pilot had ongoing social care packages and all of whom had two or more long term conditions. Table 1 below summarises the characteristics of our 106 people.

Characteristic	Number	%
Mortality	19	18
Female	64	60
Male	42	40
Age: 54-65	4	4
Age: 65-74	12	11
Age: 75-84	43	41
Age: 85+	47	44
Social care users	30	27

Table 1: Characteristics of Newquay cohort

### The Newquay approach

Through an analysis of international and national best practice, the team identified a range of morbidities most receptive to supporting behaviour changes and reducing clinical demand. This was used as the evidence for a series of local shared care management plans.

### Shared Management Plans

It was imperative that organisations involved in the pathfinder understood their respective roles and responsibilities, this was achieved through the development of shared care management plans. They were written with the clinical nurse lead for long term conditions and brought together best practice with defined roles and responsibilities for the team. There is an agreed overarching frailty management plan together with specific plans for each of the long term conditions identified; every plan includes a protocol for clinical escalation.

## The Newquay team

The shared care management plans define potential interventions to support a person to become more independent – a starting point for redefining the locality team and the resources that were likely to be needed. The locality team was redesigned from existing resources across Age UK, social care and primary/community health and with full support from GPs. The team, who were co-located but not managed within a single structure, included a Promoting Independence in People (PIP) key worker role and trained volunteers managed by Age UK Cornwall and the Isles of Scilly. The team offers the person and their carer a personal, coordinated and flexible response, using the most appropriate team member at the right time. It starts with a conversation between the PIP and the person in which

the worker uses motivational coaching techniques, which focus on the person's aspirations and is designed to build self confidence and personal resilience. This approach actively avoids creating a new type of dependency on one specific individual or service.

The Age UK local team acts as an integrated network pulling in community, specialist or further clinical expertise where required and with advice from the social care and community nursing team. Together the integrated care team works towards achieving agreed and shared outcomes for the individual based on the shared management plans.

The team offers the person and their carer a personal, coordinated and flexible response, using the most appropriate team member at the right time



# Did we deliver our outcomes?

The Newquay Pathfinder programme was established to test whether we could deliver three outcomes:

- 1. Improved wellbeing and quality of life
- 2. Integrated working works
- 3. Reduced cost across the whole system

The outcomes and performance framework has been developed as a social impact bond model. The evidence and lessons learnt from Newquay Pathfinder are being used to inform Cornwall's Pioneer programme over the next five years.

## Outcome One / Improved Wellbeing and Quality of Life

Our first outcome is to understand whether the Newquay approach improves people's health, wellbeing and quality of life. To measure this we used the Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS).

SWEMWBS comprises of a series of seven simple questions. The process is designed to be simple to undertake and Questionnaire 1 is completed at the first visit with the second questionnaire completed after six weeks on the programme. The question set is fixed for both.

Our analysis shows that the population's self reported wellbeing improved by **23%** against an average improvement locally of **8%-11%**.

## Building Social Capital

We were also interested to see if the Newquay approach impacted on whether people were able to actively support others in their community or peer group and thus increase our chain of wellbeing. In order to do this we monitored the percentage of our population who were providing community/peer support at the start of the Pathfinder and again at the end.

We found that prior to the Pathfinder, **0%** of our population were providing community/peer support to others. Twelve months after being on the Pathfinder, **10%** are providing this support.

## Outcome Two / Integrated Working Works

This outcome focuses on the practitioners working as part of the integrated multidisciplinary team. Without the people who work in the system and who are prepared to challenge and change the way they work, we could not have piloted the Newquay approach.

The Newquay locality team integrates volunteers, district nurses, community matrons, GPs, voluntary sector staff, local social workers and case coordinators. The team are co-located in a single building and created their own team charter and role definitions. They have multidisciplinary team meetings.

The key measurement tool used has been a locally designed staff survey which looked at a range of questions. At the end of the pilot **87%** of practitioners felt that their work on the Newquay pilot was **very or extremely meaningful**. **87%** of practitioners also said that integration was working **very well or extremely well**.

## Observations from the locality team

Feedback from one of the team leaders observed increased morale as they feel more supported with other options for signposting. Practitioners feel there are better step up and step down processes and an improved range of services to offer instead of just discharging a person. The team is operating as a truly integrated team with volunteer workers an intrinsic part of multidisciplinary case meetings and social events.

A key finding is the importance of trust to the effective working of an integrated team. Trust to discuss sensitive issues and work together to find solutions, trust to hand work over to volunteers and trust that volunteers will hand work back when appropriate, with respect for each other's expertise and contribution. In particular, volunteers are regarded as full members of the team – they are recruited, trained and work to a specification in the same way as paid staff, the difference being they give their time freely. This team ethos needs to be continually nurtured and commitment to a different way of working reinforced.

## Outcome Three – Reduced cost across the whole system

Our experience in Cornwall when we've tried to implement integrated or joined up service delivery, is that there are unexpected cost and activity impacts on other parts of the system. In the current financial climate where both the NHS and social care are experiencing reductions in funding, it was important to know if the Newquay approach was costing the system less overall. In addition, if it was costing less, was there a cost impact on other parts of the system in order that both commissioners and providers can make future decisions? We also wanted to ensure as far as possible we were able to attribute any impacts to the Newquay approach and not to other interventions in the system.

### Cost of non-elective acute admissions

We explored two methods of analysis:

1. Counterfactual modelling using a comparator population
2. Historical cost modelling

Using the counterfactual approach we can demonstrate a **30%** for **non elective emergency admissions**. Long term conditions non elective emergency admissions were reduced by **40%**.

We developed historic cost modelling using two different scenarios. Scenario 1 was to measure pre-pathfinder days back to the point of first hospital admission for the people with long term conditions and here we can demonstrate a **56%** reduction.

Scenario 2 was to look back a further twelve months from the point of first hospital admission and here we can demonstrate a **25%** reduction.

### Cost and number of community activity

Analysis of community health cost and activity shows a cost neutral position. However there has been a shift in case load management between district nurses and community matrons due to a change in staff capacity and a community matron vacancy.

### Cost and number of adult social care packages

Adult social care costs represent a significant proportion of the whole system public service cost for over 65s in Cornwall.

Using counterfactual modelling we can demonstrate a 5.7% reduction in the cost of ongoing social care packages in our pathfinder cohort. What is even more interesting is the reduction in the rate of new packages of social care.

## Conclusions

The Newquay Pathfinder programme has clearly demonstrated that by working with people to understand their aspirations we can:

- Improve peoples' own feeling of wellbeing
- Improve practitioners' morale and the efficiency of the team and
- Reduce costs across the system

The challenge for our next stage on the journey in Penwith Pioneer, is to be able to identify and demonstrate cashable cost reductions that can result in changes to how services are commissioned and provided in Cornwall.

# Lessons Learnt

## What Worked Well

The importance of trust – spending time engaging and building the multidisciplinary team as well as sharing learning and using informal social events is vital to ensure effective working and case management

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 – to redesign services around the individual, putting people first

Finding the pioneers – work with people who are interested and passionate in wanting to change the system, not necessarily those in charge

Focus on what people can do - treating people as active participants, not passive recipients of care

Developing shared outcomes and measures - shared passion, commitment to finding solutions and positive challenge

Changing Lives – having a shared vision of the future across the public and voluntary sectors

## Recommendations

We know we can make a difference to 100 people, we need to test this approach with a larger cohort across a large geographical area

We must continue to develop the model and test this with other population groups in Cornwall focusing on a whole person/ whole life approach

Leaders need to understand and accept that transformational change is complex, messy and doesn't fit neatly into a project box

We must continue to challenge organisational and national process and bureaucracy

Involving all levels of organisations in the change – ownership for the change needs to be with practitioners, middle managers and strategic leaders

Agree a methodology for cost/benefit data analysis up front and define an evaluation framework at the start

Use information governance as an enabler not a blocker

Identify innovators at all levels in organisations, engage their passion and use this to create sustainable change

If you would like further information  
on the Newquay Pathfinder Project  
please contact...

**Tracey Roose**  
CEO, Age UK Cornwall & Isles of Scilly  
email: [tracey@ageukcornwall.org.uk](mailto:tracey@ageukcornwall.org.uk)

