NHS
North West Surrey
Clinical Commissioning Group

Health Scrutiny Committee
8 January 2015

Better Care Fund
Locality Hubs

Purpose of the report: Service Development and Improvement

This report is to give an update to the Select Committee on the North West Surrey Clinical Commissioning Group Locality Hubs Programme.

Introduction

In North West Surrey the population is ageing; currently there are around 29,360 people over 75, which is predicted to rise to 32,736 by 2018. Of these, a significant proportion will be 'frail', that is at risk of deterioration in their health status, leading to the need for urgent and often avoidable health and care service interventions.

NHS England defines frailty as:

> '*a consequence of age-related decline in multiple body systems, which results in vulnerability to sudden health status changes, triggered by minor stress or events such as an infection or a fall at home*'.

With a significantly ageing population, frailty is a fast-growing challenge to the delivery and affordability of health and care services in the future.

In response to this challenge North West Surrey CCG, in partnership with social care, local GP practices and colleagues in acute, community and mental health providers, aims to integrate services around the needs of the patient and make them accessible through one point - the Locality Hub.

1. Locality Hubs

1.1. One of North West Surrey's Better Care Fund (BCF) programmes focuses on developing an integrated care model focusing on enhancing support to the frail and elderly. The programme will provide our residents with the best possible, fully integrated, appropriate and most cost-effective care; delivering better outcomes for one of our most vulnerable groups of patients.

1.2. The proposed change is very much viewed as a large, transformational service improvement, which will deliver tangible benefits to patients in terms of outcomes and experience. The nature of this service improvement will require the reconfiguration of existing services as there is a shift from delivering care in a number of fragmented silos to delivering care and support genuinely integrated around an individual.

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1.3. This integrated model of care will be delivered in three Locality Hubs, one in each one of our GP Locality areas (Woking, Thames Medical and SASSE). A *Locality Hub* is a GP-led integrated care centre, bringing together and providing access to primary care, community services, social care, third sector and planned care services.

1.4. Each Locality Hub will be led and managed by a Locality Network Board (LNB), which is chaired by a local GP. Each LNB is made up of GPs from practices in that locality.

1.5. Locality Hubs will integrate a wide range of services around some of the most complex frail elderly patients. They will provide health, social and voluntary care services, through a single access point, to some of our most complex frail elderly patients. They will plan and provide proactive services aimed at keeping people healthier for longer and slowing rates of functional deterioration while also possessing the capability to deliver prompt reactive care in situations of crisis or exacerbation.

2. Model of Care

2.1. The model of care is being developed in partnership with patients, clinicians and multi-disciplinary professionals from across the health and social care system and will encompass all elements of the model pathway defined by NHS England[1].The array of services is still to be finalised but is expected to include some of the services outlined in Appendix 1, aligned to care and support plans.

2.2. When fully operational, Locality Hubs will operate seven days per week and will provide every patient on the 'hub caseload' with a dedicated Care Coordinator and/or Case Manager who will develop a holistic personalised care and support plan. Care Co-ordinators/Case Managers will also ensure access to a diverse portfolio of services both at the hub site and within the wider community.

2.3. Hub services will have the capability to outreach to a person's place of residence and to acute hospitals to support discharge as well as seeing patients and their carers within the hub itself. Each person supported within a Locality Hub will have access to dedicated transport to and from appointments where required to enable physical attendance wherever

[1] Safe, compassionate care for frail older people using an integrated care pathway, NHS England, February 2014 http://www.england.nhs.uk/wp-content/uploads/2014/02/safe-comp-care.pdf

possible. This is important in light of the particular challenge of social isolation that can arise within this cohort.

3. Plans and progress to date

3.1. The CCG has set a challenging goal of having a Locality Hub in each GP locality by the end of 2015/16, beginning with the incremental implementation of the Woking Hub by the end of this financial year.

3.2. The CCG is holding a series of design and process mapping workshops with GP representatives, health and social care staff and the voluntary sector to agree the first cohort of patients and the initial portfolio of services to be provided from the Hub. This design work will be completed in January 2015.

3.3. Locality Hub services are to be community based and may involve the movement of some services from the hospital setting, these could include specialist outpatient consultations and certain diagnostic and elective procedures e.g. catheter replacement, diagnostic scoping and infusion therapies.

3.4. Other work is also progressing to secure and refurbish clinical premises, develop a shared IT and records infrastructure and organise support services such as patient transport. The first Locality Hub in Woking will operate out of Woking Community Hospital.

4. Stakeholder Engagement

4.1. A Strategic Change Board and a core group have been set up to oversee the design and implementation of the Locality Hubs. Membership of both groups includes senior representation from Ashford & St Peter's Hospital, Surrey County Council, Virgin Care, Surrey & Borders Partnership and Local GP leaders. More focussed design and operational groups have also been set up to ensure a multi disciplinary team approach to the design and mobilisation of new services.

4.2. We are fully committed to involving stakeholders in the design and development of our Locality Hubs programme and have an on-going schedule of patient and public engagement. We have already held a number of interactive stakeholder engagement sessions with local people. A recent example is the whole system event we held on 7 November 2014 attended by approximately 90 patients and professionals. Feedback from all our stakeholder engagement has been incorporated into our plans.

4.3. We will continue to develop our communications and engagement channels which will include regular stakeholder newsletters, web enabled engagement and more targeted stakeholder events.

5. Public Health Impacts

This service development aligns with a number of JSNA priorities and the Joint Health & Wellbeing Strategy including:

5.1. **Improving Older Adults' Health and Wellbeing-** the central premise of the Locality Hub model is delivering a better level of care and support to older people in our community.

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5.2. **Developing a Preventative Approach-** the Locality Hub model ultimately aims to improve levels of health and wellbeing before the need for a clinical intervention. A fundamental part of this ethos is building a range of preventative services around the needs of the individual, this must involve significant input from the voluntary and local government sectors and could include things such as befriending, exercise classes and social activities etc.

5.3. **Promoting Emotional Wellbeing and Mental Health-** one of the elements within the Locality Hubs care plan explicitly relates to a patient's emotional resilience. Common psychological conditions such as depression, anxiety and dementia have a particularly high prevalence within the Locality Hub cohort. Outline any impacts the proposal/policy may have on the wider determinants of health or tackling inequalities.

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APPENDIX 1

Potential services aligned to care and support plans

Section of Care Plan	Objective of this Care Plan Section	Example Activities
Adherence & Persistence	*"I do the things that keep me well and I will do them for the long term"*	**Coaching, training & education-** nutrition, hydration, catheter care **Well-being classes/activities-** exercise classes, meals, socialisation
Adaptive Environment & Assistive Technology	*"I get the tools I need to keep me mobile, enable me to function day to day and manage my own health"*	**Electronic Devices-** remote monitoring, sensory aids, telecare, CPAP **Mobility Aids-** walking aids, splints, supports **Home Adaptations-** home assessments, lifts, hoists, meal preparation
Medical Monitoring & Testing	*"I have the regular check-ups I need to stay well and get treatment quickly when I need it"*	**Regular Check-ups-** GP / nurse /pharmacist-led **Specialist Consultation-** geriatric medicine, respiratory medicine, neurological disorders **Diagnostics & Screening-** blood pressure, spirometry, memory, continence **Minor Elective Procedures-** catheter replacement, pressure sore care, infusion treatment
Medication Management	*"I'm on the medications that best suit me, I know how to use them properly and I'm reviewed regularly"*	**Medications Review-** review of drug portfolio, drug-disease interaction **Medications Support-** training in administering medications and managing them within lifestyle
Carers, Family, Friends & Community	*"I make best use of the resources around me and my carers are supported to help me"* *"I feel supported in my caring role and get support to have a life outside caring"*	**Information & Signposting-** local community centres, neighbourhood schemes **Assessment for carer support-** carer assessment and advice **Carer support and training-** local carer groups, respite services, care advice

		and training
Emotional Resilience	*"I feel happy and able to cope with my circumstances and I know where to get help when I need it"*	**Individual Support-** befriending, counselling, telephone outreach **Group Support-** support meetings at the hub, community schemes
Transitions	*"I know what to do when things change and the people that know me and my circumstances are there to support me"*	**Crisis Management-** single point of contact, management of exacerbations **Rapid Response-** 2hr response service, same day care, wound management, **Discharge to Assess-** Proactive in-reach to A&E and hospital, rehab and package of care assessments

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