



**North West Surrey
Clinical Commissioning Group**

Locality Hubs:

An integrated model of community care for older people with frailty in North West Surrey.

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Background & Context



A number of familiar challenges were our primary drivers for change...

- Ageing population, people living longer and with more long term conditions
- Cost and demand pressures
- Overreliance on hospital and residential care
- Limited focus on prevention and early intervention
- Disconnect between social and medicalised care, and a lack of attention to the whole person
- Fragmented delivery of services led to duplication, a lack of co-ordination, and gaps in care



We have a larger than average population aged 75+ but were not addressing their needs effectively

- A hospital survey revealed that **29% of patients** did not meet the criteria for an acute care admission (never met)
- **50% of inpatient days** on the medical units were potentially avoidable
- The review identified **95 out of 459 days of care** (21%) were provided to patients who never met the criteria for admission
- **Physician reasons accounted for 64%; Community 23%; and Hospital 12%** of the avoidable days and avoidable admissions
 - Most significant categories: waiting for physician orders, waiting for packages of care, and waiting for specific therapies, such as OT and PT

Source: Appropriate Length of Stay Audit Final Report Ashford & St. Peter's Hospitals and Virgincare, MEDWOXX Patient Flow Platform



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Hypothesis & Approach



We had a hypothesis that we have most of the services we need to provide best possible care for our population and set ourselves two key ambitions...

Better outcomes
& quality of life

1) No one should be in an acute bed *because* they are frail
and

2) No one should *become* frail (or more frail) if they can be helped to stay well and independent

Less pressure on the acute sector

Optimised health & social care resources

Improved care quality & patient experience

More cost-effective and better value care

In 2014 we went on a study trip to the U.S....



Approach

- One-stop-shop health center:
 - Risk stratification – proactive case management
 - Primary care
 - Diagnostics and pharmacy
 - Life style support
 - Outpatient appointments
- Complex patients supported by:
 - Enhanced IT/analytics
 - Free patient transport
 - Shared access to patient records

Impact

- 38% fewer hospital bed days
- 18% lower hospitalisations
- 17% lower readmissions
- 86% of specialist consultations delivered in the health center
- 29% improvement in medication adherence (from 44% to 73%)

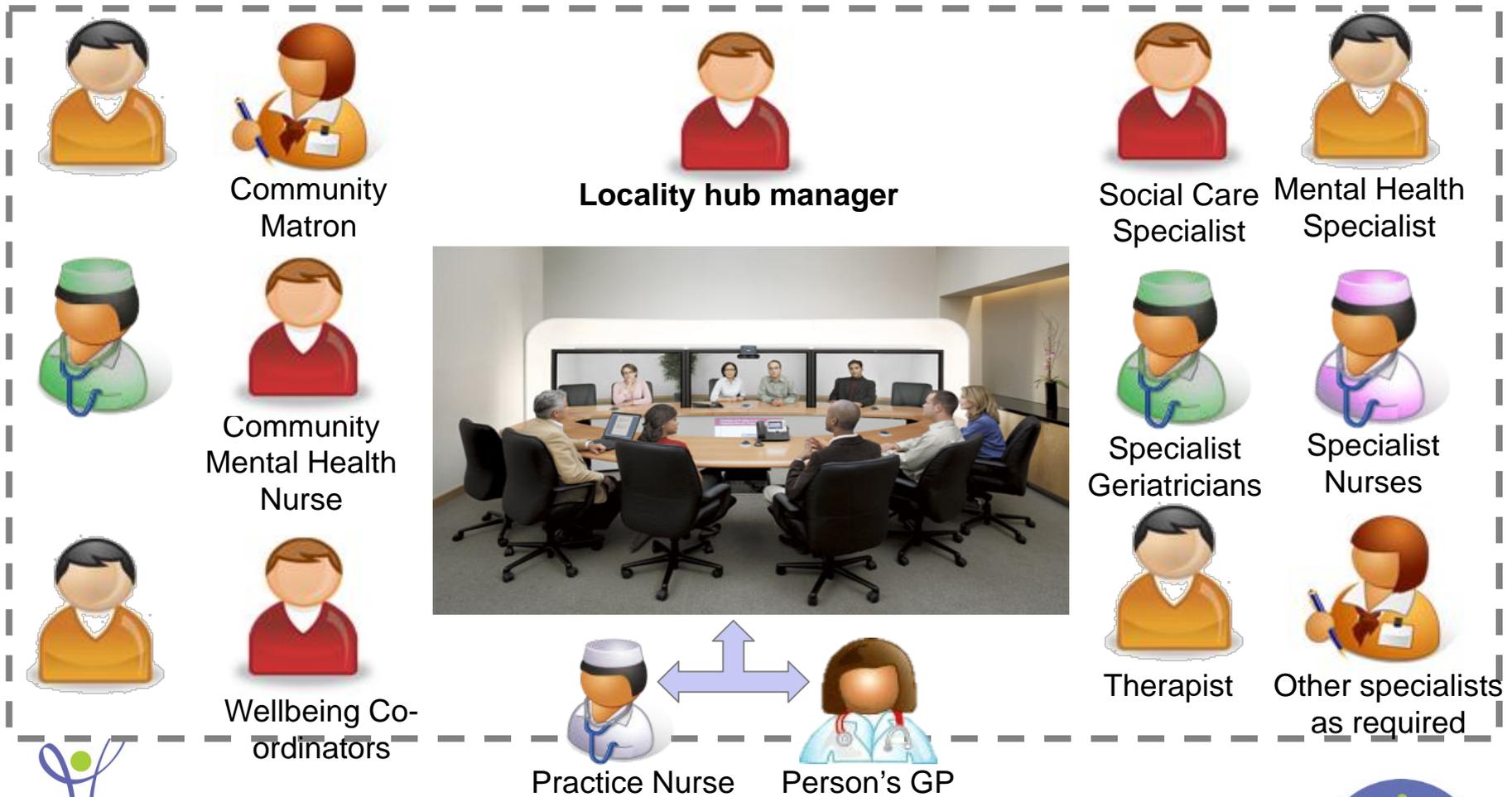


...and so Locality Hubs were born!

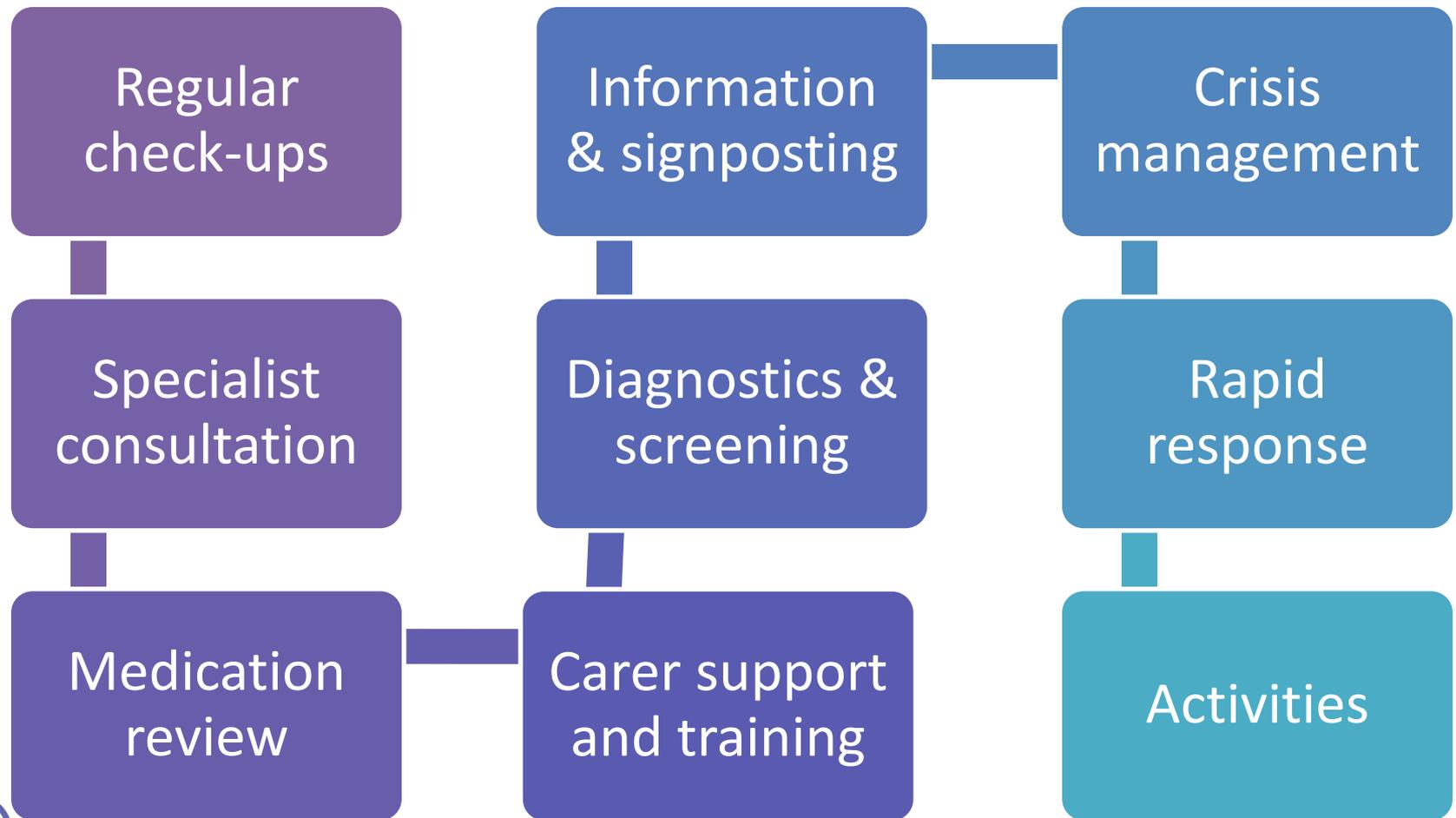
- **A physical space** within a community hospital providing an **integrated frailty service** for **people & their carers** with all locality GP practices and services operating in a **provider network** underpinned by a **single care record** within the EMIS platform
- People are referred to the Hub from local services based on flags for high risk and formal screening at GP surgeries
- The Hub provides out-reach to care homes where required, and into hospital to proactively pull people through the urgent care system
- Transport is provided as routine for hub patients



A multi-disciplinary team approach is key to the hub's success



... and offers a wide range of services in a single location





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Our initial results



c.2000 people are registered with the Bedser hub today and we have seen some encouraging early results

- A&E attendances 
- Ambulance Conveyances 
- Emergency Admissions to Hospital 
- **Strong Positive Feedback from Patients & Clinicians** 



Friends and Family Feedback

	Average satisfaction	No. of surveys
March	5.00	6
June	4.90	20
July	4.83	18
August	5.00	4
September	4.88	9
October	5.00	7
November	5.00	24
December	5.00	26
Average	4.95	114

Qualitative Feedback

“Great to have it all under one roof less anxiety at the Bedser hub my husband is much more relaxed”

“The Hub has made such a difference to both of us. We know who we are going to see each time we visit. There is never the common mantra of ‘your file is missing’ because it is all there on the computer. I hope this service can be extended to many parts of the country.”

“When there was a problem, my husband was able to have an x-ray along the corridor and be back with the doctor looking at the results on the screen within half an hour.”



Clinicians like it too...

“[Older frail] people come to hospital because their social and functional needs are not met in the community and hence they pitch up in A&E as an emergency admission. In this Hub setting, specialists and generalists work well together, removing that divide between primary and secondary care.”

“People who are elderly with complicated needs are difficult to sort out in the restricted time that is available in general practice. In a consultation you will only have enough time to deal with the immediate problem, whereas at the Hub we have a bit more opportunity to talk to people and we can identify the key problems – there is often more than one.”

“Collaborative working at the Hub has enabled GPs to build their confidence in managing the very frail with complex co-morbidities. Providing regular geriatrician sessions alongside the GPs, along with regular training sessions in various aspects in geriatric medicine allows collaborative working and up-skilling.”



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Challenges, Successes & Learning



We've had a number of challenges...

- The original search did not identify as many patients as the modelling suggested
- Some people refused attendance as they felt themselves to be 'too well'
- Patient assessments took longer than originally anticipated, resulting in increased impact on Hub activity
- Patients found it too tiring to see everyone on a single visit and didn't like practitioners rotating around them
- We initially underestimated the culture change required to work in this way



...and many successes

- Delivered primary care leadership with GP cover at all times, and secured the buy-in of our practices
- Integrated health, social care and the voluntary sector to provide a one-stop shop of services
- Wellbeing co-ordinators provided by the voluntary sector as named key workers for all clients, ensuring access to all relevant support within and beyond the Hub and providing regular follow up of all patients on the caseload
- Socialisation and engagement activities at the group and community level - including provision of exercise classes in the Hub
- Used EMIS to provide a single care record for each patient, which is available to all professionals in the Hub
- Transport provided for all clients to facilitate attendance at the Hub



Overall we have established a set of clinical principles that are having a measurable for a complex patient cohort

But...the work continues...

Any Questions???

