Your Care, Your Future

Working together for a healthier west Herts

Update to Dacorum District Council

9 September 2015

NHS Herts Valleys Clinical Commissioning Group

Hertfordshire Community NHS Trust

West Hertfordshire Hospitals NHS Trust

as one

Hertfordshire Partnership NHS University NHS Foundation Trust

East of England Ambulance Service NHS Trust

Hertfordshire

Key objectives

1. Recap on:
    - Objectives of the Strategic Review
    - What's driving the Case for Change?
    - Principles underpinning the future model of care for West Hertfordshire

2. Developing proposals for Dacorum

3. Discussion

4. Next steps

Who are we?

- Hertfordshire County Council
- NHS Herts Valleys Clinical Commissioning Group
- West Hertfordshire Hospitals NHS Trust
- Hertfordshire Partnership University NHS Foundation Trust
- Hertfordshire Community NHS Trust
- East of England Ambulance Service NHS Trust

Your Care, Your Future

The review has been addressing the following four questions:

1. How well (how effectively and efficiently) are patients' needs met by the current health and social care system across west Hertfordshire?

2. What are the opportunities to meet future health and social care needs of the west Hertfordshire population more effectively and efficiently?

3. How should health and social care services across west Hertfordshire be configured to realise these opportunities?

4. What organisational form(s) and commissioning/contracting model(s) best support the deliver of the preferred future configuration of services?

What's driving the Case for Change?

- **Patient needs not being met**
- **Demographic changes**
- **Variation in performance**
- **Financial pressures**
- **National challenges and the *Five Year Forward View***
- www.yourcareyourfuture.org.uk/case-for-change/

What we have heard

Key themes that emerged from stakeholder engagement to date include:

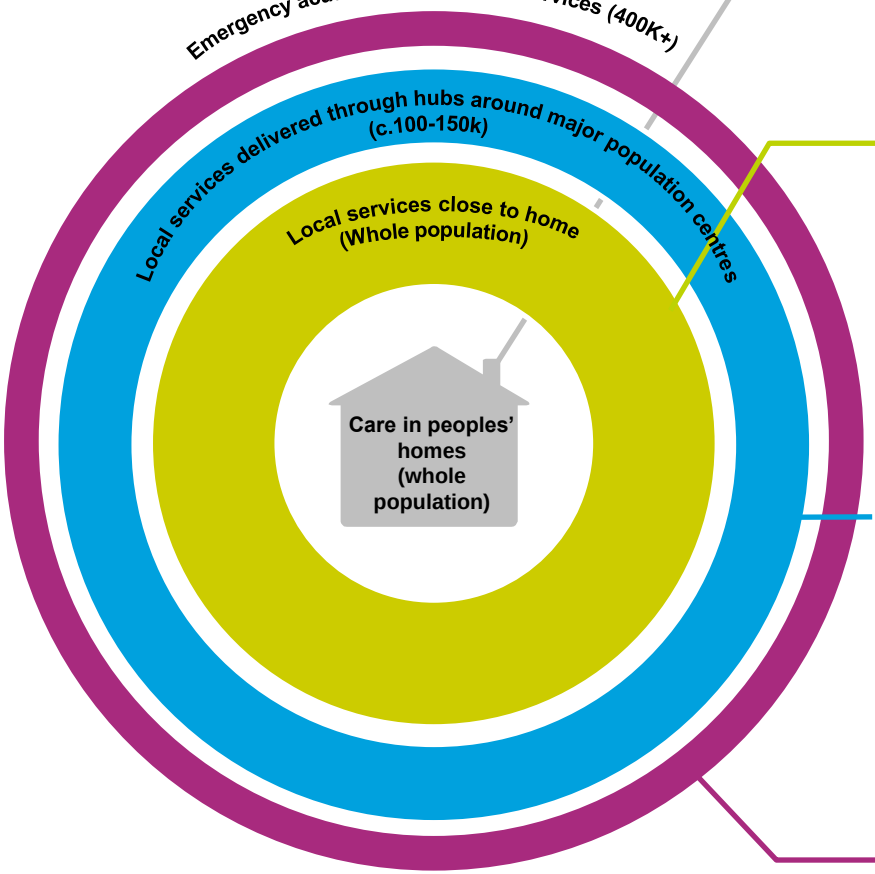
- ✓More patient-centred care and care closer to home;
- ✓More effective prevention to support people to stay well;
- ✓Better access to services, particularly primary care;
- ✓Better signposting to services and services being more joined-up;
- ✓Making efficient use of facilities and estates; and
- ✓Better community care for older people.

Note: Messages are accurate as of 15/07/15

This is leading to developing proposals for the future that will look and feel different

- Greater emphasis on prevention and support to stay well.
- A foundation of joined-up services provided closer to people's homes – multi-specialty teams operating across clusters of GP practices to include a care navigator, district nurse, community care, specialist care, social care worker and community psychiatric nurse.
- Health and social care providers (including the third sector) will be better connected with each other. This will mean patients find it easier to access the right care and because information will be shared more effectively they won't have to repeat their story over and over.
- Some services will benefit from co-location in a physical space. The type and amount of services provided will be designed to meet the needs of the local population.
- Specialist services will be delivered to a population size of 400,000+. This will include things like vascular, acute stroke care and aspects of cancer and paediatric care.

The Future Model of Care – developing proposals



The "Foundation"

A foundation of existing and new services provided within peoples' homes

Health and care services delivered in peoples' homes

Our fundamental offer, consistent across all Localities

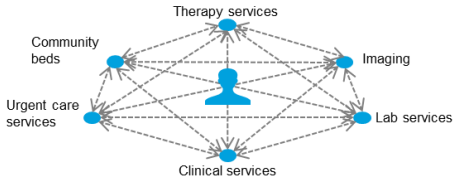
GP assesses needs of the person through risk stratification

A joined up care model, patients are actively managed within primary care and a multi-specialty team offers the right support based on the needs of the person

Communal spaces
Wellbeing services
Primary care
Pharmacy services

Flexed according to the needs of the local population

Some services will benefit from co-location in a physical space. These services will be flexed according to the needs of the local population



Therapy services
Imaging
Lab services
Clinical services
Urgent care services
Community beds

Delivered in defined centralised locations

Specialist services will be delivered to a population size of 400,000+

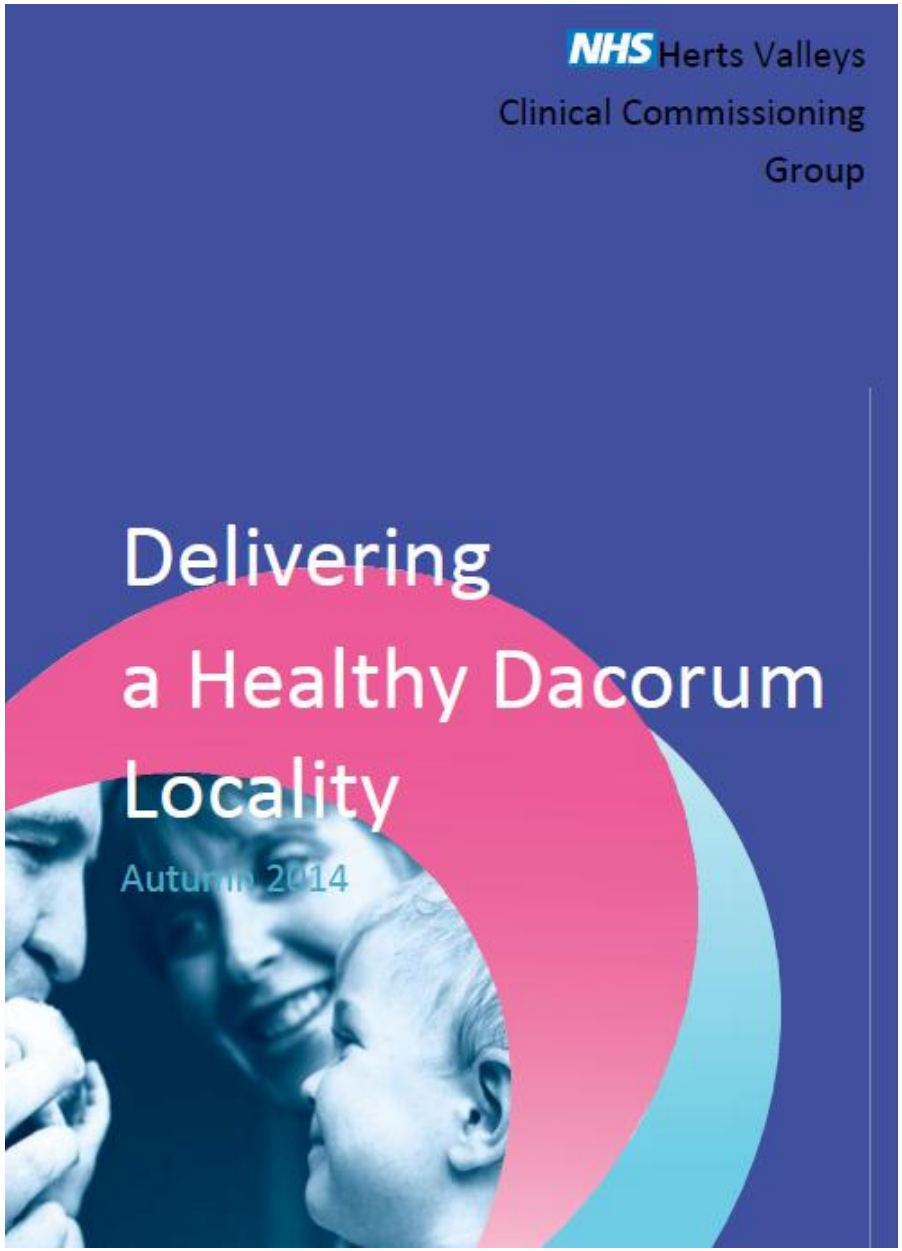
Emergency acute care & specialist services

Planned care & complex diagnostics

Specialist mental health

Emergency acute care
Specialist acute services
Planned care
Complex diagnostics
Specialist mental health

Developing proposals for Dacorum



Potential ‘hub’ at Hemel Hempstead – key features

Co-location of integrated health and social care teams in a physical facility

- A common team ethos and mind-set, joined-up working, training and processes

A network of joined-up local health and social care services closer to home

- People will be able to access GPs and other primary care services in the ‘hub’, and in existing practices and community facilities in and around the locality. Health and wellbeing services will also be available and ‘hub’ services will be linked with emergency, specialist, community and social services
- Most primary care will continue to be delivered in existing GP practices and other community-based settings.

Community services from the ‘hub’ will:

- Enable the co-location of teams, better joint ways of working, and as a result greater opportunities to reduce overlap in services across organisations

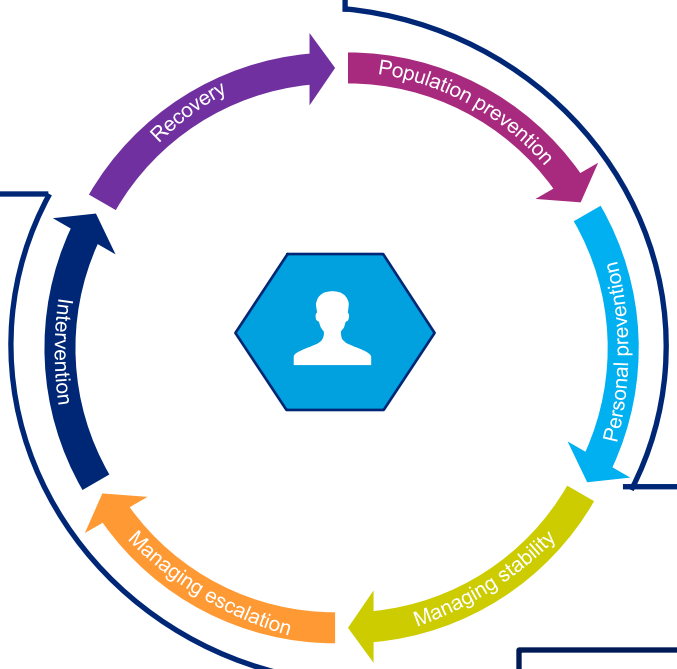
Emergency services

- Joined up care in ‘hubs’ closer to home aims to provide an improved urgent care offer which will improve accessibility and reduce hospital admissions

An example hub for the frail elderly in Dacorum

Future model of care

Adam is 82 year old man that lives alone in Hemel. He likes to do his chores by himself, but lately has been feeling short of breath. Adam is identified by his social worker as a older person living alone and a comprehensive geriatric assessment is completed. A care plan is developed which involves his GP and other care professionals. His GP plays a bigger role working out of the hub in Dacorum where Adam can find out help from local voluntary groups. He mainly interacts with the hub and only goes to hospital when there is really a need. He has access to a community navigator and a rapid response service for times of crisis that keep him in Dacorum.
His son, who takes care of him, feels fully supported and linked in to the community.



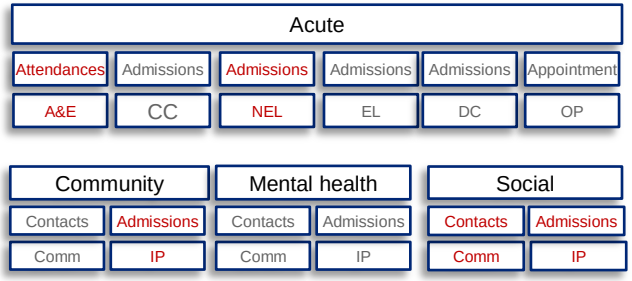
Model of care when things go wrong

Adam is an 82 year old man that lives alone in Hemel Hempstead. He likes to do his chores by himself, but lately has been feeling short of breath. During his normal walks, he feels light headed and falls.

He is taken by ambulance to Watford General Hospital's emergency department, where he is then admitted and stays for 2 weeks losing his independence, becoming even more frail.

When Adam is discharged, services back in the community are not joined up between his GP and the rehabilitation and re-ablement teams

Impact



An example for people with long-term conditions

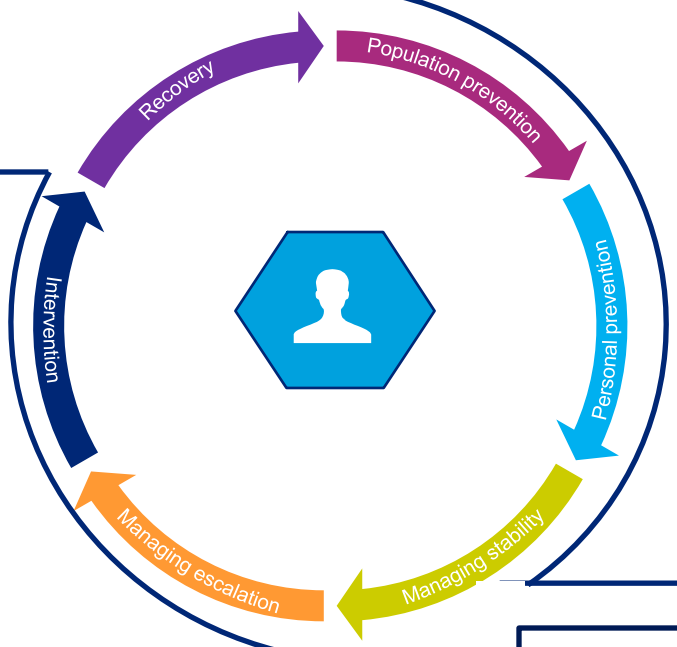
Future model of care

Claire is 58 years old and suffers from diabetes and chronic heart failure. Despite having recently lost her job, Claire has been managing her conditions well due to the support of the services she can access in the hub. An MDT has defined a care plan where she receives planned and ambulatory care at the Hemel hub, including her specialist appointments, when needed. Referral support for planned care will be managed and delivered through primary care. Acute services will only be used when they are necessary and are the best options for Claire.
She is involved in several voluntary groups at the hub, which help her keep active and she's also working on improving her skills by accessing the educational courses in her community.

Model of care when things go wrong

Claire is 58 years old and suffers from diabetes and chronic heart failure. She has lived well with her long-term conditions but has recently lost her job and began to show some signs of depression.

She has been in and out of the hospital several times with urine infections and cannot keep up with all the appointments she needs to attend at Watford General Hospital
(endocrinology, cardiology, etc.). These appointments are at different days of the week and do not help her find time to focus on finding a new job.



Impact

Acute					
Attendances	Admissions	Admissions	Admissions	Admissions	Appointment
A&E	CC	NEL	EL	DC	OP

Community		Mental health		Social	
Contacts	Admissions	Contacts	Admissions	Contacts	Admissions
Comm	IP	Comm	IP	Comm	IP

Moving towards options for future hospital care

- Alongside the provision of more joined-up care closer to home, a long-list of options for acute care is currently being reviewed and analysed.

- These are undergoing a robust scoring process to determine the most beneficial options for patients and local residents.

- This will include local stakeholders including local patients, carers, clinicians, third sector representatives and service delivery partners.

- Following this process a short-list of options will be proposed to the Boards. If adopted, the short-list would then be tested with local residents, patients, carers, clinicians and other stakeholders.

Current hospital configurations under discussion

Option 1	Consolidate all acute care services onto a single site at “another site”
Option 2	Consolidate all acute care services onto a single site at WGH
Option 3	Consolidate acute, emergency and specialised care services at WGH. Deliver the majority of planned care (day case only*) and complex diagnostics at SACH.
Option 4	Consolidate acute, emergency and specialised care services at WGH. Deliver the majority of planned care (day case only*) and complex diagnostics at HHH.
Option 5	Consolidate acute, emergency and specialised care services at WGH. Deliver the majority of planned care (day case only*) and complex diagnostics at “another site”.
Option 6	Consolidate acute, emergency and specialised care services at “another site”. Deliver the majority of planned care (day case only*) and complex diagnostics at WGH.
Option 7	Consolidate acute, emergency and specialised care services at “another site”. Deliver the majority of planned care (day case only*) and complex diagnostics at SACH.
Option 8	Consolidate acute, emergency and specialised care services at “another site”. Deliver the majority of planned care (day case only*) and complex diagnostics at HHH.

Next Steps

- **11 September 2015** – stakeholder engagement group to review and quality assure some of the options for future acute hospital care

- **23 October 2015** – joint boards meeting to approve and adopt the Strategic Outline Case

- **October 2015 and beyond** – ongoing engagement with local community, stakeholders, patients and carers on implementing joined-up services closer to people's homes.

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Thank you

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