Report

Hub Update

Edinburgh Integration Joint Board

15 July 2016

1. Executive Summary

1. The purpose of this report is to update the Edinburgh Integration Joint Board, (IJB), on the outline for the roll out of the localities Hub model, with a description of the key services that will be included in the Hub, as requested at the 13 May IJB.

1.1 It has come to this meeting as a current standing item.

2. Recommendations

To accept the report as assurance that the Edinburgh Health & Social Care Partnership (EHSCP), is taking a whole system approach to improve the effective use of resources to improve pathways for our adult population.

3. Background

3.1 The Scottish Government's 2020 Vision is that by 2020 everyone is able to live longer healthier lives at home, or in a homely setting, through:

- integrated health and social care
- a focus on prevention, anticipation and supported self-management
- where hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm
- regardless of setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions
- a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission

3.2 Moving this thinking forward within the partnership, consideration has been given to the services and functions within the locality Hub, as it develops. These current services and teams are valued contributors to improving outcomes for people and the organisation, however it has been considered by

those who deliver the services, and wider evidence that, for community services to work effectively and efficiently, the following is required:

- complexity needs to be removed that has resulted from different policy and project initiatives over the years
- a simple pattern of services should be developed, based around primary care and natural geographies and with a multidisciplinary team
- these functions need to work in new ways with specialist services – both community and hospital based, to offer people much more streamlined and less fragmented service, including less hand-offs
- new models need to include the management of the health and social care budget for the care of their population
- these more comprehensive and cohesive functions need to be capable of a very rapid response to ensure people can be maintained at home, and to work with hospitals to enable timely discharge
- access to community or nursing home beds for short stays can make an important difference

4. Main report

Hub and Cluster Model, with Triage function

4.1 Through previous IJB papers it was noted that the development of the **Locality Hub** model is underway, which is associated with the new integrated health and social care organisational and management structure proposals. The shape of the Hub is currently being developed through due engagement, governance and consultation processes across NHS Lothian and City of Edinburgh Council health and social care. This process predicates timelines for implementation, which are illustrated later in this paper.

4.2 The aim of the Hub is to improve and optimise a way of collaborative working in Edinburgh, to an assets based approach, optimising access to all the community resources from all providers, and improve integrated working across Acute, Primary care and Health & Social Care services, ensuring people are in the right place at the right time by:

- preventing avoidable admission
- increasing the number of supported discharges in each locality
- developing a co-ordinated, responsive and preventative model of care through the locality hub approach

4.3 The development of the Locality Hub will provide a strong foundation, allowing all those who provide care to become aware of their population needs across the locality. This will provide better opportunities to provide a focus on prevention, early intervention and self management, alongside ensuring people remain in, and return to their communities as quickly as possible. This is seen as a key gain of integration. Those involved in the Hub includes:

- social care workers
- nurses
- occupational therapists
- physiotherapists
- pharmacists and other allied health professions
- housing workers
- third sector
- independent providers
- doctors

4.4 With this in mind, the thinking around the Hub model is becoming clearer, with it being most effective for:

- Urgent and new referrals
- Immediate assessment
- Short term interventions up to six weeks

4.5 It is anticipated that as is the case at the moment, Social Care Direct will undertake the initial screening process, and this will be developed to become the Care Direct process, where a wider group of people can access the Hub functions:

Access to the Hub Via 'Care Direct'

- **Hospital referrals**
- **GPs**
- **Police**
- **Ambulance Service**
- **Third Sector**
- **Self referrals**
- **Community health and social care referrals**
- **Other professionals, including Housing**
- **SEFAL (Safe Effective FLow Across Lothian)**

4.6 Recent thinking has more clearly defined the *Huddle* function as a **Multi Agency Triage Team, (MATT)**, which will meet within the Hub to determine immediate responses that may be required to maintain people safely at home, or enable their discharge from hospital. Various people will be present within the MATT, including:

4.7 It is proposed that the each Locality Hub will have a number of services, both council and NHS, which are locally delivered, with all management posts integrated. The multi agency triage team arrangements will consider all **new and urgent referrals**. Close links with the wider Council Community Planning and Place Locality structures will be made, with housing, third and independent sector colleagues being integrally linked in as well.

4.8 The social care and NHS specific **Hub functions**, that will make this multiagency **urgent response** possible, will it is proposed, as part of the Organisational Change, include the re-ablement, intermediate care, care at home, hospital at and to home functions. These functions include a wide variety of professions, including:

- social care workers
- nurses
- occupational therapists
- physiotherapists
- pharmacists and other allied health professions
- housing workers
- third sector
- independent providers
- care at home
- doctors
- others as required

4.9 There will of course be elements of 'Business As Usual' for those who are known to services and supports. This **longer term care, support and maintenance**, will be provided through the **Cluster Functions**, with it being proposed, that this will include, wider community nursing, packages of care, technology solutions for care and support, third sector and wider community supports. These functions too will include a variety of professions, including:

- social care workers
- nurses
- occupational therapists
- physiotherapists
- pharmacists and other allied health professions
- housing workers
- third sector
- independent providers
- doctors
- others as required

4.10 **Wider community assets** focussing on tackling inequalities, preventative supports are also key elements to the whole system approach to maintaining independence and well being, see proposed illustration below:

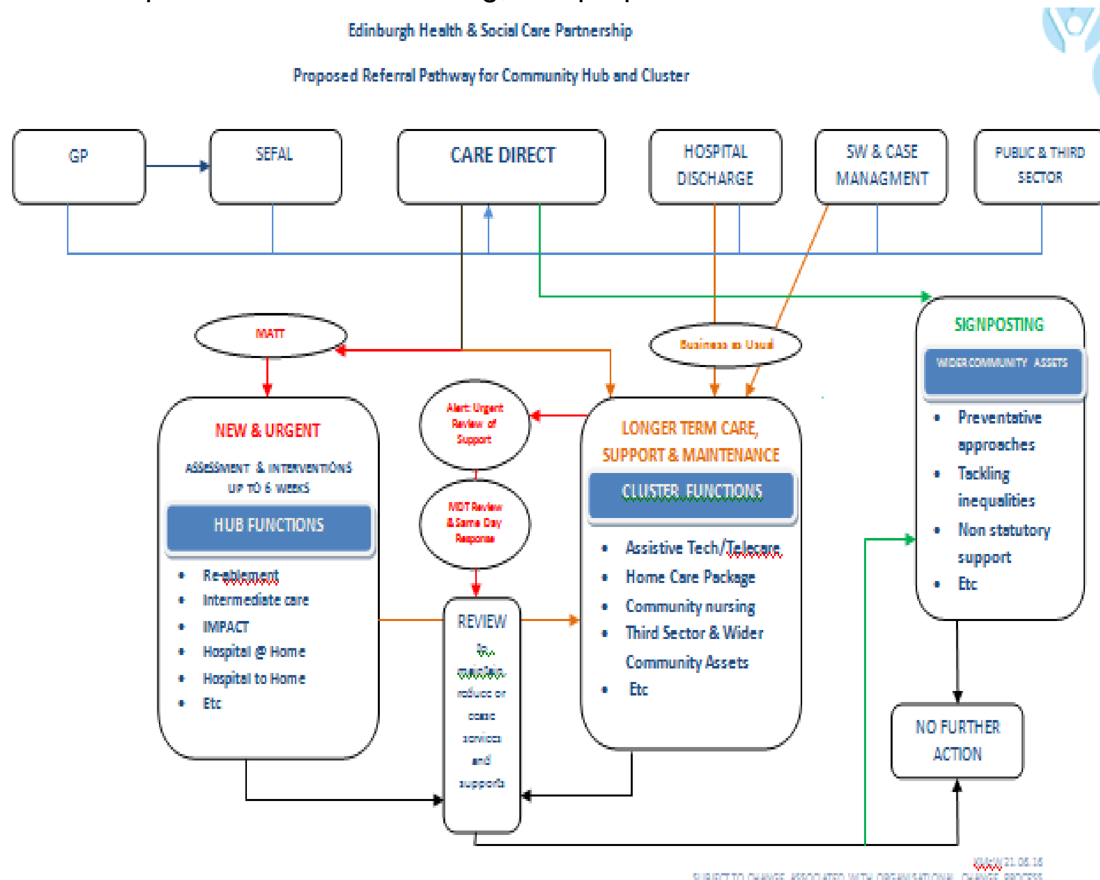

Illustration of proposed Pathway for Community Hub and Cluster Pathway
SEFAL - Safe & Effective Flow Across Lothian

4.11 Locality Mental Health and Substance Misuse services are already integrated, and include the Recovery Hubs, in which third sector partners play a significant role, and it is proposed that these continue to operate with close links to the adult Hubs described above.

4.12 Key discussions to ensure awareness and links are made are underway with colleagues across the localities, primary care, Lothian Unscheduled Care Service, third, independent and housing sectors, as well as the newly formed Safe & Effective Flow Across Lothian (SEFAL) team.

Time lines

4.13 As part of the current formal Organisation Change Process, it is anticipated that the Hub and Cluster Managers will be in post in early September 2016, they will be instrumental in taking this cohesive approach to meeting needs forward.

4.14 The proposed composition of our management arrangements in each Locality across the Hub and two Clusters, per Locality, will include a Registered Social Worker, Nurse and Allied Health Professional. These posts will operate on a matrix management model, whereby they will line manage the team for which they are directly responsible, and will also have governance responsibility for the quality of the work undertaken within their registered profession across the whole Locality.

4.15 The Key Timelines are highlighted, taking into consideration Phase 1 and Phase 2 of the Organisational Change process are illustrated below for implementation of the MATT, Hub and Cluster functions:

	2016									**2017**		
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Test, refine and apply Huddle/MATT Function								MATT fully implemented				
Develop Phase 1 Organisational Change Proposals												
Phase 1 Org Change Consultation												
Phase 1 Locality, Hub, Cluster & Strategic Managers Confirmed												
Formation of Locality Implementation Board												
Phase 2 Org Change Development												
Phase 2 Org Change Consultation												
Phase 2 Hub & Cluster staff recruited to												

Note the MATT, Hub and Cluster functions will be implemented throughout autumn 2016 and early Spring 2017 as staff teams are realigned to the new management positions which will be completed by the end of September 2016.

On-going Work

4.16 Phase 1 of the organisational change process will be complete by September 2016. This will allow the confirmation of the geographical locations of where the Hub function will be based for each locality.

4.17 Phase 2 requiring careful consideration, as this includes incorporating the wider implications of the Transformation agenda, with the creation of new posts to populate the Hub and Cluster models, to enable a truly integrated workforce going forward. Given the complexities of Phase 2, additional project management support has been secured to ensure this process moves as swiftly as possible. With this support, it is anticipated that all staff will be recruited no later than February 2017.

5. Key risks

5.1 Key risks to the Hub and Cluster model not being implemented are associated with the Organisational Change process. Delays may impact quality of care and experience, and performance against standards and targets for delays in discharge. In time, the performance information will clearly identify progress made across Edinburgh, however there is pressure to deliver quickly, which is not always conducive when major organisational change, with staff requiring support along the way.

5.2 If due process of engagement, involvement, consultation and communication about the wider Hub proposals are not robust, and don't include learning from experiences thus far, to inform the process going forward, there is a risk that the there may be resistance to change operationally in the long term.

5.3 It is recognised that this programme of work is significant and requires support both locally and strategically to ensure successful implementation. Locality Development Managers, the Hub and Cluster Managers and Strategic Programme Manager will be supported by the formation of the Locality Implementation Board, to ensure implementation, impact is measured, continuous quality improvement and learning occurs. As these are key actions in the Strategic Plan, this work will report to the Strategic Planning Group in the first instance, and to the IJB by exception.

6. Financial implications

6.1 The full restructure will meet savings targets across 16/17 and 17/18 of £11.2m.

7. Involving people

7.1 Edinburgh Partnership has engaged with, involved, and consulted with the local population, staff and other stakeholders and had in place a formal consultation process as part of developing the Strategic Plan, with the development of Locality working being a key action to deliver against the agreed priorities within the Strategic Plan.

7.2 Much of the current thinking about the Hub, multiagency triage function, and Cluster model is based upon the learning from those who have been testing the triage function across the localities and from the recent learning event about how to progress the model to implementation.

7.3 Health and Social Care Interim Locality Managers, and professional leads continue to engage and involve stakeholders across their localities and communities.

8. Impact on plans of other parties

8.1 The key impact of the Hub development is on the whole system pathway for adults, and in particular older people, which will impact partners across community social care and health care, housing, third and independent sectors, and acute care.

Background reading/references

Scottish Government 2020 Vision
http://www.gov.scot/Topics/Health/Policy/2020-Vision

Community services: How they can transform care, Nigel Edwards, 2014
http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/community-services-nigel-edwards-feb14.pdf

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Links to actions in strategic plan

1. Ensure local collaborative working arrangements across partners
2. Establish integrated Teams to support flexible working
3. Establishments of locality hubs
4. Establishment of clusters

20. improving the interface between primary and secondary care

23. Embedding rehabilitation, re-ablement and recovery approaches

38. Increased use of technology enabled care

Links to priorities in strategic plan

Priority 1- Tackling Inequalities	In particular being an active partner in the locality based multi-agency Hubs designed to tackle inequalities, and engaging with a wide range of community based organisations at the locality level in a preventative approach which recognises and works alongside community assets
Priority 2 – Prevention and Early Intervention	People will be supported through appropriate response, to remain at home or in a homely setting
Priority 3 – Person Centred Care	Care and interventions will be wrapped around the individuals, with the most appropriate response from the statutory, third or independent sectors being arranged.
Priority 4- Right Care, Right Time, Right Place	People will be supported at home for as long as possible, and will only remain in hospital for as long as is required, with timely discharge being arranged.

Priority 5 – Making best use of the capacity across the system	It is clear form previous recommendations associated with Living Well in Communities and delayed discharge management, that there is room for improvement to make better use of workforce, capacity and financial resources in a more cohesive way
Priority 6 – Managing our resources effectively	As priority 5