WELLBEING HUBS

Update and timeline

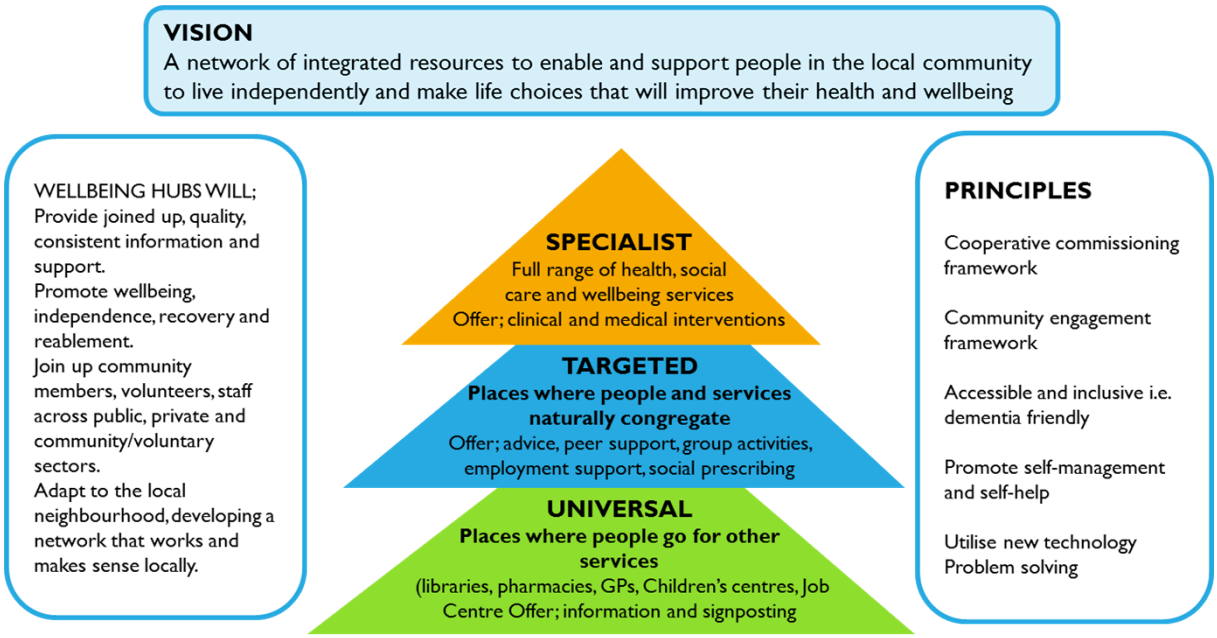
Aims of wellbeing hubs

What we are seeking to do with wellbeing hubs;

1. Align services so that they work better for people, giving them a coherent 'journey' through the services that they may need to improve and promote their own health and wellbeing. This is particularly aimed at helping people to find services that are more appropriate for their need than a GP/A&E.
2. Help people and communities to support each other, by bringing the current CVS services and opportunities to meet and take part into contact with more people. This will support a shift from GP to wellbeing service, from wellbeing service to community support, then from user of community support to a volunteer supporting others generate more volunteers and therefore widen the opportunities and the benefits.

Both of these aims result in finding the most cost-effective intervention for the person when they need it.

It should be noted that the hubs have been designed to reduce spend from the commissioned contracts; saving approximately £200k per annum. There is an initial investment, in the order of £260k.



How this links with deprivation

Need is the ability to benefit from an intervention; demand reflects whether someone with a need presents and asks for the support. The Inverse Care Law shows that people in more deprived areas are less likely to ask for help, even though they have need. In less deprived areas, people will ask for help, and will ask for it earlier, meaning that they are more likely to receive the early intervention services, which we know has a positive effect on health and wellbeing.

In our more deprived areas, we want to do two things;

- help those who are seeking support by making the right support easily available to them (social prescribing and wellbeing services). This will make GP visits less frequent but more effective as some of the underlying issues are improved
- help those who are not currently seeking support but do have high risks (these might be social, or they might be linked to lifestyle, or both). This will help to prevent declining health and wellbeing

We anticipate that we will see increasing demand for wellbeing services, but some reducing demand for GPs and other medical specialists as we shift to more cost effective care.

In areas of lower need, we want to bring the community together to tackle some of those things that will relieve pressures on some of our services. For example, social isolation is as bad for health as smoking but is entirely avoidable if the community work together and are inclusive; and have help to reach the people in need. This provides a reduction of resources needed in these areas allowing a flow towards more deprived areas.

LOCATION OF HUBS

Targeted Hub Locations

A piece of work considered factors which would influence the locations of hubs (there was a desire to have at least one hub in each of the localities used by Livewell SW, to incorporate community services).

This looked first at high use of healthcare services (since an aim is to reduce demand to more cost-effective interventions) and need, current provision/assets in the local area, and then suitability of buildings.

Key points were;

- Populations under 5 years and over 75 years are generally considered to be the highest users of health and care services and so illustrate where additional need may be present over and above that of the general population.
    - Greatest concentration of under 5 population in West locality – Barne Barton and Honicknowle neighbourhoods.
    - Greatest concentration of over 75 population in East Locality but with smaller concentrations in North and South. Neighbourhoods with particular concentrations – Colebrook Newnham and Ridgeway, Plympton St Maurice and Yealmstone and Elburton and Dunstone.
- The general Index of Multiple Deprivation enables areas to be identified where deprivation is highest. Deprivation is a determinant for many health and care needs.
    - Greatest concentration of deprivation as measured by IMD is within the West Locality but with significant concentrations in North and South. The most deprived LSOAs [lower super output areas] are within the following neighbourhoods – Barne Barton, Devonport, North Prospect and Weston Mill and Stonehouse.
- Asset mapping took place, looking at community facilities already present and what was offered at each one. This identified that, although most areas already had some assets, the city centre and Devonport areas already had considerable assets which could be developed into hubs relatively easily. It was decided that development of hubs in these areas should be part of phase 2/3.

Buildings

In order to identify potential buildings for 'targeted' hubs, a desktop feasibility study was completed. This considered and scored potential locations based on space, accessibility, sustainability, statutory requirements, current usage, and connectivity.

Following that, consultation was carried out with providers and specific groups likely to use hubs as well as the public (led by Healthwatch). The final buildings were agreed at Cabinet in January 2018.

The current list of Hubs is as follows, the opening timelines are based on a combination of prioritising deprived areas where needs are greater and opportunistic use of existing buildings where space can be created. Where new builds may be required we will work to deliver an 'interim' hub building, estimate openings relate to the 'interim' hub openings and don't reflect any required building works.

Specialist Health Hubs		Estimate Opening
Cumberland Centre	The Cumberland Centre is an Urgent Treatment Centre including locality mental health teams, which will incorporate the full range of Wellbeing Hub Services; it also has a large GP Practice and a pharmacy within the same complex.	**March 2019**
Mount Gould Local Care Centre	Mount Gould is subject to a master planning exercise which will result in more acute services being delivered here and will include GPs and wellbeing services.	**October 2019**
Derriford Hospital	Derriford Hospital is a large teaching hospital serving Plymouth and nearby areas of Devon and Cornwall. It is a regional trauma centre and also provides tertiary cardiothoracic surgery, neurosurgery and renal transplant surgery for the South West Peninsula. Many people attending hospital have the capacity to benefit from the services being offered as part of Wellbeing Hubs, and being able to start to support people during an attendance or an admission is likely to help their health and wellbeing as well as having the potential to reduce demand on the hospital.	**TBC**
Targeted Health and Wellbeing Hubs		
Ocean Health (Stirling Road)	Ocean Health is GP Practice, in a deprived area. The Wellbeing element of the hub will be delivered across 3 locations in a hub-and-spoke manner; the GP practice, the local library (St Budeaux) and in Barne Barton Pharmacy (Barne Barton is an isolated deprived area).	**March 2019**
City Centre	In early stages of planning, it is hoped to develop a GP practice, Dental surgery and Wellbeing Hub in a city centre building. This may also include relocation of an existing Young People's support services providing much better facilities. We aim to locate this in an area in the city centre that is easily accessible and regularly used by our most in-need communities; close to other facilities such as pharmacy and Council 'First Stop Shop',	**March 2020**
Estover	Building yet to be identified, will work with GPs and Livewell Southwest to identify a building	**March 2020**
Efford TBC	Council owned Youth and Community Centre, OPE plan to redevelop site as a health and wellbeing hub including a GP practice and pharmacy, youth and wellbeing facilities	**March 2020**
Stonehouse	A 'Complex Lives' hub, based in one of our most deprived areas, which will provide services for people and families with significant health, social and wellbeing challenges (such as the homeless and those with substance misuse issues). This will include a GP practice with specialist skills working with this group. Being led by CVS.	**TBC**
Rees Youth Centre, Plympton	Discussions are underway around the development of a 'Primary Care Home' Wellbeing Hub to explore further the potential of this model of healthcare for potential spread across the city. This is based in one of our less deprived areas, so offers less opportunity for reducing inequalities but does offer potential for shifting demand to lower cost services. Timeline to be confirmed	**TBC**
Targeted Wellbeing Hubs		
Jan Cutting Healthy Living Centre	Wellbeing Hub in a deprived area, providing full range of support to the local community. Includes Head Space, an out-of-hours service for people who consider that they are approaching a mental health crisis. This runs in a non-clinical setting with a safe, calm and structured environment, with the goal of de-escalating crises.	**OPENED March 2018**
Four Greens	A Community Economic Development Trust in a deprived part of the city, already includes a Children's Centre and community activity; is	**OPENED October 2018**

	now developing an offer for people with long-term conditions including time banking, education, peer support; is a target area for the National Diabetes Prevention Programme	
Improving Lives, Mannamead	A Wellbeing hub with a specific remit to work across the city to promote and improve the health of some specific groups in the population who are in need, including veterans, carers, people with learning disabilities and those with Sensory disabilities.	**7th November 2018**
Southway TBC	Building yet to be identified, possibly the Council Community Centre and Children's Centre	**March 2020**

COMMISSIONED SERVICES BEING REMODELLED FOR WELLBEING HUBS

The following list describes services that consultation has suggested need to be available in each hub. There are citywide commissioned services available to provide these services and in some instances the hubs will provide these services themselves. The citywide services will be targeted and aligned to support each hub according to hub requirements and the needs of each community

Advice and Information. The citywide commissioned information and advice provider will offer training, consultancy and outreach to the hub. Any service commissioned locally by one of the hubs to provide information and advice will need to work with the citywide commissioned service to ensure that there is good quality information and advice being given.

Social prescribing. The Wolseley Trust holds a PCC contract to deliver a social prescribing programme across 12 neighbourhoods in Plymouth. The service will work with each hub as it rolls out to ensure that the social prescribing link worker based in the GP practices is linking people into the appropriate hub. The hubs will be expected to have a good local knowledge about opportunities to support people.

Befriending. A befriending service will provide 1-1 and group befriending in the geographical area of the Wellbeing Hub

Time banking. The time banking service can support the hub to develop a local time bank and referrals can be made from the Wellbeing Hub to the commissioned time banking service

Health Improvement. Livewell Southwest One You Service will provide healthy lifestyles advice and services within the Wellbeing Hub and surrounding areas according to need

Mental and Physical Health/Long-term conditions support services. A range of generalist and specialist support will be offered to people using the wellbeing hub with mental health and long-term conditions needs. There will be a clear referral process into these services which are in the process of being reshaped but currently consist of the Stroke Service (Stroke Association), Mental Health Support (Rethink), Recovery College (MIND), the Sensory Support Service (Improving Lives Plymouth) and the Mental Health drop-in (Crossroads).

Long-term conditions self-management and education. Commissioners and providers will work with the hubs to offer options for long-term conditions self-management support which will include education programmes and outreach clinics.

OTHER RELATED SERVICES

Livewell South West will work with the hubs to provide an integrated approach to people needing primary care and adult social care support

Carers. The Caring for Carers service will ensure that the hubs understand the support that can be offered to carers and, if possible, some direct support can be provided in each hub including drop-ins and peer support groups.

Community Connections will work with the hubs to provide information and advice to individuals in housing need or who are victims of anti-social behaviour, will support problem solving in neighbourhoods and community regeneration

INVESTMENT IN WELLBEING HUBS

Wellbeing hubs are being developed to deliver cost savings. These savings amount to around £200k per year (potentially more). The one-off investment in wellbeing hubs is relatively small (£260k)

The delivery of the programme is being carried out with minimal resource.

Investment in infrastructure is through partnership working and use of OPE, rather than PCC funding. This requires a collaborative partnership approach.

IMPACT

The benefits across the system have been considered, and will be evaluated, using a logic model approach; there are a number of outputs which will lead to short term outcomes, which will build into longer term outcomes. In the short term, we would expect to see people's key issues resolved; evidence of better financial management, housing problems resolved, learning new skills and gaining work experience, for example. Also in the shorter term, we would expect to see more people in specific cohorts engaging in community activities. In the medium term, this should start to show in improvements in wellbeing, in reduced social isolation and loneliness, in healthier lifestyles. In the longer term, we would expect to see health outcomes improving. All of these have beneficial impacts for the health and wellbeing systems as well as individuals and families.

We will be taking a formative evaluation approach and are working with University of Plymouth through our Thrive Plymouth evaluation. We are determined that the approach taken will be responsive to local needs and local assets and so we will expect to iteratively optimise our approach.

There are some specific programmes and interventions that are evidence –based with known likely benefits; such as smoking cessation, weight management etc. These are already delivered but will be better targeted so we expect to maximise return on investment.

In April 2018, social prescribing was made available to 19 practices across Plymouth (with a further widening in the near future).

The demand for the service has been high and there were 197 new referrals and 132 people who took up the service, which is 345% of the target and the number of hours of support is at 105% of the target. Since starting there has been an average of 11 cases open at any one time per surgery.

It is very early to evaluate any outcome measures; however, of the fifteen people who have passed through the service and completed their journey, thirteen had a significantly improved WEMWBS score at close than at the initial contact; the average metric score for these people at their assessment appointment was 16.4. The average highest metric score during subsequent appointments was 20.56, indicating an overall improvement in mental health and wellbeing for most patients.

A range of feedback has been gathered both from GPs and users of the service;

GP feedback: "The staff at the surgery find the project very valuable and have had no problems with referring to the service. It's difficult to say whether it has helped reduce pressure on GPs as the project is still young and cases are only just starting to be closed with positive outcomes. Feedback generally from staff at a recent Sound Health Alliance meeting was that it's a valuable resource and they would like to see it continue and develop".

Service user feedback;

- *Nine people felt they had achieved their goal totally while working with a link worker, seven felt they had partially and were still working towards it with support from other organisations.*
- *100% planned to continue using the services they had accessed through social prescribing.*

- *Fifteen people said they would recommend the VCS organisation / activity they were accessing, one was unsure.*
- *The average score out of ten for helpfulness of Healthy Futures staff was 9.75.*
- *The average score out of ten for patients to rate their experience of using Healthy Futures social prescribing service was 9.6.*

Comments included;

- *'Helped a lot with losing weight and contacting groups.'*
- *'Getting my life back on track because I wouldn't be here if it wasn't for the team.'*
- *'I feel much more relaxed since seeing Link Worker, she is very friendly and willing to listen, also gave me great advice which has certainly been working, I don't show any aggression like I used to.'*
- *'Made me want to take that step forward. Link Worker has helped me feel more confident and to go out and do it. I feel relaxed and have started eating healthier.'*
- *'I have achieved the goals that were set and am feeling I could maybe achieve much more.'*
- *'I feel Calmer, plus if I start to get worked up, I think what would Link Worker say, so I seem to calm myself down.'*

Evaluation for people who have completed the programme will include a minimum three month follow up.

The Sheffield Hallam University evaluation of the Rotherham Social Prescribing Service[1], found the following reductions in the use of acute hospital services:

- non-elective inpatient episodes reduced by 7 per cent
- non-elective inpatient spells reduced by 11 per cent
- Accident and Emergency attendances reduced by 17 per cent.

Using this evaluation, we anticipate a reduction of 530 non-elective inpatient episodes and 500 A&E attendances per annum, a saving to the system of £702,000 per annum. A review of the evidence[2] on the effect of social prescribing on demand for General Practice, found an average 28% reduction in demand for GP services following referral. Based on the above numbers this would mean an annual reduction of 3 visits per year for 825 people i.e. almost 2500 appointments per year (around £50,000).

Though our initial phase of rolling out will focus around primary care there are many opportunities to connect across the system, and this would be anticipated to directly impact NHS resources. Models of social prescribing could be based around A&E attenders, or around discharges following admissions. We will be working closely with our clinical colleagues to identify appropriate cohorts of people to consider, and then co-design models.

[1] The social and economic impact of the Rotherham Social Prescribing Pilot, Centre for regional Economic and Social Research, Sheffield Hallam University https://www4.shu.ac.uk/research/cresr/sites/shu.ac.uk/files/social-economic-impact-rotherham.pdf

[2] University of Westminster, June 2017, 'A review of the evidence assessing impact of social prescribing on healthcare demand and cost implications' Polley, M., Bertotti, M., Kimberlee, R., Pilkington, K., and Refsum