Shropshire Council

Date: Monday, 25 March 2019

Time: 10.00 am

Venue: Shrewsbury Room, Shirehall, Abbey Foregate, Shrewsbury, Shropshire, SY2 6ND

Contact: Amanda Holyoak, Committee Officer
Tel: 01743 257714
Email: amanda.holyoak@shropshire.gov.uk

HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

TO FOLLOW REPORT (S)

6 Care Closer to Home (Pages 1 - 4)

To consider a report on Care Closer to Home to help develop an understanding of the role of partners, whether there are any opportunities to link with the Telford and Wrekin Neighbourhood Scheme and understand whether transport is an issue, particularly non-emergency patient transport.

Contact: Lisa Wicks, Deputy Director of Performance & Delivery/Head of Out of Hospital, Shropshire CCG, 01743 277500

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Shropshire Care Closer to Home

Lisa Wicks, Deputy Director of Performance & Delivery
Shropshire CCG

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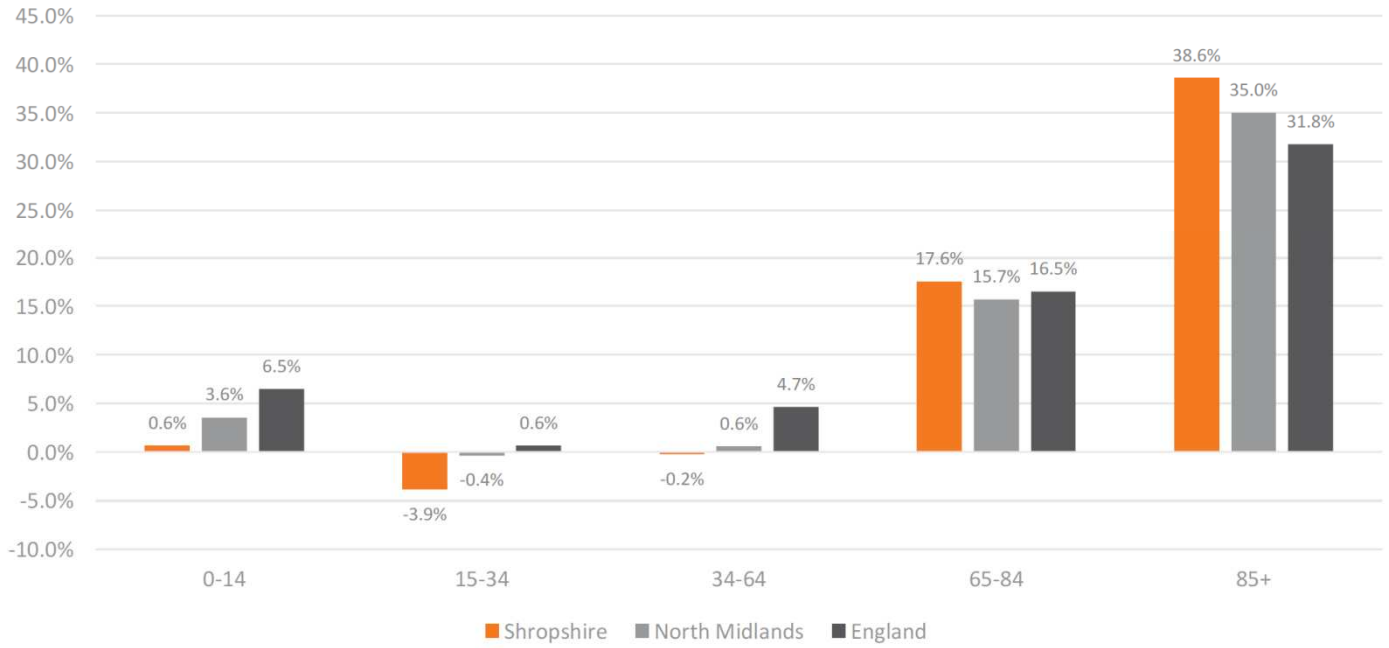
Shropshire's population

Source: ONS population estimates and projections

Shropshire Population

Estimated population change between 2016 and 2025

Population growth, 2016-2025



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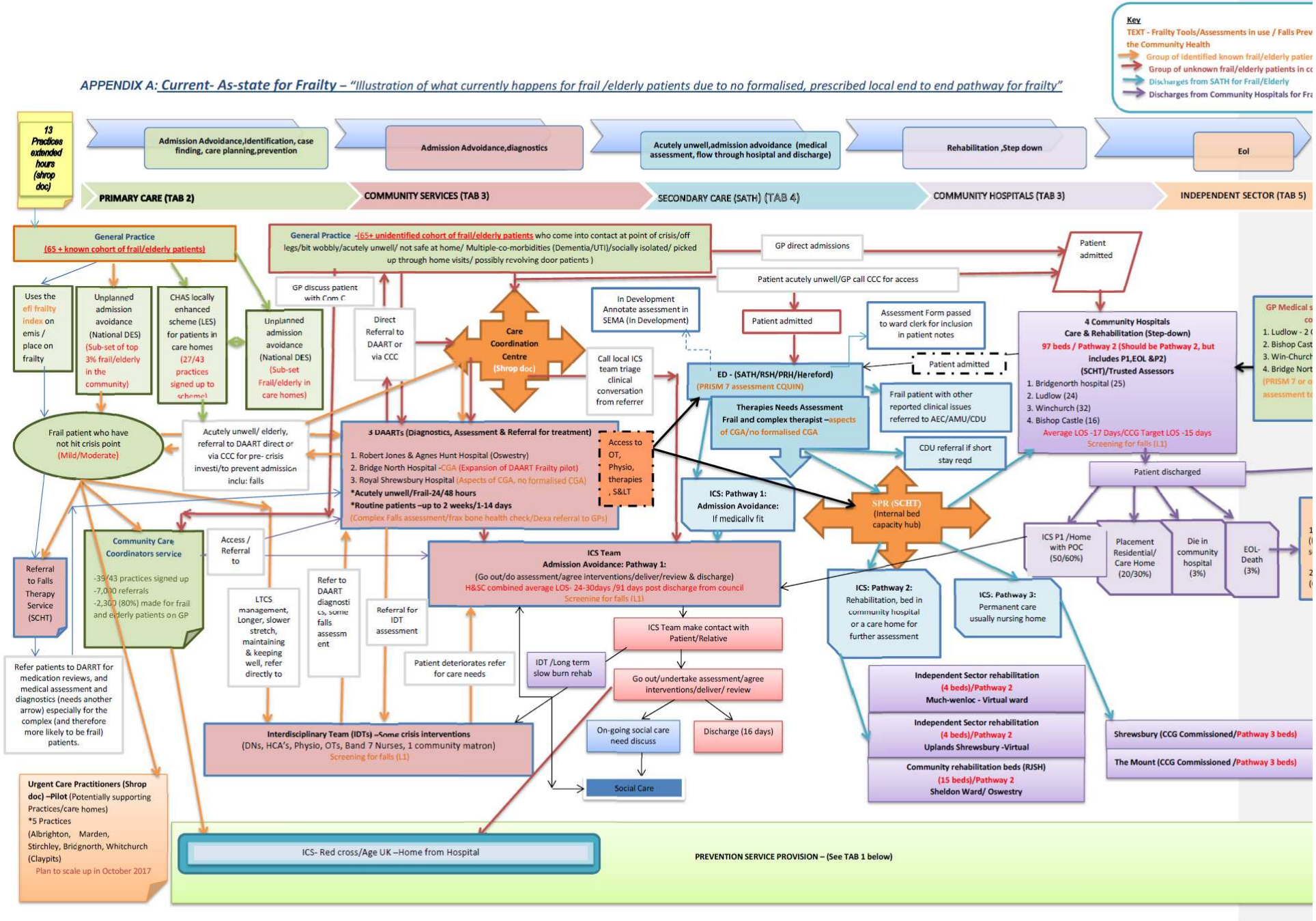
APPENDIX A: Current- As-state for Frailty – "Illustration of what currently happens for frail /elderly patients due to no formalised, prescribed local end to end pathway for frailty"

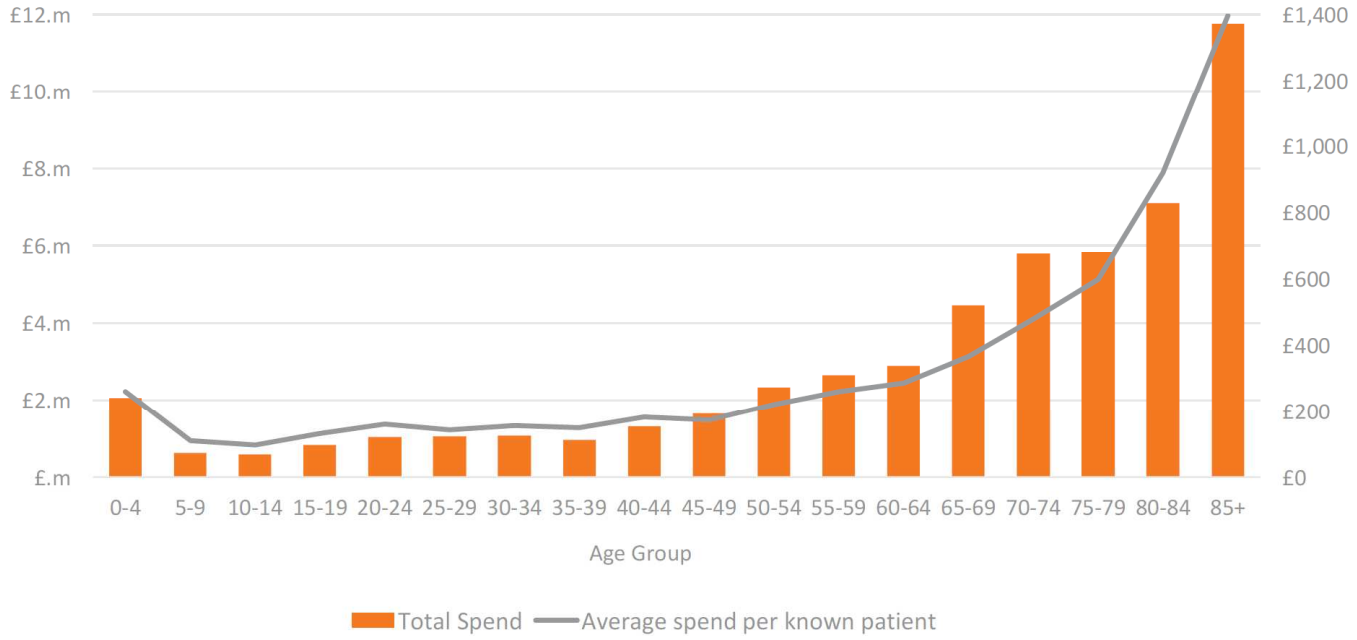


There's something about frailty[8]

Source: Analysis of Shropshire CCG SUS data

A&E and Emergency Admissions

Total spend on emergency admissions and the average cost emergency care per patient



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What is the problem we are trying to solve?

Analysis of frail elderly emergency admissions, 2015/16

* The table below shows the total number of emergency admissions by frail elderly patients from Shropshire and Telford & Wrekin CCGs in 2015/16. In total there were nearly 4.5K admissions in 15/16, costing nearly £11M.
* Of these, around 2,800 were classified as those who could usually be managed elsewhere if appropriate services were available.

Frail Group	Age group	Emergency Admissions	Total Emergency Bed Days	Total Cost of Admissions (£)
Usually	65 – 74	584	4,430	1,248,293
	75+	2,213	23,469	5,662,382
Sometimes	65 – 74	537	3,938	1,190,421
	75+	1,076	9,958	2,613,805
Grand Total		**4,410**	**41,795**	**10,714,901**

Optimity, 2017

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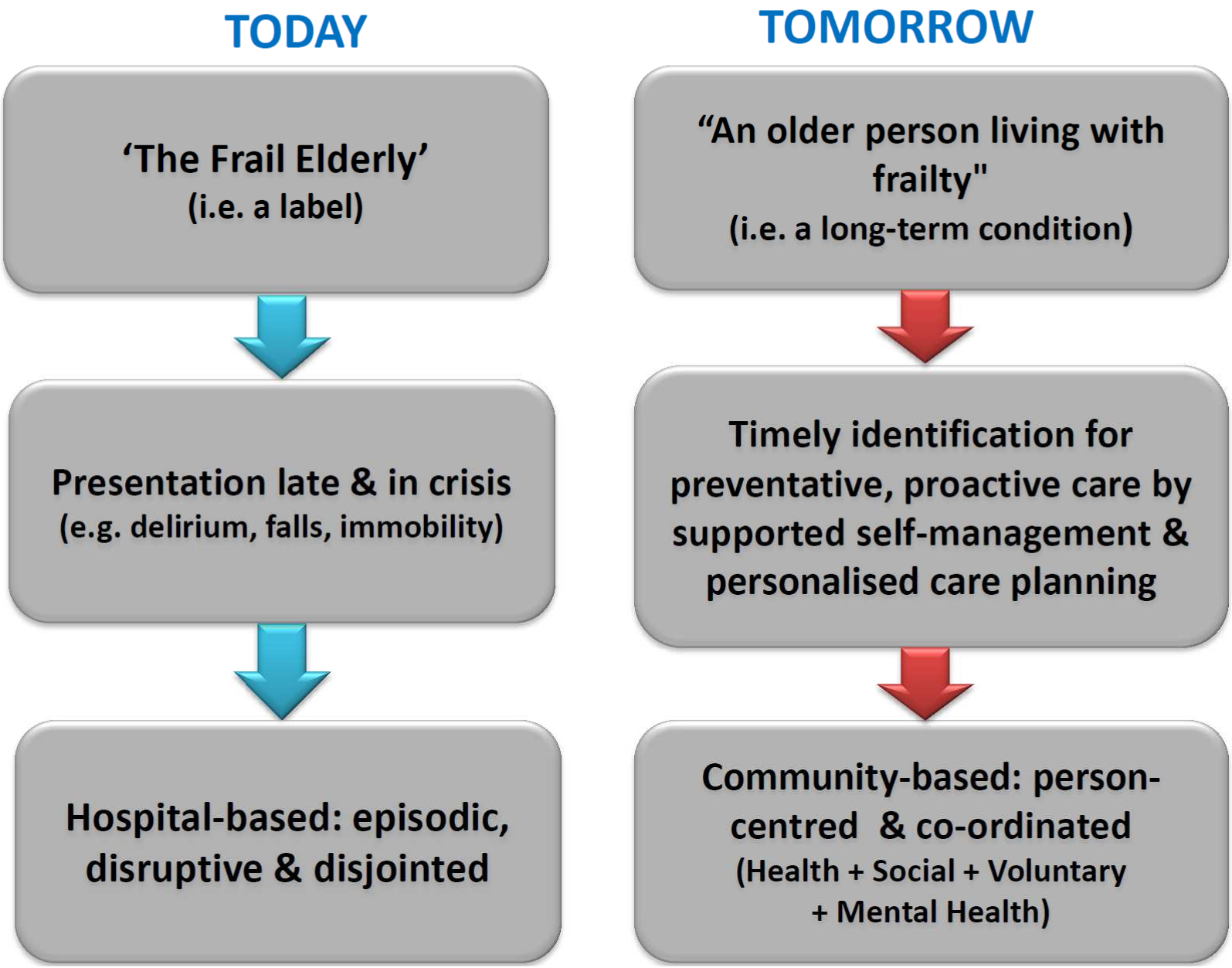
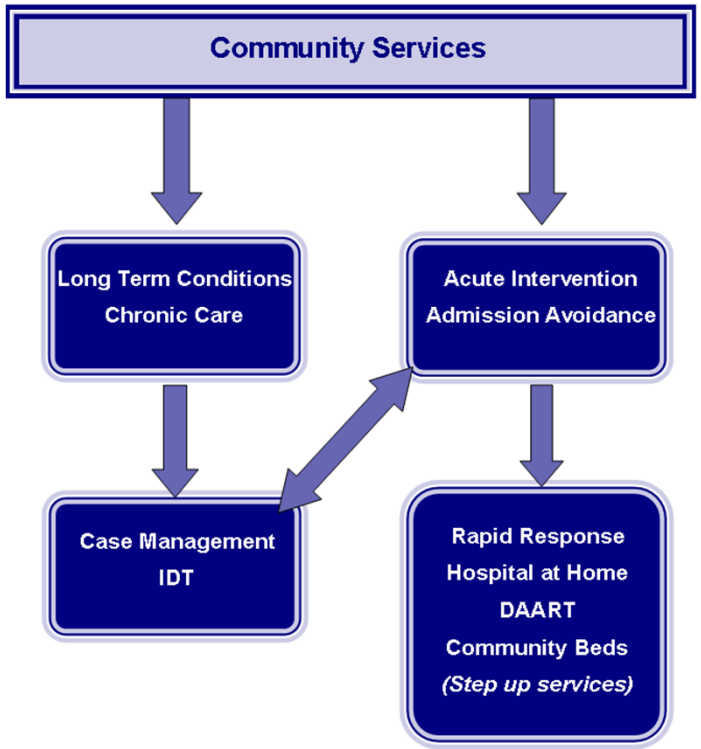
New Care Paradigm for Older People & Frailty



Our Vision for The Community Model of Care
Appropriate care, right place, right time

Shropshire Care Closer to Home

Pathways



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The programme is made up of 3 phases

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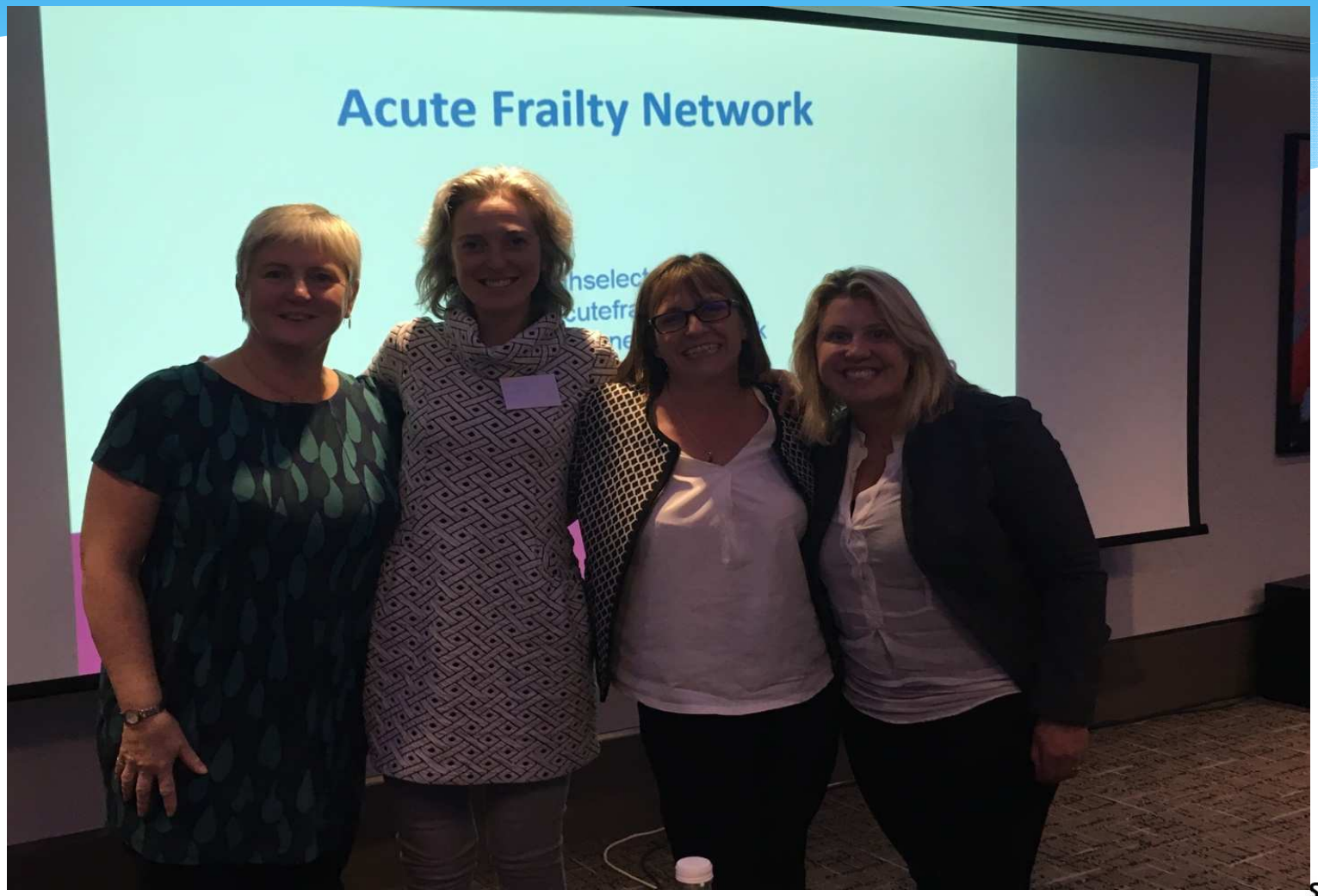
Phase 1: Frailty Intervention Team



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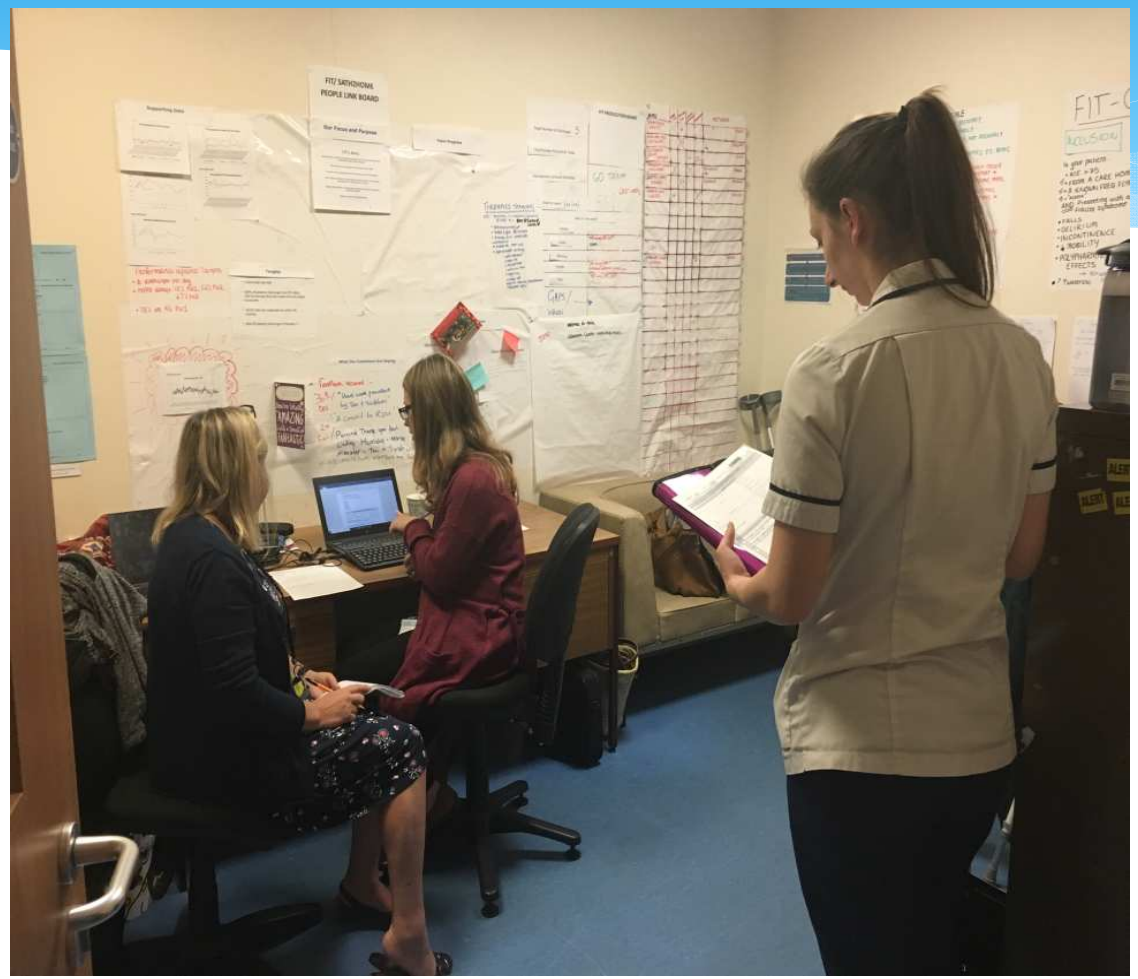
Dedicated team



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Frailty Intervention Team (FIT) – 4 Week Evaluation

Profession	Provider
Advanced Care Practitioner	SaTH
Consultant Geriatrician	SaTH
Therapy Quality Improvement Lead	SaTH
Clinical Lead Therapist	SaTH
Physiotherapist	SaTH
Occupational Therapist	SaTH
ICS Nurse/Therapist	SCH
Community Matron	SCH
General Practitioner	SCH
Social Worker	Local Authority

"Capacity is not beds. Capacity is clinical decision makers."

Proud To Care
Make It Happen
We Value Respect
Together We Achieve

Phase 2 - Case Management helps us to find people in need and offer them support…

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…before they find us

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Phase 2: Dedicated Team working with General Practice to identify and manage hidden vulnerabilities

Risk stratification of population using Aristotle

* >65 Shropshire patient PLUS any 1 or more:
* 2 or more active long term conditions
* 2 or more admissions in the past 12 months
* 2 or more A&E attendances in the past 12 months
* >4 weeks hospital stay in past 12 months
* Exacerbation of chronic condition within the past 90 days
* Top 3% frequent GP attenders
* GP judgement of patients requiring case management

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Confirmed Pilot Sites

* Albrighton Medical Practice
* Belvidere Medical Practice
* Plas Ffynnon Medical Practice
* Wem & Prees Medical Centre
* Bridgnorth Medical Practice
* Bishops Castle Medical Practice
* The Meadows Medical Practice
* Pontesbury Medical Practice

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Locality GPs

* GPs wanted to engage in Phase 3 development
* A GP from each locality was invited onto working group
* Draft specifications for these services shared
* GPs asked to fill in a template which allowed feedback to be collected, referenced and themed
* Part of their remit to communicate models to localities, LMC and other stakeholders/patients/public

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Who are you going to call?

* Rapid response
* DAART
* Crisis Intervention
* Hospital at Home
* Step-up beds

"One phone call; one referral"

Single call access to service for all proposed referrals. Expert triagers ensuring patients get to correct modality of the service first time.

CLINICAL HANDOVER

Shropshire Care Closer to Home Activities

All patient care coordinated and provided through seamless integration of services, with medical oversight and input where needed.

Holistic patient centred approach, with patient's journey through the service determined at the outset, with appropriate discharge planning.

Flexibility to adapt to variations in acuity of condition by either stepping up to acute admission or by having pre-prepared discharge planning, stepping back down to normal level of care.

Discharge process

Expert discharge planning, preparing patient return to normal levels of care seamlessly.

CLINICAL HANDOVER

Kieran's Model

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Roy's story

* The practice receives a call from Roy's daughter.
* He hasn't got out of bed today. He has a temperature and he's coughing
* He has already started his prophylactic antibiotics/steroids
* You visit him and suspect he has a UTI as well as an infective exacerbation of COPD
* He has a care plan through Phase 2
* Depending on his wishes and how unwell he is you might want to…

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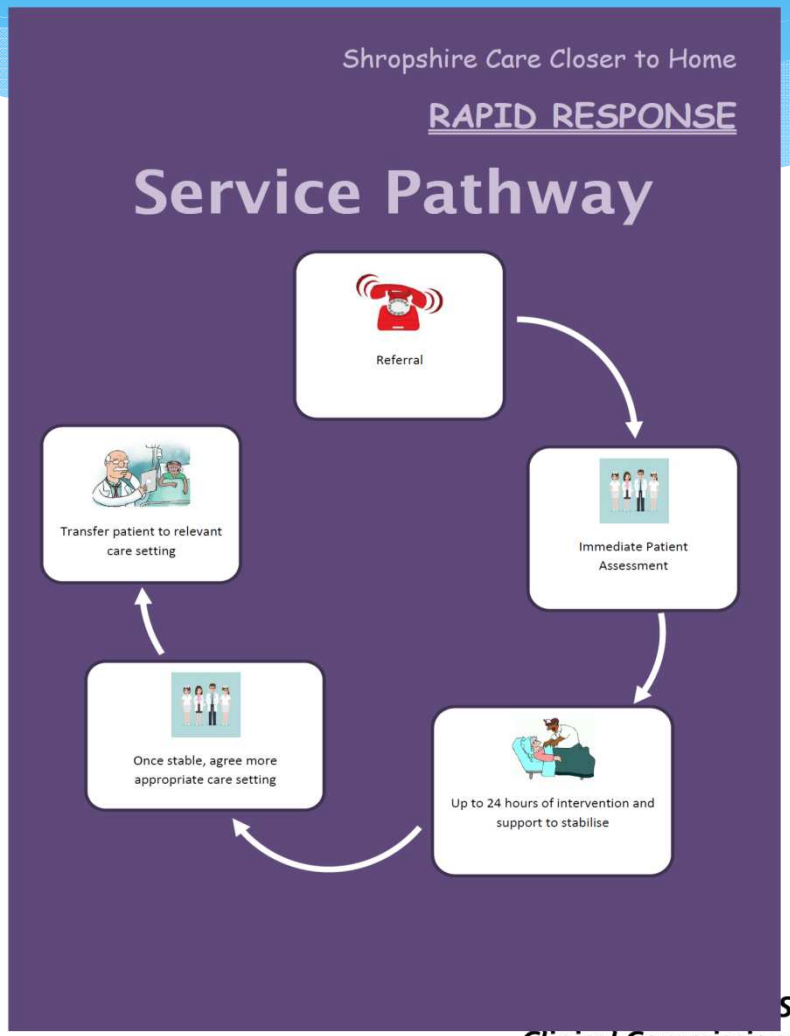
Rapid Response

* 24/7
* Immediate assessment (within 2 hours)
* Up to 24h care/ intervention and support to stabilise
* Once stable agree on most appropriate care setting
* Eg IV AB for UTI at home; develops dehydration- intensive input and therapy
* **Service will refer patient onto other services/escalate as appropriate**



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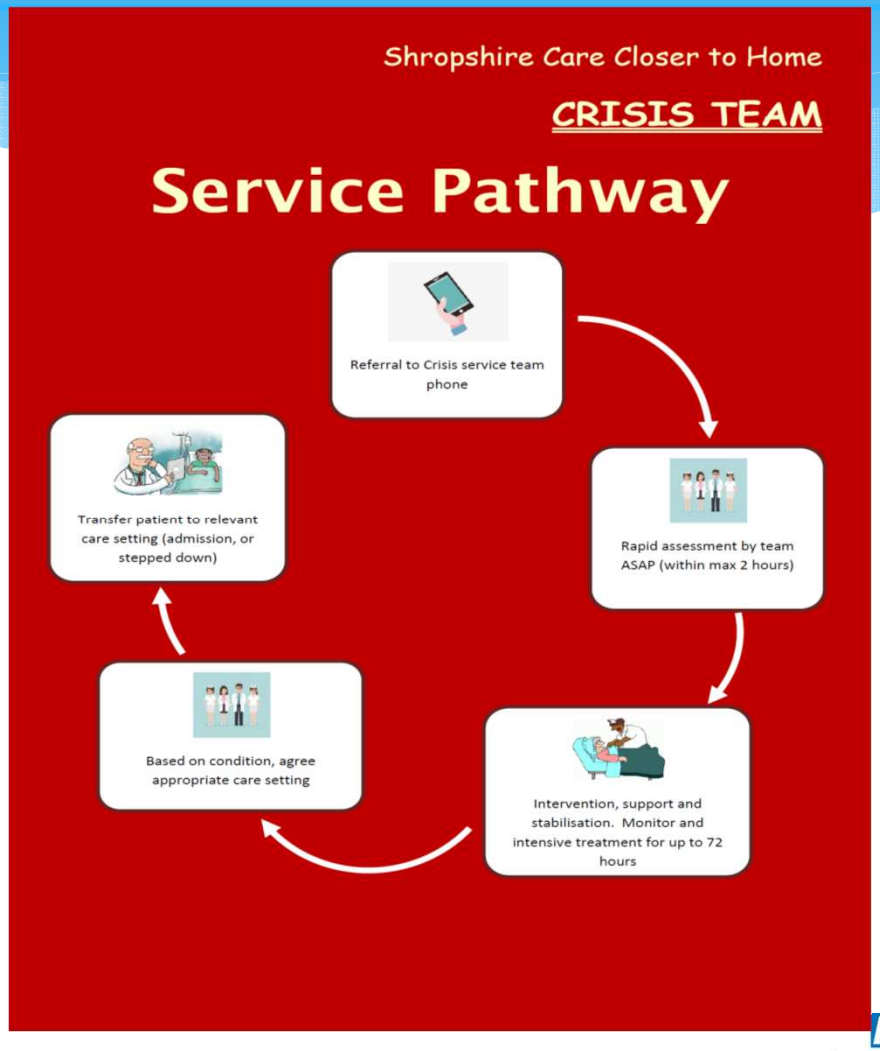
Crisis Team

- **72-hours intensive treatment, like FIT in SaTH**
- 24/7
- Specialist nurse led team with consultant support
- Daily MDT ward rounds
- Heightened level illness/ IV treatments
- Includes mental health crisis
- Eg UTI requiring IV AB who develops confusion
- **Service will review and refer, according to patient response**



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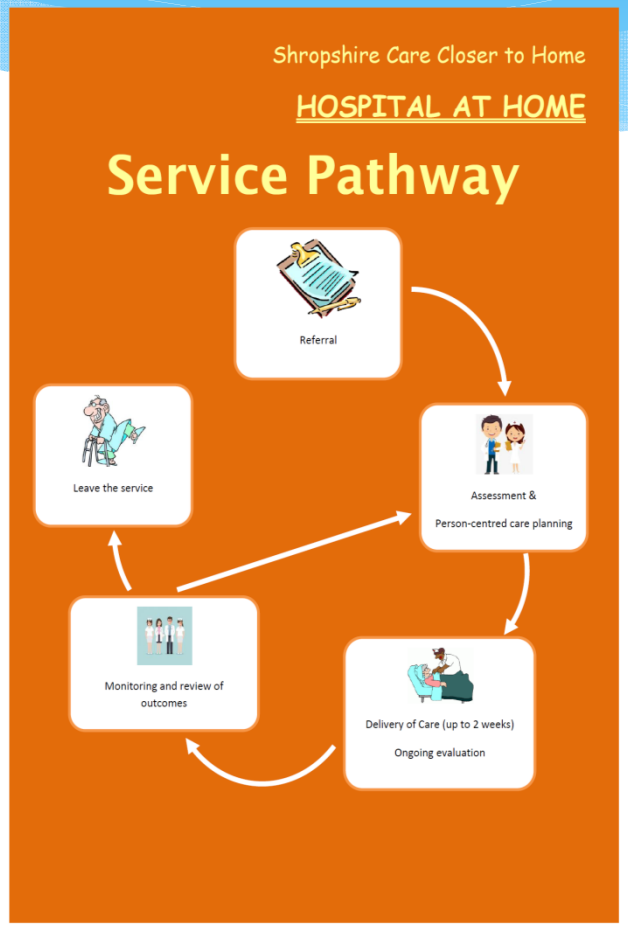
Hospital at Home

* 7 days a week, 8am-6pm
* 2 weeks semi-acute care
* Specialist nurse led team with SaTH consultant support
* Therapists, mental health nurses
* Eg oxygen at home, nebulisers, IV therapy, physio. COPD, asthma, CCF, UTI



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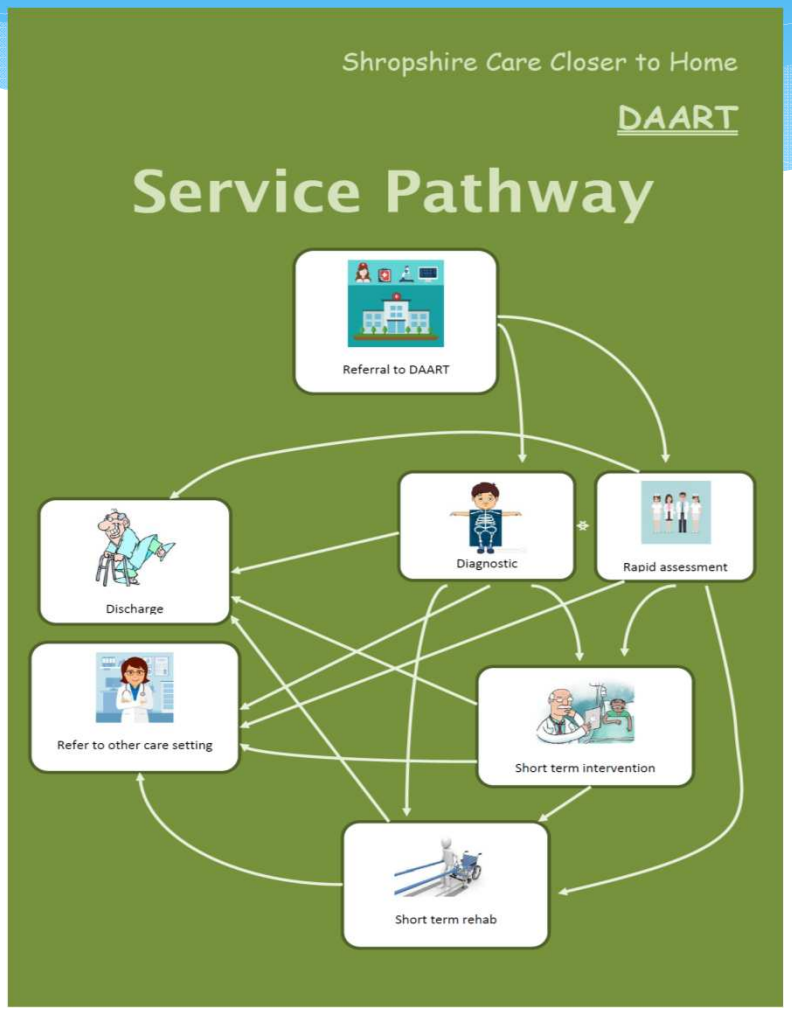
DAART

* A designated space that provides timely access to assessment, diagnostics, and short term intervention without the need for hospital admission; before being referred to an ongoing care setting or discharged

* **Note Roy's GP has not been contacted**



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Benefits to Patients

* Single point of entry into the system
* Only have to tell their story once
* Easier to navigate for patient and their carer(s)
* Better experience of care
* Earlier identification of needs means better quality of life for patient and their carers
* Improved range of services at varying levels of acuity, can flex to patient need
* Improved and timely access to diagnostics
* Shorter waiting times
* Minimising risk by sharing of information eg allergies, DNARs

Benefits to GPs

* Single point of entry – "One phone call, one referral"
* Providing appropriate care right place, right time when needs of patient escalate
* Joining up health and social care and understanding what other providers can do for patients
* Empowering community teams to provide care, reducing the 5pm on a Friday telephone call
* Making care more proactive, not reactive
* Impact on workload, job satisfaction and resilience

Partnership Across CCGs

* Shared approach of case management using a predictive data tool (Aristotle) supplemented by Primary care data
* Shared approach of integrated teams to deliver admission avoidance , in reach and facilitated early discharge
* Shared ambition that the acuity of care available in community setting increases
* Shared approach of promoting self care and integration with community resources
* Shropshire has community hospitals and beds in independent sector ,Telford just has independent sector beds
* Working towards aligning governance structures for wider system change

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Next Steps……

* Report on Phase 3 feedback from all partners including GPs; Further iterations of the service specifications. Aim for sign-off May 2019
* IT sub-group now developing IT infrastructure
* Memorandum of Understanding with Shropcom **signed**
* Alignment with Telford CCG
* Funding breakthrough
* STP chair has a place at programme board…

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The story continues…

* Questions and feedback about what you've heard so far

Programme Report

Project Name:	**Shropshire Care Closer to Home**		
Date:	15th March 2019	**Release:**	
Author:	Lisa Wicks Deputy Director of Performance & Delivery/Head of Out of Hospital		
Owner:	Lisa Wicks Deputy Director of Performance & Delivery/Head of Out of Hospital		
Reporting to:	Shropshire Care Closer to Home Programme Board		
Document Number:	09		

Vision Using all available resources to commission integrated health and care services that are clinically effective and cost-efficient and as close as possible to where people with the greatest need live.

Date of Highlight Report	15th March 2019
Period Covered	20th February 2019 – 20th March 2019

Status Summary & Update

Phase 1 - Frailty Intervention Team in place at RSH with team being recruited to implement at PRH. An NHSE film detailing the work of the FIT "Roy's Story" at RSH has been launched a link to it is on the CCG website. This team works to ensure that where possible people with complex needs (also referred to as frail) have their needs met quickly in order to either prevent a hospital admission from occurring, or to achieve a shorter admission than would otherwise be possible through coordinating discharge requirements to a higher degree than was previously achieved.

Phase 2 – Risk Stratification & Case Management - this model has two parts; the first is about our community-based workforce working closely with GP practices across Shropshire to get a clear understanding of how many people over the age of 65 have complex care needs. A crucial part of this process relates to categorising the people identified in terms of whether their need complexity is low, moderate, or severe, a process known as "Risk Stratification".

Once Risk Stratification is complete, those identified as severe are given the opportunity to work with a designated professional also known as a "Case Manager" who in turn will be responsible for a group of patients. The professional background of a Case Manager may vary dependent on what the most pressing needs of the recipient of support are, for example in some cases a nurse would be best placed to provide support, whereas in others a social worker may be more suitable.

The Case Manager is responsible for developing and reviewing care plans with those on the caseload, and where required, coordinating services to meet their needs. Case Managers will promote recovery and identify when people under their supervision are deteriorating. This will enable them to put preventative measures to be put in place to minimise the occurrence of acute and severe ill health, also known as a "health crisis". This development of care plans and their delivery represents the second part of the Case Management model.

The Risk Stratification and Case Management model approved by the CCG Clinical Commissioning Committee on 15th August 2018. A number of GP practices expressed an interest in participating in the Case Management pilots and these are agreed as follows:

- Albrighton Medical Practice – 65+ patient list size = 2,629
- Belvidere Medical Practice – 65+ patient list size = 1,192
- Plas Ffynnon Medical Practice – 65+ patient list size = 2,189
- Wem & Prees Medical Practice – 65+ patient list size = 2,685
- Bridgnorth Medical Practice – 65+ patient list size = 4,585
- Bishops Castle Medical Practice – 65+ patient list size = 1,604
- The Meadows Medical Practice – 65+ patient list size = 1,034
- Pontesbury Medical Practice – 65+ patient list size = 2,011

It was agreed that the Pilot Implementation Group would undertake a year-on-year comparison of the same period and practices against themselves to capture benefits to patients and citizens.

Due to delays on an IT solution being available the Pilot Implementation Group agreed a manual workaround at the meeting on 5th February in order to continue pace and prevent any delays to implementing these pilots.

An IT sub-group has been established and this group will continue work on the Shared Care Plan. Work continues to finalise the risk stratification policy, Privacy Impact Assessment, risk stratification assurance statement and a Fair Process Notice, all of which need to be in place and available to the public before data sharing agreements can be completed for the pilot sites identified.

Phase 3 – The third phase is made up of three high-level models; the first is called "Hospital at Home". The aim of Hospital at Home is to provide diagnostic testing and treatment interventions traditionally associated with care in a hospital setting, in peoples own homes, or from places close-by.

Just as is the case in the local general hospital, this model would be delivered by a multi-disciplinary team made up of a range of health professionals including: GPs; Specialist Consultants; Social workers; Community Nurses; District Nurses; Advanced Nurse Practitioners; Mental Health Nurses; Pharmacists, Physio Therapists, Occupational Therapists and Dieticians to names but a few. However, Hospital at Home is not a rapid-response (second model of care delivery), it functions in a planned fashion working alongside the Case Management model to prevent health crisis from happening.

The third model of the third phase of Shropshire Care Closer to Home is about creating a Health Crisis Response Team. This would be set up to deliver both diagnostic testing and treatment interventions similar to those available from in the Hospital at Home model, but within a standardised 2 hour response window. This team would be made up of senior clinical staff, for example Advanced Nurse Practitioners who are capable of making clinical decisions and in most cases prescribing and administering medicines to manage acute health needs. However, if the Health Crisis Response Team should feel that the person is too unwell to be safely managed at home, there are two options which they can consider; they could admit the person to a "Step-up bed", or to the general hospital.

Draft Phase 3 model possibilities and service specifications for Phase 3 services Hospital at Home, Rapid Response, Crisis and DAART have been circulated and the Programme Team have consolidated the responses. The model options and service specifications have been shared more widely at GP Locality Meetings in February and March and a provider and patient representative stakeholder workshop is taking place next week to gather further feedback and comment. Consolidation and finessing of the modelling based on the outputs from these engagement events will follow in April 2019. The option appraisal process on the proposed models will commence in May 2019.

Scope
Draft service specifications to underpin the Phase 2 services have been written and feedback has been consolidated and analysed.

Clarity on which aspects of Phase 3 require formal consultation will be ascertained as the models emerge from the design process, and the level of involvement & engagement at earlier stages in the design process.

The design of Phase 3 models of care is well underway with the timeline for being able to propose models for approval by May 2019.

Planning to commence on Step Up Community Beds once in receipt of the full written JSNA. The full engagement and option appraisal process will follow from May 2019 for the areas and models where it is necessary.

Timings
The actual against planned timings of the 3 agreed phases are as follows:

- *Phase 1* – in place with ongoing evaluation and plans to expand to PRH.
- *Phase 2* – Pilot Implementation Group shaping the more detailed operational service delivery and workforce models at identified pilot sites. Service specs reviewed and passed to Pilot Implementation Group; further amendments to the specs may result as the pilots get underway. The original plan was for the pilots to be mobilised by March 2019 however, with the IT and data requirements needed to enable risk stratification and a shared care plan not being in place, work is underway to develop and agree a manual workaround solution that will still deliver pilot demonstrator sites but to a slightly delayed timeline. The refreshed timeline for the implementation of pilot sites will come out of the work of the Pilot Implementation Group now that detailed planning has commenced but it is envisaged by 1st June 2019.
- *Phase 3* – The Programme Team have received feedback and critique on the draft models and service specs following presentations at GP Locality meetings; a stakeholder workshop is also taking place in March 2019. Working towards having a tangible longlist of model options for CCC consideration by May 2019 as part of the option appraisal process.

Collaborative Working

A Memorandum of Understanding with providers (the CCG, Shropshire Community Trust and Shropshire Council) to enable operationalization of the model has been signed and work is now underway to include Midlands Partnership.

Alignment with Telford CCG

- Shared approach of case management using a predictive data tool (Aristotle) supplemented by Primary care data
- Shared approach of integrated teams to deliver admission avoidance, in reach and facilitated early discharge
- Shared ambition that the acuity of care available in community setting increases
- Shared approach of promoting self-care and integration with community resources
- Shropshire has community hospitals and beds in independent sector, Telford just has independent sector beds
- Working towards aligning governance structures for wider system change

What Matters to Me National Event

The Programme Team facilitated a What Matters to Me event at the Darwin Shopping Centre in Shrewsbury on 25th February which was well attended and the views and thoughts of 13 people were gathered and added to the engagement log.