FOR INFORMATION

Health and Wellbeing Board
Meeting Date

Shropshire Care Closer to Home – An Overview

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1. Summary

The report provides an overview of the Shropshire Care Closer to Home programme of change that is being organised and coordinated by Shropshire CCG to achieve better value care for our population.

2. Recommendations

The Health and Wellbeing Board is recommended to note the information in the report.

REPORT

3. Background

Unlike health systems in many other western countries, the past 40 years has seen relatively little change in the way in which the NHS delivers care. The way care is delivered (also known as the "model" of care delivery), is still heavily dependent upon the use of general hospitals. Whilst there is absolutely a need for general hospitals, it is important to remember that hospitals were built to provide care to people who could not be looked after safely at home.

Some aspects of our modern lives would have been considered science fiction 40 years ago, with huge changes seen in the way that we communicate, shop and manage our finances. However, despite advancements in technology, our dependence on general hospitals in the UK has altered very little. The pressure that the NHS is now faced with is unprecedented; people are living for longer with far higher levels of need complexity than has ever been seen. This is particularly true for Shropshire whose population is older than most other counties in the UK.

In many parts of the country, changes in the model of care delivery are being seen with a view to move the NHS towards a place that embraces technology, in order to meet the needs of the people it serves. Whilst this will be key to the health service being able to meet the long-term needs of the population, another crucial element is the way in which the organisations that make-up our local health systems, also known as "Health Economies", work together. In order for the Health Economy of Shropshire to successfully evolve to meet the needs of Shropshire people, the organisations that belong to it need to agree to work towards a common goal, in other words they need to be "Strategically Aligned".

Once the change is complete, it is then the CCGs responsibility to keep the providers on-track and monitor the impact that the change is making. The process then begins again, working to understand the needs of the population and how they have changed and so on. This is also known as the commissioning cycle, and it is this process that has led to the CCGs ambition to work with stakeholders to bring Shropshire Care Closer to Home.

4. What is Shropshire Care Closer to Home?

When service change is required in order to attain a higher value of provision for the population, the change must be organised and coordinated to ensure that the change takes place in a planned way. For small-scale changes, this process is referred to as a "project", however some changes, such as bringing Shropshire Care Closer to Home, require a collection of projects to be managed

simultaneously, this is referred to as a "programme" of change. Shropshire Care Closer to Home is a programme of change that is being organised and coordinated by Shropshire CCG to achieve better value care for our population.

5. Why is Change Needed?

Care delivered in general hospitals often comes at a significant price for the recipient, at worst it can result in the end of independent living, contracting additional health needs or a change in home address. Enabling people to receive treatment that allows them to live their day to day lives is a priority for not only Shropshire CCG, but for the NHS as a whole. If we were to bring Shropshire Care Closer to Home for our population, we would enable people to avoid the risks associated with being admitted to hospital whilst experiencing minimal levels of disruption to their lives whilst receiving treatment.

As discussed earlier, we at the CCG absolutely believe that there is a need for general hospitals as some of the diagnostic testing and treatments delivered cannot safely be undertaken in another environment. However, in Shropshire just like many other parts of the UK we have developed an unhealthy cultural dependence upon our general hospital. We at the CCG have engaged with our stakeholders and have reached the conclusion that we have a duty to address this overdependence, and bring Shropshire Care Closer to Home.

6. Who is it for?

Long-term health conditions are those that a person lives with for a long time, such as diabetes, coronary heart disease and dementia. When a person lives with a number of these conditions, their needs are known as complex. Information collected locally, also known as "data" tells us these people are particularly susceptible to being admitted to the general hospital, and that if there were suitable services in place, many of them could be treated at home. Due to this, Shropshire Care Closer to Home is being aimed at improving health outcomes for people with multiple long-term health conditions aged 65 and over. Although our future ambition is that other patient groups or "cohorts" as they are also known will be targeted for improving health outcomes, moving Shropshire Care Closer to Home represents a big change for our Health Economy. If we were to try to change everything that needs fixing all at once, we would be likely to fail, and fail we must not!

7. What Changes will we see?

In the CCG, we often describe services at a "high level", which means describing them in a non-detailed way. The reason for this is that in a Health Economy such as Shropshire, details surrounding local-level service provision may differ from place to place. For example people in Whitchurch may receive services differently to those in Craven Arms. When considering how we will bring Shropshire Care Closer to Home, it is important to understand that at this stage, this can only be described at a high level. Considering this, Shropshire Care Closer to Home will initially be comprised of three high-level phases,

Phase 1

Phase 1 is already in place, it is the Frailty Intervention Team (FIT) based at the A&E department at the Royal Shrewsbury Hospital. 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

The second phase is about delivering a model of care called "Case Management", this model has two parts; the first is about our community-based NHS 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, also known as a "caseload". 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.

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 model of care delivery, it functions in a planned fashion working alongside the Case Management model to prevent health crisis from happening. That said, we do not live in a perfect world and sometimes health crises do occur.

The second 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.

The provision of "Step-up beds" is the final model of the third phase of moving Shropshire Care Closer to Home, and involves the provision of bed-based care in the localities in which people live, albeit away from their usual place of residence. These beds which could be provided in community hospitals or nursing homes will allow for high-intensity supervision of acutely unwell people whilst they undergo diagnostic testing and receive treatment. Should the Health Crisis Response Team decide to admit someone to a local Step-up bed, it may be that they continue to provide support to the recipient of care with a view to promoting safe discharge in as timely a way as is possible.

8. Are Models Going to be the Same Across the County?

As described earlier, this document provides a high-level overview of the models that are required to move Shropshire Care Closer to Home. The detail surrounding exactly how and who delivers them has not yet been agreed. There are a number of ways in which the models described above could be delivered, and this will vary across the county depending upon a number of factors.

9. What is Happening Right Now?

The CCG is working on an ongoing basis with the public and all stakeholders in the process of designing how we with enable Shropshire Care Closer to Home. As this is a rapidly developing programme of work, things are changing all of the time.

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)
Cabinet Member (Portfolio Holder)
Local Member
Appendices