NHS Shropshire CCG
Shropshire Care Closer to Home Transformation Programme

The vision for the out of hospital transformation programme for Shropshire is:

"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'".

Background

A review of the provision of community based services in Shropshire in 2017 identified the need to make changes to the overall system that is required to better deliver services closer to home. The Community Services Review identified a case for change and the Out of Hospital Programme was agreed to develop options for future delivery models of community services that are:

- Equitable, clinically and financially sustainable and consistent
- Fit for the future needs of the people of Shropshire
- Functionally integrated with the rest of the county's urgent care system as required by NHS England's Next Steps on the NHS Five Year Forward View
- Deliver the activity assumptions for the Pre Consultation Business Case (PCBC) for Future Fit

This supports the delivery of the The Five Year Forward View that advocates collaborative whole system solutions**.** Out of hospital care will become a much larger part of what we do across the Shropshire care economy.

Rationale

In the work completed by Optimity (2017) and Deloitte (2016) their observations were "Shropshire's over dependency on in-patient resources secondary to inadequate, poorly commissioned community-based services." Optimity (2017) suggest that through shifting secondary service utilization by a 5 year age band will reduce emergency usage of secondary services by 385 cases per 5000 head of population within the 65+ age band equating to 4586 admission avoidances.

Based upon the existing parameters in the Future Fit Outline Business Case, the target admission avoidance for this age band is set at 2689. The work produced to inform the target for the Frailty Intervention Team focused upon the 75+ population of Non-elective admissions during previous years. This methodology has been expanded to include patients 65+, this has provided an admission avoidance target of circa 3000 per year.

The following table presents the potential admission avoidance for the phases of the programme:

Optimity admission avoidance figures considered against resources required to meet need			
Service	**Admission Avoidability**		
	Usually avoidable	Sometimes avoidable	Total
Hospital at Home	1093	48	1141
Hospital at Home or Crisis Response/Step up beds	1796	1215	3011
Hospital at Home or Crisis Response/Step up beds or Admission	0	464	464
Crisis Response/Step up beds	72	0	72
Crisis Response/Step up beds or admission	0	358	358
Total	2963	2085	5048

Phases of the Programme

Phase 1 Frailty Intervention Team (presently operational)

A dedicated Frailty Intervention Team (FIT) based in the Emergency Department and are responsible for the early identification, treatment, risk assessment and planning for frail and long term condition patients. The team facilitate appropriate triage of patients to either the acute/community/home setting. This team liaise and work with existing teams in the community such as intermediate care, Care Co-ordinators etc. 90+ patients are added to the FIT case load each week and the team facilitate an average of 7 discharges every day. 83% of those discharged go home. There has been a reduction in the conversion rate from ED to admission for >75s at RSH to 53.02% compared to 57.71% in the same period the previous year. The target admission avoidance for this phase of the Programme is 558 in 18/19.

Phase 2 – 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 being in severe need will be 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, for some patients 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 in their 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 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. For a more detailed description of Case Management please see Appendix B.

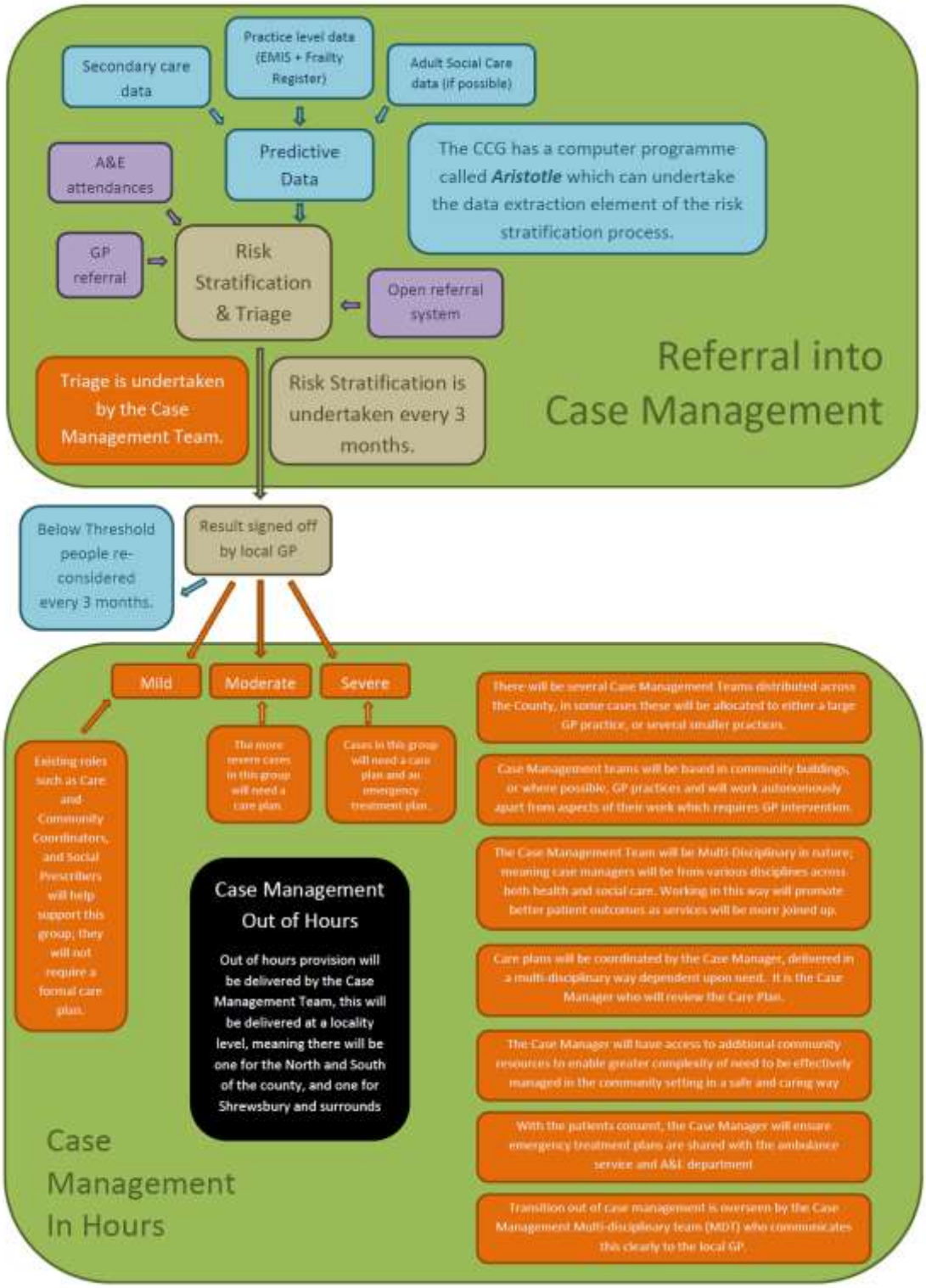
Service specifications have been drafted and shared with providers and stakeholders for:

- Shropshire Care Closer to Home Community Model
- Risk Stratification
- Case Management
- Interdisciplinary Teams
- Intermediate Care

A series of design and engagement workshops took place between December 2017 and July 2018 involving a wide range of stakeholders across the health and social care economy including patients and public representatives, Shropshire CCG, Shropshire Council, SaTH, Shropshire Community Health NHS Trust, Midlands and Partnership Foundation NHS Trust, GPs and Primary Care colleagues and the voluntary and care sector. This ensured fully collaborative co-design of the case management model options as well as fulfilling engagement requirements.

The collaboratively designed Risk Stratification and Case Management model was approved by the CCG Clinical Commissioning Committee on 15th August 2018 and is shown below:

Shropshire Care Closer to Home Case Management Model



For full details of decisions made around Phase 2 of the programme see Appendix C. For details of engagement activities undertaken during the design phase for Case Management please see Appendix D.

Additional resource is now focusing on progressing the Alliance Agreement Partnership needed to enable operationalisation of the model through developing more detailed service delivery and workforce models that underpin demonstrator pilot sites. Detailed service specifications are being developed for all aspects of Case Management to enable workforce planning.

Phase 3 Hospital at Home/Crisis Response/Rapid Response/DAART and Step-Up Beds

The third phase is made up of a number of high-level models:-

The aim of Hospital at Home is to provide diagnostic testing and treatment interventions that are traditionally associated with care in a hospital setting either 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.

However, Hospital at Home is not a rapid-response model of care delivery. It functions as a planned care service alongside the Case Management model to prevent health crises from happening. Design work on possible Hospital at Home models is currently underway. Feedback and critique on the options will be sought from public and patient representatives and stakeholders before a longlist of model options is produced.

A Rapid Response model will be developed in the same way. This service would 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.

The modelling of Step Up beds has been deferred awaiting the Joint Strategic Needs Analysis which is essential in shaping a sustainable and fit-for-purpose service.

Programme Progress Update as at October 2018

Project Plan Areas

Project Plan Ref	Work Package Name	Status[1]	Notes[2]
1	Programme Management	In place	As per overarching Project Plan
2	Vision & Model Design	In progress (Phase 3 delay)	Change to design approach with some impact on timeline – currently being refreshed.
3	Impact Assessments	In progress – behind agreed timeline	Joint Strategic Needs Assessment under development by Shropshire Council (delayed).

[1] Either Pending Authorisation, In Execution or Completed (in the period)
[2] For example if Work Packages are being performed by external suppliers, this information may be accompanied by purchase order and invoicing data

			Full QIA, PIA and EQIA to be completed on agreed models. QIA on Phase 2 complete.
Project Plan Ref	**Work Package Name**	**Status[3]**	**Notes[4]**
4	Phase 1	In place	FIT requirements in SaTH should diminish and reduce in time with the implementation of Phase 2. Positive impact reported with plans being developed to expand and rollout to PRH.
5	Phase 2	In progress	Final preferred model for risk stratification and case management agreed by the CCC. Developing operational and workforce models for implementation once Alliance agreement in place.
6	Phase 3	In progress (delay)	Design sessions planned for October & November have been cancelled. Programme Team now working on scoping model options & possibilities before seeking input and critique from stakeholders.
7	Patient Involvement	Ongoing	Regular stakeholder workshops and ability to email queries. Further What Matters to Me events to be arranged.
8	Comms & Engagement	Ongoing	Strategy and plan undergoing refresh to reflect change in design process for phase 3. High level support in place to oversee strategy and orchestrate comms activities of various providers. Inadequate comms and engagement support identified and added as a programme risk.
9	Quality & Safety	Pending	To be reviewed once shortlist of model options is being finalised. Phase 2 QIA complete.
10	Finance	Pending	To be modelled and reviewed once shortlist of model options is being finalised, and dependant on alliance working or not.
11	Workforce	Pending	To be reviewed once shortlist of model options is being finalised, and dependant on alliance

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[4] For example if Work Packages are being performed by external suppliers, this information may be accompanied by purchase order and invoicing data

			working or not. Remit of provider(s).
Project Plan Ref	**Work Package Name**	**Status[5]**	**Notes[6]**
12	IT	In progress	Dedicated IT Task & Finish Group addressing data and IT infrastructure requirements (data sharing, risk stratification tools and shared electronic Care Plan, emergency care plan and end of life plan).
13	Options Appraisal Process	Pending	Consultation not required for Phase 2, and will be planned in for Phase 3 – the formal requirements dependant on the models and potential changes that emerge.
14	Decommissioning	Pending	Decision depends on alliance working outcomes.
15	Procurement & Contracting	Pending	To commence once model is agreed and again, dependant on outcome of alliance discussions.
16	Commissioning	Pending	To commence once model is agreed, and again, dependant on outcome of alliance discussions.
17	Enhanced Commissioning	Pending	To commence once model is agreed.
18	Pilot Demonstrator Sites	Pending	To be developed, pending the outcome of alliance working discussions.
19	Full Mobilisation	Pending	To commence once model is agreed and/or following pilot of demonstrator sites.
20	Monitoring and Evaluation	Pending	Independent clinical review of implemented models. Routine monitoring and reviews established following mobilisation, feeding back into a constant loop of improvements or changes if necessary (PDSA).

[5] Either Pending Authorisation, In Execution or Completed (in the period)
[6] For example if Work Packages are being performed by external suppliers, this information may be accompanied by purchase order and invoicing data

Products

Product Ref	Product name	Status[7]	Notes[8]
P1	Aristotle	In progress	Being utilised as the software to support and enable risk stratification. Meetings being planned to ascertain reporting criteria.
P2	Information Leaflet	Complete	Overview information leaflet ratified. Circulated widely to the media and public from, and uploaded to the CCG website 1st August 2018.
P3	Generic Email	Complete	Generic programme email address established for public to make contact.
P4	Ideas Proforma	In progress	Template to be used for the submission of concepts to the Programme Board for consideration of inclusion within the Programme. Final changes to process being agreed.
P5	Staff Briefing	Complete	Provided and actioned by each provider organisation on 1st August 2018.
P6	FIT evaluation	Complete	Evaluation of RSH pilot of frailty intervention team complete.
P7	Preferred Case Management Model	In Progress	Model identified through collaborative design process and approved by the Clinical Commissioning Committee making decision on 15th August 2018.
P8	SharePoint	In Progress	SharePoint platform being developed which will provide one online forum to hold all papers, reports and documents relating to the programme; improving shared access and visibility of programme information.
P9	Primary Care Networks	In Progress	NHSE initiative that reflects the intentions and aspirations of Case Management in the Care Closer to Home Programme. Work underway to map synergy to ensure integrated approach. SOP on case management and risk stratification operational compliance for GP colleagues also being developed for inclusion in a Primary Care Commissioning Framework.
P10	FIT filming	In progress	NHSE filming RSH FIT team
P11	Ideas Pro-forma and submission process	Complete	Template agreed and ideas process complete – going to Programme Working Group for final sign-off.

Corrective Actions Undertaken

- **Following a poor response from required stakeholders, the phase 3 design sessions were stood down and instead, as a contingency measure approach, the Programme Team are working on draft models to take to stakeholders in January 2019 for critique and feedback.**
- **Communication & Engagement team working on a refresh of strategy to reflect the change in design process and a refresh of timeline to allow for stakeholder involvement and feedback on draft models.**

[7] Completed (in the period), Planned (but not started or completed) or Underway (as planned)
[8] Indicate if any products are running behind schedule.

Appendix A

The table below outlines the figures that were originally modelled for the Out of Hospital Case management.

Table 1

Locality	July 2017 65+	July 2017 65+ with 1+ LTC	2019/20		2020/21		2021/22	
			Case Management numbers (assuming 20% NEL admission avoidance)	NEL Admission Avoidance Target	Case Management numbers (assuming 24% NEL admission avoidance)	NEL Admission Avoidance Target	Case Management numbers (assuming 28% NEL admission avoidance)	NEL Admission Avoidance Target
North	**23,190**	**19,233**	1430	286	2383	572	2454	687
Central	**22,135**	**17,442**	1510	302	2517	604	2589	725
South	**27,962**	**22,034**	1490	298	2492	598	2564	718
Total	**73,287**	**58,709**	**4430**	**886**	**7392**	**1772**	**7607**	**2130**

Method for establishing the above:

- *Practice prevalence of 65+ populations is based upon NHS Digital July statistics;*
- *Size of 65+ LTC cohorts is based upon Age UK (2017) statistics;*
- *Size of cohorts with 1, 2, 3, 4, 5, 6, and 7+ LTC's is based upon locally produced data (Optimity, 2017);*
- *All non-elective (NEL) admission data for 65+ people with LTC's is derived from the Secondary Users Service (SUS) data;*
- *All NEL admissions registered with non-Shropshire GP Practices have been excluded;*
- *Total numbers of NEL admissions for people over 65 with between 1 and 3 LTC's have been established in order to understand a benchmark to work against for the purpose of NEL admission avoidance;*
- *Target admission avoidance has been set at 10% of these figures for 2019/20, 20% for 2020/21, and 24% for 21/22.*

Additional Work Undertaken

The work undertaken to establish the projected hospital avoidance figures to occur as a consequence of the Frailty Intervention Team (FIT) focused upon NEL admissions in the 75+ cohort. Based upon the ICD10 codes used by Optimity, CCG Business Intelligence have projected within this group, admissions that could usually be managed out of hospital, those that could sometimes be managed out of hospital, and those where hospital admission is not avoidable.

This report has been re-run to include all 65+ NEL admissions, and this method indicates the following:

Total NEL Admissions August 16 – July 17	14,556
Admission Avoidability	
Unavoidable	9,508
Sometimes avoidable	2,085
Usually avoidable	2,963

Based upon the above figures, the target Admission avoidance will be set at circa 3,000 patients, equating to 20.6% of the total NEL admissions reported for the timeframe. Data underlying the original modelling demonstrates that of the 14,556 NEL admissions recorded, 8,987 were for individuals with between 1 and 3 LTC's. Our expectation is that the 3,000 circa admission avoidance target will be realised within this cohorts of patients meaning 33.4% admission avoidance (AA) needs to be achieved. This has been broken down as follows:

65+ NEL Admissions with between 1 and 3 LTC's between August 16 and July 17			
Number of LTC's	1	2	3
Numbers of NEL admissions	3,481	3,299	2,207
Target % of AA	45%	33.4%	15%
Numbers of AA	1566	1102	331

Based upon Optimity figures, the scope of primary care risk stratification will include all 65+ registered patients, equating to around 240 patients per 1,000 head of population registered. Of this 240 patients, it is expected (based upon initial modelling) that around 50% will have between 1 and 3 LTC's requiring case management in order to achieve the admission avoidance target.

The table below indicates what this would look like at a locality and county level

Numbers for Case management based upon projected volume of people with 1-3 LTC's		
Locality	% of population	Numbers for case management
North	31.6%	2,782
Central	30.2%	2,656
South	38.2%	3,355
Total	**100%**	**8,793**

Considering the ICD10 codes constituting the Optimity reporting, CCG medical resources have been drawn upon to help determine where those admissions identified as sometimes and usually avoidable would best be managed in the Out of Hospital context. The table below indicates what this would look like in terms of numbers requiring input from which community resources:

Optimity Admission Avoidance Figures Considered Against Resources Required to Meet Need over a 1 Year Period			
Service	**Admission Avoidability**		
	Usually avoidable	Sometimes avoidable	Total
Hospital at Home	1093	48	1141
Hospital at Home or Crisis Response/Step up beds	1796	1215	3011
Hospital at Home or Crisis Response/Step up beds or Admission	0	464	464
Crisis Response/Step up beds	72	0	72
Crisis Response/Step up beds or admission	0	358	358
Total	2963	2085	5048

Some of the service rows in the above table illustrate the level of difficulty surrounding the task of projecting service demand, it is crucial therefore that the reader understands that these projections reflect **"best guess"** methodology. This approach will be robustly tested within the locality task and finish groups. Although it is entirely possible that admission avoidance (AA) could be achieved for the "sometimes avoidable" cohort, the "Usually avoidable" cohort will be used to project the community resource requirement to achieve the target circa 3,000 AA's.

In order to discern the proportionate split of the "Hospital at Home or Crisis Response/Step up beds" row pertaining to "Usually avoidable" admissions, the following will be assumed: Based upon the target of 45% of this cohort having 1 LTC, it will be assumed that 45% of this row (808 AA's) will be enabled by the hospital at home service. This equates to 64.2% of the services required to achieve the AA target being Hospital at Home. The following table provides the resource breakdown required to achieve the circa 3000 AA target by locality:

Overview of projected model for achieving target 3000 AA's per year					
Locality	% of population	Numbers for case management	Target AA Numbers	Numbers for Hospital at Home (64.2%)	Numbers for Crisis Response/Step up beds (35.8%)
North	31.6%	2,782	948	609	339
Central	30.2%	2,656	906	582	324
South	38.2%	3,355	1146	736	410
Total	**100%**	**8,793**	**3000**	**1927**	**1073**

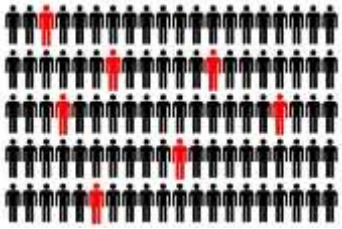
Appendix B

Case Management Process

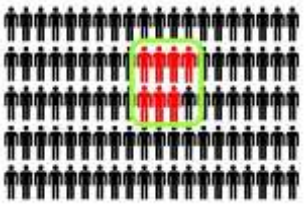
Reporting, predictive data modelling and risk stratification

Combined primary and secondary care patient data. A routine report is generated that draws out a cohort of patients deemed to be at risk of hospital admission in the following 12 months, or in possible need of case management as per the agreed reporting criteria. This includes new individuals each time the report is produced as well as patients who are already being case managed. Depending on the size of the GP practice and its population, this report and supporting Case Management team can work with one practice, or a number of smaller practices, or supporting a collective cluster.

Dispersed unknown healthcare needs



A predictive risk model identifies and groups a cohort of patients



Review and Triage

A routine meeting is established for the Case Manager, Community Matron, GP and/or practice nurse to review and discuss the predictive report. Using a combination of practice knowledge of the patient, with assessment against agreed eligibility criteria, a decision is made on whether to include in, or exclude from case management. Where a patient is excluded, a note can be added to the data system to advise of the next planned review. This prevents unnecessary repeat reviews of the same patient every month. Review and triage also takes place on an ongoing basis of direct referrals, in addition to the planned routine review of patients identified through the risk stratification and predictive reporting process.

Assigning to appropriate care setting

The GP and Case Management team agree the most appropriate care setting based on their respective level of need; whether that be mild, moderate or severe. The team also discusses potential admissions identified from the predictive risk report and any other cases identified by staff at the meeting.

In addition to predictive modelling and proactive earlier intervention, direct referrals into case management can also be made by GP's, A&E, other clinicians, and patient self-referral. In other UK versions of this system, the ratio of patients seen is usually around 80% through predictive modelling and risk stratification, and 20% direct referrals.

Agreeing the Care Plan

Patients are assigned a dedicated Case Manager, who acts as the one point of contact for the patient, as well as being the interface between the various providers; co-ordinating the package of wraparound health and social care.

Based on patient information and a health assessment, a Care Plan is collectively agreed between the Case Management team, GP and any other providers involved in the care of that individual. This same multi-disciplinary team would also set the baseline against which to monitor, agree suitable review dates, and conduct regular reviews. Where necessary, to go with the Care Plan with also be an Emergency Care Plan to be enacted in the case of crisis or sudden deterioration, and an End of Life Plan. It is anticipated that it will be an electronic shared Care Plan accessible to all involved in the care of that individual on a need to know basis. It shall also include alerts such as medication allergies and DNAR notes to ensure the provision of shared vital information and minimising risk and error.

Delivering the Care Plan

As the main point of contact, the Care Plan is co-ordinated by the Case Manager who acts as an interface between all of the providers and care teams, as well as ensuring ongoing regular reviews and updates to the GP and practice teams.

Ongoing monitoring

At the time of agreeing the Care Plan, based on the acuity and complexity of the individual, review requirements are agreed as an MDT. The Case Manager and community Matron and nursing teams are responsible for that ongoing review, monitoring and evaluation, reporting back into regular MDT meetings where decisions are made to either continue with the current Care Plan, adjust the Care Plan, transfer the patient to another setting or discharge from case management. This forms part of the constant cycle of case management, with existing patients being reviewed as some are discharged, and new cases are considered and triaged.

Discharge or continuing care

MDT reviews of each individual will determine the next steps, whether to continue with the existing Care Plan, make changes to it, transfer to a different more appropriate setting, or discharge. Discharge would be on the basis of marked improvement where it was felt that case management for the individual was no longer necessary. This would also be assessed against strict agreed discharge criteria.

The other discharge routes out of case management are patient choice where support is refused, or through death.

Appendix C

Shropshire Care Closer to Home
Decision Making Record

Date	Group	Decision or Action
Monday 4th December 2017	Commissioning Team	High level scoping complete
Wednesday 20th December 2017	Clinical Commissioning Committee (CCC)	Strategic intent of Programme formally noted
Friday 15th December 2017	Commissioning Team	Project Team and Programme Plan established
Friday 12th January 2018	Commissioning Team	Current and future state scoping complete (from GP and patient rep workshops)
Monday 15th January 2018	Commissioning Team	Programme governance established
Wednesday 17th January 2018	Clinical Commissioning Committee (CCC)	Approach and phasing of Programme approved
Monday 29th January 2018	Commissioning Team	Programme Risk Log Established
Wednesday 15th February 2018	Programme Management Team	Programme Working Group and ToR established
Wednesday 21st February 2018	Clinical Commissioning Committee (CCC)	Srategic intent and progress noted
Friday 9th March 2018	Programme Management Team	High level modelling complete
Thursday 22nd March 2018	Programme Management Team	Programme Board and ToR established
Wednesday 25th April 2018	Programme Board	Programme officially named 'Shropshire Care Closer to Home'
Friday 27th April 2018	Programme Management Team	High level scoping of other Case Management models complete
Wednesday 16th May 2018	Clinical Commissioning Committee (CCC)	Strategic intent of Phase 2 (Case Management) and its links with Frailty formally noted
Thursday 7th June 2018	Programme Board	Public-facing information leaflet, and provider staff briefing ratified for circulation
Friday 29th June 2018	Programme Management Team	Design outputs consolidated into Case Management model options
Monday 2nd July 2018	Programme Management Team	Agreement to utilise existing Aristotle system for risk stratification
Thursday 5th July 2018	Programme Working Group	Emerging model and various options agreed
Wednesday 18th July 2018	Programme Board	Agreed the Case Management core model and 9 areas of variability
Thursday 19th July 2018	Programme Working Group	Explored the 9 areas of variability and agreed the final preferred Case Management model
Wednesday 16th August 2018	Clinical Commissioning Committee (CCC)	Agreed the final Case Management model. Agreed strategic intent and approach to Phase 3.
Wednesday 4th October 2018	Programme Management Team	Invitations to Phase 3 design circulated, along with input template
Tuesday 16th October 2018	Programme Management Team	Phase 3 design sessions stood down due to poor uptake & response from stakeholders
Thursday 18th October 2018	Programme Board	Alternative Phase 3 design approach proposed - CCG in house design following by stakeholder critique

Appendix D

Shropshire Care Closer to Home
Involvement and Engagement Record

Date	Event	Aims/Purpose of Session
Thursday 7th December 2017	Patient Representative Workshop	Current and future state scoping complete
Thursday 7th December 2017	Shrewsbury/Central GP Locality Workshop	Current and future state scoping complete
Thursday 4th January 2018	South GP Locality Workshop	Current and future state scoping complete
Thursday 11th January 2018	North GP Locality Workshop	Current and future state scoping complete
Wednesday 28th February 2018	Patient & Provider Stakeholder Event	Overview of Programme, and exploring comms & engagement of local population
Wednesday 7th March 2018	GP Task & Finish Group	High level modelling of Care Closer to Home possibilities/needs
Wednesday 6th June 2018	What Matters to You event	Open dialogue with public and gathering feedback & suggestions
Wednesday 6th June 2018	What Matters to You event	Open dialogue with public and gathering feedback & suggestions
Thursday 7th June 2018	NA	Ratified public information leaflet circulated, public email to make contact and dedicated section of website launched
Wednesday 13th June 2018	South GP Locality Workshop	Developing possibilities for Phase 2 Case Management model
Thursday 14th June 2018	Shrewsbury/Central GP Locality Workshop	Developing possibilities for Phase 2 Case Management model
Wednesday 20th June 2018	North GP Locality Workshop	Developing possibilities for Phase 2 Case Management model
Tuesday 26th June 2018	North GP Locality PLT	Overview presentation and update on progress of programme & emerging Case Management model
Tuesday 10th July 2018	Shrewsbury/Central GP Locality Workshop	Overview presentation and update on progress of programme & emerging Case Management model
Wednesday 25th July 2018	Stakeholder Event (patient reps, GP's, providers, voluntary & care sector)	Progress update on Programme, and emerging Case Management model
Friday 14th September 2018	MP and Oswestry Health Group	Overview and update on Care Closer to Home Programme
Wednesday 19th September 2018	Voluntary & Care Sector Assembly	Overview and update on Care Closer to Home Programme
Wednesday 19th September 2018	Shropshire Patient Group	Overview and update on Care Closer to Home Programme
Thursday 20th September 2018	Shrewsbury/Central GP Locality Workshop	Overview and progress update on programme, and the Case Management model
Thursday 25th October 2018	North GP Locality Meeting	Update on journey of Phase 2 (Case Management) and use of their input.
Friday 26th October 2018	Shropshire Making It Real Board	Overview and progress update on Shropshire Care Closer to Home