Shropshire Care Closer to Home

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Shropshire CCG

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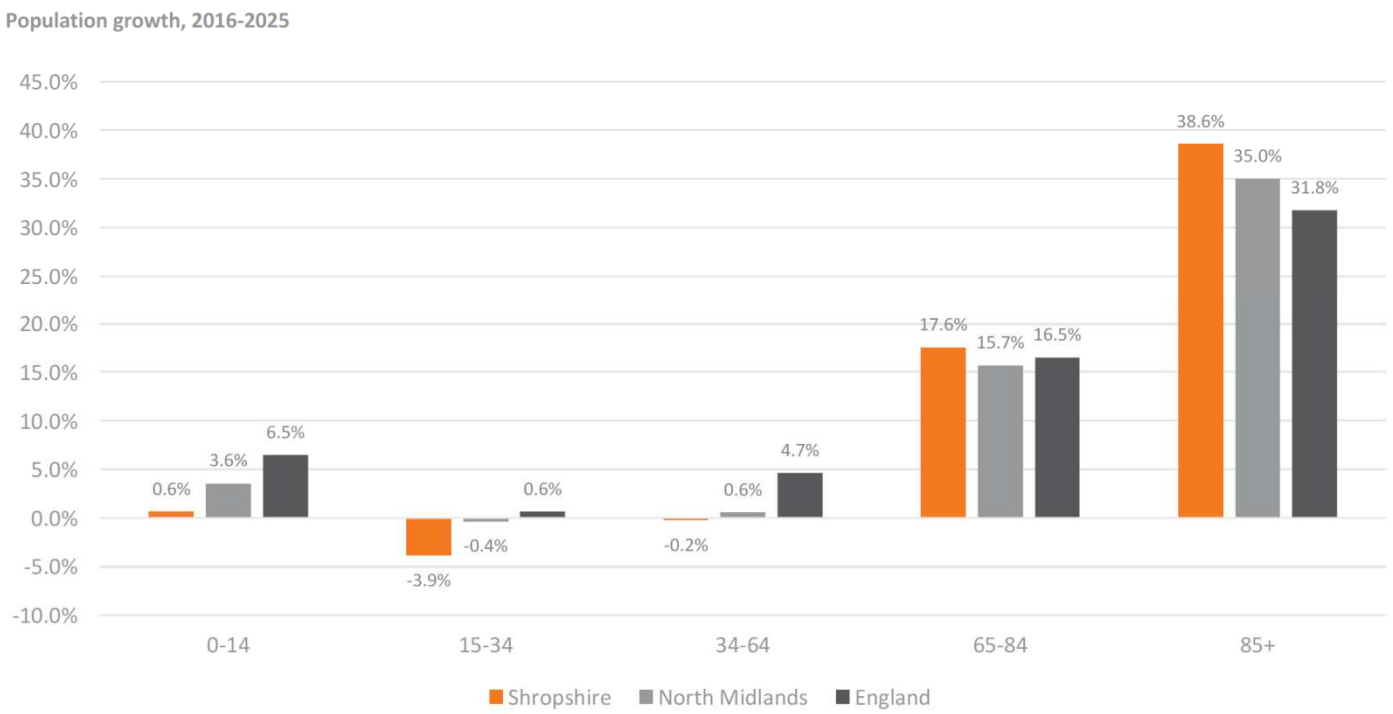
Shropshire's population

Source: ONS population estimates and projections

Shropshire Population

Estimated population change between 2016 and 2025



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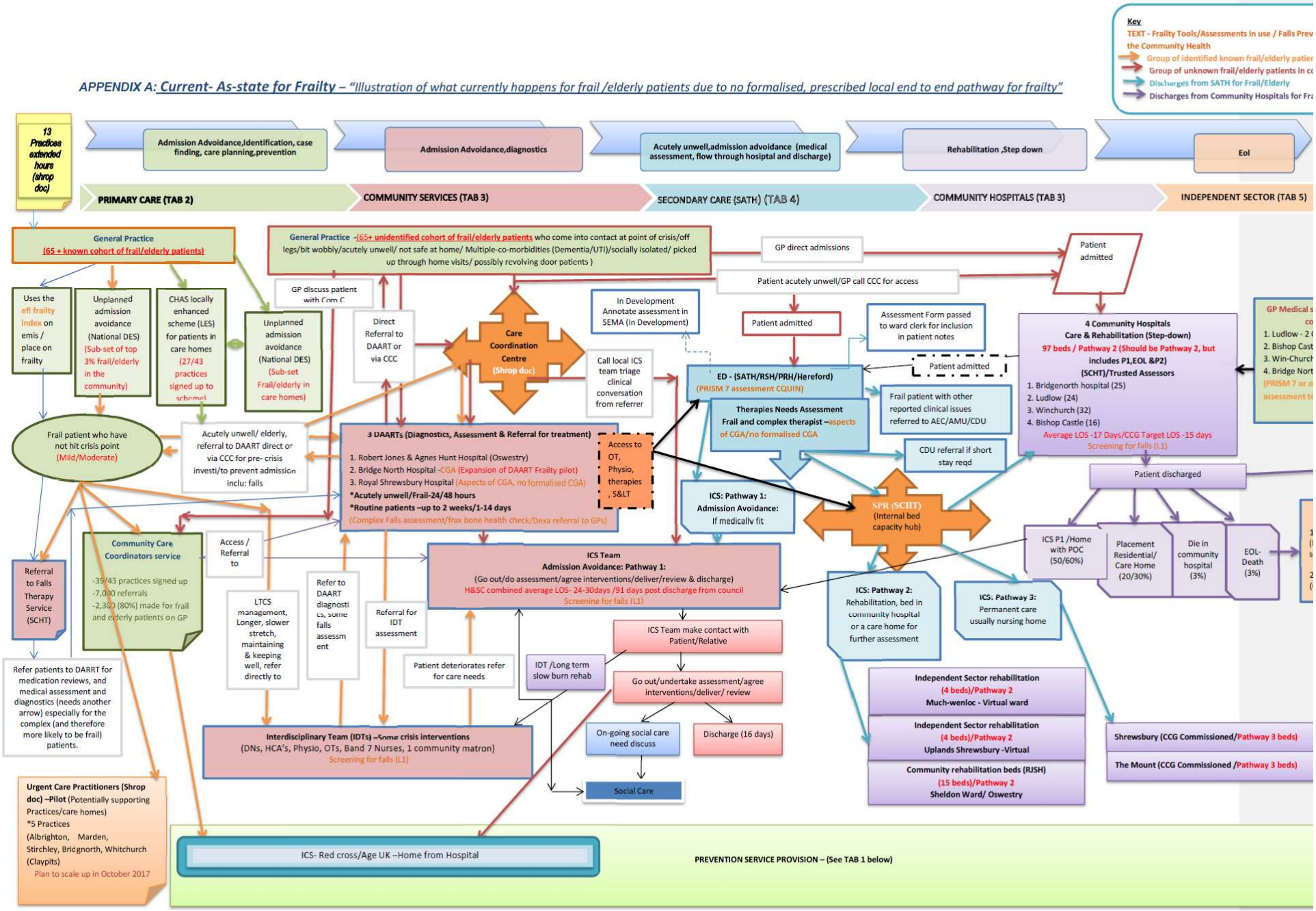
APPENDIX A: Current- As-state for Frailty – "Illustration of what currently happens for frail /elderly patients due to no formalised, prescribed local end to end pathway for frailty"

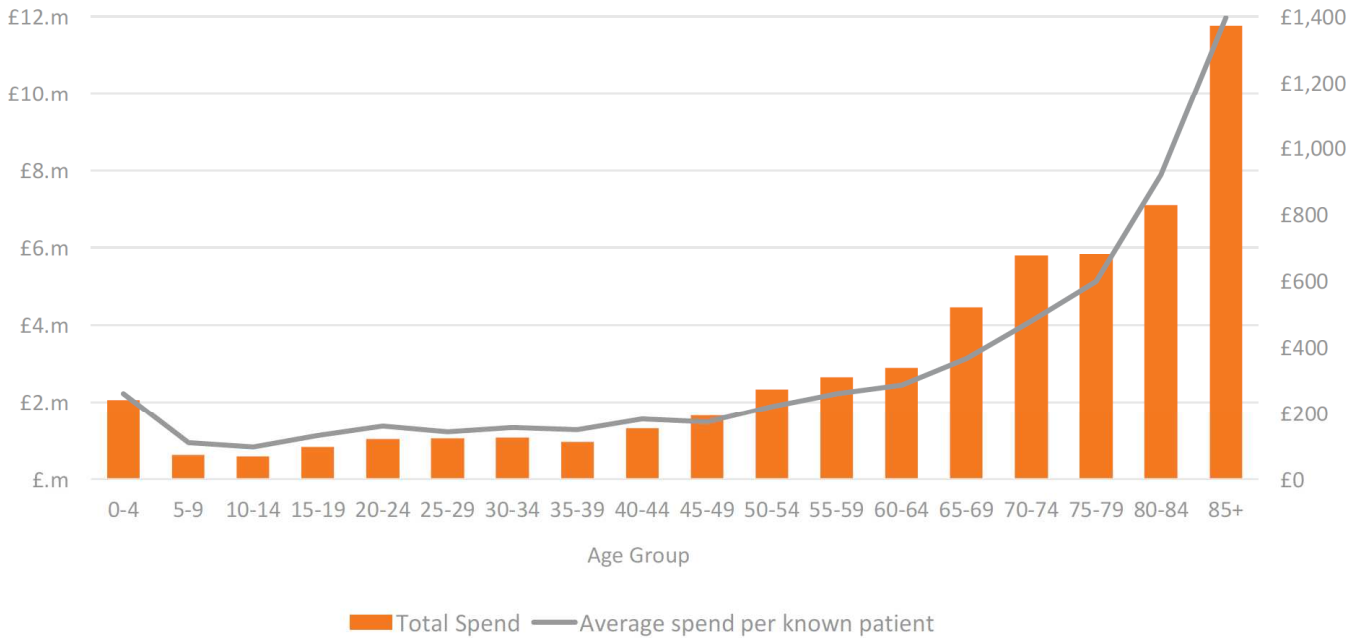


There's something about frailty[8]

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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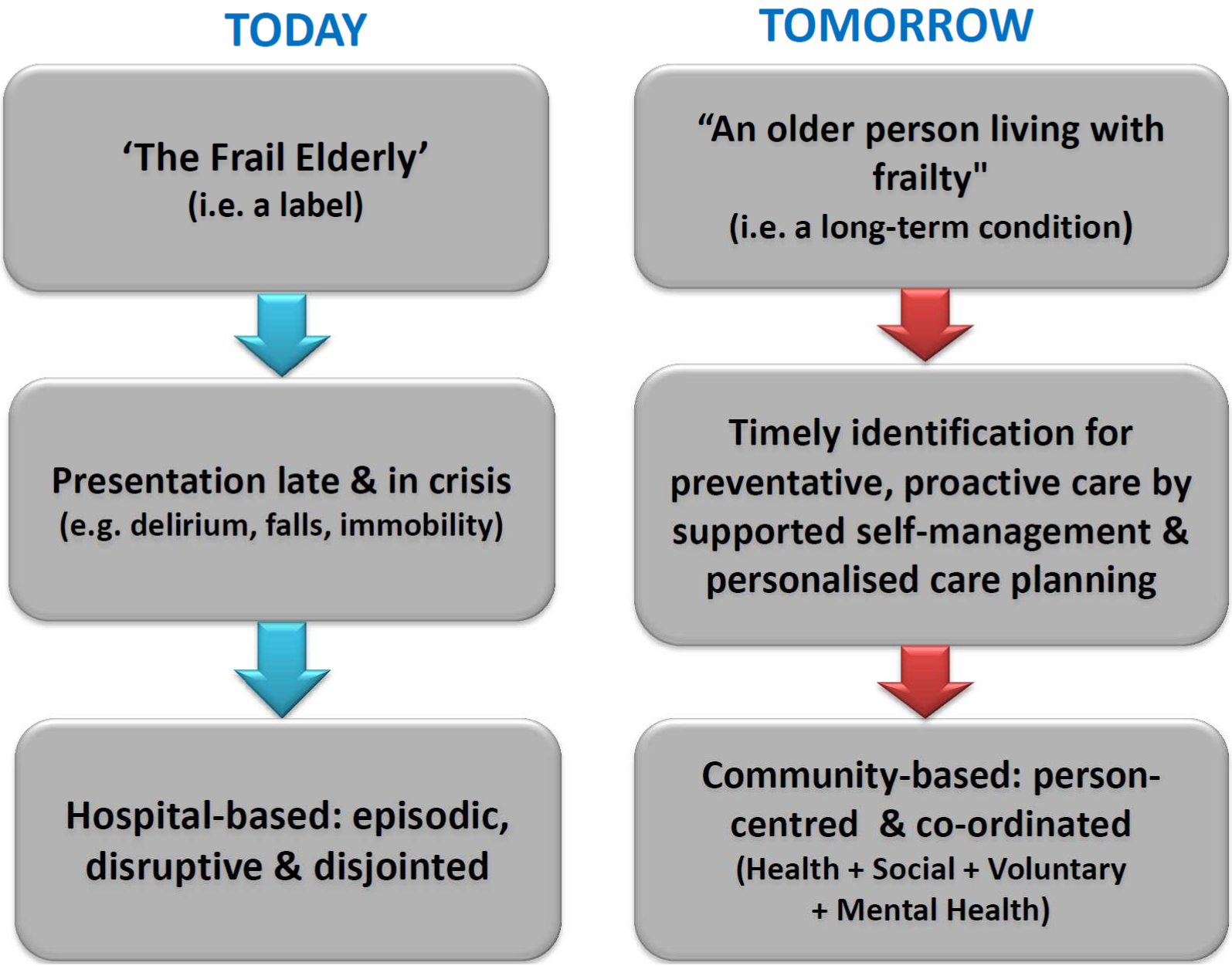
New Care Paradigm for Older People & Frailty



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

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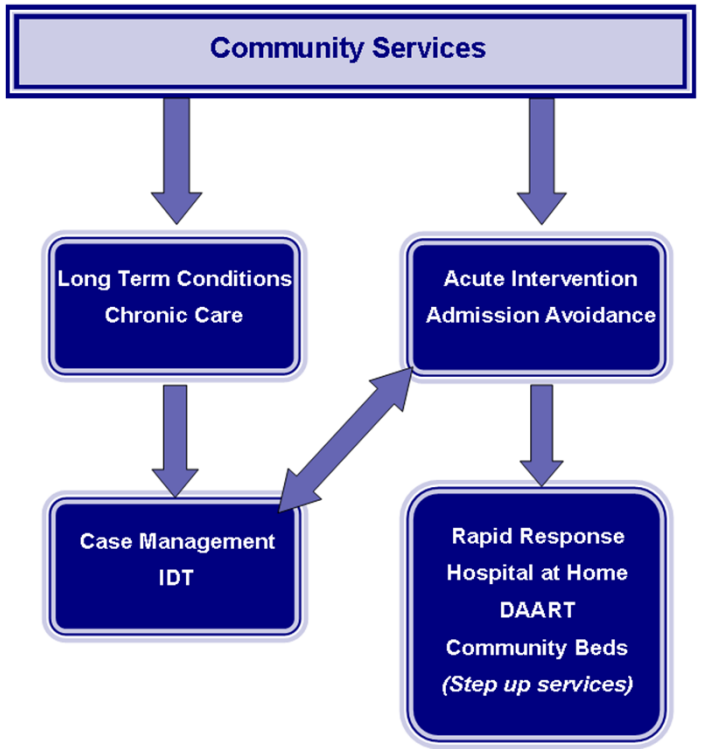
Pathways



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The programme is made up of 3 phases

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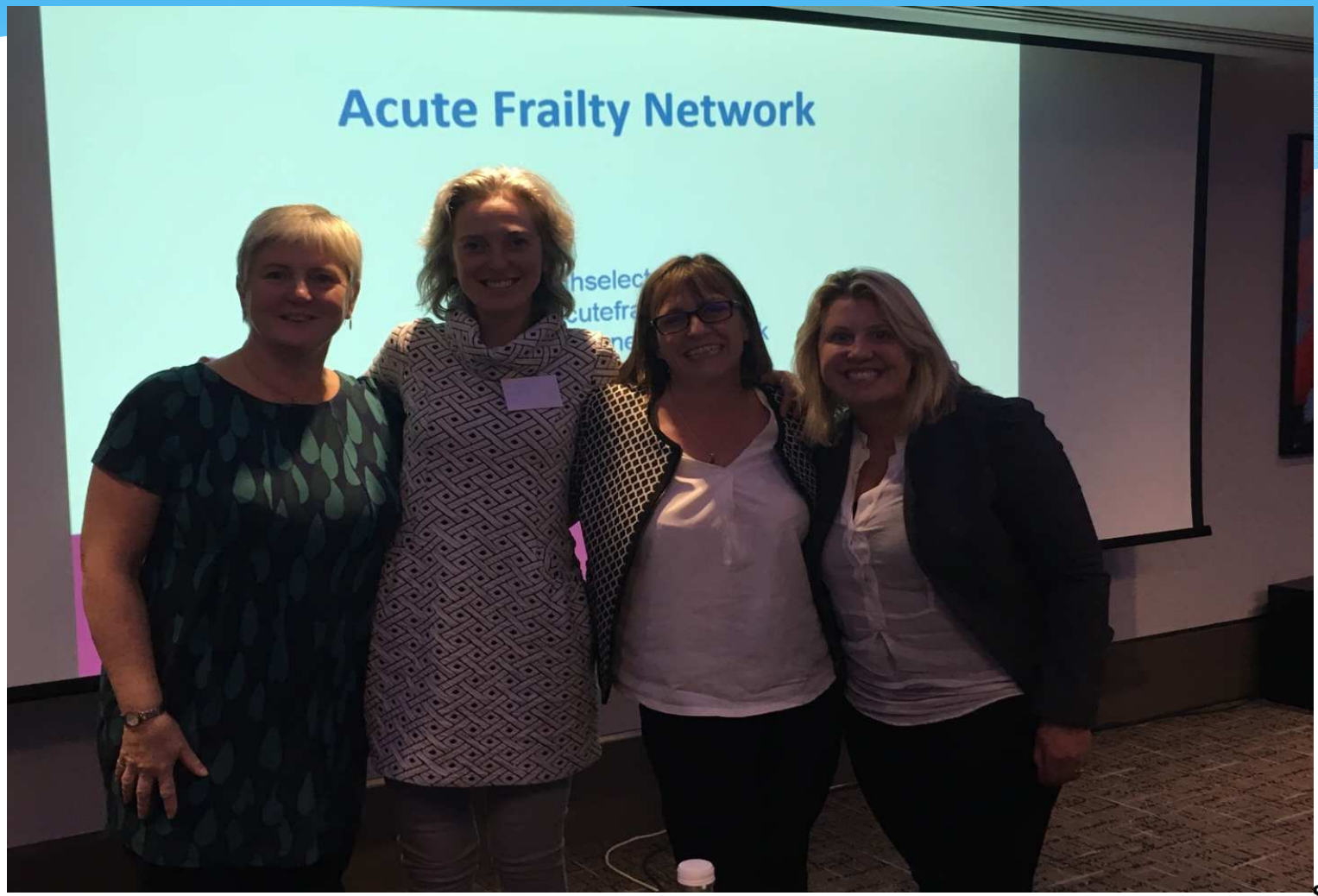
Phase 1: Frailty Intervention Team



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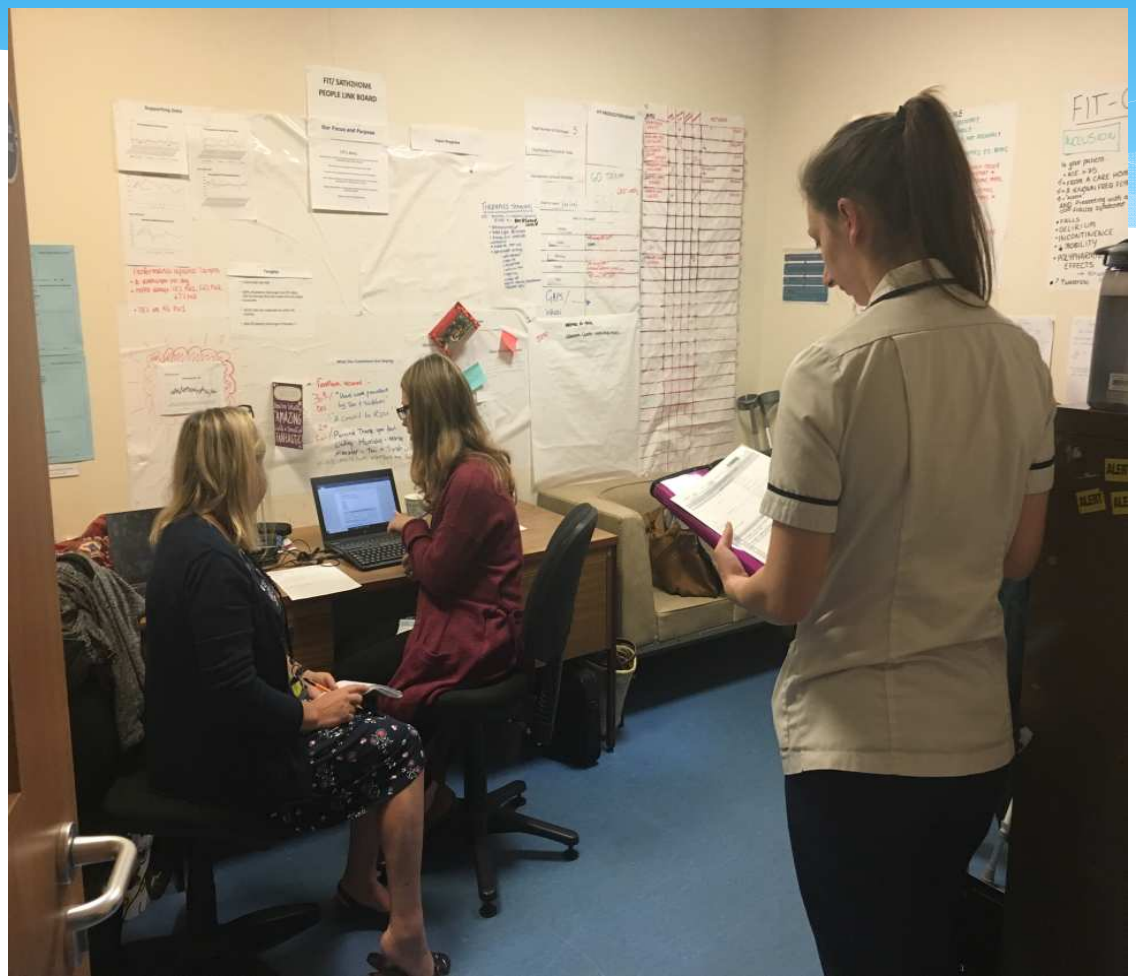
Dedicated team



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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

Who are you going to call?

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

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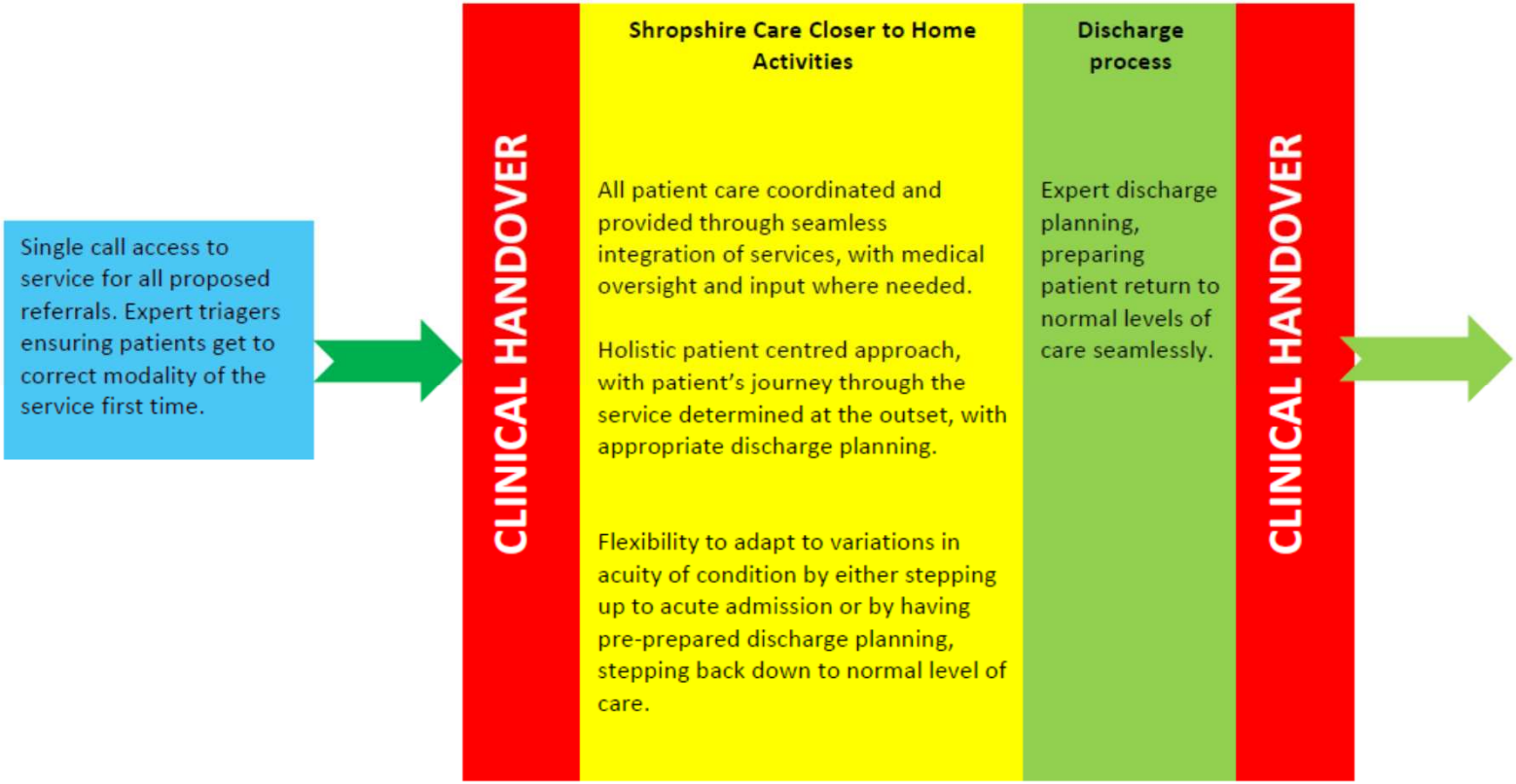
“One phone call; one referral”



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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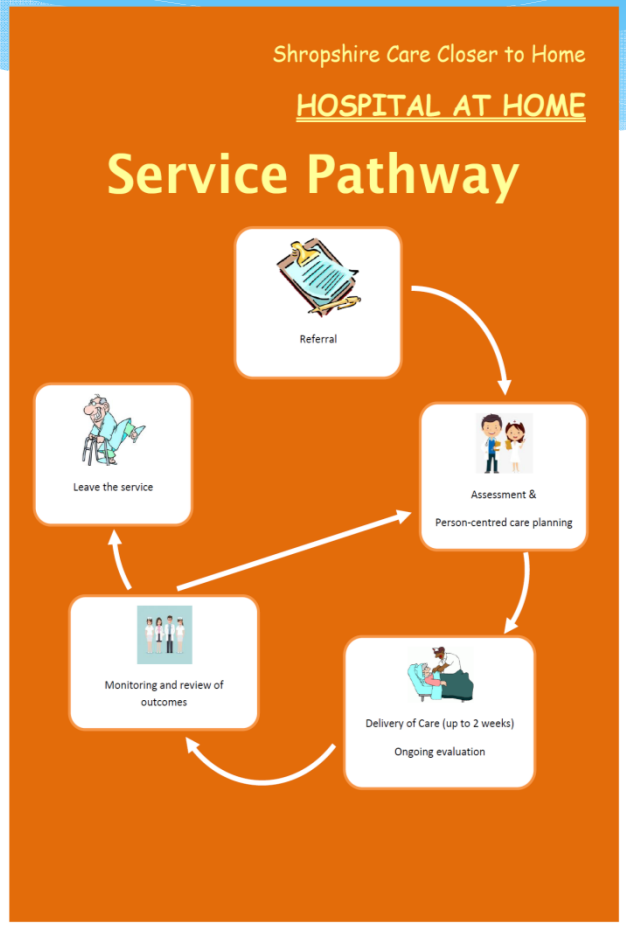
Crisis Team

* **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**

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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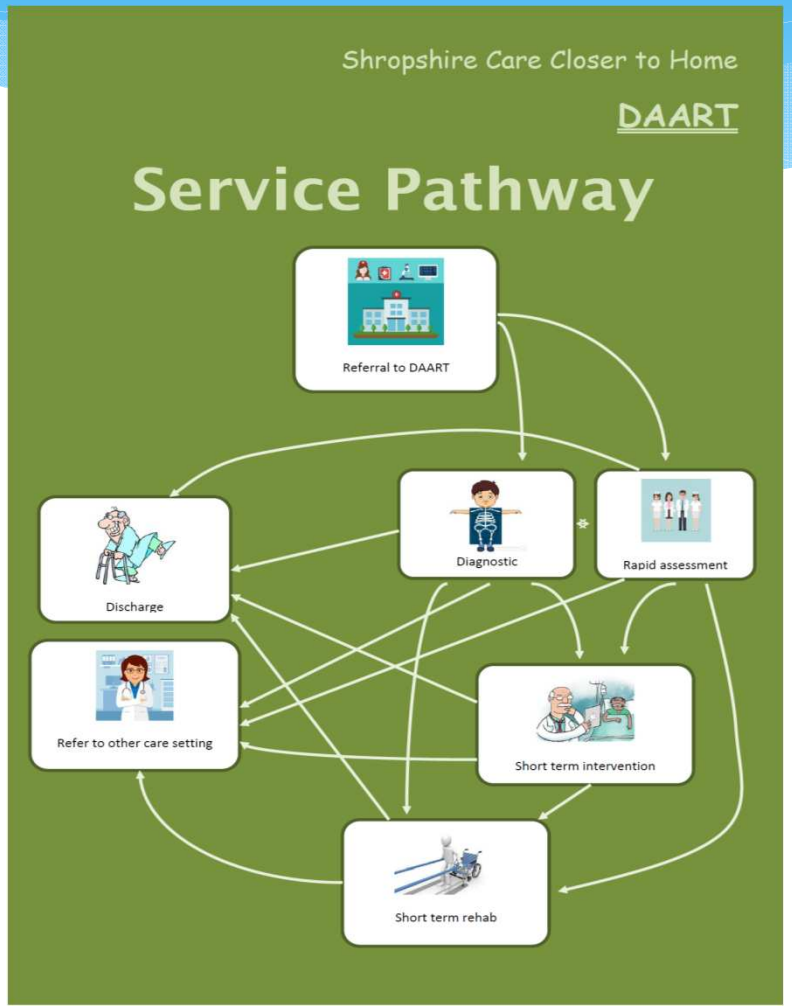
DAART

* 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

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