Health and Wellbeing Board
Meeting Date: 23rd May 2019

Item Title Shropshire Care Closer to Home – Update Report

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1. Summary

This paper provides an update on the Shropshire Care Closer to Home programme.

2. Recommendations

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

REPORT

Programme Phases & Progress Updates

Phase 1
Phase 1 is presently operational in the form of the Frailty Intervention team (FIT) who are based within the A&E Department of Royal Shrewsbury Hospital providing rapid frailty assessments and transferring to more appropriate care settings; with the aim of minimising unnecessary hospital admissions and ensuring the person is in the right place for their care and support. A phased launch has now commenced at the A&E Department of Princess Royal Hospital in Telford.
A short film on the work of the Shropshire Frailty Team commissioned by NHS England has also been finalised and launched.

Phase 2
The Phase 2 model of earlier identification of people's needs and proactive integrated health and social care delivered by a community based Case Management team was approved by the Governing Body in August 2018. A Pilot Implementation Group was established, made up of stakeholders spanning the whole health and social care system including CCG, Shropshire Council, GP's, SaTH NHS Trust, Midlands Partnership Foundation Trust, Shropshire Community Trust, patient and public representatives, and the voluntary & care sector; with the remit of collectively planning and implementing pilot demonstrator sites that will test the model prior to robust evaluation and wider rollout across the county. The service specifications, model, demonstrator site criteria and required outcomes were all agreed, and the providers are now taking this forward by co-ordinating the developing and shaping of the more detailed operational functionality of the pilots including locations, workforce, governance and ways of working.

The commitment is that the pilot demonstrator sites will be functional from June 2019 and will run for 9 months, including at the latter stages a 3 month robust evaluation against control sites and required outcomes.

The 8 locations for the pilot demonstrator sites of this service are:

- 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

Work is still underway to develop the required IT and data elements including flow of data between providers, data sharing agreements, GDPR requirements, risk stratification or case finding using merged data, and shared electronic Care Plan meaning everyone involved in the care of that person has all of the required information and that the person has to only ever tell their story once. This will also be added to with an emergency care plan, end of life plan, and links to vital information such as allergies and DNAR notes.
While this enormous piece of work continues, automated risk stratification and data sharing agreements will be in place for the 8 named GP practices for the pilots to commence on 1st June 2019. A manual workaround process is currently being developed and agreed for the shared Care Plan as that technical development will not be in place by June.
All of this IT and data work us also fully aligned with the agenda of the STP Digital Enabling Group.

Phase 3
The design process for Phase 3, which is acute and semi-acute services but still in the community, commenced with extensive scoping and research of other similar national and international models at the end of 2018. The first draft concepts of these new models of care were then shared with stakeholders across the whole health and social care system for critique, comment and feedback.

The draft models were then also shared with the Programme Working Group, Programme Board, GP's and primary care colleagues, and a large-scale patient/public and provider stakeholder event. This ensured ongoing collaborative do-design of the new models and services by enabling us to gather as much feedback and input as possible.

The programme team then spent April consolidating all of the comments and feedback harnessed from all workshops and meetings, before undertaking thematic analysis of the core themes. This condensed feedback is now being considered and reviewed by the Programme Board in order to make any final adjustments to the model designs as part of refining and finessing them, and ensuring they are fit for purpose and sustainable.

If endorsed by the Programme Board in May 2019, the proposed models will then be taken to an extraordinary Shropshire Clinical Commissioning Committee on 11th June 2019 for consideration and approval. If agreed, planning will then commence for the implementation of pilot demonstrator sites following the same process as Phase 2.

The modelling and design has included the development of not only high level model and pathway descriptions, but also detailed robust service specifications that sets out the criteria for using the service or being discharged from it, location, conditions treated, governance, quality and safety, outcomes, and workforce.

The Phase 3 models can be summarised as follows:

Hospital at Home A model for an episode of specialist care delivered for a limited time period in person's home, or at the person's care/residential home, as an alternative to being treated in an acute hospital setting.	**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.
Rapid Response A model that provides a Rapid Response Team of professionals who respond to a person with early signs of deterioration, or heading towards a crisis, and provide a rapid intervention and assessment that stabilises, before triaging to the appropriate setting and then departing.	**Crisis** A service that provides an emergency responsive team of professionals who respond to a person with unmanageable signs of deterioration, or who has tipped into a crisis, and provide assessment, stabilisation, similar to the Rapid Response team but also provide short term high level intensive treatment and monitoring for up to 72 hours before referring to a more appropriate care setting; whether that is stepping down if the person's condition has improved or escalating as a hospital admission of the person deteriorates.

The fifth element of Phase 3 (Step Up beds) will be revisited now that local population disease profiling and prediction information has been received and once the full written report is received.

It will be the implementation and embedding of Phase 3, along with Phase 2, that will see the full benefits realisation of Shropshire Care Closer to Home in vastly improved patient experience, whole system functionality and flow, transformed community services, enabling Future Fit, and reduction of non-elective admissions into secondary care; reflecting the recommendations also set out in the National 5 Year Forward View and the NHS 10 Year Plan.

It is worth noting that whilst these are described as individual services, they will function collectively as one cohesive model of care where the individual moves seamlessly from one service to another without handoffs, co-ordinated by the Case Manager who provides the sole consistent point of contact for the patient and their family. A high level service map of the overarching Shropshire Care Closer to Home models demonstrating these interdependencies is enclosed for information as ***Appendix A*** and ***Appendix B***.

Enablers

A dedicated Care Closer to Home Communications and Engagement Group was established to support delivery across the whole system of the communications and engagement strategy required to support the programme.

A dedicated IT Lead has now been identified within Shropshire CCG who has established a dedicated Care Closer to Home IT Group, with the remit of driving through development and delivery of the necessary IT and data work; essential for the running of the Care Closer to Home services. This includes two-way flow of data between providers, data sharing agreements, GDPR

requirements, risk stratification or case finding using merged data, and shared electronic Care Plans. This is aligned with the work underway in the background of the STP Digital Group on achieving the same agenda of work but on a broader whole system scale.

A software tool purchased by Shropshire Council is now in place which provides a wealth of information into the local population disease prevalence, profiling and predictions. Work is underway to convert this information into a written Joint Strategic Needs Analysis (JSNA) which will enable work to start on developing the fifth strand of Phase 3, Step Up Community Beds.

Once these phases are fully embedded and functional, there is a Phase 4 that will see an expansion to include all ages, and not just those aged 65 and over. The reason for starting with 65 plus and frailty is this group being the predominant proportion of population in the Shropshire demographic.

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

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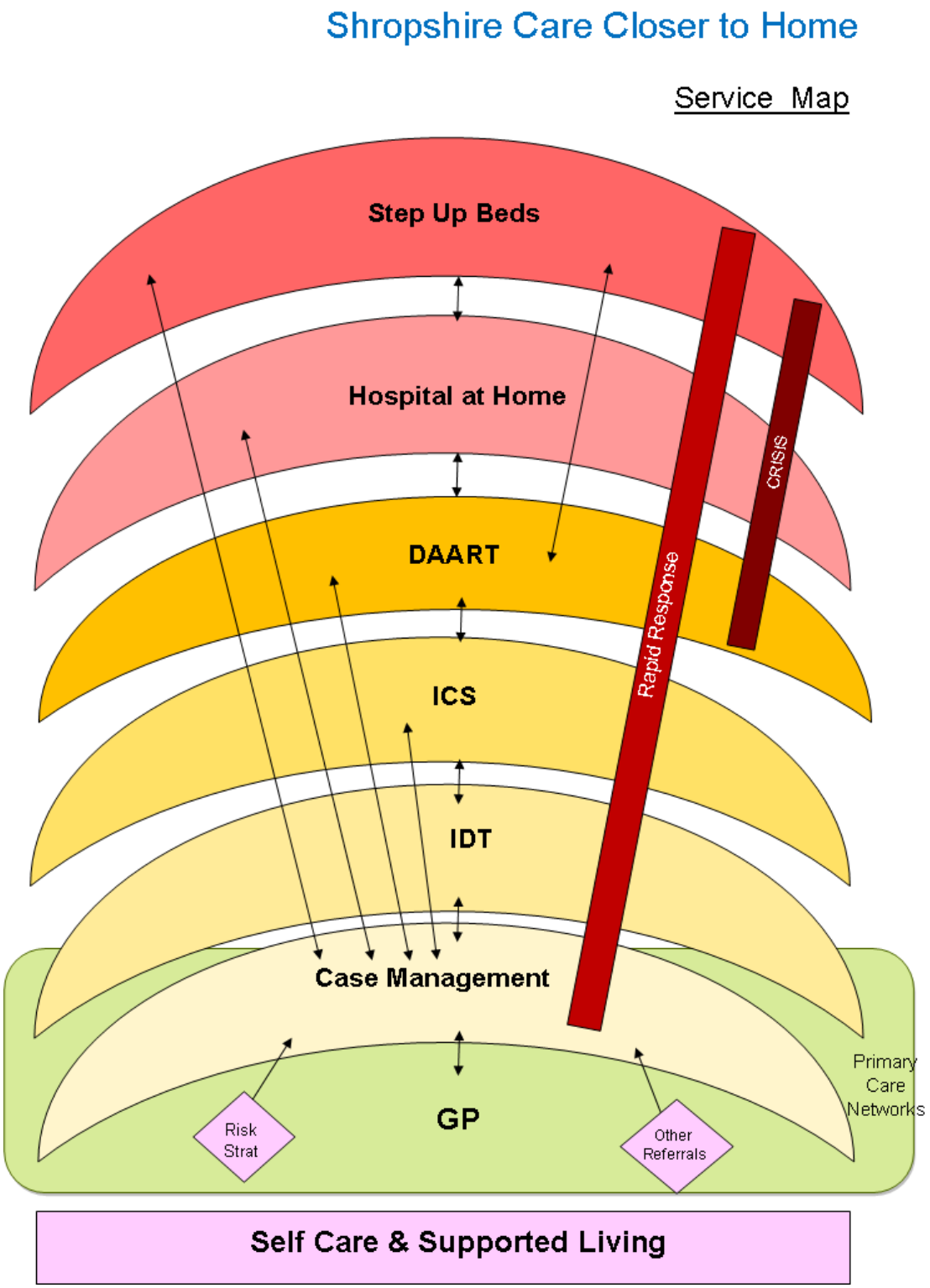
Appendix A

High Level Services Map



Appendix B

Shropshire Care Closer to Home

Pathways