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Report to Joint HOSC 26th March 2014

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Senior Responsible Officers

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Programme Scope

- To agree the best model of care for excellent and sustainable acute and community hospital services that meet the needs of the urban and rural communities in Shropshire, Telford and Wrekin, and Mid Wales.

- Whole-system model of care

- Key interdependencies:
  - Re-design of primary care service
  - Re-design of community health services
  - Plans for sustaining A&E services in the short to medium term

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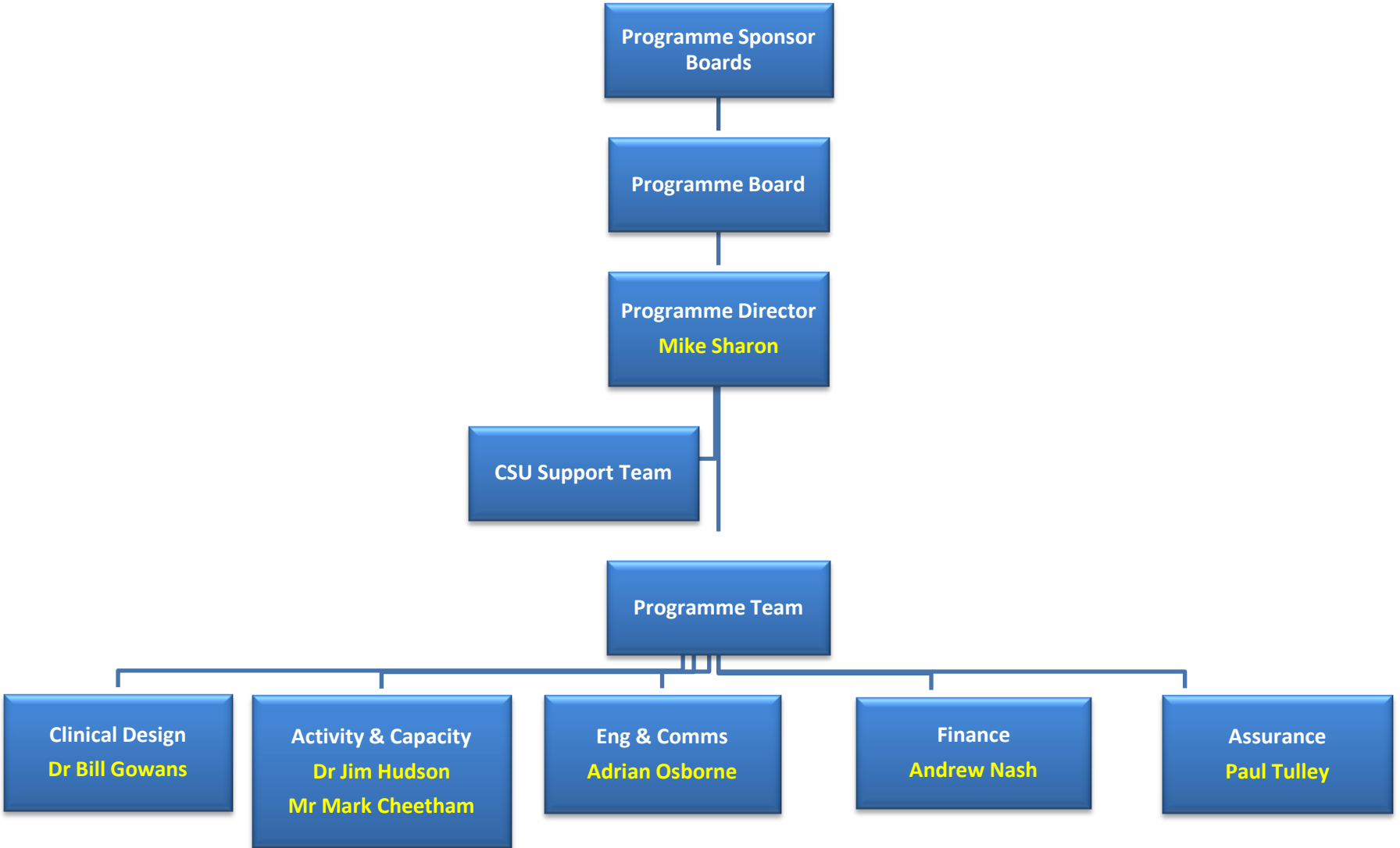
Programme Structure



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Programme Update

- Phase 1 completed
  - Programme Execution Plan approved Jan ’14 including Case for Change & Principles for Joint Working
  - Acute and community hospital activity projections developed
  - Extensive work undertaken on emerging clinical model
  - Initial engagement activities held
  - Recurring affordability envelope & capital investment capacity assessed
  - Assurance Plan developed (with HOSC input)
  - Risk Register & Benefits Realisation Plan drafted
  - Gateway Zero Review completed

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Programme Update – Gateway Zero

- Rated ‘Amber’
- High calibre of personnel recognised
- 9 recommendations:

1. Determine whether the current scope of the Programme remains appropriate
2. Review the proposed approach for the development of options
3. Clarify the business case requirement as part of the next phase
4. Take action to improve the engagement with GPs from Telford and the Wrekin
5. Allocate additional resource to Communications and Engagement
6. Institute a formal review of risks and issues in accordance with best practice
7. Seek their CCGs’ commitment to an approach that will facilitate a shared and binding decision being taken on the future configuration of services
8. Adopt a revised structure for the strategic management of the Programme consisting of a small Programme Board and a separate Stakeholder Group
9. Agree the priorities for the new Programme Director

- Action Plan being develop by Programme Team

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Programme Update

- Phase 2 underway
  - Board to make decisions by consensus
  - CCGs exploring joint decision making processes
  - Further development of models of care through
    - Clinical Reference Group
    - Clinical Design sub groups with patient representatives
    - Patient focus groups
  - Activity and capacity projections for new model to be developed
  - Engagement and Communication approach to be co-created with patient representatives, and additional resource agreed
  - Whole health economy financial model to be developed
  - Evaluation criteria and process to be agreed
  - Timeline under review

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Programme Update

- Phase 3 - Identification and Appraisal of Options
- Phase 4 - Public Consultation & Outline Business Case
- Phase 5 - Full Business Case(s)
- Phase 6 - Implementation
- Phase 7 - Evaluation

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Programme Update

The Committee is invited formally to endorse:

- **Case for Change**
- **Principles for Joint Working**

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Emerging Clinical Model of Care

- Builds on ‘Call to Action’
- Co-created by clinicians & patients
- Core principles agreed
- Informed by evidence base
- High level models drafted for 3 main areas of healthcare deliver:
  - Acute and Episodic Care
  - Long Term Conditions / Frailty
  - Planned Care
- External Clinical Assurance through Senate

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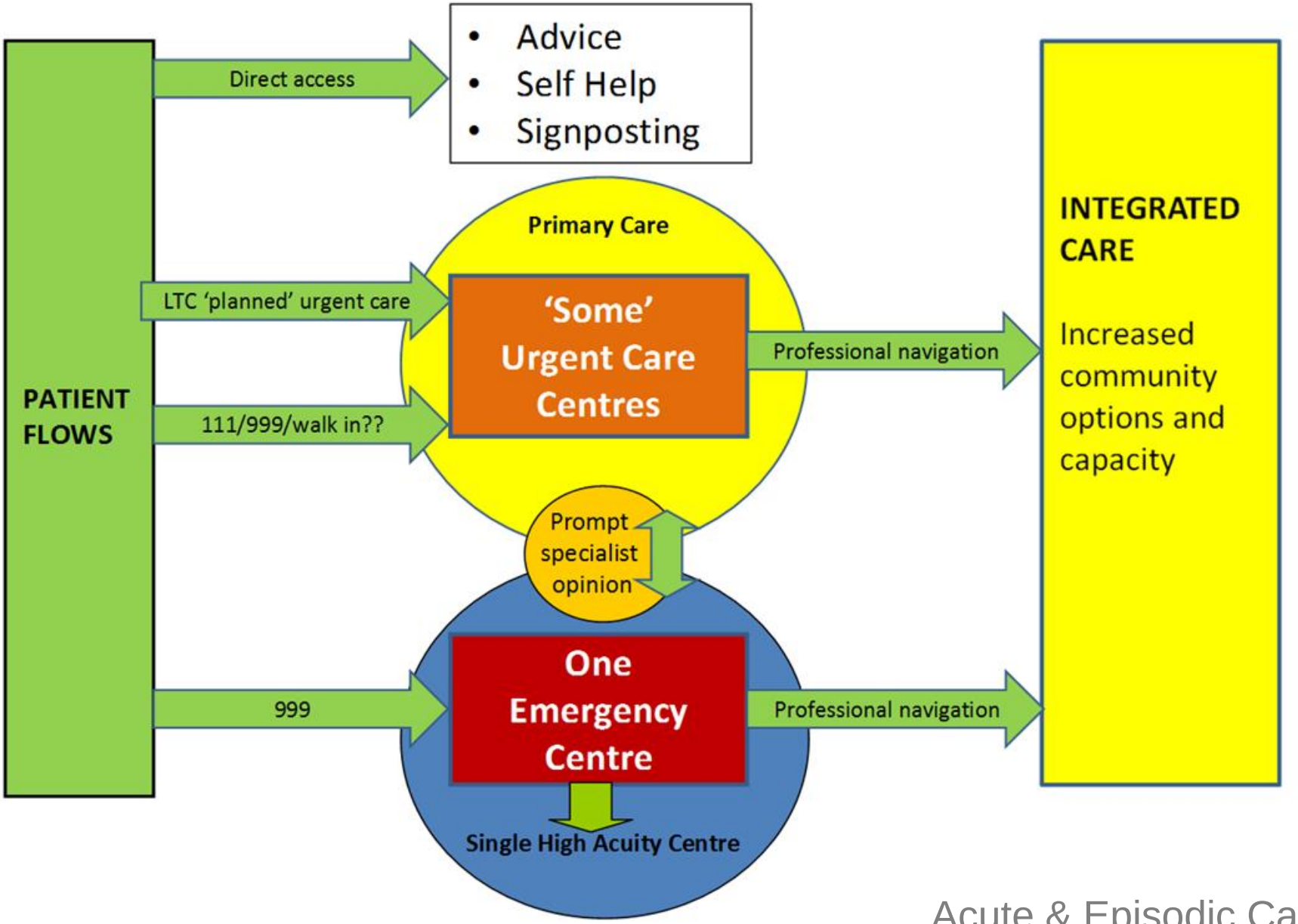
Emerging Clinical Model of Care

PRINCIPLES

- Build for the future through radical change
- Patients and Clinicians working together (professionalism)
- Linking up to serve patients' needs (integrating systems)
- Working for patients (operational issues)
    - enhance the role and involvement of primary care
    - deliver re-ablement in the community
    - consistently deliver right care in the right place by the right staff
      keep people at home and out of hospital
    - streamline diagnostics and planned care
    - commit to sustainable 7 day working with (8am-8pm)
- Securing sustainable change for the future


PATIENT FLOWS
Direct access
Advice
Self Help
Signposting
Primary Care
LTC 'planned' urgent care
'Some' Urgent Care Centres
111/999/walk in??
Professional navigation
INTEGRATED CARE
Increased community options and capacity
Prompt specialist opinion
999
One Emergency Centre
Professional navigation
Single High Acuity Centre

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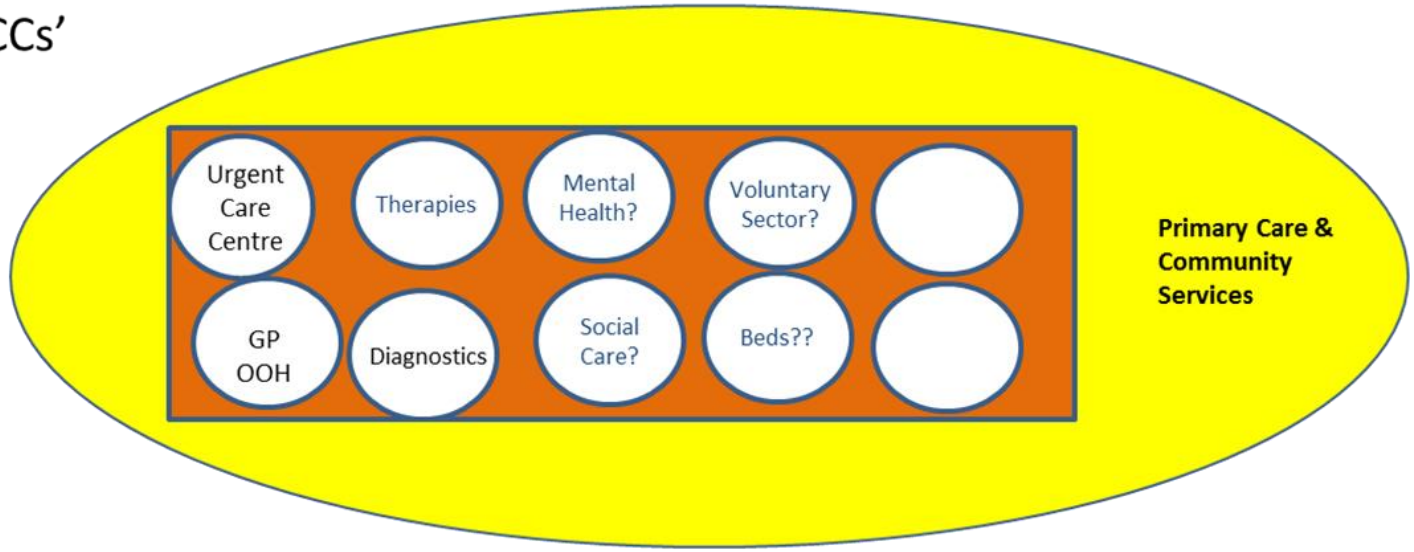
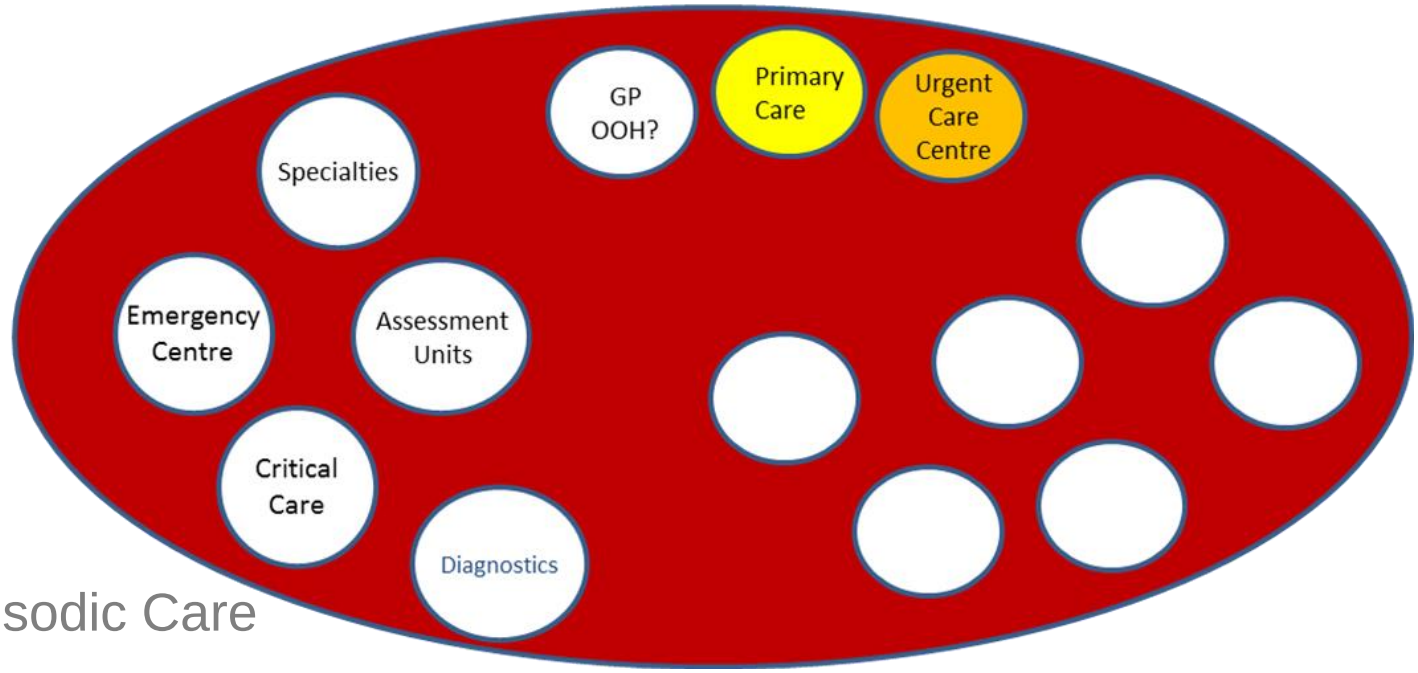
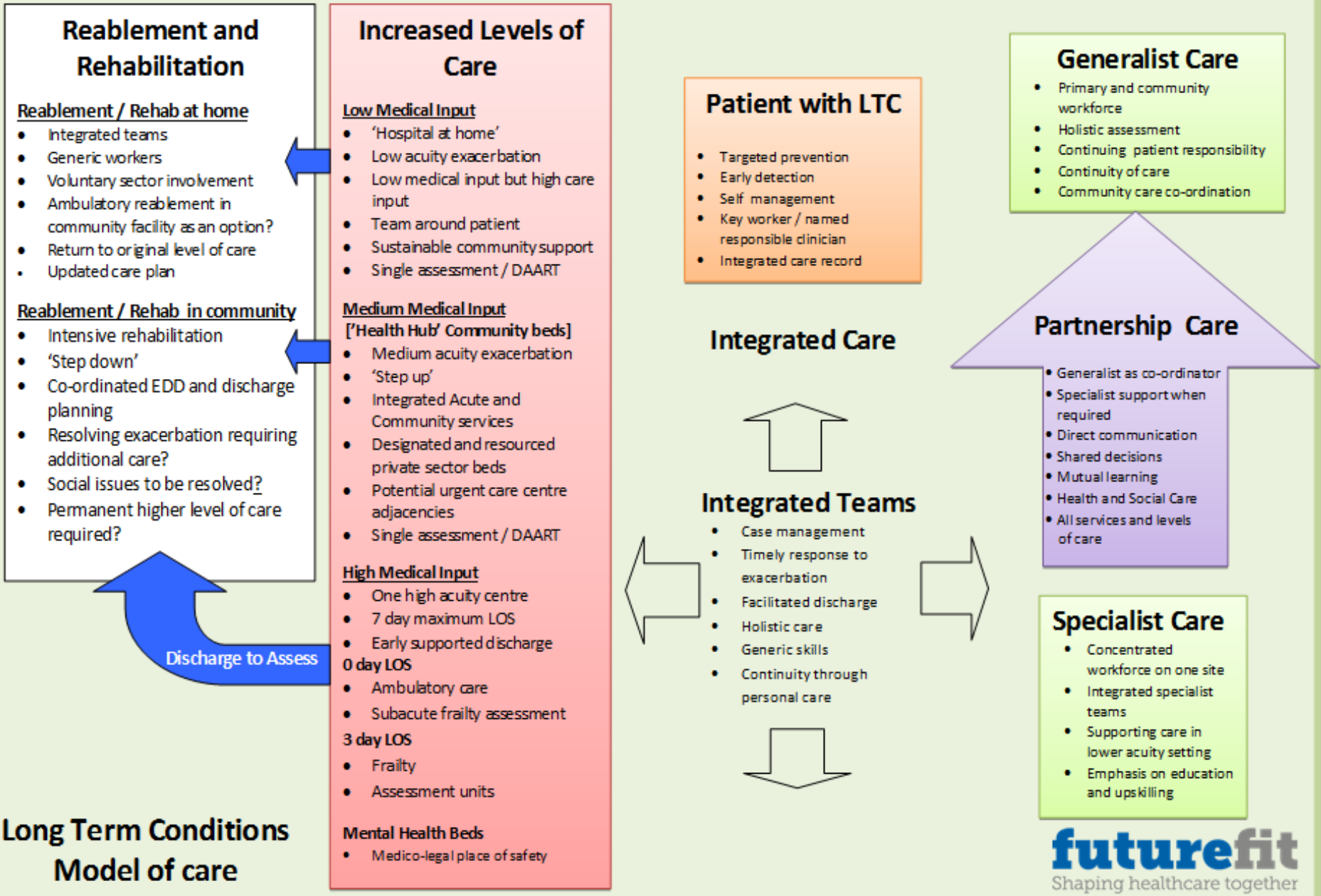
‘Some UCCs’



‘One EC’



Acute & Episodic Care


Reablement and Rehabilitation
Reablement / Rehab at home
Integrated teams
Generic workers
Voluntary sector involvement
Ambulatory reablement in community facility as an option?
Return to original level of care
Updated care plan
Reablement / Rehab in community
Intensive rehabilitation
'Step down'
Co-ordinated EDD and discharge planning
Resolving exacerbation requiring additional care?
Social issues to be resolved?
Permanent higher level of care required?
Discharge to Assess
Increased Levels of Care
Low Medical Input
'Hospital at home'
Low acuity exacerbation
Low medical input but high care input
Team around patient
Sustainable community support
Single assessment / DAART
Medium Medical Input
['Health Hub' Community beds]
Medium acuity exacerbation
'Step up'
Integrated Acute and Community services
Designated and resourced private sector beds
Potential urgent care centre adjacencies
Single assessment / DAART
High Medical Input
One high acuity centre
7 day maximum LOS
Early supported discharge
0 day LOS
Ambulatory care
Subacute frailty assessment
3 day LOS
Frailty
Assessment units
Mental Health Beds
Medico-legal place of safety
Patient with LTC
Targeted prevention
Early detection
Self management
Key worker / named responsible clinician
Integrated care record
Integrated Care
Integrated Teams
Case management
Timely response to exacerbation
Facilitated discharge
Holistic care
Generic skills
Continuity through personal care
Generalist Care
Primary and community workforce
Holistic assessment
Continuing patient responsibility
Continuity of care
Community care co-ordination
Partnership Care
Generalist as co-ordinator
Specialist support when required
Direct communication
Shared decisions
Mutual learning
Health and Social Care
All services and levels of care
Specialist Care
Concentrated workforce on one site
Integrated specialist teams
Supporting care in lower acuity setting
Emphasis on education and upskilling
Long Term Conditions Model of care
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- Patient
- Peer worker
- Specialist Nurse
- Therapist
- GP
- IT

System Navigators

PATIENTS

- Education
- Information
- Prevention

Facilitated self management:

- IT/Map of Medicine
- Expert Patients
- Voluntary groups

INFORMED DIRECT ACCESS

Diagnosis known (simple)

Diagnosis unknown (complex)

PRIMARY CARE

Skill mix
Unit size

Self Help
- Guided self care

Low Professional Input
- Multiple centres for day case/minors
- Basic diagnostics (Xray/USS)
- Access to therapies

Medium Professional Input
- One or two local centres for intermediates/ day case (may or may not be co-located with high input centre)
- Diagnostics (USS/CT/MRI/Nuclear etc.)

High Professional Input
- One centre for majors (co-located with but separate from emergency centre)
  - HDU
  - Diagnostics (USS/CT/MRI/Nuclear etc.)
- Referrals out of area for cardiac, neuro, etc.

Communication

Information/Education

Reablement	Increased Levels of Care for LTC	Levels of Care Planned care	Acute and Episodic Care
Reablement at home • Integrated teams • Generic workers • Voluntary sector involvement • Ambulatory reablement in community facility as an option? • Return to original level of care • Updated care plan	**Low Medical Input** • 'Hospital at home' • Low acuity exacerbation • Low medical input but high care input • Team around patient • Sustainable community support	**Low Professional Input** •Multiple centres for day case/minors •Basic diagnostics (Xray/USS) •Access to therapies	
Reablement in community • Intensive rehabilitation • 'Step down' • Co-ordinated EDD and discharge planning • Resolving exacerbation requiring additional care? • Social issues to be resolved? • Permanent higher level of care required?	**Medium Medical Input** **['Health Hub' Community beds]** • Medium acuity exacerbation • 'Step up' • Integrated Acute and Community services • Designated and resourced private sector beds • Potential urgent care centre adjacencies	**Medium Professional Input** •One or two local centres for intermediates/ day case (may or may not be co-located with high input centre) •Diagnostics (USS/CT/MRI/Nuclear etc.)	**'Some' Urgent Care Centres**
	High Medical Input • One high acuity centre • 7 day maximum LOS • Early supported discharge **0 day LOS** • Ambulatory care • Subacute frailty assessment **3 day LOS** • Frailty • Assessment units **Mental Health Beds** • Medico-legal place of safety	**High Professional Input** •One centre for majors (co-located with but separate from emergency centre) • HDU • Diagnostics (USS/CT/MRI/Nuclear etc.) •Referrals out of area for cardiac, neuro, etc.	**One Emergency Centre**

Whole System Synergies

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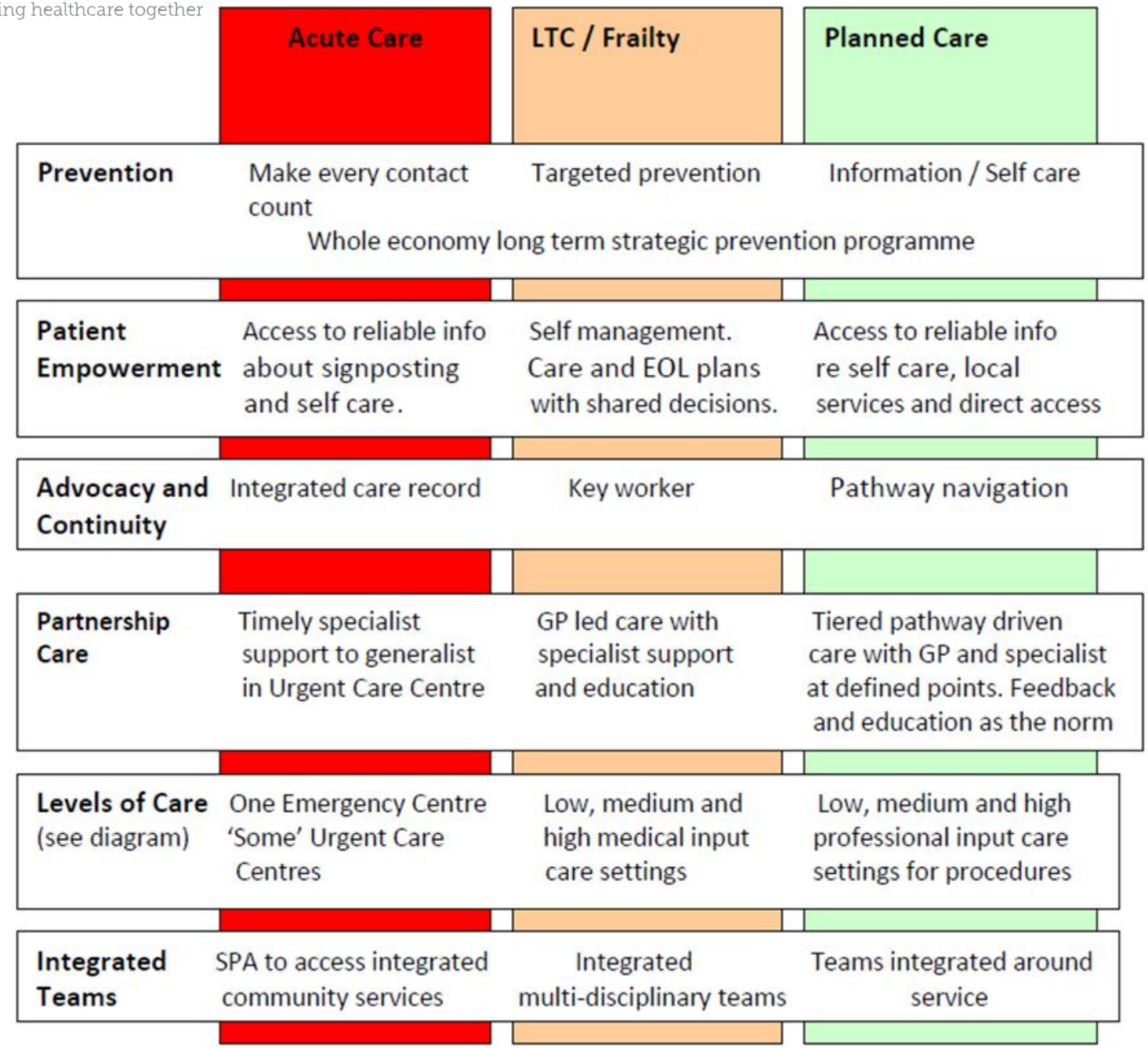

Whole System Synergies

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Emerging Clinical Model of Care

NEXT STEPS

- Testing of models through
  - sub groups with increased patient involvement
  - Clinical Reference Group
  - Patient Focus Groups
  - Engagement with West Midlands Clinical Senate
- Exploration of cross- cutting themes (e.g. mental health, social care, women & children)
- Alignment with evidence base, JSNAs and Health & Wellbeing Board Strategies
- Activity modelling

Benefits Realisation Plan

- Initial comprehensive draft developed
- Further drafts to be
  - Informed by patient & public views
  - Focused on measurable benefits expected directly as a result of the model
- Key areas of benefit are:

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Benefits Realisation Plan

- Highest quality of clinical services with acknowledged excellence;
- A service pattern that will attract the best staff and be sustainable clinically and economically for the foreseeable future;
- A coherent service pattern that delivers the right care in the right place at the right time, first time, coordinated across all care provision;
- A service which supports care closer to home and minimises the need to go to hospital;
- A service that meets the distinct needs of both our rural and urban populations across Shropshire, Telford & Wrekin and in Wales , and which anticipates changing needs over time;
- A service pattern which ensures a positive experience of care; and
- A service pattern which is developed in full dialogue with patients, public and staff and which feels owned locally.

The committee is invited to consider how programme success against these benefits might be measured.

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Evaluation Criteria & Process

- Board to agree process & criteria prior to identification of options
- Committed to transparent & objective decision making
- Desire to maximise benefit for the whole population
- Consequences of options to be considered for:
  - specific local populations
  - minority and deprived groups
- Rationale & weighting for this will be explicit
- Process & criteria to be brought to HOSC for endorsement

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Alignment with other Strategic Plans

- CCG 5 year strategic plans
- Better Care Fund
- Re-design of primary care service
- Re-design of community health services
- Plans for sustaining A&E services in the short to medium term

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Proposed Future Reports to HOSC

The committee is invited to consider receiving further reports on the following matters:

• Evaluation Criteria & Process
• Clinical Model of Care
• Benefits Realisation Plan
• Selection of short list of Options
• Selection of Preferred Option
• Consultation Document
• Outline Business Case [Confirming Preferred Option]

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